2020

2020 Supplement Vol. 2

American Dental Association

ADA American Dental Association®

America's leading advocate for oral health

2020

Supplement to

Annual Reports and Resolutions

Volume 2

161st Annual Session

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Dental Education, Science and Related Matters

Resolution No. 1 New

Report: N/A Date Submitted: June 2020

Submitted By: Council on Dental Education and Licensure

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

REVIEW OF ADA POLICIES: DENTISTRY AND DENTISTRY AS AN INDEPENDENT PROFESSION

Background: In accord with Resolution 170H-2012, Regular Comprehensive Policy Review (*Trans.* 2012:370), the Council on Dental Education and Licensure (CDEL) has reviewed the policy *Dentistry* (*Trans.*1997:687; 2015:254) and the policy *Dentistry as an Independent Profession* (*Trans.*1995) for accuracy and currency.

CURRENT POLICIES:

Dentistry (*Trans*.1997:687; 2015:254)

Resolved, that dentistry is defined as the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) or 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.

Dentistry as an Independent Profession (*Trans*.1995:640)

Resolved, that dentistry should continue to be a profession of its own and should not become a medical specialty.

The Council believes that the two policies should be combined into one declarative positive statement that defines the independent profession of dentistry and notes dentistry's commitment to professionalism and interprofessional health. The Council sought input on the proposal from the Council on Dental Practice (CDP) and the Council on Ethics, Bylaws and Judicial Affairs (CEBJA). The Council considered the CDP and CEBJA input and concluded that the intent of the policy *Dentistry as an Independent Profession* should be reflected in the policy *Dentistry* and that the policy *Dentistry as an Independent Profession* could then be rescinded. CEBJA supported combining the policies, believing that the combination policy is a much stronger and positive statement concerning the profession of dentistry than the current statements.

Accordingly, the Council on Dental Education and Licensure has concluded that the two policies should be combined by amending the policy *Dentistry* and rescinding the policy *Dentistry as an Independent Profession* and recommends adoption of the following resolution:

Resolution

1. Resolved, that the ADA policy *Dentistry* (*Trans*.1997:687; 2015:254) be amended as follows (additions underscored; deletions ~~stricken~~):

> **Resolved**, that the profession of 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~~ dentists, within the scope of ~~his/her~~ their education, training and experience, in accordance with the ethics of the profession and applicable law, and be it further
>
> **Resolved**, that dentistry is and should remain an independent health care profession that safeguards, promotes and provides care for the health of the public in collaboration with other health care professionals.

and be it further

Resolved that the policy *Dentistry as an Independent Profession* (*Trans*.1995:640) be rescinded.

BOARD COMMENT: The Board agrees with the amendments to the policy as proposed by the Council and urges one additional change, modifying the term maxillofacial to craniomaxillofacial. The Board believes that the term craniomaxillofacial more accurately reflects the profession's role in the evaluation, diagnosis, prevention and/or treatment of the mouth, jaws, face, skull, and associated structures. In particular, with oral and maxillofacial surgeons serving in both oncology and craniofacial fellowships, some state practice acts using this term, and some dentists performing facial and muscular injections of Botox in the craniofacial region including the neck, the Board urges adoption of the following substitute resolution.

1B. Resolved, that the ADA policy *Dentistry* (*Trans*.1997:687; 2015:254) be amended as follows (additions double underscored; deletions ~~stricken~~):

> **Resolved**, that the profession of 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, craniomaxillofacial area and/or the adjacent and associated structures and their impact on the human body, provided by ~~a dentist~~ dentists, within the scope of ~~his/her~~ their education, training and experience, in accordance with the ethics of the profession and applicable law, and be it further
>
> **Resolved**, that dentistry is and should remain an independent health care profession that safeguards, promotes and provides care for the health of the public in collaboration with other health care professionals.

and be it further

Resolved that the policy *Dentistry as an Independent Profession* (*Trans*.1995:640) be rescinded.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

Vote: Resolution 1B

ARMSTRONG	Absent	HERRE	Yes	LEARY	Yes	ROSATO	Yes
DOROSHOW	Yes	HIMMELBERGER	Yes	MCDOUGALL	Yes	SABATES	Yes
EDGAR	Yes	KESSLER	Yes	NORBO	Yes	SHEPLEY	Yes
FIDDLER	Yes	KLEMMEDSON	Yes	RAPINI	Yes	STEPHENS	Yes
HARRINGTON	Yes	KYGER	Yes	RODRIGUEZ	Yes	THOMPSON	Yes

WORKSHEET ADDENDUM

POLICY TO BE RESCINDED

Dentistry as an Independent Profession (*Trans*.1995:640)

Resolved, that dentistry should continue to be a profession of its own and should not become a medical specialty.

Resolution No. None N/A

Report: Board Report 4 Date Submitted: August 2020

Submitted By: Board of Trustees

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Membership-Obj. 3: 10% increase in assessment of member value

How does this resolution increase member value: See Background

REPORT 4 OF THE BOARD OF TRUSTEES: ADA LIBRARY AND ARCHIVES ADVISORY BOARD ANNUAL REPORT

Background: In November 2013, the ADA House of Delegates approved the ADA Library and Archives Transition Plan, including the establishment of a volunteer board to oversee operations of the ADA Library and Archives. An engaged and functioning advisory board is considered a best practice for library management. The ADA Library and Archives Advisory Board serves in an advisory capacity to the Board of Trustees.

At its August 2020 meeting, the Board of Trustees approved the appended Annual Report of the ADA Library Archives Advisory Board for transmittal to the 2020 House of Delegates.

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Appendix 1

ADA Library & Archives Advisory Board

Harrington, Jr., John F., 2021, Board of Trustees, 5th District (chair)
Doroshow, Susan, 2020, Board of Trustees, 8th District
Dionne, Raymond, 2021, North Carolina, Council on Scientific Affairs
Lefebvre, Carol A., 2020, Georgia, Council on Scientific Affairs
Niessen, Linda, 2020, Texas, Council on Dental Education and Licensure
Lim, Jun, 2020, Illinois, Council on Dental Education and Licensure
Masters, Antonette, 2020, California, at-large member
Jhaveri, Viren, 2020, New York, at-large member
Nevius, Amanda, 2020, public member, special/dental librarian

Nickisch Duggan, Heidi, director, ADA Library & Archives
Fleming, Anna, electronic resources & research services librarian, ADA Library & Archives
Matlak, Andrea, archivist & metadata librarian, ADA Library & Archives
O'Brien, Kelly, informationist, ADA Library & Archives
Pontillo, Laura, coordinator, ADA Library & Archives
Strayhorn, Nicole, data informationist, ADA Library & Archives

Areas of Responsibility as Set Forth in the *Bylaws* or *Governance and Organizational Manual of the American Dental Association*

The areas of responsibility for the ADA Library & Archives Advisory Board (LAAB) are as follows:

- Creating and developing the mission and strategic plan of the ADA Library & Archives.
- Ensuring that the ADA Library & Archives remain relevant to the ADA strategic plan.
- Providing input during the annual ADA budgeting process on library funding, priorities and needs.
- Adopting policies and rules regarding library governance, assets and use; developing, approving, and codifying all policies, based on input from the library staff; also delegating procedural work to the library staff.
- Regularly planning and evaluating the library's service program.
- Evaluating the library facility to ensure that it continues to meet ADA member and ADA staff needs.
- Launching a marketing plan for the promotion of the ADA Library & Archives to ADA members; ADA component and constituent societies; the local dental and medical communities; and affiliated dental organizations.
- Conducting the business of the library in an open and ethical manner in compliance with all applicable laws and regulations and with respect for the association, staff and public.

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

Objective 1: Grow Active, Full Dues Paying Membership

Initiative/Program: Scientific Support/Utilization of Library Content

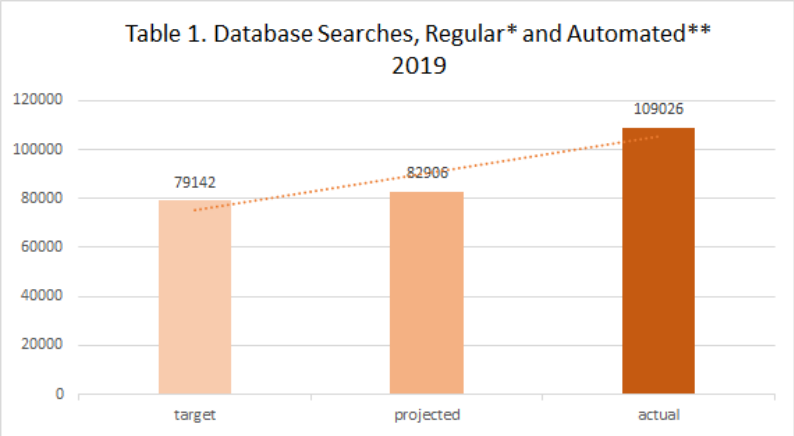
Success Measure: Achieve a 5% annual increase in the number of user searches via electronic resources by December 2019.

Target: 79,142 (Regular and automated searches)

Range: 75,000-80,000

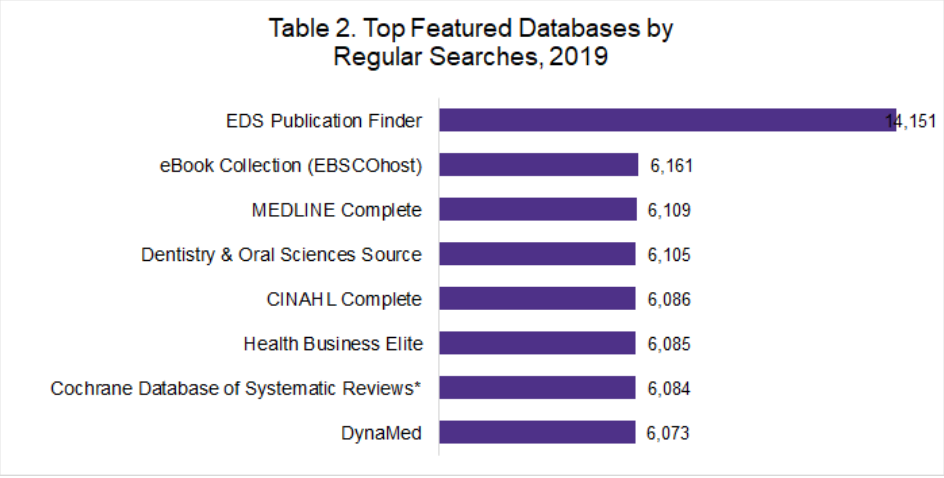
Outcome: Exceeded, 109,026

Usage statistics show continued increased use of the Library's electronic resources (journals, databases, e-books, clinical resources). ADA members and staff conducted approximately 44% more regular and automated searches in 2019 over 2018's 75,373 regular and automated searches.

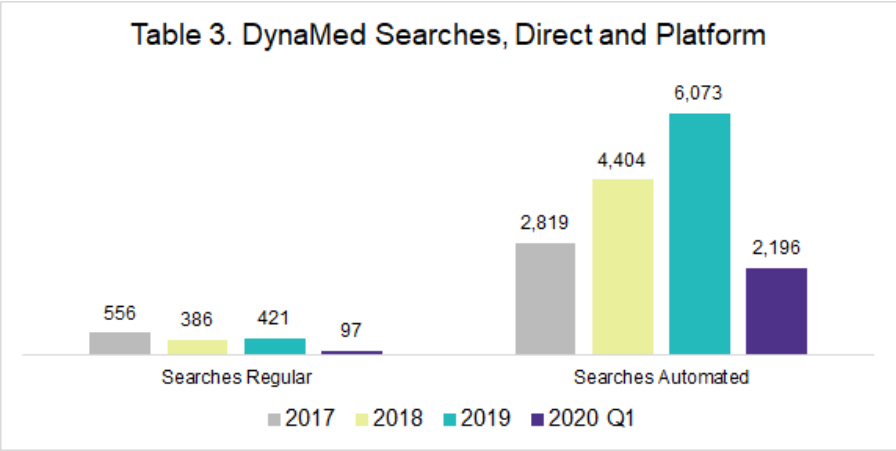


*Regular Searches refers to the number of times a user searches a database, where they have actively chosen that database from a list of options OR there is only one database available to search.

** Automated Searches refers to the number of times a user searches a database, where they have not actively chosen that database from a list of options. That is, Searches Automated is recorded when the platform offers a search across multiple databases by default, and the user has not elected to limit their search to a subset of those databases.



DynaMed, an evidence-based resource of drug information and clinical summaries intended to reduce time-to-answer, is available through the ADA Library & Archives website. DynaMed incorporated enhancements such as CE in 2019.



Objective 2: Grow Active, Full Dues Paying Membership

Initiative/Program: Scientific Support/Utilization of Library Content

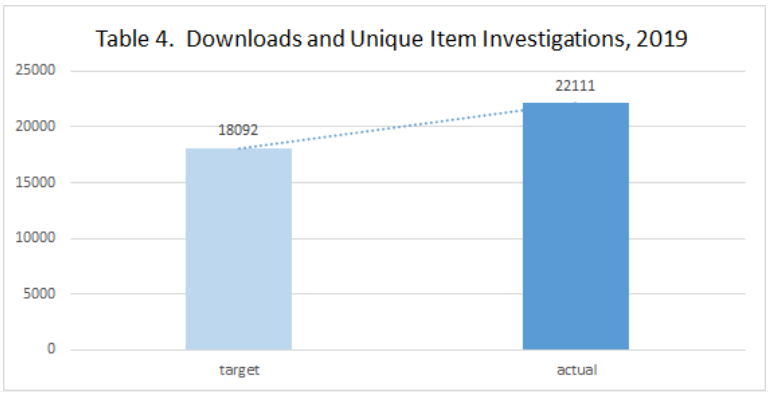
Success Measure: Achieve a 5% annual increase in the number of unique item investigations and full-text downloads via electronic resources by December 2019.

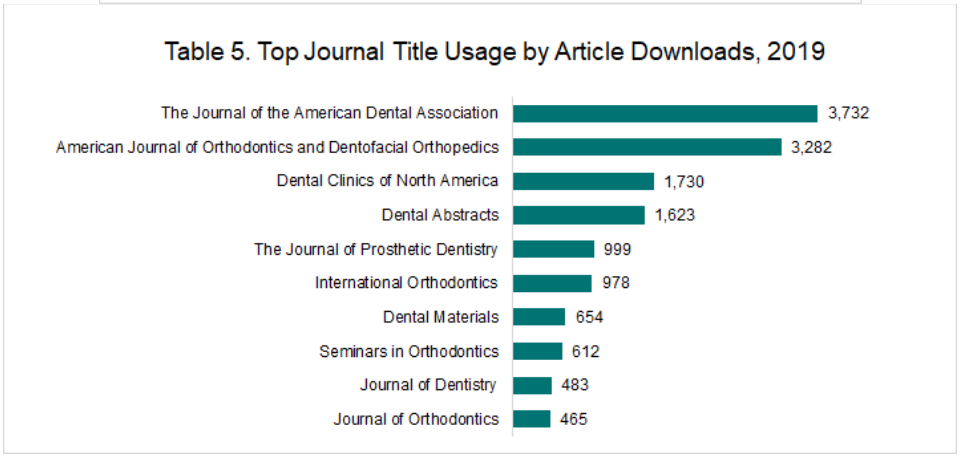
Target: 18,092

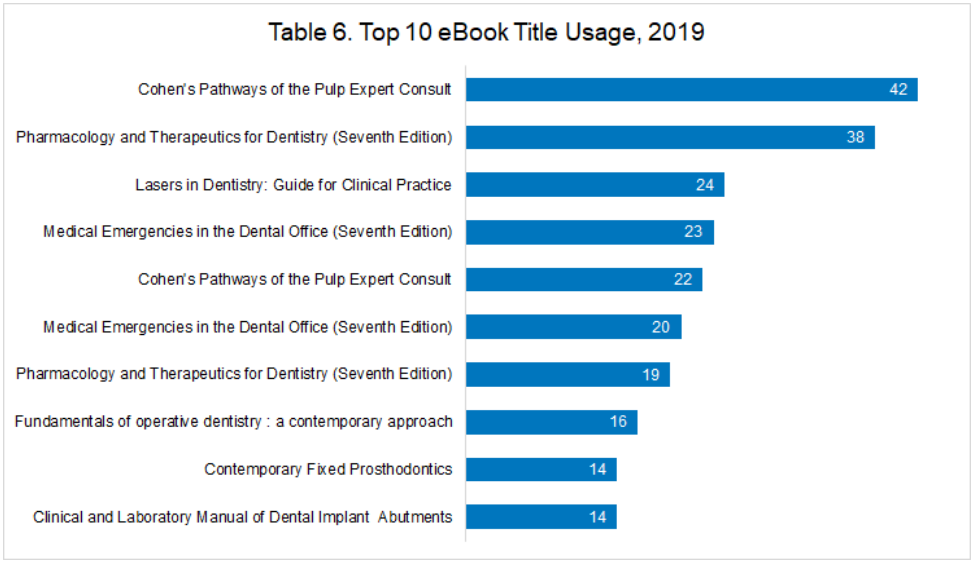
Range: 17,500-18,500

Outcome: Exceeded

Downloads and unique item investigations (the number of unique content items (e.g. chapters) investigated by a user) are more difficult to predict because ADA staff and members tend to search for known items and ask for staff assistance when conducting more open research, for instance, to answer a clinical question. As a result, ADA Library & Archives staff search more broadly, thus increasing the total search numbers but selecting fewer and more focused full-text downloads than the typical user might. ADA Library & Archives service goals influence sending only the most relevant full-text downloads combined with abstracts and citations to prompt user evaluation.



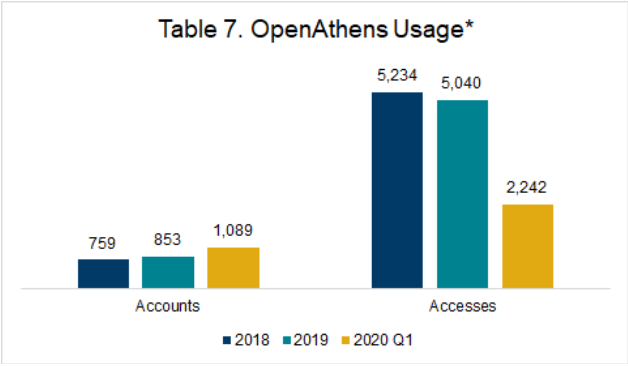




Emerging Issues and Trends

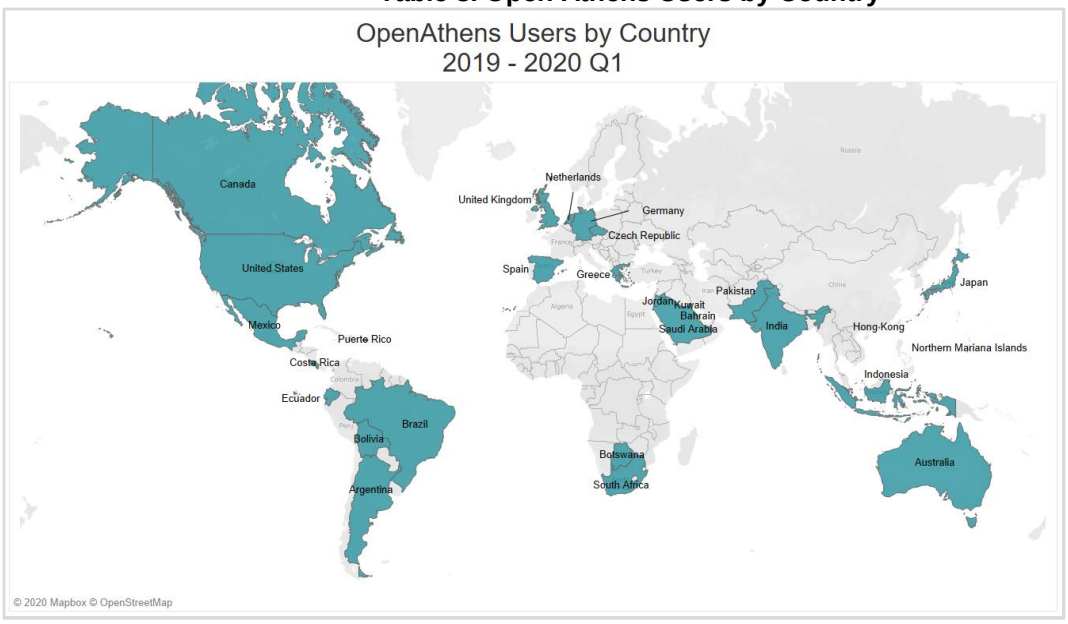
Libraries continue to maximize resources through the expanded use of digital and electronic means to convey information to their patrons. The ADA Library & Archives continually reviews these rapid changes in order to remain relevant to ADA Members and the profession. The LAAB is committed to:

- Providing efficient searching using current eResources and making the Library & Archives a 24/7 knowledge center. This is partially accomplished by the implementation of DISCOVERY and OpenAthens, an identity access management tool that allows members to access subscribed electronic content 24/7.



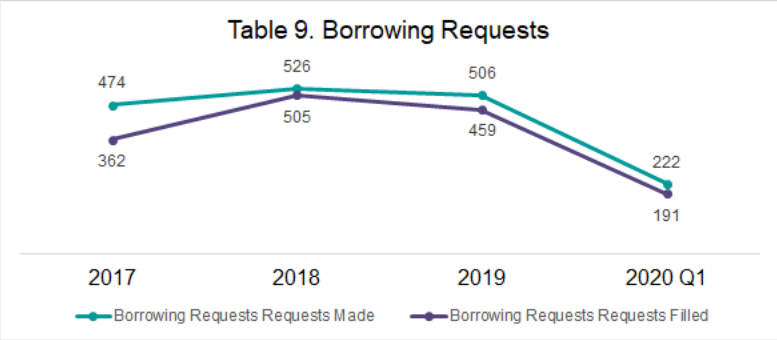
*On-site (ADA building at 211 E. Chicago) usage is not reflected in these statistics; complete resource use is much higher and includes staff use, in-house research, etc.

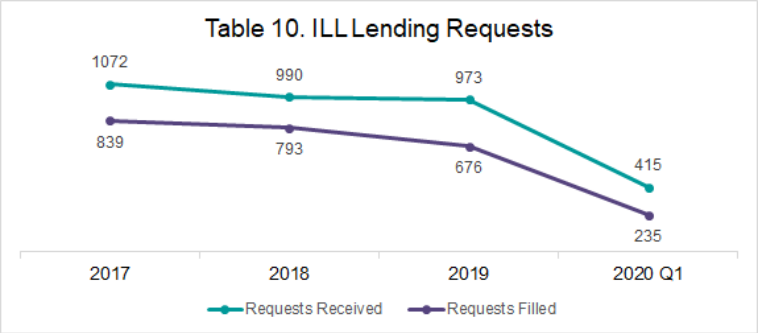
Table 8. Open Athens Users by Country



- Maintaining and developing a comprehensive collection of evidence-based and clinical information sources for ADA members in appropriate formats. The current staff roles allow for faster, more robust reference assistance and user education, expert searching, and new means of engaging with members.

- Continued interlibrary loan (ILL) services to provide ADA Staff and members with scholarly articles not held in the collections of the ADA Library & Archives (borrowing), and providing those same services to outside researchers via other libraries (lending). In 2019, we fulfilled 69% of ILL requests from outside libraries. Outside libraries fulfilled 91% of the ILL requests from ADA members and staff.





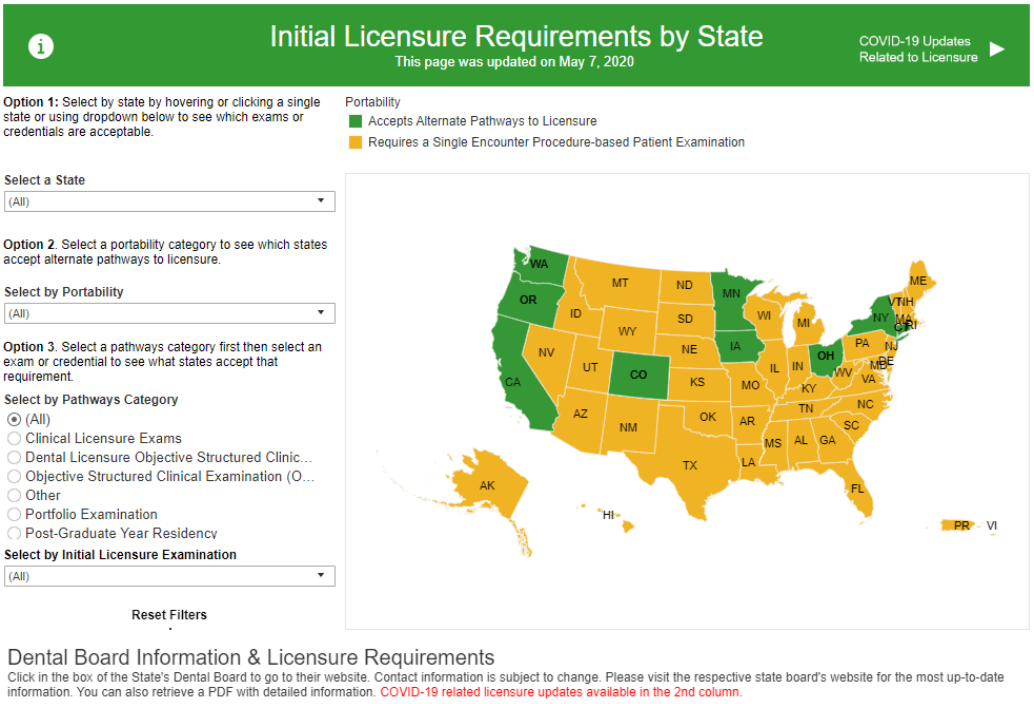
- Continuous support of various information needs of the Division of Science. Informationist Kelly O'Brien actively engages in expert searching for EBD clinical guideline development and systematic reviews, provides education and access to evidence-based clinical tools and drug information, and provides expert support for initiatives such as an HPV vaccine efficacy safety and effectiveness umbrella review and ADA COVID-19 Interim Recommendation & Guidance.

- Archives expert support for ADA administration and operations provides information on organizational and dental history for policy and product development, legal review, marketing, communications, and public relations. Archivist Andrea Matlak assisted a researcher/writer working to discover the identity of the victims of a 50 year old still-unsolved SC murder case by locating dental charts of the victims that were published in The Journal of the American Dental Association at the time of the murders. She oversaw the conservation of 32 books related to operative dentistry, dental anatomy and pathology, dental education, oral hygiene, and dental equipment that were selected from the ADA Library & Archives Rare Book Collection to be rebound, rehoused, or refurbished. Ms. Matlak earned the Certified Archivist (CA) credential through the Academy of Certified Archivists (ACA). She also provided photographs and timeline to the Division of Conferences and Continuing Education for the creation of a large scale wall display on the history of the American Dental Association for the Exhibit Hall at the 2019 ADA FDI Annual Meeting. The display was seen by over 31,000 attendees and received many positive comments.

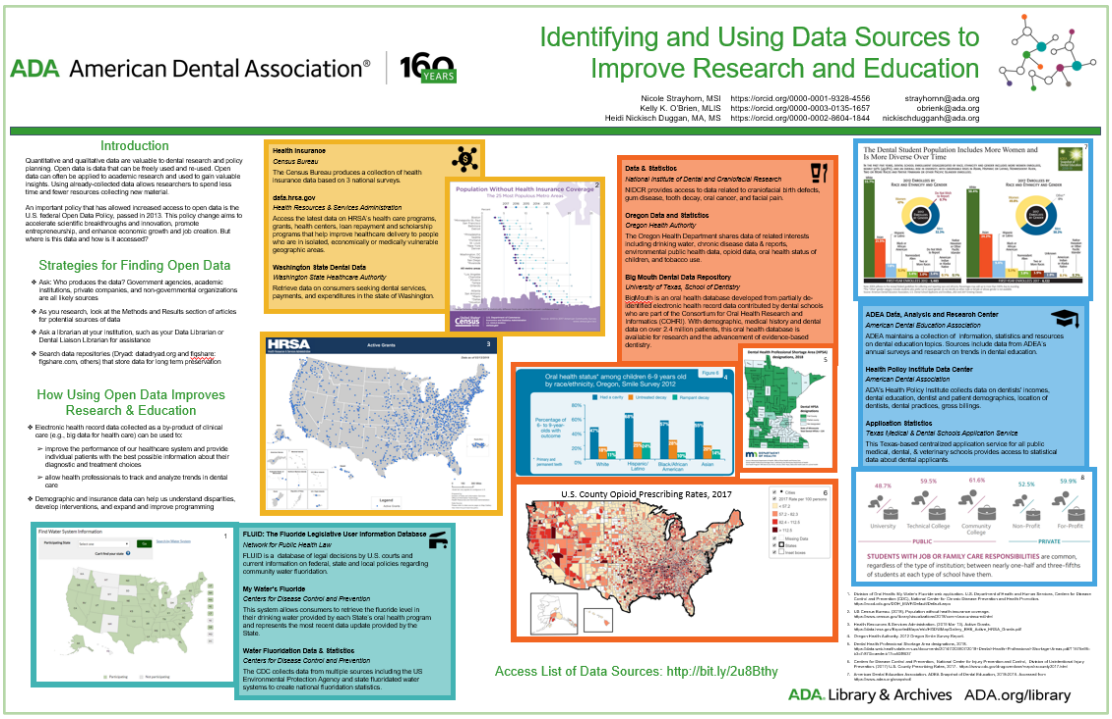
- Developing short, search-skill focused online tutorials and instructional videos for members to assist in their acquisition of evidence-based clinical research materials and search skill enhancement, as well as database navigation and use. Current tutorials can be viewed at: https://www.youtube.com/channel/UCanBwg0mHr17EHaBdHFgkXA/featured

- Extending the reach of data visualization services. Data Informationist Nicole Strayhorn joined the ADA permanently in August 2019 after spending her second National Library of Medicine fellowship year with the ADA Library & Archives. She serves as the data management and data visualization specialist and the liaison for data visualization to other departments. Successes in

2019 include the development and implementation of the National Membership Dashboard accessed by staff and Board of Trustees, the creation and deployment of two dental licensure maps, and the infographics design for the ADA's dues simplification project.



- Engaging members, staff, and affiliates. The ADA Library & Archives staff exhibited at the 2019 ADEA Annual Meeting, ADA's Eldercare Symposium, and the 2019 ADA FDI Annual Meeting to help people navigate our resources, share knowledge, and make connections. Ms. O'Brien trained research award winners of the National Eldercare Advisory Committee on the systematic review process and assisted researchers and their librarians in developing systematic review search strategies in support of their projects. The library staff facilitated multiple workshops for the Department of Testing Services Test Construction committees to demonstrate how to use research resources available to them. Ms. Strayhorn, Ms. O'Brien and director Heidi Nickisch Duggan presented a poster at ADEA 2019 that highlighted accessible open data sources that pertain to dentistry and oral health, and showcased unique ways to visualize data to tell a compelling story to improve education and research.



- Enhancing engagement with public oral health efforts. The library staff received a grant from the Greater Midwest Region of the National Network of Libraries of Medicine (NNLM), a program of the National Institutes for Health. The federal grant will be used to develop multi-language oral health information to empower more health consumers to make informed oral and dental health decisions. Partners include the Skokie, IL Department of Health and Erie Family Health Centers, Evanston/Skokie.

- Contributing to professional activities and remaining active in the library and archive community-at-large by participating in professional organization committees and building partnerships. Most recently, electronic resources & research services librarian Anna Fleming has been named the incoming chair of the Medical Library Association's (MLA) Donald A. B. Lindberg Research Fellowship selection committee; Ms. Strayhorn is a member of MLA's Annual Meeting Innovation Task Force; Ms. Nickisch Duggan serves on the Advisory Board of Dominican University's School of Information Studies, and serves as a member of Institutional Review Boards IRBs at the ADA, Northwestern University and the Anne and Robert H. Lurie Children's Hospital of Chicago. The library staff hosted Brenna Cox, a National Library Medicine Associate Fellow during her Spring Practicum to observe the operations of the ADA Library & Archives, and to meet with library staff and ADA leadership. Ms. Matlak submitted a letter of support for the proposed project *Hidden Behind the Smile – Establishing a Digital Collection of the History of Professional Dentistry in America* by the Samuel D. Harris National Museum of Dentistry as a finalist in the Council of Library and Information Resources' (CLIR) Digitizing Hidden Special Collections and Archives funding program. This project has the potential to meet the need by scholars, researchers, and members of the public, for a cooperative online, digitized resource of freely-accessible information on dental history and related artifacts that could change the face of historical research in dentistry through expanded access to important materials.

Policy Review

The Library & Archives Advisory Board will hold its annual meeting in summer 2020 and will review policies at that meeting.

Resolution No. None N/A

Report: Council on Scientific Affairs Report 1 Date Submitted: August 2020

Submitted By: Council on Scientific Affairs

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

COUNCIL ON SCIENTIFIC AFFAIRS REPORT 1 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 84H-2019 – CLARIFICATION OF ADA POLICY REGARDING TOBACCO PRODUCTS

Background: In September 2019, the ADA House of Delegates adopted Resolution 84H-2019, Clarification of ADA Policy Regarding Tobacco Products:

> **Resolved**, that the American Dental Association add "vaping" and any other alternative delivery system for both tobacco and non-tobacco products to ADA Policy, and be it further
>
> **Resolved**, that this be referred to the appropriate Council and that a report be made to the 2020 ADA House of Delegates to update current ADA Policy.

The Council on Scientific Affairs (CSA) was assigned as lead agency for implementation of the resolution, with assistance from the Council on Advocacy for Access and Prevention (CAAP).

ADA Interagency Task Force on Vaping

Immediately following the 2019 House of Delegates meeting, Dr. Marcelo Araujo, chief executive officer, ADA Science and Research Institute, convened an interagency team to help ensure consistent messaging to members on this issue, as well as consider the development of resources to educate and inform members and their patients. The team included staff from the ADA Science and Research Institute, Marketing and Communications, the Council on Advocacy for Access and Prevention (CAAP), Dental Practice Institute, and Government Affairs. Key activities included:

- In November 2019, the interagency team submitted Dr. Purnima Kumar (CSA consultant) for consideration as an ADA spokesperson on vaping and e-cigarettes. Dr. Kumar was subsequently approved for this role via expedited review, and has been made available for a variety of press inquiries via the Communications team.

- A commentary on this topic was developed to provide a brief overview of the existing literature on vaping and oral health. Dr. Purnima Kumar (CSA consultant) and Dr. Mia Geisinger (CSA Chair) served as lead authors. The commentary, entitled "Living under a cloud: Electronic cigarettes and the dental patient," was accepted by JADA in January 2020; and published in the March 2020 issue.

ADA Interim Policy on E-Cigarettes and Vaping

In December 2019, the ADA Board of Trustees adopted ad interim policy on e-cigarettes and vaping:

> **Resolved**, that the ADA Board of Trustees adopts the following statement, which mirrors a recent action from the American Medical Association, as ad Interim ADA Policy to address the public health crisis related to e-cigarettes and vaping:
>
> > That the American Dental Association (1) urgently advocate for regulatory, legislative, and/or legal action at the federal and/or state levels to ban the sale and distribution of all e-cigarette and vaping products, with the exception of those approved by the FDA for tobacco cessation purposes and made available by prescription only; and (2) advocate for research funding to study the safety and effectiveness of e-cigarettes and vaping products for tobacco cessation purposes and their effects on the oral cavity.

In support of this interim policy, the ADA Interagency Vaping Task Force coordinated release of an ADA News story and coverage in the Morning Huddle. A "Tobacco Use and Vaping" webpage also was created on ADA.org (www.ada.org/vaping) with all related ADA content on this topic.

CSA Activities

In December 2019, the CSA approved a "Vaping and Oral Health Workgroup" to study the impact of vaping on oral health and propose policy language or other possible ADA actions, as appropriate, in accordance with Resolution 84H-2019, with a report back by the June 2020 CSA meeting. The Workgroup included:

- Dr. Purnima Kumar, chair (CSA consultant)
- Dr. Ryan Braden (CDP member)
- Dr. Mia Geisinger (CSA chair)
- Dr. Ana Karina Mascarenhas (CSA member)
- Dr. Shamik Vakil (CAAP member)

The Workgroup assessed the available scientific literature to support the development of new ADA policy on this subject. Based on this assessment, the Workgroup determined that a full systematic review was not feasible at this time. An informational report was developed to outline the current state of the science on this subject, the underlying regulatory framework, and specific concerns related to the practice of dentistry, and the oral health of patients. In June 2020, the CSA approved transmittal of the informational report to the House of Delegates. The report is provided in Appendix 1.

Conclusion

Based on the limited currently available evidence, the CSA supports the proposed "ADA Interim Policy on E-Cigarettes and Vaping" and does not feel that additional ADA policy is necessary at this time.

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Appendix 1

REPORT ON THE CURRENT SCIENTIFIC UNDERSTANDING OF VAPING AND ORAL HEALTH

Background

As healthcare professionals who focus on oral health, dental professionals are in a unique position to provide guidance and evidence-based care to patients seeking information on the risks associated with tobacco usage of any form, as well as cessation assistance for those seeking to quit. This informational report provides a brief overview of vaping products, health concerns surrounding their use, the current regulatory landscape, ADA responses and resources, and anticipated or recommended needs and next steps.

Vaping-Related Health Concerns

In 2019, a case series report in The New England Journal of Medicine outlined concerns around e-cigarette– or vaping product–associated lung injury (EVALI),[1] and prompted interim guidance issued by the Centers for Disease Control and Prevention (CDC).[2] As of February 18, 2020, the final update from the CDC on this investigation, a total of 2,807 hospitalizations have been reported, and 68 deaths.[3] Data suggests a strong link between the EVALI outbreak and a vitamin-E additive in some THC-containing e-cigarette, or vaping, products.[3] In addition to lung injuries, various other adverse events associated with electronic nicotine delivery systems (ENDS) have been reported, including seizures and other neurologic events, gastric distress, mental health issues, chest pain, and other various respiratory complaints.[4] Finally, concerns exist around oral and facial trauma caused by explosions from malfunctioning e-cigarettes.[5]

ADA Response

The ADA has long advocated against the use of tobacco or nicotine products,[6] and in September 2019, in response to these health concerns, the ADA House of Delegates adopted Resolution 84H-2019, Clarification of ADA Policy Regarding Tobacco Products,[7] which stated as follows:

> **Resolved**, that the American Dental Association add “vaping” and any other alternative delivery system for both tobacco and non-tobacco products to ADA Policy, and be it further
>
> **Resolved**, that this be referred to the appropriate Council and that a report be made to the 2020 ADA House of Delegates to update current ADA Policy.

In December 2019, the ADA Board of Trustees approved an ad interim policy on e-cigarettes and vaping, which advocated for research on cessation-related ENDS, and against the sale of vaping products not approved for cessation purposes.[8]

Federal Regulation of ENDS

The US Food and Drug Administration (FDA) has the power to regulate tobacco products, including e-cigarettes and e-liquids.[9] However, until recently, commercially available vaping products were subject to minimal regulatory oversight due to delayed implementation of that authority. New enforcement priorities and guidance were issued in January 2020; as of September 9, 2020, any ENDS products that have been on the market since August 2016 and have not submitted premarket applications are subject to FDA enforcement actions.

Vaping, Dentistry, and Oral Health

Because of the rapidly changing market for tobacco products and shifting regulations, many dental professionals may not be aware of common terminology, or of the most recent oral impact data that would allow them to comfortably or effectively engage with their patients on this topic.

Terminology

A better understanding of basic terms common among ENDS users is important for effective and accurate patient communication. The following are terms that can help dental professionals better navigate conversations around a patient's use of tobacco products and the associated risks.

Term	Definition
Electronic nicotine delivery systems (ENDS)	ENDS is an umbrella term that encompasses a variety of products intended to deliver nicotine and tobacco using a vaporized liquid. Common examples include e-cigarettes (also commonly referred to as cig-a-likes, electronic cigarettes, vape pens, or vapes), e-pipes, e-cigars, and e-hookahs.
base liquid	A base liquid is the primary delivery agent for ENDS, to which nicotine and flavoring are combined to form e-juice. Glycerol and propylene glycol are the two most common delivery agents.
e-juice, e-liquid	E-juice or liquid is heated to produce the aerosol in an electronic cigarette, and most commonly contains three main components: a delivery agent (base liquid), nicotine, and flavoring. It is important to note that some versions are nicotine-free, or deliver cannabidiol products in lieu of nicotine.
vape/vaping	Vaping is the use of an electronic cigarette. This does not necessarily include the use of nicotine.

Impact on Oral Health

While oral health concerns related to traditional tobacco usage are well established, early research has suggested that e-cigarettes deliver fewer tobacco-related toxicants than cigarettes.[10, 11] Leveraging this belief, tobacco companies have marketed ENDS as cessation tools or healthier alternatives to traditional tobacco products. In part due to these beliefs, ENDS usage has increased significantly, particularly among youth populations,[12-14] despite the fact that the oral health risks associated with the use of ENDS devices were largely unknown.

A 2018 report from the National Academies of Sciences, Engineering, and Medicine reported a lack of evidence on the impact of e-cigarettes on periodontal disease, and available evidence showed conflicting comparative data when compared to traditional cigarette usage.[11] Similarly, conflicting evidence around the effectiveness of ENDS as cessation tools in different age groups suggests more research is necessary to fully understand the impact of ENDS on cessation, dual usage, or increased adoption rates of ENDS in non-smokers.[11]

In March 2020, members of the workgroup, along with several ADASRI staff, published a commentary in *JADA* entitled "Living under a cloud: Electronic cigarettes and the dental patient,"[15] which builds upon the 2018 report, and outlines currently available scientific literature regarding the potential impact of vaping on oral health. In addition to the health concerns stemming from the EVALI outbreak, subsequent research into the potential impact on oral health points to several areas of concern. Though the toxicants between traditional tobacco products and ENDS differ, components of many ENDS liquids—nicotine, propylene glycol, glycerol, and flavoring agents—all present unique and potentially adverse oral health outcomes, particularly since the oral cavity is the first point of contact. Nicotine consumption/absorption has shown potential for increased risk of periodontal disease and caries, while propylene glycol and glycerol, extremely common in e-liquids as a delivery agent, are known to release carcinogens when heated under pressure (a key requirement for vaping devices).[15]

Additionally, sweet flavoring agents may have cariogenic properties.[16] Other reports of symptoms like dry mouth, or “vape tongue,” where a loss of sensation occurs, taken together with the novelty of these products, and a dearth of long-term data on their usage, may portend long-term health effects yet unknown.[15]

While these findings focus on nicotine-containing products, it is important to remember that not all ENDS products contain nicotine, and some e-liquids contain cannabidiol products and other additives, such as the vitamin E acetate strongly linked to the EVALI outbreak.[3] These products create unique risks not expanded upon in this report, but are deserving of additional research.

Next Steps

Ongoing and rolling guidance in this area will be necessary as additional data becomes available. To date, no systematic review on the oral health impact of vaping has been conducted due to a dearth of available research in this area. Specifically, data highlighting the impact of ENDS on the risks of oral cancer, periodontal disease, and caries are crucial; and a better understanding of their impact on tooth sensitivity, gingival tissue, and salivary function can help to counsel patients on undesirable and avoidable outcomes. Increased monitoring and reporting of adverse outcomes, particularly through the US Department of Health and Human Services Safety Reporting Portal,[17] can bolster data, and encourage research funding in this important area.

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Resolution No. 21 N/A

Report: Council on Scientific Affairs Report 2 Date Submitted: August 2020

Submitted By: Council on Scientific Affairs

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

COUNCIL OF SCIENTIFIC AFFAIRS REPORT 2 TO THE HOUSE OF DELEGATES: PROPOSED ADA POLICY STATEMENT ON OPTIMIZING DENTAL HEALTH PRIOR TO SURGICAL/MEDICAL PROCEDURES AND TREATMENT

Background: In October 2016, the ADA House of Delegates adopted Resolution 86H-2016, Proposal to Convene Three Expert Panels to Address Optimizing Oral Health Prior to Surgical/Medical Procedures and Treatment:

> **86H-2016. Resolved,** that the Council on Scientific Affairs work with other appropriate ADA agencies and external stakeholders to develop proposed policy and evidence-based resources to optimize oral health prior to the performance of complex medical and surgical procedures, and be it further
>
> **Resolved,** that the Council on Scientific Affairs submit a progress report to the 2017 House of Delegates.

The Council on Scientific Affairs (CSA) was assigned as lead agency for implementation of the resolution.

This report serves as the final progress report on this resolution. It includes a Council recommendation for new Association policy to address the importance of optimal oral health prior to certain medical procedures or treatments.

Council Activities

In 2017, the Council approved an implementation plan for all efforts under Resolution 86H-2016. Per that plan, each systematic review conducted in support of the resolution would include an in-person meeting of a panel of dental and medical subject matter experts to review available evidence and analyses, and to formulate conclusions (with implications for both research and practice). Expert panel members and expert panel reports were approved by the Council. Each report would address the effect of dental treatment prior to major medical interventions on morbidity and mortality outcomes.

Also in 2017, the Council approved conducting research on the following topics:

- Patients who are scheduled for cardiac valve repair/replacement or left ventricular assist device placement (as a bridge to transplantation);
- Cancer patients, prior to head and neck radiation and chemotherapy; and
- Patients about to undergo solid organ transplantation.

Cardiology: In 2019, the Council approved the first report under this resolution. The report, "Impact of Dental Treatment Prior to Cardiac Valve Surgery: Systematic Review and Meta-Analysis" was published as a cover story in *JADA's* September 2019 issue.

Head and Neck Cancer: In April 2019, ADA Science Institute staff completed the initial data screening process of approximately 12,000 studies, and are currently working on data extraction and synthesis. An in-person meeting for the head and neck cancer expert panel was held in Q4 2019, and a subsequent round of data cleaning followed. The Council anticipates submission of a manuscript from these results by December 31, 2020.

Organ Transplantation: At its June 2020 meeting, the Council determined through exploratory work, that data on solid organ transplantation and oral health are extremely limited, and thus was unlikely to result in actionable information. Based on this assessment, the Council adopted a resolution to remove organ transplantation as a condition to be studied under Resolution 86H-2016.

Development of Evidence-Based Resources: Resolution 86H-2016 asks the CSA to work with other appropriate ADA agencies and external stakeholders to develop evidence-based resources to optimize oral health prior to the performance of complex medical and surgical procedures. In June 2020, the CSA approved a resolution to formalize the CSA's belief that manuscripts submitted for publication in *JADA* adequately fulfill the directive in Resolution 86H-2016 to develop evidence-based resources to optimize oral health prior to the performance of complex medical and surgical procedures.

Conclusion

In June 2020, leveraging the work completed under the cardiac and cancer projects, the Council approved a proposed policy statement titled, "ADA Policy Statement on Optimizing Dental Health Prior to Surgical/Medical Procedures and Treatment," and requested its transmittal to the House of Delegates for consideration at its October 2020 meeting. The findings of both projects suggest that there is high value in continuing to encourage collaboration between a patient's dental and medical teams. While the impact of dental pre-clearance on morbidity or mortality remain unclear for these particular patient groups, additional concerns or outcomes, including patient access to, or delay of, care; and post-treatment complications or healing time, remain important points of discussion across care teams when determining course of treatment. With submission of the proposed policy statement, the Council approved a resolution to inform the House of Delegates that the CSA considers implementation of Resolution 86H-2016 to be completed. This report serves as the Council's notification to the House of this action.

The following resolution is presented for House consideration:

Resolution

21. Resolved, that the following ADA policy statement on Optimizing Dental Health Prior to Surgical/Medical Procedures and Treatment be adopted:

> The ADA believes that optimizing dental health prior to the performance of complex medical and surgical procedures can be an important component of clinical care. Inter-professional communication and collaboration are crucial to identifying pre-existing or underlying oral health concerns that may impact post-medical/surgical complications or healing time, particularly for patients who are immunocompromised or otherwise at greater risk of adverse medical outcomes because of underlying health problems. Direct communication with patients and their medical teams regarding the need for, and ability to obtain, a dental examination and consultation prior to initiation of complex surgical and medical treatments is especially recommended.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 21S-1 Amendment

Report: Council on Scientific Affairs Report 2 Date Submitted: September 28, 2020

Submitted By: Ninth Trustee District

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

PROPOSED ADA POLICY STATEMENT ON OPTIMIZING DENTAL HEALTH PRIOR TO SURGICAL/MEDICAL PROCEDURES AND TREATMENT

The following amendment to Resolution 21 (Worksheet:4019) was adopted by the Ninth Trustee District.

Background: Evidence shows poor oral health may negatively impact the management and outcomes of persons with diabetes, CVD, HIV/AIDS, and pregnant women. Chronic conditions have the greatest impact on health care expenditures. Resolution 21 does not address optimizing dental health in the management of medical conditions such as, but not limited to, diabetes, CVD, HIV/AIDS or optimizing dental health during pregnancy and the perinatal period.

The Ninth District believes this is a missed opportunity to advocate the dental profession among medicine and for dental-medical integration for collaborative care.

Therefore the Ninth District proposes an amendment to Resolution 21 (additions underscored; deletions ~~stricken~~).

Resolution

21S-1. Resolved, that the following ADA policy statement on Optimizing Dental Health Prior to Surgical/Medical Procedures,~~and~~ Treatments, and Management of Medical Conditions be adopted:

The ADA believes that optimizing dental health prior to the performance of complex medical and surgical procedures, and in the management of medical conditions can be an important component of clinical care. Inter-professional communication and collaboration are crucial to identifying pre-existing or underlying oral health concerns that may impact post-medical/surgical complications or healing time, particularly for patients who are immunocompromised or otherwise at greater risk of adverse medical outcomes because of underlying health problems. Direct communication with patients and their medical teams regarding the need for, and ability to obtain, a dental examination and consultation prior to initiation of complex surgical and medical treatments and in the management of medical conditions is especially recommended.

BOARD RECOMMENDATION: Received after the August 2020 Board of Trustees meeting.

Resolution No. 100 New

Report: N/A Date Submitted: August 28, 2020

Submitted By: Second Trustee District

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: $100,000 Net Dues Impact:

Amount One-time $100,000 Amount On-going $0

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

SPECIAL NEEDS DENTISTRY

Background: In 2018, the following resolution was submitted to the American Dental Association (ADA) House of Delegates from the Third Trustee District (Pennsylvania Dental Association):

Resolution

> **83. Resolved**, that the Council on Dental Education and Licensure (CDEL) explore, with other appropriate communities of interest, the feasibility of requesting the development of an accreditation process and accreditation standards for advanced education programs in geriatric dentistry by the Commission on Dental Accreditation (CODA). The feasibility study is to be provided to the 2019 House of Delegates.

The resolution generated considerable debate both at the Reference Committee and on the floor of the House of Delegates. In general, there was broad-based support for the concept. The only controversy was who should provide the initial impetus for the study; the communities of interest or CDEL.

When the resolution was ultimately considered by the House, it was asked if the Council *could* be the appropriate agency to originate the process. Dr. Anthony Ziebert, senior vice president for ADA Education/Professional Affairs suggested it would not necessarily be inappropriate although it would be unprecedented. With that knowledge, the House ultimately referred the resolution to the Council, requesting that in its report back to the 2019 House of Delegates, CDEL address actionable strategies to

1. enhance and expand pre-doctoral training;
2. develop and promote continuing education programs for existing practitioners; and
3. investigate advanced educational opportunities.

Utilizing its vast resources, CDEL conducted an extensive survey and study to address its directive. In addition, the Council considered the criteria outlined in the CODA's *Policies and Procedures for Accreditation of Programs in Areas of Advanced Dental Education* that provide a framework for the Commission in determining whether a process of accreditation review should be initiated for advanced dental education programs.

CDEL chair, Dr. Rekha Gehani and CDEL vice chair, Dr. Linda Niessen, also sought input from the National Elder Care Advisory Committee (NECAC), who suggested the possibility of including standards related to treating "special needs patients." However, in considering NECAC's suggestion to include the

terminology “special needs patients” in addition to “geriatric dentistry,” the Council concluded that because the scope of the resolution was specific to geriatric dentistry, the response to the House of Delegates should remain similarly focused. Ultimately, the following resolution, was adopted by the 2019 ADA House of Delegates:

Resolution

69. Resolved, that the findings of the feasibility study conducted by the Council on Dental Education and Licensure be provided to the Special Care Dentistry Association (SCDA) for its consideration in pursuing an accreditation process and accreditation standards for advanced education programs in geriatric dentistry by the Commission on Dental Accreditation.

SCDA was pleased to have received the feasibility study and is actively pursuing an accreditation process and accreditation standards for advanced education programs in geriatric dentistry. Nevertheless, the issues for the special needs patient population remain unanswered. The special needs patient population’s dental needs remain grossly underserved in large part due to the dearth of training programs for dentists specifically focused on them.

In 2015, Special Care Dentistry Association pursued CODA accreditation for advanced general dentistry education programs in special care dentistry. In support of its application, a survey of all US General Practice Residency program directors was conducted in 2013. Sixty-five GPR programs responded (a summary of the survey results demonstrating overwhelming support for the proposed programs in Special Care Dentistry appears in Appendix A). It was also noted that according to the US Census Bureau Report, “Americans with Disabilities: 2010,” approximately 56.7 million citizens have some type of disability that affects their daily lives. The disability of thirty-eight million persons or approximately 10% of the disabled population is considered severe. And clearly, the provision of oral care services for people with physical, medical, developmental, or cognitive conditions which limits their ability to receive routine dental care (individuals with special needs) remains largely unmet.

The precedent has now been established by the House’s action in referring Resolution 83 to the Council on Dental Education and Licensure, which provides a much-needed and welcome roadmap for CDEL to utilize in addressing the special needs patient population. Clearly the need is there for the delivery of dental services to this underserved patient population. The question is developing the ironclad case for CODA to consider. It is the opinion of The New York State Dental Association, that with its vast resources, the ADA Council on Dental Education and Licensure can help pave the way for a similar initiative as that which was undertaken by the ADA’s CDEL in 2018-2019. Accordingly, the following resolution is submitted for consideration:

Resolution

100. Resolved, that the ADA Council on Dental Education and Licensure (CDEL) explore, with other appropriate communities of interest, the feasibility of requesting the development of an accreditation process and accreditation standards for advanced education programs in special care dentistry by the Commission on Dental Accreditation (CODA), and be it further

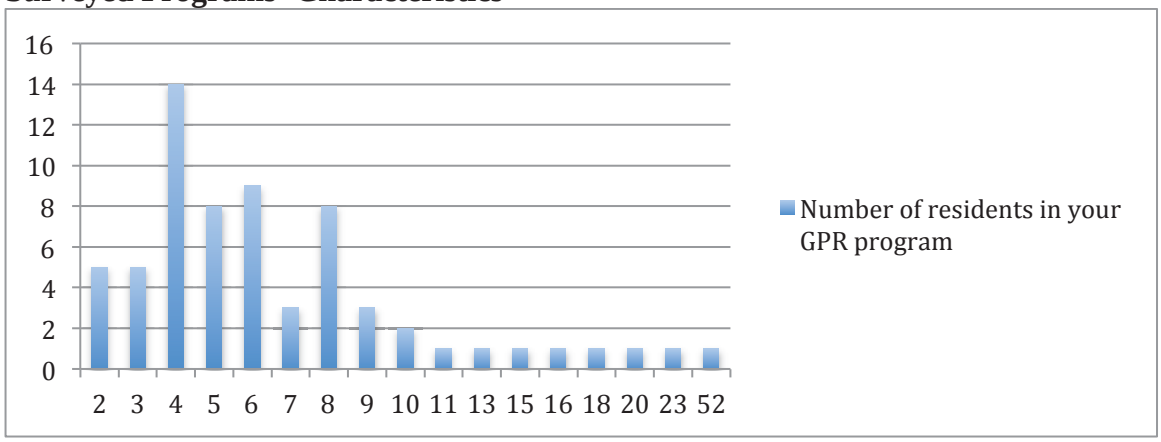
Resolved, that CDEL address actionable strategies to enhance and expand pre-doctoral training; develop and promote continuing education programs for existing practitioners; and investigate advanced educational opportunities, and be it further

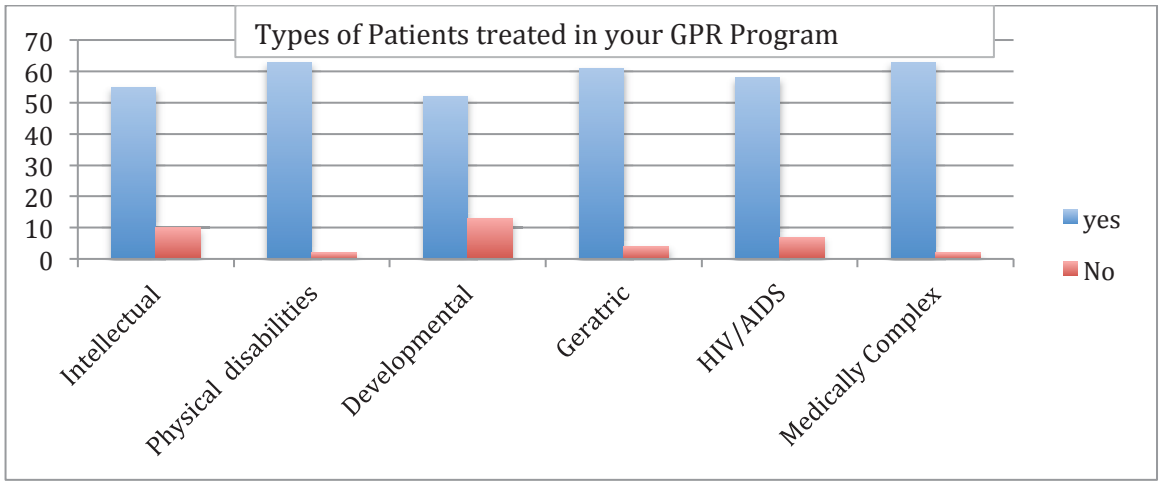
Resolved, that the feasibility study with any recommendations be provided to the 2021 ADA House of Delegates.

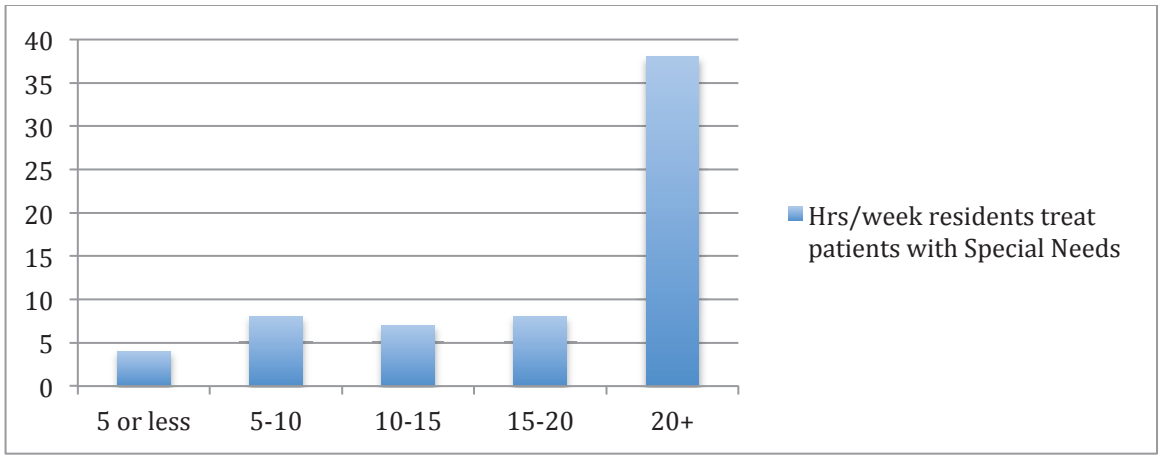
BOARD RECOMMENDATION: Received after the August 2020 Board of Trustees meeting.

Appendix A*

Surveyed Programs' Characteristics

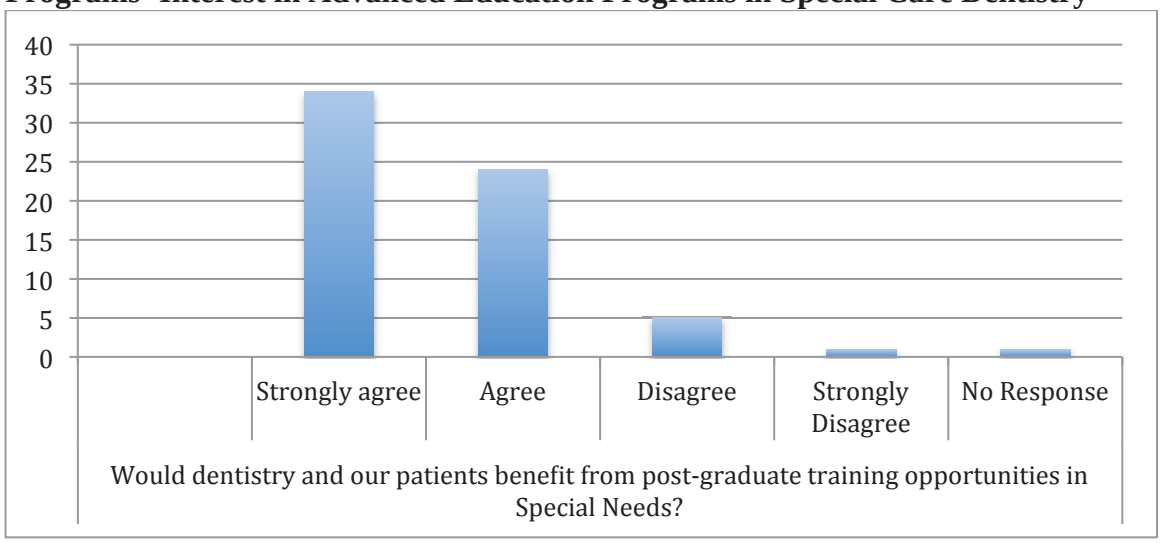


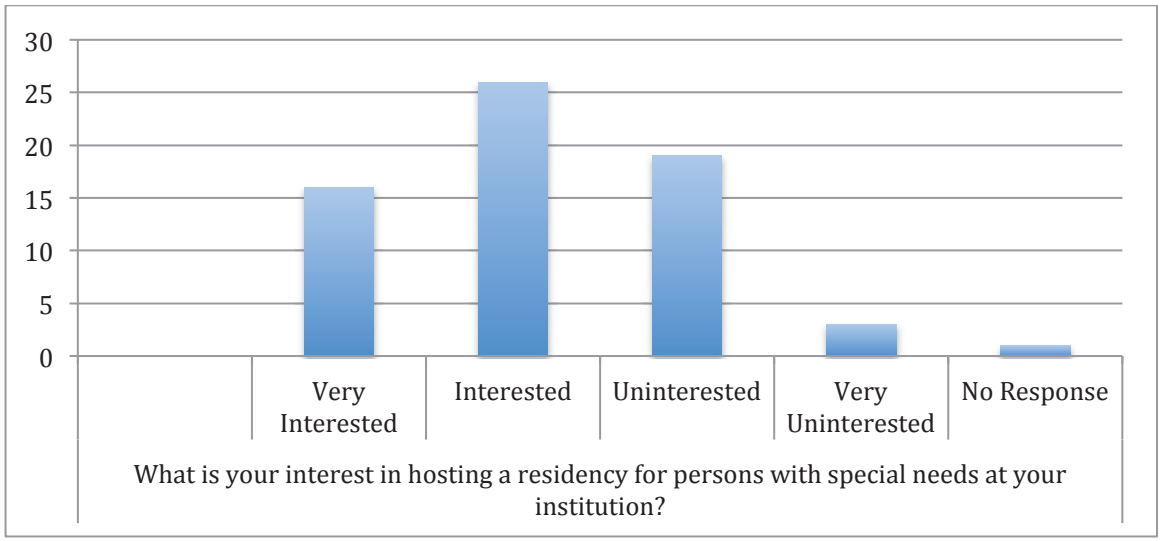


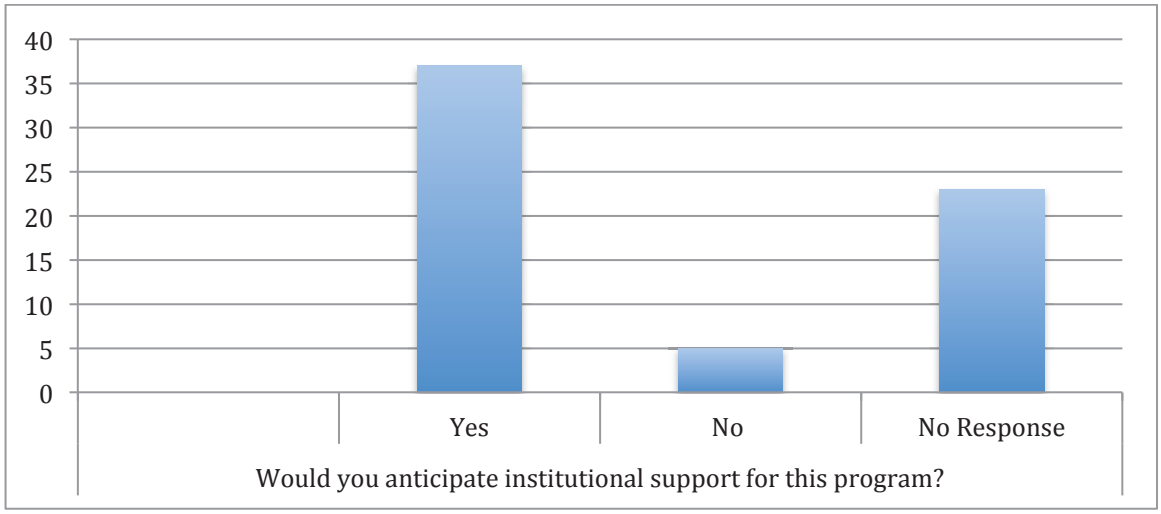


*Data used with permission from the Special Care Dental Association

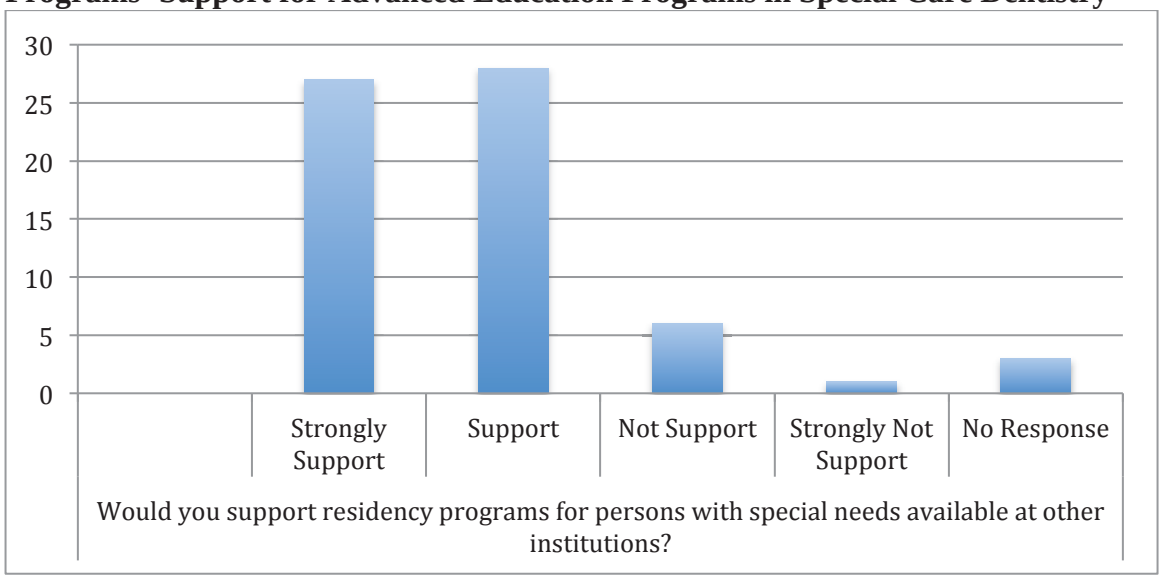
Programs' Interest in Advanced Education Programs in Special Care Dentistry

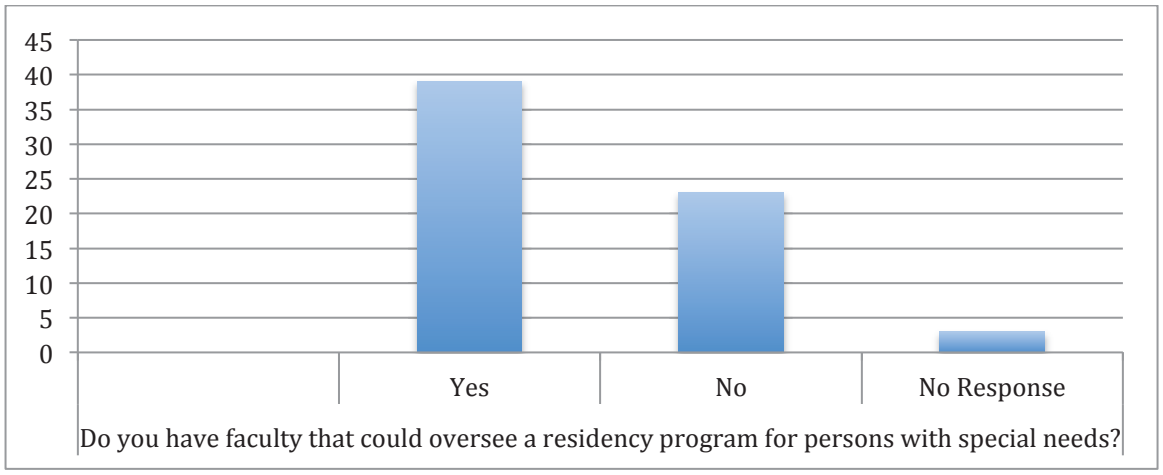


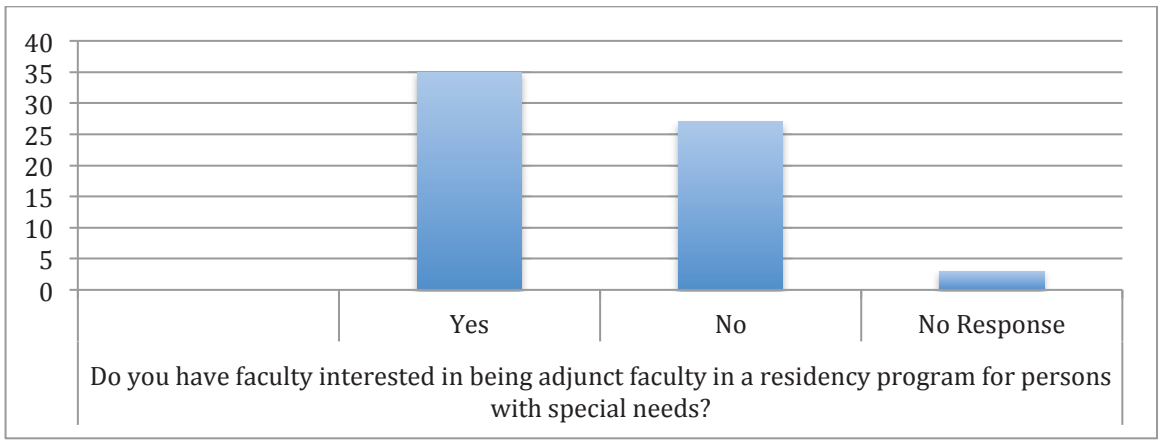




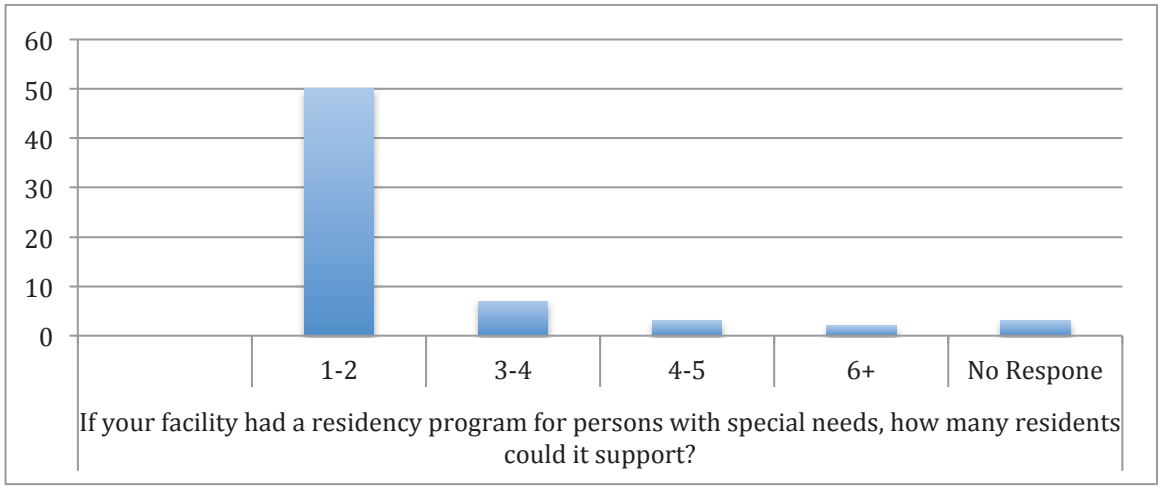
Programs' Support for Advanced Education Programs in Special Care Dentistry

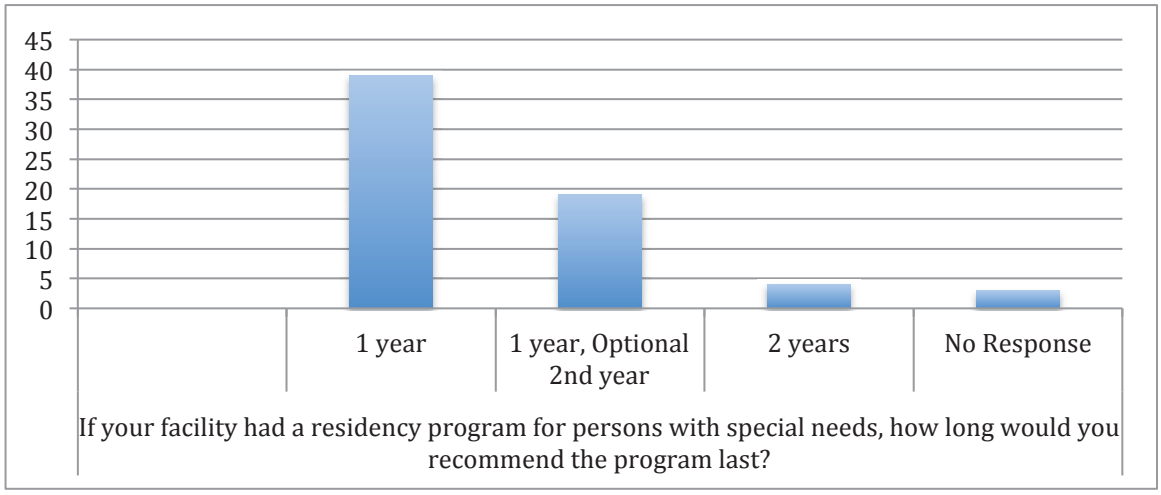






Programs' Support for Advanced Education Programs in Special Care Dentistry





Resolution No. 100S-1 Substitute

Report: N/A Date Submitted: September 24, 2020

Submitted By: Second Trustee District

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT TO RESOLUTION 100: SPECIAL NEEDS DENTISTRY

This substitute resolution, removes asking for CDEL to develop CE programs for Special Needs patients which was never the intention of the Second District and eliminates the financial implication.

Background: In 2018, the following resolution was submitted to the American Dental Association (ADA) House of Delegates from the Third Trustee District (Pennsylvania Dental Association):

Resolution

> **83. Resolved**, that the Council on Dental Education and Licensure (CDEL) explore, with other appropriate communities of interest, the feasibility of requesting the development of an accreditation process and accreditation standards for advanced education programs in geriatric dentistry by the Commission on Dental Accreditation (CODA). The feasibility study is to be provided to the 2019 House of Delegates.

The resolution generated considerable debate both at the Reference Committee and on the floor of the House of Delegates. In general, there was broad-based support for the concept. The only controversy was who should provide the initial impetus for the study; the communities of interest or CDEL.

When the resolution was ultimately considered by the House, it was asked if the Council *could* be the appropriate agency to originate the process. Dr. Anthony Ziebert, senior vice president for ADA Education/Professional Affairs suggested it would not necessarily be inappropriate although it would be unprecedented. With that knowledge, the House ultimately referred the resolution to the Council, requesting that in its report back to the 2019 House of Delegates, CDEL address actionable strategies to

1. enhance and expand pre-doctoral training;
2. develop and promote continuing education programs for existing practitioners; and
3. investigate advanced educational opportunities.

Utilizing its vast resources, CDEL conducted an extensive survey and study to address its directive. In addition, the Council considered the criteria outlined in the CODA's *Policies and Procedures for Accreditation of Programs in Areas of Advanced Dental Education* that provide a framework for the Commission in determining whether a process of accreditation review should be initiated for advanced dental education programs.

CDEL chair, Dr. Rekha Gehani and CDEL vice chair, Dr. Linda Niessen, also sought input from the National Elder Care Advisory Committee (NECAC), who suggested the possibility of including standards related to treating "special needs patients." However, in considering NECAC's suggestion to include the terminology "special needs patients" in addition to "geriatric dentistry," the Council concluded that because the scope of the resolution was specific to geriatric dentistry, the response to the House of Delegates should remain similarly focused. Ultimately, the following resolution, was adopted by the 2019 ADA House of Delegates:

Resolution

69. Resolved, that the findings of the feasibility study conducted by the Council on Dental Education and Licensure be provided to the Special Care Dentistry Association (SCDA) for its consideration in pursuing an accreditation process and accreditation standards for advanced education programs in geriatric dentistry by the Commission on Dental Accreditation.

SCDA was pleased to have received the feasibility study and is actively pursuing an accreditation process and accreditation standards for advanced education programs in geriatric dentistry. Nevertheless, the issues for the special needs patient population remain unanswered. The special needs patient population's dental needs remain grossly underserved in large part due to the dearth of training programs for dentists specifically focused on them.

In 2015, Special Care Dentistry Association pursued CODA accreditation for advanced general dentistry education programs in special care dentistry. In support of its application, a survey of all US General Practice Residency program directors was conducted in 2013. Sixty-five GPR programs responded (a summary of the survey results demonstrating overwhelming support for the proposed programs in Special Care Dentistry appears in Appendix A). It was also noted that according to the US Census Bureau Report, "Americans with Disabilities: 2010," approximately 56.7 million citizens have some type of disability that affects their daily lives. The disability of thirty-eight million persons or approximately 10% of the disabled population is considered severe. And clearly, the provision of oral care services for people with physical, medical, developmental, or cognitive conditions which limits their ability to receive routine dental care (individuals with special needs) remains largely unmet.

The precedent has now been established by the House's action in referring Resolution 83 to the Council on Dental Education and Licensure, which provides a much-needed and welcome roadmap for CDEL to utilize in addressing the special needs patient population. Clearly the need is there for the delivery of dental services to this underserved patient population. The question is developing the ironclad case for CODA to consider. It is the opinion of The New York State Dental Association, that with its vast resources, the ADA Council on Dental Education and Licensure can help pave the way for a similar initiative as that which was undertaken by the ADA's CDEL in 2018-2019. Accordingly, the following resolution is submitted for consideration:

Resolution

100S-1. Resolved, that the ADA Council on Dental Education and Licensure (CDEL) explore through a survey with other appropriate communities of interest, the feasibility of requesting the development of an accreditation process and accreditation standards for advanced education programs in special care dentistry by the Commission on Dental Accreditation (CODA), and be it further

Resolved, that CDEL address actionable strategies to:

1. enhance and expand pre-doctoral training;
2. develop and promote continuing education programs for existing practitioners; and
3. investigate advanced educational opportunities, and be it further

Resolved, that the feasibility study with any recommendations be provided to the 2021 ADA House of Delegates.

BOARD RECOMMENDATION: Received after the August 2020 Board of Trustees meeting.

Resolution No. 100S-2 Citation for Original Resolution: 100S-1

Submitted By: Dr. Rhoda J. Sword, Fifth Trustee District Date Submitted: October 18, 2020

Reference Committee Report On: C (Dental Education, Science and Related Matters)

Financial Implications (if different from original resolution): $ 0

AMENDMENT TO RESOLUTION 100: SPECIAL NEEDS DENTISTRY

The following amendment to Resolution 100S-1 (Worksheet: 4023a) was submitted by Dr. Rhoda J. Sword of the Fifth Trustee District on October 18, 2020.

Background: While the district agrees with the intent of 100S-1 that special care patients need to be further addressed, we believe that the existing educational system should be examined and improved prior to creating independent advanced education training programs in special care dentistry. Therefore, the 5th would like to have the communities of interest in this process include the 12 dental specialties recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards, the AGD, as well as the Special Care Dentistry Association (SCDA).

Resolution

100S-2. Resolved, that because all dentists can treat special needs patients, the ADA Council on Dental Education and Licensure (CDEL) explore through a survey to the 12 dental specialties recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards, the AGD, and Special Care Dentistry Association (SCDA), the feasibility of the following, concerning Special Care Dentistry:

1. enhancing and expanding pre-doctoral training;
2. developing and promoting continuing education programs for existing practitioners; and
3. exploring how each organization/program, through advanced educational opportunities, are educating and preparing dentists to best address the needs of this population, and be it further

Resolved, that the survey results with any recommendations be provided to the 2021 ADA House of Delegates.

Resolution No. 109 New

Report: N/A Date Submitted: September 4, 2020

Submitted By: Fourteenth Trustee District

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

ADA POLICY ON TOOTH GEMS AND JEWELRY

Background: Tooth gems were a popular trend in the 1990s and have recently started to make a comeback due to celebrity notoriety. Tooth gems and jewelry present several potential concerns, particularly when attached improperly. In addition to risks such as aspiration of improperly attached tooth gems and jewelry, many OTC adhesives, utilized for attaching tooth gems, can be damaging to enamel and may result in discoloration and increased risk of carious lesions.

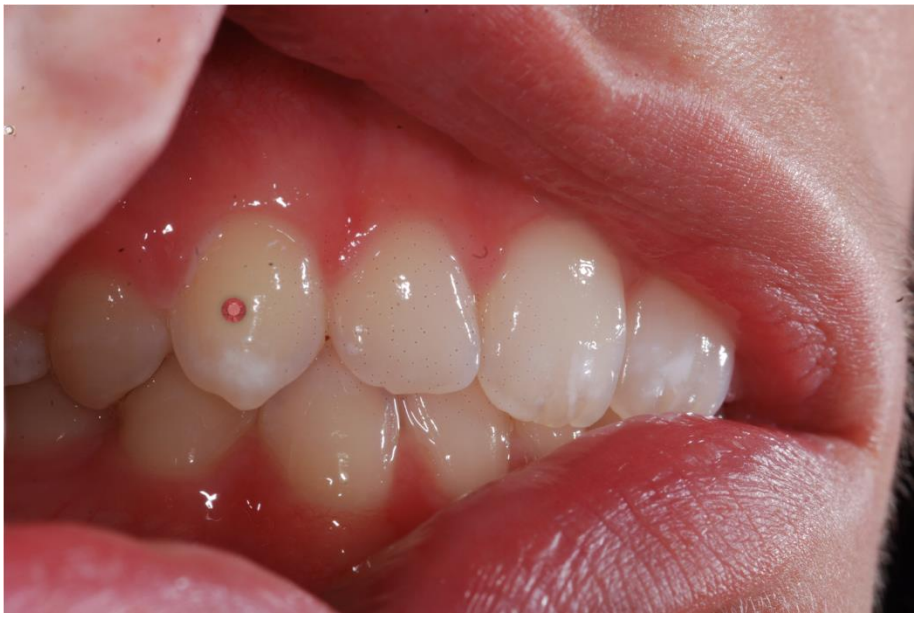
The ADA does not currently have a policy statement on tooth gems and jewelry. It would be helpful for clinical decision making, as well as dealing with media inquiries, for the ADA to have a policy statement on tooth gems and jewelry.

Resolution

109. Resolved, that the appropriate ADA agencies recommend a policy on tooth gems and jewelry to the 2021 House of Delegates.

BOARD RECOMMENDATION: Received after the August 2020 Board of Trustees meeting.

Resolution 109—Appendix 1



Legislative, Health, Governance and Related Matters

Resolution No. 2 New

Report: N/A Date Submitted: May 2020

Submitted By: Board of Trustees

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: Not Applicable

REVIEW AND CONSIDERATION OF ADA AD INTERIM POLICY ON E-CIGARETTES AND VAPING

Background: Pursuant to ADA *Bylaws*, Chapter V, Section 70, the Board of Trustees, as the managing body of the Association, is vested with the following power:

> H. Establish *ad interim* policy when the House of Delegates is not in session and when such policies are essential to the management of the Association provided, however, that all such policies must be presented for review and consideration by the House of Delegates at its next session.

At its December 2019 meeting, the Board of Trustees considered *ad interim* ADA policy on e-cigarettes and vaping. The Board concluded that there was an immediate need for interim policy because current ADA policy is silent regarding the terms "vaping" and "vaping products." Accordingly, the Board adopted the following *ad interim* policy:

> **B-122-2019. Resolved,** that the ADA Board of Trustees adopts the following statement, which mirrors a recent action from the American Medical Association, as *ad Interim* ADA Policy to address the public health crisis related to e-cigarettes and vaping:
>
> ***AD INTERIM* ADA POLICY ON E-CIGARETTES AND VAPING**
>
> That the American Dental Association (1) urgently advocate for regulatory, legislative, and/or legal action at the federal and/or state levels to ban the sale and distribution of all e-cigarette and vaping products, with the exception of those approved by the FDA for tobacco cessation purposes and made available by prescription only; and (2) advocate for research funding to study the safety and effectiveness of e-cigarettes and vaping products for tobacco cessation purposes and their effects on the oral cavity.

The Board is asking the House to adopt final policy slightly modified from the interim policy. The Board proposes changing "urgently advocate for" to "strongly supports" to be consistent with other established policy and reflect the intensity of the ADA's support for this vaping issue.

Accordingly, the Board of Trustees submits the following Resolution to the House of Delegates:

Resolution

2. Resolved, that the following statement on E-Cigarettes and Vaping be adopted ADA policy.

E-CIGARETTES AND VAPING

That the American Dental Association (1) strongly supports regulatory, legislative, and/or legal action at the federal and/or state levels to ban the sale and distribution of all e-cigarette and vaping products, with the exception of those approved by the FDA for tobacco cessation purposes and made available by prescription only; and (2) advocate for research funding to study the safety and effectiveness of e-cigarettes and vaping products for tobacco cessation purposes and their effects on the oral cavity.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 3 New

Report: N/A Date Submitted: May 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: Not Applicable

RESCISSION OF THE POLICY, DENTAL FOCUS IN FEDERAL HEALTH AGENCIES

Background: In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Dental Focus in Federal Health Agencies (*Trans.*2012:497).

The Council found that the policy adopted in 2012 evolved from 27H-1973, HEW Dental Agency (*Trans.*1973:659) and 31H-1986, Dental Health Focus in Department of Health and Human Services (*Trans.*1986:530): two time-limited directives that became moot once the tasks to "seek to establish" and "intensify its efforts" were completed (*Trans.*1975:153, 162; *Supplement* 1987:122).

The Council also found that the current policy on Dental Focus in Federal Health Agencies is redundant to Chapter VII of the ADA Governance and Organizational Manual, which states that one of the Council's core responsibilities is to "serve and assist as liaison with those agencies of the federal government which employ dental personnel or have dental care programs, and formulate polices which are designed to advance the professional status of federally employed dentists."

The Council concluded there was no added value in retaining already completed assignments with no compelling justification—or something that merely rephrases what is already in the Association's governing documents.

The Council on Government Affairs recommends that the following resolution be adopted:

Resolution

3. Resolved, that the policy titled Dental Focus in Federal Health Agencies (*Trans.*2012:497) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED

Dental Focus in Federal Health Agencies (*Trans.*2012:497)

Resolved, that the American Dental Association seek to establish within the Department of Health and Human Services a policy level office for dental activities with appropriate status and funding administered by dentists and in close liaison with organized dentistry, and be it further

Resolved, that the ADA seek to protect and enhance the status and funding of federal dental agencies, the integrity of federal dental programs and the roles and duties of federal dental officers, and be it further

Resolved, that the ADA seek to ensure that the views of organized dentistry are appropriately reflected in the work of federal advisory committees.

Resolution No. 4 New

Report: N/A Date Submitted: May 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT OF THE POLICY, USE OF DENTIST-TO-POPULATION RATIOS

Background: In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Use of Dentist-to-Population Ratios (*Trans.*1984:538; 1996:681).

The Council determined that the policy titled Use of Dentist-to-Population Ratios (77H-1984) (*Trans.*1984:538) was worded as a time-limited directive that became moot once the task to urge various entities to "refrain from using" was completed (*Reports* 1985:90)—and that the language directing the Association to complete the task did not change when it was amended by the 1996 House of Delegates (*Trans.*1996:681) (*Reports* 1997:66, 126). The Council also determined that the subject matter is relevant enough to retain as a more enduring statement of policy or position.

The Council on Government Affairs recommends that the following resolution be adopted:

Resolution

4. Resolved, that the policy titled that the policy titled Use of Dentist-to-Population Ratios (*Trans.*1984:538; 1996:681) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the American Dental Association urges all governmental, professional and public agencies, and schools of dentistry to refrain from using~~ dentist-to-population ratios ~~exclusively in~~ should not be used as the exclusive measure for designating dental health professional shortage areas or for evaluating or recommending programs for dental education or dental care.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 5 New

Report: N/A Date Submitted: May 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT OF THE POLICY, SUGGESTED DENTAL PRACTICE ACTS

Background: In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Suggested Dental Practice Acts (*Trans.*1978:529).

The Council observed that the policy was worded as a time-limited directive that became moot once the tasks to "support" only those dental practice acts that were consistent with Association policies and "provide" analysis were completed (*Reports* 1979:149).

The Council noted that the assignment was made in response to a specific Council of State Governments study of state dental practice acts and corresponding model legislation, both of which are now 40 years-old. The Council also questioned how the ADA would practically "support" any suggested dental practice acts, since the national organization has no real authority to interfere with the policies, positions, priorities, and activities of state dental societies.

The Council believes that the policy on Suggested Dental Practice Acts can be amended to reflect the ADA's desire to see that state dental practice acts are generally consistent with ADA policy, while also acknowledging that state laws vary and the national organization has no real power to interfere with the positions or actions of state dental societies.

The Council on Government Affairs recommends that the following resolution be adopted:

Resolution

5. Resolved, that the policy titled that the policy titled Suggested Dental Practice Acts (*Trans.*1978:529) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the ADA supports only those suggested dental practice acts that are consistent with Association policies, and be it further~~

~~**Resolved,** that the appropriate agency of the Association provide a timely, ongoing analysis to constituent societies of any suggested state dental laws that are developed by any agency outside the Association, with particular references as to how such proposed dental practice acts may be in conflict with Association policies~~ state dental practice acts should be consistent with American Dental Association policies, as appropriate and feasible.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 6 New

Report: N/A Date Submitted: May 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

RESCISSION OF THE POLICY, STATE REGULATION OF ADVERTISING

Background: In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled State Regulation of Advertising (*Trans.*1984:549).

The Council determined that the current policy on State Regulation of Advertising was a time-limited directive that became moot once the task to "urge [constituent societies] to consider state legislation" was completed (*Reports* 1985:137). The Council also noted that the national organization has no real authority to interfere with the policies, positions, priorities, and activities of state dental societies.

In the context of relevance, the Council observed that many state advertising statutes and regulations have been updated in the 25 years since the policy was adopted. In some instances, the states have adopted a general rule prohibiting false or misleading advertising and have judged each case on its own merits. In other states, the legislature or state dental board has endeavored to develop more detailed statutes or regulations.

The Council concluded that there was no added value in maintaining an already completed directive addressing an issue that seems to no longer exist.

The Council on Government Affairs recommends that the following resolution be adopted:

Resolution

6. Resolved, that the policy titled State Regulation of Advertising (*Trans.*1984:549) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED

State Regulation of Advertising (*Trans.*1984:549)

Resolved, that constituent dental societies be urged to consider state legislation, consistent with the recognized rights of commercial speech, that will authorize the appropriate agencies of state government to regulate dentist advertising in the public interest to ensure the dissemination of complete and accurate information through appropriate means of communications including time, manner and place.

Resolution No. 8 New

Report: N/A Date Submitted: May 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT OF THE POLICY, NATIONAL PRACTITIONER DATA BANK SELF-GENERATED INQUIRIES

Background: In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled National Practitioner Data Bank Self-Generated Inquiries (*Trans.*1993:706; 2015:272).

The Council found that ADA policy on National Practitioner Data Bank Self-Generated Inquiries (*Trans.*1993:706) was worded as a time-limited directive to "seek appropriate federal action" that became moot once the task was completed (*Reports* 1994:110)—and that the language directing the Association to complete the task did not change when it was amended by the 2015 House of Delegates (*Trans.*2015:272). However, the Council also determined that the subject matter was relevant enough to retain as a more enduring statement of policy or position.

The Council on Government Affairs recommends that the following resolution be adopted:

Resolution

8. Resolved, that the policy titled National Practitioner Data Bank Self-Generated Inquiries (*Trans.*1993:706; 2015:272) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the Association seek appropriate federal action to prohibit an entity~~ entities not otherwise authorized to query the National Practitioner Data Bank should be prohibited from coercing a provider to provide a self-query as a requirement for employment or to participate in a health insurance plan or for professional liability coverage~~, and be it further~~

~~**Resolved,** that the Association seek appropriate federal action to prohibit providers from being required to assign their rights of self-query to third parties~~.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 9 New

Report: N/A Date Submitted: May 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

PROPOSED POLICY, NATIONAL PRACTITIONER DATA BANK STATUTE OF LIMITATIONS

Background: In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Statute of Limitations (*Trans.*1997:708).

The Council found that 87H-1997 (*Trans.*1997:708) was worded as a time-limited directive that became moot once the task was completed (*Reports* 1998:311). However, the Council also determined that the subject matter is relevant enough to retain as a longer lasting statement of policy or position.

The Council noted that the title of the policy was confusing, since there are many types of statutory limits and "National Practitioner Data Bank" was not expressly identified as the statutory limit being addressed.

The Council on Government Affairs recommends that the following resolution be adopted:

Resolution

National Practitioner Data Bank Statute of Limitations

9. Resolved, that National Practitioner Data Bank malpractice payment entries involving dentists should be expunged after seven years, provided a further incident has not been reported, and be it further

Resolved, that the policy titled Statute of Limitations (*Trans.1997*:708) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED

Statute of Limitations (*Trans.*1997:708)

Resolved, that the American Dental Association urges the appropriate federal agency to take administrative action to cause National Practitioner Data Bank malpractice payment entries involving dentists to be expunged after seven years have passed, provided a further incident has not been reported.

Resolution No. 10 New

Report: N/A Date Submitted: May 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

PROPOSED POLICY, SUPPORT FOR DEPLOYED DENTISTS

Background: In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association policies addressing deployment for dentists in the U.S. armed forces, military reserves, and Public Health Service:

- Deployed Dentists and Mandatory Continuing Education Requirements (*Trans.*2004:314)
- Exemption From Unemployment Insurance Liability for Active Duty Dentists (*Trans.*2004:321)
- Support for Dentists Temporarily Called to Active Service (*Trans.*2012:496)

The Council concluded that these policies were so similar in content that all three could be combined under a heading titled Support for Deployed Dentists—retaining the substance of these policies with minor revisions for brevity and clarity.

The Council noted that having unemployment insurance premiums increased due to staff drawing unemployment benefits during a period of deployment is probably not commonplace. The Council also noted that unemployment insurance laws vary state-to-state, and the national organization has no real authority to force state dental societies to take action or even assume a position on any given issue.

The Council on Government Affairs recommends that the following resolution be adopted:

Resolution

Support for Deployed Dentists

10. Resolved, that the American Dental Association give its utmost support to its members who may be called to active duty, and be it further

Resolved, that the ADA encourages dentists to volunteer to help maintain the practices of dentists who are temporarily activated into military service by practicing in the deployed dentist's office and treating their patients, and be it further

Resolved, that it is the ADA's position that military deployment is a learning experience that provides opportunities to treat complex cases, sometimes under difficult circumstances, and be it further

Resolved, that deployed military dentists who are serving on active duty should be eligible to have their continuing education requirements waived, and be it further

Resolved, that dentists who reopen their practices following a period of military deployment should be exempt from having their unemployment insurance premiums increased or incurring any other financial penalties due to unemployed staff having drawn unemployment benefits during the period of office closure, and be it further

Resolved, that the policies titled Exemption From Unemployment Insurance Liability for Active Duty Dentists (*Trans.*2004:321), Deployed Dentists and Mandatory Continuing Education Requirements (*Trans.*2004:314), and Support for Dentists Temporarily Called to Active Service (*Trans.*2012:496) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICIES TO BE RESCINDED

Support for Dentists Temporarily Called to Active Service (*Trans.*2012:496)

Resolved, that the American Dental Association give its utmost support to our members who may be called to active duty, and be it further

Resolved, that constituent and component dental societies be urged to develop a network of volunteer dentists to help maintain the practices of dentists who are temporarily activated into military service by practicing in the deployed dentist's office and treating their patients.

Deployed Dentists and Mandatory Continuing Education Requirements (*Trans.*2004:314)

Resolved, that it is the Association's position that military deployment is a learning experience that provides opportunities to treat complex cases, sometimes under difficult circumstances, and be it further

Resolved, that constituent dental societies be urged to support state legislation or state board regulations that would allow deployed military dentists who are serving on active duty to have their continuing education requirements waived.

Exemption From Unemployment Insurance Liability for Active Duty Dentists (*Trans.*2004:321)

Resolved, that constituent societies be urged to review their states' unemployment insurance statutes so that dentists who are called to active military duty and close their dental offices are not impacted adversely by the law upon returning to their active practices.

Resolution No. 11 New

Report: N/A Date Submitted: May 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

PROPOSED POLICY, RANK AND STATUS OF DENTISTS IN THE ARMED FORCES, MILITARY RESERVES AND PUBLIC HEALTH SERVICE

Background: In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association policies addressing dentists in the U.S. armed forces, military reserves, Public Health Service, and federal civil service:

- Compensation of Dental Specialists in the Federal Dental Services (*Trans.*1990:557; 2012:496)
- Restoration of the Rank of Brigadier General to the Army Reserve Position of Deputy Assistant Surgeon General for Dental Services (*Trans.*1992:622)
- Dentistry in the Armed Forces (*Trans.*2012:496)
- Rank Equivalency for Chief Dental Officers of the Federal Dental Services (*Trans.*2012:496)

The Council found that the policies were so similar in content that all four could be combined under a heading titled Rank and Status of Dentist in the Armed Forces, Military Reserves and Public Health Service.

The Council agreed that it would be preferable to broaden the language governing support for rank and status, update the vernacular for special pay, and acknowledge that dental specialties are now determined by the National Commission on Recognition of Dental Specialties.

The Council on Government Affairs recommends that the following resolution be adopted:

Resolution

Rank and Status of Dentists in the Armed Forces, Military Reserves and Public Health Service

11. Resolved, that flag rank(s) of dental officers should be protected and enhanced in all branches of the armed forces, military reserves and Public Health Service, and their offices should have the appropriate status and funding to carry out their missions effectively, and be it further

Resolved, that the American Dental Association supports a 2-star equivalent rank or higher for the chief dental officers for the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Public Health Services and the Veterans Administration, and be it further

Resolved, that graduates of a two year comprehensive dental residency or a dental specialty residency recognized by the National Commission on Recognition of Dental Specialties should be awarded special pay while serving in the federal dental services, and be it further

Resolved, that the following policies be rescinded:

- Compensation of Dental Specialists in the Federal Dental Services (*Trans.*1990:557; 2012:496)
- Restoration of the Rank of Brigadier General to the Army Reserve Position of Deputy Assistant Surgeon General for Dental Services (*Trans.*1992:622)
- Dentistry in the Armed Forces (*Trans.*2012:496)
- Rank Equivalency for Chief Dental Officers of the Federal Dental Services (*Trans.*2012:496)

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICIES TO BE RESCINDED

Dentistry in the Armed Forces (*Trans.*1972:718; 2012:496)

Resolved, that in order to ensure the provision of high quality health care to those in active military service, the American Dental Association affirms the dental officer's proper role in command functions relating to the provision of oral health care and supports dental corps control over the financial and other resources needed to carry out their health care missions.

Restoration of the Rank of Brigadier General to the Army Reserve Position of Deputy Assistant Surgeon General for Dental Services (*Trans.*1992:622)

Resolved, that the American Dental Association support the reinstatement of the Brigadier General rank for the position of Deputy Assistant Surgeon General for Dental Services, Army Reserves.

Rank Equivalency for Chief Dental Officers of the Federal Dental Services (*Trans.*2012:496)

Resolved, that the American Dental Association supports a 2-star equivalent rank or higher for the chief dental officers for the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Public Health Services and the Veterans Administration.

Compensation of Dental Specialists in the Federal Dental Services (*Trans.*1990:557; 2012:496)

Resolved, that the American Dental Association recommends that graduates of all ADA-recognized dental specialties and other Commission on Dental Accreditation-accredited two year residency programs be eligible for special remuneration in the federal dental services.

Resolution No. 12 New

Report: N/A Date Submitted: May 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT OF THE POLICY, DENTAL RESEARCH BY MILITARY DEPARTMENTS

Background: In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the policy titled Dental Research by Military Departments (*Trans.*1970:451; 2016:316).

The Council felt that it was critical to have a policy governing the Association's support for military dental research since it plays a unique role in improving dental readiness for combat, minimizing in-theater dental emergencies and ameliorating combat-related disfigurement and loss of facial function.

The Council questioned whether the policy should be expanded to include the oral health needs of the public, or focus on military needs exclusively. Mission creep and funding were identified as two potential barriers to expanding military dental research beyond the needs of the military.

Additionally, the Council questioned why the current policy was limited to "basic" and "applied" research, and determined that the Association's support for military research did not need to be qualified in such a prescriptive way.

The Council agreed that the current policy could be amended with modern verbiage expressing support for military dental research without being too prescriptive.

The Council on Government Affairs recommends that the following resolution be adopted:

Resolution

12. Resolved, that policy titled Dental Research by Military Departments (*Trans.*1970:451; 2016:316) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the ADA considers oral and craniofacial research to be an integral component of the military dental corps' mission and believes that each military branch should continue to support such research at the basic and applied science levels.~~ military dental research is unique in that it focuses on the oral and craniofacial needs of active duty military personnel, such as:

- Improving dental readiness.
- Minimizing in-theater dental emergencies.
- Treating and ameliorating combat-related disfigurement and loss of facial function.

and be it further

Resolved, that each military branch should continue to support such research.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 13 New

Report: N/A Date Submitted: May 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT OF THE POLICY, LEGISLATIVE DELEGATIONS

Background: In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Legislative Delegations *(Trans.*1982:550; 1995:648).

The Council found that the policy on Legislative Delegations adopted by the House of Delegates in 1982 (*Trans*.1982:550) was worded as a time-limited directive that became moot once the task to "encourage individual ADA members" was completed (*Reports* 1983:124)—and that the language directing the Association to complete the task did not change when it was amended by the House in 1995 (*Trans.*1995:648) (*Reports* 1996:107).

In terms of relevance, the Council noted that when the policy was created 25 years ago, the only opportunities for individual dentists to participate in the political process were as individuals or through their constituent and component societies. Today, the American Dental Association Political Action Committee's Grassroots Program is solidly established and arguably thriving, and provides many opportunities for dentists to participate in the political process.

The Council ceded that ADPAC's Grassroots Program is not perfect, as more states can and should be participating in the program. The sense was that the Association policy titled Legislative Delegations could be amended from being a directive to a more enduring statement of policy or position.

The Council on Government Affairs recommends that the following resolution be adopted:

Resolution

13. Resolved, that the policy titled Legislative Delegations *(Trans.*1982:550; 1995:648) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the ~~Association continue to encourage individual ADA members to join the ADA Grassroots Program, and be it further~~

~~**Resolved,** that ADA members representing constituent and component societies who travel to Washington, D.C. be encouraged to visit with their senators and representatives to discuss legislative issues of importance to the profession and to coordinate this activity with the ADA~~

~~Washington Office~~ American Dental Association continue to encourage members to join and actively participate in the American Dental Political Action Committee's Grassroots Program.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 13S-1 Substitute

Report: N/A Date Submitted: October 2020

Submitted By: Sixteenth Trustee District

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

SUBSTITUTE FOR RESOLUTION 13: AMENDMENT OF THE POLICY, LEGISLATIVE DELEGATIONS

The following substitute to Resolution 13 (Worksheet:5022) was adopted by the Sixteenth Trustee District and submitted on October 5, 2020, by Phil Latham, executive director, South Carolina Dental Association.

Background: Establishing relationships with legislators is vital to our efforts in Advocacy. Our face to face interactions with the legislators in both their Washington and constituent offices is key to our success. These visits help validate the asks our lobbyists make on our behalf. We should encourage our members to be actively involved in advocating for issues important to our membership and recommend adoption of this substitution which retains some of the previous language. It is important that our members be encouraged in ADA Policy to continue to actively engage with their elect congressional representatives.

Therefore, the Sixteenth District proposes the following substitute for Resolution 13.

Resolution

13S-1. Resolved, that the Association encourage individual ADA members to join and actively participate in the ADA Grassroots Program, and be it further

Resolved, that ADA members representing constituent and component societies be encouraged to visit with their senators and representatives to discuss legislative issues of importance to the profession and to coordinate this activity with the ADA.

BOARD RECOMMENDATION: Received after the August 2020 Board of Trustees meeting.

Resolution No. 14 New

Report: N/A Date Submitted: May 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT OF THE POLICY, ANTITRUST REFORM

Background: In accordance with Resolution 170H-2012 (*Trans.*2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed three policies directly tied to reforming federal antitrust laws (i.e., McCarran-Ferguson):

- Antitrust Reform (*Trans.*2016:314)
- Legislative Support to Allow Collective Bargaining by Professional Societies (*Trans.*2001:440; 2015:271)
- Financial, Political and Administrative Consequences of Collective Bargaining Legislation (*Trans.*2000:506)

The Council considered the policy titled Antitrust Reform (*Trans.*2016:314) to be foundational to the ADA's efforts to repeal certain provisions in McCarran-Ferguson, and should be retained.

The Council found that the policy titled Legislative Support to Allow Collective Bargaining by Professional Societies (*Trans.*2001:440; 2015:271) is worded as a time-limited directive that became moot once the task to "support legislation" was completed (*Reports* 2002:6016). However, the Council also found the subject matter is relevant enough to warrant retaining as a more enduring statement of policy or position. In fact, it is similar enough to be merged with the policy Antitrust Reform (*Trans.*2016:314) (in lieu of retaining as a stand-alone policy).

Additionally, the Council determined that the policy titled Financial, Political and Administrative Consequences of Collective Bargaining Legislation (*Trans.*2000:506) was not necessary since the ADA routinely uses outside consultants on an as needed basis—including legal, lobbying, and public relations firms—to advise the Association on technically complex topics, such as antitrust and environmental policies. A policy supporting this function for a singular issue is not necessary.

The Council suggests combining the policies titled Legislative Support to Allow Collective Bargaining by Professional Societies (*Trans.*2001:440; 2015:271) and Antitrust Reform (*Trans.*2016:314), with minor changes for brevity and clarity, and rescinding the policy titled Financial, Political and Administrative Consequences of Collective Bargaining Legislation (*Trans.*2000:506).

The Council on Government Affairs recommends that the following resolution be adopted:

Resolution

14. Resolved, that the policy titled Antitrust Reform (*Trans.*2016:314) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the ADA strongly supports eliminating the current insurance industry exemption from anti-trust laws including support for legislation to clarify, amend or, if necessary, repeal the McCarran-Ferguson Act's antitrust immunity for the business of health insurance, and be it further

Resolved, that the ADA strongly opposes any legislation that would extend an antitrust exemption to the insurance industry for information gathering endeavors such as collecting and distributing information on cost and utilization of health care services, and be it further

Resolved, that the ADA supports changes in federal antitrust laws that will enable dentists to practice effectively within the health care system, and be it further

Resolved, that the ADA supports legislative and regulatory activities to change the antitrust safe harbor guideline for dental networks based on percentage of provider participation in favor of a guideline relying on a health plan's market share, and be it further

Resolved, that the ADA work closely with constituent and component societies to provide them the most current and comprehensive antitrust information and guidance available, on an as-needed basis, and be it further

Resolved, that the ADA utilize appropriate resources to work with other provider groups to amend antitrust laws to allow dentists and other providers to negotiate collectively with health care purchasers, and be it further

Resolved, that the ADA support effective regulation of insurance companies including**:** the establishment of requirements for disclosure to dentists prior to signing network participation contracts**;** and current and complete information relating to the establishment of payment reimbursement rates and claims experience~~.~~, and be it further

Resolved, that professional societies and their members should be exempt from antitrust scrutiny for the narrow area of collective bargaining, so that dental societies can collectively negotiate on behalf of members.

and be it further

Resolved, that the policies titled Legislative Support to Allow Collective Bargaining by Professional Societies (*Trans.*2001:440; 2015:271) and Financial, Political and Administrative Consequences of Collective Bargaining Legislation (*Trans.*2000:506) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICIES TO BE RESCINDED

Legislative Support to Allow Collective Bargaining by Professional Societies (*Trans.*2001:440; 2015:271)

Resolved, that the Association support legislation that would allow professional societies and their members to be considered as "one" and exempt from antitrust scrutiny for the narrow area of collective bargaining, so that dental societies could collectively negotiate on behalf of members.

Financial, Political and Administrative Consequences of Collective Bargaining Legislation (*Trans.*2000:506)

Resolved, that in pursuing antitrust relief as mandated by current policies, the Association be mindful of any such concerns raised by consultants with respect to legal and economic aspects of collective bargaining legislation, to assure legislation is in the best interests of the profession.

Resolution No. 23 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Advocacy for Access and Prevention

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, ENCOURAGING THE DEVELOPMENT OF ORAL HEALTH LITERACY CONTINUING EDUCATION PROGRAMS

Background: In accordance with the Resolution 170H-2012 (*Trans*.2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Advocacy for Access and Prevention reviewed the Association policy titled Encouraging the Development of Oral Health Literacy Continuing Education Programs (*Trans*.2006:316).

The Council moved forward the importance of continuing education in health literacy due to the importance of patient understanding from both a quality aspect as well as a risk management strategy. The Council recommends that the following resolution be adopted:

Resolution

23. Resolved, that the policy titled Encouraging the Development of Oral Health Literacy Continuing Education Programs (*Trans*.2006:316) be amended as follows (additions are underscored; deletions are ~~stricken~~):

> **Resolved**, that the Council on Dental Education and Licensure and other appropriate ADA agencies encourage the development of undergraduate, graduate and continuing education programs to train dentists and allied dental team members to effectively communicate in a culturally-competent, plain language, accurate manner with all patients. ~~with limited literacy skills.~~

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 24 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Advocacy for Access and Prevention

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: 0 Net Dues Impact: None

Amount One-time _____ Amount On-going _____

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

RESCISSION OF THE POLICY, PREVENTIVE DENTAL PROCEDURES

Background: In accordance with Resolution 170H-2012(*Trans*.2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Advocacy for Access and Prevention reviewed the Association policy titled Preventive Dental Procedures (*Trans*.1967:325; 2013:342).

The Council felt that the language was very broad and non- specific with the importance of various preventive procedures already noted in other policies. The Council recommends that the following resolution be adopted:

Resolution

24. Resolved, that the policy titled Preventive Dental Procedures (*Trans.*1967:325; 2013:342) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON ADVOCACY FOR ACCESS AND PREVENTION
ADA POLICY TO BE RESCINDED

Preventive Dental Procedures (Trans.1967:325; 2013:342)

Resolved, that constituent dental societies support the use of preventive procedures in all dental offices, and be it further

Resolved, that constituent and component societies support continuing education programs in the effective us of preventive procedures.

Resolution No. 25 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Advocacy for Access and Prevention

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

PROPOSED POLICY, GUIDELINES FOR MEDICAID DENTAL REVIEWS

Background: The goal of the ADA's Action for Dental Health Medicaid Initiative is to increase the availability of quality dental care to Medicaid-eligible individuals in order to improve the oral and overall health outcomes of this population, such as by increasing the participation of dentists who provide care to this population. Many dentists decline to participate as Medicaid providers due to frustration associated with perceived unfairness and inequity within Medicaid reviews and audits conducted by a variety of governmental agencies or their contractual representatives.

While it is reasonable to expect a degree of oversight when public resources are being utilized to improve the health of individuals; there should be clear and transparent guidelines that all parties acknowledge and agree to abide by as part of participation in the program. Adopting such guidelines for dental reviews by state dental Medicaid agencies could serve to attract new Medicaid providers and curb attrition of existing participants. States that use a managed care model could incorporate such guidelines into their request for proposal (RFP) to third-party payers interested in managing the dental benefit.

To that end, the Council on Advocacy for Access and Prevention recommends the following resolution to the 2020 House of Delegates:

Resolution

25. Resolved, that the American Dental Association encourages state dental associations to work with their respective state Medicaid agency to adopt such guidelines for Medicaid Dental Reviews and/or in States that use a managed care model to incorporate such guidelines into their request for proposal (RFP) to third-party payers interested in managing the dental benefit:

Guidelines for Medicaid Dental Reviews

The Auditor/Reviewer shall demonstrate adherence, not only to individual State Board regulations and requirements, but also an understanding, acceptance and adherence to Medicaid State guidelines and specific specialty guidelines as applicable. In addition, the Auditor/Reviewer shall demonstrate experience in treatment planning specific patient demographic groups and/or unique care delivery sites that influence treatment planning being reviewed.

It is recommended that entities, which conduct Medicaid Dental reviews and audits, utilize auditors and reviewers who:

1. Have a current active license to practice dentistry in the State where audited treatment has been rendered and be available to present their findings.

2. Are of the same specialty (or equivalent education) as the dentist being audited.

3. Document and reference the guidelines of an appropriate dental or specialty organization as the basis for their findings, including the definition of *Medical Necessity* being used within the review.

4. Have a history of treating Medicaid recipients in the state in which the audited dentist practices.

5. Have experience treating patients in a similar care delivery setting as the dentist being audited, such as a hospital, surgery center or school-based setting, especially if a significant portion of the audit targets such venues.

In addition, these entities shall be expected to conduct the review and audit in an efficient and expeditious manner, including:

1. Stating a reasonable period of time in which an audit can proceed before dismissal can be sought.

2. Defining the reasonable use of extrapolation in the initial audit request.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 26 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Advocacy for Access and Prevention

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

RESCISSION OF THE POLICY, HIGH BLOOD PRESSURE PROGRAMS

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy review, the Council on Advocacy for Access and Prevention reviewed the Association policy titled High Blood Pressure Programs (*Trans.*1974:643; 2013:343).

The Council noted that the National High Blood Pressure Program no longer is in existence which does not add relevance to this outdated resolution. The Council recommends that the following resolution be adopted:

Resolution

26. Resolved, that the policy titled High Blood Pressure Programs be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON ADVOCACY FOR ACCESS AND PREVENTION
ADA POLICY TO BE RESCINDED

High Blood Pressure Programs (*Trans*.1974:643; 2013:343)

Resolved, that the ADA support members participation in the National High Blood Pressure Program.

Resolution No. 28 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT OF THE POLICY, PROTECTION OF RETIREMENT ASSETS

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Protection of Retirement Assets (*Trans.*1987:521).

The Council determined that the policy is worded as a time-limited assignment that effectively became moot once the task to "strongly support efforts by the constituent society at the state legislature level" was complete (*Reports* 1988:143). The Council also found that the 30 year-old policy is woefully outdated, particularly given that some of the retirement accounts now go by different names (e.g., Keogh plan vs. "qualified plan") or hardly exist (e.g., corporate pensions).

It is unclear why the policy contains the term "nondomestic judgment." The impetus for the policy was a New York law "to protect retirement plan assets from creditors" (*Supplement* 1987:355). The Eighth District asserted that the New York law did not protect Individual Retirement Accounts (IRAs), leading to a House assignment to urge state dental societies to advocate for IRAs to be included in similar state laws.

After consulting the Council on Dental Practice, the Council on Government Affairs recommends that the following policy be adopted:

Resolution

28. Resolved, that the policy titled Protection of Retirement Assets (*Trans.*1987:521) be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the ADA strongly support efforts by the constituent society at the state legislature level to enact laws which exempt IRS qualified Keogh, Corporate Pension or Profit Sharing Plans, and Individual Retirement Accounts from attachment to satisfy any nondomestic judgment~~ retirement savings accounts should be exempt from nondomestic judgments.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 29 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT TO SECTION 3.A. OF THE ADA PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT

Background: To emphasize that oral health is integral in the oral health of the population, the Council on Ethics, Bylaws and Judicial Affairs believes that the ADA *Principles of Ethics and Code of Professional Conduct* should be amended to explicitly state that dentists have an obligation to use their skills and training to improve not only the dental health, but the overall health of the public.

Discussion: Former Surgeon General C. Everett Koop has been cited as saying "You're not healthy without good oral health."[1] Oral health is an integral component of primary care, especially since more than 64% of adults have visited the dentist in the last year according to the Centers for Disease Control. *Healthy People 2020,* in recognition of this has as one of its goals to: "Prevent and control oral and craniofacial diseases, conditions, and injuries, and improve access to preventive services and dental care."[2] This is not only a public health goal, but arguably, is a professional obligation. All professions earn the trust of society based on agreeing to a common set of rules, including self-regulating, licensing, lifelong learning, and service to the community including trying to help all in need of service. This also includes a special duty to care for or protect the most vulnerable including the disabled, the uninsured, and the undocumented. According to Chalmers, et. al "improving health in the United States will require a coordinated multisystem solution, and oral health is a key to improving the overall health of the nation."[3] From pediatric care[4] to geriatric care[5] the role of oral health in overall health is apparent.

This comports with the dentist's obligation under the ADA *Principles of Ethics and Code of Professional Conduct* (the Code) under the Principle of Beneficence which states that "the dentist's primary obligation is service to the patient ***and the public at large***."[6] (emphasis added)

In addition to the ethical support of the importance oral health to overall health, there is economic support as well. According to work done by the ADA's Health Policy Institute in partnership with the Dartmouth Institute in 2016, "Better coordination of oral care should be motivated by the opportunity to improve population health through preventive dental care and oral screening while reducing costs of emergency department visits and late stage treatments."[7]

The current pandemic has demonstrated the important role that dentists play in protecting and promoting the public's health.

Citations to the material referenced in the foregoing discussion are included in **Appendix 1**.

For these reasons, the Council on Ethics, Bylaws and Judicial Affairs proposes to amend Section 3.A. of the *Principles of Ethics & Code of Professional Conduct* by deleting the word “dental,” as illustrated in the following resolution.

Resolution

29. Resolved, that Section 3.A. of the ADA *Principles of Ethics & Code of Professional Conduct* be amended by deletion as follows (deletion ~~stricken through~~):

3.A. COMMUNITY SERVICE.

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

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

APPENDIX 1

REFERENCES

1. Allukian M Jr. The neglected epidemic and the surgeon general's report: a call to action for better oral health. *Am J Public Health*. 2008;98(9 Suppl):S82-S85. doi:10.2105/ajph.98.supplement_1.s82

2. *Healthy People 2020*, https://www.healthypeople.gov/2020/topics-objectives/topic/oral-health [Accessed on 19 July 2020].

3. Chalmers, Natalia I, Joseph S Wislar, Sean G Boynes, Mark Doherty, and Brian B Nový. "Improving Health in the United States: Oral Health Is Key to Overall Health." *The Journal of the American Dental Association: JADA.* 148.7 (2017): 477-80. Web.

4. Gauger, Tylor L, Prosser, Lisa A, Fontana, Margherita, and Polverini, Peter J. "Integrative and Collaborative Care Models between Pediatric Oral Health and Primary Care Providers: A Scoping Review of the Literature." *Journal of Public Health Dentistry.* 78.3 (2018): 246-56. Web.

5. Kaufman, Laura B, Henshaw, Michelle M, Brown, Blase P, and Calabrese, Joseph M. "Oral Health and Interprofessional Collaborative Practice." *Dental Clinics of North America.* 60.4 (2016): 879-90. Web.

6. The ADA Principles of Ethics and Code of Professional Conduct. https://www.ada.org/~/media/ADA/Member%20Center/Ethics/Code_Of_Ethics_Book_With_Advisory_Opinions_Revised_to_November_2018.pdf?la=en#:~:text=Section%203%20PRINCIPLE%3A%20BENEFICENCE%20(%E2%80%9C,for%20the%20benefit%20of%20others. [Accessed on 16 July 2020]

7. Colla CH, Stachowski C, Kundu S, Harris B, Kennedy G, Vujicic M. Dental care within accountable care organizations: challenges and opportunities. Chicago (IL): American Dental Association; 2016 Mar.

Resolution No. 30 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT OF CHAPTER XII., SECTION A OF THE GOVERNANCE AND ORGANIZATIONAL MANUAL OF THE AMERICAN DENTAL ASSOCIATION

Background: Pursuant to the *Governance and Organizational Manual of the American Dental Association* (*Governance Manual*), Chapter VIII., Section K.6.b.ii., the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) reviews the governance documents of the Association to correct punctuation, grammar spelling and syntax. Under the procedures adopted by CEBJA, different portions of the governing documents are reviewed each year so that the entirety of the governance documentation is reviewed every four (4) years. Among the material reviewed in 2020 was Chapter XII. of the *Governance Manual*.

Discussion: During its review of Chapter XII. of the *Governance Manual*, CEBJA noted that eligibility for remitting dues payments in installments was not extended to retired members of the Association. While it is understood that the annual dues for retired members are significantly less than the annual dues for active, life and provisional members of the ADA, many retired members have no regular incomes and rely on whatever sources of retirement income they have. It is not unusual for retirement income to be less than the income enjoyed by active, life and provisional members of the Association and, in some cases, drastically so. Retired members with fixed or limited retirement incomes may welcome the opportunity to pay their dues in smaller regular installments rather than to be obligated to remit membership dues in one lump sum. The opportunity to remit dues via installments can thus be seen as a benefit to retired members of the Association. Moreover, allowing the installment payment of dues may allow some number of retired members who would otherwise terminate their membership to continue to enjoy the benefits of membership in the ADA during their retirement years.

Extending eligibility to pay dues by installment payments is a benefit that can be provided by the ADA at little or no additional cost. Constituents and components can already offer the flexibility of installment dues payment to active, life and provisional members; it is not believed that making retired members eligible for installment dues payments would add any additional direct or indirect costs to the dues collection process. There might be a negligible cost to the ADA arising from not receiving the entirety of the dues payment at once. However, the dues would ultimately be paid in full, and whatever cost may be associated with delay associated with offering installment payments might be offset by retired members opting to continue ADA membership because of the availability of the payment of dues in installments.

In view of the above discussion, the Council on Ethics, Bylaws and Judicial Affairs proposes revision of Chapter XII, Section A. of the *Governance Manual* as set forth below:

Resolution

30. Resolved, that Chapter XII., Section A. of the *Governance and Organizational Manual of the American Dental Association* be amended as shown below (additions underscored, deletions ~~stricken through~~):

CHAPTER XII. FINANCIAL MATTERS

A. Installment Payments of Dues and Special Assessments. Any constituent or component may establish a plan for the installment payment of dues and special assessments for active, life, retired and provisional members. This Association may establish a plan for the installment payment of dues and special assessments for active, ~~and~~ life and retired members who are direct members of the Association. Any such installment plan shall require:

1. Monthly installment payments that conclude with the current dues and any special assessment amount being paid by December 15.

2. The expeditious transfer of installments of member dues and any special assessments collected to this Association and any applicable constituent or component.

3. Any installment plan adopted under this provision of the *Governance Manual* may impose a reasonable transaction fee upon the member. Transaction fees collected shall be prorated between this Association and the constituent and component, if any, based on the amount of dues and special assessment collected on each organization's behalf.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 31 New

Report: N/A Date Submitted: August 2020

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT OF THE ADA MEMBER CONDUCT POLICY

Background: The Member Conduct Policy (*Trans.*2011:530) was first adopted by the House of Delegates ten years ago, and has not been revised or amended since its adoption. The Council on Ethics, Bylaws and Judicial Affairs (CEBJA) has undertaken a review of the policy in light of changes that have occurred in dentistry and issues that have arisen in society since the adoption of the policy in 2011. CEBJA believes that the policy can benefit from some revisions, as is discussed below.

Discussion: One facet of everyday life that has become far more prevalent over the past decade is social media. Millions of individuals have Facebook, Twitter and Instagram accounts, and widespread use of social media for communication purposes is exemplified by the frequent, everyday use of Twitter by the President of the United States to convey positions on a vast array of topics. Closer to home, the Election Commission and Campaign Rules that govern the conduct of campaigns for the ADA President-elect permits the candidates to use Facebook to facilitate their campaigns and communications with delegates and alternate delegates (*see*, *Manual of the House of Delegates and Supplemental Information*, Election Commission and Campaign Rules, Paragraphs 14-16). The Member Conduct Policy currently in existence makes no mention of social media despite its tremendous growth as a communications vehicle. While the generality of the language used in current policy certainly encompasses members' use social media, CEBJA believes that it would be beneficial for the policy to explicitly refer to social media when setting the standards for members' communications and actions.

Another phenomenon that has arisen in dentistry over the past ten years is the significant expansion of dental service organizations (DSOs). In the past several years, young, recently graduated dentists have been recruited in increasing numbers by DSOs and many have found practicing dentistry in the DSO setting as a viable, and often attractive, entrée into professional practice. Examples given by young dentists for choosing employment by a DSO over private practice are a desire to focus on treating patients without the need to devote time to the "business" aspects of dentistry and the belief that the amount of educational debt carried by recently graduated dentists will adversely affect their ability to purchase dental practices.

In recent years, the ADA has struggled to retain as members the same percentage of recently graduated dentists as historically has been the case. When young dentists associated with DSOs are asked about ADA membership, a comment that is sometimes heard is that they do not find ADA members to be welcoming and inclusive, and that they feel shunned by ADA members as a result of their affiliation with DSOs. CEBJA believes the policy to be an appropriate place to remind members that discussions concerning practice modalities need to have a respectful and professional tone. Members should also be sensitive to and tolerant of the decisions and practice choices that their professional colleagues have

made. These reminders have been inserted into the proposed amended Member Conduct Policy as Paragraph 2.

While reviewing the Member Conduct Policy, some of the CEBJA members objected to the prohibition of "disruptive behavior" as being vague and susceptible to interpretations that may not have been intended when the Members Conduct Policy was first written. For example, it was thought that challenging an existing policy might be characterized as disruptive behavior. The Council believed that the use of the phrase "disruptive behavior" may create an unnecessary impediment or barrier to having frank and candid discussions when a portion of the Association membership believes that Association policies have become outdated or otherwise have outlived their usefulness. CEBJA has thus rewritten current Paragraph 2 (renumbered as the third paragraph of the amended Member Conduct Policy proposed by CEBJA to more clearly and precisely define the conduct that is prohibited by that paragraph of the policy.

In light of the foregoing, the Council on Ethics, Bylaws and Judicial Affairs proposes the following resolution to amend the Member Conduct Policy:

Resolution

31. Resolved, that the Member Conduct Policy (*Trans.*2011:530) be amended as follows (additions underscored, deletions ~~stricken through~~):

ADA Member Conduct Policy

1. Members' ~~should communicate respectfully in all~~ discussions, social media activities, communications and interactions with other dentists, dentist members, Association officers, trustees and staff should be respectful and free of demeaning, derogatory, offensive or defamatory language.

2. Discussions and communications relating to modes of practicing dentistry should be courteous and professional, and members should be respectful of the practice choices of their colleagues.

~~2~~3. Members should abide by and respect the decisions and policies of the Association ~~and must not engage in disruptive behavior in actions with other members, Association officers, trustees and staff~~. Any criticism or challenges to existing Association policies or decisions shall be undertaken in a professional manner.

~~3~~4. Members have an obligation to be informed about and use Association policies for communication and dispute resolution.

~~4~~5. Members are expected to comply with all applicable laws and regulations, including but not limited to antitrust laws and regulations and statutory and common law fiduciary obligations.

~~5~~6. Members must respect and protect the intellectual property rights of the Association, including any trademarks, logos, and copyrights.

~~6~~7. Members must not use Association membership directories, on-line member listings, or attendee records from Association-sponsored conferences or CE courses for personal or commercial gain, such as selling products or services, prospecting, or creating directories or databases for these purposes.

~~7~~8. Members must treat all confidential information furnished by the Association as such and must not reproduce materials without the Association's written approval.

~~8~~9. Members must not violate the attorney-client privilege or the confidentiality of executive sessions conducted at any level within the Association.

~~9~~10. Members must fully disclose conflicts, or potential conflicts, of interest and make every effort to avoid the appearance of conflicts of interest.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 32 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT AND SIMPLIFICATION OF BYLAWS CHAPTER I., SECTION 20.B.

Background: Pursuant to the *Governance and Organizational Manual of the American Dental Association* (*Governance Manual*), Chapter VIII., Section K.6.b.ii., the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) reviews the governance documents of the Association to correct punctuation, grammar spelling and syntax. Different portions of the ADA's governing documents are reviewed by CEBJA each year so that the entirety of the Association's governance material is reviewed every four (4) years. Among the material reviewed in 2020 was Chapter I. of the *Bylaws*.

During the course of the Council's editorial review, if the Council finds an area in the governance documentation that it believes could be better stated, simplified or made clearer, and, in the judgment of the Council, that revision does not fall within the type of revision that can be the made upon the unanimous vote of the Council without approval of the House of Delegates under Chapter VIII., Section K.6.b.ii. of the *Governance Manual*, CEBJA proposes its suggested the revision to the House of Delegates for consideration and adoption.

Discussion: Section B. of Chapter I. of the ADA *Bylaws* specifies the criteria under which a member qualifies to be a life member of the Association. One of the listed criteria is the length of time the member has been a member in good standing of the ADA. Subsection a. of Section B. states that a member must either be an active and or retired member in good standing of the ADA for thirty (30) consecutive years or for at least forty (40) non-consecutive years to qualify for life membership. Subsection d. of Section B. states that a member can be eligible for life membership if the member has held ADA membership for at least ten (10) years and has reached the age of sixty-five (65) if, prior to holding ADA membership, the member has been a member of the National Dental Association for (25) twenty-five years.

To simplify and clarify the ADA *Bylaws*, CEBJA believes that subsections a. and d. of Chapter I., Section B. of the *Bylaws* should combined as follows:

B. LIFE MEMBER. Any person holding a D.D.S., D.M.D. or equivalent degree shall be eligible to be a life member of this Association if he or she meets the following qualifications:

a. Association Membership. The member:

1. Has been an active and/or retired member in good standing of this Association for at least thirty (30) consecutive years or a total of at least forty (40) non-consecutive years; or

2. Has been or was a member of the National Dental Association for twenty-five (25) years

and has been an active and/or retired member in good standing of this Association for at least ten (10) years;

Combining subsections a. and d. of Section B. places the length of membership eligibility criterion in a single subsection, rather than having that the membership criterion in two separate subsections that are separated by listing additional eligibility criteria for becoming a life member. The proposed amendment thus simplifies the *Bylaws* and makes the *Bylaws* more understandable to and readable for the average member.

In light of the above analysis, CEBJA proposes that Chapter I, Section 20.B. of the ADA *Bylaws* be amended as follows:

Resolution

32. Resolved, that Chapter I, Section B. of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

B. LIFE MEMBER. Any person holding a D.D.S., D.M.D. or equivalent degree shall be eligible to be a life member of this Association if he or she meets the following qualifications:

a. Association Membership. The member has been:

1. ~~Has been an~~ An active and/or retired member in good standing of this Association for at least thirty (30) consecutive years or a total of at least forty (40) non-consecutive years; or

2. ~~Was a~~ A member of the National Dental Association for twenty-five (25) years and has been an active and/or retired member in good standing of this Association for at least ten (10) years;

b. Reached the age of at least sixty-five (65) during the previous calendar year; and

c. Maintains membership in good standing in a constituent and component, if such exists, and in this Association.

~~d. A member may also qualify for life member status by having been a member of the National Dental Association for twenty-five (25) years and subsequently holding membership in this Association for at least ten (10) years and having reached the age of at least sixty-five (65) during the previous calendar year.~~

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 33 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Advocacy for Access and Prevention

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, LIMITED ORAL HEALTH LITERACY SKILLS AND UNDERSTANDING IN ADULTS

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Advocacy for Access and Prevention reviewed the Association policy titled Limited Oral Health Literacy Skills and Understanding in Adults (*Trans.*2006:317; 2013:342).

The Council noted that according to population health experts from the National Academy of Medicine, an estimated 88% of Americans lack basic health literacy skills. The National Advisory Committee on Health Literacy in Dentistry (NACHLD) recommended the following addition to existing policy which was unanimously accepted by the Council.

Resolution

33. Resolved, that the policy titled Limited Oral health Literacy Skills and Understanding in Adults (*Trans.*2006:317; 2013:342) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ADA recognizes health literacy as a significant barrier to effective prevention, diagnosis and treatment of oral disease, and be it further

Resolved, that dental offices encourage staff training in health literacy to improve health outcomes.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 34 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Advocacy for Access and Prevention

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, COMPREHENSIVE POLICY STATEMENT ON ALLIED DENTAL PERSONNEL

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Advocacy for Access and Prevention reviewed the Glossary of the Association policy titled Comprehensive Policy Statement on Allied Dental Personnel (*Trans.*1996:699; 1998:713; 2001:467; 2002:400; 2006:307; 2010:505). See Appendix 1.

The Council has noted that the evolution of the Community Dental Health Coordinator (CDHC) has moved away from the language of the pilot program and into a menu of activities compatible with state dental practice acts.

As the CDHC program now has over 600 graduates with a normalized educational structure, the Council on Advocacy for Access and Prevention recommends that the following resolution be adopted.

Resolution

34. Resolved, that the terminology describing the Community Dental Health Coordinator provided in the "Glossary of Terminology Related to Allied Dental Personnel Utilization and Supervision" of the ADA Comprehensive Policy Statement on Allied Dental Personnel (*Trans.*1996:699; 1998:713; 2001:467; 2002:400; 2006:307; 2010:505) be amended as follows (new language underscored, deletions ~~stricken through~~):

Community Dental Health Coordinator (CDHC): an individual trained ~~in an ADA pilot program as a community~~ ~~health worker with dental skills~~ through the ADA licensed curriculum as a dental trained professional with community health worker skills. Their aim is to improve oral health education and to assist at risk communities with disease prevention. Working under the supervision of a dentist, a CDHC helps at risk patients improve their preventive oral health through education and awareness programs, navigate the health system and receive care from ~~a dentist in an appropriate clinic~~ licensed dentists.

~~CDHCs also perform limited duties such as screenings, fluoride treatments, placement of sealants and temporary restorations and simple cleanings.~~ CDHCs also perform limited clinical duties only as allowed by their State Practice Acts such as screenings, fluoride treatments, and sealant placement until the patient can receive care from a dentist or dental hygienist. Upon graduation, they will work primarily in a public health and community settings like clinics, schools,

~~churches,~~ faith based settings, senior citizen centers, and Head Start programs in with a variety of dental providers, including clinics, community health centers, the Indian Health Service and private practice ~~dentists~~ dental offices.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

APPENDIX 1
COMPREHENSIVE POLICY STATEMENT ON ALLIED DENTAL PERSONNEL

General Principles

Dentistry is committed to improving the health of the American public by providing the highest quality comprehensive dental care, which includes the inseparable components of medical and dental history, examination, diagnosis, treatment planning, treatment services and health maintenance. Preventive care services are an integral part of the comprehensive practice of dentistry and should be rendered in accordance with the needs of the patient as determined by a diagnosis and treatment plan developed and executed by the dentist.

The dentist is ultimately responsible, ethically and legally, for patient care. In carrying out that responsibility and to increase the capacity of the profession to provide patient care in the most cost-effective manner, the dentist may delegate to allied dental personnel certain patient care functions for which the allied dental personnel has been trained. In an ongoing effort to address the health care needs of the American public, new members of the dental team may be developed. The scope of function and level of supervision should be determined by the profession so as to ensure adequate patient care and safety.

The recognized categories of allied dental personnel are dental hygienists, dental assistants, community dental health coordinators and dental laboratory technicians. (See the glossary for definitions of each category.) A dental laboratory technician who is employed in the dental office is considered to be allied dental personnel. A dental technician who performs a supportive function in an environment outside the dental office may be properly termed a supportive or allied member of the dental health team.

Delegation of Functions

The primary purpose of dentists delegating functions to allied dental personnel is to increase the capacity of the profession to provide patient care while retaining full responsibility for the quality of care. This responsibility includes identification of the need for specific types of allied dental personnel and establishment of appropriate controls on the patient care services provided by allied dental personnel.

The American Dental Association has the responsibility to provide guidance to all agencies, organizations and governmental bodies, such as state dental boards and legislatures, that have an interest in, or responsibility and authority for, decisions on utilization, education, and supervision of allied dental personnel. In this context, the primary responsibility is to assure that decisions on allied dental personnel utilization will not adversely affect the health and well-being of the public or cause an increased risk to the patient. In meeting these responsibilities, dentists must also identify those functions or procedures that require the knowledge and skill of the dentist. Thus, the ADA must continue to promote that these functions be performed by a licensed dentist in order to support the highest quality of oral health care by maintaining that the dentist be the healthcare provider that performs examinations/evaluations; diagnoses; treatment planning; and surgical/ irreversible procedures; prescribes work authorizations; prescribes drugs and other medications; and administers enteral, parenteral or inhalational sedation, or general anesthesia.*

Nothing in this statement should be interpreted to limit a dentist from delegating to a properly trained allied dental personnel responsibility for assisting the dentist in the performance of these functions under the dentist's personal, direct or indirect supervision and in accordance with state law, if, in the dentist's professional judgment, this is in the patient's best interest. The transfer of permissible functions from the dentist to the allied dental personnel must not result in a reduced quality of patient care. In all cases, the

* Note: This sentence was editorially corrected in 2011 at the request of the Council on Dental Education and Licensure from "… ; and administers enteral, parenteral, inhalational, or general anesthesia" to "…; and administers enteral, parenteral or inhalational sedation, or general anesthesia."

authority and responsibility of the dentist for the overall oral health of the patient must be maintained to assure cost-effective delivery of services to the patient and avoid fragmentation of the dental team.

Utilization of allied dental personnel must be based on (1) the best interests of the patient; (2) the education, training and credentialing of the allied dental personnel; (3) considerations of cost-effectiveness and efficiency in delivery patterns; and (4) valid, independent research demonstrating the feasibility and practicality of utilizing allied dental personnel in such roles in actual practice settings.

Delegation of Expanded Functions

Provision for the delegation of intraoral expanded functions to allied dental personnel which are included in state dental practice acts and regulations should specify (1) education and training requirements by a program accredited by the Commission on Dental Accreditation; (2) level of supervision by the dentist; (3) assurance of quality; and (4) regulatory controls to assure protection of the public. Final decisions on delegation of expanded functions should be made by the dentist, based on the best interests of the patient and in compliance with legal requirements in the jurisdiction. Because of the complexity of the procedures involved and the need to assure protection of the public, intraoral expanded functions as defined in state dental practice acts and regulations shall be performed by allied dental personnel only under the personal, direct or indirect supervision of the dentist and in accordance with state law.

Supervision of Allied Dental Personnel

In all instances, a dentist assumes responsibility for determining, on the basis of diagnosis, the specific treatment patients will receive and which aspects of treatment may be delegated to qualified personnel. As the dentist is best educated and trained to provide the care and has the responsibility for patient care, supervision by the dentist is paramount in assuring the highest quality of care and the safety of the patient. The degree of supervision required to assure that treatment is appropriate and does not jeopardize the systemic or oral health of the patient varies with the nature of the procedure and the medical and dental history of the patient, as determined with evaluation and examination by the dentist. Supervision and coordination of treatment by a dentist are essential to comprehensive oral health care and unsupervised practice by allied dental personnel has the potential to reduce the quality of oral health care and could fail to protect the public. The unauthorized and improperly supervised delivery of care by allied dental personnel is opposed by the American Dental Association. The types of supervision are defined in the glossary of terminology at the end of this policy statement.

The ADA has always promoted policy that protects the health of the public. Personal, direct and indirect supervision are the appropriate levels of supervision for the delegation of duties to allied dental personnel. However in some states licensed dental hygienists are permitted to perform duties, except for intraoral expanded functions, under general supervision or public health supervision, as delegated by the supervising dentist. In order to assure the safety of the patient, the following criteria must be followed whenever functions are performed under general supervision.

1. Any patient to be treated by a dental hygienist must first become a patient of record of a dentist. A patient of record is defined as one who:

    a. has been examined by the dentist;

    b. has had a medical and dental history completed and evaluated by the dentist; and

    c. has had his/her oral condition diagnosed and a treatment plan developed by the dentist.

2. The dentist must provide to the dental hygienist prior written authorization to perform clinical dental hygiene services for that patient of record. Such authorization should remain in effect for a limited time period as specified by state law.

3. The dentist shall examine the patient following performance of clinical services by the dental hygienist. Such examination shall be performed within a reasonable time as determined by the nature of the services provided, the needs of the patient and the professional judgment of the dentist.

Appropriate Settings for Dental Hygiene Services

The settings in which a dental hygienist may perform legally delegated functions shall be limited to treatment facilities under the jurisdiction and supervision of a dentist. When the employer of the dental hygienist is not a licensed dentist, the method of compensation and other working conditions for the dental hygienist must not interfere with the quality of dental care provided or the relationship between the responsible supervising dentist and the dental hygienist.

The federal dental services are urged to assure that their utilization of allied dental personnel is in compliance with policies of the American Dental Association.

Public oral health programs should utilize all appropriate dental team members in implementation of programs which have been endorsed by constituent dental societies. The dental hygienist, in this setting, may provide screening and preventive care services under an appropriate supervisory arrangement, as specified in state practice acts and regulations, as well as oral health education programs for groups within the community served.

Allied Dental Personnel Education

All personnel who participate in the provision of oral health care must have appropriate education and training and meet any additional criteria needed to assure competence. The type and length of education needed to prepare allied dental personnel to perform specific delegated patient care procedures should be specified in state dental practice acts and regulations.

Licensed or legally permitted dentists must be involved in the clinical supervision of allied dental personnel education programs, in accordance with state law. Programs should be administered or directed by a dentist whenever possible.

Dental hygiene education programs are designed to prepare a dental hygienist to provide preventive dental services under the direction and supervision of a dentist. Two academic years of study or its equivalent in an education program accredited by the Commission on Dental Accreditation (CODA) typically prepares the dental hygienist to perform clinical hygiene services. However, other programs, CODA accredited or approved by the respective state’s board of dental examiners, which utilize such methods as institutionally-based didactic course work, in-office clinical training, or electronic distance education can be an acceptable means to train dental hygienists. Boards of dentistry are urged to review such innovative programs for acceptance.

Expanded functions education programs are designed to prepare dental auxiliaries to provide expanded dental services under the direction and appropriate supervision of a dentist. Programs accredited by the Commission on Dental Accreditation (CODA) typically prepare the expanded functions auxiliary to perform legally permitted clinical services. However, other programs, CODA accredited or approved by the respective state’s board of dental examiners, which utilize such methods as institutionally-based didactic course work, in-office clinical training, or electronic distance education can be an acceptable means to train expanded functions auxiliaries. Boards of dentistry are urged to review such innovative programs for acceptance.

Neither the dental hygiene education curriculum nor the expanded function education program provides adequate preparation to enable graduates to provide comprehensive oral health care or to practice without the supervision of a dentist.

Formal education and training are essential for preparing allied dental personnel to perform intraoral expanded functions which are permitted by state law. Such expanded functions training should be provided only in educational settings with the resources needed to provide appropriate preparation for clinical practice under the supervision of a dentist.

Licensure of Dental Hygienists

There should be a single state board of dentistry in each state which serves as the sole licensing and regulatory authority for all dental personnel. Graduation from a dental hygiene education program accredited by the Commission on Dental Accreditation, or the successful completion by dental students of an equivalent component of a predoctoral dental curriculum accredited by the Commission on Dental Accreditation, is the essential educational eligibility requirement for dental hygiene licensure and practice. The clinical portion of the dental hygiene licensure examination, during which patient care is provided, must be conducted under the supervision of a licensed dentist.

Constituent Legislative Activities

Constituent dental societies should work with the state dental boards to assure that delegation of functions, educational requirements, supervisory and setting provisions for allied dental personnel in state dental practice acts and regulations are structured according to the basic principles contained in this policy statement.

In order to maintain the highest standard of patient care, assure continuity of care and achieve cost-effective delivery of services to the patient, constituent dental societies should seek to maintain, in statute and regulation, the authority and responsibility of the dentist for the overall oral health of the patient.

Glossary of Terminology Related to Allied Dental Personnel Utilization and Supervision

This Glossary is designed to assist in developing a common language for discussion of allied dental personnel issues by dental professionals and public policy makers. It should be noted that some of the terms included do not lend themselves to rigid definition and can only be described as to use and meaning. Also, certain terms are defined in dental practice acts and regulations, which vary from state to state.

Allied Dental Personnel: Team members who assist the dentist in the provision of oral health care and who are employed in dental offices or other patient care facilities.

Authorization: The act by a dentist of giving permission or approval to the allied dental personnel to perform legally allowable functions, in accordance with the dentist's diagnosis and treatment plan.

Community Dental Health: (1) The overall oral health status of a geographically based population group, (2) the branch of dentistry concerned with the distribution and causes of oral diseases in the population and the management of resources for their prevention and treatment and (3) commonly used to refer to programs which are designed to improve the oral health status of the population as a whole and conducted under the direction of a dentist (such as access programs, education programs, fluoridation and school-based mouthrinse programs).

Community Dental Health Coordinator (CDHC): An individual trained in an ADA pilot program as a community health worker with dental skills. Their aim is to improve oral health education and to assist at-risk communities with disease prevention. Working under the supervision of a dentist, a CDHC helps at-risk patients improve their preventive oral health through education and awareness programs, navigate the health system and receive care from a dentist in an appropriate clinic. CDHCs also perform limited clinical duties, such as screenings, fluoride treatments, placement of sealants and temporary restorations and simple teeth cleanings, until the patient can receive comprehensive services from a dentist or dental hygienist. Upon graduation, they will work primarily in public health and community settings like clinics,

schools, churches, senior citizen centers, and Head Start programs in coordination with a variety of dental providers, including clinics, community health centers, the Indian Health Service and private practice dental offices.

Comprehensive Dental Care: A coordinated approach, by a dentist, to the restoration or maintenance of the oral health and function of the patient, utilizing the full range of clinically proven dental care procedures, which includes examination and diagnostic, preventive and therapeutic services.

Delegation: The act by a dentist of directing allied dental personnel to perform specified legally allowable functions.

Dental Assistant: An individual who may or may not have completed an accredited dental assisting education program and who aids the dentist in providing patient care services and performs other nonclinical duties in the dental office or other patient care facility. The scope of the patient care functions that may be legally delegated to the dental assistant varies based on the needs of the dentist, the educational preparation of the dental assistant and state dental practice acts and regulations. Patient care services are provided under the supervision of a dentist. To avoid misleading the public, no occupational title other than dental assistant should be used to describe this allied team member.

Dental Hygienist: An individual who has completed an accredited dental hygiene education program and has been licensed by a state board of dental examiners to provide preventive care services under the supervision of a dentist. Functions that may be legally delegated to the dental hygienist vary based on the needs of the dentist, the educational preparation of the dental hygienist and state dental practice acts and regulations, but always include, at a minimum, scaling and polishing the teeth. To avoid misleading the public, no occupational title other than dental hygienist should be used to describe this allied team member.

Dental Laboratory Technician/Certified Dental Technician: An individual who has the skill and knowledge in the fabrication of dental appliances, prostheses and devices in accordance with a dentist's laboratory work authorization. To avoid misleading the public, no occupational title other than dental laboratory technician or certified dental technician (when appropriate) should be used to describe this allied team member.

Examination/Evaluation, Comprehensive: A dentist performs an evaluation and recording of the patient's dental and medical history and a general health assessment, and a thorough evaluation and recording of the extraoral and intraoral conditions of the hard and soft tissues. This may require interpretation of information acquired through additional diagnostic procedures. It includes an evaluation for oral cancer where indicated, the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.

Examination/Evaluation, Limited: A dentist performs an evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.

Expanded Functions: Additional tasks, services or capacities, often including direct patient care services, which may be legally delegated by a dentist to allied dental personnel. The scope of expanded functions varies based on state dental practice acts and regulations but is generally limited to reversible procedures which are performed under the personal, direct or indirect supervision of a dentist. Authorization to perform expanded functions generally requires specific training in the function (also expanded duties or extended functions).

Functions: An action or activity proper to an individual; a task, service or capacity which has been legally delegated by a dentist to allied dental personnel (also duties or services).

Oral Diagnosis: The determination by a dentist of the oral health condition of an individual patient, achieved through the evaluation of data gathered by means of history taking, direct examination, patient conference, and such clinical aids and tests as may be necessary in the judgment of the dentist.

Preventive Care Services: The procedures used to prevent the initiation of oral diseases, which may include screening, fluoride therapy, nutritional counseling, plaque control, and sealants.

Screening: Identifying the presence of gross lesions of the hard or soft tissues of the oral cavity.

Supervision: The authorization, direction, oversight and evaluation by a dentist of the activities performed by allied dental personnel.

Personal supervision. A type of supervision in which the dentist is personally operating on a patient and authorizes the allied dental personnel to aid treatment by concurrently performing a supportive procedure.

Direct supervision. A type of supervision in which a dentist is in the dental office or treatment facility, personally diagnoses and treatment plans the condition to be treated, personally authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the allied dental personnel, and evaluates their performance before dismissal of the patient.

Indirect supervision. A type of supervision in which a dentist is in the dental office or treatment facility, has personally diagnosed and treatment planned the condition to be treated, authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the allied dental personnel, and will evaluate the performance of the allied dental personnel.

General supervision. A type of supervision in which a dentist is not required to be in the dental office or treatment facility when procedures are provided, but has personally diagnosed and treatment planned the condition to be treated, has personally authorized the procedures, and will evaluate the performance of the allied dental personnel.

Public Health Supervision. A type of supervision in which a licensed dental hygienist may provide dental hygiene services, as specified by state law or regulations, when such services are provided as part of an organized community program in various public health settings, as designated by state law, and with general oversight of such programs by a licensed dentist designated by the state.

Treatment Plan: The sequential guide for the patient’s care as determined by the dentist’s diagnosis and used by the dentist for the restoration to and/or maintenance of optimal oral health**.**

Resolution No. 34S-1 Amendment

Report: N/A Date Submitted: October 2020

Submitted By: Sixteenth Trustee District

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT TO RESOLUTION 34: AMENDMENT OF THE POLICY, COMPREHENSIVE POLICY STATEMENT ON ALLIED DENTAL PERSONNEL

The following amendment to Resolution 34 (Worksheet:5050) was adopted by the Sixteenth Trustee District and submitted on October 5, 2020, by Phil Latham, executive director, South Carolina Dental Association.

Background: The role of the CDHC needs to be clarified, the level of care of a dentist and dental hygienist should not be considered equivalent and language needs to be added regarding a dental home to be consistent with the aim of the CDHC.

To clarify these intentions, the Sixteenth District proposes an amendment to Resolution 34 (additions underscored; deletions ~~stricken~~).

Resolution

34S-1. Resolved, that the terminology describing the Community Dental Health Coordinator provided in the "Glossary of Terminology Related to Allied Dental Personnel Utilization and Supervision" of the ADA Comprehensive Policy Statement on Allied Dental Personnel (*Trans*.1996:699; 1998:713; 2001:467; 2002:400; 2006:307; 2010:505) be amended as follows (new language underscored, deletions ~~stricken through~~):

Community Dental Health Coordinator (CDHC): an individual trained ~~in an ADA pilot program as a community health worker with dental skills~~ through the ADA licensed curriculum as a dental trained professional with community health worker skills. Their aim is to improve oral health education and to assist at risk communities with disease prevention. Working under the supervision of a dentist, a CDHC helps at risk patients improve their preventive oral health through education and awareness programs, navigate the health system and receive care from ~~a dentist in an appropriate clinic~~ licensed dentists.

~~CDHCs also perform limited duties such as screenings, fluoride treatments, placement of sealants and temporary restorations and simple cleanings.~~ CDHCs also perform limited clinical duties only as allowed by their State Practice Acts such as screenings, fluoride treatments, and sealant placement until the patient can receive care from a licensed dentist ~~or dental hygienist~~ and establishment of a dental home. Upon graduation, they will work primarily in a public health and community settings like clinics, schools, ~~churches,~~ faith based settings, senior citizen

centers, and Head Start programs in with a variety of dental providers, including clinics, community health centers, the Indian Health Service and private practice ~~dentists~~ dental offices.

BOARD RECOMMENDATION: Received after the August 2020 Board of Trustees meeting.

Resolution No. 35 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Advocacy for Access and Prevention

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, WOMEN'S ORAL HEALTH: PATIENT EDUCATION

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Advocacy for Access and Prevention reviewed the Association policy titled Women's Oral Health: Patient Education.

The Council found that the language referring only to women was prescriptive and limiting. The Council recommends that the following resolution be adopted.

Resolution

35. Resolved, that the policy titled Women's Oral Health: Patient Education (*Trans.*2001:428; 2014:504), be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

~~Women's~~ Parent and Caregiver Oral Health: Patient Education

Resolved, that the ADA work with federal and state agencies, constituent and component societies and other appropriate organizations to incorporate oral health education information into health care educational outreach efforts directed at ~~mothers~~ parents, caregivers and their children, and be it further

Resolved, that the ADA work with the ~~obstetric~~ prenatal and perinatal professional community to ensure that ~~pregnant mothers~~ expectant parents and caregivers are provided relevant oral health care information during the perinatal period.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 36 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Advocacy for Access and Prevention

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, COMMUNICATION AND DENTAL PRACTICE

Background: In accordance with the Resolution 170H-2012 (*Trans*.2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Advocacy for Access and Prevention reviewed the Association policy titled Communication and Dental Practice (*Trans*.2008:454; 2013:342).

The communication strategies utilized in a contemporary dental practice must incorporate the principles of health literacy and cultural competence that are recognized in population health. The Health Literacy Advisory Committee of CAAP offered the following modifications to existing policy which were supported by the Council.

Resolution

36. Resolved, that the policy titled Communication and Dental Practice (*Trans*.2008:454; 2013:342) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the ADA affirms that culturally competent, plain language, accurate ~~clear, accurate and effective~~ communication is an essential skill for patient-centered dental practice.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 37 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Advocacy for Access and Prevention

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, HEALTH PLANNING GUIDELINES

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Advocacy for Access and Prevention reviewed the Association policy titled Health Planning Guidelines (*Trans.*1983:545; 2014:503).

The Council felt in necessary to add language to show the Association support of collaboration with state and local oral health coalitions to complete these items. The Council recommends that the following resolution be adopted.

Resolution

37. Resolved, that the policy titled Health Planning Guidelines (*Trans.*1983:545; 2014:503) be amended to read as follows (additions are underscored; deletions are ~~stricken~~**):**

Resolved, that the following health planning objectives be adopted:

1. The Association supports a voluntary system of cooperative health planning at the state and local level.

2. Health planning should be directed at locally determined efforts to improve access to health care and avoid duplication of effort to maximize limited resources.

3. Dentists should have equal input along with other health care providers

4. Public and private sector financing for health planning should have adequate appropriations designated to accomplish the state objectives.

5. The Association supports collaboration with state and local oral health coalitions to complete these objectives.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 37S-1 Amendment

Report: N/A Date Submitted: October 2020

Submitted By: Sixteenth Trustee District

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT TO RESOLUTION 37: AMENDMENT OF THE POLICY, LEGISLATIVE DELEGATIONS

The following amendment to Resolution 37 (Worksheet:5060) was adopted by the Sixteenth Trustee District and submitted on October 5, 2020, by Phil Latham, executive director, South Carolina Dental Association.

Background: The added language strengthens the resolution by including that the coalition's objectives must be consistent with Association policy. To simply work with organizations that help us to achieve our goals, might inadvertently partner us with a coalition that gains strength from our good reputation but has objectives that are inconsistent with ADA policy. For instance, some state and local coalitions have traded on the Association's good name to achieve credibility while continuing to advocate for mid-level providers as a main objective or attempt to position themselves as the voice for oral health care.

To clarify the intentions, the Sixteenth District proposes an amendment to Resolution 37 (additions underscored; deletions ~~stricken~~).

Resolution

37S-1. Resolved, that the policy titled Health Planning Guidelines (*Trans*.1983:545; 2014:503) be amended to read as follows (additions are double ~~underscored~~; deletions are double ~~stricken~~**):**

Resolved, that the following health planning objectives be adopted:

1. The Association supports a voluntary system of cooperative health planning at the state and local level.

2. Health planning should be directed at locally determined efforts to improve access to health care and avoid duplication of effort to maximize limited resources.

3. Dentists should have equal input along with other health care providers

4. Public and private sector financing for health planning should have adequate appropriations designated to accomplish the state objectives.

5. The Association supports collaboration with state and local oral health coalitions ~~to complete these objectives~~ when the objectives of said coalition are consistent with Association policy.

BOARD RECOMMENDATION: Received after the August 2020 Board of Trustees meeting.

Resolution No. 38 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Advocacy for Access and Prevention

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, NON DENTAL PROVIDERS NOTIFICATION OF PREVENTIVE DENTAL TREATMENT

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Advocacy for Access and Prevention reviewed the Association policy titled Non Dental Providers Notification of Preventive Dental Treatment (*Trans.*2004:303; 2014:505).

The increasing relevance of medical-dental collaboration utilizes bi-directional referral to provide patients with integrated medical and dental homes, which increases the quality of care. The importance of communication in these instances is critical to keep all practitioners informed. Significant collaboration with the American Academy of Pediatrics emphasizes the necessity of notification to the patient's dental home of any oral health services provided within a medical setting. The Council recognizes the gap in communication between medical and dental software programs, but agreed that this modification to existing policy is a necessary step and recommends that the following resolution be adopted:

Resolution

38. Resolved, that the policy titled Non Dental Providers Notification of Preventive Dental Treatment (*Trans.*2004:303; 2014:505) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that prior to any preventive dental treatment, a dental disease risk assessment should be performed by a dentist or appropriately trained medical provider, and be it further

Resolved, that risk assessments, screenings or oral evaluations of patients by non-dentists are not to be considered comprehensive dental exams, and be it further

Resolved, that it is essential that non-dentists who provide preventive dental services utilize care coordination to refer the patient to a dental home with a report of the services rendered given to the custodial parent or legal guardian.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 39 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Advocacy for Access and Prevention

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: 0 Net Dues Impact: None

Amount One-time _____ Amount On-going _____

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT OF THE POLICY, NON-DENTAL PROVIDERS COMPLETING EDUCATIONAL PROGRAM ON ORAL HEALTH

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Advocacy for Access and Prevention reviewed the Association policy titled Non-Dental Providers Completing Educational Program on Oral Health (*Trans*. 2004:301).

The Council found the language to be prescriptive to local dental societies and the expectation of oral pathology knowledge for non dental providers to be unrealistic. The Council recommended that the following resolution be adopted:

Resolution

39. Resolved, that the policy titled Non-Dental Providers Completing Educational Program on Oral Health (*Trans.*2004:301) to be amended as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that only dentists, physicians and their properly supervised and trained designees, be allowed to provide preventive dental services to infants and young children, and be it further

Resolved, that anyone that provides preventive dental services to infants and young children should have completed an appropriate educational program on oral health, ~~common oral pathology~~, dental disease risk assessment, dental caries and dental preventive techniques for this age group, and be it further

Resolved, that the ADA encourage constituent societies to support this policy.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 41 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

PROPOSED POLICY, TOBACCO USE, VAPING, AND NICOTINE DELIVERY PRODUCTS

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Policies and Recommendations on Tobacco Use (*Trans.*2016:323).

The Council determined that the policy was relevant enough to retain. However, the Council also determined that the policy could be updated to account for newer products on the market (e.g., snus, nicotine gels, etc.), changes in vernacular (e.g., e-cigarettes vs. electronic nicotine delivery systems, etc.) and new strategies tobacco companies have been using to market tobacco and non-tobacco nicotine products (e.g., claims of "modified risk").

On the matter of vaping, the Council noted that the policy already supports regulating vaping products in the same manner as all tobacco products. The term "vaping" was not widely used when the policy was adopted, however, so it instead identifies vaping and vaping devices as "non-traditional tobacco products" that include "e-cigarettes, e-cigarette cartridges…and other products made or derived from tobacco."

The Council consulted the ADA Science Institute regarding its efforts to implement the 2019 House of Delegates directive which called for the appropriate agency to "add 'vaping' and any other alternative delivery system for both tobacco and non-tobacco products to ADA Policy" and "that a report be made to the 2020 ADA House of Delegates to update current ADA Policy."

ADA Science Institute agreed that none of the content proposed in this resolution would interfere with implementing that directive or the Board of Trustees' *ad interim* Policy on E-Cigarettes and Vaping.

Concerning modified risk tobacco products (MRTPs), the Council noted that cigarette use in the United States is on the decline, and tobacco product manufacturers have adapted by developing a new generation of nicotine products, such as snus, nicotine gels, and electronic nicotine delivery systems. They have also sought to market these next-generation products as being safer (or less harmful) than cigarettes.

Before a product can be labeled as safer (or less harmful) than cigarettes, the Food and Drug Administration (FDA) must approve a modified risk tobacco product (MRTP) application demonstrating that the product will (or is expected to) benefit the health of the population as a whole. The application must take into account:

- the relative health risks to individuals of the tobacco product that is the subject of the application;
- the increased or decreased likelihood that existing users of tobacco products who would otherwise stop using such products will switch to the tobacco product that is the subject of the application;
- the increased or decreased likelihood that persons who do not use tobacco products will start using the tobacco product that is the subject of the application;
- the risks and benefits to persons from the use of the tobacco product that is the subject of the application as compared to the use of products for smoking cessation approved as medical products to treat nicotine dependence; and
- comments, data, and information submitted by interested persons.

Current policy states that "the ADA does not consider marketing some tobacco products as safer or less harmful to an individual's health than others to be a viable public health strategy to reduce the death and disease associated with tobacco use." Requiring tobacco manufacturers to include oral health data in their MRTP applications will add another barrier to having those products approved as "modified risk" products. It may also help build the body of literature about the oral health effects of these products.

After consulting the Council on Advocacy for Access and Prevention, the Council on Government Affairs recommends that the following resolution be adopted:

Resolution

41. Resolved, that the following policy titled Tobacco Use, Vaping, and Nicotine Delivery Products be adopted:

Tobacco Use, Vaping, and Nicotine Delivery Products

Dentist's Role in Preventing Tobacco Use

Resolved, that dentists should be fully aware of the oral and maxillofacial health risks that are causally associated with tobacco use, including higher rates of tooth decay, receding gums, periodontal disease, mucosal lesions, bone damage, tooth loss, jaw bone loss and more, and be it further

Resolved, that dentists should routinely screen patients for tobacco and non-tobacco nicotine use and provide clinical preventive services, such as in-office cessation counseling, to prevent first-time tobacco use and encourage current users to quit, and be it further

Resolved, that the dentists and health organizations should provide educational materials to help prevent first-time use and encourage current users to quit, and be it further

Resolved, that these educational materials should be developed or provided by credible and trustworthy sources with no ties to the tobacco industry or its affiliates, and be it further

Cessation Counseling and Nicotine Replacement Therapies

Resolved, that aside from the intended use of approved tobacco cessation products and nicotine replacement therapies, the American Dental Association discourages the use of all nicotine products made with or derived from tobacco, and be it further

Resolved, that dentists should be fully informed about nicotine cessation interventions and routinely apply those techniques to help patients stop using tobacco, and be it further

Resolved, that third-party payers should cover professionally administered cessation products and services (e.g., cessation counseling, prescription medications, etc.) as an essential plan benefit, and be it further

Modified Risk Tobacco Products

Resolved, that the American Dental Association does not consider the concept of "modified risk"—which is allowing some tobacco and other nicotine products (e.g., snus, electronic nicotine delivery systems) to be marketed as having a reduced or modified health risk compared to others (e.g., cigarettes)—to be a viable public health strategy to reduce the death and disease associated with tobacco use, and be it further

Resolved, that modified risk tobacco product (MRTP) applications should include extensive data examining the comparative impact on oral and maxillofacial health, both to the individual and the population as a whole, and the data should be made publicly available, and be it further

Regulation of Tobacco Products, Vaping Devices, and Other Nicotine Delivery Systems

Resolved, that the American Dental Association recognizes nicotine as an addictive chemical and supports its regulation as a controlled substance, and be it further

Resolved, that the ADA supports state and federal authority to investigate and strictly regulate nicotine and nicotine-containing products, including those made or derived from tobacco, and be it further

Resolved, that these nicotine-containing products include, but are not limited to:

- Cigarettes.
- Cigars (both premium and non-premium).
- Pipe tobacco.
- Hookah (also called waterpipe tobacco).
- Roll-your-own tobacco.
- Smokeless tobacco (e.g., chewing tobacco, moist snuff, snus, etc.).
- Dissolvables (e.g., nicotine lozenges, strips, sticks, etc.).
- Nicotine gels (absorbed through the skin).
- Electronic nicotine delivery systems (e.g., e-cigarettes, e-hooka, e-cigars, vape pens, advanced refillable personal vaporizers, e-pipes, etc.).

and be it further

Resolved, that the ADA supports strict regulation of these and other nicotine-containing products by (but without being limited to):

- Prohibiting product sales in all venues, including through vending machines and the internet.
- Levying significant taxes on these products.
- Setting age restrictions to purchase and receive these products.
- Requiring oral health warning statements, graphic images and ingredient disclosures on product packaging.
- Restricting the addition of added flavors (including menthol) and other ingredients and ingredient levels (including nicotine).
- Regulating second hand exposure to environmental smoke and vapor.
- Banning all forms of advertising and marketing (including bans on free sampling, product giveaways, promotional items, event sponsorships, etc.).

- Imposing licensure requirements for product wholesalers and retailers.
- Prohibiting the use of these products on and around public and private property, including government buildings and school campuses.

and be it further

Resolved, that the policy titled Policies and Recommendations on Tobacco Use (*Trans.*2016:323) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED

Policies and Recommendations on Tobacco Use (*Trans.*2016:323)

Dentist's Role in Preventing Tobacco Use

Resolved, that the ADA supports professional education related to the importance of primary prevention of tobacco use, and be it further

Resolved, that the ADA urges its members to become fully informed about tobacco cessation intervention techniques to effectively educate their patients to overcome their addiction to tobacco, and be it further

Resolved, that the ADA supports training and education for dental professionals to ensure that all clinicians in the United States have the knowledge, skills and support systems necessary to inform the public about the health hazards of tobacco products and to provide effective tobacco cessation strategies, and be it further

Resolved, that the ADA urges dentists and health organizations to provide educational materials on tobacco use prevention or cessation to patients and consumers developed by credible and trustworthy sources with no ties to the tobacco industry or its affiliates, and be it further

Access and Prevention

Resolved, that the ADA continue to educate and inform its membership and the public about the many health hazards attributed to the use of traditional and non-traditional tobacco products, including e-cigarettes, e-cigarette cartridges, snus, dissolvable tobacco, tobacco gels, and other products made or derived from tobacco, and be it further

Resolved, that the ADA encourages its members and dental societies to collaborate with students, parents, school officials, and members of the community to establish tobacco-free schools, and be it further

Resolved, that the ADA does not consider marketing some tobacco products as safer or less harmful to an individual's health than others to be a viable public health strategy to reduce the death and disease associated with tobacco use, and be it further

Government Affairs

Resolved, that the ADA should give priority to the following when advancing public policies to prevent tobacco use:

1. Protecting and enhancing state and federal regulatory authority to ban or otherwise prevent the use of traditional and non-traditional tobacco products;
2. Banning the sale of traditional and non-traditional tobacco products in all venues, including through vending machines and the internet;
3. Levying significant excise taxes on traditional and non-traditional tobacco products;
4. Setting age restrictions for purchasers of traditional and non-traditional tobacco products;
5. Requiring oral health warning statements and graphic images on traditional and non-traditional tobacco products;
6. Barring companies from marketing some traditional and non-traditional tobacco products as being less harmful to the oral health than others;
7. Regulating exposure to environmental tobacco smoke (ETS);

8. Banning all forms of traditional and non-traditional tobacco product advertising and marketing (including bans on free sampling);
9. Imposing licensure requirements for traditional and non-traditional tobacco product retailers;
10. Prohibiting the use of traditional and non-traditional tobacco products on public and private property, including government buildings and school campuses;
11. Requiring third-party payers to cover professionally administered tobacco cessation services (e.g., cessation counseling, prescription medications, etc.) as an essential plan benefit.

and be it further

Resolved, that the ADA should encourage federal research agencies to develop the body of credible, peer-reviewed scientific literature examining, among other things:

1. The immediate and long-term effects of traditional and non-traditional tobacco product use on oral health;
2. The viability of new cessation products and strategies;
3. The validity of claims that some traditional and non-traditional tobacco products are less harmful to the oral cavity than others.

Resolution No. 42 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT OF THE POLICY, USE OF EXPERT WITNESSES IN LIABILITY CASES

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Use of Expert Witnesses in Liability Cases (*Trans.*1986:531).

The Council determined that the policy was worded as a time-limited assignment that effectively became moot once the task to "urge constituent dental societies" was complete (*Reports* 1987:122). However, the Council agreed that the subject matter was relevant enough to retain in a more enduring form.

The Council noted that the national organization has no real authority to interfere with the policies, positions, priorities, and activities of state dental societies.

After consulting the Council on Dental Practice, the Council on Government Affairs recommends that the following resolution be adopted.

Resolution

42. Resolved, that the policy titled Use of Expert Witnesses in Liability Cases (*Trans.*1986:531) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the American Dental Association urge constituent dental societies to actively support legislation and changes in court rules that would require~~ plaintiffs and their attorneys in professional liability actions should be required to include with each complaint the affidavit of a health care professional~~,~~ who practices in the same field or specialty as the defendant and who has reviewed the patient record and related materials, stating that there is reasonable and meritorious cause for filing the action, and be it further

Resolved, that ~~constituent dental societies be urged to actively support legislation and changes in court rules that would require~~ expert witnesses in court proceedings should be required to possess the clinical knowledge and skill to qualify them on the subject of their testimony and familiarity with the practices and customs of practitioners in good standing in the locality where the defendant practiced when the incident occurred, and be it further

Resolved, that ~~constituent dental societies also be urged to actively support legislation and changes in~~ court rules ~~requiring courts in appropriate cases to instruct~~ should require that juries

be instructed on the availability of alternative treatments and the role of patients in their own care, as appropriate.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 43 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

PROPOSED POLICY, PRINCIPLES FOR TORT REFORM

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Federal Tort Reform Legislation (*Trans.*1993:708).

The Council concluded that the policy was worded as a time-limited assignment that effectively became moot once the task to "support tort reform legislation" was complete (*Reports* 1994:109). However, the Council also determined that the subject matter was still relevant enough to retain in a more enduring form.

After consulting the Council on Dental Practice, the Council on Government Affairs recommends that the following resolution be adopted:

Resolution

43. Resolved, that the following policy titled Principles for Tort Reform be adopted:

Principles for Tort Reform

The ADA supports the following provisions for tort reform:

1. mandatory periodic payments of substantial awards for damages;
2. a ceiling on non-economic damages;
3. mandatory offsets of awards for collateral sources of recovery;
4. limits on attorneys' contingency fees;
5. a statute of limitations on health care-related injuries; and
6. state duties concerning alternative methods of resolving disputes.

and be it further

Resolved, that the policy titled Federal Tort Reform Legislation (*Trans.*1993:708) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED

Federal Tort Reform Legislation (*Trans.*1993:708)

Resolved, that the Association support changes in federal tort reform legislation designed to rectify the problems in the current system which, in the judgment of the Association, unnecessarily contribute to the cost of health care, and be it further

Resolved, that the Association support tort reform legislation that includes but is not limited to mandatory periodic payments of substantial awards for damages; a ceiling on non-economic damages; mandatory offsets of awards for collateral sources of recovery; limits on attorneys' contingency fees; a statute of limitations on health care-related injuries; and state duties concerning alternative methods of resolving disputes.

Resolution No. 44 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

PROPOSED POLICY, LIMITS ON NON-ECONOMIC DAMAGES

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled ADA Support for Medical Injury Compensation Reform (*Trans.*2005:342).

The Council concluded that the policy is worded as a time-limited assignment that effectively became moot once the tasks to "proactively lobby for…legislation" and "actively communicate its position" were complete (*Reports* 2006:89). However, the Council also determined that the subject matter is still relevant enough to retain in a more enduring form.

After consulting the Council on Dental Practice, the Council on Government Affairs recommends that the following resolution be adopted:

Resolution

44. Resolved, that the following policy titled Limits on Non-Economic Damages be adopted:

Limits on Non-Economic Damages

Resolved, that medical liability reform legislation should not override state limits on non-economic damages, and be it further

Resolved, that the policy titled ADA Support for Medical Injury Compensation Reform (*Trans.*2005:342) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED

ADA Support for Medical Injury Compensation Reform (*Trans.*2005:342)

Resolved, that the ADA proactively lobby for liability reform legislation and such legislation should not override state limits on non-economic damages, and be it further

Resolved, that the ADA actively communicate its position on medical liability reform in all appropriate policy/decision-making venues, and be it further

Resolved, that the ADA continue to pursue coalition opportunities with other impacted health care professionals.

Resolution No. 45 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

RESCISSION OF THE POLICY, PROFESSIONAL LIABILITY INSURANCE LEGISLATION

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Professional Liability Insurance Legislation (*Trans.*1984:548).

The basis for the policy was that "professional liability premiums are increasing at significant rates" and that "a legislative approach is likely to be one of the viable alternatives to addressing this complex and growing problem" (*Supplement* 1984:240). The Council also concluded that this 30 year-old directive is no longer relevant to the current situation.

The Council determined that professional liability insurance premiums are negligible in modern times. They are not "rapidly increasing" and do not "contribute significantly to higher costs of health care services for patients," as the policy states. The Council also concluded that 28H-1984 was worded as a time-limited assignment that effectively had been fulfilled once the task to "support federal and state legislation" was completed (*Reports* 1985:137).

After consulting the Council on Dental Practice, the Council on Government Affairs recommends that the following resolution be adopted:

Resolution

45. Resolved, that the policy titled Professional Liability Insurance Legislation (*Trans.*1984:548) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED

Professional Liability Insurance Legislation (*Trans.*1984:548)

Resolved, that the American Dental Association and constituent dental societies support federal and state legislation, as appropriate, to deal fairly and equitably with the problems of rapidly increasing professional liability insurance costs which contribute significantly to higher costs of health care services for patients, and be it further

Resolved, that legislative or other approaches to the professional liability problem be studied and developed in cooperation with other health organizations and interested parties.

Resolution No. 46 New

Report: NA Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT OF THE POLICY, FEE-FOR-SERVICE MEDICAID PROGRAMS

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Fee-For-Service Medicaid Programs (*Trans.*1999:957).

The Council determined that the policy was worded as time-limited assignment that effectively became moot once the task to "support and encourage states to adopt" was completed (*Reports* 2000:118). The Council also considered the subject matter relevant enough to retain in a more enduring form.

The Council noted that the national organization has no real authority to interfere with the policies, positions, priorities, and activities of state dental societies.

After consulting the Council on Advocacy for Access and Prevention, the Council on Government Affairs recommends that the following resolution be adopted.

Resolution

46. Resolved, that the policy titled Fee-For-Service Medicaid Programs (*Trans.*1999:957) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the ADA support and encourage states to~~ states should adopt adequately funded fee-for-service models for Medicaid programs to increase dentist participation and increase access to care for Medicaid participants.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 47 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT OF THE POLICY, MEDICAID AND INDIGENT CARE FUNDING

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Medicaid and Indigent Care Funding (*Trans.*2006:338; 2014:499).

The Council determined that the 2014 House of Delegates adopted technical amendments to the policy on Medicaid and Indigent Care Funding, which was worded as time-limited directive that effectively has been fulfilled once the tasks to "make lobbying a priority," "carry out an intensive educational program," and "study how to improve health outcomes" were completed (*Reports* 2007:114). The Council also considered the subject matter relevant enough to retain in a more enduring form.

The Council noted that the national organization has no real authority to interfere with the policies, positions, priorities, and activities of constituent and component dental societies.

After consulting the Council on Advocacy for Access and Prevention, the Council on Government Affairs recommends that the following resolution be adopted.

Resolution

47. Resolved, that the policy titled Medicaid and Indigent Care Funding (*Trans.*2006:338; 2014:499) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the ~~ADA make lobbying for adequate funds~~ American Dental Association supports adequate funding to provide oral health care to Medicaid and other indigent care populations ~~a high priority and that the constituent and component societies be urged to do the same, and be it further~~.

~~**Resolved,** that the ADA and its constituent and component societies carry out an intensive educational program, subject to current budgetary limits, to enlighten the public and government agencies of the value of oral health care and the consequences of untreated oral health disease to the overall health of our citizens and to health care payment systems, and be it further~~

~~**Resolved,** that the appropriate ADA agency study how to improve health outcomes through greater accountability and responsibility of dental patients to the care, educational and preventive opportunities provided to them.~~

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 48 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT OF THE POLICY, SUPPORT FOR ADULT MEDICAID DENTAL SERVICES

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Support for Adult Medicaid Dental Services (*Trans.*2004:327).

The Council determined that the policy was worded as time-limited assignment that effectively became moot once the tasks to "adopt policy" and "educate policy makers" were completed (*Reports* 2005:94). The Council also considered the subject matter relevant enough to retain in a more enduring form.

After consulting the Council on Advocacy for Access and Prevention, the Council on Government Affairs recommends that the following resolution be adopted.

Resolution

48. Resolved, that the policy titled Support for Adult Medicaid Dental Services (*Trans.*2004:327) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the ADA adopt policy supporting the inclusion of~~ adult dental services should be included in the federal Medicaid program, and be it further

~~**Resolved,** that the ADA take every opportunity to educate policy makers that, consistent with ADA's position on health system reform (*Trans.*1993:664; *Trans.*1994:656) oral health is an integral part of overall health, and be it further~~

Resolved, that adult coverage under Medicaid should not be left to the discretion of individual states, but rather should be provided consistent with all other basic health care services.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 48S-1 Amendment

Report: N/A Date Submitted: October 2020

Submitted By: Sixteenth Trustee District

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT TO RESOLUTION 48: AMENDMENT OF THE POLICY, SUPPORT FOR ADULT MEDICAID DENTAL SERVICES

The following amendment to Resolution 48 (Worksheet:5080) was adopted by the Sixteenth Trustee District and submitted on October 5, 2020, by Phil Latham, executive director, South Carolina Dental Association.

Background: Dentistry is essential to overall healthcare. The inclusion of dentistry into the federal Medicaid program provides access to care and allows the treatment of dental disease. By managing dental disease and infection, individuals have a better chance at controlling systemic diseases such as diabetes and heart disease. We believe that it is important to emphasize in the policy the importance maintaining the statement of the importance of oral health's role in overall health.

To clarify the intentions, the Sixteenth District proposes an amendment to Resolution 48 (additions underscored).

Resolution

48S-1. Resolved, that the policy titled Support for Adult Medicaid Dental Services (*Trans.*2004:327) be amended to read as follows (additions are double underscored; deletions are ~~stricken~~):

Resolved, that ~~the ADA adopt policy supporting the inclusion of~~ adult dental services should be included in the federal Medicaid program as oral health is an integral part of overall health, and be it further

~~**Resolved,** that the ADA take every opportunity to educate policy makers that, consistent with ADA's position on health system reform (*Trans.*1993:664; *Trans.*1994:656) oral health is an integral part of overall health, and be it further~~

Resolved, that adult coverage under Medicaid should not be left to the discretion of individual states, but rather should be provided consistent with all other basic health care services.

BOARD RECOMMENDATION: Received after the August 2020 Board of Trustees meeting.

Resolution No. 49 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

PROPOSED POLICY, FEDERAL MEDICAID FUNDING

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Increase Federal Medicaid Funding (*Trans.*2002:409).

The Council determined that the policy on Federal Medicaid Funding was worded as time-limited assignment that effectively has been fulfilled once the task to "work to enact federal legislation" was completed (*Reports* 2003:99). The Council also considered the subject matter relevant enough to retain in a more enduring form.

After consulting the Council on Advocacy for Access and Prevention, the Council on Government Affairs recommends that the following resolution be adopted:

Resolution

49. Resolved, that the following policy titled Federal Medicaid Funding be adopted:

Federal Medicaid Funding

Resolved, that the federal Medicaid match for dental care should be enhanced to 90/10 or better, and be it further

Resolved, that the policy titled Increase Federal Medicaid Funding (*Trans.*2002:409) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED

Increase Federal Medicaid Funding (*Trans.*2002:409)

Resolved, that the American Dental Association work to enact federal legislation to enhance the federal Medicaid match to 90/10 for dental care.

Resolution No. 50 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

PROPOSED POLICY, TAX INCENTIVES FOR MEDICAID PARTICIPATION

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Federal Tax Credit/Voucher for Medicaid Dentist Providers (*Trans.*2003:383; 2014:499).

The Council determined that the 2014 House of Delegates adopted technical amendments to the policy on Tax Incentives for Medicaid Participation, which were worded as a time-limited directive that effectively became moot once the task to "seek to enact" was completed (*Reports* 2004:82). The Council also considered the subject matter relevant enough to retain in a more enduring form.

After consulting the Council on Advocacy for Access and Prevention, the Council on Government Affairs recommends that the following resolution be adopted:

Resolution

50. Resolved, that the following policy titled Tax Incentives for Medicaid Participation be adopted:

Tax Incentives for Medicaid Participation

Resolved, that dentists should be allowed to claim a tax credit for the first $10,000 of services provided under the Medicaid program, and be it further

Resolved, that the tax credit should be based upon the most recent Code on Dental Procedures and Nomenclature (CDT) codes and credited at a rate consistent with the most recent ADA Survey of Dental Fees for that region or state, and be it further

Resolved, that the policy titled Federal Tax Credit/Voucher for Medicaid Dentist Providers (*Trans.*2003:383; 2014:499) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED

Federal Tax Credit/Voucher for Medicaid Dentist Providers (*Trans.*2003:383; 2014:499)

Resolved, that the American Dental Association seek to enact a federal tax credit/voucher to apply to the first $10,000 of Medicaid dental services provided by a licensed dentist, and be it further

Resolved, that these credits be based upon the most recent CDT codes and credited at a rate consistent with the most recent ADA Survey of Dental Fees for that region or state.

Resolution No. 51 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

PROPOSED POLICY, SUPPORT FOR THE CHILDREN'S HEALTH INSURANCE PROGRAM

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Reauthorization of the State Children's Health Insurance Program (*Trans.*2007:451).

The Council determined that the policy was worded as time-limited assignment that effectively was fulfilled once the task to "support the reauthorization" was completed (*Reports* 2008:139). The Council also considered the subject matter relevant enough to retain in a more enduring form.

The Council noted that the State Children's Health Insurance Program (SCHIP) is now called the Children's Health Insurance Program (CHIP). Other changes have also been made in the 12 years since the policy was adopted.

After consulting the Council on Advocacy for Access and Prevention and the Council on Dental Benefits and Practice, the Council on Government Affairs recommends that the following resolution be adopted:

Resolution

51. Resolved, that the following policy titled Support for the Children's Health Insurance Program be adopted:

Support for the Children's Health Insurance Program

Resolved, that that the American Dental Association supports the Children's Health Insurance Program (CHIP), and be it further

Resolved, that funds dedicated to the program should be used to provide medical and dental care to children with family income less than or equal to 200 percent of the federal poverty level before any expansion to children in families above that level, and be it further

Resolved, that decisions to cover children beyond 200 percent of the federal poverty level continue to be made on a state-by-state basis, and be it further

Resolved, that the policy titled Reauthorization of the State Children's Health Insurance Program (*Trans.*2007:451) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED

Reauthorization of the State Children's Health Insurance Program (*Trans.*2007:451)

Resolved, that the ADA support the reauthorization of the State Children's Health Insurance Program (SCHIP) but make every effort to emphasize that funds dedicated to the program be used to provide medical and dental care to children with family income less than or equal to 200% of the federal poverty level before any expansion to children in families above that level, and that decisions to cover children beyond 200% of the federal poverty level continue to be made on a state-by-state basis.

Resolution No. 52 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

RESCISSION OF THE POLICY, AVAILABILITY OF DENTISTS FOR UNDERSERVED POPULATIONS

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Availability of Dentists for Underserved Populations (*Trans.*1986:532; 2016:318).

The Council determined that the 2016 House of Delegates adopted editorial changes to the policy on Availability of Dentists for Underserved Populations, which were worded as a time-limited assignment that effectively became moot once the tasks to "[urge] constituent societies…to participate in programs" and "[urge] constituent societies…to seek fiscal resources" were complete (*Reports* 1987:81, 122). Additionally, the Council noted that the national organization has no real authority to directly influence the policies, positions, priorities, and activities of state dental societies.

After consulting the Council on Advocacy for Access and Prevention, the Council on Government Affairs recommends that the following resolution be adopted:

Resolution

52. Resolved, that the policy titled Availability of Dentists for Underserved Populations (*Trans.*1986:532; 2016:318) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED

Availability of Dentists for Underserved Populations (*Trans.*1986:532; 2016:318)

Resolved, that constituent societies be urged to participate in programs that encourage dentists to serve underserved populations and that offer case management resources to enable dentists to provide oral health care for institutionalized and homebound individuals, including those who are physically, emotionally and mentally disabled, and be it further

Resolved, that constituent societies be urged to seek fiscal resources to provide case management in support of dentists providing oral health care for these individuals, and be it further

Resolved, that the ADA, working with other affected organizations, review or conduct studies on the availability and scope of dental programs for the treatment of special needs populations, including physically, emotionally and mentally disabled patients.

Resolution No. 52S-1 Substitute

Report: N/A Date Submitted: September 2020

Submitted By: Ninth Trustee District

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: See Background

SUBSTITUTE TO RESOLUTION 52: RESCISSION OF THE POLICY, AVAILABILITY OF DENTISTS FOR UNDERSERVED POPULATIONS

The following substitute to Resolution 52 (Worksheet:5088) was adopted by the Ninth Trustee District and submitted on September 28, 2020, by Michelle Nichols-Cruz, Michigan Dental Association.

Background: COVID 19 is going to stress the safety net and private practice involvement in care for the underserved, including the physically, emotionally and disabled populations. While the task of urging constituent societies to participate and seek fiscal resources may be completed, the aspirational goal of supporting the development of policies that support the availability of dentists to serve this population is still very necessary and appropriate. The existing policy on Access to Dental Services for the Underserved (*Trans.* 2000:500) only mentions availability of providers in the context of educational loan reductions and grants for mobile facilities. This substitute resolution allows support for any policies that promote availability and does not limit to only the items listed in existing policy. Passage will increase member value by ensuring that the profession is a driver of health for the public.

Therefore Ninth District proposes a substitute resolution for 52 (which is to rescind).

Resolution

52S-1. Resolved, that the policy titled Availability of Dentists for Underserved Populations (*Trans*.1986:532; 2016:318) be amended as follows (additions are <u>underscored</u>; deletions are ~~stricken~~):

~~**Resolved**, that constituent societies be urged to participate in programs that encourage dentists to serve underserved populations and that offer case management resources to enable dentists to provide oral health care for institutionalized and homebound individuals, including those who are physically, emotionally and mentally disabled, and be it further~~

~~**Resolved**, that constituent societies be urged to seek fiscal resources to provide case management in support of dentists providing oral health care for these individuals, and be it further~~

~~**Resolved**, that the ADA, working with other affected organizations, review or conduct studies on the availability and scope of dental programs for the treatment of special needs populations, including physically, emotionally and mentally disabled patients.~~

Resolved, that the American Dental Association supports the development of governmental and regulatory policy at the federal, state and local levels that promotes the availability of dentists for underserved populations.

BOARD RECOMMENDATION: Received after the August 2020 Board of Trustees meeting.

Resolution No. 53 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

RESCISSION OF THE POLICY, MALDISTRIBUTION OF THE DENTAL WORKFORCE

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Maldistribution of the Dental Workforce (*Trans.*2001:442; 2014:500).

The Council agreed that the policy was worded as a time-limited directive that effectively was fulfilled once the task to "develop a framework" was complete (*Supplement* 2002:6020). Moreover, the Council observed that all aspects of this assignment—legislation, taxes, student loan forgiveness, and scholarships—are covered elsewhere in ADA policy, including some that were adopted as recently as 2019.

- Federal Student Loan Repayment Incentives addresses payback of all or a portion of dental school tuition if a new dentist practices in an underserved area, as well as loan forgiveness for dental students and post-doctoral residents and students who practice in underserved areas after graduation. The policy was adopted in 2019.

- Tax Treatment of Student Loan Interest, Scholarships and Stipends and Federal Student Loan Repayment Incentives both address scholarships for dental students and post-doctoral residents and students who practice in underserved areas after graduation. Both policies were adopted in 2019.

- Universal Healthcare Reform (*Trans.*2008:433) addresses tax incentives for dentists to practice in underserved areas. The policy was reviewed and retained as written in 2019.

- Access to Dental Services for the Underserved (*Trans.*2000:500) outlines a series of model practices to resolve access issues for the underserved, indigent, and special needs groups.

The Council concluded that there was no added value in maintaining an assignment that is now moot and simply rephrases what is addressed elsewhere in Association policy.

After consulting the Council on Advocacy for Access and Prevention, the Council on Government Affairs recommends that the following resolution be adopted:

Resolution

53. Resolved, that the policy titled Maldistribution of the Dental Workforce (*Trans.*2001:442; 2014:500) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED

Maldistribution of the Dental Workforce (*Trans.*2001:442; 2014:500)

Resolved, that appropriate agencies of the ADA develop a framework to help those states with a maldistribution of the dental workforce, and be it further

Resolved, that the framework may include, but is not limited to:

- Model legislation to help attract dentists to underserved areas of states. The legislation may include, but is not limited to:
    - Tax incentives for dentists practicing in underserved areas.
    - Payback of all or a portion of dental school tuition if the new dentist practices in an underserved area.
    - Scholarships for dental students and post-doctoral residents and students who practice in underserved areas after graduation.
    - Loan forgiveness for dental students and post-doctoral residents and students who practice in underserved areas after graduation.
- Establishing a list of opportunities that are available from rural communities who are willing to provide financial support to dentists moving to their area.

Resolution No. 54 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT OF THE POLICY, FREEDOM OF CHOICE IN PUBLICLY FUNDED AID PROGRAMS

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Freedom of Choice in Publicly Funded Aid Programs (*Trans.*2006:344).

The Council determined that the policy was worded as time-limited directive that effectively became moot once the task to "pursue regulatory or legislative action" was completed (*Supplement* 2007:6031). The Council also considered the subject matter relevant enough to retain in a more enduring form.

After consulting the Council on Dental Benefits and Practice, the Council on Government Affairs recommends that the following resolution be adopted.

Resolution

54. Resolved, that the policy titled Freedom of Choice in Publicly Funded Aid Programs (*Trans.*2006:344) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the ADA pursue regulatory or legislative action to mandate that~~ any licensed dentist ~~may~~ should be able to participate in a publicly funded program without joining a third-party network that requires them to also see privately funded commercial patients under a managed care contract.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 55 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT OF THE POLICY, LEGISLATIVE SEPARATION OF MEDICINE AND DENTISTRY

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Legislative Separation of Medicine and Dentistry (*Trans.*1996:715).

The Council determined that the policy was worded as time-limited directive that effectively was fulfilled once the task to "work to assure…in any health care reform legislation" was completed (*Reports* 1997:128). The Council also considered the subject matter relevant enough to retain in a more enduring form.

After consulting the Council on Advocacy for Access and Prevention and the Council on Dental Benefits and Practice, the Council on Government Affairs recommends that the following resolution be adopted.

Resolution

55. Resolved, that the policy titled Legislative Separation of Medicine and Dentistry (*Trans.*1996:715) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that ~~the American Dental Association work to assure that~~ dentistry ~~is~~ should be addressed separately from medicine in any health care reform legislation.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 56 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT OF THE POLICY, LIMITED ENGLISH PROFICIENCY

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Limited English Proficiency (*Trans.*2005:338).

The Council found that portions of the policy are worded as time-limited assignments were fulfilled once the tasks to "work with the appropriate federal agencies," "support appropriate legislation," and "[encourage] constituent and component dental societies" were complete (*Reports* 2006:89). The Council also observed that the intent of the policy on Limited English Proficiency was to address proposals dating back to when President Clinton was in office.

Although the basis for the policy is nearly 20 years old, the Council determined that Sec. 1557 of the Affordable Care Act also contains certain nondiscrimination provisions that warrant having such a policy in a more enduring form.

After consulting the Council on Advocacy for Access and Prevention and the Council on Dental Practice, the Council on Government Affairs recommends that the following resolution be adopted.

Resolution

56. Resolved, that the policy titled Limited English Proficiency (*Trans.*2005:338) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

Resolved, that the American Dental Association ~~work with the appropriate federal agencies, advocacy groups, trade associations, and other stakeholders to ensure that~~ considers accommodating the language needs of English-limited patients ~~is recognized as~~ to be a shared responsibility, which cannot be fairly visited upon any one segment of a community, and be it further

~~**Resolved,** that the Association support appropriate legislation and initiatives that would enhance the ability of individuals of limited English proficiency to effectively communicate in English with their dentist and the dental office staff, and be it further~~

Resolved, that the ~~Association oppose federal legislative and regulatory~~ ADA opposes efforts that would unreasonably add to the administrative, financial, or legal liability of providing dental

services to limited English proficient patients, such as being required to provide interpreters on demand as a condition of treating patients receiving state and/or federal benefits~~, and be it further~~

~~**Resolved,** that constituent and component dental societies be encouraged to support state, local, and private sector efforts to address the language needs of English-limited patients, and be it further~~

~~**Resolved,** that dental and allied dental programs be encouraged to educate students about the challenges associated with treating patients of limited English proficiency~~.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 57 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

PROPOSED POLICY, DISCRIMINATION OF BENEFIT PAYMENT BASED ON PROFESSIONAL DEGREE OF PROVIDER

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Legislation Prohibiting Discrimination of Benefit Payment Based on Professional Degree of Provider (*Trans.*1989:562).

The Council determined that the policy is worded as a time-limited assignment that effectively became moot once the tasks to "prepare model legislation" and "actively assist constituent dental societies" were complete (*Reports* 1990:157). However, the Council determined that the subject matter was still relevant enough to warrant retaining in a more enduring form.

The Council notes that the basis for offering technical assistance to constituent societies is codified in Chapter VIII, Section K.7.d. of the *ADA Governance and Organizational Manual*, which states that one of the Council's core responsibilities is to "disseminate information which will assist the constituents and components involving legislation and regulation affecting the dental health of the public."

The Council also noted that the national organization has no real authority to interfere with the policies, positions, priorities, and activities of state dental societies.

After consulting the Council on Dental Benefits and Practice, the Council on Government Affairs recommends that the following resolution be adopted:

Resolution

57. Resolved, that the following policy titled Discrimination of Benefit Payment Based on Professional Degree of Provider be adopted:

Discrimination of Benefit Payment Based on Professional Degree of Provider

Resolved, that that the American Dental Association opposes discrimination of benefit payment based on the type of license and/or professional degree of the dentist and/or physician, and be it further

Resolved, that the policy titled Legislation Prohibiting Discrimination of Benefit Payment Based on Professional Degree of Provider (*Trans.*1989:562) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
POLICY TO BE RESCINDED

Legislation Prohibiting Discrimination of Benefit Payment Based on Professional Degree of Provider (*Trans.*1989:562)

Resolved, that appropriate agencies of the American Dental Association prepare model legislation and, upon request, actively assist constituent dental societies in the pursuit of any legislative and administrative initiatives that may be needed to ensure that all states prohibit discrimination of benefit payment based on the type of license and/or professional degree of the dentist and/or physician.

Resolution No. 58 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

PROPOSED POLICY, GUARANTEEING THE PATIENT'S FREEDOM OF CHOICE OF DENTIST

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Legislation to Guarantee Patient's Freedom of Choice of Dentist (*Trans.*1995:631).

The Council determined that the policy was worded as time-limited directive that effectively was fulfilled once the tasks to "pursue legislation" to "take legislative action" were completed (*Reports* 1996:108). The Council also considered the subject matter relevant enough to retain in a more enduring form.

The Council on Government Affairs recommends that the following resolution be adopted:

Resolution

58. Resolved, that the following policy titled Guarantee Patient's Freedom of Choice of Dentist be adopted:

Guarantee Patient's Freedom of Choice of Dentist

Resolved, that the patient's right to choose any licensed dentist to deliver his or her oral health care without any type of coercion must be preserved, and be it further

Resolved, that the American Dental Association opposes any arrangement that eliminates, interferes with, or otherwise limits the patient's freedom of choice, and be it further

Resolved, that the policy titled Legislation to Guarantee Patient's Freedom of Choice of Dentist (*Trans.*1995:631) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
POLICY TO BE RESCINDED

Legislation to Guarantee Patient's Freedom of Choice of Dentist (*Trans.*1995:631)

Resolved, that the American Dental Association actively pursue legislation that will guarantee the patient's right to choose any licensed dentist to deliver his or her oral health care without any type of coercion, and be it further

Resolved, that the American Dental Association take legislative action to oppose any arrangement that eliminates, interferes with, or otherwise limits the patient's freedom of choice.

Resolution No. 59 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

PROPOSED POLICY, REGULATORY DEFINITIONS OF DENTISTRY

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Adding the ADA Definition of Dentistry to Existing Dental Regulatory Provisions (*Trans.*2001:440).

The Council determined that the policy is worded as time-limited assignment that effectively became moot once the task to "[encourage] constituent dental societies [to]…seek legislative and regulatory changes" was complete (*Supplement* 2002:6020). The Council also noted that the national organization has no real authority to interfere with the policies, positions, priorities, and activities of state dental societies.

Moreover, the policy titled ADA Definition on Dentistry to Existing Dental Regulatory Provisions does not provide the flexibility needed to accommodate the ongoing changes to the definitions of dentistry and the recognized dental specialties. For example, the text of this nearly 20 year-old policy does not include Dental Anesthesiology and Oral Medicine and Orofacial Pain, which were recognized as dental specialties by the National Commission on Recognition of Dental Specialties and Certifying Boards in 2019 and 2020, respectively.

The Council on Government Affairs recommends that the following resolution be adopted:

Resolution

59. Resolved, that the following policy titled Regulatory Definitions of Dentistry be adopted:

Regulatory Definitions of Dentistry

Resolved, that the American Dental Association's definitions of dentistry and the dental specialties should be reflected in all dental statutory and regulatory provisions to delineate the scope of dental education and training for dentistry and the dental specialties, as appropriate and feasible, and be it further

Resolved, that the policy titled Adding the ADA Definition of Dentistry to Existing Dental Regulatory Provisions (*Trans.*2001:440) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
POLICY TO BE RESCINDED

Adding the ADA Definition of Dentistry to Existing Dental Regulatory Provisions (*Trans.*2001:440)

Resolved, that the American Dental Association encourages and supports efforts to include the ADA Definition of Dentistry into existing dental statutory and regulatory provisions, and be it further

Resolved, that the states should be encouraged and supported to include in their statutory and regulatory processes, ADA definitions of existing dental specialties in order to delineate the scope of dental education and training, and be it further

Resolved, that the constituent dental societies should seek legislative and regulatory changes to incorporate the following definitions as recognized and promulgated by the ADA:

Definition of Dentistry (*Trans.*1997:687)—"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 the current definition of the recognized specialties: Dental Public Health, Endodontics, Oral and Maxillofacial Pathology, Oral and Maxillofacial Radiology, Oral and Maxillofacial Surgery, Orthodontics and Dentofacial Orthopedics, Pediatric Dentistry, Periodontics and Prosthodontics; as approved by the Council on Dental Education and Licensure.

Resolution No. 60 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

RESCISSION OF THE POLICY, ADA ASSISTANCE IN LEGISLATIVE INITIATIVES

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled ADA Assistance in Legislative Initiatives (*Trans.*1982:513).

The Council found that the title of the policy to be misleading. “ADA Assistance in Legislative Initiatives” suggests that the policy is about the foundational authority for the national organization to help constituent societies address legislative issues. However, the policy is not about the national organization’s authority to provide technical assistance, but the manner in which that assistance is provided—with an emphasis on constituent control over media and messaging.

The Council appreciated the desire not to undermine constituent lobbying on sensitive state issues. However, the Council questioned whether the national organization’s reputation and lobbying efforts could also be compromised should a national media outlet ask a constituent society to comment on a sensitive national issue without input from the national organization.

Additionally, the Council on Communications (CC) agreed that the policy should be rescinded. The CC determined that the 28 year-old policy is outdated and addresses association operations (rather than policy). The CC noted that the successful media messaging in the State Public Affairs program is a prime example of why the policy is no longer needed.

The Council notes that the basis for offering technical assistance to constituent societies is codified in Chapter VIII, Section K.7.d. of the *ADA Governance and Organizational Manual*, which states that one of the Council’s core responsibilities is to “disseminate information which will assist the constituents and components involving legislation and regulation affecting the dental health of the public.”

After consulting the Council on Communications, the Council on Government Affairs recommends that the following resolution be adopted:

Resolution

60. Resolved, that the policy titled ADA Assistance in Legislative Initiatives (*Trans.*1982:513) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED

ADA Assistance in Legislative Initiatives (*Trans.*1982:513)

Resolved, that when a state dental association notifies the American Dental Association that it is involved in the signature gathering phase of an initiative petition which would adversely affect dentistry in that state, then the American Dental Association shall assist the state dental association in developing strategy for media releases, and be it further

Resolved, that all media responses during the signature gathering phase be released through the state dental association.

Resolution No. 61 Substitute

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

RESCISSION OF THE POLICY, COSTS FOR THE SUBMISSION OF ELECTRONIC DENTAL CLAIMS

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Costs for the Submission of Electronic Dental Claims (*Trans.*1995:623).

The Council determined that the policy was worded as a time-limited assignment that effectively was fulfilled once the tasks to "work to protect" and "[seek] to minimize or eliminate" were complete (*Reports* 1996:50). The Council also found no added value in maintaining a directive that is not particularly relevant in modern times.

The "current dynamics" of the "electronic claims payment marketplace" have changed significantly in the 30-plus years since the policy titled Costs for the Submission of Electronic Dental Claims was adopted, particularly with the evolution of the Internet. The administrative simplification provisions in the Health Insurance Portability and Accountability Act of 1996 have also transformed the way electronic claims are used in the marketplace.

After consulting the Council on Dental Practice, the Council on Government Affairs recommends that the following resolution be adopted:

Resolution

61. Resolved, that the policy titled Costs for the Submission of Electronic Dental Claims (*Trans.*1995:623) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED

Costs for the Submission of Electronic Dental Claims (*Trans.*1995:623)

Resolved, that because of the current dynamics of the electronic claims payment marketplace, the ADA should work to protect the interest of the dentist by seeking to minimize or eliminate the costs to the dentist for the submission of electronic dental claims.

Resolution No. 63 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

RESCISSION OF THE POLICY, ADVOCATING FOR ERISA REFORM

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled Advocating for ERISA Reform (*Trans.*2009:474; 2014:500).

The Council determined that this policy is redundant of the policies titled Employee Retirement Income Security Act (ERISA) Enforcement Activities (*Trans.*1992:622) and Amendment of Employee Retirement Income Security Act (*Trans.*1994:644). The Council also determined that the policy titled Advocating for ERISA Reform was worded as a time-limited assignment that effectively was fulfilled once the tasks to "identify those features" and "seek legislation" were complete (*Reports* 2010:149).

After consulting the Council on Dental Benefits and the Council on Dental Practice, the Council on Government Affairs recommends that the following resolution be adopted:

Resolution

63. Resolved, that the policy titled Advocating for ERISA Reform (*Trans.*2009:474; 2014:500) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED

Advocating for ERISA Reform (*Trans.*2009:474; 2014:500)

Resolved, that the appropriate agencies of the ADA identify those features of ERISA that exempt some plans from state regulation to protect consumers, and be it further

Resolved, that the ADA aggressively seek legislation to change the Act to create these consumer safeguards under federal law or allow regulation of these plans by the states.

Resolution No. 64 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

AMENDMENT OF CHAPTER III., SECTION 120 OF THE ADA BYLAWS

Background: Pursuant to the *Governance and Organizational Manual of the American Dental Association* (*Governance Manual*), Chapter VIII., Section K.6.b.ii., the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) reviews the governance documents of the Association to correct punctuation, grammar spelling and syntax. Different portions of the ADA's governing documents are reviewed each year so that the entirety of the Association's governance material is reviewed every four (4) years.

Chapter III. of the ADA *Bylaws* was reviewed during the course of CEBJA's 2020 editorial review. In the course of that study, some members of CEBJA requested clarification of the meaning of the term "non-cumulative," in the second numbered paragraph of *Bylaws* Chapter III., Section 120., as the meaning of that term was not understood in relation to voting scenarios.

Discussion: CEBJA believes that one of the most important attributes for the Association's governance documents to have is to be written with clarity and precision, in such a way to be accessible to and easily understood by members of the Association. Consequently, when a provision in the *Bylaws* or *Governance Manual* is not understood, CEBJA reviews that provision very carefully and looks for alternative language to more simply and clearly express the provision without altering the provision's import or meaning. That is the case here. The Council on Ethics, Bylaws and Judicial Affairs proposes revision of the second numbered paragraph of Chapter III., Section 120. of the ADA *Bylaws* that it believes is easier to understand, as follows:

Resolution

64. Resolved, that Chapter III., Section 120. of the ADA *Bylaws* be amended as shown below (additions <u>underscored</u>, deletions ~~stricken through~~):

Section 120. METHOD OF ELECTION: Elective officers and members of councils and committees shall be elected by ballot, except that when there is only one candidate, such candidate may be declared elected by the Speaker of the House of Delegates. The Secretary shall provide facilities for voting.

1. When one is to be elected, and more than one has been nominated, the majority of the ballots cast shall elect. In the event no candidate receives a majority on the first ballot, the candidate with the fewest votes shall be removed from the ballot and the remaining candidates shall be balloted upon again. This process shall be repeated until one (1) candidate receives a majority of the votes cast.

2. When more than one is to be elected, and the nominees exceed the number to be elected, ~~the votes cast shall be non-cumulative,~~ votes equal to or less than the number to be elected may be cast by each voting member, but only one vote may be cast per nominee, and the candidates receiving the greatest number of votes shall be elected.

BOARD RECOMMENDATION: Vote Yes.

Vote: Resolution 64

ARMSTRONG	Yes	HERRE	Absent	LEARY	Yes	ROSATO	Yes
DOROSHOW	Yes	HIMMELBERGER	Yes	MCDOUGALL	Yes	SABATES	Yes
EDGAR	Yes	KESSLER	Yes	NORBO	Yes	SHEPLEY	Yes
FIDDLER	Yes	KLEMMEDSON	Yes	RAPINI	Yes	STEPHENS	Yes
HARRINGTON	Yes	KYGER	Yes	RODRIGUEZ	Yes	THOMPSON	Yes

Resolution No. 65 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

PROPOSED POLICY, ANESTHESIA COVERAGE UNDER HEALTH PLANS

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policy titled ERISA Reform (*Trans.*1998:738).

The Council determined that this policy was worded as time-limited assignment that was fulfilled once the task to "seek federal legislation" was completed (*Supplement* 1999:372). The Council also found that the title, "ERISA Reform," was misleading. It suggests that the policy is about significantly overhauling the Employee Retirement Income Security Act, when it is actually about adding a single provision that would require all ERISA plans to cover general anesthesia and/or hospital or outpatient surgical facility charges.

Ultimately, the Council concluded that the subject matter was relevant enough to retain in a more enduring form.

After consulting the Council on Dental Benefits and Practice, the Council on Government Affairs recommends that the following resolution be adopted:

Resolution

65. Resolved, that the following policy titled Anesthesia Coverage Under Health Plans be adopted:

Anesthesia Coverage Under Health Plans

Resolved, the ADA supports the position that all health plans, including those governed by the Employee Retirement Income Security Act, should be required to cover general anesthesia and/or hospital or outpatient surgical facility charges incurred by covered persons who receive dental treatment under anesthesia, due to a documented physical, mental or medical reason as determined by the treating dentist(s) and/or physician, and be it further

Resolved, that the policy titled ERISA Reform (*Trans.*1998:738) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICY TO BE RESCINDED

ERISA Reform (*Trans.*1998:738)

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

Resolution No. 69 New

Report: N/A Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

PROPOSED POLICY, PROVISIONS FOR ERISA PLANS

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the Association policies titled Support Legislation Amending the Employee Retirement Income Security Act (*Trans*.1982:550; 1989:561), Employee Retirement Income Security Act (ERISA) Enforcement Activities (*Trans.*1992:622), Amendment of Employee Retirement Income Security Act (*Trans.*1994:644), and Amendments to ERISA to Achieve Greater Protections for Patients and Providers (*Trans.*1995:649).

The Council found that all of the above mentioned polices are worded as time-limited assignments that effectively were fulfilled once the tasks to "initiate and actively support legislation," "continue its efforts…to achieve vigorous enforcement," "seek federal legislation," and "support legislative activities" were completed (*Reports* 1990:157; 1993:114; 1995:106; 1996:107).

The Council also determined that the subject matter was relevant enough to be retained in the form of more enduring statements of policy or position—and that many of the resolving clauses are similar enough to be bundled into a single umbrella policy with modest changes for brevity and clarity.

After consulting the Council on Dental Benefits and the Council on Dental Practice, the Council on Government Affairs recommends that the following resolution be adopted:

Resolution

69. Resolved, that the following policy titled Provisions for ERISA Plans be adopted:

Provisions for ERISA Plans

The ADA supports the following provisions for ERISA Plans:

1. Beneficiaries of employee health benefit plans should have the right to receive health care from the providers of their choice

2. Employee health benefit plans should be prohibited from discriminating against legally qualified health care providers and to assure the solvency of such plans

3. Plan subscribers in Employee Retirement Income Security Act-regulated dental benefit programs should have the same protections that are commonly enjoyed by subscribers of state-regulated programs

4. Self-insured payers and/or utilization review organizations should be held liable for any negligent utilization review decision that overturns the health care provider's clinical decision

5. Patients who suffer as the result of negligent utilization review decisions should be entitled to meaningful remedies and fair compensation

6. Patients who are denied benefits should have the right to an appropriate appeal mechanism under self-funded group health plans

and be it further

Resolved, that the policies titled Support Legislation Amending the Employee Retirement Income Security Act (*Trans.*1982:550; 1989:561), Employee Retirement Income Security Act (ERISA) Enforcement Activities (*Trans.*1992:622), Amendment of Employee Retirement Income Security Act (*Trans.*1994:644), and Amendments to ERISA to Achieve Greater Protections for Patients and Providers (*Trans.*1995:649) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

WORKSHEET ADDENDUM
COUNCIL ON GOVERNMENT AFFAIRS
ADA POLICIES TO BE RESCINDED

Support Legislation Amending the Employee Retirement Income Security Act (*Trans.*1982:550; 1989:561)

Resolved, that the ADA initiate and actively support legislation amending the Employee Retirement Income Security Act (ERISA) to assure that beneficiaries of employee health benefit plans have the right to receive health care from the providers of their choice, to prevent plans from discriminating against legally qualified health care providers and to assure the solvency of such plans.

Support Legislation Amending the Employee Retirement Income Security Act (*Trans.*1982:550)

Resolved, that the ADA initiate and actively support legislation amending the Employee Retirement and Income Security Act (ERISA) to permit the respective states to regulate employee health benefit plans in order to assure that beneficiaries of such plans have the right to receive health care from the providers of their choice, to prevent plans from discriminating against legally qualified health care providers and to assure the solvency of such plans.

Employee Retirement Income Security Act (ERISA) Enforcement Activities (*Trans.*1992:622)

Resolved, that the American Dental Association continue its efforts in concert with appropriate public and private entities to achieve vigorous enforcement of the provisions of the Employee Retirement Income Security Act in order to provide plan subscribers in ERISA-regulated dental benefit programs with the same protections as are commonly enjoyed by subscribers of state-regulated programs.

Amendment of Employee Retirement Income Security Act (*Trans.*1994:644)

Resolved, that the appropriate agencies of the American Dental Association seek federal legislation to amend the Employee Retirement Income Security Act (ERISA) to hold self-insured payers and/or utilization review organizations liable for any negligent utilization review decision which overturns the health care provider's clinical decision, and ensure meaningful remedies and fair compensation to patients who suffer as a result of such negligent utilization review decisions, and be it further

Resolved, that the appropriate agencies of the American Dental Association work to ensure that any health system reform proposals address the problems of remedy and compensation created by ERISA for patients in self-funded plans.

Amendments to ERISA to Achieve Greater Protections for Patients and Providers (*Trans.*1995:649)

Resolved, that the Association support legislative activities to directly amend the ERISA statute in an effort to achieve greater protections for patients and providers, and be it further

Resolved, that one of these protections assure that patients who are denied benefits have the right to an appropriate appeal mechanism.

Resolution No. 70 - 82 New

Report: Elder Care Workgroup Report Date Submitted: August 2020

Submitted By: Elder Care Workgroup

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: N/A Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

REPORT OF THE ELDER CARE WORKGROUP IN RESPONSE TO RESOLUTION 33H-2018: PRESIDENTIALLY-APPOINTED ELDER CARE WORKGROUP

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

Executive Summary

Key Issues: The American Dental Association's 2018 House of Delegates authorized ADA Presidential appointment of the Elder Care Workgroup (ECW). The ECW was comprised of independent diverse expertise from geriatric dentists, public health advocates, educators, private practitioners and was guided by an outside facilitator to develop the following Comprehensive Strategic Eldercare Policy as was mandated by the 2019 ADA HOD. Pertinent background information and references are provided in our extensive report which was crafted through eighteen months of research, discussion and discernment. The ECW agreed that the current national strategy is essentially no strategy at all and respectfully recommend the following tangible solutions as proposed ADA policy, intended to address all facets of dental access for the elderly, including:

- Advocacy on behalf of elderly patients.
- Current national trends
- Variances in state Medicaid programs for the elderly, or those age 65 and older
- Those in long term care (LTC) and the medically frail, both of whom are among the most vulnerable to dental disease
- Low and middle income seniors who often fall below the threshold of affordability
- The disparity in oral health between high and low income seniors

The ECW presents the following thirteen resolutions to the House of Delegates. The first five resolutions are policy-driven while the final eight resolutions are strategic actions to address specific areas:

70) Oral Healthcare for the Elderly – An overarching statement of ADA belief in supporting equitable, choice driven, dental care to elderly patients.

71) Financing Oral Health Care for Adults 65 and Older – Provides five sustainable mechanisms of care financing, variable by income and patient choice, while defining clear levels of dental benefit plan design to best serve the needs of patients and dentists.

1. The ECW believes it is imperative that no elderly die due to infected teeth. All states should offer Adult Medicaid to those living below the 100% Federal Poverty Level (FPL) threshold with a minimum of providing emergent, preventive and basic restorative services. Details within.
2. The ECW believes that the federal/state partnership known as the Children's Health Insurance Program (CHIP) should be replicated for our elderly population. Such a program would be appropriate for those between 100-400% of FPL. Details within.
3. The ECW believes Medicare Part C, aka Medicare Advantage, should provide dental services at defined levels of care. Details within.
4. The ECW believes that the ADA and its members could participate in an insurance product via a co-joined ADA/insurance carrier product, including within the private insurance carriers participating in Medicare Advantage, as a network of providers.
5. The ECW believes a different approach is warranted regarding levels of care, and program design should be based on these levels, ranging from emergent to comprehensive. Details of Levels 1-4 are within.

72) Modifying the Existing Medicare Dental Coverage: Statutory Dental Exclusion – Recommends further evidence-based evaluation and seeks proposed changes, by the appropriate ADA agencies, concerning that which Medicare currently covers for frail seniors with very specific medical conditions, before recommendations are made to modify the current statute in Medicare.

73) National Eldercare Advisory Committee Review – Ensures the National Eldercare Advisory Committee has what it needs to assist ADA to accomplish ongoing eldercare strategies.

82) Review of Existing ADA Policies Related to Eldercare – The Eldercare Workgroup completed a comprehensive review of related policy and recommends modifications to clarify and align our position.

Eldercare Strategies – Details a variety of program strategies to address the overarching oral health needs of an aging population in specific areas.

Resolutions 74-81
74) Continuing Education
75) Research
76) Increased Preparedness of Educational Institutions
77) Public Advocacy
78) Intra-Professional Advocacy
79) Long Term Care Facilities
80) Inter-Agency Advocacy
81) Practice Management

Budget Impact/Financial or Operational Requirements: Though the originating resolution charged the ECW with identifying an implementation plan and timeline to address elder care, current economic conditions and the disruptive nature of COVID-19 to the normal flow of work has led the ECW to reframe its strategic recommendations as policy statements. The ECW looks to the 2020 House of Delegates to adopt the following elder care policies for the appropriate ADA agencies to consider integrating these elder care strategies both diligently and as appropriate.

Risk/Benefit: The United States (U.S.) Census Bureau projects that the U.S. population**,** aged 65 and older (seniors)**,** will grow by nine percentage points from 2016 to 2060, making it the fastest growing age group. Expanding dental care utilization among this large and growing population could grow the profession and may aid in membership recruitment and retention. As with any program, the risk of prioritizing the development of additional elder care resources may limit the ability to pursue other priorities; however, establishing and aligning ADA policy on the issue of eldercare, is essential in creating viable and necessary improvements in access to dental care for the elderly.

REPORT OF THE ELDER CARE WORKGROUP IN RESPONSE TO RESOLUTION 33H-2018: PRESIDENTIALLY-APPOINTED ELDER CARE WORKGROUP

Background: In 2018, the House of Delegates adopted Resolution 33H, which directed the President to appoint an ad hoc committee to review the Association's current policies and to identify an implementation plan to address elder care, including Medicare.

> **33H-2018. Resolved,** that the President appoint an ad hoc committee with the relevant expertise to review and update Resolution 5H-2006 (*Trans.*2006:319) and identify an implementation plan and timeline to address elder care including Medicare, and be it further
>
> **Resolved,** that Resolution 33B, which reads as follows, be referred to the ad hoc committee for consideration within the comprehensive strategy, with a progress report submitted to the 2019 House of Delegates:
>
> > **Resolved,** that if potential legislation is being developed then a dental benefit in Medicare shall minimally provide:
> >
> > - Coverage for comprehensive services in an appropriate part within Medicare with adequate program funding
> > - Reimbursement rates at or above median fees (50th percentile) as described in the current ADA Survey of Dental Fees to ensure adequate dentist participation
> > - Funding for technical support for dental practice participation including adoption of health IT standards
> > - Minimal and reasonable administrative requirements for dental practice participation
> > - Medicare beneficiaries with the freedom to choose any dentist while continuing to receive the full Medicare benefit

This presidentially-appointed Elder Care Workgroup (ECW), charged with developing new or updated elder care strategies, was formed in February 2019. Dr. Jeffrey Cole appointed Dr. Cesar Sabates, trustee, Seventeenth District, chair; and members-at-large Dr. Joseph Battaglia, New Jersey; Dr. Michael Eggnatz, Florida; Dr. William Gerlach, Texas; Dr. Judith Jones, Michigan; Dr. Matthew Messina, Ohio; Dr. Richard Nagy, California; Dr. Marsha Pyle, Missouri; Dr. Diane Romaine, Maryland; Dr. Ronald Riggins, Illinois; Dr. Thomas Sollecito, Pennsylvania; and Paul Mulhausen, M.D., Iowa to the ECW.

A substantial amount of written background material was provided to the work group members, including the Resolution 5H-2006 Taskforce Report, briefing notes on executed ADA strategies in elder care since 2006, the April 2019 *California Dental Association Journal* dedicated to comprehensive older adult care, extensive material from CDEL on accreditation standards pertaining to geriatrics and the annual survey to advanced dental education programs report, articles and presentations from *Health Affairs* on health and housing needs for US seniors, comprehensive documents from the FDI on "Achieving a Healthy Ageing Society," and briefing notes from the ADA's Health Policy Institute. The ECW also used the services of a neutral and independent facilitator, Mr. Bruce Withrow of Meeting Facilitators International.

Meetings were conducted via conference calls, video conferences and in person meetings. Extensive foundational groundwork preceded each workgroup meeting with the efficient use of survey tools and compilation of data in advance. The first conference call was held in April and the first in-person meeting of the ECW was held June 1-2, 2019. Progress was made towards developing a comprehensive elder care strategy excluding financing of dental care. Since the workgroup could not complete its assignment before the 2019 HOD meeting, a resolution to continue the group was submitted and adopted.

Reauthorization of Elder Care Work Group

> **72H-2019. Resolved,** that the *ad hoc* Elder Care Committee, comprised of members appointed by the President, be reauthorized for another year to review and update Resolution 5H-2006 (*Trans.*2006:319) and to identify an implementation plan and timeline to address elder care

including Medicare and report to the 2020 House of Delegates with a recommended Comprehensive Strategic Elder Care policy.

Following the 2019 House of Delegates (HOD), Dr. Gehani reappointed the existing group and in addition, appointed Dr. Craig Armstrong, trustee, Fifteenth District, as an at-large-member.

Introduction

An exhaustive compilation of background material was provided to the workgroup, and the efficient use of an online survey and a conference call laid the groundwork for the workgroup's second meeting. This two-day in-person meeting was held October 5-6, 2019 and mechanisms for financing care were discussed. The ECW agreed on a framework for financing care and also reviewed recommendations from the first meeting on elder care strategies outside of the financing topic. The workgroup met again by conference call in December 2019, and then a third and final survey prepared the group for a series of four Zoom meetings on March 28 and 29. These meetings were to review and finalize the ECW's recommendations to the 2020 HOD. The ECW continued to use Zoom meetings throughout the month of July to complete its work and prepare this final report for the 2020 HOD.

Key Issues

Demographic shifts in the U.S. population have been well reported for many years. The number of retiring baby boomers is expanding. The 2016 American Community Survey estimated the number of people in the United States aged 65 and over as 49.2 million.[1] The United States (U.S.) Census Bureau projects that the U.S. population**,** aged 65 and older (seniors)**,** will grow by nine percentage points from 2016-2060, making it the fastest growing age group. By 2035, the number of seniors over 65 will be greater than people under 18.[2]

Approximately 37 percent of seniors have some source of dental coverage.[3] About 26 percent have private dental benefits, and the remaining 11 percent have some form of public dental coverage (e.g. Medicaid, Veterans Affairs, or Tricare). Of those with private dental benefits, approximately 86 percent obtain their dental benefits via a Medicare Advantage (Medicare Part C) plan.[4] These plans range in coverage from preventive only coverage (e.g. exam, prophylaxis, and x-rays) to more comprehensive coverage (i.e. similar to a commercial PPO plan). The remaining 14 percent of seniors with private dental benefits may obtain their coverage through an employer, via a pension plan, or through a stand-alone purchase (e.g. through a health insurance exchange or a broker). The remaining 63 percent of seniors do not have dental benefits coverage.

In terms of utilization, approximately 43.3 percent of seniors visited the dentist at least once in 2016.[5] Among seniors with private dental benefits, 68.7 percent had at least one dental visit. Among those with public dental benefits, 16.1 percent visited the dentist at least once. Thirty-seven percent of seniors that do not have dental coverage, or cash-pay patients, visited the dentist at least once in 2016.

Utilization also varies by income, with high-income seniors much more likely to visit the dentist than low-income seniors. In this analysis, high-income was defined as household incomes at or above 400 percent of the federal poverty line (in 2020, 400 percent of the Federal Poverty Line for a two-person household

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[1] https://www.census.gov/content/dam/Census/library/publications/2018/acs/ACS-38.pdf
[2] United States Census. An Aging Nation: Projected Number of Children and Older Adults. March 13, 2018. Available from: https://www.census.gov/library/visualizations/2018/comm/historic-first.html. Accessed March 8, 2019.
[3] Health Policy Institute analysis of Medical Expenditure Panel Survey, 2016.
[4] Health Policy Institute analysis of Medical Expenditure Panel Survey, 2016 and Kaiser Family Foundation data, 2019.
[5] Health Policy Institute. Annual Dental Industry Report 2019. American Dental Association. February 2019.

would be $68,960). In 2016, 61.3 percent of high-income seniors[6] visited the dentist compared to 24.4 percent of low-income seniors.[7, 8] In this analysis, low-income was defined as household incomes below the federal poverty level (in 2020 below the Federal Poverty Level would be income less than $17,420 for a two-person household). This gap in utilization has widened over the past decade, with utilization among high-income seniors slowly increasing while low-income senior utilization remains stagnant. This disparity in utilization is reinforced when seniors are asked why they do not visit the dentist more often. Among seniors that have not visited a dentist in the past year, 69 percent of low-income seniors[9] report cost as a barrier to dental care utilization, compared with 24 percent of high-income seniors.[10]

Cost, as a barrier to needed care, may become more problematic as baby-boomers age into Medicare eligibility. A recent study published in the *Journal of the American Dental Association* reported on the oral health of U.S. seniors.[11] Edentulism has decreased for adults 50 years or older over the past twenty years, but this decrease was not significant among low-income adults.[12] Complete tooth retention has increased over the same time period, but almost entirely among adults with incomes at or above 200 percent of the federal poverty level (in 2020, 200 percent of the Federal Poverty Line for a two-person household would be $34,480)[13]. The percentage of older adults reporting functional dentition also increased over this time period, but again this improvement was only significant among individuals that live above the poverty line. In other words, though overall dental health and tooth retention has improved for U.S. seniors over the past twenty years, these improvements have largely been among the non-poor, exacerbating the oral health disparities exemplified by dental care utilization rates. Further, prolonged tooth retention necessitates more oral health care later in life, which may be difficult for low-income or middle-income seniors to afford.

Further, low-income and minority seniors are more likely to have untreated caries than high-income and white seniors. According to the most recent data, 33.5 percent of seniors living below the poverty line have untreated caries compared to 7 percent of high-income seniors.[14] Additionally, 39 percent of Mexican American and 31.1 percent of non-Hispanic Black seniors have untreated caries compared to 14.1 percent of non-Hispanic white seniors.[15]

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[6] In this analysis, high-income was defined as household incomes at or above 400 percent of the federal poverty line. In 2020 400 percent of the Federal Poverty Line for a two-person household would be $68,960. Paying for Senior Care https://www.payingforseniorcare.com/federal-poverty-level. Accessed April 2, 2020

[7] In this analysis, low-income was defined as household incomes below the federal poverty level. In 2020 below the Federal Poverty Level would be income less than $17,420 for a two-person household. Paying for Senior Care

[8] Health Policy Institute. Annual Dental Industry Report 2019. American Dental Association. February 2019.

[9] In this analysis, low-income was defined as household incomes below 133 percent of the federal poverty level.

[10] Health Policy Institute. Oral Health and Well-Being Among Seniors in the United States. September 2016. Available from: https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_0916_2.pdf?la=en. Accessed March 8, 2019.

[11] Dye B, Weatherspoon D, Mitnik G. Tooth loss among older adults according to poverty status in the United States from 1990 through 2004 and 2009 through 2014. JADA. January 2019;150(1): 9-23.

[12] In this analysis, low-income was defined as household incomes below the federal poverty line.

[13] https://www.payingforseniorcare.com/federal-poverty-level

[14] Health Policy Institute. Untreated Caries Rates Falling Among Low-Income Children. June 2017. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_0617_2.pdf?la=en. Accessed March 8, 2019.

[15] Health Policy Institute. Racial Disparities in Untreated Caries Narrowing for Children. June 2017. Available from:

While oral health disparities between high- and low-income children have narrowed in recent years, the trend is opposite among America's seniors. High-income seniors are visiting the dentist more often, report fewer cost barriers to care, and have markedly better overall oral health compared with low-income seniors. For these reasons it is important that appropriate recommendations are made to address the disparity in dental health between high and low income seniors.

Recognizing this disparity, it is important to learn about how older adults pay for their medical care and how that differs from the current available options to finance their dental care.

Understanding Medicare[16]

Medicare is the federal health insurance program created in 1965 for people ages 65 and over, regardless of income, medical history, or health status. The program helps to pay for many medical care services, including hospitalizations, physician visits, prescription drugs, preventive services, skilled nursing facility and home health care, and hospice care. However, traditional Medicare does not pay for some services that are important for older people and people with disabilities, including long-term services and supports, dental services, eyeglasses, and hearing aids.

- **Part A** covers inpatient hospital stays, skilled nursing facility (SNF) stays, some home health visits, and hospice care. Part A benefits are subject to a deductible ($1,364 per benefit period in 2019). Part A also requires coinsurance for extended inpatient hospital and SNF stays.
- **Part B** covers physician visits, outpatient services, preventive services, and some home health visits. Many Part B benefits are subject to a deductible ($185 in 2019), and, typically, coinsurance of 20 percent. No coinsurance or deductible is charged for an annual wellness visit or for preventive services that are rated 'A' or 'B' by the U.S. Preventive Services Task Force, such as mammography or prostate cancer screenings.
- **Part C** refers to the Medicare Advantage program, through which beneficiaries can enroll in a private health plan, such as a health maintenance organization (HMO) or preferred provider organization (PPO), and receive all Medicare-covered Part A and Part B benefits and typically also Part D benefits. Enrollment in Medicare Advantage plans has grown over time, with more than 20 million beneficiaries enrolled in Medicare Advantage in 2018, or 34 percent of all Medicare beneficiaries.
- **Part D** covers outpatient prescription drugs through private plans that contract with Medicare, including stand-alone prescription drug plans (PDPs) and Medicare Advantage plans with prescription drug coverage (MA-PDs). In 2019, beneficiaries have a choice of 27 PDPs and 21 MA-PDs, on average. The Part D benefit helps pay for enrollees' drug costs and provides coverage for very high drug costs. Additional financial assistance is available for beneficiaries with low incomes and modest assets. Enrollees pay monthly premiums and cost sharing for prescriptions, with costs varying by plan. Enrollment in Part D is voluntary; in 2018, 43 million people on Medicare were enrolled in a PDP or MA-PD. Of this total, roughly one in four receive low-income subsides.

Currently adults age 65 and older have a few different options to finance their dental care (see Table 1).

Current Medicare Advantage: Medicare Advantage or "Medicare Part C" is the "privatized" option of Medicare Parts A and B. Services covered under Parts A and B are necessarily covered in Part C. However, Part C plans can include additional benefits such as dental and vision as a means to attract enrollees. Coverage within these plans is highly variable and is often limited to mostly

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http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_0617_1.pdf?la=en. Accessed March 8, 2019.

[16] Kaiser Family Foundation (https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/; accessed March 16, 2020)

radiographs and annual prophylaxis. According to the National Association of Dental Plans, over 50% of Medicare Part C (Advantage) plans include a dental benefit in their policy and an additional 13% offer it as a voluntary buy-up option. Seniors in most states can choose to enroll in Original Medicare administered by CMS or enroll in a private plan to access their Part A and B benefit. Unlike original Medicare, the private plan may limit a beneficiary's physician or hospital network but also limits the beneficiary's out-of-pocket cost exposure.

Current Commercial Policies: Employed seniors may continue to receive a dental benefit through their employers. Retired persons may receive a dental benefit through a previous employer. For those not covered by employer sponsored plans, some group policies are available to seniors through organizations such as AARP. Some carriers also offer individual policies through brokers and online sites for consumers to purchase. Regardless, in most of these instances the consumer is responsible for the full premium.

ACA Marketplaces: With the advent of the Affordable Care Act (ACA) Marketplaces, many dental carriers offer individual policies through the federal and state marketplaces. However, seniors eligible for Medicare are not allowed (in most exchanges) to purchase a dental benefit separate from their medical Medicare policy within the federal and state ACA Marketplaces. A change to these rules could enable seniors to purchase dental plans from the marketplaces.

Paying out-of-pocket: Some seniors continue to be able to finance their own care out-of-pocket. Further, many dental offices also offer in-office dental plans and care financing programs to assist patients with financing their care. According to the most recent estimates, seniors account for $28B of the $126B spent on dental care in the United States. Roughly two-thirds of dental care spending among seniors is out of pocket with another quarter accounted for by private dental insurance. Put another way, out of pocket spending among seniors represents about 14% of total dental spending in the United States.

Table 1: Financing options for adults age 65 and older

Current Program	***Dental Coverage***	***% of Seniors Covered***
Medicare Advantage	Coverage within these plans is highly variable and is often limited to mostly radiographs and annual prophylaxis. Benefits such as dental care are often included in the plans as an incentive to attract enrollees.	Private dental coverage = 26%
Commercial Policies	Employer-provided, group policies (ex. AARP) or individual policies through online sites or brokers.	
ACA Marketplaces	Seniors eligible for Medicare are not allowed (in most exchanges) to purchase a dental benefit separate from their medical Medicare policy within the federal and state ACA Marketplaces.	
Uninsured (includes self-pay/out-of-pocket)	Some seniors continue to be able to finance their own care out-of-pocket. Further, many dental offices also offer in-office dental plans and financing programs to assist patients with paying for their care.	63%
Public Programs (Medicaid, Tricare, Veterans Affairs)	Coverage varies by state or public provider.	11%

Financing Oral Health Care

The key to success of any of the strategies outlined in this report is dependent on fair, equitable, choice driven financing of dental care. ADA policies support principles that private dental benefits are effective; that dentistry should be addressed separately from medicine in any health care reform legislation; that cost-effective allocation of limited government funding is essential; that patients with the greatest needs should be first in line for care; and that a patient should have the right to choose their dentist and their level of care.

Keeping in mind existing ADA policies, as well as the original charge in Resolution 33H-2018 for the ECW to consider proposed minimum provisions the ADA would support for a dental benefit in Medicare, the ECW deliberated over extensive data and research regarding financing oral health care. The ECW weighed and balanced a comprehensive set of factors, including: increasing the total number of persons covered by oral health care benefits; the willingness of dentists to participate in the solutions; the solutions do not add administrative burdens to dentists; the solutions modify existing dental plans; solutions are simple and easy to understand by the patients; solutions support the continuation of independent private practices; solutions may provide cost savings to the system; solutions support free market principles; and solutions are supported by state dental associations.

The ECW concluded that targeted solutions to provide equitable access to care are most appropriate and are recommending several solutions to provide dental benefits to adults age 65 and older. These include:

- Defining essential dental care through the existing Medicare structure for medically frail persons (Federal rules require that medically frail adults include at least individuals with: Disabling mental disorders, including serious mental illness; Chronic substance use disorders; Serious and complex medical conditions; Physical, intellectual or developmental disabilities that significantly impair the ability to perform one or more activities of daily living; or A disability determination based on Social Security Administration criteria),
- Providing uniform benefits through state Medicaid programs for persons at or below 100% of the Federal Poverty Rate (FPL) ($17,420 for a two-person household in 2020),
- Developing a new dental benefit program for adults age 65 and older, whose incomes are between 100-400% of the FPL (between $17,420 and $68,960 for a two-person household in 2020)[17];
- Advocating for a uniform dental benefit in Medicare Part C (Medicare Advantage Plans), and
- Endorsing dental benefit plans for purchase by adults age 65 and older with varying levels of benefits through the appropriate ADA agency. Each of these recommendations is discussed in greater detail below.

Existing dental benefits under Medicare

> Currently, Medicare will pay for dental services that are an integral part either of a covered procedure (e.g., reconstruction of the jaw following accidental injury), or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. Medicare will also make payment for oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances. Such examination would be covered under Part A if performed by a dentist on the hospital's staff or under Part B if performed by a physician.[18]

The statutory language in the Social Security Act (Section 1862 (a) states: *"Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services*— Section 1862 (a (12)) states:

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[17] Federal Poverty Guidelines (updated January 2020): https://aspe.hhs.gov/poverty-guidelines
[18] https://www.cms.gov/Medicare/Coverage/MedicareDentalCoverage

…where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services.[19]

The ECW reviewed the current covered dental services, which is very narrowly focused on a subset of frail seniors with very specific medical conditions within Medicare, and proposes changes to the statutory exclusion of certain dental services in order to expand them for these medically frail seniors. Recognizing that the American Dental Association is an evidenced-based organization, the ECW advises that before any recommendations are made to modify the current statute in Medicare, it should seek input from the ADA Council on Scientific Affairs as to procedures that can be substantiated by clinical research.

Design of Dental Benefits Programs for Adults Age 65 and Older

The ECW addressed the financing of care for the majority of adults age 65 and older who are not included in the small, medically frail group covered under traditional Medicare as proposed.[20] Initial focus was on the level of benefits that should be provided under these programs.

Rather than follow the traditional approach to dental benefits, the ECW determined a more defined plan design for providing levels of care which would be clear, transparent, and better serve the needs of adults age 65 and older. These are:

Level I:
- Emergency treatments: Procedures to treat or relieve pain and infection, including emergent extractions
- Prevention: Annual exam, diagnostic radiographic images, and at least twice a year prophylaxis
- Scaling and Root Planing
- Fluoride and Silver Diamine Fluoride (SDF) treatments

Level II:
- All Level I procedures
- Direct restorative procedures
- Extraction of non-restorable teeth
- Pulpotomy
- Removable prosthetics to restore function

Level III:
- All Level I and Level II procedures
- Crowns
- Fixed prosthetics
- Implants to support a full denture
- Endodontics
- Periodontal surgery

[19] https://www.cms.gov/Medicare/Coverage/MedicareDentalCoverage

[20] Federal rules require that medically frail adults include at least individuals with: Disabling mental disorders, including serious mental illness; Chronic substance use disorders; Serious and complex medical conditions; Physical, intellectual or developmental disabilities that significantly impair the ability to perform one or more activities of daily living; or A disability determination based on Social Security Administration criteria.

Level IV:
All Level I, Level II, and Level III procedures
Cosmetic Procedures
Any procedure not listed in another level

State/Federal Programs for Adults Age 65 and Older ≤400% of Federal Poverty Level
Data available indicates the primary reason given as to why people over 65 do not seek dental care are financial concerns. The median income of older persons in 2017 was $32,654 for males and $19,180 for females.[21] In 2011, the U.S. Census Bureau released a new Supplemental Poverty Measure (SPM). The SPM methodology shows a significantly higher number of older persons below poverty than is shown by the official poverty measure. For persons age 65 and over, this poverty measure showed a poverty level of 14.1% in 2017 (almost 5 percentage points higher than the official rate of 9.2%). Unlike the official poverty rate, the SPM takes into account regional variations in the cost of housing etc. and, even more significantly, the impact of both non-cash benefits received (e.g. SNAP/food stamps, low income tax credits, and The Special Supplemental Nutrition Program for Women, Infants and Children (WIC)) and non-discretionary expenditures including medical out-of-pocket (MOOP) expenses. For persons 65 and over, MOOP was the major source of the significant differences between these measures. The SPM does not replace the official poverty measure. [22]

The ECW recognizes these individuals need financial assistance to access dental care, and recommends that persons whose income is ≤100% of the FPL ($17,420 for a two-person household in 2020) should access dental care through their state's Medicaid program. The ADA should advocate that each state program provide Level II benefits at a minimum to income-eligible adults age 65 and over.

The forgotten middle income adults age 65 and older, whose incomes are between 100-400% of the FPL (between $17,420 and $68,960 for a two-person household in 2020), also need assistance in financing care.[23] The ECW recommends the ADA seek development of a new federal program for these individuals, modeled after the federal Children's Health Insurance Program (CHIP) that should provide Level II benefits at a minimum.

Medicare Advantage Program
In 2018, one in three (34%) Medicare beneficiaries – 20.4 million people – is enrolled in a Medicare Advantage plan.[24] These private plans contract with Medicare and provide the equivalent of Part A and Part B Medicare benefits. Often, these plans provide prescription drug coverage; some offer dental benefits, vision and hearing services. Deductibles apply according to the plan selected. There are usually procedures in place to be referred for treatment but the plans may limit physicians and hospitals for non-emergency care.

Dental benefits in Medicare Advantage plans vary widely when available. The ECW supports freedom of choice for those who opt to purchase Advantage plans over traditional Medicare A and B. In order to provide standard dental benefits for adults age 65 and older enrolled in Advantage plans, the ECW recommends appropriate action be taken to require all Advantage plans to provide Level 1 services, with optional Level II and Level III benefit plans available at increased premiums.

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[21] Administration on Aging "2018 Profile of Older Americans"; accessed March 18, 2020
[22] U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement; POV01: Age and Sex of All People, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race: 2017; "Income and Poverty in the United States: 2017," P60-263, issued September, 2018; Poverty Thresholds for 2017 by Size of Family and Number of Related Children Under 18 Years; and "The Supplemental Poverty Measure: 2017," P60-265, revised September 2018.

[23] Federal Poverty Guidelines (updated January 2020): https://aspe.hhs.gov/poverty-guidelines
[24] https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage/; accessed March 16, 2020

ADA Endorsed Dental Plans

A majority of adults age 65 and older enroll in traditional Medicare Parts A and B, which provide very limited dental benefits, even after successfully adopting the ECW proposed coverage for medically frail persons. The ECW recognized that the Medicare system has been built since its inception for the delivery of medical care, with complex payment systems for hospitals, physicians, pharmacies, and durable medical equipment, among other providers. Dental care delivery is fundamentally different, using a separate coding set and reimbursement system that is well known to US dentists and office personnel. Dental care delivered in office settings allows patients suffering from dental pain to receive appropriate, effective treatment less expensively than in hospital emergency rooms. In order to provide dental benefits to this large population of adults age 65 and older, while preventing disruption of dental office workflows, minimizing administrative burdens, and diverting unnecessary hospital emergency room visits, the ECW recommends that the ADA endorse dental benefit plans designed to cover Level I, II, III and IV services which can be purchased by adults age 65 and older.

Elder Care Strategies

The ECW discussed a variety of strategies apart from financing care that the ADA should implement in order to serve the older adult population, age 65 and over. It is essential that oral health be recognized as a vital component of health, by practitioners, patients and the public at large. For older adult patients, barriers to access and the perception about affordability of care are contributing factors to a utilization rate below fifty percent. As patients age, it is important to deliver needed treatment with a focus on preventing later decay, so that as older adults become increasingly medically, functionally, and cognitively complex patients, their oral health does not decline. And, as older adult patients do become more complex, there is a large body of practitioners who require additional training on providing treatment to these patients in a variety of practice settings.

At this time the research and teaching pipeline to address this is insufficient to meet the growing need to build the knowledge and confidence of dentists to treat older adult patients, specifically those with medical, functional and/or cognitive complexity. The ECW brainstormed a wide range of potential ideas and used a multi-vote process to prioritize the ideas that would make the strongest recommendations and positive impact on providing oral health care to older adult patients and improving their outcomes. The ECW recognizes the ADA's ongoing commitment to addressing the needs of this population through the establishment and ongoing support for the National Elder Care Advisory Committee (NECAC). In light of the continuing opportunity to support this patient population, the ECW recommends the ADA review the funding, mandate, reporting structure and composition of the NECAC to assist the ADA in accomplishing its updated elder care strategies.

Part of the challenge in providing good oral health care to older adult patients is that the oral systemic health connection is not well understood by practitioners, patients and the population at large. Oral health care is important for elderly patients to be pain free, infection free and able to perform the activities of daily living. The disease incidence in this population includes both oral disease and other diseases where periodontal infection is a contributing factor (e.g. diabetes, Parkinson's, and coronary disease). The ECW recommends elevating the importance of both the oral-systemic connection and the dental management of the medically complex older adult to members and the public, as appropriate, by providing educational opportunities for the profession; promoting dental continuing education on treating the medically, functionally or cognitively complex patients through the Annual Meeting or other ADA meetings; developing and maintaining a roster of qualified speakers on both the oral-systemic connection and the dental management of the medically complex older adult; and developing presentations for use by member state or local dental societies, and to be shared with other Associations and other Health Care Professionals.

The ECW recognizes that the provision of treatment to older adult patients would be strengthened with a more robust research effort of peer-reviewed, published data on the impact of oral health prevention, the total cost of care, and improved health outcomes. Equally important, the lack of translatable research on oral health treatment in the geriatric population as a whole, for medically, functionally and/or cognitively

complex patients, limits the ability of clinicians to provide optimal care to this population. The ECW recommends the ADA prioritize a more focused research effort by pursuing translatable research on the oral health treatment of these geriatric populations to establish the linkage between oral health care and overall health; lead in the collection and dissemination of evidence-based recommendations on the oral systemic health connection; study states with dual eligible Medicare and Medicaid beneficiaries to determine the financial savings, health outcomes and costs of the programs; study cost savings and health outcomes from dental benefit plans; and promote the implementation of new treatment approaches, such as Silver Diamine Fluoride or other minimally invasive interventions, and determine the beneficial effects of the treatments on older adult patients in terms of quality of life and cost effectiveness.

Complementing this support for a more robust research effort, the ECW recommends that the ADA advance the increased preparedness of educational institutions to train dentists, and specialists, in elder care by advocating for geriatric fellowship programs; and encourage universities, Veterans' Administration (VA), and hospitals to develop these. The fellows will play an important role in both the delivery of care, and the education of dental students. Further, the ECW supports the ongoing advocacy for the inclusion of treating the elderly population, including complex cases, for pre-doctoral and relevant specialties in school curriculum, as well as collaborating with other relevant associations to develop curriculum guidelines for inter-professional education on the oral systemic health connection in older adult patients.

In addition to enhanced, clinical education, ongoing education of the public to understand and advocate for the importance of good oral health care of dependent older adult patients is critical. The ECW recommends the ADA provide information on older adult oral health matters to the public by developing educational material, targeted at the families of patients, that addresses their role in assisting in oral care and make it available on the public facing ADA website; supporting and evaluating community based interdisciplinary programs that bring health promotion and prevention and care to seniors where they live and congregate; and developing a public service campaign on the oral systemic connection and oral care of the elderly.

As older adult patients become more medically, functionally, cognitively complex, they face increasing mobility limitations when they become homebound or move into long term care facilities (LTC). The challenges for these patients are twofold--they often are not receiving the daily oral care they require, and they are not accessing dental care to treat their disease. The ECW recommends the ADA increase oral health care delivery in long term care facilities by developing an inventory of existing oral health training material and promote its use by care providers and accrediting facilities; publish this information to the public through the ADA public facing website; develop recommendations in cooperation with State Dental Directors as to how the oral health needs of medically, functionally, or cognitively complex patients in LTC should be addressed, including the evaluation of mobile clinics, dental chairs in the facility, teledentistry and other options; advocate for dental directors in all LTC facilities, and improve oral health care by utilizing community dental health coordinators (CDHCs) and dental hygienists; promote the educational content from the course developed through the National Elder Care Advisory Committee on working in LTC and make the content available to educational institutions at no charge. Further, the ECW encourages the ADA to promote inter- and intra-professional education and practice in LTC and that the ADA advocate to have LTC facilities included as Health Professional Shortage Areas (HPSA).

The ECW recognizes the strength of the ADA's advocacy efforts at the local, state and federal levels and encourages the ADA to prioritize advocacy efforts to improve oral health care in seniors by hosting a periodic all-stakeholder summit to discuss issues related to oral health of the elderly; advocate for state, private and federally funded programs that use incentives such as forgiveness of student debt in return for a work placement for specified periods of time in areas of need; and improve communications to underserved communities through use of health literacy guidelines, patient navigators, CDHCs and dental hygienists.

And finally, the ECW recognizes that the workflow of a dental practice is not well integrated with the workflow of other health care providers and payers, resulting in barriers to the smooth flow of referrals, information and patients within the health care system. The ECW recommends the ADA continues to

support the simplification of practice management by developing best practices to facilitate consent for treatment from legal guardians; developing best practices compliant with HIPAA for information sharing with family members and dual consent; reducing the administrative burden of government funded plans; improving intercommunication and information sharing between providers of electronic health records and electronic dental record systems; and participating in discussions with the Office of the National Coordinator for Health Information Technology.

Summary of Elder Care Strategies

As the population ages, it is critical that the oral health needs of the elderly be recognized through a variety of strategies discussed in this report. The recommendations listed are consistent with the goals and objectives for ADA's Strategic Plan 2020-2025. These recommendations address Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

Resolutions

(Resolution 70:Worksheet:5132)
(Resolution 71:Worksheet:5137)
(Resolution 72:Worksheet:5140)
(Resolution 73:Worksheet:5141)
(Resolution 74:Worksheet:5142)
(Resolution 75:Worksheet:5145)
(Resolution 76:Worksheet:5146)
(Resolution 77:Worksheet:5148)
(Resolution 78:Worksheet:5150)
(Resolution 79:Worksheet:5152)
(Resolution 80:Worksheet:5154)
(Resolution 81:Worksheet:5156)
(Resolution 82:Worksheet:5158)

Resolution No. 70 New

Report: Report of the Elder Care Workgroup Date Submitted: August 2020

Submitted By: Elder Care Workgroup

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

ORAL HEALTH CARE FOR THE ELDERLY

Background: In 2018, the House of Delegates adopted Resolution 33H, which directed the President to appoint an ad hoc committee to review the Association's current policies and to identify an implementation plan to address elder care, including Medicare. This presidentially-appointed elder care workgroup (ECW) was formed in February 2019. Progress was made throughout the year to develop a comprehensive elder care strategy and in order to continue the charge in the original resolution to also address financing of dental care, a resolution to continue the group was submitted and adopted at the 2019 House, Resolution 72H, to present a recommended Comprehensive Strategic Elder Care policy to the 2020 House.

The ECW discussed a variety of strategies apart from financing care that the ADA should implement in order to serve the older adult population, age 65 and over. It is essential that oral health be recognized as a vital component of health, by practitioners, patients and the public at large. For older adult patients, barriers to access and the perception about affordability of care are contributing factors to a utilization rate below fifty percent. As patients age, it is important to deliver needed treatment with a focus on preventing later decay, so that as older adults become increasingly medically, functionally, and cognitively complex patients, their oral health does not decline.

Therefore, the ECW recommends the following overarching policy resolution to support the ADA's efforts:

Resolution

70. Resolved, that the American Dental Association supports the development of policy at the federal, state, and local levels that supports the fair, equitable, choice-driven provision of dental care to elderly patients.

BOARD COMMENT: The Board approved proposed additional language to explain and clarify why this new policy was necessary.

70B. Resolved, that the American Dental Association supports the development of policy at the federal, state, and local levels that supports the fair, equitable, choice-driven provision of dental care to promote improved health and well-being in elderly patients.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

Vote: Resolution 70B

ARMSTRONG	No	HERRE	Yes	LEARY	Yes	ROSATO	Yes
DOROSHOW	Yes	HIMMELBERGER	Yes	MCDOUGALL	Yes	SABATES	Yes
EDGAR	Yes	KESSLER	Yes	NORBO	Yes	SHEPLEY	Yes
FIDDLER	Yes	KLEMMEDSON	Yes	RAPINI	Yes	STEPHENS	Yes
HARRINGTON	No	KYGER	Yes	RODRIGUEZ	Yes	THOMPSON	Yes

Resolution No. 71 New

Report: Report of the Elder Care Workgroup Date Submitted: August 2020

Submitted By: Elder Care Workgroup

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

FINANCING ORAL HEALTH CARE FOR ADULTS AGE 65 AND OLDER

Background: In 2018, the House of Delegates adopted Resolution 33H, which directed the President to appoint an ad hoc committee to review the Association's current policies and to identify an implementation plan to address elder care, including Medicare. This presidentially-appointed elder care workgroup (ECW) was formed in February 2019. Progress was made throughout the year to develop a comprehensive elder care strategy and in order to continue the charge in the original resolution to also address financing of dental care, a resolution to continue the group was submitted and adopted at the 2019 House, Resolution 72H, to present a recommended Comprehensive Strategic Elder Care policy to the 2020 House.

The key to success of any strategy to increase dental care utilization among adults age 65 and older is dependent on fair, equitable, choice driven financing of dental care. ADA policies support principles that private dental benefits are effective; that dentistry should be addressed separately from medicine in any health care reform legislation; that cost-effective allocation of limited government funding is essential; that patients with the greatest needs should be first in line for care; and that a patient should have the right to choose their dentist and their level of care.

Keeping in mind existing ADA policies, as well as the original charge in Resolution 33H-2018 for the Elder Care Workgroup (ECW) to consider proposed minimum provisions the ADA would support for a dental benefit in Medicare, the ECW deliberated over extensive data and research regarding financing oral health care. The ECW weighed and balanced a comprehensive set of factors, including: increasing the total number of persons covered by oral health care benefits; the willingness of dentists to participate in the solutions; the solutions do not add administrative burdens to dentists; the solutions modify existing dental plans; solutions are simple and easy to understand by the patients; solutions support the continuation of independent private practices; solutions may provide cost savings to the system; solutions support free market principles; and solutions are supported by state dental associations.

The ECW concluded that targeted solutions to provide equitable access to care are most appropriate and are recommending several solutions to provide dental benefits to adults age 65 and older.

These include: Defining essential dental care through the existing Medicare structure for medically frail persons; providing uniform benefits through state Medicaid programs for persons at or below 100% of the Federal Poverty Rate (FPL) ($17,420 for a two-person household in 2020); developing a new dental benefit program for adults age 65 and older whose incomes are between 100-400% of the FPL (between

$17,420 and $68,960 for a two-person household in 2020)[1]; advocating for a uniform dental benefit in Medicare Part C (Medicare Advantage Plans); and endorsing dental benefit plans for purchase by adults age 65 and older with varying levels of benefits through the appropriate ADA agency. Each of these recommendations is discussed in greater detail below.

Rather than follow the traditional approach to dental benefits, the Elder Care Workgroup (ECW) determined a different plan design for providing levels of care would better serve the needs of adults age 65 and older. These are:

Level I:
- Emergency treatments: Procedures to treat or relieve pain and infection, including emergent extractions
- Prevention: Annual exam, diagnostic radiographic images, and at least twice a year prophylaxis
- Scaling and Root Planing
- Fluoride and Silver Diamine Fluoride (SDF) treatments

Level II:
- All Level I procedures
- Direct re-storative procedures
- Extraction of non-restorable teeth
- Pulpotomy
- Removable prosthetics to restore function

Level III:
- All Level I and Level II
- Crowns
- Fixed prosthetics
- Implants to support a full denture
- Endodontics
- Periodontal surgery

Level IV:
- All Level I, Level II, and Level III procedures
- Cosmetic Procedures
- Any procedure not listed in another level

State/Federal Programs for Adults Age 65 and Older ≤400% of Federal Poverty Level

Data available indicates the primary reason given as to why people over 65 do not seek dental care are financial concerns. The median income of older persons in 2017 was $32,654 for males and $19,180 for females.[2] In 2011, the U.S. Census Bureau released a new Supplemental Poverty Measure (SPM). The SPM methodology shows a significantly higher number of older persons below poverty than is shown by the official poverty measure. For persons age 65 and over, this poverty measure showed a poverty level of 14.1% in 2017 (almost 5 percentage points higher than the official rate of 9.2%). Unlike the official poverty rate, the SPM takes into account regional variations in the cost of housing etc. and, even more significantly, the impact of both non-cash benefits received (e.g. SNAP/food stamps, low income tax credits, and WIC) and non-discretionary expenditures including medical out-of-pocket (MOOP) expenses.

[1] Federal Poverty Guidelines (updated January 2020): https://aspe.hhs.gov/poverty-guidelines
[2] Administration on Aging "2018 Profile of Older Americans"; accessed March 18, 2020

For persons 65 and over, MOOP was the major source of the significant differences between these measures. The SPM does not replace the official poverty measure. [3]

The ECW recognizes these individuals need financial assistance to access dental care, and recommends that persons whose income is ≤100% of the FPL ($17,420 for a two-person household in 2020) should access dental care through their state's Medicaid program. The ADA should advocate that each state program provide Level II benefits to income-eligible adults age 65 and over.

The forgotten middle income adults age 65 and older, whose incomes are between 100-400% of the FPL (between $17,420 and $68,960 for a two-person household in 2020), also need assistance in financing care.[4] The ECW recommends the ADA seek development of a new federal program for these individuals, modeled after the federal Children's Health Insurance Program (CHIP) that should provide Level II benefits.

Medicare Advantage Programs

In 2018, one in three (34%) Medicare beneficiaries – 20.4 million people – is enrolled in a Medicare Advantage plan.[5] These private plans contract with Medicare and provide the equivalent of Part A and Part B Medicare benefits. Often, these plans provide prescription drug coverage; some offer dental benefits, vision and hearing services. Deductibles apply according to the plan selected. There are usually procedures in place to be referred for treatment but the plans may limit physicians and hospitals for non-emergency care.

Dental benefits in Medicare Advantage plans vary widely when available. The ECW supports freedom of choice for those who opt to purchase Advantage plans over traditional Medicare A and B. In order to provide standard dental benefits for adults age 65 and older enrolled in Advantage plans, the ECW recommends appropriate action be taken to require all Advantage plans to provide Level 1 services, with optional Level II and Level III benefit plans available at increased premiums.

ADA Endorsed Dental Plans

A majority of adults age 65 and older enroll in traditional Medicare Parts A and B, which provide very limited dental benefits, even after successfully adopting the ECW proposed coverage for medically frail persons. The ECW recognized that the Medicare system has been built since its inception for the delivery of medical care, with complex payment systems for hospitals, physicians, pharmacies, and durable medical equipment, among other providers. Dental care delivery is fundamentally different, using a separate coding set and reimbursement system that is well known to US dentists and office personnel. Dental care delivered in office settings allows patients suffering from dental pain to receive appropriate, effective treatment less expensively than in hospital emergency rooms. In order to provide dental benefits to this large population of adults age 65 and older, while preventing disruption of dental office workflows, minimizing administrative burdens, and diverting unnecessary hospital emergency room visits, the ECW recommends that the ADA endorse dental benefit plans designed to cover Level I, II, III and IV services which can be purchased by adults age 65 and older.

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[3] U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement; POV01: Age and Sex of All People, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race: 2017; "Income and Poverty in the United States: 2017," P60-263, issued September, 2018; Poverty Thresholds for 2017 by Size of Family and Number of Related Children Under 18 Years; and "The Supplemental Poverty Measure: 2017," P60-265, revised September 2018.

[4] Federal Poverty Guidelines (updated January 2020): https://aspe.hhs.gov/poverty-guidelines

[5] https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage/; accessed March 16, 2020

Oral health care for a large and growing segment of our population depends on acceptable and sustainable financing of that care. Therefore, the ECW proposes the following resolution to accomplish this goal:

Resolution

Financing Oral Health Care for Adults Age 65 and Older

71. Resolved, recognizing that oral health care for a large and growing segment of our population depends on acceptable and sustainable financing of that care, the ADA supports access to oral health services by providing dental benefit programs through the following mechanisms:

1. All state Medicaid programs should offer Levels I and II benefits for adults age 65 and older whose income is at or below 100% of the Federal Poverty Level (FPL $17,420 for a two-person household in 2020);
2. A new federal program for oral health care, similar to the Children's Health Insurance Plans and providing Level I and Level II benefits, should be developed to assist adults age 65 and older whose incomes are between 100-400% of the FPL (between $17,420 -$68,960 for a two-person household in 2020);
3. All Medicare Advantage plans should include Level I dental benefits, with optional Level II and III plans offered to adults age 65 and older at increased premiums;
4. The ADA should consider entering into endorsement agreements with private dental benefit plans offering ADA's designated Levels I, II, III or IV plans to all adults age 65 and over;
5. Rather than follow the traditional approach to dental benefits, the ADA supports a different plan design for providing levels of care that would better serve the needs of adults age 65 and older.

Level I:
- Emergency treatments: Procedures to treat or relieve pain and infection, including emergent extractions
- Prevention: Annual exam, diagnostic radiographic images, and at least twice a year prophylaxis
- Scaling and Root Planing
- Fluoride and Silver Diamine Fluoride (SDF) treatments

Level II:
- All Level I procedures
- Direct restorative procedures
- Extraction of non-restorable teeth
- Pulpotomy
- Removable prosthetics to restore function

Level III:
- All Level I and Level II procedures
- Crowns
- Fixed prosthetics
- Implants to support a full denture
- Endodontics
- Periodontal surgery

Level IV:
- All Level I, Level II, and Level III procedures
- Cosmetic Procedures
- Any procedure not listed in another level

BOARD RECOMMENDATION: Vote Yes.

Vote: Resolution 71

ARMSTRONG	Yes	HERRE	Yes	LEARY	Yes	ROSATO	No
DOROSHOW	Yes	HIMMELBERGER	Yes	MCDOUGALL	Yes	SABATES	Yes
EDGAR	Yes	KESSLER	No	NORBO	Yes	SHEPLEY	Yes
FIDDLER	Yes	KLEMMEDSON	Yes	RAPINI	Yes	STEPHENS	No
HARRINGTON	Yes	KYGER	Yes	RODRIGUEZ	Yes	THOMPSON	No

Resolution No. 71S-1 Substitute

Report: Report of the Elder Care Workgroup Date Submitted: September 2020

Submitted By: Ninth District

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

SUBSTITUTE FOR RESOLUTION 71: FINANCING ORAL HEALTH CARE FOR ADULTS AGE 65 AND OLDER

The following substitute for Resolution 71 (Worksheet:5137) was submitted by the Ninth Trustee District and transmitted on September 28, 2020, by Michelle Nichols-Cruz, Michigan Dental Association.

Background: The Eldercare Workgroup has put forth a comprehensive policy on financing oral health for adults over age 65. However, the proposed four-program (Medicaid, CHIP, Medicare Advantage and Private model) with four levels of benefits (Level I, II, III, IV) proposed in Resolution 71 is a significantly complex policy proposal, places seniors into a program that is already challenged, does not address the issue of reimbursement and creates a tiered-system of procedures moving us away from our position that dentistry (as a whole) is essential. A policy that is less specific but stipulates our position on the most relevant issues may provide a stronger basis for advocacy efforts. Our goal is to achieve common ground in the form of a model that is both sustainable for practices and supports oral health for our seniors.

Specific policy issues included in Resolution 71 as proposed by the Eldercare are discussed below:

Program Eligibility. Limited public funding should be used towards supporting our most vulnerable seniors. At 400% FPL, around 60% of U.S. seniors over age 65 will be eligible for a benefit (incomes of $68,960 for a 2-person household).[1]

Leveraging existing public programs. With regards to Medicaid, the ADA has argued for years that the Medicaid program is underfunded and must be fixed. Medicaid is often dependent on state budgets and has thus far not supported meaningful coverage for low-income working-age adults. A *single federal* Child Health Insurance Program-like (CHIP-like) program may be a viable policy option as long as the fee schedules are sufficient to support access to care.

Medicare Advantage is a program structured to deliver Part A and Part B covered services through private insurers. It is unclear to us how additional benefits such as dental, not covered within one of these parts, can be offered as a standard benefit to all Medicare Advantage enrollees (1/3 of individuals over age 65) with no path to offer a similar benefit to those enrolled in Original Medicare (2/3 of

[1] How Many Seniors Live in Poverty? Kaiser Family Foundation Issue Brief. Juliette Cubanski, Wyatt Koma, Anthony Damico, and Tricia Neuman. Published: Nov 19, 2018. Accessed September 10, 2020.

individuals over age 65). Current commercial Medicare Advantage plans already offer a dental benefit either to attract enrollees or a buy-up product that can be purchased.

A program like Medicare has enormous market power and is known to influence and shape the rest of the private sector. However, consumer advocacy groups and certain congressional legislators may be fixated on Medicare as the program of choice under which a dental benefit should be pursued. Under these circumstances, a policy that is less specific but offers guidance on critically important funding and structure issues may provide a stronger basis for advocacy efforts.

Program funding. Cost is a perceived barrier to oral health care. Fair fee schedules that satisfactorily sustain a dental practice are necessary to support access to care. In balance, advocating for an adequately funded program that is not dependent on state budgets is essential.

"Levels of care". Dentistry is essential. Achieving and maintaining optimal oral health should be the goal and the patient's dental needs must dictate treatment plans. Therefore, an arbitrary categorization of service types (e.g., excluding surgical periodontal care as a basic covered service) into "levels of care" cannot be justified. Instead, our position must support "comprehensive" services to the extent that such coverage is benchmarked against the benefit that is currently covered by commercial dental plans.

Resolution

71S-1. Resolved, that the American Dental Association recognizes that oral health care for adults age 65 and older depends on acceptable and sustainable financing of that care, and be it further

Resolved, that IF potential legislation is being developed to include dental benefits for adults age 65 and over in public programs, then the ADA shall support a program administered either at the state or federal level that:

- Covers individuals under 400% FPL
- Covers comprehensive services necessary to achieve and maintain oral health
- Is funded by the federal government and not dependent upon state budgets
- Is adequately funded to support an annually reviewed reimbursement rate such that at least 50% of dentists within each geographic area receive their full fee to support access to care
- Includes minimal and reasonable administrative requirements
- Allows freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit

BOARD RECOMMENDATION: Received after the August 2020 Board of Trustees meeting.

Resolution No. 71S-2 Substitute

Report: Report of the Elder Care Workgroup Date Submitted: October 2020

Submitted By: Fourteenth Trustee District

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-10: Dental benefit programs will be sufficiently funded and efficiently administered.

How does this resolution increase member value: See Background

SUBSTITUTE FOR RESOLUTION 71: REMOVING BARRIERS TO CARE FOR THOSE AGED 65 AND ABOVE

The following resolution was adopted by the Fourteenth Trustee District and transmitted on October 12, 2020, by Ms. Molly Pereira, associate executive director, operations, Colorado Dental Association.

Background: The statistics outlined in the Elder Care Workgroup's report are unequivocal. Seniors access dental care far less than the population at-large. The problem is primarily that they lack the means to access the current delivery system and the available assistance is ineffective. This is especially alarming because, while being the fastest growing demographic, they are the demographic most likely to have systemic health problems complicated by poor oral health. While we have an ethical responsibility to advocate for senior's health, we also have a market interest in ensuring that seniors continue to access appropriate oral care.

Our approach to this problem must be both principled and pragmatic. We must begin by establishing the principles that will guide any effort to solve the problem. We have to establish the ideal that is our goal and the thresholds that cannot be violated before we enter into the pragmatic compromises forced on us by politics and negotiation. Only then can we achieve an acceptable plan that accomplishes all the goals.

This resolution is based on five principles for an elder care program. It then suggests minimum thresholds that are consistent with our current policies. These principles are outlined in more detail in the appendix, but can be summarized as:

1. Any stratification of care is antithetical to dental care being essential.
2. Means as a basis for eligibility is antithetical to providing freedom of choice.
3. Not providing comprehensive care is antithetical to oral health being essential to overall health.
4. Allowing politics to dictate the care of our most honored citizens is antithetical to our professional responsibility.
5. The massive pool of health care dollars already allocated to senior care has room for dentistry's "little sliver of the pie."

These principles are not sacrosanct, but they are consistent with our current policies. This is what should guide us in any discussion of a program to provide seniors with access to oral health care. All of us will be seniors someday. Some of us sooner than others. In that spirit, we offer the following resolution as a substitute for the Elder Care Taskforce's recommendation:

Resolution

71S-2. Resolved, that the ADA advocate for a program to remove the significant barriers to essential oral health care for adults aged 65 and older and be it further

Resolved, that a program for adults aged 65 and older must have the following attributes:

- It must recognize that oral health care is essential to overall health and well-being
- It must allow access to the full scope of dental services necessary for overall health, function and well-being
- It must not prevent seniors from electively receiving any services for which they may be deemed ineligible by the program
- It must not discriminate on the basis of means, but should encourage individual participation in financing oral health care through graduated individual contributions based on means
- It must provide and maintain levels of reimbursement at or above the median of prevailing regional uncontracted fees
- It must be acceptable to enough dentists to build and maintain a robust network capable of providing the full scope of services in all areas of proximal need
- It must minimize or reimburse the cost of excessive bureaucratic burdens for claiming or required reporting
- It must be funded to the maximum extent possible by savings to publicly-funded programs created by the prevention and mitigation of systemic disease resulting from improved oral care
- It must reasonably protect people's ability to choose the dentist and treatment plan best suited to their needs and goals

BOARD RECOMMENDATION: Received after the August 2020 Board of Trustees meeting.

APPENDIX – RESOLUTION 71S-2

Five Principles for an Elder Care Plan

1. **Any stratification of care is antithetical to dental care being essential.**

There are no gradations to essential. Something either is essential, or it is not. We wouldn't have to adopt a policy saying dental care is essential if we didn't so loudly proclaim that it is not by the current reimbursement system. That is a different discussion, but that thinking runs deep in the proposal from the elder care taskforce and as a result risks cross-contaminating our entire delivery system. The biases resulting from the limits of our current system should not prevent us from seeking a system we believe will work better.

Whether there are two tiers, four tiers, or a continuum of priority, it only provides a framework on which we label the care we provide essential or "not as essential" (read that non-essential). Medicine does not create these hierarchies or at least not to the level of stark relief seen in dental care. What is "necessary" is determined by the patient's condition, not an artificial hierarchy created by a benefit plan. Unlike dental benefits, health insurance plans pool risk so that even rare conditions can receive the care required. While we may complain about the high premiums of health insurance, if we, or God forbid, our child, requires a treatment we cannot afford, the pooled resources are available and welcome.

A bone marrow transplant doesn't seem essential until you have leukemia. A dental implant may not seem essential either, but it is likely that you know patients whose struggle with an impossible removable prosthesis accelerated or directly led to their early demise from other health complications. That doesn't mean that these treatments must be available simply on-demand, but if we truly believe that oral health is essential to overall health, we should not arbitrarily hinder its accessibility.

Resolution 71 not only stratifies care by types of procedures, but also creates tiers of accessibility by means. Apparently, whether dental care is essential is not only dependent on what you need, but also how much you make. It effectively rations care rather than facilitating it. The proposal takes what is worst from a dysfunctional Medicaid system and presents it as a solution for our fastest growing and most vulnerable population

If we propose such a hierarchical system, why wouldn't commercial dental benefits plans apply those same hierarchies to their products? Not only do we propose a system for seniors that is doomed to failure, or at least to chronic dysfunction, we also risk poisoning the system that currently supports us.

2. **Means as a basis for eligibility is antithetical to providing freedom of choice.**

In a humanitarian society, means should determine what a person is able to contribute to their care, not what they should have access to. While the principle that "if you can't afford it, you can't have it" is useful from a budgeting standpoint, the very existence of any kind of insurance is a testament to our societal belief that it doesn't apply to everything. We have mechanisms that allow us to overcome our short-term limitations like financing. We provide relief in the form of disaster assistance. We have safety net programs that provide food, shelter and health care.

Health care is unique because availability is so closely tied to the institutions that underwrite it. For example, the hospitals in most communities are quasi-public institutions that almost no one can afford. To access them you must be part of certain health plans or public assistance programs. Your means may give you more choices, but you only access it through an institutional avenue like a provider network or health plan. That is quite different from dentistry where our concept of "freedom-of-choice" is predicated on patients having the ability to select their own provider and treatment plan. Ironically, that is all but an

anachronism in dentistry as managed care is pervasive and patients that are willing to look beyond their provider network are increasingly scarce.

To a great extent, if you are over 65 your only choice for health care is through Medicare. If you have the means, you can supplement or augment Medicare coverage to a very limited extent, but Medicare will color even those choices indelibly. It might be what scares us the most about Medicare, but it is inevitable because, unlike benefits for the active workforce, there simply are not large-scale plan purchasers to bring competition to the system. We can resist, but the wind is blowing with increasing ferocity in the opposite direction.

Resolution 71, in an effort to avoid these prevailing winds, recommends a complex and nuanced plan that is otherwise familiar in its embrace of Medicaid and avoidance of Medicare. It preserves choice for the few at the expense of the many. It would require considerable investment by both state and federal sources to "fix" what is wrong with Medicaid with no thought to how those funds would be raised or concept of how to build the broad consensus of both state and federal lawmakers that would be required to enact such a plan. In a word, it is doomed.

We must recognize that true choices require both means and commitment. Our priority should first be commitment. What would a successful plan look like? It must be a plan that considers oral health to be an essential element of overall health. It must be comprehensive in the sense that it is responsive to patient need in the broadest sense with a lesser emphasis on what patient's may want but not necessarily need. It must recognize that its parameters will largely dictate the extent of how both will be met. It must be not just acceptable, but desirable to practitioners. That means adequately funded with a manageable bureaucracy. It must have adaptation built into its DNA so that it neither becomes obsolete nor unworkable. Those principles must be maintained. It is imperative that past history not dictate future performance.

3. **Not providing comprehensive care is antithetical to oral health being essential to overall health**

How could we as health professionals advocate for something whose goal was less than optimal health for seniors? For the most part, those that fall into the elder care age group are permanently in the fixed or limited income category. While some are still employed for a few years or have secure investment portfolios, as a rule, the future likely brings less discretionary cash and increasing difficulty allocating resources to dental care. That means that it will only become more difficult to afford more complex care. In addition, age brings more complex and limiting systemic health problems that might put restraints on the scope and quality of care that can be received. Both these reasons argue against a "safety net" solution.

Comprehensive care is not the same as unlimited care. Limits can arise from many sources, including funding, but the ability of the program to be responsive to needs requires that these limitations be secondary rather than tying the hands of practitioners as a primary function of the program. Health is not replaceable; it must be preserved and restored. What it will take to maintain that health throughout an individual's waning years should remain adequately accessible even as circumstances change.

Comprehensive care does not come without responsibilities. Reasonable requirements for health maintenance or financial participation could be included, but they must be non-discriminatory and fundamentally fair for all participants.

Resolution 71 avoids comprehensive care, or limits access to it by an inverse means test. It is short-sighted because it almost ensures that those who need care the most are forced into a more costly track

of belated complex care or recurrent chronic palliative care. This says nothing of the potential loss of quality of life.

Comprehensive care is not elective. We often are frustrated by patients that ignorantly refuse necessary care, but we should lament any system that withholds necessary care by design. That is bad for dentists and patients.

4. **Allowing politics to dictate the care of our most honored citizens is antithetical to our professional responsibility.**

The program we advocate for should not be determined by whether there are Republicans or Democrats in power. Our highest calling is to our personal and professional values, not our affiliations or human allegiances. The public expects that as professionals our ethics will not be sacrificed to profit or self-interest. Patients expect our entire dedication to their health and reasonably construe that to our public advocacy on their behalf. If we cannot uphold that trust, we should be prepared for the costly consequences of lost trust.

We need not be pushed into an expansion of an existing program, nor should we simply be stymied by the negative connotations of the label it currently carries. Do we really care whether our ideal program for seniors carries the Medicare label or are we simply allowing a gut reaction to negative past experiences prevent us from getting what we really want? Equally problematic is limiting our pursuit of that ideal by accepting the limitations and dysfunction of an existing program or allowing the limits of the other perceived “stakeholder’s” imaginations keep us from what we know will work.

Resolution 71, simply put, lacks imagination. It fails to see possibilities while miring us in the dysfunctions of programs that have consistently grown worse in spite of our best efforts to improve them. At best, it acquiesces to an incremental expansion of Medicaid. Is a program that most of us would find inadequate for our own kids the place we want our parents or ourselves to be? By all means, let’s fix Medicaid, but let’s not relegate our fastest growing segment to its current dysfunction. How practical is that anyway based on the state’s responsibility to fund and structure it?

We cannot ignore politics, but we should not let it dictate, when we know what is best. We have shown ourselves to be highly capable and successful at influencing political outcomes. (Much more ably than we have influenced other third parties.) We should be influential advocates not passengers on the winds of politics.

5. **The massive pool of health care dollars already allocated to senior care has room for dentistry’s “little sliver of the pie.”**

The resources dedicated to senior care are not unlimited. Additional revenues may be required, but the level may be decidedly less than many anticipate. It is impossible to calculate what the impact of maintaining adequate oral health would have on the amount spent on treating a whole host of chronic diseases, nutritional deficiencies or behavioral health. We know that preventing oral disease is cheap and even treating it pales in comparison to what it costs to treat chronic diseases.

There is no reason to believe that a properly constructed dental benefit would escalate costs the way that medicine has. It is even possible that the thoughtful conception of a dental benefit could instruct the out-of-control problems of our broader health system. For years we have touted, “Dentistry: Health Care that Works.” That must be more than a platitude. We need to bring that attitude to senior care.

Resolution 71 avoids any connection to the potential resources of Medicare. It would rely on the combined resources of state and local government, something which has proved decidedly unreliable and inconsistent for decades.

Seniors are not going to receive more health care for nothing. What they might receive is much better health care and an improved quality of life for only a little more. It is time to explore the possibilities.

Resolution No. 71RCS-1 Citation for Original Resolution: Grey:5183

Submitted By: Tenth Trustee District Date Submitted: October 18, 2020

Reference Committee Report On: D (Legislative, Health, Governance and Related Matters)

Financial Implications (if different from original resolution): $ None

SUBSTITUTE FOR RESOLUTION 71RC: FINANCING ORAL HEALTH CARE FOR ADULTS AGE 65 AND OLDER

The following substitute for Resolution 71RC was submitted by the Tenth Trustee District and submitted Dr. Kevin Dens, past president and past speaker of the House, Minnesota Dental Association.

Background: The Tenth District opposes 71RC because it contains a prescriptive plan design using levels of care. A proposed plan design with tiers has no place in Association policy. Passing a policy that proposes tiers could be seen as the ADA's statement for an "essential oral health benefit for seniors." Moreover, current third party payers will see this as ADA policy endorsing tier design. That policy could migrate into the commercial marketplace and result in the proliferation of low-cost PPO plans touted to provide a dental benefit but are capped at a limited tier 1 level endorsed by the ADA. What follows is a proposed substitute to 71RC. The ADA must not punt on the development of such an essential position statement. Our members deserve an Association who is prepared to address their needs. The House should not leave such an important decision to the Board.

Resolution

71RCS-1. Resolved, that the American Dental Association recognizes that oral health care for adults age 65 and older depends on acceptable and sustainable financing of that care, and be it further

Resolved, that for the purpose of presenting potential legislation that includes dental benefits for adults age 65 and over in a tax payer-funded public program such as Medicaid, CHIP, privately administered Medicare or other federal or state programs, then the ADA shall support a program that:

- Covers individuals under 300% FPL
- Covers the range of services necessary to achieve and maintain oral health
- Is primarily funded by the federal government and not fully dependent upon state budgets
- Is adequately funded to support an annually reviewed reimbursement rate such that at least 50% of dentists within each geographic area receive their full fee to support access to care
- Includes minimal and reasonable administrative requirements
- Allows freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit

and be it further,

Resolved, that the appropriate agency urge passage of legislation to enable dental offices to offer in-office membership plans to support direct care for all seniors.

Resolution No. 71RCS-3 Citation for Original Resolution: Grey:5183

Submitted By: Third Trustee District Date Submitted: October 18, 2020

Reference Committee Report On: D (Legislative, Health, Governance and Related Matters)

Financial Implications (if different from original resolution): $ None

SUBSTITUTE FOR RESOLUTION 71RC FINANCING ORAL HEALTH CARE FOR ADULTS AGE 65 AND OLDER

The following substitute for resolution 71RC was submitted by the Third Trustee District and transmitted on October 18, 2020, by Ward Blackwell, Executive Director, Pennsylvania Trustee District.

Resolution

71RCS-3. Resolved, that the American Dental Association recognizes that oral health care for adults age 65 and older depends on acceptable and sustainable financing of that care, and be it further

Resolved, that IF potential legislation is being developed to include dental benefits for adults age 65 and over in public programs, such as Medicaid or CHIP, the ADA shall support a privately administered program either at the state or federal level that:

- Covers individuals under 200% FPL.
- Covers a range of services necessary to achieve and maintain oral health.
- Includes an optional, premium-based, privately administered component for those over 200% FPL that is not dependent upon government budgets.
- Is adequately funded to support an annually reviewed reimbursement rate such that at least 50% of dentists within each geographic area receive their full fee to support access to care.
- Includes minimal administrative requirements.
- Allows freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit.

Resolution No. 72 New

Report: Report of the Elder Care Workgroup Date Submitted: August 2020

Submitted By: Elder Care Workgroup

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

MODIFYING THE EXISTING MEDICARE DENTAL COVERAGE: STATUTORY DENTAL EXCLUSION

Background: In 2018, the House of Delegates adopted Resolution 33H, which directed the President to appoint an ad hoc committee to review the Association's current policies and to identify an implementation plan to address elder care, including Medicare. This presidentially-appointed elder care workgroup (ECW) was formed in February 2019. Progress was made throughout the year to develop a comprehensive elder care strategy and in order to continue the charge in the original resolution to also address financing of dental care, a resolution to continue the group was submitted and adopted at the 2019 House, Resolution 72H, to present a recommended Comprehensive Strategic Elder Care policy to the 2020 House.

The ECW reviewed the current covered dental services in Medicare, which is very narrowly focused on a subset of frail seniors with very specific medical conditions, and proposes changes to the statutory exclusion of certain dental services in order to expand them for these medically frail seniors.

Recognizing that the American Dental Association is an evidenced-based organization, the ECW advises that before any recommendations are made to modify the current statute in Medicare, that it should seek input from the ADA Council on Scientific Affairs as to procedures that can be substantiated by clinical research

Currently, Medicare will pay for dental services that are an integral part either of a covered procedure (e.g., reconstruction of the jaw following accidental injury), or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. Medicare will also make payment for oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances. Such examination would be covered under Part A if performed by a dentist on the hospital's staff or under Part B if performed by a physician.[1]

The statutory language in the Social Security Act (Section 1862 (a)) states: *"Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services*— Section 1862 (a (12)) states:

> *…where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental*

[1] https://www.cms.gov/Medicare/Coverage/MedicareDentalCoverage

services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services.[2]

Therefore, the ECW proposes the following resolution to accomplish the goal of expanding covered dental services for medically frail seniors under Medicare:

Resolution

Modifying the Existing Medicare Dental Coverage: Statutory Dental Exclusion

72. Resolved, that the appropriate ADA agencies should consider conducting a review of the current scientific evidence that would support expanding the oral health services provided to medically frail recipients prior to major medical or surgical treatments available through Medicare in order to determine next steps for modifying the Medicare statutory exclusion, with the recommendation that the review include but not be limited to the following:

- head and neck radiation therapies
- IV bisphosphonate therapy for cancer care
- organ transplants
- cancer chemotherapy including hematopoietic cell transplantation
- joint replacement
- cardiac valve replacement

BOARD RECOMMENDATION: Vote Yes.

Vote: Resolution 72

ARMSTRONG	Yes	HERRE	Yes	LEARY	Yes	ROSATO	Yes
DOROSHOW	Yes	HIMMELBERGER	Yes	MCDOUGALL	Yes	SABATES	Yes
EDGAR	Yes	KESSLER	No	NORBO	Yes	SHEPLEY	Yes
FIDDLER	Yes	KLEMMEDSON	Yes	RAPINI	Yes	STEPHENS	No
HARRINGTON	Yes	KYGER	Yes	RODRIGUEZ	Yes	THOMPSON	Yes

[2] https://www.cms.gov/Medicare/Coverage/MedicareDentalCoverage

Resolution No. 73 New

Report: Report of the Elder Care Workgroup Date Submitted: August 2020

Submitted By: Elder Care Workgroup

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

NATIONAL ELDER CARE ADVISORY COMMITTEE REVIEW

Background: In 2018, the House of Delegates adopted Resolution 33H, which directed the President to appoint an ad hoc committee to review the Association's current policies and to identify an implementation plan to address elder care, including Medicare. This presidentially-appointed elder care workgroup (ECW) was formed in February 2019. Progress was made throughout the year to develop a comprehensive elder care strategy and in order to continue the charge in the original resolution to also address financing of dental care, a resolution to continue the group was submitted and adopted at the 2019 House, Resolution 72H, to present a recommended Comprehensive Strategic Elder Care policy to the 2020 House.

The ECW discussed a variety of strategies apart from financing care that the ADA should implement in order to serve the older adult population, age 65 and over. It is essential that oral health be recognized as a vital component of health, by practitioners, patients and the public at large. For older adult patients, barriers to access and the perception about affordability of care are contributing factors to a utilization rate below fifty percent. As patients age, it is important to deliver needed treatment with a focus on preventing later decay, so that as older adults become increasingly medically, functionally, and cognitively complex patients, their oral health does not decline.

The ECW recognizes the ADA's ongoing commitment to addressing the needs of this population through the establishment and ongoing support for the National Elder Care Advisory Committee (NECAC). In light of the continuing opportunity to support this patient population, the ECW proposes the following resolution to assist the ADA in accomplishing its updated elder care strategies.

Resolution

73. Resolved, that the appropriate ADA agency should consider reviewing the funding, mandate, reporting structure and composition of the National Elder Care Advisory Committee to assist the ADA in accomplishing elder care strategies.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 74 New

Report: Report of the Elder Care Workgroup Date Submitted: August 2020

Submitted By: Elder Care Workgroup

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

ELDER CARE STRATEGIES ON CONTINUING EDUCATION

Background: In 2018, the House of Delegates adopted Resolution 33H, which directed the President to appoint an ad hoc committee to review the Association's current policies and to identify an implementation plan to address elder care, including Medicare. This presidentially-appointed elder care workgroup (ECW) was formed in February 2019. Progress was made throughout the year to develop a comprehensive elder care strategy and in order to continue the charge in the original resolution to also address financing of dental care, a resolution to continue the group was submitted and adopted at the 2019 House, Resolution 72H, to present a recommended Comprehensive Strategic Elder Care policy to the 2020 House.

The ECW discussed a variety of strategies apart from financing care that the ADA should implement in order to serve the older adult population, age 65 and over. It is essential that oral health be recognized as a vital component of health, by practitioners, patients and the public at large. For older adult patients, barriers to access and the perception about affordability of care are contributing factors to a utilization rate below fifty percent. As patients age, it is important to deliver needed treatment with a focus on preventing later decay, so that as older adults become increasingly medically, functionally, and cognitively complex patients, their oral health does not decline.

The ECW brainstormed a wide range of potential ideas and used a multi-vote process to prioritize the ideas that would make the strongest recommendations and positive impact on providing oral health care to older adult patients and improving their outcomes.

Part of the challenge in providing good oral health care to older adult patients is that the oral systemic health connection is not well understood by practitioners, patients and the population at large. Oral health care is important for older adults to be pain free, infection free and able to perform the activities of daily living. The disease incidence in this population includes both oral disease and other diseases where periodontal infection is a contributing factor (e.g. diabetes, Parkinson's, and coronary disease). Therefore, the ECW proposes the following resolution to accomplish this goal of increased understanding of the oral systemic health connection:

Resolution

74. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder

care strategies on both the oral-systemic connection and the dental management of the medically complex older adult as priority projects and be it further

Resolved, elevate the importance of both the oral-systemic connection and the dental management of the medically complex older adult to members and the public, as appropriate, by:

1. providing educational opportunities for the profession on the oral-systemic connection
2. promoting dental continuing education on treating the medically, functionally or cognitively complex patients through the Annual Meeting or other ADA meetings
3. developing and maintaining a roster of qualified speakers both the oral-systemic connection and the dental management of the medically complex older adult
4. developing presentations on both the oral-systemic connection and the dental management of the medically complex older adult for use by member state or local dental societies, and to be shared with other Associations and other Health Care Professionals

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 75 New

Report: Report of the Elder Care Workgroup Date Submitted: August 2020

Submitted By: Elder Care Workgroup

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

ELDER CARE STRATEGIES ON RESEARCH

Background: In 2018, the House of Delegates adopted Resolution 33H, which directed the President to appoint an ad hoc committee to review the Association's current policies and to identify an implementation plan to address elder care, including Medicare. This presidentially-appointed elder care workgroup (ECW) was formed in February 2019. Progress was made throughout the year to develop a comprehensive elder care strategy and in order to continue the charge in the original resolution to also address financing of dental care, a resolution to continue the group was submitted and adopted at the 2019 House, Resolution 72H, to present a recommended Comprehensive Strategic Elder Care policy to the 2020 House.

The ECW discussed a variety of strategies apart from financing care that the ADA should implement in order to serve the older adult population, age 65 and over. It is essential that oral health be recognized as a vital component of health, by practitioners, patients and the public at large. For older adult patients, barriers to access and the perception about affordability of care are contributing factors to a utilization rate below fifty percent. As patients age, it is important to deliver needed treatment with a focus on preventing later decay, so that as older adults become increasingly medically, functionally, and cognitively complex patients, their oral health does not decline.

At this time the research and teaching pipeline to address this is insufficient to meet the growing need to build the knowledge and confidence of dentists to treat older adult patients, specifically those with medical, functional and/or cognitive complexity.

The ECW brainstormed a wide range of potential ideas and used a multi-vote process to prioritize the ideas that would make the strongest recommendations and positive impact on providing oral health care to older adult patients and improving their outcomes.

The ECW recognizes that the provision of treatment to older adult patients would be strengthened with a more robust research effort. The lack of published data on the impact of oral health prevention on the total cost of care and improved health outcomes is currently not well understood or documented. And as important, the lack of translatable research on oral health treatment in the geriatric population as a whole, for medically, functionally and/or cognitively complex patients, limits the ability of clinicians to provide optimal care to this population. Therefore, the ECW proposes the following resolution to accomplish this goal:

Resolution

75. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder care strategies on research as priority projects, and be it further

Resolved, focus research by:

1. pursuing translatable research on the oral health treatment of geriatric populations including medically, functionally or cognitively impaired complex patients to establish the linkage between oral health care and overall health
2. leading in the collection and dissemination of evidence-based recommendations on the oral systemic health connection
3. studying states with dual eligible Medicare and Medicaid beneficiaries to determine the financial savings, health outcomes and costs of the programs
4. studying cost savings and health outcomes from dental benefit plans
5. promoting the implementation of new treatment approaches, such as Silver Diamine Fluoride or other minimally invasive interventions, and determining the beneficial effects of the treatments on older adult patients in terms of quality of life and cost effectiveness

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 76 New

Report: Report of the Elder Care Workgroup Date Submitted: August 2020

Submitted By: Elder Care Workgroup

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

ELDER CARE STRATEGIES ON INCREASED PREPAREDNESS OF EDUCATIONAL INSTITUTIONS

Background: In 2018, the House of Delegates adopted Resolution 33H, which directed the President to appoint an ad hoc committee to review the Association's current policies and to identify an implementation plan to address elder care, including Medicare. This presidentially-appointed elder care workgroup (ECW) was formed in February 2019. Progress was made throughout the year to develop a comprehensive elder care strategy and in order to continue the charge in the original resolution to also address financing of dental care, a resolution to continue the group was submitted and adopted at the 2019 House, Resolution 72H, to present a recommended Comprehensive Strategic Elder Care policy to the 2020 House.

The ECW discussed a variety of strategies apart from financing care that the ADA should implement in order to serve the older adult population, age 65 and over. It is essential that oral health be recognized as a vital component of health, by practitioners, patients and the public at large. For older adult patients, barriers to access and the perception about affordability of care are contributing factors to a utilization rate below fifty percent. As patients age, it is important to deliver needed treatment with a focus on preventing later decay, so that as older adults become increasingly medically, functionally, and cognitively complex patients, their oral health does not decline.

At this time the research and teaching pipeline to address this is insufficient to meet the growing need to build the knowledge and confidence of dentists to treat older adult patients, specifically those with medical, functional and/or cognitive complexity.

The ECW brainstormed a wide range of potential ideas and used a multi-vote process to prioritize the ideas that would make the strongest recommendations and positive impact on providing oral health care to older adult patients and improving their outcomes.

The ECW recommends that the ADA advance the increased preparedness of educational institutions to train dentists and specialists in elder care. Therefore, the ECW proposes the following resolution to accomplish this goal:

Resolution

76. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder

care strategies on increased preparedness of Educational Institutions as priority projects, and be it further

Resolved, increase preparedness of educational institutions to train dentists and specialists in elder care by:

1. advocating for geriatric fellowship programs; and encourage universities, the Department of Veterans' Affairs (VA), and hospitals to develop these; the fellows will play an important role in both the delivery of care, and the education of dental students
2. advocating for the inclusion of treating the elderly population, including complex cases, for pre-doctoral and relevant specialties in school curriculum
3. working with other relevant associations to develop curriculum guidelines for inter-professional education on both the oral-systemic connection and the dental management of the medically complex older adult

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 77 New

Report: Report of the Elder Care Workgroup Date Submitted: August 2020

Submitted By: Elder Care Workgroup

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

ELDER CARE STRATEGIES ON PUBLIC ADVOCACY

Background: In 2018, the House of Delegates adopted Resolution 33H, which directed the President to appoint an ad hoc committee to review the Association's current policies and to identify an implementation plan to address elder care, including Medicare. This presidentially-appointed elder care workgroup (ECW) was formed in February 2019. Progress was made throughout the year to develop a comprehensive elder care strategy and in order to continue the charge in the original resolution to also address financing of dental care, a resolution to continue the group was submitted and adopted at the 2019 House, Resolution 72H, to present a recommended Comprehensive Strategic Elder Care policy to the 2020 House.

The ECW discussed a variety of strategies apart from financing care that the ADA should implement in order to serve the older adult population, age 65 and over. It is essential that oral health be recognized as a vital component of health, by practitioners, patients and the public at large. For older adult patients, barriers to access and the perception about affordability of care are contributing factors to a utilization rate below fifty percent. As patients age, it is important to deliver needed treatment with a focus on preventing later decay, so that as older adults become increasingly medically, functionally, and cognitively complex patients, their oral health does not decline.

The ECW brainstormed a wide range of potential ideas and used a multi-vote process to prioritize the ideas that would make the strongest recommendations and positive impact on providing oral health care to older adult patients and improving their outcomes.

Ongoing education of the public to understand and advocate for the importance of good oral health care of dependent older adult patients is critical. Therefore, the ECW proposes the following resolution to accomplish this goal:

Resolution

77. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder care strategies on public advocacy as priority projects, and be it further

Resolved, provide information on elder oral health matters to the public by:

1. developing educational material, targeted at the families of patients, that addresses their role in assisting in oral care and make it available on the public facing ADA website
2. supporting and evaluating community based interdisciplinary programs that bring health promotion and prevention and care to seniors where they live and congregate
3. developing a public service campaign on both the oral-systemic connection and the dental management of the medically complex older adult

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 78 New

Report: Report of the Elder Care Workgroup Date Submitted: August 2020

Submitted By: Elder Care Workgroup

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

ELDER CARE STRATEGIES ON INTRA-PROFESSIONAL ADVOCACY

Background: In 2018, the House of Delegates adopted Resolution 33H, which directed the President to appoint an ad hoc committee to review the Association's current policies and to identify an implementation plan to address elder care, including Medicare. This presidentially-appointed elder care workgroup (ECW) was formed in February 2019. Progress was made throughout the year to develop a comprehensive elder care strategy and in order to continue the charge in the original resolution to also address financing of dental care, a resolution to continue the group was submitted and adopted at the 2019 House, Resolution 72H, to present a recommended Comprehensive Strategic Elder Care policy to the 2020 House.

The ECW discussed a variety of strategies apart from financing care that the ADA should implement in order to serve the older adult population, age 65 and over. It is essential that oral health be recognized as a vital component of health, by practitioners, patients and the public at large. For older adult patients, barriers to access and the perception about affordability of care are contributing factors to a utilization rate below fifty percent. As patients age, it is important to deliver needed treatment with a focus on preventing later decay, so that as older adults become increasingly medically, functionally, and cognitively complex patients, their oral health does not decline.

The ECW brainstormed a wide range of potential ideas and used a multi-vote process to prioritize the ideas that would make the strongest recommendations and positive impact on providing oral health care to older adult patients and improving their outcomes.

Ongoing education of medical professionals to understand and advocate for the importance of good oral health care of dependent older adult patients is critical. Therefore, the ECW proposes the following resolution to accomplish this goal:

Resolution

78. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder care strategies on intra-professional advocacy as priority projects, and be it further

Resolved, elevate the importance of oral health care in the elderly to medical professionals by:

1. advocating for the addition of teeth, gums, mucosa, tongue, and palate examination to the traditional head, ears, eyes, nose, and throat (HEENT) examination (HEENOT[1])
2. identifying, evaluating and promoting risk assessment tools for oral health care to nursing professionals
3. advocating for the US Preventive Services Task Force Guidelines to be updated to include additional and revised guidelines on oral health care

BOARD RECOMMENDATION: Vote Yes.

Vote: Resolution 78

ARMSTRONG	Yes	HERRE	Yes	LEARY	Yes	ROSATO	No
DOROSHOW	Yes	HIMMELBERGER	Yes	MCDOUGALL	Yes	SABATES	Yes
EDGAR	Yes	KESSLER	No	NORBO	Yes	SHEPLEY	Yes
FIDDLER	Yes	KLEMMEDSON	Yes	RAPINI	No	STEPHENS	Yes
HARRINGTON	Yes	KYGER	Yes	RODRIGUEZ	Yes	THOMPSON	Yes

[1] Am J Public Health. 2015 Mar;105(3):437-41. doi: 10.2105/AJPH.2014.302495. Epub 2015 Jan 20.

Putting the mouth back in the head: HEENT to HEENOT.

Haber J1, Hartnett E, Allen K, Hallas D, Dorsen C, Lange-Kessler J, Lloyd M, Thomas E, Wholihan D. PMID:25602900

Resolution No. 79 New

Report: Report of the Elder Care Workgroup Date Submitted: August 2020

Submitted By: Elder Care Workgroup

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

ELDER CARE STRATEGIES ON LONG TERM CARE FACILITIES

Background: In 2018, the House of Delegates adopted Resolution 33H, which directed the President to appoint an ad hoc committee to review the Association's current policies and to identify an implementation plan to address elder care, including Medicare. This presidentially-appointed elder care workgroup (ECW) was formed in February 2019. Progress was made throughout the year to develop a comprehensive elder care strategy and in order to continue the charge in the original resolution to also address financing of dental care, a resolution to continue the group was submitted and adopted at the 2019 House, Resolution 72H, to present a recommended Comprehensive Strategic Elder Care policy to the 2020 House.

The ECW discussed a variety of strategies apart from financing care that the ADA should implement in order to serve the older adult population, age 65 and over. It is essential that oral health be recognized as a vital component of health, by practitioners, patients and the public at large. For older adult patients, barriers to access and the perception about affordability of care are contributing factors to a utilization rate below fifty percent. As patients age, it is important to deliver needed treatment with a focus on preventing later decay, so that as older adults become increasingly medically, functionally, and cognitively complex patients, their oral health does not decline.

The ECW brainstormed a wide range of potential ideas and used a multi-vote process to prioritize the ideas that would make the strongest recommendations and positive impact on providing oral health care to older adult patients and improving their outcomes.

As older adult patients become more medically, functionally, cognitively complex, they face increasing mobility limitations when they become homebound or move into long term care facilities (LTC). The challenges for these patients are twofold – they often are not receiving the daily oral care they require, and they are not accessing dental care to treat their disease. Therefore, the ECW proposes the following resolution to accomplish this goal:

Resolution

79. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder care strategies on long term care facilities as priority projects, and be it further

Resolved, increase oral health care delivery in long term care facilities by:

1. developing an inventory of existing oral health training material and promote its use by care providers and accredited facilities
2. publishing this information to the public through the ADA public facing website
3. developing recommendations in cooperation with State Dental Directors as to how the oral health needs of medically, functionally, or cognitively complex patients in long term care facilities (LTC) should be addressed and include the evaluation of mobile clinics, dental chairs in the facility, teledentistry and other options
4. advocating for dental directors in all Long Term Care facilities, and improving oral health care by utilizing community dental health coordinators (CDHCs) and dental hygienists
5. promoting the educational content from the course developed through the National Elder Care Advisory Committee on working in Long Term Care facilities and making the content available to educational institutions at no charge
6. promoting inter- and intra-professional education and practice in LTC
7. advocating for Long Term Care to be included in Health Professional Shortage Areas

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 80 New

Report: Report of the Elder Care Workgroup Date Submitted: August 2020

Submitted By: Elder Care Workgroup

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

ELDER CARE STRATEGIES ON INTER-AGENCY ADVOCACY

Background: In 2018, the House of Delegates adopted Resolution 33H, which directed the President to appoint an ad hoc committee to review the Association's current policies and to identify an implementation plan to address elder care, including Medicare. This presidentially-appointed elder care workgroup (ECW) was formed in February 2019. Progress was made throughout the year to develop a comprehensive elder care strategy and in order to continue the charge in the original resolution to also address financing of dental care, a resolution to continue the group was submitted and adopted at the 2019 House, Resolution 72H, to present a recommended Comprehensive Strategic Elder Care policy to the 2020 House.

The ECW discussed a variety of strategies apart from financing care that the ADA should implement in order to serve the older adult population, age 65 and over. It is essential that oral health be recognized as a vital component of health, by practitioners, patients and the public at large. For older adult patients, barriers to access and the perception about affordability of care are contributing factors to a utilization rate below fifty percent. As patients age, it is important to deliver needed treatment with a focus on preventing later decay, so that as older adults become increasingly medically, functionally, and cognitively complex patients, their oral health does not decline.

The ECW brainstormed a wide range of potential ideas and used a multi-vote process to prioritize the ideas that would make the strongest recommendations and positive impact on providing oral health care to older adult patients and improving their outcomes.

The ECW recognizes the strength of the ADA's advocacy efforts at the local, state and federal levels and encourages the ADA to prioritize advocacy efforts to improve oral health care in seniors. Therefore, the ECW proposes the following resolution to accomplish this goal:

Resolution

80. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies should consider integrating the following elder care strategies on inter-agency advocacy as priority projects and be it further

Resolved, focus advocacy efforts to improve oral health care in seniors by:

1. hosting a periodic all-stakeholder summit to discuss issues related to oral health of the elderly
2. advocating for state, private and federally funded programs that use incentives like forgiveness of student debt in return for a work placement for specified periods of time in areas of need
3. improving communications to underserved communities through use of health literacy guidelines, patient navigators, community dental health coordinators and dental hygienists

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 81 New

Report: Report of the Elder Care Workgroup Date Submitted: August 2020

Submitted By: Elder Care Workgroup

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

ELDER CARE STRATEGIES ON PRACTICE MANAGEMENT

Background: In 2018, the House of Delegates adopted Resolution 33H, which directed the President to appoint an ad hoc committee to review the Association's current policies and to identify an implementation plan to address elder care, including Medicare. This presidentially-appointed elder care workgroup (ECW) was formed in February 2019. Progress was made throughout the year to develop a comprehensive elder care strategy and in order to continue the charge in the original resolution to also address financing of dental care, a resolution to continue the group was submitted and adopted at the 2019 House, Resolution 72H, to present a recommended Comprehensive Strategic Elder Care policy to the 2020 House.

The ECW discussed a variety of strategies apart from financing care that the ADA should implement in order to serve the older adult population, age 65 and over. It is essential that oral health be recognized as a vital component of health, by practitioners, patients and the public at large. For older adult patients, barriers to access and the perception about affordability of care are contributing factors to a utilization rate below fifty percent. As patients age, it is important to deliver needed treatment with a focus on preventing later decay, so that as older adults become increasingly medically, functionally, and cognitively complex patients, their oral health does not decline.

The ECW brainstormed a wide range of potential ideas and used a multi-vote process to prioritize the ideas that would make the strongest recommendations and positive impact on providing oral health care to older adult patients and improving their outcomes.

The ECW recognizes that the workflow of a dental practice is not well integrated with the workflow of other health care providers and payers, resulting in barriers to the smooth flow of referrals, information and patients within the health care system. The ECW recommends the ADA continues to support the simplification of practice management and proposes the following resolution to accomplish this goal:

Resolution

81. Resolved, that in order to prepare the profession for the increased demographic shift to an older population, the appropriate ADA agencies consider integrating the following elder care strategies on practice management as priority projects, and be it further

Resolved, simplify practice management by:

1. developing best practices to facilitate consent for treatment from legal guardians
2. developing best practices compliant with HIPAA for information sharing with family members and dual consent
3. reducing the administrative burden of government funded plans
4. improving intercommunication and information sharing between providers of electronic health records and electronic dental record systems
5. participating in discussions with Office of the National Coordinator for Health Information Technology

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 82 New

Report: Report of the Elder Care Workgroup Date Submitted: August 2020

Submitted By: Elder Care Workgroup

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT OF POLICY, SUMMARY OF RECOMMENDATIONS, REPORT 5 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES, ON PREVENTION AND CONTROL OF DENTAL DISEASE THROUGH IMPROVED ACCESS TO COMPREHENSIVE CARE

Background: In 2018, the House of Delegates adopted Resolution 33H, which directed the President to appoint an ad hoc committee to review the Association's current policies and to identify an implementation plan to address elder care, including Medicare. This presidentially-appointed elder care workgroup (ECW) was formed in February 2019. Progress was made throughout the year to develop a comprehensive elder care strategy and in order to continue the charge in the original resolution to also address financing of dental care, a resolution to continue the group was submitted and adopted at the 2019 House, Resolution 72H, to present a recommended Comprehensive Strategic Elder Care policy to the 2020 House.

The ECW reviewed existing policy, as outlined in the "Recommendations to the Board on the Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care *(Trans.1979:357, 596)."*

As directed via 33H-2018, the ECW is making the proposed amendments to bring this current policy in line with the recommendations of the workgroup. Subsequently, the Workgroup recommends that the following resolution be adopted:

Proposed Resolution

82. Resolved, that the ADA policy on Recommendations to the Board on the Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care (Trans:1979:357, 596) be amended as follows (Additions are <u>underlined</u>, deletions are ~~stricken~~):

1. Increase Association efforts to promote the concepts of prevention within the profession and the public sector, including government.
2. Draw freely on the special professional abilities of dentists who are expert in practice, in public health, in research and in education.
3. Actively seek allies throughout society on specific activities that will help improve access to care for all.
4. Maintain and coordinate council and other Association activities involved in this program.
5. Maintain quality dental care in all aspects of the delivery system.

6. Seek new ways for the Association to assist state and local dental health units to strengthen themselves.
7. Speak clearly to the public and to government about their respective responsibilities with respect to dental health.
8. Recognition that the traditional form of private practice will remain the major source of dental care coupled with an understanding that other sources of care exist and should receive objective attention.
9. Press for more efficient administration of and more equitable reimbursement under Medicaid and similar programs.
10. Intensify efforts at the federal level to mandate basic dental benefits for all Medicaid recipients.
11. Explore the funding of a pilot program to obtain broader Medicaid dental care benefits at the state level.
12. Explore the use of elementary and secondary schools in providing patient education, referral and oral prophylaxis dental services to children.
13. Emphasize comprehensive dental services in addressing the need of the elderly.
14. ~~Intensify efforts to amend Medicare to include dental benefits.~~
15. Seek ways to extend private group dental prepayment benefits to the elderly.
16. Develop minimal criteria that state dental societies must take to be eligible for Association assistance to provide access programs for denture care.
17. Investigate ways to improve increased opportunity for dental care for the elderly through a greater availability and effective utilization of dentists and dental auxiliaries.
18. Establish a national organization concerned with the dental health of the elderly.
19. Develop a program to provide assistance and information to state and local societies to assist dentists in caring for handicapped and disabled patients.
20. Maintain support of the Dental Lifeline Network ~~National Foundation of Dentistry for the Handicapped~~.
21. Identify and publicize other sources of care for the handicapped, institutionalized and homebound.
22. Develop a better information base on the dental health needs of the long-term homebound.
23. Help establish appropriate continuing education for practitioners and cooperate with dental educators regarding any necessary additions to the undergraduate and postgraduate dental school curricula.
24. Implement appropriate methods of providing more accessible dental care to nursing home residents.
25. Explore the potential for resolving problems of limited health manpower and capital resources in nursing homes.
26. Reexamine existing Association policy respecting the National Health Service Corps and program activity.
27. Continued support of the Health Professions Placement Network.
28. Continued support of the Dental Planning Information System to enhance its ability to provide information on care delivery in remote areas.
29. Cooperate more closely with dental health departments in states with a high number of remote area residents, including possible funding of demonstration projects.
30. Expansion of the Association’s present role in stimulating the growth of dental prepayment.
31. Broaden sources of prepayment coverage beyond the workplace.
32. Support extension of group dental prepayment benefits to federal employees and military dependents.
33. Work with private and governmental groups in developing a more detailed base of information on dental prepayment.

BOARD RECOMMENDATION: Vote Yes.

Vote: Resolution 82

ARMSTRONG	Yes	HERRE	Absent	LEARY	Yes	ROSATO	Yes
DOROSHOW	Yes	HIMMELBERGER	Yes	MCDOUGALL	Yes	SABATES	Yes
EDGAR	Yes	KESSLER	No	NORBO	Yes	SHEPLEY	Yes
FIDDLER	Yes	KLEMMEDSON	Yes	RAPINI	Yes	STEPHENS	No
HARRINGTON	Yes	KYGER	Yes	RODRIGUEZ	Yes	THOMPSON	Yes

.

Resolution No. 89 New

Report: N/A Date Submitted: August 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

PROPOSED POLICY, RESOURCES FOR VETERANS INELIGIBLE FOR VA DENTAL CARE

Background: Only around 8 percent of veterans are eligible for dental care through the VA. There are many programs that provide charitable dental care to veterans, but these programs are often not coordinated and do not provide a dental home to the veterans. It is the desire of the Council to submit a broad based policy to the House of Delegates to express ADA support for those persons and/or organizations providing needed dental care to veterans.

The Council on Government Affairs recommends that the following resolution be adopted.

Resolution

89. Resolved, that the following policy titled Resources for Veterans Ineligible for VA Dental Care be adopted:

Resources for Veterans Ineligible for VA Dental Care

Resolved, that the American Dental Association supports the federal authorization of administrative support resources within the Veterans Administration Medical Centers to assist veterans to identify and utilize dental services offered by federally qualified health centers, not for profit dental care facilities, and volunteer dental professionals, and be it further

Resolved, that the ADA supports the work of component and constituent dental associations, dental organizations, societies and dentists to develop new programs with outreach strategies to assist veterans with unmet dental treatment needs, and to serve as a resource in finding dental homes for veterans.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 92-93 New

Report: CEBJA Report 1 Date Submitted: August 2020

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: See Background

COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS REPORT 1 TO THE HOUSE OF DELEGATES: AMENDMENT OF GOVERNANCE MATERIAL RELATING TO EXTRAORDINARY EMERGENCIES

Background: This report summarizes the work of the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) concerning two closely related but distinct subjects – first, proposed amendments to the ADA *Bylaws* and the *Governance and Organizational Manual of the American Dental Association* (*Governance Manual*) that will serve to simplify and clarify how a declaration of extraordinary emergency is adopted, and second, proposed additional provisions to the ADA *Bylaws* that would take effect when a time of extraordinary emergency is declared either by the House of Delegates or the Board of Trustees, when operations of the Association under the existing governance structure is impossible.

Proposed Bylaws and Governance Manual Revisions on Declaring an Extraordinary Emergency

During the periodic review of governance material that was conducted this year by CEBJA, several members had difficulty finding all the provisions in the ADA *Bylaws* and *Governance Manual* relating to how an extraordinary emergency is declared and the consequences of such a declaration. In examining how those provisions are currently stated, CEBJA determined that clarity and understanding of the process for declaring a time of extraordinary emergency can be enhanced if those provisions are assembled in a single place, rather than being divided between the ADA *Bylaws* and the *Governance Manual*. Even though some of the provisions that CEBJA proposes be moved to the Bylaws are procedural, it is believed that the added clarity and understanding and the greater ease of referring to these particular provisions is beneficial, especially when the stress associated with a time of an extraordinary emergency is considered.

In reviewing the mechanism for declaring an emergency, the Council expressed its concern that the unanimous agreement of the Board of Trustees is needed for declaring a time for extraordinary emergency. The concern is grounded in the fact that the present procedure allows for a single member of the Board of Trustees, for whatever reason, to defeat an attempt to declare a time of extraordinary emergency thus impacting the entire Association, even if the remaining voting members of the Board of Trustees approve issuing the declaration. To guard against this possibility, the Council believes that requiring a supermajority vote of the Board of Trustees for the issuance of a declaration of a time of extraordinary emergency is a better process that alleviates the risk of a single dissenting vote defeating the declaration. Understanding that this decision is potentially one of the most consequential decisions that the Board of Trustees may make, CEBJA elevated the threshold vote needed for issuing the declaration from the supermajority vote of two-thirds normally used in ADA governance to a three-fourths affirmative vote.

In addition to believing that the consolidation of provisions relating to the declaration of a time of extraordinary emergency would be beneficial, CEBJA also is of the opinion that, given that electronic voting is presently used by the Association, the time allowed for balloting to declare a time of extraordinary emergency by the House of Delegates can be shortened from the thirty (30) days that is currently provided. Given the systems of electronic voting presently available, CEBJA believes that the balloting period can be shortened to fourteen (14) days without any adverse effects. Effectively shortening the balloting period by fifty percent (50%) will allow the decision on the extraordinary emergency declaration by the House of Delegates to be made much more quickly during a time where rapid action may be called for.

Accordingly, the Council on Ethics, Bylaws and Judicial Affairs proposes the following resolution to amend CHAPTER III., *Section 60*. and Chapter V., *Section 70*.D. of the ADA *Bylaws* and Chapter III., Section A. of the *Governance Manual* as follows:

Resolution

92. Resolved, that CHAPTER III., *Section 60*. of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

CHAPTER III. HOUSE OF DELEGATES

*** * ***

Section 60. OPERATION DURING AN EXTRAORDINARY EMERGENCY.

A. TRANSFER OF POWERS AND DUTIES OF THE HOUSE OF DELEGATES: The powers and duties of the House of Delegates, except the power to amend, enact and repeal the *Constitution and Bylaws* or the *Governance Manual*, and the duty of electing the elective officers and installing the members of the Board of Trustees, may be transferred to the Board of Trustees of this Association in time of extraordinary emergency~~, as set forth in the *Governance Manual*~~.

B. DECLARATION OF EXTRAORDINARY EMERGENCY AND WITHDRAWAL OF SUCH A DECLARATION. The existence of a time of extraordinary emergency may be declared and withdrawn as follows:

a. By the House of Delegates. A time of extraordinary emergency may be declared by mail vote of the current members of the House of Delegates on recommendation of at least four (4) of the elective officers.[*] A mail vote to be valid shall consist of ballots received from not less than twenty-five percent (25%) of the current members of the House of Delegates. A majority of the votes cast within fourteen (14) days after the date declared for the commencement of the balloting shall decide the vote.

b. By the Board of Trustees. A time of extraordinary emergency may be declared by a three-fourths affirmative vote of the members of the Board of Trustees present and voting at a regular or special session of the Board of Trustees pursuant to CHAPTER V., *Section 70*.D. of these *Bylaws*.

c. Withdrawal of a Declaration of Extraordinary Emergency. A declaration of extraordinary emergency may be withdrawn by the House of Delegates by mail vote on recommendation of at least two (2) of the elective officers consisting of ballots received from not less than twenty-five percent (25%) of the current members of the House of Delegates or by a majority vote of the Board of Trustees present and voting at a regular or special session of the Board of Trustees pursuant to CHAPTER V., *Section 70.D*. of these *Bylaws*.

[*] As used with respect to the declaration of an extraordinary emergency, the term “mail ballot” shall mean any vote permitted pursuant to Illinois law, including an electronic vote.

and be it further

Resolved, that CHAPTER V., *Section 70*.D. of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

CHAPTER V. BOARD OF TRUSTEES

* * *

Section 70. POWERS. The Board of Trustees shall be the managing body of the Association, vested with power to:

* * *

D. By ~~unanimous consent~~ a three-fourths affirmative vote of the members of the Board of Trustees present and voting at a regular or special session, declare the existence of a time of extraordinary emergency.

and be it further

Resolved, that Chapter III., Section A. of the *Governance and Organizational Manual of the House of Delegates* be amended as follows (additions underscored, deletions ~~stricken through~~):

CHAPTER III. HOUSE OF DELEGATES

A. Convening Sessions of the House of Delegates.

1. ~~Declaration of Extraordinary Emergency. The existence of a time of extraordinary emergency may be declared by mail vote of the current members of the House of Delegates on recommendation of at least four (4) of the elective officers.* A mail vote to be valid shall consist of ballots received from not less than twenty-five percent (25%) of the current members of the House of Delegates. A majority of the votes cast within thirty (30) days after the mailing of the ballot shall decide the vote. The existence of a time of extraordinary emergency may also be declared by the Board of Trustees pursuant to the provisions set forth in the Governance Manual.~~

~~2.~~ Special Sessions. A special session of the House of Delegates shall be called by the President on a three-fourths (3/4) affirmative vote of the members of the Board of Trustees or on written request of delegates representing at least one-third (1/3) of the constituents and not less than one-fifth (1/5) of the number of officially certified delegates of the last House of Delegates. The time and place of a special session shall be determined by the President, provided the time selected shall be not more than forty-five (45) days after the request was received. The business of a special session shall be limited to that stated in the official call except by unanimous consent.

~~3.~~2. Official Call of Sessions of the House of Delegates.

a. Annual Session. The Executive Director of the Association shall direct that an official notice of the time and place of each annual session be published in The Journal of the American Dental Association. The Executive Director of the Association shall also send an official notice of the time and place of the annual session to each member of the House of Delegates at least thirty (30) days before the opening of such annual session.

b. Special Session. The Executive Director of the Association shall send an official notice of the time and place of each special session and a statement of the business to be considered to every officially certified delegate and alternate delegate of the last House, not less than fifteen (15) days before the opening of such special session.

Proposed Bylaws Provisions to Take Effect When a Time of Extraordinary Emergency is Declared

Shortly after the presence of the coronavirus was declared a pandemic, the Speaker of the House and ADA staff, and later, the Governance Committee of the Board of Trustees, began looking at the issues that might arise should it be necessary to declare a time of extraordinary emergency. Among the topics considered was whether ADA operations governed by the ADA *Bylaws* or the *Governance Manual* might be affected by the events that would lead to the extraordinary emergency declaration. Thereafter, the Governance Committee asked CEBJA, given its expertise with bylaws and governance issues, to consider the matter, and bring forward any proposals it believes are needed.

Early in March, the Speaker of the House and staff began planning for a potential virtual House of Delegates session in 2020. One of the first issues examined was whether such a change was even permissible under ADA governance provisions and, if not, what amendments would be necessary to allow for the virtual meeting. Fortunately, there has been no need to date for a declaration of a time of extraordinary emergency nor amendments to the ADA *Bylaws* or *Governance Manual* to address issues arising from the current Covid-19 pandemic. Nevertheless, the preliminary annual meeting planning work performed highlighted the fact that the current ADA governance provisions do not adequately address an occurrence of an event leading to a declaration of a time of extraordinary emergency where operations under the ADA's normal existing governance structure would be impossible. The proposed amendments being forwarded to the House of Delegates by this resolutions seek to mitigate that possibility.

It is important to reiterate that the proposed amendments are not needed to respond to any issues that have arisen because of the Covid-19 pandemic. Rather, the amendments seek to address issues that may arise in the event of some other catastrophic crisis, such as a failure of the U.S. electrical grid close to the date of the ADA annual meeting and House of Delegates annual session. Bringing this matter to the House of Delegates now allows for the House to put in place measures it thinks are appropriate before such a catastrophe strikes.

The proposed amendments to the ADA *Bylaws* and *Governance Manual* provide for:

- Suspension of the House of Delegates annual session or, when suspension of the House meeting is not necessary, modifications to the ADA governance provisions as needed to allow the operation of the ADA to continue during an extraordinary crises.

- If elections for officers cannot be held as scheduled, minimizing any ensuing disruption by calling for the President-elect to assume the office of President.

- Those who have been selected by their Trustee Districts as trustees-elect to assume their offices while allowing for the continued service of trustees whose districts have not selected new trustees until such selections have been made.

- The continued service of other volunteer leaders if a House of Delegates session is suspended until such time as the House can meet.

- If the House cannot meet, allowing the Board of Trustees to approve an *ad interim* budget for the ADA with certain key limitations: Dues set by the Board of Trustees may not exceed the then-current dues set by the House, and the *ad interim* budget must be submitted to the House for ratification when the House does convene.

- Suspension of the ADA's annual scientific session if holding the session is determined to be impossible or infeasible due to the existence of the extraordinary emergency.

The Council on Ethics, Bylaws and Judicial Affairs believes that the proposal being presented will enable the ADA to continue to operate effectively should a catastrophic emergency occur in the future. It is a hallmark of a well-run organization to have in place provisions that allow for the continued operation of the organization when unforeseen and extraordinary events occur. CEBJA

knows that everyone hopes that the provisions embodied in the proposed amendments will never need to be activated, but recent experience demonstrates that unforeseen and even unimaginable events can and do occur. When such a catastrophe does occur, the members of the ADA will have this House to thank for its foresight of providing the Association the capacity to operate effectively without the hindrance of vague or unduly restrictive bylaws.

In light of the foregoing, the Council on Ethics, Bylaws and Judicial Affairs proposes the following amendment to the ADA *Bylaws*:

Resolution

93. Resolved, that the CHAPTER III., *Section 60*. of the ADA *Bylaws* be amended by the addition of a new subsection B., as follows (additions underscored):

CHAPTER III • HOUSE OF DELEGATES

* * *

Section 60. OPERATION DURING AN EXTRAORDINARY EMERGENCY.

A. TRANSFER OF POWERS AND DUTIES OF THE HOUSE OF DELEGATES: The powers and duties of the House of Delegates, except the power to amend, enact and repeal the *Constitution and Bylaws* or the *Governance Manual*, and the duty of electing the elective officers ~~and installing the members of the Board of Trustees,~~ may be transferred to the Board of Trustees of this Association in time of extraordinary emergency, as set forth in the *Governance Manual*. To the extent not inconsistent with any provision of *Bylaws* CHAPTER III., Section 60.B., Emergency Bylaws, provisions of the *Bylaws* and *Governance Manual* shall remain in effect during the duration of the extraordinary emergency. Upon the conclusion of the declaration of the time of extraordinary emergency adopted by the House of Delegates or Board of Trustees, the emergency bylaws set forth in CHAPTER III, *Section 60.B*. of these *Bylaws* shall cease to be effective.

B. Emergency Bylaws. In the event that a time of extraordinary emergency is declared pursuant to Chapter III.A.1. of the *Governance Manual*, the provisions of this *Section 60.B*. of the ADA *Bylaws* shall be implemented and continue in effect until such time as the declaration of extraordinary emergency is withdrawn.

a. Provisions if the Annual Session of the House of Delegates Convenes During an Extraordinary Emergency. In the event the House of Delegates is convened during the period when an extraordinary emergency has been declared, the following provisions shall apply:

1. Agenda. The Speaker, in consultation with the President, may limit the agenda to matters that require the attention of the House of Delegates.

2. Quorum. A quorum for the transaction of any business at any meeting of the House of Delegates convened during a time declared as an extraordinary emergency shall be the same as stated in CHAPTER III, *Section 80*. of the *Bylaws*.

3. Delegates. Delegations may substitute new delegates for any unavailable delegates, based upon feasibility, as determined by the Speaker. The Speaker may subsequently determine that alternate delegates will not be certified.

4. Suspended Elections. Any elections to be held during a session of the House of Delegates during the period that an extraordinary emergency has been declared may be suspended by the Board of Trustees upon a two-thirds affirmative vote of the

voting members of the Board of Trustees present and voting at a regular or special session of the Board of Trustees. In the event the elections are suspended, the terms of office of the President and the trustees shall end on the date previously scheduled for the adjournment *sine die* of the House of Delegates. Vacancies in the offices of President, President-elect, First Vice President, Second Vice President, Speaker of the House of Delegates and Treasurer shall be filled in accordance with the provisions of CHAPTER VI, *Section 80*. of these *Bylaws*. The outgoing President shall install the President and any incoming trustees who have been elected by their districts. If a district has not elected a trustee to fill an expiring position, the incumbent trustee shall remain in office until a successor is duly elected and installed. All other ADA office holders in office immediately prior to commencement of the meeting of the House of Delegates shall remain in their respective offices until the first-session of the House of Delegates following the withdrawal of the declaration of an extraordinary emergency.

b. Suspension of the Annual Session of the House of Delegates. An annual session of the House of Delegates scheduled to occur during a period where an extraordinary emergency has been declared may be suspended by the Board of Trustees for good cause upon a two-thirds affirmative vote of the voting members of the Board of Trustees present and voting at a regular or special session of the Board of Trustees. If an annual session of the House of Delegates is so suspended, the following provisions shall apply.

1. Alternative Elections by Ballot without a Meeting. Regardless of whether or not the House of Delegates annual session is suspended, the Board of Trustees may direct the Speaker to arrange for some or all contested elections to be conducted electronically outside the annual session of the House of Delegates.

(a). Any such election shall be valid provided that the certified delegates are duly notified, are given an opportunity to vote, and the number of certified delegates casting votes would constitute a quorum as defined in Chapter III, Section 80, of these *Bylaws*.

(b). The method for such elections set forth in CHAPTER III, *Section 120*, of these *Bylaws* shall govern.

(c). Announcement of the election results shall be provided to the House of Delegates by the Speaker.

(d). Any candidates elected pursuant to this provision shall be installed as soon as practical after their election, provided that such installation is no sooner than the previously scheduled adjournment of the House of Delegates.

2. Incumbent Trustees. In the event that a district has not elected a trustee to fill an expiring trustee office, the incumbent trustee shall remain in office until a successor is duly elected and installed.

3. Extension of Tenure. Except as otherwise provided in these Emergency *Bylaws*, limitations on tenure of officers, trustees, council, committee and ADA commission members shall not apply during an extraordinary emergency.

4. Approval of Association Budget and Active Member Dues. If the annual session of the House of Delegates is suspended during an extraordinary emergency, the Board of Trustees shall have the authority to approve a final annual budget and active member dues for the succeeding year so long as the active member dues do not exceed the prior year's dues. Any such budget approved by the Board shall be presented to the House for ratification if the House convenes following the end of the

emergency with more than six months remaining in the fiscal year for which the budget has been established.

c. Scientific Session. If it is determined that holding the scientific session required by Chapter XVIII. of the *Governance Manual* is impossible or infeasible due to the existence of an extraordinary emergency, the Board of Trustees may suspend the holding of the scientific session upon a two-thirds affirmative vote of the voting members of the Board of Trustees present and voting at a regular or special session of the Board of Trustees.

Resolutions

(Resolution 92:Worksheet:5169)
(Resolution 93:Worksheet:5172)

Resolution No. 92 New

Report: CEBJA Report 1 Date Submitted: August 2020

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: See Background

PROPOSED BYLAWS AND GOVERNANCE MANUAL REVISIONS ON DECLARING AN EXTRAORDINARY EMERGENCY

Background: (See CEBJA Report 1 to the House of Delegates, Worksheet:5162)

Resolution

92. Resolved, that Chapter III., Section 60. of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

CHAPTER III. HOUSE OF DELEGATES

* * *

Section 60. OPERATION DURING AN EXTRAORDINARY EMERGENCY.

A. TRANSFER OF POWERS AND DUTIES OF THE HOUSE OF DELEGATES: The powers and duties of the House of Delegates, except the power to amend, enact and repeal the *Constitution and Bylaws* or the *Governance Manual*, and the duty of electing the elective officers and installing the members of the Board of Trustees, may be transferred to the Board of Trustees of this Association in time of extraordinary emergency~~, as set forth in the *Governance Manual*~~.

B. DECLARATION OF EXTRAORDINARY EMERGENCY AND WITHDRAWAL OF SUCH A DECLARATION. The existence of a time of extraordinary emergency may be declared and withdrawn as follows:

a. By the House of Delegates. A time of extraordinary emergency may be declared by mail vote of the current members of the House of Delegates on recommendation of at least four (4) of the elective officers.* A mail vote to be valid shall consist of ballots received from not less than twenty-five percent (25%) of the current members of the House of Delegates. A majority of the votes cast within fourteen (14) days after the date declared for the commencement of the balloting shall decide the vote.

b. By the Board of Trustees A time of extraordinary emergency may be declared by a three-fourths affirmative vote of the members of the Board of Trustees present and voting at a regular or special session of the Board of Trustees pursuant to CHAPTER V., Section 70.D. of these *Bylaws*.

c. Withdrawal of a Declaration of Extraordinary Emergency. A declaration of extraordinary emergency may be withdrawn by the House of Delegates by mail vote on recommendation of at least two (2) of the elective officers consisting of ballots received from not less than twenty-five percent (25%) of the current members of the House of Delegates or by a majority vote of the Board of Trustees present and voting at a regular or special session of the Board of Trustees pursuant to CHAPTER V., *Section 70.D*. of these *Bylaws*.

[*] As used with respect to the declaration of an extraordinary emergency, the term "mail ballot" shall mean any vote permitted pursuant to Illinois law, including an electronic vote.

and be it further

Resolved, *that CHAPTER V., Section 70.D. of the ADA Bylaws be amended as follows (additions underscored, deletions ~~stricken through~~):*

CHAPTER V. BOARD OF TRUSTEES

* * *

Section 70. POWERS. The Board of Trustees shall be the managing body of the Association, vested with power to:

* * *

D. By ~~unanimous consent~~ a three-fourths affirmative vote of the members of the Board of Trustees present and voting at a regular or special session, declare the existence of a time of extraordinary emergency.

and be it further

Resolved, that Chapter III., Section A. of the *Governance and Organizational Manual of the House of Delegates* be amended as follows (additions underscored, deletions ~~stricken through~~):

CHAPTER III. HOUSE OF DELEGATES

A. Convening Sessions of the House of Delegates.

1. ~~Declaration of Extraordinary Emergency. The existence of a time of extraordinary emergency may be declared by mail vote of the current members of the House of Delegates on recommendation of at least four (4) of the elective officers.* A mail vote to be valid shall consist of ballots received from not less than twenty-five percent (25%) of the current members of the House of Delegates. A majority of the votes cast within thirty (30) days after the mailing of the ballot shall decide the vote. The existence of a time of extraordinary emergency may also be declared by the Board of Trustees pursuant to the provisions set forth in the Governance Manual.~~

~~2.~~ Special Sessions. A special session of the House of Delegates shall be called by the President on a three-fourths (3/4) affirmative vote of the members of the Board of Trustees or on written request of delegates representing at least one-third (1/3) of the constituents and not less than one-fifth (1/5) of the number of officially certified delegates of the last House of Delegates. The time and place of a special session shall be determined by the President, provided the time selected shall be not more than forty-five (45) days after the request was received. The business of a special session shall be limited to that stated in the official call except by unanimous consent.

~~3.~~2. Official Call of Sessions of the House of Delegates.

a. Annual Session. The Executive Director of the Association shall direct that an official notice of the time and place of each annual session be published in The Journal of the American Dental Association. The Executive Director of the Association shall also send an official notice of the time and place of the annual session to each member of the House of Delegates at least thirty (30) days before the opening of such annual session.

b. Special Session. The Executive Director of the Association shall send an official notice of the time and place of each special session and a statement of the business to be considered to every officially certified delegate and alternate delegate of the last House, not less than fifteen (15) days before the opening of such special session.

BOARD RECOMMENDATION: Vote Yes.

Vote: Resolution 92

ARMSTRONG	Yes	HERRE	Yes	LEARY	Yes	ROSATO	Yes
DOROSHOW	Yes	HIMMELBERGER	Yes	MCDOUGALL	Yes	SABATES	No
EDGAR	Yes	KESSLER	Yes	NORBO	Yes	SHEPLEY	Yes
FIDDLER	Yes	KLEMMEDSON	Yes	RAPINI	Yes	STEPHENS	Yes
HARRINGTON	Yes	KYGER	Yes	RODRIGUEZ	Yes	THOMPSON	Yes

Resolution No. 93 New

Report: CEBJA Report 1 Date Submitted: August 2020

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: See Background

PROPOSED BYLAWS PROVISIONS TO TAKE EFFECT WHEN A TIME OF EXTRAORDINARY EMERGENCY IS DECLARED

Background: (See CEBJA Report 1 to the House of Delegates, Worksheet:5162)

Resolution

93. Resolved, that the CHAPTER III. *Section 60*. of the ADA *Bylaws* be amended by the addition of a new subsection B., as follows (additions underscored):

Section 60. OPERATION DURING AN EXTRAORDINARY EMERGENCY.

A. TRANSFER OF POWERS AND DUTIES OF THE HOUSE OF DELEGATES: The powers and duties of the House of Delegates, except the power to amend, enact and repeal the *Constitution and Bylaws* or the *Governance Manual*, and the duty of electing the elective officers ~~and installing the members of the Board of Trustees,~~ may be transferred to the Board of Trustees of this Association in time of extraordinary emergency, as set forth in the *Governance Manual*. To the extent not inconsistent with any provision of *Bylaws* CHAPTER III., Section 60.B., Emergency Bylaws, provisions of the *Bylaws* and *Governance Manual* shall remain in effect during the duration of the extraordinary emergency. Upon the conclusion of the declaration of the time of extraordinary emergency adopted by the House of Delegates or Board of Trustees, the emergency bylaws set forth in CHAPTER III, *Section 60.B*. of these *Bylaws* shall cease to be effective.

B. Emergency Bylaws. In the event that a time of extraordinary emergency is declared pursuant to Chapter III.A.1. of the *Governance Manual*, the provisions of this *Section 60.B*. of the ADA *Bylaws* shall be implemented and continue in effect until such time as the declaration of extraordinary emergency is withdrawn.

a. Provisions if the Annual Session of the House of Delegates Convenes During an Extraordinary Emergency. In the event the House of Delegates is convened during the period when an extraordinary emergency has been declared, the following provisions shall apply:

1. Agenda. The Speaker, in consultation with the President, may limit the agenda to matters that require the attention of the House of Delegates.

2. Quorum. A quorum for the transaction of any business at any meeting of the House of Delegates convened during a time declared as an extraordinary emergency shall be the same as stated in CHAPTER III, *Section 80*. of the *Bylaws*.

3. Delegates. Delegations may substitute new delegates for any unavailable delegates, based upon feasibility, as determined by the Speaker. The Speaker may subsequently determine that alternate delegates will not be certified.

4. Suspended Elections**.** Any elections to be held during a session of the House of Delegates during the period that an extraordinary emergency has been declared may be suspended by the Board of Trustees upon a two-thirds affirmative vote of the voting members of the Board of Trustees present and voting at a regular or special session of the Board of Trustees. In the event the elections are suspended, the terms of office of the President and the trustees shall end on the date previously scheduled for the adjournment *sine die* of the House of Delegates. Vacancies in the offices of President, President-elect, First Vice President, Second Vice President, Speaker of the House of Delegates and Treasurer shall be filled in accordance with the provisions of CHAPTER VI, *Section 80*. of these *Bylaws*. The outgoing President shall install the President and any incoming trustees who have been elected by their districts. If a district has not elected a trustee to fill an expiring position, the incumbent trustee shall remain in office until a successor is duly elected and installed. All other ADA office holders in office immediately prior to commencement of the meeting of the House of Delegates shall remain in their respective offices until the first-session of the House of Delegates following the withdrawal of the declaration of an extraordinary emergency.

b. Suspension of the Annual Session of the House of Delegates. An annual session of the House of Delegates scheduled to occur during a period where an extraordinary emergency has been declared may be suspended by the Board of Trustees for good cause upon a two-thirds affirmative vote of the voting members of the Board of Trustees present and voting at a regular or special session of the Board of Trustees. If an annual session of the House of Delegates is so suspended, the following provisions shall apply.

1. Alternative Elections by Ballot without a Meeting. Regardless of whether or not the House of Delegates annual session is suspended, the Board of Trustees may direct the Speaker to arrange for some or all contested elections to be conducted electronically outside the annual session of the House of Delegates.

(a). Any such election shall be valid provided that the certified delegates are duly notified, are given an opportunity to vote, and the number of certified delegates casting votes would constitute a quorum as defined in Chapter III, Section 80, of these *Bylaws*.

(b). The method for such elections set forth in CHAPTER III, *Section 120*, of these *Bylaws* shall govern.

(c). Announcement of the election results shall be provided to the House of Delegates by the Speaker.

(d). Any candidates elected pursuant to this provision shall be installed as soon as practical after their election, provided that such installation is no sooner than the previously scheduled adjournment of the House of Delegates.

2. Incumbent Trustees. In the event that a district has not elected a trustee to fill an expiring trustee office, the incumbent trustee shall remain in office until a successor is duly elected and installed.

3. Extension of Tenure. Except as otherwise provided in these Emergency *Bylaws*, limitations on tenure of officers, trustees, council, committee and ADA commission members shall not apply during an extraordinary emergency.

4. Approval of Association Budget and Active Member Dues. If the annual session of the House of Delegates is suspended during an extraordinary emergency, the Board of Trustees shall have the authority to approve a final annual budget and active member dues for the succeeding year so long as the active member dues do not exceed the prior year's dues. Any such budget approved by the Board shall be presented to the House for ratification if the House convenes following the end of the emergency with more than six months remaining in the fiscal year for which the budget has been established.

c. Scientific Session. If it is determined that holding the scientific session required by Chapter XVIII. of the *Governance Manual* is impossible or infeasible due to the existence of an extraordinary emergency, the Board of Trustees may suspend the holding of the scientific session upon a two-thirds affirmative vote of the voting members of the Board of Trustees present and voting at a regular or special session of the Board of Trustees.

BOARD RECOMMENDATION: Vote Yes.

Vote: Resolution 93

ARMSTRONG	Yes	HERRE	Yes	LEARY	Yes	ROSATO	Yes
DOROSHOW	Yes	HIMMELBERGER	Yes	MCDOUGALL	Yes	SABATES	No
EDGAR	Yes	KESSLER	Yes	NORBO	Yes	SHEPLEY	Yes
FIDDLER	Yes	KLEMMEDSON	Yes	RAPINI	Yes	STEPHENS	Yes
HARRINGTON	Yes	KYGER	Yes	RODRIGUEZ	Yes	THOMPSON	Yes

Resolution No. N/A New

Report: Task Force Report to Study Alternate Loan Repayment Strategies Date Submitted: July 2020

Submitted By: Task Force to Study Alternate Student Loan Repayment Strategies

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

REPORT OF THE TASK FORCE TO STUDY ALTERNATE STUDENT LOAN REPAYMENT STRATEGIES (81H-2019)

Background: The 2019 ADA House of Delegates adopted Resolution 81H-2019, Study Innovations for Alternate Student Loan Repayment Strategies, which called on the Board of Trustees to form a Task Force to find creative solutions to the student debt crisis, and report the progress on its recommended initiatives to the 2020 House of Delegates.

> **81H-2019. Resolved,** that the Board form a task force and appoint stakeholders to examine, identify, and creatively address solutions to the student debt crisis, and be it further
>
> **Resolved,** that the Task Force will report back on its progress to the 2020 House of Delegates on its recommended initiatives.

Workgroup Appointed: At its December 2019 meeting, the Board appointed the following members to the Task Force: Dr. Deborah Bishop, chair and Council on Government Affairs representative (District 5); Dr. Emily Mattingly, New Dentist Committee representative (District 6); Dr. Nader Nadershahi, dental education representative (District 13); and Dr. Lindsey Robinson, former Board member (District 13).

Progress Report: The Task Force has thus far carried out its work via electronic communications, individual phone calls, and two conference calls convened on February 18, 2020, and March 10, 2020. Due to the novel coronavirus (COVID-19) pandemic, the Task Force temporarily suspended its work in March 2020 with the intent of reconvening in summer 2020. A final report will be submitted to the 2021 House of Delegates, pending the Board of Trustees' reauthorization of the Task Force and its members.

The Task Force observed that since 2010 there have been fourteen House assignments to address student debt, including the formation of several task forces, research, member benefits, advocacy, and more (Appendix A). The Task Force also noted that ADA has spent approximately $500,000 studying and advocating for student debt reduction since 2010, according to the ADA Board of Trustees (*Supplement* 2018:4107).

The Task Force determined that revisiting these activities in-depth would not be productive. The Task Force also determined that its charge did not include addressing why dental school is so expensive; why dental students are borrowing so much money (and how they are spending it); and why the federal government is in the student loan business.

Instead, the Task Force decided there would be more value in presenting the House of Delegates with three to five recommendations that would be impactful (and attainable) instead of a long list of recommendations that are interesting (but aspirational). The Task Force also agreed that its recommendations should add member value and be consistent with the ADA strategic plan.

The Task Force agreed to the following plan to implement 81H-2019:

1. Solicit preliminary ideas from a variety of internal and external consultants (e.g., the New Dentist Committee, ADA Business Enterprises, dental schools, dental students, financial institutions, community health centers, etc.).
2. Complete a weighted ranking of the ideas based on originality; impact; member value; attainability (in five years); cost; and alignment with the ADA strategic plan.
3. Thoroughly research the highly rated items, discuss the results, and decide which ideas should be put forward as recommendations.
4. Present a final report to the 2021 House of Delegates with three to five of the most promising ideas.

The Task Force was beginning to solicit ideas from outside consultants when the novel coronavirus (COVID-19) pandemic disrupted business throughout the country. The Task Force suspended its work in March 2020 with the intent of reconvening in summer 2020. A final report will be submitted to the 2021 House of Delegates, pending the Board of Trustees' reauthorization of the Task Force and its members.

Resolution

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION).

APPENDIX A
TASK FORCE REPORT TO STUDY ALTERNATE LOAN REPAYMENT STRATEGIES

HOUSE POLICIES AND ASSIGNMENTS ON STUDENT LOANS AND POSTGRADUATE EDUCATIONAL DEBT (2010-2019)

Between 2010 and 2019, the following House resolutions have been acted upon to address student loans and postgraduate educational debt. During this time, the ADA has spent approximately $500,000 studying and advocating for student debt reduction, according to the ADA Board of Trustees (*Supplement* 2018:4107).

This report does not cover additional resolutions that the House of Delegates considered and did not adopt or refer.

APPENDIX A
TASK FORCE REPORT TO STUDY ALTERNATE LOAN REPAYMENT STRATEGIES

* * * * *

87-2010 **Study Impact of Existing and Emerging Models of Dental Education**
(Referred) (*Trans.*2010:572, 578) (*Supplement* 2010:4286)

Resolved, that the ADA Council on Dental Education and Licensure study the short and long term impact (positive and negative) of existing and emerging models of dental education in resolving the challenge of preservation of the profession as a learned profession while meeting the changing needs of oral health for diverse patient groups in a time of economic challenge, and be it further

Resolved, that relevant stakeholders be invited to participate in the discussion at their expense or the sponsoring organization's expense, and that recommendations include collaborative new strategies for working together as a profession to resolve these important issues through partnerships, and be it further

Resolved, that the Council on Dental Education and Licensure report its findings to the 2011 ADA House of Delegates.

(See response at *Reports* 2011:78.)

112-2010 **A Viable Mid-Level Solution: Improving Access by Reinventing**
(Referred) **Dentists' Education** (*Trans.*2010:572, 578) (*Supplement* 2010:4359) ($75,000)

Resolved, that the ADA invite to a conference of appropriate stakeholders and leaders, to include, but not be limited to representatives of CAPIR, CDEL, CGA, ASDA, CODA, ADEA, AADB, CMS and the Kellogg Foundation to consider development of dental education models that facilitate fourth- and fifth-year dental students and residents to provide care in underserved and unserved settings, and be it further

Resolved, that the conference agenda will include, but not be limited to, the following:

- Utilization of pre-doctoral dental students as an alternative to mid-level providers for improved access to care and maintaining a high quality single tier delivery system.
- Consideration of conversion of some basic science curricula to undergraduate prerequisites.
- Education cost-reduction through provision of services by both students and faculty.
- Alternative faculty/student supervisory models to reduce barriers to access in remote locations.
- Concurrent loan forgiveness programs and stipends for pre-doctoral practice in remote locations.
- Statutory consideration of utilizing dental students in alternative settings.
- Testing and licensing considerations in alternative educational models.
- Applications for teledentistry and distance education via interactive links.
- Funding needs for pilot projects and transition to new models.
- Accreditation considerations for alternative educational models.

- Limitations of public funding and subsidies as educational clinic revenue sources.

and be it further

Resolved, that the appropriate Association agencies provide a report on the conference with a recommended action plan to the 2011 House of Delegates.

(See response at *Reports* 2011:86, 101.)

66H-2011 Deflating the Dental Education Bubble
(*Trans.*2011:409, 463, 481) (*Supplement* 2011:4076) ($230,000)

Resolved, that the Board of Trustees with the assistance of appropriate councils and expert consultants, study, document and analyze the current and future economics of dental education, student debt and the impact on dental practice and access to care, utilizing existing environmental scan and other available data, and be it further

Resolved, that the Board with the assistance of CDEL and consultants with expertise in dental education identify innovations in dental education that reduce costs without diminishing quality and recognize barriers to broader implementation, and be it further

Resolved, that the Board, with the assistance of consultants with expertise in practice economics and subsidized care, consider the role educational institutions, students, residents and new graduates have played in the dental "safety net," and innovative ideas to improve that function while reducing student debt, and be it further

Resolved, that the Board prepare a detailed report including short term and long range action recommendations to reduce dental student debt for consideration at the 2012 House of Delegates.

(See responses at *Supplement* 2012:5158; 2013:3036)

91H-2011 Student Loan Reduction Program
(*Trans.*2011:433, 551) (*Supplement* 2011:8000)

Resolved, that the appropriate councils and ADA agencies investigate the development and implementation of a student loan repayment grant program for dentists working in a non-profit community dental clinic, and report to the 2012 House of Delegates.

Resolved, that the appropriate councils and ADA agencies investigate the development and implementation of a student loan repayment grant program for dentists working in a non-profit community dental clinic, and report to the 2012 House of Delegates.

(See responses at *Supplement* 2012:5158; 2013:3036)

113H-2012 Dental Education Economics and Student Debt
(*Trans.*2012:458, 480) (*Supplement* 5158) ($230,000)

Resolved, that the Board of Trustees' Taskforce on Dental Education Economics and Student Debt conduct the research as outlined in its 2012 report and report findings to the 2013 House of Delegates, and be it further

Resolved, that any unspent amount from the $230,000 from the 2012 budget be returned to the Reserves and funding for completion of the study in 2013 come from the Reserve Account.

(See response at *Supplement* 2013:3036)

53H-2013 ADA Advocacy Agenda
(*Trans.*2013:329) (*Supplement* 2013:3078, 3078a)

Resolved, that the ADA advocacy agenda on behalf of dental education, dental students, and recent dental school graduates include:

1. Dental school approval as Federally Qualified Health Centers (FQHC) or ability to partner with FQHC's.
2. Graduate Medical Education (GME) funding for non-hospital-based programs (i.e., dental schools).
3. Increased Medicaid fees and cost-based reimbursement for dental schools.
4. Increased number of loan forgiveness programs at the state and national level, including additional debt relief programs targeting rural/underserved areas.
5. Financial incentives to practice in underserved areas through supplemental payments or tax credits.
6. Increased eligibility for dental graduates for all health profession loan forgiveness programs.
7. Student loan interest rate reform.

(See response at *Supplement* 2014:5054.)

54-2013 Development of a Robust Information Portal
(Referred) (*Trans.*2013:330) (*Supplement* 2013:3079)

Resolved, that the ADA Health Policy Resources Center (HPRC), the ADA/ADEA/CODA Liaison Committee for Surveys and Reports, and the Center for Professional Success (CPS) in collaboration with the communities of interest develop and promote a robust information portal via ADA.org to help current and prospective students be fully informed, financially literate consumers about a career in dentistry, including workforce forecasting reports, student debt, expected income, life-long financial planning, and a central registry of all loan/tuition relief programs.

(See response at *Reports* 2014:105.)

55H-2013 Expanding Research Efforts in the Area of Dental Education Financing
(*Trans.*2013:332) (*Supplement* 2013:3080)

Resolved, that the ADA Health Policy Resources Center (HPRC), in preparation for the future of the profession and reexamination of the dental education model, expand its research efforts in the area of dental education financing, the impact of student debt and other factors on career choices in order to better position the ADA as a thought leader and knowledge broker in this area and to strengthen advocacy efforts.

(See response at *Supplement* 2014:1006.)

56H-2013 A Comprehensive Study of the Current Dental Education Model
(*Trans.*2013:332) (*Supplement* 2013:3081, 3082a) ($80,000)

Resolved, that the ADA seek collaboration with broad communities of interest, including dental educators, students, practicing dentists, health economists, and others with appropriate expertise to define the scope and specific aims of a comprehensive study of current dental education models, to include:

1. Evaluation of the long-term sustainability of dental schools.
2. Evaluation of the efficiency of the current dental school curricula and delivery methods.
3. Analysis of the impact of student debt on dentistry as a career choice and subsequent practice choices.
4. A determination of whether dental schools are meeting the appropriate level of scholarship to ensure that dentistry continues to be a learned profession;

and be it further

Resolved, that the ADA's financial implication for this resolution shall not exceed $80,000, to be used to define the scope and specific aims of the study, to determine the estimated cost of the study, to identify potential funding sources for the study, and to report to the 2014 ADA House of Delegates.

(See responses at *Reports* 2014:106 and *Supplement* 2014:4053.)

57H-2013 Revision of Accreditation Standards
(*Trans.*2013:334) (*Supplement* 2013:3083)

Resolved, that the ADA seek collaboration with broad communities of interest, including dental educators, students, practicing dentists, health economists, and others with appropriate expertise to define the scope and specific aims of a comprehensive study of current dental education models, to include:

1. Evaluation of the long-term sustainability of dental schools.
2. Evaluation of the efficiency of the current dental school curricula and delivery methods.
3. Analysis of the impact of student debt on dentistry as a career choice and subsequent practice choices.
4. A determination of whether dental schools are meeting the appropriate level of scholarship to ensure that dentistry continues to be a learned profession;

and be it further

Resolved, that the ADA's financial implication for this resolution shall not exceed $80,000, to be used to define the scope and specific aims of the study, to determine the estimated cost of the study, to identify potential funding sources for the study, and to report to the 2014 ADA House of Delegates.

(See response at *Supplement* 2014:4076.)

91-2013 **Disclosure of Costs Incurred by Dental Students**
(Referred) (*Trans.*2013:331) (*Supplement* 2013:3106)

Resolved, that the ADA encourage dental schools, as part of their application and interview process, to disclose the actual costs incurred by their students to complete their degrees based on exit data collected for the two most recent classes.

(See response at *Reports* 2014:106.)

92-2013 **Presentations for Long-Term Financial Implications of Debt Incurred by Students**
(Referred) **During Dental School**
(*Trans.*2013:331) (*Supplement* 2013:3107)

Resolved, that the appropriate agencies of the ADA develop presentations for pre-dental students explaining the long-term financial implications of debt incurred during dental school, and be it further

Resolved, that the ADA be urged to make these presentations available in the public area of the Center for Practice Success website.

(See response at *Reports* 2014:106.)

35H-2014 **A Comprehensive Study of the Current Dental Education Models**
(*Trans.*2014:463) (*Supplement* 2014:4053, 4060)

Resolved, that the ADA conduct a focused study relative to the following:

Domain 3: Impact of Student Debt on Dentistry as a Career Choice and Subsequent Practice Choices

1. How does the cost of dental education and/or level of student borrowing influence students' decisions to enter dental education and their future career choices?
2. Do higher levels of educational debt have a greater impact on career choices?
3. What is the critical point at which the perceived return on investment means that dentistry is no longer seen as a desired profession?
4. Are there differences in the perceived return on investment for specific subsets of dental careers?
5. At what income/debt ratio are specific labor force choices impacted (disaggregating the data to determine impact on generalist, specialist, public health, Medicaid providers, etc.)?
6. How long does it actually take for dentists to pay off their educational debt?
7. What is the impact of new loan repayment programs/options on student debt?

8. Are there other strategies we can use to reduce the cost to students and/or students' educational debt (e.g., subsidizing loans, level of clinical production while in school, alternative investment pools, philanthropy, and planned giving)?
9. What is the impact of educational debt on graduates' decisions to enter subsets of practice such as solo practice, small group practice and large group practice, and to be a practice owner or an employed dentist?
10. Does educational debt primarily have a short-term impact on practice choices (i.e., decisions upon graduation or in the first few years of practice) or does it impact longer-term practice choices?

and be it further

Resolved, that the ADA pursue a focused study relative to the following:

Domain 1: Long-Term Sustainability of Dental Schools

1. What are the major revenue and expense drivers for dental education, and how do these differ across schools?
2. What opportunities exist to increase revenue for dental schools other than increases in tuition and fees (for example, increased reimbursement for clinical care, increased net clinical income, private philanthropy, intellectual property and technology transfer, and increased federal and state funding)?
3. What opportunities exist to reduce the cost of dental education (for example, sharing of faculty and educational resources, increasing the productivity of clinical faculty, use of technology, addressing the financial impact of accreditation standards and state regulations)?

Domain 2: Efficiency of the Current Dental School Curricula and Delivery Methods

1. Which dental schools are utilizing each of the curricular models and what is the financial model that supports each approach?

Domain 4: Appropriate Level of Scholarship to Ensure that Dentistry Continues to Be a Learned Profession

1. Is the profession attracting and retaining the highest quality faculty who can lead the research enterprise?
2. How can the dental community provide more effective advocacy for research support?

and be it further

Resolved, that the study results be reported to the 2016 House of Delegates.

(See response at *Supplement* 2016:4058.)

57H-2016 National Health Service Corps Policy
(*Trans.*1988:488; 2016:347) (*Supplement* 2016:5065)

Resolved, that the ADA work to expand the availability of National Health Service Corps (NHSC) scholarships and loan repayments for dentists and dental students who agree to work in a NHSC-approved site.

36H-2019 Federal Student Loan Programs
(*Supplement* 2019:5021)

Resolved, that the American Dental Association supports the federal graduate and professional degree student loan programs authorized under the Higher Education Act of 1965, with an emphasis on:

1. Protecting access to federal Direct Unsubsidized Stafford Loans (Direct Loans) and Grad PLUS loans for graduate and professional degree students.
2. Reinstating eligibility for graduate and professional degree students to take advantage of federal Direct Subsidized Stafford Loans.
3. Removing annual and cumulative borrowing limits on federal student loans.
4. Lowering the interest rates and fees on federal student loans.
5. Capping total amount of interest that can accrue on federal student loans.
6. Halting the accrual of federal student loan interest while a dentist is completing a medical/dental internship or residency.
7. Extending the period of federal student loan deferment until after a new dentist has completed his or her medical/dental internship or residency.
8. Permitting federal graduate student loans to be refinanced more than once.
9. Simplifying and adding more transparency to the federal graduate student loan application process.
10. Encouraging institutions of higher education and lenders to offer training to help students make informed decisions about how to finance their graduate education.
11. Encouraging collaborative approaches to handling borrowers who fail (or are at risk of failing) to fully repay their federal student loan(s) in the required time period.

and be it further

Resolved, that the ADA's position on allowing private lenders to have a role in the federal student loan program shall depend on whether the loan terms and conditions and borrower protections are guaranteed to be as favorable or better than the existing system of federal student loans, and be it further

Resolved, that the ADA supports strengthening federal regulations for the protection of all student loan borrowers.

37H-2019 Federal Student Loan Repayment Incentives
(*Supplement* 2019:5023)

Resolved, that the American Dental Association supports using state and federal funds to provide payments toward a dental professional’s outstanding federal student loans in exchange for practicing in underserved areas, entering and remaining in public service and academic teaching and research positions, and filling other gaps in areas of national need, and be it further

Resolved, that the ADA supports removing barriers that prohibit those with private graduate student loans from taking advantage of state and federal student loan repayment programs.

38H-2019 Tax Treatment of Federal Student Loan Interest, Scholarships and Stipends
(*Supplement* 2019:5025

Resolved, that the American Dental Association supports the tax deductibility of interest on health profession student loans, and be it further

Resolved, that the ADA supports a tax exemption for scholarship assistance and stipends awarded to health professions students under federal programs.

81H-2019 Study Innovations for Alternate Student Loan Repayment Strategies
(*Supplement* 2019:5096)

Resolved, that the Board form a task force and appoint stakeholders to examine, identify, and creatively address solutions to the student debt crisis, and be it further

Resolved, that the task force will report back on its progress to the 2020 House of Delegates on its recommended initiatives.

Resolution No. None N/A

Report: Council on Advocacy for Access Prevention Report 1 Date Submitted: July 2020

Submitted By: Council on Advocacy for Access and Prevention

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: Not Applicable

COUNCIL ON ADVOCACY FOR ACCESS AND PREVENTION REPORT 1 TO THE HOUSE OF DELEGATES: ADA POLICY REVIEW

Background: In accordance with Resolution 170H-2012 (*Trans.*2010;603;2012;370), Regular Comprehensive Policy Review, the Council on Advocacy for Access and Prevention reviewed the following Association policies and determined that they should be maintained.

- Physical Examination by Dentists (*Trans.*1977:924;1991:618)
- Educating Dental Professionals on Recognizing and Reporting Abuse (*Trans.*2014:507)
- Guidelines for Hospital Dental Privileges (*Trans.*2015:274)
- Definition of Oral Health Literacy (*Trans.*2005:322; 2006:316)
- Drinking Water in Schools (*Trans.*2016:323)
- Oral Evaluation for High School Athletes (*Trans.*2016:343)
- Integration of Oral Health and Disease Prevention Principles in Health Education Curricula (*Trans.*2016:322)
- Designation of Individuals with Intellectual Disabilities as a Medically Underserved Population (*Trans.*2014:508)
- Vision Statement on Access for Underserved Promotional Activities (*Trans.*2004:321; 2014:503)
- The Alaska Native Oral Health task Force – Strategies to Assure Access to Quality Care for Native Alaskans (*Trans.*2004:291; 2010:521)
- Access to Dental Services for the Underserved (*Trans.*2000:500)
- Prevention and Control of Dental Disease through Improved Access to Comprehensive Care (*Trans.*1979:357; 596)
- Summary of Recommendations: Report 5 of the Board of Trustees to the House of Delegates on Prevention and Control of Dental Disease through Improved Access to Comprehensive Care (*Trans.*1979:357,596)
- State Dental Programs (*Trans.*1954:278; 2013:341)
- Oral Health Assessment for Schoolchildren (*Trans.*2005:323; 2013:360)
- Orofacial Protectors (*Trans.*1994:654; 1995:613; 2016:322)

The Council has submitted resolutions to amend or rescind other ADA policies based on their continued need, relevance and consistency with other Association policies. Those recommendations are contained on separate worksheets.

Resolution

This report is informational and no resolutions presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. N/A New

Report: Council on Government Affairs Report 1 Date Submitted: July 2020

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Organizational Obj-7: Improve overall organizational effectiveness at the national and state levels.

How does this resolution increase member value: Not Applicable

COUNCIL ON GOVERNMENT AFFAIRS REPORT 1 TO THE HOUSE OF DELEGATES: ADA POLICY REVIEW

Background: In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association policies and determined that they should be maintained.

- Trade Agreements (*Trans.*1993:711)
- Health Care Reform (*Trans.*2009:485)
- ADA Support for Constituent Societies Dealing With Dental Mid-Level Provider Proposals (*Trans.*2008:502)
- Advocate for Adequate Funding Under Medicaid Block Grants (*Trans.*2011:498; 2014:499)

After consulting the Council on Advocacy for Access and Prevention, the Council on Dental Benefits and Practice, and the Council on Dental Practice, the Council opted to delay review of the following Medicare-related policies until after the ADA Elder Care Task Force completes its work.

- Elimination of Disparities in Coverage for Dental Procedures Provided Under Medicare (*Trans.*1993:705)
- Dentists as Providers in All Public and Private Health Care Programs and Discrimination in Payment for Services Performed by a Licensed Dentist (*Trans.*1990:559)
- Legislative Clarification for Medically Necessary Care (*Trans.*1988:474; 1996:686)

The Council has submitted resolutions to amend or rescind other ADA policies based on their continued need, relevance and consistency with other Association policies, and appropriateness of language and terminology. Those recommendations are contained on separate worksheets.

Resolution

This report is informational and no resolutions presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)

Resolution No. 103 New

Report: N/A Date Submitted: September 2020

Submitted By: Fourteenth Trustee District

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Membership Obj-1: Increase membership market share of lagging demographics by 2% per year.

How does this resolution increase member value: See Background

REEXAMINE COUNCIL ON COMMUNICATION LIAISON PROGRAM

The following resolution was adopted by the Fourteenth Trustee District and transmitted on September 16, 2020, by Ms. Molly Pereira, associate executive director, operations, Colorado Dental Association.

Background: In 2015, as part of a series of cost cutting measures, it was decided to discontinue the ADA Liaison Program from the Council on Communications. This measure, while well meaning, has had side effects. Programs and initiatives, such as the Third-Party Concierge Service have not been effectively marketed, and many programs remain unknown to members and prospective members.

It is frequently stated that departmental barriers are being broken down at the ADA. While this may be the case at the staff level, those barriers still exist between Councils. The 2CL program has not adequately addressed this breakdown in communication. Reestablishing the Liaison program would enable more collaborative coordination of efforts between the Councils, allow better integration with the ADA's Strategic Communication Plan and would help the ADA to market these important initiatives through successful channels such as the Volunteer Engagement Program.

Since this program was cut, great technological strides have been made in improving the capabilities of virtual meeting platforms. While these platforms are not a substitute for a live, "in-person" meeting, they can be used to supplement these meetings and are a channel to convey information. Adding an additional liaison using this technology would have minimal budgetary implications, but could help to improve the promotion of ADA programing and enhance inter-council collaboration.

Resolution

103. Resolved, that the appropriate ADA agency examine the viability of the Council on Communication Council Liaison Program utilizing virtual meeting platforms, and be it further;

Resolved, that a report be prepared for the 2021 House of Delegates.

BOARD RECOMMENDATION: Received after the August 2020 Board of Trustees meeting.

Resolution No. 104 New

Report: N/A Date Submitted: September 2020

Submitted By: Fourteenth Trustee District

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

FORMULATING INNOVATIONS TO ADDRESS UNDERSERVED AREAS

The following resolution was adopted by the Fourteenth Trustee District and transmitted on September 16, 2020, by Ms. Molly Pereira, associate executive director, operations, Colorado Dental Association.

Background: One of the most challenging issues facing the dental profession is our public perception of caring for the poor and those people living in rural areas. The ADA needs to encourage innovative resources to address these issues and cultivate relationships with lawmakers that share our concerns for our citizens access to dental care.

States often mistakenly turn to seemingly easy alternatives such as dental therapists to address these issues, when it would be more appropriate to provide incentives to the already available dentist workforce. The ADA must develop creative solutions to tap the underutilized capacity of our newest dentists. The relief of oppressive student debt is an effective incentive to attract and retain these dentists to locations where they will be highly valued.

Resolution

104. Resolved, that the appropriate ADA agency review and make recommendations regarding the loan forgiveness incentives available to new dentists that practice in rural and underserved areas including community health centers, FQHCs, Indian Health Service clinics and tribally-operated clinics with consideration to whether they adequately reflect increased levels of student debt, flexibility for part-time commitments and the difficulty attracting dentists to these locations and, be it further

Resolved, that the ADA assist graduating dental students to find employment opportunities in underserved areas by:

- Publishing and promoting available loan forgiveness resources
- Actively encouraging them to consult with dentists currently practicing in rural and underserved areas regarding practice opportunities
- Encouraging dentist employers in rural and underserved areas to offer flexible hours, part-time opportunities and extended tenure

BOARD RECOMMENDATION: Received after the August 2020 Board of Trustees meeting.

Resolution No. 107 New

Report: N/A Date Submitted: September 2020

Submitted By: Thirteenth Trustee District

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AVAILABILITY OF ADA COMMUNITY WATER FLUORIDATION WEBINAR SERIES

The following resolution was submitted by the Thirteenth Trustee District and transmitted on September 30, 2020, by Dr. Lindsey Robinson, delegation chair.

Background: 2020 marks the 75th anniversary of the implementation of community water fluoridation, described by the Centers for Disease Control and Prevention as one of the 10 greatest public health achievements of the 20th century. The American Dental Association positions itself as the leader in oral health, and community water fluoridation is a key element in the prevention of oral disease. Providing scientifically accurate knowledge from a trusted source can be one of the best defenses against fluoridation cessation activities. Often, the best advocates for fluoridating a community's water supply come from the community itself and are frequently not dentists. For these reasons, we propose making the 75th Anniversary of Community Water Fluoridation ADA Webinar Series available at no cost to the public; however, for nonmembers seeking continuing education credit, fees may apply. Examining the history, scientific research and advocacy efforts, this four-part series is a strong cross-sectional approach to discussing community water fluoridation. Local public health officials, oral health advocates and interested members of the community should have access to this valuable resource at no cost.

Resolution

107. Resolved, that the American Dental Association's 75th Anniversary of Community Water Fluoridation Webinar Series be made available, in digital format, at no cost to the public, and be it further

Resolved, that nonmembers seeking to earn continuing education credit upon completion of the courses be charged appropriate fees.

BOARD RECOMMENDATION: Received after the August 2020 Board of Trustees meeting.

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* *Resolutions 71RCS-1, 71RCS-3 and 111–113 will be indexed in* Transactions *2020.*

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