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2012

Annual Reports and Resolutions

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Table of Contents

Councils and Commissions	9	Access, Prevention and Interprofessional Relations, Council on
	21	ADA Sessions, Council on
	24	Communications, Council on
	30	Dental Accreditation, Commission on
	38	Dental Benefit Programs, Council on
	66	Dental Education and Licensure, Council on
	135	Dental Practice, Council on
	150	Ethics, Bylaws and Judicial Affairs, Council on
	156	Government Affairs, Council on
	162	Members Insurance and Retirement Programs, Council on
	166	Membership, Council on
	176	National Dental Examinations, Joint Commission on
	184	Scientific Affairs, Council on
 ADA Business Enterprises, Inc.	 203	 ADA Business Enterprises, Inc.
 ADA Foundation	 209	 ADA Foundation
 Appendix	 215	 Index of Resolutions
 Map of Trustee Districts		 Inside Back Cover

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Councils and Commissions

Notes

Council on Access, Prevention and Interprofessional Relations

Holwager, David R., 2012, Indiana, chair
Hebl, Monica, 2013, Wisconsin, vice chair
Allen, Nolan W., 2012, Florida
Chase, Timothy D., 2014, Arkansas
Ciebien, Gerald J., 2012, Illinois
Enos, Jennifer, 2012, Arizona, *ex officio**
Fisher, John P., 2015, Massachusetts
Gill, Eleanor A., 2012, Mississippi
Gillette, Jane, 2015, Montana
Hanck, John J., 2013, Colorado
Heddens, Heather B., 2013, Iowa
Logan, Bernadette A., 2015, Pennsylvania
Napier, Rocky L., 2014, South Carolina
Pankratz, Todd A., 2012, Nebraska, American Medical Association
Roberts, Matthew B., 2014, Texas
Schirmer, David C., 2015, New York
Scott, Brian E., 2013, California
Thompson, William R., 2014, Tennessee
Whitman, Sidney A., 2012, New Jersey

Lampiris, Lewis N., director
Geiermann, Steven P., senior manager
Strock, Sheila A., senior manager
McGinley, Jane S., manager
Podschun, Gary D., manager
Smith, Barbara J., manager
Stoufflet, Nicole M., manager
Sweis, Luciana, project manager

Mission and Purpose

The Council on Access, Prevention and Interprofessional Relations (CAPIR) is the primary agency dedicated to providing leadership, vision and coordination of ADA's activities to advance oral health care within the health delivery system, promote prevention as the cornerstone of oral health and improve access to oral health services to underserved populations. The Council facilitates collaboration and promotes dialogue between the ADA and a broad array of communities which serve, support or impact the health care environment and delivery of oral health care. It assists members to position themselves as community leaders on oral health. The Council has assumed major responsibility in assuring that programs, policies and strategies are established to address the preventive and therapeutic oral health needs of sizable segments of the population that do not see a dentist on an annual basis.

In April 2012, the Council transitioned from the Division of Dental Practice and Professional Affairs to the Division of Government and Public Affairs. Its volunteer leaders, staff and consultants have expertise in epidemiology/population health, health policy, environmental health and health education/health promotion. This expertise will add value to the work of the Council on Government Affairs, the Department of State Government Affairs and the State Public Affairs program.

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

Supporting the Strategic Plan: Activities, Results and Accomplishments

Table 1. Major Accomplishments

- 73.9% of all Americans now have access to fluoridated water
- 17 communities in seven states voted to initiate community water fluoridation
- 35 communities in 35 states voted to retain community water fluoridation
- 66 water systems in 28 states were recognized for 50 years of fluoridation
- 1,600 programs participated in the annual Give Kids a Smile (GKAS) program
- Over 40,000 dental team members participated in GKAS events, including nearly 10,000 dentists
- Collaboration with Health Resources and Services Administration (HRSA) resulted in the development of a perinatal consensus statement with the American Congress of Obstetricians and Gynecologists (ACOG). It is anticipated that the statement will be disseminated to 35 organizations and potentially impact the vast majority of childbearing American women.
- In collaboration with the American Academy of Pediatrics (AAP), an oral health risk assessment tool has been developed and made available to 60,000 pediatric physicians.
- Through the National Interprofessional Initiative on Oral Health (NIOH), over 88,000 primary care providers have downloaded the Smiles for Life Curriculum.
- The Incurred Medical Expense (IME) reimbursement strategy for dentists treating patients in long-term care facilities has been widely disseminated.
- Dentist leaders have been appointed within both the HRSA and the Centers for Medicaid and Medicare Services (CMS).
- In collaboration with the Centers for Disease Control and Prevention (CDC) National Diabetes Education Program, 50 stakeholder organizations are working together to reduce the burden of diabetes through increased awareness and knowledge.
- Corporate and philanthropic support for the Community Dental Health Coordinator (CDHC) pilot program, to date, is valued at approximately \$435,000.
- ADA leadership and commitment to community water fluoridation, oral health literacy, children's oral health, improving the oral health of vulnerable elders, fixing the broken Medicaid system, and the common goal of improving the oral health and overall health of the public, was demonstrated through invitations received by Council volunteers and staff to present at multiple venues as articulated below.

The Council's volunteer leaders and staff have participated in symposia, served on advisory committees, provided training and technical assistance, and engaged in dialogue with a broad array of communities over the past year—including, but not limited to those identified in Appendix 1. This has afforded the ADA, through the Council, the opportunity to influence policy, foster informed decision making, and correct misperceptions about ADA policies and positions with government officials, public health agencies, foundations, medical providers and other individuals and organizations who impact the health care environment and the delivery of oral health services.

The Council utilizes the expertise of the following advisory committees to inform and make recommendations for its consideration: National Fluoridation Advisory Committee, National Advisory Committee on Health Literacy in Dentistry, National Elder Care Advisory Committee, Public Health Advisory Committee, Medicaid Provider Advisory Committee and Give Kids A Smile National Advisory Committee (Appendix 2).

The following is a summary of agency-specific activities, results and accomplishments in support of the *Strategic Plan*. Many of the activities articulated below require longer term and continuous investment to achieve desired results.

- Educated members and other stakeholders through presentations at various meetings—including, but not limited to, the Special Care Dentistry Association, National Oral Health Conference, American Geriatrics Association, and American Public Health Association—about the [Incurred Medical Expenses](#) (IME) process to assist dentists being reimbursed for dental care provided to nursing home residents on Medicaid.
- Obtained Centers for Medicaid and Medicaid Services (CMS) assistance in promotion of IME to state Medicaid agencies to facilitate dentist's use of this reimbursement mechanism for dental care provided to nursing home residents on Medicaid.
- In conjunction with the Council on Government Affairs, facilitated communication between the leadership of the National Association of Community Health Centers (NACHC) and the ADA. This resulted in the wide dissemination of a joint letter supporting health centers contracting with private dentists to increase health center oral health capacity and provide reimbursement opportunities for private practitioners.
- Facilitated CMS' online posting of the portion of the [Overcoming Obstacles to Oral Health](#) training program focused on screening the mouth and the Minimum Data Set (oral evaluation section) required on all nursing home residents on admission (and periodically thereafter).
- Presentations were given at the annual meeting of the National Network for Oral Health Access (NNOHA), which represents federally qualified health centers, and the Indian Health Service annual Area Dental Chiefs meeting, highlighting the benefits of Community Dental Health Coordinators in improving access to care. At the NNOHA meeting the Council presentations were well received in stark contrast to other presenters who were advocating for midlevel providers who could perform irreversible/surgical procedures.
- Created practice and training volunteer opportunities for dentists and dental students through Indian Health Service (IHS) and tribal dental clinics.
- Initiated the planning process to convene a three-day national prevention summit in November 2013 that will provide an opportunity for stakeholders to develop a comprehensive integrated strategy for the prevention of oral disease.
- The Institute of Medicine (IOM) Committee on Preventive Services for Women reached out to the Council to identify gaps in the current U.S. Preventive Services Task Force guidelines specific to the prevention of oral disease in women. A presentation to the IOM committee resulted in the recently published IOM Report, "Clinical Preventive Services for Women: Closing the Gaps," which references the importance of including dental benefits for preventive oral health services for women.
- With the counsel of the National Fluoridation Advisory Committee (NFAC), technical assistance and support for fluoridation issues was provided to 24 state dental societies as well as numerous individual dentist members.
- As a result of Council participation at the annual meeting of the Hispanic Dental Association (HDA), HDA was encouraged to develop a policy on community water fluoridation. Some recent activities by anti-fluoridationists targeted the Hispanic community. The HDA released a policy in support of such in the spring of 2012.
- In collaboration, the Health Resources and Services Administration (HRSA) and the American Congress of Obstetricians and Gynecologists (ACOG) participated in the development of a consensus statement on the importance of perinatal oral health, which will be disseminated among a wide interdisciplinary group of providers, including oral health professionals.
- The tenth annual Give Kids A Smile (GKAS) Day took place February 3, 2012. In 2012, over 40,000 dental team members participated in GKAS events. That total includes nearly 10,000 dentists and over 30,000 other volunteers: hygienists, dental assistants, office managers, spouses, school health nurses, dental students, etc. Some 1,600 programs signed up to participate in GKAS. Registered participants estimated that they would treat approximately 400,000 children in 2012.
- Convened research and other experts to address early childhood caries in American Indians.
- Created a Dental Public Health (DPH) orientation module for ADA volunteer leaders which was also widely disseminated through the ADA website and the DPH listserve to state and local dental societies, academia, state and local oral health programs, and the Department of Defense dental programs.

- Coordinated continuing education courses on dental public health topics for practicing dentists at the ADA annual session and the American Public Health Association annual meeting.
- *Xerostomia and Salivary Hypofunction in Vulnerable Elders: Prevalence and Etiology* is the first of the Council's manuscript project gap analysis articles to be published. It was accepted for publication in the Journal on Oral Surgery, Oral Medicine, Oral Pathology, and Oral Radiology.
- Provided technical assistance and guidance related to health literacy and communication to internal agencies.
- The ADA and the Council continued to influence the Institute of Medicine regarding the Association's commitment to health literacy through the implementation of the Council's Health Literacy in Dentistry Action Plan. This emphasizes the key role that member dentists and their teams can play in communicating messages to the public to be stewards of their oral health.
- In December 2010, the Board of Trustees approved the ADA's formal partnership with the U.S. National Oral Health Alliance, which is a demonstrable outcome of the ADA-convened 2009 Access to Dental Care Summit.
- The Council was the lead agency supporting the 2012 conference of the National Roundtable for Dental Collaboration. Priorities for research were determined to be the medical-dental connection, patient outcomes research, health disparities and measuring the impact of the Ad Council campaign on health outcomes.
- The Council was invited to send a representative to participate in the Strategic Advisory Group of the Centers for Disease Control and Prevention (CDC's) National Diabetes Education Program (NDEP).
- Council staff and volunteers continue to collaborate with the National Interprofessional Initiative on Oral Health to further the education of primary care providers on the prevention of oral disease.
- Through the Council, the ADA applied for membership to the Accreditation Association for Ambulatory Health Care (AAAHC). The AAAHC has an existing accreditation program for dental services that has accredited many oral surgery practices, large group general dentistry practices and some solo practitioner dental offices.
- The ADA appointed its new commissioner to The Joint Commission (TJC), Dr. David Perrott. The Council provides support to the commissioner and monitors emerging topics of interest to the dental profession—especially for those members who practice in institutional settings. The ADA commissioner assures that the dentistry voice is heard when TJC develops new standards or revises standards focused on patient safety and quality of care in the healthcare environment.
- The Council received external support for its 2012 Symposium on Caries in the Primary Dentition of American Indian and Alaska Native Children from Oral Health America through a grant from the DentaQuest Foundation and from the Delta Dental Plans Association.
- The Council received grant funding from the ADA Foundation in 2011 to support the CDHC pilot program.
- The Council in conjunction with Department of Salable Materials and Wiley-Blackwell Publishers completed the manuscript review for the textbook, *The ADA Practical Guide to Patients With Medical Conditions*. It is anticipated that the book will be released in July 2012. It is designed to assist in the safe delivery of coordinated oral health care for patients with medical conditions.
- Five manuscripts were developed in conjunction with the ADA-hosted National Coalition Consensus Conference, Oral Health of Vulnerable Older Adults and Persons With Disabilities, and will be published as a regular issue of the journal of the Special Care in Dentistry Association (SCDA) without cost to ADA.
- Volunteer leaders, Council members and ADA staff actively participated at this year's National Oral Health Conference (NOHC) joining 800 dentists, dental hygienists and other health professionals to discuss dental public health issues. Participation afforded the ADA the opportunity to demonstrate its leadership and commitment to community water fluoridation, oral health literacy, children's oral health, improving the oral health of vulnerable elders, fixing the broken Medicaid system, and the common goal of improving the oral health and overall health of the public. The NOHC provided the ADA with a communications platform that reinforced the ADA reputation as the nation's oral health advocacy leader.

Emerging Issues and Trends

Oral diseases, along with chronic and systemic diseases, share common risk factors, which necessitates close collaboration between dentists and other primary care providers. The U.S. population is increasingly older and more diverse. Key determinants of health such as biology, behavior, the environment and health systems require a great integration between the disciplines of dentistry, medicine and public health. Programs and advocacy strategies must be developed within the context of political, economic, and cultural forces that collectively influence prevention, health management and both the individual's and community's ability to take the actions necessary to improve or maintain oral health throughout the lifespan.

The relationship between socio-economic status, age, racial/ethnic identity, cultural beliefs, physical and mental ability, geography, access to optimally fluoridated water and other population-based preventive strategies impacts oral health status. Furthermore, establishing programs to assist individuals to navigate the delivery systems through which preventive and therapeutic services are delivered (private dental offices, safety net clinics, schools, physicians' offices, nursing homes, senior center, etc.) must be considered for the ADA to develop, implement and maintain robust advocacy strategies to improve the nation's oral health.

As more Americans find themselves outside of the oral health care delivery system, it is necessary for the ADA to develop advocacy strategies targeting this growing segment of the population. This will enhance the Association's reputation and demonstrate to policymakers, regulators and, perhaps most importantly, the public, that the ADA is indeed the oral health authority committed to both the public and the profession.

Considering the impact of the Affordable Care Act (ACA) and the potential impact of having over five million additional underserved children eligible for healthcare, there are many questions that must be answered: Where will these children go to receive care? How will adequate capacity be built into state exchanges? How are third parties preparing for such? How will they engage dentists to sign up for their networks? What strategies does CMS currently have in place to address this increase in demand? How will access to care be defined? These questions can only be answered with the input of multiple ADA agencies and external stakeholders. Contingent on the outcome of the Supreme Court's decision on the legality of ACA, the ADA must be prepared to take a leadership role in addressing this issue.

Access to Oral Health Care

The U.S. National Oral Health Alliance (USNOHA) held its first three leadership colloquia over the past year addressing medical/dental collaboration, prevention and public health infrastructure, and oral health literacy. The ADA and organized dentistry continue to play a visible role in fostering collaboration and finding common ground through support of the Alliance. Additional information will be provided in a supplemental report to the 2012 House of Delegates.

Having met with HRSA on four occasions, with the most recent being in March 2012, the ADA continues to advocate for greater collaboration with the federal government regarding perinatal oral health, health literacy, integration of oral health into overall health, the oral health needs of the elderly, and increasing familiarity between private practice dentists and health centers. In several meetings with Howard Koh, the U.S. Assistant Secretary for Health, the ADA has expressed concern about the lack of visible coordination of oral health activities across the federal agencies. The ADA has also expressed concern about consistent federal oral health leadership that is supported internally and also able to partner fully with external stakeholders. To that end, a "new" Oral Health Initiative plan was presented to Dr. Koh by ADA leadership. Dr. Koh has expressed a keen interest in the U.S. National Oral Health Alliance, so the ADA's participation may be a catalyst for more meaningful dialogue and results with the federal government.

The joint letter signed by NACHC and the ADA that advocates for greater collaboration among private dentists contracting with health centers to increase oral health capacity continues the work of educating constituents about the dental safety net. With continued misunderstanding of the role and necessity of safety net dental clinics in addressing access for the underserved, this familiarity is seen as an essential

step towards greater public/private partnering. The “ABCs of Federally Qualified Health Centers (FQHC)” and other similar continuing educational courses targeting member dentists, are laying a foundation for better understanding between the public and private sectors. Additional information will be provided in a supplemental report to the 2012 House of Delegates.

Obstacles to providers participating in dental Medicaid programs continue to hinder access to care. Due to the health care reform, there are increasing dollars to assure program integrity. Unfortunately, many states rely upon contractors with little or no dental experience or expertise. This results in unwarranted allegations against those providers who are most likely to serve the Medicaid-eligible population. The vast majority of dentists adhere to the highest ethical standards as set by the profession for the benefit of patients and the public. Too many state Medicaid programs suffer from inefficiencies, administrative red tape, weak oversight and chronic underfunding. Addressing these problems will help ensure that every Medicaid-eligible child receives the oral health care he or she needs in a way that does not waste taxpayer dollars.

Prevention

Access disparities cannot be fixed simply by performing more procedures. The dental health crisis is caused by a failure to prevent disease. The nation needs a fundamentally different approach—one that accentuates risk management, disease management and health promotion. In the past year, numerous government and public health agencies, including the Department of Health and Human Services (DHHS) and the Institute of Medicine (IOM), have released reports that stress the importance of using proven prevention interventions to improve the oral health and overall health of the public. The Council is the lead agency in planning the 2013 Prevention Summit that will define a comprehensive integrated strategy for the prevention of oral diseases.

Challenges to fluoridation programs have greatly increased with the DHHS notice of intent announcement in early 2011 to change the recommended fluoride level used in community water fluoridation. While the final recommendations were expected to be released in March 2011, no action has yet been taken, which adds to the uncertainty for fluoridation programs. Fluoridation is in the middle of a perfect storm that involves reduced infrastructure support, an economic downturn with resulting budget cuts, a strong “less government” sentiment sweeping the nation, and an anti-fluoridation movement that is fueled by the Internet and social media. The yet-to-be-finalized DHHS recommendations and the ongoing EPA evaluation of fluoride in drinking water only add to the public’s concerns. Members and dental societies will continue to need additional support in their efforts to maintain successful fluoridation programs in the year to come.

Community Outreach and Cultural Competency

The federal Office of Minority Health (OMH) is creating an oral health cultural competency e-learning program as part of the OMH [Think Cultural Health](#). CAPIR is helping to guide the development of the materials.

Health literacy continues to be an advancing topic in public and private sectors. In the fall of 2011, the Institute of Medicine (IOM) and its [Health Literacy Roundtable](#) invited Dr. William Calnon, ADA President, to provide dentistry perspective in a roundtable workshop devoted to the “Attributes of a Health Literate Organization.” In the spring of 2012, Dr. Kathleen T. O’Loughlin, ADA executive director, CAPIR staff and consultants were invited to participate in an IOM workshop on health literacy in dentistry. Both Dr. Calnon and Dr. O’Loughlin described the ADA’s leadership in health literacy.

The Council approved development of a health literacy video and educational toolkit for dentists and their team members. External funding is being sought to support the development of these materials in order to assist dentists in communicating with their patients, improving health literacy, increasing patient satisfaction and decreasing risk.

Interprofessional Relations

The Council continues to participate in a joint project with the CDC to address usage of the emergency room for dental treatment. A literature review on the subject funded through a grant has been completed. An emerging area of interest and study is the response to communities throughout the nation in diverting patients from the ER to community-based resources.

The National Roundtable for Dental Collaboration (NRDC) continues to meet on an annual basis. In 2012 the focus of the NRDC was research. Outcomes included several action items to further research in oral health, such as: developing a repository of key research initiatives, convening a joint meeting of professional organizations and industry, and furthering the work of the Practice-Based Research Networks (PBRNs). As a follow-up to the meeting, the American Association for Dental Research (AADR) invited member organizations to attend the public session of the Advisory Council for the National Institute for Dental and Craniofacial Research (NIDCR).

Dr. David Perrott was appointed as the new commissioner to The Joint Commission. The ADA greatly appreciates the years of service given by Dr. David Whiston, who held the position for 11 years. ADA staff continues to provide support, attend meetings and monitor emerging topics of interest to the dental profession. The ADA officially joined the Accreditation Association for Ambulatory Healthcare (AAAHC) in July 2012. An ADA representative to the AAAHC Board of Directors will be appointed. Currently, AAAHC accredits 5,012 organizations, including dental practices, and plans to expand its reach in the oral health care environment. Patient safety remains a priority for the Organization for Safety, Asepsis and Prevention (OSAP), and the Council continues to monitor and collaborate with OSAP to assure that organized dentistry's interests are represented within the organization.

Engaging primary care providers in the prevention of oral and systemic disease is a significant emerging issue. The Council continues to investigate opportunities to promote the Smiles for Life curriculum (developed by the Society of Teacher of Family Medicine) and engage primary care providers in promoting oral health and managing oral disease in collaboration with dental colleagues through a preventive-focused approach. The Council is represented on the Executive Committee of the American Academy of Pediatrics Section on Oral Health. The AMA convenes its House of Delegates in the fall each year to address issues pertaining to advocacy. Dr. David Whiston stepped down as the ADA representative to the American Medical Association (AMA). The Council appreciates his many years of service as the ADA's liaison to the AMA. Dr. Donald Seago, ADA Fifth District trustee, attended the AMA's interim meeting in November 2011. In May of 2012, Dr. Lee Pollan was appointed by Dr. William Calnon to serve as the new ADA representative to the AMA. In September 2011, the ADA was invited to become a member of the National Diabetes Education Program's (NDEP) Strategic Directions Group. The Strategic Directions Group is charged with helping NDEP develop broad strategies and goals focused on the interdisciplinary management of diabetes.

The Council was instrumental in working with ADA's Department of Salable Materials and the Wiley-Blackwell Publishing Company to produce *The ADA Practical Guide to Patients With Medical Conditions*. This text is designed to assist in the safe delivery of coordinated oral health care for patients with medical conditions. Many diseases, as well as some medical treatments, have oral manifestations that may reflect the patient's general health status. Based on practical advice anchored in the best available evidence, this clinical resource takes a system-based approach. The Practical Guide offers vital information in a user-friendly format, featuring clinical images, summary tables, key questions, and quick reference guides to key dental care issues. The manuscript review has been completed and the textbook is in publication with an anticipated release date of July 2012.

CAPIR/CGA Special Initiative Workgroups

In light of the transition to Government and Public Affairs, six cross-agency initiatives are underway to assist state constituent societies and member dentists and demonstrate the profession's commitment to prevention of oral disease and improving access to care. The initiatives are focused on: the reduction of Medicaid administrative barriers; providing care to vulnerable older adults; demonstrating the profession's commitment to improving the oral health of at-risk children to policymakers through access to care

programs, such as GKAS and Missions of Mercy (MOM); supporting state and community efforts in the area of fluoridation; the role of the Council and other ADA agencies in promoting and transitioning the Community Dental Health Coordinator (CDHC) model; and decreasing emergency room utilization for dental care. The Council is also assisting the Council on Government Affairs in determining the feasibility of a study of the payment methodologies of Federally Qualified Health Centers (FQHCs). The intent of the survey is to gather information to determine the best type of assistance we can offer to states. Additional information regarding the status of these initiatives will be provided in CAPIR's supplemental report to the 2012 House of Delegates.

Community Dental Health Coordinator Pilot Program

A supplemental report regarding the CDHC pilot program will be prepared for the 2012 House of Delegates.

Responses to House of Delegates Resolutions

18H-2011. Leading Community Efforts to Improve Oral Health (Trans.2011:453)

Resolution 18H-2011 calls for the ADA to encourage active participation by member dentists to serve as leaders in grassroots community efforts that impact the oral health of the public.

The Council is seeking out innovative as well as customary ways for dentists to be recognized as leaders within their communities, while seeking to improve the health of the public and advocate for the needs of the underserved. For example, through association with NACHC, the ADA is encouraging private practice dentists to contract with health centers to increase capacity for servicing the needs of Medicaid-eligible individuals. This can be an opening for dentists serving upon health center advisory committees and, eventually, being invited to provide guidance within its Board of Directors. Through similar partnering with the National Association of School Nurses, dentists are being sought to provide guidance on school health advisory committees.

Efforts are being investigated on several fronts to better equip dentists to be advocates for their communities as well as individuals. For example, the National Fluoridation Advisory Committee is developing highly effective, easily understood talking points on the benefits of community water fluoridation. The Dental Public Health Advisory Committee recently developed a dental public health orientation module to better familiarize private practitioners with the challenges of addressing oral health at a population level. Additional information will be provided in the Council's supplemental report to the 2012 House of Delegates.

35-2011. Rescission of Policy, "American Dental Association Dental Health Policy for Children" (Trans.1966:179; 1967:336; 2010:552; 2011:454)

Resolution 35-2011 referred the policy to the appropriate agency (CAPIR) to review and to provide a report to the 2012 House of Delegates.

In response to Resolution 35-2011, an ADA Dental Health Program for Children Workgroup has been formed with three representatives from the Council. This workgroup has been charged with developing a comprehensive document that includes a framework for guiding policy development at the federal, state and local level for improving children's oral health. Further information will be provided in the Council's supplemental report to the 2012 House of Delegates.

50H-2011. Developing the Native American Dental Workforce (Trans.2011:536)

Resolution 50H-2011 requests that participants of the Native American Oral Health Care Project be urged to build upon existing educational programs, develop coalitions, and engage young Native American students to consider careers in the oral health field.

The Council on Government Affairs will report on this issue in its annual report to the 2012 House of Delegates.

51H-2011. Policy on Native American Workforce (Trans.2011:491)

Resolution 51H-2011 calls upon the ADA to support efforts by Native American communities to build capacity and improve the availability of community-based oral health services, advocate for a more diverse Native American dental workforce, and build upon existing educational programs to improve access to dental education resources of Native Americans.

The Council on Government Affairs will report on this resolution in its annual report to the 2012 House of Delegates.

Policy Review

The Council was assigned 55 policies as part of the ADA policy review process requested by Res. 111H-2010. The Council chair appointed a four-member workgroup to allocate the assigned policies to its standing subcommittees and its ad hoc advisory committees for review. Recommendations on whether each policy should be maintained, amended or rescinded will be made in the Council's 2012 supplemental report to the House of Delegates and future annual reports.

Summary of Resolutions

This report is informational and no resolutions are presented.

Council Minutes

For more information on recent activities, see the Council's minutes on ADA.org:
<https://www.ada.org/members/1293.aspx#relations>.

**Appendix 1. Organizations With Which CAPIR Has Coordinated or
Collaborated During This Reporting Period**

TYPE	NAME
Professional Health Care Organizations	AMDA-Dedicated to Long-Term Care
	American Academy of Pediatrics
	American College of Obstetrics and Gynecology
	American College of Physicians
	American Geriatrics Society
	American Health Care Association
	American Hospital Association
	American Medical Association
	National Association of School Nurses
	National Interprofessional Initiative on Oral Health
National Dental Organizations	Academy for Sport Dentistry
	American Association of Public Health Dentistry
	American Dental Education Association
	Association of State and Territorial Dental Directors
	Hispanic Dental Association
	National Dental Association
	Oral Health America
	Society of American Indian Dentists
	Special Care Dentistry Association
Federal Agencies	Administration on Aging
	Agency for Health Care Quality
	Centers for Disease Control and Prevention
	Centers for Medicare and Medicaid Services
	Health Resources and Services Administration
	Indian Health Service
	National Institute for Dental and Craniofacial Research
	Office of Minority Health
	Office of Women's Health
Public Health Community	American Association of Community Dental Programs
	American Public Health Association
	National Association of Community Health Centers
	National Coordinating Committee on School Health and Safety
	National Consortium on Tobacco Use Prevention
	National Health Service Corps
	National Network for Oral Health Access
	National Rural Health Association
	State and Regional Primary Care Associations

Corporate America	3M
	CareCredit
	Colgate
	DEXIS
	Henry Schein
	Scholastic
	Sesame Workshop
Foundations	ADA Foundation
	Dental Lifeline Network
	Dental Trade Association Foundation
	DentaQuest Foundation
	Kaiser Family Foundation
	Pew Charitable Trusts
	Robert Wood Johnson Foundation
	Washington Dental Service
Other Key External Organizations	Accreditation Association of Ambulatory Health Care
	Alliance of the ADA
	American Water Works Association
	Friends of Indian Health
	Institute of Medicine
	Medicaid-CHIP State Dental Association
	National Commission on Correctional Health Care
	Organization for Asepsis and Prevention
	Pathways Into Health
	Safety Net Solutions
	The Joint Commission
	U.S. National Oral Health Alliance

Appendix 2. CAPIR Advisory Committees

The **National Fluoridation Advisory Committee (NFAC)** serves the important role of assisting the Council with proactive community water fluoridation activities. Originally formed in the late 1970s, NFAC helps the Council monitor scientific and community-based trends associated with national, state and local water fluoridation initiatives. It also provides the Council with valuable input for development and/or revision of fluoridation education materials and campaign strategy development.

The **National Elder Care Advisory Committee (NECAC)** met first in April 2010 arising from an amalgamation of three Elder Care ad hoc advisory committees formed to address the Resolution 5H-2006 initiatives (Strategies to Address Oral Health Issues of Vulnerable Elders), as well as to provide guidance to the Council on elder care activities going forward. The goals of NECAC are to:

1. Equip dentists with the funding, education and delivery systems needed to meet the needs of the elderly.
2. Enable elders and/or their caregivers to be good stewards and advocates for their own health, through health education and promotion with an emphasis on prevention.
3. Improve elder oral health outcomes by building national coalitions, promoting legislative and regulatory reform.
4. Build and transfer the knowledge base needed to improve the oral health of elders.

The **National Advisory Committee on Health Literacy in Dentistry (NACHLID)** was authorized by the 2006 House of Delegates, which also affirmed that limited health literacy is “a potential barrier to effective prevention, diagnosis and treatment of oral disease,” and “clear, accurate and effective communication is an essential skill for effective dental practice.” This committee developed the Health Literacy in Dentistry Action Plan 2010-2015, which is a set of principles, goals and specific strategies to provide guidance to the Association and its Councils and Commissions, dental professionals, policy makers and others to improve health literacy. A detailed description of the Committee may be found in the action plan.

The **Public Health Advisory Committee (PHAC)** was formed in 2009 to inform and support CAPIR’s advocacy position between the ADA and the public health community by advising the Council about issues related to public health outreach and building collaborative relationships.

The **Medicaid Provider Advisory Committee (MPAC)** was formed in 2011 as a recommendation of the 2010 Medicaid Provider Symposium, which sought to explore various business models and lessons learned for successfully incorporating Medicaid and Children’s Health Insurance Program (CHIP) patients into a private practice. The MPAC is composed of dentists who treat Medicaid and CHIP patients to advise the Council and the ADA about issues related to serving this specific patient population.

The **Give Kids A Smile National Advisory Board/Committee (GKAS)** was established in December 2006 to expand the GKAS Day program and reported directly to the ADA Foundation. The initial goal of the committee was to position GKAS as an umbrella brand to champion and support access to care for dentally underserved children nationwide. The vision of the GKAS National Advisory Committee is to eliminate cavities in U.S. five-year-olds by 2020. In April 2011, this committee’s reporting responsibilities were transferred from the ADA Foundation to CAPIR and it provides recommendations to the Council regarding the ADA’s GKAS initiative.

CAPIR advisory committees are comprised of expert consultants and Council liaisons who actively participate in the discussion and recommendations of these committees.

Council on ADA Sessions

Percy, Kent H., 2012, Georgia, chair
Barsley, Robert E., 2013, Louisiana, *ex officio*
Bertagni, Hugo F., 2013, Illinois
Blicher, Michael M., 2013, Washington, DC
Cohen, Barry I., 2015, Pennsylvania
Foster, James R., 2014, Texas
Fussell, Randy G., 2012, North Carolina
Galati, James E., 2014, New York
Huberty, Mark C., 2012, Wisconsin
Lee, William E., 2013, Kentucky
Niewald, Matthew A., 2012, Missouri, *ex officio* *
Okano, David K., 2012, Wyoming
Parker, Steven E., 2015, Ohio
Peppes, Gregory J., 2013, Kansas
Pietrasik, John P., 2014, Massachusetts
Roesch, Robert E., 2015, Nebraska
Rounsavelle, Richard K., 2012, California
Samy, S. Shane, 2014, Oregon
Shinbori, Dennis D., 2012, California, *ex officio*
Torgerson, Neil E., 2015, Florida

Mills, Catherine H., director

The Council's 2011-12 liaisons included: Dr. Joseph F. Hagenbruch (Eighth District trustee, Board of Trustees); and Mr. Richard Andolina, Jr. (American Student Dental Association).

Mission and Purpose

The Council on ADA Sessions and the Strategic Plan of the American Dental Association:

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.

During the CAS May 2012 meeting, the Council on ADA Sessions adopted the following strategic focus with corresponding goals resulting from the mega topic session held during its February 2012 meeting. The May strategic planning session was facilitated by Dr. Kathleen O'Loughlin and was built around the ADA Strategic Plan:

To create a world-class dental experience that incorporates value, innovation, and diversity of attendees and location, to the benefit of the entire dental community.

- Make the ADA annual session the first meeting the professional dental community and exhibitors select for participation.

* New Dentist Committee member without the power to vote.

- Attract new and diverse attendees and create brand loyalty among current and new attendees, as well as exhibitors.
- Add value to our membership by maintaining a profitable meeting to drive future success and yearly expansion, increasing the perceived benefits of ADA membership.

The next steps are to create tactics and quantifiable measures for these goals. These will be reviewed by the Council during the 2012 annual session.

Supporting the Strategic Plan: Activities, Results and Accomplishments

152nd Annual Session, Las Vegas, Nevada, October 10–13, 2011

The ADA's 152nd Annual Session was held at the Mandalay Bay Convention Center under the direction of the Council on ADA Sessions. Total actual registration for the meeting was 27,054 attendees. There were 8,767 dentists and 7,004 professional staff at the meeting, totaling 58.2% of all meeting registrants. The ADA Marketplace featured 1,396 booths from more than 600 companies during a three-day exhibition period.

Table 1. Financial Overview*	
<i>Revenue</i>	
Exhibit	\$5,277,587
Registration	\$1,247,070
Sponsorship/Advertising	\$1,007,825
CE Tickets	\$996,122
Housing Rebate	\$322,706
Other	\$54,030
<i>Gross Revenue</i>	\$8,905,340
<i>Total Expenses</i>	\$4,897,713
<i>Net Revenue</i>	\$4,007,627
<i>*All figures above are unofficial and unaudited.</i>	

New Initiatives

The NEW ADA 365—A Virtual Extension of the ADA Annual Session: Acknowledging the fact that approximately 6 to 8% of ADA members attend the annual session in a given year, the Council made the decision to bring the best of the Annual Session to the members by offering the opportunity to view numerous offerings of the Annual Session live over the three full days of the meeting.

The original estimate of virtual viewers was 1,200 prior to launching the virtual event. After the third day of live streaming of our most exciting educational courses—such as Education in the Round (live patient procedures), the opening general session with Dr. Condoleezza Rice, exhibit hall booth tours and live panel discussions—over 4,300 unique individuals signed in and participated virtually in the annual session.

The Council will send unique marketing materials to those individuals to attend the 2012 annual session and track the number of ADA365 participants that did not attend the 2011 meeting who register and attend the 2012 annual session.

Collaboration

Continuing Education Program Collaboration: Courses were presented in collaboration with ADA divisions and councils, including: Council on Dental Practice, Council on Dental Education and Licensure, Center for Continuing Education and Lifelong Learning, Department of Dental Society Services, Federal Dental Services, JADA, New Dentist Committee and Council on Scientific Affairs.

In addition, courses were presented in cooperation with the following organizations: American Academy of Sleep Medicine, American Association of Endodontists, American Association of Oral and Maxillofacial Radiology, American Association of Oral and Maxillofacial Surgeons, American Association of Orthodontics, American College of Prosthodontics, American Dental Assistants Association and Academy of Laser Dentistry.

Responses to House of Delegates Resolutions

There were no assignments from the 2011 ADA House of Delegates.

Summary of Resolutions

This report is informational and no resolutions are presented.

Council Minutes

For more information on recent activities, see the Council's minutes on ADA.org:

<https://www.ada.org/members/1293.aspx#sessions>

Council on Communications

Brown, W. Carter, 2012, South Carolina, chair
Shenkin, Jonathan, 2013, Maine, vice chair
Boghossian, Alice G., 2015, Illinois
Campbell, Jeffrey A., 2014, Ohio
Chesser, William E., 2014, Alabama
Elliott, Anita W., 2012, Arizona
Hewett, Sally J., 2014, Washington
Jenkins, James F., 2014, Nebraska
Johnson, J. Michael, 2013, Kentucky
Jones, Krista M., 2013, Oklahoma
Maihofer, Michael G., 2015, Michigan
Nase, John B., 2013, Pennsylvania
Olinger, Thomas J., 2012, California
Patel, Minerva, 2015, New York
Ray, Pamela S., 2012, Texas
Shepley, George R., 2015, Maryland
Wunderlich, Hugh T., 2012, Florida
Radjabli, Edgar M., Maryland, *ex officio**

MacLachlan, Janine, director
Cebula, Marcia, coordinator

The Council's 2011-12 liaisons included: Dr. Charles L. Steffel (Seventh District trustee, Board of Trustees); and Ms. Jaclyn Rivera (American Student Dental Association).

Mission and Purpose

The Council on Communications is the primary ADA agency responsible for advising on reputation management, providing strategic oversight and advising the Association on the image and brand implications of Association plans, programs, services and activities. Further, this Council shall advise the Association regarding integrated and strategic communications plans and policies between itself, the public, members and the profession.

Supporting the Strategic Plan: Activities, Results and Accomplishments

Public Outreach

Ad Council Public Service Initiative on Oral Health: The Partnership for Healthy Mouths, Healthy Lives was formed in 2011 by the National Roundtable for Dental Collaboration (NRDC), a coalition of 31 organizations, with the purpose of improving children's oral health by proposing an oral health literacy campaign to the Ad Council. The ADA was a primary organizing member and serves on the Executive Committee. The partnership's proposal was accepted by the Ad Council and campaign development centered on improving children's oral health, especially among those most at risk. The Partnership now has 34 members. The campaign helps address ADA strategic plan goal #2: be the trusted resource for oral health information that will help people be good stewards of their own oral health.

The initiative had the full support of the Council, and in April 2011 the ADA entered into a memorandum of understanding forming the coalition to pursue a national public awareness campaign on children's oral health by the Ad Council. The campaign, which was approved in June 2011, targets parents and caregivers of young children with an emphasis on lower income and minorities, to raise awareness of the

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

importance of oral health to overall health. In order to raise awareness, the campaign will feature basic oral health information in public service advertising, as well as on a web site dedicated to Healthy Mouths, Healthy Lives. Research and ideas from the developing campaign were shared with the Council. The campaign is scheduled to launch in the summer of 2012, after the launch of the ADA consumer website, MouthHealthy.org.

Sharecare: In support of ADA strategic plan goal #2, the Council on Communications forwarded a resolution to the Board supporting the ADA's involvement with Sharecare, a new consumer health website and business venture founded by Dr. Mehmet Oz, Mr. Jeff Arnold (founder of WebMD), and investors Harpo Productions and Discovery Communications. Sharecare.com is designed as a robust question-and-answer platform to provide the public with health information from unbiased experts in a manner that is intuitive and user friendly. In April 2011, the ADA Board granted approval for the ADA to enter into a multi-year contractual agreement with Sharecare, Inc. to provide intellectual property in the form of consumer information, online content from ADA.org, video and original answers to public questions. The ADA is now a leading resource of oral health information on the site. The ADA offers active, licensed members the opportunity to apply to become contributors on Sharecare to increase visibility of their practices as well as help the public be good stewards of their oral health.

The ADA has participated with Sharecare by serving as the primary provider of oral health information, with final approval over all ADA-provided content so that Sharecare could repurpose existing ADA content into the desired format at their sole expense. The Council, through its Brand Management Workgroup, provides volunteer oversight of the collaboration between the ADA and Sharecare. A staff work team led by Communications executes the day-to-day operational responsibilities. The work team is comprised of representatives from the Division of Communications and Marketing, Dental Practice, Science, Membership, Legal, and Information Technology.

Sharecare agreed to provide a financial incentive to the ADA for every 2,000 answers provided by the ADA, ADA spokespersons or ADA Sharecare contributors prior to December 31, 2011. As of December 31, the ADA qualified for and was paid a \$10,000 financial incentive which was paid to the ADA's general fund. The site is a unique and financially attractive method of providing ADA-branded oral health information to the public, and, by creating a mechanism for selective member participation it can build recognition of the essential role of the dentist in meeting the oral health needs of the country.

Since the inception of the program, there have been approximately 2,000,000 views of the ADA profile page and oral-health-related questions are now the most asked category on the site.

Consumer Website: In June 2011, the Council on Communications reviewed a strategic approach to address renewed efforts to expand and enhance outreach to public audiences and grow non-dues revenue in support of the ADA's strategic goals. This perspective was further refined and, in August 2011, a consumer-directed website designed as a central mechanism for public engagement was presented to and approved by the Board of Trustees.

To gather consumer feedback on the most resonant possible positioning of the site for the ADA, a variety of concepts were tested through a series of focus groups of primary caregivers with children up to 18 years old in the household.

Consumers will be able to enter MouthHealthy.org directly or through ADA.org, where they will be redirected. In effect, this will separate the consumer-oriented content from the professional. There will remain significant cross-linking and relevant content sharing, but casting ADA.org as the most important resource that exists for dentistry will further enhance its usability and relevance to members, the profession and other stakeholders.

In addition to providing consumers with the most authoritative resource on oral health information, the consumer website also presents the opportunity to generate non-dues revenue by offering advertising and sponsorships to marketers both within the dental products category and those unrelated to oral care. The Council on Communications Brand Management Workgroup developed advertising guidelines for

MouthHealthy.org to ensure that such advertising is factual, dignified and tasteful, and provides useful product and service information. The advertising guidelines were approved at the March 2012 Board of Trustees meeting.

The Brand Management Workgroup oversees the development of MouthHealthy.org with input from the Social and Digital Media Subcommittee. In addition, a senior level steering committee meets monthly to ensure management involvement, guidance and review. The website will be managed on a daily basis by staff from Communications & Marketing.

MouthHealthy.org is being developed and launched with the use of existing budgeted funding, and both the Council on Communications and Association senior management approved a reallocation for this purpose. The site also can be managed and maintained as a direct expense without offsetting revenue through the reallocation of staff. However, growth of the site will require additional staffing. The site is targeted to launch in June, 2012, prior to the launch of the Ad Council campaign in early August.

Advocacy Communications Workgroup

The Advocacy Communications Workgroup has taken a leadership role in supporting and advising on communications issues related to the “Barriers to Oral Health” series of papers—the first paper focused on the role of workforce and the second addressed the tattered safety net. The newest paper on financing care was reviewed by the Council and was released in April 2012. The workgroup has also been instrumental in helping to plan an innovative research campaign involving in-depth interviews, online focus groups and a nationwide survey to measure perception of the ADA as a leader in addressing access disparities. This project was contingent on approval for supplemental finding, which the ADA Board approved at its March 2012 meeting.

The workgroup changed its name from Access Communications to Advocacy Communications to encompass a wider scope of issues.

Workgroup members include Dr. W. Carter Brown, chair, Dr. William Chesser, Dr. Anita Elliott, Dr. J. Michael Johnson, Dr. Krista Jones, Dr. Pamela Ray, Dr. Jonathan Shenkin and Dr. George Shepley.

The Brand Management Workgroup

The Brand Management Workgroup provides volunteer oversight for Sharecare; the Partnership for Healthy Mouths, Healthy Lives coalition campaign with the Ad Council; and the new consumer website, MouthHealthy.org. In addition to overseeing the implementation of the advertising guidelines for the new site, the Workgroup is also reviewing the feasibility of licensing videos and accepting advertising in the Kids section, as well as feature enhancements on the Find-a-Dentist tool.

Workgroup members include Dr. J. Michael Johnson, chair, Dr. William Chesser, Dr. Sally Hewett, Dr. James Jenkins, Dr. Michael Maihofer and Dr. Jonathan Shenkin.

The Advisory Workgroup on Reputation Management

The workgroup adopted a statement of purpose and goals to guide their work and make recommendations to the Council. The Council is an advisory body to the Board of Trustees on matters pertaining to reputation management.

The workgroup's statement of purpose: The Council on Communications, with recommendations from the Council's Advisory Workgroup on Reputation Management, serves as an advisory body to the Association and its agencies by providing strategic communications insight and recommendations related to the reputational implications of its plans, programs, services and activities.

The workgroup's goals are to:

- a) Develop an issues management plan, as part of an overarching strategic communications plan, to monitor and track short- and long-term reputational challenges and opportunities;
- b) Develop a system to identify and analyze threats and opportunities related to the ADA's reputation; and
- c) Provide ongoing reports to the Council on Communications in order to engage in long-range issues management planning related to protecting and promoting the ADA's reputation.

The workgroup created a draft ADA issues management plan designed to protect and promote the ADA's reputation with a variety of audiences. The Council agreed with the workgroup to pilot the draft plan by focusing on the issue of community water fluoridation. The report, "Community Water Fluoridation Issues Management Plan," was developed in collaboration with an interdivisional staff workgroup with volunteer input and oversight provided by the Council's workgroup as well as the National Fluoridation Advisory Committee of the Council on Access, Prevention and Interprofessional Relations (CAPIR).

The plan calls for the development of a communications resource kit, to be completed and available to ADA component and constituent dental societies in the summer of 2012. Constituent Dental Society Executive Directors were surveyed to capture their input and interest in the kit.

Workgroup members include Dr. Jeffrey Campbell, chair, Dr. Alice Boghosian, Dr. Thomas Olinger, Dr. Edgar Radjabli and Dr. Jonathan Shenkin.

Social and Digital Media Subcommittee

In January 2012 the Social Media Workgroup requested and the Council approved a change in their title to the Social and Digital Media Subcommittee.

The subcommittee advises on implementation of the Social Media Strategic Plan, including planning for long-term expansion across the Association. The subcommittee has focused their efforts this year on drafting guidelines for volunteers and staff representing the ADA in social media communities; developing a book to help dentists incorporate social media into their marketing efforts; and new social media efforts in support of the launch of MouthHealthy.org. The subcommittee also provided support of a Twitter chat with two ADA spokespersons answering questions from the public about children's oral health.

Social media for annual session was expanded to include a Facebook group and Twitter feed, both of which were included in an updated annual session mobile phone application. Give Kids A Smile NASCAR events were showcased in social media with Facebook and Twitter posts.

Subcommittee members include Dr. John Nase, chair, Dr. Jeffrey Campbell, Dr. James Jenkins, Dr. Minerva Patel and Dr. Hugh Wunderlich.

Spokesperson Review Workgroup

The Council on Communications initiated a new workgroup to review the ADA spokesperson appointment process, in part to ensure that the ADA has an adequate number of spokespersons with expertise on a variety of issues in order to effectively respond to media interview requests. The workgroup's recommendations will be considered by the Council at its July 2012 meeting, and any additions or revisions to the spokesperson program would then need approval from the ADA Board of Trustees.

Workgroup members include Dr. Anita Elliott, chair, Dr. Alice Boghosian, Dr. Pamela Ray, Dr. Jonathan Shenkin and Dr. George Shepley.

ADA Policy Review Workgroup

The Council initiated a new workgroup to review ADA policies related to communications issues on an annual basis in accordance with 111H-2010. The group is reviewing six policies in 2012, which will be presented in the 2012 Council on Communications Supplemental Report.

Workgroup members include Dr. Sally Hewett, chair, Dr. James Jenkins, and Dr. Minerva Patel.

Interagency Subcommittee on Science and Research (ISSR)

In February 2012, the Council on Scientific Affairs (CSA) invited councils to appoint liaisons to a new interagency subcommittee on science and research. The subcommittee will advise CSA on emerging scientific issues, make recommendations on the ADA Research Agenda, monitor and advise on activities in the field of evidence-based dentistry, and serve as a resource to CSA on external stakeholder groups involved in relevant scientific issues. Since evidence-based dentistry is being addressed by the ISSR, the Evidence-Based Dentistry Advisory Committee has been dissolved. Other councils participating in the subcommittee are the Council on Access, Prevention and Interprofessional Relations; Council on Dental Benefit Programs; Council on Dental Education; Council on Dental Practice; Council on Ethics, Bylaws and Judicial Affairs; and Council on Government Affairs.

Dr. Alice Boghosian represents the Council on Communications on the ISSR.

Ad Hoc Committee on Safety Awareness Campaign

An interagency Ad Hoc Committee on Safety Awareness was convened by the Council on Dental Education and Licensure in November 2011 with a charge to establish a safety awareness campaign promoting routine biannual equipment safety checks in dental offices. Included in the ad hoc committee were representatives from the Council on Communications, Council on Dental Practice, Council on Scientific Affairs and the Council on Membership. Their downloadable "[Safety Checklist for Dental Equipment](#)" is posted on ADA.org, and the campaign will be promoted through various ADA print and electronic publications.

Dr. Pamela Ray is the Council on Communications representative on the ad hoc committee.

Responses to House of Delegates Resolutions

The Council has a supporting role in several House of Delegates resolutions.

29H-2010. ADA Public Relations Campaign (Workforce Campaign Materials) (Trans.2010:611)

121H-2010. Dental Access Barriers (Trans.2010:566)

The Council on Communications took a leadership role in developing the second in the series of papers about barriers to care, entitled "Breaking Down Barriers to Oral Health for all Americans: The Tattered Safety Net." The Tattered Safety Net was shared with the Council's Advocacy Communications Workgroup, and with the entire Council, for comment. The third paper in the series on financing care was released in late April.

41H-2011. ADA Scientific Review of Alternative Dental Workforce Models (Trans.2011:467)

The Council on Communications was asked by the Council on Scientific Affairs to provide input on the framing question "In populations where non-dentists conduct diagnostic, treatment planning, and/or irreversible/surgical dental procedures, is there a change in disease increment, untreated dental disease, and/or cost-effectiveness of dental care?" The Council will also provide comment to the draft findings as part of the publication review process.

46H-2011. Revision of ADA Specialty Logo (Trans.2011:547)

The Council on Communications consulted with the Council on Membership to reach consensus concerning removal of the date on the membership logo. The Council on Membership plans to present a resolution to the 2012 House of Delegates.

Policy Review

In accordance with 111H-2010, the Council is reviewing assigned ADA policies. Additional information will be provided in the Council's supplemental report.

Summary of Resolutions

This report is informational and no resolutions are presented.

Council Minutes

For more information on recent activities, see the Council's minutes on ADA.org:
<https://www.ada.org/members/1293.aspx#communications>.

Commission on Dental Accreditation

Tonelli, J. Steven, 2012, Massachusetts, chair, American Dental Association
Knoernschild, Kent L., 2013, Illinois, vice chair, American College of Prosthodontists
Biermann, Michael E., 2013, Oregon, American Dental Association
Benson, Byron, 2015, Texas, American Academy of Oral and Maxillofacial Radiology
Buchanan, Richard, 2012, Utah, American Dental Education Association
Burr, Kristi, 2014, Ohio, Public Member
Cangialosi, Thomas, 2015, New Jersey, American Association of Orthodontists
Carlson, Eric R., 2013, Tennessee, American Association of Oral and Maxillofacial Surgeons
Curran, Elizabeth, 2013, Arizona, National Association of Dental Laboratories
DiFranco, Geri Ann, 2013, Illinois, American Association of Dental Boards
Dodge, William, 2015, Texas, American Dental Education Association
Donly, Kevin, 2015, Texas, American Association of Pediatric Dentists
Eliason, Joseph, 2013, California, American Student Dental Association and American Dental Education Association
Gagliardi, Lorraine, 2012, California, American Dental Assistants Association
Giasolli, Robert, 2014, California, Public Member
Greenwell, Henry, 2014, Kentucky, American Academy of Periodontology
Hardesty, W. Stan, 2015, North Carolina, American Association of Dental Boards
Messura, Judith, 2013, North Carolina, American Association of Hospital Dentists and American Dental Education Association
Neville, Brad Wesley, 2014, South Carolina, American Academy of Oral and Maxillofacial Pathology
Ray, Robert G., 2012, Washington, D.C., American Association of Dental Boards
Rivera-Nazario, Yilda, 2013, Puerto Rico, American Dental Education Association
Royeen, Charlotte, 2015, Missouri, Public Member
Schonfeld, Steven E., 2014, California, American Dental Association
Shepherd, Kathi, 2015, Michigan, American Dental Hygienists Association
Sherrard, James, 2015, Connecticut, Public Member
Sims, Paul G., 2014, Montana, American Association of Dental Boards
Tuneberg, Perry K., 2015, Illinois, American Dental Association
Wenkus, Christopher, 2012, Illinois, American Association of Endodontists
White, B. Alexander, 2012, North Carolina, American Association of Public Health Dentistry
Williams, John N., 2014, Indiana, American Dental Education Association

Ziebert, Anthony J., interim director
Horan, Catherine A., manager, Advanced Specialty Education Programs
Renfrow, Patrice, manager, Dental Hygiene Education Programs, and interim manager, Dental Assisting and Dental Laboratory Technology Education Programs
Soeldner, Peggy, manager, Advanced General Dentistry Education Programs
Tooks, Sherin, manager, Advanced Specialty Education Programs

The Commission's 2011-2012 Board of Trustees liaisons included: Dr. Roger L. Kiesling (Eleventh District trustee), and Dr. Maxine Feinberg (Fourth District trustee).

Mission and Purpose

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

Supporting the Strategic Plan: Activities, Results and Accomplishments

Summary of Accreditation Actions

The Commission's accreditation actions from August 2011 through February 2012 are summarized in Table 1. These actions were based on site visit reports, progress reports and other information submitted by educational programs and their sponsoring institutions that detailed the degree to which specific recommendations included in previous evaluation reports had been implemented. In addition, other actions (report of major change, change in sponsorship, etc.) were taken at the August 2011 and February 2012 meetings, for a total of 566 accreditation actions. Applications for initial accreditation of education programs were reviewed. During this time, two predoctoral dental education programs, six advanced general dentistry education programs, nine advanced specialty education programs, 10 dental hygiene education programs, and three dental assisting education programs were granted the accreditation status of "Initial Accreditation." As indicated in Table 2, the total number of educational programs accredited is 1,449. This represents an increase of 37 programs from the previous reporting period. Of the 1,449 accredited programs, 74 (5.1%) hold the status of "Initial Accreditation," 1,333 programs (92.0%) are in compliance with all requirements and have been awarded "Approval *Without* Reporting Requirements." During this reporting period, 42 programs (2.9%) were found to have deficiencies or areas of noncompliance and hold the status of "Approval *With* Reporting Requirements." Each of the 42 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 six complaints against programs during this time.

During this reporting period, one dental hygiene education program and two dental assisting education programs had accreditation withdrawn. As 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. Selected Accreditation Actions: Two Meetings—August 2011 and February 2012

	Dental	Specialty	Advanced General Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Initial Accreditation Granted	2	9	6	3	10	0	30
Initial Accreditation—Continuing	2	4	1	5	3	0	15
Approval Without Reporting Requirements	8	79	55	45	55	3	245
Approval With Reporting Requirements	1	10	11	18	12	1	53
Accreditation Denied	0	0	0	0	0	0	0
Discontinued Programs	0	0	3	8	0	1	12
Intent to Withdraw	0	3	1	5	2	0	11
Accreditation Withdrawn	0	0	0	2	1	0	3
Decision Appealed	0	0	0	0	0	0	0
Number of Accreditation Actions	13	105	77	86	83	5	369

Table 2. Total Number of Accredited Programs as of February 2012

	Dental	Specialty	Advanced General Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Initial Accreditation	6	21	13	7	27	0	74
Approval Without Reporting Requirements	55	427	275	267	290	19	1,333
Approval With Reporting Requirements	1	8	6	10	17	0	42
Number of Accredited Programs	62	456	294	284	334	19	1,449

Proposed Revised Standards

The Commission directed the following proposed revisions to Accreditation Standards be circulated to the communities of interest for comment:

- Advanced Education Programs in Dental Anesthesiology, for circulation to the communities of interest for review and comment until December 1, 2012, and consideration at the February 2013 meeting of the Commission;
- Accreditation Standards for Dental Assisting Education Programs, including new standards that address programs with an Expanded Function Dental Auxiliary (EFDA) component, for circulation to the communities of interest for review and comment until December 1, 2012, and consideration at the February 2013 meeting of the Commission;
- Accreditation Standards for Advanced Specialty Education Programs in Dental Public Health, for circulation to the communities of interest for review and comment until December 1, 2012, and consideration at the February 2013 meeting of the Commission;
- Accreditation Standards for Advanced Specialty Education Programs in Endodontics, for circulation to the communities of interest for review and comment until December 1, 2012, and consideration at the February 2013 meeting of the Commission;
- Accreditation Standards for Advanced Specialty Education Programs in Oral and Maxillofacial Pathology, for circulation to the communities of interest for review and comment until December 1, 2012, and consideration at the February 2013 meeting of the Commission;
- Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery, proposed revised Standard 6-4.2 on surgical experience for the pediatric craniomaxillofacial surgery category, for consideration at the August 2012 meeting of the Commission;
- Accreditation Standards for Advanced Specialty Education Programs in Orthodontics and Dentofacial Orthopedics, for circulation to the communities of interest for review and comment until December 1, 2012, and consideration at the February 2013 meeting of the Commission; and
- Accreditation Standards for Advanced Specialty Education Programs in Periodontics, for circulation to the communities of interest for review and comment until December 1, 2012, and consideration at the February 2013 meeting of the Commission.

Adoption of Accreditation Standards

The Commission adopted revisions to the following Accreditation Standards:

- The addition of an intent statement to the Postdoctoral General Dentistry Standard on continuous basic life support (BLS) recognition to include advanced cardiac life support (e.g., ACLS, PALS) as an acceptable substitute for BLS since BLS is a component of the advanced courses;

- The addition of a standard to the Postdoctoral General Dentistry Accreditation Standards requiring that individuals enrolled in postdoctoral general dentistry education programs must be dentists, with an implementation date of July 1, 2012;
- The deletion of the intent statements for Advanced Specialty Education in Endodontics Accreditation Standards 2-4 and 2-4.1;
- The addition of a standard to the Advanced Specialty Education in Orthodontics and Dentofacial Orthopedics Accreditation Standards on monitoring board certification of students/residents with an implementation date of July 1, 2012;
- Predoctoral Dental Education Program Standard 2-23(e) for immediate implementation;
- Dental Hygiene Education Programs for implementation on January 1, 2013, along with revisions to the initial application document;
- Advanced Specialty Education Programs in Oral and Maxillofacial Surgery for implementation on July 1, 2012;
- Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery for implementation on July 1, 2012;
- Advanced Specialty Education Programs in Pediatric Dentistry for implementation on July 1, 2013;
- All appropriate advanced dental education standards for implementation on July 1, 2012, regarding equivalency to institutional accreditation by the Joint Commission; relevant standards will be revised to reflect that accreditation by an organization recognized by the Centers for Medicare and Medicaid Services (CMS) is equivalent to accreditation by the Joint Commission.

Dental Anesthesia Accreditation Standards

The Commission chair appointed a Task Force comprised of representatives from the Postdoctoral General Dentistry Review Committee and the dental anesthesia community to review proposed revisions to the accreditation standards for advanced general dentistry programs in dental anesthesiology. The proposed revisions include an expansion in the length of the educational programs in dental anesthesiology from two years to three years.

Dental Therapy Accreditation Standards

The Commission granted the request from the University of Minnesota School of Dentistry to begin the process of developing accreditation standards for dental therapy education programs. The Commission chair appointed a Task Force to develop standards, with a progress report to the Commission at the summer 2012 meeting.

Discontinuation of the Process of Accreditation for International Certificate Programs

The Commission discontinued the process of accreditation for two-year, predoctoral dental education certificate programs for international dental school graduates, with immediate implementation. There have been no accredited certificate programs operating in the United States and Canada for the past five years.

United States Department of Education Renewal of Recognition

The United States Department of Education (USDE) periodically publishes a list of Nationally Recognized Accrediting Agencies and Associations, which is used to determine eligibility for U.S. federal funding or government assistance under certain legislation. Agencies and associations included on the USDE list are those determined to be the reliable authorities in evaluating the quality of education offered by educational institutions or programs. In order for institutions to become eligible for federal funds, the accrediting agency for that institution must be recognized by USDE. The authority and recognition responsibility of USDE is governed by the Higher Education Act (HEA) of 1965, as amended. This legislation is periodically reauthorized, usually at five-year intervals. Following each reauthorization, the Department promulgates new Procedures and Criteria for Recognition of Accrediting Agencies. The Secretary of Education requires the Commission on Dental Accreditation to submit to USDE the

standards, policies and procedures used in its evaluation program. Periodic reviews by USDE are conducted to determine the Commission's continued eligibility for recognition. The Commission was last reviewed in June 2006 and has been recognized since the first recognition list was published in 1952. The Commission's scope of recognition is for "the accreditation of predoctoral dental education programs (leading to the D.D.S. or D.M.D. degree), advanced dental education programs, and allied dental education programs that are fully operational or have attained the 'Initial Accreditation' status, and for its accreditation of programs offered via distance education." In June of 2011, the Commission was advised that application for renewal of its listing by the Secretary as a nationally recognized accrediting agency, or compliance report, has been scheduled to be reviewed at the June 2012 meeting of the National Advisory Committee on Institutional Quality and Integrity. The Commission submitted its written petition for renewal on January 9, 2012.

Revised Policies

The Commission adopted the following revised policies:

- *Policy on Off-Campus Sites*—In order to ensure that complete documentation is available at the regularly scheduled meetings of the Commission, programs must submit in writing a request for initiating an off-campus site at least thirty (30) days prior to the appropriate, regularly scheduled semi-annual Review Committee meeting. A program must receive Commission on Dental Accreditation approval of the off-campus site prior to initiating use of the site.
- *Policy on Program Changes*—Program changes must be reported at least thirty (30) days prior to a regularly scheduled, semi-annual Review Committee meeting and must be reviewed by the appropriate Review Committee and the Commission to ensure that the program continues to meet the accreditation standards. In addition, expansion of an existing dental hygiene program will only be considered after the program has demonstrated success by graduating the first class, measured outcomes of the academic program, and received approval without reporting requirements.
- *Policy on Resident Duty Hours Restrictions*—This policy was adopted in response to newly implemented Accreditation Council for Graduate Medical Education (ACGME) guidelines for restrictions on resident duty hours and resident supervision requirements in a hospital setting.
- *Policy on Customized Survey Data Requests*—This policy was adopted in response to requests for data collected in the annual surveys of accredited dental education programs from agencies and individuals outside the ADA.
- Editorial changes to the "Policy on Regard for Decisions of States and Other Accrediting Agencies," "Notice of Reasons for Adverse Actions," and "Accreditation Status Definitions" to reflect current recognition criteria from the United States Department of Education.

Joint Advisory Committee on International Accreditation (JACIA) Activities

Mission and Purpose

This standing joint advisory committee of the American Dental Association and the Commission on Dental Accreditation provides guidance to the Commission in the selection, development and implementation of a program of consultation and accreditation for international, predoctoral dental education programs.

Members of the JACIA include Dr. Roger Kiesling, trustee, Eleventh District, chair; Dr. Steven Bruce, ADA; Dr. Richard Buchanan, CODA; Dr. Yilda Rivera-Nazario, CODA; and Dr. Roger Simonian, ADA. The ADA president, Dr. William Calton, and the CODA chair, Dr. J. Steven Tonelli, serve as *ex officio* members of this committee. It is staffed by Lorraine Lewis, manager, predoctoral dental education, and Dr. Anthony J. Ziebert, interim director, CODA.

Background

On January 1, 2007, the Joint Advisory Committee on International Accreditation began accepting initial applications (PACV surveys) from international, predoctoral programs. The JACIA has met regularly since

2007 to review applications from international programs, review and update policies and procedures, and monitor budgetary matters, including revision of international accreditation fees. The following international programs have submitted PACV surveys since 2007:

1. Saraswati Medical and Dental College, Lucknow, India
2. King Abdulaziz University School of Dental Medicine, Jeddah, Saudi Arabia
3. Universidad de la Salle Bajio AC Dental Education Program, Leon, Mexico
4. Universidad de San Martin de Porres, Lima, Peru
5. Yonsei University College of Dentistry, Seoul, South Korea
6. Seoul National University, School of Dentistry, Seoul, South Korea
7. Yeditepe University Faculty of Dentistry, Istanbul, Turkey
8. Sri Dharmasthala Manjunatheshwara College of Dental Sciences and Hospital, Dharwad, India
9. King Khalid University, College of Dentistry, Abha, Saudi Arabia
10. Universidad Autonoma de Nuevo Leon, Monterrey, Mexico

Following review and discussion, JACIA approved all of the programs listed above to attend a U.S. comprehensive visit and submit a PACV self-study.

Since 2009, four international programs have submitted a PACV self-study and have requested a PACV site visit. Following review of the self-studies, the JACIA determined that one program in Lima, Peru, did not provide sufficient information to warrant a PACV site visit. Three programs (Dharwad, India; Jeddah, Saudi Arabia and Monterrey, Mexico) provided sufficient documentation to schedule a comprehensive PACV site visit. Staff were directed to make arrangements for a committee of dental professionals with experience in dental education in the United States and/or who have served as site visitors to predoctoral programs to complete a consultation visit to the schools. No international predoctoral dental education programs have been accredited by the Commission on Dental Accreditation at this time.

Activities, Results and Accomplishments

The JACIA met on July 28, 2011, and January 30, 2012, via conference call. The following is a summary of the activities, results and accomplishments of those meetings:

- A consultation site visit was conducted at the SDM College of Dental Sciences and Hospital, Dharwad, India on September 18-24, 2011. The visiting committee made 21 recommendations related to compliance with the standards. Further recommendations were made regarding the organization of the submitted self-study and regarding the nature of documentation required to show that assessment has occurred throughout the program including evidence that data has been collected, analyzed and re-measured as needed when related to program goals and quality improvement within the patient care program. The JACIA noted that the number of recommendations is significantly more than a U.S. program typically receives following a site visit. In addition, the JACIA was concerned that the recommendations were related to the accreditation standards on quality assurance, outcomes assessment, determination of student competency, curriculum review and the research program all of which will require significant resources and expertise to bring the program up to the U.S. accreditation standards. The JACIA came to the consensus that the program does not have the potential to pursue accreditation through the Commission on Dental Accreditation at this time and that the program could benefit from further consultation with U.S. dental school faculty and administrators. Further consideration of whether the program has documented that the recommendations have been addressed can only be made through a new self-study which should be submitted, at the earliest, in two years.
- A consultation site visit was conducted at the King Abdulaziz University School of Dental Medicine, Jeddah, Saudi Arabia, on April 1-4, 2012. The report of the visiting committee will be considered by the JACIA at its next meeting.
- A PACV self-study and consultation fees from the Universidad de la Salle Bajio, Faculty of Odontology, Leon, Mexico were received in the Commission office on May 31, 2011. At its July 28, 2011 meeting, JACIA reviewed documentation related to equivalency to Standard 1-7 as well as standards one (1) through six (6) of the Accreditation Standards for Dental Education

Programs. The program provided a detailed response to additional questions from the JACIA, and after review and discussion, the Committee came to the consensus that sufficient documentation was provided. A comprehensive Preliminary Accreditation Consultation Visit (PACV) has been scheduled for September 2012.

- A PACV survey and appropriate fees were received from Faculty of Dentistry at Universidad Autonoma de Nuevo Leon, Monterrey, Mexico. Using the Broad Eligibility Criteria for Preliminary Accreditation Consultation Visit Surveys, JACIA determined that the program has the potential to achieve a PACV consultation and can observe a U.S. comprehensive visit and submit a PACV self-study.
- The JACIA granted Seoul National University, Seoul, South Korea, an extension until December 31, 2013, to complete the PCV self-study utilizing the revised predoctoral dental education accreditation standards.

The JACIA expressed concern that international programs may not have enough information and understanding regarding competency-based education, outcomes assessment and quality assurance even after program representatives observe a United States site visit. The Committee discussed possible ways to ensure that program representatives have a good understanding of these concepts, including providing further information and references at the post-site visit session conducted by the site visit chair.

Emerging Issues and Trends

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);
- United States Department of Education (USDE) regulations regarding accreditation recognition renewal petitions;
- Trends in the National Advisory Committee on Institutional Quality and Integrity (NACIQI) evaluation of accreditors for USDE recognition; and
- Reports of accreditation standard frequency of citings for all disciplines.

Responses to House of Delegates Resolutions

53H-2011. Accreditation Standards for Dental Therapy Programs (Trans.2011:467)

Resolved, that the Commission on Dental Accreditation be strongly urged to delay the process of developing accreditation standards for dental therapy programs for the purpose of further review of compliance with CODA's Principles and Criteria Eligibility of Allied Dental Programs.

Commission Response: The Commission reviewed ADA House of Delegates Resolution 53H-2011, along with both written and verbal comments from the CODA Open Hearings at the ADA Annual Session, urging the Commission to delay the process of developing accreditation standards for dental therapy education programs until there is further evidence that Criteria #2 and #5 of the "Principles and Criteria for Eligibility of Allied Dental Programs for Accreditation by the Commission on Dental Accreditation" are met. The Commission reaffirmed that the Task Force on Development of Accreditation Standards for Dental Therapy Education Programs should continue the process of developing accreditation standards for dental therapy education programs; however, the Commission determined that no implementation date will be set until further documentation has been provided which shows that Criteria #2 and #5 are fully satisfied.

40H-2011. Funding Support for CODA Strategic Planning Efforts (Trans.2011:467)

Resolved, that the ADA allocate funding up to \$23,750 for the Commission on Dental Accreditation to engage an outside facilitator to design and support its strategic planning efforts as directed by the 2008 ADA Task Force on CODA Report and Recommendations.

Commission Response: The Commission engaged Mr. Bennett Napier as an outside facilitator for the development of a strategic plan. The Commission's Standing Committee on Quality Assurance and Strategic Planning met with Mr. Napier on February 1, 2012, prior to the Commission meeting to initiate the strategic planning process. At this meeting, the committee developed a draft mission statement, vision statement, values statement and strategic plan. Mr. Napier will facilitate a Commission-wide strategic planning session and mega-issue discussion to be held in conjunction with the August 2012 Commission meeting.

Policy Review

The Commission did not review Current Policies in accord with Resolution 111H-2010, as a comprehensive review of policies was conducted in 2010. The 2010 ADA House of Delegates accepted the Commission's recommendations to either maintain, amend, rescind, or remove policies.

Summary of Resolutions

This report is informational and no resolutions are presented.

Commission Minutes

For more information on recent activities, see the Commission's minutes on ADA.org: <https://www.ada.org/members/1293.aspx#accreditation>.

Council on Dental Benefit Programs

Richeson, James G., 2012, Washington, DC, chair
Ura, Stephen C., 2012, New Hampshire, vice chair
Blaisdell, Mark H., 2015, Utah
Coggin, C. Celeste, 2012, Georgia
Eder, B. Scott, 2013, West Virginia
Harrell, Gavin G., 2014, North Carolina
Hoffman, Charles W., 2015, Florida
Jurkovich, Mark W., 2014, Minnesota
Masak, John G., 2015, Wisconsin
May, A. David, 2013, Texas
Mazzola, Robert L., 2015, Ohio
Passeri, Lauri A., 2012, Pennsylvania
Poteet, Sarah, 2012, Texas, *ex officio* *
Prator, D. Mark, Alaska, 2012
Riggins, Ronald D., 2013, Illinois
Toy, Bruce G., 2013, California
Vorrasi, Andrew G., 2014, New York
Wood, C. Rieger, III, 2014, Oklahoma

Preble, David M., director
Aravamudhan, Krishna, senior manager
Pokorny, Frank, senior manager
Avalos, Rocio, manager
McHugh, Dennis, manager

The Council's 2011-12 liaisons included: Dr. Charles H. Norman, III, (Sixteenth District trustee, Board of Trustees); and Mr. Benjamin Youel (American Student Dental Association).

Mission and Purpose

The Council on Dental Benefit Programs is the ADA agency dedicated to promoting quality dental care through the development, promotion and monitoring of dental benefit programs for the public, as well as by development and maintenance of coding taxonomies and quality assessment and improvement tools and methodologies.

Supporting the Strategic Plan: Activities, Results and Accomplishments

In December 2011 the Board of Trustees approved the formation of the Council on Dental Benefit Programs' (CDBP) Code Advisory Committee (CAC), comprised of dental community stakeholders that include the third-party payer organizations named to the former Code Revision Committee (CRC), representatives of the nine recognized dental specialty organizations, the Academy of General Dentistry and the American Dental Education Association.

The *CDT Code on Dental Procedures and Nomenclature* maintenance process incorporates best practices of other entities that maintain HIPAA medical code sets. In addition, the Council incorporated features (e.g., formal participation of dental specialty organizations) of the maintenance process in place before the advent of the Code Revision Committee in 2001. Key features of the new process are:

1. The CAC, which is a 21-member body that will vote on recommendations to accept or decline a *CDT Code* change request. This is a more comprehensively representative body than the CRC

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

which had 12 voting members, evenly divided between the ADA and the third-party payer community only.

2. A portion of the CAC meetings will be open, when the submitters of change requests and any other interested parties are encouraged to voice their comments on requested changes. In the second portion of the CAC meeting, members will publicly discuss all code change requests and vote on recommendations to approve or decline.

The next closing date for *CDT Code* change requests is October 1, 2012. All submissions will be on the CAC agenda when the Committee convenes on February 28, 2013, and March 1-2, 2013. The CAC recommendations will be ratified when the Council meets on April 19-20, 2013 and those accepted will be incorporated into the version of the *CDT Code* that is effective January 1, 2014.

To foster member awareness of the *CDT Code* maintenance process at the ADA Annual Session, there will be a CDT Code Open Forum beginning in 2012. The Council expects to identify concepts that it may wish to pursue further to ensure that this code taxonomy continues to fulfill the needs of the dental community.

The Dental Quality Alliance (DQA) has made significant progress and has proposed programmatic performance measures for use with the Medicaid and CHIP programs to satisfy its initial charge. The Alliance continues to work with the commercial payers and federal agencies to ensure implementation of these measures. In addition, the DQA has published an educational document, entitled “Quality Measurement in Dentistry: A Guidebook,” to enable the profession to understand “quality” as it applies to dentistry. Working with all the stakeholders in the quality measurement arena, the Council hopes to ensure that appropriate measures are developed and implemented in dentistry.

In 2011, the DBIS (Dental Benefit Information Subcommittee) met with representatives from Guardian and HealthCare Insight (HCI) on August 4 (immediately preceding the National Dental Benefits Conference). The purpose of the meetings was to meet with representatives from various dental insurance carriers and consulting firms to discuss issues of mutual concern and other matters as deemed appropriate. This year’s meeting is scheduled for September 13 and CIGNA and MetLife have agreed to meet with the Subcommittee.

Emerging Issues and Trends

The new version of the HIPAA standard electronic dental claim transaction (837Dv5010), effective January 1, 2012, supports reporting of up to four diagnosis codes per procedure. This action prompted the Council to revise the ADA Dental Claim Form in a similar manner, in accordance with ADA policy. HIPAA regulations recognize only ICD-9-CM and ICD-10-CM as sources of diagnosis codes. SNODENT (Systematized Nomenclature of Dentistry) is not used in the HIPAA standard electronic dental claim as the ADA considers it a granular input taxonomy that supports a robust electronic dental health record.

Implementation specifications for the HIPAA standard electronic dental claim transaction identify diagnosis code as a situational data element, meaning it is not required on every dental claim. This information should only be submitted when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient’s oral and systemic health conditions.

The implication is that the dentist determines when a diagnosis code should be included. However, HIPAA regulations do not prohibit a participating provider contract from having legally enforceable provisions that require a network dentist to include diagnosis codes on claim submissions.

Procedure code modifiers are also data elements on the HIPAA standard electronic dental claim form, and the ADA’s *CDT Code* is the only recognized source of modifier codes. The *CDT Code* does not include any procedure code modifiers as no current need has been identified. In 2012, the Council convened an ad-hoc “brainstorming” meeting with individuals who are senior level “thought leaders” within the payer and health care electronic commerce community. The consensus among the payer

representatives was that there is no imminent need for procedure code modifiers. Council action is deferred to 2013, after additional payer feedback is received.

Responses to House of Delegates Resolutions

2H-2011. Definitions of Usual and Customary Fees (Trans.2010:545; 2011:452)

The ADA policy was amended to reflect changes to the term “usual fee” and to use the term “maximum plan benefit” in lieu of “customary fee.” A letter was sent to seven insurance regulators, consumer advocacy groups and dental benefits administrators urging them to adopt these guidelines as an industry-wide standard for defining these terms. This revised policy will be added to the next edition of *Current Policies*.

3H-2011. Statement on Determination of Customary Fees by Third Parties (Trans.1991:633; 2010:545; 2011:453)

The ADA policy was amended to use the term “maximum plan benefit” in lieu of “customary fee.” This revised policy will be added to the next edition of *Current Policies*.

4H-2011. Limitations in Benefits by Dental Insurance Companies (Trans.1997:680; 2011:453)

The ADA policy was amended to substitute the term “maximum plan benefit” in lieu of the term “maximum plan allowance.” This revised policy will be added to the next edition of *Current Policies*.

5H-2011. Definitions of Fraudulent and Abusive Practices in Dental Benefit Plans and Claims (Trans.1998:701; 2001:428; 2010:548; 2011:454)

The ADA policy was amended to use the term “maximum plan benefit” in lieu of “customary fees.” This revised policy will be added to the next edition of *Current Policies*.

60-2011. Learning the Lessons of Contract Analysis (Trans.2011:458)

This resolution was referred to the Council on Dental Benefit Programs as the lead agency in consultation with the Legal Division, the Division of Communications and the New Dentist Committee. The resolution reads as follows:

Resolved, that the Council on Dental Benefit Programs in consultation with the Contract Analysis Service and the Division of Communications, prepare a series of articles suitable for publication that document and explain commonly encountered areas of concern in third party contracts, and be it further

Resolved, that content from the articles be used to prepare a brochure for distribution to new dentists and others with questions about managed care contracts, and made available on the Association website.

The Council on Dental Benefit Programs—in consultation with the Legal Division, the Division of Communications and the New Dentist Committee—has reviewed Resolution 60-2011 and agrees with its spirit. The Council continues work consistent with the resolution but sees no reason for this resolution to be adopted.

A series of three articles appeared in the February, April and May 2012 issues of *ADA News* which identified and explained commonly encountered areas of concern in third-party contracts. The articles are available on ADA.org.

In addition to the articles, the Council determined that existing ADA materials can be used to create financial tools that members can use on their own to assess the financial impact of signing participating provider agreements. The tools will allow individual dentists to run a series of *what if*

financial scenarios in regard to potential managed care participation. Using a web-based form to collect practice financials will make changes easy. This will enable each dentist to compare an unlimited number of options and visualize the range of effects that the plan may have on his or her practice. These tools will be available through the Center for Professional Success.

Two variations of the financial tool may be pursued. The first involves development of a user-friendly application accompanied by an online user guide that the individual dentist will access via ADA.org. If desired, it could have the added benefit of sharing information about the dentist and the prospective contracting managed care organization (MCO) with the ADA.

The second variation will offer the additional benefit of minimizing any data entry beyond the terms of the contract. The practice management system will access the data needed directly from the practice database and produce various reports and “what if” analyses. The anticipated result will be a push button solution that requires the least amount of effort on the part of the dentist.

At the time of this writing, the Council was preparing a request for proposal (RFP).

Policy Review

In accord with Resolution 111H-2010, Regular Comprehensive Policy Review, the Council on Dental Benefit Programs reviewed association policies and presents a series of resolutions with recommendations to maintain, rescind or amend those policies.

Recommendations—Policies to be Maintained

The CDBP concluded that the following policies should be maintained as written. The full text of each policy is included in Appendix 1.

1. **Resolved**, that the following policies be maintained:

- Real-Time Claims Adjudication (*Trans.*2007:419)
- Payment for Temporary Procedures (*Trans.*1999:922)
- Monitoring and Resolution of Code Misuse (*Trans.*2007:419)
- Proposal for the ADA Dental Claim Form to be Maintained in a Form That Coincides With the HIPAA-Required ANSI X12 837—Dental Transaction Set (*Trans.*2001:434)
- Itemization of Dental Charges (*Trans.*1979:634)
- Supporting Constituents With Third-Party Payer Issues (*Trans.*2004:307)
- Definitions of Fraudulent and Abusive Practices in Dental Benefits Plans and Claims (*Trans.*1998:701; 2001:428; 2010:551)
- Definitions of “Usual Fee” and “Maximum Plan Benefit” (*Trans.*2010:545; 2011:452)
- Review of Evidence-Based Reports Denying Reimbursement (*Trans.*2002:423)
- Government-Sponsored Dental Programs (*Trans.*1998:705)
- Guidelines on Coordination of Benefits for Group Dental Plans (*Trans.*1996:685; 2009:423)
- Opposition to Dental Benefit Plans or Programs Conflicting With ADA Policies (*Trans.*1995:620)
- Evaluation of Dental Care Programs (*Trans.*1989:548)
- Standards for Dental Benefit Plans (*Trans.*1988:478; 1989:547; 1993:696; 2000:458; 2001:428; 2008:453; 2010:546)
- Education of Prospective Purchasers of Dental Benefit Programs (*Trans.*1986:515)
- Direct Reimbursement Concept (*Trans.*1982:518)
- Programs in Conflict With ADA Policies (*Trans.*1979:638)
- Limitations in Benefits by Dental Insurance Companies (*Trans.*1997:680)
- Guidelines on the Use of Images in Dental Benefit Programs (*Trans.*1995:617; 2007:419)
- Eligibility and Payment Dates for Endodontic Treatment (*Trans.*1994:674)
- Extending Dental Plan Coverage to Dependents of Beneficiaries (*Trans.*1993:694)
- Plan Coverage for Treatment of Teeth Needing Restoration Due to Attrition, Wear and Abrasion (*Trans.*1993:693)

Appropriate Use of Dental Benefits by Patients and Third-Party Payers (*Trans.*1993:688)
 Preauthorization of Benefits (*Trans.*1992:597)
 Qualifications of Participating Dentists (*Trans.*1991:639)
 Least Expensive Alternative Treatment Clauses (*Trans.*1991:634)
 Pre-Existing Condition Exclusion (*Trans.*1991:634)
 Audits of Private Dental Offices by Third-Party Payers (*Trans.*1990:540; 2005:325)
 Coverage for Treatment of Temporomandibular Joint Dysfunction (*Trans.*1989:549)
 Payment for Prosthodontic Treatment (*Trans.*1989:547)
 Benefits for Services by Qualified Practitioners (*Trans.*1989:546)
 Equitable Dental Benefits for Relatives of Dentists (*Trans.*1987:502)
 Identification of Claims Reviewer (*Trans.*1985:584)
 Frequency of Benefits (*Trans.*1983:548)
 Maximum Fees for Non-Covered Services (*Trans.*2010:616)
 Statement on Reporting Fees on Dental Claims (*Trans.*2009:419)
 Statement on Determination of Maximum Plan Benefit (Formerly “Customary Fees”) by Third Parties (*Trans.*1991:633; 2010:545; 2011:453)
 State No Fault and Workers’ Compensation Programs (*Trans.*2008:460)
 Coordination of Benefits Reform (*Trans.*2008:496)
 Dental Claims Processing (*Trans.*1999:930)
 Third-Party Payers Overpayment Recovery Practices (*Trans.*1999:930)
 ERISA Reform (*Trans.*1998:738)
 Legislative Recognition of the Patient’s Right to Assign Payment (*Trans.*1997:708)
 Prohibition of Contract Provisions Permitting the Automatic Assignment of Participating Dentist Agreements Among Entities Engaged in the Business of Insurance (*Trans.*1995:648)
 Update on Dental Tourism (*Trans.*2008:454)
 Responsibility for the Oral Health of Patients (*Trans.*2004:334)
 Community Rating, Risk Pools and Portability for Health Benefit Coverage Plans (*Trans.*1995:648)
 Statement on Dental Consultants (*Trans.*2010:555)

Recommendations—Policies to be Amended

The CDBP believes that the policy “Dental Benefit Plan Terminology” should be amended to better reflect that definitions will be supported in the glossary on ADA.org and not in the *CDT Manual* or as part of Association policy.

2. Resolved, that the ADA policy on “Dental Benefit Plan Terminology” (*Trans.*1991:634) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that all parties involved with dental benefits be encouraged to use dental benefit plan terminology consistent with definitions included in ~~Association policy and the current edition of the publication entitled *Current Dental Terminology (CDT)*, Glossary of Dental Clinical and Administrative Terms on ADA.org~~, and be it further

Resolved, that the American Dental Association support continued development and use of consistent and accurate terms relating to dental benefits.

Recommendations—Policies to be Rescinded

The CDBP concluded that the following policies should be rescinded. The full text of each policy is included in Appendix 2.

The CDBP reviewed the policy “Participation in Public Agency Sponsored Programs Involving Dental Health Benefits” and recommends rescission because constituent and component societies actively participate in the planning and preparation of these programs and there is no need to keep this as policy.

3. Resolved, that Resolution 113H-1995, "Participation in Public Agency Sponsored Programs Involving Dental Health Benefits" (*Trans.*1995:648), be rescinded.

The CDBP reviewed the policy "Support for Individual Practice Associations (IPAs)" and recommends rescission because of the lack of interest and requests for information from dentists regarding dental individual practice associations.

4. Resolved, that Resolution 38H-1988 and Resolution 2H-1994, "Support for Individual Practice Associations (IPAs)" (*Trans.*1988:475; 1994:655), be rescinded.

The CDBP reviewed the policy "Representation of Participating Dentists in Dental Service Corporations" and recommends rescission because the policy is outdated and no longer relevant today.

5. Resolved, that Resolution 51H-1978, "Representation of Participating Dentists in Dental Service Corporations" (*Trans.*1978:511), be rescinded.

The CDBP reviewed the policy "Direct Reimbursement Mechanism" and recommends rescission because direct reimbursement has already achieved its goal of being a recognized dental benefits program by plan purchasers and brokers.

6. Resolved, that Resolution 50H-1978, "Direct Reimbursement Mechanism" (*Trans.*1978:510), be rescinded.

The CDBP reviewed the policy "Principles for Budget Payment Plans for Dental Care" and recommends rescission because the policy is outdated and no longer relevant today.

7. Resolved, that Resolution 41-1957-H, "Principles for Budget Payment Plans for Dental Care" (*Trans.*1957:93, 389), be rescinded.

The CDBP reviewed the policy "Request for Insurance Companies to Retain Dentists' Social Security Numbers" and recommends rescission because the Council is opposed to insurance companies requesting the Social Security number from a dentist as there are other provider identifier numbers in use now.

8. Resolved, that Resolution 98H-2001, "Request for Insurance Companies to Retain Dentists' Social Security Numbers" (*Trans.*2001:428), be rescinded.

The CDBP reviewed the policy "Freedom of Choice of Dentists" and recommends rescission because this is not policy. It is a directive that should have been carried out in the early 1980s.

9. Resolved, that Resolution 51H-1983, "Freedom of Choice of Dentists" (*Trans.*1983:582), be rescinded.

The CDBP reviewed the policy "Mathematical Analysis of Health Care Related Data" and recommends it be rescinded because the policy is outdated and no longer relevant today with the advent of evidence-based dentistry.

10. Resolved, that Resolution 119H-1999, "Mathematical Analysis of Health Care Related Data" (*Trans.*1999:922), be rescinded.

The CDBP reviewed the policy "Patient and Provider Advisory Panel" and recommends it be rescinded because this is a directive that should have been carried out in the early 2000s. To our knowledge, advisory panels made up of covered patients never gained popularity.

11. Resolved, that Resolution 64H-1997, "Patient and Provider Advisory Panel" (*Trans.*1997:704) be rescinded.

The CDBP reviewed the policy “Disputes Concerning Dental Treatment Provided Under Dental Benefits Programs” and recommends it be rescinded because this has been incorporated into the ADA’s Guidelines for the Peer-Review Process.

12. Resolved, that Resolution 4H-1992, “Disputes Concerning Dental Treatment Provided Under Dental Benefits Programs” (*Trans.*1992:600), be rescinded.

The CDBP reviewed the policy “Use of Peer Review Process by Patients and Third-Party Payers” and recommends it be rescinded because this has been incorporated into the ADA’s Guidelines for the Peer-Review Process.

13. Resolved, that Resolution 4H-1990, “Use of Peer Review Process by Patients and Third-Party Payers” (*Trans.*1990:534), be rescinded.

The CDBP reviewed the policy “Reassignment of the Development and Maintenance of Dental Practice Parameters” and recommends it be rescinded because this policy was updated in 2010.

14. Resolved, that Resolution 34H-1999, “Reassignment of the Development and Maintenance of Dental Practice Parameters” (*Trans.*1999:932), be rescinded.

The CDBP reviewed the policy “Monitoring the Use and Application of Dental Practice Parameters” and recommends it be rescinded because it is outdated and no longer relevant today with the advent of evidence-based guidelines/recommendations.

15. Resolved, that Resolution 12H-1993, “Monitoring the Use and Application of Dental Practice Parameters” (*Trans.*1993:697), be rescinded.

Summary of Resolutions

Resolution 1. Policies to be Maintained as Recommended by the Council on Dental Benefit Programs

Resolution 2. Amendment of the Policy, Dental Benefit Plan Terminology

Resolution 3. Rescission of the Policy, Participation in Public Agency Sponsored Programs Involving Dental Health Benefits

Resolution 4. Rescission of the Policy, Support for Individual Practice Associations (IPAs)

Resolution 5. Rescission of the Policy, Representation of Participating Dentists in Dental Service Corporations

Resolution 6. Rescission of the Policy, Direct Reimbursement Mechanism

Resolution 7. Rescission of the Policy, Principles for Budget Payment Plans for Dental Care

Resolution 8. Rescission of the Policy, Request for Insurance Companies to Retain Dentists’ Social Security Numbers

Resolution 9. Rescission of the Policy, Freedom of Choice of Dentists

Resolution 10. Rescission of the Policy, Mathematical Analysis of Health Care Related Data

Resolution 11. Rescission of the Policy, Patient and Provider Advisory Panel

Resolution 12. Rescission of the Policy, Disputes Concerning Dental Treatment Provided Under Dental Benefits Programs

Resolution 13. Rescission of the Policy, Use of Peer Review Process by Patients and Third-Party Payers

Resolution 14. Rescission of the Policy, Reassignment of the Development and Maintenance of Dental Practice Parameters

Resolution 15. Rescission of the Policy, Monitoring the Use and Application of Dental Practice Parameters

Council Minutes

For more information on recent activities, see the Council's minutes on ADA.org:
<https://www.ada.org/members/1293.aspx#benefit>.

Appendix 1. Policies to be Maintained

As Recommended by the Council on Dental Benefit Programs

Real-Time Claims Adjudication (*Trans.2007:419*)

Resolved, that the appropriate ADA agencies monitor any new real-time claims adjudication initiatives to determine the impact on dentists, and be it further

Resolved, that the appropriate ADA agencies communicate to dental plans, employers and patients the concerns about current payment issues, while encouraging the dental benefits industry to move towards real-time claims adjudication, and be it further

Resolved, that the appropriate ADA agencies educate dentists about the complexities of claims adjudication and third-party payment processes to enable them to more efficiently manage their practices, and be it further

Resolved, that the appropriate ADA agencies work with the national organizations responsible for developing electronic standards for electronic data interchange (EDI) to encourage the development of real-time claims adjudication standards.

Payment for Temporary Procedures (*Trans.1999:922*)

Resolved, that provisional or interim restorations and prostheses are valid treatment modalities that should be reimbursable, and be it further

Resolved, that the American Dental Association urge third-party payers to accept this policy.

Monitoring and Resolution of Code Misuse (*Trans.2007:419*)

Resolved, that the ADA educate members on the appropriate use of the *Code on Dental Procedures and Nomenclature* and encourage them to report misuse by third-party payers, and be it further

Resolved, that the ADA actively pursue violations of the third-party licensing agreement for use of the *Code on Dental Procedures and Nomenclature*.

Proposal for the ADA Dental Claim Form to be Maintained in a Form That Coincides With the HIPAA-Required ANSI X12 837—Dental Transaction Set (*Trans.2001:434*)

Resolved, that the appropriate Association agencies endeavor to coordinate modifications to both the ADA Dental Claim Form and the Health Insurance Portability and Accountability Act of 1996 standard 837, electronic dental claim for consistency and location of data content.

Itemization of Dental Charges (*Trans.1979:634*)

Resolved, that the American Dental Association is opposed to legislation which would mandate that patient invoices contain an itemization of charges related to the dental treatment, including separation of commercial dental laboratory fees, because of the ensuing confusion it would certainly create.

Supporting Constituents With Third-Party Payer Issues (*Trans.2004:307*)

Resolved, that the ADA actively solicit information regarding third-party payer problems from members and all tripartite data sources, and be it further

Resolved, that the appropriate ADA agencies identify these third-party trends and critical issues and proactively use this analysis to facilitate efforts by constituent societies to address and resolve these issues with state and regional regulatory authorities.

Definitions of Fraudulent and Abusive Practices in Dental Benefits Plans and Claims
(Trans.1998:701; 2001:428; 2010:551)

Resolved, that the following definitions related to potentially fraudulent and abusive practices committed by third-party payers administering dental benefits be adopted.

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

Bad Faith Insurance Practices: The failure to deal with a beneficiary of a dental benefit plan fairly and in good faith; or an activity which impairs the right of the beneficiary to receive the appropriate benefit of a dental benefits plan or to receive them in a timely manner. Some examples of potential bad faith insurance practices include: evaluating claims based on standards which are significantly at variance with the standards of the community; failure to properly investigate a claim for care; and unreasonably and purposely delaying and/or withholding payment of a claim.

Inappropriate Fee Discounting Practices:

Intentionally engaging in practices which would force a dentist, who does not have a participating provider agreement, to accept discounted fees or be bound by the terms and conditions set forth in the participating provider contract.

Some examples of inappropriate fee discounting practices include: issuing reimbursement checks which, upon signing, result in the dentist accepting the amount as payment in full; using claim forms which, upon signing, require the dentist to accept the terms of the plan's contract; issuing insurance cards which state that the submittal of a claim by a dentist means that he or she accepts all terms and conditions set forth in the participating provider contract; and sending communications to patients of nonparticipating dentists which state that he or she is not responsible for any amount above usual, customary and reasonable fees as established by the plan.

Downcoding: A practice of third-party payers in which the benefit code has been changed to a less complex and/or lower cost procedure than was reported except where delineated in contract agreements.

Bundling of Procedures: The systematic combining of distinct dental procedures by third-party payers that result in a reduced benefit for the patient/beneficiary. and be it further

Resolved, that the following definitions related to potentially fraudulent and abusive practices by a dentist who is submitting claims to a third-party carrier be adopted.

Claims Reporting Fraud: The intentional misrepresentation of material facts concerning treatment provided and/or charges made, in that this misrepresentation would cause a higher payment.

Overcoding: Reporting a more complex and/or higher cost procedure than was actually performed.

Unbundling of Procedures: The separating of a dental procedure into component parts with each part having a charge so that the cumulative charge of the components is greater than the total charge to patients who are not beneficiaries of a dental benefit plan for the same procedure

Definitions of “Usual Fee” and “Maximum Plan Benefit” (*Trans.2010:545; 2011:452*)

Resolved, that the ADA policy, Definitions of Usual and Customary Fees (*Trans.2010:545*), be amended as follows (additions are shown by double underscoring; deletions are shown by double strikethroughs):

Definitions of “Usual Fee” and “Maximum Plan Benefit”

Resolved, that the following definitions of “usual fee” and “maximum plan benefit” be adopted:

Usual fee is the fee which an individual dentist most frequently charges for a specific dental procedure independent of any contractual agreement.

It is always appropriate to modify this fee based on the nature and severity of the condition being treated and by any medical or dental complications or unusual circumstances.

Maximum plan benefit is the reimbursement level determined by the administrator of a dental benefit plan for a specific dental procedure. This may vary widely by geographic region or by benefit plans within a region.

and be it further

Resolved, that the use of the terms “customary” or “UCR” to justify denial of a claim or communicate with patients or dental benefit plan purchasers is inappropriate due to the arbitrary and prejudicial manner in which it can be designated, and be it further

Resolved, that the ADA should communicate these definitions to insurance regulators, consumer advocacy groups, and dental benefits administrators to encourage the proper use of these terms.

Review of Evidence-Based Reports Denying Reimbursement (*Trans.2002:423*)

Resolved, that all complaints reported to the ADA between third-party payers and ADA members regarding interpretation of evidence-based reports be referred to the Council on Dental Benefit Programs with input from the appropriate Association agencies for review.

Government-Sponsored Dental Programs (*Trans.1998:705*)

Resolved, that the ADA strongly encourage all government-sponsored dental programs to support the concept of patient/enrollee freedom of choice in selection of dental benefit plans, and be it further

Resolved, that all government-sponsored programs allow for patient/enrollee selection of dental benefits plans independently from their selection of other health/medical benefit plans, and be it further

Resolved, that all government-sponsored dental benefit programs include a fee-for-service dental benefit option, where the patient/enrollee may use the services of any licensed dentist of their choice.

Guidelines on Coordination of Benefits for Group Dental Plans (*Trans.1996:685; 2009:423*)

When a patient has coverage under two or more group dental plans the following rules should apply:

- a. The coverage from those plans should be coordinated so that the patient receives the maximum allowable benefit from each plan.
- b. The aggregate benefit should be more than that offered by any of the plans individually, allowing duplication of benefits up to the full fee for the dental services received.

and be it further

Resolved, that third-party payers, representing self-funded as well as insured plans, should be urged to adopt these guidelines as an industry-wide standard for coordination of benefits, and be it further

Resolved, that constituent societies are encouraged to seek enactment of legislation that would require all policies and contracts that provide benefits for dental care to use these guidelines to determine coordination of benefits, and be it further

Resolved, that all third parties providing or administering dental benefits should adopt a unified standardized formula for determining primary or secondary coverage and that the formula should be readily applied by dental providers based on information easily obtained from the patient, and be it further

Resolved, that the ADA seek federal legislation requiring that third parties comply with a standardized formula for determining primary and secondary coverage, and be it further

Resolved, that the ADA, through its appropriate agencies, urge the National Association of Insurance Commissioners (NAIC) to amend their model legislation to conform with ADA policy.

Opposition to Dental Benefit Plans or Programs Conflicting With ADA Policies (*Trans.1995:620*)

Resolved, that the American Dental Association is opposed to any dental benefit plan or program and any financing mechanism for the delivery of dental care which conflicts with the policies or mission of the ADA.

Evaluation of Dental Care Programs (*Trans.1989:548*)

Resolved, that the American Dental Association recognizes the propriety of providing group dental care as a benefit of employment, and urges that the methods of financing and administering such programs be in keeping with the policies and principles of the Association, and be it further

Resolved, that the Association and its constituent and component societies maintain active communication with all groups interested in the development and operation of group programs for dental care, providing them with the Association's guidelines for dental benefit coverage, and be it further

Resolved, that the policy on "Evaluation of Dental Care Programs" (*Trans.1954:279*) and on "Labor Union Dental Programs" (*Trans.1954:279*) be rescinded.

Standards for Dental Benefit Plans (*Trans.1988:478; 1989:547; 1993:696; 2000:458; 2001:428; 2008:453; 2010:546*)

1. Organized dentistry at all levels should be regularly consulted by third-party payers with respect to the development of dental benefit plans that best serve the interests of covered patients.
2. Joint efforts should be made by organized dentistry and third-party payers to promote oral health with emphasis on preventive treatment.
3. Plan purchasers should be informed that oral conditions change over time and, therefore, "maximum lifetime benefit" reimbursement restrictions should not be included in dental plans. Dental plans should be designed to meet the oral health needs of patients.
4. Patients should have freedom of choice of dentist and all legally qualified dentists should be eligible to render care for which benefits are provided.
5. Plans that restrict patients' choice of dentists should not be the only plans offered to subscribers. In all instances where this type of plan is offered, patients should have the annual option to choose a plan that affords unrestricted choice of dentist, with comparable benefits and equal premium dollars.
6. The provisions and promotion of the program should be in accordance with the *Principles of Ethics* of the American Dental Association and the codes of ethics of the constituent and component societies involved.
7. The design of dental benefits plans differs from that of medical plans:

- Dental disease does not heal without therapeutic intervention, so early treatment is the most efficient and least costly.
- The need for dental care is universal and ongoing, rather than episodic.
- The need for dental care is highly predictable and does not have the characteristics of an insurable risk.
- The dental needs of individuals in an insured group vary considerably.
- Patient cooperation and post-treatment maintenance is critical to the success of dental treatment and the prevention of subsequent disease.

Therefore, the American Dental Association recommends that for preventive, diagnostic and emergency services, dental benefit plans should not contain deductibles or patient copayments, because they discourage patients from entering the system. Patient participation in the cost of complex care should be sufficient to motivate patients to adequately maintain their oral health.

Rather than excluding categories of services, the Association believes that cost containment is best achieved by varying the patient participation in the costs of treatment and imposing annual limitations on benefits.

8. In order that the patient and dentist may be aware of the benefits provided by a dental benefit plan, the extent of any benefits available under the plan should be clearly defined, limitations or exclusions described, and the application of deductibles, copayments and coinsurance factors explained to the patients by the third-party payers and employers. This should be communicated in advance of treatment.

The patient should also be reminded that he or she is fundamentally responsible to the dentist for the total payment of services received. In those instances where the plan makes partial payment directly to the dentist, the remaining portion for which the patient is responsible should be prominently noted in the Explanation of Benefits Statement (EOB) provided to the patient.

9. Each dentist should have the right to determine whether to accept payment directly from a third-party payer.

10. Third-party payers should make use of dental society peer review mechanisms as the preferred method for the resolution of differences regarding the provision of professional services. Effective peer review of fee disputes, quality, and appropriateness of treatment should be made available by the dental profession.

11. Procedures for claims processing should be efficient and reimbursement should be prompt. The third-party payer should use or accept the American Dental Association's "ADA Dental Claim Form" and the *Code on Dental Procedures and Nomenclature* that the Council on Dental Benefit Programs has approved after appropriate consultation with representatives of nationally recognized dental benefit organizations and the ADA recognized dental specialty organizations.

12. Dentists should comply with reasonable requests from third-party payers for information regarding services provided to patients covered under a plan.

13. Third-party payers' administrative procedures should be designed to enhance the dentist-patient relationship and avoid any interference with it.

14. When patient eligibility is certified through the predetermination process, the third-party payer shall be committed to reimburse on the basis of that initial certification within the provisions of that plan, unless and until written notification is provided in a timely manner to the dentist and the patient by the payer that change in eligibility status has occurred.

15. When such a change in eligibility occurs, a period of not less than 30 days should be allowed for continuation and, when possible, completion of treatment.

16. The treatment plan of the attending dentist, as agreed upon by the patient, shall remain the exclusive prerogative of the dentist and should not be unilaterally interfered with by third-party administrators or payers, or their consultants.

17. The American Dental Association opposes any abuse of the "Least Expensive, Professionally Acceptable Treatment" concept and will inform the public of the barrier such abuse represents to the attainment of quality dental care. When an insoluble dispute occurs between an attending dentist and third party regarding a treatment plan, peer review should be accepted by all parties involved as the mechanism for solution. Peer review should be entered into prior to the third-party payer's determination of reimbursable benefits in such cases.

18. A dental benefit plan should include the following procedures:

- A. *Diagnostic*. Provides the necessary procedures to assist the dentist in evaluating the conditions existing and the dental care required.
- B. *Preventive*. Provides the necessary procedures or techniques to assist in the prevention of dental abnormalities or disease.
- C. *Emergency Care*. Provides the necessary procedures for treatment of pain and/or injury. It should also cover the necessary emergency procedures for treatment to the teeth and supporting structures.
- D. *Restorative*. Provides the necessary procedures to restore the teeth.
- E. *Oral and Maxillofacial Surgery*. Provides the necessary procedures for extractions and other oral surgery including preoperative and postoperative care.
- F. *Endodontics*. Provides the necessary procedures for pulpal and root canal therapy.
- G. *Periodontics*. Provides the necessary procedures for treatment of the tissue supporting the teeth.
- H. *Prosthodontics*. Provides the necessary procedures associated with the construction, replacement, or repair of fixed prostheses, removable partial dentures, complete dentures and maxillofacial prostheses.
- I. *Orthodontics*. Provides the necessary treatment for the supervision, guidance and correction of developing and mature dentofacial structures.

19. The financial reserves of the plan should be adequate to assure continuity of the program.

20. Reimbursement schedules and claim documentation requirements should be based on procedures performed by the dentist and not on the specialty status of the dentist performing them.

21. The methodology used by plan administrators to set reimbursement schedules should rely on current, geographic and other relevant data and be readily available to patients, plan purchasers and dentists.

22. Profiling to establish a different rate of reimbursement for the provider should not be used as a means of cost control by the plan administrators.

23. The data, calculations and methodology used for practice profiling of individual dentists should be made available to those dentists upon request.

24. Information on the possibility of post-payment utilization review, and any consequences of same, must be provided to both participating and nonparticipating dentists.

Education of Prospective Purchasers of Dental Benefit Programs (*Trans.1986:515*)

Resolved, that the Association engage in an aggressive program to educate prospective purchasers to the advantages of dental benefit programs that are compatible with private practice, fee-for-service dentistry and freedom of choice, and be it further

Resolved, that in this effort, promotion of the direct reimbursement model is preferable, but other models may be acceptable.

Direct Reimbursement Concept (*Trans.1982:518*)

Resolved, that the ADA recognizes that the direct reimbursement concept can be an efficient, economical and cost-effective method of reimbursing the patient for dental expenses, and be it further

Resolved, that the Council on Dental Benefit Programs continue to present the direct reimbursement concept to both the public and the business community.

Programs in Conflict With ADA Policies (*Trans.1979:638*)

Resolved, that the Association does not advocate programs that are in conflict with ADA policies.

Limitations in Benefits by Dental Insurance Companies (*Trans.1997:680*)

Resolved, that, since the term “usual, customary and reasonable” is often misunderstood by patients and tends to raise distrust of the dentist in the patient’s mind by suggesting the dentist’s fees are excessive, the American Dental Association urges all third-party payers employing this terminology to substitute the term “maximum plan allowance” in all patient communications and explanations of benefits, and be it further

Resolved, that appropriate agencies of the American Dental Association and constituent dental societies urge purchasers of dental benefit plans to eliminate preexisting condition clauses from their contracts, and be it further

Resolved, that appropriate agencies of the American Dental Association urge purchasers of dental benefit plans to increase yearly maximum benefits to be consistent with cost-of-living increases, and be it further

Resolved, that appropriate agencies of the American Dental Association notify all providers of dental benefits of these new policies, and be it further

Resolved, that the American Dental Association seek legislation and/or regulations to accomplish these goals, and be it further

Resolved, that constituent dental societies be urged to seek legislation or regulation in their individual states to accomplish these same requirements.

Guidelines on the Use of Images in Dental Benefit Programs (*Trans.1995:617; 2007:419*)

Resolved, that the following Guidelines on the Use of Images in Dental Benefit Programs be adopted as policy of the Association:

Guidelines on the Use of Images in Dental Benefit Programs

The American Dental Association’s recommendations on selection criteria for images states that diagnostic imaging should be used only after clinical evaluation, review of the patient’s history, and consideration of the dental and general health needs of the patient. The type, frequency and extent of diagnostic images necessary for each individual patient will be provided in accordance with the dentist’s professional judgment. Federal and state laws regarding patient privacy are subject to change and may supersede these guidelines.

The Association believes that the following guidelines should be applied in the use of images in dental care plans:

1. Images should be generated only for clinical reasons as determined by the patient's dentist. Clinical images may be used as part of a system for determining those benefits to which the patient is entitled under the terms of a contract. Third-party payers should not request that images be generated solely for administrative purposes. If a third party requests an image which was not generated as part of the dentist's clinical treatment, dentists should consider the clinical necessity of the image in connection with the request.
2. When a dentist determines that it is appropriate to comply with a third-party payer's request for images, it is recommended that a duplicate set be submitted and the originals retained by the dentist. All images, including duplicates, except those submitted in digital or other electronic form, and whether or not it has been requested, should be returned to the dentist.
3. There are many instances in which a determination of care cannot be made solely on the basis of images and it is improper for third-party payers to deny authorization for payment or make determinations about treatment based solely on images.
4. Third-party payers should not use images to infringe upon the professional judgment of the treating dentist or to interfere in any way with the dentist-patient relationship. All questions of interpretation of images must be reviewed by a dentist consultant.
5. Clinical images should only be requested when they will be reviewed by a dentist to make a determination regarding the patient's entitlement to benefits. Dentists reviewing images for this purpose should be licensed in the U.S., preferably within the jurisdiction of the dentist providing the images in accordance with applicable state law.
6. Patients should be exposed to radiation only when clinically necessary, as determined by the treating dentist. Postoperative images should be required only as part of dental treatment.
7. It is important that images be correctly identified and be of diagnostic quality.
8. Third-party payers, except those in digital or other electronic form, should protect the confidentiality of all records, including images, which are submitted to them by dental offices. All images submitted to third-party payers should be returned to the treating dentist within fifteen (15) working days. Images received in an electronic form should be permanently deleted within 30 days of the completion of claims adjudication.
9. Images held by parties other than the treating dentist should not be transmitted to any agency or entity without written consent of the dentist or patient.
10. Where a claim or predetermination request indicates that images are provided, the third-party payer should immediately notify the submitting dentist's office if the images are missing.
11. A patient's predetermination request or claim should not be prejudiced by the third-party payer's loss or misplacement of images.
12. Images are an integral part of the dentist's clinical records and, as such, should be considered the property of the dentist where consistent with state law. Because it is necessary for a dentist to maintain accurate and complete records, third-party payers should accept copies of images in lieu of originals.
13. Any additional costs incurred by the dentist in copying images and clinical records for claims determination should be reimbursed by the third-party payer or the patient.

and be it further

Resolved, that the Guidelines on the Use of Radiographs in Dental Care Programs (*Trans.1990:540*) be rescinded.

Eligibility and Payment Dates for Endodontic Treatment (*Trans.1994:674*)

Resolved, that the American Dental Association, through its Council on Dental Benefit Programs, encourages all third-party payers to recognize the date that endodontic therapy is begun as the eligibility date for coverage for endodontic therapy, and be it further

Resolved, that the Association, through its Council on Dental Benefit Programs, encourages all third-party payers to recognize the completion date as the date of service, that is, the payment date, for endodontic therapy.

Extending Dental Plan Coverage to Dependents of Beneficiaries (*Trans.1993:694*)

Resolved, that dental plan purchasers be encouraged to extend coverage to the dependents of beneficiaries, and be it further

Resolved, that the term “dependent” include spouse, children, and other members of the household who are financially dependent on the beneficiary as defined by the Internal Revenue Service (IRS).

Plan Coverage for Treatment of Teeth Needing Restoration Due to Attrition, Wear and Abrasion (*Trans.1993:693*)

Resolved, that dental benefit plans should provide coverage for restoration of teeth that have structural loss due to attrition, abrasion and/or erosion.

Appropriate Use of Dental Benefits by Patients and Third-Party Payers (*Trans.1993:688*)

Resolved, that the American Dental Association supports the appropriate use of dental benefits by patients and third-party payers, and be it further

Resolved, that in order for patients to receive the benefits to which they are entitled, the ADA opposes the practice by third-party payers of reclassifying treatment in such a way as to reduce or limit the patient’s rightful dental benefit coverage.

Preauthorization of Benefits (*Trans.1992:597*)

Resolved, that the American Dental Association is opposed to any dental benefit clause that would deny or reduce payment to the beneficiary, to which he or she is normally entitled, solely on the basis of lack of preauthorization, and be it further

Resolved, that Resolution 14H-1990 (*Trans.1990:539*), Preauthorization Requirements, be rescinded.

Qualifications of Participating Dentists (*Trans.1991:639*)

Resolved, that the American Dental Association supports the position that all dentists licensed in their state shall be eligible to participate in all public and private third-party programs, and be it further

Resolved, that Resolutions 38-1966-H (*Trans.1966:347*), Qualifications of Participating Dentists, as amended by Resolution 120H-1976 (*Trans.1976:865*), be rescinded.

Least Expensive Alternative Treatment Clauses (*Trans.1991:634*)

Resolved, that the use of a clause in a dental plan which restricts benefits to those for the least expensive alternative treatment as defined by the third-party payer can be misleading to the plan purchaser and the dental patient, and be it further

Resolved, that plans which contain this clause should make the limitations of this clause understood to the plan purchaser and the dental patient, and be it further

Resolved, that to best educate the public as to the application of this clause when it is applied to limit benefit coverage, the plan should inform the plan purchaser of that application and should provide the patient and treating dentist with the name and qualifications of the individual making the determination, along with the basis for determination that another treatment is in the best interests of the patient and appropriate for the patient's condition, and be it further

Resolved, that the ADA Council on Dental Benefit Programs be directed to inform consumer groups of the potential problems involved in accepting a contract that will pay only for the least expensive alternative treatment as determined by the third-party payer, and be it further

Resolved, that Resolution 58-1972-H (*Trans.1972:676*), Least Expensive Adequate Treatment (LEAT) Clause, be rescinded.

Pre-Existing Condition Exclusion (*Trans.1991:634*)

Resolved, that the American Dental Association, along with its constituent and component societies, urge inclusion of coverage in all dental benefits plans for preexisting conditions which would otherwise be covered, including replacement of missing teeth, and to provide coverage for the continuation of treatment plans already in progress when the patient first becomes enrolled in the plan.

Audits of Private Dental Offices by Third-Party Payers (*Trans.1990:540; 2005:325*)

Resolved, that where the dentist is under no direct contractual obligation with a third-party payer, the decision to comply with requests for in-office audits should be made independently by the individual dentist after consulting with his or her attorney for a determination of the legal implications of such decision, and be it further

Resolved, that in those instances where the dentist has expressly agreed in a contract to comply with office audit procedures, and in the event of an audit, the dentist is encouraged to obtain a written description and scope of the audit procedures and should seek the advice of his or her legal counsel, in order to be informed of his or her rights and potential liabilities regarding such audit, and be it further

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

Coverage for Treatment of Temporomandibular Joint Dysfunction (*Trans.1989:549*)

Resolved, that the American Dental Association encourage all third-party payers to offer benefit coverage for diagnosis and treatment of bone and joint disorders without discrimination, and be it further

Resolved, that the ADA strongly recommends that all third-party payers coordinate the coverage between medical and dental plans to eliminate any disparity in benefits coverage and reimbursement for such disorders, and be it further

Resolved, that the ADA strongly encourages constituent dental societies to seek legislation and/or a ruling from the state insurance commissioner that health benefit plans offer coverage for diagnosis and treatment for bone or joint disorders without discrimination, and be it further

Resolved, that Resolutions 111H-1981 (*Trans.1981:583*) and 27H-1982 (*Trans.1982:526*) be rescinded.

Payment for Prosthodontic Treatment (*Trans.1989:547*)

Resolved, that the Council on Dental Benefit Programs encourages all third-party payers to recognize the preparation date as the date of service, that is, payment date, for fixed prosthodontic treatment, and be it further

Resolved, that the Council on Dental Benefit Programs encourages all third-party payers to recognize the final impression date as the date of service, that is, payment date, for removable prosthodontic treatment, and be it further

Resolved, that Resolution 46H-1981 (*Trans.1981:579*) be rescinded.

Benefits for Services by Qualified Practitioners (*Trans.1989:546*)

Resolved, that beneficiaries of a health benefits plan are entitled to benefits for covered treatment if that treatment is provided by a legally qualified dentist or physician operating within the scope of his or her training and licensure, and be it further

Resolved, that benefits that would otherwise be payable should not be denied solely on the basis of the professional degree and licensure of the dentist or physician providing treatment, if that treatment is provided by a legally qualified dentist or physician operating within the scope of his or her training and licensure, and be it further

Resolved, that in those states that do not have such a law, constituent dental societies be urged to seek legislation that would prohibit discrimination in benefit payments based on the professional degree and licensure of the dentist or physician providing treatment, and be it further

Resolved, that all constituent dental societies be encouraged to monitor the way in which these laws are enforced in their states, and to bring to the attention of the state legislatures and the public any efforts that are clearly too inadequate to succeed, and be it further

Resolved, that Resolution 45-1957-H (*Trans.1957:390*), Resolution 44-1957-H (*Trans.1957:390*) and Resolution 19-1974-H (*Trans.1974:635*) be rescinded.

Equitable Dental Benefits for Relatives of Dentists (*Trans.1987:502*)

Resolved, that group benefit plan contracts should not contain exclusions for reimbursement for treatment based on the familial relationship of the treating dentist and the beneficiary, and be it further

Resolved, that such existing exclusions be deleted from all dental benefit plan contracts as they are renewed, and be it further

Resolved, that carriers, service corporations, other third-party payers and state insurance regulatory agencies be informed of this policy.

Identification of Claims Reviewer (*Trans.1985:584*)

Resolved, that in all correspondence between a third-party carrier and a dentist regarding a patient or a claim, the carrier should provide the name of a specific individual with whom to make contact in reference to that claim, and be it further

Resolved, that the patient's full name, the claim number and a toll-free telephone number should also be provided.

Frequency of Benefits (*Trans.1983:548*)

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

Maximum Fees for Non-Covered Services (*Trans.2010:616*)

Resolved, that, as a matter of policy, the American Dental Association opposes any third party contract provisions that establish fee limits for non-scheduled dental services, and be it further

Resolved, that the American Dental Association continue to actively pursue passage of federal legislation to prohibit ERISA covered plans from applying such provisions, and be it further **Resolved**, that the American Dental Association encourage constituent dental societies to work for the passage of state legislation to prohibit insurance plans from applying such provisions.

Statement on Reporting Fees on Dental Claims (*Trans.2009:419*)

Resolved, that the following Statement on Reporting Fees on Dental Claims be adopted.

Statement on Reporting Fees on Dental Claims

1. A full fee is the fee for a service that is set by the dentist, which reflects the costs of providing the procedure and the value of the dentist's professional judgment.
2. A contractual relationship does not change the dentist's full fee.
3. It is always appropriate to report the full fee for each service reported to a third-party payer.

Statement on Determination of Maximum Plan Benefit (Formerly "Customary Fees") by Third Parties (*Trans.1991:633; 2010:545; 2011:453*)

Resolved, that the Statement on Determination of Customary Fees by Third Parties (*Trans.1991:633; 2010:545; 2011:453*) be amended by deleting the word "customary" (except in the title of the Statement where the word "formerly" was added to facilitate search capabilities; and the word "Fees" was placed inside the parentheses) and adding the words "Maximum Plan Benefit"; and removing the word "Fee" in the fifth and sixth bullet points (additions are shown by double underscoring; deletions are shown by double strikethroughs), and be it further

Resolved, that appropriate agencies of the ADA take action to encourage the adoption of these guidelines at both the state and federal level.

Statement on Determination of Maximum Plan Benefit (Formerly "Customary Fees") by Third Parties

The legitimate interests of insured patients are best served by use of precise, accurate and publicly announced methodologies for determining ranges of fees for all dental services.

Therefore, policy-makers should develop guidelines for regulations which:

- Establish standard terminology for identifying benefits in policies, Explanation of Benefits and other descriptive materials
- Establish a standard screen setting method (such as percentile) and/or require a policy statement, which describes the overall percentage of services (percentile) the policy should allow in full
- Require disclosure regarding the average percentage of claim dollars submitted anticipated to be allowed
- Require disclosure describing the frequency of updates and/or the basis for screen development
- Require disclosure describing how region and specialty were considered in setting the Maximum Plan Benefit Screens
- Require carriers to use sufficient data when determining Maximum Plan Benefit Screens (whether from claims experience or other sources)
- Require carriers to demonstrate how they have set their screens and how they have determined if sufficient data were employed

State No Fault and Workers' Compensation Programs (*Trans.2008:460*)

Resolved, that the American Dental Association, together with its constituent and component societies, urge state no fault and workers' compensation programs to include dental coverage for workplace and motor vehicle injuries, and be it further

Resolved, that the ADA supports application of the following principles in legislation governing no-fault and workers' compensation programs:

1. that the objective of such programs should be to restore to health those patients requiring treatment as the result of a workplace or motor vehicle injuries
2. that such programs should allow patients the freedom to choose their own dentist
3. that coverage for treatment include or take into account the need for present and future treatment needed as result of workplace or motor vehicle injuries
4. that treatment of pre-existing medical or dental conditions should be covered when the injury exacerbated the condition, or treatment of the condition is necessary as part of the final therapy to restore the patient's oral and maxillofacial health
5. that such programs should accept and use the ADA *Code on Dental Procedures and Nomenclature* and the ADA Dental Claim Form when processing dental claims for workplace and motor vehicle injuries
6. that the timeframes for reimbursement or payment on claims for dental treatment resulting from workplace and motor vehicle injuries be in accordance with the state prompt payment laws where applicable
7. that the patient should bear no financial loss for treatment costs as a result of receiving treatment resulting from workplace or motor vehicle injuries
8. that the dentist should be compensated for care rendered in accordance with the dentist's treatment plan and existing fee schedule
9. that such programs should make available an appeals process to patients and dentists for benefits determinations made on claims resulting from workplace or motor vehicle injuries

Coordination of Benefits Reform (*Trans.2008:496*)

Resolved, that the American Dental Association work with government agencies and dental carriers to enact coordination of benefit laws requiring that when a premium is paid and a claim submitted, that each benefit plan will pay the same amount they would allow if no other coverage was applicable up to 100% of the total claim, and be it further

Resolved, that the ADA encourage states to enact similar laws, and be it further

Resolved, that the ADA use its staff and resources to assist states in this process.

Dental Claims Processing (*Trans.1999:930*)

Resolved, that the American Dental Association seek or support legislation, and/or a directive through agency rules and/or regulations, that requires the purchaser of a dental benefit program to also provide a means, other than dental offices, through which the recipient of the benefit can process a claim.

Third-Party Payers Overpayment Recovery Practices (*Trans.1999:930*)

Resolved, that the American Dental Association seek or support legislation opposing all inappropriate third-party payer overpayment recovery practices, and be it further

Resolved, that the American Dental Association encourage state dental societies to seek or support legislation to prevent third-party payers from withholding fully assigned benefits to a dentist when an incorrect payment has been made to the dentist on behalf of a previous patient with the same third-party payer.

ERISA Reform (*Trans.1998:738*)

Resolved, that the ADA seek federal legislation and/or regulation that would prohibit ERISA and all health benefit plans from excluding coverage of general anesthesia and/or hospital or outpatient surgical facility charges incurred by covered persons who receive dental treatment under anesthesia, due to a documented physical, mental or medical reason as determined by the treating dentist(s) and/or physician.

Legislative Recognition of the Patient's Right to Assign Payment (*Trans.1997:708*)

Resolved, that the American Dental Association seek, and constituent societies be urged to seek, appropriate relief through legislation and/or administrative process to require third-party payers to recognize the right of patients to authorize payment directly to the dentist, without changing and without regard to the participation status of the dentist.

Prohibition of Contract Provisions Permitting the Automatic Assignment of Participating Dentist Agreements Among Entities Engaged in the Business of Insurance (*Trans.1995:648*)

Resolved, that the appropriate Association agencies initiate legislative and/or regulatory actions to prohibit PPO brokers and third-party payers in contractual relationships with dentists from selling and/or using the discount rate information about those dentists to any other third-party payers and/or extended managed care networks, and be it further

Resolved, that the Association encourage state dental societies to initiate legislative and/or regulatory action to prohibit these practices on a state level.

Update on Dental Tourism (*Trans.2008:454*)

Resolved, that the following definition of dental tourism be adopted:

Dental tourism is the act of traveling to another country for the purpose of obtaining dental treatment, and be it further

Resolved, that the appropriate agencies of the ADA continue to promote the importance of a dental home while working for increased affordable access to dental care and freedom of choice so that every American who needs dental care can receive it, and be it further

Resolved, that the appropriate agencies of the ADA establish a repository of information relevant to dental tourism, that the information be collected in a manner that protects patient confidentiality and that the information is used in a lawful manner, and be it further

Resolved, that the appropriate agencies of the ADA increase efforts to provide patients, insurance companies and plan purchasers with credible information and resources about quality dental care, including follow-up, delivered by professionals with accredited education, and be it further

Resolved, that in keeping with the ADA position on freedom of choice, patients seeking dental care outside of the U.S. should do so voluntarily, and that prior to travel, be urged to arrange for local follow-up care to ensure continuity of care upon return to the U.S., and be it further

Resolved, that patients who have insurance coverage for dental care performed outside the U.S. should confirm with their insurer and/or employer that follow-up treatment is covered upon return to the U.S., and be it further

Resolved, that patients choosing to travel outside the U.S. for dental care should seek information about the potential risks of combining certain procedures with long flights and vacation activities, and be it further

Resolved, that the transfer of patient records to-and from facilities outside the U.S. should be consistent with current U.S. privacy and security guidelines.

Responsibility for the Oral Health of Patients (*Trans.2004:334*)

Resolved, that a dentist must have the primary responsibility for the oral health care of each patient, regardless of the provision of some preventive or education services by non-dentists

Community Rating, Risk Pools and Portability for Health Benefit Coverage Plans (*Trans.1995:648*)

Resolved, that the Association endorses appropriate legislative initiatives establishing the concept of community rating for health benefit coverage plans, and be it further

Resolved, that the Association endorses appropriate legislative initiatives establishing the concept of risk pools for small employers and individuals to facilitate the purchase of health benefit coverage plans, and be it further

Resolved, that the Association endorses appropriate legislative initiatives intended to facilitate the portability of health benefit coverage plans.

Statement on Dental Consultants (*Trans.2010:555*)

Resolved, that the following Statement on Dental Consultants be adopted.

Statement on Dental Consultants

Third-party payers and plan purchasers have used dental consultants in order to streamline the claims review process for many years.

The American Dental Association initially saw a positive potential in the use of dental consultants by third-party payers as a means of receiving professional advice on certain aspects of dental benefits plans. While the ADA still believes that there is value to third-party payers' use of dental consultants, it also believes that some clear distinctions must be made between dental consultants and dental claims reviewers.

Dental claims reviewers work under supervision. They do not necessarily have, or need, clinical dental or dental practice background, and are trained specifically by the third-party payer to review dental claims that are uncomplicated and require straightforward processing.

Dental consultants are licensed dentists who, even if not currently practicing, have many years of experience in practice and can and should:

- Offer a professional opinion regarding complicated dental treatment
- Provide their name, degree, license number and direct phone number to the treating dental office
- Request consultations from specialists for certain specialty-related cases, when necessary
- Provide advice to third-party payers regarding the merit and value of dental benefits plan designs
- Educate plan purchasers regarding the impact alternative, less costly treatment may have on the life of a tooth, overall oral health, etc.
- Alert third-party payers when dentists' treatment patterns are changed by cost containment strategies to the detriment of the patients
- Provide guidance to third-party payers regarding the importance of the dentist/patient relationship

- Inform third-party payers, plan sponsors and subscribers about the availability and value of the profession's peer review system
- Initiate dialogue with organized dentistry regarding questionable treatment modalities
- Inform the dental profession of those treatment procedures on which questions of judgment between the dentist and the dental consultant are most likely to result in areas of disagreement
- Discuss treatment decisions with dentists on a professional level
- Explain clearly to practicing dentists the provisions of particular contracts and the benefit limitations of those contracts
- Demonstrate knowledge of contract interpretation, and laws and regulations governing dental practice in those jurisdictions affected by their consulting activities, as well as accepted standards of administrative procedure within the dental benefits industry
- Dentists reviewing claims submissions must be licensed in the United States, preferably within the jurisdiction of the dentist treating the patient in accordance with applicable state law

Dentists have a fundamental obligation to serve the best interests of the public and their profession. This obligation can never be abrogated for any reason. In order to maintain independent thought and judgment regarding dental matters, dental consultants should be competent with regard to current clinical procedures and practice through such mechanisms as continuing education, or have been in practice for a minimum of ten years immediately preceding employment as a dental consultant, and remain involved in the continuing dental education process in order to stay current with clinical procedures and changing technology.

It is strongly recommended that dental consultants be members of the American Dental Association.

and be it further

Resolved, that the American Dental Association distribute copies of this Statement to all third-party payers, and be it further

Resolved, that third-party payers, including dental consultants to payers, should not exceed their legitimate role in the processing of dental benefit claims, and specifically, third-party payers and dental consultants should not:

- Change code numbers as submitted without written permission of the attending dentist
- Redefine code numbers, nomenclatures or descriptors except as provided for in their CDT license agreements
- Disapprove complex cases without seeking the advice of appropriately trained consultants

and be it further

Resolved, that the ADA urge third-party payers and administrators to identify dental consultants by name in any correspondence to attending dentists, and be it further

Resolved, that the policies on Disclosure of Dentist Consultants Upon Request (*Trans.*1984:531; 1985:583), Statement on Dental Consultants (*Trans.*1989:542) and Identifying Dental Consultants (*Trans.*2002:412) be rescinded.

Appendix 2. Policies to be Rescinded
As Recommended by the Council on Dental Benefit Programs

Participation in Public Agency Sponsored Programs Involving Dental Health Benefits
(*Trans.*1995:648)

Resolved, that the American Dental Association urges constituent and component societies to participate actively in planning and preparation of all programs involving dental health benefits which may be sponsored by public agencies at any level, and be it further

Resolved, that Resolution 33H-1966 (*Trans.*1966:336), Dental Society Participation in Program Planning, be rescinded.

Support for Individual Practice Associations (IPAs) (*Trans.*1988:475; 1994:655)

Resolved, that the American Dental Association provide information to members and plan purchasers about dental individual practice associations (IPAs) that are established and/or directed by organized dentistry and that conform to Association policy, and be it further

Resolved, that discussion of IPAs be included in the Purchaser Information Service Program.

Representation of Participating Dentists in Dental Service Corporations (*Trans.*1978:511)

Resolved, that the American Dental Association urges all dentists who are participating in dental service plans to take an active role in the organizational, administrative and professional affairs of their respective plans.

Direct Reimbursement Mechanism (*Trans.*1978:510)

Resolved, that the Direct Reimbursement mechanism, a method of assistance in which beneficiaries are reimbursed by the employer or benefits administrator for any dental expenses, or a specified percentage thereof, upon presentation of a paid receipt or other evidence that such expenses were incurred, is a recognized dental benefits approach available to purchasers of dental assistance plans.

Principles for Budget Payment Plans for Dental Care (*Trans.*1957:93, 389)

1. The most desirable method of making a budget payment plan available to all of the people in a state is through a plan operated on a state-wide basis. It is desirable, therefore, that budget payment plans be developed by the state society or that plans which are developed at the component level be expanded or associated in order to provide state-wide coverage as rapidly as possible.
2. The plan should be administered by the sponsoring dental society in accordance with regulations established by the society through the agency to which it has assigned responsibility for operating the plan.
3. The disposition of complaints arising from the financial operation of the plan should be the responsibility of the plan's governing body.
4. The disposition of complaints arising from the dentist-patient relationship should be the responsibility of the dental society's mediation or counseling committee which normally handles all such complaints. The availability of mediation or counseling service is essential to the successful operation of a budget payment plan.
5. The plan should include a continuing program of education for the membership in order to effect maximum utilization and to avoid the unnecessary burden of improper use.

6. The policies governing the management of the loss reserve of the plan should have the approval of a majority of the participating dentists and should be developed and adopted only with the advice and assistance of competent legal and tax counsel.

7. The plan should make provision for semiannual audits and such additional statistical evaluations as may be necessary to determine appropriate adjustments or alterations of the plan in the interest of the public, the dentists and the bank.

8. The promotion of the plan to the public should be in keeping with the *Principles of Ethics* of the American Dental Association and the codes of ethics of the sponsoring constituent and component dental societies. The promotional information should follow the highest standards of dental health educational concepts.

9. All members of the sponsoring society should be eligible to participate in the plan within the agreed limitations of the plan.

10. The maximum success of the plan depends on maximum participation by the membership of the sponsoring society.

Request for Insurance Companies to Retain Dentists' Social Security Numbers (*Trans.2001:428*)

Resolved, that the ADA, through the appropriate agency, urge insurance companies to keep on file the Social Security numbers of those dentists who accept assignment of benefits, and cease requesting them on claim forms or walkout statements.

Freedom of Choice of Dentists (*Trans.1983:582*)

Resolved, that constituent dental societies be urged to support enactment of legislation that would allow any dentist the right to participate as a contracting provider for a dental prepayment plan, provided the dentist is licensed to furnish the dental care services offered by said plan.

Mathematical Analysis of Health Care Related Data (*Trans.1999:922*)

Resolved, that the American Dental Association supports the concept for documentation of methods, data and supporting analysis that may be performed on health care related data, and which may affect the delivery or practice of health care, and be it further

Resolved, that such analysis must be made public and reviewed by interested parties to ensure the quality, integrity and validity of such analysis methodology.

Patient and Provider Advisory Panel (*Trans.1997:704*)

Resolved, that the Association seek, and the constituent societies be urged to seek, legislation or regulation at the federal or state level, respectively, that would require any entity that offers coverage of dental benefits through a network of participating dentists to establish an advisory panel made up of covered patients and an advisory panel made up of participating dentists, and be it further

Resolved, that these panels would provide meaningful input to the plan, on an ongoing basis, on its design and policies.

Disputes Concerning Dental Treatment Provided Under Dental Benefits Programs (*Trans.1992:600*)

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

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

Use of Peer Review Process by Patients and Third-Party Payers (*Trans.1990:534*)

Resolved, that patients and third-party payers be encouraged to use the dental profession's peer review process to address issues or disputes concerning dental treatment provided under dental benefits programs, and be it further

Resolved, that the Council on Dental Benefit Programs work with third-party payers, plan purchasers, benefits consultants and government agencies to include the following paragraph in the "claim appeals" section of the

Summary Plan Description provided to dental benefits plan subscribers: State and local dental societies provide an impartial means of dispute resolution regarding your dental treatment. This process, called Peer Review, may be available to you in addition to the (*insert name of benefit plan or benefit administrator*) appeal process. For more information about Peer Review, contact your local dental society, and be it further

Resolved, that Resolution 79H-1987 (*Trans.1987:502*), Utilization of Peer Review Process, be rescinded.

Reassignment of the Development and Maintenance of Dental Practice Parameters (*Trans.1999:932*)

Resolved, that the Dental Practice Parameters Committee be continued as established by Resolution 62H-1993 (*Trans.1993:697*), Board Report 9 to the 1993 House of Delegates (*Supplement 1993:392*) and Board Report 20* to the 1996 House of Delegates (*Supplement 1996:502*), and be it further

Resolved, that the Dental Practice Parameters Committee meet by conference call, or other electronic means, except when significant issues or challenges to the parameters process arise, as determined by the Committee, and be it further

Resolved, that in addition to computer software systems, publications and presentations, the parameters documents be made available in the "Members Only" section of ADA ONLINE, and be it further

Resolved, that the Dental Practice Parameters Committee develop ways and means to educate the dental community regarding the value of parameters and their use.

*"The Impact and Use of Dental Practice Parameters" as presented in Board Report 20 was amended by the 2003 House of Delegates (*Trans.2003:361*).

Note: The Dental Practice Parameters are available online at
<https://www.ada.org/members/1945.aspx>.

Monitoring the Use and Application of Dental Practice Parameters (*Trans.1993:697*)

Resolved, that the appropriate agencies of the ADA monitor practice guidelines developed by the Agency for Health Care Policy and Research and, as appropriate, seek representation of dentists on review panels selected by AHCPH on conditions involving dental treatment, and be it further

Resolved, that the appropriate agencies of the American Dental Association monitor federal and state mandates for, and application of, practice parameters in health care systems, and be it further
Resolved, that the Association make every effort to influence federal legislative and/or regulatory activities with regard to dental practice parameters, including the development of model legislation, and be it further

Resolved, that constituent societies be encouraged to conduct similar efforts in their states, and be it further

Resolved, that when the Association becomes aware of any activity with regard to the development of dental practice parameters in any state, the constituent society will be offered the assistance of the Association to support that constituent society's efforts.

Council on Dental Education and Licensure

Kinney, George J., Jr., 2012, Minnesota, chair, American Association of Dental Boards
Venezie, Ronald D., 2014, North Carolina, vice chair, American Dental Association
Antoon, James W., 2012, Florida, American Dental Association
Boyle, James M., III, 2015, Pennsylvania, American Dental Association
Dolan, Teresa, 2014, Florida, American Dental Education Association
Edwards, Michael D., 2013, Alabama, American Dental Association
Hoelscher, Diane C., 2015, Michigan, American Dental Education Association
Javed, Tariq, 2013, South Carolina, American Dental Education Association
Johnson, Charles E., 2012, Illinois, American Dental Association
Lloyd, Patrick M., 2012, Ohio, American Dental Education Association
Miller, Jade A., 2014, Nevada, American Association of Dental Boards
Rhea, Ronald L., 2013, Texas, American Dental Association
Robinson, William F., 2013, Florida, American Association of Dental Boards
Salierno, Christopher J., New York, *ex officio**
Simonian, Roger B., 2015, California, American Dental Association
Stenberg, Donna J., 2014, Minnesota, American Dental Association
Strathearn, Jeanne P., 2015, Connecticut, American Association of Dental Boards

Hart, Karen M., director
Borysewicz, Mary, manager
Haglund, Lois J., manager
Yokom, Nanci G., manager

The Council's 2012 liaisons included: Dr. Charles R. Weber (Third District trustee, Board of Trustees) and Mr. John W. Huebner (American Student Dental Association).

Mission and Purpose

The Council on Dental Education and Licensure (CDEL) is the ADA agency dedicated to promoting high quality and effective processes of dental education, dental licensure and credentialing in the United States. CDEL, through its unique representative structure (eight ADA appointees, four ADEA appointees and four AADB appointees) conducts business in accord with its duties:

- Acts as the agency of the Association in matters related to the evaluation and accreditation of all dental educational, allied dental educational and associated subjects.
- Studies and makes recommendations including proposed policy formulation on:
 - (1) Dental education, continuing dental education and allied dental education;
 - (2) The recognition of dental specialties;
 - (3) The recognition of interest areas in general dentistry, excluding ADA recognized specialties;
 - (4) The recognition of categories of allied dental personnel;
 - (5) The approval or disapproval of national certifying boards for dental specialties and for allied dental personnel;
 - (6) The educational and administrative standards of the certifying boards for dental specialties and for allied dental personnel;
 - (7) Associated subjects that affect all dental, allied dental and related education; and
 - (8) Dental licensure and allied dental personnel credentialing.
- Acts on behalf of this Association in maintaining effective liaison with certifying boards and related agencies for dental specialties and for allied dental personnel.

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

- Monitors and disseminates information on continuing dental education and encourages the provision of and participation in continuing dental education.
- Monitors and disseminates information on careers in dentistry.

Supporting the Strategic Plan: Activities, Results and Accomplishments

The Council continues to develop and implement action plans and strategies which complement the ADA Strategic Plan 2011-2014 and are relevant to its mission and duties. The Council's strategic priorities for the 2011-2012 year were:

- Protect the overall profession's reputation and public safety by managing the dental anesthesiology specialty recognition application for consideration by the 2012 House of Delegates.
- Improve the quality and integrity of continuing education (CE) for members by: 1) studying alternative governance and business models for the ADA Continuing Education Recognition Program (ADA CERP); and 2) approving quality CE providers (426) through ADA CERP.
- Improve the safety of patient care and improve dentists' ability to provide for that safety by providing a quality CE activity to members by offering with the Council on ADA Sessions (CAS), the Recognition and Management of Complications During Minimum and Moderate Sedation Workshop at annual session.
- Host the October 2012 Student Ambassador Program and lead initiatives that attract the best individuals into the dental profession, particularly with respect to cultural and ethnic diversity.

Emerging Issues and Trends

Dental Education and Accreditation

Matters Relating to Accreditation: The Council reviews matters related to the accreditation of dental, advanced dental and allied dental education programs for the Association. This year, the Council:

- Noted that the Commission on Dental Accreditation (CODA) continues to develop accreditation standards for dental therapy education programs; however, an implementation date for accrediting programs will not be set until a request to accredit the programs satisfies the *Principles and Criteria Eligibility of Allied Dental Programs for Accreditation by the Commission on Dental Accreditation*.
- Supported the majority of proposed changes to the accreditation standards common to programs in the dental specialties, noting the new requirements for evidence-based dentistry and ethics and professionalism. The Council questioned and will study further the proposed revision to the admissions standard for specialty education programs related to international candidates who are not graduates of CODA or the Commission on Dental Accreditation of Canada (CDAC) accredited dental education programs.
- Supported proposed revisions to the accreditation standards for advanced education programs in dental anesthesiology.
- Considered proposed extensive revisions to accreditation standards for dental assisting programs, supporting most of the proposed revisions. Noting that some of the changes appeared overly prescriptive, the Council urged CODA to carefully review all proposed standards to ensure quality and continuous improvement in dental assisting education programs without being overly prescriptive.

As called for by ADA House Resolution 39H-2011, Monitoring of Accreditation Matters on Behalf of the ADA (*Trans.*2011:467), a CDEL representative (Dr. Ronald Venezie) attends CODA meetings and provides the Council with a report on observations of major policy and procedural actions taken by CODA.

Career Recruitment, Resources and Related Activities

Golden Apple Award—Inspiring Careers in Dental Education: The Council sponsors this award annually to recognize individuals for outstanding mentoring of students interested in academic careers. This year, the Council received numerous outstanding applications for the 2012 award. This year's recipient is Dr. Paul J. Berson, Clinical Associate Professor of Restorative Dentistry, School of Dental Medicine, University of Pennsylvania. He was presented with the prestigious Golden Apple Trophy along with funding to attend the ADA's 2012 Annual Session.

Student Ambassador Program: This program was held on October 9, 2011, at the MGM Grand Hotel, Las Vegas, in conjunction with the 2011 ADA Annual Session. The program, with the theme of "Increasing Diversity in the Dental Profession: For You by You," had the highest number of participants (84) and the highest number of dental schools (52) participating, resulting in a 39% increase in participants over last year, with 88% of U.S. dental schools participating. The program focused on ambassador efforts reaching out to underrepresented minority students using a variety of strategies including collaborating with new partners (on and off campuses) and community organizations.

The 7th annual Student Ambassador Program will be held on October 20, 2012, at the Hilton San Francisco Hotel, San Francisco. This student-driven program will showcase "best practices" in student outreach efforts, honoring the 2012 Ambassador Program Award recipients for innovative student recruitment/outreach programming as well as an Ambassador Meet & Greet Session at the UCSF School of Dentistry campus.

Career Resources: This year, over 500 member dentists and others showcased dentistry and dental team careers utilizing the ADA's career resource materials at career events to high school, college and other students. Available resources include:

- *Something to Smile About—Careers in the Dental Profession* career resources encompass newly updated brochures, posters, fact sheets, table top displays and other items available at ada.org/careers.
- Downloadable DVDs featuring careers in dentistry and the dental team careers are available at ada.org/3256.aspx.

Dental Licensure and Clinical Licensing Examinations

Clinical Licensure Examinations: There are five regional dental testing agencies, which consist of member states that utilize that examination for the purposes of initial licensure in their state. The five regional agencies include the Central Regional Dental Testing Service (CRDTS), Council of Interstate Testing Agencies, Inc. (CITA), North East Regional Board of Dental Examiners, Inc. (NERB), Southern Regional Testing Agency (SRTA), and Western Regional Examining Board (WREB). Nearly all U.S. licensing jurisdictions are members of one or more of the regional testing agencies; only Delaware, Florida, Nevada and the Virgin Islands are not.

The American Board of Dental Examiners (ADEX) is an examination development agency for dentistry and dental hygiene consisting of state and U.S. territory licensing jurisdictions, organized in districts throughout the nation, whose member representatives provide for the ongoing development of the ADEX Dental and Dental Hygiene Licensing Examinations. Approximately 29 states are members of ADEX and approximately 40 states accept results of the examinations.

The ADA continues to advocate for a clinical exam that is accepted by all states. Currently, NERB, Hawaii, Nevada and Florida administer the ADEX examinations while the remaining testing agencies administer their own examinations. In January 2012, the Southern Regional Testing Agency announced it will begin administering the ADEX examinations effective in 2013.

Alternative models to the clinical licensure examination continue to be explored:

Portfolio-style Examination. California's governor signed Assembly Bill 1524 to allow a dental school-based portfolio as a pathway to licensure, which went into effect January 2011. The Board is in the process of developing rules and regulations to implement this process. Once regulations are final, students from all California schools will have the option to take a school-based licensure exam that allows them to build a portfolio of completed clinical experiences and competency exams in seven subject areas over the entire course of their final year of dental school.

Canadian Exam. Through a collaborative process with the University of Minnesota, School of Dentistry, the Minnesota Board of Dentistry accepts the National Dental Examining Board of Canada licensure examination for initial licensure in Minnesota for graduates of the University of Minnesota School of Dentistry graduating after 2009. This two-part examination—a written examination and an Objective Structured Clinical Examination (OSCE)—was first hosted by the University of Minnesota, School of Dentistry, in March 2010.

Post-Graduate Residency of One-Year (PGY-1). New York continues to be the only state that mandates the PGY-1. Several other states (California, Washington, Minnesota, Connecticut) offer the option to complete a PGY-1 instead of taking a clinical licensure exam. Delaware requires both a one-year residency and a clinical licensure examination.

Licensure by Credentials: There have been no changes in state laws regarding licensure by credentials since the Council's 2011 annual report. Dental boards in 46 states plus the District of Columbia and Puerto Rico have authority to grant licensure by credentials. Only Delaware, Florida, Hawaii, Nevada and the Virgin Islands do not.

Hawaii has a community service law that allows dentists with certain credentials to work *only* in federally qualified health centers, native Hawaiian health centers and postsecondary dental training programs. Florida adopted a law in May 2008 that allows dentists who have been in practice for five years and licensed in another state to obtain a "health access" dental license without taking the clinical examination; practice under that license is limited to health access settings such as community health centers and Head Start centers.

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

Request to Recognize Dental Anesthesiology as a Dental Specialty: In June 2011, the American Society of Dentist Anesthesiologists (ASDA) submitted to the Council an application for recognition of dental anesthesiology as a dental specialty (*Reports* 2011:92). The Council announced receipt of the application, posting it on ADA.org (<http://www.ada.org/104.aspx>) and seeking comment from the communities of interest. In October 2011, CDEL referred the application and the comments to its Committee on Recognition of Specialties and Interest Areas in General Dentistry (Committee on Recognition), requesting that the Committee conduct an in-depth review and report findings and recommendations to the Council.

Following a careful review of the Committee on Recognition's report, ASDA application, community of interest comments, as well as the ASDA representatives' appearance before the Council on May 4, 2012, the Council concluded that:

- The ASDA has *demonstrated* that dental anesthesiology is represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.
- The ASDA has *demonstrated* that dental anesthesiology is a distinct and well-defined field, which requires unique knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards.
- The ASDA has *demonstrated* that the scope of dental anesthesiology requires advanced knowledge and skills that: (a) are separate and distinct from any recognized dental specialty or

combination of recognized dental specialties; and (b) cannot be accommodated through minimal modification of a recognized dental specialty or combination of recognized dental specialties.

- The ASDA has *demonstrated* scientifically, by valid and reliable statistical evidence/studies, that dental anesthesiology: (a) actively contributes to new knowledge in the field; (b) actively contributes to professional education; (c) actively contributes to research needs of the profession; and (d) provides oral health services for the public; all of which are currently not being met by general practitioners or dental specialists.
- The ASDA has *demonstrated* that dental anesthesiology directly benefits some aspect of clinical care.
- The ASDA has *demonstrated* that formal advanced education programs in dental anesthesiology of at least two years beyond the predoctoral dental curriculum as defined by the Commission on Dental Accreditation exist to provide the special knowledge and skill required for the practice of dental anesthesiology.

The Council and Committee on Recognition's Report on the ASDA Application for Recognition of Dental Anesthesiology as a Dental Specialty is provided as Appendix 1. In summary, the Committee on Recognition concluded and the Council concurred that the ASDA application for recognition of dental anesthesiology as a dental specialty meets the *ADA Requirements for Recognition of Dental Specialties*. The Council recommends that the following resolution be adopted by the 2012 House of Delegates:

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

ADA-Recognized Dental Specialty Certifying Boards: As part of its *Bylaws* responsibilities, the Council annually surveys the ADA-recognized dental specialty certifying boards. The 2012 Report of the ADA-Recognized Dental Specialty Certifying Boards is available on ADA.org at <http://www.ada.org/494.aspx>. The 2012 report shows that all nine specialty certifying boards certified diplomates in 2011. The report also reflects changes that some boards made to their eligibility requirements, application and registration procedures, re-examination policies, recertification policies or *Bylaws*. Four certifying boards (dental public health, oral and maxillofacial pathology, oral and maxillofacial surgery, and pediatric dentistry) reported offering an alternative pathway to certification for internationally trained dental specialists; however, none reported certifying individuals via this pathway in 2011.

Anesthesiology

Safety Awareness Campaign: The Council's Committee on Anesthesiology spearheaded an interagency ad hoc committee that developed a safety awareness campaign aimed at reminding dentists about the importance of performing routine checks on dental office equipment. *ADA News*, e-publications and ADA.org will publish periodic reminders to members to perform equipment checks. In addition, a downloadable checklist to assist dentists is available on ADA.org at <http://www.ada.org/1692.aspx>.

ADA CE Course on Recognition and Management of Complications During Minimal and Moderate Sedation: Part 1 of the course is available on www.adaceonline.org. Part 2 is being offered at the 2012 ADA Annual Session as a pre-session course. The five-hour course is being presented both in the morning and afternoon on October 17. The Council also collaborates with local dental societies, simulation centers and universities and residency programs in offering the course in a variety of locations. This course supports the ADA Strategic Plan by improving the safety of patient care and by improving dentists' ability to provide for that safety by providing this quality CE activity to members.

ADA Continuing Education Recognition Program (ADA CERP)

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 426 ADA CERP nationally recognized providers. ADA CERP-approved providers list their CE course offerings on <http://www.ada.org/377.aspx>.

Proposed Revisions to Eligibility Criteria Regarding Commercial Entities: The Council and the CERP Committee considered a proposal to revise the CERP Eligibility Criteria so that commercial entities would no longer be eligible to apply for CERP recognition, and reviewed comments on the proposal from the communities of interest. The Council has postponed further consideration of the proposed revisions pending results of the governance study and the development, implementation, and assessment of enhanced monitoring of CE provider activities for compliance with and enforcement of existing CERP Standards regarding management of commercial conflicts of interest.

CERP Governance Structure: The Council and CERP Committee are conducting an evaluation of the program's governance structure to identify potential modifications that could better support the program's mission, enhance its impartiality and objectivity, and minimize internal conflicts of interest. As a preliminary step, the Council has directed CERP to study the feasibility of establishing an appeals board independent of CDEL for adjudicating adverse actions against CERP approved providers. The Council will review the CERP Committee's findings related to CERP governance and an appeals board at its November 2012 meeting.

Initial Recognition Term for New Providers: The Council revised the CERP Regulations Governing the Recognition Process to establish a two-year initial term of recognition for new applicants. The initial recognition term, which will be implemented in January 2013, will facilitate CERP's ability to recommend improvements and monitor newly approved providers.

Continuing Education Matters

ADA CE Online: [ADA CE Online](#) has been in operation since July 2006. The number of registered users and revenue continue to grow with an increase in new registrants of 15% and total program revenue of 40% from 2010. More than 100 courses are featured on ADA CE Online. All six courses previously commissioned through Res. 63H-2010, "Online Continuing Education Courses for 2011" (*Trans.*2011:575), have been launched. During 2011, the Editorial Board reviewed the new courses as well as the existing courses for relevance. Sixty-nine courses have been reviewed; 22 have been removed.

ADA's Recognition as a CERP-Approved CE Provider: In 2008, the ADA submitted an abbreviated application for continued recognition as a CE provider to ADA CERP. Recognition was granted for the maximum four years; ADA was requested to submit a full application by June 29, 2012. The six areas of the Association that represent the multifaceted delivery of continuing dental education by the Association have collaborated on the 2012 application. It will be reviewed at the fall 2012 CERP Committee meeting and the outcome of this review will be reported to the House of Delegates.

Dental Admission Testing Program (DAT)

The DAT continues to be administered exclusively on computer at Prometric Testing Centers throughout the United States and its territories. Trends (2007-2011) in the DAT program include:

- During 2007 and 2011, there were 13,679 and 13,177 administrations of the DAT, respectively. Comparing 2007 with 2011 suggests an overall decrease of 502 administrations, or a decrease of 3.7%. This may be due to the revised retesting policy which requires an examinee to wait at least 90 days before retaking the DAT.
- Males and females participating in the DAT remain stable over the 2007-2011 period.
- Underrepresented groups participating in the program also have remained stable over this period. American Indians represent less than 2.0% and the percentages of African American and Hispanic examinees have remained stable between 5% and 8%.

Responses to House of Delegates Resolutions

6H-2011. Amendment of the Policy, Comprehensive Study of Dental Specialty Education and Practice (Trans.2011:465)

Appropriate ADA documents have been corrected to reflect the amended policy.

7H-2011. Rescission of the Policy, Periodic Review of Specialty Education and Practice (Trans.2011:465)

The rescinded policy has been removed from appropriate ADA documents.

8H-2011. Amendment of the Policy Statement on Continuing Dental Education (Trans.2011:465)

Appropriate ADA documents have been corrected to reflect the amended policy.

39H-2011. Monitoring of Accreditation Matters on Behalf of the ADA (Trans.2011:467)

This resolution called for CDEL as well as the ADA Trustee Liaisons to CODA and CDEL to serve as the ongoing mechanisms for monitoring and communicating accreditation matters among ADA agencies and CODA. In accord with the resolution, an ADA-appointed CDEL member (Dr. Ronald Venezie) serves as the CODA monitor, attending CODA meetings and reporting observations and findings to the Council and other appropriate agencies.

48H-2011. Recognition of Specialty Groups (Trans.2011:478)

By adopting Resolution 48H-2011, the ADA House of Delegates directed the Council on Dental Education and Licensure to review the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists* with a particular focus on Requirement 1(a). The current Requirements were adopted by the ADA House of Delegates in October 2009 (Appendix 2).

The requirements were used by CDEL as a basis for its Periodic Review of Dental Specialty Education and Practice that was reported to the 2011 House of Delegates. Although CDEL unanimously agreed that all the currently recognized dental specialties meet the spirit of these criteria, Council members did voice concern that Requirement 1(a), in particular, is vague and difficult to apply in a consistent manner across all specialties. This opinion was shared in extensive correspondence from the Eighth Trustee District, which subsequently offered Resolution 48 to the House of Delegates as a potential solution. The ADA Board of Trustees agreed with the Eighth Trustee District and unanimously recommended approval of substitute Resolution 48B that was adopted by the House of Delegates as Resolution 48H-2011:

48H-2011. Resolved, that the Council on Dental Education and Licensure (CDEL) review the criteria and process for the recognition of specialty sponsoring organizations, and be it further **Resolved**, that this review consider Requirement 1(a) in the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists* which states that a recognized specialty sponsoring organization's membership should be reflective of the special area of dental practice (as defined by the ADA Code of Ethics, Section 55.H., General Standards, for announcing specialization or limitation of practice), and be it further **Resolved**, that CDEL consider interpreting "reflective" to mean that only specialist dentist members be able to vote and to hold office, and be it further **Resolved**, that any additional recommendations for change be reported to the 2012 House of Delegates.

As directed, CDEL has carefully deliberated on this issue and considered the recommendation of its Committee on Recognition of Specialty Groups and Interest Areas in General Dentistry. CDEL also has considered the input received by the two specialty groups that responded to its call for comment. CDEL offers the following rationale for its recommendation:

- The recognized specialties of dentistry are a vital part of the profession and must be maintained at the highest standards.
- A dentist who represents himself/herself as a specialist must adhere to a set of rigorous ethical standards contained in the *ADA Principles of Ethics and Code of Professional Conduct*.
- Those standards dictate that—at a minimum—a dental specialist must be a dentist who has completed the requisite education and training in that specialty.
- Consequently, the organization that sponsors a dental specialty must be controlled by dentists who have at least that same level of education and training.
- The Council also places great weight on the sense of the House of Delegates and the Board of Trustees as elucidated in Resolution 48H-2011.
- The Council strongly supports the right of any specialty sponsoring organization to maintain one or more affiliate membership categories that foster its ability for cross-discipline collaboration—provided that such membership categories do not include the privilege to vote or hold office in the specialty sponsoring organization.

Thus, the Council on Dental Education and Licensure recommends that the following resolution be adopted by the 2012 House of Delegates:

17. Resolved, that Requirement (1) of the Requirements for Recognition of Dental Specialties be revised as follows (additions are underscored; deletions are ~~stricken~~):

(1) In order for an area to ~~become and/or remain~~ become and/or remain recognized as a dental specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of ~~the special area of that proposed or recognized dental specialty practice~~; (b) in which the privileges to vote and hold office are reserved for dentists who have either completed a CODA-accredited residency program in that proposed or recognized specialty or a formal advanced education program as defined in Requirement (6); and ~~(b)~~ that demonstrates the ability to establish a certifying board.

and be it further

Resolved, that the introductory paragraph of the Requirements for Recognition of National Certifying Boards for Dental Specialists be revised as follows (additions are underlined; deletions are ~~stricken~~):

In order to become, and remain, eligible for recognition by the American Dental Association as a national certifying board for a ~~special area of practice~~ dental specialty, the ~~area specialty~~ shall have a sponsoring or parent organization ~~whose membership is reflective of the recognized special area of dental practice that meets all the elements of Requirement (1) of the Requirements for Recognition of Dental Specialties~~. A close working relationship shall be maintained between the parent organization and the board. Additionally, the following requirements must be fulfilled.

and be it further

Resolved, that requirement (2) in the section on Organization of Boards be revised as follows (additions are underscored; deletions are ~~stricken~~):

(2) Each board shall submit in writing to the Council on Dental Education and Licensure a program sufficiently comprehensive in scope to meet the requirements established by the American Dental Association for the operation of a certifying board. This statement should include evidence of sponsorship of the board by a national organization ~~representing dental practitioners interested in that special area of practice that meets all the elements of Requirement (1) of the Requirements for Recognition of Dental Specialties~~.

and be it further

Resolved, that the sponsoring organizations representing the currently recognized dental specialties be given until July 1, 2015, to demonstrate compliance with this revised requirement, and be it further

Resolved, that the Council on Dental Education and Licensure develop and implement a procedure to certify compliance by each sponsoring organization representing a currently recognized dental specialty and report its findings to the 2015 House of Delegates.

Policy Review

In accord with Resolution 111H-2010, Regular Comprehensive Policy Review, the Council on Dental Education and Licensure reviewed the Association's policies related to anesthesia and sedation, continuing education and licensure. Following is a series of resolutions with recommendations to maintain, amend or rescind those policies.

Recommendations—Policies to be Maintained

The Council on Dental Education and Licensure concluded that the following ADA policies should be maintained. The full text of each policy is included in Appendix 3.

18. Resolved, that the following policies be maintained:

ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists
(*Trans.*2007:384)
Definition of Curriculum Integrated Format (*Trans.*2007:389)
Definition of Continuing Competency (*Trans.*1999:939)
Policy on Dental Licensure (*Trans.*1998:720; 2003:341)
Policy on Licensure of Dental Assistants (*Trans.*2000:474)
Dental Practice by Unqualified Persons (*Trans.*1959:207)
Acceptance of Formal Continuing Medical Education Courses Offered by ACCME Accredited
CE Providers (*Trans.*2010:576)
Policy Statement on Continuing Dental Education (*Trans.*2006:331; 2011:465)
Policy Statement on Lifelong Learning (*Trans.*2000:467)
Lifelong Continuing Education (*Trans.*1999:941)
Cardiopulmonary Resuscitation Instruction (*Trans.*1976:860)
Promotion of Continuing Dental Education (*Trans.*1968:257)

Recommendations—Policies to be Rescinded

The Council on Dental Education and Licensure reviewed the policy "Communication Between State Boards of Dentistry" (*Trans.*1989:527) and recommends rescission because it is unnecessary. State boards communicate well through the American Association of Dental Boards and have access to the AADB Clearinghouse for Board Actions. The full text of the policy is included in Appendix 4.

19. Resolved, that Resolution 34H-1989 "Communication Between State Boards of Dentistry" (*Trans.*1989:527) be rescinded.

Recommendations—Policies to be Amended

The Council on Dental Education and Licensure believes that the policy "Monitoring Clinical Dental Licensure Examinations" should be amended to strengthen it as ADA policy rather than as a directive to another agency and to provide clarification on the ADA's position on the issue.

20. Resolved, that the ADA policy "Monitoring Clinical Dental Licensure Examinations" (*Trans.*2005:333) be amended in the second resolving clause as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the ADA ~~encourage the clinical testing agencies to~~ supports the use of good testing practices in the development, administration and scoring of ~~their licensing~~ examinations that produce results which are reliable, valid and with the highest validity possible.

so the amended policy reads:

Monitoring Clinical Dental Licensure Examinations

Resolved, that the appropriate agency of the ADA continue to monitor activities of the clinical testing agencies and report annually to the House of Delegates on its findings, and be it further **Resolved**, that the ADA supports the use of testing practices in the development, administration and scoring of licensing examinations that produce results which are reliable, valid and with the highest validity possible.

The Council on Dental Education and Licensure believes that the policy “Clinical Licensure Examinations in Dental Schools” should be amended to make it consistent with the ADA policy “Definition of Integrated Format” (*Trans.*2007:389) and to delete the reference to Resolution 89H-2001 which was rescinded in 2003.

21. Resolved, that the ADA policy “Clinical Licensure Examinations in Dental Schools” (*Trans.*2003:368) be amended as follows:

- In the first resolving clause, after the word “schools” delete the words “to senior dental students” and insert the words “using a curriculum integrated format.”
- In the second resolving clause, after the word “given” delete the words “early enough in the senior year to allow those who do not pass the board examinations to be remediated in time for a second examination to be given prior to graduation” and insert the words “frequently enough within each institution to allow candidates to remediate and retake any portions of the examination that they have not completed successfully.”
- Delete the words “and be it further” in the second resolving clause and the entire third resolving clause as the 2003 House of Delegates’ action rescinded Resolution 89H-2001.

so the amended policy “Clinical Licensure Examinations in Dental Schools” reads (additions are underscored; deletions are ~~stricken~~):

Clinical Licensure Examinations in Dental Schools

Resolved, that the Association encourages all dental licensing agencies to collaborate with dental educators to offer a clinical licensing examination on patients within dental schools ~~to senior dental students~~ using a curriculum integrated format, and be it further

Resolved, that these examinations be given ~~early enough in the senior year to allow those who do not pass the board examinations to be remediated in time for a second examination to be given prior to graduation,~~ frequently enough within each institution to allow candidates to remediate and retake any portions of the examination that they have not completed successfully; ~~and be it further~~

Resolved, that Resolution 89H-2001 (*Trans.*2001:411) be rescinded.

The Council on Dental Education and Licensure believes that the policy “State Board Support for CDA as Responsible to Evaluate Dental Education Programs” should be amended to more accurately reflect current terminology and the role of CODA.

22. Resolved, that the ADA policy “State Board Support for CDA as Responsible to Evaluate Dental Education Programs” (*Trans.*2003:367) be amended as follows (additions are underscored; deletions are ~~stricken~~):

State Board Support for ~~CDA~~ CODA as Responsible to ~~Evaluate~~ Accredit Dental Education Programs

Resolved, that the Association urge state boards of dentistry to continue to support the role of the Commission on Dental Accreditation as the agency responsible for the ~~evaluation~~ accreditation of dental education programs.

The Council on Dental Education and Licensure believes that the “Policy on One Standard of Competency: State Boards Review Limited Licensure Graduates of Nonaccredited Dental Schools for Providing Access to Care for Underserved Populations” should be amended to give the policy broader applicability and to strengthen it as ADA policy rather than House directives to other agencies.

23. Resolved, that the ADA policy, “Policy on One Standard of Competency: State Boards Review Limited Licensure Graduates of Nonaccredited Dental Schools for Providing Access to Care for Underserved Populations,” be amended as follows (additions are underscored; deletions are ~~stricken~~):

Policy on One Standard of Competency: ~~State Boards Review Limited Licensure Graduates of Nonaccredited Dental Schools for Providing Access to Care for Underserved Populations~~

Resolved, that it ~~be~~ is the policy of the Association that there is one standard of competency for licensure in order to provide quality oral health care to the public, ~~and be it further~~

~~**Resolved**, that this policy be forwarded with appropriate background information provided from the ADA to state boards of dentistry, requesting them to review the full implications of using limited licensure graduates of non-accredited dental schools as a mechanism for providing access to dental care for underserved populations, and be it further~~

Resolved, that the constituent societies be urged that when necessary, use this information with their state legislature.

so the amended policy reads:

Policy on One Standard of Competency

Resolved, that it is the policy of the Association that there is one standard of competency for licensure in order to provide quality oral health care to the public.

The Council on Dental Education and Licensure believes that the ADA “Policy on Dual Degreed Dentists” should be amended to strengthen it as policy rather than be a directive to other agencies.

24. Resolved, that the ADA “Policy on Dual Degreed Dentists” (*Trans.*2003:367) be amended in the first resolving clause by deleting the words “and be it further” and by deleting the second, third and fourth resolving clauses in their entirety, so the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

Policy on Dual Degreed Dentists

Resolved, that in order to protect the health, welfare and safety of the public, the American Dental Association believes that individuals who possess both a medical degree and a dental degree and elect to practice dentistry should be required to obtain a dental license issued by the jurisdiction in which they practice, and that oversight for their practice of dentistry should fall under the purview of their state dental practice act and their state boards of dentistry, ~~and be it further~~

~~**Resolved**, that constituent dental societies be urged to promote this concept to their respective state boards of dentistry, and be it further~~

~~**Resolved**, that constituent dental societies be urged to promote to their respective state boards of dentistry the guidelines for specialty licensure and specialty licensure by credentials as stated in the ADA policy Guidelines for Licensure (*Trans.*1976:919; 1977:923; 1989:529; 1992:632; 1999:936; 2002:401), and be it further~~

~~**Resolved**, that the ADA constituent dental societies be urged to support changes in legislation or regulation as may be necessary to accomplish this purpose.~~

The Council on Dental Education and Licensure believes that the policy “Endorsement of Recommendations of the ADA Guidelines for Licensure by Credentials” (*Trans.*1992:628, 2009:447) should be amended to more accurately reflect the intent of the statement.

25. Resolved, that the ADA policy “Endorsement of Recommendations of the ADA Guidelines for Licensure by Credentials” (*Trans.*1992:628, 2009:447) be amended in the second resolving clause by deleting the word “endorsement” and inserting the word “use” so the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

Endorsement of Recommendations of the ADA Guidelines for Licensure by Credentials

Resolved, that the ADA actively endorse and urge all dental licensing jurisdictions to utilize the ADA Guidelines for Licensure by Credentials, and be it further

Resolved, that the ADA Council on Dental Education and Licensure monitor the ~~endorsement~~ use of these recommendations by the dental licensing jurisdictions and report annually to the House of Delegates.

The Council on Dental Education and Licensure believes that the “Policy on Licensure of Graduates of Nonaccredited Dental Schools” (*Trans.*1984:539) should be amended to eliminate language that is no longer current because CODA now has a process for accreditation of international dental programs in place and to reflect correct terminology; CODA accredits dental programs, not schools. Further, it would strengthen this as ADA policy rather than being a directive to another agency.

26. Resolved, that the ADA “Policy on Licensure of Graduates of Nonaccredited Dental Schools” be amended as follows (additions are underscored; deletions are ~~stricken~~):

Policy on Licensure of Graduates of Nonaccredited Dental Schools-Programs

The United States has a long and proud tradition of affording opportunities to immigrants. The American Dental Association fully supports application of this principle in dentistry, but not at the expense of the standards of dental practice in this country. State licensure is a critical element in preserving that standard of practice and for the protection of citizens of the state.

Although licensing provisions vary among U.S. licensing jurisdictions, all jurisdictions have the same three types of requirements: an educational requirement, a written examination requirement and a clinical examination requirement. The traditional educational requirement is graduation from ~~an accredited dental school~~ a dental education program accredited by the Commission on Dental Accreditation (CODA). ~~Only dental schools in the United States and Canada are recognized as accredited. Extending accreditation to schools in other countries is not feasible.~~

In the absence of accreditation, an educational requirement for dental licensure has limited significance. The Association questions whether written and clinical examinations alone provide sufficient verification of competence to serve the purpose of licensure. Thus, the ~~Association urges jurisdictions to require~~ ADA believes that any graduate of a nonaccredited ~~school program~~ should be required to obtain supplementary education in an accredited ~~school program~~ program prior to licensure. The amount of additional training needed by graduates of nonaccredited ~~schools~~ programs may vary. While some flexibility is needed, the licensure process requires well-defined minimum standards. Recommended minimum educational standards for licensure of a graduate of a nonaccredited ~~school~~ program are:

1. Completion of ~~a an~~ an accredited supplementary predoctoral education program ~~in an accredited dental school~~. A supplementary education program of at least two academic years is required.
2. Certification by the dean of the accredited dental school that the candidate has achieved the same level of didactic and clinical competence as expected of a graduate of the school program.

The Council on Dental Education and Licensure believes that the "Guidelines for Licensure" (*Trans.*1976:919, 1977:923, 1989:529, 1992:632, 1999:938, 2000:401, 2003:340) should be amended to reflect current terminology. Further, the Council believes that it would be beneficial for the ADA to have policy in support of volunteer licensure. The ADA supports and encourages volunteerism by members and the *Principles of Ethics and Code of Professional Conduct* reminds members of the obligation to help those who may not have access to care. Rather than a stand-alone policy, the Committee believes a new section should be incorporated at the end of the existing policy, Guidelines for Licensure.

27. Resolved, that the ADA policy "Guidelines for Licensure" (*Trans.*1976:919, 1977:923, 1989:529, 1992:632, 1999:938, 2000:401, 2003:340) be amended as follows:

- In the section "Licensure by Credentials, item "a," delete "school" wherever it appears and replace with "program." In item "g" change AADE Clearing House for Disciplinary Information to AADB Clearing House for Board Actions.
- In the section addressing "Possible documentation..." item #1, after the word "accredited" and before the word "general," insert the words "advanced education program in general dentistry or." Further, delete the words "or dental internship."
- Add a new section, "Volunteer Licensure"

so the amended policy reads (additions are underscored; deletions are ~~stricken~~):

Guidelines for Licensure

Dental licensure is intended to ensure that only qualified individuals provide dental treatment to the public. Among qualifications deemed essential are satisfactory theoretical knowledge of basic biomedical and dental sciences and satisfactory clinical skill. It is essential that each candidate for an initial license be required to demonstrate these attributes on examination, a written examination for theoretical knowledge and a clinical examination for clinical skill. The clinical examination requirement may also be met by successful completion of a postgraduate program in general dentistry that contains competency assessments or in an ADA recognized dental specialty, at least one year in length, which is accredited by the Commission on Dental Accreditation. These guidelines suggest alternate mechanisms for evaluating the theoretical knowledge and clinical skill of an applicant for licensure who holds a dental license in another jurisdiction. Requiring a candidate who is seeking licensure in several jurisdictions to demonstrate his or her theoretical knowledge and clinical skill on separate examinations for each jurisdiction seems unnecessary duplication.

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

No clinical examination has achieved as broad recognition as have National Board written examinations. Clinical examinations used for dental licensure are conducted by individual state

boards of dentistry and by regional clinical testing services. It is recommended that satisfactory performance within the last five years on any state or regional clinical examination at least equivalent in quality and difficulty to the state's own clinical examination be considered adequate testing for clinical skill provided that the candidate for licensure:

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

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

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

- a. has graduated from a dental ~~school~~ program accredited by the Commission on Dental Accreditation, or has completed a supplementary predoctoral education program of at least two academic years in an accredited dental ~~school~~ program and has been certified by the dean of an accredited dental school as having achieved the same level of didactic and clinical competence as expected of a graduate of the ~~school~~ program, or has completed an educational experience that is recognized by the respective state dental board as equivalent to the above.
- b. is currently licensed by a licensing jurisdiction in a state, the District of Columbia, the Commonwealth of Puerto Rico or a dependency of the United States.
- c. has been in practice or full-time dental education immediately prior to applying.
- d. is endorsed by the state board of dentistry in the state of current practice.
- e. has not been the subject of final or pending disciplinary action in any state in which he or she is or has been licensed.
- f. has not failed the clinical examination of the state to which he or she is applying within the last three years.

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

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

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

Alternate ways that current theoretical knowledge might be documented follow. It is recommended that for a candidate who meets eligibility requirements for licensure by credentials, these methods be considered as possible alternatives to the written examination requirement.

1. Successful completion of an accredited advanced dental education program in the last ten years.
2. A total of at least 180 hours of acceptable, formal scientific continuing education in the last ten years, with a maximum credit of 60 hours for each two-year period.
3. Successful completion of a recognized specialty board examination in the last ten years.
4. Teaching experience of at least one day per week or its equivalent in an accredited dental education program for at least six of the last ten years.

Possible documentation for current clinical skill appears in the following list. Provided that eligibility requirements for licensure by credentials are met, it is recommended that these methods be considered as possible alternatives to satisfactory performance on a clinical examination.

1. Successful completion of an accredited advanced education program in general dentistry or general practice residency or dental internship within the last ten years.
2. Successful completion of an accredited dental specialty education program in a clinical discipline within the last ten years.
3. A total of at least 180 hours of acceptable clinically-oriented continuing education in the last ten years, with a maximum credit of 60 hours for each two-year period.
4. Clinical teaching of at least one day per week or its equivalent in an accredited dental education program, including a hospital-based advanced dental education program, for at least six of the last ten years.
5. Presenting case histories of patients treated by the candidate in the last five years, with preoperative and postoperative radiographs, covering procedures required on the state clinical examination, for discussion with the state board.

Licensure by Credentials for Internationally Trained Dentists: It is ADA policy that internationally trained dentists, who were licensed by their respective jurisdictions prior to implementation of the requirement of a two-year supplementary education program in an accredited dental school, be granted the same benefits of freedom of movement as any other member of the Association.

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

- a. All specialists should be required to have passed a state dental board approved general dentistry examination and have an entry-level dental license issued by a state or a U.S. territory before being eligible to be credentialed or to take a specialty examination in another state.
- b. Specialists should not be required to pass an additional general dentistry examination when applying for a license to practice the specialty.
- c. Specialists who have passed a specialty licensure examination in another state should be granted licensure by credentials without further clinical examination.
- d. States should be urged to enact provisions by which a dental specialist licensed in another jurisdiction may be issued a license by credentials to allow the specialist who holds diplomate status from an ADA-recognized dental specialty certifying board or who

- has completed an advanced specialty education program accredited by the Commission on Dental Accreditation to practice the specific specialty.
- e. Specialists who hold diplomate status from an ADA-recognized dental specialty certifying board or who have completed an advanced specialty education program accredited by the Commission on Dental Accreditation and meet all other state requirements for licensure should not be required to take any additional general dentistry examinations.
 - f. Specialty licensure examinations and criteria for credentialing should be reviewed annually for reliability and validity and updated regularly to protect the public.

Volunteer Licensure: The ADA supports and encourages volunteerism by members. The Principles of Ethics and Code of Professional Conduct require members to recognize the obligation to help those who many not have access to care. A limited or volunteer license by credentials should be available to dentists who wish to provide services to indigent or critical needs populations within a state without compensation. Often, the expense of initial licensure, licensure renewal and liability insurance prevent many dentists from volunteering services. The Association urges states to consider the following provisions regarding limited/volunteer licensure for dentists:

1. Allow dentists to provide services to indigent or critical need populations within a state without compensation.
2. Waive any associated fees for limited or volunteer licenses so long as the dentist continues to provide services without compensation.
3. Grant sovereign immunity for dentists when providing services to indigent or critical need patients without compensation.
4. Require the same standards for education and training as for initial licensure in that jurisdiction.

The Council on Dental Education and Licensure believes that the ADA “Position Statement on Federal Intervention in Licensure” (*Trans.*1975:187, 718) should be amended to reflect correct terminology.

28. Resolved, that the “Position Statement on Federal Intervention in Licensure” (*Trans.*1975:187, 718) be amended in the section, Influence on the Dental Curriculum, by deleting the word “schools” wherever it appears and inserting in its place the words “education programs,” so the amended section reads (additions are underscored; deletions are ~~stricken~~):

Influence on the Dental Curriculum: Dental ~~schools~~ education programs have a responsibility to graduate individuals capable of practicing dentistry. Since meeting licensure requirements is a prerequisite to practice, dental ~~schools~~ education programs also prepare students to pass licensure examinations. Consequently, the agency that establishes licensure standards can have an influence over dental curriculums. Under the state licensure system this influence is shared among 53 jurisdictions, and thus moderated. With a single federal agency setting standards, the influence of licensure examinations might become excessive and virtually dictate the content and emphasis for all dental curriculums. This centralization would tend to make a static situation that would inhibit evolution and change. Also, the cooperation that has developed among educators, examiners and the practicing profession at the state level has been effective in dealing with the relationship between licensure requirements and the dental curriculum. The same degree of cooperation could not be expected at the federal level.

The Council on Dental Education and Licensure believes that the policies “Eliminating Use of Human Subjects in Board Examinations” (*Trans.*2005:335) and “Use of Human Subject in Clinical Licensure Exams” (*Trans.*1996:712) should be combined into one comprehensive policy since they both address the issue of use of patients in clinical examinations. This would eliminate redundancies.

Eliminating Use of Human Subjects in Board Examinations

Resolved, that the Association supports the elimination of human subjects/patients in the clinical licensure examination process with the exception of the curriculum integrated format within dental schools, and be it further

Resolved, that the Association encourages all states to adopt methodologies for licensure that are consistent with this policy.

Use of Human Subject in Clinical Licensure Exams

Resolved, that the Association supports the concept of dental students providing direct patient care under the direct and indirect supervision of qualified faculty as a method of learning clinical skills and patient care including the ability to deal with the anxiety, fears, reflexes and other emotions of the “human” aspects of dental treatment, and be it further

Resolved, that the House strongly supports the position of the Council on Ethics, Bylaws and Judicial Affairs as stated in the Council’s annual report to the 1993 House of Delegates (*Trans.*1993:109) that, although the use of human subjects in licensure examinations raises certain ethical concerns, the practice is not in and of itself unethical, and be it further

Resolved, that the Association urges the clinical testing agencies to adopt policies to ensure that follow-up care is available for patient procedures performed during clinical licensure examinations.

29. Resolved, that the ADA policy “Eliminating Use of Human Subjects in Board Examinations” (*Trans.*2005:335) be amended by inserting language from the policy “Use of Human Subject in Clinical Licensure Exams” before the first resolving clause of the policy so the new, comprehensive policy “Eliminating Use of Human Subjects in Board Examinations” reads: (additions are underscored):

Eliminating Use of Human Subjects in Board Examinations

Resolved, that dental students providing patient care under the direct and/or indirect supervision of qualified faculty is an essential method of learning clinical skills including the ability to manage the anxieties, fears, reflexes and other emotions related to dental treatment, and be it further

Resolved, that although the use of human subjects in licensure examinations raises certain ethical concerns, the practice is not in and of itself unethical as determined by the ADA Council on Ethics, Bylaws and Judicial Affairs (*Trans.*1993:109), and be it further

Resolved, that the Association supports the elimination of human subjects/patients in the clinical licensure examination process with the exception of the curriculum integrated format within dental schools, and be it further

Resolved, that the Association encourages all states to adopt methodologies for licensure that are consistent with this policy and be it further

Resolved, that Resolution 147H-1996, Use of Human Subject in Clinical Examinations (*Trans.*1996:712), be rescinded.

The Council recommends combining three Association policies, “Acceptance of Results of Regional Boards” (*Trans.*1992:630; 2001:468), “Acceptance of Successful Completion of State or Regional Licensure Examinations by State Boards of Dentistry” (*Trans.*1998:725) and “Standardization of State Dental Licensure Examinations” (*Trans.*1992:629), to eliminate redundancies. All three policies address the issue of acceptance of clinical licensure examinations.

Acceptance of Results of Regional Boards

Resolved, that the Association supports efforts to create substantial similarities in the administration, content and scoring of the clinical examinations so as to increase acceptance of results by state boards of any state or regional examination, and be it further

Resolved, that the ADA encourage constituent societies in those states that participate in regional boards to promote to their state's licensing agency the acceptance, with appropriate review of credentials, of the clinical examination results of each regional board, and thereby facilitate freedom of movement for dental professionals.

Acceptance of Successful Completion of State or Regional Licensure Examinations by State Boards of Dentistry

Resolved, that all constituents of the American Dental Association be urged to submit formal proposals to their respective state dental licensing agencies that would provide for acceptance of successful completion of a licensure examination administered by any recognized individual state or regional testing agency for the purpose of licensure in their state.

Standardization of State Dental Licensure Examinations

Resolved, that the Association, in cooperation with the American Association of Dental Examiners, actively support standardization of dental and dental hygiene licensure clinical examinations by continuing to encourage state boards of dentistry to accept a common core of requirements and guidelines for clinical examinations.

30. Resolved, that the ADA policy "Acceptance of Results of Regional Boards" (*Trans.*1992:630) be amended by incorporating concepts from the language in the policies "Acceptance of Successful Completion of State or Regional Licensure Examinations by State Boards of Dentistry" (*Trans.*1998:725) and "Standardization of State Dental Licensure Examinations" (*Trans.*1992:629) so the new, comprehensive policy "Acceptance of Results of Regional Boards" reads as follows (additions are underscored):

Acceptance of Results of Regional Boards

Resolved, that the Association supports efforts to create substantial similarities in the administration, content and scoring of the dental and dental hygiene clinical examinations by continuing to encourage state boards of dentistry to accept a common core of requirements and guidelines for clinical examinations, so as to increase acceptance of results by state boards of any state or regional examination, and be it further

Resolved, that the ADA encourage constituent societies in those states that participate in regional boards to promote to their state's licensing agency the acceptance, with appropriate review of credentials, of the clinical examination results of each regional board for the purpose of licensure in their state, and thereby facilitate freedom of movement for dental professionals, and be it further

Resolved, that Resolution 56H-1998 "Acceptance of Successful Completion of State or Regional Licensure Examinations by State Boards of Dentistry" (*Trans.*1998:725) be rescinded, and be it further

Resolved, that Resolution 27H-1992 "Standardization of State Dental Licensure Examinations" (*Trans.*1992:629) be rescinded.

The Council on Dental Education and Licensure believes that the "Guidelines for the Use of Sedation and General Anesthesia by Dentists" (*Trans.*2007:282) should be amended. The majority of the proposed amendments are for editorial or clarifying purposes. A summary of the proposed amendments is provided here:

Section II. Definitions

- Added definitions for "conscious sedation" and "combination inhalation-enteral conscious sedation" to reflect that, though not current terminology, the terms appear in many states' rules and regulations.
- Language added under the definition of "minimal sedation" provides clarification regarding the use of preoperative sedatives for children prior to arrival in dental office.

Section III. Educational Requirements

- Under B. Moderate Sedation and C. Deep Sedation and General Anesthesia, language added to clarify that 1) completion of an appropriate airway course for dentists is acceptable, not certification in such course because few, if any, emergency airway courses for dentists provide certification, and 2) completion of such a course should be on the same re-certification cycle that is required for ACLS.
- Language added at the end of Section III clarifies that though a dentist might be grandfathered by a state dental board for the educational criteria, the dentist still should comply with Section IV. Clinical Guidelines.

Section IV. Clinical Guidelines

- B. Moderate Sedation
 - Language added under item 4. Monitoring and Documentation, Documentation, to clarify what a time-oriented record should include. Also, language added to indicate proper documentation during moderate sedation.
 - Language added under item 5. Recovery and Discharge to clarify the importance of longer monitoring of a patient if a pharmacological reversal agent is administered.
- C. Deep Sedation and General Anesthesia
 - Language added under item 3. Equipment to indicate that a capnograph must be used if a volatile anesthetic agent is utilized.
 - Language added under item 4. Monitoring and Documentation, Documentation, to clarify what a time-oriented record should include. Also, language added to indicate proper documentation during deep sedation/general anesthesia.
 - In Item 6. changed “Pediatric and Special Needs Patients” to “Pediatric Patients and Those With Special Needs” to be more politically correct.

Section V. Additional Resources

- Added a reference regarding a sample time-oriented anesthesia record.
- Deleted an outdated reference.

Editorial amendments to agency names, American Academy of Pediatric Dentistry and American Society of Anesthesiologists.

31. Resolved, that the “ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists” (*Trans.*2007:282) be amended as it appears in Appendix 5 of the Council’s annual report.

The Council on Dental Education and Licensure believes that the “Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students” (*Trans.*2007:282) should be amended. The majority of the proposed amendments are for editorial or clarifying purposes. A summary of the proposed amendments is provided here:

Section II. Definitions:

- Added definitions for “conscious sedation” and “combination inhalation-enteral conscious sedation” to reflect that, though not current terminology, the terms appear in many states’ rules and regulations.
- Language added under the definition of “minimal sedation” regarding pediatric patients to be consistent with the Definitions section in the Guidelines for the Use of Sedation and General Anesthesia by Dentists.

Section III. Teaching Pain Control

- In section C. Sequence of Pain Control Didactic and Clinical Instruction, third paragraph, changed “pediatric and special needs patients” to “pediatric patients and those with special needs” to be more politically correct.

Section V. Teaching Administration of Moderate Sedation

- In section C. Moderate Enteral Sedation Course Duration and Moderate Parenteral Sedation Course Duration added language to clarify that those enrolling in these courses must first have completed a competency course in nitrous oxide to be consistent with requirements for those enrolling in minimal sedation enteral and/or combination inhalation-ental sedation courses.

Section VI. Additional Sources of Information

- Added a reference regarding a sample time-oriented anesthesia record.
- Deleted an outdated reference.

Editorial amendments to agency names, American Academy of Pediatric Dentistry and American Society of Anesthesiologists.

32. Resolved, that the “ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students” (*Trans.*2007:282) be amended as it appears in Appendix 6 of the Council’s annual report.

Summary of Resolutions

Resolution 16. Recognition of Dental Anesthesiology as a Dental Specialty

Resolution 17. Amendment to the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists*

Resolution 18. Policies to be Maintained as Recommended by the Council on Dental Education and Licensure

Resolution 19. Rescission of the Policy, Communication Between State Boards of Dentistry

Resolution 20. Amendment of the Policy, Monitoring Clinical Dental Licensure Examinations

Resolution 21. Amendment of the Policy, Clinical Licensure Examinations in Dental Schools

Resolution 22. Amendment of the Policy, State Board Support for CDA as Responsible to Evaluate Dental Education Programs

Resolution 23. Amendment of the Policy on One Standard of Competency: State Boards Review Limited Licensure Graduates of Nonaccredited Dental Schools for Providing Access to Care for Underserved Populations

Resolution 24. Amendment of the Policy on Dual Degreed Dentists

Resolution 25. Amendment of the Policy, Endorsement of Recommendations of the ADA Guidelines for Licensure by Credentials

Resolution 26. Amendment of the Policy on Licensure of Graduates of Nonaccredited Dental Schools

Resolution 27. Amendment of the Policy, Guidelines for Licensure

Resolution 28. Amendment of the Position Statement on Federal Intervention in Licensure

Resolution 29. Amendment of the Policy, Eliminating Use of Human Subjects in Board Examinations

Resolution 30. Amendment of the Policy, Acceptance of Results of Regional Boards

Resolution 31. Amendment of the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists

Resolution 32. Amendment of the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students

Council Minutes

For more information on recent activities, see the Council’s minutes on ADA.org:

<https://www.ada.org/members/1293.aspx#licensure>.

Appendices

Appendix 1. Report on the ASDA Application for Recognition of Dental Anesthesiology as a Dental Specialty

Appendix 2. *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists*

Appendix 3. Policies to be Maintained as Recommended by the Council on Dental Education and Licensure

Appendix 4. Policies to be Rescinded as Recommended by the Council on Dental Education and Licensure

Appendix 5. Proposed Amendments to the Guidelines for the Use of Sedation and General Anesthesia by Dentists

Appendix 6. Proposed Amendments to the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students

Appendix 1. Council on Dental Education and Licensure

Report on the ASDA Application for Recognition of Dental Anesthesiology as a Dental Specialty

The American Society of Dentist Anesthesiologists' Request for Recognition of Dental Anesthesiology as a Dental Specialty: On June 1, 2011, the American Society of Dentist Anesthesiologists (ASDA) submitted an application for recognition of dental anesthesiology as a dental specialty to the Council on Dental Education and Licensure (CDEL). The application and appendices (<http://www.ada.org/104.aspx>) included the necessary information and documentation relating to the six requirements for dental specialty recognition as specified in the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists*.

The Council announced receipt of the application to communities of interest, made it available electronically on ADA.org, and called for comments. The call was sent to constituent dental societies, recognized dental specialty organizations, recognized dental specialty certifying boards, state boards of dentistry, American Association of Dental Boards, American Dental Education Association and Academy of General Dentistry. The Council notified deans of U.S. dental schools, directors of advanced dental specialty education programs, ADA officers and the Board of Trustees, members of the ADA House of Delegates, and members and directors of ADA Councils and Commissions. In addition, the call for comment was published in *ADA News*, the ADA Leadership Update and on ADA.org.

The Council received 285 comments from professional dental organizations, academic institutions and individuals in 20 states and Canada. Of those comments, eight came from professional dental organizations, one from an academic institution and 269 from individuals. Of the respondents, 97% (269) support the application; 3% (16) do not support the application. Over 70% of the respondents who support the application are dentist anesthesiologists, general practitioners and pediatric dentists. Many respondents directed their comments to one or more of the six requirements: Requirement 4 was cited the most frequently at 176 times, with 95% of the comments supporting the application's compliance with the requirement.

In October 2011, CDEL referred the application and the comments to its Committee on Recognition of Specialties and Interest Areas in General Dentistry (Committee on Recognition). The members of the Committee are:

- Dr. Jeanne P. Strathearn, general dentist, practitioner, CDEL member, committee chair
- Dr. Joel H. Berg, pediatric dentist, educator
- Dr. George T. Goodis, endodontist, practitioner
- Dr. Scott Houfek, general dentist, practitioner
- Dr. Jeffery C. B. Stewart, oral and maxillofacial pathologist, educator

The Council requested that the Committee conduct an in-depth review and report findings and recommendations to the Council at the May 3-4, 2012, meeting. The Committee met monthly between November 2011 and April 2012, studying the application to determine if it demonstrated compliance with each of the six requirements.

In April 2012, the Committee on Recognition teleconferenced with the members of CDEL and discussed preliminary findings.

On May 4, 2012, representatives of the American Society of Dentist Anesthesiologists (ASDA) appeared before the Council to discuss the application and answer questions.

The following summarizes each of the Requirements for Recognition and presents the conclusions of the Committee on Recognition and CDEL.

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

To comply with this requirement, the Council requires the applicant to submit specific information on the sponsoring organization's founding and historical development, its officers, membership, bylaws, activities and contributions of its members to the art and science of the discipline. The sponsoring organization is also requested to identify other national dental organizations with a primary interest in the same area of dental practice.

ASDA Application: The American Society of Dentist Anesthesiologists (ASDA) is the sponsoring organization for the proposed specialty, Dental Anesthesiology. ASDA was founded February 16, 1980, to support and encourage the clinical practice of anesthesia by dentists and to promote the acquisition and dissemination of associated scientific knowledge. The application states that ASDA is a “strong professional organization with ongoing commitments to quality education for all dentists, advocacy for all patients requiring sedation or general anesthesia, advocacy for all dentists in order to maintain the privilege of administering sedation and general anesthesia with various practice models and advancing the field of anesthesiology for dentists through research and clinical application of current insights into the field of anesthesiology for dental practice.”

ASDA's membership is reflective of the special practice area, dental anesthesiology. Total membership has grown from 112 members in 2001 to 274 members in 2010, and 65% of dentists who have completed two or more years of dental anesthesiology training are members of ASDA. Active members, licensed dentists who have completed a two-year residency, fall into one of the nine membership categories. Only active members in good standing “may participate in the deliberations and voting of the general Assembly and shall be eligible for election or appointment to any office or agency of the society.” (See Appendix 3 of ASDA's Application Appendices.)

As an organization, ASDA contributes to the field by pursuing specialty recognition, sponsoring continuing education programs for its members and others, sponsoring professional publications such as *Anesthesia Progress* and developing and maintaining parameters of care for dental anesthesiology. ASDA members have and continue to contribute to the art and science of the field of anesthesia in many ways. The application identifies many of the contributions to research in dental anesthesiology. The application highlights the discovery and development of safer, more effective therapeutic alternatives for pain and anxiety control, separation between anxiety relief and central nervous system depression, and separation between profound analgesia and respiratory depression.

In the fall of 1994, ASDA developed its certifying board, the American Dental Board of Anesthesiology (ADBA). Currently there are 164 diplomates. The ADBA has a constitution, bylaws, officers, appears to be financially stable and has a professional executive director. Several other national dental organizations/agencies—American Dental Society of Anesthesiology (ADSA), American Society for the Advancement of Anesthesia in Dentistry (ASAAD), American Analgesia Society, National Board of Anesthesiology and National Dental Board of Dental Anesthesiology—are involved in the field of dental anesthesiology.

Comments From Communities of Interest: Those who commented that Requirement 1 is met acknowledged that ASDA's membership and officers are reflective of the proposed specialty and noted that ASDA is an organized and proactive association. ASDA has established a certifying board.

The comment that Requirement 1 is not met stated that ASDA membership is not reflective of the specialty as others—general practitioners, oral surgeons—also provide dental anesthesia.

Committee Conclusion: *Following review of all information provided, the Committee believes that ASDA has demonstrated that its organization is reflective of the special area of practice and that a certifying board has been established and Requirement 1 has been met.*

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

To comply with this requirement, the Council requires the applicant to provide a definition of the proposed specialty and demonstrate the unique knowledge and skills beyond those commonly possessed by dental school graduates by comparing and contrasting the accreditation standards for predoctoral and advanced specialty education programs.

ASDA Application: The application presents the following definition of dental anesthesiology: “Anesthesiology is that specialty of dentistry pertaining to the art and science of pain, anxiety, and behavior management achieved through pharmacologic and other interventions.” The application also borrows from the Accreditation Standards noting that dental anesthesiology residents are trained “in the most comprehensive manner, to use pharmacologic and non-pharmacologic methods to manage anxiety and pain of adults, children, and patients with special care needs undergoing dental, maxillofacial and adjunctive procedures as well as to be qualified in the diagnosis and non-surgical treatment of acute orofacial pain and to participate in the management of patients with chronic orofacial pain.”

An in-depth analysis of the differences between the knowledge and skills possessed by a dental school graduate versus the knowledge and skills possessed by a dentist anesthesiologist program graduate are presented in the application. The application clearly demonstrates distinct differences in the level and depth of instruction by comparing the *Accreditation Standards for Dental Education Programs* and the ADA’s *Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry* to the CODA Accreditation Standards for advanced education programs in Dental Anesthesiology.

The application reported the results of a 2006 study related to sedation education in dental schools. The study revealed that over “24% of those surveyed did not perform or have any demonstration of sedation in dental school” and “over 80% had limited exposure to sedation education including nitrous oxide inhalation sedation while in dental school.” The application also referenced a 2007 ADA Survey of Current Issues in Dentistry related to use of pain and anxiety control modalities by dentists. The survey found that “62% of dentists did not provide any sedation service and the remaining 38% mainly used inhalation sedation.”

Differences in the level of knowledge (i.e., in-depth vs. familiarity) between the proposed specialty and predoctoral didactic and biomedical sciences and clinical curricula demonstrate that the knowledge and skill levels required are beyond those possessed by dental school graduates. Further, the application references ADA’s *Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry* that states “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.”

Comments From Communities of Interest: Those who commented that Requirement 2 is met believe that anesthesia is a well-defined field which requires education, knowledge and skill beyond that possessed by dental school graduations. They point to the ADA *Guidelines for Teaching Pain Control and Sedation to Dentist and Dental Students* that states: “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.”

Those who commented that Requirement 2 is not met believe that dental graduates receive the anesthesia education they need to begin practice. If dentists want to use additional techniques in their practice, there are many avenues to obtain the required advanced knowledge and skills.

Committee Conclusion: *The Committee believes that the information provided in this section of the application documents that dental anesthesiology is a distinct and well-defined field that requires knowledge and skills beyond those commonly possessed by dental school graduates. Accordingly, the Committee believes that dental anesthesiology meets Requirement 2.*

Requirement 3: **The scope of the proposed specialty requires advanced knowledge and skills that: (a) are separate and distinct from any recognized dental specialty or combination of recognized dental specialties; and (b) cannot be accommodated through minimal modification of a recognized dental specialty or combination of dental recognized specialties.**

To comply with this requirement, the Council requires the applicant to identify the advanced knowledge and skills required for practice of the proposed specialty that are not included with the scope of other recognized specialties and to identify and comment on areas of perceived and actual overlap between the proposed specialty and one or more of the recognized dental specialties.

ASDA Application: To demonstrate compliance with Requirement 3, the application presents a comparison of the advanced knowledge and skills described in the accreditation standards for those specialties involved in surgical dental procedures i.e., endodontics, pediatric dentistry, periodontics, oral and maxillofacial surgery and advanced education programs in general practice residency, to the accreditation standards for advanced education programs in dental anesthesiology. Prosthodontics, while noted in the application, does not have accreditation standards related to sedation or general anesthesia training. The application notes that because there are no requirements for knowledge and training of any kind in deep sedation or general anesthesia for the dental specialties in dental public health, oral and maxillofacial pathology, and oral and maxillofacial radiology, these specialties are not included in the review. In addition, because the accreditation standards for the specialty of orthodontics and dentofacial orthopedics only require “familiarity with pain and anxiety control” this specialty is not included in the review.

The application describes the full scope and depth of knowledge and skill required to achieve the levels of competency and proficiency required of those completing advanced training in dental anesthesiology as compared to the instruction provided for the listed advanced specialty education programs. Specifically, information addresses the required depth of knowledge and skills in the areas of general anesthesia, deep sedation, and methods of pain, anxiety and behavior control for the each of the comparison specialties based on their respective Commission on Dental Accreditation standards. The application highlights the volume of additional training for dental anesthesiology residents, but also describes the scope of training that extends beyond that of those in the other relevant dental specialty programs.

The application explains that while others dental specialties, particularly Oral and Maxillofacial Surgery (OMFS), do incorporate anesthesia training into their postgraduate courses, the extent and scope of the training is not as extensive as the training found within dental anesthesiology programs. The application includes a listing and associated measurement methods used to assess attainment of the specific unique competencies and proficiencies for this specialty. There is a clear explanation of the technical training required for this specialty and the quality and volume of additional unique training required.

The application states that some aspects of the proposed dental specialty naturally overlap with other specialties: “local anesthesia and conscious sedation will always be used by specialists and general dentists and these pain control modalities are not the exclusive province of any one discipline of dentistry.” The application identifies the overlaps in scope between the proposed specialty and existing specialties of periodontics, endodontics, pediatric dentistry, oral and maxillofacial surgery and general practice residency, but also demonstrates that the extensive in-depth knowledge and skills in general anesthesia, deep sedation, and methods of pain, anxiety and behavior control for dental anesthesiology are beyond those of these specialties. While certain procedures could be subsumed within the scope of other recognized dental specialties, it appears evident that the full range of procedures cannot be easily incorporated within the scope of any other recognized dental specialty.

Among the currently recognized dental specialties, only oral and maxillofacial surgery programs devote more than one month of formal training in anesthesiology. The application states that “OMFS programs would need to add approximately 13-19 months to their programs to include these proficiencies,” demonstrating the field of anesthesiology cannot be “readily incorporated” by OMFS. Even the very definition and scope of the specialty of OMFS would have to undergo change to incorporate the full scope of dental anesthesiology, since the defined scope of oral and maxillofacial surgery does not include the experience of providing general anesthesia for general dentistry or other specialties. Further, it was noted that oral and maxillofacial surgeons do not routinely provide anesthesia services for other areas of dentistry while dentist anesthesiologists and medical anesthesiologists provide services for both general dentists and specialists.

Comments From Communities of Interest: Those who commented that Requirement 3 is met believe that dental anesthesiology is separate and distinct from other dental specialties. While noting some knowledge and skills overlap, the education standards and clinical requirements for deep sedation and general anesthesia are well beyond those required for oral and maxillofacial surgery and pediatric dentistry programs. For example, dental anesthesiology program requirements include 12 months of hospital anesthesia service for residents versus four months for OMFS residents. Dentist anesthesiologists work with patients of all ages with a variety of psychological and physical conditions in a variety of settings.

Those who commented that Requirement 3 is not met believe that the knowledge and skills required for dentist anesthesiologists are not separate and distinct from other dental specialists, particularly oral and maxillofacial surgeons and pediatric dentists. They view the overlap in knowledge and skills of the specialties as extensive, especially when compared to oral and maxillofacial surgery, leaving dental anesthesiology with a narrow exclusive focus. Also, they believe that the curricula in oral and maxillofacial surgery and pediatric dentistry can easily be adapted to include more anesthesiology training and experiences. Some view dental anesthesiology on a continuum with various levels and types of training widely available.

Committee Conclusion: *Following review of all information provided, the Committee believes that ASDA has provided evidence to support that the scope of this practice area is separate and distinct from any recognized dental specialty or combination of recognized dental specialties and further, that it cannot be accommodated through minimal modification of a recognized dental specialty or combination of recognized dental specialties. Accordingly, the Committee believes that dental anesthesiology meets Requirement 3.*

Requirement 4: The specialty applicant must document scientifically, by valid and reliable statistical evidence/studies, that it: (a) actively contributes to new knowledge in the field; (b) actively contributes to professional education; (c) actively contributes to research needs of the profession; and (d) provides oral health services for the public; all of which are currently not being met by general practitioners or dental specialists.

To comply with this requirement, the Council requests the applicant to cite epidemiological studies which indicate the incidence and/or prevalence of conditions diagnosed and/or treated by practitioners of the proposed specialty; document and assess the need for services that are not being met by general practitioners or recognized dental specialists; provide information on who contributes to the body of knowledge for the proposed specialty; identify and analyze new and emerging trends in the field; number of individuals who devote the majority of time to the practice of the discipline and document how the proposed specialty contributes to the educational needs of the profession.

ASDA Application: There is significant epidemiological data supporting the need for an organized specialty to provide the full scope of pain and anxiety control for all areas of dental practice. The application provides extensive data regarding the type of patients typically receiving the services of the dentist anesthesiologists, including dental phobics, children with special needs, adults with intellectual disabilities, patients with local anesthesia problems, patients who require invasive procedures, and patients with chronic orofacial pain who cannot tolerate dental care while conscious. Each of these

categories of special needs is described in detail, including a set of conditions where anesthesia services are warranted, and is accompanied by literature references and studies to demonstrate the incidence and/or prevalence of each condition as it relates to the need for dental care.

The need for the services of dentist anesthesiologists comes from the following groups: children with special needs, adults with intellectual disabilities, geriatric and medically complex patients, and patients with local anesthesia problems, chronic pain, invasive and stressful procedures. The application states there is a growing need for anesthesia services especially among children. The management of uncooperative children is changing as the use of physical restraints is becoming unacceptable and many parents are more accepting of general anesthesia in order to provide a positive experience for their children. The application notes that by the year 2020, the number of children with neuropsychiatric disorders is “projected to rise by proportionally 50%” according to the World Health Organization. As the life span of special needs children is increasing and many are living into adulthood, the need for anesthesia services in these populations will continue.

As noted previously, the demand for the services of dentist anesthesiologists comes mainly from pediatric dental specialists and general practitioners. An American Academy of Pediatric Dentistry survey in 1997 found that 38.6% of pediatric dentists utilized in-office deep sedation/general anesthesia for their patients. The availability of dentist anesthesiologists has increased in the last 15 years and there are practitioners in many states and Canada. As stated in the application, “As operating room charges are sky-rocking, it is likely that the percentage of pediatric dentists utilizing the service of dentist anesthesiologists will increase.” In addition, demographic trends show the need for dental care for the underserved population is increasing. Improving access to dental care can occur by improving the profession’s approach to advanced pain and anxiety control techniques.

The application states that “dentist anesthesiologists significantly contribute to knowledge in the field of anesthesiology similar to that of the clinically oriented dental specialties.” An extensive list of publications and presentations of ASDA members was presented in Appendices 11 and 12 of the application. Included in the application are the results of a recent study by Ganzberg, et al., looking specifically at the contributions of dentist anesthesiologists to research in the field. Ganzberg’s study used the Hirsch Index which looks at the quantity and quality of a researcher’s publications and is based on the number of times the papers are cited in other publications. Results of the study indicate that the output of the top three dentist anesthesiologist researchers was not significantly different than the output of the top three dentist researchers in other clinically oriented dental specialties studied. The study also found that of the “273 of dentist anesthesiologists identified, 70% had published at least one article.” The study also stated the research output of dentist anesthesiologists is “notable as there are only two dental schools with dedicated anesthesiology departments.”

Several new and emerging trends were identified in the application. First, there is growing opposition by non-dentists groups to dentistry’s “operator-anesthetist model” for the provision of deep sedation or general anesthesia, a “long-standing” mode of delivery of anesthesia in dentistry. ASDA believes a specialty in anesthesia could have impact on this movement. Another trend is the “increased use of oral sedatives to achieve moderate sedation, rather than minimal sedation.” However, the application points out this has not been without risk and suggests that the “benefits of oral sedation be balanced by an appropriate amount of training and prudence on the part of the dentist practitioner.” Lastly, the application cited a 2007 ADA survey that found that of the dentists who use sedation in their practices, over 70% reported using inhalation sedation/nitrous oxide for sedation. Approximately 8% of dentists provide deep sedation/general anesthesia. Of this group, almost three-quarters are oral and maxillofacial surgeons who limit their practices to oral surgery. These facts indicate that the dentist anesthesiologist can have a significant practice and education roles in the use of sedation.

The application summarized and itemized the number of individuals who devote the majority (greater than 50%) of time to the practice of the discipline. To the best knowledge of the ASDA, of the “273 two-year trained dentist anesthesiologists, at least 188 (almost 70%) are practicing anesthesiology at least 50% of the time.” These practitioners can be found in many states and Canada. The projected need for practitioners in the specialty over the next five years, taking into account disease trends, demographic

changes and other pertinent factors, is great. The projected need does not reconcile the effect of the growing number of medical anesthesiologists, many of whom are providing “office-based anesthesia” services. However, a recent article in the *Physician’s Weekly* discussed the Rand Study which looked at the manpower in medical anesthesia and concluded that if “current trends continue, a dramatic shortage of anesthesiologists is projected by 2020.” (Warner, MA, Efforts Needed to Meet Anesthesiologist Demand, *Physician’s Weekly* (online), July 5, 2011, No.25.)

Dentist anesthesiologists contribute to the educational needs of the profession at the predoctoral, postdoctoral, and continuing education levels in real and significant ways in the areas of local anesthesia, sedation, general anesthesia, clinical medicine, general and dental pharmacology, emergency medicine, pain management as well as other disciplines. This is spelled out in terms of not only the impact of dental anesthesiology on the training of postgraduate students in the discipline itself, but in other disciplines such as Oral and Maxillofacial Surgery, Pediatric Dentistry and elsewhere.

The application demonstrates that dentist anesthesiologists actively contribute to new knowledge in the field, contribute to professional education, contribute to the research needs of the profession, and provide oral health services for the public, all of which are currently not being met by non-general anesthesia-trained general practitioners or dental specialists.

Comments From Communities of Interest: Those who commented that Requirement 4 is met believe that dentist anesthesiologists provide services that are not being met by general practitioners or specialists, practice at a high level of skill and have ability to manage patients with complex condition. Many of the comments include the statement that “using anesthesiologists makes treatment easier and less traumatic for patients.” The majority of comments were submitted by pediatric dentists followed by general practitioners. Other specialists supporting this requirement included endodontists, oral and maxillofacial surgeons, orthodontists and periodontists. The general practitioners and specialists who commented on Requirement 4 were from more than 20 states.

Those who commented that Requirement 4 is not met believe that that data does not support the need for dentist anesthesiologists, but that general practitioners, oral surgeons, medical anesthesiologists and nurse anesthetists can meet existing needs. Some believe ASDA does not contribute to new knowledge in the field and the number of practitioners is too small and regional.

Committee Conclusion: *Following review of all the information provided, the Committee believes that the application provided evidence demonstrating that the proposed dental specialty actively contributes to new knowledge in the field; actively contributes to professional education; actively contributes to research needs of the profession; and provides oral health services for the public; all of which are currently not being met by general practitioners or dental specialists. Accordingly, the Committee believes that dental anesthesiology meets Requirement 4.*

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

To comply with this requirement, the Council requires the applicant to identify the principle health services provided and to identify the setting in which these services are customarily provided.

ASDA Application: The application identifies the following as the principle health services of dental anesthesiology:

- (1) The physical evaluation, physiologic monitoring, and anesthetic management of patients during the perioperative period of surgical, operative, prophylactic, and diagnostic procedures.
- (2) The perioperative management of:
 - a. pain, fear, anxiety, phobia and dysfunctional behavior;
 - b. physiologic manifestations of emotional and physiologic stress;
 - c. the patient with systemic disease;

- d. the special care patient with mental, physical, or emotional disability; and
- e. alterations or disruptions of homeostasis.

(3) The diagnosis and management of acute and chronic orofacial pain."

Anesthesia in dentistry is primarily provided in private dental office settings. The private, fully equipped dental office is the ideal place to bridge the gap between the availability of dental treatments and provision of advanced anesthesiology services for groups of children and adult patients that are in need of this service. Dentist anesthesiologists also provide services in ambulatory surgicenters, hospitals and dental schools.

Pediatric dental specialists are the most dependent on the services of dentist anesthesiologists. The availability of dentist anesthesiologists has increased greatly in the last 15 years. At the same time, operating room charges have increased. Because of these changes, it is likely that the percentage of pediatric dentists utilizing the services of a dentist anesthesiologist will increase in the private dental office setting. The application cites a 1997 survey conducted by the American Academy of Pediatric Dentistry that found 38.6% of pediatric dentists utilized in-office deep sedation/general anesthesia for their pediatric patients. It is not surprising to find that a significant portion of the comments received in support of the application were submitted by pediatric dentists.

The services of dentist anesthesiologists in the private office setting are needed in order to expand the opportunity for dental care for those individuals that need to be managed because of anxiety, pain, medical complexities and special needs. Dentist anesthesiologists, with their expertise and knowledge and proficiency, can assist general practitioners and specialists providing care for patient groups that require management in pain, anxiety and behavior management through pharmacologic and other interventions.

Dental care for small children, patients with mental and/or physical challenges and those that avoid dentists due to severe, often incapacitating dental phobias need access to sedation/general anesthesiology specialty services so that they can comfortably receive the dental procedures required to maintain their oral health. Oral and maxillofacial surgeons do not routinely support general dentists and specialists in the provision of anesthesia services for these patients. However, dentist anesthesiologists routinely provide anesthesia services for both general dentists and specialists.

Comments From Communities of Interest: Those who commented that Requirement 5 is met believe that dentist anesthesiologists provide a more cost effective service for patients. The cost of dental services delivered in an office/clinic setting is less than delivery of that same care in a hospital operatory. Dentist-operators will be working in their own familiar space with the equipment they need for procedures. Dentist anesthesiologists understand the dental procedures involved in the treatment and can more readily anticipate the dentist-operator's needs.

Those who commented that Requirement 5 is not met believe that there is no or limited benefit to patient care for this specialty. They believe that the need for anesthesia services can be provided by medical anesthesiologists or nurse anesthetists. Some suggest ASDA is a small group of dentists who could better benefit from American Dental Society of Anesthesiology in terms of continuing education, research and advancement of the field. Some responders expressed concern regarding the ability of itinerant dental anesthesiologists to practice safely and comfortably in a dental office.

Committee Conclusion: *Following review of all the information provided, the Committee believes that the services provided by the dental anesthesiologist directly benefit aspects of clinical patient care. Accordingly, the Committee believes that dental anesthesiology meets Requirement 5.*

Requirement 6: Formal advanced education programs of at least two years beyond the predoctoral dental curriculum as defined by the Commission on Dental Accreditation must exist to provide the special knowledge and skills required for practice of the proposed specialty.

To comply with this requirement, the Council requires the applicant to identify all currently operational advanced education programs in the proposed specialty, to provide a description of the minimum curricula requirements for advanced education programs in the proposed specialty and provide a representative sample of curricula used in several existing advanced education programs in the proposed specialty.

ASDA Application: At the time the application was submitted, nine U.S. institutions and one Canadian institution were offering advanced educational programs in the area of dental anesthesiology. All of these programs are at least two years in duration; three of the programs are 26-36 months in length. Two programs lead to Master's degrees while the remaining programs offer certificates. The names, degrees, and educational backgrounds of each of the program directors were provided. Institutional letters of verification of program sponsorship were submitted. A letter submitted by Indiana University indicated that a program was in the developmental stages and that the institution anticipated enrolling residents in fall 2011. Initial accreditation was granted to this program in February 2012; however, students have not yet been enrolled.

The application identifies 273 dentists practicing in the United States with two or more years of formal advanced education in dental anesthesiology. An additional 27 dentists with two or more years of advanced education in dental anesthesiology subsequently obtained medical degrees and currently practice medical anesthesiology or another medical specialty. Fourteen dentists with two or more years of advanced education in dental anesthesiology currently practice in another of the ADA recognized dental specialties. Finally, 35 dentists in Canada have received two or more years of training in dental anesthesiology. The application indicates an increase in the number of advanced education programs from six in 2006 to 10 in 2010. At current enrollment levels, 26 anesthesia-trained dentists will complete programs each year for a total of 130 new anesthesia-trained dentists potentially entering the field over the next five years. The application states that this will be an insufficient number of new practitioners to meet the future needs of the specialty in terms of demand for services and that additional training program will be required.

The application refers to the CODA Accreditation Standards for Advanced General Dentistry Programs in Dental Anesthesiology for a description of the minimum biomedical, behavioral and clinical science requirements that provide the advanced knowledge and skills for the practice of dental anesthesiology. The statement that all of the listed U.S.-based dental anesthesiology programs should be CODA accredited in 2011 is offered as evidence that curricular requirements of training programs adequately provide the knowledge and skills required. As of February 2012, 10 U.S.-based advanced education programs in dental anesthesiology were accredited by CODA.

The application presented curricula from three programs. One of the programs is hospital based while the other two are dental school based. The descriptions of each of the three vary somewhat in terms of the depth and complexity presented, although the ability to contrast these three curricula does provide evidence regarding varying but successful methods and approaches to structure and delivery of curricula in CODA-approved programs in a variety of educational settings.

The application offers additional information in support of compliance with this requirement. ASDA states that efforts to attain CODA accreditation for all of the dental anesthesiology training programs exemplifies the intent of the sponsoring organization and the practitioners in this field to manage dental patients who require sedation and general anesthesia services. Contributions to the education of residents in other dental specialty programs in regard to the anesthesia components of their curricula, especially in the hospital setting, are also cited. It is ASDA's belief that ADA recognition of dental anesthesiology as a specialty would provide a significant impetus for the development of new and reactivation of dormant training programs. Such recognition will contribute to more opportunities for training in anesthesia for dentists to meet the future needs of dental patients including patients with special needs, medically complex patients and patients with intellectual and/or physical disabilities.

Comments From Communities of Interest: Those who commented that Requirement 6 is met believe that dental anesthesiology residency programs are evidence of a strong and growing specialized practice

area. Further, the CODA-approved residency programs established in academic settings demonstrate that dental anesthesiology is accepted as a bona fide advanced education academic program area.

The comment that Requirement 6 is not met noted that the curricular elements “did not reveal advanced training in any dental diagnosis or treatment.”

Committee Conclusion: *Following review of the curricular information, current program enrollments and other information provided, the Committee believes that dental anesthesiology meets Requirement 6.*

Council’s Final Summary and Recommendations

The Council thoroughly discussed the report and conclusions of the Committee on Recognition. The Council had an extensive discussion related to Requirement 3(a) and whether dental anesthesiology is separate and distinct from any recognized dental specialty or combination of recognized dental specialties. In regards to Requirement 4(d), the Council also discussed at some length dental anesthesiologists’ provision of oral health services for the public and whether those services are met by general practitioners or dental specialists.

Following careful review and discussion of the application for recognition of dental anesthesiology as a dental specialty, the Council agreed with the Committee on Recognition and concluded that:

- The ASDA has *demonstrated* that dental anesthesiology is represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.
- The ASDA has *demonstrated* that dental anesthesiology is a distinct and well-defined field, which requires unique knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards.
- The ASDA has *demonstrated* that the scope of dental anesthesiology requires advanced knowledge and skills that: (a) are separate and distinct from any recognized dental specialty or combination of recognized dental specialties; and (b) cannot be accommodated through minimal modification of a recognized dental specialty or combination of recognized dental specialties.
- The ASDA has *demonstrated* scientifically, by valid and reliable statistical evidence/studies, that dental anesthesiology: (a) actively contributes to new knowledge in the field; (b) actively contributes to professional education; (c) actively contributes to research needs of the profession; and (d) provides oral health services for the public; all of which are currently not being met by general practitioners or dental specialists.
- The ASDA has *demonstrated* that dental anesthesiology directly benefits some aspect of clinical care.
- The ASDA has *demonstrated* that formal advanced education programs of at least two years beyond the predoctoral dental curriculum as defined by the Commission on Dental Accreditation exist to provide the special knowledge and skill required for the practice of dental anesthesiology.

Accordingly, the Council recommends that the following resolution be adopted by the 2012 House of Delegates:

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

Appendix 2.

Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists

Adopted as Amended by the ADA House of Delegates, October 2009

Introduction

A specialty is an area of dentistry that has been formally recognized by the American Dental Association as meeting the "Requirements for Recognition of Dental Specialists" specified in this document. Dental specialties are recognized by the Association to protect the public, nurture the art and science of dentistry, and improve the quality of care. It is the Association's belief that the needs of the public are best served if the profession is oriented primarily to general practice. Specialties are recognized in those areas where advanced knowledge and skills are essential to maintain or restore oral health.*

Not all areas in dentistry will satisfy the requirements for specialty recognition. However, the public and profession benefit substantially when non-specialty groups develop and advance areas of interest through education, practice and research. The contributions of such groups are acknowledged by the profession and their endeavors are encouraged.

The sponsoring organization must submit to the Council on Dental Education and Licensure a formal application which demonstrates compliance with all the requirements for specialty recognition. The Council will submit its recommendation for approval or denial of the proposed specialty to the Association's House of Delegates.

Following approval by the House of Delegates, the sponsoring organization must establish a national board for certifying diplomates in accordance with the "Requirements for National Certifying Boards for Dental Specialists" as specified in this document. Additionally, the Commission on Dental Accreditation develops educational requirements and establishes an accreditation program for advanced educational programs in the specialty. The Council on Dental Education and Licensure and the sponsoring organization monitors the administrative standards and operation of the certifying board.

* Association policies regarding ethical announcement of specialization and limitation of practice are contained in the ADA Principles of Ethics and Code of Professional Conduct.

Requirements for Recognition of Dental Specialties

A sponsoring organization seeking specialty recognition for an area must document that the discipline satisfies all the requirements specified in this section.

- (1) In order for an area to be recognized as a specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.
- (2) A proposed specialty must be a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards. *
- (3) The scope of the proposed specialty requires advanced knowledge and skills that: (a) are separate and distinct from any recognized dental specialty or combination of recognized dental specialties; and (b) cannot be accommodated through minimal modification of a recognized dental specialty or combination of recognized dental specialties.
- (4) The specialty applicant must document scientifically, by valid and reliable statistical evidence/studies, that it: (a) actively contributes to new knowledge in the field; (b) actively contributes to professional education; (c) actively contributes to research needs of the profession; and (d) provides oral health services for the public; all of which are currently not being met by general practitioners or dental specialists.
- (5) A proposed specialty must directly benefit some aspect of clinical patient care.
- (6) Formal advanced education programs of at least two years beyond the predoctoral dental curriculum as defined by the Commission on Dental Accreditation must exist to provide the special knowledge and skills required for practice of the proposed specialty.

* *Predoctoral accreditation standards are contained in the Commission on Dental Accreditation's document Accreditation Standards for Dental Education Programs.*

Requirements for Recognition of National Certifying Boards for Dental Specialists

In order to become, and remain, eligible for recognition by the American Dental Association as a national certifying board for a special area of practice, the area shall have a sponsoring or parent organization whose membership is reflective of the recognized special area of dental practice. A close working relationship shall be maintained between the parent organization and the board. Additionally, the following requirements must be fulfilled.

Organization of Boards:

- (1) Each Board shall have no less than five or more than 12 voting directors designated on a rotation basis in accordance with a method approved by the Council on Dental Education and Licensure. Although the Council does not prescribe a single method for selecting directors of boards, members may not serve for more than a total of nine years. Membership on the board shall be in accordance with a prescribed method endorsed by the sponsoring organization. All board directors shall be diplomates of that board and only the parent organizations of boards may establish additional qualifications if they so desire.
- (2) Each board shall submit in writing to the Council on Dental Education and Licensure a program sufficiently comprehensive in scope to meet the requirements established by the American Dental Association for the operation of a certifying board. This statement should include evidence of sponsorship of the board by a national organization representing dental practitioners interested in that special area of practice.
- (3) Each board shall submit to the Council on Dental Education and Licensure evidence of adequate financial support to conduct its program of certification.
- (4) Each board may select suitable consultants or agencies to assist in its operations, such as the preparation and administration of examinations and the evaluation of records and examinations of candidates. Consultants who participate in clinical examinations should be diplomates.

Operation of Boards:

- (1) Each board shall certify qualified dentists as diplomates only in the special area of dental practice approved by the American Dental Association for such certification. No more than one board shall be recognized by the Association for the certification of diplomates in a single area of practice.
- (2) Each board, except by waiver of the Council on Dental Education and Licensure, shall give at least one examination in each calendar year and shall announce such examination at least six months in advance.
- (3) Each board shall maintain a current list of its diplomates.
- (4) Each board shall submit annually to the Council on Dental Education and Licensure data relative to its financial operations, applicant admission and examination procedures, and results thereof. A diplomate may, upon request, obtain a copy of the annual financial report of the board.
- (5) Each board shall encourage its diplomates engage in lifelong learning and continuous quality improvement.
- (6) Each board shall provide periodically to the Council on Dental Education and Licensure evidence of its examination and certification of a significant number of additional dentists in order to warrant its continuing approval by the American Dental Association.

- (7) Each board shall bear full responsibility for the conduct of its program, the evaluation of the qualifications and competence of those it certifies as diplomates, and the issuance of certificates.
- (8) Each board shall require an annual registration fee from each of its diplomates intended to assist in supporting financially the continued program of the board.

Certification Requirements:

- (1) Each board shall use, in the evaluation of its candidates, standards of education and experience approved by the Commission on Dental Accreditation.
- (2) Each board shall require, for eligibility for certification as a diplomate, the successful completion of an educational program accredited by the Commission on Dental Accreditation of two or more academic years in length, as specified by the Commission.*

Although desirable, the period of advanced study need not be continuous, nor completed within successive calendar years. An advanced educational program equivalent to two academic years in length, successfully completed on a part-time basis over an extended period of time as a graduated sequence of educational experience not exceeding four calendar years, may be considered acceptable in satisfying this requirement. Short continuation and refresher courses and teaching experience in specialty departments in dental schools will not be accepted in meeting any portion of this requirement.

Each board may establish an exception to the qualification requirement of completion of an advanced specialty education program accredited by the Commission on Dental Accreditation for the unique candidate who has not met this requirement per se, but can demonstrate to the satisfaction of the certifying board, equivalent advanced specialty education. A certifying board must petition the Council on Dental Education and Licensure for permission to establish such a policy. If granted, the provisions of the certifying board's policy shall be reported to the House of Delegates in the Annual Report of the Council on Dental Education and Licensure.

*The following interpretation for educational eligibility was provided by the 1975 House of Delegates of the American Dental Association (*Trans.*1975: 690).

Candidates for board certification who graduated after January 1, 1967, must have successfully completed an accredited advanced specialty program. Candidates for board certification who completed the prescribed length of education for board certification in a program of an institution then listed by the Council on Dental Education and Licensure prior to 1967, and who have announced ethically limitation of practice in one of the recognized dental specialties, are considered educationally qualified.

- (3) Each board shall establish its minimum requirements for years of practice in the area for which it grants certificates. The years of advanced education in this area may be accepted toward fulfillment of this requirement.
- (4) Each board, in cooperation with its parent organization, shall prepare and publicize its recommendations on the educational program and experience requirements which candidates will be expected to meet.

Founding Boards and Waivers: Members of a founding board in an area of practice not recognized previously by the American Dental Association shall be exempt from certifying examination. Newly recognized boards may petition the Council on Dental Education and Licensure for permission to waive the formal education requirements for candidates who apply for examination. If granted, the provisions of the waiver shall be reported to the House of Delegates in the Annual Report of the Council on Dental Education and Licensure.

Appendix 3. Policies to be Maintained

As Recommended by the Council on Dental Education and Licensure

American Dental Association Policy Statement: The Use of Sedation and General Anesthesia by Dentists (*Trans.2007:384*)

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 obliterating 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 Association's *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 Association's *Guidelines for Teaching Pain Control and Sedation for 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 Association 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;
- Treating high-risk patients in a setting equipped to provide for their care.

The Association expects that patient safety will be the foremost consideration of dentists who use 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 Association 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 Association strongly supports the expansion of both basic and clinical research in anxiety and pain control. It urges institutions and agencies that fund and sponsor research to place a high priority on this type of research, which should include: 1) epidemiological studies 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.

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.

Definition of Curriculum Integrated Format (*Trans.2007:389*)

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 within each institution 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.

Definition of Continuing Competency (*Trans.1999:939*)

Resolved, that the following definition of continuing competency be adopted.

Continuing competency: The continuance of the appropriate knowledge and skills by the dentist in order to maintain and improve the oral health care of his or her patients in accordance with the ethical principles of dentistry.

Policy on Dental Licensure (*Trans.1998:720; 2003:341*)

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

1. that the state board of dentistry in each state should be the sole licensing and regulating authority for all dental personnel, including dental specialists;
2. that each state continue to require of all candidates for licensure satisfactory performance on the National Board Dental Examinations, Parts I and II;
3. that each state accepts satisfactory performance on National Board examinations as a requirement of satisfactory performance on a written examination for licensure;
4. that each state continue to require of all candidates for initial licensure satisfactory performance on an individual state or regional clinical examination, or successful completion of a postgraduate program in general dentistry that contains competency assessments or in an ADA recognized dental specialty at least one year in length that is accredited by the ADA Commission on Dental Accreditation.
5. that each state consider active participation in regional clinical examinations;
6. that each state consider requiring dentists to maintain records to show evidence of continuing education as a condition for re-registration of their licenses;
7. that states consider including in their practice acts provisions to require for licensure maintenance, proof of remedial study for those dentists identified through properly constituted peer review mechanisms as being deficient; and
8. that state dental associations, state boards of dentistry and dental schools work in close cooperation to provide supplemental education opportunities for those dentists who lack clinical proficiency but are otherwise eligible for a dental license.

Policy on Licensure of Dental Assistants (*Trans.2000:474*)

Resolved, that it is the policy of the American Dental Association that licensure of dental assistants is not warranted.

Dental Practice by Unqualified Persons (*Trans.1959:207*)

Resolved, that the efforts of untrained and unqualified persons to gain a limited or unqualified right to serve the public directly in the field of dental practice be opposed as detrimental to the health, safety and welfare of the public.

Acceptance of Formal Continuing Medical Education Courses Offered by ACCME Accredited CE Providers (*Trans.2010:576*)

Resolved, that the American Dental Association urges state boards of dentistry to accept for licensure renewal purposes dentists' participation in formal continuing medical education courses offered by continuing education providers accredited by the Accreditation Council for Continuing Medical Education (ACCME).

Policy Statement on Continuing Dental Education (*Trans.2006:331; 2011:465*)

Definition of Continuing Dental Education: Continuing dental education consists of educational activities designed to review existing concepts and techniques, to convey information beyond the basic dental education and to update knowledge on advances in scientific, clinical, and non-clinical related subject matter, including evidence-based dentistry and ethics. The objective is to improve the knowledge, skills and ability of the individual to provide the highest quality of service to the public and the profession. All continuing dental education should strengthen the habits of critical inquiry, balanced judgment and ethics that denote the truly professional and scientific person and should make it possible for new knowledge to be incorporated into the practice of dentistry as it becomes available.

Continuing education programs are designed for part-time enrollment and are usually of short duration, although longer programs with structured, sequential curricula may also be included within this definition. In contrast to accredited advanced dental education programs, continuing dental education programs do not lead to eligibility for ethical announcements or certification in a specialty recognized by the American Dental Association. Continuing dental education should be a part of a lifelong continuum of learning.

Acceptable Subject Matter: In order for specific course subject material to be acceptable for credit, the stated course objectives, overall curriculum design or topical outlines should be clearly stated. The information presented should enable the dental professional to enhance the dental health of the public, either directly or through improved effectiveness of operations in dental practice, or through expansion of present knowledge through research. The dental professional should be able to apply the knowledge gained within his or her professional capacity.

Acceptable Activities: Continuing education activities are conducted in a wide variety of forms using many methods and techniques which are sponsored by a diverse group of institutions and organizations. State boards and/or legislatures may specify acceptable activities or content. The Association urges the state boards to allow maximum flexibility for an individual to choose content and learning activities based on individual preferences, needs, interests and resources. Additionally, clinical credit should be awarded for all activities related to the delivery of dental procedures including those with ethical components and self-study activities.

Acceptable forms might include but are not limited to:

- Attendance at and/or delivery of a formal continuing education course (a didactic and/or participatory presentation to review or update knowledge of new or existing concepts and techniques)
- General attendance at a multi-day convention type meeting (a meeting held at the national, state or regional level which involves a variety of concurrent educational experiences)
- Authorship of publications (e.g., a book, a chapter of a book or an article or paper published in a professional journal)
- Completion of self-study activities such as online courses and research, webinars, journal articles and downloadable books (individualized course of study which is structured and organized, but is available on an unscheduled and unsupervised basis; a method of providing feedback to the learner on performance or comprehension must be incorporated into the self-study activity)
- Enrollment in a preceptor program (an independent course of study with a formally structured, preplanned and prescheduled curriculum where the participant observes and provides patient treatment using criteria and guidelines provided by the instructors; this type of study does not lead to an academic degree)
- Academic service (e.g., instruction, administration or research related to undergraduate, postgraduate or graduate dental or allied dental training programs)
- Presenting posters or table clinic
- Participation on a state dental board, a board complaint investigation, peer review or quality care review procedures
- Successful completion of part ii of the national board dental examination, a recognized dental specialty examination or the national board dental hygiene examination if taken after initial licensure
- Test development for written and clinical dental, dental hygiene and dental specialty examinations
- Volunteering pro bono dental services or community oral health activities through instruction at a public health facility
- Participation in dental research as a principal investigator or research assistant

Policy Statement on Lifelong Learning (*Trans.2000:467*)

The Association advocates lifelong learning to enhance and update the knowledge base of dentists, to stimulate ongoing professional growth and development and to improve professional skills. Dentists have a responsibility to pursue lifelong learning throughout their professional careers. The Association recognizes that its members represent a broad community of interest and possess highly diverse learning styles that can be accommodated by a variety of educational methods. Members are encouraged to identify individual needs and develop and implement a plan to meet these needs. This plan may include, but not be limited to, staying current with professional literature, seeking current information applicable to one's practice, and participating in formal continuing dental education activities. The increasing pace of change in technology and skills necessary to practice dentistry necessitates the continuous deliberate acquisition of knowledge and skills to provide the highest quality of oral health care. A professional should address a broad spectrum of topics to update his or her knowledge and skills in all appropriate areas of the profession.

The Association is committed to serving as a supportive resource to facilitate the lifelong learning process and to assist members in identifying appropriate sources and mechanisms for meeting this responsibility for the benefit of the public and the profession.

Lifelong Continuing Education (*Trans.1999:941*)

Resolved, that the American Dental Association supports lifelong continuing education of its members and encourages various methods of demonstrating continuing competency through the oversight of dental practitioners by state boards of dentistry and peer review, and be it further

Resolved, that the Association discourages methods such as mandated periodic in-office audits and/or comprehensive written examinations as a means of measuring or assessing the continuing competency of dentists or as a requirement for license renewal, and be it further

Resolved, that the Association encourages the investigation of new methods of supporting continuing competency of its members, and be it further

Resolved, that the American Dental Association promote and defend this policy in any and all discussions concerning the issue of competency.

Cardiopulmonary Resuscitation Instruction (*Trans.1976:860*)

Resolved, that constituent and component societies be encouraged to make regularly available to their members and their auxiliary personnel continuing education in cardiopulmonary resuscitation.

Promotion of Continuing Education (*Trans.1968:257*)

Resolved, that constituent dental societies, in consultation with state boards of dentistry, are urged to develop mechanisms to foster the continued education of dentists licensed in their jurisdiction.

Appendix 4. Policies to be Rescinded

As Recommended by the Council on Dental Education and Licensure

Communication Between State Boards of Dentistry (*Trans.1989:527*)

Resolved, that the ADA urge state boards of dentistry to work towards a more effective communication among themselves and be it further

Resolved, that disciplinary action including, but not limited to, consent orders, agreed orders, consent agreements and stipulations of a dental board should be accessible to any dental board that makes a formal inquiry when it considers the credentials of an applicant for licensure.

Use of Human Subject in Clinical Licensure Exams (*Trans.1996:712*)

Resolved, that the Association supports the concept of dental students providing direct patient care under the direct and indirect supervision of qualified faculty as a method of learning clinical skills and patient care including the ability to deal with the anxiety, fears, reflexes and other emotions of the “human” aspects of dental treatment, and be it further

Resolved, that the House strongly supports the position of the Council on Ethics, Bylaws and Judicial Affairs as stated in the Council’s annual report to the 1993 House of Delegates (*Trans.1993:109*) that, although the use of human subjects in licensure examinations raises certain ethical concerns, the practice is not in and of itself unethical, and be it further

Resolved, that the Association urges the clinical testing agencies to adopt policies to ensure that follow-up care is available for patient procedures performed during clinical licensure examinations.

Acceptance of Successful Completion of State or Regional Licensure Examinations by State Boards of Dentistry (*Trans.1998:725*)

Resolved, that all constituents of the American Dental Association be urged to submit formal proposals to their respective state dental licensing agencies that would provide for acceptance of successful completion of a licensure examination administered by any recognized individual state or regional testing agency for the purpose of licensure in their state.

Standardization of State Dental Licensure Examinations (*Trans.1992:629*)

Resolved, that the Association, in cooperation with the American Association of Dental Examiners, actively support standardization of dental and dental hygiene licensure clinical examinations by continuing to encourage state boards of dentistry to accept a common core of requirements and guidelines for clinical examinations.

Appendix 5. Proposed Amendments to the Guidelines for the Use of Sedation and General Anesthesia by Dentists

The Council recommends that the below policy be amended by deletion and addition as follows (additions are underscored; deletions are ~~stricken~~).

Proposed Amendments to the Guidelines for the Use of Sedation and General Anesthesia by Dentists (*Trans.2007:282*)

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.

conscious sedation¹ - a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command and that is produced by a pharmacological or non-pharmacological method or a combination thereof.

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

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

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

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

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

respond *normally* to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.²

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.

The use of preoperative sedatives for children (aged 12 and under) prior to arrival in the dental office, 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 Dentists 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 (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 on the day of treatment.

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.³

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

² 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.

³ 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.

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 Classification⁴

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).

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 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 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.

⁴ ASA Physical Status Classification System is reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

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. 1) a current certification in 4) Basic Life Support for Healthcare Providers and 2) either current certification in Advanced Cardiac Life Support (ACLS) or completion of an appropriate dental sedation/anesthesia emergency management course on the same recertification cycle that is required for ACLS.
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. 1) a current certification in 4) Basic Life Support for Healthcare Providers and 2) either current certification in Advanced Cardiac Life Support (ACLS) or completion of an appropriate dental sedation/anesthesia emergency management course on the same re-certification cycle that is required for ACLS.
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 (BLS) Course for the Healthcare Provider.

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. However, all dentists providing sedation and general anesthesia in their offices or the offices of other dentists should comply with the Clinical Guidelines in this document.

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. Pre-Operative 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.
- Pre-operative 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 pre-operatively, post-operatively 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 level of consciousness, oxygenation, ventilation and circulation are satisfactory prior to discharge.
- Post-operative 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. Pre-operative 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.

- Pre-operative 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. When active treatment concludes and the patient recovers to a minimally sedated level a qualified auxiliary may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility. 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 CO₂ 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:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages and their administration times administered, including local anesthetics, ~~dosages~~ and monitored physiological parameters. (See Additional Sources of Information for sample of a time-oriented anesthetic record).
- Pulse oximetry, heart rate, respiratory rate ~~and~~ blood pressure and level of consciousness 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 level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.
- If a pharmacological reversal agent is administered before discharge criteria have been met, the patient must be monitored until recovery is assured for a longer period than usual before discharge, since re-sedation may occur once the effects of the reversal agent have waned.

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. Pre-operative 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.
- Pre-operative 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 of successfully completing a Basic Life Support (BLS) Course for the Healthcare Provider.
- 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, a capnograph must be utilized and 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 CO₂ must be continuously monitored and evaluated.

- Non-intubated patient: Breath sounds via auscultation and/or end-tidal CO₂ 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.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, administered dosages and their administration times, including local anesthetics, ~~doses~~ and monitored physiological parameters. . (See Additional Sources of Information for sample of a time-oriented anesthetic record)
- Pulse oximetry and end-tidal CO₂ measurements (if taken), heart rate, respiratory rate and blood pressure must be recorded continually ~~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 level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

6. Pediatric Patients and Those with 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.

V. Additional Sources of Information

American Dental Association. Example of a time oriented anesthesia record at www.ada.org.

American Academy of Pediatric Dentists 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/sqstoc.htm>

Commission on Dental Accreditation (CODA). *Accreditation Standards for Predoctoral and Advanced Dental Education Programs*. Available at <http://www.ada.org/115.aspx>.

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>

Appendix 6. Proposed Amendments to the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students

The Council recommends that the below policy be amended by deletion and addition as follows (additions are underscored; deletions are ~~stricken~~).

Proposed Amendments to the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (*Trans.2007:282*)

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. Though Basic Life Support 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.

conscious sedation¹ - a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command and that is produced by a pharmacological or non-pharmacological method or a combination thereof.

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

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

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

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.

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

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.²

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.

The use of preoperative sedatives for children (aged 12 and under) prior to arrival in the dental office, 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 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 on the day of treatment.

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

² 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.

interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.³

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

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.

³ 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.

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 Classification⁴

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.

⁴ ASA Physical Status Classification System is reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

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 courses and advanced education programs). 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, 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 patients and those with 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, and 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-ental 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-ental minimal sedation (combined minimal sedation).
4. List and discuss the indications and contraindications for the use of enteral and/or combination inhalation-ental minimal sedation (combined minimal sedation).
5. List the complications associated with enteral and/or combination inhalation-ental minimal sedation (combined minimal sedation).
6. Discuss the prevention, recognition and management of these complications.
7. Administer enteral and/or combination inhalation-ental 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, and 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 combining enteral moderate sedation with nitrous oxide-oxygen must have first completed a nitrous oxide competency course.

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. Participants combining parenteral moderate sedation with nitrous oxide-oxygen must have first completed a nitrous oxide competency course.

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.

VI. Additional Sources of Information

American Dental Association. Example of a time oriented anesthesia record at www.ada.org.

American Academy of Pediatric Dentists 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/115.aspx> .

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>

Council on Dental Practice

Zust, Mark R., 2012, Missouri, chair
Knapp, Jonathan B., 2013, Connecticut, vice chair
Armstrong, Craig S., 2013, Texas
Childs, Miranda M., 2015, Arkansas
Cole, Jeffrey M., 2013, Delaware
D'Aiuto, Charles W. "Bill", 2012, Florida
Dawley, Joanne, 2014, Michigan
Dowd, Brendan, 2014, New York
Johnston, Jonathan J., 2013, Pennsylvania
Maxwell, Charles B., 2015, South Carolina
Newman, Roger K., 2012, Montana
Sessa, Kevin D., 2014, Colorado
Sledd, Jamie L., 2012, Minnesota
Thomas, J. Mark, 2015, Indiana
Tippett-Whyte, Judee, 2012, California
Torbush, Douglas B., 2014, Georgia
Unger, Joseph G., 2015, Illinois
Unkenholz, Eric, 2012, South Dakota, *ex officio**

Willey, James L., director
Porembski, Pamela M., senior manager
Bregenzer, James, manager
Furlong, Arlene M., manager
Siwek, Alison M., manager

The Council's 2011-12 liaisons included: Dr. Donald L. Seago (Fifth District trustee, Board of Trustees); Dr. Thomas J. Olinger (Council on Communications); and Mr. Marcus "Ken" Randall (American Student Dental Association)

Mission and Purpose

The mission of the Council on Dental Practice is to recommend policies and provide resources to empower our members to continue development of the dental practice, and to enhance their personal and professional lives for the betterment of the dental team and the patients they serve.

Supporting the Strategic Plan: Activities, Results and Accomplishments

The activities of the Council on Dental Practice (CDP) are consistent with and continue to support the ADA Strategic Plan 2011-14. In keeping with Goal 1—provide support to dentists so they may succeed and excel throughout their careers—the CDP is leading interagency efforts to create an ADA Center for Professional Success (CPS). The development and implementation of the CPS has three goals. The first goal is to increase ADA membership, both net member growth and overall membership market share. The second goal is to strengthen the value of ADA membership through specific integrated products and services designed to meet the ongoing needs of the pre-professional, the early-career dentist, the mid-career dentist and the mature-career-stage dentist, regardless of the personal career path chosen. The objective is to establish the CPS as one of the top five most highly rated member benefits within the ADA portfolio of products and services. The third goal is to increase both dues and non-dues revenue through premium level services and products, advertising, and sponsorship—all while preserving the basic concept of a true member benefit. The CPS will incorporate two major product features. The first is a world class, web-based practice management portal that is simple to navigate and provides a dedicated,

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

comprehensive set of information, including interactive resources. These resources are envisioned to contain topics related to evidence-based knowledge, continuing education, business decision support, practice growth and marketing support, business analytics, consultative services and networking opportunities. The second is a portfolio of online dental practice management certificate programs, offered in collaboration with highly respected universities. The ADA would be the first dental organization to offer programs that reflect the wider trend toward online business education. In addition, an in-person executive dental practice management certificate program will be offered for those who wish to participate in live continuing education experiences. Further, the CDP added practice management content to its Dental Practice Hub website on ADA.org. In addition, CDP manages the ADA Hillenbrand Fellowship Program. The council director provided mentoring for the 2011-12 Hillenbrand Fellow. The biennial Conference on Dentist Health and Well-Being held in August 2011 received positive feedback and generated revenue of \$37,675. The Council supports Goal 2—be the trusted resource for oral health information that will help people be good stewards of their own oral health. The CDP collaborated with the Department of Product Development and Sales (DPDS) to develop 21 oral health brochures. The Council fulfills Goal 3—improve public health outcomes through a strong collaborative profession and through effective collaboration across the spectrum of our external stakeholders—by attending annual meetings and collaborating with national organizations representing members of the dental team. These include the American Dental Assistants Association (ADAA), the American Dental Hygienists' Association (ADHA), the American Association of Dental Office Managers (AADOM), the National Association of Dental Laboratories (NADL) and the Lab Summit. Staff attended annual meetings of the American Academy of Dental Group Practice (AADGP) and the New Dentist Committee (NDC) to develop an enhanced expertise and knowledge base and identify emerging issues related to dental practice management. The CDP also maintains its commitment to providing leadership in disaster planning and emergency planning by fulfilling voting member responsibilities to the National Disaster Life Support Education Consortium (NDLSEC), sponsored by the American Medical Association, and also attending the annual Illinois Public Health Emergency Preparedness Summit. To satisfy Goal 4—ensure that the ADA is a financially stable organization that provides appropriate resources to enable operations and strategic initiatives—the CDP contributes to non-dues revenues with its collaboration on the aforementioned oral health brochures and practice management publications. The CDP also maintains a modest revenue provided from advertising revenues derived from its *Directory of Dental Practice Appraisers and Brokers* and *Directory of Dental Practice Management Consultants*.

The Council held a strategic planning session at its May 31-June 2, 2012 meeting to answer the question: "What should CDP do in the next three years to create both tangible and measurable member value?" The Council narrowed its focus to three major priorities. The first was to create and provided oversight to the new CPS initiative. Outcomes for this project could be evaluated by measuring: the number of member hits on its website; the amount of non-dues revenue generated; membership retention; and member satisfaction. The second initiative is centered on gaining a better understanding of, and making policy recommendation related to, emerging practice models and related economic factors. Outcomes for this could be measured by the number of ideas generated for the CPS and the number of proposed policy resolutions generated for the House of Delegates. The third priority involves promoting the health, wellness and well-being of the dentist and members of the dental team. Results could be measured through data obtained from the Health Screening Program held during the ADA annual session, by monitoring the percentage of addicted dentists and by gathering data on the retirement of dentists as a result of disability (this information should be obtainable from insurance companies and other sources).

Emerging Issues and Trends

Impact on Information Technology on Dentistry

The Council formed an Electronic Health Record (EHR) Interagency Workgroup to coordinate the ADA's EHR activities as directed by the Board of Trustees at its June 2011 meeting. The Council drafted a project charter and strategic plan for the Workgroup, made revisions to its EHR continuing education course, created and made regular updates to its online EHR *Frequently Asked Questions* resource, as well as collaborated with key ADA agencies on research and emerging trends in EHR-related technologies with guidance and feedback from the members of the Workgroup.

The Department of Standards

The CDP reviews the work products of the Standards Committee on Dental Informatics (SCDI) as part of its ADA *Bylaws* duties.

The objective of the Department of Standards is to help dentists succeed by developing standards and technical reports for current and emerging technologies used in dental practice. The ADA's voluntary standards program is the American National Standards Institute (ANSI) accredited program that supports development of voluntary consensus standards to help provide safe and effective dental products.

Over the past year, the ADA Standards Department supported dentists through the following informatics activities:

Strategic Plan for the ADA Standards Program: Over the past year, a series of strategic planning sessions and focus groups were held with stakeholders to discuss the challenge facing the ADA Standards program today, which is to preserve the strengths of the private-sector, voluntary consensus approach to standards development. From these discussions, a strategic plan emerged that enumerates opportunities to capitalize on the program's strengths and then prescribes a plan of action to ensure the development of relevant standards to assist the dentist in practice and the health and safety of the public.

SCDI Digital Technologies Activities: The Integrating the Healthcare Enterprise (IHE) Dental Domain was established to accelerate the adoption of digital technologies by improving the real-world functionality, usability and exchange of digital information among healthcare systems. It achieves the goals set by Resolution 83H-2009 (*Trans.*2009:415), Development of a Standard for Secure Electronic Transmission of Digital Radiographs. In February 2012, the Dental Domain approved its first project, "Dental Profile for the Secure Exchange and Interoperability of Digital Dental Images."

The ADA SCDI held a working group session on digital technologies in October 2011. The session covered the activities of both the IHE Dental Domain and SCDI Working Group 12.1 on digital imaging. The purpose of the session was to determine how the two committees will work together in the future to develop and approve new work projects.

SCDI Vendors Symposium: A vendors symposium was held at the October 2011 SCDI meeting and subsequently, a vendor ad hoc committee was formed to address issues and find solutions to lower the barriers to implementation of informatics standards in dental practice management and digital imaging systems. The group plans to meet and plan the next symposium to be held in October 2012.

Forensic Dental Data Standard Implementation Activities: The ADA SCDI is working with Interpol, the Federal Bureau of Investigation and the National Institute of Standards and Technology to incorporate ANSI/ADA Standard No. 1058 for Forensic Dental Data Set as the dental component of a new forensics standard. The goal is to develop a single, unified standard for disaster victim identification for use by law enforcement agencies worldwide.

New Work Item: The following new work item was approved by SCDI this past year:

- *Proposed ADA Technical Report No. 1073 for Monitoring the Patient's Exposure to Ionizing Radiation in Dentistry.*

This new technical report will provide a standard template that can be utilized in electronic patient records to record the patient's history of x-rays.

Drafts for Circulation for All Interested Parties' Review: The following documents were completed and forwarded to CDP for approval to circulate to all interested parties this past year:

- *Proposed ANSI/ADA Standard No. 1067 for Electronic Dental Record System Standard Functional Requirements.*

This new standard marks a major advancement in the ADA's development of the electronic dental record by enumerating functional requirements.

- *Proposed ADA Technical Report No. 1065 for Use Cases of the Orthodontic Health Record.*

This new technical report will assist the SCDI in development of the orthodontic EHR.

Trends in Dental Group Practice

The CDP is developing an action plan to educate members in response to the emerging trend towards larger dental group practice models. It is also updating member resources on affiliating with a dental services organization.

Point of Service Testing

Information on regulatory requirements of providing point of service testing in dental offices was developed for the 2011 Health Screening Program demonstration project, which focused on obtaining finger stick blood samples for immediate testing. These fact sheets, "Clinical Laboratory Improvement Amendments (CLIA) Flowchart" and "Laboratory Testing and CLIA," were posted on the Dental Practice Hub website.

Responses to House of Delegates Resolutions

61H-2011. Practical Development of Teledentistry (Trans.2011:459)

Resolution 61H-2011 directed that CDP, in collaboration with the Council on State Government Affairs, investigate the emerging issue of teledentistry as it relates to dental practice and report to the 2012 House of Delegates. It also provided for funds to allow a representative of the Division of Dental Practice to attend the 2012 American Telemedicine Association Meeting. The CDP established a Subcommittee on Teledentistry to study this topic. The Subcommittee met by conference calls to discuss a response to the 2012 House of Delegates. An informational report was shared with the Subcommittee on the findings from the American Telemedicine Association annual meeting. A supplemental report on Resolution 61H-2011 will be submitted to the 2012 House of Delegates.

110H-2010. Advocating for Victims of Addictive Disease (Trans.2010:564)

The 2010 House of Delegates adopted Resolution 110H-2010, which directed the CDP, through its Dentist Well-Being Advisory Committee, to develop strategies to communicate the value and importance of safe, confidential treatment and monitoring for dental team members suffering from addiction. A report and three-year action plan with recommendations was submitted and approved by the 2011 House of Delegates. The CDP focused on the development of grassroots promotions of well-being programs through articles in *ADA News*, *ADA New Dentist News*, *ADA Practice and Thrive* and Leadership Updates. A follow-up constituent dentist well-being survey was issued to constituent dentist well-being program (CDWP) directors. The strengths and weaknesses of each CDWP were identified and used to develop resources, including: educational webinars on opioid prescribing and abuse, and a CDWP director communications portal on ADA Connect. The CDP is collaborating with the ADA Council on Government Affairs to develop advocacy and legislative efforts to support the positive impact of well-being programs.

Policy Review

In accordance with Resolution 111H-2010, Regular Comprehensive Policy Review, the Council on Dental Practice reviewed ADA policies and presents a series of resolutions with recommendations to maintain, rescind or amend those policies.

Recommendations—Policies to be Maintained

The Council concluded that the following policies should be maintained as written. The full text of each policy is included in Appendix 1.

33. Resolved, that the following policies be maintained:

Definition of Cosmetic Dentistry (*Trans.*1976:850)
 Definition of Oral Diagnosis (*Trans.*1978:499)
 Definition of Treatment Plan (*Trans.*1978:499)
 Definition of Dental Care (*Trans.*1996:688)
 Primary Dental Care Provider (*Trans.*1994:668; 2010:548)
 Definition of Denturist and Denturism (*Trans.*1976:868; 2001:436)
 Amendment of Policy on Opposition to “Denturist Movement” (*Trans.*2001:436)
 Dental Identification Efforts (*Trans.*1985:587)
 Statement on the Use of Opioids in the Treatment of Dental Pain (*Trans.*2005:327)
 Statement on Substance Abuse Among Dentists (*Trans.*2005:328)
 Statement on Provision of Dental Treatment for Patients With Substance Use Disorders (*Trans.*2005:329)
 Statement on Alcohol and Other Substance Use by Pregnant and Postpartum Patients (*Trans.*2005:329)
 Statement on Dentist Health and Wellness (*Trans.*2005:321)
 Statement on Substance Abuse Among Dental Students (*Trans.*2005:328)

Recommendations—Policies to be Amended

The Council believes that the policy “Definition of Fee-For-Service Private Practice” should be amended to reflect the changes in third-party reimbursement.

34. Resolved, that the ADA policy “Definition of Fee-for-Service Private Practice” (*Trans.*1979:620) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the following definition of the traditional fee-for-service private practice of dentistry be approved:

The ~~traditional~~ fee-for-service private practice of dentistry, historically the basic ~~and most prevalent~~ method for delivery of oral health care, is a one model in which the dentist, as a solo practitioner or in a group, is ultimately responsible for all professional and business aspects of the practice. In this model the fee to the patient is dictated by the service rendered, the patient maintains the freedom of choice of the dentist and the dentist has the freedom of choice of patients.

The Council believes that the policy “Active and Inactive Dental Patients of Record” should be amended to improve the accuracy of the definition of active patients.

35. Resolved, that the ADA policy “Active and Inactive Dental Patients of Record” (*Trans.*1991:621) be amended as follows (additions are underscored):

Resolved, that only for the purposes of evaluating or appraising the assets of a dental practice do the following definitions of the terms “active” and “inactive” dental patients of record apply:

Active Dental Patient of Record: An active dental patient of record is any individual in either of the following two categories: Category I – patients of record who have had dental service(s) provided by the dentist in the past twelve (12) months; Category II – patients of record who have had dental services(s) provided by the dentist in the past twenty-four (24) months, but not within the past twelve (12) months. Patients who have requested their records be transferred to another dentist or who have indicated they will be discontinuing their treatment,

as substantiated in the patient's record, should be excluded from the "active" patient category. Each of these categories of active patients of record can be further divided into: (1) new or regular patients who have had a complete examination done by the dentist and, (2) emergency patients who have only had a limited examination done by the dentist.

Inactive Dental Patient of Record: An inactive dental patient of record is any individual who has become a patient of record and has not received any dental services(s) by the dentist in the past twenty-four (24) months.

The Council believes that the policy "Primary Dental Care" should be amended to be consistent with the descriptor of evaluations found in the *Code of Dental Procedures and Nomenclature* and current ADA policy.

36. Resolved, that the ADA policy "Primary Dental Care" (*Trans.*1994:668; 2010:562) be amended by the addition of the words "treatment planning" after the word "prevention" so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

Primary Dental Care. The dental care provided by a licensed dentist to patients beginning no later than age one and throughout their lifetime. Primary dental care is directed to evaluation, diagnosis, patient education, prevention, treatment planning and treatment of oral disease and injury, the maintenance of oral health, and the coordination of referral to specialists for care when indicated. Primary dental care includes services provided by allied personnel under the dentist's supervision.

The Council believes that the policy on "Uniform Procedure for Permanent Marking of Dental Protheses" should be amended to incorporate key elements of the 1978 policy on Identification through Prosthetic Devices as follows:

37. Resolved, that the ADA policy on "Uniform Procedure for Permanent Marking of Dental Protheses" (*Trans.*1979:637) be amended by deletion of the first resolving clause; deletion of the words "urge constituent societies to actively" in the second resolving clause; and the addition of a new second resolving clause, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

~~**Resolved**, that the procedure recommended by the Council on Federal Dental Services in its 1978 Supplemental Report 1 to the House of Delegates (Supplement 1, 1978:181) be strongly promoted for use by the dental profession, and be it further~~

~~**Resolved**, that the American Dental Association ~~urge constituent societies to actively~~ supports the use of uniform methods of marking dental prostheses for identification purposes, and be it further~~

Resolved, that a system of dental prosthetic identification should meet the following criteria:

1. Standardized identification, including the patient's first and last names, typed on onionskin, linen, nylon, foil or similar materials, should be inserted into the dental prosthesis before final closure.
2. The identification should be legible and permanent.
3. The procedure for applying the identification markings should be clinically safe, economically practical and cosmetically acceptable.

The Council believes that the policy "Dental Identification Teams" should be amended to clarify the ADA's support for constituent society dental identification teams and its support for the American Board of Forensic Odontologists' recommendations for those constituents who have developed programs.

38. Resolved, that the ADA policy on "Dental Identification Teams" (*Trans.*1994:654) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the American Dental Association ~~urge all constituents supports the American Board of Forensic Odontologists' recommendation~~ to develop dental identification teams that can be mobilized at times of need for local or regional mass fatality incidents (MFI), and be it further **Resolved**, that state and regional ID teams receive initial and ongoing training by forensic odontologists experienced in MFI response.

The Council believes that the policy "Dental Radiographs for Victim Identification" should be amended because this policy, well known in the dental community, no longer requires active promotion.

39. Resolved, that the ADA policy on "Dental Radiographs for Victim Identification" (*Trans.*2003:363) be amended by deletion of the word "actively" after the word "ADA" in the first resolving clause to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the ADA ~~actively~~ promote to practicing dentists the importance of providing, as permitted by state law, original radiographs and original records on patients of record that are requested by a legally authorized entity for victim identification and which will be returned to the dentist when no longer needed, and be it further

Resolved, that copies of these records should be retained by dentists as required by law.

The Council believes that the policy "Insurance Coverage for Chemical Dependency Treatment" should be amended because this coverage is now typically provided in health and disability plans.

40. Resolved, that the ADA policy "Insurance Coverage for Chemical Dependency Treatment" (*Trans.*1986:519) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the ADA believes that any constituent and component societies of the Association be urged to review current tripartite~~ sponsored or endorsed medical and disability insurance coverage should include coverage for the treatment of chemical dependency (including alcoholism), ~~treatment and to seek to ensure the existence and adequacy of such coverage for their members, and be it further~~

Resolved, that ~~the societies examine state and local statutes and regulations relative to medical and disability insurance coverage for chemical dependency (including alcoholism) treatment and take appropriate action to ensure nondiscriminatory regulations and/or legislation.~~

The Council believes that the policy "Guiding Principles for Dentist Well-Being Activities at the State Level" should be amended to take a more proactive approach in the treatment of substance use disorders to prevent alcohol- or drug-related incidents.

41. Resolved, that the ADA policy on "Guiding Principles for Dentist Well-Being Activities at the State Level" (*Trans.*2005:330) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the ADA supports efforts by constituent and component dental societies in the development, maintenance, and collaboration with effective programs to identify and assist those dentists and dental students affected by conditions which potentially impair their ability to practice dentistry, and be it further

Resolved, that constituent and/or component dental societies be urged to adopt the following Guiding Principles for Dentist Well-Being Activities at the State Level.

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

1. Constituent dental societies, on behalf of their well-being programs, are encouraged to negotiate contracts or agreements with state dental boards, licensing agencies and other regulatory agencies to encourage dentists with substance use disorders to get into treatment before they have an alcohol- or drug-related incident. ~~have some level of involvement in services for dentists affected by conditions which potentially or actually impair their ability to practice dentistry.~~

2. State-level programs to prevent and intervene in dentist and dental team member impairment should be strengthened, supported and well publicized as the most humane and effective method of protecting the interest of the public and of dental professionals.
3. Dental societies should be advocates for dentists to have the same rights of privacy and confidentiality of personal medical information as other persons.
4. Those dental societies that administer dentist well-being programs are urged to maintain a strong working relationship with their state boards of dentistry and with the appropriate ADA agencies.
5. The dental society should ensure that those who serve as dentist peer assistance volunteers are provided immunity from civil liability, except for willful or wanton acts.
6. The dental society should also ensure that those who serve as dentist peer assistance volunteers are appropriately trained and supervised in these activities.
7. Dental societies in states where services are provided to dentists by multidisciplinary or physician health programs are urged to develop strong relationships with those programs, in order to:
 - a. educate service providers about the particular needs of dentists and the dynamics of dental practice
 - b. assist providers in outreach to dentists in need of assistance
 - c. support dentists and families if treatment is necessary
 - d. assist program providers in developing monitoring contracts appropriate to individual dentist's practice situations
 - e. assist program providers in advocating for program participants with the dental board or licensing agency
8. Constituent and component dental societies are strongly encouraged to offer continuing education programs on the prevention, recognition and treatment of professional impairment.
9. Dental societies are encouraged to support well-being volunteer liaison activities to their dental schools.

and be it further

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

Recommendations—Policies to be Rescinded

The Council reviewed the policy "Promotion of Careers in General Practice of Dentistry" and recommends rescission due to the success of the promotion of general practice in dentistry; approximately 80% of all dentists are currently in general practice.

42. Resolved, that Resolution 86-1973-H, "Promotion of Careers in General Practice of Dentistry" (*Trans.*1973:725), be rescinded.

The Council reviewed the policy "Primary Care Providers" and recommends rescission because this policy is redundant to the 1994 policy "Primary Dental Care Provider" (*Trans.*1994:668; 2010:548).

43. Resolved, that Resolution 140H-1995, "Primary Care Providers" (*Trans.*1995:610), be rescinded.

The Council reviewed the policy "Dental Society Activities Against Illegal Dentistry" and recommends rescission because this policy is no longer needed as the ADA State Public Affairs (SPA) program provides needed financial support.

44. Resolved, that Resolution 141H-1977 and Resolution 14H-2001, "Dental Society Activities Against Illegal Dentistry" (*Trans.*1977:934; 2001:435), be rescinded.

The Council reviewed the policy “Activity to Stop Unlicensed Dental or Dental Hygiene Practice” and recommends rescission because this policy is no longer needed as legislative authority for this activity belongs to the states.

45. Resolved, that Resolution 74H-1999, “Activity to Stop Unlicensed Dental or Dental Hygiene Practice” (*Trans.*1999:947), be rescinded.

The Council also reviewed the policy “Sale of Dental Equipment to Illegal Practitioners” and recommends rescission because there is little to no benefit gained from this policy and the Council believes it carries a degree of legal risk.

46. Resolved, that Resolution 33H-2001, “Sale of Dental Equipment to Illegal Practitioners” (*Trans.*2001:436), be rescinded.

The Council also reviewed the policy “Professional Quality Denture Treatment for the Financially Disadvantaged” and recommends rescission because this policy is outdated and no longer necessary.

47. Resolved, that Resolution 144H-1977, “Professional Quality Denture Treatment for the Financially Disadvantaged” (*Trans.*1977:929), be rescinded.

The full text of each policy recommended for rescission is included in Appendix 2.

Summary of Resolutions

Resolution 33. Policies to Be Maintained as Recommended by the Council on Dental Practice
 Resolution 34. Amendment of the Policy, Definition of Fee-for-Service Private Practice
 Resolution 35. Amendment of the Policy, Active and Inactive Dental Patients of Record
 Resolution 36. Amendment of the Policy, Primary Dental Care
 Resolution 37. Amendment of the Policy, Uniform Procedure for Permanent Marking of Dental Prostheses
 Resolution 38. Amendment of the Policy, Dental Identification Teams
 Resolution 39. Amendment of the Policy, Dental Radiographs for Victim Identification
 Resolution 40. Amendment of the Policy, Insurance Coverage for Chemical Dependency Treatment
 Resolution 41. Amendment of the Policy, Guiding Principles for Dentist Well-Being Activities at the State Level
 Resolution 42. Rescission of the Policy, Promotion of Careers in General Practice of Dentistry
 Resolution 43. Rescission of the Policy, Primary Care Providers
 Resolution 44. Rescission of the Policy, Dental Society Activities Against Illegal Dentistry
 Resolution 45. Rescission of the Policy, Activity to Stop Unlicensed Dental or Dental Hygiene Practice
 Resolution 46. Rescission of the Policy, Sale of Dental Equipment to Illegal Practitioners
 Resolution 47. Rescission of the Policy, Professional Quality Denture Treatment for the Financially Disadvantaged

Council Minutes

For more information on recent activities, see the Council's minutes on ADA.org:
<https://www.ada.org/members/1293.aspx#denprac>.

Appendix 1. Policies to be Maintained As Recommended by the Council on Dental Practice

Definition of Cosmetic Dentistry (*Trans.1976:850*)

Resolved, that cosmetic dentistry be defined as encompassing those services provided by dentists solely for the purpose of improving the appearance when form and function are satisfactory and no pathologic condition exist.

Definition of Oral Diagnosis (*Trans.1978:499*)

Resolved, that the following definition of “oral diagnosis” be adopted:

The determination by a dentist of the oral health condition of an individual patient achieved through the evaluation of data gathered by means of history taking, direct examination, patient conference, and such clinical aids and tests as may be necessary in the judgment of the dentist.

Definition of Treatment Plan (*Trans.1978:499*)

Resolved, that the following definition of “treatment plan” be adopted:

The treatment plan is the sequential guide for the patient’s care as determined by the dentist’s diagnosis and is used by the dentist for the restoration to and/or maintenance of optimal oral health.

Definition of Dental Care (*Trans.1996:688*)

Resolved, that the following definition of professional dental care be adopted.

Professional dental care is the diagnosis, treatment planning and implementation of services directed at the prevention and treatment of diseases, conditions and dysfunctions relating to the oral cavity and its associated structures and their impact upon the human body.

The implementation of professional dental care, which includes diagnostic, preventive, therapeutic, restorative, oral and maxillofacial surgical, endodontic, orthodontic, periodontic, prosthodontics and aesthetic (cosmetic) services shall be provided to dental patients by a legally qualified dentist or physician operating within the scope of his or her training.

Primary Dental Care Provider (*Trans.1994:668; 2010:548*)

Resolved, that the definition of Primary Dental Care Provider (*Trans.1994:668*) be amended to read as follows:

Primary Dental Care Provider. A licensed dentist who accepts the professional responsibility for delivering primary dental care.

Definition of Denturist and Denturism (*Trans.1976:868; 2001:436*)

Resolved, that when the words “denturist” or “denturism” and all synonymous terms are used in American Dental Association publications, the terms should be accompanied by a brief but prominent footnote indicating that a “denturist” is a person who is educationally unqualified to practice dentistry in any form on the public, and be it further

Resolved, that constituent and component societies act in concert with the American Dental Association.

Amendment of Policy on Opposition to “Denturist Movement” (*Trans.2001:436*)

Resolved, that the Association vigorously opposes denturism, the denturism movement, and all other similar activities, regardless of how they are designated, in this country.

Dental Identification Efforts (*Trans.1985:587*)

Resolved, that the ADA encourage dental societies, related dental organizations and the membership to participate in efforts designed to assist in identifying missing and/or deceased individuals through dental records and other appropriate mechanisms.

Statement on the Use of Opioids in the Treatment of Dental Pain (*Trans.2005:327*)

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

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

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

Statement on Substance Abuse Among Dentists (*Trans.2005:328*)

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

Statement on Substance Abuse Among Dentists

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

**Statement on Provision of Dental Treatment for Patients With Substance Use Disorders
(Trans.2005:329)**

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

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

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

**Statement on Alcohol and Other Substance Use by Pregnant and Postpartum Patients
(Trans.2005:329)**

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

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

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

Statement on Dentist Health and Wellness (Trans.2005:321)

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

Statement on Dentist Health and Wellness

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

point of interfering with a dentist's ability to engage safely in professional activities, the dentist is said to be impaired.

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

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

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

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

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

Statement on Substance Abuse Among Dental Students (*Trans.2005:328*)

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

Statement on Substance Use Among Dental Students

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

Appendix 2. Policies to be Rescinded As Recommended by the Council on Dental Practice

Promotion of Careers in General Practice of Dentistry (*Trans.1973:725*)

Resolved, that the American Dental Association make a concentrated effort to promote the status of the general practice of dentistry and encourage graduating dental students to seek a career in the general practice of dentistry.

Primary Care Providers (*Trans.1995:610*)

Resolved, that the American Dental Association recognizes that dentists in general practice are primary care providers regardless of the age of the patient.

Dental Society Activities Against Illegal Dentistry (*Trans.1977:934; 2001:435*)

Resolved, that the American Dental Association urge constituent and component dental societies to inform the Council on Dental Practice of society activities which relate to combating illegal dentistry, and be it further

Resolved, that the Council on Dental Practice provide this information to all constituent and component societies on a timely and periodic basis, and be it further

Resolved, that the American Dental Association Board of Trustees be authorized to provide financial aid to any constituent dental society that is faced with the imminent prospect of a substantial effort to legalize or promote denturism or any illegal practice of dentistry in its state through legislative action or use of the initiative process.

Activity to Stop Unlicensed Dental or Dental Hygiene Practice (*Trans.1999:947*)

Resolved, that each constituent dental society be urged to support enactment of legislation which gives each Board of Dental Examiners the means to stop the illegal practice of dentistry or dental hygiene by an unlicensed person.

Sale of Dental Equipment to Illegal Practitioners (*Trans.2001:436*)

Resolved, that the ADA strongly urges dental equipment manufacturers and suppliers to develop and implement guidelines which preclude the sale, transfer or conveyance of new and used dental equipment and supplies (except "over the counter" consumer care products) to illegal practitioners of dentistry, and be it further

Resolved, that the guidelines include the requirement that before manufacturers or suppliers sell, transfer or convey dental equipment and supplies to persons they believe plan to use the products in the practice of dentistry, the manufacturers and suppliers first verify that the purchaser is licensed to practice dentistry in the state where the products will be delivered, and be it further

Resolved, that the guidelines also include a requirement that contracts, purchase orders, and invoices used to sell, transfer or convey dental equipment and supplies require purchasers intending to use the equipment or supplies to provide dental care to include their dental license number, and be it further

Resolved, that in the case of as yet unlicensed dental students or recent graduates, the guidelines allow for the sale, transfer or conveyance of dental equipment and supplies, provided that the student or recent graduate supplies verification of current attendance in or graduation from an accredited dental school.

Professional Quality Denture Treatment for the Financially Disadvantaged (*Trans.*1977:929)

Resolved, that it be the policy of the American Dental Association that the phrase "Professional Quality Denture Treatment for Financially Disadvantaged" be used when referring to low cost, comprehensive denture care, and be it further

Resolved, that all members be urged to continue to deliver high quality care in all phases of dentistry, and be it further

Resolved, that all members be urged to continue to provide fee relief where indicated for purposes of allowing patients of all economic levels the opportunity to receive high quality treatment in all phases of dentistry including professional denture service.

Council on Ethics, Bylaws and Judicial Affairs

Lantz, Marilyn S., 2012, Michigan, chair
Henner, Kevin A., 2013, New York, vice chair
Beard, Darryll L., 2015, Illinois
Brooks, Dwyte E., 2013, Nevada
Chinoy, Walter I., 2013, New Jersey
Curry, Barry D., 2015, Kentucky
Esterburg, Jeffrey C., 2013, Ohio
Foy, Patrick J., 2012, Minnesota
Himmelberger, Linda K., 2015, Pennsylvania
McCarley, David H., 2012, Texas
Ortego, L. Stephen, 2012, Louisiana
Palcanis, Kent G., 2012, Alabama
Pansick, Ethan A., 2014, Florida
Reynolds, Elizabeth C., 2014, Virginia
Rosato, Richard J., 2014, New Hampshire
Senseny, Charlotte L., 2014, California
Williams, Laura, 2015, Washington
Yanase, Rex R., California, *ex officio**

Elliott, Thomas C., Jr., director
Elster, Nanette R., manager

The Council's 2011-12 liaisons included: Dr. Dennis W. Engel (Ninth District trustee, Board of Trustees); and Ms. Christine Tiller (American Student Dental Association).

Mission and Purpose

The Council on Ethics, Bylaws and Judicial Affairs (CEBJA) is the ADA agency dedicated to enhancing 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.

Supporting the Strategic Plan: Activities, Results and Accomplishments

During the current term, the Council engaged in numerous activities in furtherance of the Association's 2011-2014 Strategic Plan.

Continuing Education Program (Goal 1, Goal 2)

In 2011, the Council was contacted by the Council on ADA Sessions and asked if it wished to present a continuing education course at the 2012 Annual Session in San Francisco. Following consideration of the request, the Council submitted a proposal for an ethics-based continuing education course. The three-hour course will address current controversial ethical and legal issues in dentistry. An expert panel will review select topics in health care law; advertising; scope of practice and provision of non-dental services; disclosure of patient information; offering incentives for referrals; general dentists providing specialty services and specialists providing general dentistry services; reporting a peer for quality of care or behavior issues; billing; and other topics/questions proposed by the audience. The panel will use case studies and group discussions and interactive exercises to engage participants, and will also discuss strategies for addressing ethical and legal issues that arise in dental practice.

* *New Dentist Committee Member without the power to vote.*

The course is being designed to achieve three learning outcomes:

- (1) Participants will acquire a deeper understanding of complex ethical and legal issues facing dentistry;
- (2) Participants will have the opportunity to consult an expert panel to get answers to their questions about ethical and legal issues in dentistry; and
- (3) Participants will learn some strategies to address ethical and legal issues that arise in dental practice.

New Dentist Ethics Mentorship Program (Goal 1, Goal 2)

The Council approved the development of an Ethics Mentoring Program in collaboration with the New Dentist Committee (NDC) designed to assist new dentists with evolving and/or complex ethical issues—particularly with respect to challenges encountered by new dentists in scenarios where they feel pressured to behave in ways they consider unethical. The Council has developed a proposal that it intends to have presented to the NDC at its June 2012 meeting in Washington, D.C.

Other Collaboration With the New Dentist Committee

At the request of the NDC, the Council will have a member present at the NDC meeting in June 2012 to participate in the NDC Mega Topic discussion on ethics.

Student Ethics Video Contest (Goal 1, Goal 2)

The 2011 Student Ethics Video Contest continued the growth experienced in past years with 17 submissions. The entry submitted by University of North Carolina School of Dentistry student Christopher Vo was awarded the grand prize and a video submitted by students at the Indiana University School of Dentistry received an honorable mention. The 2012 Student Ethics Video Contest was announced in January 2012 and publicity about the contest has appeared periodically in appropriate venues since that time. Members of the Council were urged to show previously received student videos in their trustee districts on appropriate occasions to publicize the contest and to encourage individual students and student groups to submit videos for the 2012 contest. To aid contest entrants, the Council has offered to prescreen videos prior to submission to determine compliance with entry rules. Prior years' winning videos may be viewed at <http://www.ada.org/4064.aspx>.

Disciplinary Appeals (Goal 1, Goal 2)

The Council conducted one judicial hearing in response to an appeal from a member disciplined by the member's constituent dental association for unethical conduct. Following the hearing, the Council sustained the constituent society's disciplinary penalty of expulsion from membership. At present, the Council has two appeals pending for hearing at the Council's meeting in November 2012.

Ethical Moment Articles (Goal 1)

The Council continued its contributions to *The Journal of the American Dental Association (JADA)* feature entitled "Ethical Moment." This monthly feature provides practical answers to everyday dental practice dilemmas based on the ADA *Principles of Ethics and Code of Professional Conduct*. During this term, subjects addressed included treating patients who lack insurance for necessary care, dentists' responsibilities in a corporate dental practice and specialists' responses to a patient's request for recommendations to a new general dentist, among other topics. The Council welcomes questions from members. Suggestions should be sent to ethics@ada.org.

Emerging Issues and Trends

Social Couponing

During this term, the Council investigated the offering of dental services through the marketing technique known as social couponing. Through its investigation, the Council learned that one method social couponing marketing services employ in offering their services is the use of contractual arrangements where the advertised fee for the goods or services purchased by the consumer is collected by the couponing service and then divided with the entity supplying the goods or services marketed. Upon paying the advertised fee, the customer receives a coupon that is redeemable for the goods or services purchased.

The Council determined that this business model implicates Section 4.E. of the ADA *Principles of Ethics and Code of Professional Conduct* ("Rebates and Split Fees"). Consequently, the Council issued an Advisory Opinion to educate members about that concern. The text of the Advisory Opinion (4.E.1., Split Fees in Advertising and Marketing Services) can be found at the following link:

http://www.ada.org/sections/about/pdfs/code_of_ethics_2012.pdf

Corporate and Retail Dentistry

During the term, the Council continued to receive requests for information and guidance from dentists practicing in large group, corporate and retail dental practice settings. Accordingly, the Council appointed a workgroup to study the ethical issues that may exist in those settings. The workgroup is to report on its work at the November 2012 Council meeting.

Validity of Licensure Exams

The Council discussed the possibility of the existence of ethical issues respecting the use of licensure examinations in light of a recent article questioning the reliability of those examinations and, therefore, the validity of using them to assess the clinical competence of the test takers. The Council tasked a workgroup to request that the Council on Dental Education and Licensure collaborate with the Council in developing information concerning the reliability and predictive validity of licensure examinations in measuring clinical competence to allow the Council to study this question in more detail.

Responses to House of Delegates Resolutions

72H-2011. *Autonomy of the ADA Editor* (Trans.2011:485)

Background: As presently written, the ADA *Bylaws* give the Board of Trustees the power to "cause to be published in, or to be omitted from, any official publication of the Association any article in whole or in part" (Chapter VII. BOARD OF TRUSTEES, Section 90 POWERS, Subsection D). The Board's editorial control of *The Journal of the American Dental Association (JADA)* is at odds with current guidelines promulgated by the World Association of Medical Editors (WAME), which call for editors having complete editorial autonomy over their journals' content. Consequently, the 2011 House of Delegates passed 72H-2011, calling for a review of the ADA *Bylaws* to suggest language to make the *Bylaws* consistent with the WAME guidelines, and to submit those suggestions to the 2012 House of Delegates:

Resolved, that the appropriate ADA agency review Chapter VII, Board of Trustees, Section 90. Powers: paragraph D of the ADA *Bylaws* to suggest new language for the bylaws consistent with the principles supported by the World Association of Medical Editors, and be it further
Resolved, that the changes be submitted to the 2012 ADA House of Delegates.

The resolution was referred to the Council on Ethics, Bylaws and Judicial Affairs. The Council's deliberations and review of the authority and autonomy of the editor of *JADA* focused on: (1) the

current standards to be met by scientific journals today; and (2) *JADA*'s role with respect to the ADA. The Council noted that *JADA*'s strength and the trust put in *The Journal* are built on the integrity of *JADA* and its content. Autonomy of the editor enhances the integrity of *The Journal*, as does publication of opinions and views via the "Letters to the Editor" section of *The Journal*. After its review, the Council came to a consensus that the *JADA* editor should be given editorial autonomy over the scientific content of *The Journal*. The Council was also in agreement, however, that because *JADA* serves as the "official journal" of the ADA (*ADA Bylaws*, Chapter XVII., Section 10.A.), unlimited autonomy over the entirety of *JADA*'s content should not be granted to the editor. Rather, the Council agreed that the editor's autonomy should be limited to allow the Board of Trustees to retain the power to "cause to be published in, or to be omitted from, any official publication of the Association any article in whole or in part" relating to ADA policy, ADA advocacy efforts and/or the ADA's legislative agenda.

As indicated above, the current standards set by the WAME indicate that the editor of *JADA*, rather than the Board of Trustees, should have the autonomy to determine editorial content. According to WAME, editors-in-chief should have full authority over the editorial content of the journal, generally referred to as "editorial independence." Editorial content includes original research, opinion articles and news reports, both in print or electronic format, and how and when information is published. Owners should not interfere in the evaluation, selection or editing of individual articles, either directly or by creating an environment in which editorial decisions are strongly influenced.¹

However, the Council noted that *JADA* is not just a scientific journal, but is also "the official publication of the Association (*ADA Bylaws*, Chapter XVII. PUBLICATIONS, Section 10. OFFICIAL JOURNAL, Subsection A:

- A. TITLE. This Association shall publish or cause to be published an official journal under the title of *The Journal of the American Dental Association*...

As "the official journal" of the Association, *JADA*'s objective is to "report, chronicle and evaluate activities of scientific and professional interest to members of the dental profession" (*ADA Bylaws*, Chapter XVII. PUBLICATIONS, Section 10. OFFICIAL JOURNAL, Subsection B. OBJECT). Consequently, in fulfillment of the role as the "official journal" of the ADA, *JADA* reports on matters relating to ADA policy and the ADA's legislative agenda and advocacy efforts as well as matters of scientific interest to the members of the Association.

CEBJA recognizes that the editor of *JADA* should have editorial autonomy over the scientific-based content of *JADA*, and that the trust, authority and credibility of *JADA* in matters relating to science and scientific research will be maintained, and perhaps burnished, by allowing the *JADA* editor to have editorial autonomy over such material. However, the policies of the ADA and the Association's advocacy efforts and legislative agenda are matters that are peculiarly within the purview of the House of Delegates and the Board of Trustees. Thus, these subjects are distinctly different than reports of scientific advances. Thus, CEBJA is concerned about extending the editor's autonomy in matters relating to ADA policy and the Association's advocacy efforts and legislative agenda, and believes the better course of action would be to leave decisions concerning publication of content regarding those matters within the purview of the Board of Trustees.

In addition, CEBJA agrees that the authority of the editor to set the editorial policy of *JADA* should not rest within the office of the editor alone. Rather, as suggested by the WAME guidelines, written editorial policy for *JADA* should be established by the editor with the assistance of the *JADA* editorial board.

Based on the considerations summarized above, the Council on Ethics, Bylaws and Judicial Affairs recommends the adoption of the following resolution:

¹ *The Relationship Between Journal Editors-in-Chief and Owners* (formerly titled "Editorial Independence"). Originally posted June 19, 2000; modified versions posted May 15, 2006, and July 25, 2009, at <http://www.wame.org/resources/policies#independence>.

48. Resolved, that the ADA *Bylaws*, Chapter VII. BOARD OF TRUSTEES, Section 90. POWERS, Subsections D. through K., be amended as set forth below (additions underscored):

Chapter VII. BOARD OF TRUSTEES, Section 90. POWERS:

D. Cause to be published in, or to be omitted from, any official publication of the Association any article in whole or in part relating to ADA policies, advocacy efforts and legislative agendas.

E. Appoint an editor of *The Journal of the American Dental Association*.

F. Appoint an editorial board whose members have been nominated by the editor of *The Journal of the American Dental Association*.

and that Chapter VII, *Section 90* Subsections currently lettered E. through K. be re-lettered as G. through M., respectively.

and be it further

Resolved, that the ADA *Bylaws*, Chapter XVII. PUBLICATIONS, Section 10. OFFICIAL JOURNAL, be amended as set forth below (additions underscored):

Chapter XVII. PUBLICATIONS, *Section 10*. OFFICIAL JOURNAL:

D. EDITOR OF THE JOURNAL. Except as otherwise provided in the powers of the Board of Trustees under these *Bylaws*, as provided in Chapter VII, Section 90D, the editor of *The Journal of the American Dental Association* shall have the authority to determine the editorial content of *The Journal* and shall, with the assistance of an editorial board nominated by the editor and appointed by the Board of Trustees, establish and maintain a written editorial policy for *The Journal*.

73H-2011. ADA Council Vacant Terms (Trans.2011:492)

Background: As presently written, the ADA *Bylaws* give the President the authority to appoint a member of the Association to fill a Council vacancy. If 50% or more of the vacated term remains to be served, the appointed member is ineligible to serve an additional term (Chapter X. COUNCILS, Section 70. VACANCY). Due to the fact that members filling a partial term with 50% or more of a term remaining are ineligible to serve an additional term, councils have reported difficulty in filling these partial term vacancies on ADA councils. Consequently, the 2011 House of Delegates passed 73H-2011 calling for proposed revision of the ADA *Bylaws* to suggest language to amend the *Bylaws* to eliminate the limitation prohibiting a member from serving a full four-year term if the member has been appointed to fill a vacancy for two years or longer:

Resolved, that the eligibility of appointment to fill vacated council positions be evaluated by the appropriate council, and be it further

Resolved, that the changes be submitted to the 2012 House of Delegates.

At the start of its evaluative process, the Council on Ethics, Bylaws, and Judicial Affairs (the Council) desired to determine the pervasiveness of the problem of filling council vacancies. A survey of the councils and commissions was done and it was discovered that all but one of the councils had at least one vacancy in the last five years, and several councils had multiple vacancies during that period. Under the current *Bylaws*, Chapter X, Section 70. VACANCY "If fifty percent (50%) or more of the vacated term remains to be served at the time of the appointment or election, the successor member shall not be eligible for another term." It has been reported that this prohibition makes filling council vacancies difficult when the vacancy extends beyond two years because of the desire to have complete, four year council terms.

As the next step in the evaluation of the issue, five options were identified for discussion: (1) making no change to the existing *Bylaws*; (2) eliminating the limitation which prohibits a full four-year term if filling a vacancy for two years or longer; (3) permitting those filling the vacancy to serve a full four-year term; (4) allowing a past council member to fill the vacancy no more than one time; or (5) measuring the duration of the vacancy from the date the vacancy is filled rather than the actual vacancy to reduce the number of vacancies that are two years or longer. After the advantages and disadvantages of each option were examined and discussed, the Council initially found options (1) and (2) to be the most viable. The Council subsequently determined, however, that a combination of options (2) and (4) would best satisfy the concerns raised by the current process for filling council vacancies.

Consequently, the Council recommends passage of the following resolution amending the second paragraph of Chapter X. COUNCILS, Section 70. VACANCY, of the ADA *Bylaws*:

49. Resolved, that the second paragraph of Chapter X. COUNCILS, Section 70. VACANCY of the ADA *Bylaws* be amended as follows (additions underscoring; deletions ~~stricken~~):

~~If the term of the vacated council position has less than fifty percent (50%) of a full four year term remaining at the time the successor member is appointed or elected, the successor member shall be eligible for election to a new, consecutive four-year term. If fifty percent (50%) or more of the vacated term remains to be served at the time of the appointment or election, the successor member shall not be eligible for another term.~~ In the event of a vacated council position, the successor member serving on that council for the first time shall complete the vacated term and shall be eligible to serve a subsequent four-year term. Alternatively, the successor to be appointed to fill a council vacancy may be a former member of that council, provided that the former member has not previously filled a vacancy on that council and is not serving as a member of another council. Time served on a council is limited to one full term and one partial term.

Policy Review

The Council is a secondary reviewer of the Statement on Infectious Diseases of Uncertain Transmission (<http://www.ada.org/1858.aspx>). During the term, the Council was requested by the statement's primary reviewer, the Council on Scientific Affairs, to provide input on any revisions to the statement that the Council believed appropriate. The Council's input was provided to the Council on Scientific Affairs in February 2012. As a secondary reviewer, the Council advised the Council on Scientific Affairs that it approves of the Council on Scientific Affairs' recommendations for revisions to the ADA Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting (*Trans.*1998:743; 2000:481; 2004:309) (<http://www.ada.org/1891.aspx>), and agrees and joins with the Council on Scientific Affairs in recommending the rescission of the 1999 ADA Policy Statement on HIV/AIDS as an Infectious and Communicable Disease (*Trans.*1996:734; 1999:977). As of the date of this report, other secondary reviews of policies are being conducted by the Council. The Council also endorsed the proposed revisions of the Council on Scientific Affairs to the ADA Policy Statement on Evidence-Based Dentistry (*Trans.*2001:462) (<http://www.ada.org/1754.aspx>) and suggested additional revisions for consideration.

Summary of Resolutions

Resolution 48: Amendment of the ADA *Bylaws* Regarding Autonomy of the ADA Editor
 Resolution 49: Amendment of the ADA *Bylaws* Regarding Filling of Council Vacancies

Council Minutes

For more information on recent activities, see the Council's minutes on ADA.org:
<https://www.ada.org/members/1293.aspx#judicial>.

Council on Government Affairs

Weinman, Richard A., 2012, Georgia, chair
Fields, Henry W., 2013, Ohio, vice chair
Black, Richard A., 2015, Texas
Bowen, Ronald S., 2013, Utah
Breault, Michael R., 2015, New York
Dater, Steven M., 2012, Michigan
Determan, Amber A., 2013, South Dakota
Hall, William M., 2014, Louisiana
Howard, H. Fred, 2014, Kentucky
Jennings, Mary S., 2014, Washington
Jernigan, Kim U., 2012, Florida
Lebovics, Irving S., 2015, California
LoMonaco, Carmine J., 2014, New Jersey
Mooney, John J., 2012, Connecticut
Murray, Rhett L., Colorado, *ex officio* *
Ray, Herbert L., 2013, Pennsylvania
Testa, Ronald G., 2012, Illinois
Vakil, Shamik S., 2012, Virginia, *ex officio* †
Vlahos, Gus C., 2015, Virginia
Zent, Dennis J., Indiana, *ex officio* *

Spangler, Thomas J., director

The Council's 2012 liaisons included: Dr. Edward Vigna (Tenth District trustee, Board of Trustees); Dr. Michael Johnson (Council on Communications); Dr. Monica Hebl (Council on Access, Prevention and Interprofessional Relations); Ms. Georjan Kudyba (Alliance of the American Dental Association); and Ms. Veena Vaidyanathan (American Student Dental Association).

Mission and Purpose

The Council's duties include: advising the ADA staff, Board of Trustees and House of Delegates as to the effect of legislative and regulatory actions on the health of the public and the art and science of dentistry; recommending changes in legislative and regulatory policy to the Board of Trustees, House of Delegates and ADA staff; commenting on proposed legislation to be submitted to Congress with the Board's approval; disseminating legislative and regulatory information to the constituent and component societies; working with other ADA agencies having subject matter jurisdiction concerning issues affected by proposed legislative and/or regulatory activity; and serving as a liaison with agencies of the federal government.

Supporting the Strategic Plan: Activities, Results and Accomplishments

The following activities support dentists so they may succeed and excel throughout their careers and/or help improve public health outcomes through effective collaboration with other stakeholders.

Federal Activity

The U.S. Supreme Court heard oral arguments on the Patient Protection and Affordable Care Act (P.L. 111-148; 111-152, known as the ACA) and is scheduled to issue a decision in June. Unless the court overturns the law in its entirety, implementation of the ACA will continue. The ADA, along with outside

* ADPAC co-chairs without the power to vote.

† New Dentist Committee member without the power to vote.

consultant Leavitt Partners, has provided the constituent dental societies with a variety of advocacy materials and advice on ADA Connect and through webinars and monthly calls, as many of the decisions concerning the establishment of state exchanges will be decided by state authorities. This process will continue at least through 2012. The ADA has continued to communicate with the relevant federal agencies regarding the final rules on the exchanges and the essential health benefit package. It is important to note that there must be a pediatric dental benefit as part of the essential benefit package and implementation of the ACA could have profound effects on the dental delivery and financing systems.

Rep. Paul Gosar (R-AZ) introduced the “Dental Insurance Fairness Act of 2012” (H.R. 4818) that would require all health plans that offer dental benefits to provide uniform coordination of benefits and would also require them to permit assignment of benefits. When a consumer is covered by more than one plan, the secondary payer should be responsible for paying the remainder of the claim (up to, but not exceeding, 100% of the amount of the claim). The bill also will permit consumers to designate payment of dental benefits to a provider who is not participating in the network.

On March 22, the House of Representatives passed legislation that included a McCarran-Ferguson provision. The ADA is seeking introduction of a companion bill in the Senate.

The ADA will continue to spend considerable resources advocating for increased funding of very important public programs, such as: the oral health related programs in the Indian Health Service; the Division of Oral Health in the Centers for Disease Control and Prevention; the National Institute for Dental and Craniofacial Research; and programs within the Health Resources and Services Administration (HRSA), including General Dentistry and Pediatric Dentistry Residencies, Training Programs for Minority and Disadvantaged Students, the Ryan White HIV/AIDS Dental Reimbursement Program, and the Maternal and Child Health Bureau. The ADA also helped draft and vigorously supports federal legislation that would expand Medicaid coverage to the aged, blind and disabled.

On February 29, 2012, the Senate Subcommittee on Primary Health and Aging, chaired by Sen. Bernie Sanders (I-Vt.), held a hearing on “The Dental Crisis in America: The Need to Expand Access.” The ADA was not invited to testify but submitted statements for the record pointing out that there are many barriers to oral health while rejecting the suggestion that there can be a simple fix to the problems. This “ad hoc” Congressional interest in oral health access occurs periodically but rarely results in legislation. However, Sen. Sanders may be an exception.

The ADA has been preparing for an announcement by the Food and Drug Administration (FDA) regarding the classification of dental amalgam. Based on perceived concerns about the potential health risks to vulnerable populations, such as pregnant women, fetuses, and young children, the agency has been under pressure by some advocates to reexamine its 2009 ruling that classified encapsulated dental amalgam is a Class II medical device. The ADA continues to monitor the issue. Conventional wisdom is that the agency will not act until after the 2012 election. The Association has also been following the Environmental Protection Agency’s (EPA) negotiated rulemaking process for a national pretreatment standard for dental office wastewater. The agency announced in 2010 that it would seek a mandate on the use of amalgam separators in dental offices. It also looks like an EPA draft proposal will not be released until after the 2012 election. The ADA continues to be in contact with EPA and advocate for a regulation that complies with the conditions set forth in the 2010 House resolution, “Negotiated Rulemaking Process Regarding a National Pretreatment Standard for Dental Office Wastewater” (50H-2010), which supports a national rule.

The Federal Trade Commission (FTC) issued a final order on December 2, 2011, asserting that the North Carolina State Board of Dental Examiners “sought to, and did, exclude nondentist providers from the market for teeth whitening services.” Five bipartisan members of Congress urged the FTC on March 2 “to cease any further intrusion in the state regulation of the practice of medicine or dentistry and withdraw from the actions you have already taken.” The five lawmakers from three committees of the House of Representatives cited this and other recent FTC actions “which we respectfully submit are a direct interference with the state regulation of the practice of medicine and dentistry.” The ADA has also been pressuring the FTC to finalize voluntary principles for use by industry to improve the nutritional profile of

foods marketed to children. The Omnibus Appropriations Act, 2009, required the FTC to study and develop nutrition standards for food marketing aimed at children who are 17 years old or younger, and determine the scope of the media to which such standards should apply. There has been substantial disagreement over the FTC's initial proposed principles, which the ADA supported in 2011.

The ADA has been working with the White House Office of National Drug Control Policy to help reduce prescription drug abuse among children and teens. In addition to supporting several campaigns and initiatives—and with the Council on Dental Practices' timely development of a continuing education course on opioid prescribing practices—the ADA has, thus far, successfully argued that it is not necessary to require dentists to complete training on responsible opioid prescribing practices as a precondition for obtaining or renewing a DEA registration number.

Resolution B-115-2004 (*Trans.*2004:272) requires a summary of activities dealing with the impact of information technology on the practice of dentistry. On March 7, 2012, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule for the implementation of the electronic health records (EHR) incentive program. Of particular note for the ADA is the inclusion of the first quality measures specific to oral health and dentistry. The first measure assesses whether a child between the ages of one and 17 has had "tooth decay or cavities" in the last six months. The second is a measure of the extent that a primary care medical provider has applied a fluoride varnish as part of an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) examination. As this report is being written, the ADA is preparing comments on the proposed rule and these dental quality measures. The ADA's comments are being prepared with the coordination and cooperation of the Dental Quality Alliance (DQA) but will be submitted as the ADA's comments only. In January 2009, HHS issued a final rule that mandated that transactions standards be upgraded to the X-12 Version 5010 by January 1, 2012, for Health Insurance Portability and Accountability Act (HIPAA) transactions. On February 16, 2012, the HHS Secretary announced that there would be a delay in implementing the conversion to ICD-10. On April 17, 2012, HHS issued a proposed rule that would set the new implementation date one year later or effective October 1, 2014. It is anticipated that the final rule will be issued later this year to make this the effective date.

State Activity

In 2009, Minnesota became the first state in the nation to authorize what has come to be commonly called a "mid-level" dental provider. In 2011, Oregon enacted a law permitting the Oregon Health Authority (OHA) to engage in dental workforce pilot projects. The only new workforce position specifically referenced in the law is the ADA's Community Dental Health Coordinator (CDHC) and no funding was provided by the state to conduct the pilots. As of the middle of 2012, the only pilot currently being considered by the OHA is the CDHC as promoted by the Oregon Dental Association and its partners. However, the authority for those initiatives does exist.

New "mid-level" initiatives will continue to be introduced in states throughout the country. As of this writing, at least 11 states have seen legislation or organizing to foster alternative dental workforce models. Those states include: Maine, Vermont, New Hampshire, Connecticut, Ohio, Kansas, New Mexico, Michigan, Washington, Pennsylvania, North Dakota and California. Five of those states are part of the Kellogg Foundation's efforts to legalize a model similar to the DHAT model (Vermont, Ohio, Kansas, New Mexico and Washington). Three other states have seen the Pew Foundation fostering the effort (Maine, New Hampshire and California). While no measure has become law in 2011 or to date in 2012 (as of this writing), expect pressure and challenges to continue over the next several years.

Dental benefit companies across the nation have been trying to impose caps on the fees dentists may charge patients, even if the procedure is not a covered benefit within that carrier's plan. Commonly referenced by the term "non-covered services" (NCS) this development has the potential to significantly intrude on the dentist/patient relationship and transform the economics of a dental marketplace.

The ADA and its constituent societies have had marked success in enacting legislation around the nation to prevent this abuse. Rhode Island enacted the nation's first law in June 2009 to prevent fee caps on

non-covered services. Since that time, a total of 27 states have enacted NCS measures. In 2012 alone, 10 additional states have introduced bills on NCS although, as of this writing, most were still working through the legislative process and have not yet been enacted. In New York, the insurance commissioner has ruled that the practice of capping non-covered services is prohibited by existing law, making legislation in that state unnecessary. The New Jersey Dental Association has approached the issue in a different matter and has filed suit against some of the benefit companies in that state.

Emerging Issues and Trends

Federal Activity

Seeking passage of federal legislation to enact ERISA reforms and antitrust reform through repeal of the McCarran-Ferguson exemption for health plans will continue to be top priorities for the ADA in 2013. In addition, the division will continue to work to identify harmful state and federal regulations pertaining to dental practices and seek to overturn those regulations. However, developing and advocating for initiatives that will improve the public's oral health and responding to other stakeholders' initiatives are taking a growing portion of the division's time and attention at the national level and within the various states. This includes attempting to work with members of Congress who sponsor legislation intended to address access to care barriers. Finally, ensuring proper implementation of the ACA by state and federal officials is a major joint ADA-constituent society activity that, barring a ruling from the United States Supreme Court that overturns the entire law, will continue to require a coordinated effort and considerable resources.

State-Level Issues

From funding, delivery systems, workforce, supervision and scope, to its impact on the profession's reputation, access to dental care has become pervasive in almost every facet of legislative and regulatory activity affecting dentistry. One of the most common health care complaints state legislators receive is how difficult or impossible it can be for those covered by a public dental benefit plan (most commonly Medicaid or CHIP) to secure dental treatment. That places extreme pressure on the profession in workforce, scope, supervision, funding and reputational matters. The underlying problem manifests itself in many ways, including underfunding of plans and efforts to make the dollars stretch; consideration of alternate workforce models with the hope of providing care at a lower cost; negative impact on reputation when dentists focus on the economic difficulties within the system without discussing delivery of care; increased demand for expanded scope of practice for allied dental professionals; and interest by foundations and other parties in creating new delivery systems to address these issues.

While it is clear that no system can deliver a significant amount of quality care without being properly funded, dentistry must remain engaged on all facets of these issues or risk having uninformed policy solutions imposed—which may negatively impact both practicing dentists and their patients. If policymakers follow the lead of foundations and no longer look to the ADA as the trusted voice for America's oral health, organized dentistry's advocacy efforts will be at risk. Therefore, it is paramount that oral health stakeholders collaborate to find common solutions in accordance with ADA Strategic Goal 3. Collaboration is no longer elective or something that we simply leave to others. In 2011, the ADA's House of Delegates took this goal one step further by encouraging all member dentists to be leaders within grassroots community efforts that impact the oral health of the public.

Responses to House of Delegates Resolutions

The Council will address Resolution 37H, "State Public Affairs Grant Funding"; Resolution 50H, "Developing the Native American Dental Workforce"; Resolution 83H, "Implications of the Affordable Care Act"; and Resolution 87H, "Study of FQHC Payment Methodologies" in its supplemental report to the House of Delegates.

12H-2011. Advocate for Adequate Funding Under Medicaid Block Grants (Trans.2011:497)

This resolution states that the ADA advocate for adequate funding and safeguards to provide comprehensive oral health care to underserved children and adults in any legislation that would convert the federal share of Medicaid to a block grant to the states and that the ADA oppose the proposed block grant in the event the adequate funding and safeguards cannot be assured. There is legislation being considered in the House of Representatives that would block grant Medicaid, but the bills have virtually no chance of passage or even serious consideration in the Senate given the current political climate. For example, the State Health Flexibility Act of 2012 (H.R. 4160) would pool the federal funds for Medicaid and CHIP (the Children's Health Insurance Program) and, starting in 2013, provide lump block grants from this reserve to every state. The total funding for these programs would be set at current levels for the next decade and decisions about how to spend these dollars would devolve to the states. As of March 2012, the bill had 30 co-sponsors, all Republicans. There is no companion bill in the Senate. A block grant proposal is also included in the Republican budget proposal, known as the Ryan plan, named after Rep. Paul Ryan, a Republican from Wisconsin who is the House Budget Committee chair. The ADA is closely monitoring these bills and will address our concerns in a timely manner as necessary.

51H-2011. Policy on Native American Workforce (Trans.2011:491)

This resolution states that the ADA supports efforts by Native American communities to build capacity and improve the availability of community-based oral health services; that the ADA should advocate for a larger and more diverse Native American dental workforce; and that Native American communities and populations be urged to build upon existing educational programs that are consistent with ADA policy with local constituent and component dental societies to improve access to dental education resources for Native Americans in their areas and to improve cultural understanding and awareness of need. Prior to the time of this writing (May 2012), the ADA's State Public Affairs Program (SPA) had already initiated discussions with the Jesuit Dental School Recruitment Collaborative for Native American Students, based at Creighton University. Follow up activity will be guided by decisions made at a meeting of the stakeholder parties later in 2012. Additionally, the ADA will have a presence at the 2012 "Pathways Into Health" conference to be held in October 2012. The Council on Dental Education and Licensure's Committee on Career Guidance and Diversity Activities, with dentist and student representatives of the Society of American Indians Dentists, continues to promote dental careers to underrepresented minority students through the Student Ambassador Program and outreach activities. The Council on Access, Prevention and Interprofessional Relations (CAPIR) and SPA continue to work with constituent societies who have expressed interest in bringing the Community Dental Health Coordinator (CDHC) to tribal educational institutions.

63H-2011. Regulating Non-Dentist Owners of Dental Practices (Trans.2011:491)

This resolution requests that the ADA urge constituent dental societies to advocate for the regulation by state dental licensing authorities of entities that provide dental services that are owned or controlled by non-dentists or dentists not licensed in that state. It also states that the licensing authorities be urged to establish regulations that hold all of these entities providing dental services to the same ethical and legal standards as applied to dentists practicing in the state. The ADA's Department of State Government Affairs sent the request to all constituent dental societies. In addition, the ADA took the opportunity to raise the issue of equal treatment of dental providers by state licensing authorities in the context of a Medicaid fraud and abuse hearing in the United States Congress. In response to an April 25, 2012, U.S. House of Representatives' Committee on Oversight and Government Reform hearing in which Medicaid dental fraud in Texas was one of the issues being investigated, the ADA prepared a statement that said, in part, that the ADA believes that a state's ethical and legal standards must be applied equally to all dentists and to all dental practices—regardless of ownership status—that provide services within that state.

91H-2011. Student Loan Reduction Program (Trans.2011:551)

This resolution requests that the appropriate councils and ADA agencies investigate the development and implementation of a student loan repayment grant program for dentists working in non-profit community dental clinics and report to the 2012 House of Delegates. While this is a worthy program, the Council on Government Affairs believes the ADA should not be taking financial responsibility for something that belongs in the realm of outside foundations and the government. The ADA Foundation stated that it does not have the resources or infrastructure to fund a student loan repayment grant program. However, the Foundation does have a scholarship program for individuals pursuing careers in dentistry, dental hygiene, dental assisting and dental laboratory technology. The number of ADA Foundation scholarships awarded is dependent upon available annual funds. Scholarships are awarded to defray school expenses, which include tuition, fees, books and supplies. ADA Foundation scholarship programs include the: Dental Student Scholarship, Underrepresented Minority Dental Student Scholarship, Dental Hygiene Scholarship, and Dental Laboratory Technology Scholarship and Dental Assisting Scholarship.

It is also important to note that the National Health Service Corps (NHSC) loan repayment program under the auspices of the U.S. Department of Health and Human Services is expressly designed to provide student loan grants to dentists and other health care providers who serve in health clinics that are located in health professional shortage areas. The ADA has long supported enhanced funding for this program. In addition, the ADA currently offers a resource that contains specific information and links on various scholarships, as well as financial assistance and/or loan forgiveness programs for dental students in exchange for a work commitment at both the state and national levels. This resource is entitled "Dental Student Loan Repayment Programs and Resources Infopak" and can be accessed through the ADA.org site: <http://www.ada.org/2904.aspx>. It contains information on programs offered by, for example, the military services, Public Health Service, Indian Health Service and the above mentioned National Health Service Corps loan repayment program. This resource also contains a list of states that have programs and includes contact information for each state program.

Policy Review

The Council will begin its review of current policy in accordance with Resolution 111H-2010 at its August meeting and will include recommendations in the Council's supplemental report to the House of Delegates.

Summary of Resolutions

This report is informational and no resolutions are presented.

Council Minutes

For more information on recent activities, see the Council's minutes on ADA.org: <https://www.ada.org/members/1293.aspx#government>.

Council on Members Insurance and Retirement Programs

Fink, Steven R., 2012, New Jersey, chair
Paumier, Thomas M., 2014, Ohio, vice chair
Chaney, Mark S., 2015, Louisiana
Coleman, Robert A., 2014, Michigan
Davidson, Madalyn M., Illinois, *ex officio* *
Dodge, Jeffrey E., 2013, Rhode Island
Dorris, George B., Jr., 2012, Florida
Eisenhart, Craig A., 2012, Pennsylvania
Gillcrist, James A., 2015, Tennessee
Hettinger, Richard F., 2014, Iowa
Jilek, Spencer S., 2012, Washington
Patel, Sanjay, 2015, California
Rashall, Gregory W., 2013, Texas
Rawls, Douglas S., 2013, South Carolina
Rosenbaum, George F., 2013, Nevada
Schwartz, Timmothy J., 2015, Illinois
Weinberger, Mark J., 2012, New York
Yarbrough, L. Wayne, 2014, Alabama

Burgess, Karen B., interim director
Tiernan, Rita, manager

Mission and Purpose

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

Supporting the Strategic Plan: Activities, Results and Accomplishments

The Council on Members Insurance and Retirement Programs supports the 2011-2014 ADA Strategic Plan goal to provide support to members so that they may succeed and excel throughout their careers. In addition, the sponsored plans and endorsed programs overseen by the Council provide a source of non-dues revenue in support of the strategic plan goal to ensure that the ADA is a financially stable organization that provides appropriate resources to enable operational and strategic initiatives.

ADA-sponsored insurance plans are offered through the Great-West Life and Annuity Insurance Company on a direct response model that eliminates many common marketing and related expenses. The ADA is reimbursed only for its direct expenses related to Council oversight and management of the program, and related non-dues revenue covers approximately two-thirds of the Council's annual budget.

The ADA Insurance Plans include Term Life, Term Plus (universal life), Disability, Office Overhead Expense and MedCash Insurance, as well as the student life and student disability plans. In comparison to insurance plans offered by other national professional associations, the ADA-sponsored member insurance plans offered through Great-West Life have a much stronger market share.

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

At end-of-year 2011, nearly 63,000 dentists were participants in at least one of the five ADA insurance plans. Nearly 20,000 of those dentists participate in multiple plans. In addition, the Life and MedCASH plans cover almost 20,000 spouses or domestic partners, along with 8,000 children.

The table below provides insured participation for policy years 2008 through 2011:

Insurance Program	2008	2009	2010	2011
Member Term Life ¹	55,143	55,171	55,128	53,989
Spouse Term Life	19,364	19,259	19,104	19,005
Child Term Life ²	7,961	7,764	7,618	7,597
Student Term Life ³	11,362	12,344	12,930	13,681
Term Plus Plan	1,694	1,629	1,577	1,520
Income Protection	17,596	17,667	17,355	18,695
Student Disability	872	1,114	6,410	11,036
Overhead Expense	8,467	8,420	8,309	9,820
MedCASH	5,101	4,851	4,612	4,408

[1] All years include graduates who were participating in the program at year-end. There were 3,223 such participants in 2011.

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

[3] 2011 graduates were reclassified from students to members on 12/31/2011.

With the aging of the member population, the need to continue to enroll young professionals into the plans has been identified as a key goal. Offering the student life plan at no charge to ADA student members, with premiums covered by the ADA Insurance Plans, was successful in increasing the number of student participants. In 2010, this strategy was also pursued for the student disability plan and there has continued to be growth in this sector, up 15% over the previous year. By year-end, the student life and disability plans had 16,900 and 11,000 participants respectively.

Focusing on a smooth conversion from the student plans to the member plans is a priority in 2012. The Council's transition to the division of Membership, Tripartite Relations and Marketing from the division of Finance has helped align membership communications and has had a positive impact on administration. The Chief Financial Officer and the division of Finance staff continue to support the Council on financial matters.

The Council undertook a financial audit and benchmarking study of the ADA Insurance Plans in January 2012. After a Request for Proposal process to evaluate potential providers, Milliman, Inc. was engaged to conduct a comprehensive financial audit of each of the insurance plans as well as a benchmarking study to assess the competitiveness of the products and pricing. The overall goal is to ensure the ADA Insurance Plans are returning maximum value to the membership. There is also a broader objective of enabling transparent oversight in the reporting of future plan performance to help ensure compliance with ADA's goals and the financial stability of the member benefit plans. While the study is ongoing, the Council has formed a workgroup to thoroughly evaluate the report and its implications and to make recommendations for full Council consideration.

In order to better serve the membership and potentially provide a source of non-dues revenue, the Council has also begun the process of addressing opportunities to enhance current insurance products and services, add new products and services, and potentially extend products to new markets. The

Milliman study will inform this effort. In addition, Great-West Life has brought forward two new product proposals for the Council's consideration.

The Council also oversees retirement programs and endorses two programs offered by AXA Equitable Life Insurance Company. The ADA is the largest client within AXA Equitable's association group. The Members Retirement Program is a tax-qualified plan that offers three types of 401(k) plans: simple, safe harbor and traditional, as well as pension and profit-sharing plans. The Individual Retirement Account (IRA) can be adopted as a traditional IRA, Roth IRA, Rollover IRA or Self-Employed IRA (SEP-IRA).

The following table provides participation statistics for the ADA-endorsed Members Retirement Program:

Members Retirement Plan Participation	2008	2009	2010	2011
Total number of dentist employers	5,781	5,527	5,198	4,930
Total number of dentists and employee participants	19,509	19,040	18,721	18,098

Number of dentists and employees participating in the IRA (300+ Series) Program:

Individual Retirement Accounts	2008	2009	2010	2011
Number of participants	1,889	1,809	1,720	1,679

In preparation for the expiration of the current five-year agreement with AXA Equitable, the Council's priority will be to evaluate how well the programs are meeting ADA member needs as well as revenue opportunities. Under the current arrangement, ADA revenue is stipulated contractually as a percent of total assets held in the programs. The table below indicates the service income ADA has received annually since 2008 under the ADA's endorsement of the Members Retirement Programs. In 2011, service income received totaled \$516,289.

Year	Amount Paid to ADA
2008	713,396
2009	466,411
2010	497,064
2011	516,289
Total	\$2,193,160

The ADA-endorsed Members Retirement Program remains strong financially with over \$1.4 billion in total assets; the IRA Program is also financially stable. However, sales of both programs have declined significantly and the Council is undertaking a review to identify additional marketing opportunities. Potential new products and services will be considered, and AXA Equitable has brought forward two new product proposals for the Council's consideration.

Raising awareness of the value of the ADA Insurance Plans and the ADA Members Retirement Programs, as well as educating the membership on principles of risk management, are key priorities for the Council. These topics have gained greater visibility this year through enhanced marketing, visibility at ADA meetings and conferences, articles in *ADA News* and e-publications, and other initiatives (such as

sponsorship of the ADA Annual Conference on Recruitment & Retention for tripartite staff and volunteers, and the ADA Success program in the dental schools). Additionally, the Council will collaborate with the Council on Dental Practice and several other agencies in launching the Center for Professional Success that will include insurance and financial risk management educational resources for dentists.

Emerging Issues and Trends

There are several emerging issues and trends that impact the Council. Through its ongoing activities, the Council will monitor, assess, or potentially take action on the following topics:

- For new graduates, managing financial risk and planning for the future is more important than ever, given the high level of student debt today. Offering appropriate, affordable products as well as information resources and education will help equip young professionals for success.
- The trend in dental practice away from solo practice to small group, large group and corporate practice is likely to impact the market for insurance and retirement plans, and will require study by the Council to assess short-term and long-term implications and opportunities.
- Emerging areas related to risk management and professional liability insurance also include the growth of group practice; “cyber-liability,” as more dentists store and share data electronically; as well as the impact of social media.

Responses to House of Delegates Resolutions

There were no assignments from the 2011 ADA House of Delegates.

Summary of Resolutions

This report is informational and no resolutions are presented.

Council Minutes

For more information on recent activities, see the Council’s minutes on ADA.org:
<https://www.ada.org/members/1293.aspx#retirement>.

Council on Membership

Rosenthal, Nancy R., 2012, Pennsylvania, chair
Bauman, Mark A., 2013, New York, vice chair
Bainbridge, Jean E., 2013, Texas
Cassidy, Kevin M., 2014, Kansas
Del Valle-Sepulveda, Edwin A., 2015, Puerto Rico
Durbin, Michael G., 2013, Illinois
Goad, Jamie Dale, 2013, New Mexico
Kelly, Thomas S., 2014, Ohio
Lee, Natasha A., 2015, California
Moore, T. Delton, 2012, Mississippi
Ogata, Randall H., 2014, Washington
Olson, Shelley Barker, 2015, North Carolina
Rich, Jonathan W., 2012, Kentucky
Schwab, Brian M., 2012, Pennsylvania, *ex officio* *
Shoemaker, Eugene, 2015, Wisconsin
Thomsen, Brett S., 2012, Nebraska
Vouras, Lisa, 2012, Massachusetts
Zuknick, Stephen J., 2014, Florida

Rauchenecker, Steven M., director
Bronson, Elizabeth, manager

The Council's 2011-12 liaisons included: Dr. Samuel Low (Seventeenth District trustee, Board of Trustees); Dr. Krista Jones (Council on Communications); and Ms. Alex Barton (American Student Dental Association).

Mission and Purpose

The Council on Membership is the American Dental Association (ADA) agency composed of volunteer dentists whose responsibility is to monitor membership trends; to collect information to assess members' needs in order to facilitate the analysis and transfer of this information throughout the ADA; to encourage the development and promotion of member benefits in order to maintain high levels of membership; and to increase membership, preserving the Association's place as the unified voice of dentistry.

The Council on Membership (CM) formulates and recommends policies related to member recruitment and retention and other related issues. The Council works closely with constituent and component dental societies to support, monitor and encourage tripartite membership activities and to enhance cooperation and communication on tripartite recruitment and retention efforts. In addition, the Council on Membership recommends, monitors and supports the development of membership benefits and services that respond to identified needs of members.

Supporting the Strategic Plan: Activities, Results and Accomplishments

The Council on Membership supports the ADA Strategic Plan through: the creation of strategies and resources that highlight member value; working with the tripartite to increase membership; encouraging a diverse membership; and through membership dues, contributing to a financially stable organization. Specifically, the Council's work primarily supports ADA Strategic Plan (2011-2014) Goals 1 and 4, which follow:

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

Goal 1: Provide support to dentists so they may succeed and excel throughout their careers.

Objective 1: Professional competency and ethical standards.

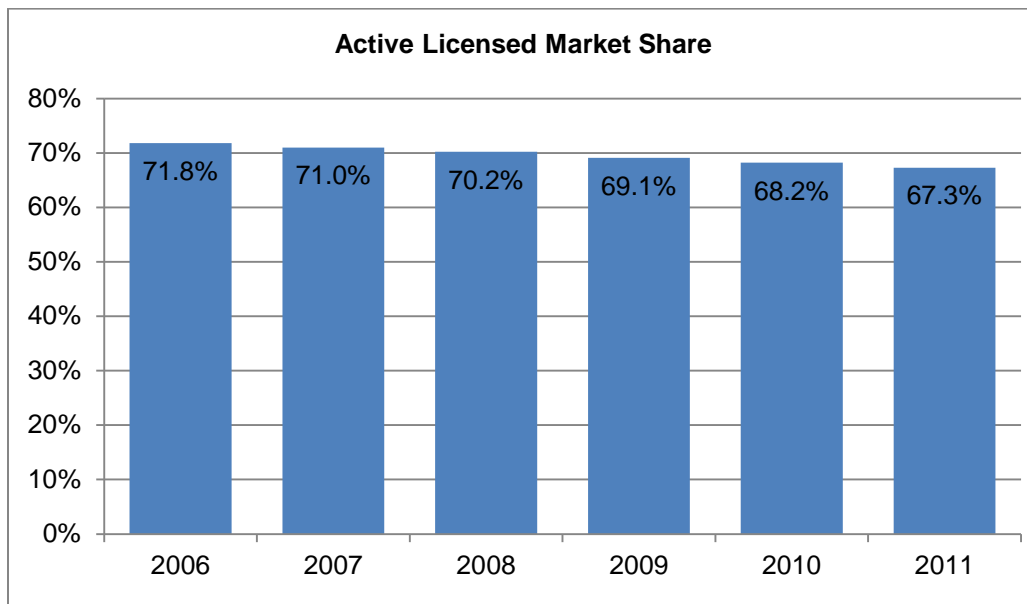
Goal 4: Ensure that the ADA is a financially stable organization that provides appropriate resources to enable operational and strategic initiatives.

Objective 1: Increase the reserves of the Association so that a reserve level of 50% of the Association's annual budgeted operating expense is achieved, as urged by HOD Resolution 59-2007H-2008.

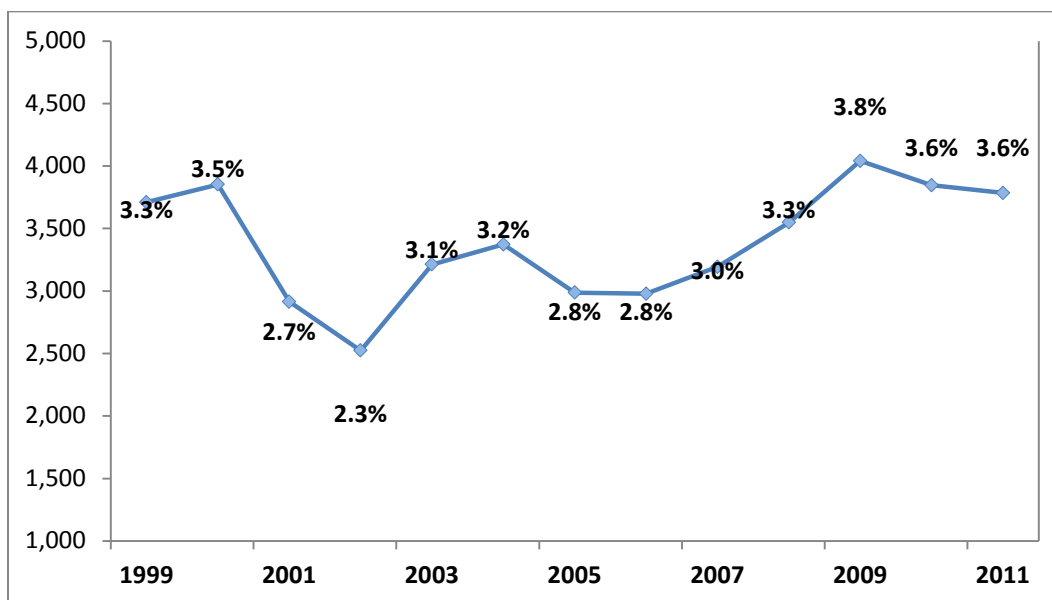
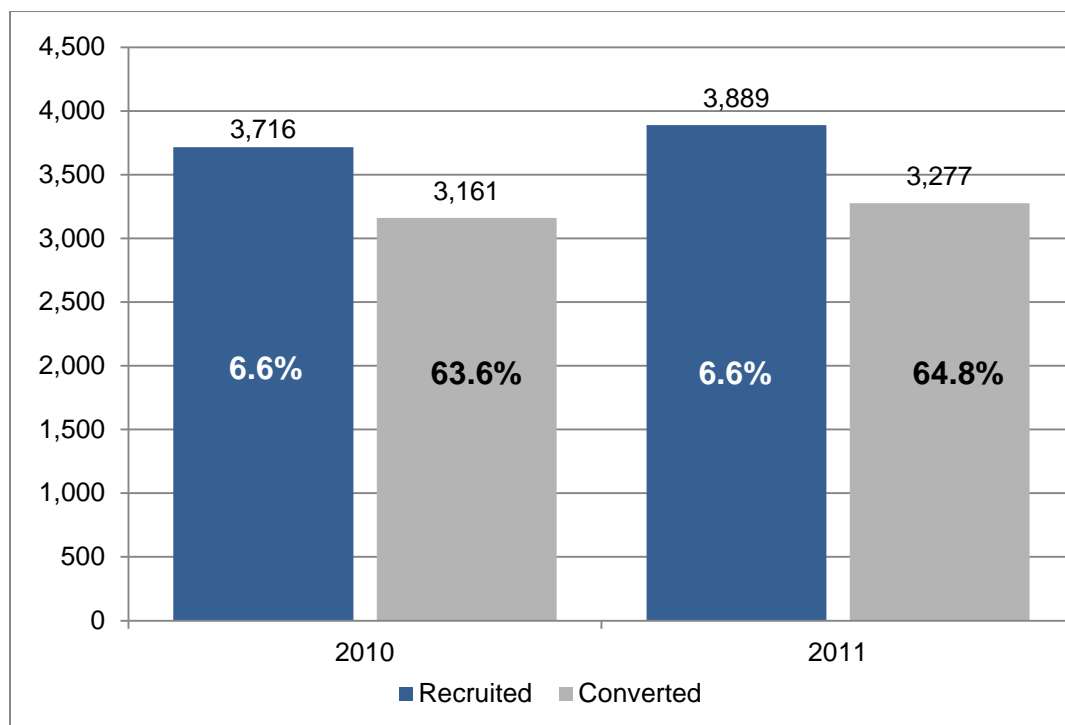
The Council on Membership is focused on closing the membership market share gap, collaborating with other agencies and stakeholders in order to increase value to members and refine its overall membership dues structure. To that end, the Council has developed plans and programs and streamlined its efforts to achieve *at least* 67.3% of the active licensed dentist market, thus reversing the downward trend. Key metrics for the Council include membership growth overall, membership market share, retention of members, recruitment of nonmembers, and conversion of dental students to active membership.

As seen in the graph below, at the end of 2011, the market share for active, licensed dentists had declined to 67.3% from 68.2%. The aggregate number of active members grew by 600 dentists during this same time period.

Figure 1. Active Licensed Market Share Trend



In addition, the non-renew rate for full dues-paying members remained unchanged at 3.6% at the end of 2011, with the total number of active member non-renews at 3,785.

Figure 2. Non-Renew Rate Among Full Dues-Paying Members**Figure 3. Recruited and Converted Members (2010–2011)**

The cost to recruit a new member in 2011 was \$126.23, up by \$49.40 per member over 2010. This increase can be attributed to the added expenses associated with the Membership Program for Growth (MPG). The cost to convert a recent graduate (class of 2010/member in 2011) remained consistent at \$70, down by \$2.11 over 2010 (for the class of 2009/member in 2010).

The tripartite structure differentiates the ADA from most other national membership organizations and more than 95% of ADA members hold membership at the local, state and national level. In 2011, \$500,000 was made available for the purpose of expanding the collaborative approach to membership outreach through the Membership Program for Growth (MPG), in order to positively impact tripartite membership in those areas and among those market segments that offer the greatest opportunity. In addition, it gives the three levels of the tripartite the ability to work together to build upon membership growth as a core competency through development and implementation of customized membership marketing plans and campaigns. In 2011, 80 individual requests for \$960,000 in funds were submitted. In the first year, 54 requests were approved totaling \$500,000. In 2012, 122 individual requests for \$1,261,000 were submitted. Of that, 80 requests were approved for either full or partial funding which totaled \$500,000. Since many of the activities occurred in the late 2011 membership year, the final reports of these activities are being monitored through June 2012, at which time a final report on the return on investment will be completed. Results to date will be shared with the Council at its June 2012 meeting and reflected in the Council's 2012 supplemental report.

During 2011, Membership Contact and Connections (MC²) continued to focus on working with state dental associations through campaigns developed through the marketing collaborative program. The three campaigns for 2011 included: a Strategic Promotional Incentive (SPI) to dentists five to 10 years out from dental school graduation; a campaign which prompted the class of 2011 to apply for active, licensed membership; and the Quarter Year \$0 Dues campaign, which provided free dues at the national level for nonmembers who had never taken advantage of this offer in the past. Many states also offered the \$0 rate. The results of the marketing collaborative campaigns have been strong, with the following results achieved in 2011:

- Strategic Promotional Incentive (SPI) to nonmembers five to 10 years out from dental school graduation: 357 new members;
- Conversion (class of 2011): As of April 30, 2012, the conversion rate for the class of 2011 is about 2% higher than the conversion rate for the class of 2010 at the same time last year; and
- Fourth Quarter \$0 Dues: 572 new members.

The three 2012 national collaborative campaigns include:

- Women dentist recruitment;
- Long-time nonmember recruitment (have not been a member since 1999 or earlier); and
- Student conversion (class of 2012).

Dental Student Outreach

The ADA has long recognized the importance of inviting dental students to participate in organized dentistry while they are in dental school. Students join the ADA as student members at the same time they join the American Student Dental Association (ASDA). The ADA does not directly recruit student members, but supports ASDA outreach. ASDA collects and remits \$5 per student membership dues to the ADA. In 2012, ASDA has planned a dues increase of \$3, which will bring the total student dues at the national level to \$75 (\$70 for ASDA; \$5 for the ADA). In addition to the \$75, chapter dues are also collected.

Through student membership, the Office of Student Affairs (OSA) provides a natural venue to support students and introduce them to the ADA community. Specifically, the goals related to students are to increase dental students' awareness of ADA membership, to position ADA membership as a valuable resource to dental students, and to establish a lifelong commitment to ADA membership among students and recent graduates.

Enrollment in the 58 U.S. dental schools at the close of the 2010-2011 academic year was 20,418. As of July 1, the date on which the ADA student membership market share is reported annually, 86.8% of students were ASDA and ADA student members. There were a total of 17,638 student members and

2,780 nonmembers. Market share is higher among first-year students, likely because a few schools offer automatic billing for freshmen only. Overall, the ASDA and ADA student market share is 2.5 percentage points higher than last year, which may be due to receiving payments earlier in the year, increased chapter outreach and the large number of automatic billing schools.

A key metric for the ADA is the conversion rate—the percentage of new dental school graduates who become ADA members the following year. For the class of 2010, at end of year 2011, the conversion rate was 64.4%—a slight increase from the year before. New activities, such as National Signing Day and the Conversion Drive incentive, which were launched in 2011, are expected to increase conversion rates for the class of 2011.

The following is a breakdown for each of the past five years of the average percentage of students converted to active, licensed ADA members from dental schools within each ADA district. This information is sorted in descending order by results for the class of 2010. Those highlighted in green achieved above-average conversion of 66.9%, and those in yellow fell below that average.

Table 1. Conversion Percentage By Class*

District	Conversion Percentage By Class*				
	Class of '06	Class of '07	Class of '08	Class of '09	Class of '10
14	81.1	99.1	112.0	93.6	95.8
12	77.8	64.4	73.3	74.7	81.5
10	85.6	78.9	79.6	78.2	79.1
5	79.8	69.1	74.8	62.6	74.3
8	84.6	76.1	75.2	68.8	72.7
9	73.3	75.7	69.3	63.3	70.8
13	67.4	68.5	67.3	68.9	69.9
7	76.5	70.1	75.8	69.3	66.4
3	58.9	60.3	59.8	59.8	65.9
11	58.6	71.5	72.5	60.6	65.8
16	66.4	60.0	60.7	62.0	61.5
6	68.9	62.3	64.8	60.1	60.8
2	53.6	58.1	59.1	62.0	58.0
15	65.4	56.3	61.7	64.1	57.7
17	73.0	64.9	61.7	67.0	53.9
1	56.7	49.1	63.9	51.9	53.6
4	51.1	45.8	48.4	51.0	50.1
Average	69.3	66.5	69.4	65.7	66.9

* Data is for the end of the year following graduation (e.g. Class of 2010 data was generated 12/31/11).

Member Recognition Through Logo Utilization

Currently, an inequity exists between the general ADA member logo and the logo that is available to ADA member dental specialists. The Council believes that in order to provide equitable member value, a member should be allowed access to the member logo that allows for greater usage and proposes the following action.

50. Resolved, that the downloadable ADA member logos, without the year of issue, be made available for all active and retired and life member dentists.

Active Life Membership

At its February 2012 meeting, the Council on Membership discussed the potential impact that the projected growth of the life and active life membership categories could have for the ADA. Based on historical data, it is expected that between 2012 and 2016, 11,794 active members will transition from active membership to active life membership. As these individuals move from paying 100% to 50% of full active dues, the projected impact to the Association is a reduction in dues revenue of \$3,343,616. The Council determined that if this same group were to pay 75% of current full active dues, over this same time period, \$4,528,896 in revenue could be gained, thus minimizing the effect of the reduction and adding nearly \$1.2 million in additional revenue over the five-year time period.

The Council also discussed the potential impact of raising dues for existing active life members. Not accounting for attrition, increasing dues to 75% of full active dues would generate an additional \$128 from each of the 12,814 current active life members. This equates to an annual increase of \$1.6 million. With respect to attrition, each year, over the past four years, attrition nationally for this group has averaged 2%. In 2010, the Illinois State Dental Society (ISDA) implemented a dues increase for its active life members that raised dues from 50% to 100% of full dues. Over the first year, 17 of the existing ISDA active life members, or 3.5%, did not renew.

The Council also considered the option of grandfathering in existing active life members. Doing so would maintain the Association's existing relationship with current life members as well as minimize the potential for increased attrition. However, doing so could foster dissatisfaction among those active life members who pay a different dues amount moving forward. It would also increase the complexity of dues collection for constituents who would need to track and collect two separate dues amounts within one category of membership.

The Council carefully weighed the importance of serving long-standing members who continue to actively practice dentistry, with the recognition that costs continue to increase to provide existing benefits. In addition, future value through offerings such as the ADA's Center for Professional Success may increase costs further. If active life member dues are raised to cover those costs, market share could be impacted by the level of attrition that may occur. This natural tension creates a fine line between covering expense and providing the greatest value for the membership dollar.

As a result of this discussion, the Council recommends that the following *Bylaws* resolution be forwarded to the 2012 House of Delegates for consideration.

51. Resolved, that the ADA *Bylaws*, Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS, Section B. LIFE MEMBER, Subsection c. DUES AND SPECIAL ASSESSMENTS, paragraph 1, be amended as follows (new language underscored; deletions ~~stricken~~):

(1) ACTIVE LIFE MEMBERS. The dues of life members who have not fulfilled the qualifications of retired membership pursuant to Chapter I, Section 20C of these *Bylaws* with regard to income related to dentistry shall be ~~fifty percent (50%)~~ seventy-five percent (75%)* of the dues of active members, due January 1 of each year. In addition to their annual dues, active life members shall pay ~~fifty percent (50%)~~ seventy-five percent (75%)* of any active member special assessment, due January 1 of each year.

*The dues and special assessment percentage for those members who attained active life membership classification prior to the adjournment *sine die* of the 2012 House of Delegates shall remain at the same percentage as they had upon entry into this category, and until such time that they move to another membership category.

Affiliate Membership

At its February 2012 meeting, the Council on Membership also discussed the potential impact that the growth of the affiliate membership category could have for the ADA. A workgroup was formed that included representation from the Committee on International Programs and Development. The workgroup will present its findings at the Council's June 2012 meeting. The results of the discussion will be included in the Council's supplemental report.

Emerging Issues and Trends

Emerging Issues

A number of existing factors have been identified by the Council on Membership as having a direct impact on tripartite membership growth. Over the past 10 years, ADA's market share has gone from 70.4% at the end of 2001 to 67.3% at the end of 2011. Specific segments such as women (60.8%), ethnically diverse (53.3%), new (66.9%) and foreign-trained dentists (49%) are lagging the overall market. ADA's core member segment, the general practitioner (64.6%), also continues to erode. Conversely, the number of group dental practices with 20 or more dentists continues to proliferate. ADA's Health Policy Resources Center has identified that during a two-year period between the second quarter of 2009 and of 2011, the 22 largest group practices grew by nearly one-third. Finally, the Council is looking closely at the dues structure for all membership categories in order to strike an optimum balance between revenue generation and value provision. Specifically, the Council is recommending an increase in the active life member dues rate.

For the existing member dentists of the baby boom era, the ADA has more than met their needs. This is substantiated by past high join rates and high retention. The trends cited contribute to a tipping point that is fast approaching, however, where the baby boom generation of dentists will retire. The average age of retirement among ADA dentists is currently 68 years old. In 18 years, one-half of the current membership will have reached that age. The ADA must continue to perform its due diligence to be relevant to the generations that follow, namely:

1. Align all agencies in a unified effort to achieve membership market share growth;
2. Analyze and adjust membership policy and strategy to leverage changing environmental, demographic and technological factors affecting organized dentistry;
3. Establish a routine process to set dues for membership categories beyond active, licensed dentist members;
4. Refine its understanding of the changing needs of existing and emerging member segments using research and other means;
5. Help ensure that the defined needs of dentists are considered in the creation, enhancement and utilization of products and services;
6. Help ensure that evaluations are done of member satisfaction with existing member benefits and services;
7. Assist the House of Delegates in shaping ADA policy related to the pricing and utilization of products and services;
8. Prioritize segments (dentists of diverse racial and ethnic backgrounds, women dentists, new dentists and foreign dentists) and geographic areas that hold the most promise for membership growth—bringing resources to bear where they will have the greatest effect;

9. Create further collaboration and alignment among the ADA, constituent and component dental societies relative to consistent, high-level satisfaction with the delivery of membership benefits and services across the tripartite; and
10. Encourage the promotion of tripartite membership value in order to stimulate membership growth.

Enhancing Member Value

The Council envisions taking a more active role in supporting the development of membership benefits and services that respond to identified needs of members, and in serving as an advocate for membership benefits. In part, the Council is looking to develop criteria that can be used to gauge which products and services are positioned as part of membership, potentially justifying an increase in membership dues, as well as those that would contribute most effectively to the organization as a separate revenue stream. In either case, there may be opportunities to cross-sell products and services to members or nonmembers, maximizing ADA's provision of value and brand position in the marketplace.

Membership Trends

The ADA maintains a high market share despite the effects the economy has had on the dental profession. Active membership at end of year (EOY) 2011 was 128,719, an increase of 600 members in comparison to EOY 2010. However, the total market size had also increased in 2011, resulting in a decline in market share percentage (Table 2).

Since 2000, the total market of active licensed dentists has increased by 25,604, an average of 2,327 a year. While some years, such as 2006, had a small increase of just 613, a total of 3,269 dentists were added in 2011—nearly three times the number of active licensed dentists added in 2010.

Table 2. Market Increase (2001–2011): Active Licensed Dentists

Year	Total Market	Increase	Percent Increase	EOY Market Share
2001	166,611	1,048	0.6%	70.4%
2002	172,058	5,447	3.3%	70.4%
2003	173,525	1,467	0.9%	71.0%
2004	176,063	2,538	1.5%	71.4%
2005	177,579	1,516	0.9%	71.3%
2006	178,192	613	0.3%	71.8%
2007	182,006	3,814	2.1%	71.0%
2008	183,624	1,618	0.9%	70.2%
2009	186,589	2,965	1.6%	69.1%
2010	187,898	1,309	0.7%	68.2%
2011	191,167	3,269	1.7%	67.3%

As a direct result, market share declined slightly, but still remained strong at 67.3%, down nine-tenths of a percentage point from EOY 2010. Membership market share may continue to fluctuate based on increases in total number of active licensed dentists entering the market.

Three of the fastest-growing market segments are: women dentists, ethnic/diverse dentists and non-U.S.-trained dentists. It is important that the ADA increase membership participation within these membership segments to keep pace with membership growth.

With increased outreach to these important segments in 2011, the ADA did experience an increase in member count within these segments, but market share continued to decline (Table 3).

Table 3. Growth Within the Fastest-Growing Market Segments

Segment	2010	2011	Growth	Percentage Change	Market Share Change
Women	27,822	29,055	1,233	+4.2%	-1.0%
Ethnic/Diverse	17,152	18,670	1,518	+8.1%	-0.3%
Non-U.S.-Trained	5,129	5,148	19	+0.4%	-0.8%

Additional recruitment and retention touch points will be added in 2012 to affect these numbers. There has also been a gradual decline in the market share of general dentists and specialists; they too will be a membership recruitment and retention focus.

Retention

The ADA continues to retain members at a very high rate when evaluated on an annual basis. In 2011, the ADA retention rate for full dues-paying members remained identical to 2010 at 96.4%. The retention rate for this group of members (those that pay rate 1, full active dues) was highest in 2003 (at 97.7%), when the ADA launched a renewed focus on membership and significant tripartite resources were devoted to membership recruitment and retention. The number of dentists paying full active dues has decreased in the last year (from 95,424 to 94,494), reflecting the trend of a greater proportion of members paying dues rates of less than 100%. In 2011, 45.6% of ADA active members paid a rate less than the full dues rate, and 54.4% of dentists overall paid the full active rate.

Deepening our understanding of the reasons for nonrenewal among all membership categories was a focus in 2011. The ADA completed a Survey of Non-Renews following the official ADA membership cutoff, and it indicated the “cost of membership” and the “benefits as they relate to costs” continue to be the main reasons why members choose not to renew. Often the cost of membership is a proxy for not seeing member value for the money.

Dental Students and New Dentists—Societal Trends and Environment

In 2011-2012, a number of trends are expected to impact dental students, namely the economic environment, licensure changes and overall generational characteristics.

Generationally, today’s dental students are mostly Millennials with characteristics reflective of this young generation. The American Dental Education Association (ADEA) reports suggest that they desire:

- Lifestyle flexibility
- Income
- Respect of being a healthcare professional
- Responsibility of providing healthcare
- The latest developments in technology and science
- Community service and team work

As Millennials continue to enter the dental profession, it is increasingly important for the ADA to welcome this new generation to membership and leadership. The ADA is utilizing different, creative ways to invite students and new dentists to participate. Short-term and project-oriented volunteer opportunities at the national and local levels may be worth exploring, as well as greater cross-collaboration opportunities

among/between councils and the tripartite. By offering increased volunteer opportunities for new dentists, the ADA can capture the spirited participation of ASDA members, known as ASDA fever. Providing clear opportunities for involvement for these enthusiastic members will help to reinforce the ADA's positioning as the premier dental organization for all dentists.

Responses to House of Delegates Resolutions

The Council on Membership was assigned the following resolutions from the 2011 ADA House of Delegates. The status of each resolution is listed below.

16H-2011. Amendment of ADA Bylaws Regarding Humanitarian Membership Category (Trans.2011:546)

Status: The ADA *Bylaws* have been amended and the Humanitarian Charitable membership category has been implemented and is available beginning with the 2012 membership year.

17H-2011. Amendment of ADA Bylaws Regarding Creation of a 25% Dues Waiver (Trans.2011:546)

Status: The ADA *Bylaws* have been amended and the 25% dues waiver has been created and is available beginning with the 2012 membership year.

20H-2011. Funding of Student Block Grant Program (Trans.2011:440)

Status: The student block grant application has been updated to include metrics for 2012.

46H-2011. Revision of ADA Specialty Logo (Trans.2011:547)

Status: The date has been removed from the ADA Specialty logo and has been available on ADA.org since November 2011.

Policy Review

The Council on Membership will identify and review policies in accordance with Resolution 111H-2010 and recommend action to maintain, amend, rescind, or remove from *Current Policies* at its June 2012 meeting. The results will be reported in the Council's supplemental report to the House of Delegates.

Summary of Resolutions

Resolution 50: Downloadable ADA Member Logos

Resolution 51: Amendment of the ADA *Bylaws* Regarding the Dues of Active Life Members

Council Minutes

For more information on recent activities, see the Council's minutes on ADA.org:

<https://www.ada.org/members/1293.aspx#membership>.

Joint Commission on National Dental Examinations

Trager, Peter S., 2013, Georgia, chair, American Dental Association
Sill, J. Stephen, 2012, Nevada, vice chair, American Association of Dental Boards
Byrne, B. Ellen, 2012, Virginia, American Dental Education Association
Donahue, Jeri Ann, 2013, Wyoming, American Association of Dental Boards
Drisko, Connie L., 2015, Georgia, American Dental Education Association
Gerosky, Mary Lou, 2014, Ohio, American Dental Hygienists' Association
Glass, Birgit J., 2013, Texas, American Dental Education Association
Hersh, Robert A., 2015, New Jersey, American Dental Association
Peterson, Lorin D., 2014, Washington, American Dental Association
Podruch, LeeAnn, 2014, Wisconsin, American Association of Dental Boards
Shampaine, Guy, 2013, Maryland, American Association of Dental Boards
Shannon, Kelley, 2014, Washington, DC, Public Member
Shisler, Adam, 2012, Texas, American Student Dental Association
Trinca, Samuel A., 2012, Louisiana, American Association of Dental Boards
VanderVeen, M. Reggie, 2015, Michigan, American Association of Dental Boards

Waldschmidt, David M., secretary and director
Hinshaw, Kathleen J., senior manager
Tsai, Tsung-Hsun, manager
Vanek, Carol A., manager

Mission and Purpose

The Joint Commission on National Dental Examinations (JCNDE) develops and conducts highly reliable, state of the art cognitive examinations that assist regulatory agencies in making valid decisions regarding licensure of oral health care professionals; develops and implements policy for the orderly, secure, and fair administration of its examinations; and is a leader and resource in assessment for the oral health care profession.

Supporting the Strategic Plan: Activities, Results and Accomplishments

2012 Implementations

Beginning in 2012, the Joint Commission implemented the following:

- **Pass/Fail Reporting.** Numerical scores are no longer reported for candidates who pass National Board examinations. Failing candidates are provided scores for remediation purposes.
- **Reduction in Application Eligibility Period.** Candidates who are granted approval to take National Board examinations are now eligible to take the test for a period of six months, as opposed to one year.
- **Examination History.** Score reports will now include a history of scores/results for all examination attempts.
- **5 Years/5 Attempts Eligibility Rule.** Candidates now must pass an examination within five years of testing or five examination attempts, whichever comes first.
- **No Advance Review of Examination Content.** Candidates are prohibited from taking National Board Examinations to practice or obtain an advance review of the content.
- **New Endodontics Terminology.** The National Board Dental Examination Part II will adopt new endodontics terminology, beginning in the summer of 2012 (subject to deployment by the test administration vendor).

- **Irregularities and Reporting.** If it is determined that a candidate engaged in irregular behavior, information regarding this determination becomes a part of the candidate's National Board record. At its sole discretion, the JCNDE may elect to send a summary report documenting the incident, with a brief statement provided by the candidate immediately following the decision by the JCNDE, to legitimately interested parties—including all persons or agencies to which the candidate has instructed that scores be sent, both presently and in the future.
- **Test Administration Survey.** The JCNDE has updated survey questions on National Board test administrations to provide additional insight from a quality control perspective.

2012 Updates

At its April 2012 meeting, the Joint Commission accomplished the following:

- **Budget Proposal and Fees.** Approved the 2013 budget proposal, including a \$10 increase to 2013 application fees, and a \$2.50 increase to score report request fees. The total 2013 examination fees charged to candidates will be \$355 for Part I, \$400 for Part II, and \$390 for the Dental Hygiene Examination. In 2013, score report request fees will be \$32.50.
- **Intellectual Property Usage.** Approved continuing the established policies and procedures for granting permission for use of the JCNDE's intellectual property by dental educational programs, dental hygiene educational programs, and ASDA.
- **Development Guides.** Approved the procedures for granting permission to educational programs for use of the Case Development and Test Item Development Guides by dental schools for faculty development.
- **Released Item Sets.** Approved existing National Board Dental Examination (NBDE) and National Board Dental Hygiene Examination (NBDHE) released item sets.
- **NBDHE Materials.** Approved procedures for the sale of NBDHE materials to individuals for a fee to cover costs of production and distribution.
- **Brown and Herbranson/eHuman Contract.** Approved actions to terminate the existing contract with Brown and Herbranson/eHuman; monitor Brown and Herbranson/eHuman's compliance with existing contract terms; and investigate delivery options for online NBDE and NBDHE practice tests.
- **ASDA Contract.** Approved efforts to renew the contract with ASDA concerning released NBDE items.
- **Examination Regulations.** Adopted revisions to the *Examination Regulations*. Many of the proposed revisions reflect changes related to the discontinuation of print-based examinations, while other changes align the document with previous JCNDE decisions concerning the release of candidate examination results.
- **Standing Rules.** Adopted revisions to the *Standing Rules*, subject to the approval of the House of Delegates. Most of the proposed revisions were editorial in nature, with the exception of a change indicating that examination results may be withheld or reported when forensic analyses provide compelling information indicating the presence of an irregularity. Previously, the *Standing Rules* had indicated that results would simply be withheld in this circumstance.
- **Practice Analysis and NBDE Part II Test Specifications.** Approved the methodology and findings of the 2011 practice analysis conducted in support of the validity of the NBDE Part II, and adopted the NBDE Part II specifications in accordance with these findings. The revised specifications will take effect in 2013.
- **Test Constructors.** Approved the reappointment of Dental and Dental Hygiene examination test constructors and the appointment of primary and alternate test constructors for the Dental and Dental Hygiene examinations for 2013.
- **Dental Hygiene Test Constructor Selection Criteria.** Approved the review of criteria for selecting dental hygiene test constructors.
- **IDEA Grant Program Topics.** Approved the identification of key research topics that would benefit the Joint Commission's testing program. These topics would be determined by key stakeholders (e.g., the Committee on Research and Development, the Committee for an Integrated Examination, staff). In reviewing future Innovative Dental Assessment (IDEA)

Research Grant Program proposals, special consideration will be given to topics that are consistent with the goals of the Joint Commission's current and future testing programs.

- **IDEA Application Procedure.** Approved the following changes to the IDEA application procedure: (1) IDEA applicants must include a letter of intent with a two-page summary of their proposed projects, (2) the timeline between application and award cycle is revised to include the submission and review of the letter of intent, and (3) the letter of intent must be reviewed by the chair of the Committee on Research and Development, one R&D consultant, and one staff member. The intention of these changes is to increase the quality of proposals received and their alignment with the goals of the Joint Commission.
- **IDEA Proposals.** Considered three IDEA proposals requesting funding for the 2011-2012 funding cycle, but denied all three requests.
- **Expenditures (Research and Development, IDEA).** Approved a list of 2012-2013 research and development projects and expenditures, and expenditures pertaining to projects currently supported by the IDEA program.
- **Technical Reports.** Approved the 2011 editions of the NBDE and NBDHE Technical Reports.
- **Request of Pharmacology Test Construction Committee.** Considered a request by the NBDE Part II Pharmacology Test Construction Committee (TCC) for Pharmacology TCC members to determine pharmacology content and its weighting for NBDE Part II. The JCNDE denied this request.
- **5 Years/5 Attempts Examination Eligibility Rule Review.** Considered additional information concerning the impact of the 5 Years/5 Attempts Examination Eligibility Rule, and reviewed existing deterrents to irregularities. The JCNDE took no action concerning this information.
- **Integrated National Board Dental Examination Review.** Considered information concerning the development and progress of the Integrated National Board Dental Examination. The JCNDE took no action concerning this information.
- **Joint Commission Elections.** Elected Dr. Guy Shampaine as chair and Dr. Lorin D. Peterson as vice chair of the Joint Commission. Their terms will begin in October 2012.
- **Meeting Dates.** Approved April 9, 2014, as the scheduled Joint Commission meeting date for 2014.

Integrated National Board Dental Examination Update

The purpose of the National Board Dental Examinations, Part I and Part II, is to assist state boards of dentistry in determining the qualifications of individuals who seek licensure to practice dentistry. The JCNDE is currently developing the Integrated National Board Dental Examination (INBDE) to supplant this two-part examination program. The INBDE integrates the basic sciences and clinical competencies, and will be implemented no sooner than 2017. The Committee for an Integrated Examination (CIE), an ad hoc committee of the JCNDE, has been charged with the development of this examination. Since the most recent Joint Commission annual report (2011), the following has been accomplished:

- Conducted two separate science panel review meetings to validate the content domain of the INBDE. These panels involved a total of 25 dentist subject matter experts.
- Released two separate draft documents for stakeholder review:
 - Foundation Knowledge for the General Dentist
 - Model of the Domain of Dentistry
- Communicated with communities of interest via a variety of mediums:
 - Joint Commission newsletter
 - Communiqués from the chair
 - INBDE website with FAQ and timeline sections (launched in summer of 2011)
 - INBDE mailing list
 - Surveys (e.g., state boards)
 - Presentations to stakeholders (e.g., ADEA, AADB)
- Extended discussions have also taken place on a variety of important topics, such as:
 - hypothetical test specifications

- composition and qualifications of test construction committee members
- potential new item types to include on the examination

Additional Updates

The Joint Commission also engaged in the following efforts:

- **Aptify Conversion.** This project is ongoing and replaces all the storage and processing programs for examination applications and score reports for all of the Joint Commission's testing programs. Data accuracy has been of paramount importance throughout this project.
- **Zoomorphix Item Bank.** This project is ongoing and involves migrating all current and historical examination items to Zoomorphix' Exam Studio item-banking software system. Staff must also adapt existing procedures to use the tool effectively within Test Construction Committee meetings. The new system should enhance Joint Commission test development processes.
- **National Dental Examiners' Advisory Forum (NDEAF).** The Joint Commission hosted the National Dental Examiners' Advisory Forum on April 23, 2012. The forum included several informational presentations by Dr. Trager, Dr. Sill, and staff.

Emerging Issues and Trends

The following presents trends in performance on the National Board Dental and Dental Hygiene Examinations over a 10-year period beginning in 2002. These trends are presented with respect to candidates' status as first-time or repeat test takers, and their enrollment in accredited or non-accredited programs.

NBDE Part I

Table 1 and Figure 1 present trends for the National Board Dental Examination Part I (NBDE Part I) over the past 10 years. As shown, the number of first-time candidates from accredited programs taking NBDE Part I was relatively stable from 2002 to 2005. From 2006 to 2007, the number fell from a 10-year high of 5,094 to a 10-year low of 4,179. From 2008 to 2011, the numbers increased from 4,697 to 5,068, showing slow but steady growth each year. The total number of candidates from non-accredited programs taking NBDE Part I decreased from 5,451 in 2002 to 2,634 in 2011. In interpreting this table, please note that effective 2007, NBDE Part I became a comprehensive examination and was no longer administered in four sections based on subject matter. Prior to 2007, candidates had to pass all four sections in order to pass the examination.

The total number of administrations (i.e., first-time candidates and repeating candidates from accredited and non-accredited programs) fell from 10,541 in 2002 to 8,098 in 2011. This represents an overall decrease of 2,443 candidates (i.e., 23.2%). Please note that effective 2010, candidates who have passed NBDE Part I may not retake the examination unless required by a state board or relevant regulatory agency.

Failure rates for first-time candidates from accredited programs were higher during the earlier years, and lower in more recent years, with the lowest rate shown for 2007 (3.5%). Failure rates for candidates from non-accredited programs were relatively higher.

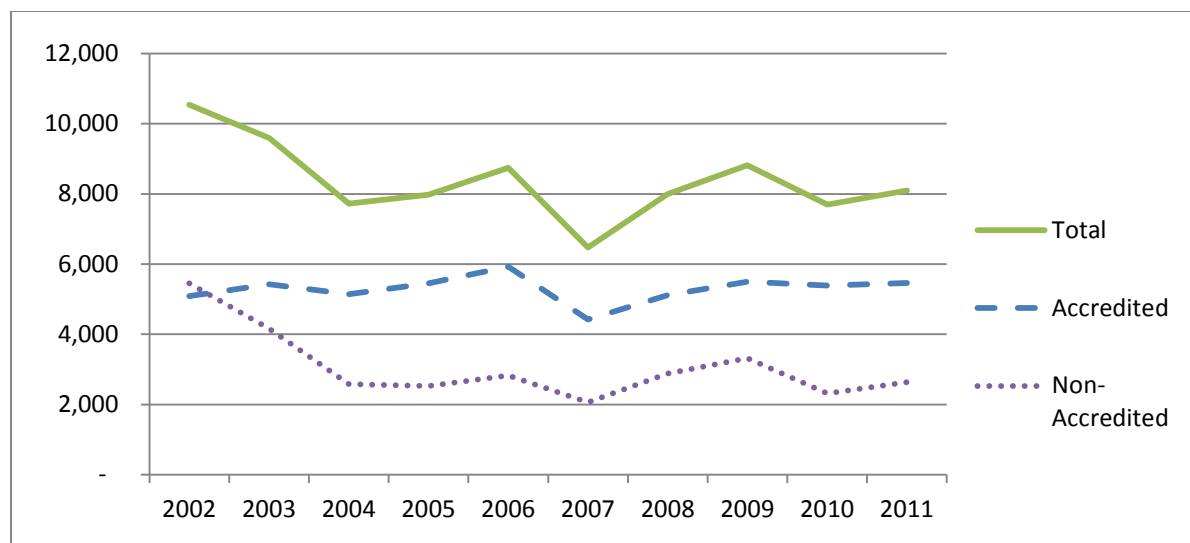
TABLE 1*
Numbers and Failure Rates for First-time and Repeating Candidates
NBDE Part I

Year	Accredited				Non-Accredited				Total	
	First-time		Repeating		First-time		Repeating		First-time and Repeating	
	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing
2002	4,423	10.5	667	36.3	2,618	58.3	2,833	73.0	10,541	40.8
2003	4,679	9.7	751	33.7	1,812	59.2	2,349	73.3	9,591	36.5
2004	4,598	10.0	545	29.7	1,109	51.0	1,470	61.2	7,722	27.0
2005	4,685	13.4	771	27.6	1,156	42.4	1,366	52.0	7,978	25.6
2006	5,094	7.8	831	21.9	1,408	39.4	1,417	37.6	8,750	20.1
2007	4,179	3.5	240	28.3	1,240	32.5	820	45.1	6,479	15.3
2008**	4,697	7.4	418	31.8	1,652	39.5	1,227	42.9	7,994	20.8
2009	4,881	5.3	615	22.3	1,684	38.5	1,635	35.3	8,815	18.4
2010	4,923	5.3	462	29.4	1,218	38.6	1,098	44.3	7,701	17.5
2011	5,068	4.5	396	33.6	1,713	32.2	921	62.2	8,098	18.3

*From 2002 to 2006, the failure rates included any candidate who failed all of Part I or any area in Part I. Effective 2007, Part I became comprehensive, the failure rate was computed based upon candidates who failed the entire Part I examination.

**A new standard was introduced this year, based on updated standard setting activities.

Figure 1. NBDE Part I Administrations (2002–2011)



NBDE Part II

Table 2 and Figure 2 present trends for National Board Dental Examination Part II (NBDE Part II) over the past 10 years. As shown, the number of first-time candidates from accredited programs was relatively stable for the first five years (generally above 4,000), jumped precipitously in 2007, and then showed continued growth through 2011. There has been quite a bit of variability over the past six years, ranging from a low of 3,775 candidates in 2006 to a high of 5,312 in 2011 (i.e., a 41% increase). The total number of first-time and repeating candidates from non-accredited programs decreased from 2,447 in 2002 to 1,521 in 2011. The number of total administrations occurring from 2002 through 2011 is stable at an overall level, with increases in the number of candidates from accredited programs being offset with

decreases in the number of candidates from non-accredited programs. However, recent data suggest a positive trend in the number of non-accredited candidates.

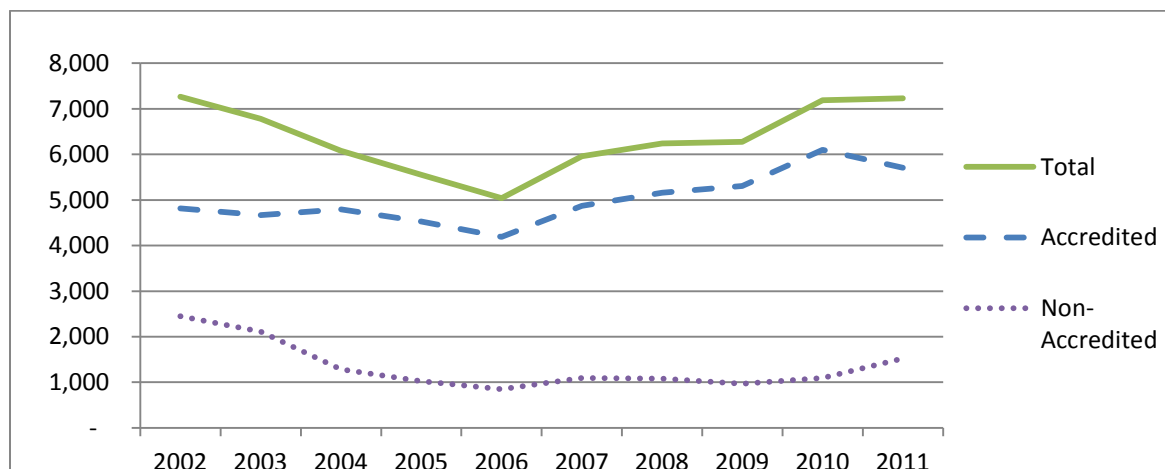
Concerning NBDE Part II failure rates, the Joint Commission recognized an increase in the failure rate from 2002 to 2009. The Joint Commission reviewed procedures and protocols associated with the development of Part II examination forms, standard-setting activities conducted in 2008, and scoring. The Joint Commission also considered additional information, such as research on the reliability and accuracy of scoring, trend data on the performance of U.S. and Canadian students on the Canadian National Dental Examinations, and research on the application of the 2009 standard to the 2008 examination results. Based on its investigation of the validity evidence relating to NBDE Part II, the Joint Commission found that the procedures utilized were appropriate. To ensure continued quality, in 2010 and 2011 staff conducted audits and quality control procedures, and monitored candidate performance on a weekly basis as part of the overall validation process. It is noted that the failure rate for NBDE Part II decreased from 13.7% in 2009 to 5.1% in 2011 for first-time candidates from accredited programs.

TABLE 2
Numbers and Failure Rates for First-time and Repeating Candidates
NBDE Part II

Year	Accredited				Non-Accredited				Total	
	First-time		Repeating		First-time		Repeating		First-time and Repeating	
	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing
2002	4,226	7.2	591	31.0	1,649	33.8	798	54.9	7,264	20.4
2003*	4,124	8.0	542	32.1	1,255	33.3	860	58.5	6,781	21.0
2004	4,200	7.3	593	29.5	810	33.2	475	62.7	6,078	17.3
2005	4,042	4.7	487	25.9	641	27.9	380	56.3	5,550	12.9
2006	3,775	6.0	417	32.6	564	30.9	286	55.9	5,042	13.8
2007	4,464	6.4	405	26.2	755	26.9	337	55.2	5,961	13.1
2008	4,721	5.3	438	30.8	760	23.4	318	58.2	6,237	12.0
2009*	4,726	13.7	584	47.6	631	43.4	334	73.4	6,275	23.0
2010	4,945	10.6	1,154	20.1	701	38.9	391	54.0	7,191	17.2
2011	5,312	5.1	395	28.9	1,050	29.6	471	48.4	7,228	12.8

* A new standard was introduced this year, based on updated standard setting activities.

Figure 2. NBDE Part II Administrations (2002–2011)



NBDHE

Table 3 and Figure 3 present trends for the National Board Dental Hygiene Examination (NBDHE) over the past 10 years. As shown, the number of first-time candidates from accredited programs increased from 5,821 in 2002 to 6,968 in 2011 (i.e., a 20% increase). The total number of candidates from non-accredited programs was relatively small compared to the total number of candidates from accredited programs, representing approximately 9% of administrations occurring in 2002 and 3% of administrations occurring in 2011. Comparing the number of total administrations occurring in 2002 with 2011 shows an overall increase of 427 first-time and repeating candidates from accredited and non-accredited programs (i.e., a 6% increase).

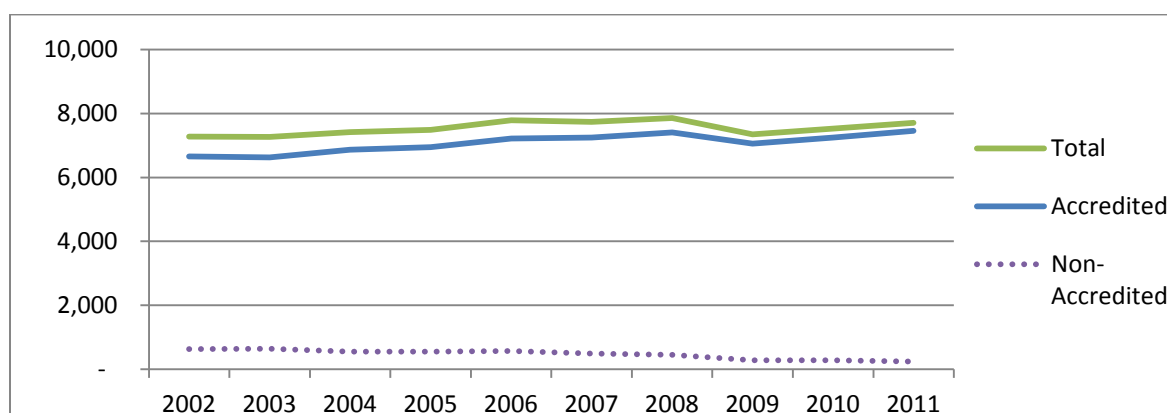
Failure rates were below 7% for all 10 years for first-time candidates from accredited programs. Failure rates for first-time candidates from non-accredited programs were substantially higher and less stable, ranging from 23.1% in 2010 to 67.3% in 2003.

TABLE 3
Numbers and Failure Rates for First-time and Repeating Candidates
NBDHE

Year	Accredited				Non-Accredited				Total	
	First-time		Repeating		First-time		Repeating		First-time and Repeating	
	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing
2002	5,821	6.5	830	56.1	358	65.1	269	78.1	7,278	17.7
2003*	5,890	5.0	735	62.6	349	67.3	292	77.4	7,266	16.7
2004	6,065	5.0	803	61.6	263	66.2	284	70.8	7,415	15.8
2005	6,136	5.6	805	57.3	237	63.3	312	77.6	7,490	16.0
2006	6,395	6.4	818	54.8	260	63.5	314	70.4	7,787	16.0
2007	6,680	4.0	569	49.2	252	50.4	239	76.2	7,740	11.0
2008	6,770	5.0	637	57.1	222	57.2	230	78.3	7,859	12.8
2009	6,708	4.2	351	55.0	170	31.8	115	72.2	7,344	8.3
2010	6,828	3.8	421	47.5	212	23.1	70	65.7	7,531	7.4
2011*	6,968	5.2	492	46.5	194	23.7	51	60.8	7,705	8.7

* A new standard was introduced this year, based on updated standard setting activities.

Figure 3. NBDHE Administrations (2002–2011)



Responses to House of Delegates Resolutions

The Joint Commission did not receive any resolutions from the House of Delegates this year.

Summary of Resolutions

This report is informational and no resolutions are presented.

Commission Minutes

For more information on recent activities, see the Joint Commission's minutes on ADA.org:
<https://www.ada.org/members/1293.aspx#examinations>.

Council on Scientific Affairs

Wright, J. Timothy, 2012, North Carolina, chair
Harrel, Stephen K., 2013, Texas, vice chair
Bruce, Daniel S., Idaho, *ex officio* *
Chalian, G. Garo, 2013, Colorado
Hart, Thomas C., 2015, Illinois
Hellstein, John W., 2012, Iowa
Michalowicz, Bryan S., 2014, Minnesota
Noraian, Kirk W., 2014, Illinois
Novy, Brian B., 2014, California
Plemons, Jacqueline M., 2013, Texas
Sauk, John J., 2012, Kentucky
Slavkin, Harold C., 2012, California
Sollecito, Thomas P., 2015, Pennsylvania
Streckfus, Charles F., 2012, Texas
Thompson, Geoffrey A., 2015, Wisconsin
Truelove, Edmond L., 2014, Washington
Whitaker, Steven B., 2013, Arkansas
Williams, Ray C., 2015, New York

Zentz, Ronald, senior director

The Council's 2011 liaisons included: Dr. Roger L. Kiesling (Eleventh District trustee, Board of Trustees); Dr. Pamela S. Ray (Council on Communications); and Mr. Trent Lally (American Student Dental Association).

Mission and Purpose

The ADA's Council on Scientific Affairs (CSA) serves the public, the dental profession and other health professions as the primary source of timely, relevant and emerging information on the science of dentistry and promotion of oral health. The CSA provides recommendations to the ADA's policymaking bodies on scientific issues. The Council also promotes, reviews, evaluates and conducts studies on scientific matters.

Supporting the Strategic Plan: Activities, Results and Accomplishments

Support Member Success

Council programs and activities "provide support to help dentists succeed and excel throughout their careers." As a learned profession, dentistry relies on scientific investigation, analysis and recommendations that are consistent with relevant, valid evidence to support excellence in clinical care. The Council improves member success by:

- Guiding the [ADA Center for Evidence-Based Dentistry](#) (EBD) in the development, review and dissemination of [evidence-based clinical recommendations](#);
- Awarding the [ADA Seal of Acceptance](#) for safety and effectiveness to over-the-counter (OTC) dental products;
- Publishing evaluations of professional dental products via the [ADA Professional Product Review](#);

* New Dentist Committee member without the power to vote.

- Authoring peer-reviewed journal reports, [policies and position statements](#), and providing oversight for online scientific resources for [professionals](#) and the [public](#); and
- Developing [dental standards](#) and [product evaluation guidelines](#).

Accomplishments: Examples of CSA's scientific support for the dental community in 2011-12 include:

- New [evidence-based clinical recommendations on non-fluoride caries preventive agents](#), such as chlorhexidine and polyol chewing gums (September 2011 *JADA*). To broadly disseminate the recommendations, an audio podcast by CSA Chair Dr. J. Timothy Wright was developed and posted on the [EBD website](#).
- New CSA advisory statement on cone beam computed tomography (CBCT) in dentistry, which was accepted for publication in *JADA* (anticipated in summer 2012). Developed in collaboration with dental agencies and other organizations, the CSA statement presents principles for the safe and appropriate use of CBCT imaging.
- Transitioning the [ADA Professional Product Review](#) (PPR) to a [digital magazine format](#), and the publication of quarterly [PPR executive summaries](#) in *JADA*.
- AAOS-ADA Collaborative Guideline: Prevention of Orthopedic Implant Infection in Patients Undergoing Dental Procedures (undergoing final review, expected publication in fall 2012).
- Revised CSA report on [Osteonecrosis of the Jaw Associated With Antiresorptive Therapy](#). The Council's Expert Panel on Antiresorptive Agents updated the 2008 CSA report. An [executive summary of the report](#) was featured in the November 2011 issue of *JADA*.
- The Council and the ADA Center for EBD are also pursuing the following evidence-based clinical recommendation topics: topical fluoride (update); periodontitis (new); and comparison of endodontic and implant therapies for single-tooth restorations (new).

Seal of Acceptance Program: The [Seal Program](#) helps dentists succeed in clinical practice by providing reliable information on safe and effective OTC oral health products to both the profession and the public. The Council is working to revitalize interest in the ADA Seal of Acceptance by more effectively communicating its value to consumers. In 2012, the Council launched a two-year pilot marketing plan to promote awareness of the program through dental offices to a target patient population. The plan relies on contributions of accepted products by companies participating in the Seal Program. The marketing plan is designed to reverse a gradual decline in industry participation and public awareness, which industry attributes to inadequate ADA promotion of the Seal. On the other hand, a separate survey of ADA members found that dentists considered the Seal Program to be the fourth most valuable member benefit. Implementation of the 2012 pilot plan is underway in collaboration with other internal agencies. The Council has proposed funding for the second year of the marketing plan through the 2013 budget process.

Standards Development: The Council supports ADA members by developing standards and technical reports for dental products and emerging technologies used in clinical practice. The [ADA's voluntary consensus standards program](#) generates standards for safe and effective dental products, and is accredited by the American National Standards Institute (ANSI). Recent standards developments include:

- *Co-Hosting the 2011 ISO/TC 106 Dentistry Meeting:* The ADA and Dental Trade Alliance co-hosted the 2011 ISO/TC 106 Dentistry meeting on behalf of ANSI. Nearly 300 delegates participated in the meeting on standards for orthodontic, restorative and prosthodontic materials, dental equipment and other areas.
- *New ISO/TC 106 Subcommittee 9 on Dental CAD/CAM Systems:* A new subcommittee on Dental CAD/CAM Systems was established to address the growing standards need. The ADA Standards Committee on Dental Products (SCDP) is developing seven draft technical reports in this field, which will address CAD/CAM implant abutments, surgical guides, CAD/CAM system interfaces, dental chairside system scanning accuracy and other topics.
- *SCDP Symposium on Digital Restorative Dentistry:* A 2012 symposium explored the evolving digital technology landscape, particularly with prosthodontic procedures. The use of CBCT to

develop 3-D models has expanded to fabrication of guides for dental implants, head and neck reconstructive surgery, and custom implant fabrication.

Trusted Resource for Oral Health Information

As a primary scientific resource for the profession, the Council keeps current with new scientific knowledge to develop evidence-based clinical recommendations, ADA policy recommendations, CSA reports and statements, a dental [research agenda](#), and other timely, clinically relevant information on critical and emerging issues. These CSA resources are designed to help dentists treat patients and respond to their questions on clinical situations and treatments.

EBD Website: Originally funded by a grant from the National Institute for Dental and Craniofacial Research, the ADA's all-purpose EBD website (<http://ebd.ada.org>) was launched in March 2009. The ADA has maintained and expanded the site through collaboration of the EBD Center, Information Technology department, the ADA Library and a committed group of volunteers. Since its debut, the EBD website has exceeded expectations based on the number of online visitors and other usage metrics. The website features the following:

- A [comprehensive online database](#) of over 1,900 systematic reviews;
- 167 critical summaries of systematic reviews prepared by ADA-trained evidence reviewers;
- A [patient-focused section](#) with plain-language summaries of systematic reviews; and
- A new ["Tutorials" section](#) that includes video tutorials on statistics (the EBD Center plans to develop tutorials with introductory EBD information and tips for using the EBD website).

ADA Evidence Reviewer Workshops: ADA Evidence Reviewers (AERs) write critical summaries of systematic reviews for the EBD website, and new AER volunteers are trained annually via workshops held at dental schools. This year, three ADA-funded workshops were held at Boston University, the University of Kentucky and the University of Iowa, and another will be held at the University of California, San Francisco, in September 2012. The ADA Center for EBD is also collaborating on a Canadian grant to offer three AER workshops in Canada in 2012-2013.

New and Updated CSA Statements and Reports: The Council targets a three-year cycle for reviewing CSA reports and statements. These documents may be updated at any time to integrate new scientific data or for other appropriate reasons. Council documents updated during this report cycle are presented below, with links to each statement or report.

Name of Statement/Report	Link to Statement/Report
Toothbrush Care: Cleaning, Storage and Replacement (<i>updated</i>)	http://www.ada.org/1887.aspx
Dental Unit Waterlines (<i>updated</i>)	http://www.ada.org/1856.aspx
Safety and Effectiveness of Tooth Whitening Products (<i>updated</i>)	http://www.ada.org/1902.aspx
Treatment of Patients With Infectious Diseases of Uncertain Transmission (<i>updated</i>)	http://www.ada.org/1858.aspx
CSA Advisory Committee Report on Antiresorptive Agent-Induced Osteonecrosis of the Jaws (<i>updated</i>)	http://www.ada.org/sections/professionalResources/pdfs/topics_ARONJ_report.pdf
CSA Advisory Statement on Cone Beam Computed Tomography in Dentistry (<i>new</i>)	Accepted for publication in <i>JADA</i> (anticipated in summer 2012)
Periodontal Disease and Atherosclerotic Vascular Disease: Does the Evidence Support an Independent Association? [<i>new</i> ; in collaboration with American Heart Association (AHA)]	http://circ.ahajournals.org/content/early/2012/04/18/CIR.0b013e31825719f3.full.pdf+html

Seal of Acceptance Program: Beginning in June 2012, the Seal Program will be prominently featured on the new ADA MouthHealthy consumer website, which is the first ADA initiative aimed at directly engaging and becoming the "go-to" reference for consumers.

PPR Collaborations: In March 2012, the [Professional Product Review \(PPR\)](#) editor invited the deans of all U.S. dental schools to explore potential collaborations with the PPR program. Discussions are underway with several schools to identify possible collaborative projects. Current PPR collaborations are listed below, and findings will be published in future issues:

- Disposable handpiece evaluation with the Department of Veterans Affairs and the military's Dental Evaluation and Consultation Service;
- Latex glove evaluation at A.T. Still University;
- Shade-matching studies at the University of the Pacific and Virginia Commonwealth University;
- A curing-light study at the Medical College of Georgia; and
- A disposable bib holder evaluation at Virginia Commonwealth University.

Guideline Development: To be awarded the Seal of Acceptance, companies must provide objective data from clinical and laboratory studies to demonstrate safety and effectiveness. The Council has developed specific [Acceptance Program guidelines](#) for a number of OTC product categories to provide direction to industry. Guidelines are intended to help companies understand and implement the types of studies that will be needed to support the safety and effectiveness of their product. In 2011-2012, the Council initiated a review of current ADA Acceptance Program guidelines as part of CSA's ongoing effort to revitalize the Seal Program. The goal of this process is to ensure that guidelines are current and scientifically sound, as well as practical and reasonable from an industry perspective. The desired outcome is a more relevant, growing program that meets the needs of all stakeholders. To date, the Council has revised 10 guidelines and more are under consideration.

Financial Stability

Restructured PPR Program: The Council is wrapping up transition of the ADA Professional Product Review from a stand-alone paper publication to a [digital PPR "flip" magazine](#) with an executive summary printed in *JADA*. Current and archived issues of PPR will continue to be available at www.ada.org/ppr. This innovative transition has produced significant cost savings. It also allows enhanced promotion in *JADA*, and indexing of PPR articles and author names in research databases.

Grant Support for EBD Programs: The ADA Center for EBD received partial grant support for the following programs:

- **EBD Champions Conference.** The primary goal of the [EBD Champions Conference](#) is to develop a network of dentists to promote the application of an evidence-based approach to patient treatment. A \$50,000 grant from the Agency for Healthcare Research and Quality helped to fund the 2012 EBD Champions Conference. Over 200 applications were submitted for 100 available spots at this year's course. The 2013 EBD Champions Conference is scheduled for April 25-27, 2013.
- **ADA/Forsyth EBD Course.** For 2012, the ADA received an educational grant from Sunstar Americas, Inc. to partially fund tuition for the weeklong [ADA/Forsyth EBD course](#), which will be held from November 5-9. The ADA Center for EBD and the Forsyth Institute (Boston) have collaborated to offer three successful EBD courses in Boston, each taught by faculty from the ADA, the Forsyth Institute, and the Oxford Centre for EBD, who provide training in critical appraisal of systematic reviews and clinical studies.

Emerging Issues and Trends

The Council addresses emerging professional issues that require response from the scientific community. Recent examples include:

- Completing a collaborative statement on safe and appropriate use of cone beam computed tomography, a rapidly evolving imaging modality and field of study;
- Updated CSA statement on dental unit waterlines to inform members of the first documented case of Legionnaire's disease that was associated with a contaminated dental unit waterline, and covered in the report in ["Science in the News" on ADA.org](#).

The Council also monitors the full spectrum of dental research, including caries risk evaluations of select human salivary mucin genes, image-guided systems for dental surgery, and innovations in tissue engineering and periodontal regeneration in order to inform dentists of their clinical implications.

Collaborative Guidance on Fluoride Toothpaste Use in Children

At its April 2012 meeting, the Council met with other oral health organizations to discuss the possible coordination and integration of consistent public messages on the use of fluoride toothpaste with very young children. Clarification of the public messaging is essential because dental caries remains a major public health concern and warrants re-assessment of current ADA recommendations. The Council agreed with representatives from the Centers for Disease Control and Prevention, American Academy of Pediatric Dentistry, and the Council on Access, Prevention and Interprofessional Relations to review the current literature and develop a draft recommendation and rationale on this topic for review and comment by internal and external agencies. The results or an update will be included in CSA's supplemental report to the 2012 House of Delegates.

Oral Fluid Screening and Salivary Diagnostics

Although marketed products are limited to date (drug tests, HIV and others), screening/diagnostic tests that use saliva and other oral fluids represent a potential shift in disease screening diagnosis. Investigators are advancing the technology via development of devices that can screen saliva samples for a broad range of proteins and other chemical markers at the point of care and perhaps at-home screening where appropriate. This technology may easily be adapted to use in the dental office. The CSA continues to track emerging research in this field.

Responses to House of Delegates Resolutions

41H-2011. ADA Scientific Review of Alternative Dental Workforce Models (Trans.2011:467)

The 2011 House of Delegates directed appropriate ADA agencies to conduct and report on a systematic review of the literature on non-dentist workforce models. The Council is the lead agency for this project, working with the ADA Center for EBD and collaborators to conduct the systematic review. The systematic review is in progress and will be delivered to the House with a subsequent report. With input from other councils, the CSA developed the following clinical question to be addressed in the systematic review:

In populations where non-dentists conduct diagnostic, treatment planning, and/or irreversible/surgical dental procedures, is there a change in disease increment, untreated dental disease, and/or cost-effectiveness of dental care?

The CSA established a systematic review workgroup that held a two-day meeting at the ADA headquarters, and also meets on alternating weeks by conference call. As of May 2012, the workgroup has:

- Developed inclusion/exclusion criteria and an extensive literature search strategy to identify all published research manuscripts addressing the clinical question;
- Searched 12 databases and screened over 4,900 abstracts and titles;
- Identified 404 citations targeted for full-text review;
- Developed criteria for data abstraction and critical appraisal;
- Hand-searched and screened relevant articles according to the inclusion criteria;
- Conducted critical appraisal and data abstraction of 46 articles that appeared to address the clinical question and meet the inclusion criteria.

The following describes the scope and quality of evidence undergoing detailed analysis:

- Eighteen articles met the inclusion criteria, and all had moderate or high risk of bias. None were of low risk of bias.
- Ten of the 18 articles above were published on or before 1976. Fluoride exposure, caries prevention and caries management were different during that time.
- There were two contemporary studies published between 2001 and 2012.

The workgroup has developed a first draft of the systematic review, and anticipates completing the project within the timeframe requested by the House. The remaining work includes: draft report development (through May 2012); internal/external peer review (May through August 2012); CSA review of the draft systematic review by e-ballot (August 2012); and submission of the final systematic review to the Board and House of Delegates (September 2012).

36H-2011. Development of a Policy Statement on Comparative Effectiveness Research (Trans.2011:455)

The Council provided substantive content to the [ADA's comments](#) on the Patient-Centered Outcomes Research Institute's (PCORI) preliminary research agenda, "[National Priorities for Research and Research Agenda](#)." As lead agency on comparative effectiveness research (CER), the Council will continue to proactively communicate the ADA's policy and perspective on CER/PCOR, focusing on the appropriate research design and application of CER/PCOR findings to improve the care of individual patients. In addition, the Council guides ADA CER/PCOR research endeavors, including grant applications. Although the ADA's first grant submission in collaboration with external researchers was unsuccessful, CSA will continue to identify and pursue grant opportunities as they arise.

71H-2010. Funding of Health Screening Program (Trans.2010:592)

Since 1962, the [Health Screening Program](#) (HSP) has supported ADA members by building an extensive longitudinal database on the occupational health and safety of dental professionals, which has been used to improve the safety of dental practice and inform important ADA advocacy efforts. Primary research conducted by HSP includes evaluation of bloodborne pathogen exposure, occupational exposure to chemicals, material hypersensitivities and assessment of nerve or musculoskeletal problems.

At the 2011 annual session, the Council implemented a re-engineered HSP in accordance with Resolution 71H-2010. The 2011 HSP was well-received by ADA members, drawing over 1,000 dentists, hygienists and assistants who participated in HSP medical screenings and research opportunities. At the 2011 HSP:

- The ADA obtained over \$277,000 in direct funding to offset ADA costs for HSP (e.g., corporate cash contributions and in-kind donations, plus an ADA Foundation grant);
- 400 dentists participated in point-of-service screenings for cholesterol and glucose, which showed how chairside screening can uncover potential health risks in patients;
- Only 6.97% of dentists showed serum antibodies indicating natural exposure to the hepatitis B virus (down from a level of 9.04% in 2007); and
- Just over 95% of dentists were vaccinated against HBV infection, up 2% from the 2007 HSP.

In addition, HSP scientists coauthored a February 2012 [Neurotoxicology](#) article that analyzed 10 years of HSP data from over 2,600 dentists, and found no stable significant correlation between dentists' urinary mercury and nerve conduction velocities in both the median and ulnar nerves. The HSP will be offered again in 2012.

67H-2011. Proposal to Realign Oversight of the Association's Evidence-Based Dentistry Activities (Trans.2011:483)

A new Interagency Subcommittee on Science and Research was established and met at the ADA in May 2012.

69H-2011. Reinstitution of the Subscription to the Cochrane Library (Trans.2011:467)

The subscription was reinstituted and funding is now included in the ADA Library expense budget.

Policy Review

Recommendations—Policies to be Amended

In accordance with Resolution 111H-2010, Regular Comprehensive Policy Review, the CSA reviewed a number of ADA policies in 2012. Draft revisions to each policy statement are presented in Appendices 1 and 2 of this annual report. The Council recommends that the following policies be amended.

The CSA reviewed the “Policy Statement on Evidence-Based Dentistry” and recommends that it be amended to reflect new developments, information and organizational changes.

52. Resolved, that the 2001 “Policy Statement on Evidence-Based Dentistry” (*Trans.2001:462*) be amended by deletion and addition as presented in Appendix 1 of this annual report.

The CSA reviewed the “Comprehensive Policy on Hazard Classification and Communication” and recommends that it be amended. The updated draft policy deletes directive language and clarifies that the ADA provides access to current information and resources to assist member dentists.

53. Resolved, that the “Comprehensive Policy on Hazard Classification and Communication” (*Trans.2003:389*) be amended by deletion and addition as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that it is the position of the American Dental Association that encourage its members, in an effort to promote a safe workplace, ~~to use~~ only those materials in the dental office that have been appropriately labeled by the manufacturer or distributor to comply with OSHA's Hazard Communication Standard and for which the manufacturer/distributor has supplied a current material safety data sheet (MSDS), and be it further

Resolved, that ~~the appropriate agencies of the ADA supports the continue to provide~~ members with updated by providing access to current information, forms and prototypes as needed to help them comply with ~~changes in~~ OSHA requirements affecting dental offices., ~~and be it further~~

Resolved, that ~~the American Dental Association requests all manufacturers and distributors of materials used in the dental office to abide by all relevant federal standards, guidelines and policies regarding the appropriate labeling of hazardous chemicals and the provision of current MSDSs, and be it further~~

Resolved, that ~~the American Dental Association inform its members of their right to report to OSHA the names of any manufacturer or distributor that fails to properly label its product or fails to provide a MSDS to the dentist as required by OSHA, and be it further~~

Resolved, that ~~those companies that fail to comply with the labeling and MSDS requirements of the OSHA Hazard Communication Standard, and who seek the ADA Seal of Acceptance for the product, be denied such Acceptance, and be it further~~

Resolved, that the following Association policies be rescinded:

~~Prototype Hazard Communication Program (Trans.1987:492)~~
~~Hazard Communication Standard Compliance (Trans.1993:718)~~
~~Dental Product Labeling to Satisfy OSHA Requirements (Trans.1992:645)~~
~~Labeling Requirements for Manufacturers of Dental Products (Trans.1992:645)~~
~~Material Safety Data Sheets (Trans.1989:569;1993:715)~~

The CSA reviewed the “Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting” and recommends that it be amended to reflect new information and remove unnecessary content on oral piercing procedures.

54. Resolved, that the “Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting” (Trans.1998:743; 2000:481; 2004:309) be amended by deletion and addition as presented in Appendix 2 of this annual report.

Recommendations—Policies to be Rescinded

The CSA reviewed the 2004 ADA policy “Fluoride Varnishes,” presented in Appendix 3, and recommends rescission. The ADA currently supports the use of fluoride varnish through CSA’s evidence-based clinical recommendations on professionally applied topical fluoride, developed with the EBD Center and published in *JADA*. Therefore, the policy is not necessary. The ADA encouraged the FDA to approve fluoride varnish for caries prevention in this policy. The CSA and others have investigated and, per FDA regulations, approval of this indication requires approval of a manufacturer-submitted new drug application. The FDA cannot act independently on this or any approval. The following resolution is presented for the House’s consideration:

55. Resolved, that the ADA policy entitled “Fluoride Varnishes” (Trans.2004:311) be rescinded.

The Council also reviewed the 1999 ADA policy “HIV/AIDS as an Infectious and Communicable Disease,” presented in Appendix 3, and recommends rescission for this policy. HIV is universally recognized as a bloodborne pathogen, and prevention of HIV transmission is covered in the 2003 CDC recommendations for infection control and OSHA’s bloodborne pathogen standard. HIV/AIDS is also covered in other ADA policies addressing treatment of HIV-positive patients in the dental office, such as the Policy on Bloodborne Pathogens, Infection Control and the Practice of Dentistry, which addresses the classification of bloodborne pathogens (HIV, HBV, HCV, others). Ethical perspectives regarding the treatment of patients with HIV/AIDS are also addressed in the *ADA Principles of Ethics and Code of Professional Conduct*. Given these and other considerations, the Council presents the following draft resolution to rescind the 1999 HIV/AIDS policy, which is redundant with the 2003 ADA Bloodborne Pathogens policy and other ADA resources.

56. Resolved, that the ADA policy statement entitled “HIV/AIDS as an Infectious and Communicable Disease” (Trans.1996:734; 1999:977) be rescinded.

Summary of Resolutions

Resolution 52. Amendment of the Policy Statement on Evidence-Based Dentistry
 Resolution 53. Amendment of the Comprehensive Policy on Hazard Classification and Communication
 Resolution 54. Amendment of the Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting
 Resolution 55. Rescission of the Policy, Fluoride Varnishes
 Resolution 56. Rescission of the Policy Statement on HIV/AIDS as an Infectious and Communicable Disease

Council Minutes

For more information on recent activities, see the Council’s minutes on ADA.org:
<https://www.ada.org/members/1293.aspx#scientific>

Appendix 1.

Policy Statement on Evidence-Based Dentistry (Trans.2001:462)

The Council recommends that the below policy be amended by deletion and addition as follows (additions are underscored; deletions are ~~stricken~~).

Introduction: Dentistry has evolved as a profession that has uniquely and successfully combined science with the art of healing. Building on this foundation, the dental profession has maintained a strong commitment to sound science, public service and an ethical obligation to protect the patient's health.

Over the last few decades, a process for reviewing scientific evidence emerged in medicine and other health fields that relies on systematic approaches to summarize the large volume of literature that health care providers need to assimilate into clinical practice. With rapidly evolving science and technology, dentistry has also faced the complex demands of integrating and effectively implementing changes in treatment modalities that can arise from new scientific evidence.

To address these challenges, the dental profession has endorsed an evidence-based approach to clinical practice and oral health care, which is commonly known as evidence-based dentistry (EBD). The American Dental Association (ADA) continues to pursue a leadership role in the field of EBD to help clinicians interpret and apply the best available evidence in everyday practice.

~~The American Dental Association (ADA) has a long history of identifying and supporting scientific advances in dentistry. During the 20th century, the ADA emerged as the leading dental organization in the world, and, by 1930, established rigorous guidelines for testing and advertising of dental products. The Association, through the Council on Scientific Affairs' Seal of Acceptance Program, continues to provide practitioners and consumers with information on safe, effective dental materials, devices and therapeutic agents. The Council's actions are based upon available scientific evidence and are subject to reconsideration at any time that significant new evidence becomes available. The Association also relies on available scientific evidence in its commitment to using credible scientific data and analyses in policymaking, and its communications with the dental profession and the public.~~

~~During the 1990s, a new process for reviewing scientific evidence emerged in medicine and other health fields that relies on systematic approaches to summarize the large volume of literature that health care providers need to assimilate into their practices. Since health care providers do not have the time to read the thousands of articles published each year, the "evidence-based medicine" (EBM) process uses a systematic approach to review and publish the evidence relevant to specific clinical questions.~~

Definition of Evidence-Based Dentistry: The ~~ADA~~American Dental Association defines the term "evidence-based dentistry" as follows:

Evidence-based dentistry ~~(EBD)~~ is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences. (*Trans. 2001:462*)

In adopting this definition for EBD, the ADA recognizes that treatment recommendations should be determined for each patient by his or her dentist, and that patient preferences should be considered in all decisions. Dentist experience and other circumstances, such as patients' characteristics, should also be considered in treatment planning. EBD does not provide a "cookbook" that dentists must follow, nor does it establish a standard of care. The EBD process must not be used to interfere in the dentist/patient relationship, nor is it to be

used solely as a cost-containment tool by third-party payers.

Elements of the EBD Process

The EBD process is not a rigid methodological evaluation of scientific evidence that dictates what practitioners should or should not do. Rather, the EBD process is based on integrating the scientific basis for clinical care, using thorough, unbiased reviews and the best available scientific evidence at any one time, with clinical and patient factors to make the best possible decision(s) about appropriate health care for specific clinical circumstances. EBD relies on the role of individual professional judgment in this process.

The EBD process consists of four steps. The first step is to define a clinically relevant and focused question in the interest of finding the best available evidence to promote the oral health of patients. "Best evidence" is a term that refers to information obtained from randomized controlled clinical trials, non-randomized controlled clinical trials, cohort studies, case-control studies, crossover studies, cross-sectional studies, case studies, or the consensus opinion of experts in appropriate fields of research or clinical practice.

The second step focuses on systematically conducting searches for all studies and databases, published or unpublished, that may help to answer a clinically relevant question. After selecting, summarizing, and synthesizing all relevant studies that directly answer the focused clinical question, the strength of the available scientific evidence is graded using predefined criteria, and qualitative or quantitative analyses are conducted. Conclusions on the quality and strength of evidence are made, and gaps in the knowledge base that require further research are identified.

The third step of the EBD process is focused on translating the findings from systematic reviews for use by practitioners.

The final step of the EBD process involves assessing the health care outcomes following the findings of the previously outlined steps. This evaluation is conducted as part of the outcome assessment that health care providers integrate into their practices. This four-step process aims to help practitioners make the best-informed decisions with their patients.

ADA Center for Evidence-Based Dentistry: The Association supports the concept of evidence-based dentistry developed through systematic examination of the best available scientific data, and will use this information to help shape the Association's Research Agenda. As such, the Association envisions developing clinical questions, setting protocols for systematic reviews, working with collaborative groups to conduct systematic reviews, critically appraising the reviews and policies developed by other organizations, and developing mechanisms for translating and disseminating information to the membership. In 2007, the Association established the ADA Center for Evidence-Based Dentistry to provide leadership in implementing ADA programs and initiatives related to EBD.

To realize its vision of disseminating the best available evidence and helping practitioners implement EBD, the ADA Center for Evidence-Based Dentistry works in collaboration with the Council on Scientific Affairs to convene expert panels that review the collective research evidence and develop evidence-based recommendations on key clinical issues. The Association will continue developing evidence-based clinical recommendations and working with collaborative groups to conduct systematic reviews, critically appraising the reviews and policies developed by other organizations, and developing mechanisms for translating and disseminating information to the membership.

Practicing Evidence-Based Dentistry: The goal of the EBM/EBD process is to help practitioners provide the best care for their patients. This process uses clinical and methodological experts to synthesize all of the evidence relative to a defined "question of interest." This information from and is published as a systematic review and then made available to practitioners for integration. The evidence is integrated with their clinical experience and other factors relevant to specific patient needs and preferences. This characteristic of the

~~EBM~~ **EBD** process is clearly explained in the classical definition of evidence-based medicine as “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research” (Sackett DL, Rosenberg WMC, Gray JAM, Haynes RB, Richardson WS. 1996. Evidence based medicine: what it is and what it isn't. *BMJ* 312: 71–2, Sackett D, et al. <http://cebm.ir2.ox.ac.uk/ebmisnt.html#coredef>). Simply stated, evidence-based medicine is “the integration of the best research evidence with clinical expertise and patient values” (Sackett et al. Evidence-based Medicine. New York: Churchill Livingstone; 2000). Though this process was originally developed in medicine, its principles apply to all health care fields, including dentistry, and they are followed rigorously by the ADA Center for EBD.

The ~~EBD~~ process is time-consuming and thorough. The current approach in medicine and other health care fields is to rely on collaborative networks of experts in systematic review methods, statisticians, clinicians and funding agencies to conduct systematic reviews that can be used by professional associations or organizations. Currently there are collaborative research networks that conduct systematic reviews (e.g., the Cochrane Collaboration; Evidence-based Practice Centers (EPCs), funded by the U.S. Agency for Healthcare Research and Quality (AHRQ); and the University of York National Health Service (NHS) Centre for Reviews and Dissemination (CRD)). In the AHRQ-sponsored reviews, it is required that health care organizations (such as the ADA) play an active role in defining the questions for review and in evaluating the research findings. The ADA may elect to collaborate with these large networks of reviewers to conduct systematic reviews of clinically relevant questions.

The Role of the ADA in the EBD Process: The Association supports the concept of evidence-based dentistry developed through systematic examination of the best available scientific data, and will use this information to help shape the Association's Research Agenda. As such, the Association envisions developing clinical questions, setting protocols for systematic reviews, working with collaborative groups to conduct systematic reviews, critically appraising the reviews and policies developed by other organizations, and developing mechanisms for translating and disseminating information to the membership.

EBD Resources: Detailed information on EBD, evidence-based clinical recommendations, systematic reviews, critical summaries of systematic reviews, EBD terminology, courses/workshops and other resources are available at the website of the ADA Center of Evidence-Based Dentistry (<http://ebd.ada.org/>). Concise, user-friendly EBD resources from the ADA Center for EBD and other organizations are useful informational resources that can assist practitioners with integrating the best available evidence with clinical expertise and the needs and preferences of the individual dental patient.

Glossary of Terms Relating to Evidence-based Dentistry²

This glossary is designed to assist dental professionals and public policymakers in developing a common language for discussion of issues pertaining to evidence-based dental care.

Best evidence is a term that refers to information obtained from randomized controlled clinical trials, non-randomized controlled clinical trials, cohort studies, case-control studies, crossover studies, cross-sectional studies, case studies or, in the absence of scientific evidence, the consensus opinion of experts in the appropriate fields of research or clinical practice. The strength of the evidence follows the order of the studies or opinions listed above.

² Some of the definitions are based on information provided in the glossary of the NHS Research and Development Centre for Evidence-based Medicine (<http://cebm.ir2.ox.ac.uk/docs/glossary.html>).

Case-control study involves identifying subjects with a clinical condition (cases) and subjects free from the condition (controls), and investigating if the two groups have similar or different exposures to risk indicator(s) or factor(s) associated with the disease.

Case-series is a report on a series of patients with an outcome of interest. No control group is involved.

Clinical practice guideline (parameter of care) is a systematically developed statement designed to assist both practitioner and patient with decisions about appropriate health care for specific clinical circumstances.

Clinical protocol is a step-by-step decision-making tool that describes how a health condition is diagnosed and managed.

Cohort study involves identifying two groups (cohorts) of subjects, one that did receive the exposure of interest and another that did not, and following these cohorts forward for the outcome of interest.

Controlled clinical trial is a study that uses the same design features of a randomized controlled clinical trial (see definition below), but, for reasons beyond the control of the investigators, the subjects are assigned using a non-random process into control or experimental groups.

Crossover study design is the administration of two or more experimental therapies, one after the other in a specified or random order, to the same group of patients.

Cross-sectional study is the observation of a defined population at a single point in time or in a specified time interval. Exposure and outcome are determined simultaneously.

Evidence-based dentistry is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences.

Evidence-based health care extends the application of the principles of evidence-based medicine (see below) to all professions associated with health care, including purchasing and management.

Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

Meta-analysis is a review that uses quantitative methods to combine the statistical measures from two or more studies and generates a weighted average of the effect of an intervention, degree of association between a risk factor and a disease, or accuracy of a diagnostic test.

Probability of success is a ratio of the number of patients who benefit from an intervention to all those who receive an intervention. A probability figure, such as 0.5 or 50%, means that out of 100 patients, 50 would benefit from an intervention and 50 would not benefit. Neither the dentist nor the patient can determine beforehand to which of the two groups a patient will belong.

Randomized controlled clinical trial is a study that randomizes a group of subjects into an experimental group and a control group. The experimental group receives the new intervention and the control group receives a placebo or standard intervention. These groups are followed up for the outcomes of interest.

Systematic review is a process of systematically locating, appraising and synthesizing evidence from scientific studies in order to obtain a reliable overview. The aim is to ensure a review process

~~that is comprehensive and unbiased. Findings from systematic reviews may be used for decision-making about research and the provision of health care.~~

Appendix 2.

Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting

(Trans.1998:743; 2000:481; 2004:309)

The Council recommends that the below policy be amended by deletion and addition as follows (additions are underscored; deletions are ~~stricken~~).

Introduction

~~Piercing and tongue splitting is becoming a more prevalent~~ are forms of body art and self-expression in today's society. However, oral piercings, which involve the tongue (the most common site),¹⁻³ lips, cheeks, uvula or a combination of sites, ~~and tongue splitting have been implicated in~~ can be associated with a number of adverse oral and systemic conditions.

~~Patients typically undergo piercing procedures without anesthetic. In tongue piercing, for example, a barbell-shaped piece of jewelry typically is placed to transverse the thickness of the tongue at the midline in its anterior one-third using a needle. Initially, a temporary device longer than the jewelry of choice is placed to accommodate postpiercing swelling. The free end of the barbell stem then is inserted into the hole in a ventral-dorsal direction. The recipient grasps the free end of the shank between the maxillary and mandibular anterior teeth and screws the ball onto the stem. The barbell also can be placed laterally, with the studs on the dorsolateral lingual surface. In the absence of complications, healing takes four to six weeks.~~

~~Tongue splitting is considered by some to be a form of body art. The process literally splits a person's tongue into two pieces, creating a "forked" appearance. Reports in the public press indicate that various primitive techniques are used by lay people for splitting tongues. For example, without anesthesia, a scalpel may be used followed by a cauterizing pen, or fishing line may be threaded through the pierced tongue and pulled forward, severing the anterior aspect. Individuals regularly pull the two tongue pieces apart to maintain the split so it does not "heal" back together. Once healed, additional surgery may be required to repair the "split" should the individual decide reversal is desired.~~

~~In lip or cheek piercing, jewelry position (usually a labrette) is determined primarily by aesthetics with consideration to where the jewelry will rest intraorally. Once position is determined, a cork is usually placed inside the mouth to support the tissue as it is pierced with a needle. The needle is inserted through the tissue and into the cork backing. The needle then is replaced with the labrette stud, and the disc backing is screwed into place. Healing time can range from weeks to months.~~

~~Common symptoms following~~ As with any puncture wound or incision, piercing and tongue splitting can cause ~~include~~ pain,³⁻⁵ swelling,²⁻⁶ and infection ~~and increased salivary flow.~~^{4,5,7} Potential complications of intraoral and perioral piercings specifically are numerous, although available scientific literature is rather limited and consists mainly of case reports. Possible adverse outcomes secondary to oral piercing include increased salivary flow;^{5,8} gingival injury or recession,^{2,6,9-13} damage to teeth,^{1,2,5,6,14} restorations and fixed porcelain prostheses; interference with speech,^{1,3,4} mastication^{3,4} or deglutition;⁴ scar-tissue formation;⁸ and development of metal hypersensitivities.^{15,16} Because of the tongue's vascular nature, prolonged bleeding can result if vessels are punctured during the piercing procedure.¹⁷ In addition, the technique for inserting tongue jewelry may abrade or fracture anterior dentition,^{1,2,5,7,14} and digital manipulation of the jewelry can significantly increase the potential for infection.⁴⁻⁷ Airway obstruction due to pronounced edema²⁻⁵ or aspiration of jewelry poses another risk, and aspirated or ingested jewelry could present a hazard to respiratory or digestive organs.^{3,6} In addition, oral ornaments can compromise dental diagnosis by obscuring anatomy and defects in radiographs. There have been reports of the jewelry becoming embedded in surrounding tissue, requiring surgical removal.^{6,9} It also has been speculated that galvanic currents from stainless-steel oral jewelry in contact with other intraoral metals could result in pulpal sensitivity.¹⁸

Secondary infection from oral piercing can be serious. The National Institutes of Health has identified piercing has been identified as a possible vector for bloodborne hepatitis (hepatitis B, C, D and G) transmission.^{19,20} Disease transmission (e.g., hepatitis B, tetanus, localized tuberculosis) has been associated with ear pierce. Cases of endocarditis also have been linked to oral piercing.^{21,22} Secondary infection from oral piercing can be serious. In addition, the recent *British Dental Journal* reported a case of Ludwig's angina, a rapidly spreading cellulitis involving the submandibular, sublingual and submental fascial spaces bilaterally, that manifested four days after a 25-year-old patient had her tongue pierced.²³ Intubation was necessary to secure the airway. When antibiotic therapy failed to resolve the condition, surgical intervention was required to remove the barbell-shaped jewelry and decompress the swelling in the floor of the mouth. In another case, a healthy 19-year-old woman contracted herpes simplex virus, presumably through a recent tongue piercing. The infection progressed to fulminant hepatitis and subsequent death.²⁴

Although reports describing the morbidity and mortality associated with tongue splitting are currently not available in the literature, the risk of complications secondary to surgical procedures (including pain, swelling and infection) is well known. Therefore, the Association recommends that its members discourage patients who request the procedure by educating them of the risks associated with this surgery.

Because of its potential for numerous negative sequelae, the American Dental Association opposes the practice of intraoral/perioral piercing and tongue splitting.

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**Appendix 3. Policies to be Rescinded
As Recommended by the Council on Scientific Affairs**

Fluoride Varnishes (*Trans.2004:311*)

Resolved, that the ADA supports the use of fluoride varnishes as safe and efficacious within a caries prevention program that includes caries diagnosis, risk assessment, and regular dental care, and be it further

Resolved, that the ADA encourages the FDA to consider approving professionally applied fluoride varnish for reducing dental caries, based on the substantial amount of available data supporting the safety and effectiveness of this indication.

Policy Statement on HIV/AIDS as an Infectious and Communicable Disease (*Trans.1996:734; 1999:977*)

Resolved, that the American Dental Association take every appropriate opportunity to publicly state the current ADA policy which supports the classification of HIV (AIDS) as an infectious and communicable disease.

ADA Business
Enterprises, Inc.

Notes

ADA Business Enterprises, Inc.

Wholly Owned Subsidiary Annual Report and Financial Affairs

Mercer, James, 2012, South Carolina, chairman
Faiella, Robert, 2012, Massachusetts*
Kiesling, Roger, 2012, Montana
Kolman, Paul, 2012, Indiana
Kunik, Burton, 2012, Texas
Meckler, Edward, 2012, Ohio

Mission and Purpose

ADA Business Enterprises, Inc. (ADABEL) is a wholly-owned subsidiary of the American Dental Association ("Association"). ADABEL's primary mission is to enhance the value of Association membership by providing a broad range of endorsed products and services from industry-leading providers. ADABEL endorses best-in-category products and services useful to ADA member dentists to help them succeed throughout their careers. The ADABEL program typically features special benefits, discounted pricing and increased customer service levels. In return, ADABEL receives a service fee for providing marketing services, program management and other services. As part of the program, the ADA also receives non-dues royalty revenue from licensing its name, logo and list to the endorsed providers. In addition, many of the state dental societies often co-endorse specific products and services and receive a share of program revenue.

For 2011, ADABEL's core business objectives were to continue steady growth and improvements preparing for the full, newly elected ADABEL Board of Directors to set new, long-term strategic direction. ADABEL's short-term operational goals included:

1. Meet the combined program revenue and expense goals
2. Provide non-dues revenue to the ADA
3. Manage endorsed providers to assist them in meeting their sales and revenue goals
4. Create member value by increasing program awareness and usage
5. Maintain and enhance the reputation of ADABEL and the ADA Business Resources brand

Supporting the Strategic Plan: Activities, Results and Accomplishments

Summary

ADABEL finished 2011 with net income positive to budget by \$407,363, driven in large part by the strong revenue performance of the financial products and lower than planned ADABEL expenses for marketing, compensation and travel.

Table 1. 2011 ADABEL Financials

	2011 Actuals (Unaudited)	2011 Budget	Variance (\$)	Variance (%)
ADABEL Revenue**	\$2,436,829	\$2,316,486	\$120,343	5.0
Expense	\$1,505,245	\$1,792,265	\$287,020	16.0
Net	\$931,584	\$524,221	\$407,363	77.7

** Revenue data is unaudited and subject to change.

* Past chairman, non-voting consultant.

At mid-year, ADABEI added its first product, business computers with Hewlett Packard, since 2009. Additionally, ADABEI reached contract renewal agreements with three companies: FedEx, Whirlpool and CareCredit. On the state dental side of business, ADABEI renewed 36 state license agreements, beginning in March 2011 and extending through March 2014.

Products

In 2011, the program included 14 products and services from 12 providers:

- Credit Card—U.S. Bank
- Credit Card Processing—Chase Paymentech, LP
- Patient Financing—CareCredit, LLC
- Practice Financing & Commercial Real Estate—Wells Fargo Practice Finance
- Payroll Services—SurePayroll, Inc.
- Message on Hold and Appointment Reminders—InTouch Practice Communications
- Staff Apparel—Lands' End Business Outfitters, Inc.
- Health Savings Accounts—Msaver Resources, LLC
- Digital & Paper Patient Charts—The Dental Record
- Shipping—FedEx and Meridian One Corporation
- Appliances—Whirlpool VIP Program and Meridian One Corporation
- Computers—Hewlett Packard and Meridian One Corporation

Marketing

Members are able to learn about the program through mail and email channels, and to access the many products and services via:

- The toll-free number, 800-ADA-2308
- The website, www.adabusinessresources.com

In 2011, ADABEI made more than 5,000,000 impressions in the dental community through various marketing channels, including direct mail, ADA News advertisements, email newsletters and the website.

ADABEI Program Revenue

ADABEI program revenue is unaudited and subject to change. In 2011, ADABEI earned \$2,436,829 in gross revenue as a result of service fees to ADABEI from the program—5.0% above the budget of \$2,316,486.

The majority of products in the program continued solid growth in 2011, building on a strong recovery in the second half of 2010. In addition, ADABEI expenses were lower than planned for marketing, compensation and travel.

The 12 months (July 2010 through June 2011) leading up to the 2012 budget development showed signs of improvement and economic conditions continued to trend positively. Therefore, the 2012 ADABEI budget was built to show solid but modest growth. For the first quarter of 2012, ADABEI earned a total of \$541,112 from program service fees, which was equal to budget.

ADA

In 2011, \$3,128,383 was earned as a result of royalties to the ADA from endorsed providers in the program. For the first quarter of 2012, a total of \$783,642 was earned as a result of royalties to the ADA from endorsed providers in the program.

State dental societies may choose to co-endorse products and services and share in program revenue through a license agreement. In 2011, the ADA paid more than \$480,000 in royalties to state dental

societies, the majority of which was contributed by the endorsements of the credit card with U.S. Bank, credit card processing with Chase Paymentech, and patient financing with CareCredit, LLC.

Governance

The newly formed ADABEI Board of Directors met for the first time in November 2011. The outgoing chairman, Dr. Robert Faiella, led the meeting and discussions regarding the state of the business, strategic direction, company operations and financials. At the conclusion, Dr. James Mercer was nominated and approved as the new chairman of the Board.

The new Board of Directors will be working to develop ADABEI's strategic direction, continue new product development, and grow existing products and value for ADA members. The ADABEI Board met again in March 2012 and began the discussion concerning longer-term strategic direction.

Emerging Issues and Trends

In addition to the three providers that renewed agreements in 2011—CareCredit (patient financing), FedEx (shipping) and Whirlpool (appliances)—ADABEI continues to receive strong interest from prospective companies to become endorsed providers of the program. ADABEI also surveys ADA members to stay current with emerging business trends and needs in the dental community.

New and Renewed Contracts

CareCredit: CareCredit is the market leader, providing patient financing to over 90,000 dentists. The CareCredit program with ADABEI began in March of 2001, renewed in 2004 and 2007, and again in 2011.

Whirlpool: Added in October 2009, the Whirlpool program includes appliances from industry-leading brands such as KitchenAid®, Maytag®, Amana®, Gladiator® and Jenn-Air®, for home and office, and continues to be popular among ADA members. The agreement was renewed for two years.

FedEx: The FedEx program was renewed for three years beginning in September 2011. It includes shipping and FedEx Office (i.e. copy and print services) and has been used by more than 5,000 ADA members. On average, ADA members saved 23% on FedEx services in the program.

Hewlett Packard: The new endorsement, HP for computers, was added in August 2011. In 2010, ADABEI conducted a survey of ADA members to evaluate member interest in a potential new endorsement of computer equipment. The key results of the survey included:

- 94.7% reported information technology is important to their practice
- Desktops are vastly more used than laptops in practices
- 73% use Hewlett Packard in practices
- 65% planned on adding new equipment over the next 24-36 months

Hewlett Packard is the world's largest technology company and a leading, global provider of products, technologies, software, solutions and services. Its customers are individual consumers, small and medium-sized businesses and large enterprises—including customers in the government, health and education sectors.

New Products

All new products and providers are researched to ensure they are industry leaders, solid financially, solve a member need and hold a higher service standard. They must offer preferred pricing for ADA members and all providers are monitored to make sure they deliver what they promise to members. In 2011, more than 80 companies were reviewed for program fit.

In 2011, an email survey was conducted with more than 1,400 respondents in regards to the ADA Business Resources brand and new product development. In terms of the ADA Business Resources brand, the key attributes reported to be most valued by members include:

- ADA Business Resources will stand behind the Program and act as my advocate (71%)
- ADA Business Resources holds each provider to a higher service standard (67.5%)
- ADA Business Resources has screened each provider for industry leadership and financial soundness (67%)
- Exclusive member pricing (66.5%)

These reported features will help set direction for analyzing ongoing program fit as well messaging to members.

The survey was also used to gauge member interest in specific new products which will be used, in conjunction with the Board of Directors' strategic plan, to set the priority for ADABEL's new product development in 2012.

Summary of Resolutions

This report is informational and no resolutions are presented.

Links

For complete ADABEL program information, see www.adabusinessresources.com.

ADA Foundation

Notes

ADA Foundation

David A. Whiston, 2012, Virginia, president
Pamela Zarkowski, 2014, Michigan, vice president of programs
Michael P. Rethman, 2012, Hawaii, vice president of scientific research
Richard A. Simms, 2012, California, vice president of development
Ronald Szarzynski, 2012, Minnesota, vice president of finance

Ronald D. Bushick, 2015, Pennsylvania
Paul D. Chibe, 2014, Missouri
Ernest L. Garcia, Jr., 2013, California
Steven Gounardes, 2014, New York
Jane S. Grover, 2012, Michigan
Pam Hemmen, 2012, Illinois
Charles H. Norman, 2012, North Carolina
Fotinos S. Panagakos, 2012, New Jersey
Michele Penrose, 2012, New York
Candy B. Ross, 2015, Georgia
Leo E. Rouse, 2013, Maryland
Donald L. Seago, 2013, Mississippi
Charles L. Smith, 2013, West Virginia
Lewis C. Walker, 2015, Florida
J. Leslie Winston, 2015, Ohio
Gary S. Yonemoto, 2015, Hawaii

Gene Wurth, executive director
Cynthia Fronczak, chief financial officer
Cristina Garcia, grants program coordinator
Walter Rabianski, senior accountant
Shirley Watson, manager, administrative services

Gary Schumacher, director, administration, Paffenbarger Research Center
Drago Skrtic, director, research, Paffenbarger Research Center

Mission and Purpose

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.

Supporting the Strategic Plan: Activities, Results and Accomplishments

Corrective Action Plan

At this time last year, the ADA Foundation was undergoing significant change. There was a great deal of staff turnover, a Board-imposed fundraising moratorium in place, challenges regarding the timely completion of its financial audit and its federal tax returns, an open review of its federal grants under an A133 audit, and an ongoing review of its operations by the Illinois Attorney General. In the past year, the Foundation has made tremendous progress and all of the foregoing issues have been resolved (as outlined below).

Financial Matters

The 2011 audit of the ADA Foundation has been completed by KPMG, and KPMG presented its report to the ADA Audit Committee in a conference call on May 14. The auditors reported that the Foundation had

a “clean” audit and that it had achieved a significant milestone with the accelerated timing of the 2011 audit. In addition, KPMG complimented ADAF staff for their cooperation and the completeness of their work product. KPMG concluded its presentation by reporting that KPMG would not be issuing a separate management letter for the Foundation in light of the unqualified opinion. KPMG also reported that there were no audit or post-closing adjustments and no uncorrected misstatements for 2011, and that all prior year control deficiencies were fully remediated and not repeated in the current year. Similar compliance control deficiencies had also been remedied with respect to the A-133 single audit report.

In addition, the ADA Foundation tax return (Form 990) was completed by KPMG on May 15, which was the original target date, and several months earlier than years past.

Regular financial reports have been reformatted and improved, and the Foundation has formed a new Investment Committee to help oversee invested assets.

The Illinois Attorney General has received all materials which it requested, materials which demonstrated that all of the administrative and financial protocols and processes have been properly documented and followed. A formal training program for the Foundation Board to address the fiduciary duties of directors was completed in March 2012. The Illinois Attorney General’s office has indicated by telephone conversation that the file has now been closed satisfactorily.

ADA Foundation Grants

From July 2011 to June 1, 2012, the ADA Foundation made grants and awards totaling nearly \$1.2 million, including nearly \$540,000 for a variety of ADA programs, such as Give Kids A Smile.

Scholarships and Awards: In the past year, the Foundation has awarded \$135,000 in scholarships for dental students (in four categories) and \$19,000 for allied dental health professionals (in three categories). Recently the Grants Committee also approved another \$130,000 for dental student scholarships and an additional \$11,000 in allied dental health scholarships to be paid in the coming months. The Foundation has also issued more than 30 grants under our Harris Awards program and two Tarrson Awards. There has been a commitment from Dr. Richard Simms to create a new award, to be named the Dr. Thomas Zwemer Award. It will be similar to the existing Tarrson Awards, which recognize outstanding student-organized programs to provide oral health services to underserved communities. While the Tarrson Awards focus on programs that help those in the U.S., the Zwemer Awards will address international communities in need.

Grants: Since July 1, 2011, the ADA Foundation has awarded grants totaling \$75,000 for financial assistance to dentists and/or their families, and more than \$207,000 for disaster assistance.

Paffenbarger Research Center

Following an extensive search for a new director for the Paffenbarger Research Center (PRC), the Foundation decided to appoint two long-time staff members to co-director positions. Dr. Gary Schumacher is the new director, administration, and Dr. Drago Skrtic is the director, research. This arrangement results in significant financial savings, while allowing the work of PRC to continue without interruption. The Foundation is also actively seeking new researchers to join the staff there to expand research efforts and to help secure new funding.

The Paffenbarger Research Center conducted its 48th Annual Dental Students Conference on Research at its facility in Gaithersburg, Maryland from April 15-17. Forty-one students from dental schools across the United States and Canada attended the program. On Monday morning they attended a panel presentation of several speakers representing PRC, Howard University, the National Institute of Standards and Technology (NIST) and the International Association for Dental Research/American Association for Dental Research (IADR/AADR), who discussed career options in oral health research. After lunch students got a tour of the facilities at PRC and had a chance to talk to the researchers there. Later in the day, 21 students presented their own poster demonstrations in the facility where they were

able to talk with other students, research staff at PRC, and staff from NIST. On Tuesday morning the students attended a half-day program at the National Institute for Dental and Craniofacial Research (NIDCR) where they were welcomed by Dr. Isabel Garcia and several other top administrators of NIDCR who also spoke about career opportunities in research at NIH. Students had a tour of the NIH research facilities and had the opportunity to see poster presentations by young researchers at NIH. Comments from the students indicated they found this program to be a valuable experience, several said it helped them clarify their thinking about the possibility of careers in research.

Give Kids A Smile Gala

Planning continues at a rapid pace for activities related to the new combined Give Kids A Smile 10th Anniversary Gala, which will also include recognition of the ADA leadership. The event will be held on Monday, October 22, at the Marriott Marquis San Francisco. This event will combine features of both the previous Presidents Gala and the Give Kids A Smile Gala, with special attention being paid to the 10th anniversary of the very successful Give Kids A Smile program. The ADA estimates that during 2012 more than 40,000 volunteers at more than 1,600 locations across the country will see more than 400,000 children to provide dental examinations.

Fund Raising

The ADA Foundation Board of Directors approved a plan last fall to conduct a campaign to raise \$150,000 in support of dental student scholarships during 2012. The Foundation plans to promote that effort during the coming months and at the annual session where we will have exposure to the largest number of dentists. In addition, the Foundation is entering into a formal agreement with the American Student Dental Association (ASDA) through which the Foundation will work to help raise money for ASDA programs in the future, and ASDA students will serve as volunteers throughout the year and at the annual session to help generate contributions to this campaign. Since the end of the fundraising moratorium, the Foundation has received gifts or commitments in excess of \$400,000 from industry and individuals.

Responses to House of Delegates Resolutions

The ADA Foundation Board has considered House of Delegates Resolution 76-2011 (*Trans.*2011:461), "ADA Alternate Proposal to the Midlevel Provider Pilot Project," which was referred to it following the 2011 ADA Annual Session. A formal response will be sent to Dr. O'Loughlin.

Summary of Resolutions

This report is informational and no resolutions are presented.

Links

For more information on recent activities, see <http://www.ada.org/adafoundation.aspx>.

Notes

Appendix

Notes

Index of Resolutions

Res. 1	<i>Reports:41</i>	Council on Dental Benefit Programs Policies to be Maintained as Recommended by the Council on Dental Benefit Programs
Res. 2	<i>Reports:42</i>	Council on Dental Benefit Programs Amendment of the Policy, Dental Benefit Plan Terminology
Res. 3	<i>Reports:42</i>	Council on Dental Benefit Programs Rescission of the Policy, Participation in Public Agency Sponsored Programs Involving Dental Health Benefits
Res. 4	<i>Reports:43</i>	Council on Dental Benefit Programs Rescission of the Policy, Support for Individual Practice Associations (IPAs)
Res. 5	<i>Reports:43</i>	Council on Dental Benefit Programs Rescission of the Policy, Representation of Participating Dentists in Dental Service Corporations
Res. 6	<i>Reports:43</i>	Council on Dental Benefit Programs Rescission of the Policy, Direct Reimbursement Mechanism
Res. 7	<i>Reports:43</i>	Council on Dental Benefit Programs Rescission of the Policy, Principles for Budget Payment Plans for Dental Care
Res. 8	<i>Reports:43</i>	Council on Dental Benefit Programs Rescission of the Policy, Request for Insurance Companies to Retain Dentists' Social Security Numbers
Res. 9	<i>Reports:43</i>	Council on Dental Benefit Programs Rescission of the Policy, Freedom of Choice of Dentists
Res. 10	<i>Reports:43</i>	Council on Dental Benefit Programs Rescission of the Policy, Mathematical Analysis of Health Care Related Data
Res. 11	<i>Reports:43</i>	Council on Dental Benefit Programs Rescission of the Policy, Patient and Provider Advisory Panel
Res. 12	<i>Reports:44</i>	Council on Dental Benefit Programs Rescission of the Policy, Disputes Concerning Dental Treatment Provided Under Dental Benefits Programs
Res. 13	<i>Reports:44</i>	Council on Dental Benefit Programs Rescission of the Policy, Use of Peer Review Process by Patients and Third-Party Payers
Res. 14	<i>Reports:44</i>	Council on Dental Benefit Programs Rescission of the Policy, Reassignment of the Development and Maintenance of Dental Practice Parameters
Res. 15	<i>Reports:44</i>	Council on Dental Benefit Programs Rescission of the Policy, Monitoring the Use and Application of Dental Practice Parameters
Res. 16	<i>Reports:69</i>	Council on Dental Education and Licensure Recognition of Dental Anesthesiology as a Dental Specialty
Res. 17	<i>Reports:72</i>	Council on Dental Education and Licensure Amendment to the <i>Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists</i>

Res. 18	<i>Reports:74</i>	Council on Dental Education and Licensure Policies to be Maintained as Recommended by the Council on Dental Education and Licensure
Res. 19	<i>Reports:74</i>	Council on Dental Education and Licensure Rescission of the Policy, Communication Between State Boards of Dentistry
Res. 20	<i>Reports:74</i>	Council on Dental Education and Licensure Amendment of the Policy, Monitoring Clinical Dental Licensure Examinations
Res. 21	<i>Reports:75</i>	Council on Dental Education and Licensure Amendment of the Policy, Clinical Licensure Examinations in Dental Schools
Res. 22	<i>Reports:75</i>	Council on Dental Education and Licensure Amendment of the Policy, State Board Support for CDA as Responsible to Evaluate Dental Education Programs
Res. 23	<i>Reports:76</i>	Council on Dental Education and Licensure Amendment of the Policy on One Standard of Competency: State Boards Review Limited Licensure Graduates of Nonaccredited Dental Schools for Providing Access to Care for Underserved Populations
Res. 24	<i>Reports:76</i>	Council on Dental Education and Licensure Amendment of the Policy on Dual Degreed Dentists
Res. 25	<i>Reports:77</i>	Council on Dental Education and Licensure Amendment of the Policy, Endorsement of Recommendations of the ADA Guidelines for Licensure by Credentials
Res. 26	<i>Reports:77</i>	Council on Dental Education and Licensure Amendment of the Policy on Licensure of Graduates of Nonaccredited Dental Schools
Res. 27	<i>Reports:78</i>	Council on Dental Education and Licensure Amendment of the Policy, Guidelines for Licensure
Res. 28	<i>Reports:81</i>	Council on Dental Education and Licensure Amendment of the Position Statement on Federal Intervention in Licensure
Res. 29	<i>Reports:81</i>	Council on Dental Education and Licensure Amendment of the Policy, Eliminating Use of Human Subjects in Board Examinations
Res. 30	<i>Reports:82</i>	Council on Dental Education and Licensure Amendment of the Policy, Acceptance of Results of Regional Boards
Res. 31	<i>Reports:83</i>	Council on Dental Education and Licensure Amendment of the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists
Res. 32	<i>Reports:84</i>	Council on Dental Education and Licensure Amendment of the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students
Res. 33	<i>Reports:139</i>	Council on Dental Practice Policies to Be Maintained as Recommended by the Council on Dental Practice
Res. 34	<i>Reports:139</i>	Council on Dental Practice Amendment of the Policy, Definition of Fee-for-Service Private Practice

Res. 35	<i>Reports:139</i>	Council on Dental Practice Amendment of the Policy, Active and Inactive Dental Patients of Record
Res. 36	<i>Reports:140</i>	Council on Dental Practice Amendment of the Policy, Primary Dental Care
Res. 37	<i>Reports:140</i>	Council on Dental Practice Amendment of the Policy, Uniform Procedure for Permanent Marking of Dental Prostheses
Res. 38	<i>Reports:140</i>	Council on Dental Practice Amendment of the Policy, Dental Identification Teams
Res. 39	<i>Reports:141</i>	Council on Dental Practice Amendment of the Policy, Dental Radiographs for Victim Identification
Res. 40	<i>Reports:141</i>	Council on Dental Practice Amendment of the Policy, Insurance Coverage for Chemical Dependency Treatment
Res. 41	<i>Reports:141</i>	Council on Dental Practice Amendment of the Policy, Guiding Principles for Dentist Well-Being Activities at the State Level
Res. 42	<i>Reports:142</i>	Council on Dental Practice Rescission of the Policy, Promotion of Careers in General Practice of Dentistry
Res. 43	<i>Reports:142</i>	Council on Dental Practice Rescission of the Policy, Primary Care Providers
Res. 44	<i>Reports:142</i>	Council on Dental Practice Rescission of the Policy, Dental Society Activities Against Illegal Dentistry
Res. 45	<i>Reports:143</i>	Council on Dental Practice Rescission of the Policy, Activity to Stop Unlicensed Dental or Dental Hygiene Practice
Res. 46	<i>Reports:143</i>	Council on Dental Practice Rescission of the Policy, Sale of Dental Equipment to Illegal Practitioners
Res. 47	<i>Reports:143</i>	Council on Dental Practice Rescission of the Policy, Professional Quality Denture Treatment for the Financially Disadvantaged
Res. 48	<i>Reports:152</i>	Council on Ethics, Bylaws and Judicial Affairs Amendment of the ADA <i>Bylaws</i> Regarding Autonomy of the ADA Editor
Res. 49	<i>Reports:154</i>	Council on Ethics, Bylaws and Judicial Affairs Amendment of the ADA <i>Bylaws</i> Regarding Filling of Council Vacancies
Res. 50	<i>Reports:171</i>	Council on Membership Downloadable ADA Member Logos
Res. 51	<i>Reports:171</i>	Council on Membership Amendment of the ADA <i>Bylaws</i> Regarding the Dues of Active Life Members
Res. 52	<i>Reports:190</i>	Council on Scientific Affairs Amendment of the Policy Statement on Evidence-Based Dentistry
Res. 53	<i>Reports:190</i>	Council on Scientific Affairs Amendment of the Comprehensive Policy on Hazard Classification and Communication

- | | | |
|----------------|--------------------|---|
| Res. 54 | <i>Reports:191</i> | Council on Scientific Affairs
Amendment of the Policy Statement on Intraoral/Perioral Piercing and
Tongue Splitting |
| Res. 55 | <i>Reports:191</i> | Council on Scientific Affairs
Rescission of the Policy, Fluoride Varnishes |
| Res. 56 | <i>Reports:191</i> | Council on Scientific Affairs
Rescission of the Policy Statement on HIV/AIDS as an Infectious and
Communicable Disease |