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2015

Annual Reports and Resolutions

156th Annual Session
Washington, DC
November 6–10, 2015

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American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611

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Carol Gomez Summerhays, president-elect
Jonathan D. Shenkin, first vice president
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Ronald P. Lemmo, treasurer
Glen D. Hall, speaker of the House of Delegates
Kathleen T. O'Loughlin, executive director and secretary

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James L. Willey, senior director, Practice Institute
Anthony J. Ziebert, senior vice president, Education/Professional Affairs

Council on Access, Prevention and Interprofessional Relations

Gillette, E. Jane, 2015, Montana, chair
 Sabates, Cesar R., 2016, Florida, vice chair
 Allen, Grant, 2015, Alabama, American Medical Association
 Cashion, Scott W., 2018, North Carolina
 Crystal, Yasmi O., 2016, New Jersey
 Fagan, Timothy R., 2018, Oklahoma
 Fisher, John P., 2015, Massachusetts
 Gerlach, William H., 2018, Texas
 Hymes, Rachael, 2015, Tennessee, *ex officio**
 Jones, Shelly F., 2017, Michigan
 Lang, Melanie S., 2015, Washington, American Hospital Association
 Logan, Bernadette A., 2015, Pennsylvania
 Mitchell, G. Lewis, Jr., 2016, Alabama
 Nunokawa, Neil C., 2017, Hawaii
 Peckosh, Valerie B., 2017, Iowa
 Schirmer, David C., 2015, New York
 Soderstrom, Andrew P., 2017, California
 Switzer-Nadasi, Rhonda M., 2018, Tennessee
 Watson-Lowry, Cheryl D., 2016, Illinois
 Wynn, Mary Ellen, 2016, Ohio

Grover, Jane S., director
 Geiermann, Steven P., senior manager
 McGinley, Jane S., manager
 Smith, Barbara J., manager
 Clough, Sharon R., manager

The Council's 2014-15 liaisons include: Dr. Julian Fair III (Sixteenth District trustee, ADA Board of Trustees); Dr. Michael Maihofer (Council on Communications); Ms. Stephanie Zastrow (American Student Dental Association); and Dr. Barry Howell, Council on Government Affairs.

***Bylaws* Areas of Responsibility**

The Council reviewed its *Bylaws* provisions and, with the Council on Ethics, Bylaws and Judicial Affairs, will be proposing revisions via an omnibus resolution to the Board of Trustees and 2015 House of Delegates. That resolution will be separately presented in the "Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the ADA *Bylaws*." Identified areas of CAPIR expertise are community oral health, access to oral healthcare, oral disease prevention and intervention, interprofessional relations, and oral health literacy.

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

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
3 - Member value	Continue roll out of Action for Dental Health in collaboration with state dental societies	Percent of state societies participating in one or more Action for Dental Health initiatives (8 initiatives)	50% of 52 constituent societies participate in one or more ADH initiatives	30-70%	58% of constituent dental societies participate in at least one ADH initiative
1 - Leaders and advocates	Working cross divisionally, CAPIR will develop specific outcomes from the Prevention Summit 2013	Outcomes from the Prevention Summit either in policy statements or specific activities issued –Health literacy –ECC strategies –National Prevention Strategy Workgroup	December 31, 2014	October 2014- March 2015	National Advisory Committee on Health Literacy in Dentistry met September 2014 Prevention Strategy Workgroup quarterly calls 2014 and 2015 ECC Prevention Video developed by Spring 2016

Action for Dental Health Initiatives

The following chart breaks down the Action for Dental Health (ADH) into its component initiatives.

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
1 - Leaders and advocates	#1 Board Workgroup on Sugar Review available research regarding sugar consumption and develop appropriate ADA policy	Propose ADA policy to the 2015 House of Delegates that increases awareness about the negative health effects of sugar consumption	2015 House of Delegates action	2015 House of Delegates action	On track 2015 House of Delegates
1- Leaders and advocates	#2 Fluoridation Initiative as part of the Action for Dental Health Campaign	Fluoridation in 80% of community water supplies	80% of U.S. population on fluoridated public water systems by 2020	72-82%	74.6%

** Results are as of the date of report preparation and do not include full-year results. As of the preparation of this report, approximately 50% of the operating plan objectives have achieved targeted results.

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
1- Leaders and advocates	#3 Community Dental Health Coordinator program	Number of states with schools integrating the curriculum	15 states with CDHC presence by 2015	13-16	11 states in June 2015
1 - Leaders and advocates	#4 Long-term care	10 states to implement long-term care programs Train 1,000 dentists to provide care in nursing homes by 2020	10 states 200 dentists per year	9-11 states 150-250 dentists	7 states with geriatric dental programs 200 dentists providing care in long-term care facilities
1 - Leaders and advocates	#5 Medicaid reform Medicaid provider education	Increased number of dentists participating in state Medicaid programs	10% increase yearly	8-25%	20%
1 - Leaders and advocates	#6 ER referral through Action for Dental Health	Number of state constituent dental societies with ER referrals program occurring in their states	25 states	25-40 states	30 states
1 - Leaders and advocates	#7 Medical dental collaboration	Number of medical providers who complete the Smiles for Life curriculum	75,000 providers	50,000-80,000 providers	43,000 providers
1- Leaders and advocates	#8 Increased number of FQHC patients receiving dental services	Increased numbers of FQHC patients receiving dental services reflected in UDS data	50% of FQHC medical users receive dental service by 2020	35-55% of FQHC medical users receive dental service by 2020	22.5%

The following provides additional information regarding Action for Dental Health initiatives.

Community Water Fluoridation: CAPIR staff continues to work with constituent societies through the State Public Affairs program and independent contacts to provide technical support and campaign information to assist with initiation and retention of fluoridation programs. The CDC Division of Oral Health conducts a national fluoridation census every two years. In 2010, 73.9% of the U.S. population on public water supplies received fluoridated water. In 2012, that number increased to 74.6%. The last census was conducted in 2014 and is anticipated for release later in 2015.

Community Dental Health Coordinator (CDHC): The goal for CDHC is to establish presence in 15 states by the end of 2015. There are currently 34 CDHCs in eight states. Central College in New Mexico currently has seven students taking the program, two of whom are Navajo.

Success in Long-Term Care (LTC): The Geriatrics and Special Needs program is actively engaged in the promotion and implementation of its particular two ADH goals. Additionally, multiple presentations about this initiative and supportive content have been made at national dental meetings, including the Association of Health Care Journalists, ADA 2014, National Oral Health Conference and Special Care Dentistry Association

** Results are as of the date of report preparation and do not include full-year results. As of the preparation of this report, approximately 50% of the operating plan objectives have achieved targeted results.

ER Referral: Various models of ER referral collected by CAPIR staff have generated significant interest by ADA members, the AAOMS Board, First Choice ER Corporation, the American College of Emergency Physicians and the American Hospital Association. Requests from states for ER referral technical assistance continue to increase.

Emerging Issues and Trends

- Access to care continues to be an emerging issue in many states. Multiple requests from states to address access issues and needs of underserved and Native populations arrive monthly.
- Dental case management code development, generated by interest in promoting and sustaining the Community Dental Health Coordinator, is a significant emerging issue in many states. A revised case management code proposal will be submitted to the Code Maintenance Committee towards the end of 2015.
- Medicaid expansion in many states could result in significant numbers of adults eligible for dental services, while the present safety net delivery system has insufficient capacity to address the present demand.
- Community water fluoridation is experiencing unprecedented challenges around the country. In 2014, there were approximately five times as many campaigns to retain fluoridation than to initiate new programs. With the USPHS recommendation finalized in April 2015, constituent societies and members will need to step up, not step back from fluoridation efforts in order to reach the ADH goal of 80% of U.S. population served by public water systems receiving fluoridated water by 2020.
- Health Literacy has emerged as a key patient-centered issue with the Academy of General Dentistry addressing the topic.
- Consumer-focused oral health awareness raising programs continue to expand.
- School-based oral health programs increase in number as a viable strategy to provide barrier-free access to oral health prevention and treatment for children.

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
38H-2010. School Based Oral Health Programs	Workgroup with Communications, Dental Practice and Science to develop ADA webpage that provides resources about school-based oral health programs	Date of launch of information on website	Content developed and ready to launch by December 2015	Launch website October 1- December 31, 2015	Members utilizing website by Jan 1, 2016
101H-2014. ADA Social Media Campaign on Water Fluoridation	ADA Social Media Campaign on Fluoridation Shared with Communications	Date of the implementation of the social media campaign	Campaign began March 27, 2015 Google Adwords began May 15, 2015 Twitter began June 19, 2015	March 27, 2015 to 2015 ADA House of Delegates	Ongoing
83 and 83RC 2014. Hospital Privileges for Dentists	Hospital Privileges for Dentists, referred back to CAPIR	New ADA policy on hospital privileges for dentists	2015 ADA House of Delegates	2015 ADA House of Delegates	2015 ADA House of Delegates

Fluoridation Social Media Campaign: Communications is the lead agency for implementation of Resolution 101H-2014 with CAPIR as a supporting agency. In support of Communications' efforts, Communications staff were included in weekly internal fluoridation conference calls conducted by CAPIR that provide internal agencies with updates on fluoridation activity across the nation. CAPIR has a representative on the Fluoridation Volunteer Workgroup established by Communications to oversee the implementation of the social media campaign. Working with the National Fluoridation Advisory Committee, CAPIR staff completed an update of the content of the Fluoride and Fluoridation pages on ADA.org. CAPIR assisted in the formation of a number of infographics, reflecting the updated fluoridation recommendation, some of which were used at the Washington Leadership Conference in April 2015.

CAPIR facilitated contact between Communications and the CDC to videotape a short segment with the HHS representative at the time of the April 2015 final announcement on fluoride at the National Oral Health Conference. Collaboration will also include future videos with dental leaders on the topic of community water fluoridation.

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2017. However, working with the Council on Ethics, Bylaws and Judicial Affairs, the Council will be proposing revisions to its *Bylaws* responsibilities. These will be presented in the "Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the ADA *Bylaws*" to the Board of Trustees and 2015 House of Delegates.

Policy Review

The Council will address assigned policies for review and resolutions within an upcoming Supplemental Report to the House.

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.

Council on ADA Sessions

Roesch, Robert E., 2015, Nebraska, chair
 Van Sicklen, James H., Jr., 2016, California, vice chair
 Cohen, Barry I., 2015, Pennsylvania
 Cram, Sally J., 2015, Washington, DC, *ex officio*
 Curcuru, Grace A., 2016, Michigan
 Evans, Henry F., III, 2018, Washington
 Foy, Charles B., Jr., 2017, Louisiana
 Fulton, David J., Jr., 2017, Illinois
 Hasty, Christopher M., Georgia, *ex officio**
 Janik, Andrea K., Texas, *ex officio**
 LaMorte, Gregory, 2017, New Jersey
 Lancaster, Harold T., 2016, North Carolina
 Lieb, Howard I.A., 2018, New York
 Lum, Calbert, M. B., 2016, Hawaii
 Macias, C. Roger, Jr., 2018, Texas
 Martin, Mary E., 2015, Oklahoma, *ex officio*
 Murray, Rhett L., 2016, Colorado, *ex officio*
 Parker, Steven E., 2015, Ohio
 Richman, Andrea, 2018, Massachusetts
 Thakkar, Nipa R., 2016, New York, *ex officio**
 Torgerson, Neil E., 2015, Florida
 Tourial, Sidney R. 2016, Georgia
 Wyckoff, Douglas A., 2017, Missouri

Mills, Catherine, H., director
 Wilkins, Glynis, P., coordinator

The Council's 2014–15 liaisons include: Dr. Terry L. Buckenheimer (Board of Trustees, Seventeenth District) and Mr. Christian R. Ortiz (American Student Dental Association).

***Bylaws* Areas of Responsibility**

The Council reviewed its *Bylaws* provisions and, with the Council on Ethics, Bylaws and Judicial Affairs, will be proposing revisions via an omnibus resolution to the Board of Trustees and 2015 House of Delegates. That resolution will be separately presented in the "Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the ADA *Bylaws*."

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

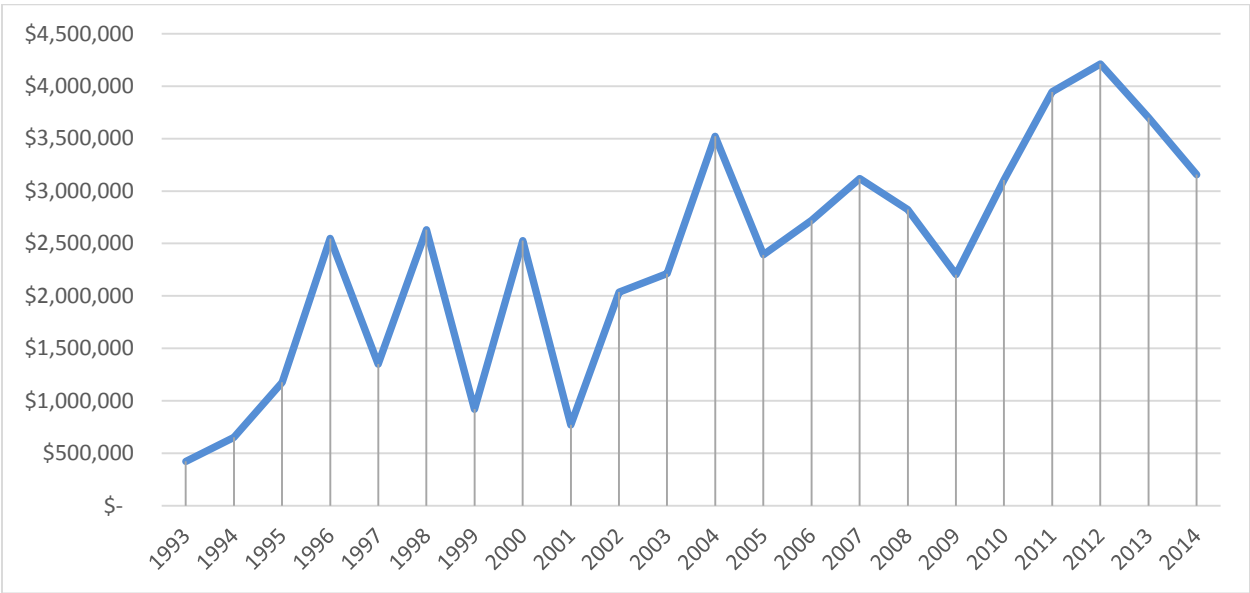
Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
Member Value	Utilize ADA 2015 as a key platform to increase awareness of total member value from various areas of the organization	Value messaging & experiences incorporated into multiple aspects of meeting including the opening general session, welcome center, course schedule, networking functions and social media communications	20 individual touch points pre, during and post ADA 2015	17 – 23 individual touch points pre, during and post ADA 2015	To be determined

* New Dentist Committee member without the power to vote.

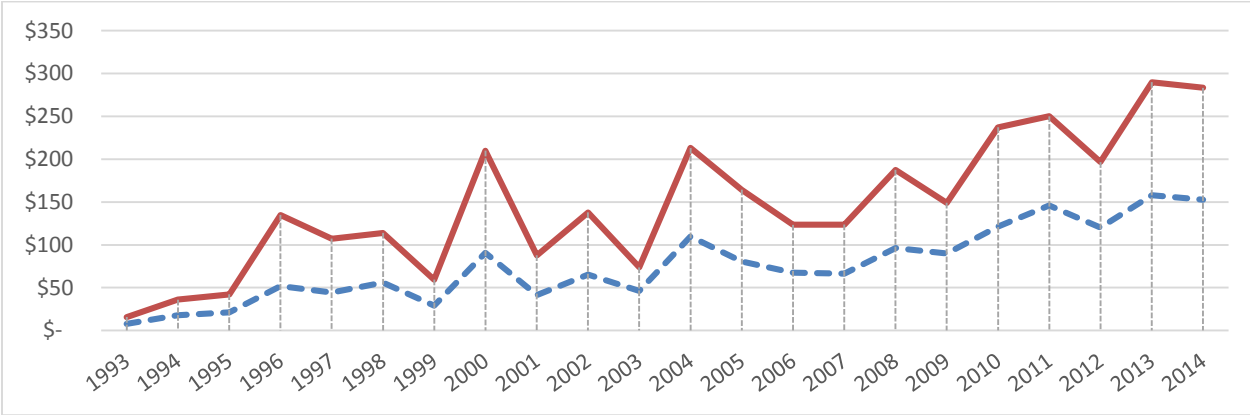
** Results are as of the date of report preparation and do not reflect full-year results.

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
Non-dues revenue will be at least 65% of total revenue	Member value-business development	Meet or exceed budgeted net revenue of CAS budget	100%	95% - 100%	To be determined
Non-dues revenue	Increase non-dues revenue through the execution of in-person and on-line education.	15% increase in overall CE revenue over 2014	15%	12%	To be determined

Annual Meeting Total Net Non-Dues Revenue History



Net Per Attendee and Net Per Professional Attendee History



— Per Professional Attendee
 - - - Per All Attendees

In support of helping our members succeed while generating net non-dues revenue, CE, in-person and online, will remain a priority in 2015.

Annual Meeting CE Trends 2010-2014

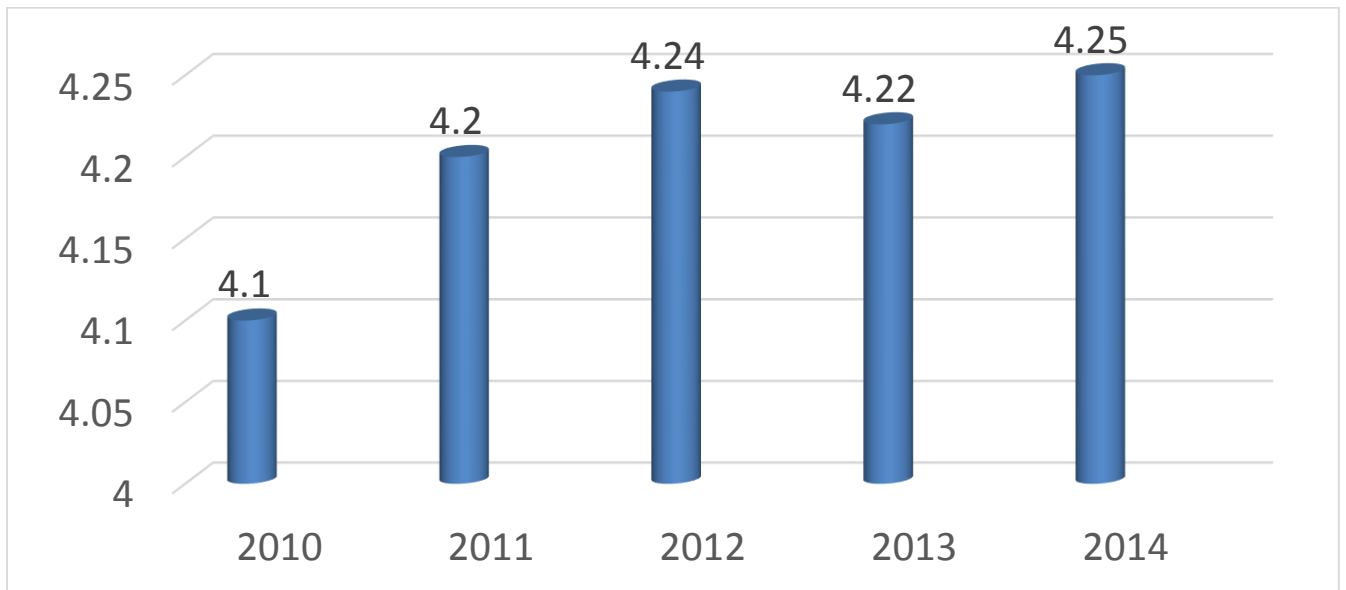
Usage – Revenue

Year	Location	Total CE Seats Occupied	Total CE Hours	Total Courses per Dental Professional	Revenue per Seat Occupied	Total Revenue for CE Sales
2010	Orlando	35,972	86,333	2.8	\$20	\$801,378
2011	Las Vegas	46,800	112,320	3	\$22	\$936,955
2012	San Francisco	49,450	118,680	2.2	\$28	\$1,384,640
2013	New Orleans	40,427	97,025	3.1	\$28	\$1,151,581
2014	San Antonio	35,462	85,109	3.2	\$31	\$1,103,116
Total		208,111	499,467	Avg. 2.86	Avg. \$25.80	\$5,377,670

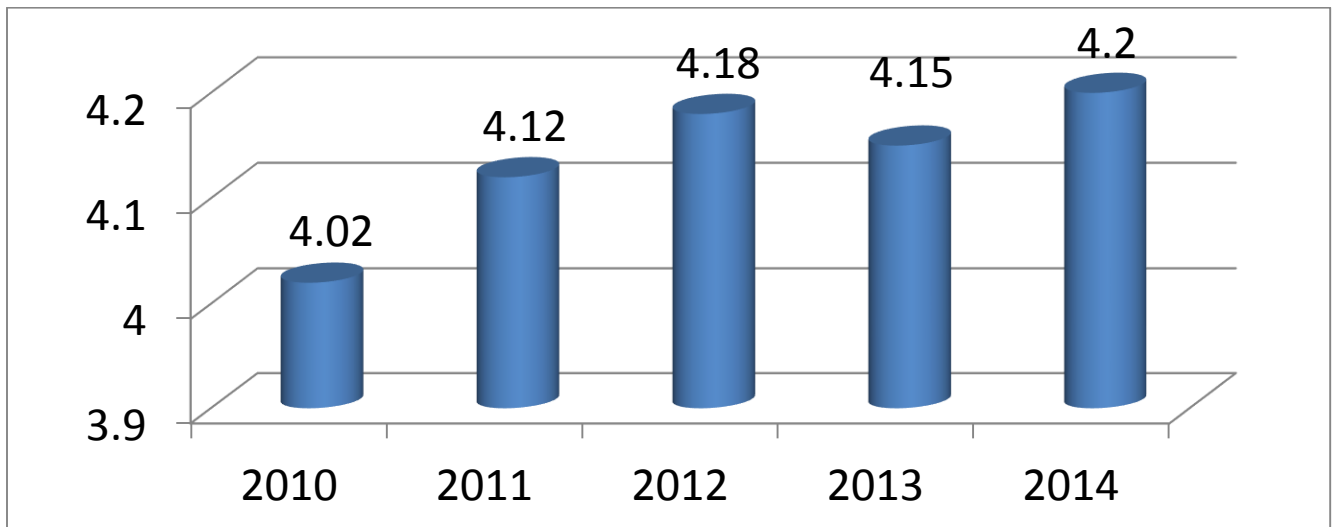
Attendee Satisfaction With Annual Meeting Continuing Education

Rating Scale is 5 = Excellent – 1 = Poor

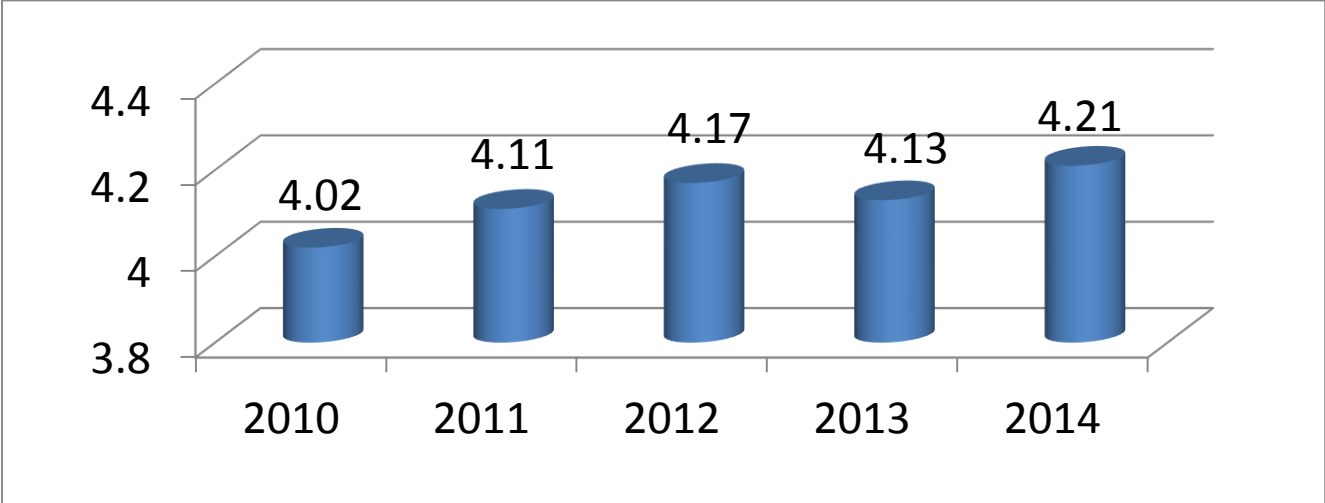
Overall Instructor Rating



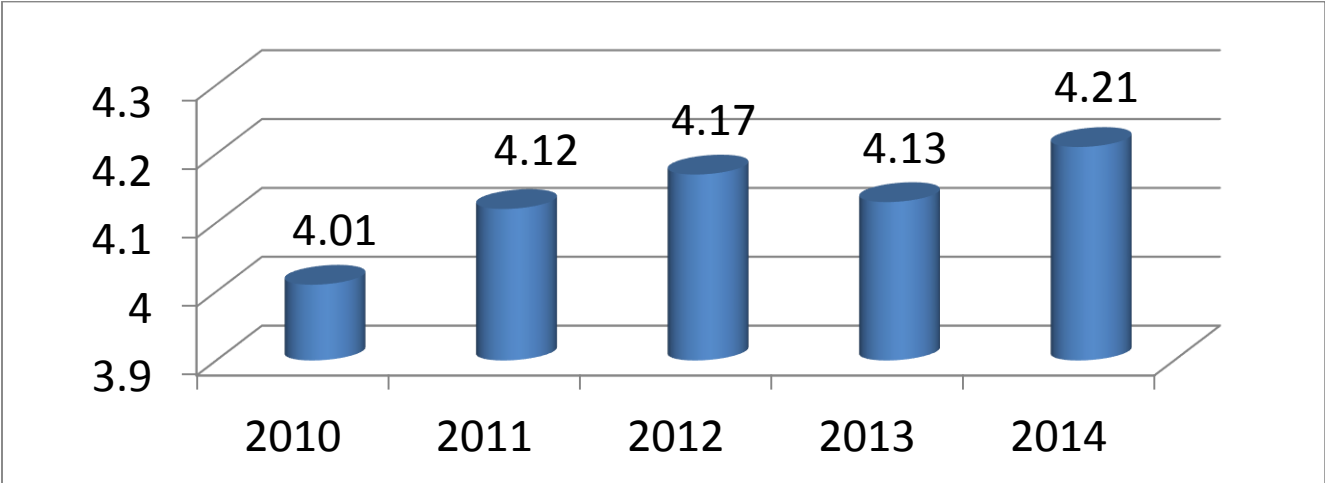
Effectiveness of Teaching Methods



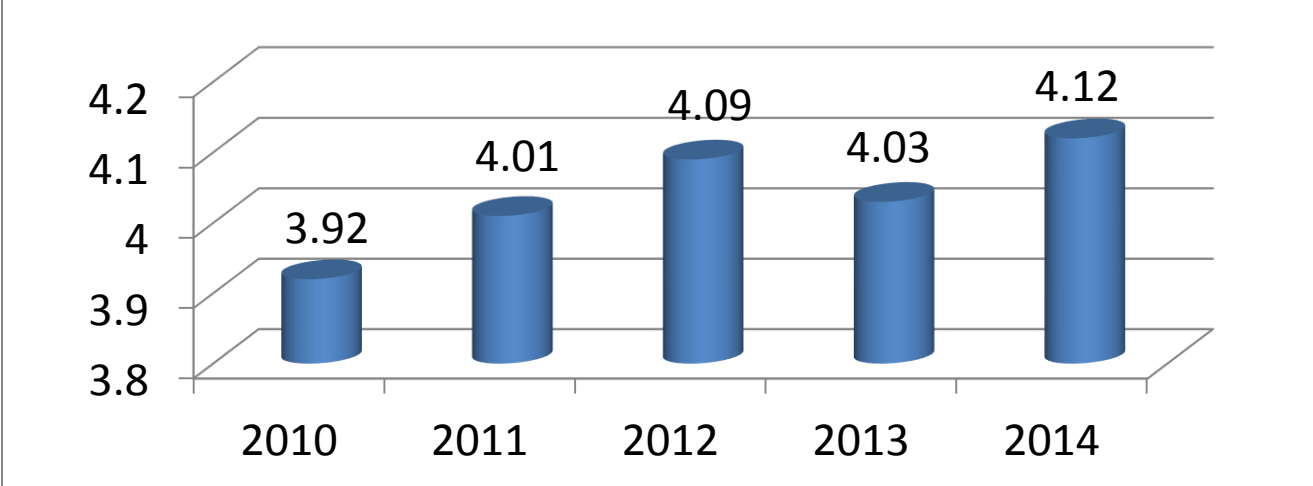
Stated Educational Objectives Were Accomplished



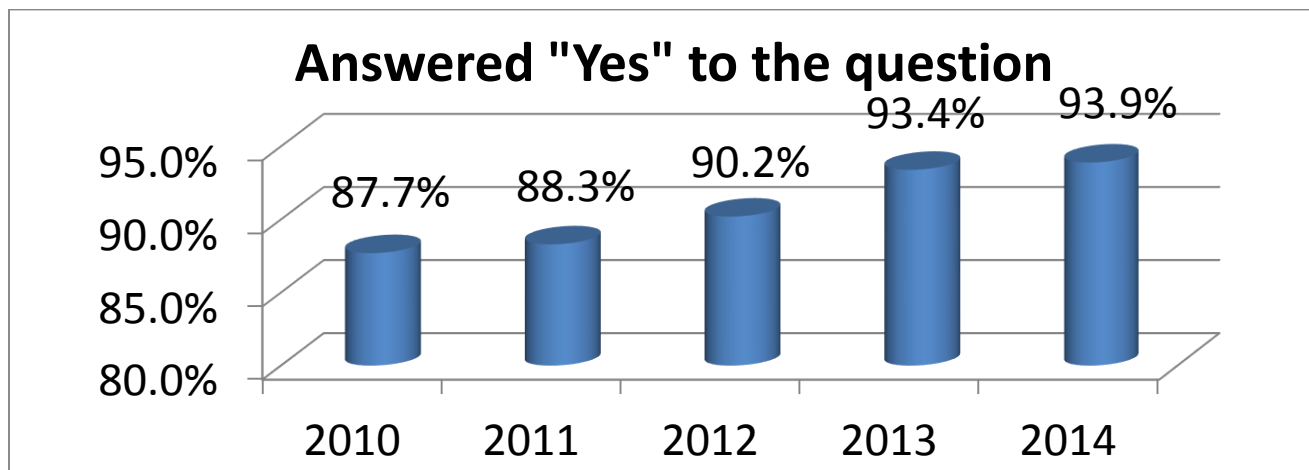
Overall Rating of Course Content



Course Enhanced Your Current Knowledge or Skill



Provided Timely Information You Could Implement Into Your Practice



The Department of Conferences and Continuing Education assumed responsibility of online CE in 2012. With cross council volunteer oversight, online offerings have been revamped. Since 2012, 60 new courses have been added and 30+ are planned for release in 2015. In-sourcing our online CE platform will also be a priority via Aptify technology to immediately improve online CE profitability by eliminating the current revenue share with our current provider.

The focus for 2015 CE will be to develop blended learning opportunities. Blended learning will correlate both face-to-face CE options with complementary online offerings. Cross marketing strategies based on a member’s interests are also being implemented.

Online CE Trends 2010-2014

	2010	2011	2012	2013	2014	2015
1st Quarter	\$9,013	\$12,061	\$20,957	\$29,119	\$27,993	\$35,691
2nd Quarter	\$8,705	\$8,315	\$17,620	\$16,460	\$33,040	\$31,350
3rd Quarter	\$7,452	\$14,654	\$18,772	\$14,117	\$17,322	
4th Quarter	\$9,298	\$10,874	\$15,009	\$11,465	\$20,974	
Total	\$34,467	\$45,902	\$72,358	\$71,161	\$99,329	\$67,041
						Through Q2

Emerging Issues and Trends

The trend of exhibiting companies consolidating and/or reducing their booth size continues. The Council is introducing Radio Frequency Identification (RFID) during ADA 2015 on the exhibit hall floor in order to gather actual data on attendee behavior. Exhibitors are looking for additional information to improve their value proposition of exhibiting and the aggregate information garnered by RFID is a first step. Email address information remains of primary interest to exhibitors. CAS will be exploring ways to share more information with exhibitors while balancing member privacy preferences in 2015-2016.

The addition of the New Dentist Conference to the annual meeting is being met very positively from our exhibitors as the new dentist is also their target market. The impact on exhibits of combining the conference with the annual meeting will hopefully be seen starting at ADA 2016.

Responses to House of Delegates Resolutions

The Council on ADA Sessions did not have any resolutions to respond to aside from the *Bylaws* resolution mentioned above.

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2019. However, a task force was created at the Council's May 2015 meeting to look at its structure and operation in order to create increased engagement with volunteer members and improve efficiency of the Council on ADA Sessions.

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.

Council on Communications

Shepley, George R., 2015, Maryland, chair
 Austin, Joshua A., 2016, Texas, vice chair
 Bean, Canise Y., 2018, Ohio
 Boghosian, Alice G., 2015, Illinois
 Childs, Eric T., Wisconsin, *ex officio**
 Hanley, Yvonne S., 2018, Minnesota
 Herre, Craig W., 2017, Kansas
 Hight, James R., Jr., 2017, Tennessee
 Howell, Ralph L., Jr., 2016, Virginia
 Lindemann, Kurt S., 2018, Montana
 Maihofer, Michael G., 2015, Michigan
 Manzanares, Robert J., 2016, New Mexico
 Patel, Minerva, 2015, New York
 Paul, John H., 2016, Florida
 Reich, Robin S., 2018, Georgia
 Sahota, Ruchi K., 2016, California
 Tauberg, James A. H., 2017, Pennsylvania
 Woods, Karl P., 2017, Maine, *ad interim*

MacLachlan, Janine, director
 Cebula, Marcia, coordinator

The Council's 2014–15 liaisons include: Dr. James K. Zenk (Board of Trustees, Tenth District) and Mr. Christian Piers (American Student Dental Association).

Bylaws Areas of Responsibility

The Council reviewed its *Bylaws* provisions and, with the Council on Ethics, Bylaws and Judicial Affairs, will be proposing revisions via an omnibus resolution to the Board of Trustees and 2015 House of Delegates. That resolution will be separately presented in the “Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the ADA *Bylaws*.”

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
1-Leaders and advocates	Creation of an Integrated Communications, Marketing and Content Strategy for the ADA	Organizational alignment of Persona Targets; ADA Communications, Marketing and Content Strategy; Social Media Strategy and Universal Content Calendar	Phase I - Member Personas: Aug ADA Communications, Marketing & Content Strategy complete: Oct Universal Content Calendar: Nov		Member Persona research underway; on-target for June Council discussion and completion in August Content Audit in-progress; identifying messaging and themes across ADA for universal content calendar and ADA strategy

* New Dentist Committee member without the power to vote.

**Results are as of the date of report preparation and do not include full-year results.

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
			Phase II – Public Personas: Dec		Kicking-off public persona research
1-Leaders and advocates	Continue to drive awareness, engagement and positive social and traditional media coverage for consumer oral health issues, access and ADA advocacy positions through Action for Dental Health	Increase compared to 2014 in positive media coverage as expressed by tracking positive, negative and neutral sentiment in top tier media; growth in ADH awareness among opinion leaders; increase in content engagement by 2% (sharing, commenting, recommending, liking, CTR); 5% increase in snackable (short and sharable content) to test, learn and scale as we take on more of a news room and paid, earned, owned approach	Less than 5% negative top tier media sentiment (measured quarterly and averaged year end); 16% awareness among key opinion leaders in annual tracking study; 2% average engagement rate (sharing, commenting, recommending, liking, CTR); 5% increase in snackable content (short and sharable); 1 content distribution test	3-8% negative sentiment; 14-18% ADH opinion leader awareness; 1-3% engagement rate (sharing, commenting, recommending, liking, CTR); 2-10% increase in snackable content (short and sharable); 1-2 content distribution tests	Average negative media sentiment for 2014 was 4.6% and for Q1 2015, 4%; an opinion leader survey is currently being fielded; results will be available Q2 2015 Q1 engagement rates (overall) AmerDentalAssn Twitter: 6% ADA Main Facebook: 1.9% Snackable content is a new metric; a baseline will be established in 2015 in order to be able to measure increase
1 - Leaders and advocates	Improve the public's oral health literacy by providing accessible, audience appropriate and snackable (short and sharable) information about dental health and oral disease prevention	Increases in visits to and page views of MouthHealthy.org; Increase of Snackable Content and Video; Completion of Target Personas and Digital Ecosystem	15% increase over 2014 year-end; 5% increase in snackable content and video; Completion of Digital Ecosystem by August	12-18%	35% increase in visits and 29% increase in page views in Q1 2015 Snackable content is in development; this is a new metric and a baseline will be established in 2015 in order to be able to measure increase

** Results are as of the date of report preparation and do not include full-year results.

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
1 - Leaders and advocates	Maintain a leadership role in the collaboration with the Ad Council and Partnership for Healthy Mouths, Healthy Lives for the development of the second phase of the public service campaign	Ad Council established campaign metrics for audience exposure and changes in brushing behaviors	Increase over year end 2014 baseline performance of donated media and consumer metrics reported by Ad Council for media exposure	Plus or minus 8% from year end 2014 baseline report	<p>2014 Baseline</p> <ul style="list-style-type: none"> • Donated Media - \$25.9 M • Web Traffic: 488.1K • Video Views: 47,100 • Facebook Impressions: 25.3 M <p>2015 Q1</p> <ul style="list-style-type: none"> • Donated Media - \$9.8 M • Web Traffic: 57K • Video Views: TBD • Facebook Impressions: 16.7 M
6 - Defined roles	Increase national, state and local success through the introduction and execution of the integrated brand platform	Adoption of brand family resources, content and materials by state and local societies; provide snackable content to states and locals	Roll-out schedule of branded web templates - 10 societies; aggregate access of ADH and issues toolkits - 15% increase in downloads and access vs. year end 2014 usage; two states or locals leverage snackable content	7-12 societies' adoption of website templates; 12-18% increase in toolkit download and or access; two state or locals leverage snackable content	<p>Two branded web templates launched by Q1 (NC and NH); two scheduled for Q2 (DC and VT); four more states (NM, MO, VA, OR) and 40+ local sites are in production for end of Q4 2015</p> <p>Toolkits:</p> <p>June 1, 2014 – April 11, 2015:</p> <p>72 for fluoridation 50 for amalgam 94 for anesthesia 251 for workforce 80 for Action for Dental Health (plus 7 accesses through a firewalled portion of www.ada.org)</p> <p>Q1 2015:</p> <p>32 for fluoridation 8 for amalgam 0 for anesthesia 250 for workforce 50 for Action for Dental Health</p> <p>Q1 2014:</p> <p>1 for fluoridation 78 for amalgam 0 for anesthesia 9 for workforce 43 for Action for Dental Health</p> <p>ADA infographic on preventing children's tooth decay had 22 shares via the social plugin</p>

** Results are as of the date of report preparation and do not include full-year results.

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
3 - Member value	Develop and promote the importance of ADA membership (and ethics) as a key differentiator for the public's perception, usage and recognition in making dental health choices	1. Increased state and local society usage of ADA Find-a-Dentist tool, (which highlights ethics). 2. Increased public visits to the Find-a-Dentist tool on MouthHealthy.org 3. Utilization of the customized Colorado Dental Association video (which highlights ethics), and others as they are developed, by state and local societies	1. 20% increase in states utilizing the Find-a-Dentist tool over 2014 (25). 2. 15% increase in visits over 2014. 3. Customization /utilization by 10 states or locals of the CDA video	1. 15-25% 2. 12-18% 3. 8-12	Eight state and 40+ local branded template sites scheduled for ADA Find-a-Dentist links by end of Q4. CO video has been customized for 9 state/local societies (Dallas, TX, FL, FL West Coast, MD, OK, VA, MO, Chicago)
1 - Leaders and advocates	Improve the public's oral health literacy by producing consumer videos and snackable content (short and sharable) about dental health and oral disease prevention for MouthHealthy.org.	Total views and downloads from all distribution channels	370,000 aggregated video views	320,000 - 450,000	97,394 video views in Q1; on track to hit target year-end goal
3 - Member value	Position ADA and HPI as the definitive sources of health policy, dental marketplace and access issues	Number of positive citations of HPI as an authoritative data source among five media sectors— dental trade, state-level policy/health policy publications, national/federal level policy publications, second tier outlets (e.g., general media in cities such as Milwaukee, Seattle, Charlotte SC, major online outlets, such as Huffington Post or CNN.com) and national outlets (e.g., WSJ, NYT, Washington Post, NPR, Network TV)	Trades: 4 placements; state-level policy: 3 placements; national/federal policy: 4 placements; second tier general: 4 placements; national outlets: 2 placements	Trade: 3-5; state policy: 2-4; national policy 3-5; second-tier general: 3-5; national general 1-3	Placements June 1, 2014-April 15, 2015/Q1 2015: Trade: 3/1 State-level policy: 5/2 National/federal policy: 1/0 Second tier general: 3/1 National outlets: 1/1

** Results are as of the date of report preparation and do not include full-year results.

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
3 - Member value	Create toolkits and execute webinars for four additional ADH initiatives	Number of states utilizing toolkit materials as measured by downloads or other access	15% increase in downloads/ access over year-end 2014	12-18% increase in downloads/ access over year-end 2014	<p>Toolkits: June 1, 2014 – April 11, 2015: 80 for Action for Dental Health (plus 7 accesses through a firewalled portion of www.ada.org)</p> <p>Q1 2015: 50 Q1 2014: 43 (16 % increase in toolkit access from Q1 2014 to Q1 2015)</p>
6 - Defined roles	Increase national, state and local success through the introduction and execution of the integrated brand platform	Develop/execute collaborative communications strategies/shared resources with input from dental society staff communications advisory committee; Adoption of template media/social media resources, issues management toolkits by state and local societies; provide snackable content to states and locals	Aggregate access of issues toolkits - 15% increase in access vs. year end 2014 usage; establish baseline metric for dental society use of template media materials; 10% increase in dental societies' use of ADA-provided social media content over 2014 usage; 2 states or locals leverage snackable content	12-18% increase in toolkit download and/or access; 7-13% increase in use of ADA-provided social media content	<p>Toolkits: June 1, 2014 – April 11, 2015: 72 for fluoridation 50 for amalgam 94 for anesthesia 251 for workforce</p> <p>Q1 2015: 32 for fluoridation 8 for amalgam 0 for anesthesia 250 for workforce</p> <p>Q1 2014: 1 for fluoridation 78 for amalgam 0 for anesthesia 9 for workforce</p> <p>Currently building a shared Communications/Marketing editorial calendar to be shared with dental societies</p> <p>ADA Infographic on preventing children's tooth decay had 22 shares via the social plugin</p>

** Results are as of the date of report preparation and do not include full-year results.

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
3 - Leaders and advocates	Council on Communications: Engage Council on Communications Subcommittee on Social and Digital Media to drive strategic engagement and expand footprint of ADA social properties	Increase social engagement with influencers and dental professionals by expanding existing social strategy with Facebook and Twitter, as well as adding LinkedIn and YouTube	Social strategy executed with 20% increases in both Facebook Likes and Twitter Followers	15-25%	June 1, 2014 – April 11, 2015 Facebook: June 1: 92,668 Apr 11: 169,785 84% growth Twitter: June 1: 21,524 Apr 11: 29,882 39% growth YouTube: June 1: 1,200 April 11: 1,963 63% growth LinkedIn: June 1: 11,210 April 11: 17,346 55% growth

Emerging Issues and Trends

Given the trend in member market share, the ADA should increase its marketing and communications efforts to dentists, residents and students to reinforce what the ADA does for them and for the profession. Communications will work with Member and Client Services to communicate how the ADA helps all members succeed.

An increasing number of traditional media stories and social media conversations are focusing on various products' impact on the environment, including oral health products. For example, the environmental impact of microbeads in soaps and in an ADA Accepted toothpaste resulted in significant media coverage and the product manufacturer announced that due to consumer preference, they would remove microbeads from the toothpaste. Legislators and regulatory agencies at the state and federal levels are also paying increased attention to environmental impacts as evidenced by the recent activity surrounding microbeads in soap and toothpaste and the EPA's long-standing regulatory interest in capturing waste dental amalgam via separators at dental offices to prevent release to wastewater systems. From a reputation management standpoint, the increasing focus of media, regulators and legislators on environmental impact of products and services is something the ADA should be aware of in relation to oral care products.

In addition, there is increased top-tier media coverage on the role of sugar, acid and bacteria on caries and overall dental disease.

** Results are as of the date of report preparation and do not include full-year results.

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
101H-2014. ADA Social Media Campaign on Water Fluoridation	Implement a proactive social media campaign and websites to promote to the public, the safe, positive effects of optimal water fluoridation to decrease the incidence of dental decay in communities	<ol style="list-style-type: none"> Increase Google "fluoridation" search position of ADA.org/fluoridation page Increase Google "fluoride" search position of ADA.org/fluoride page Increase traffic to Fluoride and Fluoridation pages on ADA.org Increase traffic to Fluoridation A-Z pages on Mouth Healthy.org Average engagement rate for Promoted Tweets and Video campaign on Twitter Average click-thru rate for Google AdWords campaign Video views on YouTube of new water fluoridation video 	<ol style="list-style-type: none"> Organic search position from #7 to #4 and paid search position to #1 Organic search position from #5 to #4 and paid search position to #1 20% 100% 1-4% >1% >50,000 		<ol style="list-style-type: none"> Web pages updated Q1, Google Adwords will be implemented Q2, results expected Q4 Web pages updated Q1, Google Adwords will be implemented Q2, results expected Q4 Web pages updated Q1, Google Adwords will be implemented Q2, results expected Q4 Content to be updated in Q2 following results of consumer messaging survey, Google Adwords will be implemented in Q2, results expected Q4 Consumer messaging survey results expected Q2, social media campaign to launch Q2, results expected Q4 Consumer messaging survey results expected Q2, Google Adwords will be implemented Q2, results expected Q4 Consumer messaging survey results expected Q2, video production and posted to YouTube in Q2, results expected Q4

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2018. However, working with the Council on Ethics, Bylaws and Judicial Affairs, the Council will be proposing revisions to its *Bylaws* responsibilities. These will be presented in the "Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the *ADA Bylaws*" to the Board of Trustees and 2015 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.

Commission for Continuing Education Provider Recognition

Felsenfeld, Alan L., 2015, California, chair, American Association of Oral and Maxillofacial Surgeons
 Ackley, Eva F., 2015, Florida, vice chair, American Association of Dental Boards
 Beitel, Brian A., 2017, Alabama, American Academy of Pediatric Dentistry
 Chehal, Hardeep K., 2017, Nebraska, American Academy of Oral and Maxillofacial Pathology
 Dixon, Debra, 2018, Illinois, American Academy of Oral and Maxillofacial Radiology
 Fiorellini, Joseph P., 2018, Pennsylvania, American Academy of Periodontology
 Friedel, Alan E., 2015, *ad interim*, Florida, American Dental Association
 Gibbs–Reed, Janice, 2015, New Jersey, Association for Continuing Dental Education
 Hutten, Mark C., 2018, Illinois, American College of Prosthodontists
 Kirkpatrick, Timothy C., 2017, Mississippi, American Association of Endodontists
 Leary, Paul, 2017, New York, American Dental Association
 McGuire, Eugene J., 2016, Pennsylvania, American Dental Association
 McNulty, Conor, 2018, Oregon, American Society of Constituent Dental Executives
 Steiner, Ann, 2017, California, American Dental Association
 Tavares, Mary A., 2016, Massachusetts, American Association of Public Health Dentistry
 Wheeler, Timothy T., 2015, Florida, American Association of Orthodontists

Borysewicz, Mary A., director

The Commission’s 2014–15 Board of Trustees liaison was Dr. Alvin “Red” Stevens, Jr. (Board of Trustees, Fifth District).

***Bylaws* Areas of Responsibility**

The Commission’s *Bylaws* responsibilities were established by the House of Delegates in 2014. No revisions are proposed at this time.

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome*
3 - Member value	Provide members access to quality continuing dental education offerings by approving CE providers through the ADA CERP Program	1) Maintain CE provider participation by providing technical support to CE providers; and 2) Achieve positive satisfaction rating for the application process from CE providers	1) Maintain number of CERP-approved CE providers (435); and 2) 80% positive response rate	1) 430-445 providers; and 2) 75-95% positive response rate	On target at time of submission (May 2015)

* Results are as of the date of report preparation and do not reflect full-year results.

Objective	Initiative/Program	Success Measure	Target	Range	Outcome*
3 - Member value	Serve members, CE providers and CCEPR more effectively and efficiently by establishing a separate website and enhancing online resources for members and providers	Timeliness of deliverables; CE providers and members accessing information on website	CCEPR website live by June 1; enhanced resources by end of Q4	Website launched between May 1- June 30; additional resources posted Q3-2015-Q1-2016	On target at time of submission (May 2015)
1 - Leaders & advocates	To enhance our members' ability to be successful and ensure the integrity of the continuing education process, initiate comprehensive review of CERP Recognition Standards	Request suggestions from communities of interest on current ADA CERP Standards and benchmark accreditation standards for continuing education in the health professions	Call for comments issued April 2015; comments and benchmarking data on accreditation/ Recognition standards by September 15, 2015	Comments from communities of interest and benchmarking data collected Q2-Q4	On target at time of submission (May 2015)

The Commission for Continuing Education Provider Recognition (CCEPR) was established by the 2014 ADA House of Delegates. The Commission is dedicated to developing recognition standards, reviewing and approving providers of continuing dental education and administering the ADA Continuing Education Recognition Program. The Commission replaces the ADA CERP Committee, a committee formerly under the ADA Council on Dental Education and Licensure.

The ADA Continuing Education Recognition Program (CERP) promotes continuous quality improvement of CE and provides dental regulatory agencies with a sound basis for uniform acceptance of CE credits that are mandated by 50 licensing jurisdictions for maintenance of licensure. At the time this report was prepared, there were 435 ADA CERP nationally recognized providers. Through the CERP Extended Approval Process (EAP), 16 of these approved providers (four specialty societies and 12 state dental associations) have extended approval to an additional 108 local societies. ADA CERP-approved providers list their [CE course offerings](#) in the ADA CERP section of ADA.org. In 2013, the most recent year for which data is available, CERP recognized providers reported offering a total of 29,000 courses, including over 200,000 hours of continuing education. Information on the size and scope of ADA CERP providers' activities is published in the [2014 CCEPR Annual Report](#) to communities of interest available on ADA.org/CERP.

Appeal Process. The Commission adopted Procedures for an Adverse Action Against a Provider, outlining an appeal process conducted by an appeal board, in accordance with the Rules of the Commission approved by the ADA House of Delegates.

Standards Review. The Commission also launched a comprehensive review of the CERP Recognition Standards to ensure the Standards continue to establish relevant criteria for quality continuing dental education. The process will include benchmarking standards for continuing education in other healthcare professions. Continuing education stakeholders and communities of interest have been invited to submit comments and suggestions on the Standards. The review and revision process will be conducted in 2015-2016. Any revisions to the Standards proposed by the Commission as a result of its review will also be circulated to the communities of interest for comment.

* Results are as of the date of report preparation and do not reflect full-year results.

CCEPR Web Content. At the time this report was prepared, online information about the Commission and ADA CERP was being migrated to a new micro-site at ADA.org/CCEPR. The site features consolidated information for members seeking information about CERP recognized providers and CE courses they offer, as well as information for CE providers about ADA CERP Standards and application processes.

Emerging Issues and Trends

Formats of continuing education continue to evolve and new information on the effectiveness of continuing professional development is emerging. As part of its comprehensive review of the CERP Recognition Standards, the Commission is monitoring changes to the way continuing education is planned and delivered, and assessing areas where new or revised criteria may be needed to establish standards for continuing education that supports continued professional development and improvements in health care. In particular, the Commission will be assessing:

- New formats of continuing education which the CERP Standards may not currently address.
- New information about effective methodologies for training health care professionals, including training in critical thinking and evidence based medicine and dentistry.
- Emphasis on the need for quality improvement, assessment, inter-professional education, and the practice of evidence-based medicine as outlined in the Institute of Medicine's 2009 [Redesigning Continuing Education in the Healthcare Professions](#) and the 2003 [Health Professions Education: A Bridge to Quality](#).
- Requirements for minimizing commercial bias in continuing education.

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
6H-2014. Amendment of Bylaws to Establish CCEPR and Approve CCEPR Rules	New agency to oversee ADA CERP	CCEPR established	October 2014		Completed on target

The Commission has elected officers and established an appeal board, in accordance with the CCEPR Rules approved by the 2014 House of Delegates, and has assumed oversight responsibility for ADA CERP. CE providers participating in ADA CERP were notified of the transition of program oversight, and advised that recognition decisions made by the CERP Committee prior to October 14 would be upheld by the Commission. Assessment of CE providers continues under the ADA CERP Recognition Standards and Procedures.

Self-Assessment

The Commission is scheduled to conduct a self-assessment in 2020.

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.

Commission on Dental Accreditation

Tuneberg, Perry K., 2015, Illinois, American Dental Association, chair
 West, Karen, 2016, Nevada, American Dental Education Association, vice chair
 Benson, Byron, 2015, Texas, American Academy of Oral and Maxillofacial Radiology
 Blanton, Patricia L., 2018, Texas, American Dental Association
 Campbell, Stephen, 2017, Illinois, American College of Prosthodontists
 Cangialosi, Thomas, 2015, New Jersey, American Association of Orthodontists
 Dodge, William, 2015, Texas, American Dental Education Association
 Donly, Kevin, 2015, Texas, American Association of Pediatric Dentists
 Gagliardi, Lorraine, 2016, California, American Dental Assistants Association
 Glicksman, Milton A., 2016, Massachusetts, American Association of Dental Boards
 Kahn, Richard B., 2016, New Jersey, American Dental Association
 Kassebaum, Denise, 2017, Colorado, American Dental Education Association
 Kolstad, James, 2015, Wisconsin, American Student Dental Association and American Dental Education Association
 Lanier, Dennis, 2017, Georgia, National Association of Dental Laboratories
 Leffler, William, 2018, Ohio, American Association of Dental Boards
 Lerman, Mark A., 2018, Massachusetts, American Academy of Oral and Maxillofacial Pathology
 Livingston, Harold Mark, 2017, Mississippi, Special Care Dentistry Association and American Dental Education Association
 Lobb, William K., 2018, Wisconsin, American Dental Education Association
 Mascarenhas, Ana Karina, 2016, Florida, American Association of Public Health Dentistry
 Mills, Michael P., 2018, Texas, American Academy of Periodontology
 Royeen, Charlotte, 2015, Missouri, Public Member
 Schindler, William G., 2016, Texas, American Association of Endodontists
 Shepherd, Kathi, 2015, Michigan, American Dental Hygienists' Association
 Sherman, Robert, 2017, Hawaii, American Association of Dental Boards
 Sherrard, James, 2015, Connecticut, Public Member
 Stanton, David C., 2017, Pennsylvania, American Association of Oral and Maxillofacial Surgeons*
 Stergar, Cindy J., 2018, Montana, Public Member
 Surabian, Stanley R., 2017, California, American Dental Association
 Torres-Nazario, Ivan, 2017, Puerto Rico, American Association of Dental Boards
 Wheeler, Matthew B., 2018, Illinois, Public Member

*Replaced Tiner, B.D., 2017, Texas, American Association of Oral and Maxillofacial Surgeons

Tooks, Sherin, director
 Baumann, Catherine, manager, Advanced Specialty Education
 Horan, Catherine, manager, Predoctoral Dental Education
 Snow, Jennifer, manager, Advanced Specialty Education
 Soeldner, Peggy, manager, Postdoctoral General Dentistry Education
 Renfrow, Patrice, manager, Allied Dental Education

The Commission's 2014–15 liaison is Dr. Jeffrey Dow (Board of Trustees, First District).

Bylaws Areas of Responsibility

The ADA *Bylaws* describe the duties of the Commission on Dental Accreditation (CODA) as follows:

- a. To formulate and adopt requirements and guidelines for the accreditation of dental, advanced dental and allied dental educational programs.
- b. To accredit dental, advanced dental and allied dental educational programs.

- c. To provide a means for appeal from an adverse decision of the accrediting body of the Commission to a separate and distinct body of the Commission whose membership shall be totally different from that of the accrediting body of the Commission.
- d. To submit an annual report to the House of Delegates of this Association and interim reports, on request, and the Commission's annual budget to the Board of Trustees of the Association.
- e. To submit the Commission's articles of incorporation and rules and amendments thereto to this Association's House of Delegates for approval by vote either through or in cooperation with the Council on Dental Education and Licensure.

Mission

The Commission on Dental Accreditation serves the oral health care needs of the public through the development and administration of standards that foster continuous quality improvement of dental and dental related educational programs.

Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome*
3 - Member value	Ensure public confidence and professional integrity adhering to best practices in accreditation of programs	Compliance with USDE Recognition Criteria; advocate for changes, or begin to implement changes, via HEA reauthorization; continue to reduce ADA contribution to CODA budget	100% compliance; develop plan to implement changes based on HEA; examine additional funding sources	90-100% compliance with Criteria; formalize written plan to implement HEA changes; investigate funding sources for CODA Q1-3	On target at time of submission (May 2015)
1 - Leaders & advocates	Protect reputation of members by increasing data collection on all aspects of dental education	Support JACDEI and data collection by developing new and modifying current instruments; for all disciplines develop mechanism for RC chair review of draft curriculum survey and post-data collection review by RC; publishing meaningful reports	Working with HPI 1-2 new or modified instruments; document distribution of draft curriculum section to RC chair and cumulative data to RC	Drafts reviewed by RC Chair, as applicable, Q2-3 and data reviewed by RC Q4	On target at time of submission (May 2015)
3 - Member value	To enhance our members' ability to be successful and ensure the integrity of the educational process, develop and revise accreditation standards	Draft Standards for Dental Therapy Education considered by the Commission and necessary follow up action taken	Draft Standards for Dental Therapy reviewed January 2015; CODA action and follow-up Q2-3	Draft Standards reviewed Q1-2; Follow-up Q2-3	On target at time of submission (May 2015)

* Results are as of the date of report preparation and do not reflect full-year results.

Objective	Initiative/Program	Success Measure	Target	Range	Outcome*
1 - Leaders & advocates	Be the trusted resource for members and the public on information about the quality of dental education programs through implementation of strategies on international accreditation and communication as part of CODA strategic plan	Continue work toward meeting objectives of strategic plan regarding international presence and enhanced communication	Further implement strategies for international accreditation; further enhance communication plan	Enhance process for communication with international programs Q1-3; expand communication through webinars to COI Q1-3	On target at time of submission (May 2015)

The Commission on Dental Accreditation took 653 accreditation actions at its July/August 2014 and February 2015 meetings based upon site visit reports, progress reports and other information (report of program change, change in sponsorship, authorized enrollment requests, etc.) submitted by educational programs and their sponsoring institutions. As indicated in Table 1, the total number of educational programs accredited is 1,462. This represents an increase of 10 programs from the previous reporting period. Eighty programs hold the status of "Approval with Reporting Requirements" and have 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 timeframe, applications for accreditation of educational programs were reviewed. A total of 17 programs were granted accreditation; these include: two advanced education in general dentistry, three advanced education in general practice residency, one advanced general dentistry in orofacial pain, one advanced general dentistry in oral medicine, two dental public health, one oral and maxillofacial radiology, two periodontics, one orthodontics and dentofacial orthopedics, one clinical fellowship in craniofacial and special care orthodontics, one dental assisting, and two dental hygiene programs.

No education programs had accreditation withdrawn during this reporting period. 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, six programs voluntarily discontinued their participation in the Commission's accreditation program.

Table 1. Total Number of Accredited Programs as of February 2015

	Dental	Specialty	Advanced General Dental	Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Initial Accreditation	7	19	15	0	7	0	48
Approval Without Reporting Requirements	56	423	271	253	314	17	1,334
Approval With Reporting Requirements	2	25	17	20	14	2	80
Total Number of Accredited Programs	65	467	303	273	335	19	1,462

* Results are as of the date of report preparation and do not reflect full-year results.

Major Actions of the Commission on Dental Accreditation

The Unofficial Report of Major Actions of the July/August 2014 and February 2015 meetings of the Commission on Dental Accreditation can be found at <http://www.ada.org/en/coda/accreditation/accreditation-news/post-meeting-actions/>.

Accreditation Standards for Dental Therapy Education Programs

In January 2015, the Commission's Task Force on Development of Accreditation Standards for Dental Therapy Education Programs conducted a thorough review of comments received on the proposed Dental Therapy Standards, which had been circulated for public comment for a second time during 2014. Four hearings were conducted in 2014 at the American Dental Education Association, American Dental Hygienists' Association, American Dental Assistants Association, and American Dental Association annual meetings. Like the prior year, the comments received in 2014 focused on several themes, including the program length, the scope of training, the level of supervision, and the program director requirements. The Task Force conducted a page-by-page review of the draft standards and made additional changes for clarification or editorial purposes in addition to the changes reflected in the key themes discussion presented above. The proposed revisions provide additional clarity and further define the Commission's expectations related to the development of quality education training programs that address the minimal entry level requirements for dental therapy practice, with flexibility to expand and incorporate further training related to additional duties which may be allowed under state dental practice acts and regulatory authority. The Task Force recommended that the Commission adopt the Standards without further circulation; however, it was noted that CODA will not implement the Accreditation Standards or an accreditation program for dental therapy until Criteria #2 and #5 of the *Principles and Criteria Eligibility of Allied Dental Programs for Accreditation by the Commission on Dental Accreditation* are fully satisfied.

At its February 2015 meeting, the Commission adopted the Accreditation Standards for Dental Therapy Education Programs. The Commission notified the communities of interest that there will be no implementation date until further documentation has been provided which shows that criteria #2 and #5 of the *Principles and Criteria Eligibility of Allied Dental Programs for Accreditation by the Commission on Dental Accreditation* are fully satisfied. The Commission noted that it will accept written documentation until June 1, 2015, which shows that criteria #2 and #5 are fully satisfied, for consideration at the August 2015 meeting of the Commission.

The adopted Accreditation Standards for Dental Therapy Education Programs, the *Principles and Criteria Eligibility of Allied Dental Programs for Accreditation by the Commission on Dental Accreditation*, and the Commission's Talking Points on Dental Therapy can be found at: <http://www.ada.org/en/coda/accreditation/accreditation-news>.

ADA/CODA Relationship Workgroup

The ADA/CODA Relationship Workgroup met in June 2014. Members of the Workgroup included Dr. Roger Kiesling (eleventh district trustee, Co-Chair), Dr. John Williams (CODA, Co-Chair), Dr. Joseph Hagenbruch (eighth district trustee and Board liaison to CODA), Dr. Gary Jeffers (ninth district trustee), Dr. Denise Kassebaum (CODA), Dr. Steven Schonfeld (CODA), Dr. Perry Tuneberg (CODA), and Dr. James Zenk (tenth district trustee and Board liaison to CDEL). The Workgroup discussed the topics of CODA budget oversight, the shared services (indirect expenses) model, the Commission's Research and Development Fund, the ADA/CODA Joint Advisory Committee on International Accreditation, and the Commission's governance within the ADA structure. The Workgroup concluded its meeting with a renewed commitment to open lines of communication between the ADA and CODA. The next meeting of the ADA/CODA Relationship Workgroup is scheduled for June 5, 2015.

Accreditation Fees

The Commission directed a 4% increase in the 2016 accreditation fees assessed to programs in an effort to ensure greater fiscal responsibility within the Commission. The increase in 2016 fees will allow the

Commission to assume a greater portion of direct and shared services (indirect) expenses associated with its accreditation program. The 2016 accreditation fees for U.S. based dental and dental-related education programs and international predoctoral programs are found at <http://www.ada.org/en/coda/accreditation/fees/>.

Joint Advisory Committee on International Accreditation (JACIA) Activities

Mission and Purpose

The 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 included Dr. Roger Kiesling, chair (May and September 2014 meetings); Dr. Chad Gehani, chair (December 2014 and February 2015 meetings); Dr. Denise Kassebaum, CODA; Dr. Gary Herman, ADA; Dr. Steven Tonelli, ADA; and Dr. Karen West, CODA. During their terms, ADA presidents, Dr. Charles Norman, and Dr. Maxine Feinberg and CODA chairs, Dr. John Williams and Dr. Perry Tuneberg, served as *ex officio* members of this committee. Dr. Michael Reed served as a consultant to the JACIA, with staff support provided by Dr. Catherine Horan, manager, predoctoral dental education, and Dr. Sherin Tooks, director, CODA.

Background

Since January 1, 2007, the JACIA has accepted Preliminary Accreditation Consultation Visit (PACV) surveys from international predoctoral programs that are interested in the Commission's accreditation program. 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. Eleven international programs have submitted PACV surveys since 2007. Following review and discussion, JACIA approved each of the programs to attend a U.S. comprehensive visit and submit a PACV self-study.

Since 2009, six international predoctoral programs have submitted PACV self-studies and have requested a PACV site visit. One program in Lima, Peru, did not provide sufficient information to warrant a PACV site visit. Five programs (Dharwad, India; Jeddah, Saudi Arabia; Leon, Mexico; Istanbul, Turkey; and Seoul, South Korea) provided sufficient documentation and received 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. Currently, only the programs in Jeddah, Saudi Arabia and Leon, Mexico have been notified by the JACIA of the potential to pursue accreditation by the Commission on Dental Accreditation.

The following is a summary of the activities, results and accomplishments of the May, September and December 2014, and February 2015 meetings of the JACIA.

- The JACIA granted a request for postponement of submission of a PACV self-study for a period of six months, from September 2014 to March 2015 for *The Faculty of Odontology Universidad Autonoma de Nuevo Leon, Monterrey, Mexico*.
- The JACIA reaffirmed the requirement that programs engaging in the consultative process must be fully established international dental education programs that have been in existence long enough to have several graduating classes.
- The JACIA approved an increase in fees for the international consultative process as follows: \$10,000 for the PACV Survey; \$50,000 for the PACV Self-Study, in alignment with the application fee for a United States-based program for 2015; and a \$5,400 Administrative Fee per visit, based

upon a practice of assessing an Administrative Fee for CODA accreditation site visits. The JACIA directed that international programs that have initiated the process be grandfathered under the current fee structure. All programs that have not begun the JACIA consultative process and any new requests would be subject to newly stipulated increases. These increases are in addition to all actual expenses for the conduct of the international consultation visit that the program must pay.

- The JACIA considered the PACV Site Visit Report and program response to the report for the dental education program offered by the *Universidad de la Salle Bajío, Leon, Guanajuato, Mexico*. Following review, the JACIA determined the program has the potential to pursue accreditation by the Commission on Dental Accreditation.
- The JACIA considered the PACV Site Visit Report and program response to the report for the dental education program offered by the *Yonsei University College of Dentistry, Seoul, South Korea*. Following review, the JACIA determined the program has potential to pursue accreditation. In addition, the program must submit a progress report on selected standards and undergo a focused consultative site visit.

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, and the standing committees considered the following:

- Activities of the Commission on Dental Accreditation of Canada (CDAC);
- United States Department of Education (USDE) regulations regarding accreditation recognition;
- Trends in the National Advisory Committee on Institutional Quality and Integrity (NACIQI) evaluation of accreditors for USDE recognition;
- Activities of other specialized accreditors and the Association of Specialized and Professional Accreditors;
- Activities related to the reauthorization of the Higher Education Act; and
- Requests from the communities of interest.

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
57H-2013. Revision of Accreditation Standards	Urge CODA to revise the Accreditation Standards for Dental Education Programs related to practice management to include instruction on personal debt management and financial planning	CODA review of a proposed standard revision for predoctoral dental education	Review Predoctoral Standards for possible revision as proposed by House	2014-2015	In Summer 2014, CODA directed a proposed standard on personal debt management and financial planning be circulated for one year for comment; comments will be considered at the Summer 2015 CODA meeting.

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
1H-2014. Revision of the Rules of the Commission on Dental Accreditation to Replace the Name "American Association of Hospital Dentists" With "Special Care Dentistry Association"	Revise the <i>Rules</i> of the Commission on Dental Accreditation to replace the name "American Association of Hospital Dentists" with "Special Care Dentistry Association" (See Appendix 1, CODA 2014 annual report)	Adoption of revision to CODA <i>Rules</i>	Update CODA <i>Rules</i> to reflect name change of dental organization	2014	House adopted and CODA <i>Rules</i> revised
2H-2014. Amendment of the ADA <i>Bylaws</i> Regarding the Duties of the Commission on Dental Accreditation	Amend Duties of the CODA in ADA <i>Bylaws</i> to reflect contemporary terminology (See Unofficial Report of Actions ADA House of Delegates October 2014)	Adoption of amendment to CODA Duties in the ADA <i>Bylaws</i>	Amend CODA Duties in ADA <i>Bylaws</i> , Chapter XV. Commissions, Section 130. Duties, Subsection A. Commission on Dental Accreditation, to reflect contemporary terminology	2014	House adopted and ADA <i>Bylaws</i> related to Duties of CODA amended
3H-2014. Amendment of the ADA <i>Bylaws</i> to Give the Commission on Dental Accreditation Authority to Make Editorial Corrections to Its <i>Rules</i>	Amend ADA <i>Bylaws</i> to give CODA authority to make editorial corrections to its <i>Rules</i> (See Unofficial Report of Actions ADA House of Delegates October 2014)	Adoption of amendment to ADA <i>Bylaws</i> granting CODA authority to make editorial corrections to its <i>Rules</i>	Amend ADA <i>Bylaws</i> , Chapter XV. Commissions, Section 120. Power to Adopt Rules, to authorize CODA to make editorial changes to its <i>Rules</i>	2014	House adopted and ADA <i>Bylaws</i> related to Power to Adopt Rules amended

Self-Assessment

The Commission is next scheduled to conduct a self-assessment in 2018.

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 the Commission's microsite at ADA.org.

Council on Dental Benefit Programs

Hoffman, Charles W., 2015, Florida, chair
 Masak, John G., 2015, Wisconsin, vice chair
 Blaisdell, Mark H., 2015, Utah
 Brady, Thomas V., 2016, Connecticut
 Davenport, Carson S., 2018, North Carolina
 Eder, B. Scott, 2017, West Virginia
 Gordon, Douglas J., 2017, California
 Hamel, David L., 2018, Kansas
 Hill, Steven J., 2017, Texas
 Krantz, Daniel B., 2016, New Jersey
 Larson, David R., 2016, Pennsylvania
 Mazzola, Robert L., 2015, Ohio
 Pak, Sammy B., 2016, Washington
 Riggins, Ronald D., 2017, Illinois
 Rives, Robert W., 2016, Mississippi
 Snyder, Steven I., 2018, New York
 Vaillant, Matthew J., 2018, Minnesota
 Zappia, Kendra J., New York, *ex officio**

Aravamudhan, Krishna, director
 McHugh, Dennis, manager
 Ojha, Diptee, senior manager
 Pokorny, Frank, senior manager

The Council's 2014–15 liaisons include: Dr. Mark R. Zust (Board of Trustees, Sixth District) and Ms. Emily Hobart (American Student Dental Association).

Bylaws Areas of Responsibility

The Council reviewed its *Bylaws* provisions and, with the Council on Ethics, Bylaws and Judicial Affairs, will be proposing revisions via an omnibus resolution to the Board of Trustees and 2015 House of Delegates. That resolution will be separately presented in the "Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the ADA *Bylaws*."

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
Objective 3: ADA will achieve a 10% increase in the assessment of member	Practice Institute - CDT Code	Deliver final, technical content for the suite of 2016 CDT products to support non-dues revenue generation— CDT 2016 ASCII file for CDT Code licensees and CDT publication	All deliverables completed by July 1, 2015	All deliverables completed between June 15 – August 1, 2015	All deliverables on target for completion and generation of non-dues revenue

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

** *Results are as of the date of report preparation and do not reflect full-year results.*

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
value from membership Objective 5: Non dues revenue will be at least 65% of total revenue		technical content for salable products			
Objective 3: ADA will achieve a 10% increase in the assessment of member value from membership	Practice Institute – Third Party Payer Issues	Maintain efficient and satisfactory call center responses to member questions on benefits and coding	95% of calls closed within 48 hours of receipt in Tier 2, as recorded in Aptify by December 1, 2015	92 – 97% of calls closed within 48 hours of receipt in Tier 2, as recorded in Aptify by December 1, 2015	98.2% of calls resolved within 48 hours of receipt; total calls received in Tier 2 on issues related to dental benefits and coding 1885
Objective 3: ADA will achieve a 10% increase in the assessment of member value from membership	Practice Institute – Third Party Payer Issues	Develop and deliver principles for legislation to assist state dental society advocacy efforts related to dental benefits issues	Principles for legislation developed and disseminated on at least 3 benefit related issues	Principles for legislation developed and disseminated on 2 - 4 benefit related issues and disseminated to state dental societies	Principles for model legislation have been developed and disseminated on: 1. Dentist rating systems 2. Network leasing 3. IRAs/deferred compensation 4. Inadequate notice to providers when carriers change policies
Objective 1: The public will recognize the ADA and its members as leaders and advocates in oral health	Practice Institute – Quality Assessment and Improvement (Dental Quality Alliance)	Maintain the DQA as the recognized leader for quality measurement in dentistry by ensuring that organizations participating in the DQA continue to remain engaged and financially contribute into the DQA Medicaid/SCHIP programs that are considering implementation of quality measures adopt DQA measures	All current DQA member organizations choose to remain as members of the DQA 2 Medicaid/SCHIP programs that are considering implementation of quality measures adopt DQA measures	95 – 100% of current DQA member organizations choose to remain as members of the DQA 1 - 3 Medicaid/SCHIP programs that are considering implementation of quality measures adopt DQA measures	100% of 2014 DQA members have renewed their membership for 2015 CMS has adopted the DQA sealant measure for the CHIP programs nationwide; CMS has included the DQA eMeasures in the Medicaid Meaningful Use Program; HRSA has adopted the DQA eMeasure on sealants for

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
		Promote the value and work of the DQA through a national quality measurement conference	Completion of training for 100 DQA ambassadors at the 2015 national conference	Completion of training for 80-110 DQA ambassadors at the 2015 national conference	reporting by grantees 115 ambassadors completed training at the May 1-2, 2015 DQA meeting held at the ADA Headquarters in Chicago

Emerging Issues and Trends

Dental Benefits Market Trends [Source: National Association of Dental Plans]:

- 191.5 million people (61% of the US population) had a dental benefit in 2013 up from 155.9 million (54%) in 2003. The 2013 national enrollment level represents a 2.2% increase compared to 2012 enrollment.
- In 2013, PPOs accounted for 78% of the dental plans in the market—up from 45% in 2003.
- In 2013, the commercial market had 62.3 million people (47%) with fully insured dental benefits versus 70.7 million (53%) with self-funded plans. Self-funded plan participation has grown by 25% since 2006 partly due to the ACA tax requirement on fully insured plans.
- More than 158,000 dentists participate in at least one PPO network. Among those who participate in PPO networks, on average, each participates in four networks.
- Plan maximums are slightly lower than last year with just under half of PPO plans providing maximum benefits of \$1500 or more per year (in-network) compared to exactly half last year.
- The percentage of enrollees reaching or exceeding plan maximums increased [6% of PPO enrollees (in-network) reach the annual maximum, while 6.9% (out-of-network) reach the same annual maximum].
- Premium increases ranged from 0.2% (DHMO) to 1.5% (PPO), just less than the consumer price index in 2012.
- Number of covered procedures per enrollee has been trending down.
- Eight percent of population covered by commercial benefit have their benefit through individual policies in 2013.
- Twenty-two percent of group dental policies are fully employee paid (i.e. voluntary)
- Use of in-network services from PPO networks is clearly trending up with 57.26% of procedures performed in network for PPO plans.

Changing Commercial Sector Landscape

The Council continues to monitor several developments in the commercial dental benefits sector. Many of these changes are being driven by increasing levels of “consumerism” from both employers and individuals. Some of these changes include emergence of:

- Exclusive Provider Organization (EPO) Networks where there is no out-of-network reimbursement
- Private exchanges with defined contribution from employer
- Embedded products (Medicaid, Marketplace)
- Transparency initiatives to provide cost and quality information to consumers to “shop” for providers

The Council also notes the trend for greater emphasis on “in-network” usage and the increasing focus on telemedicine.

Diagnosis Codes

Diagnosis codes on dental claims is an emerging reporting requirement for reimbursement in some state Medicaid programs and commercial dental benefit plans. State Medicaid agencies vary in their reporting requirements, some requiring a diagnosis code for select procedures including oral evaluations. Commercial dental benefit plans are more focused in their requirements, requiring diagnosis codes for patients with systemic health conditions (e.g., diabetes; pregnancy) where additional services such as prophylaxes or periodontal maintenance are beneficial. The CDT 2015 Companion has a chapter devoted to matching frequently used CDT Codes with applicable ICD-10-CM codes. Diagnosis coding is also addressed in the Council's educational program on Coding and Dental Benefits. The latest version will be introduced during the scientific sessions at ADA2015 where participants receive continuing education credits.

Efforts to implement ADA's SNODENT are achieving success. SNODENT is being implemented in several dental schools as part of the electronic dental records.

- University of Detroit Mercy School of Dentistry (UDM)
- New York University College of Dentistry (NYU)
- Midwestern University in Arizona College of Dental Medicine
- University of Texas Health Sciences Center San Antonio (UTHSCSA) School of Dentistry

SNODENT has been implemented in the testing environment in the following schools.

- Indiana University School of Dentistry (IU)
- University of Illinois at Chicago College of Dentistry (UIC)

Medicaid

Medicaid is one of the most significant growth sectors. Apart from fee increases, reducing administrative burden is necessary to encourage dentist participation in the Medicaid program. As more Medicaid programs transition to managed care, it is important that the contracts between the state and managed care organizations stipulate practices that establish an environment that reasonably supports dentist participation.

To this end, the Council has identified guidelines for acceptable administration of dental benefit programs. These guidelines offer a menu of parameters that states may address to improve administration of Medicaid programs. These guidelines serve as a resource for state dental associations to work with their state dental program Director to establish effective contracts. The guidelines will be disseminated by July 2015.

State Medicaid programs are also showing increasing interest in holding plans accountable through the use of quality measures. Payers are beginning to require reporting of caries risk on the claim form.

Medicare

Federal regulations require dentists who treat Medicare patients to either enroll in the program or opt out in order to prescribe medication for their qualifying patients with Part D drug plans (including Medicare Advantage plans). Failure to do so will result in these patients not receiving their prescription drug coverage effective December 1, 2015. Resources are available to assist members at the [Center for Professional Success](#) (CPS).

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/ Program	Success Measure	Target	Range	Outcome
63H-2014. Coordination of Medical and Dental Benefits Under the Affordable Care Act This resolution calls for the ADA to conduct research to develop guidance on new administrative demands relating to claims submission and coordination of benefits arising from dental benefits embedded in medical plans.	Practice Institute – Third party payer issues	Develop and disseminate guidance on Coordination of Benefits	Guidance on Coordination of benefits developed by May 30, 2015	NA	Completed and posted to the CPS website
103H-2014. Standardized Explanation of Benefits Form This resolution calls for the Council to develop a standardized explanation of benefits form (EOB) for the report of dental claim adjudication that could become the industry standard.	Practice Institute – Third party payer issues	Develop a standardized EOB form	Standardized EOB form developed by May 30, 2015	NA	Standardized EOB form has been developed; CDBP has begun conversations with the National Association of Dental Plans (NADP) to seek implementation of this form across the industry
110H-2014. Policy on Dentist Rating by Third Parties	Practice Institute – Third party payer issues	Inform payers seeking to publish ratings or rankings of dentists about ADA policies and discourage them from using ratings based on inappropriate criteria	NA	NA	Cigna was informed of ADA policies regarding dentist rating systems; Cigna postponed the implementation of the rating system; CDBP is continuing conversations with Cigna and other entities considering such ratings

In addition to the resolutions noted above, Resolution 105H-2014 was assigned to several ADA agencies. CDBP is one of the supporting agencies for this resolution.

Resolution 105H-2014. Development of Resource Materials for Members Concerning Dental Insurance and RAC Audits

Resolved, that the ADA legal division or the appropriate ADA agency expeditiously develop information/guidelines/next steps materials as a resource for members concerning public or private dental insurance audits by Third Party Payers, such as RAC audits.

CDBP has developed an educational tutorial on commercial audit compliance which can be found on the CPS website at <http://success.ada.org/>.

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2018. However, working with the Council on Ethics, Bylaws and Judicial Affairs, the Council will be proposing revisions to its *Bylaws* responsibilities. These will be presented in the “Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the *ADA Bylaws*” to the Board of Trustees and 2015 House of Delegates.

Policy Review

Policies Related to Dental Procedure Code on Explanation of Benefits (EOB)

Background: Often payers limit reimbursement for certain services using tactics such as bundling, downcoding and least expensive alternative treatment (LEAT) clauses. While the ADA opposes such practices, the ADA also advocates EOB statements clearly indicate that reimbursement was based on payer policies. In addition, current ADA policies stipulate that the EOB statement include the CDT codes for the services rendered by the dentist, as well as the CDT code against which the benefit was determined.

The Council reviewed the policy “Dental Procedure Code Changes” and recommends rescission because such a policy adds to the inconsistency between the dentist and the payers records. Since claims data is used for utilization management and frequency limits determination, some payers place frequency limits based on codes used to determine benefits rather than based on actual services rendered and reported. For example, if a dentist reported a combination of periapical and bitewing radiographs and the payer determined the benefit against CDT Code D0210 (intraoral--complete series of radiographic images), the patient is then limited from receiving a benefit for a full mouth series for the time period stipulated in the plan policies. The text of this policy can be found in Appendix 1.

9. Resolved, that the ADA policy, “Dental Procedure Code Changes” (*Trans.2001:433*), be rescinded.

Further, CDBP has reviewed the following policies that also address EOB statements and recommends that they be amended for the same reasons as stated above. The Council recommends the following revisions to these policies.

10. Resolved, that the ADA policy, Explanation of Benefits (EOB) Statement and Identification of Claims Reviewers (*Trans.1995:610*), be amended as follows (additions are underlined; deletions are ~~stricken~~):

Resolved, that in all communications from a third-party payer or other benefits administrator which attempt to explain the reason(s) for a benefit reduction or denial to beneficiaries of a dental benefits plan, the following statement be included:

Any difference between the fee charged and the benefit paid is due to limitations in your dental benefits contract. Please refer to (*insert pertinent provisions of summary plan description*) of your summary plan description for an explanation of the specific policy provisions which limit or exclude coverage for the claim submitted.

and be it further

Resolved, that in reporting the benefit determination to the beneficiary, the following information be reported on the explanation of benefits statement:

1. the treatment reported on the ~~submitted claim by CDT ADA procedure codes as submitted by the dentist numbers and nomenclature~~; and
2. ~~the ADA procedure code numbers and nomenclature on which benefits were determined~~ a statement indicating how the submitted procedures were adjudicated.

and be it further

Resolved, that if EOB statements list CDT codes on which benefits were determined that are different from what was submitted by the treating dentist then payers should not use the code applied for adjudication to limit the frequency of that procedure, and be it further

Resolved, that in all correspondence between a third-party carrier and the patient regarding the patient's dental claims, the carrier should provide the name, area code and telephone number of the individual who is acting on behalf of the carrier, 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 implement this policy.

11. Resolved, that the ADA policy, Bulk Benefit Payment Statements (*Trans.*1990:536; 2013:308), be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~although~~ the ADA goes on record as being opposed to bulk payments by a third-party payer, in the interest of facilitating prompt settlement of patients' accounts, bulk benefit payments may be made by a third-party but should include a statement containing, at a minimum, the following information for each claim payment represented in the bulk payment:

1. Subscriber (employee) name;
2. Patient name;
3. Dates of service;
4. Specific service reported on the submitted claim, by *CDT Code* number and nomenclature;
5. Total fee charged;
6. Statement indicating how the submitted procedures were adjudicated ~~Specific CDT Code number and nomenclature on which benefits were determined~~;
7. Total covered expense;
8. Total benefits paid; ~~and~~
9. In instances where benefits are reduced or denied, an explanation of the reason(s) why the total covered expense differs from the total fee charged, consistent with Association policy on Explanation of Benefits Statements; and
10. If the bulk payment amount on the EOB reflects the final amount paid to the dentist, taking into account any secondary plan payment, then the individual claim amounts should also be adjusted appropriately to avoid discrepancy between the individual claim amounts listed on the EOB and the bulk payment amount.

and be it further

Resolved, that ~~insurance companies~~ third-party payers should not withhold funds from current bulk benefit payments as a means of settling disputes over prior claims experience with the dentist or another dental office and that ~~constituent state~~ dental societies be encouraged to seek legislation to resolve this problem, and be it further

Resolved, that bulk payments should be issued to dentists at intervals of not longer than every ten business days, and be it further

Resolved, that the Council on Dental Benefit Programs work with the insurance industry and ~~dental service plans~~ third-party payers to incorporate this policy into their administrative procedures.

Proposed New Policy on Medical Loss Ratio

Background: The Affordable Care Act requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss

Ratio (MLR). It also requires them to issue rebates to enrollees if this percentage does not meet minimum standards. MLR requires insurance companies to spend at least 80% or 85% of premium dollars on medical care, with the review provisions imposing tighter limits on health insurance rate increases.

Dental plans are generally exempt from MLR reporting stipulated in the ACA. In general, the medical threshold for loss ratio cannot be directly applied to dental plans and, at present, it is difficult to determine the threshold for any universal dental loss ratio.

California recently passed legislation that requires dental plans that issue, sell, renew, or offer specialized dental health care service plan contracts to file a report, to be known as the MLR annual report. Through this legislation, California lawmakers also declared their intent that the data reported pursuant to these provisions will be considered in adopting a specific medical loss ratio standard for dental plans. The state of Washington has passed similar legislation regarding the reporting of information. Reporting from these states will allow for a determination of such a threshold.

Some key aspects included within these legislations are as follows:

- A dental plan shall file an annual report which shall be known as the MLR annual report. It will be filed with the state insurance commissioner and will contain the same information required in the 2013 federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418)¹.
- The MLR reporting year shall be for the calendar year during which dental coverage is provided by the plan. All terms used in the MLR annual report shall have the same meaning as used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), Part 158 (commencing with 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.00.
- If the state decides to conduct a financial examination, as described in Section 1382, because the state finds it necessary to verify the dental plan's representations in the MLR annual report, the state shall provide the plan with a notification 30 days before the commencement of the financial examination.
- The dental plan shall have 30 days from the date of notification to electronically submit to the state all requested records, books and papers. The state may extend the time for the plan to comply with this subdivision upon a finding of good cause.
- The state shall make available to the public all of the data provided to the state pursuant to this section.
- This section does not apply to a dental plan contract for coverage provided in the state's Medicaid or other public programs to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

The Council recommends that the following resolution be adopted:

12. Resolved, that ADA supports the concept of a "Medical Loss Ratio" for dental plans defined as the proportion of premium revenues spent on clinical services and quality improvement versus administrative services and company profits, and be it further

Resolved, that ADA support legislative efforts to require dental benefit plans to file a comprehensive MLR report annually and to establish a specific loss ratio for dental plans in each state.

Summary of Resolutions

Resolution 9. Rescission of the Policy, Dental Procedure Code Changes

Resolution 10. Amendment of the Policy, Explanation of Benefits Statement and Identification of Claims Reviewers

Resolution 11. Amendment of the Policy, Bulk Benefit Payment Statements

Resolution 12. Medical Loss Ratio for Dental Benefit Programs

¹ Note that California is working on adapting this form for standalone dental plans.

Council Minutes

For more information on recent activities, see the Council's [minutes](#) on ADA.org.

Appendix 1. Policies to be Rescinded
As Recommended by the Council on Dental Benefit Programs

Dental Procedure Code Changes (*Trans.2001:433*)

Resolved, that when a third-party payer, or any other entity adjudicating a dental claim, changes the submitted dental procedure code for internal processing purposes, all outgoing transactions, including EOBs, should show the originally submitted dental procedure code to prevent the dentist and the dental plan from having inconsistent records of the treatment rendered.

Council on Dental Education and Licensure

Boyle, James M., III, 2015, Pennsylvania, chair, American Dental Association
 Gesek, Daniel J., 2017, Florida, vice chair, American Association of Dental Boards
 Brysh, L. Stanley, 2016, Wisconsin, American Dental Association
 Edgar, Bryan C., 2018, Washington, American Association of Dental Boards
 Feldman, Cecile A., 2016, New Jersey, American Dental Education Association
 Glickman, Gerald N., 2018, Texas, American Dental Education Association
 Halpern, David F., 2018, Maryland, American Dental Association
 Hebert, Edward J., 2018, Louisiana, American Dental Association
 Hoelscher, Diane C., 2015, Michigan, American Dental Education Association
 Holm, Steven J., 2016, Indiana, American Dental Association
 Manning, Dennis E., 2016, Illinois, American Association of Dental Boards
 Price, Jill M., 2017, Oregon, American Dental Association
 Raman, Prabu, 2017, Missouri, American Dental Association
 Ritchie, Ryan L., 2015, Minnesota, *ex officio**
 Sarrett, David C., 2017, Virginia, American Dental Education Association
 Simonian, Roger B., 2015, California, American Dental Association
 Strathearn, Jeanne P., 2015, Connecticut, American Association of Dental Boards

Hart, Karen M., director
 Jasek, Jane Forsberg, manager
 Monehen, Rosemary, manager

The Council's 2014–15 liaisons include Dr. Gary L. Roberts (Board of Trustees, Twelfth District) and Dr. Andrew Welles (American Student Dental Association).

Bylaws Areas of Responsibility

The Council reviewed its *Bylaws* provisions and, with the Council on Ethics, Bylaws and Judicial Affairs, will be proposing revisions via an omnibus resolution to the Board of Trustees and 2015 House of Delegates. That resolution will be separately presented in the "Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the ADA *Bylaws*."

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
1 – Leaders & advocates	Promote best practices in the state licensure regulatory arenas	Work with two state dental associations in getting legislation introduced	Support at least 2 states in getting legislation introduced	1 to 5 states	Potential states identified

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

** *Results are as of the date of report preparation and do not reflect full-year results.*

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
1 – Leaders & advocates	Protect reputation of members by increasing data collection on all aspects of dental education	Support JACDEI and data collection efforts by developing new and modifying current instruments and mechanisms and publishing in meaningful reports	1 new instrument; 2 instruments modified; via HPI publish at least 5 reports	1-3; 1-4; 3-8	One instrument modified
5 – Non dues revenue	Develop Advanced Dental Admission Test (ADAT) for advanced dental education programs	Execute 2014 business plan; establish content and test specifications	Fourth quarter	Third and fourth quarter	Business plan completed; content and test specifications

Dental Education and Accreditation: In accord with Resolution 39H-2011, Monitoring of Accreditation Matters on Behalf of the ADA (*Trans.*2011:467), a Council representative attends Commission on Dental Accreditation (CODA) meetings and provides the Council with a report on observations of major policy and procedural actions taken by CODA. The Council also reviews matters related to accreditation of dental, advanced dental and allied dental education programs for the Association. Actions taken by the Council regarding these matters are reflected in the Council's meeting minutes.

For the first time this year, the Council sponsored two tuition scholarships to the Academy for Academic Leadership's Institute for Teaching and Learning to recognize members pursuing a career in academia. This year's recipients, Dr. Modjeh Dehghan, from the University of Tennessee's College of Dentistry and Dr. Mary Jane Hanlon, from Tufts University School of Dental Medicine were presented with the tuition scholarships.

Dental Admission Testing Programs: The Council oversees the Dental Admission Test Program, exclusively administered as a computer-based examination via Prometric Testing Centers throughout the United States and its territories. Trends in the DAT Program for 2014 include:

- Average scores for first-time examinees in 2014 on all tests in the DAT battery were slightly higher than those from 2013.
- The total number of DAT administrations has decreased each year since 2010.
- The decline in total administrations appears to be due to a decrease in repeat administrations.
- DAT reliability coefficients indicate that the DAT provides consistent, stable measurement of examinee skills and abilities.
- From highest to lowest, the percentage of administrations based on examinee self-reported ethnicity in 2014 were as follows: White (52%), Asian (24%), Hispanic (9%), Black (7%), American Indian (1%), and Pacific Islander (1%). Six percent (6%) of respondents did not provide ethnicity information.

As recommended by the Council, the Board of Trustees approved up to \$350,000 to develop and pilot test an Advanced Dental Admission Test (ADAT). The Council prepared an ADAT business plan and conducted a survey of all advanced dental education program directors. Of those responding to the survey, 63% were likely or extremely likely to require the proposed Advanced Dental Admission Test for admission purposes. Advanced dental education program directors have expressed a desire for a selection tool to enable rank ordering of applicants, based on candidate's likelihood of success. A critical mass of program directors also indicated they would participate in the pilot test in 2016.

ADA-Recognized Dental Specialties and Specialty Certifying Boards: The Council annually surveys the ADA-recognized dental specialty certifying boards. The 2015 Report of the ADA-Recognized Dental Specialty Certifying Boards shows that all nine specialty certifying boards

certified diplomates in 2014. All boards, with the exception of the American Board of Periodontics, recertified diplomates in 2014. The Report includes synopses of certification and examination data; eligibility requirements; examination, application and registration procedures; re-examination and recertification/certification maintenance policies; and a list of board executive directors/secretaries.

Recognition of Interest Areas in General Dentistry: The Council received an application from the Academy of Operative Dentistry requesting that operative dentistry be recognized by the ADA as an interest area in general dentistry (*Reports 2014:101*). Using the *Criteria for Recognition of Interest Areas in General Dentistry*, the Council followed its established review process, including the conduct of an open hearing at the 2014 ADA meeting and calling for comment from the communities of interest regarding the application. The Council reviewed the application and transmitted its preliminary report to the Academy of Operative Dentistry. At the time this annual report was prepared, the Academy intended to submit a response to the Council's report on the application and requested an appearance before the Council at its December 2015 meeting. The Council will report findings and outcomes of this process to the 2016 House of Delegates.

Dental Anesthesiology: The Council is considering updates to the 2012 *Guidelines for the Use of Sedation and General Anesthesia by Dentists* and the *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*. At the time this report was prepared, proposed amendments to both documents address revisions to anxiolysis and sedation statements regarding children age 12 and under; end-tidal CO₂ monitoring during moderate and deep sedation and general anesthesia unless precluded or invalidated by the nature of the patient; and alterations in course duration and other educational requirements for moderate sedation competency courses. The Council sought comment from the communities of interest during May and June. Following the comment period, the Council may recommend revisions to the House of Delegates via a supplemental report.

Continuing Education Matters: The Council's interagency Continuing Education (CE) Committee provides member oversight and input for CE development, including ADA CE Online and CE offered in the ADA Headquarters Building. The interagency committee includes a representative from each of the following agencies: CDEL (appointee to serve as chair), CDP/CPS, ADA CE Online (editor-in-chief), JADA Editorial Board, CAS, CEBJA (or other agency, on a rotating, as-needed basis), CSA/EBD, CM and the NDC. Actions taken by the Council regarding CE matters are reflected in the Council's meeting minutes.

The ADA Video Studio in the Headquarters Building was approved and funded by the Board of Trustees in 2014. The studio features a fully-functional dental operatory with numerous cameras for filming clinical techniques, a green screen room, production studio/control room, a conference area and speaker preparation area. CE currently produced in the Video Studio will be housed on ADA CE Online. ADA CE Online is in its eighth year of operation and the number of registered users continues to grow. The revenue for the fourth quarter of 2014 was the most profitable in ADA CE Online history, netting over \$35,000. Net revenue for the first two quarters of 2015 is \$67,000 (10% over the 2014 revenue for the same period). Table 1 summarizes activity in FY 2014.

Table 1. ADA CE Online FY 2014

Active Users	New Registrants	Total # Courses	Courses Added	Courses Eliminated
6,138	3,731	107	20	8

Initial Dental Licensure and Clinical Licensing Examinations: The five clinical dental testing agencies consist of member states that utilize the agencies' examinations for the purposes of granting initial licensure in their states. The regional agencies include Central Regional Dental Testing Service (CRDTS), Council of Interstate Testing Agencies, Inc. (CITA), the Commission on Dental Competence Assessments (CDCA) [formerly the North East Regional Board of Dental Examiners, Inc. (NERB)], Southern Regional

Testing Agency (SRTA), and Western Regional Examining Board (WREB). The ADA encourages 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. Nearly all U.S. licensing jurisdictions utilize services of one or more of the clinical testing agencies; only Delaware and New York do 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. Currently, CDCA, SRTA, CITA, Hawaii, Nevada and Florida administer the ADEX Examinations while the remaining regional testing agencies and states administer their own examinations. The results of the ADEX examination, administered by CITA, CDCA, and SRTA, are now accepted by 45 licensing jurisdictions for initial licensure. The states that do not accept the results of the ADEX examination are: Alaska, California, Delaware, Georgia, New York, Oklahoma and South Dakota.

In response to Resolution 50H-2013 (*Trans.2013:327*), the Council monitors the Dental Board of California's development and implementation of a portfolio-style licensure examination and reports progress via its Annual Report. Regulations for the portfolio examination became effective in November 2014. In February 2015 the Dental Board of California approved its audit manual for the portfolio examination. As of February 2015, eight students from the University of California at San Francisco School of Dentistry had registered to participate in the portfolio examination.

The Minnesota Board of Dentistry accepts the National Dental Examining Board of Canada's two-part examination (a written test and non-patient based Objective Structured Clinical Examination [OSCE]), for initial licensure in Minnesota for graduates of the University of Minnesota School of Dentistry graduating after 2009.

New York and Delaware continue to mandate a PGY-1 for initial licensure. Several other states (California, Colorado, Connecticut, Minnesota and Ohio) offer the option to complete a PGY-1 instead of taking a clinical licensure exam. Washington also offers the option to complete a post-doctoral residency program in lieu of a clinical examination if that residency is completed in the state of Washington and meets other specific requirements set forth by state law. 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 2014 annual report. Dental boards in 46 states plus the District of Columbia and Puerto Rico have authority to grant licensure by credentials, although the specific provisions for granting licensure by credentials vary considerably among the states. Delaware, Florida, Hawaii, Nevada and the Virgin Islands do not grant licensure by credentials. A Florida law adopted in 2014 provides licensure eligibility for active duty military, veterans, and veterans' families who serve or have served as an armed forces health care practitioner (as defined in Florida law).

State Licensure Legislation: With assistance from the ADA Department of State Government Affairs, the Council monitors proposed and enacted state legislation. The following summarizes legislation and regulation enacted by the states during this past year:

Colorado – HB 14-1227 was adopted; new statutes and rules allow the dental board to, among other provisions, accept for initial licensure an examination or other methodology, as determined by the board, designed to test the applicant's clinical skills and knowledge, which may include residency and portfolio models.

Ohio – HB 464 was adopted and provides the initial license pathway of PGY1.

Utah – UT S 92 creates an exemption to licensure requirements for the practice of dentistry for certain faculty of accredited dental schools.

Washington – WSR 15-11-005 provides for temporary practice permits for military spouses or state-registered domestic partners who hold out-of-state credentials as dentists, expanded function dental auxiliaries, dental assistants, or dental anesthesia assistants.

Emerging Issues and Trends

Higher Education Act: The Council is monitoring the reauthorization of the Higher Education Act (HEA). Since the original HEA was created in 1965, the sweeping law governing federal financial aid programs has been rewritten eight separate times. The current HEA was set to expire at the end of 2013 but has now been extended through 2015 while Congress prepares for the next reauthorization. It is anticipated that the final bill will address issues such as affordability and college costs; access, persistence and completion; better information for consumers; student loan programs; accreditation and oversight; innovation; and the burden of federal regulations.

Licensure: The Council is represented on a Dental Licensure Task Force, established by the Board of Trustees to develop a plan to address portability of dental licensure, alternatives to current licensure assessments, the fragmentation of the current licensure administrative processes and implementation of agreed upon change including accountabilities and timelines. This activity supports the ADA's initiative to "promote best practices in the state licensure regulatory arenas."

Future of Dentistry: The Council also is represented on a Future of Dentistry Workgroup, established by the Board of Trustees and charged to make a recommendation on whether to move forward with a Future of Dentistry Study, including the parameters, development plans and costs of such a study. The findings of Workgroup will be reported on to the Board in October 2015.

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
33H-2013. Amendment of Requirement 1 of the <i>Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists</i>	Amended policy and called for a process and timeline for the 9 dental specialty organizations to document compliance with revised Requirement 1	Nine dental specialty organizations will comply with revised Requirement 1	Report to 2015 House of Delegates		Achieved. Nine dental specialty organizations now meet Requirement 1
35H-2014. A Comprehensive Study of the Current Dental Education Models	With CDEL input, HPI leads research study on dental education models	Research plan developed by May 2015 Final drafts of reports by April 2016 Reports transmitted to 2016 House of Delegates	May 2015 April 2016 August 2016		On Plan

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2019. However, working with the Council on Ethics, Bylaws and Judicial Affairs, the Council will be proposing revisions to its *Bylaws* responsibilities. These will be presented in the "Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the *ADA Bylaws*" to the Board of Trustees and 2015 House of Delegates.

Policy Review

In accordance with Resolution 170H-2012, Reaffirming Existing ADA Policy, the Council on Dental Education and Licensure reviewed Association policies related to the dental specialties.

The Council reviewed the following policies and determined they should be maintained:

Specialty of Oral and Maxillofacial Surgery (*Trans.*1990:549)
Periodic Review of Dental Specialty Education and Practice (*Trans.*2001:468)
Requirements for Board Certification (*Trans.*1975:690)
Number of Areas of Dental Practice (*Trans.*1995:633)
Dentistry as an Independent Profession (*Trans.*1995:640)
Use of the Term “Specialty” (*Trans.*1957:360)
Certification in Unrecognized Practice Areas (*Trans.*1957:360)

Dentistry

The Council believes that the policy Dentistry should be amended by deleting the second and third resolving clauses which are directives related to implementation and not declarative policy statements.

13. Resolved, that the ADA policy, Dentistry (*Trans.*1997:687) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Dentistry

Resolved, that dentistry is defined as the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body; provided by a dentist, within the scope of his/her education, training and experience, in accordance with the ethics of the profession and applicable law, ~~and be it further~~

~~**Resolved**, that the approved definition of dentistry, adopted by the 1997 House of Delegates be incorporated into the beginning of the Association’s published list with the definitions of dental specialties following in alphabetical order and distributed to the communities of interest, and be it further~~

~~**Resolved**, that the Council on Dental Education and Licensure have responsibility for the periodic review and revision of the definition of dentistry, in a manner consistent with its established procedures for revision of a dental specialty definition.~~

Dental Specialties and Dental Specialty Certifying Boards

The Council believes that the policies recognizing each of the nine dental specialties and the nine dental specialty certifying boards should be amended/adopted to establish standardized declarative policy statements for the recognized dental specialties, their sponsoring organizations and the approved dental specialty certifying boards. Further, because the House of Delegates no longer “affirms” current policy, policies and policy language in that regard should be rescinded. The full text of policies recommended for rescission can be found in Appendix 1. The Council sought input from the dental specialty organizations and certifying boards regarding these recommendations.

14. Resolved, that the ADA policy, Continued Recognition of Dental Public Health as a Dental Specialty (*Trans.*1986:512) be amended as follows (additions are underscoring; deletions are ~~stricken~~):

Continued Recognition of Dental Public Health as a Dental Specialty

Resolved, that dental public health is a dental specialty recognized by the American Dental Association and sponsored by the American Association of Public Health Dentistry's request for continued recognition of dental public health as a dental specialty be approved.

15. Resolved, that the ADA policy approving the requirements of the American Board of Dental Public Health (*Trans.*1951:180) be amended as follows (additions are underscoring; deletions are ~~stricken~~):

Certifying Board in Dental Public Health

Resolved, that the ~~House of Delegates of the~~ American Dental Association approves the ~~requirements of the American Board of Dental Public Health~~ as the national certifying board for the specialty of dental public health.

16. Resolved, that the ADA policy, Recognition of Endodontics as a Specialty (*Trans.*1963:244) be amended as follows (additions are underscoring; deletions are ~~stricken~~):

Recognition of Endodontics as a Dental Specialty

Resolved, that endodontics is a dental specialty ~~be recognized by the American Dental Association and sponsored by the American Association of Endodontics as a special area of dental practice.~~

and be it further

Resolved, that the ADA policy, Continued Recognition of Endodontics as a Dental Specialty (*Trans.*1989:521), be rescinded.

17. Resolved, that the ADA policy, Certifying Board in Endodontics (*Trans.*1964:251) be amended as follows (additions are underscoring; deletions are ~~stricken~~):

Certifying Board in Endodontics

Resolved, that the American Dental Association approves the American Board of Endodontics be approved as the national certifying board in this for the special area of dental practice specialty of endodontics.

Two additional policies related to Endodontics are recommended for rescission. Both policies are obsolete. The eligibility requirement for the American Board of Endodontics mandates that candidates must be graduates of advanced specialty education programs accredited by the Commission on Dental Accreditation. The American Association of Endodontists and the American Board of Endodontics agreed with the Council that these policies should be rescinded.

18. Resolved, that the ADA policy, Requirements for Endodontists (*Trans.*1966:346) be rescinded.

19. Resolved, that the ADA policy, Requirements for Endodontics (*Trans.*1976:897) be rescinded.

20. Resolved, that the ADA policy, Continued Recognition of Oral Pathology as a Dental Specialty (*Trans.*1987:510) be amended as follows (additions are underscoring; deletions are ~~stricken~~):

Continued Recognition of Oral and Maxillofacial Pathology as a Dental Specialty

Resolved, that oral and maxillofacial pathology is a dental specialty recognized by the American Dental Association and sponsored by the American Academy of Oral and Maxillofacial Pathology's request for continued recognition of oral pathology as a dental specialty be approved.

and be it further

Resolved, that the ADA policy, Redesignation of the Specialty of "Oral Pathology" to "Oral and Maxillofacial Pathology" (*Trans.*1995:632), be rescinded.

21. Resolved, that the ADA policy approving the requirements of the American Board of Oral Pathology (*Trans.*1950:29-30) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Certifying Board in Oral and Maxillofacial Pathology

Resolved, that the American Dental Association approves the American Board of Oral and Maxillofacial Pathology ~~the requirements of the American Board of Oral Pathology as the national certifying board for the specialty of oral and maxillofacial pathology.~~

22. Resolved, that the ADA policy, Recognition of Oral and Maxillofacial Radiology as a Dental Specialty (*Trans.*1999:898) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Recognition of Oral and Maxillofacial Radiology as a Dental Specialty

Resolved, that oral and maxillofacial radiology is a dental specialty recognized by the American Dental Association and sponsored by the American Academy of Oral and Maxillofacial Radiology's request for the recognition of oral and maxillofacial radiology as a dental specialty be approved.

23. Resolved, that the proposed ADA policy, Certifying Board in Oral and Maxillofacial Radiology be adopted as follows:

Certifying Board in Oral and Maxillofacial Radiology

Resolved, that the American Dental Association approves the American Board of Oral and Maxillofacial Radiology as the national certifying board for the specialty of oral and maxillofacial radiology.

24. Resolved, that the ADA policy, Continued Recognition of Oral and Maxillofacial Surgery as a Dental Specialty (*Trans.*1990:554) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Continued Recognition of Oral and Maxillofacial Surgery as a Dental Specialty

Resolved, that oral and maxillofacial surgery is a dental specialty recognized by the American Dental Association and sponsored by the American Association of Oral and Maxillofacial Surgeons. ~~continue to recognize the dental origins and derivations of the specialty of oral and maxillofacial surgery, and be it further~~

Resolved, that the American Dental Association ~~continue to maintain its vigilance in cooperation with appropriate specialty organizations to ensure that in the interests of the public, it continue to be recognized by the public and the health care system that oral and maxillofacial surgery is best delivered by surgically trained dentists regardless of additional degree qualifications.~~

and be it further

Resolved, that the ADA policy Continued Recognition of Oral Surgery as a Dental Specialty (*Trans.*1988:491), be rescinded.

25. Resolved, that the proposed ADA policy approving the American Board of Oral and Maxillofacial Surgery be adopted as follows:

Certifying Board in Oral and Maxillofacial Surgery

Resolved, that the American Dental Association approves the American Board of Oral and Maxillofacial Surgery as the national certifying board for the specialty of oral and maxillofacial surgery.

26. Resolved, that the ADA policy, Continued Recognition of Orthodontics as a Dental Specialty (*Trans.*1989:519) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Continued Recognition of Orthodontics and Dentofacial Orthopedics as a Dental Specialty

Resolved, that orthodontics and dentofacial orthopedics is a dental specialty recognized by the American Dental Association and sponsored by the American Association of Orthodontists' ~~request for continued recognition as a dental specialty be approved.~~

and be it further

Resolved, that the ADA policy Redesignation of the Specialty of "Orthodontics" to "Orthodontics and Dentofacial Orthopedics" (*Trans.*1994:611), be rescinded.

27. Resolved, that the ADA policy approving the American Board of Orthodontics (*Trans.*1950:189) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Certifying Board in Orthodontics and Dentofacial Orthopedics

Resolved, that the American Dental Association approves the requirements of the American Board of Orthodontics as the national certifying board for the specialty of orthodontics and dentofacial orthopedics.

28. Resolved, that the ADA policy, Continued Recognition of Pediatric Dentistry as a Dental Specialty (*Trans.*1990:549) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Continued Recognition of Pediatric Dentistry as a Dental Specialty

Resolved, that pediatric dentistry is a dental specialty recognized by the American Dental Association and sponsored by the American Academy of Pediatric Dentistry's ~~request for continued recognition of pediatric dentistry as a dental specialty be approved.~~

and be it further

Resolved, that the ADA policy Redesignation of the Specialty of "Pedodontics" to "Pediatric Dentistry" (*Trans.*1985:591), be rescinded.

29. Resolved, that the proposed ADA policy approving the American Board of Pediatric Dentistry be adopted as follows:

Certifying Board in Pediatric Dentistry

Resolved, that the American Dental Association approves the American Board of Pediatric Dentistry as the national certifying board for the specialty of pediatric dentistry.

30. Resolved, that the ADA policy, Continued Recognition of Periodontics as a Dental Specialty (*Trans.*1988:490) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Continued Recognition of Periodontics as a Dental Specialty

Resolved, that periodontics is a dental specialty recognized by the American Dental Association and sponsored by the American Academy of Periodontology's request for continued recognition of periodontics as a dental specialty be approved.

31. Resolved, that the ADA policy approving the American Board of Periodontology be adopted as follows:

Certifying Board in Periodontics

Resolved, that the American Dental Association approves the American Board of Periodontology as the national certifying board for the specialty of periodontics.

32. Resolved, that the ADA policy, Continued Recognition of Prosthodontics as a Dental Specialty (*Trans.*1987:510) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Continued Recognition of Prosthodontics as a Dental Specialty

Resolved, that prosthodontics is a dental specialty recognized by the American Dental Association and sponsored by the American College of Prosthodontists the Federation of Prosthodontic Organizations' request for continued recognition of prosthodontics as a dental specialty be approved.

33. Resolved, that the ADA policy approving the American Board of Prosthodontics be adopted as follows:

Certifying Board in Prosthodontics

Resolved, that the American Dental Association approves the American Board of Prosthodontics as the national certifying board for the specialty of prosthodontics.

The Council recommends rescission of the policy Statement of Statutory Regulation of Dental Specialty Practice and Dental Specialists (*Trans.*1959:192, 205; 1994:615) because it conflicts with the more recently adopted policy, Guidelines for Licensure (*Trans.*1976:919; 1977:923; 1989:529; 1992:632; 1999:938; 2000:401; 2003:340; 2012:464).

34. Resolved, that the ADA policy Statement of Statutory Regulation of Dental Specialty Practice and Dental Specialists (*Trans.*1959:192, 205; 1994:615), be rescinded.

Finally, the Council noted that three resolutions adopted by the House of Delegates in 1978, 1983 and 2001 were directives rather than policy statements and sought guidance from the Speaker of the House regarding their continued inclusion in the Current Policies document. The Speaker agreed with the Council's assessment. Accordingly, the following statements (full text of the policies is included in Appendix 1) will not be published in future editions of Current Policies:

State Board Use of the Term "Oral and Maxillofacial Surgery" (*Trans.*1978:518)

Number of Clinical Specialty Programs (*Trans.* 1983:559)

Monitor and Increase Number of ADA Recognized Board Certified Specialists (*Trans.*2001:469)

Summary of Resolutions

- Resolution 13. Amendment of the Policy, Dentistry
- Resolution 14. Amendment of the Policy, Continued Recognition of Dental Public Health as a Dental Specialty
- Resolution 15. Amendment of the Policy, Certifying Board in Dental Public Health
- Resolution 16. Amendment of the Policy, Recognition of Endodontics as a Specialty and Rescission of the Policy, Continued Recognition of Endodontics as a Dental Specialty
- Resolution 17. Amendment of the Policy, Certifying Board in Endodontics
- Resolution 18. Rescission of the Policy, Requirements for Endodontists
- Resolution 19. Rescission of the Policy, Requirements for Endodontics
- Resolution 20. Amendment of the Policy, Continued Recognition of Oral Pathology as a Dental Specialty and Rescission of the Policy, Redesignation of the Specialty of “Oral Pathology” to “Oral and Maxillofacial Pathology”
- Resolution 21. Amendment of the Policy, Certifying Board in Oral and Maxillofacial Pathology
- Resolution 22. Amendment of the Policy, Recognition of Oral and Maxillofacial Radiology as a Dental Specialty
- Resolution 23. Certifying Board in Oral and Maxillofacial Radiology
- Resolution 24. Amendment of the Policy, Continued Recognition of Oral and Maxillofacial Surgery as a Dental Specialty and Rescission of the Policy, Continued Recognition of Oral Surgery as a Dental Specialty
- Resolution 25. Certifying Board in Oral and Maxillofacial Surgery
- Resolution 26. Amendment of the Policy, Continued Recognition of Orthodontics as a Dental Specialty and Rescission of the Policy, Redesignation of the Specialty of “Orthodontics” to “Orthodontics and Dentofacial Orthopedics”
- Resolution 27. Amendment of the Policy, Certifying Board in Orthodontics and Dentofacial Orthopedics
- Resolution 28. Amendment of the Policy, Continued Recognition of Pediatric Dentistry as a Dental Specialty and Rescission of the Policy, Redesignation of the Specialty of “Pedodontics” to “Pediatric Dentistry”
- Resolution 29. Certifying Board in Pediatric Dentistry
- Resolution 30. Amendment of the Policy, Continued Recognition of Periodontics as a Dental Specialty
- Resolution 31. Certifying Board in Periodontics
- Resolution 32. Amendment of the Policy, Continued Recognition of Prosthodontics as a Dental Specialty
- Resolution 33. Certifying Board in Prosthodontics
- Resolution 34. Rescission of the Policy, Statement of Statutory Regulation of Dental Specialty Practice and Dental Specialists

Council Minutes

For more information on recent activities, see the Council’s [minutes](#) on ADA.org.

Appendix 1. Policies to be Rescinded
As Recommended by the Council on Dental Education and Licensure

Continued Recognition of Endodontics as a Dental Specialty (Trans.1989:521)

Resolved, that the American Association of Endodontists' request for continued recognition of endodontics as a dental specialty be approved.

Requirements for Endodontists (Trans.1966:346)

Resolved, that in order to eliminate inequities still existing toward practitioners of endodontics who graduated from dental school during and after 1957, the requirements of two years advanced formal education should not be applied to candidates applying for certification to The American Board of Endodontics who have graduated from dental school in 1964 or prior thereto, provided such candidates meet all other requirements of the American Board of Endodontics.

Requirements for Endodontics (Trans.1976:897)

Resolved, that in compliance with the intent of Resolution 36-1966-H (Trans.1966:346) candidates who do not possess the required formal education and who did not apply to the American Board of Endodontics for examination prior to December 31, 1974 are ineligible for examinations, and be it further

Resolved, that candidates who do not possess the formal education requirement but applied for examination prior to December 31, 1974 are ineligible for reapplication upon expiration of their board eligibility.

Redesignation of the Specialty of "Oral Pathology" to "Oral and Maxillofacial Pathology" (Trans.1995:632)

Resolved, that the specialty currently designated "oral pathology" be redesignated "oral and maxillofacial pathology," and be it further

Resolved, that the documents and policies approved by the House of Delegates of the American Dental Association which refer to "oral pathology" be amended to reflect the change in designation to "oral and maxillofacial pathology," and be it further

Resolved, that the communities of interest be advised of the change in designation and be encouraged to utilize the new designation when referring to the specialty, and be it further

Resolved, that the *ADA Principles of Ethics and Code of Professional Conduct* be amended by deleting the second paragraph of Section 5-C, Announcement of Specialization and Limitation of Practice, in its entirety and substituting the following new second paragraph:

The special areas of dental practice approved by the American Dental Association and the designation for ethical specialty announcement and limitation of practice are: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics.

Continued Recognition of Oral Surgery as a Dental Specialty (Trans.1988:491)

Resolved, that the American Association of Oral and Maxillofacial Surgeons' request for continued recognition as a dental specialty be approved.

**Redesignation of the Specialty “Orthodontics” to “Orthodontics and Dentofacial Orthopedics”
(Trans. 1994:611)**

Resolved, that the specialty currently designated “orthodontics” be redesignated “orthodontics and dentofacial orthopedics,” and be it further

Resolved, that the documents and policies approved by the House of Delegates of the American Dental Association which refer to “orthodontics” be amended to reflect the change in designation to “orthodontics and dentofacial orthopedics” and be it further

Resolved, that the communities of interest be advised of the change in designation and be encouraged to utilize the new designation when referring to the specialty, and be it further

Resolved, that the Association’s *Principles of Ethics and Code of Professional Conduct* be amended by deleting the second paragraph of Section 5-C, Announcement of Specialization and Limitation of Practice, in its entirety and substituting the following new second paragraph:

The special areas of dental practice approved by the American Dental Association and the designation for ethical specialty announcement and limitation of practice are: dental public health, endodontics, oral pathology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics.

Redesignation of the Specialty of “Pedodontics” to “Pediatric Dentistry” (Trans.1985:591)

Resolved, that the specialty currently designated “pedodontics” be redesignated “pediatric dentistry,” and be it further

Resolved, that dental educational institutions consider redesignating departments of “pedodontics” as departments of “pediatric dentistry,” and be it further

Resolved, that state boards of dentistry consider changing their identification of the specialty of “pedodontics” to “pediatric dentistry,” and be it further

Resolved, that the documents and policies approved by the House of Delegates of the American Dental Association which refer to “pedodontics” be amended to reflect the change in designation to “pediatric dentistry,” and be it further

Resolved, that the Association’s *Principles of Ethics and Code of Professional Conduct* be amended by deleting the second paragraph of Section 5-C, Announcement of Specialization and Limitation of Practice, in its entirety and substitution of the following new second paragraph:

The special areas of dental practice approved by the American Dental Association and the designation for ethical specialty announcement and limitation of practice are: dental public health, endodontics, oral pathology, oral and maxillofacial surgery, orthodontics, pediatric dentistry, periodontics and prosthodontics.

**Statement of Statutory Regulation of Dental Specialty Practice and Dental Specialists
(Trans.1959:192:205) (1994:615)**

Provisions specifically regulating dental specialty practice and dental specialists have been incorporated within various dental laws. These statutory provisions are intended to ensure high standards of competency from dentists who hold themselves out as specialists in order to serve best the dental health needs of the public.

Although the purpose and objectives of the so-called specialty laws are worthy aims, there is unquestionably an inherent danger of conflict between what might well develop into an inelastic legal system for regulating dental specialty practice and the much more flexible private regulatory system as reflected within Association-approved requirements and ethical principles. If, for example, the law in a particular state prescribes postgraduate requirements for a specialty practice license inferior to those approved by the Association, the result may well be a legal grant of authority to specialty licenses which, if exercised, would bring them in conflict with Association policy and even professional ethics.

Again, a state specialty law may recognize specialty areas for licensure not approved by the Association. The dentist authorized to hold himself out in a nonapproved specialty area, then, could not exercise his legal privilege without exposing himself to a charge of unethical conduct

The American Dental Association recognizes that specialty licensure can be a fair and equitable means of expediting the free movement of specialists among various states. However, in creating specialty licensure laws, it is prudent to recognize that the creation and control of dental specialties is best handled by the profession acting through the American Dental Association in consultation with the specialty organizations, state boards of dentistry, and dental schools with proper regard for the protection of the dental health of the public.

Should it be determined by a constituent society that statutory regulation of specialty practice is required because of a particular local situation, the American Dental Association further recommends that the society take all precautions to ensure that the specialty provisions will permit the state board of dental examiners (1) to prescribe regulations to conform with Association requirements, and (2) to amend those regulations whenever it is necessary to conform them with changes in Association requirements.

The American Dental Association also recommends that those constituent societies representing states which now have specialty practice provisions within their dental practice acts urge their dental examining boards to (1) bring the board regulations for, and administration of, the dental specialty laws in conformity with existing Association requirements, and (2) prescribe new regulations and make appropriate administrative changes whenever it is necessary to conform with any future changes in Association requirements.

Policies No Longer Published in Current Policies

State Board Use of the Term “Oral and Maxillofacial Surgery” (*Trans.1978:518*)

Resolved, that state boards of dentistry consider appropriate revisions in their identification of oral surgery to accommodate the specialty of oral and maxillofacial surgery.

Number of Clinical Specialty Programs (*Trans.1983:559*)

Resolved, that the American Dental Association urges the American Dental Education Association and specialty programs to reassess the number of first-year positions in clinical dental specialty programs in view of disease trends, manpower projections and patient demands.

Monitor and Increase Number of ADA Recognized Board Certified Specialists (*Trans.2001:469*)

Resolved, that the sponsoring dental specialty organizations and ADA recognized dental specialty certifying boards be urged to continue to monitor the number of specialists who are board certified and identify ways to increase the percentage of specialists who seek and achieve board certification in light of dental specialty faculty shortages and the Commission on Dental Accreditation’s standard requiring that program directors of advanced dental specialty education programs be board certified.

Council on Dental Practice

Unger, Joseph G., 2015, Illinois, chair
 Brown, Andrew B., 2016, Florida, vice chair
 Bengtson, Gregory J., 2016, Idaho
 Cammarata, Rita M., 2017, Texas
 Childs, Miranda M., 2015, Arkansas
 Creasey, Jean L., 2016, California
 Kent, Leigh W., 2018, Alabama
 Landes, Christine M., 2017, Pennsylvania
 Marron-Tarrazzi, Irene, Florida, *ex officio**
 Marshall, Todd W., 2016, Minnesota
 Maxwell, Charles B., 2015, South Carolina
 Mazur-Kary, Michelle L., 2017, Maine
 O'Toole, Terry G., 2017, District of Columbia
 Ratner, Craig S., 2018, New York
 Smith, J. Christopher, 2016, West Virginia
 Theurer, Scott L., 2018, Utah
 Thomas, J. Mark, 2015, Indiana
 Wojcik, Michael S., 2018, Michigan

Porembski, Pamela M., director
 Metrick, Diane M., senior manager
 Shapiro, Elizabeth A., senior manager
 Hughes, Sarah M., manager
 Kluck-Nygren, Cynthia A., manager
 Sarver, Jordan P., manager
 Siwek, Alison M., manager

The Council's 2014–15 liaisons include: Dr. Gary S. Yonemoto (Board of Trustees, Fourteenth District); Dr. James Tauberg (Council on Communications); and Ms. Erinne Kennedy (American Student Dental Association).

Bylaws Areas of Responsibility

The Council reviewed its *Bylaws* provisions and, with the Council on Ethics, Bylaws and Judicial Affairs, will be proposing revisions via an omnibus resolution to the Board of Trustees and 2015 House of Delegates. That resolution will be separately presented in the "Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the ADA *Bylaws*."

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
1 – Member value	Center for Professional Success	1. Increase authenticated users 2. Increase total content	1. Increase over 2014 numbers by 25%	1. 20-30% increase	1. 27% increase

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

** *Results are as of the date of report preparation and do not reflect full-year results.*

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
		3. Increase visits and views 4. Increase engagement 5. Increase online course registrations 6. Upgrade to mobile-responsive design (2015-16)	2. 50 articles, 15 videos, four infographics 3. Visitor increase by 20%, page view increase by 20% 4. Increase white paper downloads by 10%, poll participation by 20%, video views by 30%, user group size increased by 40 members 5. 250 enrollees	2. 45-55 articles, 10-20 videos, three to five infographics 3. Increase 15-25% for both goals 4. Increase 5-15% downloads, 15-25% poll participation, 25-35% video views, 35-45 new user group members 5. 225-275 enrollees	2. 31 articles, 13 videos, one infographic 3. 35% increase for web visits, 55% increase in page views 4. 6.9% increase in whitepaper downloads, 28% increase in poll participation, 555% increase in video views, 18 new user group members 5. 103 enrollees 6. Responsive design to be done in 2016 concurrently with site redesign
3 – Member value	American Student Dental Association (ASDA) Wellness Collaboration	1. Conduct a dental student health and well-being survey 2. Develop resources on mental health, addiction and stress management for dental students 3. Contribute health and well-being content to ASDA member publications	1. Deploy the survey by the end of first quarter 2015 2. Develop five dental student health and wellness resources 3. Submit two resources to ASDA for publication by third quarter 2015	1. Deploy the survey between the first and third quarters 2015 2. Develop four to six health and wellness resources based on dental student health and well-being survey results 3. Submit one to three resources to ASDA for publication by third quarter	1. Survey was deployed and analyzed in February 2015 2. Three well-being videos were developed; a dental school health and well-being contact directory was developed; and the state dentist health and well-being program directory was developed A PowerPoint template on well-being programs was developed and distributed for use in dental schools

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
					<p>State dentist well-being programs presenting in dental schools has increased from 58%-86%</p> <p>3. Five articles were published in the January 2015 issue of <i>ASDA Mouth</i></p>
3 – Member value	State Well-Being Directors' Conference	<p>1. Develop an educational program to help the state dentist health and well-being programs treat and maintain the recovery of their dental peers</p> <p>2. Perform a follow-up survey with conference attendees</p>	<p>1. Develop five sessions that focus on the treatment of addiction and maintenance of recovery</p> <p>Five state dentist well-being programs incorporate dental student health and wellness into their programs</p> <p>2. Distribute the survey by October 2015</p>	<p>1. Develop three to six sessions on advocacy, treatment and management of addiction</p> <p>Three to seven programs are incorporated into dental student health and wellness programs</p> <p>2. 70-80% of attendees complete the survey</p>	<p>1. Five sessions addressed advocacy issues, treatment and management of addiction</p> <p>Five sessions addressed health and well-being issues facing dental students</p> <p>2. Survey results will be used to determine future conference topics</p>
3 – Member value	Provider's Clinical Support System-Opioid (PCSS-O) Webinar Grant	<p>1. Four PCSS-O related webinars</p> <p>2. At least 300 webinar participants for 2015</p>	<p>1. Present four webinars/training courses on prescription opioid abuse</p> <p>2. Each webinar/training course will include 100 participants for a total of 400</p>	<p>1. Four webinars with 400-475 total participants</p> <p>2. Between 80-90% of total participants rated the webinar as "meets expectations"</p>	<p>1. Completed four PCSS-O webinars for a total of 841 participants</p> <p>2. 98.9% of webinar participants rated the sessions as "meeting their expectations" and 100% were "very likely" to attend future webinars hosted by the ADA</p>

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
3 – Member value	Practice Management Guidelines	1. Develop guidelines on management of “Patients” 2. Develop guidelines on “Financial Matters” 3. Launch benchmarking platform	1. Develop guideline by fourth quarter 2015 2. Develop guideline by fourth quarter 2015 3. Launch benchmarking platform by fourth quarter 2015	1. Develop guideline between third quarter 2015 and first quarter 2016 2. Develop guideline between third quarter 2015 and first quarter 2016 3. Benchmarking platform launched between the third quarter 2015 and first quarter 2016	1. The guideline is expected to be published by fourth quarter 2015 2. The guideline is expected to be published by fourth quarter 2015 3. Benchmarking platform is expected to be launched by fourth quarter 2015
3 – Member value	Employment Contract Education for New Dentists	1. Develop a resource on dentist employment contracts 2. Deliver a seminar based on the resource to dental students	1. Resource is developed by first quarter 2015 2. Present seminar to one class of dental students by second quarter 2015	1. Resource is developed between first and second quarter 2015 2. Present seminar to one to three dental schools between first and third quarter	1. A white paper has been downloaded 36 times the first four months of 2015 and 205 times since original posting in 2014 A video of the seminar was posted on CPS in the second quarter 2015 2. The seminar was presented in-person to four dental schools by the second quarter 2015 A CE session will be presented at ADA 2015

Emerging Issues and Trends

Teledentistry

The Council appointed an Ad Hoc Advisory Committee on Teledentistry to investigate and consider proposing additional policy on teledentistry. An Interagency Workgroup on Teledentistry was created to assess whether other councils were actively discussing the topic and to ensure that any proposed policy was responsive to concerns expressed by other agencies. The Interagency group consists of

representatives from the CDP, the Council on Access, Prevention and Interprofessional Relations, the Council on Dental Benefit Programs, the Council on Dental Education and Licensure (CDEL), CEBJA and the Council on Government Affairs. A supplemental report on proposed teledentistry policy will be submitted to the 2015 House of Delegates.

Infection Control Consortium

The Council has monitored the activities of the Infection Control Consortium (ICC) since the group's inception in 2014. Organizations participating in the ICC have determined that it has completed its objectives to define competency in infection control and to outline infection control learning objectives and topics that should be included in an infection control curriculum.

CDEL has also monitored the Consortium's efforts. CDEL and CDP both passed a resolution recommending that the ADA support the ICC's communications statement which reads:

Several dental organizations* and the Centers for Disease Control and Prevention (CDC) convened in Chicago in August 2014 to conduct a national conversation about the potential need for infection control education and competency statements for those who perform and/or oversee infection control procedures in oral healthcare settings. The goal for the group is to promote the protection of the public and the dental team. Outcomes of the initial meeting included identification of overarching core competencies and learning objectives, and a suggested list of essential elements of an infection control curriculum.

**Academy of General Dentistry (AGD), American Association of Dental Boards (AADB), American Dental Assistants Association (ADAA), American Dental Association (ADA), American Dental Education Association (ADEA), Dental Assisting National Board (DANB), Organization for Safety, Asepsis and Prevention (OSAP).*

A joint report from CDP and CDEL will be prepared for the Board of Trustees after final proceedings of the ICC have been released.

The Department of Standards

The ADA's voluntary standards program is an American National Standards Institute (ANSI)-accredited program that develops voluntary consensus standards that meet the Members First 2020 Strategic Plan Objective 3.1: Pursue programs that members value and are "Best in Class." The CDP reviews the work products of the Standards Committee on Dental Informatics (SCDI) as part of its *Bylaws* duties. The SCDI's focus is to develop standards and technical reports for current and emerging digital technologies used in the dentist's practice including electronic health records, interoperability and other issues involving the safe and secure storage and exchange of digital images and patient data.

Teledentistry and Interoperability Activities: The ADA SCDI delivered a successful teledentistry demonstration CE course at ADA 2014 to carry out its mandates from the House of Delegates to develop standards for Teledentistry, Resolution 107H-2012 Teledentistry (*Trans.2012:455*), and for Resolution 83H-2009 Development of a Standard for Secure Electronic Transmission of Digital Radiographs (*Trans.2009:420*). The course, "Teledentistry: Secure Exchange of Digital Images and Data for Dental Practices," was a real-time demonstration of secure exchange of digital images via e-mail.

Digital Imaging and Communications in Medicine (DICOM) Activities: The ADA is the Secretariat of DICOM Working Group 22—Dentistry, which develops codes for interoperable digital dental images and patient data. A new DICOM dental standard consisting of new and corrected DICOM codes that describe intraoral regions for dental radiography, was approved by the DICOM Standards Committee and has been published in the DICOM Standard.

Forensic Dental Data Standard Implementation Activities: The International Organization for Standardization (ISO) is developing a new work proposal for the purpose of developing a uniform

nomenclature for the description of forensic dental data and to define a standardized set of uniform terms to convey this information. The SCDI Joint WG 10.12 Forensic Odontology Informatics is working with ISO (through the U.S. Technical Advisory Group for ISO/TC106) on this project using ANSI/ADA Standard No. 1058—*Forensic Dental Data Set* as one of the reference documents. SCDI Joint WG 10.12 also collaborates with National Institute of Justice (NIJ), the National Institute of Standards and Technology (NIST) and the newly created Organization of Scientific Area Committees (OSAC). The new work item, *Proposed Technical Report No. 1088 for the Identification of Human Remains by Dental Means*, was approved on May 7, 2015. The SCDI and JWG 10.12 delivered a successful CE demonstration course at ADA 2014, “Identifying Disaster Victims: Standards for Electronic Dental Patient Data.” The course showed how dental patient data was used to identify victims in several real-life disasters.

Standards for Electronic Claims Attachments: SCDI Working Group 10.10 Electronic Dental Claim has developed standards that address dental attachments. The ANSI/ADA Standard No. 1079 for an *Electronic Claim Attachment*, provides a general claim attachment format for periodontal and other typical uses such as orthodontic and oral and maxillofacial surgery claim attachments. The standard was approved by the Council on Dental Benefit Programs on April 23, 2015.

Universal Device Identifier (UDI) Labeling: The Food and Drug Administration (FDA) issued a rule on September 24, 2013, to establish a system to adequately identify dental devices through distribution. This rule requires the label of medical devices to include a UDI. Though the manufacture chain and responsibilities are clearly defined by the FDA, clinical use is not; therefore, the SCDI Working Group 11.8 Track and Trace for Implantable Devices addressed this issue through *ADA Technical Report No. 1081 for FDA’s Unique Device Identification (UDI) Program for Dental Devices and Biologics Regulated as Medical Devices*. The technical report was approved by CDP on May 7, 2015.

Digital Oral Health Risk Assessment Products: SCDI Working Group 11.7 Risk Assessment Software began development of *Proposed ADA Technical Report No. 1087 for Essential Characteristics of Digital Oral Health Risk Assessment Resources*. A related work item, *Proposed ADA Technical Report No. 152 on Oral Health Risk Assessment Tools*, is under development by the ADA Standards Committee on Dental Products (SCDP). The two projects are coordinated by a joint SCDP/SCDI working group.

Electronic Dental Record (EDR): The SCDI published a new guide to the EDR for practitioners. *ADA Technical Report No. 1030 for Dental Provider’s Guide to the Electronic Dental Record* was approved on November 21, 2014.

New Work Projects: Over the past year, CDP approved the following new work projects: *Proposed ADA Technical Report No. 1083 for Utilization of EDR to Support Clinical Quality Improvement*; *Proposed ADA Technical Report No. 1084 for Core Set of Reference Data for Communication among Dental Information Systems*; *Proposed ADA Technical Report No. 1085 for Direct Secure Messaging*; *Proposed ADA White Paper No. 1086 for Dental Personal Health Record*; *Proposed ADA Technical Report No. 1087 for Essential Characteristics of Digital Oral Health Risk Assessment Resources*; *Proposed ADA Technical Report No. 1088 for the Identification of Human Remains by Dental Means*; *Proposed ADA Technical Report No. 1089 for Track and Trace for Human Cells, Tissues and Cellular and Tissue-based Products*; and *Proposed ADA Technical Report No. 1090 for Exploration of Adoption and Augmentation of the Quality Matters (QM) Higher Education Design Standards for Online and Blended Courses*.

Over the past year, the following standards and technical reports were approved: *ADA Technical Report No. 1030 for Dental Provider’s Guide to the Electronic Dental Record*; *Revised ADA Technical Report No. 1041 for Content of Electronic Laboratory Prescriptions*; *ADA Technical Report No. 1069 for SCDI Standard Terms, Acronyms and Definitions*; *ADA Technical Report No. 1075 for Electronic Orthodontic Dental Laboratory Prescriptions*; *ANSI/ADA Standard No. 1079 for Electronic Attachments for Dental Claim*; and *ADA Technical Report No. 1081 for Track and Trace for Implantable Devices and Biologics*.

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
28H-2014. Chairside Medical Screenings	Examine the implications of Chairside Medical Screenings in the dental practice	A comprehensive report will be provided to the 2015 House of Delegates	Complete report for submission to the 2015 House of Delegates	Complete report between second and third quarter	A supplemental report on Resolution 28H-2014 will be submitted to the 2015 House of Delegates
34H-2014. ADA Policy for Dental Schools to Provide Education to Dental Students on Drug and Alcohol Use and Misuse	Collaborate with the American Student Dental Association (ASDA) on a Wellness initiative for dental students	<ol style="list-style-type: none"> 1. Conduct a dental student health and well-being survey 2. Develop resources on mental health, addiction and stress management for dental students 3. Contribute health and well-being content to ASDA member publications 	<ol style="list-style-type: none"> 1. Deploy the survey by the end of first quarter 2015 2. Develop five dental student health and wellness resources 3. Submit two resources to ASDA for publication by third quarter 2015 	<ol style="list-style-type: none"> 1. Deploy the survey between the first and third quarters 2015 2. Develop four to six health and wellness resources based on dental student health and well-being survey results 3. Submit one to three resources to ASDA for publication by third quarter 	<ol style="list-style-type: none"> 1. Survey was completed and analyzed in February 2015 2. Three videos on well-being issues were developed; a dental school health and well-being contact directory was developed; and the state dentist health and well-being program directory was developed 3. Five articles were published in the January 2015 issue of <i>ASDA Mouth</i> <p>A PowerPoint template on well-being programs was developed and distributed for use in dental schools</p> <p>State dentist well-being programs presenting in dental schools has increased from 58%-86%</p>

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
62H-2014. Development of Ethically Based, Voluntary Practice Management Guidelines	Develop Practice Management Guidelines in two subject matters— patients and financial matters	1. Develop guidelines on management of “Patients” 2. Develop guidelines on “Financial Matters” 3. Launch benchmarking platform	1. Develop guideline by fourth quarter 2015 2. Develop guideline by fourth quarter 2015 3. Launch benchmarking platform by fourth quarter 2015	1. Develop guideline between third quarter 2015 and first quarter 2016 2. Develop guideline between third quarter 2015 and first quarter 2016 3. Benchmarking platform launched between third quarter 2015 and first quarter 2016	1. The guideline is expected to be published by fourth quarter 2015 2. The guidelines is expected to be published by fourth quarter 2015 3. Bench-marking platform is expected to launch by fourth quarter 2015

The Practice Management Guidelines project, in response to Resolution 62H-2014, began in January. Guidelines on financial matters and the patient experience are expected to be published on the Center for Professional Success (CPS) by the end of the fourth quarter. A separate benchmarking platform is also expected to launch this year. It will allow ADA members to input select data about their practices and compare their information to that of other practices based on such variables as practice type, location, specialty, size, and other factors. The benchmarking platform is a unique member benefit not offered by any other dental association.

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2019. However, working with the Council on Ethics, Bylaws and Judicial Affairs, the Council will be proposing revisions to its *Bylaws* responsibilities. These will be presented in the “Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the *ADA Bylaws*” to the Board of Trustees and 2015 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.

Council on Ethics, Bylaws and Judicial Affairs

Himmelberger, Linda K., 2015, Pennsylvania, chair
 Auld, Douglas A., 2016, Oklahoma, vice chair
 Beard, Darryll L., 2015, Illinois
 Curry, Barry D., 2015, Kentucky
 Edwards, Adam A., 2017, New York
 Halasz, Michael H., 2017, Ohio
 Herman, Gary N., 2018, California
 Ilkka, Don J., 2018, Florida
 Ishkanian, Emily R., Nevada, *ex officio**
 Kochhar, Puneet, 2018, New Hampshire
 Merritt, Kennedy W., 2017, New Mexico
 Moss, J. David, 2018, South Carolina
 Muller, G. Jack, II, 2016, South Dakota
 Raimann, Thomas E., 2016, Wisconsin
 Scarbrough, A. Roddy, 2016, Mississippi
 Shekitka, Robert A., 2017, New Jersey
 Walton, William M., 2016, Texas
 Williams, Laura, 2015, Washington

Elliott, Thomas C., Jr., director
 Elster, Nanette, manager

The Council's 2014–15 liaisons include: Dr. Lindsey A. Robinson (Board of Trustees, Thirteenth District) and Ms. Niveditha Rajagopalan (American Student Dental Association).

Bylaws Areas of Responsibility

The Council reviewed its *Bylaws* provisions and, with the remaining councils, will be proposing revisions via an omnibus resolution to the Board of Trustees and 2015 House of Delegates. That resolution will be separately presented in the "Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the ADA *Bylaws*."

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
3 - Member value	Support member success by providing varied ethics programming accessible to membership through multiple venues	Membership access to excellent ethics continuing education programming	Highly favorable participant evaluation of continuing education ethics programming	Favorable to highly favorable participant evaluation of continuing education ethics programming	On target at time of submission (May 2015)

* New Dentist Committee member without the power to vote.

** Results are as of the date of report preparation and do not include full-year results.

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
3 - Member value	Support member success by providing communications vehicle allowing members to obtain advice on ethical questions in a very timely manner	Membership access to timely advice concerning ethics questions that arise in members' practices	Highly favorable participant evaluation of ethics advice program	Favorable to highly favorable participant evaluation of ethics advice program	Believed to be on target at time of submission (May 2015)

Continuing Education Programming in Ethics: During the 2014 annual meeting, the Council presented a continuing education course entitled "Resolving Ethical Conflicts That May Arise in the Dental Practice." One hundred twenty-five attendees registered for the course; following is a summary of course evaluation responses received from attendees:

Question	Average to Excellent	Below Average to Poor
Your overall rating of the course content.	94.22%	5.77%
The extent to which the stated educational objectives were accomplished.	96.15%	3.85%
Rate the extent to which the course provided timely information you could implement into your practice.	96.15%	3.85%

Additional activity by the Council in support of its goal of providing varied ethics programming accessible to membership through multiple venues include:

- Developing an ethics continuing education course with a revised format for the 2015 annual meeting.
- Commencing the development of videotaped ethics continuing education courses that will be available through ADA.org. Three such videos were taped in the spring of 2015; those videos are in queue for editing by the ADA's video production staff at the time of the submission of this report.
- Providing continuing education courses to state dental associations. Developed at the request of the state associations, the courses have provided both general dental ethics education as well as targeted subject matter. In 2015, courses have been given at the annual meeting of the Oklahoma Dental Association and via a live webinar to the Virginia Dental Association (VDA). A copy of the webinar will be archived for viewing by members who were unable to participate in the live VDA session.

Ethical Advice Communications Vehicle: Supporting the first goal of the ADA's strategic plan, the Council maintains a service, the Ethics Hotline, which members can call to discuss ethical issues confronting them. Members call and leave a message on a confidential voicemail; messages are retrieved and forwarded to a Council member who calls and assists the member in examining the ethical question posed. The responding member of the Council attempts to return calls within two to three business days and sooner if requested by the member.

The Council, through Council staff, has begun to investigate the collection of data from participants to evaluate the Ethics Hotline. However, the gathering of data from participants is hampered by the fact that the requests for advice are confidential and most of the ethics consultations are performed via telephone. Anecdotally, Council members providing the consultations report that the members availing themselves of the service seem very satisfied with the program and its operation. Other indicia of measuring the success and value of the program are being investigated. In addition, it was originally thought that the Aptify system used by the ADA's call center could be used to capture data by which ethics trends and emerging issues could be identified. Because the use of Aptify for this purpose has not been successful, other means of capturing such data will be developed in the coming year.

Public Differentiation of ADA Member Dentists via the ADA Principles of Ethics and Code of Professional Conduct:

With the collaboration of the ADA Division of Communications and Marketing, the Council has commissioned a survey of members of the public designed to provide knowledge on this topic which supports the first objective of ADA's strategic plan. The survey is designed to gauge the level of public awareness of the ADA *Principles of Ethics and Code of Professional Conduct* ("the ADA Code") and that one of the primary purposes of the ADA Code is to put the welfare of patients first. In addition, the survey will test if knowledge of the ADA Code will positively differentiate ADA member dentists in the minds of the public. It is anticipated that the results of the survey will be available by the conclusion of the third quarter of 2015.

Sesquicentennial Anniversary of the ADA Code: 2016 is the 150th anniversary of the adoption of the ADA Code. The Council is planning a number of events to commemorate that milestone, including the distribution of a supplement to ADA News that will, among other things, provide a full text copy of the ADA Code and an article tracing the development of the ADA Code from the first edition to its present day form. The Council is also in discussions with other agencies to provide additional events to celebrate the sesquicentennial anniversary of the ADA Code. The 150th anniversary of the ADA Code will also be commemorated by the use of the slogan "The ADA Code of Ethics – 150 Years of Putting Patients First."

Student Ethics Video Contest: As it has since 2009, in 2014 the Council sponsored the student ethics video contest to provide an opportunity for students to consider ethical decision making as they prepare to start careers in dentistry. The goals of the contest are to create greater awareness among predoctoral dental students of ethical situations that are encountered during the everyday practice of dentistry and to provide a creative forum for students to consider how those situations should be addressed using the ADA Code. In 2014, seven contest entries were received. The Council awarded the contest grand prize to a team of students from the University of Alabama School of Dentistry; the runner-up prize was awarded to students from the University of Maryland School of Dentistry.

For 2015, the Council is receiving additional support for the contest from insurance provider CNA. The additional support provided has allowed the creation of a second category. Submissions for the new contest category will depict ethical treatment promoting patient safety. The entry period for the 2015 contest has opened and will close at the end of July 2015.

Emerging Issues and Trends

Providing Dental Treatment at Temporary Charitable Events: In support of the ADA's Action for Dental Health initiative, the Council has authored a white paper that discusses ethical issues presented by temporary charitable events such as Give Kids a Smile and Missions of Mercy. The paper is designed to assist project coordinators organizing and dentists participating in such events in identifying the ethical issues that may arise in charitable temporary event settings and offers suggestions for addressing them. The white paper also includes easily understood checklists to assist event volunteers in ensuring that ethical care is being provided.

A draft of the white paper has been circulated to the Council on Access, Prevention and Interprofessional Relations for comment with the request that comments be provided by June 1, 2015, after which the paper will be finalized and distributed.

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
23-2014. Amendment of the ADA <i>Bylaws</i> Striking “ <i>Ex Officio</i> ”	<i>Bylaws</i> Review	Completion of reconsideration of the resolution in time for presentment to the 2015 House of Delegates	April 2015	April - July 2015	Completed; see below
25-2014. Amendment of Chapter XII of the ADA <i>Bylaws</i> to Add the Option of a Non-Disciplinary Action	<i>Bylaws</i> Review	Completion of reconsideration of the resolution in time for presentment to the 2015 House of Delegates	April 2015	April - July 2015	Completed; see below
26-2014. Amendment of Chapter XIII of the ADA <i>Bylaws</i> to Add the Option of a Non-Disciplinary Action	<i>Bylaws</i> Review	Completion of reconsideration of the resolution in time for presentment to the 2015 House of Delegates	April 2015	April - July 2015	Completed; see below
65H-2014. Ethics and Standards for Internet Advertising in the Dental Profession	<i>Code of Ethics</i> Review	Completion of review of the ADA <i>Principles of Ethics and Code of Professional Conduct</i> as it relates to internet advertising issues in time for reporting to the 2015 House of Delegates	April 2015	April - July 2015	Completed; see below
118H-2014. Review of the ADA <i>Constitution and Bylaws</i>	<i>Bylaws</i> Review	Complete review and revision of the ADA <i>Constitution and Bylaws</i>	April 2016	April-September 2016	On target for submission to 2016 House of Delegates at time of submission (May 2015)

Resolution 23-2014, Amendment of the ADA Bylaws Striking “Ex Officio”: At the request of the House of Delegates, the Council has conducted a second in-depth review of the use of the term “*ex officio*” in the ADA *Constitution and Bylaws*. At the conclusion of its study, the Council remains convinced that completely discontinuing the use of the term “*ex officio*” is the better approach to take in an organization of the size and make-up of the ADA. While it would certainly be possible to strike “*ex officio*” from the *Bylaws* only in those instances where the term is used incorrectly, that action does not deal with all the issues that the Council believes exist. That approach would not address the lack of understanding of the meaning of “*ex officio*” among delegates and members who have no or only limited exposure to parliamentary procedure and the definition of the term found in the *American Institute of Parliamentarians’ Standard Code of Parliamentary Procedure*.

The Council therefore recommends the adoption of Resolution 23-2014:

23-2014. Resolved, that CHAPTER V. HOUSE OF DELEGATES, *Section 10*, COMPOSITION, Paragraph B. EX OFFICIO MEMBERS. of the ADA *Bylaws* be amended as follows (additions underscored; deletions ~~stricken through~~):

Section 10. COMPOSITION.

* * *

B. ~~EX OFFICIO-NON-VOTING~~ MEMBERS. The elective and appointive officers and trustees of this Association shall be ~~ex officio~~ members of the House of Delegates without the power to vote. They shall not serve as delegates. Past presidents of this Association shall be ~~ex officio~~ members of the House of Delegates without the power to vote unless designated as delegates.

and be it further

Resolved, that CHAPTER VII. BOARD OF TRUSTEES, *Section 10. COMPOSITION* of the ADA *Bylaws* be amended as follows (additions underscored; deletions ~~stricken through~~):

Section 10. COMPOSITION: The Board of Trustees shall consist of one (1) trustee from each of the seventeen (17) trustee districts. Such seventeen (17) trustees, the President-elect and the two Vice Presidents shall constitute the voting membership of the Board of Trustees. In addition, the President, the Treasurer and the Executive Director of the Association, except as otherwise provided in the *Bylaws* shall be ~~ex officio-non-voting~~ members of the Board ~~without the right to vote~~.

and be it further

Resolved, that CHAPTER VII. BOARD OF TRUSTEES, *Section 140. COMMITTEES*, Sub-paragraph e. of the ADA *Bylaws* be amended as follows (additions underscored; deletions ~~stricken through~~):

Section 140. COMMITTEES:

* * *

e. Serve as ~~ex officio-non-voting~~ members, ~~without the power to vote~~, of councils and commissions of this Association on issues affecting new dentists; these appointments will be recommended by the Committee and assigned by the Board of Trustees.

and be it further

Resolved, that CHAPTER VIII, ELECTIVE OFFICERS, *Section 90. DUTIES* of the ADA *Bylaws* be amended as follows (additions underscored; deletions ~~stricken through~~):

Section 90. DUTIES:

A. PRESIDENT. It shall be the duty of the President to:

* * *

b. Serve as Chair and, except as otherwise provided in these *Bylaws*, ~~ex officio-non-voting~~ member of the Board of Trustees and to perform such duties as are provided in Chapters V and VII of these *Bylaws*.

B. PRESIDENT-ELECT. It shall be the duty of the President-elect to:

* * *

b. Serve as an ~~ex officio-non-voting~~ member of the House of Delegates ~~without the right to vote~~.
c. Serve as an ~~ex officio~~ member of the Board of Trustees.

C. FIRST VICE PRESIDENT. It shall be the duty of the First Vice President to:

* * *

b. Serve as an ~~ex officio non-voting~~ member of the House of Delegates ~~without the right to vote~~.
c. Serve as an ~~ex officio~~ member of the Board of Trustees.

D. SECOND VICE PRESIDENT. It shall be the duty of the Second Vice President to:

* * *

b. Serve as an ~~ex officio non-voting~~ member of the House of Delegates ~~without the right to vote~~.
c. Serve as an ~~ex officio~~ member of the Board of Trustees.

F. TREASURER. It shall be the duty of the Treasurer to:

* * *

- h. Serve as an ~~ex-officio~~ non-voting member of the House of Delegates ~~without the right to vote~~.
- i. Serve as an ~~ex-officio~~ non-voting member of the Board of Trustees ~~without the right to vote~~.

and be it further

Resolved, that CHAPTER X. COUNCILS, *Section 20* MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Paragraph A of the ADA *Bylaws* be amended as follows (additions underscored; deletions ~~stricken through~~):

Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS:

A.

* * *

Council on ADA Sessions shall be composed of nineteen (19) members, one (1) member from each trustee district whose terms of office shall be staggered in such a manner that four (4) members will complete their terms each year except every fourth year when five (5) members shall complete their terms. In addition, the General Chair of the Local Arrangements Committee for the current year and the General Chair-elect for the succeeding year shall serve as ~~ex-officio~~ members ~~with the right to vote~~ and shall not be eligible to serve as Council Chair.

* * *

Council on Government Affairs shall be composed of eighteen (18) members, one (1) member from each trustee district whose terms of office shall be staggered in such a manner that four (4) members will complete their terms each year except every fourth year when five (5) members shall complete their terms. In addition, the chair of the political action committee shall be an ~~ex-officio~~ non-voting member of the Council ~~without the power to vote~~. Consideration shall be given to a candidate's experience in the military or other federal dental services. Members of the Council shall not be in the full-time employ of the federal government. Individuals called to active duty from the military reserves or national guard forces, providing such active duty has not been requested by the individual, shall not be considered to be in the full-time employ of the federal government.

Resolutions 25-2014 and 26-2014, Amendment of Chapters XII and XIII of the ADA Bylaws to Add the Option of a Non-Disciplinary Action: By way of Resolutions 25 and 26, the Council proposed to the 2014 House of Delegates adding a non-disciplinary action to Chapter XII and Chapter XIII of the ADA *Bylaws*. The resolutions were originally submitted to allow for non-disciplinary actions in instances where minor technical ethical violations are found or where extenuating circumstances exist that make imposing a disciplinary penalty unduly harsh. The House of Delegates voted to refer the two resolutions back to the Council for further investigation. The Council understands the reasons behind the referral to be: (1) the use of the term "letter of counsel" which is also used by the Armed Forces, (2) to reconsider if the member receiving the non-disciplinary action should have the ability to appeal the issuance of the action, and (3) that the non-disciplinary action might be discoverable.

On referral, the Council amended the original resolutions and believes that the amendments address each of the issues listed in the preceding paragraph:

- The name "Reminder of Obligation" provides a description of what the non-disciplinary action is intended to convey - a reminder that certain ethical or policy obligations exist for members of the Association. The Council does not believe that the term "Reminder of Obligation" carries any negative connotations.
- The amendments are silent on the issue of a response to the non-disciplinary action.
- Although it would be possible for records kept by the Council to be discovered in response to a properly framed subpoena being issued and validly served upon the ADA, the Council deems that possibility to be remote. By its very definition, a Reminder of Obligation is a non-disciplinary action taken in response to a minor infraction of the ADA *Code* or Member Conduct Policy; it is

contemplated that it would take the form of a private communication (a letter) sent by the Council to the member receiving the Reminder of Obligation. Moreover, because of the confidential nature of the communication, the only record that the ADA would have of the Reminder of Obligation would be a single copy of the private communication in the files of the Council; no additional copies of the communication would be made or provided to any other ADA agency and no copy or other notation of the reminder would be placed in the member's membership records. To further diminish the risk of discovery, the revised resolution proposes to amend the ADA Procedures for Member Disciplinary Hearings and Appeals to require that the file copy of a Reminder of Obligation be deleted from the Council's records six (6) months after issuance.

As a result of the referral and reconsideration of Resolutions 25 and 26-2014, the Council recommends that the following resolution be adopted:

35. Resolved, that CHAPTER XII. PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT AND JUDICIAL PROCEDURE, *Section 20. DISCIPLINE OF MEMBERS* of the ADA *Bylaws* be amended by the addition of a new subsection C. as follows (additions underscored):

C. REMINDER OF OBLIGATION. In appropriate circumstances, a constituent or component society or, in the case of direct members, this Association, may issue a reminder of obligation to a member where the member may have committed a relatively minor infraction of the ADA *Bylaws*, the *Principles of Ethics and Code of Professional Conduct* or the bylaws or code of ethics of a constituent or component society of which the accused is a member. Such a reminder of obligation is not a disciplinary penalty but is a private administrative action and no record of the issuance of a reminder of obligation shall be placed in the member's membership records.

and be it further

Resolved, that the remaining subsections of CHAPTER XII. PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT AND JUDICIAL PROCEDURE, *Section 20. DISCIPLINE OF MEMBERS* of the ADA *Bylaws* be relettered accordingly, and be it further

Resolved, that CHAPTER XIII. PROCEDURES AND HEARINGS RELATING TO MEMBER CONDUCT POLICY, *Section 20. DISCIPLINARY PROCEDURES AND HEARINGS* of the ADA *Bylaws* be amended by the addition of a new subsection C. as follows (additions underscored):

C. REMINDER OF OBLIGATION. In appropriate circumstances, this Association, through the Council on Ethics, Bylaws and Judicial Affairs, may issue a reminder of obligation to a member where the member may have committed a relatively minor infraction of the ADA Member Conduct Policy or engaged in conduct to which the ADA Member Conduct Policy might apply. Such a reminder of obligation is not a disciplinary penalty but is a private administrative action and no record of the issuance of a reminder of obligation shall be placed in the member's membership records.

and be it further

Resolved, that the remaining subsections of CHAPTER XIII. PROCEDURES AND HEARINGS RELATING TO MEMBER CONDUCT POLICY, *Section 20. DISCIPLINARY PROCEDURES AND HEARINGS* of the ADA *Bylaws* be relettered accordingly, and be it further

Resolved, that the title of the ADA PROCEDURES FOR MEMBER DISCIPLINARY HEARINGS AND APPEALS be amended as follows (additions underscored):

ADA PROCEDURES FOR MEMBER DISCIPLINARY HEARINGS AND APPEALS AND THE ISSUANCE OF REMINDERS OF OBLIGATION

and be it further

Resolved, that a new chapter, Chapter V., be added to the end of the ADA Procedures for Member Disciplinary Hearings and Appeals as follows (additions underscored):

V. REMINDERS OF OBLIGATION

Because Reminders of Obligation issued pursuant to CHAPTER XII PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT, Section 20 DISCIPLINE OF MEMBERS, Subsection C. REMINDER OF OBLIGATION and CHAPTER XIII. PROCEDURES AND HEARINGS RELATED TO MEMBER CONDUCT POLICY, Section 20 DISCIPLINE OF MEMBERS, Subsection C. REMINDER OF OBLIGATION of the ADA Bylaws are private administrative actions and not disciplinary penalties, copies of such Reminders of Obligation shall only be kept by the Council on Ethics, Bylaws and Judicial Affairs for a period of six (6) months after issuance following which such copies shall be destroyed.

65H-2014, Ethics and Standards for Internet Advertising in the Dental Profession: Pursuant to the directive of Resolution 65H-2014, the Council has considered the use of the internet in the marketing of dental practices and the treatment that dental practices provide and whether the use of “keywords,” patient reviews and the use of search engine optimization are adequately addressed by the ADA *Principles of Ethics and Code of Professional Conduct* and the Advisory Opinions related thereto (collectively, “the ADA Code”). The Council determined that no action is required to address the concerns raised by Resolution 65H-2014, in that it believes that adequate ethical guidance currently exists in the ADA Code with regard to the internet-related advertising and marketing practices and activities that are raised by the resolution.

The ADA Code is written to convey to the dental profession the ethical principles governing the doctor-patient relationship and provide general guidance to the dental profession in applying those principles to specific situations. The ADA Code recites five broad fundamental ethical principles that are universally relevant to the provision of patient care. Utilizing those principles, the ADA Code then sets forth certain conduct that is either required or prohibited in view of the applicable ethical principle. The Council believes it to be impossible to describe the application of the ADA Code’s ethical principles to every situation that arises in the practice of dentistry. Instead, the examples of specifically prohibited or required conduct found in the ADA Code illustrate how the five ethical principles stated in the ADA Code should be used and applied to arrive at ethical decisions and actions. Section 5.F. of the ADA Code admonishes that dentists should not advertise or solicit patients in a manner that is false or misleading in any material respect regardless of the form or manner in which the solicitation is made. A footnote to ADA Code Section 5.F. provides further guidance on what is considered unethical advertising, marketing, solicitation or promotional activities. The footnote states:

Advertising, solicitation of patients or business or other promotional activities by dentists or dental care delivery organizations shall not be considered unethical or improper, except for those promotional activities which are false or misleading in any material respect. Notwithstanding any ADA *Principles of Ethics and Code of Professional Conduct* or other standards of dentist conduct which may be differently worded, this shall be the sole standard for determining the ethical propriety of such promotional activities. Any provision of an ADA constituent or component society’s code of ethics or other standard of dentist conduct relating to dentists’ or dental care delivery organizations’ advertising, solicitation, or other promotional activities which is worded differently from the above standard shall be deemed to be in conflict with the ADA *Principles of Ethics and Code of Professional Conduct*.

Consequently, the Council believes that the ADA Code provides adequate guidance to the profession in how to ethically approach advertising and the solicitation of patients using new technologies, techniques and practices that emerge or develop over time, including those raised in Resolution 65H-2014.

With respect to the issue of announcing the practice of unrecognized specialties, the Council noted that the courts in some jurisdictions have held that dental professionals can, in certain instances, announce that they practice in areas not recognized by the ADA as dental specialties. Because of those rulings, such announcements in those jurisdictions cannot be considered “false or misleading in any material

respect” and so are not contrary to the provisions of the ADA *Code*. However, the Council recognized that the court rulings may result in confusion or lack of clarity and decided that the issue of announcements of specialization should be studied in greater depth in view of those rulings. The Council will pursue this study in consultation with the Council on Dental Education and Licensure, the agency charged with making recommendations on the granting of specialty recognition, and the Council on Government Affairs.

118H-2014, Review of the ADA Constitution and Bylaws: In response to Resolution 118H-2014, the Council formed a task force to review the current ADA *Constitution and Bylaws* and develop proposals for the revision of those governance documents. Task force members are current and former Council members, the Council’s New Dentist Committee member, the Council’s liaison from the American Student Dental Association and two members of the Board of Trustees, both of whom are former chairs of the Council. Many members of the task force are delegates to the ADA House of Delegates and are presently or have been leaders in their state dental societies. It is anticipated that they will serve as champions of the proposals of the task force when they are completed and delivered to the House of Delegates.

The task force has concluded that detailed operational and procedural material should be removed from the ADA *Constitution and Bylaws* and placed in an ancillary document or documents, with the ultimate goal of revising the *Constitution and Bylaws* so that they contain only the fundamental governance rules of the ADA. The task force further agreed that aside from moving material from the ADA *Constitution and Bylaws* to other locations, no substantive changes to the *Constitution and Bylaws* will be made in the revision process. The task force is presently in the midst of formulating its proposals for revisions; as of May 2015, over one-half of the material in the ADA *Constitution and Bylaws* has been reviewed. It is anticipated that the initial task force proposals for amendment will be forwarded by the task force to the Council in the third quarter of 2015.

Following review of the task force proposals, the Council anticipates inviting a separate group composed of ADA delegates, present and former speakers of the houses of the ADA and state societies, national and state dental society officers and executive directors and other interested individuals with bylaws, governance or parliamentary experience to review and comment upon the initial proposed revisions to the ADA *Constitution and Bylaws*. ADA councils and commissions and the ADA Foundation may also be asked to review the proposed revisions. Following receipt of the comments and suggestions from that secondary review, the proposed amendments will be revised by the task force as needed. These revised proposals to amend the ADA *Constitution and Bylaws* will be again be reviewed by CEBJA and then communicated to the 2016 ADA House of Delegates.

Self-Assessment

The Council is scheduled to conduct its next self-assessment in 2019. However, working with the other councils of the ADA, the Council will be proposing revisions to its *Bylaws* responsibilities. These will be presented in the “Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the ADA *Bylaws*” to the Board of Trustees and 2015 House of Delegates.

Summary of Resolutions

Resolution 23-2014. Amendment of the ADA *Bylaws* Striking “*Ex Officio*”
 Resolution 35. Amendment of Chapters XII and XIII of the ADA *Bylaws* to Add the Option of a Non-Disciplinary Action

Council Minutes

For more information on recent activities, see the Council’s [minutes](#) on ADA.org.

Council on Government Affairs

Black, Richard C., 2015, Texas, chair
 Howell, J. Barry, 2016, Illinois, vice chair
 Beauchamp, K. Jean, 2018, Tennessee
 Breault, Michael R., 2015, New York
 Bronson, Mark E., 2017, Ohio
 Cobb, Regina E., 2017, Arizona
 Garrett, Marty B., 2018, Louisiana
 Graham, Frank J., 2018, New Jersey
 Harrington, John F., 2016, Georgia
 Huot, Richard A., 2016, Florida
 Incalcaterra, Charles J., 2017, Pennsylvania
 Jaeger, Frederick J., 2016, Wisconsin
 Lebovics, Irving S., 2015, California
 Martin, Raymond K., 2016, Massachusetts
 Minahan, David M., 2018, Washington
 McGinty, Charles, 2015, Missouri, *ex officio***
 Morrison, Scott L., 2017, Nebraska
 Smallidge, Martin, 2015, Georgia, *ex officio**
 Vlahos, Gus C., 2015, Virginia

Spangler, Thomas J., director

The Council's 2014–15 liaisons include: Dr. Hilton Israelson (Fifteenth District trustee, Board of Trustees), Dr. Ralph L. Howell (Council on Communications), Dr. Jane Gillette (Council on Access, Prevention and Interprofessional Relations), Ms. Teresa Theurer (Alliance of the American Dental Association), and Ms. Alena Reich (American Student Dental Association).

Bylaws Areas of Responsibility

The Council reviewed its *Bylaws* provisions and, with the Council on Ethics, Bylaws and Judicial Affairs, will be proposing revisions via an omnibus resolution to the Board of Trustees and 2015 House of Delegates. That resolution will be separately presented in the “Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the ADA *Bylaws*.”

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome ¹
Leaders & advocates	Outreach to educate dental students on the importance of advocacy, grassroots and ADPAC participation	ADA GPA staff will participate in dental student meetings (i.e. ASDA regional meetings, dental school events, coordinate ASDA DC fly-in) and advocate for student dental issues	Identify specific dental student issues and attend meetings. December 31, 2015	Enact student dental legislation and attend at least 10 student dental meetings	ADA took the lead in assisting ASDA with the agenda for their 2015 DC fly-in; three ADA lobbyists briefed ASDA students on how to lobby Congress and explained the key

** ADPAC chair without the power to vote.

* New Dentist Committee member without the power to vote.

¹ Results are as of the date of report preparation and do not reflect full-year results.

Objective	Initiative/Program	Success Measure	Target	Range	Outcome ¹
					elements of the federal legislation being lobbied; ADA ensured a bill addressing student loan debt was one of the issues lobbied at both the ASDA and ADA fly-ins

The American Dental Political Action Committee (ADPAC) was also very actively involved in working with dental students:

- 1,677 ASDA Members became ADPAC Members in the 2014-2015 school year.
- ADPAC funded over 16 advocacy Lunch and Learns throughout the 2014-2015 school year.
- ADPAC Board members and staff gave presentations at over 20 lunch and learns held at dental schools throughout the country.
- ADPAC assisted in securing issues and speakers for the 2015 ASDA fly-in.
- ADA and ASDA will combine their lobby day fly-ins for 2017 and 2018.
- ADPAC created a social media campaign around the Student Debt issue, which included creating an infographic. The infographic was shared over 65 times on Facebook, posted on student/new dentists webpages, and was used at various events including ASDA's annual meeting.
- ADPAC launched Action Alerts related to Student Debt. As of this writing, over 5,500 messages were sent to the U.S. House of Representatives on this issue.

Emerging Issues and Trends

Federal Issues

It is very difficult to predict with any certainty how, and to what extent, changes in the overall health care marketplace will have on the dental delivery system. Dentistry is a relatively small segment of overall health care costs and much of the "traditional" delivery system of stand-alone dental plans and solo practices remain in place. However, there are a variety of forces in play in the overall health care market and dental market that could result in significant changes. Early this year, at a joint Federal Trade Commission and U.S. Justice Department workshop,² experts examining medical care delivery with a focus on hospitals and physician practices³ noted that there is a trend toward narrower networks (where the number of providers is limited) and tiered networks (networks are broader but beneficiaries are given incentives to use providers that offer greater "value").

The experts at the FTC-Justice workshop also noted that more small businesses are likely to self-insure, thus avoiding many state laws that regulate insurance products. And they found that it continues to be difficult to interject competition into rural markets, which are likely to be dominated by just a few providers and carriers. The projected growth in the use of private exchanges (40 million by 2018) by employers could also result in more narrow networks, while facilitating cost shifting to employees as employers use defined contributions to limit their health care cost liabilities.⁴

² On February 24-25, 2015, the Federal Trade Commission and U.S. Justice Department, Antitrust Division co-hosted a workshop, "Examining Health Care Competition," to study changes related to health care provider organizations and payment models to determine how they might affect competition in the provision of health care services.

³ Hospitals account for about 33% of all health care costs, physicians about 21%, drug companies about 10-14%, while oral health care costs are in the single digits as a portion of overall health care costs.

⁴ Birhanzel, R., Brown S., Tauber J. (2015, April 3). Private Health Insurance Exchange Enrollment Doubled from 2014 to 2015, *Physicians for a National Health Program*, <http://www.pnhp.org/print/news/2015/april/private-insurance-exchange-enrollment-doubles>.

Implementation of the Affordable Care Act (ACA) was smoother the second time around. About 11.7 million people selected private health insurance coverage in the ACA marketplaces, up from 8 million last year.⁵ But there is still a long way to go. The ACA federal marketplaces signed up about 43% of their potential market and the states running their own programs signed up about 38% of the potential market in those states, according to the Kaiser Family Foundation.⁶ With the growth of private and ACA exchanges, increasingly individuals, not employers, are making the health coverage purchasing decision and individuals are more price sensitive. Finally, many purchasers of coverage are looking for value (a weighing of cost and quality). For example, the Centers for Medicare and Medicaid Services earlier this year announced its goal of moving 50% of Medicare payments to value-based models by 2018.⁷

State Issues

The effort to enact alternative workforce models continued unabated in 2015 as 10 states had legislation introduced to enact either a dental therapist or advanced dental hygienist position. In addition, the foundation community is active in at least five other states. It appears that no new laws will be enacted in 2015 (although legislation remains pending in two states as of this writing). Additionally, the rulemaking process following the enactment of the dental therapy law in Maine in 2014 is proceeding very slowly. No therapists have been educated and the licensure process has not begun.

The foundation community has also more widely partnered with libertarian leaning groups, such as Americans for Prosperity, to promote alternative models using the libertarian perspective. This has led to added pressure within national state policy organizations like the Council of State Governments, National Governors Association, and the American Legislative Exchange Council. Other emerging issues include increasing legislative tension concerning the regulatory framework for Dental Service Organizations (DSOs), rising access pressures due to state budget cuts, and implementation of the ADA's Action for Dental Health (ADH) campaign.

Include Adult Dental Benefit as “Essential Health Benefit” (WITHDRAWN)

Include Adult Dental Benefit as “Essential Health Benefit”: The following resolution was submitted by the Council on Government Affairs and is supported by the Council on Dental Benefit Programs:

ADA Strategic Plan Goal: Increase Member Value.

Background: At its February meeting, the Council on Government Affairs (CGA) reviewed potential amendments to the Patient Protection and Affordable Care Act (ACA). The ACA includes a requirement that individual and small group plans cover “essential health benefits” (EHB), which includes pediatric dental coverage. Some stakeholders have already indicated that they will seek to expand the EHB definition to include adult dental coverage. After discussions on potential intermediate steps, such as supporting coverage of preventive and emergency services, the CGA voted to actively seek expansion of the EHB to include comprehensive adult dental coverage.

This position is consistent with current ADA policy that supports the inclusion of adult dental benefits in Medicaid because “oral health is an integral part of overall health” [“Support for Adult Medicaid Dental Services” (*Trans.*2004:327)]. In a May 13 ADA press release, the Association reported on recently released [statistics](#) from the Centers for Disease Control and Prevention stating that 27% of adults over 20 have untreated caries with even higher rates among African Americans (42%) and Hispanics (36%). ADA president, Dr. Maxine Feinberg, emphasized ADA's belief that prevention is the best means of eliminating the majority of dental disease, which includes getting individuals into dental homes.

⁵ Pear, R. (2015, March 11). 86% of Health Law Enrollees Receive Subsidies, White House Says, *The New York Times*, p. A17.

⁶ Ibid.

⁷ Beck, M. (2015, May 5). *Health Payment Model Hailed*, *The Wall Street Journal*, p. 4.

The CGA also recognized that the cost of care is often a barrier to accessing dental services, especially for many adults, and individuals with coverage are more likely to seek care. In fact, according to the U.S. Government Accountability Office, in 2010, only 18% of uninsured individuals had a dental visit, compared to 57% of those with private dental coverage and 33% of individuals with Medicaid dental coverage.⁸ The ADA's Health Policy Institute (HPI) has developed a number of marketplace, dental practice, and other related dental industry studies, including a look at the effects of the ACA marketplaces on dental coverage.⁹ According to HPI, the latest data show no reversal of the decline in dental care use by adults. In fact, dental care utilization in 2012 was at its lowest level among working-age adults since the Medical Expenditure Panel Survey began tracking dental care use in 1996.¹⁰ Among a group of 11 types of barriers to receiving needed dental care, financial barriers were mentioned most often. And the level of financial barriers was highest among low-income, non-elderly adults.¹¹

In October 2014 studies, HPI confirmed that young adults are the most likely of any age group to face financial barriers to dental care¹² and that their dental care use has declined over time.¹³ The young adults also account for most of the increase in emergency room visits for dental conditions. In fact, the near doubling of emergency room visits for dental conditions in the United States (from 2000 to 2010) was driven almost entirely by young adults.¹⁴ On the other hand, adults (26-34 years of age) were the most likely age group to purchase dental benefits in the new ACA marketplaces in 2014, so there appears to be a recognition of a need for coverage in that population group.¹⁵

Thus, the Council on Government Affairs recommends that the following resolution be adopted by the 2015 House of Delegates:

36. Resolved, that the ADA actively seek expansion of the "Essential Health Benefits" provision of the Patient Protection and Affordable Care Act to include comprehensive adult dental coverage.

⁸ U.S. Government Accountability Office. (2013, September) *Dental Services: Information on Coverage, Payments, and Fee Variation*. (GAO Publication No. 13-754), p. 15.

⁹ The Health Policy Institute aims to be a thought leader and trusted source for critical policy knowledge related to the U.S. dental care system. Formerly the Health Policy Resources Center (HPRC), the Health Policy Institute (HPI) achieves this by generating, synthesizing, and disseminating innovative research on a variety of topics that are relevant to policy makers, health care advocates, and providers within the U.S. dental care system. Some of the key issues that HPI focuses on include the impact of health reform on the dental care sector, access to dental care for key populations, dental practice economics, dental care service delivery and financing, and dental education. See HPI research briefs. <http://www.ada.org/en/science-research/health-policy-institute/publications/research-briefs>.

¹⁰ Nasseh K, Vujicic M. Dental care utilization rate highest ever among children, continues to decline among working-age adults. Health Policy Institute Research Brief. American Dental Association. October 2014. Available from: http://www.ada.org/-/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_4.ashx.

¹¹ Wall T, Nasseh K, Vujicic M. Most important barriers to dental care are financial, not supply related. Health Policy Institute Research Brief. American Dental Association. October 2014. Available from: http://www.ada.org/-/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_2.ashx.

¹² Wall T, Nasseh K, Vujicic M. Fewer Americans forgoing dental care due to cost. Health Policy Institute Research Brief. American Dental Association. October 2014. Available from: http://www.ada.org/-/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_6.ashx.

¹³ Nasseh K, Vujicic M. Dental care utilization rate highest ever among children, continues to decline among working-age adults. Health Policy Institute Research Brief. American Dental Association. October 2014. Available from: http://www.ada.org/-/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_4.ashx.

¹⁴ Wall T, Nasseh K. Dental-related emergency department visits on the increase in the United States. Health Policy Institute Research Brief. American Dental Association. May 2013. Available from: http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_0513_1.pdf

¹⁵ Vujicic M, Yarbrough C. Young adults most likely age group to purchase dental benefits in health insurance marketplaces. Health Policy Institute Research Brief. American Dental Association. August 2014. Available from: http://www.ada.org/-/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0814_3.ashx.

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
Exempt dentists from mandate to purchase pediatric dental coverage pursuant to the terms of the Affordable Care Act	<i>Resolutions 29 and 29B. ACA Dentist Exemption From Pediatric Mandate</i>	Passage	NA	NA	The resolution was referred to the Council; see discussion below for details
Enforcing the rules governing sale of regulated dental supplies	<i>Resolution 66H-2014. Enforcing Regulations Concerning Online Marketplaces and the Sale of Dental Supplies/Materials</i>	Ensure proper enforcement measures are being taken by regulatory agency	NA	NA	The ADA sent a letter to the Food and Drug Administration (FDA) and followed up with FDA officials on this matter; discussion below provides details
Communication of State Advocacy Efforts	<i>Resolution 98H-2014. Communication of State Advocacy Efforts</i>	The ADA publishes, at least quarterly, via ADA.org and other means information on policy trends that could affect state dental societies	NA	NA	The ADA publishes a quarterly report on ADA.org and sends via the <i>Morning Huddle</i> a collection of pertinent news that includes dental public policy updates; see details below

ACA Dentist Exemption From Pediatric Mandate. Resolutions 29 and 29B were referred to the Council on Government Affairs for recommendations. The resolutions ask the ADA to pursue eliminating the requirement for dentists to purchase pediatric dental coverage for their dependents 18 years of age or younger. The essential health benefits (EHB) package as defined in the Affordable Care Act (ACA) includes a pediatric dental benefit, which applies to plans in the individual and small group markets. The Council recommended that the proposals not be adopted as ADA policy because:

- The ADA is on record as supporting the purchase of the EHB pediatric dental benefit by families with children in and outside of the ACA marketplace.
- The possible public relations backlash of seeking a narrow exception could be very significant, especially when one considers that no other health care professionals are requesting a similar exception.
- From a political standpoint, achieving an exception just for dentists would be next to impossible and would require an expenditure of considerable political capital, thereby potentially undermining efforts on other important initiatives.
- Virtually all dental plans now reimburse dentists who provide covered services for their children.

Because the Council recommends that the House of Delegates not pass such a resolution, no resolution is being proposed.

Enforcing Regulations Concerning Online Marketplaces and the Sale of Dental Supplies/Materials. Resolution 66H-2014 states that the ADA petition the appropriate federal agencies to enforce the rules

and regulations governing the sale of regulated dental supplies and materials and report to the 2015 House of Delegates. The ADA sent a [letter](#) to the Food and Drug Administration (FDA) requesting that the FDA review and aggressively enforce policies and procedures governing the purchase of dental equipment, materials and supplies to ensure these sales are restricted to licensed dentists or dental practices registered by the state and that the items sold meet FDA standards. The letter emphasized that the ADA is concerned that individuals who are not properly licensed to practice dentistry are purchasing dental equipment, frequently from grey market suppliers, for the illegal practice of dentistry contrary to the FDA's requirements. ADA staff has followed up with FDA officials on this matter and staff has been assured that the agency will work with the ADA to address our concerns. Additional information will be provided in the Council's Supplemental Report to the House of Delegates.

Communication of State Advocacy Efforts. Resolution 98H-2014 requests that the ADA publish updates on state legislative and regulatory issues via ADA.org and other platforms, as appropriate, not less than quarterly to provide members with timely information on policy trends with the potential to impact each constituent. The Department of State Government Affairs publishes the *State Legislative Report* quarterly on ADA.org. It is a compilation of current state and local-level public policy activities that affect oral health. The newsletter and archives may be found under the Advocacy (tab)/Get Involved. Or, the members-only site may be found by clicking [here](#). Additionally, the ADA publishes and sends via email the *Morning Huddle*, providing a collection of pertinent news that includes dental public policy updates.

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2020. However, working with the Council on Ethics, Bylaws and Judicial Affairs, the Council will be proposing revisions to its *Bylaws* responsibilities. These will be presented in the "Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the *ADA Bylaws*" to the Board of Trustees and 2015 House of Delegates.

Summary of Resolutions

Resolution 36. Include Adult Dental Benefit as "Essential Health Benefit"

Council Minutes

For more information on recent activities, see the Council's [minutes](#) on ADA.org.

Council on Members Insurance and Retirement Programs

Barnashuk, Frank C., 2016, New York, chair
 Miller, Paul R., 2016, Florida, vice chair
 Chaney, Mark S., 2015, Louisiana
 Coleman, J. Preston, 2017, Texas
 Ellison, Naomi L., 2015, California
 Ferguson, Larry J., 2017, South Carolina
 Gillcrist, James A., 2015, Tennessee
 Grogan, Patrick M., 2016, Washington, D.C.
 Hehli, Peter D., 2018, Wisconsin
 Hokanson, Brian N., 2017, Wyoming
 Houten, David E., 2016, Washington
 Lipton, James M., 2018, Indiana
 Mann, Marshall H., 2018, Georgia
 McLean, David E., 2017, Vermont
 Schwartz, Timmothy J., 2015, Illinois
 Shirley, Eric L., 2016, Pennsylvania
 Wieting, Scott, 2018, Nebraska
 Yates, Lindsey J., 2015, *ex officio**

Tiernan, Rita, senior manager

The Council's 2014-15 liaisons include: Dr. Alvin Red Stevens (Board of Trustees, Fifth District) and Mr. Kyle Kirk (American Student Dental Association).

Bylaws Areas of Responsibility

The Council reviewed its *Bylaws* provisions and, with the Council on Ethics, Bylaws and Judicial Affairs, will be proposing revisions via an omnibus resolution to the Board of Trustees and 2015 House of Delegates. That resolution will be separately presented in the "Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the ADA *Bylaws*."

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
Member value	Increase the number of ADA members who utilize one or more CMIRP insurance or retirement plan products in 2015 with an increased focus on utilization in lagging segments	Increase number of members who utilize one or more CMIRP products through collaboration with Great-West Financial and AXA by increasing targeted marketing to lagging segments	800 members purchase their first CMIRP insurance or retirement plan product	600-1,000 members purchase their first CMIRP product	631 members purchased their first CMIRP insurance or retirement plan product as of June 30, 2015

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

** *Results are as of the date of report preparation and do not reflect full-year results.*

The Council supports the ADA Strategic Plan 2020 by providing insurance and retirement plan products and risk management resources designed exclusively to enhance the value of ADA membership across all segments and help members succeed. The member's insurance and retirement endorsed programs also provide a source of non-dues revenue in the form of service income and royalty revenue for use of the ADA member list, brand logo and intellectual property which helps support the ADA financial goals.

The ADA Members Insurance Plans portfolio consists of six group insurance plans including: Level Term Life, Annually Renewable Term Life, Term Plus/Universal Life, Disability Income Protection, Office Overhead Expense and MedCASH (supplemental medical insurance). As a valued benefit of ADA membership, these plans help attract new members and increase retention of existing members. According to Great-West Financial policyholder data, members who do not participate in the ADA Members Insurance Plans are three to five times more likely to lapse their ADA membership.

The new member "six-month no-cost term life insurance offer," introduced in 2013, supports the ADA Strategic Plan to build member value and create additional incentive for dentists to join the ADA. This recruitment campaign helped attract 5,244 new or reinstated ADA members in 2014. As of June 30, 2015, 1,699 of these new members paid to convert their no-cost coverage and remain in the ADA Members Term Life Insurance Plan.

In addition to new ADA members, there were 1,354 first-time buyers (ADA members who have never purchased coverage under the ADA brand) enrolled in one or more of the ADA Members Insurance Plans between January 1, 2014 and June 30, 2015. A total 685 of these members are new dentists.

Aggregate participation figures as measured across all Plans have remained relatively steady over the last three years, with a total of over 58,000 members insured in at least one of the plans and nearly 18,000 in multiple plans. In addition, the Life and MedCASH Plans insure more than 20,000 spouses or domestic partners, along with nearly 8,000 dependent children. The impact of the aging baby boomer trend in the ADA membership remains the greatest challenge facing the ADA Members Insurance Plans.

Table 1. ADA Members Insurance Plans Participation for Years 2012–2014

ADA Members Insurance Plan	2012	2013	2014
Members Annually Renewable Term Life ¹	53,899	59,172	56,366 ²
Spouse Term Life	18,830	18,649	18,191
Child Term Life ³	7,493	7,391	7,211
Members Term Plus (Universal Life)	1,466	1,418	1,362
Disability Income Protection	19,314	19,956	20,455
Office Overhead Expense	10,726	11,594	11,448
Members MedCASH	4,248	4,084	3,782
Spouse MedCASH	2,320	2,260	2,100
Child MedCASH	959	928	829
Student Term Life ⁴	13,388	10,908	11,448
Student Disability	12,524	10,834	11,323
TOTAL: All Plans	145,167	147,194	144,515

¹Member participants plus 2014 graduates reclassified as active ADA members on 12/31/14.

²Overall decline in participation was largely driven by the non-conversion of policies at the end of the new member six months no-cost insurance offer.

³This is the number of dentist members who are insuring their children.

⁴Student member participants less the 2014 graduates reclassified as active ADA members on 12/31/14.

The ADA Student Term Life and Disability Insurance Plans provide guaranteed issue coverage to ADA student members at no-cost while completing their dental education and residency. Seven dental schools have contracted to ensure that all their registered dental students and residents are automatically enrolled each year in the ADA Student Member Insurance Plans. Marketing plans in 2015 will promote auto-enrollment across all dental schools to demonstrate the cost savings and value of ADA student membership.

In January 2015, the ADA Members Insurance Plans portfolio was expanded to include a new Level Term Life Plan. Additionally, several plan enhancements were implemented, as recommended in the Milliman audit, including the introduction of gender rates across all Plans, and extended age renewability and benefit duration periods under the Disability Income and Office Overhead Expense Insurance Plans. The new product option and plan enhancements are expected to increase new sales and strengthen member retention.

The Council also oversees management of the ADA-endorsed Members Retirement Program, administered by the AXA Insurance Company. The Program offers tax-qualified retirement savings plans, including three types of 401(k) plans (simple, safe harbor and traditional), pension and profit-sharing plans. The ADA-endorsed Members Retirement Program is annually reviewed by an investment consultant to ensure the product offerings are competitive and in-line with market best practices.

Table 2. ADA Members Retirement Program Participation

	2012	2013	2014
Number of Dentist Employers	4,660	4,369	3,753
Number of Dentists and Employee Participants	17,190	16,442	14,162

The decline in participation shown above in Table 2 reflects the aging ADA membership trends and a higher number of dentist employers and employee participants transitioning into retirement. In 2014, AXA also redefined its reporting criteria to identify inactive plans without a balance and/or underfunded plans which had a significant impact on the year-end number.

The ADA Members Retirement Program remains strong financially with over \$1.68 billion in assets under management as of December 31, 2014, and \$563,321 paid to the ADA in service income. The three-year ADA-AXA Strategic Plan, as defined in collaboration with the Council, is on track to meet the stated goals and objectives to ensure the Members Retirement Program remains well positioned to address the needs of the ADA membership. New marketing strategies and an outbound calling campaign to create a more personalized sales approach resulted in 29 new retirement plan sales in the first half of 2015.

A new addition to the ADA member's retirement plan portfolio in 2015 is the AXA Retirement Gateway Association product offering, which provides a competitive option for those employers with plan assets over \$500,000. Other new product development initiatives by AXA this year to broaden the marketability of the Program include arrangements to make fixed indexed annuity product solutions available to existing plan participants upon request, and to develop variable annuity product options for possible ADA endorsement.

Table 3. Individual Retirement Accounts Participation

	2012	2013	2014
Number of Participants	1,647	1,612	1,542

The Individual Retirement Account (IRA) can be adopted as a traditional IRA, Roth IRA, Rollover IRA or Self-Employed IRA (SEP-IRA). The 2014 participation figures reflect distribution of 116 retirement

accounts and the addition of 46 new participants. Eight new IRA sales have been reported to date in 2015.

Introduced in February 2014, the ADA.org Health Insurance Resource represents a collaborative effort with the state dental societies to maximize member value and increase potential non-dues revenue. The ADA-endorsed American Health Insurance Exchange web portal (AHIX.com) generated only minimal non-dues revenue to ADA during the 2014 open enrollment periods. However, it was successful in promoting the health insurance plan options available to members, including the state dental society endorsed plans.

Emerging Issues and Trends

Pursuant to its *Bylaws* responsibilities, the Council on Members Insurance and Retirement Programs will continue to monitor, evaluate and, if appropriate, recommend action be taken on the following topics:

- Insurance and financial market conditions and new product trends to ensure the ADA endorsed plans remain competitive and relevant to meet the needs of ADA's diverse membership.
- Emerging issues and market trends in dental malpractice that could impact the profession.
- The increased risk of cyber liability given industry claims and the expanded use of technology in dental practices.
- The Healthcare Insurance Exchange Marketplace conditions, the Affordable Care Act legislation and other changes impacting the availability and cost of health insurance nationwide.
- Emerging trends in large group and corporate owned dental practice models to assess the impact on the ADA members insurance and retirement plans and identify opportunities to promote ADA member value to dentists in group practice settings.
- Risk management opportunities to educate graduating student members and new dentists on the value of insurance protection and tax-qualified retirement savings.

Responses to House of Delegates Resolutions

There were no assignments from the 2014 ADA House of Delegates.

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2016. However, working with the Council on Ethics, Bylaws and Judicial Affairs, the Council will be proposing revisions to its *Bylaws* responsibilities. These will be presented in the "Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the *ADA Bylaws*" to the Board of Trustees and 2015 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.

Council on Membership

Durbin, Michael G., 2017, Illinois, chair
 Wilson, K. Drew, 2016, New Hampshire, vice chair
 Aguirre, Alejandro M., 2016, Minnesota
 Barker Olson, Shelley, 2015, North Carolina
 Del Valle-Sepulveda, Edwin, 2015, Puerto Rico
 Ellinwood, Steven P., 2018, Indiana
 Ingram, William L., 2016, Alabama
 Jones, Gary O., 2017, Arizona
 Lee, Natasha A., 2015, California
 Maranga, Maria C., 2017, New York
 Maupin, Heather, Indiana, *ex officio**
 Muncy, Marc, 2018, Arkansas
 Pohl, Gregory J., 2016, Ohio
 Romano, Rodrigo, 2018, Florida
 Shoemaker, Eugene B., 2015, Wisconsin
 Smith, Carmen P., 2017, Texas
 Stachewicz Johnson, Nicole, 2016, Pennsylvania
 Willis, Heather A., 2018, Alaska, *ad interim*

Reynolds, Andrew S., senior manager

The Council's 2014–15 liaisons are: Dr. Andrew Kwasny (Third District, Board of Trustees), Dr. Minerva Patel (Council on Communications) and Dr. Daryn Lu (American Student Dental Association).

Bylaws Areas of Responsibility

The Council reviewed its *Bylaws* provisions and, with the Council on Ethics, Bylaws and Judicial Affairs, will be proposing revisions via an omnibus resolution to the Board of Trustees and 2015 House of Delegates. That resolution will be separately presented in the “Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the ADA *Bylaws*.”

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
Objective 2: ADA's member market share is 70% or greater of active licensed dentists	ADA, state and local dental societies increase active membership by: •Implementing lagging market recruitment campaigns to non-member women and ethnic/diverse dentists	Increased number of active licensed members	132,897 active licensed members by December 2015	130,000-133,000 active licensed members by December 2015	As of May 30, 2015: 111,912 total active licensed members; 2,240 new/reinstated members; 18,360 non-renews

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

** *Results are as of the date of report preparation and do not reflect full-year results.*

Objective	Initiative/Program	Success Measure	Target	Range	Outcome**
(Continued)	<ul style="list-style-type: none"> •Collaborating with Marketing department to develop and deploy a robust communication strategy to increase the number of members recruited via the Membership Program For Growth •Using the Tiered States Assessment Tool to target bottom tiered states with a customized portfolio of products that they implement 				
Objective 2: ADA's member market share is 70% or greater of active licensed dentists	Increase active membership through a focus on dental school conversion by: <ul style="list-style-type: none"> • Expanding the Signing Day event • Encourage states to focus on dental student/faculty interaction • ADA sponsors/co-sponsors White Coat Ceremony in every school, and in collaboration with the school, establishes White Coat Ceremony at schools where the program is non-existent • ADA, state and local societies participation in ASDA events and meetings • Establish mentorships programs at 3 schools where no program presently exists 	Increase dental school conversion rate from 66.5% at EOY 2014	Increase conversion rate for the class of 2014 by 2 percentage points from 66.5% at end of year 2014 to 68.5% at end of year 2015	Increase conversion percentage by 1-3 points	47.6% YTD in 2015
Objective 3: Achieve a 10% increase in member value	Improve the member customer service experience significantly across the Association by: <ul style="list-style-type: none"> • Developing and deploying additional modules of Member Service University to the Association • Deployment of ASAE Customer Service Course to ADA staff by the end of 2015 	At least half of dental societies that did not access Member Service University in 2014 access curriculum by December 2015	75% of dental societies access Member Service University by December 2015	65-75% of dental societies access Membership Service University curriculum by December 2015	31% YTD in 2015

One way to understand the results so-far in 2015 is to consider the year-end results for 2014 when, in comparison to 2013, there were 816 fewer active members at the end of 2014, a combination of fewer renewals and new/reinstated members. The year ended with a 64.5% market share of Active Licensed Dentists compared to 65.5% in 2013. The segments that exceeded the overall average in market share are New Dentists (65%), Specialists (74.9%), Graduate Students (65.8%) and Faculty (68.6%). The biggest volume challenges continue to be General Practitioners (61.9%), Women (59.4%) and Minorities (51.9%). There is currently a research project in place to develop marketing "personas" for some of these key groups in order to develop more effective messaging. Overall, there were 5,244 new or reinstated members in 2014, as compared to 5,525 in 2013. The \$0 quarter year dues campaign performed exceptionally well with 1,012 members joining in the fourth quarter of 2014. New initiatives in 2015,

including the new member welcome, will help increase retention for those joining at a reduced, prorated or free dues rate.

Work continues on enhancing member value, optimizing marketing messages by segment and achieving better alignment of national and state member benefits into 2015. There is strong consensus that there is no “silver bullet” that will reverse the membership trends. Instead, there are a broad range of efforts underway that fall into the following initiatives: 1) removing process hurdles, 2) focused messaging and communication methods, 3) adjusting products and value packages to reflect both demographic and practice model needs.

Emerging Issues and Trends

As the landscape of business models continues to evolve, dentists are increasingly likely to be employees, associated with a dental service organization (DSO) or otherwise part of a group larger than a solo or partnership practice. These various models of practice each present a challenge to “business as usual” while at the same time presenting possible growth opportunities that would allow ADA to continue serving as the voice of an increasingly diverse profession. Further, there are increasing indications that pricing (“not enough value”) is the primary reason for not joining or renewing membership in the ADA. This is in spite of non-members sharing that they are feeling “somewhat guilty” for not being a part of the organization that supports the profession. While there is strong focus on newer dentists, there is a growing recognition that attention is needed across all ages in maintaining continued participation from experienced General Practitioners. The ADA is faced with the same trend that is being experienced by every professional association in the country – how do both experienced and younger professionals want to interact with the organization that supports their profession during a time of tremendous change? Increasingly, there are competitive alternatives to the ADA as other professional associations (specialty groups, consultants, ethnic-based organizations, etc.) all seek to increase the value they provide so that they are the only organization needed for their members.

Responses to House of Delegates Resolutions

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
92H-2009. Impact on Dues Revenues	Yearly report to House of Delegates showing five-year anticipated (projected) dues revenues impact from members' transition to life membership.	Report completed (see narrative below)	Not applicable	Not applicable	Report completed (see below)
107-2014. Amendment of ADA <i>Bylaws</i> to Permit the Optional Delegation by State Societies of Dues Collection to the ADA	Proposed permitting the optional delegation by state societies for dues collection to the ADA.	Not applicable	Not applicable	Not applicable	The Council requested and received reports from the Divisions of Finance and Information Technology about dues collection processes and the rollout of Aptify with the state societies. After careful consideration of the information received, including the complexity and expense, the Council determined

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
					it would advise the 2015 House of Delegates that the status quo should be maintained. Therefore the Council is not presenting a resolution to the House of Delegates.
36-2014. Amendment of ADA Bylaws Regarding American Dental Association Dues Assessments Exemption for Active Life Members	Proposed that individuals who were Active Life members and who had been members in good standing for a total of 50 years and who were at least 80 years old be exempt from payment of dues and assessments.	Not applicable	Not applicable	Not applicable	The Council studied the pros and cons of this bylaws change, observing that this bylaws change would reduce revenue and increase complexity within the life membership category and concluded that the current bylaws should be maintained. Therefore the Council is not presenting a resolution to the House of Delegates.

Resolution 92H-2009 (*Trans.2009:415*) calls for the appropriate ADA agency to report yearly to the House of Delegates the five-year anticipated (projected) dues revenues impact from members' transition to life membership.

The Division of Member and Client Services developed projections of the dues revenue impact from members' transition to life membership based on data from the ADA dentist masterfile and through analysis and assumptions made in the ADA Health Policy Institute (HPI) research brief from 2014 titled "Supply of Dentists in the United States Is Likely to Grow." The projections for the number of dentists expected to retire (outflows) discussed in the brief were developed through statistical modeling for the 10-year 2003-2013 period which includes the five-year period prior to the start of the recession in 2008, 2003-2007, and the five-year period from 2008-2013.

Overall, it was concluded that future outflow rates of dentists would be the same as the low outflow period of 2008-2013. This conclusion was influenced by the steady trend of increasing average retirement age, a trend that preceded the recession, which was also based on new research that the dental economy is unlikely to return to prerecession growth levels and the HPI further concluded retirement patterns are not likely to return to prerecession levels. Based on historical patterns and the current age and member longevity, it is estimated that the dues revenue reduction from members transitioning to life membership will be as follows (Table 1):

Table 1. Five-Year Impact From Members Moving to Life Membership

Year of Impact	2015	2016	2017	2018	2019
Dues Revenue Reduction From Members Transitioning to Life Membership	(\$380,636)	(\$403,548)	(\$372,045)	(\$435,442)	(\$445,075)

Note: Assumes no dues increase and no assessment in years 2015-2019 and assumes retirement to remain about the same as it has been the past five to six years. Assumes no deaths.

Table 2 shows the number of projected members who will become life members from 2015-2019. The number of members who begin paying Life membership dues over the next five years is expected to increase from 2,564 in 2015 to 2,993 by 2019. It should be noted that the further out in the projection, the less accurate the forecast.

Table 2. Forecast for Active and Retired Life Members 2015-2019

Year Paying Life Dues for First Time	2015	2016	2017	2018	2019
Expected Active Life	2,050	2,172	2,003	2,342	2,394
Expected Retired Life	514	543	501	586	599
Total Projected to Become Life Members	2,564	2,715	2,504	2,928	2,993

Note: 20% are expected to become retired life based on membership as of 5/15/15. 20% was then used to project the number expected to become Retired Life members for each year for those becoming eligible for life membership through 2019.

This projection assumes that there will be no dues increase during the next five years and that all members will retain membership. There is also an assumption that the retirement rate will remain the same during the same time period based on the information in the 2014 HPI research brief, "Supply of Dentists in the United States Is Likely to Grow."

At the end of 2014, there were 14,887 active life members and 24,988 retired life members. The ADA experienced an increase in active life nonrenews in 2013, the first year of the dues increase for active life members from 50% of full dues to 75% of full dues. Typically, the nonrenew rate for active life members was about 2.7% before the dues increase and the nonrenew percentage at end of year 2013 was 4.8%. As anticipated, in 2014 there was a reduction in the percentage of active life members who dropped their membership in 2013 (4.8%) to 3.5% at the end of the year.

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2020. However, working with the Council on Ethics, Bylaws and Judicial Affairs, the Council will be proposing revisions to its *Bylaws* responsibilities. These will be presented in the "Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the ADA *Bylaws*" to the Board of Trustees and 2015 House of Delegates.

Policy Review

In accordance with Resolution 170H-2012, Reaffirming Existing ADA Policy, the Council on Membership reviewed several ADA policies and presents a series of resolutions with recommendations to maintain or amend those policies.

Recommendations—Policies to Be Maintained

The Council on Membership reviewed the following policies and determined that they be maintained as written:

Administrative Process for Transferring Members (*Trans.2001:422*)
 Differential Charges According to Membership Status (*Trans.1982:506; 2004:294*)
 Four-Year Recent Graduate Reduced Dues Program (*Trans.2008:482*)
 Long-Term Dues Waivers (*Trans.2002:384*)
 Parallel Membership Categories (*Trans.2008:481*)
 Processing of New Member Applications (*Trans.2000:452; 2002:381; 2003:353*)
 Establishment of Dental Student Societies Within the Component or Constituent Societies
 (*Trans.2001:417*)
 Involvement of Students in Society Activities (*Trans.1979:649*)

Recommendations—Policies to Be Amended

The Council on Membership recommends that the Policy on Dues Exemption for Active Duty Members (*Trans.2004:297, 335*) be amended for clarity and offers the following resolution:

37. Resolved, the ADA Policy on Dues Exemption for Active Duty Members (*Trans.2004:297, 335*) be amended to read as follows (additions are underscored):

Resolved, that constituent and component dental associations be encouraged to waive constituent and component dental association dues of members who are temporarily called to active duty with a federal dental service for the period of active duty.

The Council on Membership recommends that the Policy on Student Membership (*Trans.1977:957; 1996:673*) be amended to emphasize the key role of dental school deans and faculty members within organized dentistry and offers the following resolution:

38. Resolved, that the ADA Policy on Student Membership (*Trans.1977:957; 1996:673*) be amended to read as follows (additions are underscored, deletions are ~~stricken~~):

Resolved, that all dental students who are preparing themselves to become members of the dental profession be urged to become active members of the American Student Dental Association, the American Dental Association and the student's respective constituent and component societies, and be it further

Resolved, that all deans and faculties of dental schools be ~~requested to encourage~~ encouraged to promote membership at all levels of organized dentistry, and be it further

Resolved, that deans and faculty members be encouraged to become members of the ADA.

Summary of Resolutions

Resolution 37. Amendment of the Policy, Dues Exemption for Active Duty Members
 Resolution 38. Amendment of the Policy, Student Membership

Council Minutes

For more information on recent activities, see the Council's [minutes](#) on ADA.org.

Joint Commission on National Dental Examinations

Hersh, Robert A., 2015, New Jersey, chair, American Dental Association
 VanderVeen, M. Reggie, 2015, Michigan, vice chair, American Association of Dental Boards
 Chamberlain, Dale R., 2018, Montana, American Association of Dental Boards
 Efurd, Melissa G., 2018, Arkansas, American Dental Hygienists' Association
 Fujimoto, Luis J., 2017, New York, American Association of Dental Boards
 Heinrich-Null, Lisa, 2018, Texas, American Dental Association
 Levitan, Marc E., 2016, South Carolina, American Dental Education Association
 Licari, Frank W., 2017, Utah, American Dental Education Association
 Mendoza, Kristopher, 2015, California, American Student Dental Association
 Murray, Rhett L., 2017, Colorado, American Dental Association
 Nadershahi, Nader A., 2019, California, American Dental Education Association
 Parker, Patricia A., 2017, Oregon, American Association of Dental Boards
 Perkins, David W., 2017, Connecticut, American Association of Dental Boards
 Robinson, William F., 2016, Florida, American Association of Dental Boards
 Shelton-Jenkins, Issie L., 2018, Maryland, Public Member

Waldschmidt, David M., secretary and director
 Hinshaw, Kathleen J., senior manager
 Hennings, Sara, manager
 Hussong, Nick, manager
 Ryske, Ellen, manager
 Yang, Chien-Lin, manager

The Joint Commission's 2014-15 liaisons and observers include: Dr. Robert N. Bitter (Board of Trustees, Eighth District) and Greg P. Shank (American Student Dental Association). Dr. Conrad P. McVea, III, Louisiana (American Association of Dental Boards) resigned in April 2015 and was replaced by Dr. William F. Robinson.

Bylaws Areas of Responsibility

The *Bylaws* duties of the Joint Commission on National Dental Examinations are:

- A. To provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of assisting state boards in determining qualifications of dentists who seek licensure to practice in any state, district or dependency of the United States, which recognizes the National Board Examinations, here and after referred to as National Board Dental Examinations.
- B. To provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of assisting state boards in determining qualifications of dental hygienists who seek licensure to practice in any state, district or dependency of the United States, which recognizes the National Board Examinations, here and after referred to as the National Board Dental Hygiene Examinations.
- C. To make rules and regulations for the conduct of National Board Dental and Dental Hygiene Examinations and for the issuance of National Board Dental and Dental Hygiene Certificates.
- D. To serve as a resource for the dental profession in the development of written examinations.

Mission

The 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.

Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective	Initiative/ Program	Success Measure	Target	Range	Outcome*
5 - Non dues revenue Develop Advanced Dental Admission Test (ADAT) for advanced dental education programs	ADAT: Under purview of CDEL	Execute 2014 business plan: establish content and test specifications	Fourth quarter	Third or fourth quarter	In progress; activities and efforts to date have occurred in alignment with this goal
3 - Member value Ensure public confidence and professional integrity by adhering to best practices in testing and measurement for the Joint Commission's examination programs	Best practices in testing and measurement	Timeliness of deliverables associated with current and future examination programs	100% completion of assigned tasks by Q4	75-100% completion of assigned tasks by Q4	In progress; activities and efforts to date have occurred in alignment with this goal
1 - Leaders & advocates Keep stakeholders and communities of interest informed and engaged regarding activities occurring in support of the Joint Commission's examination programs (NBDE, NBDHE, and INBDE)	National Board Examinations: Communication	Timeliness of communications	Communication widely disseminated at strategic points throughout the year	Q3-Q4 dissemination of information	In progress; activities and efforts to date have occurred in alignment with this goal, including presentations at the ADEA 2015 annual meeting

At its April 2015 meeting, the Joint Commission accomplished the following:

1. *Budget Proposal and Fees.* Approved the Joint Commission's budget proposal, including 2016 candidate fees. Subject to final approval by the ADA House of Delegates, the total examination fees charged in 2016 to candidates will be \$380 for the NBDE Part I, \$425 for the NBDE Part II, and \$400 for the NBDHE. Candidates from non-accredited institutions will be assessed a \$125 processing fee at the time of application. Score report request fees in 2016 will be \$35. The above examination fees are reduced relative to those in place in 2015, due to lower than expected research and development costs.
2. *Integrated National Board Dental Examination (INBDE).* Approved additional operational recommendations pertaining to the Integrated National Board Dental Examination (INBDE), a written examination that will supplant National Board Dental Examination (NBDE) Parts I and II in the future. Most notably, the Joint Commission approved item writing conventions concerning the INBDE Patient Box, a new way of presenting patient information. Item writing for the INBDE is underway, with field testing anticipated for 2016. The Joint Commission will provide stakeholders and communities of interest with at least four years' advance notice prior to formal implementation of the INBDE.

* Results are as of the date of report preparation and do not reflect full-year results.

3. *National Board Dental and Dental Hygiene Examinations.* Reaffirmed the Joint Commission's commitment to the quality and validity of its current examination programs (NBDE Parts I and II, National Board Dental Hygiene Examination (NBDHE)). This includes the following:
 - A. Adopted the recommendations of two separate, independent standard setting committees for NBDE Parts I and II. Standard setting involves the establishment of a cut score that separates passing and failing candidates. The Joint Commission's standards are criterion-referenced (i.e., established based on specific skill requirements), as opposed to normatively based. The two new standards will be scheduled for implementation no sooner than April 2016.
 - B. Adopted a resolution to appoint an ad-hoc committee to review the Joint Commission's case material development process and provide recommendations to improve the quality of all images viewed by candidates (particularly radiographic images).
 - C. Reviewed the process of administering breaks (scheduled and unscheduled) during test administration, and directed staff to pursue revisions which will reduce the likelihood of break violations.
 - D. Outlined additional steps to refine the dental hygiene competency framework that will be used for practice analysis purposes for the NBDHE. Practice analyses are used to help determine the content that appears on an examination.
 - E. Reviewed progress in incorporating various enhancements identified for the INBDE directly into the Joint Commission's current examinations, where appropriate.
 - F. Adopted a resolution to appoint an ad-hoc committee to conduct a comprehensive review of current irregularity/appeals policies and procedures, with the assistance and support of Joint Commission staff, in-house legal counsel, and others as appropriate, and that such committee report its progress and any recommendations to the Joint Commission in 2016.
 - G. Recommended that the following two positions be added to the ADA Department of Testing Services in 2016 to strengthen test security efforts: Manager, Test Security; Coordinator, Test Security.
 - H. 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 2016.
 - I. Approved the 2014 editions of the *NBDE and NBDHE Technical Reports*.
 - J. Approved a list of additional 2015 and 2016 research and development projects and expenditures.

4. *Joint Commission Standing Rules and Examination Regulations.* Adopted proposed revisions to the Joint Commission's *Standing Rules* and *Examination Regulations*. This includes editorial modifications to clarify language within each document and align language more closely with prior Joint Commission decisions. Revisions to Examination Regulations are effective immediately; revisions to Joint Commission Standing Rules are contingent upon approval by the ADA's House of Delegates. The following are noteworthy:
 - A. Candidates may not take an examination under a false identity. Candidates may not take an examination for another individual, nor can a candidate have another individual take an examination in their place.
 - B. If the JCNDE finds reason to void the NBDE Part I results of an individual who has successfully completed the NBDE Part II and received National Board certification, the decision to void the NBDE Part I results may be stayed pending the outcome of an appeal or until the time for submission of an appeal has expired. The JCNDE will not report the candidate's results until time has expired or the Joint Commission has rendered its decision concerning an appeal (whichever comes first).
 - C. The Joint Commission recommends that the following resolution be adopted by the 2015 House of Delegates:

39. Resolved, that the *Standing Rules* of the Joint Commission on National Dental Examinations be approved as revised in Appendix 1 of the Joint Commission's 2015 annual report.

5. *Joint Commission Bylaws*. Adopted proposed revisions to the *Joint Commission's Bylaws*, contingent upon approval by the ADA House of Delegates. These revisions were editorial in nature, updating the *Bylaws* and bringing them into alignment with *ADA Bylaws* and current practices. The Joint Commission recommends that the following resolution be adopted by the 2015 House of Delegates:

40. Resolved, that the *Bylaws* of the Joint Commission on National Dental Examinations be approved as revised in Appendix 2 of the Joint Commission's 2015 annual report.

6. *Communities of Interest*. Approved the following, in support of communities of interest:
- A. Adopted a revised monthly reporting approach for dental schools and dental hygiene programs, based on data involving rolling 12-month intervals. This reporting approach will be implemented in 2017.
 - B. Directed staff to publish findings from an investigation into the impact of pass/fail reporting on examinee performance. This study will be reported to both the dental and test publishing communities.
 - C. Approved procedures for granting permission for use of the Joint Commission's released examination materials by dental and dental hygiene educational programs.
 - D. Approved procedures for granting permission to educational programs for use of the Case Development and Test Item Development Guides by dental schools for faculty development.
 - E. Approved procedures for the sale of NBDHE 2006 and 2009 released examination materials to individuals for a fee to cover costs of production and distribution.
7. *Leader and Resource on Assessment*. Approved actions consistent with the Joint Commission's mission to serve as a leader and resource on assessment for the oral health care profession. Directed staff to continue to monitor the activities of the Commission on Dental Accreditation (CODA) regarding potential implementation of a process of accreditation for dental therapy education programs.
8. *Joint Commission Elections*. Elected Dr. Luis J. Fujimoto as chair and Dr. Marc E. Levitan as vice chair of the Joint Commission. Their terms will begin in November of 2015.
9. *Meeting Dates*. Approved April 26, 2017 as the scheduled meeting date for 2017.

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 2005. 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 presents performance trends for National Board Dental Examination Part I (NBDE Part I) over the past 10 years, while Figure 1 provides a graphic depiction of administration volume. Generally speaking, Table 1 shows smooth and steady growth in the number of first-time candidates from accredited programs taking NBDE Part I across the 10-year period indicated. The year 2007 represents the exception to this trend, with a 10-year low of just 4,179 candidates. The total number of first time candidates from non-accredited programs also increased during this 10-year timeframe, with 2005 being the low at 1,156 candidates and 2014 representing the peak at 2,211 candidates. The total number of administrations (i.e., first-time candidates and repeating candidates from accredited and non-accredited

programs) increased from 7,978 in 2005 to 9,617 in 2014. This represents an overall increase of 1,639 candidates (i.e., 20.5%).

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.

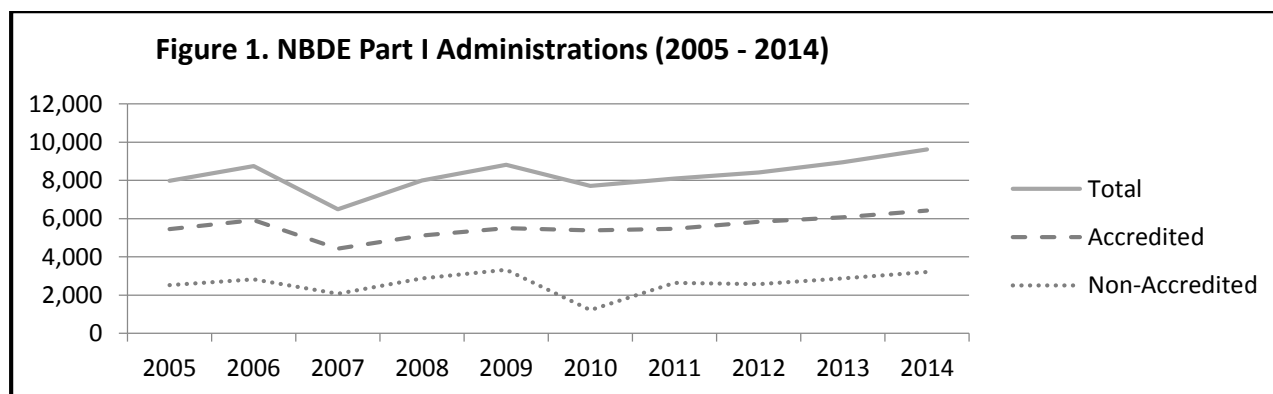
In interpreting this table, please note that effective 2007, NBDE Part I became a comprehensive examination that was no longer administered in four sections based on subject matter. Prior to 2007, candidates had to pass all four sections in order to pass the examination. Additionally, please note that effective 2010, candidates who have passed NBDE Part I are not permitted to retake the examination unless required by a state board or relevant regulatory agency.

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
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
2012	5,497	6.1	344	39.2	1,721	38.3	842	68.1	8,404	20.3
2013	5,571	6.3	502	30.3	1,919	36.1	947	63.1	8,939	20.1
2014	6,041	3.7	377	26.3	2,211	31.9	988	56.4	9,617	16.5

*From 2004 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.



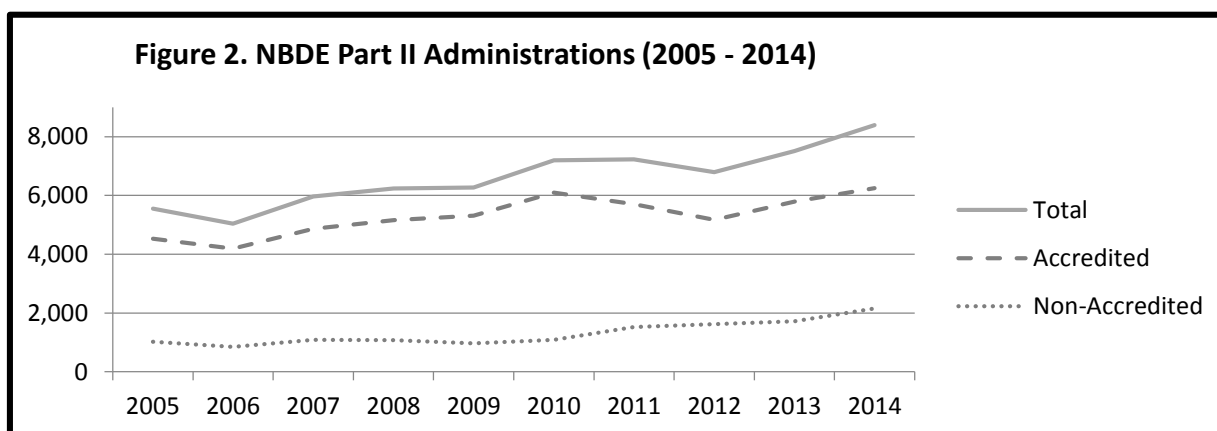
NBDE Part II: Table 2 presents performance trends for National Board Dental Examination Part II (NBDE Part II) over the past 10 years, while Figure 2 provides a graphic depiction of administration volume. As shown in Table 2, the number of first-time candidates from accredited programs was 4,042 in 2005, dropped to 3,775 in 2006, jumped precipitously in 2007, and then showed continued growth through 2011. Volume decreased from 2011 to 2012, and then increased in 2014 to a 10-year high (N=5,704). There has been quite a bit of variability since 2006, ranging from a low of 3,775 candidates in 2006 to a high of 5,704 in 2014 (i.e., a 51% increase). The total number of first-time and repeating candidates from

non-accredited programs increased from 1,021 in 2005 to 2,150 in 2014. Comparing the number of total administrations occurring in 2005 (N=5,550) with 2014 (N=8,397) shows a 51% increase in overall administration volume, with gains having occurred for both accredited and non-accredited candidates.

Concerning NBDE Part II failure rates, the Joint Commission recognized an increase in the failure rate from 2008 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, effective in 2010 staff conducted audits and quality control procedures, and monitored candidate performance on a weekly basis as part of the overall validation process. Lastly, it was noted that the failure rate for NBDE Part II first-time candidates from accredited programs was 7.4% in 2014; this represented a decrease relative to 2009 (13.7%), but an increase relative to 2013 (6.3%).

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
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
2012	4,803	5.6	363	29.2	1,216	31.3	410	49.5	6,792	14.1
2013	5,328	6.3	463	22.0	1,204	36.4	516	53.3	7,511	15.3
2014	5,704	7.4	543	21.4	1,557	37.3	593	45.2	8,397	16.5



NBDHE: Table 3 presents performance trends for the National Board Dental Hygiene Examination (NBDHE) over the past 10 years, while Figure 3 provides a graphic depiction of administration volume. As shown in Table 3, the number of first-time candidates from accredited programs increased from 6,136 in 2005 to 7,357 in 2014 (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,

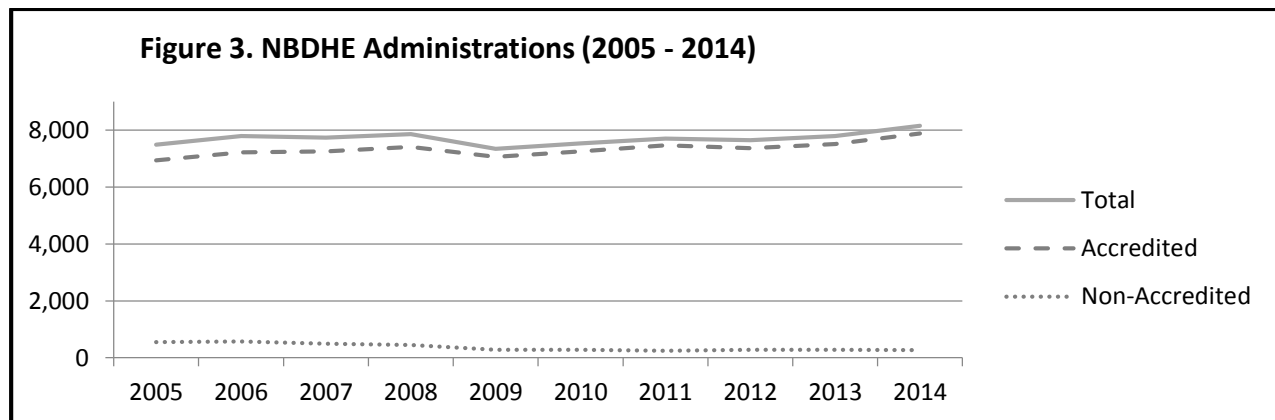
representing approximately 7% of administrations occurring in 2005 and approximately 3% of administrations occurring in 2014. Comparing the number of total administrations occurring in 2005 with 2014 showed an overall increase of 666 first-time and repeating candidates from accredited and non-accredited programs (i.e., a 9% increase). Generally speaking, NBDHE total administration volume has been stable over the 10-year period indicated.

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 higher during the earlier years, and lower in more recent years, with the lowest rate shown for 2013 (17.3%). The general trend showed a substantial decrease in failure rates for first-time candidates from non-accredited programs, decreasing from 63.3% in 2005 to 23.0% in 2014 over the 10-year period.

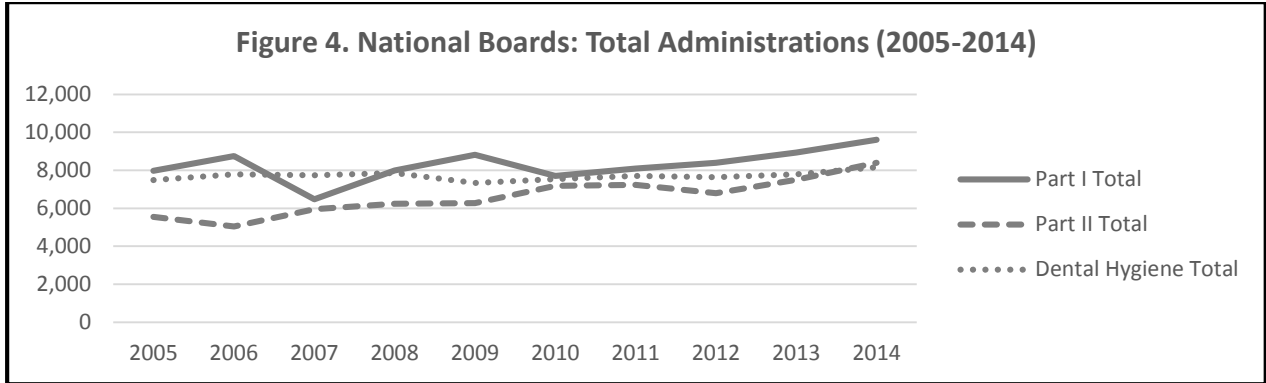
TABLE 3] Numbers and Failure Rates for First-time and Repeating Candidates NBDHE

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
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
2012	6,882	4.2	486	47.1	236	26.7	42	50.0	7,646	7.9
2013	7,016	4.8	489	45.8	231	17.3	52	53.9	7,788	8.1
2014	7,357	4.8	527	47.4	204	23.0	68	63.2	8,156	8.5

* A new standard was introduced this year, based on updated standard setting activities.



Overall: Figure 4 provides a graphic depiction of overall test administration volume for the National Boards over the past 10 years. Generally speaking, Part I total administrations have shown the greatest amount of variability over time, while Dental Hygiene administrations have shown the most consistent volume. Administration volume for the National Board Dental Examinations appears to be generally independent of the volume associated with the National Board Dental Hygiene Examination, although all three programs appear to be showing growth in the last couple of years. Part I administrations have trended upward consistently since 2010, and Part II administrations have increased consistently since 2012.



Responses to House of Delegates Resolutions

In 2014, the JCNDE received one resolution from the House of Delegates, in response to the JCNDE's request to modify its *JCNDE Standing Rules*.

Resolution Objective	Initiative/Program	Success Measure	Target	Range	Outcome
20H-2014. Revisions to <i>Standing Rules</i> of the Joint Commission on National Dental Examinations	Approval of the Joint Commission on National Dental Examinations <i>Standing Rules</i> Revisions	JCNDE Standing Rules and corresponding documents updated	4th quarter 2014	4th quarter 2014	Task completed in November 2014

Revisions to the JCNDE Standing Rules included establishment of the *JCNDE Test Construction Committees and Member Selection Criteria* as a separate document under the purview of the JCNDE, and editorial changes for clarification purposes. As indicated in the preceding table, the *JCNDE Standing Rules* have been updated, and corresponding documents have also been created and updated to reflect the amended *JCNDE Standing Rules*.

Self-Assessment

The Joint Commission on National Dental Examinations is next scheduled to conduct a self-assessment in 2017.

Policy Review

As a semi-autonomous agency of the American Dental Association, the Joint Commission on National Dental Examinations maintains its policies and procedures in three separate documents: 1) the *JCNDE Standing Rules*, 2) the *JCNDE Examination Regulations*, and 3) the *JCNDE Test Construction Committees and Member Selection Criteria*. On an annual basis, each of these documents is reviewed in accordance with Resolution 170H-2012, Reaffirming Existing ADA Policy. Changes to the *JCNDE Standing Rules* and *Examination Regulations* were noted previously in this report. No changes were necessary with respect to the *JCNDE Test Construction Committees and Member Selection Criteria*.

Summary of Resolutions

- Resolution 39. Revisions to *Standing Rules* of the Joint Commission on National Dental Examinations
- Resolution 40. Revisions to *Bylaws* of the Joint Commission on National Dental Examinations

Council Minutes

For more information on recent activities, see the Joint Commission's minutes on ADA.org:
<http://www.ada.org/en/jcnde/news-resources/>

Appendix 1. Revisions to the Standing Rules of the Joint Commission on National Dental Examinations

STANDING RULES

April 2014 2015

A publication of the Joint Commission on National Dental Examinations
American Dental Association Building
211 East Chicago Avenue, ~~Suite 600~~
Chicago, Illinois 60611-2637

The Joint Commission on National Dental Examinations operates within the limits imposed by ~~three~~ four documents, listed here in order of precedence:

1. Bylaws of the American Dental Association
2. Bylaws of the Joint Commission on National Dental Examinations
3. Standing Rules for Councils and Commissions
4. Standing Rules of the Joint Commission on National Dental Examinations

Subject to constraints defined in these documents, the Joint Commission is free to establish its own policies and procedures for the conduct of its business. Such policies and procedures as have been adopted are compiled here.

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ELECTION OF A PUBLIC MEMBER

The Joint Commission is charged with electing a public member to serve as a commissioner. Policies relating to election are as follows:

Qualifications

The public member shall not be a (n):

- a. Dentist
- b. Dental hygienist
- c. Dental student
- d. Dental hygiene student
- e. Faculty member of a dental school or dental hygiene program
- f. Employee of the Joint Commission
- g. Member of another health profession
- h. Professional who has represented the Joint Commission, dental profession, or dental hygiene profession for a fee in the last five years
- i. Spouse of any of the above

Not more than five percent of the public member's income shall be derived from the Joint Commission, dentistry, or dental hygiene.

It is suggested that the public member not be employed by a firm with a substantial interest in dentistry or dental hygiene, and that the public member be experienced in health issues, testing, credentialing, and/or advocating for the interests of the public. Individuals wishing to serve as the public member must disclose in their application materials any financial benefits they may be receiving from the Joint Commission's examination programs.

Term

The public member will serve a single four-year term.

Identification of Nominees

When a new public member is needed, nominations will be requested from appropriate agencies, such as state boards of dentistry and public service organizations. Each nominee will be requested to supply a summary of his or her qualifications. At least two qualified nominees will be identified prior to conducting an election.

ROLES OF COMMITTEES

The following four Joint Commission standing committees meet in conjunction with the annual meeting of the Joint Commission:

- a. Committee on Administration
- b. Committee on Dental Hygiene

- c. Committee on Examination Development
- d. Committee on Research and Development

Each committee is assigned a portion of the materials to be considered by the Joint Commission, and is responsible for formulating specific recommendations for Joint Commission action.

Assignments

Assignment of topics to specific committees is the responsibility of the Joint Commission Chair, but this responsibility may be delegated in part or in total to the Secretary. Listed and discussed below are examples of topics that are typically assigned to each committee.

A topic may be assigned to more than one committee. In addition, provided that it completes its assigned items, a committee may consider a topic assigned to a different committee.

Committee on Administration

This committee's responsibility relates to both National Board Dental Examinations and the National Board Dental Hygiene Examination. The committee deals with operations. Specific topics to be considered include:

- a. Examination security, including procedures for examination administration
- b. Examination regulations
- c. Joint Commission Bylaws and Standing Rules
- d. Finances, including an annual comparison of income and expenses

Committee on Dental Hygiene

This committee's responsibility relates primarily to the National Board Dental Hygiene Examination. Specific topics to be considered include:

- a. Examination content and specifications
- b. Test construction procedures, including nomination of test constructors and establishment of qualification requirements
- c. Information circulated to publicize or explain the testing program
- d. Portions of Examination Regulations that affect dental hygiene candidates
- e. Matters pertaining to finances, ADA and Joint Commission Bylaws, and Joint Commission Standing Rules that affect the National Board Dental Hygiene Examination

Committee on Examination Development

This committee's responsibility relates primarily to the National Board Dental Examinations. Specific topics to be considered include:

- a. Examination content and specifications
- b. Test construction procedures, including nomination of test constructors and establishment of qualification requirements

- c. Information circulated to publicize or explain the testing program
- d. Portions of Examination Regulations that affect dental candidates
- e. Matters pertaining to finances, ADA and Joint Commission Bylaws, and Joint Commission Standing Rules that affect the National Board Dental Examinations

Committee on Research and Development

This committee's responsibility relates to both the National Board Dental Examinations and the National Board Dental Hygiene Examination. Topics considered by this Committee include any research and development activities related to the examinations.

Committee Actions

A committee is expected to consider and report on all assigned topics. For most topics, committee actions are to be presented in the form of recommendations for Joint Commission action. The following are three exceptions:

- a. A decision about the manner in which a committee approaches its assignment. For example, a change in the personal data form for potential test constructors need not be reported.
- b. Identification of background materials requested to inform future deliberations may be reported as informational without an accompanying recommendation. If compilation of needed background materials requires substantial resources, however, a specific recommendation for action is appropriate.
- c. A decision not to act may be reported as an informational item. If the topic has generated substantial outside interest, however, a recommendation not to act is appropriate so as to allow the Joint Commission to affirm the committee's decision.

Reporting

Background information prepared for Committee deliberations is ~~circulated~~ provided to all Commissioners and all Committee members. Exceptions include, for example, the following: 1) ~~are as follows~~ 1) information about a nominee to a test construction committee is provided only to the committee charged with screening nominees and 2) technical reports containing sensitive information (e.g., involving matters of test security) that are provided as background for the Committee on Research and Development.

Committee reports are provided to the Joint Commission ~~in written or electronically form.~~ Topics are discussed in the order they are listed on the Joint Commission's agenda, and background information related to each topic is identified. For each recommendation, the report should include a brief summary or rationale. An exception is made in that no rationale is expected for appointment of a test constructor. Instead, an alternate is named for each newly proposed test constructor.

Preparation and presentation of a committee's report is the responsibility of each committee's Chair. Preparation may be delegated to a staff member assigned to the committee. If the committee Chair is not a commissioner or if, for some other reason, the committee Chair is not

present at the Joint Commission's annual meeting, responsibility for presenting the report may be delegated to a commissioner who has served on that committee.

Committee reports are presented orally, stopping for action as needed. At each stop for action, the presenter represents the committee's views through his or her answers to questions. Only after ensuring that the committee's views have been represented adequately may the presenter impart any personal views.

TEST CONSTRUCTOR SELECTION CRITERIA

The Joint Commission selects consultants to serve on its Dental and Dental Hygiene Test Construction Committees. A test constructor is appointed for a one-year term and may be reappointed to four consecutive terms. To be considered for appointment, candidates must possess appropriate qualifications and must submit a completed personal data form. Test constructor qualifications are published in the following document: Joint Commission's JCNDE Test Construction Committees and Member Selection Criteria~~Qualification Requirements for National Board Dental and Dental Hygiene Test Constructors.~~—Test constructors who have completed five years of service on a committee will not be considered for reappointment to the same committee.

DETECTION OF IRREGULARITIES BASED ON FORENSIC ANALYSES

The Joint Commission is responsible for protecting the integrity of National Board Examination results. One method involves forensic analyses of candidate performance to detect irregularities and aberrant response patterns. Candidate's results may be withheld or, as circumstances may warrant, reported when 1) aberrant response patterns or aberrant examination performance is detected through forensic analyses or 2) other evidence comes to light that supports the possibility that the candidate has given or received confidential information concerning examination content during or prior to the examination. Similarly, results may be withheld or reported if compelling information is available that suggests that the candidate was not testing for the intended purpose.

LIMITED RIGHT OF APPEALS FOR EXAMINATION CANDIDATES

The Joint Commission on National Dental Examinations (JCNDE) recognizes that strict application of the Examination Regulations for National Board Examinations may, because of unusual circumstances, impose an unusual burden on one or more candidates. In these situations, the JCNDE may consider an appeal.

Requests for an appeal pertaining to test results must be initiated within 30 days of receiving test results or, in the case of withheld results, within 30 days of receiving written notice that results are being withheld. In the event that the JCNDE has given notice that previously released results are to be invalidated or voided, the request for appeal must be submitted within 30 days of that notice. In this case, a request for appeal will stay the action to invalidate or void the results until such time as the appeal is decided or the time for submitting a request for appeal has expired. In the interim, no results will be reported. A request for an appeal must be submitted in writing and must include adequate supporting documentation. The request for an appeal must indicate the specific relief requested.

A request for an appeal will first be screened by the Chair, in consultation with the secretary. The Chair, at his/her sole discretion, may 1) grant the appeal, 2) deny the appeal, or 3) forward

the appeal to the full Joint Commission for its consideration. If during the Joint Commission's deliberations credible information becomes available indicating an error was made in the decision to withhold ~~scores~~results, the Chair in consultation with the secretary may end the deliberations and grant the appeal. At his or her discretion, the Chair may delegate the screening of appeals to another member of the Joint Commission.

In rendering a decision with respect to appeals—and particularly in situations where results have been withheld—the touchstone and foremost consideration is the validity of examination results, in alignment with the purpose of the examination. The Joint Commission strives to be fair and objective in its decision making process, as it remains true to its mission. When considering appeals, the JCNDE avoids favoritism and strives to ensure that all candidates are treated equally and fairly.

If the issue presented in an appeal is likely to recur, the JCNDE may consider a change in its Examination Regulations. The granting of an appeal will be considered a precedent only if a change in regulations is also adopted. The candidate will be notified of JCNDE action within 60 days after receipt of the written request for an appeal.

CONFLICT OF INTEREST POLICY

Policies and procedures used in National Board testing programs should provide for fairness and impartiality in the conduct of examinations and treatment of all candidates. Central to the fairness of the JCNDE's operations and the impartiality of its decision-making process is an organizational and personal duty to avoid real or perceived conflicts of interest. The potential for a conflict of interest arises when one's duty to make decisions in the public's interest is compromised by competing interests of a personal or private nature, including but not limited to pecuniary interests. Conflicts of interest can result in a partiality or bias which might interfere with objectivity in decision-making with respect to policy, or the evaluation of candidate appeals.

The Joint Commission strives to avoid conflicts of interest and the appearance of conflicts in decisions regarding examination policy or individual candidate appeals. Potential conflicts of interest for Commissioners include, but are not limited to:

- A professional or personal relationship or an affiliation with the individual or an organization that may create a conflict or the appearance of a conflict.
- Being an officer or administrator in a dental education program, testing agency, or board of dentistry with related decision-making influence regarding a candidate for National Board certification.

To safeguard the objectivity of the Joint Commission, it is the responsibility of any Commissioner to disclose any potential conflicts. Any member with a direct conflict of interest must recuse himself/herself from the decision making process regarding candidate appeals, or from discussions involving policies that impact the fairness and impartiality of the JCNDE's examination programs.

ASSISTANCE TO OTHER AGENCIES

One of the duties of the Joint Commission is to serve as a resource for the dental profession in the area of developing written examinations for licensure. This charge is fulfilled by providing

assistance to state boards of dentistry and to national and international dental organizations. This policy statement describes limitations on availability.

Availability

Operation of the National Board Examinations is the Joint Commission's primary charge. Assistance is provided to state boards of dentistry or national dental organizations only upon request and only if the Joint Commission possesses the resources to fulfill the request.

If the Joint Commission is forced to select agencies to receive assistance, highest priority will be given to state boards of dentistry that accept National Board ~~scores~~results. For dental organizations in the U.S. and its territories, assistance is limited to consultation and sharing general information about Joint Commission policies and procedures. Requests for testing services will be referred to the ADA Department of Testing Services or other organizations or individuals that provide such services.

Appendix 2. Revisions to the Bylaws of the Joint Commission on National Dental Examinations

**JOINT COMMISSION ON NATIONAL
DENTAL EXAMINATIONS**

BYLAWS

~~September 2002~~ November 2015

A publication of the Joint Commission on National Dental Examinations
American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611

The Joint Commission on National Dental Examinations is governed by ~~three~~ four documents. In order of precedence, they are:

Bylaws of the American Dental Association

Bylaws of the Joint Commission on National Dental Examinations

Standing Rules for Councils and Commissions

Standing Rules of the Joint Commission on National Dental Examinations

Joint Commission *Bylaws*, which follow, are consistent with but more comprehensive than ADA *Bylaws*.

Joint Commission *Bylaws* were adopted in 1980 and amended since. Additional modifications may be made by the ADA House of Delegates without prior notification.

ARTICLE I. PURPOSE

The purposes of the Joint Commission on National Dental Examinations are:

- A. To provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of assisting state boards in determining qualifications of dentists who seek licensure to practice in any state, district or dependency of the United States, which recognizes the National Board Examinations, here and after referred to as National Board Dental Examinations.
- B. To provide and conduct written examinations, exclusive of clinical demonstrations, for the purpose of assisting state boards in determining qualifications of dental hygienists who seek licensure to practice in any state, district or dependency of the United States, which recognizes the National Board Examinations, here and after referred to as the National Board Dental Hygiene Examinations.
- C. To make rules and regulations for the conduct of National Board Dental and Dental Hygiene Examinations and for the issuance of National Board Dental and Dental Hygiene Certificates.
- D. To serve as a resource for the dental profession in the development of written examinations.

ARTICLE II. BOARD OF COMMISSIONERS

Section 1. Legislative and Management Body

The legislative and management body of the Joint Commission on National Dental Examinations shall be the Board of Commissioners.

Section 2. Composition

The Board of Commissioners shall consist of fifteen (15) Commissioners to be selected as follows:

- A. Six (6) Commissioners who are active, life or retired members of the American Dental Association shall be selected by the American Association of Dental ~~Examiners~~ Boards from its active membership no one of whom is a member of a faculty of an accredited dental school.
 - a. For the purpose of these Bylaws, the active membership of the American Association of Dental ~~Examiners~~ Boards is defined as all active members (members who currently serve on state boards), all individual active members (members who formerly served on state boards) and all life members of that Association.
- B. Three (3) Commissioners who are active, life or retired members of the American Dental Association and who hold professorial rank at accredited dental schools shall be selected by the American Dental Education Association

from its active membership, no one of whom is a member of a state board of dentistry.

- C. Three (3) Commissioners shall be selected by the American Dental Association from its active, life and retired members, no one of whom is a faculty member of an accredited dental school or a member of a state board of dentistry.
- D. One (1) Commissioner shall be selected by the American Dental Hygienists' Association from its active membership.
- E. One (1) Commissioner shall be selected by the American Student Dental Association from its active membership.
- F. One (1) Commissioner shall be elected as a public representative by the Board of Commissioners, but such public representative shall not be a dentist, a dental hygienist, a dental student, a dental hygiene student or a faculty member of an accredited dental school or dental hygiene program.

Section 3. Term of Office

The term of office of a Commissioner shall be four (4) years except that the Commissioner selected by the American Student Dental Association shall serve a term of one (1) year.

- a. The Commissioner selected by the American Student Dental Association may be selected one (1) year in advance and may attend meetings of the Board of Commissioners as an observer before his or her term begins.

The tenure of a Commissioner shall be limited to one (1) term. Terms of Commissioners shall begin and end with adjournment of the closing session of the annual meeting of the House of Delegates of the American Dental Association in the appropriate year.

Section 4. Powers

- A. The Board of Commissioners shall be vested with full power to conduct all business of the Joint Commission on National Dental Examinations subject to laws of the state of Illinois, the *Bylaws of the American Dental Association* and these *Bylaws*.
- B. The Board of Commissioners shall have the power to establish rules and regulations to govern its organization and procedure provided that such rules and regulations are consistent with the *Bylaws of the American Dental Association* and with these *Bylaws*.

Section 5. Duties

- A. **Examination Development and Administration:** The Board of Commissioners shall:
 1. Develop, publish and periodically review specifications for National Board Dental and Dental Hygiene Examinations.
 2. Appoint consultants with appropriate qualifications to assist in the construction of National Board Dental and Dental Hygiene Examinations.
 3. Develop, publish and periodically review rules and regulations for the fair and

orderly administration of National Board Dental and Dental Hygiene Examinations.

4. Cause National Board Dental and Dental Hygiene Examinations to be administered at least annually at locations throughout the United States.
5. Cause ~~scores~~ results from National Board Dental and Dental Hygiene Examinations to be reported in a timely fashion to candidates and/or their schools and to state boards of dentistry identified by candidates.
6. Cause a permanent record of National Board dental and dental hygiene scores to be maintained so that such ~~scores~~ results may be reported to individuals or institutions identified by candidates.
7. Protect the security of National Board Dental and Dental Hygiene Examinations and the integrity of National Board dental and dental hygiene ~~scores~~results.

B. Liaison: The Board of Commissioners shall:

1. Submit an annual report of the activities and future plans of the Joint Commission on National Dental Examinations to appropriate officials of the American Association of Dental ~~Examiners~~Boards, the American Dental Education Association, the American Dental Association, the American Dental Hygienists' Association and the American Student Dental Association.
2. Conduct an annual forum for representatives of state boards of dentistry for the purposes of providing information about and receiving recommendations for National Board Dental and Dental Hygiene Examinations.

C. Financial Management: The Board of Commissioners shall:

1. Submit annually to the Board of Trustees of the American Dental Association an appropriation request for the next year.
2. Control allocated funds in a manner consistent with the budgetary policy of the American Dental Association.
3. Monitor the relationship between expenses for National Board Examinations and income from examination fees and recommend to the Board of Trustees of the American Dental Association such changes in fees as needed to avoid either profit or loss.

- D. Miscellaneous:** The Board of Commissioners shall monitor these *Bylaws* for consistency with the *Bylaws of the American Dental Association*. When or if a conflict exists, the Board of Commissioners shall describe such conflict in its annual report to sponsoring associations and recommend changes to achieve conformity.

Section 6. Meetings

- A. Regular Meetings:** There shall be one (1) regular meeting of the Board of Commissioners each year.
- B. Special Meetings:** A special meeting of the Board of Commissioners may be called at any time by the Chair of the Joint Commission on National Dental Examinations. The Chair shall call a special meeting at the request of nine (9) of the fifteen (15) members of the Board of Commissioners. Members of the Board of Commissioners shall be notified at least ten (10) days in advance of the convening of a special meeting.

Section 7. Quorum

A majority of voting members of the Board of Commissioners shall constitute a quorum.

ARTICLE III. COMMITTEES

Section 1. Committee on Dental Hygiene

The Joint Commission on National Dental Examinations shall have a standing Committee on Dental Hygiene.

- A. Composition:** The Committee on Dental Hygiene shall be composed of eight (8) members to be selected as follows:
1. One (1) Commissioner appointed by the Chair who is a representative of the American Association of Dental ExaminersBoards.
 2. One (1) Commissioner appointed by the Chair who is a representative of the American Dental Education Association.
 3. One (1) Commissioner appointed by the Chair who is a representative of the American Dental Association.
 4. The Commissioner who is a representative of the American Dental Hygienists' Association plus three (3) additional dental hygienists who are selected by the American Dental Hygienists' Association. Of the four (4) dental hygienist members, two (2) members shall be faculty members of accredited dental hygiene programs and two (2) members shall represent practicing dental hygienists.
 5. One (1) dental hygiene student who is selected by the American Dental Hygienists' Association.
- B. Meetings:** The Committee on Dental Hygiene shall have one (1) regular meeting each year. This meeting shall precede the regular, annual meeting of the Board of

Commissioners. Special meetings of the Committee on Dental Hygiene shall be convened at the request of the Board of Commissioners or at the request of a majority of Committee members subject to approval by the Board of Commissioners.

- C. Duties:** The Committee on Dental Hygiene shall consider matters related to the National Board Dental Hygiene Examination.

Section 2. Test Construction Committee

The Joint Commission on National Dental Examinations shall establish and convene regular meetings of such committees as are necessary to construct National Board Dental and Dental Hygiene Examinations.

Section 3. Other Committees

The Chair, with the advice and consent of the Board of Commissioners, may appoint such other committees as are necessary to ensure the orderly functioning of the business of the Joint Commission on National Dental Examinations. Excluding test construction committees, each committee will include at least one (1) Commissioner who is a representative of the American Association of Dental ~~Examiners~~Boards, one (1) Commissioner who is a representative of American Dental Education Association and one (1) Commissioner who is a representative of the American Dental Association.

Section 4. Authority

Decisions of committees shall be subject to approval by the Board of Commissioners.

ARTICLE IV. OFFICERS

- A. Eligibility:** The Chair of the Joint Commission on National Dental Examinations shall be a dentist who is a member of the Board of Commissioners.
- B. Election:** The Chair of the Joint Commission on National Dental Examinations shall be elected by the Board of Commissioners during its regular, annual meeting. The term of the Chair shall be one (1) year beginning and ending with adjournment of the closing session of the annual meeting of the House of Delegates of the American Dental Association.
- C. Duties:** The Chair of the Joint Commission on National Dental Examinations shall:
1. Appoint members and chairmen of such committees as are necessary for the orderly conduct of business except as otherwise provided in these *Bylaws*.
 2. Circulate or cause to be circulated an announcement and an agenda for each regular or special meeting of the Board of Commissioners.

3. Preside during meetings of the Board of Commissioners.
4. Prepare or supervise the preparation of an annual report of the Joint Commission on National Dental Examinations.
5. Prepare or supervise the preparation of an annual appropriation request for the Joint Commission on National Dental Examinations.
6. Represent the Joint Commission on National Dental Examinations during sessions of the House of Delegates of the American Dental Association.

Section 2. Vice Chair

- A. Eligibility:** The Vice Chair of the Joint Commission on National Dental Examinations shall be a dentist who is a member of the Board of Commissioners.
- B. Election:** The Vice Chair of the Joint Commission on National Dental Examinations shall be elected by the Board of Commissioners during its regular, annual meeting. The term of the Vice Chair shall be one (1) year beginning and ending with adjournment of the closing session of the annual meeting of the House of Delegates of the American Dental Association.
- C. Duties:** The Vice Chair of the Joint Commission on National Dental Examinations shall assist the Chair in the performance of his or her duties.

Section 3. Secretary:

- A. Appointment:** The Secretary of the Joint Commission on National Dental Examinations shall be an employee of the American Dental Association selected by the Executive Director of that Association.
- B. Evaluation:** The performance of the Secretary may be evaluated by the Board of Commissioners. If the Board of Commissioners exercises this option, written evaluation including recommendations signed by the Chair shall be forwarded to the Executive Director of the American Dental Association.
- C. Duties:** The Secretary of the Joint Commission on National Dental Examinations shall:
 1. Keep minutes of meetings of the Board of Commissioners.
 2. Be the custodian of records of the Joint Commission on National Dental Examinations.
 3. Manage the office and staff of the Joint Commission on National Dental Examinations.

ARTICLE V. MISCELLANEOUS

Section 1. Financial Records

Financial records of the Joint Commission on National Dental Examinations shall be maintained by the American Dental Association in a manner consistent with accepted principles of accounting. Such financial records shall be available on reasonable notice for inspection by a representative or agent of the American Association of Dental ~~Examiners~~Boards, the American Dental Education Association, the American Dental Hygienists' Association or the American Student Dental Association.

Section 2. Additional Rules

The rules contained in the current edition of the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* ~~*Sturgis Standard Code of Parliamentary Procedures*~~ shall govern the deliberations for the Board of Commissioners in all instances where they are applicable and not in conflict with the *Bylaws of the American Dental Association*, these *Bylaws* or previously established rules and regulations of the Board of Commissioners.

Section 3. Vacancy

In the event of a vacancy in the office of a Commissioner, the following procedures shall be employed:

- A. In the event that the Commissioner was selected by an association, such association shall select a successor who possesses the qualifications established by these *Bylaws* to complete the unexpired term.
- B. In the event that the Commissioner was the public representative, the Board of Commissioners shall elect a successor who possesses the qualifications established by these *Bylaws* to complete the unexpired term.
- C. In the event the vacancy involves the Chair, the Vice Chair shall immediately assume all duties of the Chair.

ARTICLE VI. AMENDMENT

These *Bylaws* may be amended only by majority vote of the House of Delegates of the American Dental Association.

Council on Scientific Affairs

Hart, Thomas C., 2015, Maryland, chair
 Abt, Elliot C., 2016, Illinois, vice chair
 Aminoshariae, Anita, 2018, Ohio
 Dmytryk, John J., 2017, Oklahoma
 Eleazer, Paul D., 2018, Alabama
 Hale, Robert G., 2016, Texas
 Jefferies, Steven R., 2016, Pennsylvania, *ad interim*
 Mariotti, Angelo J., 2015, Ohio, *ad interim*
 Milgrom, Peter M., 2015, Washington
 Moore, Paul A., 2018, Pennsylvania
 Platt, Jeffrey A., 2017, Indiana
 Roberts, Howard W., 2018, Mississippi
 Segal, Edward H., 2015, Illinois, *ad interim*
 Slayton, Rebecca L., 2017, Washington
 Sollecito, Thomas P., 2015, Pennsylvania
 Weyant, Robert J., 2017, Pennsylvania
 Young, Douglas A., 2016, California

Lyznicki, James M., senior manager

The Council's 2014–15 liaisons include: Dr. Gary Jeffers (Board of Trustees, Ninth District), Ms. Helen Yang (American Student Dental Association) and Dr. Canise Bean (Council on Communications). The ADA president, in consultation with the Board of Trustees, appointed Dr. Angelo Mariotti and Dr. Edward Segal to complete the respective terms of Dr. Thomas Wilson and Dr. Ray Williams, who resigned from the Council on Scientific Affairs (CSA) in 2014-2015. The Council had one additional vacancy following the resignation of Dr. John Ludlow. This vacancy was filled by Dr. Steven Jefferies, who was appointed to serve as an *ad interim* CSA member through ADA 2016-America's Dental Meeting.

Bylaws Areas of Responsibility

The Council reviewed its *Bylaws* provisions and, with the Council on Ethics, Bylaws and Judicial Affairs, will be proposing revisions via an omnibus resolution to the Board of Trustees and 2015 House of Delegates. That resolution will be separately presented in the "Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the ADA *Bylaws*."

Advancing ADA Strategic Goals and Objectives

The following table presents outcomes of CSA-specific projects from January-May 2015 in support of the ADA Strategic Plan, "Members First 2020," and the ADA Science Institute's Operating Plan.

Objective	Initiative/Program	Success Measure	Target	Range	Outcomes*
3. Member value	Develop scientific resources to increase ADA member, dental school faculty and student engagement by providing clinically relevant, state-of-the-art scientific information	1. Number of scientific articles/reports/pages published or posted on ADA websites in 2015	1. Six	1. Five to seven	1. Eight (additional information presented below this table)

* Results are as of the date of report preparation and do not reflect full-year results.

Objective	Initiative/Program	Success Measure	Target	Range	Outcomes*
3. Member value (cont.)	Note: initiative/ program listed on previous page (cont.)	2. Member visits to the ADA <i>Professional Product Review</i> (PPR) online	2. 25,000 unique visits	2. 18,000 to 30,000 in 2015	2. 10,400 unique visitors through first quarter 2015 (42% of the target goal for 2015)
1. Leaders & advocates	Ensure that ADA oral health information communicated to ADA members, the public and policymakers is scientifically sound and clinically relevant	Develop and collaborate to create sound, ADA peer-reviewed information to educate member providers, health professionals and the public about key oral health issues	25 JADA patient pages, brochures, Mouth Healthy.org pages and saleable materials, etc.	20-30	16 pages, standards and other resources as of May 2015
3. Member value	Advance health literacy and patient care by increasing OTC product submissions to the Seal Program & increase visits for product information to the Seal areas on MouthHealthy.org, Center for Professional Success & ADA.org	1. Increase # of Seal product submissions by December 31, 2015 2. Increase average # of visits/day to Seal site on Mouth Healthy.org by December 31, 2015	1. Increase # by 5% over 2014 2. Increase # by 5% over 2014	1. Increase 3 to 7% over 2014 2. Increase 3 to 7% over 2014	1. Two new product submissions through spring 2015 (12% of target) 2. The average number of visits/day to the Seal site on MouthHealthy.org has increased 42% from year-end 2014 to spring 2015
1. Leaders & advocates	Develop ADA CE on clinical research and EBD programs targeted toward dental school faculty and students to increase their knowledge and awareness of ADA member value	1. # of custom workshops 2. EBD Faculty Award 3. EBD Student Award 4. Pilot distance learning course on clinical research	1. Conduct two custom workshops 2. Present one EBD faculty award 3. Present one EBD student award 4. Launch one distance learning course	1. One-three workshops 2. One faculty award 3. One student award 4. Plan one distance learning course—complete distance learning course	1. Three custom workshops to be held in 2015 2 & 3. Two faculty awards and a practitioner award to be presented at ADA 2015-America's Dental Meeting. Plans for an EBD Student Award are on hold 4. EBD Center will pilot a train-the-trainer program for EBD faculty workshop development in fall 2015; plans for launching a distance learning EBD course are on hold

Objective	Initiative/Program	Success Measure	Target	Range	Outcomes*
3. Member value	Increase ADA member value by conducting and disseminating objective, peer-reviewed clinical research, scientific analyses, and scientifically based educational programs in support of the ADA's Center for Professional Success, Tripartite and Membership initiatives	<ol style="list-style-type: none"> 1. # of clinical practice guidelines 2. # of critical summaries produced for members and profession 3. Approval rating of Champion Conference & Advanced EBD Course 4. Podcasts and online tutorials 	<ol style="list-style-type: none"> 1. Two clinical guidelines 2. 20 critical summaries produced 3. 70% approval rating on courses 4. Six podcasts and two tutorials 	<ol style="list-style-type: none"> 1. One–three clinical guidelines 2. 15-25 critical summaries 3. 65-85% approval rating 4. Four to eight podcasts and one to three tutorials 	<ol style="list-style-type: none"> 1. Two guidelines completed 2. Eight critical summaries produced 3. The 2015 ADA/NYU Advanced EBD Workshop had an 85% approval rating 4. Two podcasts released and four other podcasts are under development. EBD online tutorial development is on hold as of spring 2015

EBD Center. The EBD Center's educational programs—EBD Champions Conference, Advanced EBD Workshop and customized workshops—support professional excellence in evidence-based practice. In February 2015, the EBD Center convened its annual, weeklong Advanced EBD Workshop at New York University, which covered the primary aspects of evidence-based dental practice, including implementing best evidence in clinical practice and teaching, and developing precise, structured clinical questions. The Advanced EBD Workshop drew 34 participants and received an 85% approval rate from attendees. Three customized EBD workshops will be conducted in May-June 2015 at the University of Puerto Rico, University of Tennessee, and University of Texas-San Antonio. A first “train-the-trainer” session for future EBD faculty will be held in fall 2015, and the program will be developed to lead to a certificate in evidence-based dentistry. The EBD Center also plans to solicit applications and present two EBD faculty awards and a practitioner award at ADA 2015-America's Dental Meeting in Washington D.C. Also at ADA 2015-America's Dental Meeting, the ADA will host the [EBD Champions Conference](#), which focuses on helping dentists implement clinically relevant evidence at the point of care and developing leaders in promoting oral health. ADA delegates who are interested in attending the 2015 EBD Champions Conference are welcome to [register online](#).

In early 2015, the Council and the EBD Center completed two evidence-based clinical practice guidelines addressing:

- [Management of patients with prosthetic joints undergoing dental procedures](#): This guideline was published in the January 2015 issue of JADA, and a chairside guide to assist clinicians was posted on the EBD Center website at <http://ebd.ada.org>; and
- Non-surgical treatment of chronic periodontitis: this new guideline and an executive summary of an accompanying systematic review will be published as companion pieces in the July 2015 issue of JADA.

Through first quarter 2015, the EBD Center has completed development of eight critical summaries of published systematic reviews on clinical issues of importance to dentistry. The EBD website also features [two new podcasts](#), and at least four more are under development as of May 2015. Initial plans for developing an EBD online tutorial are on hold as the custom EBD workshop program for dental school faculty is being scaled up to meet member needs.

ADA Seal of Acceptance Program. The [Seal of Acceptance Program](#) provides member dentists and the public with reliable information on safe and effective over-the-counter (OTC) oral health products. The Seal Program supports ADA members by helping them to provide credible scientific assurance that each ADA-Accepted oral care product is safe and effective, a key distinction in an ever-changing consumer marketplace. The ADA Seal is commonly viewed as the gold standard of product evaluation, and surveys

have shown that the Seal is recognized by the public and is the primary image or symbol that the public associates with the ADA.

Acceptance Program guidelines for over-the-counter product evaluation are being revised to clarify requirements for manufacturers. As of early 2015, the Seal Program has received two new product submissions for the ADA Seal of Acceptance, which is equal to 12% of the program's annual goal of a 5% increase in new product submissions (i.e., 17 new product submissions overall). The number of renewals for Seal products varies each year since the renewals occur every five years. In 2015, there are 49 Seal products that are due for renewal.

Promotion of the ADA Seal Program continues on MouthHealthy, ADA publications and Twitter, which generated 1.8 million impressions and 27,500 tweet engagements. The average number of visits/day to the Seal site on MouthHealthy.org has increased from 83 visits/day in late 2014 to 118 visits/day in spring 2015, a 42% increase.

ADA Professional Product Review. The February 2015 *ADA Professional Product Review* (PPR) featured [light-curing guidelines for clinicians](#) and an [ADA Laboratory evaluation of high-speed air turbine handpieces](#), accompanied by a computer-animated video explaining power output. In first quarter 2015, PPR content on ADA.org drew over 12,500 visits and 10,400 unique visitors, which equals a 40% increase in online visits over fourth quarter 2014. These webtrends statistics are only for the first quarter of 2015; if current webtrends remain consistent through 2015, PPR will easily meet its target goal of 25,000 unique online visitors in 2015. There were also 3,370 new visitors to the [PPR website](#) in early 2015 and, on average, visitors stayed on the site for 6.5 minutes per visit. When compared with other ADA-generated news items, PPR content appearing in the *ADA Morning Huddle* draws high numbers of online visitors who click to access links to PPR content.

This year, the PPR newsletter plans to increase its publication frequency to six times a year (every two months) to provide clinicians with more timely information and laboratory evaluations of professional products used in clinical practice. PPR is also exploring how continuing education credits may be provided in conjunction with the newsletter's articles.

Scientific Information. In early 2015, the Council published the following reports to the profession:

- The [American Dental Association Caries Classification System for Clinical Practice](#) (February 2015 JADA): The Council's caries classification system was initially developed at a 2008 international stakeholder conference at ADA Headquarters, and it was refined over time to provide the profession with a simple system for categorizing caries lesions by extent and severity.
- [Managing Xerostomia and Salivary Gland Hypofunction](#) ([executive summary](#) published in August 2014 issue of JADA; [full CSA report](#) was posted on ADA.org in February 2015): This CSA report presents a practical, evidence-guided approach for evaluating and managing patients with salivary dysfunction.

Overall, the Council and the Science Institute developed 16 new ADA peer-reviewed informational resources, including:

- one issue of the [ADA Professional Product Review](#) (published online in February 2015);
- six new ANSI/ADA standards (addressed later in this report);
- three JADA "For The Patient" pages ([Managing Dry Mouth](#); [Keeping Your Gums Healthy](#); [Bridges, Implants and Dentures](#));
- four ADA "Science Inside" videos on toothpaste ingredients, fluoride, bad breath, and tooth whitening; and
- two ADA.org "Science in the News" articles addressing: [dental caries and sealant prevalence in U.S. children and adolescents](#); and an [FDA systematic review on current cigar smoking and all-cause mortality risks](#).

ADA Research and Laboratories. Scientists from the ADA Research & Laboratories (R&L) conduct research on dental materials, instruments, and equipment. As primary content providers for the PPR

newsletter, R&L scientists performed the laboratory evaluations of high-speed air turbine handpieces and [light-emitting diode \(LED\)-curing units](#) in recent PPR newsletters, and generated companion [instructional](#) videos for both evaluations. R&L researchers are conducting evaluations of dental radiometers and carbide/diamond instrument finishing systems, and they completed testing of several brands of manual toothbrushes and fluoride mouthrinses that were submitted for evaluation for the ADA Seal of Acceptance.

R&L staff provide leadership in the development and implementation of dental standards and guidelines for product evaluations, including the standardization of test methods for measuring the brush-head retention force of powered toothbrushes and testing the power output of air-turbine handpieces. R&L scientists are also developing a test method to evaluate the corrosion susceptibility of orthodontic brackets. R&L staff also provide comments and votes for several different ANSI/ADA and ISO standards, including interoperability, dental curing units, metallic materials, test methods for characterizing corrosion susceptibility of dental implant systems, and machinable blanks for CAD/CAM.

Standards Development. The Council promotes dental excellence by participating in the development of standards and technical reports for current and emerging technologies used in clinical practice. In March 2015, the annual meetings of the [Standards Committee on Dental Products](#) (SCDP) and U.S. Technical Advisory Group (TAG) for ISO/TC 106 were held in Boston, which included two plenary sessions, nine subcommittee/TAG sessions, 21 working group meetings, and two symposia on challenges in measuring biofilm–material interactions, and oral biofilms and their implications for the dental Industry. After the SCDP’s annual meeting, the FDA Center for Devices and Radiological Health (CDRH) representative to SCDP met informally with the SCDP committee for a discussion about improved processing of 510(K) submissions, generating ideas for new standards in emerging technologies, identifying gaps where new standards might be useful, and considering how standards can help in mitigating and reporting adverse events involving dental devices.

ANSI/ADA Standards Development. The ADA’s voluntary ANSI-accredited standards program develops consensus standards that provide direct value to ADA members. Since mid-2014, the SCDP has completed work on: three new standards (Hydrocolloid Impression Materials; Products for External Tooth Bleaching; Screening Method for Erosion Potential of Oral Rinses on Dental Hard Tissues); one revised ANSI/ADA standard (Manual Toothbrushes); and nine reaffirmed standards (e.g., Double-Pointed, Parenteral, Single Use Needles for Dentistry; Powered Toothbrushes; Dental Compressed Air Quality).

Emerging Issues and Trends

The Council continuously monitors the available scientific literature and emerging issues affecting dental practice. The Council’s completion—and publication—of an ADA caries classification system, in the February 2015 issue of JADA, could have a significant impact by bringing a stronger consensus to the profession on caries classification, and providing a classification system that helps dentists with documenting the caries disease process by stage, activity and location. Many dental schools have been using the foundational parts of the ADA caries classification system for years. Expanded use of the system could encourage treatment of early carious lesions while they are still reversible, improve documentation of lesion progression over time, and facilitate evidence-based data collection through electronic dental health records. The CSA will consider collaborative efforts to promote the caries classification system through various ADA media, coordination and cooperation among numerous internal and external stakeholders, including academia, industry, research and dental practitioners.

The CSA is addressing the current “state of the science” for genetic tests for oral diseases and is preparing a position statement on this topic. In October 2015, the ADA and the Task Force on Design and Analysis in Oral Health are co-sponsoring a meeting of genetic experts called “Navigating in a Sea of Genomics Data,” which will address such issues as the lack of genetic test regulation and the development of guidelines and standards for genetic test products pertaining to the dental community.

Responses to House of Delegates Resolutions

The Council's responses to three assignments from the 2014 ADA House of Delegates are summarized in the following table, with supplemental information presented below the table.

Resolution Objective	Initiative/Program	Success Measure	Target	Outcome
67H-2014. Educating Children and Parents About the Dangers of Oral Piercings	Investigate the safety of intraoral tattoos; expand educational program & preparation of material on the dangers of oral piercing & intraoral tattoos that targets younger children, young adults, adolescents and parents.	Completing initial investigation and forwarding recommendations to 2015 House of Delegates.	Presenting report on this activity to 2015 House of Delegates.	Initial recommendations presented in this annual report.
68H-2014. Promotion of the Evidence Regarding Premedication for Patients With Prosthetic Joint Implants	Actively promote to appropriate medical organizations and practitioners the results of the 2014 systematic review regarding the efficacy of premedication prior to dental procedures performed on patients with prosthetic joint replacements.	Pursue promotions (via ADA News , ADA.org or other ADA media) of the findings of this CSA guideline to dental/medical clinicians & appropriate medical organizations. Collaborate with the Council on Access, Prevention and Interprofessional Relations (CAPIR) to promote findings to medical groups & physicians.	Present report on this activity to 2015 House of Delegates.	Status report presented in the 2015 CSA annual report (information included below this table).
69H-2014. Optimizing Dental Health Prior to and Concurrent With Surgical/Medical Procedures and Treatment	Appropriate ADA agencies investigate the fiscal implication of the development of a policy statement and evidence-based guidelines for physicians and surgeons to eliminate the impact of untreated dental disease prior to and concurrent with complex medical or surgical procedures. ADA agencies, including CSA, were asked to investigate other approaches to address this issue that may be accomplished at lower cost.	Work with the EBD Center and CAPIR to conduct an initial investigation of the developing of an ADA policy and evidence-based guidelines on this issue.	Present report on this activity to 2015 House of Delegates.	Progress presented in the 2015 CSA annual report (information included below this table).

Resolution 67H-2014—Educating Children and Parents About the Dangers of Oral Piercings. In 2015, the Council conducted a preliminary review of published evidence and emerging news reports about intraoral tattooing and oral piercing. Several U.S. states explicitly prohibit the tattooing of minors under age 18 regardless of parental consent, and some U.S. states allow tattooing or piercing procedures for minors with either parental consent or parental presence during the procedure.

Intra-oral tattooing of the inner lip introduces tattoo ink directly to the oral mucosa, and the recipient must remain stationary while holding their lower lip still for 15-30 minutes or more while tattoo inks are applied. There are currently no published reports of adverse effects of intraoral tattooing, but because intraoral tattoos require repeated touch-ups to maintain, the recipient may be placed at elevated risk of bacterial or viral infection. Like skin tattoos, intraoral tattooing can potentially cause inflammatory reactions and hypersensitivity to the tattoo materials or ink, which may contain heavy metals. The U.S. Food and Drug Administration (FDA) has published a recent voluntary recall notice for [tattoo ink products from one](#)

[company](#) due to pathogenic bacterial contamination. The FDA also has a [Consumer Advisory on tattoo inks](#), which notes that the “FDA has not traditionally regulated tattoo inks or the pigments used in them.”

With oral piercing procedures, case reports of adverse events after such procedures have appeared in research journals, ranging from infection of local tissues and allergies to materials to dental trauma and jewelry aspiration. The ADA maintains a policy statement on intraoral/perioral piercing and tongue splitting, which the Council reviews and revises periodically. This ADA policy, last reviewed in October 2012, advises against the practice of intraoral/perioral piercing and tongue splitting due their potential adverse effects, and it supports legislation requiring parental consent for minors seeking intraoral/perioral piercings. However, the 2012 ADA policy on intraoral/perioral piercing does not include any information on intra-oral tattooing.

The Council recommends updating the 2012 ADA policy statement on the adverse events associated with intraoral and perioral piercing, and reviewing existing information and evidence on intraoral tattooing and any relevant legal limitations before disseminating information to parents, young adults, members and external organizations. The Council will complete this review in 2015 and develop an updated draft policy statement, including information about intraoral tattooing, which will be targeted for submission to the 2016 House of Delegates for review and approval. After this ADA policy is amended in final format, the Council will collaborate with the Council on Access, Prevention and Interprofessional Relations (CAPIR) and the Council on Communications to develop an expanded ADA educational program on the risks of intraoral tattooing, with expanded materials and information for providers and the public.

Resolution 68H-2014—Promotion of the Evidence Regarding Premedication for Patients With Prosthetic Joint Implants. In accordance with Resolution 68H-2014, the Council is serving as lead reporting agency, with support from CAPIR, to “actively promote to appropriate medical organizations and practitioners the results of the 2014 systematic review regarding the efficacy of premedication prior to dental procedures performed on patients with prosthetic joint replacements.”

The Council and the EBD Center recently completed an evidence-based clinical practice guideline on the use of prophylactic antibiotics prior to dental procedures for patients with prosthetic joints, which was published in the [January 2015 issue of JADA](#). In addition, the Council is coordinating with the American Association of Orthopedic Surgeons (AAOS) on an “Appropriate Use Criteria” (AUC) review process. An “appropriate” procedure is one for which the expected health benefits exceed the expected health risks by a wide margin. The AUC process will include a multidisciplinary panel of ADA, AAOS and infectious disease experts, who will be asked to review the best available evidence, including lower-quality studies where appropriate. The AUC review process is expected to develop recommendations for type and dosage of antibiotics when needed, and may take up to 12 months to complete.

The Council has identified six individuals, including three current or former CSA members who were part of an earlier ADA-AAOS workgroup, who will be asked to participate in the AUC process. The ADA Science Institute is developing questions and answers on this clinical topic to be used in educating practitioners about the guidance.

Resolution 69H-2014—Optimizing Dental Health Prior to and Concurrent With Surgical/Medical Procedures and Treatment. For this House resolution, CSA and CAPIR are collaborating to “investigate the fiscal implication of the development of a policy statement and evidence-based guidelines for physicians and surgeons to eliminate the impact of untreated dental disease prior to and concurrent with complex medical or surgical procedures.” The House resolution also directed CSA and CAPIR to “investigate other approaches to address this issue that may accomplish the intent at lower cost.”

As of May 2015, the EBD Center has completed a search of the research literature (limited to the English language) to assess publications on the efficacy of dental treatment prior to major medical events, such as surgery, chemotherapy and ionizing-therapy. After conducting the literature search, EBD Center staff found little evidence on this topic area, and most of the information appears to be either in the form of case reports or case series. The relative lack of information on this clinical issue could be used to support a recommendation for more randomized studies in this important area.

To address Resolution 69H-2014 further, the Council will conduct a rapid review of the available scientific evidence, including the following steps:

- 1) Convening a panel of four to six experts.
- 2) Identifying each of the medical conditions to be addressed in this evaluation.
- 3) Reassessing the dental and medical literature in each of these conditions.
- 4) Tabulating the information.
- 5) Reaching consensus and providing recommendations.

This rapid-review process would require at least one face-to-face meeting of expert panel members and EBD Center staff support to compile information and prepare draft and final recommendations for review and approval by CSA, in collaboration with CAPIR. Final results from this rapid review will be reported to the 2016 House of Delegates.

Self-Assessment

The Council is next scheduled to conduct a self-assessment in 2016. However, working with the Council on Ethics, Bylaws and Judicial Affairs, the Council will be proposing revisions to its *Bylaws* responsibilities. These will be presented in the “Supplemental Report of the ADA Councils Proposing Amendments to Their Duties as Stated in the *ADA Bylaws*” to the Board of Trustees and 2015 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.

ADA Business Enterprises, Inc.

Wholly Owned Subsidiary

Mercer, James, 2015, South Carolina, chair

Cole, Jeffrey, 2017, Delaware

Kolman, Paul, 2015, Indiana

Meckler, Edward, 2016, Ohio

Maher, John, 2017, Wisconsin

Doherty, Deborah, managing vice president

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

ADA Business Enterprises, Inc. (ADABEI) is a wholly owned subsidiary of the American Dental Association ("Association"). ADABEI's mission is to develop and manage programs that generate revenue by providing best-in-category products and services that create member value for dentists. ADABEI's vision is to be the leader in the development of non-dues revenue and member value by providing quality products and services.

In 2014, ADABEI goals included:

- Strategic Management of Endorsement Relationships to Increase Revenue to the ADA
- Manage and Grow Endorsement Relationships to Increase Revenue to the ADA
- Increase Commitment to New Product Development
- Ensure Internal Structures, Policies and Practices support the knowledge based decision making, prudent risk taking and ongoing oversight of the program

Throughout 2014, ADABEI staff achieved each of the goals. Examples, among others efforts, included:

- Exceeded Financial Goals (Tables 1 and 2)
- Improved Product Benefits through Member Input and Analytics
 - Credit Card/Member Surveys & Research
- Improved Marketing Efforts to Increase the Number of Impressions and Leads
 - New Website (launched May 2014)
 - Targeted Marketing via Email and Direct Mail
 - Implemented ADABEI Buyer Analysis
- Increased Marketing Exposures through State Dental Society Relationships
 - Renewed 38 State Agreements
 - Added 5 State Agreements
- Added and Renewed Products
- Developed Department and Board Policies and Procedures
- Reviewed Fiscal Policies and Set Goals for Asset Management
- Resolved IRS Audit Issues

ADABEI Financials

ADABEI Financials are unaudited and subject to change. In 2014, ADABEI earned \$2,353,293 in gross revenue as a result of service fees to ADABEI from the program and finished 2014 with net income (pre-tax) of \$405,849, driven in large part by the strong revenue performance of the financial services products (i.e. credit card, practice financing, patient financing, credit card processing).

Table 1. 2014 ADABEI Financials

	2014 Actuals (Unaudited)	2014 Budget	Variance (\$)	Variance (%)
ADABEI Revenue	\$2,353,293	\$2,315,225	\$38,068	1.6%
Expense	\$1,947,445	\$2,014,933	\$67,488	3.3%
Net (Pre-Tax)	\$405,848	\$300,292	\$105,556	35.2%

ADA Royalties

In 2014, the ADA earned royalties of \$4,019,127 from endorsed providers in the program, exceeding the budget by more than \$844,000. The variance was driven by the timing of the ADA budget preparation and better than expected performance, primarily from the financial services products.

Table 2. 2014 ADA Financials

	2014 Actuals (Unaudited)	2014 Budget	Variance (\$)	Variance (%)
ADA Royalties	\$4,019,127	\$3,175,023	\$844,104	26.6%
Expenses	\$624,167	\$589,000	(\$35,167)	6.0%
Net (Pre-Tax)	\$3,394,960	\$2,586,023	\$808,937	31.3%

State dental societies may choose to co-endorse products and services and share in program revenue through a license agreement. In 2014, the ADA paid more than \$624,000 in royalties to state dental societies, the majority of which was contributed by the financial services products (i.e. credit card, credit card processing, practice financing and patient financing).

Emerging Issues and Trends**Products**

ADABEI continues to focus on organic product growth and new product development, to both increase member value and potential program revenue, for the short and long term, leveraging both internal and external relationships and resources (i.e. Center for Professional Success, Member Research & Surveys). In 2014, the program included 16 products and services from 15 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
- Luxury Vehicles—Mercedes-Benz
- Utility Benefits—Energy Plus
- Website and Marketing—PBHS, Inc.
- Amalgam Separators—HealthFirst
- Payroll Services—SurePayroll, Inc.
- Message on Hold—InTouch Practice Communications
- Staff Apparel—Lands' End Business Outfitters, Inc.
- Digital & Paper Patient Charts—The Dental Record
- Shipping—UPS and Meridian One Corporation

- Appliances—Whirlpool VIP Program and Meridian One Corporation
- Computers—Hewlett Packard and Meridian One Corporation

Renewed and New Business

ADABEI renewed its relationship with Mercedes-Benz through December 2017. Negotiations continued with ChasePaymentech. Agreements are due to be finalized in 2015.

Product development continued to be a key focus for ADABEI. In 2014, 83 companies contacted ADABEI with an interest in a business relationship. Plus, ADABEI conducted ADA member focus groups and surveys to quantify industry and product trends and gauge product interest. Based on high member interest, ADABEI conducted an RFP for a HIPAA compliant email and collaborative platform solution. An integrated RFP team was engaged, due diligence was completed and a product launch is expected in the second or third quarter of 2015.

ADA Foundation

Reyes, Reneida, president, 2016, New York
 Ross, Candy, vice president, grants, 2015, Georgia
 Bushick, Ronald, vice president, scientific research, 2015, Pennsylvania
 Walker, Lewis, vice president, development, 2015, Florida
 Hemmen, Pamela, vice president, finance, 2016, Illinois

Members at Large

Asai, Rickland, 2018, Oregon*
 Buckenheimer, Terry L., 2016, Florida*
 Bushick, Ronald D., 2015, Pennsylvania
 Calnon, William, 2017, New York
 Green, Edward J., 2017, Georgia
 Hearn, Cindy, 2016, California
 Himmelberger, Linda K., 2018, Pennsylvania
 Icyda, Teri-Ross, 2018, Florida
 Jeffers, Gary E., 2017, Michigan*
 Kiesling, Roger, 2018, Montana
 Maggio, Frank A., 2018, Illinois
 McDermott, Bernard, 2017, District of Columbia
 Morell, Maritza, 2016, Massachusetts
 Panagakos, Fotinos S., 2017, New Jersey
 Penrose, Michele, 2016, Michigan
 Ross, Candy B., 2015, Georgia
 Winston, Leslie J., 2015, Ohio
 Yonemoto, Gary S., 2015, Hawaii*
 (* ADA trustee)

ADA Foundation Administrative Staff

Wurth, Gene, executive director
 Fronczak, Cynthia, chief financial officer/chief operating officer
 Alexander, Patricia, program specialist
 Catral, Nicole, manager, children's oral health programs
 Chen, Daisy, staff accountant
 Haibach, Cathy, manager, grants program/communications officer
 Rabianski, Walter, manager, accounting and reporting
 Rowland, Briana, manager, international development and outreach
 Watson, Shirley, manager, administrative services
 Whan, Yoshie, senior manager, planning and development
 Hart, Thomas, director, administration, Volpe Research Center
 Schumacher, Gary, director of administration/chief researcher, Volpe Research Center
 Skrtic, Drago, director of research, Volpe Research Center

Mission

The ADA Foundation (ADAF) is a public charity whose mission is to provide **Charitable** assistance for the dental community, and works to improve oral health by supporting **Access** to care, **Research**, and **Education** programs. That mission is exemplified by the acronym **C.A.R.E.**

In fulfilling its mission, the ADAF operates several programs which are consistent with, and complementary to, the ADA Strategic Goals, and other important organizational documents.

Emerging Issues and Trends

There are three important and emerging aspects of the work of the ADAF.

- Expansion of the Give Kids A Smile (GKAS) Program. The ADAF has developed a new, five-year strategic plan for the expansion of the GKAS program to create a more consistent methodology to facilitate a long-term outcomes study to measure the success of the specific approach used in GKAS activities.
- Expansion of the ADAF Grants Program. In response to a growing need for funds to support worthy volunteer access to care and education programs across the U.S., the ADAF has added two new grant programs in 2014, and is seeking funding to help expand those even more. In 2014 these two new programs resulted in 59 applications, and 19 grants totaling approximately \$168,000 of new funding.
- Continued Development of Cutting-Edge Research at the ADAF/Dr. Anthony Volpe Research Center (VRC). In 2015, the ADAF hired a new full-time Director for the VRC. The research staff at the VRC is continuing its historically strong work in the area of dental materials, and is conducting research in emerging areas of significance, including tissue engineering, new composite formulations (including work under an NIH grant to develop improved, self-healing composites), nanotechnology, epigenetics, and use of oral fluids as a potential tool in genetic diagnosis.

The Mission of the American Dental Association Foundation (ADAF) and the Four Pillars—C.A.R.E.

The ADAF is a public charity whose mission is to provide charitable assistance for the dental community and to improve oral health by supporting access to care, research, and education programs. The mission of the ADAF is exemplified in the acronym **C.A.R.E.**, representing the four pillars of the organization:

1. Charitable Assistance
2. Access to care
3. Research
4. Education

All of the programs and activities of the ADAF are related to one or more of the Four Pillars, and managed within one of the two business units - Philanthropy or Research.

Structure of the ADAF

- **Philanthropy Programs within the ADAF**
- **Scientific Research Programs within the ADAF**

Philanthropy programs at the ADAF include a wide range of grants (in which funds are provided to help start or sustain a program) and awards (in which funds are provided to recognize programs, volunteers, students or others for past accomplishments). Each grant or award is associated with one or more of the Four Pillars—C.A.R.E. These include:

- **Charitable Assistance** programs that provide financial aid for dentists or their families in need, and emergency disaster grants. Financial assistance relief grants provide financial assistance to dentists and their dependents who have demonstrated financial need because of disability or severe illness after other personal, social, or governmental resources have been exhausted. In addition, disaster assistance is available both in the U.S. (such as for Hurricane Sandy, tornados in the Midwest, flooding in Texas, etc.) and internationally. The ADAF offers Emergency Assistance Grants in the amount of up to \$2,000 per individual to help cover immediate costs such as for food, shelter, medications, transportation, etc. as a result of a disaster. We also

provide occasional grants to community or professional groups for the purpose of providing oral health care in communities damaged by such disasters.

- **Access to Care** grants and awards support many volunteer programs that provide oral health care to populations that would otherwise not have access to care, or would have serious difficulty in receiving such care. These programs include both those organized and managed by dental students and those provided by community volunteers. Access to care programs include:
 - **E. “Bud” Tarrson Awards** for programs organized and managed by students in dental schools in the U.S. for U.S. populations. In 2014, the ADAF made six Tarrson Awards, and in early 2015 the ADAF made seven Tarrson Awards across the U.S. for U.S. populations. We estimate that the number of dental student leaders who are involved in those seven programs averages about 50 students per school, meaning that in 2015 the ADAF supported the volunteer efforts of about 350 enthusiastic and committed dental students-future leaders of the profession.
 - The **Dr. Thomas Zwemer Awards** are similar to the Tarrson Awards except that they are for student run programs in U.S. dental schools though which care is provided in foreign countries.
 - The **Give Kids A Smile (GKAS)** program, which involves the efforts of about 40,000 volunteers each year, in about 1,500 locations. Activities include educating, screening and in some cases treating as many as 350,000-400,000 children each year in the U.S.
 - **Semi-annual Grants-Access to Care**-to support community-based efforts to provide care to individuals who do not have access to care.
 - Support for the ADA **Mission of Mercy (MOM)** events, by way of securing financial and product donations that make the events possible.
- **Research** support includes several grants, awards and programs which are separate from the operation of the ADAF/Dr. Anthony Volpe Research Center, which is managed under the Research business unit. Those activities which are part of the Philanthropy business unit are:
 - The **Dental Student Conference on Research (DSCR)**, in which every dental school in the U.S. and Canada is invited to send a student who is interested in, or who has participated in, research to a 2 ½ day program at the VRC. This includes a visit to the campus of the NIH to meet with representatives of the National Institute for Dental and Craniofacial Research (NIDCR.)
 - **Summer dental student research opportunities** to learn about research by spending six weeks working with one of the researchers at the VRC.
 - The **Dr. Rafael Bowen Research Award**, presented in conjunction with the Academy for Operative Dentistry.
 - The **Intel International Science Award** for high school students interested in a career in research.
 - The new **Promising Researcher Development Program (PRDP)** by which the ADAF will seek funding for a series of research grants that will enable promising young researchers in the field of oral health to begin and sustain a career, gathering necessary data and learning the skills needed to eventually be successful in obtaining federal funding for a career in research.

- **Education** grants and awards include:
 - **Dental Student Scholarships**, which are available for one qualifying student at each dental school in the U.S. In 2014 the ADAF provided 34 general scholarships for dental students.
 - **Underrepresented Minority Dental Student Scholarships** for dental students from ethnic groups that are underrepresented in the student body and in the profession. In 2015, the ADAF offered 18 such scholarships from the 60 applicants.
 - **Allied Dental Student Scholarships** for students in dental hygiene (17), laboratory technology (10), and dental assisting (5) categories.
 - **Dr. Samuel J. Harris Awards** which recognize outstanding efforts by community groups whose volunteers provide education to new mothers about the importance of infant oral health care. In 2015, the ADAF made grants to 23 community-based groups who provide such educational programs.
 - **Semi-Annual Education Grants** for community groups that provide health education to the public. There were 19 Education and Access to Care grants in this new category in 2014.

ADAF Grants in Direct Support of ADA Programs

In 2014, the ADAF made several grants directly to the ADA in support of some of its programs. The total of these grants was approximately \$660,000. These included:

- the ADA MOM event held in San Antonio
- support for the ADA Dental Quality Alliance program
- a grant to support ADA Community Development project
- a grant in support of the ADA's efforts in National Children's Dental Health Month
- support for the Give Kids A Smile program (which was managed within the ADA in 2014)

All of the funds necessary to provide these grants to the ADA come from donations made during the year, or growth of funds which have been donated in the past and which are specifically dedicated to these types of programs.

Importance of the ADAF to the ADA, the Profession, and the Public

There is a strong organizational connection between the ADAF and the ADA, as identified in several significant documents of the ADA. The work of the ADAF is mentioned either directly (as in the Bylaws) or implicitly as part of the ADA Constitution, its Core Values, its Strategic Plan, its Action for Dental Health, in its efforts regarding relationships with dental students, its communications program and in its commitment to developing leaders for the profession.

Following is a summary of those relevant provisions in important ADA documents. In each case the specific language that relates to the work of the ADAF is underscored.

The ADA Constitution Article II states that:

The object of this Association shall be to encourage the improvement of the health of the public and to promote the art and science of dentistry.

This same purpose is reflected in the ADAF mission to improve the oral care of the public through its various programs under our four pillars, C.A.R.E. Those letters relate to the ADAF activities in the areas of Charitable Assistance for dentists and their families, Access to care programs, Research and Education.

The ADA Bylaws

CHAPTER XIV - AMERICAN DENTAL ASSOCIATION FOUNDATION - Section 10. FINANCIAL SUPPORT: ...The Association shall annually furnish sufficient financial support, as an addition to generated non-Association funding, to assure the continued viability of the Foundation's research activities.

This relates directly to research activities conducted at the ADAF/Dr. Anthony Volpe Research Center.

The ADA Core Values Statement

ADA Core Values

- (1) Commitment to Members
- (2) Integrity
- (3) Excellence
- (4) Commitment to Improving Oral Health
- (5) Science and Evidence-Based

All of these Core Values are embodied in the mission and programs of the ADAF. Our Charitable assistance grants for financial aid and for disaster relief clearly exhibit a commitment to helping all dentists, including ADA members, deal with challenging circumstances.

The attention to detail in handling donations, grants, financial reports, etc. is an indication of our integrity. For example, the ADAF has now had four consecutive years of clean audits, often receiving comments from the auditors about how well our books are managed.

Like our colleagues on the ADA staff, we strive for excellence in all of our efforts. That is why we have completely reviewed and improved our grants making process, and established a full year-long plan for our communications efforts, among many other workflow improvements. Our innovative efforts include a new strategic plan for GKAS, and establishing three new grants program: two to support community groups' efforts to provide care and education to the patient population, and one to foster leadership (The Dr. David Whiston Leadership Award) which complements the ADA leadership program.

Many of our programs are aimed at improving oral health, through scholarships for dental students, including the entire GKAS program, the Tarrson and Zwemer Awards which recognize outstanding volunteer access to care programs run by dental students, and our semi-annual access to care grants.

We support the commitment to science for the good of the profession and for the public by the nearly one hundred years of work done at the Volpe Research Center (VRC) and its predecessor organizations, and in our efforts to identify and encourage promising young researchers whose work will benefit the profession and its patients in the future.

ADA Strategic Plan "Helping All Members Succeed"

Objective 1.1 - Align public awareness efforts across the tripartite concerning oral health issues.

Objective 1.3 - Promote oral health through advocacy and science.

While the ADAF programs are not – and cannot – be directed specifically at ADA members or their success because of our legal structure as a public charity, much of our work is consistent with, and complementary to, the aims of the ADA strategic plan. Arguably a broad definition of "success" under the ADA strategic plan includes being part of a profession that reaches out to the public in voluntary and charitable ways to ensure access to care, by supporting and learning from new scientific research studies, by assisting their fellow dentist in times of need or by helping to support the education of the next generation of dentists and dental leaders. The charitable activities of ADAF fulfill our C.A.R.E. mission, and by extension reflect well on the ADA, the dental profession, and the individuals within it.

We add to the public awareness of the dental profession's good work by our efforts to recognize the work of our grant recipients and our volunteers on behalf of patients in need throughout the year with a continuous system of stories for the *ADA News*, in press releases, on our website, and in communications with dental schools. For example, in the past few months there were more than 55 news articles identified in the *ADA Morning Huddle* that reported on the volunteer efforts of dentists, hygienists, and others in Give Kids A Smile events across the country—that is news stories in 55 publications in different communities.

Our commitment to the research done at the VRC, and in encouraging young researchers in our other research-related grants, is also consistent with Objective 1.3 in the ADA strategic plan.

The ADA Action for Dental Health Campaign

Action for Dental Health is comprehensive in its approach and scope and is designed to address the dental health crisis in three distinct areas:

- Provide care now to people who are suffering from untreated disease.
- Strengthen and expand the public/private safety net.
- Disease prevention and dental health education.

As stated above, ADAF support for many access to care programs across the U.S. and internationally helps provide care for underserved patients through GKAS events, the Tarrson and Zwemer Awards for student-run programs, and community-based access to care and education programs supported by our semi-annual grants.

ADA Communications Program – The ADAF provides substantial amounts of information, stories, quotes, photographs to the ADA for its use in publishing the *ADA News*, the *Leadership Update*, the *Morning Huddle*, and as content for its press releases in order to help present the message that dentistry is a caring and devoted profession. The GKAS national media day event in New York City in February of 2015 was a good example of this.

Relationships With Students – The ADA has undertaken significant efforts designed to strengthen the relationships between the organization and dental students across the country. The work of the ADAF is supportive of those efforts. The ADAF estimates that the ADAF has “touch points” with dental schools about 50 times each year. This includes various written, electronic, and telephonic communications to inform administrators and students about ADAF scholarships, research grant opportunities, Tarrson and Zwemer Awards announcements, the Dental Student Conference on Research, announcements of the winners of such grants and subsequent stories about the winners.

The ADAF's reach with dental students goes much farther than just those “touch points.” During the period 2010-2015 GKAS events were conducted in 56 dental schools in the U.S., including Puerto Rico. Data received from the schools indicates that during that time period approximately 19,500 volunteers, including dental students, faculty, school alumni, local dentists, and hygienists were involved in dental school-managed GKAS programs, which educated and treated more than 81,000 children.

This type of activity resonates with the current generation of dental students and young professionals. Data shared by Dr. O'Loughlin in her various presentations indicate that this group – the “millennials” – place a much greater value on community service, giving back, helping others, etc. than previous generations did. By offering many ways in which such students and young professionals can engage in volunteerism, the ADAF is helping to position the ADA before those individuals who are so important to the future of the organization.

Leadership Development – These student-run programs highlight the fact that ADAF funds support the current leaders within dental schools. Those may be exactly the type of students who will become active

in the profession – and in organized dentistry – in the years ahead. They are potential future members of the ADA-and future leaders of the ADA.

In addition to the leadership opportunities evident in the programs that the ADAF supports, the ADAF has now established a special award program, the Dr. David Whiston Leadership Program, designed to identify and help train future leaders who will improve the oral health of the public.

Conclusion

The ADAF is a valuable aspect of the entire “ADA enterprise” – that group of affiliated organizations that together help ensure success for members, better resources for the entire profession, and improved oral health for the public. The ADAF’s role as a public charity complements much of the work of the ADA, especially as that work relates to improved oral health through volunteer efforts to increase access to care, education, and research.

Summary of Resolutions

This report is informational and no resolutions are presented.

Appendix

Notes

2015 Annual Reports Index of Resolutions

Res. 9	<i>Reports:34</i>	Council on Dental Benefit Programs Rescission of the Policy, Dental Procedure Code Changes
Res. 10	<i>Reports:34</i>	Council on Dental Benefit Programs Amendment of the Policy, Explanation of Benefits Statement and Identification of Claims Reviewers
Res. 11	<i>Reports:35</i>	Council on Dental Benefit Programs Amendment of the Policy, Bulk Benefit Payment Statements
Res. 12	<i>Reports:36</i>	Council on Dental Benefit Programs Medical Loss Ratio for Dental Benefit Programs
Res. 13	<i>Reports:44</i>	Council on Dental Education and Licensure Amendment of the Policy, Dentistry
Res. 14	<i>Reports:45</i>	Council on Dental Education and Licensure Amendment of the Policy, Continued Recognition of Dental Public Health as a Dental Specialty
Res. 15	<i>Reports:45</i>	Council on Dental Education and Licensure Amendment of the Policy, Certifying Board in Dental Public Health
Res. 16	<i>Reports:45</i>	Council on Dental Education and Licensure Amendment of the Policy, Recognition of Endodontics as a Specialty and Rescission of the Policy, Continued Recognition of Endodontics as a Dental Specialty
Res. 17	<i>Reports:45</i>	Council on Dental Education and Licensure Amendment of the Policy, Certifying Board in Endodontics
Res. 18	<i>Reports:45</i>	Council on Dental Education and Licensure Rescission of the Policy, Requirements for Endodontists
Res. 19	<i>Reports:45</i>	Council on Dental Education and Licensure Rescission of the Policy, Requirements for Endodontics
Res. 20	<i>Reports:45</i>	Council on Dental Education and Licensure Amendment of the Policy, Continued Recognition of Oral Pathology as a Dental Specialty and Rescission of the Policy, Redesignation of the Specialty of "Oral Pathology" to "Oral and Maxillofacial Pathology"
Res. 21	<i>Reports:46</i>	Council on Dental Education and Licensure Amendment of the Policy, Certifying Board in Oral and Maxillofacial Pathology
Res. 22	<i>Reports:46</i>	Council on Dental Education and Licensure Amendment of the Policy, Recognition of Oral and Maxillofacial Radiology as a Dental Specialty
Res. 23	<i>Reports:46</i>	Council on Dental Education and Licensure Certifying Board in Oral and Maxillofacial Radiology
Res. 24	<i>Reports:46</i>	Council on Dental Education and Licensure Amendment of the Policy, Continued Recognition of Oral and Maxillofacial Surgery as a Dental Specialty and Rescission of the Policy, Continued Recognition of Oral Surgery as a Dental Specialty
Res. 25	<i>Reports:47</i>	Council on Dental Education and Licensure Certifying Board in Oral and Maxillofacial Surgery

- Res. 26** *Reports:47* **Council on Dental Education and Licensure**
Amendment of the Policy, Continued Recognition of Orthodontics as a Dental Specialty and Rescission of the Policy, Redesignation of the Specialty of "Orthodontics" to "Orthodontics and Dentofacial Orthopedics"
- Res. 27** *Reports:47* **Council on Dental Education and Licensure**
Amendment of the Policy, Certifying Board in Orthodontics and Dentofacial Orthopedics
- Res. 28** *Reports:47* **Council on Dental Education and Licensure**
Amendment of the Policy, Continued Recognition of Pediatric Dentistry as a Dental Specialty and Rescission of the Policy, Redesignation of the Specialty of "Pedodontics" to "Pediatric Dentistry"
- Res. 29** *Reports:47* **Council on Dental Education and Licensure**
Certifying Board in Pediatric Dentistry
- Res. 30** *Reports:48* **Council on Dental Education and Licensure**
Amendment of the Policy, Continued Recognition of Periodontics as a Dental Specialty
- Res. 31** *Reports:48* **Council on Dental Education and Licensure**
Certifying Board in Periodontics
- Res. 32** *Reports:48* **Council on Dental Education and Licensure**
Amendment of the Policy, Continued Recognition of Prosthodontics as a Dental Specialty
- Res. 33** *Reports:48* **Council on Dental Education and Licensure**
Certifying Board in Prosthodontics
- Res. 34** *Reports:48* **Council on Dental Education and Licensure**
Rescission of the Policy, Statement of Statutory Regulation of Dental Specialty Practice and Dental Specialists
- Res. 35** *Reports:67* **Council on Ethics, Bylaws and Judicial Affairs**
Amendment of Chapters XII and XIII of the ADA *Bylaws* to Add the Option of a Non-Disciplinary Action
- ~~**Res. 36** *Reports:73* **Council on Government Affairs**
Include Adult Dental Benefit as "Essential Health Benefit" (WITHDRAWN)~~
- Res. 37** *Reports:85* **Council on Membership**
Amendment of the Policy, Dues Exemption for Active Duty Members
- Res. 38** *Reports:85* **Council on Membership**
Amendment of the Policy, Student Membership
- Res. 39** *Reports:89* **Joint Commission on National Dental Examinations**
Revisions to *Standing Rules* of the Joint Commission on National Dental Examinations
- Res. 40** *Reports:89* **Joint Commission on National Dental Examinations**
Revisions to *Bylaws* of the Joint Commission on National Dental Examinations

2014 Resolutions

- Res. 23-2014** *Reports:64* **Council on Ethics, Bylaws and Judicial Affairs**
Amendment of the ADA *Bylaws* Striking "Ex Officio"