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ADA American
Dental
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America's leading
advocate for oral health

2017

Supplement to
Annual Reports and Resolutions
Volume 1

158th Annual Session
Atlanta, Georgia
October 20–23, 2017

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American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611

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Board Report 1/
Credentials, Rules and Order

Resolution No. 27 New
 Report: Board Report 1 Date Submitted: August 2017
 Submitted By: Board of Trustees
 Reference Committee: N/A
 Total Net Financial Implication: None Net Dues Impact: _____
 Amount One-time _____ Amount On-going _____ FTE 0

1 **REPORT 1 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ASSOCIATION**
 2 **AFFAIRS AND RESOLUTIONS**

3 **Background:** This is the first in a series of reports to be presented by the Board of Trustees to the
 4 House of Delegates at the 158th Annual Meeting of the American Dental Association.

5 **Appreciation to the Advisory Committee on Annual Meetings and the 2017 Committee on Local**
 6 **Arrangements:** The American Dental Association is pleased to have its 158th Annual Meeting in Atlanta,
 7 Georgia.

8
 9 The Committee on Annual Meetings has created a meeting that lives up to the ADA’s reputation for
 10 delivering an extraordinary education and exhibition experience. The Board of Trustees wishes to express
 11 its sincere gratitude to the Committee, and the exceptional leadership of Dr. David J. Fulton, Jr., 2016-
 12 2017 committee chair and Dr. Douglas A. Wyckoff, 2016-2017 continuing education chair. They have
 13 planned and produced not only an innovative continuing education program, but an exhibition that allows
 14 dental professionals to experience firsthand the latest in cutting edge dental materials, services and new
 15 technologies.

16 *Committee Members.* Dr. Alvin W. (Red) Stevens, Jr. (Board of Trustees liaison); Dr. J. Jerald Boseman,
 17 Jr.; Dr. William H. Bragdon; Dr. Henry F. (Bud) Evans, III (2018 chair-designate, continuing education);
 18 Dr. Charles B. Foy, Jr.; Dr. Raymond A. Jarvis (2018 NDC consultant); Dr. Paul F. Kirkegaard, Jr.; Dr.
 19 Gregory LaMorte; Dr. Howard I.A. Lieb (2018 CAM chair-designate); Dr. Calbert M.B. Lum (2018 Hawaii
 20 CLA general chair); Dr. C. Roger Macias, Jr. (2019 CAM chair-designate); Ms. Sara J. Perrone (2017
 21 ASDA Liaison); Dr. Stephen T. Radack, III; Dr. Andrea Richman; Dr. David L. Rothman; Dr. Kevin M.
 22 Sloan; Dr. Wayne T. Tadsen; Dr. Beatriz E. Terry; Dr. Nanette C. Tertel and Dr. Nipa R. Thakkar (2017
 23 NDC liaison); are all to be recognized for their commendable achievement.

24 The Board also extends its sincere thanks for those chairpersons who so capably assisted Dr. Karyn L.
 25 Stockwell, general chair of the 2017 Atlanta Committee on Local Arrangements:

26 Dr. Sidney R. Tourial, vice chair; Dr. Suzanna Aguilera, operations co-chair; Dr. Thomas C. Jagor,
 27 program co-chair; Dr. Mayur C. Nayee, program co-chair and Dr. Rebecca Weinman, operations co-chair.

28 Finally, the Board expresses tremendous appreciation to all of the volunteers on the Committee on Local
 29 Arrangements for the assistance they provide to the Council in the operation of this annual meeting. The
 30 Board recognizes and thanks the Georgia Dental Association for their contributions to the success of the
 31 2017 Atlanta Annual Meeting.

32 Without the wonderful assistance from these individuals and organizations, and their efforts working as a
 33 team with the ADA, this annual meeting would not be possible.

1 **Remembrance of Former Leaders:** Since the last meeting of the House of Delegates, the following
2 ADA Officers and Trustees have passed away: Dr. Marvin L. Fishmann, former vice president, 1971-
3 1973; Dr. Jack H. Harris, former president, 1992-1993; former treasurer, 1991-1992; former trustee, 1985-
4 1991; Dr. Clifford Marks, former trustees, 2000-2004; Dr. Geraldine T. Morrow, former president, 1991-
5 1992; former treasurer, 1990-1991; former trustee, 1984-1990; Dr. Burton H. Press, former speaker,
6 1977-1981; former president, 1982-1983; Dr. Frank F. Shuler, former president, 1976-1977; former
7 trustee, 1971-1975; and Dr. Robert M. Unger, former vice president, 1973-1974, former trustee, 1980-
8 1986.

9 **Election of Honorary Membership:** In accordance with the *Bylaws* which empowers the Board of
10 Trustees to elect members of the Association, the following individuals have been elected to Honorary
11 Membership:

12
13 Mr. Lawrence F. Carl, CAE
14 Mr. Patrick W. Finnerty, B.S., M.P.H.
15 Tin Chun Wong B.D.S., L.D.S.R.C.S., M.Sc.Orth, D.Orth.R.C.S. F.H.K.A.M., F.C.D.S.H.K

16 These individuals in various ways have made outstanding contributions to the advancement of the art and
17 science of dentistry or contributions above and beyond expectation to the profession. The Board offers its
18 sincerest congratulations to newest honorary members.

19 **Distinguished Service Award:** Established in 1970, the Distinguished Service Award is the highest
20 honor conferred by the Association's Board of Trustees. Each year the Board may select one recipient
21 for the Award. The Board is pleased to announce that the recipient of the 2017 Distinguished Service
22 Award is Dr. Patricia Blanton.

23 **Patricia L. Blanton, D.D.S.:** Dr. Blanton has led a distinguished career in dentistry dating back to her
24 first faculty appointment in 1967. She received her M.S. and Ph.D. degrees in anatomy from Baylor
25 University, her D.D.S. degree from Baylor College of Dentistry, and her certificate in periodontics at
26 Baylor College of Dentistry. Dr. Blanton is currently Professor Emeritus in Baylor's Department of
27 Biomedical Sciences, and she practices periodontics and implantology and is visiting clinical
28 professor in the department of stomatology at the Medical University of South Carolina. The first
29 female president of the Texas Dental Association, she recently served as president of the American
30 College of Dentists and vice president of the ADA. Dr. Blanton is a consultant, American College of
31 Dentists Foundation; a commissioner, the Commission on Dental Accreditation; and a member,
32 Baylor Oral Health Foundation Board.

33 Among her many awards are the Baylor College of Dentistry Distinguished Alumnus Award, Dallas
34 County Dental Society Dentist of the Year Award, Dallas County Dental Society Lifetime Achievement
35 Award, American Association of Women Dentists 2008 Woman Dentist of the Year/Lucy Hobbs
36 Taylor Award, and Commanders Award from the Europe Regional Dental Command. Dr. Blanton is
37 the honored recipient of the Hall of Fame Award at Baylor College of Dentistry/TAMHSC and received
38 the highest honor given by the Texas Dental Association, the Gold Medal of Distinguished Service
39 Award.

40 **Retiring Officers and Trustees:** The Board of Trustees wishes to express its gratitude to the following
41 officers and trustees for services rendered to the Association during their tenure on the Board: Dr. Irene
42 Marron-Tarrazzi, vice president; Dr. Jeffrey M. Cole, trustee, Fourth District; Dr. Gary E. Jeffers, trustee,
43 Ninth District; Dr. Andrew J. Kwasny, trustee, Third District; and Dr. Alvin W. (Red) Stevens, Jr., trustee,
44 Fifth District.

45 **Appreciation to Employees:** The Board of Trustees is pleased to bring to the attention of the House of
46 Delegates 56 members of the Association staff for their years of service.

47 *Thirty-Five Years:* Josielen Calloway and Rita Tiernan, Finance and Operations

- 1 *Thirty Years:* Shirley Ji, Information Technology
- 2 *Twenty-Five Years:* Ferdinand Villas, Finance and Operations
- 3 *Twenty Years:* Laura Bangs, Communications; Patricia Murphy, Conferences and Continuing Education;
4 Cynthia Willett, Education and Professional Affairs; Anthony Yarus, Wayne Thompson, and Gary
5 Grzesiak, Finance and Operations; Jane McGinley, Government Affairs; Peter Bradley, Christopher
6 Maag, and Rick Limanowski, Information Technology; Barbara Ferriter, Practice Institute; and Amy Lund,
7 Publishing.
- 8 *Fifteen Years:* Anne Boris, ADA Business Enterprise, Inc.; Sherin Tooks, Education and Professional
9 Affairs; Adriana Menezes, Health Policy Institute; Paul Gorski, Raj Trivedi and Joseph Hoyle, Information
10 Technology; and Krishna Aravamudhan, Practice Institute.
- 11 *Ten Years:* Briana Rowland, ADA Foundation; Tera Lavick, Administrative Services; Mary Borysewicz,
12 Nicholas Hussong, and Anthony Ziebert, Education and Professional Affairs; Towana Davis and Jeffery
13 Davenport, Finance and Operations; Sylvia Zeno, Health Policy Institute; Pamela Lammel, Information
14 Technology; Thomas Elliott and Jeffrey Fraum, Legal Affairs; Bridget Baxter, Client Services; Valerie
15 Walston, Practice Institute; and Esther White, Gilbert Munoz, and Elizabeth Grace, Publishing.
- 16 *Five Years:* Andrea Metzger, ADA Business Enterprise, Inc.; Shirley Watson, ADA Foundation; Richelle
17 Albrecht, Communications; Naveed Mughal, Kirk Kendzior, and Jennifer Snow, Education and
18 Professional Affairs; Thomas Parcella and Christine Maher, Finance and Operations; Kamyar Nasseh,
19 Health Policy Institute; Muhammad Ishaq, Joanna Espinosa, Gregory Olsen, and Courtney Bailey,
20 Information Technology; Nanette Elster, Legal Affairs; Paul Kinsley and Rebecca Kiser, Publishing; and
21 Cameron Estrich, Science Institute.
- 22 **Nominations to Councils and Commissions:** The Board of Trustees annually submits to the House of
23 Delegates nominations for membership to the councils, commissions and the New Dentist Committee.
24 Based on the ADA *Bylaws*, the nominees for ADA open positions on the Commission on Dental
25 Accreditation, Commission for Continuing Education Provider Recognition and Council on Scientific
26 Affairs were selected by the Board from nominations open to all trustee districts. Additionally, in
27 accordance with a long-standing House directive, the Board is providing a brief narrative on each
28 nominee's qualifications (page 1006). The *Bylaws*, Chapter VI, Conflict of Interest, requires nominees for
29 Councils and Commissions to complete a conflict of interest statement and file such statement with the
30 Secretary of the House of Delegates to be made available to the delegates prior to election. Copies are
31 available upon request through the Office of The Executive Director.

ADVOCACY FOR ACCESS AND PREVENTION

Irene V. Hilton, California
Jessica A. Meeske, Nebraska
Carol M. Morrow, Colorado
Bonita D. Neighbors, Michigan

COMMUNICATIONS

Frederick V. Guthrie, Jr.
Sam Mansour, Pennsylvania
Stephen M. Pitmon, Vermont
Stephanie B. Weaver, Louisiana

CONTINUING EDUCATION PROVIDER RECOGNITION

Gary M. DeWood, Arizona
Steven E. Parker, Ohio

DENTAL ACCREDITATION

Alan R. Stein, California*

DENTAL BENEFIT PROGRAMS

Yvonne E. Maldonado, Texas
Randall C. Markarian, Illinois
Hope E. Watson, Tennessee
Walter G. Weber, California

DENTAL EDUCATION AND LICENSURE

Jacqueline M. Plemons, Texas
Meaghan D. Strotman, Illinois

DENTAL PRACTICE

Jeffrey S. Berkley, Connecticut
Duc M. Ho, Texas
Christopher G. Liang, Maryland
Cary J. Limberakis, Pennsylvania

ETHICS, BYLAWS AND JUDICIAL AFFAIRS

Jill M. Burns, Indiana
 Thomas A. Howley, Jr., Pennsylvania, *ad interim*
 Guenter J. Jonke, New York
 Onika R. Patel, Arizona
 Vishruti M. Patel, Illinois, *ad interim*
 Robert J. Wilson, Jr., Maryland

GOVERNMENT AFFAIRS

Matthew J. Messina, Ohio
 John V. Reitz, Pennsylvania
 David M. White, Nevada
 Emily S. Willett, Nebraska

MEMBERS INSURANCE AND RETIREMENT PROGRAMS

John P. Ahern, New Hampshire
 Wilma Luquis-Aponte, Texas
 Paul T. Olenyn, Virginia
 Michael R. Thompson, Arizona

MEMBERSHIP

Bryan C. Blew, Illinois
 Jeffrey A. Kahl, Colorado
 Summer C. Ketron, Texas
 Jay Skolnick, New York

NATIONAL DENTAL EXAMINATIONS

Kanthasamy K. Ragunanthan, Ohio

NEW DENTIST

Lindsay M. Compton, Colorado
 Daniel W. Hall, South Carolina
 Lauren E. Vitkus, New York
 Benjamin C. Youel, Illinois

SCIENTIFIC AFFAIRS

Satish B. Alapati, Illinois
 Ana K. Bedran-Russo, Illinois
 Parthasarathy A. Madurantakam, Virginia
 Lauren L. Patton, North Carolina

*In response to resolution 76H-2010, CODA requested that, beginning in 2012, new Commissioner appointees be identified one year in advance of their term of service in CODA activities.

Resolution

27. Resolved, that the nominees for membership on ADA councils, commissions and the New Dentist Committee submitted by the Board of Trustees in accordance with Chapter VII, Section 100(H) of the *Bylaws* be elected.

Retiring Council and Commission Members: The Board of Trustees wishes to acknowledge with appreciation the service of the following council, commission and committee members.

ADVOCACY FOR ACCESS AND PREVENTION

Shelly F. Jones, Michigan
 Neil C. Nunokawa, Hawaii
 Valerie B. Peckosh, Iowa
 Andrew P. Soderstrom, California

ANNUAL MEETINGS

Charles B. Foy, Jr., Louisiana
 David J. Fulton, Jr., Illinois
 Douglas A. Wyckoff, Missouri

COMMUNICATIONS

Craig W. Herre, Kansas
 James R. Hight, Jr., Tennessee
 James A. H. Tauberg, Pennsylvania
 Karl P. Woods, Maine

CONTINUING EDUCATION PROVIDER RECOGNITION

Paul R. Leary, New York
 Ann Steiner, California

DENTAL ACCREDITATION

Stanley R. Surabian, California

DENTAL BENEFIT PROGRAMS

B. Scott Eder, West Virginia
 Douglas J. Gordon, California
 Steven J. Hill, Texas
 Ronald D. Riggins, Illinois

DENTAL EDUCATION AND LICENSURE

Jill M. Price, Oregon
 Prabu Raman, Missouri

DENTAL PRACTICE

Rita M. Cammarata, Texas
 Christine M. Landes, Pennsylvania
 Michelle L. Mazur-Kary, Maine
 Terry G. O'Toole, California (Federal Dental Services, District 4)

ETHICS, BYLAWS AND JUDICIAL AFFAIRS

Adam A. Edwards, New York
 Michael H. Halasz, Ohio
 Ken W. Merritt, Arizona
 Robert A. Shekitka, New Jersey

GOVERNMENT AFFAIRS

Mark E. Bronson, Ohio
Charles J. Incalcaterra, Pennsylvania
Scott L. Morrison, Nebraska

MEMBERS INSURANCE AND RETIREMENT PROGRAMS

J. Preston Coleman, Texas
Brian N. Hokanson, Wyoming
David E. McLean, Vermont

MEMBERSHIP

Michael G. Durbin, Illinois
Gary O. Jones, Arizona
Maria C. Maranga, New York
Carmen P. Smith, Texas

NATIONAL DENTAL EXAMINATIONS

Rhett L. Murray, Colorado

NEW DENTIST

Emily R. Ishkanian, Nevada
Justin R. Norbo, Virginia
Tricia Quartey, New York
Lindsey Yates, Colorado (Illinois, District 8)*

SCIENTIFIC AFFAIRS

John J. Dmytryk, Oklahoma
Jeffrey A. Platt, Indiana
Rebecca L. Slayton, Washington
Robert J. Weyant, Pennsylvania

*Dr. Yates served on the New Dentist Committee as the representative for District 8, and has relocated to Colorado within the previous year.

1 **ADA Institute for Diversity in Leadership**

2 **Program Aims:** The 2002 ADA House of Delegates approved the ADA Board’s proposal for an ADA
3 Leadership Institute designed for:

- 4 • Building lifetime relationships with minority dentists;
- 5 • Mentoring promising leaders with potential to impact diverse communities; and
- 6 • Strengthening alliances with stakeholder institutions, including dental leaders, industry, public and
7 governmental communities of interest.

8 **Leadership Development:** During their year-long program, Institute participants attended faculty
9 seminars at ADA Headquarters, conference calls with faculty and advisors, and guided experience with
10 individual leadership projects for their dental societies or other community organizations. The program’s
11 faculty are Professor Tim Calkins and Professor Liz Howard Livingston from Northwestern University’s
12 Kellogg School of Management and Dr. Ashleigh Shelby Rosette from Duke University’s Fuqua School of
13 Business. They have been with the program since its inception. (The Kellogg School is not connected
14 with the W.K. Kellogg Foundation.) ADA Leadership Institute videos on ADA CE Online are also a
15 resource. ADA Connect forum also serves the Institute community along with an online community on
16 Basecamp

17 **Enrollment:** Since 2003, the program has admitted 193 dentists (including one dentist sponsored by the
18 Asociación Dental Mexicana). In 2017 the ADA Board of Trustees admitted the following new class as
19 recommended by the Board’s Diversity and Inclusion Committee from a competitive field of applicants:

- 20 Dr. Courtney Burrill, Eagle River, Alaska
- 21 Dr. Parampreet Chhina, Philadelphia, Pennsylvania
- 22 Dr. Cathy Cook, Columbus, Georgia
- 23 Dr. Rebecca Glover Andrews, Greensboro, North Carolina
- 24 Dr. Estella Irelan, Wauwatosa, Wisconsin
- 25 Dr. Ruchika Khetarpal, Cincinnati, Ohio
- 26 Dr. Donna Klauser, Arcadia, California
- 27 Dr. Janis Moriarty, Winchester, Massachusetts
- 28 Dr. Mamatha Pasala, Austin, Texas
- 29 Dr. Mehul Patel, Trenton, Michigan
- 30 Dr. Daniel Ramirez, San Francisco, California
- 31 Dr. Amisha Singh, Aurora, Colorado

1 Dr. Lyubov Slashcheva, Iowa City, Iowa
 2 Dr. Chanelle Small, New York, New York
 3 Dr. Thanh T. Ton, Arcadia, California
 4 Dr. Tawana Ware, Indianapolis, Indiana

5 **Sponsorship:** The ADA Institute for Diversity in Leadership is sponsored by Henry Schein Cares and
 6 Crest + Oral B.

7
 8 **Alumni Paths:** Institute alumni have gone on to serve as volunteer leaders at the local, state and
 9 national levels.

- 10 • At the national level, service has included:
- 11 ○ ADA First Vice President, the ADA Strategic Planning Committee, Council on Membership,
 12 Council on Communications, Council on Government Affairs, New Dentist Committee, Board
 13 of Trustees Standing Committee on Diversity and Inclusion, ADA House of Delegates, and
 14 ADA Success Program speakers.
 - 15 ○ Officers and leaders at the national levels of the Society of American Indian Dentists,
 16 National Dental Association, Hispanic Dental Association, and American Association of
 17 Women Dentists.
- 18 • With a variety of state and local dental societies, Institute alumni have served as presidents, council
 19 members and chairs, as board members, and as House delegates at the state and local level. In the
 20 Institute's 2017 alumni survey, alumni volunteered to share expertise with dental societies on a wide
 21 range of topics in strategic planning, membership development, continuing education, mentoring for
 22 students and new dentists, government affairs, access, prevention, and dentists' collaborating with
 23 physicians and nurses.
 - 24 • Over the past several years, alumni have mobilized a growing number of dentists from across the
 25 country for annual events to serve U.S. military veterans.
 - 26 • Ten Institute community members took part in the 2017 ADA Dentist and Student Lobby Day.
 - 27 • Alumni have also served on boards of community organizations.
 - 28 • In the 2017 alumni survey, 97% of respondents reported their Institute experience as valuable or very
 29 valuable in their association work.

30
 31 **Report of the Governance Committee on Comprehensive Policy Review:** In accordance with
 32 Resolution 111H-2010, (Regular Comprehensive Policy Review), the Board reviewed existing policies
 33 under its purview and voted to maintain policies noted below.

34
 35 Changes in ADA Strategic Plan (*Trans.*1997:714; 2012:518)
 36 Posting of Financial Information (*Trans.*2009:493; 2012:407)
 37 Review of Reports and Studies by the ADA Board of Trustees (*Trans.*1995:652)
 38 Joint Meeting Approval (*Trans.*1985:610)
 39 Annual Session Dress Code (*Trans.*1999:981)
 40 Availability of ADA House Materials to Members (*Trans.*1991:606)
 41 Availability of House of Delegates Transcripts (*Trans.*1990:570)
 42 Utilization of Multi-Council Task Forces (*Trans.*2001:447)
 43 Hyperlink Embedding in Policy Statements (*Trans.*2008:440)
 44 ADA Intellectual Property Licensing (*Trans.*2008:495)
 45 Conflict of Interest Policy (Disclosure Policy) (*Trans.*2010:624; 2011:537; 2013:341)
 46 Term Limits for ADA Delegates (*Trans.*2012:412)
 47 Term Limits for Alternate Delegates (*Trans.*2012:412)
 48 Review of Association Policies (*Trans.*2010:603; 2012:370)
 49 ADA Reserves (*Trans.*2008:443; 2012:409)

Resolution
 (Resolution 27:Worksheet 1019)

1 STATEMENT OF QUALIFICATIONS OF NOMINEES TO COUNCILS AND COMMISSIONS**2 ADVOCACY FOR ACCESS AND PREVENTION**

3 *Hilton, Irene V., California, 2021.* Dr. Irene Hilton has been a public health dentist for 28 years with
4 clinical experience in urban dental clinic settings working with multi-cultural populations of all ages. She
5 has extensive experience in planning, implementing and evaluating programs. She is a consultant for the
6 National Network for Oral Health Access, and Community Health Centers. Dr. Hilton has been a member
7 of the California Dental Association (CDA) Policy Development Council, Dental Care Capacity Task
8 Force, CDA Foundation Board and Council on Community Health. She has also been the Community
9 Outreach chair for the National Dental Society of the Bay Area and chair of her dental society's legislative
10 committee. Dr. Hilton is a Diplomate of the American Board of Dental Public Health, and she received her
11 dental degree and dental public health residency from the University of California, San Francisco.

12 *Meeske, Jessica A., Nebraska, 2021.* Dr. Jessica Meeske is a pediatric dentist in Hastings, Nebraska,
13 and an expert in Medicaid due to her being one of the first dentists to be audited. This experience led her
14 to being selected by the American Dental Association to testify before a congressional subcommittee
15 regarding Medicaid. She is a leader in the American Academy of Pediatric Dentistry. Her spouse served
16 on CAPIR as the American Medical Association representative which gives her insight into the past work
17 of the Council. Dr. Meeske knows the current Council on Advocacy for Access and Prevention chair, Dr.
18 Andy Soderstrom, so she is familiar with the duties and current actions of the Council.

19 *Morrow, Carol M., Colorado, 2021.* Dr. Carol Morrow lives and practices advocacy for access and
20 prevention and will be a valued member of this Council. Despite a short professional tenure (eleven
21 years), her time has been well spent. She has a general dental practice located in Walsh, Colorado, a
22 very small town in the southeast corner of the state, and she is licensed in Colorado and Kansas. Her
23 father was a dentist in the same community. She attended Colorado State University and graduated from
24 the University of Colorado School of Dental Medicine in 2006. Despite long distances, she has been
25 continually involved in organized dentistry. As an alternate delegate to the ADA from Colorado, while
26 only one or two years out of dental school, she was not shy about keeping the more "seasoned
27 delegates" informed about the needs of new and rural dental practices. The ADA continues to benefit
28 from that advice.

29 Dr. Morrow has served at both component and state levels. She has been chair of the Colorado New
30 Dentist Committee and has advanced through the chairs of the Colorado Dental Association and is
31 currently president-elect. She has been a delegate to the ADA for a number of years and has served as
32 chair of an ADA reference committee. Most importantly, in her rural communities, she has established
33 programs for comprehensive treatment in both nursing homes and in elementary schools. The dental
34 homes we talk about are a reality in her community. Her interest in elder care has led her to seek
35 additional education via a master's degree program in geriatric care at the University of Southern
36 California. Dr. Morrow's interests and experiences will directly benefit the Council on Advocacy for
37 Access and Prevention as well as the ADA and the patients we serve.

38 *Neighbors, Bonita D., Michigan, 2021.* Dr. Bonita Neighbors graduated in 1976 from Bryn Mawr College
39 with a B.A. in economics and received her D.D.S. degree from the University of Michigan, School of
40 Dentistry in 1986. She completed a general practice residency at the University of Michigan Hospital in
41 1987.

42 Dr. Neighbors is also a Certified Correctional Health Professional with years of experience working for
43 various correctional facilities in the state of Michigan. From 2011 to 2016, Dr. Neighbors served as
44 director of University of Michigan's Community Health Center in Ann Arbor, Michigan. She is currently a
45 staff dentist for the Hope Clinic in Ypsilanti, Michigan.

46 Dr. Neighbors has a long history of grant writing and service to the community to improve the dental
47 health of the underserved. She is a member of the American Dental Association, National Dental
48 Association, Michigan Dental Association and the National Commission of Correctional Healthcare. She
49 is a past president of the Washtenaw District Dental Society and has served on numerous committees at

1 the local and state levels. She has been instrumental in establishing a number of high quality programs
2 designed specifically to provide dental education and treatment for severely medically-compromised and
3 extremely low income residents of Michigan, and has designed a program that places dental and dental
4 hygiene students from the University of Michigan within the Michigan Department of Corrections allowing
5 them to work under her supervision. In 2016, Dr. Neighbors was honored by the Michigan Dental
6 Association as its recipient of the Dr. Emmet C. Bolden Dentist Citizen of the Year Award.

7 **COMMUNICATIONS**

8 *Guthrie, Frederick V., Jr., Tennessee, 2021.* Dr. Rick Guthrie has served the Tennessee Dental
9 Association throughout his 30 year career. He is from a dental family and has been around our
10 profession his entire life. Having served on many component and constituent councils, he has shown a
11 dedication to putting in the time to understand the issues and address them. Most importantly to the
12 Council on Communications, Dr. Guthrie has just led our state association through the transition to a new
13 executive director. That process involved the development of a website more enticing to younger
14 dentists, a move to more electronic communication formats, and changing a state meeting that has grown
15 stale through the years to one that will attract younger members. He understands that young dentists are
16 our future, but that all dentists must have communications that fit their style. He will be committed to the
17 time necessary to complete his Council assignments.

18 *Mansour, Sam, Pennsylvania, 2021.* Dr. Sam Mansour is a graduate of Ohio State University College of
19 Dentistry. He completed a general practice residency program at Strong Memorial Hospital in Rochester,
20 New York. He has been in private dental practice in Erie, Pennsylvania, since 1997. Dr. Mansour has
21 also been the past president of the Erie County Dental Association, the Ninth District Dental Society and
22 currently serves as the Ninth District representative to the Pennsylvania Dental Association's Board of
23 Trustees. He is currently the chair of the Pennsylvania Dental Association's National Children's Dental
24 Health Month activities. His communications skills related to this statewide effort and throughout his
25 numerous leadership responsibilities at the state and local levels have been consistent and effective. Dr.
26 Mansour also commits a significant amount of time to treating special needs patients in both the office
27 and surgery center settings.

28 *Pitmon, Stephen M., Vermont, 2021.* Dr Stephen Pitmon is a past president of the Vermont State Dental
29 Society and currently serves as long term delegate to the ADA. Dr. Pitmon was the chair of Vermont
30 Special Smiles/Special Olympics from 1997 to 2004 and State Peer Review from 2001 to 2008. He
31 currently is the state chair for the Donated Dental Services Program. A graduate of the University of
32 Minnesota School of Dentistry, he has also completed training through the Dawson Center and the
33 Pankey Institute. Involved in organized dentistry throughout his career, Dr. Pitmon is particularly
34 interested in the three year communications campaign and is prepared to function as an effective
35 communicator, collaborator and an advocate for the value of membership in the ADA. Dr. Pitmon is
36 nominated without reservation to serve on the Council on Communications.

37 *Weaver, Stephanie B., Louisiana, 2021.* Dr. Stephanie Weaver has been an integral member of the
38 Twelfth District Delegation and has a strong relationship with our younger ADA members making her an
39 excellent choice for the Council on Communications.

40 Dr. Weaver maintains a practice in Lake Charles, Louisiana, and practices with her husband, Dr. Dan
41 Weaver. Dr. Weaver knows and understands the time commitment for the Council position and would be
42 able to provide the necessary time for the Council's needs. Her background and work at the New
43 Orleans Dental Association, in the area of helping the organization expand their communications and
44 relations with their members, further strengthens her position as an excellent member for the Council on
45 Communications.

46 **CONTINUING EDUCATION PROVIDER RECOGNITION**

47 *DeWood, Gary M., Arizona, 2021.* Dr. Gary DeWood's career has been continually integrated with
48 continuing education. He has had an interest in education since college and in fact majored in Education
49 prior to applying to dental school after encouragement from his brother. His experience includes 20 years
50 as a general dentist in private practice, ten years as part time faculty at the Pankey Institute, five years as

1 clinical director at the Pankey Institute, faculty at the University of Tennessee College of Dentistry and
2 most recently seven years as vice president of Curriculum and Clinical Education at Spear Education.

3 Dr. DeWood has been involved in organized dentistry since he was a dental student at Case Western
4 Reserve University. He was a delegate for the American Student Dental Association from 1978 to 1980.
5 He has been involved in the Toledo Dental Society, Ohio Dental Society, Academy of General Dentistry,
6 Memphis and Tennessee Dental Societies and the Arizona Dental Society. He has most recently been
7 the chair of the Council on Dental Education of the Arizona Dental Association.

8 Dr. DeWood's experience in continuing education and involvement in organized dentistry speaks to
9 his knowledge of and commitment to continuing education and organized dentistry. He would make an
10 excellent addition to the Commission for Continuing Education Provider Recognition.

11 *Parker, Steven E., Ohio, 2021.* Dr. Steven Parker is a general dentist in private practice in Massillon,
12 Ohio. At the ADA, Dr. Parker served on the Council on ADA Sessions from 2011 to 2015 and served as
13 the Council's exhibit chair in 2015. Previous to that, Dr. Parker served on the Local Arrangements
14 Committee for the ADA's National Conference of the Young Dentist. At the Ohio Dental Association
15 (ODA), Dr. Parker served as chair of the Annual Session Committee and as chair of the Subcouncil on
16 New Dentists. He also served on the ODA's Council on Membership Services and Strategic Planning
17 Committee. He was awarded the ODA's N. Wayne Hiatt Rising Star Award in 1996.

18 Dr. Parker is a past president of the Stark County Dental Society and served as chair of the Society's
19 Council on Dental Education and Programs and Council on Membership Services. Dr. Parker has
20 provided countless high quality continuing education programs at the national, state and local levels and
21 has worked with national speakers to develop creative programming for colleagues across the country.

22 **DENTAL ACCREDITATION**

23 *Stein, Alan R., California, 2022.* Dr. Alan Stein's qualifications for CODA include his work as clinical
24 assistant professor, Division of Diagnostic Sciences, USC School of Dentistry. He was awarded part-time
25 instructor of the year in 2006.

26 At the California Dental Association (CDA), Dr. Stein served as trustee, chair of the Judicial Council,
27 chair of the Ethics Task Force (ADA Golden Apple Award), chair of the Component Review Work Group
28 (ADA Golden Apple Award), and chair of the CDA Governance Task Force. He also served as a member
29 of the CDA Finance Committee, The Dentists Insurance Company Insurance Solutions (TDICIS) Board of
30 Directors and The Dentists Insurance Company (TDIC)/TDICIS Finance Committee and Underwriting
31 Committee. At the component level (San Fernando Valley Dental Society), Dr. Stein served as president,
32 delegate to the CDA, and peer review examiner. Dr. Stein is currently a delegate to the ADA and has
33 served on the Council on Ethics, Bylaws and Judicial Affairs.

34 Dr. Stein is on the active medical staff at Northridge Hospital Medical Center where he has served as
35 chair, Department of Dentistry, Medical Executive Committee, Bylaws Committee, Medical Staff Peer
36 Review Redesign Task Force, Head and Neck Oncology and Voice Preservation Workshop, director,
37 Continuing Dental Education, director, Multidisciplinary Study Club and director, Foundation for Airway
38 and Maxillofacial Surgery. Dr. Stein currently is in the Department of Surgery and is the chair of the
39 Interdisciplinary Practice Committee, which evaluates all non-physician services for appropriateness,
40 efficacy and safety, and determines educational criteria for protocol inclusion and hospital privileging. In
41 addition to his private and hospital practices, he also serves as an expert witness in general dentistry.
42 His 35 plus years in organized dentistry leadership and dental education coupled with his dedication to
43 advancing dental care will serve as an asset to the Commission on Dental Accreditation.

44 **DENTAL BENEFIT PROGRAMS**

45 *Maldonado, Yvonne E., Texas, 2021.* Dr. Yvonne Maldonado attended St. Mary's University in San
46 Antonio, Texas, and graduated in 1991 with a B.S. in biology and a minor in chemistry. She attended
47 dental school at the University of Texas Health Science Center in Houston, Texas, and graduated with a
48 D.D.S. degree in 1996. She has been the owner of a private practice since 2008 with interest in
49 pediatrics. She recently opened a new location called Stevenson's Dental Ark. The focus of these two

1 offices is primarily pediatric dentistry, but she is also enrolled in various state programs that assist in
2 dental benefits for adult special needs patients. Her private practice accepts a wide variety of dental
3 benefits with over 40 insurance plans including Medicaid.

4 Dr. Maldonado was the president of the El Paso District Dental Society from 2005 to 2006. She also
5 served on the Board of Directors for the Texas Dental Association (TDA) from 2011 to 2014. Dr.
6 Maldonado represented the Southwest Division of Texas on the Board of Directors for the TDA, serving
7 as director, senior director, and vice president of the TDA from 2011 to 2014.

8 *Markarian, Randall C., Illinois, 2021.* Dr. Randall Markarian received his D.M.D. degree in 1992 from the
9 Southern Illinois University (SIU) School of Dental Medicine in Alton, Illinois. He then completed his
10 orthodontic specialty training and M.S. degree in 1994 at St. Louis University, Center for Advanced Dental
11 Education in St. Louis, Missouri. Dr. Markarian is a Diplomate of the American Board of Orthodontics.
12 From 1995 to 2000, he was section head of orthodontics at SIU School of Dental Medicine. He served as
13 president of the St. Clair District Dental Society in 2009 and he is currently the vice president of the Illinois
14 State Dental Society. Dr. Markarian currently serves on the Council on Orthodontic Health Care of the
15 American Association of Orthodontics (AAO) and was a member of the AAO Medically Necessary
16 Orthodontics Task Force in 2014-15. He has served as an alternate delegate and is currently a delegate
17 to the ADA House of Delegates from the Eighth Trustee District. He is also a member of the International
18 College of Dentists. It is with great pride that the ADA Eighth District nominates Dr. Randall Markarian to
19 serve on the ADA Council on Dental Benefit Programs.

20 *Watson, Hope E., Tennessee, 2021.* Dr. Hope Watson has served in leadership positions in her
21 component and state since graduating in 1997 from the University of Alabama School of Dentistry. She
22 has served on multiple state committees including the Council on Dental Care Benefits of which she is
23 presently the chair. She is respected by her peers and can be counted on to fulfill her committee
24 responsibilities. Her integrity is above reproach testified by her membership in both the American and
25 International Colleges of Dentistry.

26 Dr. Watson has volunteered in multiple charity dental events throughout her career and she has
27 confirmed she has adequate time to devote to the work of the ADA Council on Dental Benefit Programs.

28 *Weber, Walter G., California, 2021.* Dr. Walter Weber is a past president of the California Dental
29 Association (CDA). He has served as an ADA delegate since 2008. Dr. Weber has served as chair of the
30 The Dentists Insurance Company/The Dentist Insurance Company Insurance Solutions Board of
31 Directors and as a member of the The Dentists Service Company Board of Directors. Additionally, he has
32 served as chair of the Policy Development Council, CDA Audit Committee, Dental Benefits Task Force
33 and Direct Member Services Task Force. Dr. Weber has also served as a member of the CDA Strategic
34 Planning Committee, Core Systems Committee, and Marketing and Communications Task Force. He is a
35 past president of the Santa Clara County Dental Society and served as chair of its IT Committee and as a
36 member of the Ethics Committee and Website Development Committee.

37 Dr. Weber is a general dentist from San Jose, living in Los Gatos. He received his dental degree
38 from the University of the Pacific Arthur A. Dugoni School of Dentistry and he also has an MBA in Finance
39 from Golden Gate University.

40 **DENTAL EDUCATION AND LICENSURE**

41 *Plemons, Jacqueline M., Texas, 2021.* Dr. Jacqueline Plemons is a board certified periodontist in private
42 practice in Dallas, Texas. She received her D.D.S. and specialty training at Baylor College of Dentistry.
43 Currently, she is a clinical professor at Texas A&M College of Dentistry, Department of Periodontics and
44 assistant director of the Stomatology Center at the Texas A&M College of Dentistry. She has served as
45 president of the Dallas County Dental Society, Southwest Dental Conference chair, has served as chair of
46 the Texas Dental Association's Council on Dental Education, Training, and Ancillaries and she is currently
47 serving as a vice president of the Texas Dental Association's Board of Directors.

48 Dr. Plemons served as a member of the ADA Council on Scientific Affairs from 2011 to 2013 and also
49 served on the National Board Dental Hygiene Examination Component B Test Construction Committee
50 for the Joint Commission on National Dental Examinations from 2002 to 2006. She has been a noted CE

1 speaker around the country and is the author of numerous peer reviewed articles. She is currently a
2 consultant to the Council on Scientific Affairs and a delegate from the Fifteenth District.

3 *Strotman, Meaghan D., Illinois, 2021.* Dr. Meaghan D. Strotman received her D.D.S. degree from the
4 University of Illinois at Chicago College of Dentistry in 2004. She then completed a two year dental
5 general practice residency at Advocate Illinois Masonic General Practice Residency (2005 resident, 2006
6 chief resident) in Chicago, Illinois.

7 Dr. Strotman is currently a part-time educator (2006 to present) at the University of Illinois at Chicago
8 College of Dentistry where she is a course director for Case Based Learning, and co-authored a number
9 of case based learning modules. She has also participated in a number of conference presentations on
10 evidence based dentistry and using digital journals for classroom education; and she has been an author
11 in peer-reviewed literature regarding problem based learning. Dr. Strotman has also served as a general
12 dentist at the UIC College of Dentistry Special Patient Care Clinic providing HIV infected patients with
13 comprehensive dental services and has been a faculty advisor for volunteers at Misericordia, a home for
14 children and adults with developmental and physical disabilities. She was also a FEMA volunteer in 2005
15 in New Orleans to administer vaccinations and triage patients following Hurricane Katrina. She is a
16 member of the ADA, American Dental Education Association, Academy of General Dentistry, and the
17 American Association of Anatomists, and she will bring to the Council a wealth of knowledge regarding
18 contemporary dental education. It is with great pride that the ADA Eighth District nominates Meaghan
19 Strotman to serve on the Council on Dental Education and Licensure.

20 **DENTAL PRACTICE**

21 *Berkley, Jeffrey S., Connecticut, 2021.* Dr. Jeffrey Berkley is a graduate of the University of Illinois,
22 receiving his D.D.S. degree in 1983. He attended Sinai Hospital of Detroit from 1983 to 1987 for an oral
23 and maxillofacial surgery residency and became board certified in oral surgery in 1989.

24 Dr. Berkley has extensive private practice experience managing five different office sites within his home
25 state of Connecticut. He is also an attending provider at two different hospitals, one with a general
26 practice residency and the other with an oral and maxillofacial surgery residency. He has been very
27 involved in organized dentistry at the local and state level and has received numerous awards for his
28 service throughout his career. He understands the practice of dentistry from a private practice standpoint
29 as well as a hospital and clinical setting. Dr. Berkley's commitment to the betterment of our profession
30 and the patients we serve makes him extremely qualified to serve on the Council on Dental Practice.

31 *Ho, Duc M., Texas, 2021.* Dr. Duc "Duke" Minh Ho graduated from the University of Texas School of
32 Dentistry Houston, Texas, with a D.D.S. degree in 1996 and completed a one year general practice
33 residency at the Michael E. DeBakey VA Medical Center. He has served in the American Dental
34 Association as an alternate delegate, on the Board of Directors at the Texas Dental Association and past
35 president and president for the Greater Houston Dental Society, the largest local component in the state
36 of Texas.

37 In addition, he is a Fellow of the International College of Dentists, a member of the Academy of
38 General Dentistry and the Texas Academy of General Dentistry, and currently serves on the Board of
39 Directors for the Houston Academy of General Dentistry. Lastly, Dr. Ho is a full time practicing partner in
40 a large group practice which employs nearly 40 team members and provides care for Katy, Texas, and its
41 surrounding areas.

42 *Liang, Christopher G., Maryland, 2021.* Dr. Christopher Liang has been in private orthodontic practice
43 since 2001. Dr. Liang was appointed to the ADA New Dentist Committee in 2006. As a member of the
44 Committee he served *ex officio* appointments to the Council on Governmental Affairs, Council on
45 Membership, Council on Scientific Affairs, and Council on Dental Practice. During his year on the Council
46 on Dental Practice, the Council deliberated the dental workforce issue and was instrumental on giving
47 feedback on the EMR, among other things. In addition to his ADA committee appointment, Dr. Liang has
48 served as component president and trustee and served on committees at the constituent level. He has
49 also served as president of the Maryland State Society of Orthodontists.

50 Since 2013, Dr. Liang has been a member of the Maryland State Dental Association Foundation

1 Board and is currently serving as secretary and treasurer. The Foundation has been instrumental in
2 increasing access to care in Maryland and reducing the incidence of emergency room visits due to dental
3 problems. Through its sponsored programs the Foundation has helped to provide nearly \$10 million in
4 dental care to the people of Maryland. Since 2004, Dr. Liang has been an assistant clinical professor in
5 the Department of Orthodontics at the University of Maryland School of Dentistry. Along with lecturing to
6 and supervising the post-doctoral residents, Dr. Liang has lectured to the pre-doctoral students in
7 orthodontics and led discussion groups in an ethics class. He has served as a class advisor helping the
8 students with navigating through dental school and career choices after graduation.

9 Dr. Liang is a member of the University of Maryland School of Dentistry's Alumni Board and Board of
10 Visitors. As a member of the Board of Visitors he has assisted the dean in decision making that helps
11 keep the school's mission of being a leading dental school and research facility. He is on the Board's
12 technology advisory committee helping the school adopt technology for the 21st century.

13 *Limberakis, Cary J., Pennsylvania, 2021.* Dr. Cary Limberakis is a graduate of the University of
14 Pennsylvania and a Fellow in the Academy of General Dentistry, International College of Dentists,
15 American College of Dentists and the Pierre Fauchard Academy. He has served for multiple years in the
16 ADA House of Delegates and as a member of the Reference Committee on Membership and Related
17 Matters in 2014. He is a past president of the Valley Forge Dental Association and Montgomery-Bucks
18 Dental Society. He has been a member of the A.V. Purinton Academy of Practice Management,
19 American Academy of Implant Dentistry and the Academy of Stomatology. He serves as a clinical
20 instructor in the Expanded Function Dental Assistants Program at Manor College, clinical instructor in the
21 Department of Restorative Dentistry at the Kornberg School of Dental Medicine and as senior associate
22 surgeon/clinical instructor, Division of Dentistry at the Abington Memorial Hospital in Abington,
23 Pennsylvania.

24 Dr. Limberakis maintains a private dental practice in Jenkintown, Pennsylvania, and has participated
25 in the ongoing Mission of Mercy events in Pennsylvania as the clinical restorative lead for the past three
26 years.

27 **ETHICS, BYLAWS AND JUDICIAL AFFAIRS**

28 *Burns, Jill M., Indiana, 2021.* Dr. Jill Burns has been a strong member of the ADA since 1984. She has
29 served as the Indiana Dental Association parliamentarian in 2011, vice speaker from 2012 to 2016, and
30 speaker since 2016. Having served on several ADA reference committees, 2014 chair of the Standing
31 Committee on Credentials, Rules and Order, and many other state and national leadership positions, she
32 is extremely prepared and passionate about serving on CEBJA.

33 Dr. Burns will be an excellent addition to the Council on Ethics, Bylaws and Judicial Affairs and to the
34 leadership at the ADA.

35 *Howley, Thomas A., Jr., Pennsylvania, 2019.* In March, Dr. Thomas Howley was appointed to complete
36 the unexpired term of Dr. David Anderson. Dr. Howley has a distinguished background in organized
37 dentistry and administration. He has been the acting executive director of the Pennsylvania Academy of
38 General Dentistry and currently serves as the executive director of the Montgomery and Bucks County
39 Dental Society and the Pennsylvania Association of Orthodontists. He has also served as the president
40 of the Academy of General Dentistry from 2004 to 2005 and a member of their Board of Trustees from
41 1998 to 2006. In 2000 and 2006, he served as a representative to the Ethics Alliance of Oral Health
42 Organizations. Dr. Howley's experience is also extensive in being a Regent for the American College of
43 Dentists, Vice-Regent of the Academy of Dentistry International and the district coordinator from
44 Pennsylvania to the International College of Dentists. He has also served the ADA in being a member of
45 its Continuing Education Recognition Program Committee and the Dental Education Subcommittee on
46 Life Long Learning. He achieved his undergraduate degree from Penn State University and his dental
47 degree from Temple University School of Dentistry.

48 *Jonke, Guenter J., New York, 2021.* Dr. Guenter Jonke is an oral and maxillofacial surgeon who
49 graduated from Boston University School of Dentistry in 1985. He then went on to do his internship and
50 then residency in oral and maxillofacial surgery at Georgetown University Hospital in 1990.

1 Dr. Jonke's interest, experience and education supports his ability to become a productive council
2 member. His background includes over ten years serving on the local component, Suffolk County Dental
3 Society, and the New York State Dental Association (NYSDA) Ethics Council with the last two years
4 serving as chair. The time spent has benefited him with wonderful education as well as excellent
5 interaction with all the council members including the staff and counsel. His Fellowship at the American
6 College of Dentists has also given him additional knowledge; taking many classes and participating as a
7 board member of the New York Chapter. He has engaged the fourth year dental students at Stony Brook
8 Dental School in a variety of ethical dilemmas for the past seven years. It truly has been a rewarding
9 experience for everyone as he engages so many talented students.

10 *Patel, Onika R., Arizona, 2021.* Dr. Onika Patel is a graduate of the Arizona School of Dentistry and Oral
11 Health. She has completed an advanced education in general dentistry program. In addition she has a
12 master of public health degree. She has been continuously involved in leadership activities while in
13 dental school and since establishing her own dental practice. She served as an American Student Dental
14 Association District Trustee and served as a liaison to the Council on ADA Sessions. Dr. Patel speaks on
15 leadership at national leadership conferences. She is a graduate of an Arizona Dental Association
16 leadership development program and is currently an alternate delegate representing the Arizona Dental
17 Association and District 14 at the ADA House of Delegates. She is an officer of the Central Arizona
18 Dental Society and her dedication to the dental profession and making it better through organized
19 dentistry is readily apparent.

20 Dr. Patel's enthusiasm, drive and perspectives as a new dentist will be a great addition to the Council on
21 Ethics, Bylaws and Judicial Affairs.

22 *Patel, Vishruti M., Illinois, 2019.* Dr. Vishruti Patel was appointed to complete the unexpired term of Dr.
23 Petra von Heimburg as a member of the Council on Ethics, Bylaws and Judicial Affairs. Dr. Patel
24 received her D.D.S. degree from the University of Illinois at Chicago College of Dentistry in 2002. Dr.
25 Patel is an alternate delegate from the ADA Eighth District to the 2017 ADA House of Delegates. She is
26 currently the president of the Will County Dental Society (2017-2019), and she has served as president of
27 the Indian Dental Association of Illinois (2013-2015). Dr. Patel is also an alumnus of the ADA/Kellogg
28 Executive Management Program for Dentists (2008), and she is an alumnus of the ADA Institute for
29 Diversity in Leadership Program (2013). She is a member of the Illinois State Dental Society's
30 Government Affairs Committee (2014-2017), and she has served as treasurer of the American
31 Association of Women Dentists (2016). It is with great pride that the ADA Eighth District nominates Dr.
32 Vishruti Patel to serve on the ADA Council on Ethics, Bylaws, and Judicial Affairs.

33 *Wilson, Robert J., Jr., Maryland, 2021.* Dr. Robert Wilson has been a member of the Maryland State
34 Dental Association (MSDA) House of Delegates for 29 years and has served as its speaker for the last
35 three years. He also served in the ADA House of Delegates for the past six years. He has completed
36 Presiding Officer Training presented by Dr. Barry Glazer.

37 During his tenure as MSDA president, Dr. Wilson performed a complete review and rewrite of the
38 MSDA Bylaws and Policy Manual. He continues to serve on the MSDA Constitution and Bylaws
39 Committee. He has drafted numerous resolutions to affect bylaws changes at the constituent level and
40 more recently has been charged with writing resolutions and amendments on behalf of the ADA Fourth
41 District. Dr. Wilson has a deep appreciation of the ADA Code of Ethics and served on a panel that
42 presented a series on ethics to third year dental students at the University of Maryland School of
43 Dentistry. His background will make him a great addition to the Council.

44 **GOVERNMENT AFFAIRS**

45 *Messina, Matthew J., Ohio, 2021.* Dr. Matthew Messina is a general dentist in private practice in Fairview
46 Park, Ohio. At the ADA, he is a consumer advisor for the Association and serves as an ADA national
47 spokesperson in TV, radio, and print interviews. He served as an ADA Success Seminar presenter from
48 1996 to 2007, is a former member and chair of the Committee on the New Dentist, and served as an
49 alternate delegate to the ADA House of Delegates.

50 At the Ohio Dental Association (ODA), Dr. Messina is currently serving as the executive editor. He is
51 a former member of the ODA's Strategic Planning Committee, Council on Communications and Public

1 Service, Council on Membership Services and Annual Sessions Committee. He was awarded the ODA's
2 N. Wayne Hiatt Rising Star Award in 1997. Dr. Messina is a past president of the Greater Cleveland
3 Dental Society and served as chair of the society's Strategic Planning Committee.

4 *Reitz, John V., Pennsylvania, 2021.* Dr. John Reitz is a graduate of the Kornberg School of Dental
5 Medicine and a Fellow of the Academy of General Dentistry, American College of Dentists, International
6 College of Dentists and the Pierre Fauchard Academy. His past leadership positions include president,
7 Berks County Dental Society and the Pennsylvania Dental Association (PDA) Fourth District Dental
8 Society. He also served on the PDA Government Relations Committee for a four-year term. He is a past
9 board member and chair of the ADA's Political Action Committee.

10 Dr. Reitz has also served the Commonwealth of Pennsylvania as a member and chair of the State
11 Board of Dentistry with appointments from Governor's Tom Ridge and Edward Rendell. He has also
12 served on the advisory board for his U.S. congressman along with numerous advocacy activities at the
13 state and national levels for many years. He has been an active participant for many years along with his
14 wife, Carol, at the PDA and ADA Lobby Day events and a passionate supporter and proponent of our
15 advocacy efforts in organized dentistry.

16 *White, David M., Nevada, 2021.* Dr. David White is well qualified to serve on the Council on Government
17 Affairs. Dr. White graduated from the University of Michigan School of Dentistry in 2003. He was
18 involved in multiple organizations while a student and has continued his active involvement in organized
19 dentistry since that time. He has consistently been involved in his component and state association as
20 well as the Academy of General Dentistry and the Hispanic Dental Association. He was awarded the
21 ADA Golden Apple Award for New Dentist Legislative Leadership in 2011, for Mentorship in 2012, and for
22 New Dentist Leadership in 2013. Dr. White has served as Nevada Dental Association State
23 PAC/Government Affairs chair since 2011 and has been a member of the Nevada Dental Association
24 Legal and Legislative Committee since 2009. He is currently president of the Nevada Dental Association.
25 Dr. White will be a great asset to this very important Council.

26 *Willett, Emily S., Nebraska, 2021.* Dr. Emily Willett has been involved in organized dentistry since her
27 days in dental school when she was active with the American Student Dental Association and served on
28 ADPAC. She has continued her involvement following her graduation by serving in the Nebraska Dental
29 Association House of Delegates and on the Legislative Committee. Dr. Willett has displayed dedication
30 and passion for serving our profession and with great pleasure this young leader is nominated to serve on
31 the Council on Government Affairs.

32 MEMBERS INSURANCE AND RETIREMENT PROGRAMS

33 *Ahern, John P., New Hampshire, 2021.* Dr. John Ahern graduated from Georgetown University School of
34 Dentistry in 1984. Dr. Ahern established a group dental practice in 1989 and, in the same year, he was
35 instrumental in developing Northeast Mobile Dental Services, which provides assessments and direct
36 care to residents in long-term care facilities throughout New Hampshire. In 1991, he created the
37 Children's Dental Network in Derry, New Hampshire, which is a school based dental health program, and
38 he has been a provider of services for the program since its inception.

39 Since 1994, Dr. Ahern has been a board member for Alexander Eastman Foundation, a benevolent
40 healthcare foundation which services six towns in southern New Hampshire. His community service
41 throughout his career has been exemplary. His experience with multiple practice settings and working
42 with multiple providers has provided him with a very objective and youthful approach to issues within our
43 profession. He understands the needs of the practicing dentist and is versed in group insurance and
44 retirement plans. Dr. Ahern will be a valuable asset to the Council on Members Insurance and
45 Retirement Programs.

46 *Luquis-Aponte, Wilma, Texas, 2021.* Dr. Wilma Luquis-Aponte grew up in Caguas, Puerto Rico. She
47 attended the University of Puerto Rico at Cayey where she received her undergraduate degree in
48 sciences, later attending the University of Puerto Rico School of Dentistry where she received her degree
49 of doctor of dental medicine, and the School of Public Health where she finished a master's in public

1 health with a concentration in maternal and child health. She also holds a Ph.D. degree in public health
2 from Walden University with special interest in community health education and promotion.

3 Prior to establishing in El Paso and opening her dental practice, Dr. Luquis-Aponte worked as dental
4 director at the Brownsville Community Health, the University of Houston Dental Branch as assistant
5 professor and as associate dental provider for other dentists in the El Paso community. Her dedication
6 led her to seek and get trained in the newest advancements in cosmetic dentistry, orthodontics, implants
7 and restorative treatment; providing a gentle, caring and comprehensive approach to complete oral
8 health. She believes in conservative, preventative dentistry, and her goal is to increase the longevity of
9 her patients' teeth.

10 Dr. Luquis-Aponte has over 20 years of experience as a dentist and community leader. Dr. Luquis-
11 Aponte is a standing member of the American Dental Association, Texas Dental Association, and the El
12 Paso Dental Association. She is the past president of the Puerto Rican Medical Society of El Paso.

13 *Olenyn, Paul T., Virginia, 2021.* Dr. Paul Olenyn is currently serving on the Council on Members
14 Insurance and Retirement Programs and would like to remain on the Council. He is completing the term
15 of Dr. Larry Ferguson of South Carolina who resigned early. Dr. Olenyn is eligible for reappointment to a
16 full four-year term on the Council. He has been well prepared for council meetings and is very interested
17 in the subject matter. Dr. Olenyn is up to speed with the business of the Council and would therefore be
18 the best candidate from the 16th District to fill this position.

19 *Thompson, Michael R., Arizona, 2021.* Dr. Michael Thompson will bring significant experience and
20 knowledge to the Council on Members Insurance and Retirement Programs. He is a graduate of the
21 University of Detroit School of Dentistry and completed a general practice residency at St. Vincent
22 Hospital and Medical Center. He has also completed the Executive Management Program at Kellogg
23 School of Management, Northwestern University. His volunteer activities include both community efforts
24 and involvement in organized dentistry. Dr. Thompson is a past president of the Arizona Dental
25 Association (AzDA) and past national trustee for the Academy of General Dentistry. He served for many
26 years as an ADA delegate representing the Arizona Dental Association. His other Arizona Dental
27 Association roles have included the Task Force on Reserve Fund Management, the Budget Oversight
28 and Audit Committee, chair of AzDA Services (for profit entity), Budget and Planning, and Council on
29 Insurance. He has always kept the interests of member dentists as the highest priority in all of the roles
30 he has served, and he will continue to do so while serving on this Council.

31 **MEMBERSHIP**

32 *Blew, Bryan C., Illinois, 2021.* Dr. Byran Blew received his D.D.S. degree from the University of Illinois at
33 Chicago College of Dentistry in 1998. Dr. Blew is a dentist in Moline, Illinois, where he is a partner at
34 Riverside Family Dentistry. He was president of the Rock Island District Dental Society in 2008 and is
35 currently the chair (2012-present) of the Illinois State Dental Society (ISDS) Committee on Membership.
36 He is also the vice speaker of the ISDS House of Delegates. Dr. Blew has been an alternate delegate
37 and is currently a delegate to the ADA House of Delegates from the Eighth District. He has attended the
38 ADA Recruitment and Retention Conference (2010-present), and completed ADA community water
39 fluoridation spokesperson training in 2013. He is a Fellow of the American College of Dentists and a
40 member of the American Institute of Parliamentarians. It is with great pride that the ADA Eighth District
41 nominates Bryan Blew to serve on the ADA Council on Membership.

42 *Kahl, Jeffrey A., Colorado, 2021.* Dr. Jeffrey Kahl graduated from the University of Colorado School of
43 Dentistry in 2001. He completed a general practice residency at the National Naval Medical Center in
44 Bethesda, Maryland, followed by a pediatric dentistry residency at The Children's Hospital in Denver,
45 Colorado that he completed in 2006. He lives and practices pediatric dentistry in Colorado Springs,
46 Colorado. Dr Kahl has been a member of the ADA since 1997. He is a Diplomat of the American Board
47 of Pediatric Dentistry and continues as an adjunct professor of clinical pediatric dentistry at The Children's
48 Hospital. In the short time since he completed his training, Dr. Kahl has been actively involved in
49 organized dentistry. He is a past president of the Colorado Academy of Pediatric Dentistry and has been
50 a member of the Colorado Dental Political Action Committee and served as chair of the Colorado Dental
51 Association (CDA) Council on Governmental Relations. He is currently secretary/second vice president

1 of the Colorado Dental Association and in that role has served as co-chair of the Membership Committee
2 for the past two years. In 2016, CDA membership increased for the first time in seven years to 72.8%.
3 Dr. Kahl also serves as an ADA delegate. Dr. Kahl's involvement and dedication to dentistry is readily
4 apparent and he will be an excellent addition to the Council on Membership.

5 *Ketron, Summer C., Texas, 2021.* Dr. Summer Ketron is in private practice, general dentistry in Lubbock,
6 Texas. She attend both the University of Texas at Austin and Texas Tech University for her
7 undergraduate degree. Dr. Ketron worked on her M.S. in Immunology at the Texas Tech Health
8 Sciences Center. She completed her D.D.S. degree from the University of Texas School of Dentistry in
9 Houston and completed a general practice residency at Louisiana State University School of Dentistry.
10 While in dental school,
11 Dr. Ketron served as president of her dental class. She finished a successful senior year by being award
12 the International College of Dentists Senior Student Leadership Award, the Texas Dental Association
13 (TDA) Outstanding Senior Dental Student Award, the Greater Houston Dental Society Student of the Year
14 Award and the American Society of Dental Anesthesiology Horace Wells Senior Student Award. In 2014,
15 2016 and 2017, she was nominated for the Texas Academy of General Dentistry (TAGD) New Dentist of
16 the Year.

17 Dr. Ketron has been an enthusiastic and active participant in organized dentistry having served on the
18 TDA New Dentist committee, as chair of the TAGD New Dentist Committee and in her current positions
19 on the TDA Council on Annual Sessions, the West Texas Academy of General Dentistry Board of
20 Directors and the Lone Star Dental Conference Committee for the TAGD. She is also the South Plains
21 District Dental Society Dental Health and Public Relations chair. Her other professional memberships
22 include the International College of Dentists and the American Society of Dental Anesthesiology.

23 *Skolnick, Jay, New York, 2021.* Dr. Jay Skolnick has been involved with membership on the county,
24 district and state levels since 1997. He continues to serve as the Seventh District Dental Society
25 Membership chair and is the immediate past chair of the New York State Membership and
26 Communications Council.

27 Dr. Skolnick maintains a private practice in pediatrics and is also involved with dental resident training
28 advocating for their engagement in organized dentistry. For many years, he has presented tripartite
29 informational and membership seminars to general dental residents at local hospitals and specialty
30 residents at the Eastman Institute for Oral Health. In addition, he served on the Seventh District Strategic
31 Planning committee looking at the current state and future needs of all its members. Dr. Skolnick has
32 worked closely with constituent and component volunteers and staff on plans and programming for
33 membership engagement and growth. He will be a dedicated and hardworking member of the Council
34 and is highly recommended.

35 **NATIONAL DENTAL EXAMINATIONS**

36 *Ragunathan, Kanthasamy K., Ohio, 2021.* Dr. Kanthasamy Ragunathan is a general dentist and has
37 been in private practice in Canton, Ohio, since 1994. He is a former assistant clinical professor in the
38 Department of Oral Diagnostics at the Case Western Reserve University School of Dentistry, a former
39 clinical instructor in the Dental Assistant Program at Akron Medical Dental Institute, and a former resident
40 dentist in the Dental Hygiene Clinics at Cuyahoga Community College and Stark State Technical College.
41 Dr. Ragunathan has a wealth of experience teaching and testing dental students and dental hygiene
42 students and is familiar with testing methods.

43 At the Ohio Dental Association, Dr. Ragunathan served on the Council on Membership Services and
44 as a member of the House of Delegates. He is a past president of the Stark County Dental Society and
45 served on the society's Dental Education and Programs Committee, Long Range Planning Committee
46 and Membership Committee. Dr Ragunathan earned his B.D.S. at the University of Peradeniya in Sri
47 Lanka and later earned his D.M.D. degree from Case Western Reserve University School of Dentistry.

48 **NEW DENTIST COMMITTEE**

49 *Compton, Lindsay M., Colorado, 2021.* Dr. Lindsay Compton is the owner of a general dental practice in
50 a small suburb of Denver, Colorado. She is a graduate of the University of Iowa College of Dentistry.

1 She also completed a general practice residency at Truman Medical Center. While in dental school, she
2 participated in research activities, completed scientific publications and was the recipient of numerous
3 awards. After completing her training, she became a member of the Kansas Dental Association and
4 since 2011 she has been a member of the Colorado Dental Association and the Metro Denver Dental
5 Society. Dr. Compton has been active in the Colorado New Dentist Committee leadership, serving as
6 president (2015-16), and was instrumental in the development of a membership program called "Connect
7 the Docs." She is currently an ADA alternate delegate representing the Colorado Dental Association.

8 *Hall, Daniel W., South Carolina, 2021.* Dr. Daniel Hall began his leadership career in dentistry by serving
9 on the ASDA Executive Committee from 2011 to 2015 and was ASDA president from 2013 to 2014. In
10 February 2017, he assumed the South Carolina Dental Association (SCDA) chair of the New Dentist
11 Committee. Dr. Hall has a very impressive CV, especially since he has only been out of dental school for
12 two years. He will be an excellent addition to the ADA New Dentist Committee which will see him
13 maximize his leadership potential

14 *Vitkus, Lauren E., New York, 2021.* Dr. Lauren Vitkus will bring both experience and passion to the New
15 Dentist Committee. While a student at the University of Buffalo School of Dental Medicine she served as
16 student body president and as the American Student Dental Association (ASDA) District 2 Trustee;
17 representing both Buffalo and ASDA District 2 within the ADA second district and across the country.
18 She held a number of other positions while in dental school as well and her work and effort in these
19 positions was highly regarded.

20 Upon graduation, Dr. Vitkus received the Dr. Joseph A. Accardo Eight District Dental Society Award,
21 which recognizes a student who shows leadership and visionary skills in organized dentistry. In addition,
22 she received the ASDA Award of Excellence given to a student who achieves a superior level of
23 participation and leadership in their service to other students, their school and their local community.
24 Following graduation from dental school, Dr. Vitkus completed a two year orthodontic residency at the
25 Eastman Institute for Oral Health in Rochester, New York. She has remained active within the ADA and
26 has also become involved within the American Association of Orthodontics (AAO). While in residency,
27 she served as one of two resident representatives to the AAO Council on New and Younger Members
28 and is currently a member of the Northeastern Society of Orthodontics Communications Committee. She
29 is an active member of the New York State Dental Association Seventh District and represented the
30 District as an alternate delegate at the 2017 New York State Dental Association Annual Meeting.

31 *Youel, Benjamin C., Illinois, 2021.* Dr. Ben Youel received his D.D.S. degree from the University of Illinois
32 at Chicago (UIC) College of Dentistry in 2013. He then completed a dental general practice residency at
33 Advocate Illinois Masonic Medical Center in 2014. Dr. Youel is currently a post-graduate orthodontic
34 specialty resident at UIC College of Dentistry. He served as president of the UIC American Student
35 Dental Association (ASDA) Chapter in 2012; and he served on the national level as the ASDA District
36 Seven trustee (2012) and ASDA vice president (2013). He is currently serving as a Chicago Academy of
37 General Dentistry (AGD) officer, and serves the Illinois State Dental Society as a member of the
38 Communications Committee, and the Chicago Dental Society as a member of the Membership
39 Committee. Dr. Youel is a member of the ADA, AGD, American Association of Orthodontics (AAO), and
40 Omnicron Kappa Upsilon Sigma Chapter. He will be inducted into Fellowship in the American College of
41 Dentists in 2017. It is with great pride that the ADA Eighth District nominates Dr. Ben Youel to serve on
42 the ADA New Dentist Committee.

43 **SCIENTIFIC AFFAIRS**

44 *Alapati, Satish B., Illinois, 2021.* Dr. Satish Alapati is a tenure-track associate professor (in process) in
45 the Department of Endodontics, College of Dentistry, and serves as an adjunct faculty member in the
46 Department of Bioengineering at the University of Illinois at Chicago (UIC). He received his B.D.S. from
47 India; Certificate in General Practice Residency; M.S. (Dental Materials) and his Ph.D. (Oral Biology) from
48 The Ohio State University. He also received a Certificate in Endodontics from UIC. Dr. Alapati has
49 published extensively and presented his research at national and international dental research meetings.
50 He serves on multiple national committees related to clinical endodontics and oral health research and
51 serves as vice chair of ADA ISO TC 106, Dental Equipment, Endodontic Instruments and Materials. Dr.

1 Alapati also serves as a trustee for the American Association of Endodontists Research Foundation and
2 he is active in the Allen Anderson Faculty Dental Practice—limited to Endodontics. He also serves as a
3 consultant to the ADA Council on Scientific Affairs, Standards Subcommittee. Dr. Satish Alapati's
4 educational and research expertise in dental materials, endodontics, and oral biology will be a significant
5 asset for the Council on Scientific Affairs.

6 *Bedran-Russo, Ana K., Illinois, 2021.* Dr. Ana Bedran-Russo is an associate professor and director of
7 Applied Biomaterials and Bio-Interfaces Research. She received a D.D.S. degree from the State of Sao
8 Paulo University, Brazil, and her M.S. and Ph.D. degrees from the State University of Campinas, Brazil.
9 She pursued two years of postdoctoral training at the University of North Carolina Chapel Hill and the
10 University of Illinois at Chicago (UIC).

11 Dr. Bedran-Russo is a clinician-scientist with broad background in hard tissue and biomaterials and
12 research expertise in the biochemistry of the dentin organic matrix that regulates the tooth mechanics and
13 function. Her group has pioneered the use of bioinspired strategies using plant-derived oligomeric
14 proanthocyanidins (OPAC) to mimic native collagen cross-links at various hierarchical levels and mediate
15 the biomechanics and biostability of dentin. Her recent studies led to new insights into novel
16 bioadhesives to the inherently wet collagen rich dentin. These strategies have high translational impact in
17 many dental clinical applications including the dynamic interface between natural and artificial
18 biomaterials. Dr. Bedran-Russo has published more than 90 peer-reviewed papers and 170 abstracts.

19 Dr. Bedran-Russo is the program director of the Multidisciplinary Oral Science Training program
20 supported by a T32 NIH training grant. She is actively involved in the organization of scientific/academic
21 associations. She serves on NIH study sections, scientific journal reviewer/board member, and
22 leadership of scientific and clinical organizations, including the International Association for Dental
23 Research/American Association for Dental Research (IADR/AADR), the Academy of Dental Materials and
24 the Academy of Operative Dentistry. She received many awards; most prominent, the 2014 UIC
25 Researcher of the Year Award in the Clinical Sciences. Dr. Bedran-Russo has extensive academic and
26 clinical care experience and is a well-recognized biomaterials researcher who would be a significant
27 contributor to the Council on Scientific Affairs.

28 *Madurantakam, Parthasarathy A., Virginia, 2021.* Dr. Madurantakam is an Assistant Professor in the
29 department of General Practice at the Virginia Commonwealth University, School of Dentistry, where he
30 has held a faculty position since 2012. He received his B.D.S. from the Tamilnadu Government Dental
31 College and Hospital, in Chennai, India, where he also received a Master's of Science (MSD -
32 Orthodontics), followed by a Ph.D. (Biomedical Engineering) from The Virginia Commonwealth University
33 (VCU). Dr. Madurantakam received his USA license after completing his D.D.S. at VCU in 2012. He has
34 been focusing his research career in Evidence Based Dentistry (EBD) for the last 3 years and actively
35 participated on several ADA workshops organized by the Center for EBD. He has been funded by
36 different agencies, published peer review articles and a book chapter, mentored several graduate
37 students at VCU, where he is the course Director for all Evidence-Based Dentistry

38 *Patton, Lauren L., North Carolina, 2021.* Dr. Lauren Patton is professor and chair, Department of Dental
39 Ecology, at the University of North Carolina (UNC) School of Dentistry and director of the General
40 Practice Residency (GPR) Program at UNC School of Dentistry and UNC Hospitals. She earned her
41 D.D.S. at UNC and attended the two-year GPR at UNC, followed by a two-year Clinical Dental Staff
42 Fellowship with Oral Medicine/Research training at the National Institute of Dental and Craniofacial
43 Research (NIDCR) in Bethesda, Maryland. During her 27 years on the UNC faculty, she has conducted
44 industry and federal government funded clinical and health services research; participated in teaching at
45 dental hygiene, dental, and post-doctoral levels; published over 125 papers, monographs and book
46 chapters; and lectured internationally on oral manifestations and management of patients with medical
47 complexities, such as HIV/AIDS and oral cancer. She is editor of *The ADA Practical Guide to Patients
48 with Medical Conditions* and the Oral Medicine section editor of *Oral Surgery, Oral Medicine, Oral
49 Pathology, Oral Radiology*. She is the UNC site principal investigator of the NIDCR funded Clinical
50 Registry of Dental Outcomes in Head and Neck Cancer Patients (ORARAD).

1 In 2016, Dr. Patton represented the ADA as a voting panel member on a joint project with the
2 American Academy of Orthopedic Surgeons to develop appropriate use criteria for the management of
3 patients with orthopedic implants undergoing dental procedures. Currently, she is a member of the expert
4 panel, convened under the auspices of the ADA Council on Scientific Affairs (CSA), to develop clinical
5 practice guidelines for the evaluation of oral cancer. Dr. Patton participated on the CSA-convened expert
6 working group that proposed the work plan adopted by the ADA House of Delegates in 2016 (86H-2016)
7 to develop proposed policy and evidence-based resources to optimize oral health prior to the
8 performance of complex medical and surgical procedures. Her leadership and expertise in oral medicine
9 will benefit the CSA in implementing 86H-2016 and in fostering dialogue between medical and dental
10 professionals.

Resolution No. 27 New
Report: N/A Date Submitted: August 2017
Submitted By: Board of Trustees

Reference Committee: N/A

Total Net Financial Implication: None Net Dues Impact: _____
Amount One-time _____ Amount On-going _____ FTE _____

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

1 **NOMINATIONS TO COUNCILS, COMMISSIONS AND THE NEW DENTIST COMMITTEE**

2 **Background:** (See Page 1006 for qualifications of nominees)

ADVOCACY FOR ACCESS AND PREVENTION

Irene V. Hilton, California
Jessica A. Meeske, Nebraska
Carol M. Morrow, Colorado
Bonita D. Neighbors, Michigan

COMMUNICATIONS

Frederick V. Guthrie, Jr.
Sam Mansour, Pennsylvania
Stephen M. Pitmon, Vermont
Stephanie B. Weaver, Louisiana

CONTINUING EDUCATION PROVIDER RECOGNITION

Gary M. DeWood, Arizona
Steven E. Parker, Ohio

DENTAL ACCREDITATION

Alan R. Stein, California*

DENTAL BENEFIT PROGRAMS

Yvonne E. Maldonado, Texas
Randall C. Markarian, Illinois
Hope E. Watson, Tennessee
Walter G. Weber, California

DENTAL EDUCATION AND LICENSURE

Jacqueline M. Plemons, Texas
Meaghan D. Strotman, Illinois

DENTAL PRACTICE

Jeffrey S. Berkley, Connecticut
Duc M. Ho, Texas
Christopher G. Liang, Maryland
Cary J. Limberakis, Pennsylvania

ETHICS, BYLAWS AND JUDICIAL AFFAIRS

Jill M. Burns, Indiana
Thomas A. Howley, Jr., Pennsylvania, *ad interim*
Guenter J. Jonke, New York
Onika R. Patel, Arizona
Vishruti M. Patel, Illinois, *ad interim*
Robert J. Wilson, Jr., Maryland

GOVERNMENT AFFAIRS

Matthew J. Messina, Ohio
John V. Reitz, Pennsylvania
David M. White, Nevada
Emily S. Willett, Nebraska

MEMBERS INSURANCE AND RETIREMENT PROGRAMS

John P. Ahern, New Hampshire
Wilma Luquis-Aponte, Texas
Paul T. Olenyn, Virginia
Michael R. Thompson, Arizona

MEMBERSHIP

Bryan C. Blew, Illinois
Jeffrey A. Kahl, Colorado
Summer C. Ketron, Texas
Jay Skolnick, New York

NATIONAL DENTAL EXAMINATIONS

Kanhasamy K. Ragunathan, Ohio

NEW DENTIST

Lindsay M. Compton, Colorado

Daniel W. Hall, South Carolina

Lauren E. Vitkus, New York

Benjamin C. Youel, Illinois

SCIENTIFIC AFFAIRS

Satish B. Alapati, Illinois

Ana K. Bedran-Russo, Illinois

Parthasarathy A. Madurantakam, Virginia

Lauren L. Patton, North Carolina

1 *In response to resolution 76H-2010, CODA requested that, beginning in 2012, new Commissioner appointees be identified one
2 year in advance of their term of service in CODA activities.

3 **Resolution**

4 **27. Resolved**, that the nominees for membership on ADA councils, commissions and the New
5 Dentist Committee submitted by the Board of Trustees in accordance with Chapter VII, Section
6 100(H) of the *Bylaws* be elected.

7 **BOARD RECOMMENDATION: Vote Yes.**

8 **BOARD VOTE: UNANIMOUS.**

9

Resolution No. 24-26 New

Report: Credentials, Rules and Order Date Submitted: August 2017

Submitted By: Standing Committee on Credentials, Rules and Order

Reference Committee: N/A

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE _____

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

1 **REPORT OF THE STANDING COMMITTEE ON CREDENTIALS, RULES AND ORDER**

2 **Background: Background:** The Standing Committee on Credentials, Rules and Order of the House of
3 Delegates is charged by the ADA *Bylaws*, Chapter V, HOUSE OF DELEGATES, Section 140Bb, with the
4 following duties:

5 b. Duties. It shall be the duty of the Committee (1) to record and report the roll call of the House of
6 Delegates at each meeting; (2) to conduct a hearing on any contest regarding the certification of a
7 delegate or alternate delegate and to report its recommendations to the House of Delegates; (3) to
8 prepare a report, in consultation with the Speaker and Secretary of the House of Delegates, on
9 matters relating to the order of business and special rules of order; (4) to consider all matters referred
10 to it and report its recommendations to the House of Delegates.

11 In accordance with its duties, the Committee submits the following report.

12 **Minutes of the 2016 Session of the House of Delegates:** The minutes of the 2016 session of the
13 House of Delegates have been posted (*Trans.* 2016:267) in the [HOD Supplemental Information](#) library on
14 the House of Delegates community of ADA Connect.

15 Questions or corrections regarding the minutes may be forwarded to Kyle Smith, manager, House of
16 Delegates at smithk@ada.org. The Committee presents the following resolution for House action.

17 **24. Resolved**, that the minutes of the 2016 session of the House of Delegates, as published in
18 *Transactions*, 2016 (pages 267-359), be approved.

19 **Adoption of Agenda and Order of Agenda Items:** The Committee has examined the agenda for the
20 meeting of the House of Delegates prepared by the Speaker and Secretary of the House. Accordingly,
21 the Committee recommends adopting the agenda as the official order of business for this session. The
22 Committee also recommends that the Speaker of the House be allowed to rearrange the order of the
23 agenda as deemed necessary to expedite the business of the House.

24 **25. Resolved**, that the agenda as presented in the *2017 Manual of the House of Delegates and*
25 *Supplemental Information* be adopted as the official order of business for this session, and be it
26 further

27 **Resolved**, the Speaker is authorized to alter the order of the agenda as deemed necessary in order
28 to expedite the business of the House.

1 To maintain a quorum, members of the House of Delegates should plan to stay in Atlanta until close of
2 business Monday, October 23, which could be later than 5:00 p.m.

3 **Referrals of Reports and Resolutions:** A standing rule of the House of Delegates directs that prior to
4 each session of the House, the Speaker shall prepare a list of recommended referrals to reference
5 committees with the list to be available at the opening meeting of the House and be subject to
6 amendment or approval on vote of the House of Delegates.

7 This preliminary list of referrals (circulated in the form of an All Inclusive General Index to the resolution
8 worksheets) will be provided with the second posting of resolution worksheets in late-September and
9 updated and posted again on Thursday, October 19. The Speaker will announce additional referrals
10 during the first meeting of the House of Delegates. A complete list of referrals by reference committee, in
11 the form of an agenda, will be available in the reference committee hearing rooms on Saturday morning,
12 October 21.

13 **26. Resolved,** that the list of referrals recommended by the Speaker of the House of Delegates be
14 approved.

15 **Rules of Order:** The business of the House of Delegates will be conducted formally in accordance with
16 accepted rules of parliamentary procedure. Adopted as the parliamentary authority for the Association,
17 the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* is the document
18 that governs all deliberations of the House of Delegates in which it is applicable and not in conflict with
19 the Standing Rules or the Bylaws of the Association.

20 **Annual Reports, Manual of the House of Delegates and Resolution Worksheets:** The publication,
21 *Annual Reports, 2017* will be posted in September on ADA Connect and ADA.org and can be accessed
22 through the following link: [http://www.ada.org/en/member-center/leadership-governance/historical-](http://www.ada.org/en/member-center/leadership-governance/historical-publications-policies)
23 [publications-policies](http://www.ada.org/en/member-center/leadership-governance/historical-publications-policies).

24 In addition, it is expected that the first set of resolution worksheets will be posted on ADA Connect and
25 ADA.org by the end of day, Friday, August 18. Per 74H-2012, effective in 2013, all materials of the House
26 of Delegates are provided in an electronic format only, with the exception of reference committee reports
27 and agendas; no paper copies of worksheets will be distributed.

28 The second set of resolution worksheets will become available shortly after the Board of Trustees'
29 September 16-18 session and should be posted on ADA Connect and ADA.org by end of day, Friday,
30 September 22.

31 In advance of the 2017 session, members of the House of Delegates are advised to download to their
32 laptop or other electronic device copies of all pertinent meeting materials.

33 The *Manual of the House of Delegates and Supplemental Information* contains the "Rules of the House of
34 Delegates" and all pertinent meeting information (*i.e.*, House agendas, members of the Standing and
35 Reference Committees, reference committee hearing schedule, and schedule of the district caucuses).

36 *Supplement to Annual Reports and Resolutions* is prepared primarily for historical purposes only since it
37 is a compilation of all the reports and resolutions presented to the House of Delegates. This publication
38 will be available online in the first quarter of 2018.

39 **Reference Committees Hearings:** The reference committees of the House of Delegates will hold
40 hearings on Saturday, October 21, in various rooms of the Marriott Marquis. The list of reference
41 committee hearing rooms appears in the *Manual of the House of Delegates and Supplemental*
42 *Information*.

1 **Saturday, October 21**

2 7:00 a.m. to 9:00 a.m. Committee D (Legislative, Health, Governance and Related Matters)

3 9:00 a.m. to 10:30 a.m. Committee A (Budget, Business, Membership and Administrative Matters)

4 10:30 a.m. to 12:00 p.m. Committee B (Dental Benefits, Practice and Related Matters)

5 12:00 p.m. to 1:30 p.m. Committee C (Dental Education, Science and Related Matters)

6 Hearings may continue beyond the scheduled hours if everyone has not had an opportunity to be heard
7 or if the complete agenda has not been covered.8 In accordance with the *Manual of the House of Delegates*, section "General Procedures for Reference
9 Committees," any member of the Association, whether or not a member of the House of Delegates, is
10 privileged to attend and participate in the discussion during the reference committee hearings.
11 Nonmembers of the Association are also welcome to attend reference committee hearings provided they
12 identify themselves to the committee. Nonmembers of the Association may participate at hearings with
13 the consent of a majority of the reference committee. At reference committees, everyone
14 (individuals/members) will be obligated to disclose any personal or business relationship that they or their
15 immediate family may have with a company or individual doing business with the ADA, when such
16 company is being discussed, prior to speaking on an issue related to such a conflict of interest.17 Association staff is available at hearings to provide information requested by members of reference
18 committees or through the Chair by those participating in the hearings.19 **Reports of Reference Committees:** Printed copies of reference committee reports will be made
20 available to the chair of record of each delegation on Sunday, October 22. A sufficient number of copies
21 of each report will be provided for each delegation's delegates, alternate delegates, secretary, executive
22 director, trustee and editor. Reference committee reports will also be posted on ADA Connect and will be
23 available early morning on October 22.24 Delegates must bring their copies of reference committee reports to the meetings of the House of
25 Delegates since additional printed copies will be limited. However, if using an electronic version of the
26 reference committee report during the meetings of the House, it is imperative that the documents be
27 downloaded prior to the Monday, October 23 meeting. The Speaker would like to remind everyone that
28 this is a paperless House of Delegates. Wi-Fi is available in the House of Delegates as a convenience,
29 but members do not need to be online to participate. Advance preparation is extremely important.30 **Nominations of Officers:** The nominations of officers (president-elect and second vice president) will
31 take place at the first meeting of the House on Friday afternoon, October 20. Candidates for elective
32 office will be nominated from the floor of the House by a simple declaratory statement, which may be
33 followed by an acceptance speech not to exceed four minutes by the candidate. Seconding nominations
34 is not permitted.

35 No additional nominations will be accepted after the Friday afternoon meeting.

36 **Nomination of Trustees:** Nominations of members of the Board of Trustees from Districts 3, 4, 5, and 9
37 will take place at the first meeting of the House. Prior to such nominations, the delegates from each of the
38 districts concerned must caucus for the purpose of determining their nominee or nominees in accordance
39 with the provisions of Chapter VII, Section 40, of the *Bylaws*. A list of caucus meetings appears in the
40 *Manual of the House of Delegates and Supplemental Information*.41 The results of the caucus must be reported to the Secretary of the House of Delegates no later than the
42 opening of the meeting on Friday. In the event of a contested trustee election, candidates for the office of
43 trustee shall be nominated from the floor of the House of Delegates by a simple declaratory statement,

1 which may be followed by an acceptance speech not to exceed four minutes by the candidates from the
2 podium. Seconding nominations is not permitted.

3 **Nominations to Councils and Commissions:** The Board of Trustees presents the list of its
4 nominations to councils and commissions in Report 1, which appears on the appropriate resolution
5 worksheet. Additional nominations of council and commission members may be made from the floor of
6 the House of Delegates only during the Friday afternoon meeting.

7 **Voting Procedures in the House:** The method of voting in the House of Delegates is usually
8 determined by the Speaker who may call for a voice vote, show of hands (voting cards), standing vote,
9 general consent, roll call of the delegations, electronic voting or such other means that the Speaker
10 deems appropriate. The House may also, by majority vote, determine for itself the method of voting that it
11 prefers.

12 Only votes cast by voting members of the House of Delegates either for or against a pending motion shall
13 be counted. Abstentions shall only be counted in determining if a quorum is present. If the result of a vote
14 is uncertain or if a division is called for, the Speaker may use the electronic voting method or may call for
15 a standing vote. If a standing vote is requested, non-voting members will be asked to leave the delegate
16 seating area. Once the area is clear of all non-voting members, the Speaker will request all delegates in
17 favor of the motion to stand. Beginning with the first row, each person counts off and sits down, with the
18 count running back and forth along the rows in a serpentine fashion. When all who voted in the affirmative
19 are seated, the same is done with the negative vote. The vote will be monitored by the Standing
20 Committee on Credentials, Rules and Order.

21 In accordance with the *ADA Bylaws* and the House *Manual* proxy voting is explicitly prohibited in the
22 House of Delegates. However, an alternate delegate may vote when substituted for a voting member in
23 accordance with procedures established by the Committee on Credentials, Rules and Order.

24 **Election Procedures:** Voting for Officer Elections will take place in the House of Delegates through
25 electronic voting on the House floor and will be taken up as one of the first items of business on Monday
26 morning. Only properly certified delegates will be permitted to access the delegate section of the House
27 floor on Monday morning from the time the doors open at 6:30 a.m. until the final election results have
28 been announced. All entrances to the delegate section of the House floor will be monitored by members
29 of the Standing Committee on Credentials, Rules and Order (CRO). During this time, non-voting members
30 of the House will not be allowed in the delegate section of the House floor, but are invited to sit in the
31 alternate delegate or guest seating sections until final election results have been announced by the
32 Speaker.

33 To expedite the check-in and voting process, it is strongly recommended that any delegation changes be
34 made no later than the end of the day on Sunday, October 22. Delegate registration hours for Sunday,
35 October 22, are from 8:00 a.m. to Noon and delegate changes can be made at the Information and
36 Resources Office up until 6 p.m. Sunday evening. Delegate changes made on Monday morning, prior to
37 voting, may be delayed until after all other delegates have checked-in. Therefore, to avoid long delays,
38 please make delegation changes on Sunday.

39 To check-in, delegates must bring their officer election card to access the House floor and receive a
40 smart card for voting. Voting keypads will be on the delegate tables on the House floor. Upon entering the
41 House floor, delegates should insert their smart card into their voting keypad. It is recommended that
42 delegates do not leave the House floor until after the election results have been finalized. If a delegate
43 must leave the House floor before final election results have been announced, the delegate must
44 surrender both the smart card and officer election card to a CRO member upon exiting and then reclaim
45 the cards for reentry by showing his or her badge at the check-in desk. Any delegate absent from the
46 House floor during a vote may lose their chance to vote. For the security of the election, it is essential that
47 each delegate maintain possession of his or her smart card, unless surrendered to a CRO member. **If a
48 delegate loses his or her smart card, he or she will not be able to vote.**

1 Voting will take place as one of the first items of business. The Standing Committee on Credentials, Rules
2 and Order oversees the confirmation and reporting of election results. The results will be placed in a
3 sealed envelope and transmitted to the Secretary of the House. The Secretary will review and forward the
4 results to the Speaker for announcement. In the event a second balloting is necessary, the vote will take
5 place shortly after the Speaker has announced a runoff.

6 **Standing Order of Business—Installation of New Officers and Trustees:** The installation ceremony
7 for new officers and trustees will take place at the third meeting of the House of Delegates on Monday,
8 October 23, as the first item of business with the time to be specified by the Speaker of the House of
9 Delegates.

10 **Introduction of New Business:** The Committee calls attention to the *Bylaws*, Chapter V, Section
11 130(Ae) which provides that no new business shall be introduced into the House of Delegates less than
12 15 days prior to the opening of the annual session, unless submitted by a Trustee District or the American
13 Student Dental Association Delegation. No new business shall be introduced into the House of Delegates
14 at the last meeting of a session except when such new business is submitted by a Trustee District or the
15 American Student Dental Association Delegation and is permitted to be introduced by a two-thirds (2/3)
16 affirmative vote of the delegates present and voting. The motion introducing such new business shall not
17 be debatable. Approval of such new business shall require a majority vote except new business
18 introduced at the last meeting of a session that would require a bylaw amendment cannot be adopted at
19 such last meeting. Reference committee recommendations shall not be deemed new business.

20 **Resolutions of Reaffirmation/Commendation:** The Committee calls attention to the House rule
21 governing resolutions of reaffirmation or commendation, which states that “Resolutions which (1) merely
22 reaffirm or restate existing Association policy, (2) commend or congratulate an individual or organization,
23 or (3) memorialize an individual shall not be introduced to the House of Delegates” (*Trans.*1977:958).

24 **Explanation of Resolution Number System:** Original resolutions are numbered consecutively
25 regardless of whether the source is a council, other Association agency, constituent society, delegate,
26 Board of Trustees or House reference committee. Revisions made by the Board, reference committee or
27 House are considered “amendments” to the original resolution. If amended by the Board, the suffix “B”
28 follows the original resolution number (Res. 24B); if amended by a reference committee, the suffix “RC”
29 follows (Res. 24RC).

30 If a resolution is adopted by the House, the suffix “H” follows the resolution number (Res.24H). The “H”
31 always indicates that the resolution was adopted.

32 If a resolution is not adopted or it is referred by the House of Delegates, the resolution number remains
33 the same. For example:

34 Res. 78B is considered by the House and not adopted, the number remains the same: Res. 78B.

35 Res. 7RC is considered by the House and referred for study, the number remains the same: Res.
36 7RC.

37 If a Board (B) or reference committee (RC) resolution is a substitute for several original resolutions, the
38 Board’s recommended substitute or the reference committee’s recommended substitute uses the number
39 of the first resolution submitted and adds the proper suffix (B or RC). The report will clearly state that the
40 other resolution or resolutions have been considered and are included in the “B” or “RC” resolution. A
41 resolution submitted by an agency other than the Board or a reference committee as a substitute or
42 amendment retains the original resolution number followed by the suffix “S-1” (Res. 24S-1). If two
43 substitute resolutions are submitted for the same original resolution, the suffixes are “S-1” and “S-2” (Res.
44 24S-1, Res. 24S-2).

1 *Note.* If a substitute resolution is received too late to be introduced to the House of Delegates through a
2 reference committee report, the originator of the substitute resolution is responsible for calling it to the
3 Speaker's attention when the original resolution is being discussed by the House of Delegates.

4 **Dedicated Pro and Con Microphones:** To help ensure a balanced opportunity for debate during all
5 House discussions, microphones 1, 3, and 5 will be identified for pro testimony and microphones 2, 4,
6 and 6 will be identified for con testimony throughout the session. To preserve the microphone queue for
7 debate on the main motions the Speaker has indicated that two microphones at the front of the room
8 labeled "A" and "B" will be used for debate on subsidiary motions. A third microphone will be placed front
9 and center, labeled "P", for parliamentary inquiries, points of order, points of information or to appeal a
10 ruling of the Chair. Microphone "P" may also be used for a question of privilege that has to do with the
11 convenience, comfort, rights, or privileges of a member or of the assembly that is urgent and must be
12 decided immediately. Offering to give information is *debate* and is not a point of information, and should
13 be given at one of the six microphones in the queue.

14 **Recognition of Those Waiting to Speak:** Microphones identified as pro/con will be used throughout the
15 session. When a member wishes to address the House, the individual should approach the appropriately
16 labeled microphone, secure the attention of the Speaker through the attendant at the microphone and
17 wait to speak until recognized by the Speaker. The member shall then state his or her name, district, and,
18 for the benefit of the official reporter, the purpose of his or her comments (*e.g.*, speaking for or against a
19 motion, presenting a new motion, etc.). If all members of the House follow this procedure, work will be
20 expedited and all who wish to be heard will be given an opportunity.

21 When an electronic vote is taken, the Speaker will allow sufficient time for members at the microphone to
22 return to their places before taking the vote. In the event debate continues on the same issue, the
23 Speaker will honor the microphone sequence prior to taking the electronic vote. Therefore, a member
24 who was at the microphone and did not have an opportunity to speak before that vote was called and who
25 wishes to continue debate on the same issue should return to the microphone where he or she was prior
26 to the electronic vote.

27 **Access to Floor of House:** Access to the floor of the House of Delegates is limited to members of the
28 House of Delegates, the chairs of the councils and commissions, the secretaries and executive directors
29 of constituent societies, the executive director and president of the American Student Dental Association,
30 an officially designated representative from each of the American Hospital Association and American
31 Medical Association and members of the Headquarters Office staff. Council and commission chairs are
32 responsible for requesting floor access for any non-delegate council or commission member who desires
33 to speak during debate on the report of the council or commission consistent with the *Bylaws* and the
34 Rules of the House of Delegates.

35 Alternate delegates, former officers (except for former presidents) and former trustees do not have
36 the privilege of access to the floor but will be seated in a special area reserved for them.

37 Admission to the House will be granted to delegates with the appropriately numbered card, which must be
38 handed to the attendant at the door for each meeting so that the official attendance record may be
39 maintained. Former officers and former trustees will also be admitted to the section reserved for alternate
40 delegates and upon request will receive access to all reference committee reports available to delegates
41 and alternates.

42 **Secretaries and Executive Directors of Constituent Societies:** In accordance with the standing rule of
43 the House, "The secretary and executive director of a constituent society may be seated with the
44 constituent society delegates on the floor of the House of Delegates even though they are not official
45 delegates." Under the standing rules, it is not permissible to designate an "acting" secretary or executive
46 director of a constituent society so that he or she may be seated on the floor of the House, unless that
47 person is designated as "acting" secretary or executive director for the remaining portion of the annual
48 session.

1 **Seating of Component Executive Directors in the Alternate Section of the House of Delegates:** In
2 2015, the House of Delegates adopted Resolution 48H-2015 to provide component executive directors
3 and secretaries seating in the Alternate Delegate section. Based on seating capacity at the 2017 House
4 of Delegates, five passes have been allocated to each district caucus chair for distribution and use by
5 component executive directors. The passes will only be released to district caucus chairs and will be
6 available for pick-up at Delegate Registration beginning Thursday, October 19. Additional passes may be
7 obtained subject to availability.

8 **Replacement of Alternate Delegates for Delegates:** Delegates wanting to replace themselves with an
9 alternate delegate from their delegation as the credentialed delegate during a meeting of the House of
10 Delegates must complete the appropriate delegate-alternate substitution form. Delegates are required to
11 sign the form and surrender their admission cards for the meeting or meetings not attended before
12 admission cards will be issued to alternate delegates by the Committee on Credentials, Rules and Order.
13 Substitution of alternate delegates may be made during all three meetings of the House of Delegates. In
14 order for a complete and accurate attendance record for all meetings of the 2017 House of Delegates,
15 submission of these completed substitution forms is essential. Only credentialed delegates may vote for
16 the Officers of the Association.

17 **Temporary substitutions:** For the purpose of allowing an alternate to replace a delegate for a specific
18 resolution or issue, the substitution forms do not have to be completed. And, again this year for these
19 temporary substitutions, the switch can take place at the staffed openings between the delegate and
20 alternate sections of the House. This will be in effect for the Second and Third meetings of the House.

21 **Closed Session:** A closed session is any meeting or portion of a meeting of the House of Delegates with
22 limited attendance in order to consider a highly confidential matter. A closed session may be held if
23 agreed upon by general consent of the House or by a majority of the delegates present at the meeting in
24 which the closed session would take place. In a closed session, attendance is limited to officers of the
25 House, delegates and alternates, and the elective and appointive officers, trustees, past presidents and
26 general counsel of the Association. In consultation with the Secretary of the House, the Speaker may
27 invite other persons with an interest in the subject matter to remain during the closed session. In addition
28 to senior staff, this is likely to include members and staff of the council(s) or commission(s) involved with
29 the matter under discussion and executive directors of constituent societies and the American Student
30 Dental Association. No official action may be taken nor business conducted during a closed session.

31 Immediately after a closed session, the Speaker will inform delegates that they may present a motion to
32 request permission to review information which was discussed in the closed session, with the information
33 being discussed only with members present at the session. This provision is not applicable to an attorney-
34 client session.

35 **Attorney-Client Session:** An attorney-client session is a form of closed session during which an
36 attorney acting in a professional capacity provides legal advice, or a request is made of the attorney for
37 legal advice. During these sessions, the legal advice given by the attorney may be discussed at length,
38 and such discussion is "privileged." The requests, advice, and any discussion of them are protected,
39 which means that opponents in litigation, media representatives, or others cannot legally compel their
40 disclosure. The purpose of the privilege is to encourage free and frank discussions between an attorney
41 and those seeking or receiving legal advice. The privilege can be lost (waived) if details about the
42 attorney-client session are revealed to third parties. Once the privilege has been waived, there is a
43 danger that all privileged communications on the issues covered in the attorney-client session, regardless
44 of when or where they took place, may become subject to disclosure. For attorney-client sessions, the
45 Speaker and Secretary shall consult with the General Counsel regarding attendance during the session.
46 No official action may be taken nor business conducted during an attorney-client session.

47 In accordance with the above information, all those participating in an attorney-client session shall refrain
48 from disclosing information about the discussion held during the attorney-client session. In certain cases,
49 a decision may be made to come out of the attorney-client session for purposes of conducting a non-

1 privileged discussion of the same or related subject matter. The difference will be that during the non-
2 privileged session there will be no discussion of any legal advice requested by attendees during the
3 attorney-client session or about any of the legal advice given by the legal counsel. It is such requests for
4 legal advice, legal advice given, and discussion of the legal advice during the attorney-client session that
5 are protected by the privilege and that shall not be disclosed or discussed outside of the attorney-client
6 session.

7 **Manual of the House of Delegates:** Each member of the House of Delegates has access to the 2017
8 *Manual of the House of Delegates* through ADA Connect. The *Manual* contains the standing rules of the
9 House of Delegates and the pertinent provisions of the *Bylaws*.

10 Members of the House should familiarize themselves with the rules and procedures set forth in the
11 Manual so that work may proceed as rapidly as possible.

12 **Distribution of Materials in the House of Delegates:** In 2016, the House adopted Resolution 6H-2016,
13 to prohibit the distribution of campaign literature in the House of Delegates. The Committee calls attention
14 to the procedures to be followed for distributing materials in the House of Delegates: (1) no material may
15 be distributed in the House without obtaining permission from the Secretary of the House; (2) material to
16 be distributed must relate to subjects and activities that are proposed for House action or information.

17 **Media Representatives at Meetings of the House of Delegates:** On occasion, representatives of the
18 press and other communications media may be in the visitors' section of the House and in reference
19 committee hearings.

20 **House of Delegates Information and Resource Office:** An Information and Resource Office will be
21 open Thursday, October 19 through Sunday, October 22, and will be located in the Marriott Marquis,
22 Marquis Level, behind Delegate Registration. This office will be open to delegates, alternates, constituent
23 society officers and staff. The office will be equipped with computers with printing capability, a copy
24 machine, and general information about the meetings of the House of Delegates and related activities.
25 Everyone is urged to use the Information and Resources Office when drafting resolutions or testimony.

26 Individuals having resolutions for submission to the House of Delegates will be directed to the
27 Headquarters Office where final resolution processing will occur.

28 Resolutions

29 (Resolution 24:Worksheet:1029)

30 (Resolution 25:Worksheet:1030)

31 (Resolution 26:Worksheet:1031)

32

Resolution No. 24 New

Report: Credentials, Rules and Order Date Submitted: August 2017

Submitted By: Standing Committee on Credentials Rules and Order

Reference Committee: N/A

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE _____

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

- 1 **MINUTES OF THE 2016 SESSION OF THE HOUSE OF DELEGATES**
- 2 **Background:** The minutes of the 2016 session of the House of Delegates have been posted
- 3 (*Trans.* 2016:267) in the [HOD Supplemental Information](#) library on the House of Delegates community of
- 4 ADA Connect.
- 5 Questions or corrections regarding the minutes may be forwarded to Kyle Smith, manager, House of
- 6 Delegates at smithk@ada.org. The Committee presents the following resolution for House action.
- 7 **Resolution**
- 8 **24. Resolved,** that the minutes of the 2016 session of the House of Delegates, as published in
- 9 Transactions, 2016 (pages 267-359), be approved.
- 10

Resolution No. 25 _____ New
 Report: Credentials, Rules and Order _____ Date Submitted: August 2017 _____
 Submitted By: Standing Committee on Credentials Rules and Order _____

Reference Committee: N/A _____

Total Net Financial Implication: None _____ Net Dues Impact: _____
 Amount One-time _____ Amount On-going _____ FTE _____

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

1

ADOPTION OF AGENDA AND ORDER OF AGENDA ITEMS

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Background: The Committee has examined the agenda for the meeting of the House of Delegates prepared by the Speaker and Secretary of the House. Accordingly, the Committee recommends adopting the agenda as the official order of business for this session. The Committee also recommends that the Speaker of the House be allowed to rearrange the order of the agenda as deemed necessary to expedite the business of the House.

7

Resolution

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25. Resolved, that the agenda as presented in the *2017 Manual of the House of Delegates and Supplemental Information* be adopted as the official order of business for this session, and be it further

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13

Resolved, the Speaker is authorized to alter the order of the agenda as deemed necessary in order to expedite the business of the House.

Resolution No. 26 New
Report: Credentials, Rules and Order Date Submitted: August 2017
Submitted By: Standing Committee on Credentials Rules and Order

Reference Committee: N/A

Total Net Financial Implication: None Net Dues Impact: _____
Amount One-time _____ Amount On-going _____ FTE _____

ADA Strategic Plan Objective: None

How does this resolution increase member value: Not Applicable

1 **REFERRALS OF REPORTS AND RESOLUTIONS**

2 **Background:** A standing rule of the House of Delegates directs that prior to each session of the House,
3 the Speaker shall prepare a list of recommended referrals to reference committees with the list to be
4 available at the opening meeting of the House and be subject to amendment or approval on vote of the
5 House of Delegates.

6 This preliminary list of referrals (circulated in the form of an All Inclusive General Index to the resolution
7 worksheets) will be provided with the second posting of resolution worksheets in late-September and
8 updated and posted again on Thursday, October 19. The Speaker will announce additional referrals
9 during the first meeting of the House of Delegates. A complete list of referrals by reference committee, in
10 the form of an agenda, will be available in the reference committee hearing rooms on Saturday morning,
11 October 21.

12 **Resolution**

13 **26. Resolved,** that the list of referrals recommended by the Speaker of the House of Delegates be
14 approved.
15

Budget, Business,
Membership and
Administrative Matters

Resolution No. 2 New

Report: N/A Date Submitted: April 2017

Submitted By: Illinois State Dental Society

Reference Committee: A (Budget, Business, Membership and Administrative Matters)

Total Net Financial Implication: \$25,000-\$35,000 Net Dues Impact: 0

Amount One-time \$25,000-\$35,000 Amount On-going FTE 0

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

How does this resolution increase member value: See Background

1 **ADA SPONSORED MEMBERS ASSOCIATION HEALTH PLAN**

2 The following resolution was submitted by the Illinois State Dental Society and transmitted on April 11,
3 2017, by Mr. Greg A. Johnson, executive director.

4 **Background:** Currently in Washington, D.C., the President and Congress are working on a number of
5 initiatives to repeal and replace the Affordable Care Act (ACA) and are endeavoring to establish criteria
6 for associations to develop organization-wide health plans for their members. An association health plan
7 may be either a self-funded plan or a fully-insured plan; may offer coverage to its members, their
8 dependents and their employees; and may be offered to members across state lines.

9
10 Since the enactment of the ACA in 2010, the insurance market for members has dramatically and
11 detrimentally changed. Rates for individual and small groups have experienced unprecedented
12 increases, while the number of viable plans has diminished in many areas of the country. A few
13 constituent dental societies have developed health plan options in their states, but financial solvency
14 remains the underlying concern.

15
16 The current circumstances present the American Dental Association (ADA) with a unique opportunity to
17 investigate the feasibility of developing a nationwide association health plan for its members. Developing
18 an association-wide health plan for the collective 179,792 ADA members, their dependents and their staff
19 would result in far better actuarial rates and stability than any plan that could be offered solely by one
20 individual state, along with affordability, desirable coverage, and reasonable deductibles.

21
22 **Resolution**

23
24 **2. Resolved**, that the American Dental Association investigate the financial and legal possibilities
25 of offering a national association health plan for its members and report to the 2018 ADA House
26 of Delegates.

27
28 **BOARD COMMENT:** The Board wishes to thank ISDS for its resolution raising awareness of the current
29 health insurance market conditions and proposed legislation under the Small Business Health Fairness
30 Act (H.R. 1101) in support of the development of association group health plans. While the Board
31 appreciates the concerns expressed by the Illinois State Dental Society, the Board notes that the ADA
32 has in past years explored the feasibility of developing a national health insurance plan in response to the
33 introduction of similar legislation. There are fundamental risks inherent in the underwriting and pricing of
34 voluntary group health insurance plans, namely adverse selection and inflation, which can negatively

1 influence the financial viability of the program. These are factors that fall outside the control of a plan
 2 sponsor.

3
 4 In addition, from a competitive perspective, there are tripartite considerations due to the number of state
 5 dental society endorsed plans already available which generate non-dues revenue to the ADA affiliate
 6 association or their for-profit subsidiary. It is unlikely that all states would be interested in supporting a
 7 nationally endorsed program unless ADA’s plan could provide new tangible economic value combined
 8 with a consensus by the states on revenue-sharing arrangements.

9
 10 The recent proposal for new legislation further assumes that more insurance companies would reenter
 11 the association group marketplace under new rules to underwrite plans at the *national* level. Inasmuch as
 12 a self-funded plan would not likely be a financially viable long-term option for the ADA membership, it
 13 would be necessary to identify an insurer who could meet ADA plan specifications, in addition to the legal
 14 and reserve funding requirements of plan sponsors as proposed in H.R. 1101, which as drafted appears
 15 onerous.

16
 17 The Board believes that the needs of its members are currently being met through plan offerings at the
 18 state level and access to the ADA-endorsed AHIX.com (American Health Insurance Exchange) web
 19 portal, administered by JLBG Health, Inc. The Board will continue to monitor the broader health insurance
 20 marketplace and pending legislation to ensure ADA is well positioned to address any changes impacting
 21 the availability and affordability of coverage for ADA members.

22
 23 For these reasons and pending Senate approval of H.R.1101, the Board does not recommend further
 24 study of the legal and financial possibilities of offering a national health insurance plan for its members at
 25 this time. To do so would necessitate retaining an outside consultant to conduct an initial feasibility study
 26 at an estimated cost of \$25,000-\$35,000.

27

28 **BOARD RECOMMENDATION: Vote No.**

29 **Vote: Resolution 2**

ASAI	No	CROWLEY	No	KWASNY	No	NORBO	No
BITTER	Yes	FISCH	No	KYGER	No	ROBINSON	No
BLACK	No	GEHANI	No	MARRON-TARRAZZI	Yes	SABATES	No
COHLMIA	No	JEFFERS	No	MCDUGALL	No	STEVENS	No
COLE	No	KLEMMEDSON	No	MITCHELL	No	THOMPSON	No

Resolution No. 18 New
Report: N/A Date Submitted: August 2017
Submitted By: Board of Trustees

Reference Committee: A (Budget, Business, Membership and Administrative Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Objective: None

How does this resolution increase member value: See Background

1

REVISION OF THE POLICY, FUNDING OF VISITS BY ADA OFFICERS

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Background: The Board notes that there are currently two policies addressing payment of costs associated with ADA officer attendance at events hosted by other organizations. The ADA policy, Payment of President's and/or President-elect's Expenses by Host Organizations (*Trans.*1989:519), requires host dental organizations to pay all expenses related to a visit by the ADA President and/or President-elect, except for transportation expenses. Another policy, Funding of Visits to Constituent and Component Societies by ADA Officers (*Trans.*1988:456), urges state and local societies to fund trips by ADA officers to their functions.

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The Board believes that a single policy applicable to any host dental organization (including state and local societies) will be clearer and further believes that ADA officers need flexibility with respect to requiring funding for these trips. While the ADA should seek such funding when feasible, the Board recognizes that some organizations will not be in a position to provide funding and the interests of the ADA would still be best served by attendance of ADA officers at such an organization's event.

14

Accordingly, the Board recommends that both policies be rescinded and replaced by the following.

15

Resolution

16
17

18. Resolved, that any host dental organization inviting ADA officers to an event be asked when feasible to fund the costs of such attendance, and be it further

18
19
20

Resolved, that Payment of President's and/or President-elect's Expenses by Host Organizations (*Trans.* 1989-519) and Funding of Visits to Constituent and Component Societies by ADA Officers (*Trans.* 1988-456) be rescinded.

21

BOARD RECOMMENDATION: Vote Yes.

22

BOARD VOTE: UNANIMOUS.

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WORKSHEET ADDENDUM
ADA POLICIES TO BE RESCINDED

**Payment of President’s and/or President-Elect’s Expenses by Host Organizations
(Trans.1989:519)**

Resolved, that all host dental organizations that request the presence of the ADA President and/or President-elect at their meetings be required to pay all expenses related to that visit, except transportation expenses.

Funding of Visits to Constituent and Component Societies by ADA Officers (Trans.1988:456)

Resolved, that constituent and component societies when inviting ADA officers to their functions, be urged to fund those visits in whatever manner possible.

Resolution No. 19 New

Report: N/A Date Submitted: August 2017

Submitted By: Board of Trustees

Reference Committee: A (Budget, Business, Membership and Administrative Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: None

How does this resolution increase member value: See Background

1 **AMENDMENT OF THE POLICY, TRANSPARENCY**

2 **Background:** The Board of Trustees reviewed the policy, Transparency (*Trans.2009:404*), and notes that
3 when this policy was adopted, ADABEI minutes could only be made available in electronic format by
4 posting them on ADA.org. Since then, the ADA Connect platform has been made available to provide
5 materials electronically to ADA delegates and alternate delegates. The Board does not believe that
6 ADABEI minutes should be made generally available to membership because of the proprietary nature of
7 those documents.

8 Accordingly, the Board recommends that this policy be amended in the second resolving clause to reflect
9 that ADA Connect is currently utilized to post minutes of ADABEI Board meetings and the meetings of
10 any other subsidiaries.

11 **Resolution**

12 **19. Resolved**, that the ADA policy, Transparency (*Trans.2009:404*) be amended (additions are
13 underscored; deletions are ~~stricken~~):

14 **Resolved**, that action items and approved minutes of all open meetings of ADA councils,
15 committees and of the Board of Trustees be promptly posted in the Members Only section on
16 ADA.org, and be it further

17
18 **Resolved**, that the ADA, as the sole shareholder of ADABEI, shall direct ADABEI and any other
19 subsidiaries to post on ADA Connect or its equivalent for the House of Delegates, ~~the Members~~
20 ~~Only section of ADA.org~~ all approved minutes of Board meetings, and be it further

21
22 **Resolved**, that security in the Members Only section on ADA.org be enhanced as may be
23 necessary so as to ensure that members will have exclusive access to the information contained
24 in this website area.

25 **BOARD RECOMMENDATION: Vote Yes.**

26 **BOARD VOTE: UNANIMOUS.**

1 In 2017 the Council reviewed the technological capabilities of the Aptify membership database system, to
2 ensure that the system could support the Council's recommendation. At one time it appeared that an
3 auto-renewal option for credit cards was a distant possibility, while auto-renewal for ACH was imminent.
4 However new information upended both of those assumptions. Auto-renewal for credit cards is now
5 operational and being utilized in many locations. Meanwhile, PayPal, which has served as the interface
6 for ACH installments, informed its customers in fall of 2016 that it would no longer support use of ACH.

7 In recognition that the future success of the ADA depends on focusing on what is best for the member,
8 rather than what is best for the organization, the Council on Membership is pleased to put forward the
9 following resolution for consideration:

10

Resolution

11 **28. Resolved**, that to simplify the member experience, all constituent societies are urged to use a
12 uniform dues transaction which allows acceptance of dues payments in installments, permits
13 payment of dues with a credit or debit card, and permits auto-renewal of dues, with an opt-out
14 option.

15 **BOARD RECOMMENDATION: Vote Yes.**

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

1 Association's proper reliance on the strategic plan and program metrics, as opposed to one undefined set
 2 of "universal" criteria.

3 Accordingly, the Board is proposing rescission of Resolution 44H-2011 and adoption of a new policy
 4 which retains the still-relevant portions of the resolution and updates the rest. For purposes of clarity only,
 5 the below markup of 44H-2011 shows how the new policy would revise the existing policy (deletions
 6 shown by ~~strike through~~ and additions through underscoring):

7 **44H-2011. Resolved**, that all councils receive annual training on their fiduciary responsibilities to the
 8 Association, and be it further

9 ~~Resolved~~, that the appropriate agency of the Association develop a ~~universal set of assessment~~
 10 ~~criteria to be applied by each council (and the Administrative Review Committee) in ranking programs~~
 11 ~~as part of the budget process. Criteria should include the following:~~

- 12
- 13 ● ~~How closely the program is aligned with the Strategic Plan,~~
- 14 ● ~~An assessment of the comparative value of the program in relation to other existing and~~
 15 ~~proposed programs,~~
- 16 ● ~~The effectiveness of the program in meeting its goals and its efficiency in do so, and~~
- 17 ● ~~Consideration of budget offsets and alternative sources of funding~~

18 and be it further

19 ~~Resolved~~, that each council shall utilize the universal set of assessment criteria in evaluating its
 20 programs and reporting to the Administrative Review Committee, and be it further

21 Resolved, that each agency of the Association apply the strategic plan and the effectiveness of each
 22 program to meet the goals of the program in order to evaluate Association programs under its control
 23 or oversight, and be it further

24 **Resolved**, that each councils, (or, where appropriate, the Board), shall review all resolutions having
 25 cost implications for the Association associated with that council or the Board, provided the resolution
 26 has been submitted prior to the first posting of ~~which have been submitted prior to the first mailing~~
 27 resolutions to delegates, and shall provide a written report to the House that includes the council's (or
 28 Board's) recommendation with respect to the final disposition of the resolution and assessment in
 29 light of the ~~universal set of assessment criteria~~ strategic plan, and be it further

30 **Resolved**, that Resolution 44H-2011 (*Trans.2011:444*) be rescinded.

31 Accordingly, the Board proposes the following resolution to the House:

32 **Resolution**

33 **29. Resolved**, that all councils receive annual training on their fiduciary responsibilities to the
 34 Association, and be it further

35 **Resolved**, that each agency of the Association apply the strategic plan and the effectiveness of each
 36 program to meet the goals of the program in order to evaluate Association programs under its control
 37 or oversight, and be it further

38 **Resolved**, that each council, or, where appropriate, the Board, shall review all resolutions having cost
 39 implications for the Association associated with that council or the Board, provided the resolution has
 40 been submitted prior to the first posting of resolutions to delegates, and shall provide a written report

1 to the House that includes the council's (or Board's) recommendation with respect to the final
2 disposition of the resolution and assessment in light of the strategic plan, and be it further

3 **Resolved**, that Resolution 44H-2011 (*Trans.2011:444*) be rescinded.

4 **BOARD RECOMMENDATION: Vote Yes.**

5 **BOARD VOTE: UNANIMOUS.**

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WORKSHEET ADDENDUM

POLICY TO BE RESCINDED

UNIVERSAL ASSESSMENT CRITERIA (TRANS.2011:444)

44H-2011. Resolved, that all councils receive annual training on their fiduciary responsibilities to the Association, and be it further

Resolved, that the appropriate agency of the Association develop a *universal set of assessment criteria* to be applied by each council (and the Administrative Review Committee) in ranking programs as part of the budget process. Criteria should include the following:

- How closely the program is aligned with the Strategic Plan,
- An assessment of the comparative value of the program in relation to other existing and proposed programs,
- The effectiveness of the program in meeting its goals and its efficiency in do so, and
- Consideration of budget offsets and alternative sources of funding

and be it further

Resolved, that each council shall utilize the universal set of assessment criteria in evaluating its programs and reporting to the Administrative Review Committee, and be it further

Resolved, that councils, (or, where appropriate, the Board), shall review all resolutions having cost implications for the Association which have been submitted prior to the first mailing of resolutions to delegates and shall provide a written report to the House that includes the council's (or Board's) recommendation and assessment in light of the universal set of assessment criteria.

Resolution No. 31 New

Report: Board Report 9 Date Submitted: August 2017

Submitted By: Board of Trustees

Reference Committee: A (Budget, Business, Membership and Administrative Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

1 **REPORT 9 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: AMENDMENT OF**
 2 **ADA BYLAWS WITH RESPECT TO THE EXECUTIVE DIRECTOR**

3 **Background:** The Board is in the process of finalizing a new three-year contract with the Executive
 4 Director. As part of that process, an anomaly in the ADA *Bylaws* has been noted and the Board is asking
 5 the House to amend the *Bylaws* to clarify them and to allow future executive directors necessary flexibility
 6 in appropriately staffing the organization.

7 The *Bylaws* currently state that the Executive Director, “[a]s agent and under the direction of the Board of
 8 Trustees and elective officers, . . . shall be the chief operating officer of this Association and all its
 9 branches.” *Bylaws*, Chapter IX, Section. 40. Duties. The *Bylaws* then go on and list the duties of the
 10 Executive Director. The Board proposes, in line with its organizational systems, that the *Bylaws* simply
 11 list the duties of the Executive Director “as agent for the Board of Trustees and elective officers.” The
 12 Board seeks this change for several reasons:

- 14 • The change will allow the Board greater flexibility in shaping the position of Executive Director
 15 once the current Executive Director’s next contract expires.
- 17 • The position is actually closer to a “chief executive officer” (CEO) than a “chief operating officer”
 18 and this change will eliminate confusion caused by inclusion of the term “chief operating officer”
 19 in the *Bylaws*.
- 21 • Indeed, elsewhere in the *Bylaws*, executive directors of state associations are referred to as
 22 “executive director or equivalent chief executive officer.” The Board’s proposal aligns with this
 23 existing language. *Bylaws*, Chapter. V, Section.
- 25 • The Board is concerned that many viable candidates for the position will not pursue it if they will
 26 be required to assume the responsibilities of a COO in addition to an Executive Director/CEO.
 27 Most organizations of the size and complexity of the ADA have both a CEO and a COO who
 28 reports to the CEO.

29 No change to the actual duties of the Executive Director is being proposed. The Executive Director will
 30 continue to work as an “agent of the Board of Trustees and elective officers.”

1 Accordingly, the Board submits the following resolution for the House’s consideration

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Resolution

4 **31. Resolved**, that Chapter IX, APPOINTIVE OFFICERS, Section 40. DUTIES, of the ADA *Bylaws*
5 be amended as follows (deletions: ~~stricken~~):

6 *Section 40. DUTIES:* The Executive Director shall be the principal agent of the Board of Trustees and
7 elective officers. As agent and under the direction of the Board of Trustees and elective officers, the
8 Executive Director shall be the chief operating officer of this Association and all its branches. In this
9 capacity, the Executive Director shall

10 (a) preserve and protect the *Constitution and Bylaws* and the standing rules of this Association;

11 (b) facilitate the activities of the officers and trustees of this Association in carrying out their
12 respective administrative responsibilities under these *Bylaws*;

13 (c) engage the staff of this Association and direct and coordinate their activities;

14 (d) provide leadership in the formulation and recommendation of new policies to the Board of
15 Trustees and elective officers;

16 (e) oversee the management of Association policies that have been adopted by the Board of
17 Trustees and/or the House of Delegates;

18 (f) assist the Board of Trustees in supervising, monitoring and providing guidance to all
19 Association councils, commissions and committees in regard to their administrative functions
20 and specific assignments, and to systematize the preparation of their reports, and to encourage
21 the exchange of information concerning mutual interests and issues between councils,
22 committees and commissions;

23 (g) maintain effective internal and external relationships through frequent and comprehensive
24 communication with all officers and trustees of this Association, the leadership of related dental
25 organizations, and representatives from other leading public and private organizations that
26 interact with this Association; and

27 (h) perform such other duties as are prescribed by these *Bylaws*.

28 **BOARD RECOMMENDATION: Vote Yes.**

29 **BOARD VOTE: UNANIMOUS.**

Resolution No. 32 New
 Report: N/A Date Submitted: August 2017
 Submitted By: Board of Trustees
 Reference Committee: A (Budget, Business, Membership and Administrative Matters)
 Total Net Financial Implication: \$3,100,000 Net Dues Impact: \$30
 Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Finance-Obj. 4: Unrestricted liquid reserves targeted at no less than 50%.

How does this resolution increase member value: Not Applicable

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SPECIAL ASSESSMENT

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Background: The House of Delegates passed Resolution 67H-2016 (*Trans.*2016:278), a Three-Year Initiative to Drive Utilization of Dental Services for ADA Members as follows:

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5

67H-2016. Resolved, that the initiative “Drive Utilization of Dental Services for ADA Members” be approved, and be it further

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Resolved, that the Council on Communications submit annual status updates to the House of Delegates for the duration of the campaign, and be it further

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Resolved, that the House of Delegates urges funding for this program shall come from the reserves for the first year, and be it further

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Resolved, that funding for the second and third years shall be at the discretion of the Board of Trustees, and be it further

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Resolved, that the Council on Communications shall provide evidence of the value of this media campaign to the 2017 HOD.

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Because this initiative was funded from reserves in the first year, 2017, and is to be funded at the discretion of the Board of Trustees in the second and third years, 2018 and 2019, an analysis of the ADA’s projected reserves was performed to review options for funding this initiative. This analysis was inherently linked to the complete picture of the ADA’s projected financial position and the reserve objective of the ADA’s 2020 finance strategic plan goal to target unrestricted liquid reserves at no less than 50% of annual operating expenses. After careful consideration of all the options, the Board recommended funding the Busyness Initiative in 2018 from several sources as follows:

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- \$ 30 Special Assessment (which represents a temporary 5.6% increase in National dues).
- General Reserves until they reach the goal floor of 50% of the annual operating budget.
- If General Reserves reach the 50% target floor, then the remainder of the Business Initiative would be funded from the Royalty Reserve.

1

Resolution

2

32. Resolved, that a \$30 special assessment for 2018 and 2019 in order to fund the House initiative
Resolution 67H-2016, Utilization of Dental Services for ADA Members, be approved.

3

4

BOARD RECOMMENDATION: Vote Yes.

5

BOARD VOTE: UNANIMOUS.

Resolution No. 32S-1 Substitute

Report: N/A Date Submitted: August 2017

Submitted By: Fourteenth Trustee District

Reference Committee: A (Budget, Business, Membership and Administrative Matters)

Total Net Financial Implication: <u>\$3,100,000</u>	Net Dues Impact: <u>Reserves Spending</u>
Amount One-time _____	Amount On-going _____ FTE <u>0</u>

ADA Strategic Plan Objective: Finance-Obj. 4: Unrestricted liquid reserves targeted at no less than 50%.

How does this resolution increase member value: Not Applicable

SUBSTITUTE FOR RESOLUTION 32: SPECIAL ASSESSMENT

The following resolution was adopted by the Fourteenth Trustee District on August 20, 2017, and submitted by Dr. Carol Morrow, Fourteenth District caucus chair.

Background: The House of Delegates passed Resolution 67H-2016 (Trans.2016:278), a Three-Year 2 Initiative to Drive Utilization of Dental Services for ADA Members as follows:

67H-2016. Resolved, that the initiative “Drive Utilization of Dental Services for ADA Members” be approved, and be it further

Resolved, that the Council on Communications submit annual status updates to the House of Delegates for the duration of the campaign, and be it further

Resolved, that the House of Delegates urges funding for this program shall come from the reserves for the first year, and be it further

Resolved, that funding for the second and third years shall be at the discretion of the Board of Trustees, and be it further

Resolved, that the Council on Communications shall provide evidence of the value of this media campaign to the 2017 HOD.

Because this initiative was funded from reserves in the first year, 2017, and is to be funded at the discretion of the Board of Trustees in the second and third years, 2018 and 2019, an analysis of the ADA's projected reserves was performed to review options for funding this initiative. This analysis was inherently linked to the complete picture of the ADA's projected financial position and the reserve objective of the ADA's 2020 finance strategic plan goal to target unrestricted liquid reserves at no less than 50% of annual operating expenses. After careful consideration of all the options, the Board recommended funding the Busyness Initiative in 2018 from several sources as follows:

- \$30 Special Assessment (which represents a temporary 5.6% increase in National dues).
- General Reserves until they reach the goal floor of 50% of the annual operating budget.
- If General Reserves reach the 50% target floor, then the remainder of the Business Initiative would be funded from Royalty Reserve.

1 We understand the General Reserve cannot go below 50% of the annual operating budget and it is our
2 opinion that a special assessment is not necessary because adequate funds exist in both the General
3 and Royalty Reserve Funds.
4

5 The Fourteenth Trustee District therefore moves to amend Resolution 32 so that the amendment would
6 read as follows (deletions ~~stricken~~, additions underscored):

7 **Proposed Resolution**

8 ~~**32S-1.** Resolved, that a \$30 special assessment for 2018 and 2019 in order to fund the House
9 initiative 2 Resolution 67H-2016, Utilization of Dental Services for ADA Members, be approved.~~

10
11 **Resolved,** that the Board of Trustees be urged to utilize funds from reserves for 2018 in order to fund
12 the House Initiative Resolution 67H-2016, Utilization of Dental Services for ADA members, and be it
13 further

14
15 **Resolved,** if the needed funds results in the reserve fund dropping below the 50% of budget
16 threshold, then the Board is urged to use funds from the Royalty Reserves to complete amounts
17 budgeted for this project for 2018, and be it further

18
19 **Resolved,** that the Board of Trustees be encouraged to use the same funding mechanism for 2019.
20

21 **BOARD COMMENT:** The House of Delegates passed resolution 67H-2016, a Three-Year Initiative to
22 Drive Utilization of Dental Services for ADA Members, with the first year, 2017, funded from reserves and
23 the second and third years, 2018 and 2019, funded at the discretion of the Board of Trustees. As a
24 result, the Board reviewed the ADA's projected reserves and several different scenarios as a source of
25 funding the initiative which are discussed in Board Report 2 beginning on page 2054. While the Board
26 appreciates the concerns expressed, the Board considered potential impacts of these different scenarios
27 in the bigger picture context of financial stability given the long term needs of the Association.

28 In recent years, reserve spending which is reported in quarterly financial statements and anticipated
29 future spending has addressed important needs and, long term, can help grow non-dues revenue and
30 build member value. Because the Members First 2020 Strategic Plan financial goal includes an objective
31 that unrestricted liquid reserves will be targeted at no less than 50% of annual operating expenses, the
32 Board sought to find a funding solution for this initiative that would balance the need to meet this target
33 with the need to limit impact on member dues. After careful consideration of all the options, the Board
34 agreed that it would be best to fund the Busyness Initiative in 2018 from several sources as follows:

- 35
- \$30 Special Assessment (which represents a temporary 5.6 % increase in National dues).
 - 36 • General Reserves until they reach the target floor of 50 % of the annual operating budget.
 - 37 • If General Reserves reach the 50 % target floor, then the remainder of the Busyness Initiative
38 would be funded from the Royalty Reserve.

39 **BOARD RECOMMENDATION: Vote No.**

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

Resolution No. 32S-2 Substitute

Report: N/A Date Submitted: October 2017

Submitted By: Sixteenth Trustee District

Reference Committee: A (Budget, Business, Membership and Administrative Matters)

Total Net Financial Implication: \$3,100,000 Net Dues Impact: \$30

Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Finance-Obj. 4: Unrestricted liquid reserves targeted at no less than 50%.

How does this resolution increase member value: Not Applicable

1 **SUBSTITUTE FOR RESOLUTION 32: SPECIAL ASSESSMENT**

2 The following resolution was submitted by the Sixteenth Trustee District and transmitted on October 11,
3 2017, by Phil Lathem, executive director, South Carolina Dental Association.

4 **Background:** We firmly believe that the ADA’s long term financial sustainability is at an increased risk for
5 several reasons:

- 6 1) Diminishing liquid reserves,
- 7 2) Future challenges with budgeting a surplus for the end of the year,
- 8 3) Soaring, but progressively more uncertain stock market, and
- 9 4) The notion that we will remove money from the Royalty reserves to fund initiatives which still have
10 uncertainty and risk.

11 With so many moving parts to maintain long term sustainability, each with its own uncertainty and risks,
12 locking in a method of payment for two years for the Busyness Campaign is not a good business practice.

13 Further funding, from Reserves or dues assessment, will be based on the review and metrics to the 2018
14 House as well as a better understanding of the financial risk and financial requirements of the frog
15 Initiative, therefore be it (deletions ~~stricken~~, additional underscored).

16 **Resolution**

17 **32S-2. Resolved** that a \$30 special assessment for only 2018 ~~and 2019~~ in order to fund the House
18 initiative Resolution 67H-2016, Utilization of Dental Services for ADA Members, be approved.

19 **BOARD RECOMMENDATION: Received after the September 2017 Board of Trustees Meeting.**

Resolution No. None N/A

Report: Board Report 3 Date Submitted: May 2017

Submitted By: Board of Trustees

Reference Committee: A (Budget, Business, Membership and Administrative Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE 0

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

How does this resolution increase member value: See Background

1 **REPORT 3 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: NEW DENTIST**
2 **CONFERENCE DIRECTION**

3 **Background:** In response to the Resolution 104H-2014, the New Dentist Committee (NDC), at the
4 Board’s direction, evaluated the format of the New Dentist Conference at the annual meeting. The report
5 is included as Appendix 1. The Board agrees with the NDC recommendation to continue the new format
6 with ongoing enhancements to meet the needs of new dentist attendees and intends to follow that
7 direction.
8

9 **BOARD RECOMMENDATION: Vote Yes to Transmit.**

10 **BOARD VOTE: UNANIMOUS.**

APPENDIX 1 (Report 3) Reference Committee A

REPORT OF NEW DENTIST COMMITTEE: THE FUTURE OF THE NEW DENTIST CONFERENCE

This report provides the recommendation from the New Dentist Committee (NDC) that the New Dentist Conference should continue to be held alongside the annual meeting with ongoing enhancements to create an outstanding member experience for the new dentist attendee.

Background: In 2014, the House of Delegates adopted Resolution 104, which reads:

Resolved, that the Board of Trustees monitor and evaluate the New Dentist Conference, as a meeting coinciding with America's Dental Meeting 2015, 2016 and 2017, ensuring that it will foster inclusiveness, leadership development, and provide opportunities for interaction and engagement with ADA Board of Trustees and other leadership, and be it further

Resolved, that the Board of Trustees report to the 2016 and 2017 House of Delegates on whether the ideals and atmosphere of the previous stand-alone New Dentist Conferences have been maintained, and be it further

Resolved, based on the findings of these reports, the Board of Trustees is urged to take timely and appropriate actions to ensure the New Dentist Conference be maintained as a meeting coinciding with America's Dental Meeting, or be reinstated as a stand-alone conference, or some other option in 2018.

The Committee acknowledges that the meeting within a meeting and the standalone conference are two different experiences. The purpose has changed -- the standalone meeting focused on growing leadership while the combined meeting is focused on meeting the need of the general attendee. As such, evaluating the new format of the Conference against the previously approved metrics as well as the points raised in the House resolution is not an "apples to apples" comparison. Moving forward, the Committee recommends re-evaluating the metrics to align with the revised purpose. The report provides an overview of the Conference evaluation of the 2015 and 2016 meeting.

A snapshot of 2015 and 2016 metrics can be found in Appendix 2 and 2016 survey results can be found in Appendix 3. In general, the meeting met the attendance and satisfaction metrics. It fell short of the metric to have leaders represented from every state, though the percentage of new dentist leadership attendance was similar to the standalone conference. The metric for the percentage of new dentists who sign up for annual meeting and also register for the Conference was met in 2015, but not in 2016, so there is opportunity to increase participation.

The 2016 survey shows that 85% of respondents were likely to recommend the New Dentist Conference at ADA 2016 to a friend or colleague. There was also general satisfaction with the courses and networking with new dentists, though there was interest to reinstate clinical courses, such as hands-on workshops, into the schedule. Other high points included the New Dentist Lounge and New Dentist Reception. The mobile app, registration process and overlapping schedules were noted downfalls of the meeting. The Committee also raised concerns that there are challenges for Committee members to host the Conference because of additional leadership commitments at the annual meeting, such as House of Delegates, Caucuses and Reference Committees.

Attendance: The Committee discussed that the new dentist registration, while slightly higher than the standalone conference, had not significantly increased. It was noted that two years of meetings was not enough time to gauge attendance trends in the new format, but agreed that efforts should continue to attract new dentist attendees to attend the Conference, and especially to increase the percentage of new dentists already registered for the ADA meeting to participate in the Conference.

Table A

NEW DENTIST CONFERENCE ATTENDANCE 2009-2016

Year	2016	2015	2014	2013	2012	2011	2010	2009
	<i>Denver</i>	<i>DC</i>	<i>KC</i>	<i>Denver</i>	<i>DC</i>	<i>Chicago</i>	<i>San Diego</i>	<i>Miami</i>
Total Attendees	327	396	400	300	263	330	409	369
New Dentist Attendees	258	327	233	178	166	206	281	254
Students/Grad Students	41	18	36	27	31	13	55	42
Paid Attendees *	274	363	290	189	183	226	321	275
Repeat Attendees**	TBD	TBD	33	23	15	30	22	N/A
New Attendees**	TBD	TBD	223	168	143	206	250	N/A

*Paid attendees exclude NDC & Board members, sponsors, speakers, ADA staff.

**Excludes ADA Board Members, Sponsors, Speakers and ADA Staff. This number was estimated based on past attendee records since the 2003 New Dentist Conference. The repeat attendance information for 2016 will take further analysis and is not yet available.

Table B

NEW DENTIST ATTENDANCE AT ANNUAL MEETING

Year	2016	2015	2014	2013	2012	2011	2010	2009
	<i>Denver</i>	<i>D.C.</i>	<i>San Antonio</i>	<i>New Orleans</i>	<i>San Fran</i>	<i>Vegas</i>	<i>Orlando</i>	<i>Hawaii</i>
Total Dentists	6,734	7,148	6,215	7,225	10,147	7,732	6,931	7,405
New Dentist Attendees	1,236	996	782	1,063	1,727	1,479	1,150	1,356
% at New Dentist Conference	21%	36%	-	-	-	-	-	-

Expense: The Committee shared concerns about the cost of the Conference, since the combined format did not reduce expenses as originally expected. The main reasons for the increased bottom line was the reduction in sponsorship revenue and increase in “bells and whistles” to make the meeting attractive to new dentists. Since there are a number of sponsorship opportunities at the annual meeting already, it was challenging to obtain the previous levels of sponsorship at the New Dentist Conference at the annual meeting setting during the first two years. Conference Services is working on efforts to increase sponsorship and reduce expenses; however, these cost reductions may not be realized in the current environment. Given this, the Committee requests that the Board consider the New Dentist Conference at annual meeting an investment in member value for new dentists and accept that this meeting may not be a revenue-generator for the organization.

Table C

CONFERENCE FINANCIALS

Year	2016*** <i>Denver</i>	2015 <i>D.C.</i>	2014 <i>Kansas City</i>	2013 <i>Denver</i>	2012 <i>DC</i>	2011 <i>Chicago</i>	2010 <i>San Diego</i>	2009 <i>Miami</i>
Sponsor Revenue	\$105,000	\$125,000	\$221,775	\$196,150	\$155,950	\$128,800	\$133,500	\$78,000
Registration Revenue	\$74,500	\$89,000	\$102,068	\$87,127	\$69,867	\$85,517	\$116,833	\$93,499
Total Revenue	\$179,500	\$214,00	\$323,843	\$283,277	\$225,817	\$214,317	\$250,333	\$171,499
Direct Cost Expenses*	\$323,650	\$349,652	\$210,880	\$213,206	\$173,352	\$187,277	\$214,100	\$222,742
Indirect Expenses**	\$200,000	\$200,000	\$231,651	\$226,001	N/A	N/A	N/A	N/A
Net Revenue	(\$344,150)	(\$335,652)	(\$118,688)	(\$155,930)	N/A	N/A	N/A	N/A
Cost / Paid Attendee	\$1,256	\$924	\$409	\$838	N/A	N/A	N/A	N/A

*These expenses are direct costs only, which include the costs to put on the conference, such as the meeting space, food and beverage, event costs, travel expenses for NDC and for required staff. **Indirect costs were calculated for 2013 and estimated in 2014. These costs include staff time, travel for the ADA Board of Trustees and other ADA staff. As of the time of the writing of this report, 2015 and 2016 indirect costs are estimates. ***2016 Conference revenue and direct expenses are estimates as invoices are still coming in and final audit will be done in early 2017.

Inclusiveness: The 2016 New Dentist Conference survey showed that 92% of respondents said they felt welcomed and included, this indicates that the Conference was successful at fostering inclusiveness, one of the points outlined in the House resolution. The 2015 survey showed that 78% of respondents said they agreed or strongly agreed that they felt welcome and included at the New Dentist Conference.

Interaction with Leadership: The House resolution states that Conference should ensure that opportunities for interaction and engagement with ADA Board of Trustees and other leadership are retained. The 2016 survey indicated that the 85% of respondents were satisfied or very satisfied with the participation of the New Dentist Committee in the meeting. The 2015 survey did not ask this question. The Board of Trustees were invited, and most participated, in leadership day to the extent schedules allowed. The Committee discussed that the involvement of the Board of Trustees continues to be valued and shows that the ADA cares about new dentists. The Committee thanks the Board for its continued participation in the New Dentist Conference and asks the Board to continue to participate in the future. Information about the 2017 New Dentist Conference and Board participation will be available by the August Board meeting. The Committee discussed that the format did present challenges for new dentist leaders to share ideas and discuss issues because of the number of activities available and conflicts with Reference Committees and House of Delegates meetings. However, they agreed that the experience for a general attendee would not be heavily impacted by these conflicts.

Fostering Leadership: The purpose of the New Dentist Conference in this format is no longer to foster

leadership. And while the Committee discussed that leadership development was important, it concluded that it should be addressed separately and that there were other ways to cultivate new dentist leaders, outside of the Conference. The Committee will address leadership development separately.

Changes for 2017: The House resolutions state that the 2017 meeting should be evaluated as part of the three-year evaluation period. A number of enhancements are being planned for 2017. To address the scheduling challenges, the New Dentist Conference programming will take place over three days to allow more flexibility for attendees, including leaders with other duties, and better integration with the annual meeting. New Dentist Conference attendees will have an exclusive morning continuing education with unique keynote speakers on Thursday and Friday, and after lunch, will attend one of 7-10 courses most of which are paid lectures for annual meeting attendees, free of charge to new dentist attendees. On Saturday, the morning session will begin with that choice for attendance in 4-6 hot topics courses or attendance at the Reference Committee hearings, or time at the exhibit hall, and then lunch and an afternoon closing keynote and final remarks from the Committee. New Dentist Conference attendees also have the option to select courses on Thursday and Friday afternoon or Saturday morning that are outside the recommended track within the annual meeting courses allowing for further flexibility and individualized conference experience. Expanded lunch breaks will allow for additional time for networking and interaction with peers and available leadership. A preliminary schedule can be found [HERE](#) on ADA.org. The 2018 Hawaii meeting is in development and adjustments may need to be made to accommodate space and cost constraints.

In addition, with the expanded purpose of the Conference to create the best member experience for the new dentist, it will be important to re-evaluate marketing efforts. The Board should consider a broader strategy to promote the meeting to more new dentists, including non-members, so that they have the opportunity to experience all that the New Dentist Conference and ADA has to offer. Doing so reinforces the Board's recent decision to direct the Committee to focus its efforts on advising the Board on issues affecting the decision of new dentists to join or renew membership.

Ideals and Atmosphere: The Committee believes that with ongoing enhancements, such as those being planned for 2017, the New Dentist Conference at ADA will be successful in delivering an outstanding experience for the new dentist member. It can continue to foster inclusiveness as well as promote interaction and engagement with attendees and the Board of Trustees. While the Committee acknowledges that the new format is not designed to foster leadership, it believes that cultivating leaders can and should be addressed in other ways. The Committee acknowledges the differences in the two meeting formats and has decided that at this time, the Committee should continue to improve the New Dentist Conference at ADA to create an outstanding and memorable experience for the new dentist member. The New Dentist Conference should continue to be evaluated in all areas indicated in this report to ensure that the Committee's charter is being fulfilled.

Resources: Another significant reason that the Committee opted to continue on with the existing format of a meeting within a meeting was that a separate meeting, if approved by the Board, would be a strain on staff and Committee time. The Committee was informed that Conference Services could provide limited support for meeting planning services, but that the strategic direction, continuing education course selection, leadership programming and additional planning would likely fall to the Committee and its staff. The Committee recognized that they should focus on other important initiatives to most effectively advise the Board on new dentist matters rather than taking on the responsibility of meeting planning. The Committee agreed that, in addition to other reasons, it was more resource-efficient to retain the current format.

Recommendation: The Committee discussed the direction of the Conference and agreed that the current format should be continued. Additionally, the Committee was pleased with the quality of the continuing education courses, especially the general session speakers and agreed that the New Dentist Lounge was a great addition to the meeting. The New Dentist Reception, a carryover from past years, was especially well-received the past two years. The Committee discussed that the purpose of the meeting was to create a meaningful face-to-face experience for new dentists that provides a platform to acquire knowledge from experts, share knowledge and network with peers in a supportive environment. All of this is intended to foster a lifetime connection to the ADA and state and local dental societies. The Committee believes that the New Dentist Conference at the annual meeting is a valuable touch point for membership and should continue into the future.

If the Board agrees with the NDC, no resolution is required; work will continue on upcoming meetings along the lines described in this report.

APPENDIX 2 (Report 3) Reference Committee A

New Dentist Conference at ADA Metrics

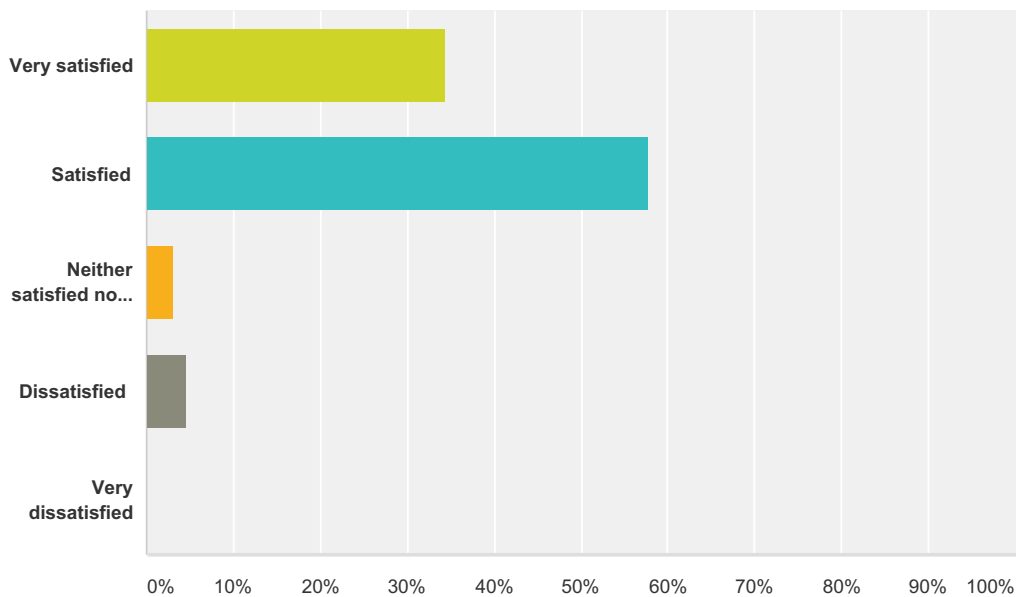
Results from 2015 and 2016 meeting

Metric	2015 Results	Comments	2016 Results	Comments
Achieve 350 New Dentist Conference Registrants (range of 300-400)	396 Total	On Plan: There were 396 total registrants, which included the Board. There were 335 new dentist and 31 dental student registrants	327	On Plan There were 327 total registered, including the Board. There were 258 dentists and 41 dental student registrants.
Minimum of 30% of overall new dentist attendees from the annual meeting register for the Conference (range of 27-32%)	38% or 1,053	On Plan	There were 1236 new dentist attendees overall, or about 21%	Off Plan
Minimum of one new dentist leader from each state in attendance (excluding national NDC)	Approximately 62 leaders from 36 states registered (this excludes NDC members)	Off Plan Leadership attendance at past New Dentist Conferences has varied, ranging from 16-33% of total conference registrants and about 75 leaders attending on average since 2000.	106 leaders self-identified as being a volunteer (excluding NDC and Board members)* <i>*The registration system included the question: "Are you in a volunteer role within your state or local society?" A total of 106 attendees said "yes" to that question.</i>	Off plan. While 106 is an impressive number, there were 15 states that did not have a leader in attendance
4.1 average evaluation on a 5 point scale (range 3.8-4.4)	4.3 score	On Plan: The Board is pleased with this result but notes that the follow-up survey	4.2 weighted score*	On Plan

		had a lower response rate than desired		*This was the result of a follow-up survey.	
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Q1 In general, how satisfied were you with the New Dentist Conference?

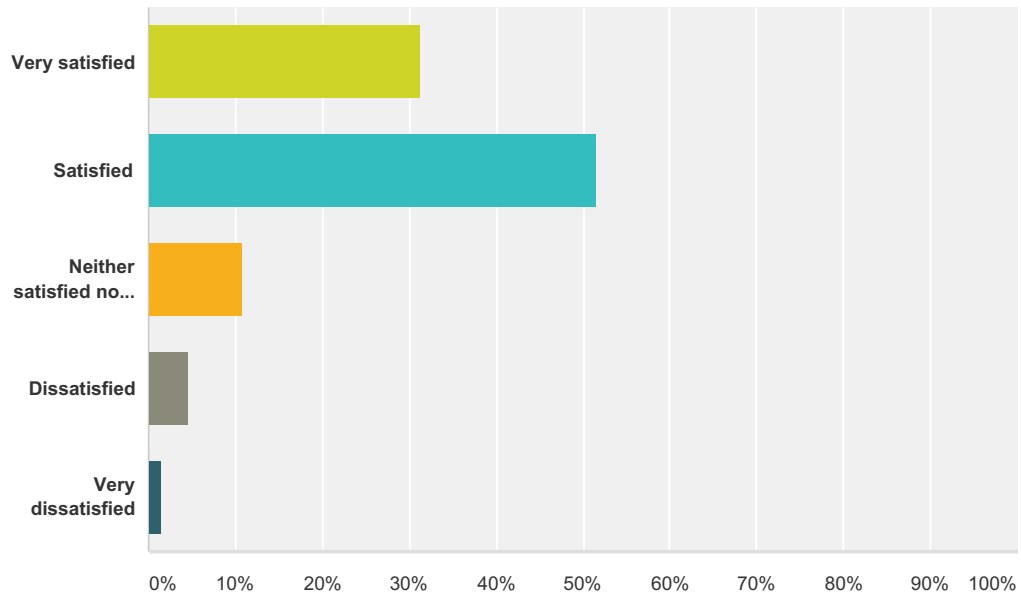
Answered: 64 Skipped: 0



Answer Choices	Responses	Count
Very satisfied	34.38%	22
Satisfied	57.81%	37
Neither satisfied nor dissatisfied	3.13%	2
Dissatisfied	4.69%	3
Very dissatisfied	0.00%	0
Total		64

Q2 In general, how satisfied were you with the CE courses offered at the New Dentist Conference?

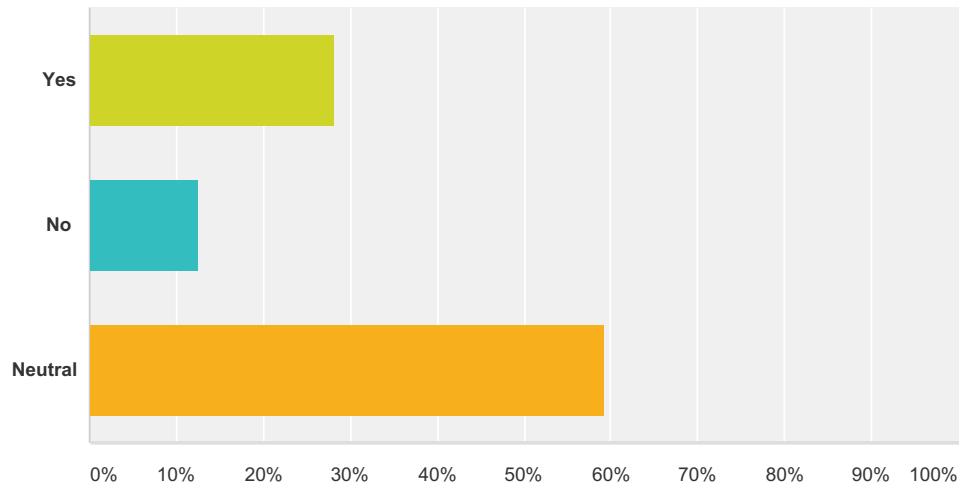
Answered: 64 Skipped: 0



Answer Choices	Responses	Count
Very satisfied	31.25%	20
Satisfied	51.56%	33
Neither satisfied nor dissatisfied	10.94%	7
Dissatisfied	4.69%	3
Very dissatisfied	1.56%	1
Total		64

Q3 Would you recommend offering campfire session at the New Dentist Conference in 2017?

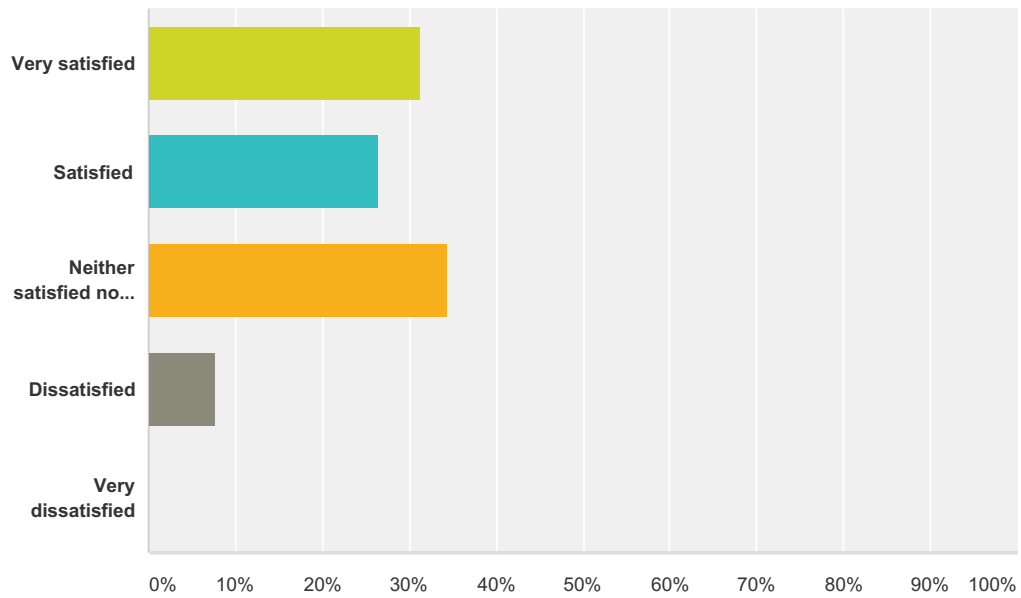
Answered: 64 Skipped: 0



Answer Choices	Responses
Yes	28.13% 18
No	12.50% 8
Neutral	59.38% 38
Total	64

Q4 How satisfied were you with the keynote speaker, Peter Sheahan?

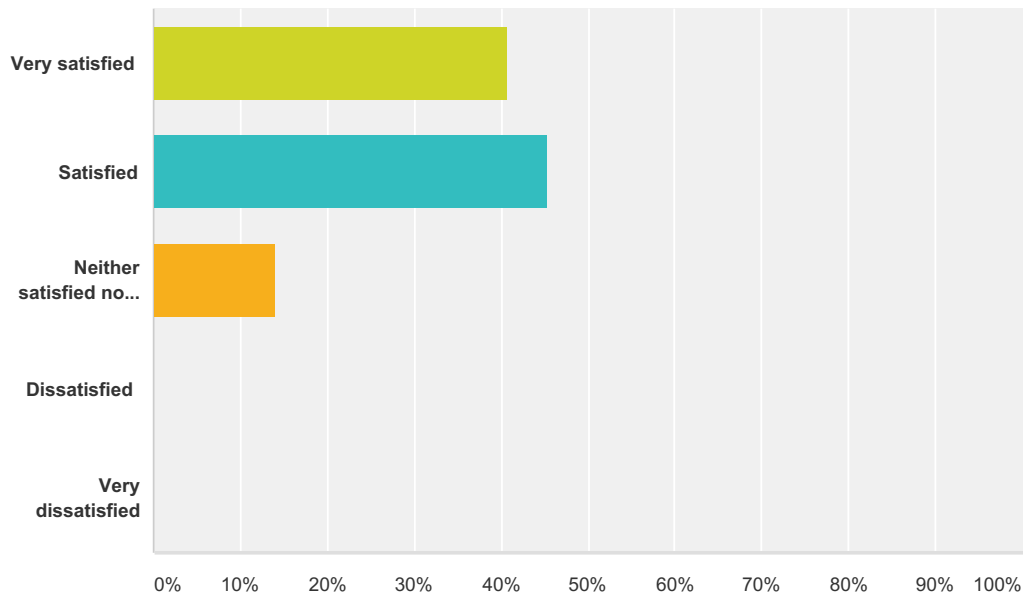
Answered: 64 Skipped: 0



Answer Choices	Responses	Count
Very satisfied	31.25%	20
Satisfied	26.56%	17
Neither satisfied nor dissatisfied	34.38%	22
Dissatisfied	7.81%	5
Very dissatisfied	0.00%	0
Total		64

Q5 How satisfied were you with the emcee, Judi Holler?

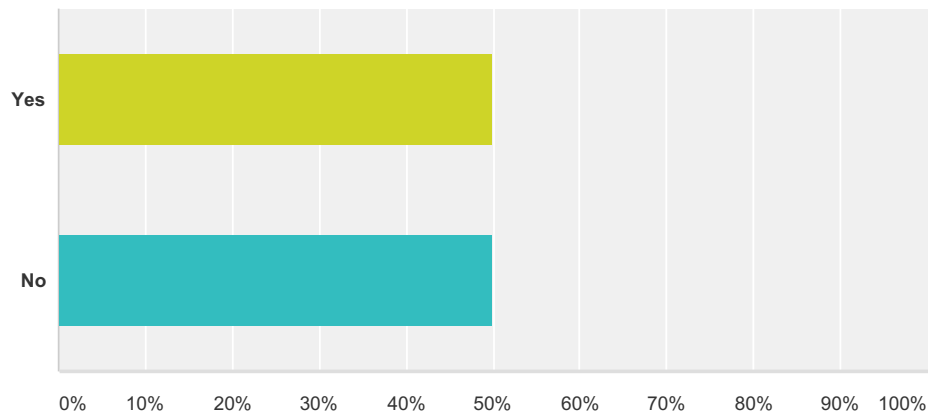
Answered: 64 Skipped: 0



Answer Choices	Responses	Count
Very satisfied	40.63%	26
Satisfied	45.31%	29
Neither satisfied nor dissatisfied	14.06%	9
Dissatisfied	0.00%	0
Very dissatisfied	0.00%	0
Total		64

Q6 Are you currently in a leadership role in your state or local dental society?

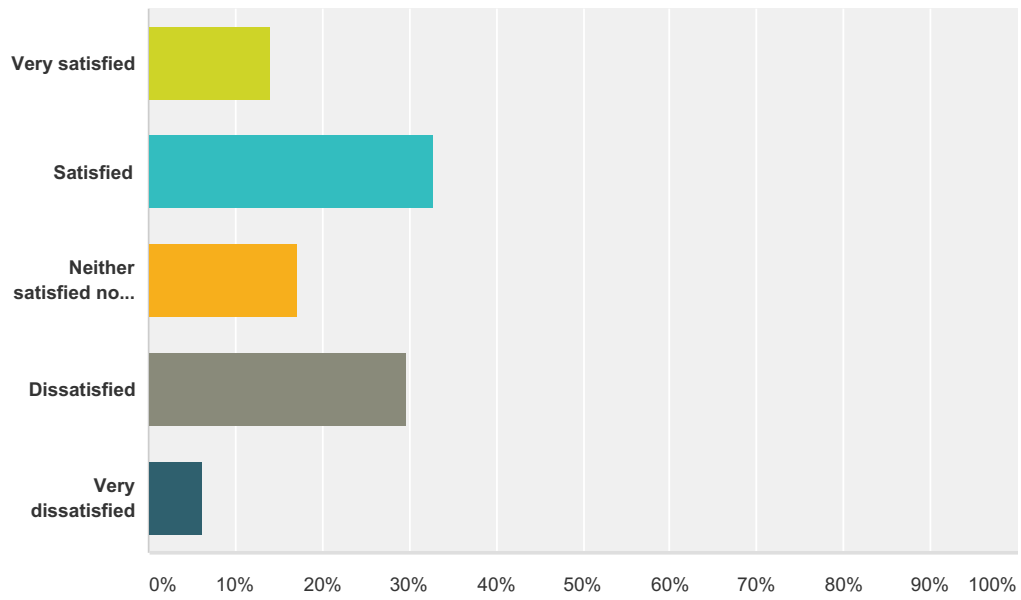
Answered: 64 Skipped: 0



Answer Choices	Responses	
Yes	50.00%	32
No	50.00%	32
Total		64

Q7 How satisfied were you with the mobile app?

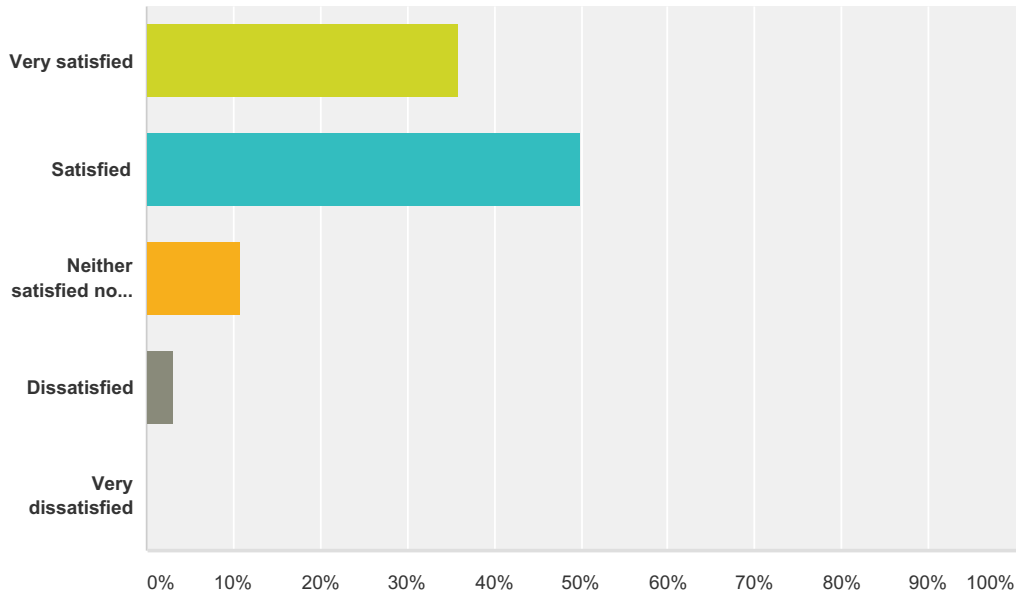
Answered: 64 Skipped: 0



Answer Choices	Responses
Very satisfied	14.06% 9
Satisfied	32.81% 21
Neither satisfied nor dissatisfied	17.19% 11
Dissatisfied	29.69% 19
Very dissatisfied	6.25% 4
Total	64

Q8 How satisfied were you with the participation/engagement of the ADA New Dentist Committee during the New Dentist Conference?

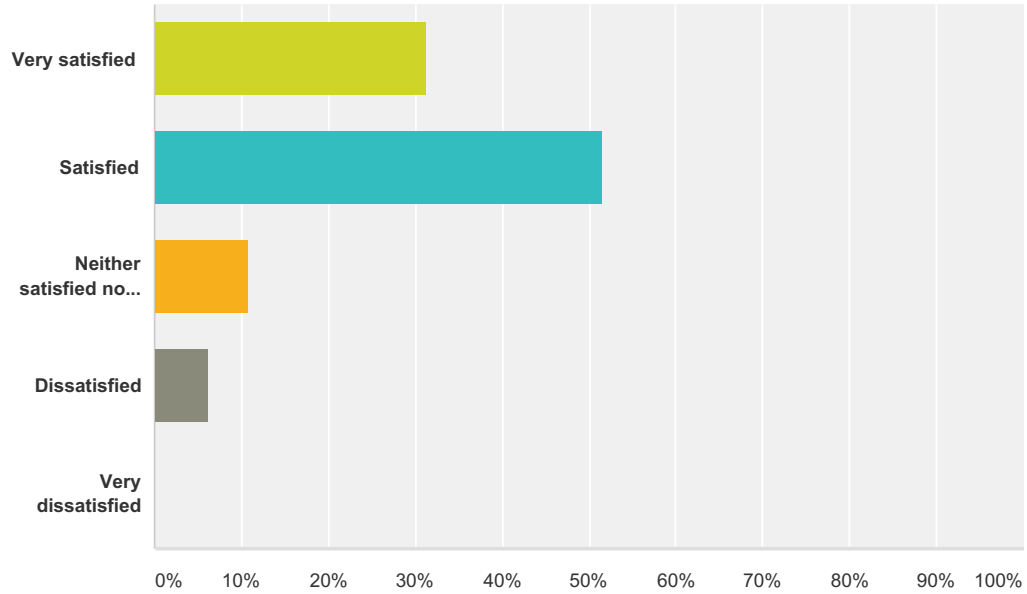
Answered: 64 Skipped: 0



Answer Choices	Responses	
Very satisfied	35.94%	23
Satisfied	50.00%	32
Neither satisfied nor dissatisfied	10.94%	7
Dissatisfied	3.13%	2
Very dissatisfied	0.00%	0
Total		64

Q9 How satisfied were you with the networking opportunities at the New Dentist Conference?

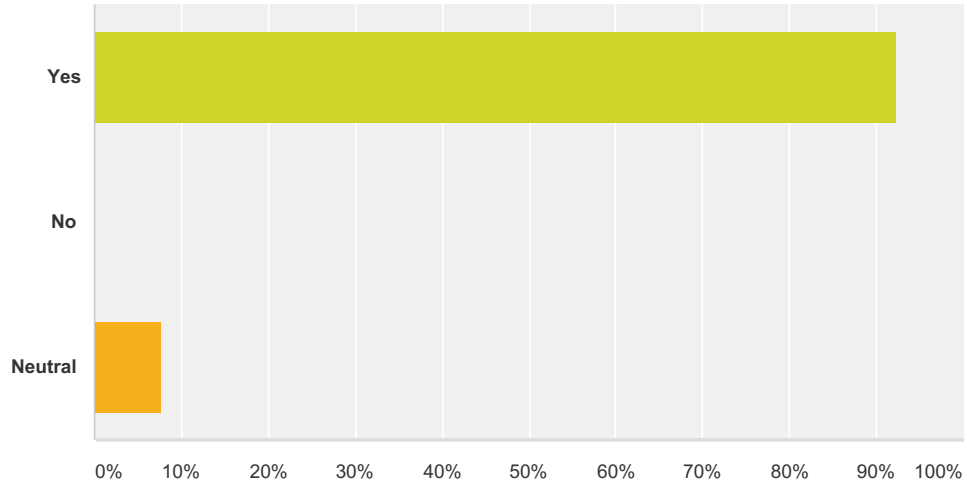
Answered: 64 Skipped: 0



Answer Choices	Responses	Count
Very satisfied	31.25%	20
Satisfied	51.56%	33
Neither satisfied nor dissatisfied	10.94%	7
Dissatisfied	6.25%	4
Very dissatisfied	0.00%	0
Total		64

Q10 Did you feel welcomed and included during your time at the New Dentist Conference?

Answered: 64 Skipped: 0



Answer Choices	Responses
Yes	92.19% 59
No	0.00% 0
Neutral	7.81% 5
Total	64

Q11 What types of leadership programs do you want to see next year?

Answered: 64 Skipped: 0

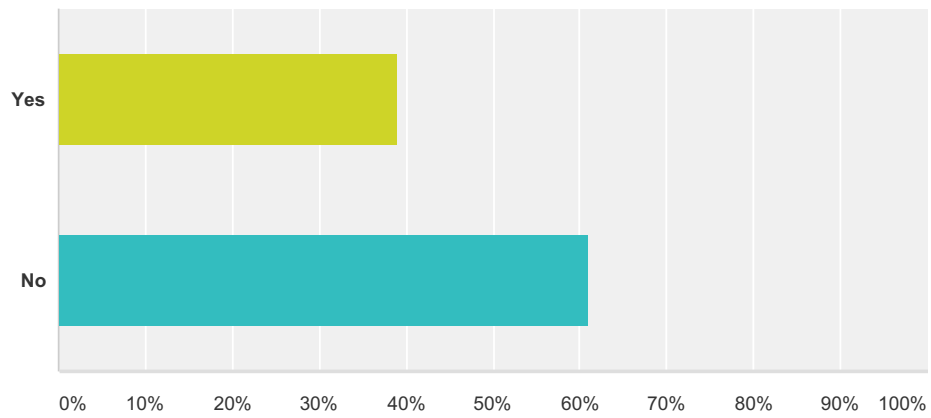
#	Responses	Date
1	More practice management ce courses	12/5/2016 4:32 PM
2	Practice transition	12/1/2016 1:01 PM
3	This year was good	12/1/2016 9:07 AM
4	More networking	12/1/2016 7:38 AM
5	Multicultural/diversity team and public health/outreach team	12/1/2016 7:12 AM
6	women in leadership, minorities in leadership	11/30/2016 9:53 PM
7	Unsure	11/30/2016 9:47 PM
8	Staff management	11/30/2016 9:44 PM
9	how to solve conflicts among staff members	11/30/2016 7:55 PM
10	Nuetral	11/30/2016 5:43 PM
11	Making the connection from ADA leadership to New Dentist	11/30/2016 5:08 PM
12	engaging in state society and legislative actions	11/30/2016 4:58 PM
13	more State level	11/28/2016 10:31 AM
14	I would like to see more information on how to be a member of the New Dentist Committee. It seems like an exclusive group.	11/26/2016 1:04 PM
15	we need an idea exchange that is NOT a campfire or breakout - it needs to be with all the attendees so everyone can participate without competing programs. All attendees should be able to hear ideas, success stories, failures, and get energized and bring them back to their components and states and implement them into their new dentist programming	11/23/2016 3:09 PM
16	Entrepreneurship and business start-ups	11/22/2016 3:05 PM
17	not sure	11/22/2016 2:35 PM
18	I am not sure as I didn't participate.	11/22/2016 1:34 PM
19	Dynamic speaker	11/22/2016 11:07 AM
20	Scenarios specifically addressing leadership challenges in the dental office	11/21/2016 8:54 PM
21	Volunteering	11/21/2016 5:21 PM
22	n/a	11/21/2016 4:36 PM
23	-	11/21/2016 4:15 PM
24	any type!	11/21/2016 4:08 PM
25	This year was great	11/21/2016 4:00 PM
26	More opportunities to network.	11/21/2016 2:02 PM
27	Mentorship program	11/21/2016 1:39 PM
28	More wellness mindfulness	11/21/2016 12:41 PM
29	na	11/21/2016 12:31 PM
30	More ideas for involvement locally, event ideas, how to become involved and how to inspire others to get involved.	11/21/2016 12:08 PM
31	This years topics were great and diverse	11/21/2016 12:03 PM
32	I really enjoyed the personal development focus this year, I would like to see more of that	11/21/2016 11:59 AM

New Dentist Conference at ADA 2016

33	Personal growth and development	11/21/2016 11:48 AM
34	N/a	11/21/2016 11:36 AM
35	Working into an existing practice culture as a leader and head of a team	11/21/2016 11:34 AM
36	Programs about being a successful associate in a practice, how to get respect from staff when you're a young/new dentist	11/21/2016 11:30 AM
37	N/A	11/21/2016 11:14 AM
38	How to engage new dentists on a state level with dental association. Networking and socials.	11/21/2016 11:01 AM
39	Similar to this past year	11/21/2016 10:37 AM
40	Not sure what this question means	11/21/2016 10:37 AM
41	Better understanding of national leadership opportunities for new dentists	11/21/2016 10:32 AM
42	None. I'm there for CE, not leadership. Those can be done on Wednesday or Thursday or Sunday for those that want to attend.	11/21/2016 10:23 AM
43	More female centric - female specific methods of engagement and leadership.	11/21/2016 10:22 AM
44	More sessions were NDC leaders from different cities can exchange programming ideas. Campfire like, but not so pointed discussions. The campfire sessions were forced and people wanted to talk about other things.	11/21/2016 10:21 AM
45	Community-- outside of dentistry	11/21/2016 10:18 AM
46	More programs that are not optional. I felt that the campfire sessions were not large enough and competed with networking at lunch or break sessions. I think a panel discussion that all attended would be helpful.	11/21/2016 10:03 AM
47	All were good this year	11/21/2016 9:59 AM
48	implementing technology in the dental office or bringing in an additional dentist--so many times these lectures are geared toward those nearing retirement, however, there are new dentists who are looking for associates as well.	11/16/2016 4:22 PM
49	More difficult conversation development	11/16/2016 9:11 AM
50	Maybe assigned seats with icebreakers during lunch so you get to know other new dentists easier.	11/15/2016 6:13 PM
51	N/A	11/15/2016 9:15 AM
52	Public health campfire	11/14/2016 4:23 PM
53	n/a	11/14/2016 3:19 PM
54	n/a	11/14/2016 2:12 PM
55	How to get involved	11/13/2016 7:33 PM
56	Continue the fireside chats	11/10/2016 4:53 PM
57	How to be a good team member and motivate other members of a team	11/10/2016 10:05 AM
58	advocacy initiatives relevant to our generation and views	11/10/2016 9:13 AM
59	Practice management and team building	11/9/2016 10:42 PM
60	Leading staff successfully	11/9/2016 8:55 PM
61	International leadership opportunities	11/9/2016 7:57 PM
62	Practice management	11/9/2016 7:25 PM
63	Something less general/more tailored to dentistry	11/9/2016 6:00 PM
64	Less leadership, more clinical.	11/9/2016 4:10 PM

Q12 Have you attended the New Dentist Conference in the past two years?

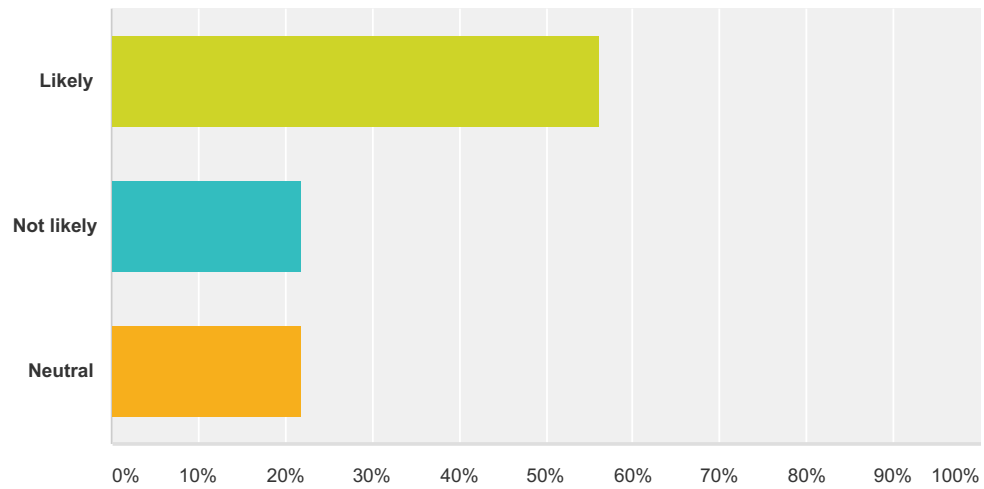
Answered: 64 Skipped: 0



Answer Choices	Responses	
Yes	39.06%	25
No	60.94%	39
Total		64

Q13 How likely are you to attend the New Dentist Conference next year in Atlanta?

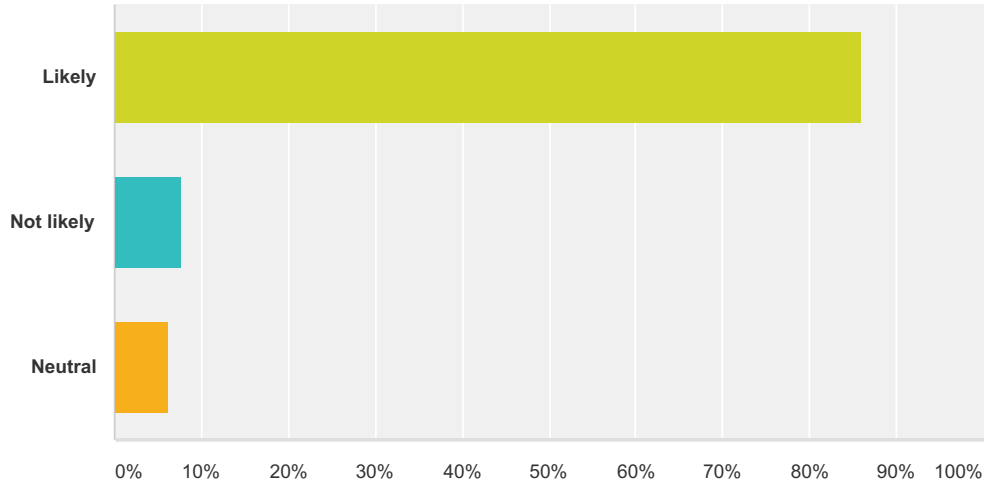
Answered: 64 Skipped: 0



Answer Choices	Responses	
Likely	56.25%	36
Not likely	21.88%	14
Neutral	21.88%	14
Total		64

Q14 How likely are you to recommend the New Dentist Conference to a friend or colleague?

Answered: 64 Skipped: 0



Answer Choices	Responses
Likely	85.94% 55
Not likely	7.81% 5
Neutral	6.25% 4
Total	64

Q15 What additional courses or events would you like to see at future New Dentist Conferences?

Answered: 64 Skipped: 0

#	Responses	Date
1	More on informed consent	12/5/2016 4:32 PM
2	Practice Transition	12/1/2016 1:01 PM
3	more restorative	12/1/2016 9:07 AM
4	Differences between corporate, private and public health jobs	12/1/2016 7:38 AM
5	More meaningful all ceramic course/ laser	12/1/2016 7:12 AM
6	touch on community health centers as a means to increase access to care and get some loan forgiveness (provided that the new administration does not make major changes to HRSA and its programs)	11/30/2016 9:53 PM
7	Pediatric dentistry, Patient management, Staff management	11/30/2016 9:47 PM
8	Managing debt	11/30/2016 9:44 PM
9	more clinical cases	11/30/2016 7:55 PM
10	Hands on CE	11/30/2016 5:43 PM
11	Basic info, Pedo, Sx, Composites	11/30/2016 5:08 PM
12	clinical courses on pediatrics, biopsies/pathology/ updates on exodontia	11/30/2016 4:58 PM
13	implants	11/28/2016 10:31 AM
14	More about getting involved with the New Dentist Committee.	11/26/2016 1:04 PM
15	need more clinical CE. almost all the Ce was personal development or practice/financial management and doesnt count for most states CE requirements. NDC should get bigger name speakers like it used to - Gordon Christensen, Harold Crossley, etc - they were willing to come at a fraction of their normal speaking fees because it was a unique engagement and not lumped in with the rest of the Annual Session	11/23/2016 3:09 PM
16	I'd like to see more clinically-relevant courses.	11/22/2016 3:05 PM
17	not sure	11/22/2016 2:35 PM
18	I am not sure.	11/22/2016 1:34 PM
19	More clinical based courses. Mentor/mentee system.	11/22/2016 11:07 AM
20	Dental materials review	11/21/2016 8:54 PM
21	Invisalign	11/21/2016 5:21 PM
22	n/a	11/21/2016 4:36 PM
23	Implants	11/21/2016 4:15 PM
24	How to protect yourself from getting sued	11/21/2016 4:08 PM
25	Perio, preventative, infections	11/21/2016 4:00 PM
26	Better speakers	11/21/2016 2:02 PM
27	More networking opportunities	11/21/2016 1:39 PM
28	More restorative	11/21/2016 12:41 PM
29	more pedo/ financial planning	11/21/2016 12:31 PM
30	chapter engagement, more brainstorming on things to do locally to engage members and new dentists	11/21/2016 12:08 PM
31	Speakers this year were awesome. I would see them again	11/21/2016 12:03 PM

New Dentist Conference at ADA 2016

32	More on staff relations	11/21/2016 11:59 AM
33	More on navigation of financials	11/21/2016 11:48 AM
34	More business courses	11/21/2016 11:36 AM
35	clinical courses	11/21/2016 11:34 AM
36	Courses on: Anesthetic Techniques, Proper diagnostic codes for treatment	11/21/2016 11:30 AM
37	n/a	11/21/2016 11:14 AM
38	More application on owning new practice and patient management.	11/21/2016 11:01 AM
39	botox/dermal filler	11/21/2016 10:37 AM
40	Welcome reception Wednesday night and organized function Thursday evening... In the past we would meet people at the Friday evening social and then see them again Saturday. With the new setup after Friday night everyone parts ways. Would like to see a time for sharing of ideas.	11/21/2016 10:37 AM
41	Treatment planning	11/21/2016 10:32 AM
42	Include Saturday CE Courses. Keynote on Friday.	11/21/2016 10:23 AM
43	More technique specific events	11/21/2016 10:22 AM
44	More high quality speakers for longer sessions.	11/21/2016 10:21 AM
45	Marketing	11/21/2016 10:18 AM
46	Discussions on local leadership and sharing of ideas	11/21/2016 10:03 AM
47	oral surgery courses	11/21/2016 9:59 AM
48	More geared toward dentists that have been out at least 5 years	11/16/2016 4:22 PM
49	more clinical and hands on	11/16/2016 9:11 AM
50	More on investing and setting up a corp.	11/15/2016 6:13 PM
51	N/A	11/15/2016 9:15 AM
52	More socializing events at night at lounges	11/14/2016 4:23 PM
53	New office start up or acquisition	11/14/2016 3:19 PM
54	n/a	11/14/2016 2:12 PM
55	Hands on interactive courses	11/13/2016 7:33 PM
56	No recommendations. Maybe specific lunch roundtable discussions related to practice setup, running, and maintenance.	11/10/2016 4:53 PM
57	More scientific courses	11/10/2016 10:05 AM
58	emotional intelligence speaker	11/10/2016 9:13 AM
59	Clinical/new tech	11/9/2016 10:42 PM
60	Examples of new dentists that have taken different routes after graduation including corporate dentistry, associates and partner/buy in opportunity in private practice, educator, research etc	11/9/2016 8:55 PM
61	Volunteer opportunities	11/9/2016 7:57 PM
62	Hands on classes?	11/9/2016 7:25 PM
63	More clinical courses	11/9/2016 6:00 PM
64	I would like to see more clinical courses. The leadership day is great, but in my state we do not get any CE counted for non clinical course we attend. Therefore, I was not able to get many CE's to go toward my license renewal. I usually have more than enough but it still is making me think twice about registering for the NDC in the future.	11/9/2016 4:10 PM

Q16 What aspect of the New Dentist Conference were you most satisfied with?

Answered: 64 Skipped: 0

#	Responses	Date
1	Everyone was very open and friendly	12/5/2016 4:32 PM
2	Organization	12/1/2016 1:01 PM
3	the financial course	12/1/2016 9:07 AM
4	Mindfulness	12/1/2016 7:38 AM
5	Practice mgmt-related courses	12/1/2016 7:12 AM
6	networking, engagement of the audience with the speakers	11/30/2016 9:53 PM
7	New dentist lounge, free CE	11/30/2016 9:47 PM
8	Focus on the non-clinical skills	11/30/2016 9:44 PM
9	the setup of the lounge and the conference rooms all in close proximity	11/30/2016 7:55 PM
10	The CE	11/30/2016 5:43 PM
11	Ted talk style CE	11/30/2016 5:08 PM
12	CE	11/30/2016 4:58 PM
13	Financial planning	11/28/2016 10:31 AM
14	The New Dentist Lounge and the Reception.	11/26/2016 1:04 PM
15	the new dentist reception at Wynkoop - which actually existed on its own during Annual Session before the Conference was merged with Annual Session	11/23/2016 3:09 PM
16	The networking opportunities and chances to connect with old friends.	11/22/2016 3:05 PM
17	the food, the lounge, the availability to answer questions	11/22/2016 2:35 PM
18	Break area	11/22/2016 1:34 PM
19	Timeliness of courses allowed for more courses and a wider range of them, networking, happy hour, TV's in room for Distinguished Speaker Series	11/22/2016 11:07 AM
20	Free coffee!!	11/21/2016 8:54 PM
21	Ease of things. Classes and food are done for you.	11/21/2016 5:21 PM
22	n/a	11/21/2016 4:36 PM
23	The whole experience	11/21/2016 4:15 PM
24	The CE options and keynote speaker	11/21/2016 4:08 PM
25	Lounge	11/21/2016 4:00 PM
26	Good topics related to new dentists	11/21/2016 2:02 PM
27	The continuing education classes	11/21/2016 1:39 PM
28	Dr Uche and the food	11/21/2016 12:41 PM
29	pedo	11/21/2016 12:31 PM
30	Networking!	11/21/2016 12:08 PM
31	I thought it was well organized and had great content! Food was good too!	11/21/2016 12:03 PM
32	the networking opportunities	11/21/2016 11:59 AM
33	Financials/personal development	11/21/2016 11:48 AM

New Dentist Conference at ADA 2016

34	Great speakers	11/21/2016 11:36 AM
35	options to coordinate with both NDC and ADA	11/21/2016 11:34 AM
36	Food	11/21/2016 11:30 AM
37	n/a	11/21/2016 11:14 AM
38	new dentist lounge and networking opportunities	11/21/2016 11:01 AM
39	networking	11/21/2016 10:37 AM
40	To Tax, Financial Planning and Investment Strategies for New Doctors- Hands down best speaker we had in my opinion	11/21/2016 10:37 AM
41	I loved the wellness aspect	11/21/2016 10:32 AM
42	Course Content was relevant and up to date.	11/21/2016 10:23 AM
43	Opportunity to meet and get to know other young dentists	11/21/2016 10:22 AM
44	Good variety of speakers.	11/21/2016 10:21 AM
45	Marketing and branding	11/21/2016 10:18 AM
46	CE	11/21/2016 10:03 AM
47	social networking	11/21/2016 9:59 AM
48	engagement	11/16/2016 4:22 PM
49	the environment and new dentist lounge	11/16/2016 9:11 AM
50	the food was amazing! Also great organization at the event.	11/15/2016 6:13 PM
51	N/A	11/15/2016 9:15 AM
52	The young dentists in dentologie	11/14/2016 4:23 PM
53	Pre-planned	11/14/2016 3:19 PM
54	branding/marketing info	11/14/2016 2:12 PM
55	Coordinated events	11/13/2016 7:33 PM
56	Overall, very satisfied with the whole conference, though I only attended the first day due to the ICD induction ceremony on the second day.	11/10/2016 4:53 PM
57	Lunch	11/10/2016 10:05 AM
58	the key note speaker	11/10/2016 9:13 AM
59	McGill speaker was helpful for financial planning	11/9/2016 10:42 PM
60	Courses with pearls of wisdom from people who have been there and done that	11/9/2016 8:55 PM
61	Networking	11/9/2016 7:57 PM
62	Networking, lectures	11/9/2016 7:25 PM
63	The lounge and having breakfast and lunch as as opportunity to meet other young dentists	11/9/2016 6:00 PM
64	Friday's lectures were great! Nice to have a couple options to pick from.	11/9/2016 4:10 PM

Q17 What aspect of the New Dentist Conference were you least satisfied with?

Answered: 64 Skipped: 0

#	Responses	Date
1	I would've liked an option to buy new Dentist courses ala carte instead of buying the whole conference	12/5/2016 4:32 PM
2	Mobile App	12/1/2016 1:01 PM
3	the pedo. i wanted more actually tx. lecture	12/1/2016 9:07 AM
4	Nons	12/1/2016 7:38 AM
5	Some courses really have poor contents	12/1/2016 7:12 AM
6	lunch...run 2 buffet lines both sides. We spent a lot of time in line and missed some valuable conversations over the meal.	11/30/2016 9:53 PM
7	Couldn't go to campfire sessions due to CE time conflict	11/30/2016 9:47 PM
8	Registering for classes was confusing	11/30/2016 9:44 PM
9	the signup for the classes on the website was confusing	11/30/2016 7:55 PM
10	nothing	11/30/2016 5:43 PM
11	Confrence was pretty good	11/30/2016 5:08 PM
12	some of the CE was pretty soft ball	11/30/2016 4:58 PM
13	Networking	11/28/2016 10:31 AM
14	The keynote speaker wasn't as engaging as some of the other speakers.	11/26/2016 1:04 PM
15	There was barely any time to interact with the ADA Leadership, aside from Kathy O Loughlin and Carol Summerhays at the opening session. The new format of the conference misses the mark in terms of what its supposed to achieve. The Conference has lost its identity since merging with Annual Session. Everyone was pulled in a million directions because there were so many other competing events. There was a general lack of organization - with registration - we could not see the topics in advance or what time events began and ended. Once on site, there times were published incorrectly in 3 different places - the app, the handout, and the big signs in the hallway. Very confusing. Also, the campfires should not have been staggered so that attendees would miss significant portions of Ce courses. Having two tracks is OK, but staggering that way was not well planned. Also, the keynote speaker was just average. The keynote speakers used to be awesome and big name - this one was kind of a let down and unknown.	11/23/2016 3:09 PM
16	I think the overall level of speakers was less impressive than in 2015. I was hoping to get more clinically-relevant material and less general leadership-themed content.	11/22/2016 3:05 PM
17	CE schedule seemed to populate after the other courses so I'd already registered for different CE	11/22/2016 2:35 PM
18	Sign up	11/22/2016 1:34 PM
19	Timeliness of courses (some content meant for 4 hours crammed into an hour)	11/22/2016 11:07 AM
20	No hands on courses	11/21/2016 8:54 PM
21	Repetition of classes, focused on business more than I'd like.	11/21/2016 5:21 PM
22	n/a	11/21/2016 4:36 PM
23	Nothing	11/21/2016 4:15 PM
24	the app not working	11/21/2016 4:08 PM
25	No discount on rooms this year	11/21/2016 4:00 PM
26	Some speakers were too long/not engaging	11/21/2016 2:02 PM
27	Too crammed into two days, wish more classes on saturday	11/21/2016 1:39 PM
28	Not enough time to network in between packed schedule	11/21/2016 12:41 PM

New Dentist Conference at ADA 2016

29	none dental related speakers	11/21/2016 12:31 PM
30	Some of the presentations were a bit basic...but if people found them helpful, I have no issue with that.	11/21/2016 12:08 PM
31	Na. I enjoyed it a lot!	11/21/2016 12:03 PM
32	the mobile app	11/21/2016 11:59 AM
33	Pedo lecture	11/21/2016 11:48 AM
34	Learning about the speakers and topics beforehand	11/21/2016 11:36 AM
35	n/a	11/21/2016 11:34 AM
36	Difficult to find time to attend campfire sessions due to other CE I signed up for	11/21/2016 11:30 AM
37	n/a	11/21/2016 11:14 AM
38	depth and scope of the CE classes compared to ADA regular session	11/21/2016 11:01 AM
39	none	11/21/2016 10:37 AM
40	organization of meals. Would love to have th awards during the lunch again so those receiving them get the recognition they deserve. Did not like that the campfire sessions were during the other speakers.	11/21/2016 10:37 AM
41	The keynote was a little bit lacking	11/21/2016 10:32 AM
42	Saturday	11/21/2016 10:23 AM
43	Soft skills emphasized in CE	11/21/2016 10:22 AM
44	The speakers were not given long enough to talk.	11/21/2016 10:21 AM
45	Speakers were fun!	11/21/2016 10:18 AM
46	Discussions on local leadership and sharing of ideas	11/21/2016 10:03 AM
47	none	11/21/2016 9:59 AM
48	I wasn't dissatisfied with any particular NDC event, but it was frustrating that many other events overlapped. I know that the ADA tries to fit a lot into a small window, so I was upset to have to miss certain events due to other obligations. I don't have a solution to offer, but it was probably the only negative because I had to miss some of the NDC events/lectures.	11/16/2016 4:22 PM
49	the ce courses were terrible, except the finance lecture with Andrew Tucker	11/16/2016 9:11 AM
50	The after party should be saturday night when there aren't early classes in the morning.	11/15/2016 6:13 PM
51	N/A	11/15/2016 9:15 AM
52	Campfire sessions.	11/14/2016 4:23 PM
53	mobile app & some speakers were not relevant/waste of time	11/14/2016 3:19 PM
54	no espresso machine like 2015! :)	11/14/2016 2:12 PM
55	Some CE topics	11/13/2016 7:33 PM
56	Overall, very satisfied.	11/10/2016 4:53 PM
57	Quality of the courses and the conference seemed unorganized	11/10/2016 10:05 AM
58	none	11/10/2016 9:13 AM
59	ADA promotion of DRB refinancing student loans. The ADA should be working toward legislation to help the new dentist members.	11/9/2016 10:42 PM
60	Mindfulness course	11/9/2016 8:55 PM
61	None	11/9/2016 7:57 PM
62	Mobile app crashing	11/9/2016 7:25 PM
63	Too many courses on leadership	11/9/2016 6:00 PM
64	Thursday	11/9/2016 4:10 PM

New Dentist Conference at ADA 2016

Q18 Please include any additional comments you have about the New Dentist Conference at ADA 2016.

Answered: 18 Skipped: 46

#	Responses	Date
1	There should be opportunity for non NDC to register and join the lounge meeting	12/1/2016 7:12 AM
2	It was a great meeting, I hope to return in the future	11/30/2016 9:53 PM
3	the new dentist gathering at the brewery was fantastic!	11/30/2016 7:55 PM
4	Enjoyed networking and social aspect greatly. would like to include more clinical discussions	11/30/2016 4:58 PM
5	The app had bugs and needed an update almost immediately - that should have been corrected before the conference began. The Curtis hotel was OK - it was pricey for being average, and it was not as convenient as the delegate hotel. The conference was better when the meetings were held in the same hotel as people were staying (i.e. Kansas City).	11/23/2016 3:09 PM
6	Improved app use	11/22/2016 2:35 PM
7	When I signed up I didn't realize there were classes offered specific to the conference so I really didn't participate.	11/22/2016 1:34 PM
8	The NDC is very much geared to recent grads, less to those that have been out several years. This was my third conference attended, and I am finding less for the (older: 5-10 year out) new dentist every year.	11/21/2016 4:36 PM
9	Thank you	11/21/2016 4:00 PM
10	Great job planning, I understand this is a massive undertaking and it takes a lot of hard work. Kudos to you all!	11/21/2016 12:08 PM
11	n/a	11/21/2016 11:14 AM
12	I think the New Dentist Committee should be more engaging during the conference and organize evening social activities for attendees.	11/21/2016 10:37 AM
13	Need additional day of CE courses. Not everyone can get there on a Thursday unfortunately. Also, keynote speaker should be on Friday for same reason.	11/21/2016 10:23 AM
14	Thank you!!	11/21/2016 10:03 AM
15	The app kept crashing if you were logged in. it worked fine while logged out of it.	11/16/2016 4:22 PM
16	Please have better CE's that are more in-depth and worth while attending	11/16/2016 9:11 AM
17	This was my last official year to attend the conference. I graduated in 2007 from dental school but did not finish my educational process and enter private practice until December 2010. I had not decided to attend the conference until this year. I would recommend opening this up for those who have graduated from residency, possibly also up to 10 years out. It shifts the overall age demographic, but not the practice demographic. The speakers were very valuable. I enjoyed myself very much and would love the opportunity to visit at least one more year.	11/10/2016 4:53 PM
18	It's totally fine that the first day is about leadership, but it would have been a lot more beneficial to have the second day be strictly clinical. Maybe like basic reviews of endo/pedo/surgery and other topics that we might not deal with day to day as a new dentist.	11/9/2016 6:00 PM

Resolution No. N/A N/A

Report: Board Report 5 Date Submitted: August 2017

Submitted By: Board of Trustees

Reference Committee: A (Budget, Business, Membership and Administrative Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

1 **REPORT 5 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: COMPENSATION**
2 **AND CONTRACT RELATING TO THE EXECUTIVE DIRECTOR**

3 **Background:** This report is provided for informational purposes and does not include any resolutions. In
4 March 2015, the Board of Trustees executed a three-year employment agreement with the current
5 Executive Director, which expires on March 15, 2018. The Executive Director is the only member of the
6 ADA staff with a written employment contract.

7 **Compensation and Benefits:** The Executive Director's current annual base salary is \$558,502 and is
8 paid in accordance with the Association's standard payroll schedule and policies. The contract provides
9 that in March 2016 and March 2017, respectively, the Executive Director's annual salary shall increase
10 3% over the prior annual base salary. The current salary level was set in February 2017 based on the
11 contracted increase of 3% over the prior annual base salary of \$542,235.

12 The 2015 contract provides that the Executive Director is eligible to receive an annual bonus ranging from
13 0%-5% of her base salary, as determined by the Board, based upon criteria jointly approved by the
14 Executive Director and the Board, and subject to the availability of funds. In February 2017, the Executive
15 Director received a bonus in the amount of \$27,112 (5% of the 2016 base), based on the assessment of
16 2016 performance.

17 The Executive Director is entitled to the fringe benefits offered during the term of this Agreement to
18 similarly situated Association employees having her length of service in the employ of the Association;
19 provided, however, that such fringe benefits do not include "Severance Pay" under the ADA Employee
20 Handbook or any other ADA policy or procedure relating to severance pay because such severance pay
21 is covered by the terms of the employment contract.

22 The 2015 contract provided additional fringe benefits including a \$15,000 annual contribution to the
23 Great-West Variable Annuity Plan; a parking space in the Association Headquarters building; the
24 reimbursement of reasonable, substantiated expenses incurred to purchase and maintain a membership
25 in one city or athletic club in the Chicago area; one cellular telephone, reasonable expenses for spousal
26 travel to the Association's annual session and any other required spousal travel consistent with the ADA
27 Board's spousal travel policy in effect at the time; and membership dues in professional associations up
28 to \$5,500 (except for the dues of the American Dental Association and its constituent and component
29 dental societies).

30

1 **Resolutions**

2 This report is informational and no resolutions are presented.

3 **BOARD RECOMMENDATION: Vote Yes to Transmit.**

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

Resolution No. None N/A

Report: Board Report 8 Date Submitted: August 2017

Submitted By: Board of Trustees

Reference Committee: A (Budget, Business, Membership and Administrative Matters)

Total Net Financial Implication: 0 Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 2: Net increase of 4,000 active licensed members by end of 2019

How does this resolution increase member value: Not Applicable

1 **REPORT 8 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:**
 2 **MEMBERS FIRST 2020 STRATEGIC PLAN CHANGE**

3 **Background:** The Board has previously posted its revision to the ADA's strategic plan, Members First
 4 2020, on ADA.org in December. This report will further explain that change and its benefits.

5 As part of the ongoing responsibility of the Strategic Planning Committee to monitor the strategic plan, the
 6 Board has modified one of the plan objectives. Objective 2, under the membership goal of Members First
 7 2020, had previously stated:

8 “ADA’s member market share will be 70% or greater of active licensed dentists”
 9

10 In its evaluation of this objective, the Board noted that the ever changing market size made it difficult to
 11 set strategic membership targets based on a percentage of that fluctuating market. This is particularly
 12 true at the state level. In an expanding market, even a gain in members may result in a flat or declining
 13 market share. On the other hand, in a decreasing market, a flat or growing market share could mask an
 14 actual loss in membership. Rather than chasing after ever shifting targets, the Board decided to amend
 15 the objective to focus on net member gains of active licensed dentists, as opposed to market share. The
 16 new objective is:

17 “Achieve a net increase of 4,000 active licensed members by the end of 2019”
 18

19 In addition, the Board adopted several subsidiary numerical targets which will allow the Board to better
 20 manage under the plan and to know what will be necessary to meet this objective. These subsidiary
 21 targets are more granular and will help us target our efforts. They are:

- 22 • The Reduce Full-Dues-Payer non-renews to 4%
- 23 • Increase net number of New Dentists by 1,500 each year
- 24 • Increase net number of Women Dentists by 1,500 each year
- 25 • Increase net number of Ethnically Diverse dentists by 1,250 each year

26
 27 The results from 2016 demonstrate that we are moving in the right direction in meeting the new objective.
 28 In 2016, we gained a net of 1,276 members. Last year’s results also demonstrate the validity of the
 29 subsidiary targets. With such a gain in total membership, we would expect similar positive results for the
 30 subsidiary targets. In fact, we gained in all but one of these targets:
 31

- 1 • Non-renews - dropped to 4%
- 2 • New Dentists - +2185
- 3 • Women - +1633
- 4 • Ethnic Diverse - (143) a loss of 143 members
- 5

6 The Board will, of course, continue to monitor progress under Members First 2020 and the new objective
7 and subsidiary targets will help it do so more effectively.

8 **Resolutions**

9 This report is informational and no resolutions are presented.

10 **BOARD RECOMMENDATION: Vote Yes to Transmit.**

11 **BOARD VOTE: UNANIMOUS.**

Resolution No. 22-23 New

Report: Board Report 2 Date Submitted: August 2017

Submitted By: Board of Trustees

Reference Committee: Budget, Business, Membership and Administrative Matters

Total Net Financial Implication: <u>\$134</u>	Net Dues Impact: <u>No change</u>
Amount One-time _____	Amount On-going _____ FTE <u>427.8</u>

ADA Strategic Plan Objective: 2018 Budget Supports All Strategic Plan Objectives

How does this resolution increase member value: Not Applicable

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REPORT 2 OF THE BOARD OF TRUSTEES: 2018 BUDGET

Contents

- 1. [Summary](#)
- 2. [Introduction: Overview of ADA Budget Process](#)
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- 4. [Budget Changes and Other Key Decisions](#)
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- 6. [Projected Reserve Levels and Funding the Three-Year Initiative to Drive Utilization of Dental Services for ADA Members](#)
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- 8. [Headquarters Building Valuation](#)

I. Summary

All dollar figures are in thousands with unfavorable variances in parentheses.

In accordance with its *Bylaws* duties, the Board of Trustees presents the proposed 2018 operating budget for the Association. The Board of Trustees is recommending a 2018 operating budget of \$130,787 in revenues and \$130,653 in expenses and income taxes, generating a surplus of \$134. Long term uncommitted reserves at the end of 2018 are projected to be at the target of 50 % of operating expenses, assuming a \$6,000 expense for the initiative to drive utilization of dental care and \$3,100 in

1 revenue from an associated special membership assessment. In addition, 2018 royalty revenue from
2 the ADA Members Insurance Plans is projected to contribute \$6,800 to the Royalty Reserve.

3 The Royalty Reserve is dedicated to member value and long term dues and financial stabilization as
4 urged by the House of Delegates Resolution 84H-2013 and Board action. In arriving at this proposed
5 2018 budget, the Board of Trustees analyzed budget requests relative to the Association's strategic
6 priorities, as directed by the 2011 House of Delegates in resolutions 44H-2011 and 12 52H-2011
7 (*Trans.*2011:444;445). Resources were allocated between programs and divisions in an effort to
8 maximize their effective use in executing the ADA's Strategic Plan for 2015-2020. No national dues
9 increase is included in the 2018 proposed budget.

10

11 **II. Introduction: Overview of ADA Budget Process**

12

13 **Introduction to new information included in this year's edition of Board Report 2**

14 Although the primary purpose of this report is to present the proposed operating budget for the next
15 fiscal year, new information has been added to address recent initiatives adopted at the 2016 ADA
16 House of Delegates.

17 Because the House of Delegates passed resolution 67H-2016, a Three-Year Initiative to Drive Utilization
18 of Dental Services for ADA Members, to be funded from reserves in the first year, 2017, and funded at
19 the discretion of the Board of Trustees in the second and third years, 2018 and 2019, this report includes
20 a review of the ADA's projected reserves as a source of funding this initiative. While the action to fund
21 part of this initiative through a special assessment will come through a separate resolution similar to
22 membership dues, the analysis of this funding approach is inherently linked to the complete picture of
23 the ADA's projected financial position and therefore appropriate to include in this report on the 2018
24 budget. A benefit of this additional information is that this new analysis of the ADA's projected 2018
25 reserve balances combined with the proposed 2018 budget that includes non-dues revenue sources
26 effectively provides a full view each objective of the ADA's 2020 financial strategic plan goal.

27

28 **Budget Approach and Strategic Plan Goals**

29 First, it is important to recognize that the budget presented in this report is the result of the combined
30 efforts of many volunteers and staff over many months that has built on process improvements resulting
31 from suggestions over many years. Engagement of its Councils in development of Council priorities is
32 one important way that the House fulfills its fiduciary duty to review and approve the budget. Although
33 there weren't many proposed changes that affected Councils included in the proposed 2018 budget,
34 again this year Council leaders received the first draft of this report in advance of the Board's review
35 meeting to enable input to the Board's discussions before the vote to approve the final budget sent to
36 the House. Many thanks are due to everyone who contributed to both the content and process
37 improvement suggestions during development of the 2018 budget.

38 The 2018 budget represents the fourth year of the Members First 2020 five year Strategic Plan. This
39 strategic plan consists of:

- 40 • Three **Goals** which are basically fixed,
- 41 • Six **Objectives** that can be adjusted if met or if major changes in conditions require it, and
- 42 • Ten **Strategies** which need to be revisited regularly and prioritized.

43 Using this framework, an annual review of the Strategic Plan in advance of the financial budgeting
44 process considered priorities based on organizational needs to focus on long term goals and objectives,

1 updated environmental scanning, as well as input from senior staff to revisit priority strategies that
2 may result in a proposal to amend strategies found in Members First 2020.
3 Again this year, two of the six stated objectives in the Member First 2020 plan, member market share
4 and non-dues revenue, pose significant challenges under current conditions. After many years of
5 continued erosion in active, full dues membership, the most important priorities for 2018 were
6 reassessed.

7
8 The ADA Mission Statement is “Helping all members succeed.” ADA Core Values related to the mission
9 include:

- 10 • Commitment to Members
- 11 • Integrity
- 12 • Excellence
- 13 • Commitment to the Improvement of Oral Health
- 14 • Science/Evidence–Based

15
16 The current strategic plan consists of the following high level goals and objectives as follows:

17
18 **Membership Goal: The ADA will increase member value and engagement.**

19 Objective 1: The public will recognize the ADA and its members as leaders and advocates in oral health.

20 *1.1 Align public awareness efforts across the tripartite concerning oral health issues*

21 *1.2 Position ADA membership as a positive differentiating factor for patients*

22 *1.3 Promote oral health through advocacy and science*

23 Objective 2: Achieve a net increase of 4,000 active licensed members by the end of 2019.

24 *2.1 Focus the message to connect with individual members, potential members and key market*
25 *segments*

26 *2.2 Design unique member outreach and benefit programs targeting dental students and new*
27 *dentists*

28 Objective 3: ADA will achieve a 10% increase in the assessment of member value from membership.

29 *3.1 Pursue programs that members value and are “Best in class.”*

30
31 **Finance Goal: The ADA will be financially sustainable.**

32 Objective 4: Unrestricted liquid reserves will be targeted at no less than 50% of annual operating expenses.

33 *4.1 Budget for a surplus consistently year to year*

34 Objective 5: Non dues revenue will be at least 65% of total revenue

35 *5.1 Develop cooperative ways to increase non-dues revenue across the tripartite*

36 *5.2 Increase member utilization of existing products and services and pursue new markets*

37
38 **Organizational Capacity Goal: All levels of the ADA will have sufficient organizational capacity**
39 **necessary to meet member needs.**

40 Objective 6: The roles and responsibilities of each element of the tripartite will be clearly defined and agreed
41 upon.

42 *6.1 Simplify, standardize and rationalize how each level of the ADA operates and delivers programs*
43 *and services and interacts with members, acting in the best interests of the member rather than the*
44 *organization*

45
46 **Another Input to the Process: Program Assessments Using McKinley Survey Results**

47 Similar to last year, the use of program assessment criteria tied to goals was integrated into survey
48 questions to provide member input to the process and add to the framework for common
49 understanding of program prioritization. Again, all ADA divisions, working with councils, defined a list

1 of programs that represents its work product, i.e. what the division accomplishes that creates member
2 value. This list of programs may include new initiatives for review against existing programs carried
3 forward from the prior budget year to focus on the ADA's strategic plan priorities.
4 The assessment criteria were consistent with last year's survey criteria. Grass roots dentists were again
5 the primary focus of surveys but volunteer council leaders were also added this year to provide a
6 comparison of customer perceptions. This member focused survey approach continues to provide a
7 good connection to strategic plan goals but in this second consecutive year, the big question was
8 whether we would see significantly different results. To maintain consistency, McKinley Advisors, the
9 same consultant used last year, was selected to conduct dentist surveys designed to collect our general
10 member and non-member perspectives on our programs.

11
12 Identical to last year, survey questions first asked about a respondent's awareness of a program, and
13 only then would they be presented with questions on their personal usage of the program. Dentists
14 who had used direct member benefit programs or were aware of programs that interface with third
15 parties were then asked about their satisfaction with the results. Lastly, all dentists were provided
16 with a short description of the program and asked to rate the value and impact of the program on their
17 decision to join the ADA. The survey results summarized for prioritization were focused on those
18 member value metrics.

19
20 Similar to universal assessment criteria scores in prior years, this survey data is only one input to the
21 budget prioritization process. Other inputs include:

- 22 1. Alignment of programs with ADA 2020 Strategic Plan Priority Strategies to:
 - 23 a. Fill the Pipeline
 - 24 b. Focus the Message
 - 25 c. Simply and Standardize processes
- 26 2. Net Costs or Revenue generated by program (to support a balanced budget).
- 27 3. Council Leader input – such as:
 - 28 a. ADA risk of not doing the program in 2017,
 - 29 b. House resolutions that, directly or indirectly, require the program,
 - 30 c. Any other factors that should be considered by the Board before a final decision.

31
32 The results of the 2017 McKinley Survey will be posted to the House of Delegates for reference. The
33 summary of 2017 results also includes the 2016 scores for comparison. Many key findings from the
34 survey were similar to last year with ADA value indicated from activities that provide support for
35 professional development and business in direct and tangible ways. Following are a few excerpts from
36 this year's study:

- 37 • ADA's advocacy work was also considered a top priority, including programs that address core issues
38 which may affect dentists' day-to-day work such as regulation, public education and insurance. The
39 findings reflect trends observable in this year's study, as well as the initial wave of research
40 conducted in 2016.
- 41 • ADA activities that support and meet professional development and networking needs continue to
42 rank as "high" or "medium-high" priorities. And those activities' survey results generally improved in
43 value, impact and/or satisfaction since the previous year.
- 44 • ADA efforts that impact dentists' day-to-day practice and business continue to be part of the
45 association's core-value proposition. Programs that fall into this category support administration,
46 provide a competitive advantage, or support patient service. Efforts affecting the profession are also
47 important such as those supporting industry standards and regulation.

- 1 • Council members indicate high levels of support for ADA activities, but mirror dentists in general
2 perspective. Council members rate very few programs as having negative value scores (i.e., less than
3 average “value” rating), but they view programs similarly to dentists.
4

5 While this study was a reference point to this year’s budget process, the fact that results were not
6 dramatically different from last year’s study meant that this was not a big driver of changes in the 2018
7 budget compared to the 2017 budget.
8

9 **The Continuing Need for Innovation**

10 Building on concepts identified in planning over the past several years, the ADA has continued to focus
11 on innovation. Consistent with prior years, this budget again proposes setting aside up to \$1 million
12 from reserves, subject to the approval and oversight of the Board, to support innovation projects.
13 Although a more structured innovation process identifies new ideas, explores potential value to
14 members, and evaluates the feasibility of new products and/or services to decide if the new idea meets
15 long term goals under the oversight of a Business Innovation Committee of the Board, this year the
16 Board has authorized a broader and deeper review of the whole ADA business model. This study led by
17 frog, a design firm, is likely to yield recommendations which could significantly change the focus of the
18 Association in future years. However, the business model review is still underway and, as a result, has
19 virtually no impact on the proposed 2018 operating budget. The project and continued focus on
20 innovation is critical to the generation and cultivation of new sources of non-dues revenue to support
21 the 2020 strategic plan objective.
22

23 **Designated Reserve Contributions, Surplus Budgeting, and Use of Reserves**

24 In addition to the annual operating budget, this report also includes a projection of planned
25 contributions to reserves and anticipated spending plans. The capital replacement reserve contribution
26 represents a provision for the future repair and replacement of large and infrequent capital projects.
27 Setting aside these funds in consistent amounts tied to depreciation less the total cost of smaller
28 operating capital projects during each annual budget cycle enables the ADA to avoid special assessments
29 which supports the goal of dues stabilization. Estimates for planned 2018 capital reserve spending
30 projects subject to designated board review and approval are also included.
31

32 In addition, royalty revenue from ADA Members Insurance Plans is also planned for transfer to a
33 designated reserve and *is not included in the calculated net surplus/(deficit) in the ADA operating budget*.
34 This Royalty Reserve is set aside to build member value and long term dues and financial stabilization as
35 directed by the House of Delegates Resolution 84H-2013 and Board action.
36

37 While the strategic plan strategy to strive for surplus budgets supports the accumulation of reserves, a
38 long term perspective on the financial stability of the Association should also consider strategic
39 investments – especially during periods of high investment values. Related to this, it should be noted
40 that, in the ADA’s budget basis income statement presentation, the ADA’s annual contributions to
41 reserves represent additional surplus. For example, if the royalty from the ADA Members Insurance
42 Plans now reported as a component of revenue was not transferred to the Royalty Reserve, then the
43 ADA would report a larger surplus driven by the \$6.8 million of royalties expected in 2018. The House
44 suggested this royalty recognition and reserve process to avoid automatically enabling increased

1 spending in the ADA's annual operating budget and to ensure that decisions on spending of the Royalty
2 Reserve would be kept separate from the determination of the annual royalty from the ADA Members
3 Insurance Plans. In this way, the ADA would not become dependent on royalties from the plan.
4 However, to realize the intended purpose for the reserves, there must be a common understanding
5 and a will to spend from reserves when it's appropriate.
6

7 **Financial Budget Development, Review and Approval Process Overview**

8 The ADA *Bylaws* charge the Treasurer with design of the budgetary process in concert with the Board of
9 Trustees, oversight of the Association finances and development of a budget for approval by the House
10 of Delegates. The overall planning process stretches over more than a year due to: multiple layers of
11 volunteer involvement; the timing of council, committee and Board meetings; and the *Bylaws*
12 requirement that the House be informed of the budget and membership dues 30 days before the annual
13 session.
14

15 *Initial Budget Development:* ADA management is tasked by the board to draft a budget in the best
16 interests of the Association that increases ADA net assets. Using the data gathered in the initial
17 planning process, each ADA division began the budget process by creating draft budgets based on
18 its portfolio of programs that support strategic priorities. At this stage, budget work is initiated by
19 division staff and, from the start, staff are directed to engage ADA councils, committees and
20 commissions in the budget process to help set direction and priorities.
21

22 The ADA deployed a new budgeting system this year, cloud based Adaptive Planning, achieving
23 more than a 50 % cost savings versus the old system while simplifying budgeting for department
24 managers, creating new reports, and directly integrating with the Human Resources system. In
25 order to create realistic budgets, the Executive Director and Chief Financial Officer provided each
26 division with "starting point" 2018 financial benchmarks and required that any proposed spending
27 above the goal be identified separately with a written explanation. Next, staff input the initial draft
28 budgets into the Adaptive system with expense required to equal the assigned benchmark,
29 excluding any proposed new spends that had been identified separately. Isolation of the proposed
30 new spends gave clear visibility and increased scrutiny to any proposed increase. Only later in the
31 process were any approved new expenditures allowed to be input into the Adaptive Planning
32 system.
33

34 *Internal Budget Reviews:* As always at this first step in the financial budget process, the first rollup
35 reflected a net deficit because it included all "wishlist" items from every group. Yet the ADA Board of
36 Trustees has directed the ADA Senior Management Team to submit balanced budgets with
37 recommendations for the Board's review and rationale for all decisions. As a result, the next filter for
38 prioritization of funding decisions was how the organization can identify synergies and reduce costs to
39 deliver the same or similar results through cross-functional collaboration. This final filter reflects "what
40 we can forward" in 2018 to deliver results and revenues on the path to long term growth.
41

42 It should also be noted that once the budget is balanced through review and revision, the initial draft
43 does not assume any dues increase. Although financial analysis of actual results shows that ADA
44 expenses have been growing faster than revenues, one driver of this trend has been the absence of

1 dues increases for several years. Although there was a dues increase for FY 2017, we had 3 years with
2 no dues increases. While this provides pricing stability for members, several years with no dues serves
3 as a self-limiting strategy that takes resources away from the ADA that deliver programs.

4
5 The Executive Director and Chief Financial Officer then held budget review meetings with division vice
6 presidents as a group to: evaluate the reasonableness of proposed budgets, identify synergies across the
7 ADA, provide oversight on expenditure effectiveness, and make decisions to prioritize spending for a
8 draft budget that's in the best interests of the ADA that increases net assets. After initial budgets were
9 updated in Adaptive to reflect management decisions, a recommended budget was prepared for the
10 ADA Budget and Finance Committee for its review and approval.

11 As part of this process:

- 12 1) All proposed budget changes which materially reduce funding or that add costs compared
13 to levels included in the prior year House-approved 2017 budget were documented with the
14 rationale for each recommended change.
- 15 2) Once the draft budget with detail is submitted to the Budget & Finance Committee, the
16 committee invited some councils to discuss specific programs that may be affected by
17 proposed changes.

18
19 Before the Budget and Finance Committee met for its formal budget review, the ADA Treasurer, the
20 Executive Director, and ADA Financial management reviewed all budget materials in detail. This helped
21 to identify some of the more substantive issues to be considered at the subsequent Committee meeting.
22 In advance of its meeting, the Budget and Finance Committee was provided with budget reports that
23 included detailed itemization of every proposed change in the 2018 budget versus the 2017 budget, and
24 trends in revenues, expenses, and reserve funds under alternative budget scenarios. The Budget &
25 Finance Committee was also provided the following for every program: revenue, staff full time
26 equivalent employees (FTE), expense including staff time, as well as consolidated ADA budget financial
27 statements versus prior year actual and budget.

28
29 *Budget and Finance Committee Review:* Led by the Committee Chair and Treasurer, the Budget and
30 Finance Committee discussed and modified the 2018 budget so that its budget recommendations
31 could be summarized into the first draft of Board Report 2 which would then be sent for review by
32 the Board. Two House members also serve on the Committee and play an invaluable role in the
33 analysis of the proposed budget. It should be noted that this group is essentially the same as the
34 Administrative Review Committee in the prior year's process because it is led by the Treasurer. This
35 name change was only made to simplify board governance since the Admin Review Committee was
36 originally set up as a subcommittee of the Budget and Finance Committee through the Organization
37 and Rules of the Board of Trustees. This meeting is a milestone in the budget process and is where
38 the responsibility for developing the budget passes from management to the Budget and Finance
39 Committee. Similarly, once the proposed 2018 budget reflecting changes approved by the Budget
40 and Finance Committee is sent to the Board, responsibility for refinement of the budget passes from
41 the Budget and Finance Committee to the Board.

42 Based on many inputs, the Budget and Finance Committee reviewed and adjusted resources across
43 divisions in a way that optimizes the Associations' total portfolio of programs. Final budget

1 decisions are always in the hands of the ADA's volunteer leaders, who may also consider other
2 factors.

3
4 Once the first draft of Board Report 2 was completed and approved to be sent for Board review, it
5 was also posted for Council leaders as well. This was introduced as a completely new step in the
6 process last year that was intended to make the Board's budget review more open to input before
7 the Board votes on the final budget that is sent to the House of Delegates. The Treasurer and
8 appropriate Finance staff were also available to review all recommended changes to the budget
9 with the appropriate Council Leadership, as requested. In doing so, Council leaders are provided an
10 opportunity to discuss proposed budget changes with the Council's Board Liaison and, if needed, the
11 rest of the Board Members before the final vote. In this way, the Board has removed barriers to
12 communication during the budget review process.

13
14 Board of Trustees Review: Based on the work of the Budget & Finance Committee, the Finance
15 Division staff developed the next iteration of the draft budget for review by the full Board. Budget
16 summaries, including background on the Budget & Finance Committee's view of the merits of
17 proposed programs, were then prepared for the full Board of Trustees. In addition to the written
18 material, the Treasurer provided guidance and comment to the Board. The Board thoroughly
19 reviewed the work of the Committee and its recommendations, questioned staff on specific issues
20 in the budget and discussed input received by the councils' trustee liaisons.
21 The Board reviewed, made changes, and approved its recommended budget which is now
22 forwarded to the House.

23
24 After the Board approved the recommended budget, the Treasurer was available, as necessary, to
25 meet with Council chairs to discuss the rationale for the Board's decision. At this point in the process,
26 it should be noted that the 2018 budget review and prioritization of resources in support of
27 strategic priorities represents a considerable expenditure of time and effort to arrive at a
28 recommendation. House resolutions passed after this budget process do not go through this same
29 review and prioritization process. However, it is hoped that the House of Delegates, at its annual
30 session, will share this high level view of the ADA and that all resolutions introduced will also be
31 reviewed and prioritized with consideration of the same criteria.

32
33 With this background, it should be noted that this 2018 budget represents the estimates of ADA revenue
34 and expenses to deliver the listed programs and services based on the best information and assumptions
35 available at the time these detail budgets were created and built into the ADA budget in mid-2017. As a
36 result, it is very possible that some estimates or assumptions could change based on new information
37 that becomes available closer to the start of the budget year. If that new information results in
38 significant, quantifiable impacts to the 2018 budget, then those will be reported by the Treasurer to that
39 House at the annual session as possible amendments to the budget subject to the discretion of the
40 House. Unfortunately, potential changes are an inherent risk of the ADA's current budget process due to
41 this long timeline. Some budget estimates made long before the start of the budget period may be less
42 accurate than those that are built later.

43

1 *House of Delegates Review and Final Approval:* In accordance with its *Bylaws* duties, the Board of
2 Trustees presents the preliminary annual operating budget for the Association to the House of
3 Delegates through this document, Board Report 2. This background commentary and any analysis
4 provided, together with Reference Committee testimony and the Reference Committee
5 recommendations, serve as the basis for the House approval of the budget at its Annual Meeting.
6 Following budget approval, resources may be reallocated between programs and divisions as required,
7 in an effort to maximize their effective use in executing the ADA's Strategic Plan.
8 If not funded in the draft budget, councils or caucuses may propose new initiatives which may have a
9 financial impact by sending resolutions to the House of Delegates. State dental societies, trustee
10 districts, the American Student Dental Association, as well as the branches of the federal dental
11 services, may also submit resolutions which have a financial impact to the House of Delegates.

12
13 Requests to fund programs that were in the prior year's budget are handled differently than new
14 programs. Programs that were funded in the 2017 budget but recommended for elimination or cost
15 reduction by the Board in the 2018 budget as reflected in Board Report 2 require that the requestor
16 refer the entire budget back to the Board for reconsideration with a recommendation to change that
17 specific item. If the House votes to refer the budget back to the Board for revision is passed, the Board
18 will then meet separately during the annual meeting to decide on the change. The Board could adopt
19 the change but also make other adjustments to pay for the program or vote to resubmit Board Report
20 2 to the House with no changes. After more testimony, the House could then a) vote again to either
21 accept the budget or b) refer the budget back the Board again and this process would continue until
22 the House approves a budget.

23
24 If approved by House vote, new resolutions for program spending would then be added into the
25 budget and would have to be funded. The final actions of the House of Delegates at each annual
26 session are:

- 27 1) Approval of the next year's annual operating budget, and
- 28 2) Approval of the dues, and
- 29 3) Approval of a special assessment, if any.

30

31 **Conclusions**

32 The proposed 2018 budget has been built through a rational and systematic process that is focused on
33 strategic priorities on a path to long term goals. This report is intended to document the careful
34 consideration of many inputs including collaboration with many subject matter experts and stakeholders
35 in a transparent budget review process.

36 This budget is not only the end result of this year's process, it is also an outcome of many years of
37 change built upon the input of many volunteer leaders, key stakeholders, and prior efforts to improve
38 the ADA. During this time, there have been many key learnings that were earned through hard work to
39 drive process improvements. One change proposed this year is a Board proposal to amend 44H-2011
40 (*Trans.2011:444*) to better reflect the Association's improved budget processes. 44H-2011 called for
41 universal assessment criteria to serve as single tool to review all programs. At the time, it represented
42 the best effort to assure that the Association's programs were rigorously assessed as part of the
43 budget process. The Board is proposing rescinding 44H-2011 and replacing it with new policy more

- 1 reflective of the Association's more developed budget process. See Report 6 of the Board of Trustees
- 2 to the House of Delegates: Program Assessment Criteria.

1

2 **III. Operating Budget**

3 The following table presents a summary of the proposed 2018 budget.

ADA Operations Statement of Activities

Excludes Reserve Spending (Busyness Initiative, Frog, etc.) and Reserve Revenue (Insurance Royalties, Appreciation of Financial Assets)

Condensed Income Statement

Millions of Dollars

	2015	2016	2017 Budget	2018 Budget	2018 v 2016		2018 v 2017B	
					Fav / (Unfav)		Fav / (Unfav)	
					\$	CAGR %	\$	%
Membership Dues Revenue	55.6	54.5	55.9	55.2	0.7	0.7%	(0.7)	-1.2%
Non Dues Revenue	71.6	73.5	78.7	82.4	8.9	5.9%	3.7	4.7%
Remove Ins. Royalty Revenue	(6.5)	(6.5)	(7.0)	(6.8)	(0.3)	-2.1%	0.2	2.9%
Total Revenue	120.7	121.5	127.6	130.8	9.3	3.7%	3.2	2.5%
Employee Costs	56.4	58.3	59.3	63.1	(4.8)	-4.2%	(3.8)	-6.5%
Non-Employee Costs	61.7	61.5	66.3	66.3	(4.8)	-4.0%	(0.0)	-0.1%
Taxes	1.6	1.3	1.7	1.3	(0.0)	-1.4%	0.4	21.4%
Total Expenses & Taxes	119.7	121.1	127.3	130.7	(9.6)	-4.0%	(3.4)	-2.7%
Net Before Reserves	1.0	0.4	0.3	0.1	(0.3)		(0.2)	

7

- 8 The budget projects revenue growth of 2.5 % versus the 2017 budget, including growth in non-dues
9 revenue partially offset by declines in membership dues revenue. The ADA 2018 budget has the same
10 number of employees as the 2017 budget, but growth in employee benefits costs and employee
11 compensation rates drive total expenses and taxes to be 2.7 % higher than the 2017 budget.
12 The following table presents the 2018 budget by account group.

ADA Operations Statement of Activities

Excludes Reserve Spending (Busyness Initiative, Frog, etc.) and Reserve Revenue (Insurance Royalties, Busyness Special Assessment)
Thousands of Dollars

	2015	2016	2017 Budget	2018 Budget	2018 v 2016		2018 v 2017B	
					Fav / (Unfav)		Fav / (Unfav)	
					\$	CAGR %	\$	%
Membership Dues	55,627	54,476	55,869	55,199	723	0.7%	(670)	-1.2%
Advertising	6,386	6,223	6,436	6,537	313	2.5%	101	1.6%
Rental Income	3,676	4,055	5,791	6,837	2,783	29.9%	1,046	18.1%
Publication and Product Sales	6,220	6,449	6,837	6,932	483	3.7%	95	1.4%
Testing Fees & Accreditation	23,554	25,110	26,848	27,387	2,277	4.4%	539	2.0%
Meeting & Seminar Income	8,422	8,049	8,942	9,652	1,603	9.5%	710	7.9%
Grants, Contributions, Sprship	1,717	1,395	1,343	1,437	42	1.5%	94	7.0%
Royalties	16,045	17,033	17,303	17,705	673	2.0%	402	2.3%
Investment Income	1,632	2,058	1,500	1,800	(258)	-6.5%	300	20.0%
Other Income	3,896	3,147	3,768	4,100	954	14.2%	333	8.8%
Remove Insurance Royalties	(6,457)	(6,520)	(7,000)	(6,800)	(280)	2.1%	200	-2.9%
Total Revenue	120,717	121,474	127,637	130,787	9,313	3.8%	3,151	2.5%
Salaries and temporary help	42,952	43,845	44,731	46,554	(2,709)	-3.1%	(1,824)	-4.1%
Fringe Benefits	13,467	14,442	14,533	16,583	(2,142)	-7.7%	(2,051)	-14.1%
Consulting Fees & Outside Svcs	9,781	9,427	10,250	9,340	87	0.5%	910	8.9%
Print., Publicat. & Marketing	7,968	8,493	9,642	9,324	(831)	-5.0%	318	3.3%
Meeting Expenses	2,623	2,443	2,543	3,219	(776)	-17.4%	(676)	-26.6%
Travel Expenses	6,930	6,426	7,202	6,937	(511)	-4.1%	265	3.7%
Professional Services	8,526	9,037	9,063	9,456	(419)	-2.3%	(393)	-4.3%
Bank & Credit Card Fees	1,279	1,409	1,338	1,411	(2)	-0.1%	(73)	-5.5%
Office Expenses	5,150	4,491	4,775	5,036	(545)	-6.3%	(261)	-5.5%
Facility and Utility Costs	5,642	5,869	6,017	6,310	(440)	-3.8%	(293)	-4.9%
Grants and Awards	2,574	2,516	2,468	2,627	(112)	-2.2%	(160)	-6.5%
ADA Health Foundation Grant	2,320	2,361	2,629	2,200	161	3.4%	429	16.3%
Endorsement Costs	1,246	1,391	1,354	1,408	(17)	-0.6%	(54)	-4.0%
Depreciation and Amortization	6,398	6,325	6,988	7,098	(773)	-6.3%	(110)	-1.6%
Other Expenses	1,233	1,360	2,135	1,825	(464)	-18.8%	310	14.5%
Total Expenses	118,089	119,835	125,665	129,327	(9,492)	-3.9%	(3,662)	-2.9%
Income Tax Expense	1,639	1,251	1,650	1,326	(75)	-3.1%	324	19.6%
Net Income	989	389	322	134	(254)		(188)	
Depreciation	6,398	6,325	6,988	7,098				
Operating Capital Expenditures	(2,609)	(3,223)	(2,407)	(2,858)				
Contribution to Capital Reserve	(4,462)	(2,118)	(4,581)	(4,240)				
Operating Surplus	316	1,373	322	134				

1 The above financial summary compares the proposed 2018 budget against prior actual results and
2 budgets. The operating surplus / (deficit) as defined by the House of Delegates is shown at the bottom
3 of the schedule. The House of Delegates created the capital replacement reserve fund beginning with
4 the 2014 budget. The amount of the contributions to the capital replacement reserve fund is
5 determined by the excess of budget depreciation over the operating capital expenditures. This
6 assumes that over a multi-year period depreciation is a rough indicator of the future capital
7 expenditures that will be required to replace ageing assets.

8 9 **Changes in 2018 Budget Versus 2017**

10 **Revenues**

11 Total revenues in the 2018 budget are \$137,587, or \$130,787 excluding the royalties from the ADA
12 Members Insurance Plans. Highlights of various revenue categories are provided below.

13
14 Membership Dues: The Division of Member and Client Services estimates the future membership levels
15 for each of 28 dues paying categories and multiplies by the 28 dues rates. The 2018 budget anticipates
16 182,746 members, of which 85,292 will pay full dues of \$532 per year. The average dues rate per
17 member is \$302 per year including discounts such as Active Life and Recent Graduate. These figures do
18 not reflect any dues increase nor the proposed special assessment.

19
20 Advertising: This category primarily includes advertising sales in ADA publications, electronic media, and
21 secondarily, banner advertising at the America's Dental Meeting. The 2018 revenue of \$6,537 is a \$ 101
22 or 2 % increase from 2017 budget. This positive variance is attributable to an increase in digital
23 advertising.

24
25 Rental Income: This revenue category primarily includes rental income from the Chicago Headquarters
26 and Washington DC Buildings. Revenue of \$6,837 is an increase of 18 % from 2017 budget. Both
27 buildings are 100% leased. Lurie Children's Hospital leased five floors in the Chicago building and moved
28 into the space in June 2017.

29
30 Publication and Product Sales: The category is anticipating a minimal increase of \$95 or 1.4 %. An
31 increase is forecasted as a result of more products being offered using digital delivery platforms and
32 selling more products at dental conferences. Partially offsetting the increase is a \$(100) reclassification
33 from this category to Other Income related to revenue in the Division Conferences and Continuing
34 Education.

35
36 Testing Fees and Accreditation: This category continues to be the ADA's largest source of non-dues
37 revenue. Revenues from testing and accreditation fees are expected to rise by \$539 or 2 % versus 2017
38 budget. 2018 budget includes incremental fee increases in National Board exams, Dental Admission test
39 and Optometry Admissions test. Additionally, Credentialing Verification Services which is a new program
40 added \$150 of revenue.

41
42 Meeting and Seminar Income: Most of the \$710 or 8 % increase is due to incentive from the Hawaii
43 Convention Bureau totaling \$1.5M. Additionally, ticket sales are being increased based on historical

1 actuals. Partially offsetting these increases are declines in exhibit fees, advertising revenue and product
2 sales due to smaller convention hall in Hawaii.

3
4 Grants, Contributions, and Sponsorships: Grants, contributions, and sponsorships are projected to
5 increase by \$94 or 7 %. Sponsorship/contribution revenue increases will be realized in Evidence Based
6 Dentistry, Center for Professional Success and the Recognition of Dental Specialties and Certifying Boards
7 program.

8
9 Royalties: Includes royalties received from the *ADA Business Resources* program, *CDT* licenses, domestic
10 and international product licenses, selling of mailing lists and *JADA* royalties to be paid by Elsevier. This
11 category is projected to increase by \$402 or 2 % in 2017. The variance is due to a \$550 increase in
12 royalties from *ADA Business Resources* programs. Partially offsetting the increase is a \$200 decline in
13 royalty income from the *ADA Members Insurance Plans*.

14
15 Investment Income: A projection for revenue of \$1,800 for 2018 includes both interest and dividends on
16 reserve fund assets and investment earnings on cash in the operating account. The increase of \$300 is
17 an attempt to bring 2018 revenue forecast more in line with 2016 actuals. These amounts fluctuate
18 annually.

19
20 Other Income: This category is composed of miscellaneous revenue, including such items as overhead
21 reimbursement from subsidiaries and the *ADA Members Insurance Plans*, Seal Program revenues, Health
22 Policy Institute performing work for external clients and miscellaneous income from continuing
23 education. The \$333 increase is largely attributable to \$100 being reclassified from Publication and
24 Product Sales in the Division Conferences and Continuing Education, \$132 increase in overhead recovery
25 in the Division of Central Administration and \$75 in revenue budgeted related to groups renting the *ADA*
26 Townhouse in Washington D.C.

27 28 **Expenses**

29 Total operating expenses are budgeted at \$129,327, an increase of \$(3,662) or (2.9) % versus the 2017
30 budget.

31
32 Highlights of various expense categories are provided below.

33
34 Salaries (Base Compensation): Base salary expenses are budgeted at \$44,729 which is unfavorable by
35 \$(1,311) or (3) % from the 2017 budget. As shown in the table below under “*ADA Employee Staffing*”,
36 the number of full time equivalent employees at year end is projected at 428, which is equal to the 2017
37 budget. The 2018 budget includes funds for a 3% merit pool and 1% for market adjustments. The
38 budget also assumes salary offsets due to anticipated open positions throughout the year.

39
40 Agency Compensation (includes Severance): This category includes expense associated with severance
41 pay and service awards and the 2018 budget is expected to increase by \$(109) when compared to 2017.

42 Temporary Help: The *ADA* hires temporary/interim staff for annual session and to assist divisions when
43 staff positions are open during the year. This category is expected to increase by \$(403) when compared

1 to the 2017 budget. The increase is largely due to ADA Publishing and Integrated Marketing hiring
2 interim staff in 2018. Additionally, interim staff was rolled-up into the Salaries category in prior years.

3
4 Pension Fund: This category covers annual contributions to the scaled back pension plan that went into
5 effect January 1, 2012 as well as the liability of the full employee pension plan that was offered to
6 employees prior to 2012. The cost reflected in this category represents estimated plan contributions
7 required by the IRS rules for current employees, based on actuarial assumptions. This category is
8 expected to increase in 2018 by \$(1,431) when compared to 2017. Changes in Treasury mortality tables
9 caused the contribution to increase in 2018.

10
11 401K Contribution: No significant change is anticipated for 2018.

12
13 All Other Benefit Costs: Expenses in this category include group medical premiums, dental direct
14 reimbursement, life insurance and workers compensation. The expenses in this category are expected
15 to increase by \$(369) or (8.2) % from 2017, driven by increases in dental direct reimbursement costs and
16 group medical premiums.

17
18 Payroll Taxes: This category includes expense associated with employer related taxes such as FICA, SUI
19 and FUI. This category is expecting an increase of \$(285) in 2018. The unfavorable variance is an
20 attempt to bring the budget more in line with historical spending and change in payroll tax rates.

21
22 Travel Expenses: Travel expenses are usually comprised of about three quarters volunteer travel and
23 one quarter staff travel. Budget expenses for travel are projected to decrease by 3.7 % or \$265 versus
24 the 2017 budget. Travel was reduced in most divisions to bring the budget more in line with historical
25 actuals. Additionally, international travel was reduced in Practice Institute for standards related
26 activities.

27
28 Printing, Publications and Marketing: In 2018, this category anticipates a decrease of \$ 318 or 3 % when
29 compared to 2017. The decline is largely due to reductions in cost of goods sold, print advertising and
30 catalog production in Product Development and Sales division. Partially offsetting this decline is higher
31 commission costs associated with the increase in digital advertising revenue in the Publishing division.

32
33 Meeting Expenses: The 2018 budget anticipates an unfavorable variance of \$(676) or (26.6) %, largely
34 attributable to expenses associated with the ADA's Annual Meeting site (Hawaii) in 2018. In particular,
35 site distribution, shuttle service, meeting set-up and exhibit costs are significantly higher for Hawaii in
36 2018 versus Atlanta in 2017. A formula for site distribution is used in determining this expenditure. Also
37 contributing to this variance is an increase in expense related to ADA Dentist & Student Lobby Day in
38 Washington, D.C. This event has doubled the number of attendees and the added funds will bring the
39 budget more in line with actual expenses.

40
41 Consulting Fees and Outside Services: 2018 expenses in this area are expected to decrease by \$910 or
42 9 % when compared to the 2017 budget. The Division of Information Technology projects a decline of
43 \$554 in outside services and consulting in 2018 to bring budgeted expenses more in-line with historical

1 actuals and software licensing costs being reclassified to the Office Expense category. The 2017 budget
2 included an uptick in consulting expenses for a major rework of the ADA.org website. Similarly, the
3 Division of Government and Public Affairs reduced their 2018 budget based on historical spending.
4 The Division of Integrated Marketing and Communications budget was also favorable in this category
5 as a result of reductions in the Advocacy and Action for Dental Health program as well as a one-time
6 activity approved in 2017 that is not included in the 2018 budget. Partially offsetting the reductions
7 are increases related to a periodic audit of the ADA Members Insurance Plans, costs associated with
8 ADA's Annual Meeting in Hawaii and funding for a new pilot initiative in the Health Policy Institute.

9
10 Professional Services: 2018 expenses are expected to increase by \$(393) or (4) % versus 2017. The
11 unfavorable variance is driven by higher costs in the Chicago Headquarters Building as a result of the
12 building being 100% leased and additional expense related to the ADA Annual meeting in Hawaii.

13
14 Bank and Credit Card Fees: This category represents transaction fees paid to financial institutions and
15 reimbursements to state and local societies for credit card fees related to ADA membership dues
16 collection.

17
18 Office Expenses: The \$261 increase versus 2017 budget in office expenses is primarily attributable to an
19 increase in ADA Library subscription costs being reclassified from the Outside Services category.

20
21 Facility and Utility Costs: These expenses represent costs for building management and operations,
22 maintenance, and real estate taxes for the ADA Headquarters and Washington DC buildings. The
23 increase of \$(293) is the due an increase property taxes for the Chicago Headquarters and Washington
24 DC building. Additionally, cleaning, utilities and general building expenses are expected to increase as a
25 result of the buildings being fully leased in 2018.

26
27 Grants and Awards: The ADA distributes grants to support various organizations for specific functions.
28 The 2018 budget anticipates an increase of \$(160) when compared to the 2017 budget. The largest
29 contributing factor is the ADA budgeting additional funds for SPA grants to state societies.

30
31 Endorsement Costs: This category represents royalty payments to state dental societies that participate
32 in the *ADA Business Resources* program and to the AMA for use of medical codes in *CDT* related
33 products. The minimal change is a direct result of the additional Royalty revenue being forecasted for
34 2018.

35
36 Depreciation and Amortization: Depreciation is calculated annually based on prior year and proposed
37 current year capital acquisitions. The increase of \$(110) in 2018 is due to tenant build outs as a result of
38 the Lurie Children's Hospital leasing five floors of the Chicago Headquarters building with occupancy
39 commencing in June 2017.

40
41 Other Expenses: Other expenses include general insurance, recruiting costs, staff development, and the
42 Board contingency. The ADA budgeted \$750 in 2018 for the Board contingency, against which spending

1 during the year is approved by the Board of Trustees. The decline in this category is largely due to the
2 Board contingency fund being reduced by \$250 to better align with actual history
3
4 ADA Foundation Grant: The Association's annual grant to the Foundation is budgeted to decrease by
5 \$429 to \$2,200. The grant in 2018 is solely restricted to scientific research activities, support for which
6 would increase from \$768 in 2017 to \$2,200 in 2018, an increase of \$1,432. The budget does not
7 include any funding for overall ADAF administration costs nor philanthropic activities.
8
9 The following three pages provide the revenue, expense, and net for each ADA division, comparing the
10 proposed 2018 budget against 2015 and 2016 actual results and the 2017 budget.

ADA Statement of Activities by Operating Division

Excludes Reserve Spending (Busyness Initiative, Frog, etc.) and Reserve Revenue (Insurance Royalties, any Busyness Special Assessment)

Thousands of Dollars

	2015	2016	2017 Budget	2018 Budget	2018 v 2016 Variance		2018 v 2017B	
					Fav / (Unfav)		Fav / (Unfav)	
					\$	CAGR %	\$	%
Revenue								
ContFund - Contingency General	31	-	-	-	-	NA	-	NA
AdminSvc - Administrative Services	54	19	72	75	56	96.9%	3	4.2%
BusRelations - Business Relations	1	(0)	-	-	0	-100.0%	-	NA
CentAdmin - Central Administration	4,525	4,936	4,626	5,329	393	3.9%	704	15.2%
Comm - Communications	2	2	4	4	2	45.4%	-	0.0%
Conferences&CE - Conferences and Continuing	9,425	9,246	10,306	10,897	1,650	8.6%	590	5.7%
Educ - Education	23,961	25,534	27,281	28,035	2,501	4.8%	754	2.8%
FinOpsBld - Finance and Operations - Buildings	13,769	13,947	15,701	16,853	2,906	9.9%	1,151	7.3%
GovPubAffr - Government & Public Affairs	160	(28)	50	130	158		80	159.6%
HealthPolResCntr - Health Policy Institute	242	83	295	184	101	48.6%	(111)	-37.6%
HumanRes - Human Resources	-	-	-	-	-	NA	-	NA
InfoTech - Information Technology	3	-	-	-	-	NA	-	NA
LeglAffr - Legal Affairs	33	45	43	45	(0)	-0.5%	2	4.7%
MbrTriMktg - Member and Client Services	55,996	54,891	56,099	55,396	505	0.5%	(703)	-1.3%
PracticeInst - Practice Institute	355	202	135	179	(23)	-5.8%	44	32.2%
ProdDevSales - Product Development and Sales	9,166	9,797	10,084	10,274	477	2.4%	190	1.9%
ADAPub - ADA Publishing	8,573	8,553	8,671	9,040	487	2.8%	369	4.3%
Sci - Science	881	766	1,270	1,147	381	22.3%	(123)	-9.7%
Remove Insurance Royalties	(6,457)	(6,520)	(7,000)	(6,800)	(280)	2.1%	200	-2.9%
Total	120,717	121,474	127,637	130,787	9,313	3.8%	3,151	2.5%

ADA Statement of Activities by Operating Division

Excludes Reserve Spending (Busyness Initiative, Frog, etc.) and Reserve Revenue (Insurance Royalties, any Busyness Special Assessment)

Thousands of Dollars

	2015	2016	2017 Budget	2018 Budget	2018 v 2016 Variance		2018 v 2017B	
					Fav / (Unfav)		Fav / (Unfav)	
					\$	CAGR %	\$	%
Expenses								
ContFund - Contingency General	759	393	1,000	750	(357)	-38.1%	250	25.0%
AdminSvc - Administrative Services	7,187	6,830	7,191	7,301	(471)	-3.4%	(110)	-1.5%
BusRelations - Business Relations	805	642	-	-	642	100.0%	-	NA
CentAdmin - Central Administration	8,670	8,757	10,224	9,776	(1,019)	-5.7%	448	4.4%
Comm - Communications	5,672	6,630	7,141	7,335	(705)	-5.2%	(194)	-2.7%
Conferences&CE - Conferences and Continuing	8,760	9,093	9,178	10,712	(1,618)	-8.5%	(1,534)	-16.7%
Educ - Education	14,329	15,565	16,271	17,166	(1,601)	-5.0%	(895)	-5.5%
FinOpsBld - Finance and Operations - Buildings	10,799	11,302	11,648	13,153	(1,851)	-7.9%	(1,505)	-12.9%
GovPubAffr - Government & Public Affairs	8,656	9,065	9,383	9,481	(416)	-2.3%	(98)	-1.0%
HealthPolResCntr - Health Policy Institute	2,828	2,697	2,814	2,970	(273)	-4.9%	(156)	-5.5%
HumanRes - Human Resources	1,916	2,146	2,008	2,046	100	2.4%	(38)	-1.9%
InfoTech - Information Technology	13,841	13,084	13,566	13,351	(267)	-1.0%	216	1.6%
LeglAffr - Legal Affairs	3,887	4,033	3,997	4,108	(75)	-0.9%	(112)	-2.8%
MbrTriMktg - Member and Client Services	8,314	7,660	8,060	7,851	(191)	-1.2%	209	2.6%
PracticeInst - Practice Institute	5,404	5,362	5,092	5,214	148	1.4%	(121)	-2.4%
ProdDevSales - Product Development and Sales	4,057	4,050	5,024	4,822	(772)	-9.1%	202	4.0%
ADAPub - ADA Publishing	7,790	7,584	7,537	7,908	(324)	-2.1%	(371)	-4.9%
Sci - Science	4,414	4,941	5,532	5,385	(444)	-4.4%	147	2.7%
Total	118,089	119,835	125,665	129,327	(9,492)	-3.9%	(3,662)	-2.9%

ADA Statement of Activities by Operating Division

Excludes Reserve Spending (Busyness Initiative, Frog, etc.) and Reserve Revenue (Insurance Royalties, Busyness Special Assessment)

Thousands of Dollars

	2015	2016	2017 Budget	2018 Budget	2018 v 2016 Variance		2018 v 2017B	
					Fav / (Unfav)		Fav / (Unfav)	
					\$	CAGR %	\$	%
Revenue-Expenses								
ContFund - Contingency General	(728)	(393)	(1,000)	(750)	(357)	-38.1%	250	25.0%
AdminSvc - Administrative Services	(7,133)	(6,811)	(7,119)	(7,226)	(415)	-3.0%	(107)	-1.5%
BusRelations - Business Relations	(805)	(642)	-	-	642	100.0%	-	NA
CentAdmin - Central Administration	(4,145)	(3,821)	(5,598)	(4,447)	(626)	-7.9%	1,151	20.6%
Comm - Communications	(5,670)	(6,628)	(7,137)	(7,331)	(702)	-5.2%	(194)	-2.7%
Conferences&CE - Conferences and Continuing	665	153	1,128	185	32	9.9%	(943)	-83.6%
Educ - Education	9,632	9,968	11,010	10,869	901	4.4%	(141)	-1.3%
FinOpsBld - Finance and Operations - Buildings	2,969	2,645	4,053	3,700	1,055	18.3%	(354)	-8.7%
GovPubAffr - Government & Public Affairs	(8,496)	(9,092)	(9,333)	(9,351)	(259)	-1.4%	(18)	-0.2%
HealthPolResCntr - Health Policy Institute	(2,586)	(2,613)	(2,519)	(2,786)	(173)	-3.2%	(267)	-10.6%
HumanRes - Human Resources	(1,916)	(2,146)	(2,008)	(2,046)	100	2.4%	(38)	-1.9%
InfoTech - Information Technology	(13,838)	(13,084)	(13,566)	(13,351)	(267)	-1.0%	216	1.6%
LeglAffr - Legal Affairs	(3,854)	(3,988)	(3,954)	(4,063)	(76)	-0.9%	(110)	-2.8%
MbrTriMktg - Member and Client Services	47,682	47,231	48,040	47,545	314	0.3%	(494)	-1.0%
PracticeInst - Practice Institute	(5,050)	(5,160)	(4,957)	(5,035)	126	1.2%	(78)	-1.6%
ProdDevSales - Product Development and Sales	5,110	5,747	5,060	5,452	(295)	-2.6%	392	7.7%
ADAPub - ADA Publishing	783	969	1,134	1,132	163	8.1%	(2)	-0.2%
Sci - Science	(3,534)	(4,175)	(4,262)	(4,238)	(63)	-0.8%	24	0.6%
Remove Insurance Royalties	(6,457)	(6,520)	(7,000)	(6,800)	(280)	-2.1%	200	2.9%
Total	2,628	1,640	1,972	1,460	(179)	-5.6%	(512)	-25.9%
Taxes	1,639	1,251	1,650	1,326	(75)	-3.0%	324	19.6%
Net Income	989	389	322	134	(254)	-41.2%	(188)	-58.3%

1 **IV. Budget Changes and Other Key Decisions**

2
3 The following pages present additional revenue and expense detail for each division's 2018 budget,
4 followed by the corresponding variances versus 2017 budget.
5

2018 Operating Budget

Thousands of Dollars

	Board Contingency	Administrative Services	Central Administration	Communications & Marketing	Conferences & Continuing Education	Education Division	Finance, Operations, & Buildings	Government Affairs	Health Policy Institute	Human Resources	Information Technology	Legal Affairs	Member & Client Services	Practice Institute	Product Development & Sales	Publishing	Science Institute	Total ADA
Membership Dues	-	-	-	-	-	-	-	-	-	-	-	-	55,199	-	-	-	-	55,199
Non-Dues Revenue	-	75	5,329	4	10,897	28,035	16,853	130	184	-	-	45	197	179	10,274	9,040	1,147	82,388
Remove Insur Royalties							(6,800)											(6,800)
Total Revenue	-	75	5,329	4	10,897	28,035	10,053	130	184	-	-	45	55,396	179	10,274	9,040	1,147	130,787
Salaries and temp help	-	2,505	2,809	3,470	2,113	5,725	2,855	3,204	1,495	993	5,547	2,359	4,002	3,045	1,315	2,077	3,039	46,554
Fringe Benefits	-	703	95	1,169	839	2,485	1,503	1,118	533	283	1,974	701	1,629	1,074	507	745	1,225	16,583
Consulting & Outside Svcs	-	572	71	887	854	277	291	1,336	869	22	2,174	3	119	168	292	1,330	77	9,340
Print., Publicat & Marketg	-	82	-	1,602	873	30	28	63	1	112	-	10	496	127	2,359	3,470	72	9,324
Meeting Expenses	-	93	-	15	2,368	34	-	371	2	-	-	2	135	50	72	21	56	3,219
Travel Expenses	-	1,339	4	154	800	1,961	87	934	42	8	53	81	379	564	61	77	393	6,937
Professional Services	-	1,381	44	3	1,079	5,503	329	30	-	-	-	913	-	2	-	44	128	9,456
Bank & Credit Card Fees	-	0	27	-	171	455	-	0	-	-	5	-	530	1	178	43	1	1,411
Office Expenses	-	601	94	33	1,461	396	150	259	29	18	1,269	32	144	179	19	52	301	5,036
Facility and Utility Costs	-	2	2	-	23	-	6,204	43	-	-	11	-	9	-	-	16	1	6,310
Grants and Awards	-	18	73	-	-	-	-	2,122	-	-	-	7	405	3	-	-	-	2,627
ADA Foundation Grant	-	-	2,200	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2,200
Endorsement Costs	-	-	1,108	-	-	300	-	-	-	-	-	-	-	-	-	-	-	1,408
Depreciation	-	-	2,913	1	98	-	1,686	-	-	-	2,318	-	-	-	-	-	82	7,098
Other Expenses	750	5	336	-	35	-	22	0	-	610	-	-	4	-	19	33	11	1,825
Total Expense	750	7,301	9,776	7,335	10,712	17,166	13,153	9,481	2,970	2,046	13,351	4,108	7,851	5,214	4,822	7,908	5,385	129,327
Income Taxes	-	-	1,326	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,326
Net Income	(750)	(7,226)	(5,773)	(7,331)	185	10,869	(3,100)	(9,351)	(2,786)	(2,046)	(13,351)	(4,063)	47,545	(5,035)	5,452	1,132	(4,238)	134

2018 Operating Budget Variances versus 2017 Budget

Thousands of Dollars; "()" denotes unfavorable variances

	Board Contingency	Administrative Services	Central Administration	Communications & Marketing	Conferences & Continuing Education	Education Division	Finance, Operations, & Buildings	Government Affairs	Health Policy Institute	Human Resources	Information Technology	Legal Affairs	Member & Client Services	Practice Institute	Product Development & Sales	Publishing	Science Institute	Total ADA
Membership Dues	-	-	-	-	-	-	-	-	-	-	-	-	(670)	-	-	-	-	(670)
Non-Dues Revenue	-	3	704	-	590	754	1,151	80	(111)	-	-	2	(33)	44	190	369	(123)	3,621
Remove Insur Royalties	-	-	-	-	-	-	200	-	-	-	-	-	-	-	-	-	-	200
Total Revenue	-	3	704	-	590	754	1,351	80	(111)	-	-	2	(703)	44	190	369	(123)	3,151
Salaries and temp help	-	(127)	(132)	(558)	(212)	(315)	(136)	(38)	(27)	(22)	(153)	(46)	176	(82)	(90)	(151)	91	(1,824)
Fringe Benefits	-	(24)	245	(195)	(167)	(465)	(509)	(86)	(47)	(32)	(179)	(28)	(151)	(94)	(64)	(114)	(141)	(2,051)
Consulting & Outside Svcs	-	(23)	(11)	884	(205)	(164)	(271)	282	(69)	13	499	2	19	(33)	(54)	(14)	55	910
Print., Publicat & Marketg	-	32	-	(257)	(77)	7	(1)	10	-	27	-	41	244	(13)	470	(177)	11	318
Meeting Expenses	-	(8)	-	(10)	(431)	(16)	-	(211)	(1)	-	-	-	(21)	(4)	(27)	(2)	55	(676)
Travel Expenses	-	86	(4)	(51)	(213)	219	(4)	79	7	(8)	9	(6)	66	120	(25)	5	(15)	265
Professional Services	-	(33)	(16)	-	(181)	4	(202)	(8)	-	-	-	(75)	21	5	-	77	15	(393)
Bank & Credit Card Fees	-	0	16	-	4	39	-	(0)	-	-	1	-	(101)	0	(29)	(3)	(1)	(73)
Office Expenses	-	(13)	(65)	(8)	(58)	(195)	7	(25)	(20)	1	39	(1)	18	(17)	1	11	66	(261)
Facility and Utility Costs	-	1	8	-	(7)	-	(292)	(0)	-	-	0	1	(3)	-	-	(4)	3	(293)
Grants and Awards	-	(4)	0	-	-	-	-	(99)	-	-	-	1	(55)	(3)	-	-	-	(160)
ADA Foundation Grant	-	-	429	-	-	-	-	-	-	-	-	-	-	-	-	-	-	429
Endorsement Costs	-	-	(44)	-	-	(10)	-	-	-	-	-	-	-	-	-	-	-	(54)
Depreciation	-	-	58	-	-	-	(168)	-	-	-	(0)	-	-	-	-	-	0	(110)
Other Expenses	250	2	(36)	-	12	2	71	(0)	-	(17)	-	-	(4)	-	19	3	9	310
Total Expense	250	(110)	448	(194)	(1,534)	(895)	(1,505)	(98)	(156)	(38)	216	(112)	209	(121)	202	(371)	147	(3,662)
Income Taxes	-	-	324	-	-	-	-	-	-	-	-	-	-	-	-	-	-	324
Net Income	250	(107)	1,475	(194)	(943)	(141)	(154)	(18)	(267)	(38)	216	(110)	(494)	(78)	392	(2)	24	(188)

- 1
- 2 The following pages itemize each change from the 2017 budget to the proposed 2018 budget. Each
- 3 row represents either an increase or decrease in the proposed budget. Some changes are due to
- 4 starting and stopping of activities, while other changes may simply align the 2018 budget closer to the
- 5 2016 actual spending rates.
- 6

Roll-Forward - 2017 Budget to 2018 Budget

2017 Budget Surplus			\$	322	
	Revenue	Expense			
	Adjustment	Adjustment		Net	
<u>2018 Budget Adjustments</u>	<u>Inc/(Dec)</u>	<u>Dec/(Inc)</u>	<u>Adjustment</u>		<u>Rationale</u>
Association-Wide					
Merit Increase 3% and Salary Adjustment of 1%	-	(1,450)	(1,450)		Merit increase of 3% is in line with Chicago area and HR performs market analysis of compensation levels by job type and uses these funds to adjust salary levels for those individuals who are below norm.
Adjustment to Compensation based FTE Shifts/Rate Offsets	-	220	220		Net compensation differential of positions eliminated and new positions added to budget
Increase in Temporary Help	-	(403)	(403)		Augment staff openings and bring baseline budget more in line with 2016 actual
Increase in FICA Tax	-	(302)	(302)		Based on increase in Social Security maximum salary rate
Increase in Dental Reimbursement	-	(146)	(146)		Based on baseline adjustments as a result of 2016 actual spend
Increase in Group Medical Premiums	-	(203)	(203)		Group medical premiums increase on an annual basis.
Increase in Pension Contribution	-	(1,416)	(1,416)		Changes in Treasury Mortality Tables caused the contribution to increase in 2018
Increase Agency Compensation Expense	-	(109)	(109)		Based on Assumptions from HR
Decline in other Payroll Tax/Benefit Areas	-	52	52		Based on Assumptions from HR
Board Contingency					
	-	250	250		Reduce Board Contingency based on consistent year-end favorable results
Central Administration					
Decrease Income Tax Expense	-	323	323		Based on historical actuals
Increase in Affinity Program Revenue and Expense	551	(44)	507		Actual Revenue from this program always exceeds budget.
Increase in general liability insurance premiums	-	(35)	(35)		Baseline adjusted based 2016 actual
Increase in Miscellaneous Income	153	-	153		Baseline adjusted based 2016 actual
Decline in Depreciation Expense	-	58	58		Depreciation of assets in Central Admin will continue to decline due to depreciation of new asset purchases being expensed in divisions who make request
Increase in Office Expenses	-	(65)	(65)		Baseline - adjusted based on 2016 actual
Reduce Grant to ADA Foundation	-	429	429		Eliminates Philanthropy Grant which is a reduction of \$861k and Volpe Research Grant increased by \$432k
Other Miscellaneous Changes	-	(8)	(8)		Baseline - adjusted based on 2016 actual
Administrative Services					
Officer and Trustee Stipend Increase	-	(33)	(33)		BOT annual recommendation
Reduction in Travel Costs Based on Historical Actual Spending	-	203	203		Baseline - adjusted based on 2016 actual
Decrease in Other Baseline Expenses Based on Historical Actual Spending	-	110	110		Baseline - adjusted based on 2016 actual
Reduction in HOD Expense Based on Initial Budget Submission	-	92	92		Baseline - adjusted based on 2016 actual
Fund New Dentist Committee - Additional Travel Expenses	-	(15)	(15)		Due to higher travel costs for Hawaii meeting
Fund National Roundtable for Dental Collaboration Meeting	8	(14)	(6)		Budget moved from CAPIR to Admin Services for 2018
Fund Standing Committee Additional Travel Costs	-	(15)	(15)		Board approved board member attendance to Committee meetings
Fund Additional In-District Travel	-	(32)	(32)		Level of funding outlined in Board Rules
Fund House of Delegates - Cover Addl Expense for Hawaii	-	(192)	(192)		Increase due to location of annual meeting in Hawaii
Fund FDI World Dental Federation Expense	-	(42)	(42)		Due to meeting location business class airfare required per ADA policy
Fund Increase in FDI Membership Dues	-	(22)	(22)		Increase due to dollar exchange rate based on meeting location
Add New Dentist Committee Second Meeting	-	(26)	(26)		Board approved a second meeting for 2017 and this request then funds a second meeting in 2018
Other Net Changes	(5)	27	22		Baseline - adjusted based on 2016 actual

	Revenue	Expense	Net	
	Adjustment	Adjustment	Adjustment	Rationale
2018 Budget Adjustments	Inc/(Dec)	Dec/(Inc)	Adjustment	
Legal Affairs				
Increase in Legal, Audit and Tax Preparation Fees	-	(75)	(75)	External Auditors have increased their rates. Outside legal firms have increased their hourly rates and the prospects of litigation and/or other expenses are unpredictable.
Other Net Changes	2	37	39	Baseline - adjusted based on 2016 actual
Integrated Marketing & Communications				
Reduction - Action for Dental Health	-	740	740	A reduction of \$550k reflects the need to prioritize our marketing focus (and efficiencies) in the year ahead. While a worthwhile venture, Action for Dental Health is further down on the priority list as we look at the overall goals for the ADA. This amount cuts all IMC support as well as agency engagement.
Partially restore Funding for Action for Dental Health	-	(250)	(250)	Restores 1/2 year of funding for outside firm
Reduction in Research Fees	-	60	60	Reduce external research consulting and utilize ADA research panel
Other Net Changes	-	8	8	Baseline - adjusted based on 2016 actual
Member & Client Services				
Reduction in Membership Dues Revenue	(670)	-	(670)	Based on historical trends
Reduce Tangibles Expense	-	50	50	Reduced to help fund Outreach Manager Position
Reduce expenses in Membership Marketing	-	20	20	Savings proposed by the division to help reduce association wide expenses in 2018
Eliminate Spot Grants	-	100	100	Eliminated to help fund Outreach Manager position
Reduction in Special Projects Expense in Client Services	-	120	120	In 2018, funding resides in the Client Services cost center under the grants and awards account
Increase in Grants and Awards Expense in Client Services	-	(55)	(55)	Reclassification from Special Projects Expense
Reduction in Travel Expense Division-Wide	-	66	66	The ADA's dental school outreach activities and programs have become more aligned with the Client Services approach, we have increasingly deployed local speakers for the ADA Success program, reducing travel costs associated with the Dental School Programs budget, and have deployed the Client Service managers for dental school outreach trips, reducing staff travel costs in the Office of Student Affairs budget.
Increase in Credit Card Fees Related to ADA's portion of Fees Paid by States		(101)	(101)	ADA reimburses states for its portion of fees associated with dues collected via credit card
Add Additional Outreach Manager		(120)	(120)	Assist the Association in achieving annually set membership market share and other membership growth goals; enhance dentists' recognition and personal acknowledgement of the value of membership; enhance dental society membership collaboration and communication; and effectively advocate for membership benefits that respond to identified wants and needs.
Other Net Changes	(33)	(16)	(49)	Baseline adjusted based 2016 actual
Science Institute				
Reduction in Seal Program Revenue	(112)	-	(112)	Impacted by decrease in new submissions. Manufacturers are submitting new products in 2017 and they will most likely slow down in 2018.
Decline in EBD Workshop Fees	(95)	-	(95)	Workshop fees will not be part of Science revenue because they are managed by the CE group.
Reduction in Laboratory Supplies and Repair Costs	-	66	66	Due to sunseting of the PPR
Reduction in Miscellaneous Meeting Expenses Based on Prior Year Spending	-	56	56	Baseline - adjusted based on 2016 actual
Add EBD Sponsorship Revenue	50	-	50	Confident that additional sponsorship revenue can be obtained
Other Net Changes	34	75	109	Baseline - adjusted based on 2016 actual

	Revenue	Expense	Net	
	Adjustment	Adjustment	Adjustment	Rationale
2018 Budget Adjustments	Inc/(Dec)	Dec/(Inc)	Adjustment	
Conferences & Continuing Education				
Decline in Exhibit Rental Income	(1,025)	-	(1,025)	Smaller exhibit hall in Hawaii
Decline in Advertising Revenue	(107)	-	(107)	Less opportunity / smaller convention center
Decline in Publication & Product Sales	(145)	-	(145)	Should be \$100k in 2018 - entered in Misc. Income (see Other Net Changes)
Increase in Ticket Sales	272	-	272	Based on actuals from 2015 and 2016
Payment from Hawaii Convention Bureau	1,478	-	1,478	Incentive to come to Hawaii from Convention Bureau
Increase in Outside Services Expense	-	(205)	(205)	High labor costs in Hawaii
				\$150k added for Welcome Reception - all costs for welcome reception are in Reception Costs for 2017 - not split out between F&B and giveaways.
Increase in Print & Publication Expense	-	(77)	(77)	
Increases in Exhibit Prep, Meeting Set-Up, Shuttle Service and Site Distribution Costs	-	(431)	(431)	High labor costs in Hawaii
Increase in Travel Expense	-	(213)	(213)	Higher travel costs to go to Hawaii
Increase in Professional Fees and Honoraria	-	(181)	(181)	Higher travel costs to go to Hawaii
Other Net Changes	117	(49)	68	Baseline - adjusted based on 2016 actual
Education				
New Revenue from Credentialing Verification Services	150	-	150	Anticipated New program in 2018
Increase in National Board Related Revenue	620	-	620	Fee Increment by 4% over 2017 with Test admin increment
				ADAT revenue is adjusted in line with 2016 and fee decrease from 2017 budget , DAT revenue was
Decline in DAT Revenue	(652)	-	(652)	adjusted based on actual 2016
Increase in Accreditation Revenue	201	-	201	Fee Increment by 8% over 2017
Increase in OAT Revenue	70	-	70	Fee Increment by 5% over 2017
				Adjusted based on 2016 actual for National Board exams requirement for regular test construction and relevant activities , secondly two new exams ADAT and OSCE require initial consultation and outside
Increase in Outside Services/Consulting	-	(164)	(164)	services for establishment.
Increase in Publications & Subscriptions	-	(205)	(205)	Cost was allocated in IT Budget 2017 for Library services, shifted to education in 2018
Reduction in Travel Expenses	-	219	219	Baseline - adjusted based on 2016 actual
Additional National Board Revenue	300	-	300	Based on updated projections
Other Net Changes	65	35	100	Baseline - adjusted based on 2016 actual
Government Affairs				
Increase Reception Costs - ADA Dentist & Student Lobby Day	-	(192)	(192)	Increase expense due to doubling attendees/ food and beverage costs
Increase Revenue Related to Hosting Events at Townhouse	75	-	75	Projected rental income
Reduction in Travel Based on Historical Actual Spending	-	123	123	Baseline - adjusted based on 2016 actual
Increase SPA Grants to States Based on Historical Actual Spending	-	(101)	(101)	100% of grant funding will be executed in 2017 and possible increase in funds needed in 2018
Preventative Health - Reduction National Academies	-	77	77	2017 approved funding; likely not needed in 2018
Preventative Health - Partially Reinstate funding for National Academies	-	(27)	(27)	Board thought a portion of the funding should be reinstated
Reduction in Consulting Expense Based on Prior Year Spending	-	244	244	Baseline - adjusted based on 2016 actual
Reinstate NECAC Budget	-	(25)	(25)	Inadvertantly omitted from 2017 budget
Other Net Changes	5	(72)	(67)	Baseline - adjusted based on 2016 actual
Health Policy Institute				
Reduction in Service Revenue to External Clients	(101)	-	(101)	Baseline - adjusted based on 2016 actual
Funding for Marshalling the Evidence for Innovation in Oral Health Policy	-	(146)	(146)	This is a new pilot initiative for 2018
Other Net Changes	(10)	64	54	Baseline - adjusted based on 2016 actual

	Revenue Adjustment	Expense Adjustment	Net Adjustment	Rationale
2018 Budget Adjustments	Inc/(Dec)	Dec/(Inc)	Adjustment	
Practice Institute				
Reduce Travel Throughout the Division	-	120	120	Reduced International travel in Standards
Other Net Changes	44	(65)	(21)	Increased Annual Meeting expenses (Hawaii); Adjustment for grant received in 2017 which will not be renewed for 2018.
Publishing				
Increase in Classified and Display Advertising Revenue	208	-	208	This includes the \$260K approved to be added to digital advertising
Increase in Royalty Revenue	162	-	162	Increase part of the the Elsevier agreement
Increase in Sales Commission Due to Additional Revenue	-	(179)	(179)	Increase in commission due to increase in digital advertising revenues on ADA online, JADA+, Bulletin Healthcare and MCA/RJA
Decline in Professional Services Expense	-	77	77	JADA Live series suspended until further notice
Other Net Changes	-	(3)	(3)	Baseline - adjusted based on 2016 actual
Product Development & Sales				
Fund New & Revised Catalog Products with New Sales Channels and Marketing	477	(401)	76	PDS is developing new ways to reach dentists where they are located, whether online, in their office or at a dental conference. Through digital delivery platforms, dental conferences, efficient and improved shipping methods, dentists can receive content quicker, easier and more efficiently.
Decline in Product Sales - Initial Budget Submission	(237)	-	(237)	Baseline - adjusted based on 2016 actual
Decline in Royalty Revenue	(50)	-	(50)	Baseline - adjusted based on 2016 actual
Eliminate McKinnley Study	-	90	90	Didn't think it was necessary to conduct this study in 2018
PDS - Reduce Digital Marketing/Advertising Expense	-	100	100	Baseline - adjusted based on 2016 actual
Decline n COGS, Print & Mtkg Expenses - Initial Budget Submission	-	567	567	Baseline - adjusted based on 2016 actual
Other Net Changes	-	30	30	Baseline - adjusted based on 2016 actual
Information Technology				
Fund Aptify Application Enhancements	-	(58)	(58)	\$350k in Capital - to implement system enhancements requested by ADA and the Tripartite. Additional capital needed to cover software development work. Expense covers the additional depreciation costs.
Fund NetSuite Financial Management Software Implementation	-	(34)	(34)	\$83k in Capital - additional system enhancements to implement the legal/contract process not in original project scope. Additional capital needed to cover software development work. Expenses cover additional depreciation and travel expenses.
Fund .Information Builders Webfocus Licenses	-	(7)	(7)	\$20k in Capital - additional end-user software licenses to support the Enterprise Reporting & Analytics project. Additional capital needed to purchase licenses and expense covers the added maintenance and depreciation costs.
Fund Snow Owl Software for SNODENT	-	(30)	(30)	New software service for DDI to manage SNODENT reference codes.
Fund Mobile Applications Enhancements	-	(55)	(55)	\$200k in Capital - The current mobile apps require upgrades to meet new iOS and Android operating systems as well as major redesigns. Additional capital needed to cover software development work. Expenses cover additional depreciation costs.
Fund Personalization - State and Locals	-	(84)	(84)	\$168k in Capital - additional capital to cover the software development costs for requested enhancements from Tripartite and update the Pof 3 pages to improve the member data interfaces and user experience. Expense covers the additional depreciation.
Reduction in Consulting & Outside Services Due to Adjusted Baseline	-	613	613	Baseline - adjusted based on 2016 actual
Other Net Changes	-	202	202	Baseline - adjusted based on 2016 actual

	Revenue	Expense		
	Adjustment	Adjustment	Net	
2018 Budget Adjustments	Inc/(Dec)	Dec/(Inc)	Adjustment	Rationale
Finance, Operations & Buildings				
Increase in Rental Income	1,034	-	1,034	Lurie Children's Hospital taking 5 Floors
Increase in Investment Income	300	-	300	Estimate based on historical returns
Reduction in CMIRP Royalty Revenue	(203)	-	(203)	Based on projection from Great West Life
Increase in Outside Services in CMIRP	200	(200)	-	The required outside audit will occur in 2018 but was not budgeted for in 2017.
Increase in Misc Professional Fees - HQ Building	-	(202)	(202)	Amoritization of Prepaid Leasing Comissions.
Increase in Facility & Utility Expenses - HQ Building	-	(168)	(168)	Additional expenses as a result of renting out 5 floors to Lurie Children's Hospital
Increase in Utility, Cleaning and Service Contract Costs - Washington Bldg	-	(124)	(124)	Increase in Mgmt Fee due to 100% occupied building, increase in service contracts, and general increases in utilities.
Increase in Depreciation Expense	-	(168)	(168)	Capital Additions are projected in 2018 this will increase the Deprecation expense.
Fund McKinley Study		(30)	(30)	Reinstate study
Other Net Changes	23	4	27	Baseline - adjusted based on 2016 actual
Human Resources				
Other Net Changes	-	16	16	Baseline - adjusted based on 2016 actual
Total 2018 Budget Adjustments	3,154	(3,342)	(188)	
2018 Budget Surplus/(Deficit) - After Board of Trustees Review			\$ 134	

ADA Operations

Number of Full Time Equivalent Employees

As of Year End; New Positions Assumed to Begin on July 1

	2017 Budget	2018 Budget	Change	
Administrative Services	17.0	17.0	-	
Communications & Marketing	31.0	31.0	-	
Conferences and Continuing Education	22.0	22.0	-	
Education	69.0	71.0	2.0	+3 Clin Exam; +1 Commis on Specialty Recog; -1 ADA Credentialling; -1 Research Testing Analyst
Finance, Buildings & Operations	33.0	31.8	(1.2)	-1 Purchas Asst; -0.2 to part time
Government Affairs	28.0	29.0	1.0	+1 Dentist, Access & Community Capacity
Health Policy Institute	14.0	14.0	-	
Human Resources	7.4	7.4	-	
Information Technology	50.0	50.0	-	
Legal Affairs	16.6	16.6	-	
Member & Client Services	45.0	45.0	-	+2 Membership Outreach Managers; -2 Leadership Team Services
Practice Institute	27.0	27.0	-	
Product Development & Sales	14.0	13.0	(1.0)	-1 Digital Products Manager
Publishing	19.0	20.0	1.0	+1 Digital Advertising Operations Specialist
Science Institute	35.0	33.0	(2.0)	-2 Professional Products Review
Total	428.0	427.8	(0.2)	

1 **Selected Other Items Considered but Not Included in the Operating Budget**

2 In addition to the above changes between 2017 budget and 2018 budget, below are some items that
3 were discussed but not included in the 2018 budget.

- 4
- 5 1. ADA Foundation Grants: The Foundation had requested a \$932K increase in the ADA cash
6 grant, but the proposed ADA budget reflects a reduction of \$429K. In addition, the full 2018
7 grant would be restricted to scientific and research activities only. All philanthropic activities
8 would be funded by donors other than the ADA and if necessary from the Foundation’s
9 financial reserves.

10

Area	2017 Budget	2018 Grant Request Submitted by ADA Foundation	Reflected in this 2018 Budget	Change: 2018 Budget vs 2017 Budget
Volpe Research Center	768	2,200	2,200	+ 1,432
Philanthropy	1,871	1,361	0	- 1,871
Total ADAF	2,629	3,561	2,200	- 429

11

- 12 2. The 2016 House of Delegates approved the Initiative to Increase Utilization of Dental Care (aka
13 “Member Busyness Initiative”). The initiative is underway, at a cost of approximately \$6M per
14 year for three years, from 2017 through 2019. The cost of this initiative is not included in this
15 2018 operating budget and the proposed funding is discussed below under the heading
16 “Projected Reserve Levels and Funding the Three-Year Initiative to Drive Utilization of Dental
17 Services for ADA Members”.

18

- 19 3. The 2018 operating budget includes no budget for frog design, nor for implementation of any
20 ideas that might be recommended by frog. frog’s initial project will be completed in 2017 and
21 funded from reserves. Future spending needs related to next steps are unknown at this time.

22

- 23 4. This 2018 budget may not include continuation of all activities currently funded in 2017 from
24 reserves or the Board Contingency. For example, the ADA 2017 grant to the Dental Lifeline
25 Network was increased by \$50K from the Board Contingency, raising the 2017 total grant to
26 \$100K. The proposed 2018 budget restores the grant back to the 2017 budget level of \$50K.

27

- 28 5. The budget reflects a reprioritization of work within the Division of Scientific Affairs. The
29 Professional Product Review publication would be discontinued and resources previously
30 devoted to PPR are reallocated to higher value activities in 2018.

31

1 **V. Capital Expenditures and Capital Replacement Reserve**
2

American Dental Association		
Budget Depreciation and Capital Expenditures		
\$ 000		
	2017 Budget	2018 Budget
Depreciation/Amortization	\$6,988	\$7,098
Operating Capital Expenditures		
Science Institute	(241)	(553)
Division of Conferences and Continuing Education	(35)	(105)
Finance & Operations, Buildings	(270)	(518)
Information Technology	(1,861)	(1,682)
Total	(2,407)	(2,858)
Net-Contribution to Replacement Fund	(4,581)	(4,240)
Total Operating Capital + Contribution to Replacement Fund	(6,988)	(7,098)
Capital Replacement Fund		
Contributions	(4,581)	(4,240)
Replacement Fund Capital Expenditures		
Finance and Operations, Buildings	(5,968)	(1,253)
Replacement Fund Net Contributions Less Expenditures	\$ (1,387)	\$ 2,987
Total Capital Expenditures	\$ (8,375)	\$ (4,111)

1 **VI. Projected Reserve Levels and Funding the Three-Year Initiative to Drive**
2 **Utilization of Dental Services for ADA Members**

3
4 The House of Delegates passed resolution 67H-2016, a Three-Year Initiative to Drive Utilization of Dental
5 Services for ADA Members as follows:

6
7 Resolved, that the initiative “Drive Utilization of Dental Services for ADA Members” be
8 approved, and be it further

9
10 Resolved, that the Council on Communications submit annual status updates to the House of
11 Delegates for the duration of the campaign, and be it further

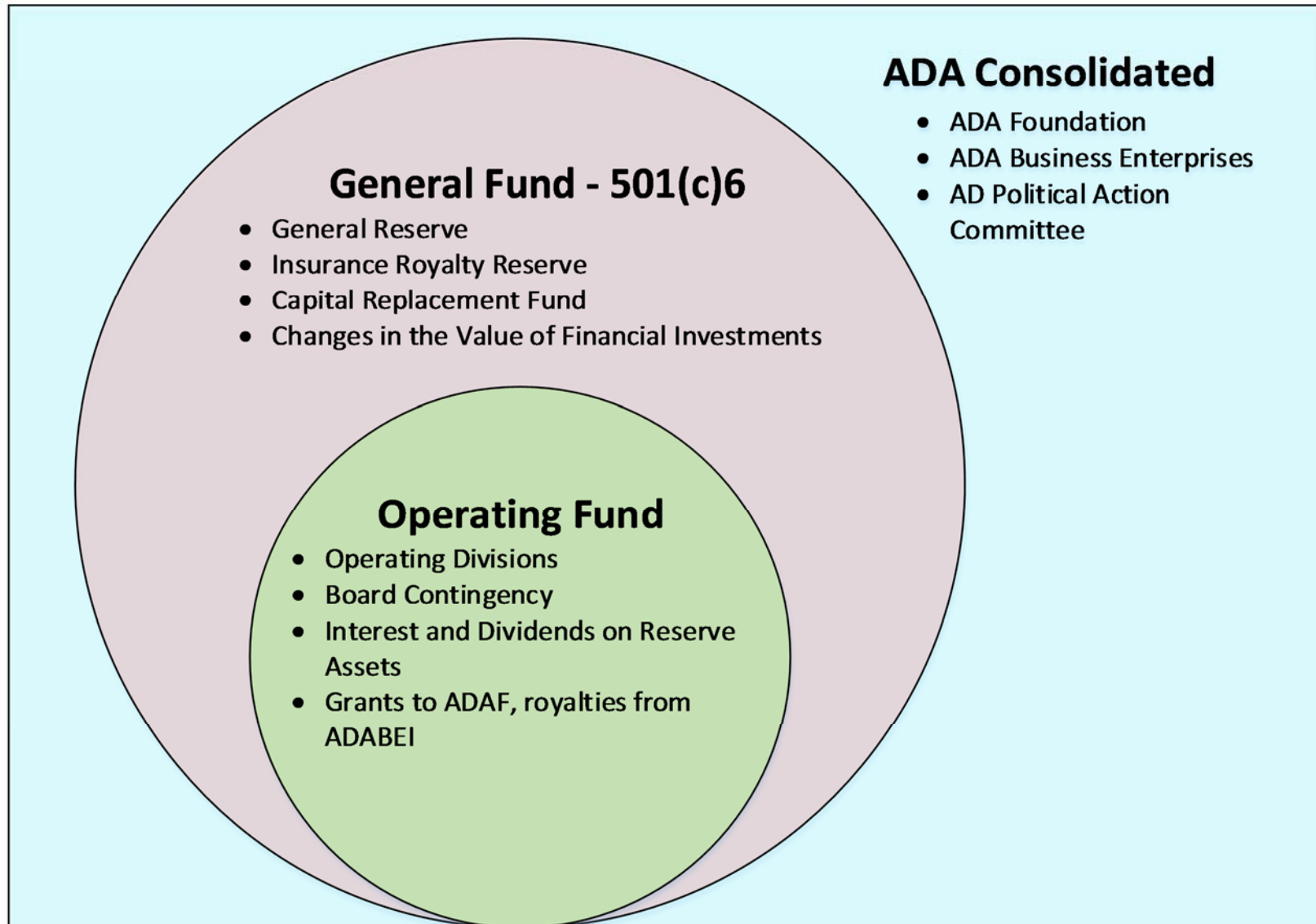
12
13 Resolved, that the House of Delegates urges funding for this program shall come from the
14 reserves for the first year, and be it further

15
16 Resolved, that funding for the second and third years shall be at the discretion of the Board of
17 Trustees, and be it further

18
19 Resolved, that the Council on Communications shall provide evidence of the value of this media
20 campaign to the 2017 HOD.

21
22 Because this initiative was funded from reserves in the first year, 2017, and is to be funded at the
23 discretion of the Board of Trustees in the second and third years, 2018 and 2019, the following analysis
24 reviews the ADA’s projected reserves as a source of funding this initiative. This analysis is inherently
25 linked to the complete picture of the ADA’s projected financial position and the reserve objective of the
26 ADA’s 2020 finance strategic plan goal to target unrestricted liquid reserves at no less than 50% of
27 annual operating expenses.

Organizational Scope of ADA Entities



1

2 Overview of ADA Financial Structure

3 The diagram above shows the relationship between three levels of ADA funds and entities: The ADA
4 Operating Account, the General Fund and other entities within the Consolidated ADA. The ADA's
5 501(c)(6) General Fund is comprised of the Operating Account and Reserve Funds, while Consolidated
6 ADA includes the General Fund plus other ADA subsidiaries. The ADA 501(c)(6) organization is the
7 entity under the oversight of the ADA Board and house of delegates. The other ADA entities in the
8 consolidation fall under the governance of separate boards.

9

10 Although the ADA's financial packages report results on each of these levels, the ADA operating budget
11 discussions focus primarily on the Operating Account. The ADA 501(c)(6) General Fund includes long
12 term reserves. There are only two ways to make expenditures of ADA resources: the annual operating
13 budget as approved by the House of Delegates and reserve spending authorized by the Board and/or
14 House. As a result, the ADA's financial reports include reports for both of these types of spending.
15 The value of the ADA's cash and marketable securities ("financial assets") in the General Fund has been
16 increasingly affected by expenditures authorized against reserves. For example, in 2017, several
17 million dollars of spending from reserve accounts was reported separate from the operating budget.
18 Each dollar of spending reduces the cash balances in the General Fund by one dollar, regardless of
19 whether the expense is reported from the Operating Account or from Reserves. It should be noted
20 that the ADA operating budget does not plan for any appreciation of reserve investments, only the
21 dividends and interests from investments which are predictable.

22

23 Although ADA's reserve balances are still strong today, the ADA's biggest financial planning decision for
24 2018 is how to fund the Initiative to Increase Utilization of Dental Care ("Busyness Initiative") taking
25 into account the expected impact on future reserve balances. Therefore, this budget report includes
26 projections for both the Operating Account and the General Fund. This is important because the
27 Members First 2020 Strategic Plan includes a goal that ADA will be financially sustainable. To reiterate,
28 this goal includes a specific objective that "unrestricted liquid reserves will be targeted at no less than
29 50 % of annual operating expenses."

30

31 Funding the Busyness Initiative

32 A key decision in financial planning for 2018 is how to fund the \$6.0M cost of the 2nd year of the
33 Busyness Initiative. Options considered by the Budget & Finance Committee included the following
34 and various combinations of the following:

- 35 • \$60 special assessment
- 36 • Fund from general reserves
- 37 • Fund from the Royalty Reserve
- 38 • \$60 dues increase
- 39 • Reallocate existing resources

40

41 The first option, a \$60 assessment, carries risks:

42

- 1 1. Members may expect Special Assessments to be temporary and expire in the future. The
2 Busyness Initiative could be a recurring cost rather than a one-time investment that provides
3 lasting benefits over multiple years. If the Busyness initiative proves successful and valuable,
4 then the Initiative would require funding to continue beyond the initial three years.
- 5 2. State and local societies may feel that the ADA special assessment would limit states' ability to
6 implement state dues increases to help shore up state finances.
- 7 3. Some state associations suggest that the total national membership dues and assessments
8 should be modest compared to the dues bill for State and Local societies, citing evidence that
9 dentists' decision to join is based more on local activities. If National dues and assessments
10 become the largest segment of the members' dues bill, this could be perceived as a
11 misallocation of total resources across Local/State/National.
- 12 4. The ADA continues to experience declines in the number of full dues paying members. frog
13 design attributes this in part to a "diffused value proposition" and "emerging competitors
14 attracting engagement." Until those issues are addressed, there is a real risk that a \$60
15 assessment might materially accelerate the downward trend in full dues members.

16
17 After careful consideration of all the options, the Budget & Finance Committee has proposed funding
18 the Busyness Initiative in 2018 from several sources as follows:

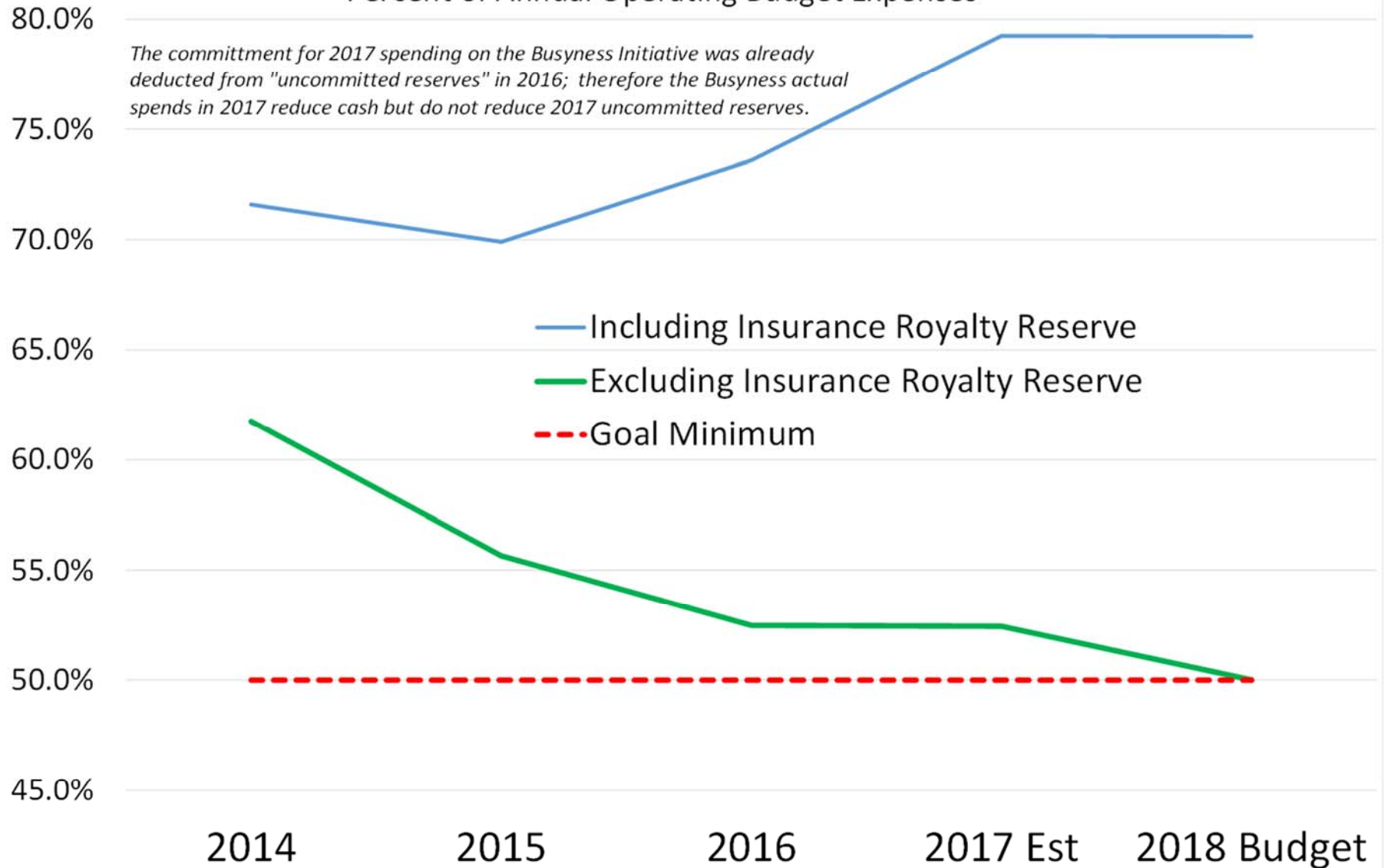
- 19 • \$ 30 Special Assessment (which represents a temporary 5.6 % increase in National dues).
- 20 • General Reserves until they reach the goal floor of 50 % of the annual operating budget.
- 21 • If General Reserves reach the 50 % target floor, then the remainder of the Busyness
22 Initiative would be funded from the Royalty Reserve .

23
24 The projected impact on reserve funds is presented in the following chart. The information presented
25 in this section represents cash and marketable securities ("Financial Assets") in the ADA General Fund,
26 which includes both Operations and Reserve funds, but not the assets of other subsidiaries such as the
27 ADA Foundation, ADABEI, and ADPAC.

28
29 It should also be noted that the reserve levels presented are conservative because they assume no
30 investment appreciation due to market value increases. The projected reserve levels were built on
31 actual values as of December 31, 2016.

ADA Long Term Uncommitted Reserves Percent of Annual Operating Budget Expenses

The commitment for 2017 spending on the Busyness Initiative was already deducted from "uncommitted reserves" in 2016; therefore the Busyness actual spends in 2017 reduce cash but do not reduce 2017 uncommitted reserves.



1 In the chart above, the projected 2018 budget uncommitted general reserves are prevented from
2 dipping below the 50% goal by a \$3.0M Busyness Special Assessment plus a transfer of \$2.7M from
3 the Royalty Reserve. The actual transfer from the Royalty Reserve required to stay above the 50 %
4 floor would depend on both operating results and financial asset appreciation. For example, if
5 investment values remain strong through 2018, then uncommitted long term reserves may not need
6 any transfers from the Royalty Reserve in order to remain above the 50 % goal.

7
8 The chart also includes a third line at the top which includes the Royalty Reserve in the calculation of
9 uncommitted long term reserves. Since the Royalty Reserve is not committed to any particular
10 expenditure, arguably Royalty Reserve could be classified as uncommitted reserves which supports the
11 overall financial stability of the ADA. This approach appears to provide the financial stability of the
12 ADA while also limiting the impact of increasing costs to members.

13

1 **VII. Recap of 2016 Actual Results**

2
3 For detailed reporting on actual 2016 financial results, please refer to the quarterly and year end
4 financial reports that are posted to the House of Delegates. A high level summary is provided below
5 for your convenience.
6

ADA Operations

2016 Statement of Activities

Excludes Non-Operating Revenue and Expenses

Millions of Dollars

	2015 Actual	2016 Budget	2016 Actual	2016 v 2015		2016 v 2016B	
				Fav / (Unfav)		Fav / (Unfav)	
				\$	%	\$	%
Revenue							
Membership Dues	\$ 55.6	\$ 55.1	\$ 54.5	\$ (1.2)	-2.1%	\$ (0.6)	-1.1%
Education Division	24.0	25.9	25.5	1.6	6.6%	(0.3)	-1.3%
Publishing, Products, Annual Meeting	27.2	29.5	27.6	0.4	1.6%	(1.9)	-6.4%
Other Revenue	14.0	14.7	13.9	(0.1)	-0.7%	(0.9)	-5.8%
Total	120.7	125.2	121.5	0.8	0.6%	(3.7)	-3.0%
Expenses							
Employee Costs	56.4	56.9	58.3	(1.9)	-3.3%	(1.3)	-2.4%
Outside Services							
Education Division	5.9	7.2	6.6	(0.7)	-11.8%	0.6	8.9%
Publishing, Products, Annual Meeting	13.8	15.5	13.5	0.3	2.0%	2.0	12.7%
Information Technology	4.2	3.5	3.3	0.8	19.7%	0.1	4.2%
Buildings	6.1	6.6	6.3	(0.3)	-4.3%	0.3	4.2%
Board Contingency	0.4	1.0	0.3	0.1	16.3%	0.7	67.3%
Communications & Marketing	2.0	2.5	2.4	(0.5)	-23.0%	0.1	2.8%
Administrative Services	2.6	2.7	2.5	0.1	3.1%	0.2	7.0%
Member and Client Services	2.1	1.7	1.6	0.5	23.7%	0.2	9.6%
Government Affairs	3.6	4.4	4.1	(0.5)	-14.1%	0.3	7.9%
Other Divisions	5.5	6.3	5.7	(0.2)	-4.1%	0.6	9.1%
Total Outside Services	46.0	51.5	46.4	(0.4)	-0.9%	5.1	9.8%
Travel Expenses	6.9	7.5	6.4	0.5	7.3%	1.1	14.4%
Cash Grant to ADA Foundation	2.3	2.4	2.4	(0.0)	-1.8%	0.0	0.0%
Depreciation	6.4	6.6	6.3	0.1	1.1%	0.3	4.3%
Total Expenses	118.1	124.9	119.8	(1.7)	-1.5%	5.1	4.1%
Taxes	1.6	1.5	1.3	0.4	23.7%	0.2	16.6%
Net Income Before Reserves	1.0	(1.2)	0.4	0.6	60.7%	1.6	

1 Membership dues revenue fell slightly faster in 2016 than anticipated in the budget, while Education
2 related revenue grew but not quite as fast as budgeted. Publishing, Products, and Annual Meeting had
3 budgeted 8.5 % growth for 2016, but actual growth was 1.6 %, driven by CDT Code license fees.
4

5 Within employee costs, base salaries were on budget but temporary employees and employee benefits
6 were slightly over budget. Outside services, which includes expenses for consulting, printing, and
7 marketing, was up slightly from last year but had been budgeted to grow by 12 %. Much of the
8 expected growth in outside services was in Publishing, Products and Annual Meeting, but 2016 actual
9 costs in this area were instead very similar to 2015. Also in outside services, spending from the Board
10 Contingency remained at a typical level rather than growing as assumed in the budget. Travel
11 expenses had been budgeted to grow but actually declined in 2016, with the largest budget variances
12 in Education, Administrative Services, and Practice Institute. The 2018 budget for travel expense is
13 back down to the 2015 actual level.
14

15 **VIII. Headquarters Building Valuation**

16
17 The House adopted Resolution 69H-2002 (Trans.2002:372) directing that the estimated market value of the ADA
18 headquarters building be included in Board Report 2. In July of 2017, real estate transaction professionals in
19 Chicago estimated a gross sale value (before transaction costs) of \$80.5 million. This is an increase of \$5.0
20 million from last year's estimate, reflecting the value of new tenant leases existing tenant renewals recently
21 signed. The increase demonstrates the real value of the capital expenditures for leasehold improvements and
22 transaction costs which are paid from the capital replacement reserves set aside for this purpose.
23

24 As added reference, the same real estate professionals also estimated the gross sale value (before transaction
25 costs) of the ADA Washington D.C. office building at \$17.2 million.
26

27 **Resolutions**

28
29 (See Resolution 22; Worksheet:2060)

30 (See Resolution 23; Worksheet:2061)

Resolution No. 23 New

Report: Board Report 2 Date Submitted: August 2017

Submitted By: Board of Trustees

Reference Committee: A (Budget, Business, Membership and Administrative Matters)

Total Net Financial Implication: \$0 Net Dues Impact: \$0

Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Supports All Strategic Plan Objectives

How does this resolution increase member value: See Background

1 **ESTABLISHMENT OF DUES EFFECTIVE JANUARY 1, 2018**

2 **Background:** The Board of Trustees at its August 2017 meeting approved a preliminary budget with net
3 income before reserves of **\$134,000** based on the current full dues rate of five hundred and thirty-two
4 dollars \$(532). A dues increase of \$0 is being sought. Notification of the proposed dues level will be
5 circulated electronically to all constituent dental societies and announced in an official Association
6 publication. The following resolution is submitted by the Board of Trustees.

7 **Resolution**

8 **23. Resolved,** that the dues of ADA active members shall be \$532.00, effective January 1, 2018.

9 **BOARD RECOMMENDATION: Vote Yes.**

10 **BOARD VOTE: UNANIMOUS.**

- 1 **BOARD RECOMMENDATION: Vote No.**
- 2 **BOARD VOTE: UNANIMOUS.**

Resolution No. 49 New

Report: N/A Date Submitted: September 2017

Submitted By: Council on Members Insurance and Retirement Programs

Reference Committee: A (Budget, Business, Membership and Administrative Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: None

How does this resolution increase member value: See Background

COUNCIL ON MEMBERS INSURANCE AND RETIREMENT PROGRAMS: PROPOSED COUNCIL RESTRUCTURE

Background: In accordance with Resolution 1H-2013, the Council on Members Insurance and Retirement Programs (“CMIRP”) conducted its self-assessment in August 2016 and subsequently formed a workgroup to explore all possible options for increasing governance efficiency. The overarching goals were to identify an effective governance structure which would deliver ADA member value, preserve the financial integrity of the ADA members insurance and retirement programs and align with the ADA Strategic Plan. Most importantly, there was a strong desire to ensure the permanence of any newly created structure to guard against any potential change in the future without consultation with and approval by the House of Delegates.

Pursuant to its charge, the workgroup evaluated the pros and cons and unique characteristics of alternate structures including a council, standing committee of the Board or a separate legal entity under its own Board structure. The merits of each option were comprehensively assessed to determine which would be the most appropriate to reflect the unique relevance and financial significance of CMIRP’s Bylaws responsibilities and what was in the best interests of the ADA membership.

In addition, careful consideration was given to developing recommendations on group size, composition and characteristics. Based on best practice research, the workgroup recommended that the council be comprised of not less than 7 nor no more than 9 members in order to foster greater engagement and diversity, ensure functionality and maximize cost efficiency. Moreover, larger councils increase the likelihood of turnover which often complicates the orientation process. There was also consensus that skills-based criteria for volunteer nominations are more relevant than the need for geographic representation given CMIRP’s oversight responsibilities of technical insurance, retirement and plan financial subject matters.

At its March 2017 meeting the Council thoughtfully considered the workgroup’s recommendation that CMIRP become a committee of the Board; however, the council strongly supported the option of being a small, skills-based council. Following its deliberations, the Council voted to recommend being reconstituted as a skills-based council comprised of nine ADA members selected at large. The Council further recommended that the term of service be changed from four years to three years, with a tenure of up to two terms, and that there be a transition period beginning at the close of the 2018 House of Delegates to allow current council members to complete their existing terms of service.

1 Accordingly, the Council proposes the following resolution to the House:

2 **Resolution**

3 **49. Resolved**, that the ADA *Bylaws*, CHAPTER X. COUNCILS, *Section 20. MEMBERS,*
 4 SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection A, unnumbered paragraph on the
 5 Council on Members Insurance and Retirement Programs, be amended as follows (additions
 6 underscored; deletions ~~stricken~~):

7 Council on Members Insurance and Retirement Programs shall be composed of ~~seventeen (17)~~
 8 nine (9) members, one (1) member from each trustee district whose terms of office shall be
 9 staggered in such a manner that four (4) members will complete their terms each year except
 10 every fourth year when five (5) members shall complete their terms nominated by the Board of
 11 Trustees from any trustee district and whose terms of office shall be staggered in such a manner
 12 that three (3) members will complete their terms each year.*

13 * In order to establish the Council's revised composition, the Council members in office at the
 14 time this footnote becomes effective shall finish their terms in accordance with their scheduled
 15 completion dates. For each of the service term years of 2018-2019 through 2020-2021, 3 new
 16 members shall be selected for nomination by the Board of Trustees for three-year service terms
 17 in order to achieve the new 3-year rotational pattern. This footnote shall expire at adjournment
 18 sine die of the 2021 House of Delegates.

19 and be it further

20 **Resolved**, that the ADA *Bylaws*, Chapter X. COUNCILS, *Section 60. TERM OF OFFICE*, be
 21 amended as follows (additions underscored):

22 *Section 60. TERM OF OFFICE:* The term of office of members of councils shall be four (4) years
 23 except as otherwise provided in these *Bylaws*. The tenure of a member of a council shall be
 24 limited to one (1) term of four (4) years except as otherwise provided in these *Bylaws*. The term
 25 of office of members of the Council on Members Insurance and Retirement Programs shall be
 26 three years, with a tenure of up to two (2) terms. A member shall not be eligible for appointment
 27 to another council or commission for a period of two (2) years after completing a previous council
 28 appointment. The current recipient of the Gold Medal Award for Excellence in Dental Research
 29 shall serve on the Council on Scientific Affairs until the award is bestowed on the next honoree.

30 and be it further

31 **Resolved**, that the ADA *Bylaws*, Chapter X. COUNCILS, *Section 70. VACANCY*, second paragraph,
 32 be amended as follows (deletions ~~stricken~~):

33 If the term of the vacated council position has less than fifty percent (50%) of a full ~~four-year~~ term
 34 remaining at the time the successor member is appointed or elected, the successor member shall
 35 be eligible for election to a new, consecutive ~~four-year~~ term. If fifty percent (50%) or more of the
 36 vacated term remains to be served at the time of the appointment or election, the successor
 37 member shall not be eligible for another term.

38 and be it further

39 **Resolved**, if Resolution 7, Amendment of the ADA *Bylaws* pursuant to 118H-2014 is adopted, that
 40 the following conforming changes to the foregoing ADA *Bylaws* amendments be approved for
 41 placement into the newly proposed CHAPTER VIII. COUNCILS, Sections A.1., E. and F (second
 42 paragraph) of the *Governance and Organizational Manual of the American Dental Association*
 43 (Insertions double underlined, deletions ~~double struck~~):

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CHAPTER VIII. COUNCILS

A. Members, Selections, Nominations and Elections.

1. Composition. The composition of the councils of this Association shall be as follows:

a. Council on Dental Education and Licensure. The Council on Dental Education and Licensure shall be composed of sixteen (16) members selected as follows:

i. Nominations.

(a) Eight (8) members shall be nominated by the Board of Trustees on a rotational system by trustee district from the active, life or retired members of this Association, no one of whom shall be a full-time member of a faculty of a school of dentistry, a current dental examiner or member of a state or regional testing agency, state board of dentistry or jurisdictional dental licensing agency.*

(b) Four (4) members who are active, life or retired members of this Association shall be selected by the American Association of Dental Boards from the active membership of that body, no one of whom shall be a member of a faculty of a school of dentistry.

(c) Four (4) members who are active, life or retired members of this Association shall be selected by the American Dental Education Association from its active membership. These members shall hold positions of professorial rank in dental schools accredited by the Commission on Dental Accreditation and shall not be current dental examiners or members of any state or regional testing agency, state board of dentistry or jurisdictional dental licensing agency.

ii. Committees. The Council on Dental Education and Licensure shall establish a standing Committee on Dental Education and a standing Committee on Licensure, each consisting of eight (8) members selected by the Council. The Council may establish such additional committees believed to be essential to carrying out its duties.

b. Council on Members Insurance Retirement Program. The Council on Members Insurance Retirement Programs shall be composed of nine (9) active, life or retired members who are selected from nominations open to all trustee districts whose terms of office shall be staggered in such a manner that three (3) members will complete their terms each year.**

* A person shall be considered to be a full-time member of a faculty if he or she works for the school of dentistry more than two (2) days or sixteen (16) hours per week.

** In order to establish the Council's revised composition, the Council members in office at the time this footnote becomes effective shall finish their terms in accordance with their scheduled completion dates. For each of the service term years of 2018-2019 through 2020-2021, 3 new members shall be selected for nomination by the Board of Trustees for three-year service terms in order to achieve the new 3-year rotational pattern. This footnote shall expire at adjournment sine die of the 2021 House of Delegates.

1 c. Council on Scientific Affairs. The Council on Scientific Affairs shall be composed of
2 sixteen (16) members who shall be selected from nominations open to all trustee
3 districts, and the current recipient of the Gold Medal Award for Excellence in Dental
4 Research.

5 d. Remaining Councils. The remaining councils of this Association shall each be
6 composed of seventeen (17) members, one (1) member from each trustee district
7 whose terms of office shall be staggered in such a manner that four (4) members will
8 complete their terms each year except every fourth year when five (5) members shall
9 complete their terms.

10 * * * * *

11 E. Term of Office. Except for members of the Council on Members Insurance and Retirement
12 Programs whose term of office shall be three (3) years, the ~~The~~ term of office of members of councils
13 shall be four (4) years except as otherwise provided in the *Bylaws* or this *Governance Manual*. Except
14 for members of the Council on Members Insurance and Retirement Programs whose tenure on the
15 council shall be limited to two terms of three (3) years, the ~~The~~ tenure of a member of a council shall
16 be limited to one (1) term of four (4) years except as otherwise provided in the *Bylaws* or this
17 *Governance Manual*. The current recipient of the Gold Medal Award for Excellence in Dental
18 Research shall serve on the Council on Scientific Affairs until the award is bestowed on the next
19 honoree.

20 * * * * *

21 If the term of the vacated council position has less than fifty percent (50%) of a full ~~four-year~~ term
22 remaining at the time the successor member is appointed or elected, the successor member shall be
23 eligible for election to a new ~~four-year~~ term. If fifty percent (50%) or more of the vacated term remains
24 to be served at the time of the appointment or election, the successor member shall not be eligible for
25 another term.

26 **BOARD RECOMMENDATION: Vote Yes.**

27 **Vote: Resolution 49**

ASAI	Yes	CROWLEY	Yes	KWASNY	Yes	NORBO	Yes
BITTER	No	FISCH	Yes	KYGER	Yes	ROBINSON	Yes
BLACK	Yes	GEHANI	Yes	MARRON-TARRAZZI	Yes	SABATES	Yes
COHLMIA	Yes	JEFFERS	Yes	MCDOUGALL	Yes	STEVENS	Yes
COLE	Yes	KLEMMEDSON	Yes	MITCHELL	Yes	THOMPSON	Yes

1 current information later in the year, and should result in a more accurate budget.

- 2
- 3 • There will be no need for the Board to “go behind the curtain” (a practice which, fortunately,
4 has become less common in recent years) and make hurried budget decisions based on late
5 House action. Instead, the Board will have ample time to carefully address all budget issues
6 after the close of the House and the end of the year and use information gathered from the
7 House to make more thoughtful changes.
 - 8
 - 9 • The proposal will allow *all* programs to be assessed by the Board in making funding
10 decisions. Currently, any program passed by the House (or created by the Board or councils)
11 in prior years is so assessed. But any programs created by the House in the current year are
12 given a “super priority” and are not subject to such analysis. The Board believes that the
13 distinction between programs created in one year versus another is not a logical one and is a
14 poor foundation on which to base budget decisions.

15 Shifting budget authority to the Board will also allow greater flexibility to develop better budget
16 processes to assure the financial future of the ADA. For example, the Board is considering the
17 advantages of a three-year budget. Such innovation is more easily accomplished by the entity
18 responsible for the management of the Association and which meets with greater frequency.

19 **Information Considered by the Board:** The Board has reviewed a recent report from the ADA’s
20 internal auditor, the experience of state societies which have recently shifted budget authority to their
21 Boards, and prior advice received on this question:

- 22 A. **2016 Audit Report:** Last year, the ADA’s auditors provided a report to the Board’s Audit
23 Committee. In reviewing the strategic plan goals, the auditors noted²: *“Based upon our
24 review, to meet these goals in today’s rapidly changing environment, the ADA should align its
25 governance structure in a manner consistent with other major professional associations.”*

26
27 As part of this alignment, the auditors described the appropriate roles for the Board:

28 *The role of the Board of Trustees is to represent the House of Delegates and
29 perform oversight of the management of the association to meet the needs of the
30 membership. This oversight includes the approval of the Association’s strategy
31 and budget.*

32 The auditors expanded on this analysis:

33 **Observation #1: Budget Review and Approval Process**

34 *Based on our discussions with management and understanding of the process to review
35 and approve the ADA’s annual operating budget, we observed the following:*

- 36
- 37 • *When compared to other similar professional Associations (e.g. American Bar
38 Association, American Medical Association, etc.), the Constitution and Bylaws of the
39 ADA appears to be unique in vesting budget approval authority to the House of
40 Delegates.... In the other Associations we reviewed, this authority rested with the
41 Board of Trustees and the House of Delegates was primarily responsible for
42 representing the membership, setting policy, and authorizing the appointment of
43 Board members.*
- 44

² To make clearer when another text is quoted, the quotation is italicized in this report.

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- *Currently, the House of Delegates meets once a year to receive and review informational materials related to the budget. The time devoted to reviewing and approving the budget, could be time used for engaging and discussing the Associations strategic direction and member needs.*

- *The size of the governance body/committee responsible for reviewing the budget should be sufficient to assure adequate representation to make an informed decision on approving a budget that aligns to the Association’s goals and objectives, but should not be too large as to present inefficiencies. Given the large size of the House of Delegates (~450 members), it may be difficult to obtain a consensus view of the items most important to the Association’s strategy. Budget decisions may favor the perpetuation of the status quo. Through our discussions, we identified the following inefficiencies inherent in the process:*
 - *During the Board’s review of the budget, it is expected to justify any elimination of Council programs included in the last House-approved budget. If the House disagrees with the Board’s decision to sunset a program, the House can vote to send the budget back to the Board for reconsideration. According to the Speaker of the House, that process could be repeated until the House votes to approve the budget within a 60% vote.*

 - *Reviews and approvals by governance bodies/committees earlier in the review process are based on more information and operational knowledge than those in proceeding groups.*

 - *Any decisions made by a governance body/committee during the review process can be undone by another group later in the process. At times, a decision may be undone without understanding the unintended impacts to management’s plan toward achieving the association’s strategic objectives.*

- *The final decision to approve an Association’s budget should reside with the same body that decides the strategic and operating plans in order to align the Association’s goals and objectives with how time and money are to be allocated. Generally, if one body has ultimate accountability ... over any aspect of management, it is most appropriate for the same body to have control and authority to make decisions over that aspect of management. Further, Section 108.05(a) of the Illinois Not-for-Profit Corporation Act of 1986 provides that “except as provided in articles of incorporation, the affairs of the corporation shall be managed by or under the direction of the board of directors.” As the annual operating budget is considered an affair of the Association, it is more appropriate for the Board of Trustees to approve and oversee the budget.*

The auditors researched how other associations handle their budgets and produced the following chart:

Name of Professional Association	Role of House of Delegates per Bylaws	Role of Board per Bylaws
American Dental Association (ADA)	Per Chapter V, Section 50, “it shall be the duty of the House of Delegates to (e) adopt an annual budget and establish the dues of active members for the following year.”	Per Chapter VII, Section 100, “It shall be the duty of the Board of Trustees to....(f) prepare a budget for carrying on the activities of the Association for each ensuing fiscal year, and present for action by each House of Delegates

		<i>a resolution setting forth the proposed dues of active members for the following year."</i>
American Bar Association (ABA)	<i>Per Article 6, Section 1, "the House of Delegates, the legislative body of the Association, shall formulate policy for the Association. It may adopt rules consistent with the Constitution and Bylaws. It is the ultimate governing body of the Association. It shall elect the officers of the Association and the members of the Board of Governors. It is the judge of the election and qualifications of its members. It has all the powers necessary or incidental to performing those functions."</i>	<i>Per Article 28, Section 1, "the Board shall formulate and administer Association policy respecting authorized expenditures and procedures for reimbursement. If a proposal requiring the expenditure of funds originates in the House of Delegates, it may be acted on only after the Board reports on its feasibility."</i>
American Medical Association (AMA)	<i>Per Article IV, "the House of Delegates is the legislative and policy-making body of the Association. It is composed of elected representatives and others as provided in the Bylaws. The House of Delegates shall transact all business of the Association not otherwise specifically provided for in this Constitution and Bylaws, and shall elect the general officers except as otherwise provided in the Bylaws"</i>	<i>Per Article V, Section 3.7.1, "the Board shall oversee the development and approve the annual budget for the AMA, consistent with the AMA's vision, goals, and priorities."</i>
American Veterinary Medical Association (AVMA)	<i>Per Article VII, Section 1, "the House of Delegates shall be the principal body within the Association responsible for establishing policy and providing direction for matters relating to veterinary medicine and shall be the representative body of the Principal and Constituent Allied Veterinary Associations of the Association."</i>	<i>Per Article V, Section 1, "the affairs of the Association shall be managed by the Board of Directors....which shall have supervision, control, and direction of the Association, shall determine its policies or changes therein within the limits of these Bylaws, shall actively promote its purposes, and shall have discretion in the disbursement of its funds."</i>
American Pharmacists Association (APhA)	<i>Per Article VI, Section 3, "the House of Delegates shall serve as a legislative body in the development of ASSOCIATION policy. It shall</i>	<i>Per Article XI, Section 2, "all disbursements of ASSOCIATION funds shall be pursuant to such policies and procedures as may be established from time to time by the</i>

	<i>act on such policy recommendations as shall come before it and shall adopt rules or procedures for the conduct of its business.”</i>	<i>Board of Trustees and are to be monitored and reviewed on a regular basis by the Treasurer and the Executive Vice President or by the Executive Vice President alone.”</i>
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1 **B. Practice by Constituent Societies:** The Board also considered how our constituent
 2 societies approve their budgets. Recognizing that this has been changing in recent years,
 3 the Board understands that the following constituent societies provide for the board to
 4 approve the budget for the association (and others may be considering it as well):
 5

- 6 California
- 7 Colorado
- 8 Wyoming
- 9 Idaho
- 10 Montana
- 11 Oregon
- 12 Pennsylvania
- 13 North Carolina
- 14 West Virginia
- 15 Missouri
- 16 Michigan
- 17 Vermont
- 18 Maine
- 19 DC Dental Society

20 The task force that advised the Board on this question included House members from
 21 California and Michigan (both of which have recently shifted budget authority to their
 22 boards). Both task force members shared their experiences about this transition and noted
 23 that the change had been well received.

24 **C. 2012 Governance Report:** In 2012, the Board reported to the House on a comprehensive
 25 review of the ADA’s governance structures and processes. A copy of that report and
 26 appendices may be found on the House ADA Connect site under Archived Documents—
 27 2012. Below are links to the 2012 Board Report 3 and the consultant report:
 28

29 <http://connect.ada.org/governance/hod/Archived%20Documents/2012%20House%20Material/Amendable%20Format%20Documents/Governance/Board%20Report%2003.docx>

30 <http://connect.ada.org/governance/hod/Archived%20Documents/2012%20House%20Material/Amendable%20Format%20Documents/Governance/Board%20Report%2003%20-%20Appendix%2001%20Westman%20Report.pdf>

31

32 The consultants proposed the following:

33 *Suggestion #49:* *Delegate more fiduciary responsibilities to the BOT, such as approving*
 34 *the budget.*

35

36 *Commentary:* *[The ADA Consultant] strongly believes that this represents “best practice”*
 37 *in association governance. The HOD meets infrequently, is large/cumbersome, and*
 38 *members simply do not have the requisite time, knowledge, and expertise to undertake*
 39 *the budgeting role effectively – especially for an organization as large and complex as*
 40 *ADA.*
 41
 42
 43

1 *Most associations have come to realize that the HOD is not in the best position to*
2 *undertake key fiduciary responsibilities....*

3 The 2012 Governance Report included a benchmarking survey of 21 associations as an
4 appendix to the report. Of those, 71% placed the authority to approve the budget with the
5 Board. The report also separated out from the respondents the largest associations (budgets
6 over \$30 million) and the same percentage (71%) gave the board budget authority.

7 **D. Legal Issues:** The Board considered legal issues relating to the placement of budget
8 authority and has concluded that the ADA is not legally mandated to take the action proposed
9 here.

10 Because the auditors raised the issue of the Illinois General Not For Profit Corporation Act of
11 1986, 805 ILCS 105/ (“the Act”) and similar issues have arisen when state societies have
12 examined the question, the Board is including here an analysis of that act on the question
13 before the House.

14 The Illinois General Not For Profit Corporation Act of 1986 provides the basic governance
15 framework that all nonprofit corporations organized under the Illinois law, including the ADA,
16 must follow. Article 8 of the Act provides that each nonprofit corporation formed under Illinois
17 law must have a board of directors. The default governance structure provided by the Act is
18 that the Board of Directors shall be responsible for the management of the affairs of the
19 corporation. The Act does, however, provide a mechanism for shifting some or all of that
20 management responsibility by indicating that the corporation’s articles of incorporation can
21 place that responsibility elsewhere (805 ILCS § 108.05(a)):

22 Each corporation shall have a board of directors, and except as provided in
23 articles of incorporation, the affairs of the corporation shall be managed by or
24 under the direction of the board of directors.

25 Section 7 of the ADA’s *Articles of Incorporation* call for the governance of the affairs and
26 exercise of corporate authority of the Association to be divided between the Board of
27 Trustees, the House of Delegates, officers, councils, committees, members, agents and
28 employees of the Association as specified in the *Constitution of Bylaws* of the ADA:

29 7. EXERCISE OF CORPORATE POWERS. Except as otherwise provided by law, the
30 affairs of this corporation shall be governed and the corporate powers of the corporation
31 shall be exercised by a Board of Directors (to be known as the Board of Trustees),
32 House of Delegates, officers, councils, committees, members, agents and employees as
33 set forth in the *Constitution and Bylaws* and the titles, duties, powers, and methods of
34 electing, designating or selecting all of the foregoing shall be as provided therein.

35 As it relates to the authority over the budget of the ADA, Chapter V, Section 50E of the ADA
36 *Bylaws*, as permitted under the Act, vests the duty to adopt an annual budget with the
37 House of Delegates:

38 Section 50. DUTIES: It shall be the duty of the House of Delegates to:

39 * * *

40 E. Adopt an annual budget and establish the dues of active members for the following
41 year.
42 year.

43 The mechanism for the adoption of the Association’s annual budget is provided for in
44 Chapter V, Section 130Ac of the ADA *Bylaws*:
45 year.

1 c. APPROVAL OF ANNUAL BUDGET. The proposed annual budget shall be submitted
2 by the Board of Trustees to the members of the House of Delegates at least thirty (30)
3 days prior to the opening meeting of the annual session, shall be referred to a special
4 reference committee on budget for hearings at the annual session and then shall be
5 considered for approval as a special order of business at the second meeting of the
6 House of Delegates. In the event the budget as submitted is not approved, all
7 recommendations for changes shall be referred to the Board of Trustees to prepare and
8 present a revised budget. This procedure shall be repeated until a budget for the ensuing
9 fiscal year shall be adopted.

10 **How the New Process Will Operate:** The Board recognizes the complexities inherent in addressing
11 the issues raised here. For that reason, the Board outlines the process here:
12

- 13 • The Board will prepare the initial draft budget and submit to the House the same level of
14 information it currently provides (the Board recognizes that Board Report 2 has evolved over
15 the years and, no doubt, this will continue, but the basic information provided will remain the
16 same).
17
- 18 • The Councils, as committees of the House, will continue to have the same role they currently
19 have in developing the budget. Councils provide essential direction to the ADA divisions in
20 setting priorities. There will be no change in this process.
21
- 22 • The Board will submit to the House its tentative budget and a proposed dues level, consistent
23 with current practice. The Board's dues proposal will reflect the revenue levels needed to
24 implement the proposed budget.
25
- 26 • The House will retain full control over establishing dues for the coming year.
27
- 28 • The Board will urge the Speaker to retain a budget reference committee (or will arrange an
29 open forum) to allow House members a full opportunity to offer comments on the budget.
30
- 31 • If the House chooses to set the dues at a level below that recommended by the Board, the
32 Board would then revise its budget by managing to meet the revenue level associated with
33 the dues as approved by the House of Delegates. This will be done following adjournment of
34 the House and before the start of the new budget year, allowing the Board the time needed to
35 fully consider changes needed to the budget.
36
- 37 • If the House proposes new spending and supports that proposal with a funding mechanism
38 (e.g., added dues, an assessment or a suggestion to spend from reserves), the Board would
39 almost certainly add the new spending to the budget, except in extraordinary circumstances
40 such as legal considerations or fiscal emergencies.
41
- 42 • If the House proposes new spending and does not support that request with a funding
43 mechanism, the Board would consider that new spending priority in the context of all other
44 programs when it finalizes the budget. Options could include funding the new initiative with
45 existing resources (if that is possible), cutting funding for other programs to fund the new
46 initiative, not funding it or not funding it but committing to include it in for the next budget and
47 operating plan. As is discussed later, the Board would provide a full report to the House on
48 the final budget decisions.
49
- 50 • Another funding option available to the House that suggests a new program to the Board
51 could include eliminating an existing program, which could free up resources in the budget.
52

- Whatever final budget decisions the Board reaches, it will present to the House before the close of the year a full report on those decisions, highlighting changes from the prior draft budget and how any new proposals from the House are addressed in the final budget.

Continuing Authority of the House: As has been stated already, the House will maintain full authority to set the dues for our members. In addition, the House will continue to be fully informed about the programs being executed and the proposed budget for the next fiscal year. As noted above, the House will retain authority to stop any existing program and to urge the Board to undertake any new program. The ADA has a representative form of government. The House represents the members and the House directly elects the officers and the Board. Related to that is the existing power to remove any officer or Board member. All of this will continue and represents the ultimate authority of the House.

Conclusion: The Board believes the ADA has made great progress in its governance and in the relationship between the House and the Board. The Board believes its proposal is needed to continue our progress and assure our future and that the trust between the House and the Board allows this to occur. The Board thanks the House for its consideration of this proposal.

Proposed Resolution

52. Resolved, that CHAPTER V. HOUSE OF DELEGATES, *Section 50. DUTIES* of the ADA *Bylaws* be amended as follows (additions underscored, deletions ~~stricken through~~):

Section 50. DUTIES: It shall be the duty of the House of Delegates to:

- A. Elect the elective officers.
- B. Elect the members of the Board of Trustees.
- C. Elect the members of the councils and commissions except as otherwise provided by these *Bylaws*.
- D. Receive and act upon reports of the committees of the House of Delegates.
- E. ~~Adopt an annual budget and~~ Establish the dues of active members for the following year.
- F. Serve as the court of appeal from decisions of the Council on Ethics, Bylaws and Judicial Affairs involving disputes arising between constituent societies or between constituent and component societies, and as provided in Chapter XII of these *Bylaws*.

and be it further

Resolved, that CHAPTER V. HOUSE OF DELEGATES, *Section 130. RULES OF ORDER, Subsection A. STANDING RULES AND REPORTS, paragraph b. APPROPRIATION OF FUNDS* and paragraph c. APPROVAL OF THE ANNUAL BUDGET of the ADA *Bylaws* be deleted in their entirety as follows (deletions ~~stricken through~~):

A. STANDING RULES AND REPORTS.

- a. REPORTS. All reports of elective officers, councils and committees, except supplemental reports, shall be sent to each delegate and alternate delegate at least fourteen (14) days in advance of the opening of the annual session. All supplemental reports shall be distributed to each delegate before such report is considered by the House of Delegates.
- ~~b. APPROPRIATION OF FUNDS. Any resolution proposing an appropriation of funds, except those relating to the annual budget, shall be referred to the Board of Trustees for a report at the same session on the availability of funds for the purpose specified.~~

1 ~~e. APPROVAL OF ANNUAL BUDGET. The proposed annual budget shall be submitted~~
2 ~~by the Board of Trustees to the members of the House of Delegates at least thirty (30)~~
3 ~~days prior to the opening meeting of the annual session, shall be referred to a special~~
4 ~~reference committee on budget for hearings at the annual session and then shall be~~
5 ~~considered for approval as a special order of business at the second meeting of the~~
6 ~~House of Delegates. In the event the budget as submitted is not approved, all~~
7 ~~recommendations for changes shall be referred to the Board of Trustees to prepare~~
8 ~~and present a revised budget. This procedure shall be repeated until a budget for the~~
9 ~~ensuing fiscal year shall be adopted.~~

10 and be it further

11 **Resolved**, that the remaining paragraphs d. through f. of CHAPTER V. HOUSE OF
12 DELEGATES, *Section 130. RULES OF ORDER, Subsection A. STANDING RULES AND*
13 *REPORTS*, be re-lettered as paragraphs b. through d., respectively, and be it further

14 **Resolved**, that CHAPTER VII. BOARD OF TRUSTEES, *Section 100. DUTIES, Subsection F.*
15 *of the ADA Bylaws* be amended as shown below (additions underscored):

16 F. Develop, prepare and adopt a budget for carrying on the activities of the Association
17 for each ensuing fiscal year, and present for action by each House of Delegates a
18 resolution setting forth the proposed dues of active members for the following year.
19 Notice of such a resolution shall be sent electronically to each constituent society and
20 posted ADA Connect or its equivalent for the House of Delegates not less than thirty (30)
21 days before such session to permit prompt, adequate notice by each constituent society
22 to its delegates and alternate delegates to the House of Delegates of this Association,
23 and shall be announced to the general membership in an official publication of the
24 Association at least fifteen (15) days in advance of the annual session.

25 and be it further

26 **Resolved**, that the section entitled "Consideration of Budget" contained in the *Rules of the*
27 *House of Delegates* be deleted in its entirety (deletions ~~stricken through~~):

28 **Consideration of Budget**

29 ~~The proposed annual budget shall be submitted to the members of the House of Delegates~~
30 ~~at least 30 days prior to the opening meeting of the annual session. In the event the~~
31 ~~proposed budget as submitted is not approved, all recommendations for changes adopted~~
32 ~~by the House of Delegates shall be referred to the Board of Trustees to prepare and~~
33 ~~present a revised, proposed budget.~~

34 ~~Recommendations for changes shall be made in the form of fully debatable motions which~~
35 ~~shall be individually considered and acted upon by the House of Delegates. To be in order,~~
36 ~~the proper wording for such a motion must be:~~

37 ~~"I move that the proposed budget be returned to the Board of Trustees for revision with~~
38 ~~the recommendation that..."~~

39 ~~If any recommendations for changes in the proposed budget receive House approval, they~~
40 ~~shall be identified as House Budget Recommendation 1, House Budget Recommendation~~
41 ~~2, etc.~~

42 ~~House approval of any recommendations for changes automatically returns the proposed~~
43 ~~budget to the Board of Trustees for revision and subsequent resubmission to the House of~~

1 ~~Delegates for approval or further recommendations for modification. This procedure will be~~
 2 ~~repeated until a preliminary budget for the ensuing fiscal year is adopted.~~

3 ~~This preliminary budget includes all items that the Board of Trustees and House of~~
 4 ~~Delegates have approved, but it remains a preliminary budget since it does not incorporate~~
 5 ~~any programs that may subsequently be adopted by the House at this session which~~
 6 ~~require additional funding. The final budget is established and adopted by the House of~~
 7 ~~Delegates through its approval of the preliminary budget plus the changes made as a result~~
 8 ~~of actions by the House of Delegates. The Board of Trustees will present this final budget,~~
 9 ~~which will include the preliminary budget plus any additions made as a result of action by~~
 10 ~~the House of Delegates, to the House at the last meeting of the annual session.~~

11 **BOARD RECOMMENDATION: Vote Yes.**

12 **Vote: Resolution 52**

ASAI	Yes	CROWLEY	Abstain	KWASNY	Yes	NORBO	Yes
BITTER	Yes	FISCH	Yes	KYGER	No	ROBINSON	Yes
BLACK	Yes	GEHANI	Yes	MARRON-TARRAZZI	No	SABATES	No
COHLMIA	Yes	JEFFERS	Yes	MCDUGALL	Yes	STEVENS	Yes
COLE	No	KLEMMEDSON	Yes	MITCHELL	No	THOMPSON	Yes

- 1 • *Websites.* In 2016, projects were completed to implement the Coveo search software to improve
2 search functionality for all ADA websites as well as an upgrade to Sitecore, the website content
3 management software. The MouthHealthy.org, MouthHealthy for Kids.org and the Ctr. for
4 Professional Success (CPS) websites were moved to a responsive web design so that visitors
5 can easily view them from any device, whether it be a phone, tablet, laptop or desktop computer.
6 The redesign helps future-proof the sites and brings them up to the same code base as all other
7 ADA websites.

8 As part of the Power of 3 initiative, the ADA developed branded website templates to deploy to
9 the states and local societies who were also converting from the Tripartite System (TS) to Aptify.
10 The branded templates offer the states and locals a similar “look and feel” web presence, which
11 gives visitors a similar web experience at the local, state and national level. As of this report, 92
12 states and locals have been rolled out with another 10 states and locals on the schedule.
13 Website template enhancements that were identified by state and local societies were
14 implemented in 2016, which included an Aptify member data update integration. This integration
15 allows ADA member data entered into a web form to be updated in Aptify. In 2017, custom
16 website templates were designed for California components wanting a branded website until CDA
17 completes its Aptify implementation. Those website templates will then be able to interface with
18 CDA’s Aptify environment. In 2018, an initiative is planned to update the branded website
19 templates and Power of 3 pages to include technology necessary to integrate a State/Local
20 branded ADA member experience for all Aptify member data interfaces and to ensure all ADA
21 member online experiences work seamlessly with new technology.

- 22 • *Digital Member Experience/Personalization.* In 2017 and 2018, a major website redesign is
23 planned to begin that will include personalization development and usage. This program is
24 designed to identify specific content for unique members and deliver this content to them through
25 their preferred communication channels (Facebook, Websites, etc.). This service will help
26 demonstrate to the membership that the ADA understands their interests and will specialize the
27 content they receive rather than inundating them with all ADA content, which can be confusing
28 and overwhelming. In addition, a new single sign-on solution will be identified and implemented
29 that allows users to log into ADA systems (e.g. Aptify, eCatalog, ADA Members-only areas) with a
30 single user ID and password to gain access rather than having a different user ID and password
31 for each system. An artificial intelligence-based community software called Rasa is scheduled to
32 be piloted by the ADA as well as states and local societies using Aptify. This software solution
33 provides an updated stream of content and conversation that is uniquely personalized to each
34 member. A Digital Asset Management System to manage and control all ADA digital assets will
35 be implemented to support all content development including JADA, ada.org, ADA News, etc.
36 This system will enable more coordinated digital asset permissions and utilization to improve
37 content distribution and management. A new Find-a-Dentist search tool was built and
38 implemented. In addition, pilots for Virtual Study Groups and a Career Center are being
39 developed and scheduled for implementation in 2018.

- 40 • *Mobility.* In 2016, the CDT mobile app was updated to include current codes and update the
41 operating system platform. The Aptify State Branded Mobile for Member app was also updated
42 to include new features and functionality such as photo uploads, Facebook integration and alert
43 management for posting and retrieving information. This new free member benefit allows ADA
44 members to access their information stored in Aptify from their smart phones and/or tablets and
45 includes such functionality as updating their profile; accessing newsfeeds; connecting with
46 members; and managing meeting and CE information. In 2017, existing mobile apps will be
47 updated as needed. In 2018, CDT Code Check, Oral Pathologist and Toothflix 2.0 mobile
48 applications will be upgraded to latest iOS and Android platforms. In addition, the Chairside
49 Instruction mobile application will require a major redesign as this mobile app has not been
50 updated in several years.

- 51 • *ADA Connect.* The ADA Connect upgrade to MS SharePoint 2013 that began in 2016 has been
52 completed. This upgrade uses a design that improves the look and feel of the user experience

1 and enhances the interaction with discussions documents. The upgrade also integrates ADA
2 Connect and ADA Knowledge Center to ensure each maintains a secure environment while
3 allowing the proper level of collaboration as appropriate. An ADA Connect Pilot is scheduled to
4 begin August 2017 with the Arizona Dental Association. The same ADA Connect functionality
5 used by the Board, House, Committees and Councils would be available to any State society. If
6 the pilot proves viable and states show interest, a rollout plan will be scheduled for 2017 and
7 2018 using existing staff resources.

- 8 • *Finance/HR/Payroll.* In 2015, a vendor was selected to work with ADA staff to select a
9 replacement for Oracle PeopleSoft Financials and HR/Payroll systems. NetSuite ERP was
10 chosen as the new financial system and UltiPro as the new HR/Payroll system. The HR/Payroll
11 system went live in October 2016. In November 2017, NetSuite was bought out by Oracle. This
12 ownership change plus the dissatisfaction ADA staff had with the NetSuite implementation team
13 caused the financial system implementation to be delayed. A new system implementation team
14 with extensive experience with the NetSuite product was retained in January 2017 to assist with
15 the system implementation. Work is well underway and the system is scheduled to go into
16 production in January 2018.
- 17 • *Hyperion/Adaptive Budgeting.* In 2016, minor system updates were completed to Hyperion to
18 prepare the system for the 2017 budget process. As part of the Finance/HR/Payroll system
19 replacements project, it was determined that Hyperion should also be replaced. Adaptive
20 Planning was the selected system. Data migration work was completed as part of the conversion
21 to the new budget system, which went live in March 2017 in time for the 2018 budget process.
22 As of June 2017, all budget management and reporting has moved from Hyperion to Adaptive
23 Planning.
- 24 • *Tripartite System.* The Tripartite System (TS) was officially shutdown on June 1, 2017. The
25 shutdown came after all TS users were converted to Aptify and the 2016 dues billing process was
26 completed.
- 27 • *Infrastructure, Hardware and Software Licenses.* The expenditures reflected in 2016, 2017 and
28 2018 are primarily for hardware and software licenses to maintain the Association's network
29 infrastructure as well as provide end-user equipment such as desktops, laptops and printers. In
30 addition, funding is budgeted annually for a manufacturer-certified on-site technician. This
31 technician is available on-site to fix hardware under warranty instead of depending on "depot
32 warranty service" thus minimizing downtime for users. In 2016, work began to implement digital
33 signage for the Lobby, 2nd Floor, ADABEI and the Newsroom. This project was completed in
34 August 2017. AV upgrades are planned for the Washington DC office this year. PCI compliance
35 and network security continue to be monitored with security improvements implemented as
36 needed in 2017 and 2018.
- 37 • *Aptify.* All Aptify rollouts to the states are now completed. As of this report, 47 states,
38 Washington DC and Puerto Rico are on Aptify. In 2016, a broadcast email solution for the states
39 and local societies was also implemented to allow them to create and send bulk email messages
40 and to easily create and send newsletters. A Learning Management System (LMS) was
41 developed that integrates with the Education module and eCommerce functionality to manage CE
42 activities. An upgrade to the latest version of Aptify was completed that moves Aptify to a web-
43 based version, which allow access from any Internet browser. In 2017, an eCatalog solution for
44 the states and local societies was implemented that allows them to collect online voluntary dues
45 (PAC, Foundation, etc.) and to sell products to generate non-dues revenue. Projects also
46 completed in 2017 include ADA eCatalog enhancements; upgrades to the Meetings module;
47 enhancements to the LMS module and a Lockbox import process for the Accounts Receivable
48 (AR) module. An Aptify Value Workshop was conducted that included key Aptify business users
49 from the ADA, States and Locals. The purpose of this workshop was to help Aptify business
50 users realize the full value-potential of the ADA's investment in Aptify, which included identifying
51 and addressing barriers to adoption, and working with state and local member organizations to
52 help them understand and take full advantage of the Aptify's capabilities. In 2018, system

1 enhancements are planned for all areas of Aptify as requested by the business users at the ADA;
2 the States and Local Societies.

- 3 • *Aptify/Education.* In 2016, several system features and functionality improvements were
4 implemented so DTS staff can process transactions more efficiently resulting in better user
5 experience for dentists and students. A project began to move the existing CODA Accreditation
6 database, CODA Consulting Training website and the CERP Online Provider Application to
7 Aptify. This project is slated to be completed in 2017. In 2017, accounting processes will be
8 updated to get accounting data from Aptify into NetSuite, the ADA's new financial system, which
9 will eliminate manual work for DTS staff. In 2018, a system enhancements are planned for this
10 area as identified by ADA Education staff.

11 The table below outlines actual expenditures in the core areas in 2016; projected spending in 2017
12 and planned spending in 2018. Also disclosed is spending related to infrastructure hardware and
13 major projects.

	2016	2017	2018
	Actual	Projected	Planned
IT Core Area	Spending	Spending	Spending
Enterprise Reporting & Analytics	0	0	20,000
Enterprise Reporting & Analytics (Contingency)	0	256,000	0
Websites (National)	173,650	0	0
Websites (States & Locals)	210,797	8,450	224,000
Mobile Applications	43,010	0	225,000
Digital Member Experience/Personalization	235,216	760,611	0
ADA Connect	123,045	200,397	20,000
Finance/HR/Payroll	262,156	725,687	99,000
Finance/HR/Payroll (Contingency Fund)	174,580	192,000	0
Finance/HR/Payroll (ADA Reserves)	35,000	0	0
Adaptive Budgeting System	34,081	39,158	0
Hyperion Budgeting System (Contingency Fund)	9,760	0	0
Infrastructure, Hardware & Software Licenses	827,188	1,052,473	996,000
Aptify (National)	329,841	681,938	175,000
Aptify (States & Locals)	317,900	150,612	175,000
Total Project Spending	2,776,224	4,067,326	1,934,000
Balance of IT Operating Budget	12,396,981	12,478,680	13,099,000
Total IT Spending	15,173,205	16,546,006	15,033,000

14
15 The tables below summarize the previous information based on the source of funding. The IT division
16 continues to maintain and upgrade its current core areas while also providing ongoing support and
17 completing various IT-related projects for ADA divisions.
18

2016 Actual Spending	Operating Budget	Capital Budget	Contingency Fund	ADA Reserves	Total
Enterprise Reporting & Analytics (1)	0	0	0	0	0
Websites National (2)	58,800	114,850	0	0	173,650
Websites States & Locals (3)	93,739	117,058	0	0	210,797
Mobile Applications (4)	12,710	30,300	0	0	43,010
Digital Member Experience (5)	13,736	221,480	0	0	235,216
ADA Connect (6)	25,000	98,045	0	0	123,045
Finance/HR/Payroll (7)	39,450	222,706	174,580	35,000	471,736

Hyperion/Adaptive Budgeting (8)	17,106	16,975	9,760	0	43,841
Infrastructure, Hardware, Software (9)	126,309	700,879	0	0	827,188
Aptify National (10)	179,900	149,941	0	0	329,841
Aptify States & Locals (11)	120,100	197,800	0	0	317,900
Total Project Spending	686,850	1,870,034	184,340	35,000	2,776,224
Balance of IT Operating Budget	12,396,981	0	0	0	12,396,981
Total IT Spending	13,083,831	1,870,034	184,340	35,000	15,173,205

1

2016 Consulting Projects	Operating Budget	Capital Budget	Contingency Fund	ADA Reserves	Total Actual Spending
Enterprise Reporting & Analytics Totals (1)	0	0			0
Coveo Search Tool Implementation	16,900	41,100			58,000
Mouthhealthy Responsive Design	18,000	37,500			55,500
Interactive Presentation	3,900	0			3,900
CPS Responsive Design	20,000	36,250			56,250
Websites (National) Totals (2)	58,800	114,850			173,650
Website Template Enhancements	93,739	117,058			210,797
Websites (States & Locals) Totals (3)	93,739	117,058			210,797
Dental Products Mobile App	6,200	0			6,200
CDT Mobile App	6,510	0			6,510
Aptify Mobile for Members	0	30,300			30,300
Mobile Application Totals (4)	12,710	30,300			43,010
Digital Asset Management System	13,736	75,000			88,736
Sitecore PXM Connector	0	146,480			146,480
Digital Member Experience Totals (5)	13,736	221,480			235,216
ADA Connect Upgrade	25,000	98,045			123,045
ADA Connect Totals (6)	25,000	98,045			123,045
PeopleSoft HR/Payroll Support	0	0	174,580	0	174,580
New Finance/HR/Payroll System Selection	0	0	0	35,000	35,000
NetSuite Finance Implementation	30,000	151,469	0	0	181,469
UltiPro HR/Payroll Implementation	9,450	71,237	0	0	80,687
Finance/HR/Payroll Totals (7)	39,450	222,706	174,580	35,000	471,736
Hyperion Budget System Support	0	0	9,760	0	9,760
Adaptive Budget Implementation	17,106	16,975	0	0	34,091
Hyperion/Adaptive Totals (8)	17,106	16,975	9,760	0	43,841
Warranty Technician	62,723	0			62,723
PCI Compliance/Network Security	15,049	0			15,049
Software	48,537	38,673			87,210
Hardware	0	368,363			368,363
Network Infrastructure	0	261,397			261,397
AV Upgrade - Chicago	0	32,446			32,446
Infrastructure Totals (9)	126,309	700,879			827,188
Aptify Support	103,600	0			103,600

Aptify Accounts Receivable	32,300	0		32,300
Aptify DTS Updates	0	39,100		39,100
Aptify CODA/CERP	27,500	0		27,500
Aptify CE	0	26,050		26,050
Online Signing Day Application	0	10,000		10,000
Aptify eCatalog Updates	0	25,291		25,291
Aptify 5.5.4 Upgrade	16,500	49,500		66,000
Aptify National Totals (10)	179,900	149,941		329,481
Aptify Support	103,600	0		103,600
Aptify 5.5.4 Upgrade	16,500	49,500		66,000
Aptify eCatalog	0	70,520		70,520
Broadcast Email System	0	77,780		77,780
Aptify States & Locals Totals (11)	120,100	197,800		317,900
2016 Grand Totals	686,850	1,870,034	184,340	35,000

1

2017 Projected Spending	Operating Budget	Capital Budget	Contingency Fund	ADA Reserves	Total
Enterprise Reporting & Analytics (1)	0	0	256,000	0	256,000
Websites States & Locals (2)	8,450	0	0	0	8,450
Digital Member Experience (3)	174,560	586,051	0	0	760,611
ADA Connect (4)	26,552	52,995	0	120,850	200,397
Finance/HR/Payroll (5)	360,887	364,800	192,000	0	917,687
Adaptive Budgeting (6)	22,183	16,975	0	0	39,158
Infrastructure, Hardware, Software (7)	119,142	933,331	0	0	1,052,473
Aptify National (8)	237,800	258,513	0	185,625	681,938
Aptify States & Locals (9)	138,125	12,487	0	0	150,612
Total Project Spending	1,087,699	2,225,152	448,000	306,475	4,067,326
Balance of IT Operating Budget	12,478,680	0	0	0	12,478,680
Total IT Spending	13,566,379	2,225,152	448,000	306,475	16,546,006

2

2017 Consulting Projects	Operating Budget	Capital Budget	Contingency Fund	ADA Reserves	Total Projected Spending
Enterprise Reporting & Analytics (1)	0	0	256,000		256,000
CA Components Customized Templates	8,450	0			8,450
Websites States & Locals (2)	8,450	0			8,450
Personalization/SSO/Rasa	172,252	554,000			726,252
Digital Asset Management System	2,308	32,051			34,359
Digital Member Experience (3)	174,560	586,051			760,611
ADA Connect Upgrade	26,552	52,995		120,850	200,397
ADA Connect Totals (4)	26,552	52,995		120,850	200,397
PeopleSoft HR/Payroll Support	99,760	0			99,760
NetSuite Finance Implementation	256,577	364,800	192,000		813,377
UltiPro HR Reports	4,550	0			4,550
Finance/HR/Payroll Totals (5)	360,887	364,800	192,000		917,687

Adaptive Budget Implementation	22,183	16,975		39,158
Adaptive Totals (6)	22,183	16,975		39,158
Warranty Technician	75,000	0		75,000
Software	29,142	128,024		157,166
Hardware	0	446,988		446,988
Network Infrastructure	15,000	238,319		253,319
AV Upgrades (Chicago & DC)	0	120,000		120,000
Infrastructure Totals (7)	119,142	933,331		1,052,473
Aptify Support	75,000	0		75,000
Aptify 5.5.5 Upgrade	30,000	90,000		120,000
AR Lockbox Improvements	15,000	45,000		60,000
Aptify ADA eCatalog Updates	5,550	24,250		29,800
CODA/CERP Replacements	18,500	0	185,625	204,125
Aptify DTS Updates	15,000	45,000		60,000
Aptify LMS/CE Enhancements – Phase II	9,375	25,200		34,575
Aptify Meetings Upgrade	9,375	29,063		38,438
Aptify Value Workshop	60,000	0		60,000
Aptify National Totals (8)	237,800	258,513	185,625	681,938
Aptify Support	75,000	0		75,000
Aptify LMS/CE Enhancements – Phase II	0	2,800		2,800
Aptify Meetings Upgrade	3,125	9,687		12,812
Aptify Value Workshop	60,000	0		60,000
Aptify States & Locals Totals (9)	138,125	12,487		150,612
2017 Grand Totals	1,087,699	2,225,152	448,000	306,475

1

IT Core Area

2018 Planned Spending	Operating Budget	Capital Budget	Total
Enterprise Reporting & Analytics(1)	0	20,000	20,000
Websites States & Locals (2)	56,000	168,000	224,000
Mobile Applications (3)	25,000	200,000	225,000
Digital Member Experience (4)	0	0	0
ADA Connect (5)	20,000	0	20,000
Finance/HR/Payroll (6)	16,000	83,000	99,000
Infrastructure, Hardware, Software (7)	135,000	861,000	996,000
Aptify National (8)	0	175,000	175,000
Aptify States & Locals (9)	0	175,000	175,000
Total Project Spending	252,000	1,682,000	1,934,000
Balance of IT Operating Budget	13,099,000	0	13,099,000
Total IT Spending	13,351,000	1,682,000	15,033,000

2

1

2018 Planned Consulting Projects	Operating Budget	Capital Budget	Total Planned Spending
Reporting & Analytics Software Licenses	0	20,000	20,000
Enterprise Reporting & Analytics Totals (2)	0	20,000	20,000
Personalization – States & Locals	56,000	168,000	224,000
Websites States & Locals Totals (4)	56,000	168,000	224,000
Mobile Application Updates	25,000	200,000	
Mobile Application Totals (5)	25,000	200,000	225,000
ADA Connect Enhancements	20,000	0	20,000
ADA Connect Totals (7)	20,000	0	20,000
Post-Go Live System Support	16,000	83,000	99,000
Finance/HR/Payroll Totals (8)	16,000	83,000	99,000
Warranty Technician	70,000	0	70,000
Software	30,000	0	30,000
Hardware	0	516,000	516,000
Network Infrastructure	15,000	345,000	360,000
Telephone System Support	20,000	0	20,000
Infrastructure Totals (10)	135,000	861,000	996,000
Aptify Application Enhancements	0	175,000	175,000
Aptify National Totals (11)	0	175,000	175,000
Aptify Application Enhancements	0	175,000	175,000
Aptify States & Locals (12)	0	175,000	175,000
2018 Grand Totals	252,000	1,682,000	1,934,000

2

Resolutions

3

This report is informational and no resolutions are presented.

4

BOARD RECOMMENDATION: Vote Yes to Transmit.

5

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

6

1 Resolution 77H-2011 asks for reporting on the ADA Pension Plan using two sources of information that
2 provide two perspectives of plan status based on two different actuarial calculations of the future pension
3 benefit liability:

- 4
- 5 a. the accrual basis liability included in the ADA's 12/31/16 balance sheet (based on ASC 715
6 accounting rules), and
- 7 b. the "cash basis" liability, percent funded status and funding requirements included in the ADA's
8 1/1/17 Adjusted Funding Target Attainment Percentage ["AFTAP"] Range Certification Report
9 (based on ERISA calculation rules).

10
11 Although these two liability calculation methods differ, in general terms the net Pension liability represents
12 the amount of projected total pension funds needed to cover "100% funding" of future benefits less the
13 value of actual funds invested in pension plan assets. In each case, this "100% funded" liability is an
14 amount calculated by our actuary based on a formula that uses certain assumptions including interest
15 rates and mortality tables determined by either government or accounting rules. When interest rates go
16 down or longevity estimates increase, the amount needed to reach 100% funded status goes up.

17 The pension liability, under both methods, accrual basis and cash basis, is recalculated by our actuary as
18 of the end of every plan year, December 31.

19 **Accrual Basis Pension Liability (included in the ADA's 12/31/16 audited balance sheet):** The
20 following roll-forward analysis of the ADA's 12/31/16 balance sheet liability shows all the changes in the
21 net accrual basis liability since the beginning of the year compared to prior periods.

22 There are four major types of changes that affect the ADA's net pension liability:

- 23
- 24 1. The ADA's contribution of cash to the plan assets which reduces the liability includes two parts:
 - 25 a. The funding of "normal service" costs for current employees of the ADA who earn benefits during
26 the plan year; and
 - 27 b. The funding of supplemental payments to help get the plan to 100% funded status which
28 represent "catch up" funding of benefits earned in prior periods as defined by government funding
29 rules initially introduced by the Pension Protection Act ("PPA") of 2006; and
- 30 2. The increase in the net plan liability due to the accrual of the "normal service" benefit costs plus
31 interest on the pension liability; and
- 32 3. The decrease in the net pension liability due to the increase in the value of the plans investment
33 assets; and
- 34 4. The impact of an increase or decrease in the net pension liability due to the decrease or increase in
35 the "spot rate" of interest used to calculate the actuarial present value of those future retirement
36 benefits at December 31 each year.

37 In addition to these changes to the pension liability, the ADA also made the "one time" change to future
38 employee benefits effective January 1, 2012 that significantly reduced the ADA's accrual basis pension
39 liability as well as its ongoing pension expense. This one time change reduced the liability by \$8.9 million
40 at 12/31/2011 and reduces "normal service costs" annually in 2012 and future years by over \$3 million
41 compared to 2011.

1 Finally, studies of mortality experience for participants in pension plans have been published by the
2 Society of Actuaries in recent years. These studies have indicated that pension plan participants are
3 generally living longer. As such, updated mortality assumptions have been published to reflect the results
4 of these studies. The ADA has made changes to its mortality assumptions as a result of these studies,
5 and the impact on results due to these changes is included below.

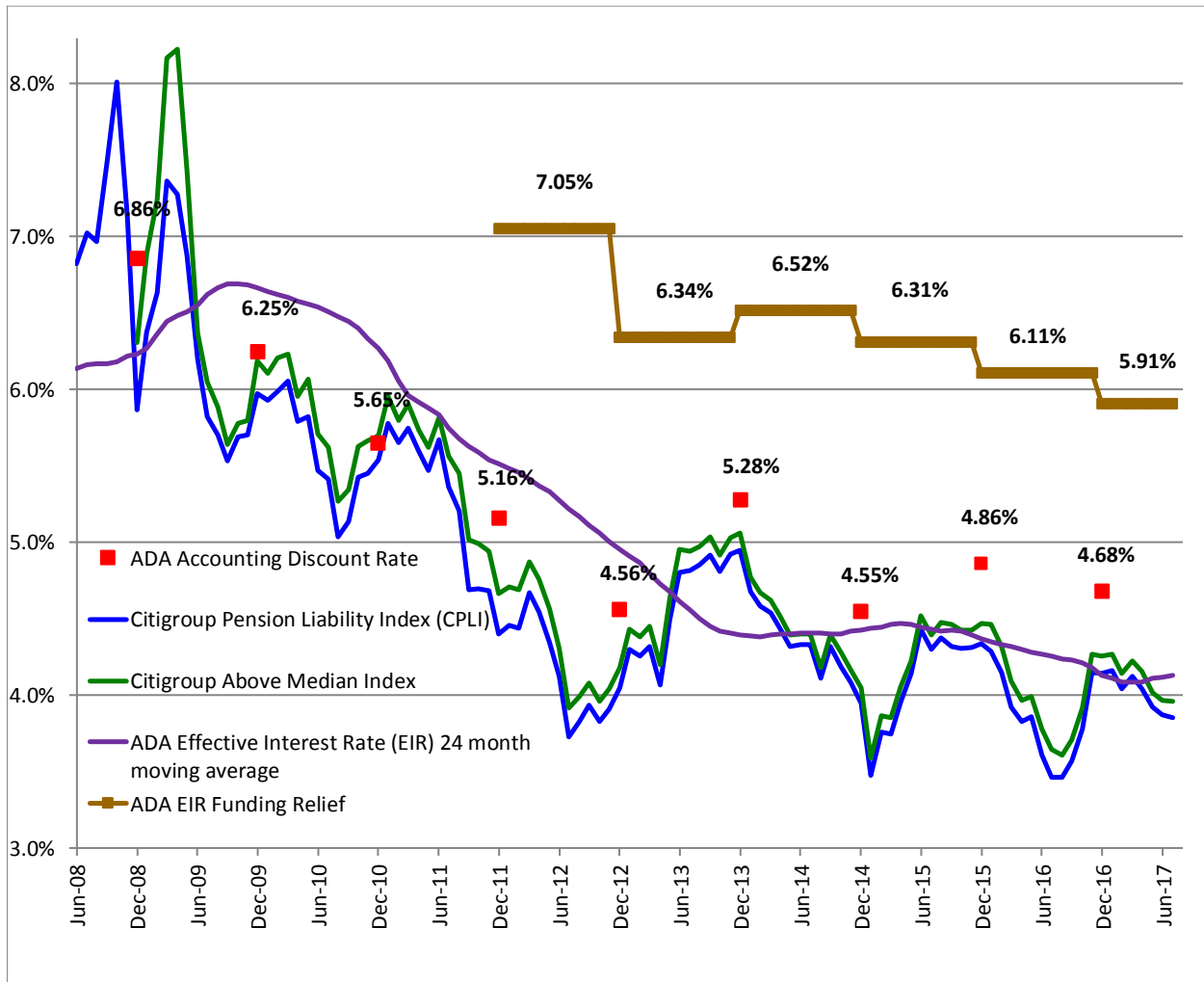
6 The following historical roll-forward analysis chart shows a six year history of the pension plan. The
7 results for fiscal year 2011 shows normal service costs under the old plan while years 2012 through 2016
8 present the actual results after plan changes. Beyond normal service costs and interest on the pension
9 liability (i.e., Expected Obligation Increase), the biggest change to the accrual basis Net Pension Liability
10 is the non-cash impact of the discount rate on the year-end valuation. For year-end 2012, discount rates
11 dropped from 5.16% to 4.56%, which was offset by favorable investment performance. For year-end
12 2013, discount rates increased from 4.56% to 5.28% and the Plan experienced favorable investment
13 performance. For year-end 2014, the liability increased due to a decrease in discount rates from 5.28%
14 to 4.55%, updated mortality assumptions, and a one-time adjustment to reflect the impact of a change in
15 IRS regulations. These increases were partially offset by favorable investment performance. For year-
16 end 2015, the liability decreased due to an increase in discount rates from 4.55% to 4.86%, but was offset
17 by unfavorable investment performance and updated mortality assumptions. For year-end 2016, the
18 liability increased due to a decreased in discount rates, but was offset by favorable investment
19 performance and updated mortality assumptions. So far in 2017, interest rates have been decreasing
20 while asset performance has been improving. The impact of increasing "spot" interest rates has a big
21 impact on the year-end valuations of future benefit liabilities but these are non-cash adjustments. For
22 further reference, the rates used for accounting purposes, and approved by our auditors, are shown at the
23 bottom of the chart for each year.

ADA Consolidated							
Net Pension Liability Analysis - Historical							
Millions of Dollars; Increase/(Decrease) in Liability							
	Fiscal Year Ending						Notes
	2011	2012	2013	2014	2015	2016	
Beginning Balance, December 31 of prior year	48.8	51.1	56.8	29.0	50.4	54.1	Net Liability, based on discount rate in effect at start of year less plan assets
Contributions (Cash):							Actual cash cost to ADA in each plan year:
<i>Normal Service Cost Funding- current employees</i>	(5.2)	(1.7)	(1.8)	(2.0)	(2.1)	(2.1)	Based on Old Plan formula in 2011; New Plan formula for 2012 to 2016
<i>Supplemental/Catch-up Funding of Prior Service</i>	(7.6)	(4.6)	(4.4)	(5.1)	(3.0)	(3.5)	Required contributions of prior service costs on path to 100% status
Expected Obligation Increase	13.4	10.0	10.0	10.5	11.1	11.5	Service Cost (benefit accrual) and Interest Cost (interest on prior obligation)
Net Investment (Gains)/Losses	(2.0)	(16.7)	(15.5)	(13.0)	3.1	(10.5)	Actual plan investment results based on market values at each year end
Actuarial (Gain)/Loss	2.1	4.5	0.4	0.6	1.5	2.1	Impact of updated participant population, salaries and mortality experience
Reduction in Benefits	(8.9)	-	-	-	-	-	2011 reflects impact of change in Plan formula
Annual FAS 158 Actuarial Valuation Adjustment							
Discount Rate	10.0	14.1	(16.4)	18.2	(7.9)	4.7	Estimated non-cash impact of changing discount rate per accounting rules
Mortality Assumption	N/A	N/A	N/A	9.0	1.1	0.1	Estimated non-cash impact of updating mortality assumption per actuarial studies
Impact due to adjustment for application of IRS Regs	-	-	-	3.1	-	-	
Supplemental Benefit Trust	0.5	0.1	(0.1)	0.1	(0.1)	-	Net Change in supplemental plan liability as reported
Ending Balance, December 31	51.1	56.8	29.0	50.4	54.1	56.4	Net Liability, based on discount rate in effect at end of year less plan assets
Discount Rate							
Beginning of Year	5.65%	5.16%	4.56%	5.28%	4.55%	4.86%	
End of Year	5.16%	4.56%	5.28%	4.55%	4.86%	4.68%	

24

25 Low interest rates, more than any other factor, result in increases to the year-end valuations of
26 Retirement Benefit Obligations. The next graph shows the general downward trend of the rates used to
27 calculate these long term liabilities. Rates decreased during 2016 (though less than initially feared due to
28 increases at the end of the year) and have decreased to date in 2017.

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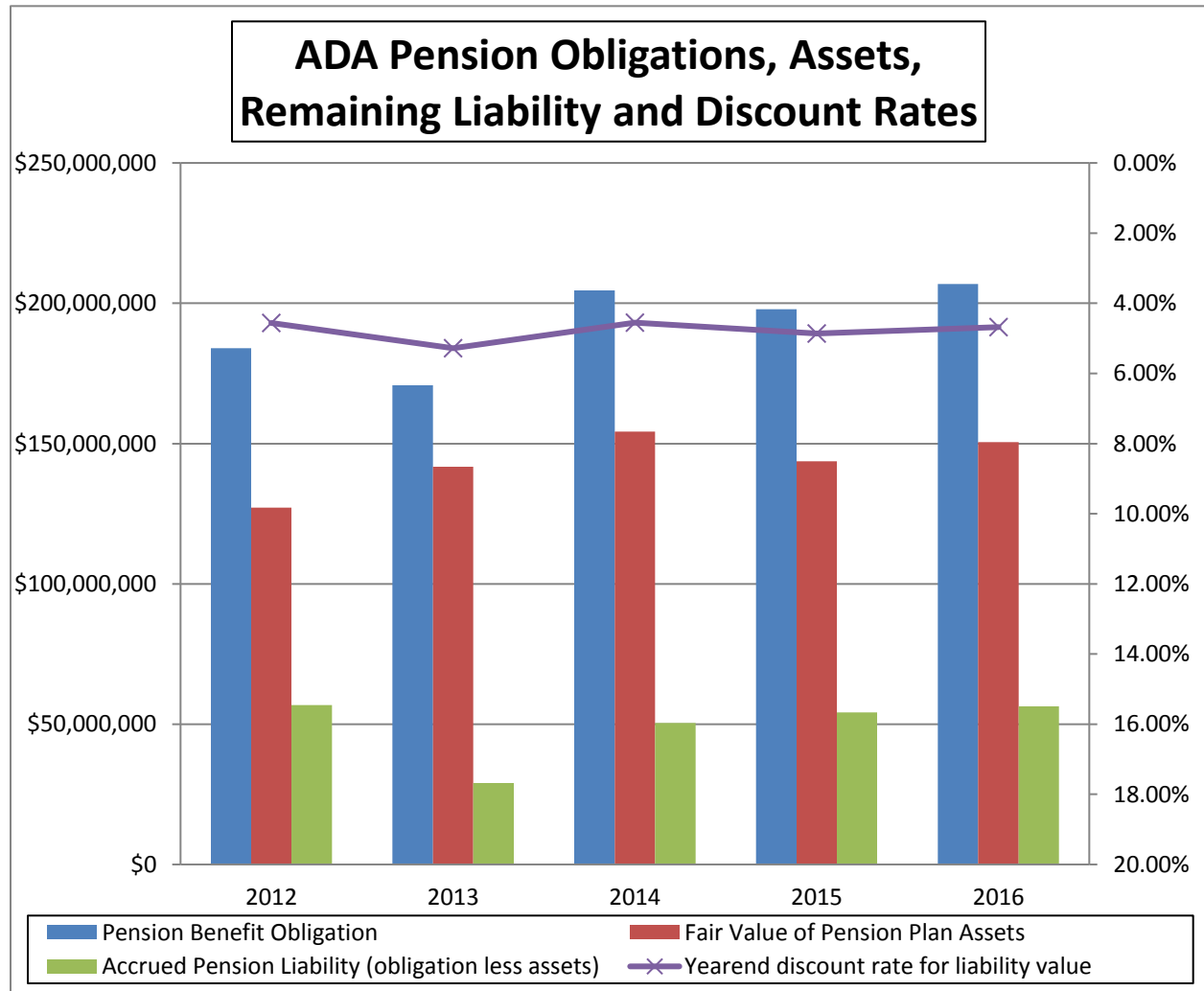
4 The “ADA Accounting Discount Rate” shown in this graph reflects the rates used for the year-end
 5 financial statements. The “ADA Effective Interest Rate (EIR)” is a 24 month moving average of rates
 6 published by the IRS which would typically apply to funding requirements. However, the “MAP-21 Rates”,
 7 further modified by “HATFA”, reflect higher rates based on a 25 year average to provide pension relief
 8 which reduced the Plan’s funding requirements for 2012, 2013, 2014, 2015, 2016 and 2017.

9 The Citigroup Indexes are also included as an indicator of current interest rate trends. These rates
 10 moved downward in 2016 resulting in a lower accounting rate at 12/31/16 than at 12/31/15. So far during
 11 2017, these rates have slightly decreased.

12 The inverse relationship between interest rates and the valuation of the year-end pension liability can also
 13 be seen in the following multi-year graph that includes:

- 14 a) the gross pension obligation,
- 15 b) the pension plan asset balance,

- 1 c) the net ADA pension liability balance, and
- 2 d) the year-end discount rate used to value the pension liability.
- 3

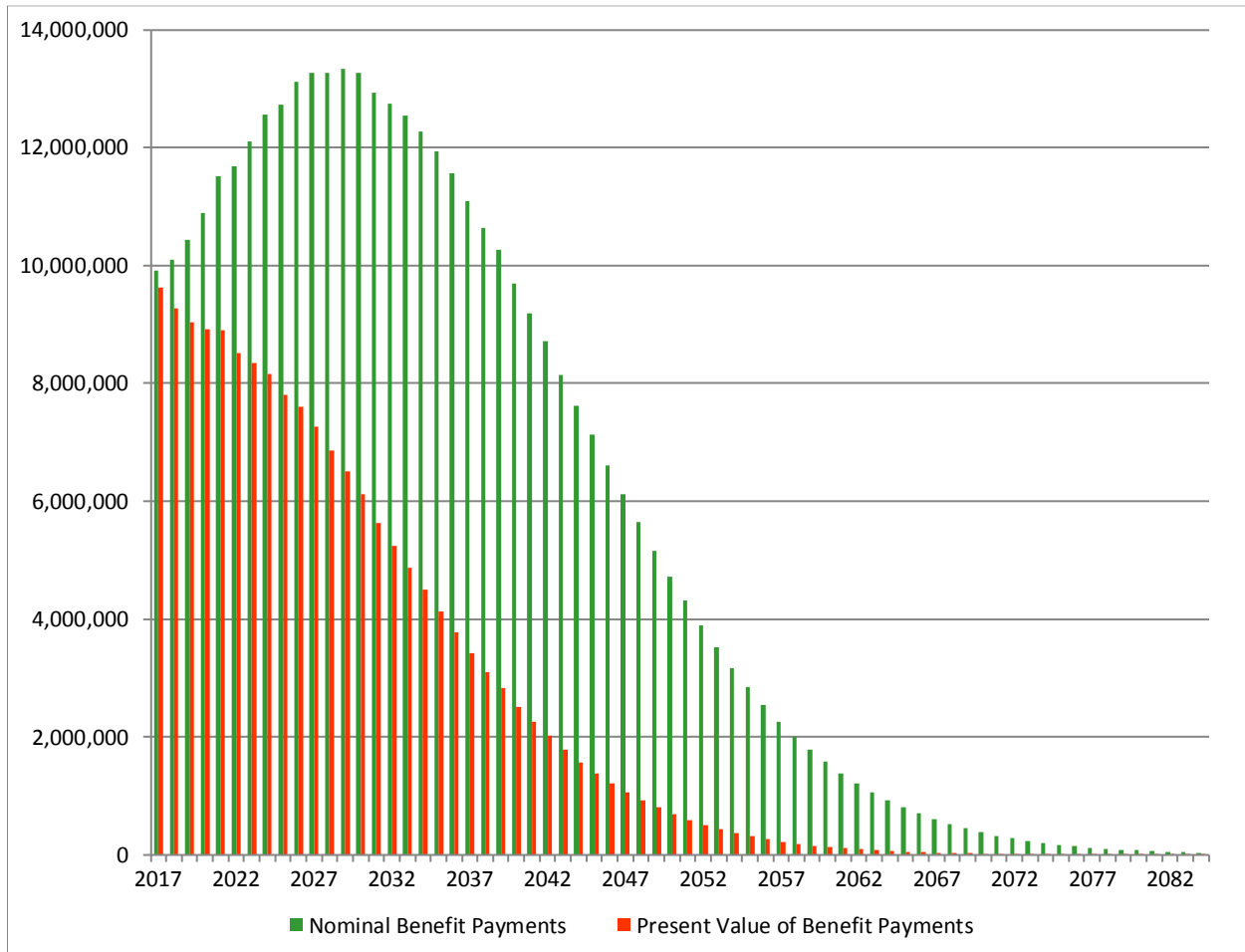


4

5 The line graph of the year-end discount rate is shown at the top of the chart with a separate vertical axis
 6 on the right side with “zero” at the top of the chart and higher rates extending downward. In this format,
 7 the chart shows the correlation between the changes in the discount rate and the liability balance. It
 8 should also be noted that this graph also shows the benefits of a consistent funding policy and investment
 9 results through the steady increase in plan assets.

10 Each year, the ADA’s investment advisors review the pension benefit obligation in relation to the pension
 11 plan asset strategy to update investments. As part of this review, these advisors estimate the non-cash
 12 impact of interest rates on the “net” accrued pension liability. The latest estimates indicate that a 1%
 13 change in the year-end spot rates will result in an impact of \$26.7M on the liability with an offsetting
 14 impact on the plan assets estimated at \$8.2M which combine to a total “net impact” of \$18.5M. Because
 15 U.S. interest rates have remained near historical low values based on a Fed funds rate between 1.00%-
 16 1.25%, this means that there is considerable potential for favorable valuation adjustments if and when
 17 interest rates rise in the future.

1 It is important to note that although the use of year end “spot rates” determines the value of the liabilities
 2 for accounting purposes at year end, and while lower rates can also drive higher contribution rates to plan
 3 assets, it is the actual cash payout of the retirement benefits that will only happen over many decades
 4 that represents the true economic cost of the plan. Cash contributed to the plan to fund future benefits
 5 stays in the plan until those benefits are paid. And the actual payout of the 12/31/16 pension plan liability
 6 through monthly benefits to retirees will only happen over the next 30 to 40 years with the final payments
 7 expected into the next century. The following graph shows these expected annual payments to plan
 8 participants from plan assets:



9
 10 This graph effectively shows that the maturity of the ADA’s pension liability is made up of predictable
 11 annuities unlike many other plans that allow lump sum benefit payouts.

12 **Pension Relief:** Because so many actuaries for large pension plans questioned the use of “spot rates” to
 13 value pension liabilities and lobbied legislators to use a longer 25 year average interest rate to calculate
 14 the requirements for cash contributions to pension plans, “pension relief” was passed under MAP-21 in
 15 2012 to reduce the short-term funding burden on pension plan sponsors caused by the current, low
 16 interest rate environment. This “pension relief” was further modified and extended by HATFA in 2014 and
 17 the Bipartisan Budget Act (BBA) of 2015.

18 **Cash Basis Pension Liability (included in the annual actuarial certification of the pension plan**
 19 **funding status):** The other pension liability recalculated by our actuary each year is the Cash Basis
 20 Pension Liability which is published in the ADA’s annual Adjusted Funding Target Attainment Percentage

1 ["AFTAP"] Certification Report (based on ERISA calculation rules). This report is significant because it
2 includes the annual funded status of the plan. In addition, as this "cash basis" liability fluctuates, the
3 amount of annual cash contributions required from the next year's Operating Budget will also fluctuate.

4 The following chart shows the Cash Basis Pension Liability based on the AFTAP certification report:

5

American Dental Association Employees' Retirement Trust Adjusted Funding Target Attainment Percentage ("AFTAP") Funding Status as of January 1 (valuation date)										
(\$000s)	Year End 2012		Year End 2013		Year End 2014		Year End 2015		Year End 2016	
	amount	%	amount	%	amount	%	amount	%	amount	%
AFTAP Net Effective Interest Rate	6.35%		6.52%		6.31%		6.11%		5.91%	
Cash Basis Target Liability (= 100% status)	\$ 146,710	100.0%	\$ 147,812	100.0%	\$ 156,344	100.0%	\$ 163,231	100.0%	\$ 170,791	100.0%
Less: Plan Assets	(127,125)	86.7%	(148,591)	100.5%	(159,182)	101.8%	(143,349)	87.8%	(150,126)	87.9%
Net AFTAP Report Unfunded Plan Liability	\$ 19,585	13.3%	\$ (779)	-0.5%	\$ (2,838)	-1.8%	\$ 19,882	12.2%	\$ 20,665	12.1%

6

7 The data in this chart also shows, in a simple format, how the year end valuation of investments also
8 contributes to the funded status of the plan.

9 **Conclusions:** Although the use of "spot" rates of interest, in effect at the end of each year, determine the
10 GAAP accounting basis of the liabilities and, although the annual cash basis valuation can drive higher
11 contributions to the plan's assets, the final cost of the plan is ultimately tied to the payment of these
12 benefits to plan participants.

13 Because the ADA stopped lump sum payments for benefits earned after 1993, the pension plan operates
14 as a simple annuity plan which greatly reduces transactions other than normal portfolio management and
15 the payment of monthly benefits to participants. This results in very predictable cash flows.

16 Once the ADA contributes cash into the plan, it stays in plan investments to generate long term returns
17 until benefits are paid out. Under this plan structure, the ADA's actuaries and investment advisors have
18 explained that temporary investment valuation and interest rate volatility have minimal impact on the long
19 term economics of the pension plan.

20 Board changes to retirement benefit plans helped reduce total pension liabilities by over \$7 million at
21 12/31/11 (all plan changes actually account for \$21.8 million of direct reduction which was partially offset
22 by the impact of interest and investment).

23 In addition, the significant cut in pension plan benefits reduced "normal" pension costs, for 1 year of
24 service, from \$5.2 million in 2011 to \$1.7 million in 2012 to \$1.8 million in 2013 to \$2.0 in 2014 to \$2.1 in
25 2015 and to \$2.1 in 2016.

26 Although the historic low "point in time" interest rates at year end (in conjunction with mortality
27 improvements) have resulted in higher pension liability valuations, expected long term higher interest
28 rates will turn this liability into an asset in the future. Pension relief intended to reduce the funding
29 burdens on pension plan sponsors caused by the current, low interest rate environment was signed into
30 law in 2012 as part of the MAP-21 Act and further modified by both HATFA in 2014 and BBA in 2015.
31 While these laws will provide some relief from the low interest rate environment, prolonged decreasing
32 rates and investment performance in 2015 and 2016 could result in higher contribution requirements in
33 future years. While these laws will provide some relief from the low interest rate environment, prolonged

1 decreasing rates, updated mortality assumptions for 2018, and investment performance during the
2 remainder of 2017 could result in higher contribution requirements in future years.

3 Over the long term, the plan will provide the ADA with a valuable benefit to attract and retain employees
4 critical to its mission based on an asset that will eventually pay for itself once 100% funded status is
5 reached.

6 Without any continuing pension plan in place, there would be a long term risk of an overfunded pension
7 plan, with the ADA being unable to utilize any portion of the resulting overfunded asset balance.

8 With a continuing pension plan, any overfunding that may occur due to fluctuating interest rates can be
9 used to help minimize annual plan contributions going forward.

10 On a related topic, the Board's action in 2011 to reduce retiree health benefits resulted in an immediate
11 \$10 million improvement in the ADA's financial position at December 31, 2011. That reduction also
12 eliminated the ADA's exposure to escalating health care costs by capping the future maximum annual
13 cost per retiree.

14 **Resolutions**

15 This report is informational and no resolutions are presented.

16 **BOARD RECOMMENDATION: Vote Yes to Transmit.**

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

1 It has been 12 years since this was revisited and credit card processing fees have been on the rise thus
2 burdening the dental societies with the difference of the 2% reimbursement to actual rates and costs of
3 processing dues for the ADA.

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Resolution

7 **60. Resolved**, that beginning with the 2018 membership year, the ADA shall reimburse each dental
8 society 100% of processing fees incurred up to 2.75% with regard to credit card payments, to collect
9 and remit ADA dues.

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BOARD RECOMMENDATION: Received after the September 2017 Board of Trustees meeting.

REPORT OF PRESIDENT

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Imagine that you are in dental school 70 years ago.

It's 1947, and life was so different back then. Gas was 15 cents a gallon and the average home cost sixty-six hundred dollars. Jackie Robinson joined the Brooklyn Dodgers. And an unidentified flying object crashed near Roswell, New Mexico.

The world was still rebuilding from a devastating World War and trying to settle into a new normal.

Dentistry was returning to normal, too.

The War hit the profession pretty hard. More men serving at the Front meant that more dental professionals were needed to care for them. Every effort was made to enlist more dentists, and the dental education system joined the effort to train more dentists, by compressing the time to complete the curriculum from four years to three.

The need was great. Almost one-fourth of the men who joined the Army had, or needed, dentures. Oral health was awful, and we can suspect that the dental health of the older, non-military population was even worse.

After the war ended, the biggest issue for the ADA was a social one: How can we improve dental health for the nation as a whole?

There were two main sides to the debate.

On one side was a push to make universal dental care a reality, possibly rolling it into the new Social Security program.

On the other side of the argument—and this was dentistry's position—was a push for a more thoughtful approach. The belief was that in order to make a dent in the dental health crisis, we needed to address the causes underlying the problem. We needed to first invest in research, then in preventive education.

To fund dental health care, without first addressing the causes of the disease, was a Band-Aid solution.

Our colleagues 70 years ago won the debate, and the country invested in education and research. That was a big risk and it was unpopular, but in hindsight, this clearly was the right path.

The very next year, in 1948, President Truman signed the National Dental Research Act, establishing what is now the NIDCR. Not long after that, in 1950, the results from the first fluoridation trial in Grand Rapids, Michigan demonstrated that water fluoridation was an effective way to reduce caries.

Dental health started improving across the nation.

The dental profession, led by the ADA, took a position that over time proved wise.

As this House of Delegates plans for our future and turns its attention toward the business at hand, let's look to the past as a guide: That we not put Band-Aids on problems, but address root causes. That we act on plans that promise long-term viability. We want future generations to look back and see that we took a wise position and a long view.

Fast forward to today.

1 I'd like to touch on what we accomplished this year to become a more nimble Association that's
2 responsive to member needs, and those things that position us to continue to be America's leading
3 advocate for oral health.

4 For example, the Council on Scientific Affairs revitalized the trusted ADA Seal of Acceptance program
5 and established the new category of enamel erosion.

6 We also continued to work more closely with the dental industry, with repeat partnerships like Oral Health
7 Month with Colgate. And we are also working together with major medical centers like the University of
8 Texas MD Anderson Cancer Center to prevent oral and oropharyngeal cancer.

9 We strengthened our relationships with tribal nations, opening up new pathways for working together.
10 Many of those pathways involve the Community Dental Health Coordinator program which continues to
11 grow, with more than 115 graduates now working in 25 states, and another 130 students in training.
12 CDHC training is available in all 50 states through one national program, with another 14 programs
13 offering the curriculum locally.

14 We worked on a number of fronts to ease burdens and make life easier for our member dentists.

15 In March, for example, we made significant progress toward our longstanding goal to overturn the
16 McCarran-Ferguson Act. The House of Representatives voted to overturn the Act, and we are waiting for
17 the Senate and President to act.

18 We also continue to double-down on enhancing our technology portfolio. This week we launched the ADA
19 credentialing service, powered by CAQH ProView, to save dentists time on credentialing paperwork from
20 multiple dental plans. It's a one-and-done solution that reduces administrative burdens on their offices.

21 Earlier this year we launched a new Find-a-Dentist, the new search tool that patients can use to find our
22 members, and we started advertising it in July.

23 Since then, consumers have completed more than 238,000 searches, and conducted more than 348,000
24 views of profiles of our members.

25 These results have far surpassed our expectations.

26 Our investment in this marketing campaign demonstrates to our members that the ADA is responsive to
27 their needs.

28 It means that patients turn to the ADA—and not some other organization—to find their dentist. That builds
29 trust with the public.

30 It means that patients are being introduced to *our* consumer health resources, which they can access
31 from the site.

32 It means that when future ADA members go to Google and search for dental topics, they are seeing the
33 ADA's name at the top of those search results. It shows that we're a major player in the market.

34 The House set the right tone last year by implementing this innovative program to help members
35 succeed, and it's great that so many consumers are now looking to us to help them find an ADA dentist.
36 We need to continue to invest in programs like this one that promise long-term payoffs.

37 Another long-term effort that we moved forward this year is licensure.

38 We're forging ahead to make licensure portability and the elimination of patient based exams a reality,
39 consistent with the House's longstanding policies on these matters.

1 You know the portability stats: Today, the majority of students at over half of the country's dental schools
2 don't practice in the same state where they're educated.

3 We've been working on these extremely complex issues for years. We've made some progress. For
4 example, several states that just a few years ago only accepted one licensure exam, now accept all
5 exams. We're also pleased that the OSCE is gaining acceptance in several states.

6 The pace of progress is slow, and we're not backing down.

7 This year, based on the recommendation of the Joint ADA-ADEA-ASDA Licensure Task Force, the Board
8 approved the development of a Dental Licensure OSCE. We are taking a leadership role in moving this
9 issue forward.

10 We're also taking a leadership role in revising a specialty recognition process that was in bad need of
11 revision.

12 As you well know, ADA's current specialty recognition process is perceived to be biased and subject to
13 conflict of interest issues. It is also out of the norm when compared to other health professions.

14 There have been legal challenges to specialty advertising in California, Florida, Ohio, Indiana, and Texas.

15 It's time to make a change before outside forces do it for us.

16 That's what we're doing here.

17 This year the Task Force on Specialty and Specialty Certifying Board Recognition evaluated the process
18 and criteria by which specialties and specialty certifying boards are recognized, and it put forth a proposal
19 which this House will consider. It proposes transferring the specialty recognition function to a new,
20 independent Commission while keeping the criteria for specialty recognition under the purview of the
21 Council on Dental Education and Licensure and the House of Delegates.

22 The goal is to mitigate the risk of a challenge to the process, and I believe that the Taskforce's proposal is
23 the best way forward.

24 Finally, let's talk about the budget.

25 And I want to ask you the same questions I asked you last year.

26 How many of you have spent 50 hours studying the budget?

27 How many of you spent 25 hours?

28 How many districts rely on 1 or 2 members to tell them what's in the budget?

29 These are things we need to think about. We need to let the people who are best informed, and who have
30 worked on this, and who have the most knowledge, do this work.

31 This is about being responsive to member needs, and about being positioned to rapidly respond to
32 changes in our market—two things that are absolute requirements if our Association is going to continue
33 to prosper.

34 Three out of four associations like ours place authority to approve the Budget with the Board, and they do
35 it because it's a process that works. The ADA needs to adopt a process in which the House maintains its
36 responsibility for setting dues and the policy direction of the Association, but in which the approval of the
37 Budget to enact the House's policies and programs rests with the Board.

- 1 My friends, from the budget process, to specialty recognition, licensure and Find-a-Dentist, we've made
2 incredible progress. And now we have to make decisions. We can continue to put Band-Aids on
3 problems.
- 4 We can maintain the status quo.
- 5 We can wait for government to mandate change or for market forces to make us irrelevant.
- 6 But we don't have to do that.
- 7 We have a proud history. Our colleagues who came before us, who 70 years ago made unpopular and
8 difficult decisions, took the long view. Let's move forward with their courage.
- 9 And let's act so that in another 70 years, when an entirely new generation of dentists looks back on what
10 did here, they are as proud of their history as we are.
- 11 It's been an honor to serve as President of this Association, and today—because of all that we've
12 accomplished together—I'm proud as ever to be an ADA member.

Dental Benefits, Practice and Related Matters

Resolution No. 12 New
Report: N/A Date Submitted: August 2017
Submitted By: Council on Dental Benefit Programs
Reference Committee: B (Dental Benefits, Practice and Related Matters)
Total Net Financial Implication: None Net Dues Impact: _____
Amount One-time _____ Amount On-going _____ FTE 0
ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health
How does this resolution increase member value: See Background

1 **RESCISSION OF POLICY, COORDINATION OF BENEFITS REFORM**

2 **Background:** This resolution is submitted by the Council on Dental Benefit Programs as a result of its
3 scheduled review of ADA policies to ensure their continuing relevance.

4 **Coordination of Benefits Reform**

5 This was a directive that was carried out in 2009 shortly after the resolution was originally adopted. About
6 half of the states have laws that reference secondary plans with respect to paying a portion of the claim if
7 benefits are available. In addition, ADA has a more comprehensive current policy on how benefits should
8 be coordinated entitled, "Guidelines on Coordination of Benefits for Group Dental Plans" (*Trans.*1996:685;
9 2009:423). This policy captures the ADA position on the topic more clearly thus bolstering advocacy
10 efforts for state legislative and/or regulatory campaigns on this topic.

11 Therefore, the Council recommends rescission of the policy, Coordination of Benefits Reform.

12 **Proposed Resolution**

13 **12.Resolved**, that the ADA policy, Coordination of Benefits Reform (*Trans.*2008:496) be rescinded.

14

15 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM

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POLICY TO BE RESCINDED

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

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

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

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

Resolution No. 13 New
 Report: N/A Date Submitted: August 2017
 Submitted By: Council on Dental Benefit Programs
 Reference Committee: B (Dental Benefits, Practice and Related Matters)
 Total Net Financial Implication: None Net Dues Impact: _____
 Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 RESCISSION OF POLICY, PATIENT'S RIGHT TO ASSIGN PAYMENT

2 Background: This resolution is submitted by the Council on Dental Benefit Programs as a result of its
3 scheduled review of ADA policies to ensure their continuing relevance.

4 The policy "Patient's Right to Assign Payment" is duplicative and contains language which is currently
5 included in the policy "Authorization of Benefits" (*Trans.*1994:665; 2013:306).

6 AUTHORIZATION OF BENEFITS

7 Resolved, that the American Dental Association supports the right of each dentist to accept or
8 reject authorized benefits from any dental benefits plan, and be it further

9 Resolved, that the Association supports the right of every patient to authorize that his or her
10 benefits be paid to the treating dentist and to have the authorization honored by the third-party
11 payer, and be it further Resolved, that when a third-party payer submits payment directly to the
12 patient, contrary to the patient's authorized preference, it is the third-party payer's responsibility to
13 submit the correct payment to the dentist and reclaim the erroneously submitted payment from the
14 patient, and be it further

15 Resolved, that in those states where dentists are not notified of the rescission of a prior
16 authorization of benefits, the Association encourage state dental societies to seek legislative relief.

17 Therefore, the Council recommends rescission of the policy "Patient's Right to Assign Payment."

18 Proposed Resolution

19 13. Resolved, that the ADA policy, Patient's Right to Assign Payment (*Trans.*1997:708) be
20 rescinded.

21 BOARD RECOMMENDATION: Vote Yes.

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

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WORKSHEET ADDENDUM

POLICY TO BE RESCINDED

Patient's Right to Assign Payment (*Trans.1997:708*)

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

Resolution No. 14 _____ New

Report: N/A _____ Date Submitted: August 2017 _____

Submitted By: Council on Dental Benefit Programs _____

Reference Committee: B (Dental Benefits, Practice and Related Matters) _____

Total Net Financial Implication: None _____ Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE 0 _____

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 **RESCISSION OF POLICY, DENTIST’S RIGHT TO PARTICIPATE IN DENTAL PREPAYMENT PLAN**

2 **Background:** This resolution is submitted by the Council on Dental Benefit Programs as a result of its
3 scheduled review of ADA policies to ensure their continuing relevance.

4 This policy, Dentist’s Right to Participate in Dental Prepayment Plan is a directive. At least 13 states have
5 laws that allow any dentist to participate as a contracted dentist for a network dental plan. Another
6 comprehensive policy statement titled, Qualifications of Participating Dentists (*Trans.*1991:639),
7 addresses the rights of dentists to participate in all plans.

8 **Proposed Resolution**

9 **14. Resolved**, that the ADA policy, Dentist’s Right to Participate in Dental Prepayment Plan
10 (*Trans.*1983:582) be rescinded.

11 **BOARD RECOMMENDATION: Vote Yes.**

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

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WORKSHEET ADDENDUM

POLICY TO BE RESCINDED

Dentist's Right to Participate In Dental Prepayment Plan (*Trans.1983:582*)

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

Resolution No. 15 New

Report: N/A Date Submitted: August 2017

Submitted By: Council on Dental Benefit Programs

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 **REVISION OF POLICY, AUTHORIZATION OF BENEFITS**

2 **Background:** This resolution is submitted by the Council on Dental Benefit Programs as a result of its
3 scheduled review of ADA policies to ensure their continuing relevance. Suggested revisions update
4 terminology to be consistent with the ADA Glossary of Dental Clinical and Administrative Terms.

5 **Proposed Resolution**

6 **15. Resolved**, that the ADA policy, Authorization of Benefits (*Trans.1994:665; 2013:306*) be
7 amended as follows: (additions are underscored; deletions are ~~stricken~~)

8 **Assignment of Benefits ~~Authorization of Benefits~~ (*Trans.1994:665; 2013:306*)**

9 **Resolved**, that the American Dental Association supports the right of each dentist to accept
10 or reject ~~authorized~~ assignment of benefits from any dental benefits plan, and be it further

11 **Resolved**, that the Association supports the right of every patient to assign ~~authorize~~ that his
12 or her benefits ~~be paid~~ to the treating dentist and to have the ~~authorization~~ assignment
13 honored by the third-party payer, and be it further

14 **Resolved**, that when a third-party payer submits payment directly to the patient, contrary to
15 the patient's authorized preference, it is the third-party payer's responsibility to submit the
16 correct payment to the dentist and reclaim the erroneously submitted payment from
17 the patient, and be it further

18 **Resolved**, that in those states where dentists are not notified of the rescission of a prior
19 ~~authorization~~ assignment of benefits, the Association encourage state dental societies to
20 seek legislative relief.

21 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 16 New
 Report: N/A Date Submitted: August 2017
 Submitted By: Council on Dental Practice

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 **AMENDMENT OF POLICY, STATEMENT ON DENTIST HEALTH AND WELLNESS**

2 **Background:** The Council reviewed the current ADA policy Statement on Dentist Health and Wellness
 3 and determined that the third paragraph of the policy should be deleted since it references the ADA's
 4 Health Screening Program, which is no longer offered at the annual meeting. The remainder of the policy
 5 has been determined to be relevant.

6 The Council therefore recommends amending the policy to ensure its accuracy and relevance.

7 **Proposed Resolution**

8 **16. Resolved,** that the ADA policy "Statement on Dentist Health and Wellness" (*Trans.*2005:321), be
 9 amended by deletion of the third paragraph (deletion ~~stricken~~).

10 **Statement on Dentist Health and Wellness (*Trans.*2005:321)**

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

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

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

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

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

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

14 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 17 New

Report: N/A Date Submitted: August 2017

Submitted By: Council on Dental Practice

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 **RESPONSE TO RESOLUTION 96H-2015: DEVELOPMENT OF ADA POLICY ON DENTISTRY’S ROLE**
2 **IN SLEEP-RELATED BREATHING DISORDERS**

3 **Background:** In 2015, the ADA House of Delegates proposed the development of ADA Policy on
4 Dentistry’s Role in Sleep Related Breathing Disorders (SRBD) (*Trans.2015:262*). The Council on
5 Scientific Affairs (CSA) and the Council on Dental Practice (CDP) were charged with fulfilling this
6 directive.

7 CSA developed an evidence brief: *Oral Appliances for Sleep-Related Breathing Disorders* and released it
8 to CDP in July 2016 (Appendix 1). CDP used the evidence brief and all available research and literature
9 to develop draft policy. The draft policy was posted online and circulated to dental specialty groups and
10 communities of interest for comment and review from January 6 to February 28, 2017. Eighty seven
11 comments were received and carefully considered, resulting in a revised draft. A second round of review
12 followed in which 47 comments were received and reviewed, resulting in the submitted, proposed policy
13 (Appendix 2).

14 Based on the evidence brief, literature, documentation, comments from the communities of interest, as
15 well as the professional knowledge and expertise of the Council, CDP believes that the proposed policy
16 provides a current basis for the treatment of patients with sleep related breathing disorders and
17 recommends the adoption of the following resolution. Should the policy be adopted, the Council will
18 sponsor continuing education opportunities to educate the profession about SRBD, inform the Council’s
19 medical colleagues of the evidence brief and the policy, and develop information for the public on
20 dentistry’s role in SRBD.

21 **Proposed Resolution**

22 **17. Resolved,** that the following policy on Sleep Related Breathing Disorders be adopted.

23 **Proposed Policy Statement on the Role of Dentistry**
24 **in the Treatment of Sleep Related Breathing Disorders**

25 Sleep related breathing disorders (SRBD) are disorders characterized by disruptions in
26 normal breathing patterns. SRBDs are potentially serious medical conditions caused by
27 anatomical airway collapse and altered respiratory control mechanisms. Common SRBDs
28 include snoring, upper airway resistance syndrome (UARS) and obstructive sleep apnea
29 (OSA). OSA has been associated with metabolic, cardiovascular, respiratory, dental and
30 other diseases. In children, undiagnosed and/or untreated OSA can be associated with
31 cardiovascular problems, impaired growth as well as learning and behavioral problems.

1 Dentists can and do play an essential role in the multidisciplinary care of patients with certain
2 sleep related breathing disorders and are well positioned to identify patients at greater risk of
3 SRBD. SRBD can be caused by a number of multifactorial medical issues and are therefore
4 best treated through a collaborative model. Working in conjunction with our colleagues in
5 medicine, dentists have various methods of mitigating these disorders. In children, the
6 dentist's recognition of suboptimal early craniofacial growth and development or other risk
7 factors may lead to medical referral or orthodontic/orthopedic intervention to treat and/or
8 prevent SRBD. Various surgical modalities exist to treat SRBD. Oral appliances, specifically
9 custom-made, titratable devices can improve SRBD in adult patients compared to no therapy
10 or placebo devices. Oral appliance therapy (OAT) can improve OSA in adult patients,
11 especially those who are intolerant of continuous positive airway pressure (CPAP). Dentists
12 are the only health care provider with the knowledge and expertise to provide OAT.

13 The dentist's role in the treatment of SRBD includes the following:

- 14 • Dentists are encouraged to screen patients for SRBD as part of a comprehensive medical
15 and dental history to recognize symptoms such as daytime sleepiness, choking, snoring
16 or witnessed apneas and an evaluation for risk factors such as obesity, retrognathia, or
17 hypertension. If risk for SRBD is determined, these patients should be referred, as needed,
18 to the appropriate physicians for proper diagnosis.
- 19 • In children, screening through history and clinical examination may identify signs and
20 symptoms of deficient growth and development, or other risk factors that may lead to
21 airway issues. If risk for SRBD is determined, intervention through medical/dental referral
22 or evidenced based treatment may be appropriate to help treat the SRBD and/or develop
23 an optimal physiologic airway and breathing pattern.
- 24 • Oral appliance therapy is an appropriate treatment for mild and moderate sleep apnea,
25 and for severe sleep apnea when a CPAP is not tolerated by the patient.
- 26 • When oral appliance therapy is prescribed by a physician through written or electronic
27 order for an adult patient with obstructive sleep apnea, a dentist should evaluate the
28 patient for the appropriateness of fabricating a suitable oral appliance. If deemed
29 appropriate, a dentist should fabricate an oral appliance.
- 30 • Dentists should obtain appropriate patient consent for treatment that reviews the
31 proposed treatment plan, all available options and any potential side effects of using OAT
32 and expected appliance longevity.
- 33 • Dentists treating SRBD with OAT should be capable of recognizing and managing the
34 potential side effects through treatment or proper referral.
- 35 • Dentists who provide OAT to patients should monitor and adjust the Oral Appliance (OA)
36 for treatment efficacy as needed, or at least annually. As titration of OAs has been shown
37 to affect the final treatment outcome and overall OA success, the use of unattended
38 cardiorespiratory (Type 3) or (Type 4) portable monitors may be used by the dentist to
39 help define the optimal target position of the mandible. A dentist trained in the use of
40 these portable monitoring devices may assess the objective interim results for the
41 purposes of OA titration.
- 42 • Surgical procedures may be considered as a secondary treatment for OSA when CPAP
43 or OAT is inadequate or not tolerated. In selected cases, such as patients with
44 concomitant dentofacial deformities, surgical intervention may be considered as a
45 primary treatment.

- 1 • Dentists treating SRBD should continually update their knowledge and training of dental
2 sleep medicine with related continuing education.

- 3 • Dentists should maintain regular communications with the patient's referring physician
4 and other healthcare providers to the patient's treatment progress and any recommended
5 follow-up treatment.

- 6 • Follow-up sleep testing by a physician should be conducted to evaluate the improvement
7 or confirm treatment efficacy for the OSA, especially if the patient develops recurring
8 OSA relevant symptoms or comorbidities.

9 **BOARD RECOMMENDATION: Vote Yes.**

10 **BOARD VOTE: UNANIMOUS.**

APPENDIX 1

EVIDENCE BRIEF: ORAL APPLIANCES FOR SLEEP-RELATED BREATHING DISORDERS

Evidence Brief: Oral Appliances for Sleep-Related Breathing Disorders

Key Points

- The evidence reviewed in this brief consists of a 2015 clinical practice guideline from the American Academy of Sleep Medicine/American Academy of Dental Sleep Medicine (AASM/AADSM, based on a systematic review and meta-analysis), as well as a 2015 consensus guideline co-authored by dental sleep medicine societies in Italy; 6 randomized trials of oral appliances (OAs) published since the last literature search date of the 2015 AASM/AADSM guideline and that were not already included in the guideline; a 2015 review of systematic reviews; and 8 systematic reviews/meta-analyses published in 2015/2016, two of which were focused on pediatric populations.
- The evidence shows that oral appliances, specifically custom-made, titratable devices, can improve obstructive sleep apnea (OSA) in adult patients compared to no therapy or placebo devices.
- OAs are generally less effective than continuous positive airway pressure (CPAP), but have a role in patients who are intolerant of or who reject CPAP.
- The AASM/AADSM guideline/systematic review found that patient adherence with OAs was better than that for CPAP and that OAs have fewer adverse effects that result in discontinuation of therapy, compared with CPAP.
- The two recent systematic reviews evaluating the data for oral appliances in pediatric OSA found very limited published evidence for their use and called for additional short- and long-term evidence, especially for health outcomes, such as neurocognitive and cardiovascular function.
- Another gap identified is the lack of published comparative evidence evaluating comprehensive management of oral appliance therapy for OSA (i.e., diagnosis, treatment, and monitoring/titrating therapy) in dental versus other contexts.

Objective

The objective of this brief narrative review is to provide a summary of recent literature published in 2015 and 2016, including systematic reviews (SR), meta-analyses (MA), and selected randomized trials, for the use of oral appliances (e.g., mandibular advancement devices) in the management of sleep-related breathing disorders, principally obstructive sleep apnea/hypopnea syndrome (OSAHS or OSA). In addition, this brief will review and grade the clinical practice guidelines (CPGs) published in 2015: a SR/MA/CPG from the American Academy of Sleep Medicine (AASM) and the American Academy of Dental Sleep Medicine (AADSM) on the treatment of obstructive sleep apnea and snoring with oral appliances¹ and a consensus guideline co-authored and published in 2015 from dental sleep medicine societies in Italy.²

1 This evidence brief was developed in response to ADA Resolution 96H-2015--Development of ADA
2 Policy on Dentistry's Role in Sleep-Related Breathing Disorders, which directed the Council on Scientific
3 Affairs (CSA) to collaborate with other appropriate ADA agencies to develop policy on "dentistry's role in
4 sleep-related breathing disorders." This brief narrative review is intended to provide a "state of the
5 science" for oral appliances in the management of sleep-related breathing disorders, and will be shared
6 with other ADA Councils (e.g., Council on Dental Practice) to inform discussion regarding the
7 development of policy, as directed by the Resolution. This document was reviewed by a CSA-assembled
8 workgroup (Appendix Table 1) of identified subject-matter experts, as well as members of the ADA
9 Council on Dental Practice.

10 Background: Sleep-Related Breathing Disorders

11 Description. Sleep-related breathing disorders comprise a variety of diagnoses, including simple snoring,
12 upper airway resistance syndrome (UARS), central sleep apnea/hypopnea syndrome (CSAHS), and
13 obstructive sleep apnea/hypopnea syndrome (OSAHS or OSA).^{3, 4} Both snoring and OSA are common
14 sleep disorders resulting from repetitive narrowing and collapsing of the upper airway.⁵ In the U.S. the
15 prevalence of OSA is estimated to be 3% to 7% in men and 2% to 5% in women.⁶ Prevalence is higher,
16 i.e., greater than 50%, in patients with cardiac or metabolic disorders, relative to the general population.⁷

17 Risk factors for OSA include obesity (the strongest risk factor), upper airway abnormalities, male sex,
18 menopause, and age.⁷ Untreated OSA is associated with multiple adverse sequelae, including systemic
19 hypertension, coronary artery disease, stroke, atrial fibrillation, increased motor vehicle accidents,
20 congestive heart failure, daytime sleepiness, decreased quality of life, and increased mortality.^{7, 8} Snoring
21 is also a significant social problem and contributes to decreased quality of life for bed partners through
22 disrupted sleep and may have an independent negative effect on health (e.g., increased risk for
23 cardiovascular disease or Type II diabetes mellitus).⁹⁻¹¹

24 Diagnosis. Apneas are defined as temporary cessation of breathing of 10 seconds or more, while
25 hypopneas are periods of shallow breathing that result in oxygen desaturation.⁷ OSA is defined by the
26 presence or absence of symptoms (e.g., daytime sleepiness, fatigue, snoring, choking during sleep,
27 nocturia, alterations in performance) and objective assessment of the respiratory disturbance index (RDI;
28 the number of apneas, hypopneas, and arousals from sleep because of respiratory efforts per hour of
29 sleep).⁷ OSA is the presence of subjective symptoms plus an RDI of 5/hr or greater or an RDI of 15/hr in
30 the absence of symptoms.⁷ OSA severity is classified by the number of apneas and/or hypopneas per
31 hour of sleep as detected by polysomnography, known as the Apnea/Hypopnea Index (AHI); an AHI of 5
32 to 15/hr is considered mild, 16 to 30 moderate, and greater than 30/hr severe OSA). Another measure of
33 OSA severity is the oxygen desaturation index (ODI).¹² The ODI, which is also evaluated during sleep
34 studies, measures the number of times per hour of sleep that the blood's oxygen level drops by a certain
35 percentage from baseline.¹²

36 The standard for diagnosis of OSA is overnight, attended polysomnography to detect the frequency of
37 apneic and hypopneic events, traditionally done as a standardized, facility-based technique, with
38 multichannel recordings that determine sleep time, sleep stages, respiratory effort, airflow, cardiac
39 rhythm, oximetry, and limb movements.^{4, 5} However, there are portable sleep monitors that may be used
40 in-home; these monitors include at least 3 sensors that detect respiratory events in the home setting.⁵
41 The AASM recommends considering these in patients with a high pretest likelihood for moderate-to-
42 severe OSA without other substantial comorbid conditions.^{5, 13} A 2014 clinical practice guideline¹⁴ from
43 the American College of Physicians (ACP) provided the following recommendations regarding sleep
44 studies in the diagnosis of OSA in adults:

45 *Recommendation 1:* ACP recommends a sleep study for patients with unexplained daytime
46 sleepiness. (Grade: weak recommendation, low-quality evidence)

47 *Recommendation 2:* ACP recommends polysomnography for diagnostic testing in patients suspected
48 of obstructive sleep apnea. ACP recommends portable sleep monitors in patients without serious

1 comorbidities as an alternative to polysomnography when polysomnography is not available for
2 diagnostic testing (Grade: weak recommendation, moderate-quality evidence)

3 Excessive daytime sleepiness, which is the most common daytime symptom, is measured by the Epworth
4 Sleepiness Scale (ESS), which is a subjective, a self-administered questionnaire measuring the patient's
5 assessment of how likely they are to nod off doing usual daily activities (e.g., watching television).¹⁵
6 Other questionnaires such as the STOP-BANG^{16, 17} or Berlin questionnaire¹⁸ evaluate both daytime
7 alertness and sleep variables (e.g., snoring, breathing problems during sleep), as well as presence of risk
8 factors such as high BMI and hypertension. The Sleep Apnea Quality of Life Scale is a validated
9 instrument for evaluating disease-related quality of quality of life.¹⁹

10 Treatment. First-line therapy, especially for severe OSA, is use of continuous positive airway pressure
11 (CPAP) devices during sleep.^{5, 20, 21} CPAP uses pressure to counteract airway narrowing through the
12 delivery of compressed air to the oropharynx, thereby splinting the airway (i.e., keeping it open with
13 increased air pressure) and maintaining airway patency.^{5, 20} CPAP devices are available with a wide
14 variety of mask types and machine sizes.⁵ When used properly and consistently, CPAP can result in
15 improved sleep patterns and quality of life.²⁰ However, these devices may not be well tolerated by
16 patients and adherence to therapy may be an issue.^{5, 20} Data on adherence to CPAP, defined as 4 hours
17 or more of use per night, are reported to range from 17% to 60%.^{22, 23} CPAP therapy also may not fully
18 resolve the OSA.²⁰

19 Another commonly used treatment is oral appliance (OA) therapy. OAs can be divided into three general
20 groups: soft-palate lifters (which are virtually no longer in use), tongue-retaining devices, and mandibular
21 advancement appliances (MAA).²⁴ Tongue-retaining devices are rarely used, mainly if there are dental
22 reasons precluding the use/construction of MAA.²⁴ The most commonly used type of OA is a mandibular
23 advancement device that either advances the mandible over time (i.e., adjustable) or provides a fixed
24 protrusion of the mandible.²⁴ Mandibular advancement moves the tongue base forward, and enlarges the
25 retropharyngeal region.^{5, 24} The most frequent adverse effects of these devices include excessive
26 salivation, mouth and teeth discomfort, temporomandibular adverse effects, and orthodontic changes.^{24, 25}
27 Summary compliance data from 2007 showed that at 30 months, 56% to 68% of patients continue to use
28 an oral appliance.²⁴

29 There are also surgical treatments, which are used less commonly; these include removal of tissue from
30 the posterior pharyngeal region (e.g., laser-assisted uvulopalatoplasty [LAUP]) and maxillary-mandibular
31 advancement, in which both the maxilla and the mandible are surgically advanced, thereby permanently
32 enlarging the posterior pharyngeal region.⁵ Other interventions include devices to alter sleep position,
33 physical therapy to improve oropharyngeal muscle tone, atrial overdrive pacing for patients with nocturnal
34 bradycardia, complementary and alternative medicine, interventions to achieve weight loss, including
35 bariatric surgery, and avoidance of alcohol and tobacco.^{20, 26}

36 Dental Specialty Society Statements. A statement²⁷ from the Canadian Dental Association (CDA;
37 approved by the CDA Board of Directors in 2005 and revised November 2012) recommends that before a
38 dentist prescribes an oral appliance for snoring indications, the patient be referred for a medical
39 assessment to determine the presence and severity of OSA. Further, the medical assessment should
40 "provide confirmation that snoring may be treated independently, or, if obstructive sleep apnea is
41 involved, in cooperation with an attending physician."

42 A 2013 position paper overview from the American Association of Oral and Maxillofacial Surgeons
43 (AAOMS)²⁸ on "Evaluation and Management of Sleep Apnea" states, as follows:

44 "Oral appliances have been shown to be an effective therapy in a significant percentage of
45 patients with mild to moderate OSA. While not considered a first-line treatment in patients with
46 OSA, custom-made oral appliances may be indicated for use in patients with severe OSA who
47 have failed first-line treatment with CPAP. Oral appliances should be fitted by qualified dental
48 personnel who are trained and experienced in the overall care of oral health, the
49 temporomandibular joint, dental occlusion and associated dental structures...."

1 The AAOMS position paper overview also states that although oral and maxillofacial surgeons are
2 “uniquely qualified to provide diagnostic input...into the evaluation of patients suspected of having
3 OSA....[u]sing all available data, the diagnosis of OSA is ultimately made by a qualified physician who is
4 trained in sleep medicine.”

5 Methods

6 MEDLINE® was searched (via PubMed) 12/11/15 with the terms “((mandibular advancement) OR (oral
7 appliance*)) AND sleep,” resulting in 1269 hits. The search was downloaded into an EndNote® database
8 and titles and abstracts were reviewed to identify relevant clinical practice guidelines, systematic reviews,
9 technology assessments, and meta-analyses published in 2015, as well as randomized trials published
10 since the last search date of the 2015 AASM/AADSM systematic review/clinical practice guideline¹
11 (February 2013) not already included in the guideline. Bibliographies of selected articles were further
12 examined for relevant references. This search was updated 04/18/16.

13 Evidence Review

14 Clinical Practice Guidelines

15 **Ramar et al. 2015¹**: In 2015, the AASM/AADSM published a systematic review/meta-analysis/clinical
16 practice guideline¹ on the treatment of obstructive sleep apnea and snoring in adults with oral appliance
17 therapy. The primary objective of the 2015 document was to update the prior 2006 AASM guideline and
18 systematic review.^{29, 30} Eleven PICO (Patients, Interventions, Comparisons, Outcomes) questions were
19 developed (see Appendix Table 2) and were used to formulate the literature search strategies. Searches
20 of the MEDLINE (via PubMed) and EMBASE databases were first performed in July and August 2012,
21 respectively, and subsequently updated in February 2013.

22 Search results were limited to: humans, English, all adults (no pediatrics), and RCTs (although the RCT
23 restriction was not used for PICO questions 7 and 11, owing to a lack of trials available). Articles were
24 excluded if they focused on diagnosis, described the use of OAs to treat central or complex sleep apnea,
25 or if they evaluated treatment in pediatric patients. A total of 51 articles met the inclusion criteria and were
26 used for data extraction, meta-analysis, and quality grading.

27 Evidence quality was assessed according to a modified Grading of Recommendations Assessment,
28 Development, and Evaluation (GRADE) process. Meta-analysis was performed with Review Manager 5.2
29 and all analyses were performed using a random-effects model. The AASM/AADSM Task Force then
30 developed strengths of recommendation based on both the strength of evidence and an assessment of
31 the relative benefits of the treatment versus the potential risks (see Appendix Table 3). The strength of
32 each recommendation also incorporated patient preference along with other factors such as cost, value,
33 and other patient-related factors.

34 The authors acknowledged that for the treatment of OSA, the evidence available for analysis of oral
35 appliances was limited. Meta-analysis showed that oral appliances can reduce arousal index, AHI, and
36 oxygen desaturation index, and increase oxygen saturation index; however, CPAP was more effective
37 than oral appliances on each of these parameters.

38 Other meta-analytic findings:

- 39 • Oral appliances have no significant effect on sleep architecture (i.e., % REM sleep) or sleep
40 efficiency (i.e., % of time spent in bed asleep).
- 41 • Oral appliances improve quality of life measures and decrease excessive daytime sleepiness in
42 adult patients with OSA and are nearly equivalent or equivalent to CPAP on both of these,
43 respectively.
- 44 • OAs are modestly effective in reducing blood pressure and are nearly equivalent to CPAP for this
45 outcome.

- 1 • Patient adherence with oral appliances is better overall than with CPAP in adult patients with
- 2 OSA and serious adverse effects resulting in discontinuation of oral appliance therapy are less
- 3 common than serious adverse effects causing discontinuation of CPAP.

4 The summary of AASM/AADSM recommendation statements appears in Table 1.

5 **Table 1. AASM/AADSM Summary of 2015 Recommendation Statements**

Recommendation Statement	Strength of Recommendation ^a	Quality of Evidence	Benefits vs. Harms/Burdens Assessment
<i>The Use of Oral Appliances for Treatment of Primary Snoring in Adults</i>			
We recommend that sleep physicians prescribe oral appliances, rather than no therapy, for adult patients who request treatment of primary snoring (without obstructive sleep apnea).	Standard	High	Benefits clearly outweigh harms
<i>The Use of Oral Appliances for Treatment of Obstructive Sleep Apnea in Adults</i>			
When oral appliance therapy is prescribed by a sleep physician for an adult patient with obstructive sleep apnea, we suggest that a qualified dentist use a custom, titratable appliance over non-custom oral devices.	Guideline	Low	Benefits clearly outweigh harms
We recommend that sleep physicians consider prescription of oral appliances, rather than no treatment, for adult patients with obstructive sleep apnea who are intolerant of CPAP therapy or prefer alternate therapy.	Standard	Moderate	Benefits clearly outweigh harms
We suggest that qualified dentists provide oversight—rather than no follow-up—of oral appliance therapy in adult patients with obstructive sleep apnea, to survey for dental-related side effects or occlusal changes and reduce their incidence.	Guideline	Low	Benefits clearly outweigh harms
We suggest that sleep physicians conduct follow-up sleep testing to improve or confirm treatment efficacy, rather than conduct follow-up without sleep testing, for patients fitted with oral appliances.	Guideline	Low	Benefits clearly outweigh harms
We suggest that sleep physicians and qualified dentists instruct adult patients treated with oral appliances for obstructive sleep apnea to return for periodic office visits—as opposed to no follow-up—with a qualified dentist and a sleep physician.	Guideline	Low	Benefits clearly outweigh harms

6 ^aSee Appendix Table 3

7 The AASM/AADSM guideline provides a section outlining research gaps and suggestions for future
8 research, including:

- 9 • adoption of a consistent and standardized nomenclature when referring to oral appliances;
- 10 • obtaining objective, rather than subjective, assessments of treatment adherence to oral appliance
11 therapy;
- 12 • development of a consistent and objective measure of snoring to evaluate benefit of oral
13 appliance therapy;
- 14 • standard protocols to document adverse effects related to oral appliances;

- 1 • larger and longer RCTs examining the benefits of oral appliance therapy on cardiac, metabolic,
- 2 and neurocognitive health as well as studies evaluating long-term outcomes associated with oral
- 3 appliance therapy in adult patients with OSA; and
- 4 • future studies to evaluate cost-benefit analysis and effectiveness compared to CPAP.

5 Definitions. The AASM/AADSM guideline uses the term “qualified dentist” as “the dental provider of

6 choice to provide oral appliance therapy.” Although not explicitly supported by an evidence base, the

7 guideline developers assert that “successful delivery of oral appliances requires technical skill, acquired

8 knowledge, and judgment regarding outcomes and risks of these therapies” and that “The need to

9 append the word ‘qualified’ stems from two things: (1) all of the studies conducted to evaluate the efficacy

10 and risks of oral appliances were conducted by dentists with considerable experience in dental sleep

11 medicine, and (2) the unfortunate fact that training in dental sleep medicine is uncommon.” Also, “[f]or the

12 purposes of this guideline, a sleep physician is defined as a physician who is either sleep board-certified

13 or sleep board-eligible.” The AADSM published a definition of an “effective” OA in 2014, focusing on

14 custom-titratable OAs. This definition was developed via consensus of a group of experienced dental

15 sleep medicine researchers and clinicians using a modified RAND Appropriateness Method.³¹

16 AGREE-II Group Guideline Appraisal. In January 2016, three staff members of the ADA Scientific

17 Information department undertook a group appraisal of the AASM/AADSM guideline using the Appraisal

18 of Guidelines for Research & Evaluation-II (AGREE-II) instrument tool.³² The AGREE-II rates each of 23

19 key items across 6 domains (i.e., Scope and Purpose; Stakeholder Involvement; Rigor of Development;

20 Clarity of Presentation; Applicability; and Editorial Independence), followed by two global rating items (i.e.,

21 “Overall Assessment). The 23 key items and the two global rating items are rated on a 7-point scale (1–

22 strongly disagree to 7–strongly agree). The calculated group scores for the 6 main domains can be found

23 in Table 2.

24 **Table 2. AGREE-II Domain Scores for the ADA Group Appraisal of the AASM/AADSM Clinical**

25 **Practice Guideline (Ramar et al. 2015)¹**

Domain (Description)	Group Appraisal Score
Domain 1. Scope and Purpose (the overall aim of the guideline, the specific health questions, and the target population [items 1-3])	89%
Domain 2. Stakeholder Involvement (the extent to which the guideline was developed by the appropriate stakeholders and represents the views of its intended users [items 4-6])	69%
Domain 3. Rigor of Development (the process used to gather and synthesize the evidence, the methods to formulate the recommendations, and to update them [items 7-14])	75%
Domain 4. Clarity of Presentation (the language, structure, and format of the guideline [items 15-17])	85%
Domain 5. Applicability (identification of the likely barriers and facilitators to implementation, strategies to improve uptake, and resource implications of applying the guideline [items 18-21])	32%
Domain 6. Editorial Independence (the formulation of recommendations not being unduly biased with competing interests [items 22-23])	64%

26 The group score for the overall assessment of quality of the guideline was 72%; 2 of the raters indicated

27 they would recommend the guideline, while one indicated recommendation of the guideline with

28 reservations.” The AGREE-II User’s Manual states that “although the domain scores are useful for

29 comparing guidelines and will inform whether a guideline should be recommended for use, the

30 Consortium has not set minimum domain scores or patterns of scores across domains to differentiate

31 between high quality and poor quality guidelines.”

32 **Levrini et al. 2015²:** In 2015, a group of seven specialty societies in fields relevant to dental sleep

33 medicine in Italy co-authored and published a consensus guideline on the “dental support in the treatment

1 of obstructive sleep apnea syndrome.” The primary objective of the document was “to present a set of
 2 proposed clinical recommendations aimed at Italian dentists involved in the management of patients with
 3 obstructive sleep apnea syndrome or snoring.” Although no formal search strategy or literature base was
 4 delineated, the document seemed to be developed on the basis of an iterative consensus process that
 5 was “based on the available literature data.” Where data were found to be absent, “conclusions were
 6 reached on the basis of a combined evaluation of the clinical and practical evidence together with expert
 7 opinion.”

8 Four questions were addressed:

- 9 • What approaches, anamnestic and clinical, might be helpful to dentists seeking to identify adult
 10 patients affected by OSAS or snoring?
- 11 • When can an intraoral device be applied in an adult patient with OSAS or snoring?
- 12 • What are the features of a device employed for the treatment of adult patients affected by OSAS
 13 or snoring?
- 14 • What therapeutic process should the dentist follow in the case of an adult patient affected by
 15 OSAS or snoring?

16 Although each conclusion was associated with a level of evidence and a power of recommendation, the
 17 process by which these aspects were graded was not explicit and appeared to be based heavily on
 18 consensus and expert opinion. The recommendations were, as follows:

19 Oral appliances can be used to treat: simple snoring, in patients who do not respond to, or do not
 20 appear to be suitable candidates for behavioral measures such as weight loss or positional
 21 therapy; mild or moderate OSAS, in patients who prefer OAs to [CPAP] or who are not suitable
 22 candidates for CPAP, because of its failure or failure of behavioral approaches like weight loss or
 23 positional therapy; severe OSAS, in patients who do not respond to or do not tolerate CPAP and
 24 in whom no indication for either maxillofacial or [ear, nose , and throat] surgery appears
 25 applicable.

26 The guidelines concluded, “The application of oral appliances is highly desirable in cases of simple
 27 snoring or mild to moderate OSAS, whereas considerable caution is warranted when treating severe
 28 OSAS. It is fundamental to ensure that the patient understands his problem and, at the same time, to
 29 present all the various treatment options.”

30 AGREE-II Group Guideline Appraisal. In April 2016, three staff members of the ADA Scientific
 31 Information department undertook a group appraisal of the Italian consensus guideline using the AGREE-
 32 II instrument.³² The calculated group scores for the 6 main domains can be found in Table 2.

33 **Table 2. AGREE-II Domain Scores for the ADA Group Appraisal of the Italian Consensus**
 34 **Guideline (Levrini et al. 2015)²**

Domain (Description)	Group Appraisal Score
Domain 1. Scope and Purpose (the overall aim of the guideline, the specific health questions, and the target population [items 1-3])	61%
Domain 2. Stakeholder Involvement (the extent to which the guideline was developed by the appropriate stakeholders and represents the views of its intended users [items 4-6])	41%
Domain 3. Rigor of Development (the process used to gather and synthesize the evidence, the methods to formulate the recommendations, and to update them [items 7-14])	12%
Domain 4. Clarity of Presentation (the language, structure, and format of the guideline [items 15-17])	44%
Domain 5. Applicability (identification of the likely barriers and facilitators to implementation, strategies to improve uptake, and resource implications of applying the guideline [items 18-21])	17%

Domain (Description)	Group Appraisal Score
Domain 6. Editorial Independence (the formulation of recommendations not being unduly biased with competing interests [items 22-23])	25%

1 The group score for the overall assessment of quality of the guideline was 17%; all three of the raters
 2 indicated they would not recommend the guideline.

3 Recent Randomized Trials

4 The following section reviews the randomized trials of oral appliances published since the last literature
 5 search date of the 2015 AASM/AADSM guideline and that were not already included in the guideline
 6 (e.g., the OA vs. CPAP RCT by Phillips et al. 2013³³).

7 OA vs. CPAP

8 **Glos et al. 2015³⁴:** This trial evaluated the effect of a mandibular advancement device (MAD;
 9 SomnoDent®) versus CPAP on cardiovascular parameters and autonomic activity in a 2-period crossover
 10 design in which 48 patients were either randomized to the sequence MAD/CPAP (12 weeks of MAD
 11 followed by 12 weeks of CPAP; n=24) or the sequence CPAP/MAD (3 months of CPAP followed by 3
 12 months of MAD; n=24); 40 patients completed the study. At baseline and after each treatment period,
 13 patients were assessed by polysomnography, as well as by a daytime cardiac autonomic function test
 14 that measured heart rate variability, continuous blood pressure, and baroreceptor sensitivity under
 15 conditions of spontaneous breathing. Both CPAP and MAD therapy “substantially eliminated apneas and
 16 hypopneas,” although CPAP had a greater effect. During daytime with all conditions of controlled
 17 breathing, 3-minute mean values of continuous diastolic blood pressure were significantly reduced by
 18 both MAD and CPAP. Selective increases in high-frequency heart rate variability were observed with
 19 MAD therapy. No changes were observed for baroreceptor sensitivity with either treatment. The authors
 20 concluded that **both MAD and CPAP result in similar beneficial changes in cardiac autonomic
 21 function during daytime, especially in blood pressure, but that CPAP was more effective than
 22 MAD in eliminating respiratory events.**

23 OA vs. Inactive Controls

24 **Durán-Cantolla et al. 2015³⁵:** This small, randomized, placebo-device-controlled, double-blinded,
 25 crossover trial evaluated the safety and efficacy of a mandibular advancement device (KlearWay™) in
 26 adult patients with confirmed diagnosis of mild-to-moderate OSA ($5 \leq \text{AHI} < 30$) by polysomnography and
 27 chronic snoring. The active treatment arm received mandibular advancement to a maximum tolerable
 28 distance or to a minimum of 65% of the maximum protrusion, while the placebo arm received a splint in
 29 centric occlusion that did not provide mandibular advancement. Of 42 patients randomized, 38 completed
 30 the study. Patients received active or placebo device for 4 weeks of adaptation and 12 weeks of therapy
 31 and then crossed over to the other arm. After each sequence of treatment, patients were assessed by
 32 questionnaires, conventional polysomnography, and objective home measurement of patient snoring.
 33 MAD decreased AHI from 15.3 (+/-10.2) to 11.9 (+/-15.5; $p < 0.01$ compared with placebo devices), while
 34 AHI increased in placebo device patients. A 50% reduction in AHI was achieved in 46.2% of active
 35 treatment patients and in 18.4% of the patients treated with placebo devices ($p < 0.01$). The subjective
 36 evaluation of chronic snoring was improved in the MAD phase; however, the objective evaluation of
 37 snoring did not show significant improvements. **The authors concluded that “MAD could be
 38 considered in the treatment of mild-to-moderate OSA and chronic [snoring].”**

39 **Marklund et al. 2015³⁶:** This 4-month³⁶, randomized, single-blinded, parallel trial compared the efficacy of
 40 an active, adjustable (via Herbst mechanism), custom-made oral appliance versus an intraoral placebo
 41 appliance (no advancement) in terms of improvement in daytime sleepiness and quality of life in patients
 42 with daytime sleepiness and snoring or mild-to-moderate obstructive sleep apnea ($\text{AHI} < 30$). Of 96

1 patients randomized, 91 completed the trial (n=45 active device; n=46 placebo device). The primary
2 study outcomes were daytime sleepiness (assessed by questionnaire) and quality of life (assessed by
3 SF-36); secondary outcomes included AHI and sleep quality (assessed by polysomnography),
4 headaches, and adverse effects. **The trial failed on its primary outcomes, showing no difference
5 between active device and placebo device in terms of self-reported daytime sleepiness or quality
6 of life. However, there were relative improvements in the objective secondary outcomes of AHI:
7 the active device decreased AHI from 15.6 (+/-9.8) to 6.7 (+/-4.9; p<0.001 compared with placebo
8 device); there were no differences between groups in sleep quality or headaches. Snoring
9 (p<0.001) and restless legs symptoms (p<0.02) were significantly improved in the active device
10 arm, compared with the placebo device.**

11 **Quinnell et al. 2014³⁷:** This randomized, controlled, crossover trial compared three types of
12 nonadjustable oral mandibular advancement devices (“boil and bite,” patient-molded semi-custom, and
13 fully custom monobloc) to no treatment for mild-to-moderate OASHS (AHI 5 to <30/h). Of 90 adult
14 patients randomized, 74 completed all 4 crossover phases of the trial. Patients were either newly
15 diagnosed and not requiring or rejecting CPAP or patients who were CPAP intolerant. Device-based
16 treatment was 6 weeks (2 weeks of acclimatization and 4 weeks’ treatment); no treatment was 4 weeks.
17 One week of washout followed active treatments and outcomes were obtained at baseline and at the end
18 of each treatment period. The primary outcome was AHI scored by a polysomnographer blinded to
19 treatment. Secondary outcomes included subjective sleepiness, quality of life, resource use, and cost. All
20 devices significantly reduced AHI and sleepiness compared with no treatment. Compliance was lower for
21 the “boil and bite” appliance, which was the least preferred treatment at the end of the trial. **Although all
22 devices were cost-effective compared with no treatment, the semi-custom device was the most
23 cost-effective. The authors concluded that the nonadjustable devices can achieve clinically
24 important improvements in mild-to-moderate OSAHS and are cost-effective. Of those tested, the
25 semi-custom device was considered by the authors as an appropriate first choice.**

26 OA vs. OA

27 **Bishop et al. 2014³⁸:** This small, randomized, crossover trial was designed to compare two different
28 designs of mandibular repositioning appliances (MRAs) for treatment of OSA. Twenty-four subjects who
29 were recruited consecutively following a diagnosis of OSA by polysomnography underwent an initial
30 home sleep study to establish a baseline RDI. They were then randomized to one of two MRAs that
31 differed in advancement hardware and acrylic configurations, both in bulk and interocclusal contact.
32 Eighteen patients completed the study. The primary outcome of the study was change in the RDI;
33 secondary outcomes included quality of life, subjective sleepiness, oxygen saturation, and subjective
34 feedback regarding experience with the device. At the end of research participation, patients were asked
35 to choose between the two devices for ongoing treatment and their choice was recorded. There were no
36 statistically significant differences in treatment outcomes between the two devices. There was a
37 statistically significant preference for a device design with minimal coverage of teeth and palate (p≤0.05).
38 **The authors concluded that device selection should favor titratable, unobtrusive designs with
39 appropriate construction to promote acceptance and adherence to therapy.**

40 **Geoghegan et al. 2015³⁹:** This was a prospective, randomized, crossover trial of treatment with two
41 different mandibular advancement devices. Twenty-two subjects were randomly allocated to the
42 monobloc/twin bloc treatment sequence and 23 subjects to the twin bloc/monobloc treatment sequence;
43 of the 45 original subjects, 38 completed the trial. Lateral cephalograms were taken, and the Epworth
44 Sleepiness Scale and the Sleep Apnea Quality of Life Index were completed at baseline. The treatment
45 sequences consisted of a baseline evaluation, a 2-week acclimatization period and 10-week treatment
46 phase, followed by full evaluation and a 2-week washout period. AHI was the primary outcome measure;
47 secondary outcomes included subjective sleepiness and quality of life. **Although both designs resulted
48 in a significant change in AHI, the monobloc was significantly superior to the twin bloc. No
49 differences were seen in the subjective indicators of sleepiness and quality of life. Significant but
50 similar cephalometric changes were observed, indicating that both devices alter the position of
51 the surrounding musculature and improve upper airway patency.**

1 **Other Systematic Reviews, Meta-Analyses, and “Reviews of Reviews” Published in**
2 **2015/2016**

3 **“Review of Reviews” by Johal et al. 2015⁴⁰:** A 2015 “review of reviews”⁴⁰ provided an overview and
4 quality assessment of systematic reviews evaluating mandibular advancement splint therapy for OSA.
5 The authors searched PubMed and relevant Cochrane Library databases (Cochrane Database of
6 Systematic Reviews, Database of Abstracts of Reviews of Effects [DARE], and the Health Technology
7 Assessment [HTA] database) in September 2013 to identify systematic reviews and assessed the quality
8 of the reviews using the AMSTAR (A Measurement Tool to Assess Systematic Reviews) validated tool
9 (see Appendix Table 4 for AMSTAR criteria).

10 Eight systematic reviews,^{30, 41-47} four incorporating meta-analyses, were identified that reported on
11 objective and subjective outcome measures. The effectiveness of MAS therapy was compared to no
12 treatment, non-active appliance, CPAP, surgical intervention, and a different MAS appliance. The quality
13 of the reviews was reported as variable (median=7, range=3 to 11), with only two of higher quality
14 (AMSTAR scores >10), one of them a Cochrane review.⁴⁴ The Cochrane review showed significant
15 benefits of MAS therapy compared with inactive appliances in terms of both daytime sleepiness and AHI
16 outcomes.

17 **Johal et al. concluded that the results from the higher-quality systematic reviews of MAS therapy**
18 **for OSA showed that oral appliances can improve OSA** and recommended that, “Current reporting
19 guidelines for systematic reviews (e.g., PRISMA) and sources of high-quality existing reviews should be
20 closely followed to enhance the validity and relevance of future reviews.”

21 Table 3 provides an array of the systematic reviews and meta-analyses published in 2015 and 2016. The
22 detail included in the table indicates whether meta-analysis was performed; what was the stated objective
23 of the review; search sources (including gray literature), dates, and parameters of the literature search;
24 whether included studies were restricted to English language only; the PICO (patients, interventions,
25 comparators, and outcomes) question being addressed; whether the authors performed any risk of
26 bias/quality analysis of the individual included studies or body of evidence considered in the review and
27 what the findings of these analyses were; and what were the main conclusions of the review.

Table 3. Systematic Reviews and Meta-Analyses Published in 2015/2016 on Oral Appliance Therapy for SRBD

Review	MA	Objective	Search Sources	Language Restriction	Study Designs (n)	PICO	RoB/Quality Rating(s) Used in Report: Findings	Conclusions
<i>Adult Populations</i>								
Bartolucci et al. ⁴⁸	Y	To investigate the effectiveness of different mandibular advancement amounts in reducing AHI in adult pts with OSA	MEDLINE, Cochrane Database, Google Scholar Beta, ISI Web of Knowledge, Scopus, and LILACS 1/1/90 through 4/30/15; also gray literature and manual searches	N/A	RCTs (13)	In adult patients with OSA, what is the effectiveness of different mandibular advancement amounts in reducing AHI?	Cochrane Collaboration RoB tool (individual studies): Unclear/Low RoB for most of the included studies GRADE (body of evidence): Moderate	There is small body of moderate quality evidence to suggest that increasing the mandibular advancement does not produce significant improvements in the success rate since there is a high inter-individual variability in response to the MAD therapy.
Bratton et al. ⁴⁹ (2015a)	Y	To compare using network meta-analysis the association of CPAP, MADs, and inactive control groups (placebo or no treatment) with changes in SBP and DBP in adult (>18y) pts with OSA	MEDLINE, EMBASE, and Cochrane searched from inception through 8/15; study bibliographies reviewed	English	RCTs (51)	In adult patients with OSA, are CPAP, MADs, or no treatment associated with an effect on SBP or DBP?	Cochrane Collaboration RoB tool: In most domains, the majority of trials were at low risk, except for the allocation concealment category in which most trials were at an unclear risk due to inadequate reporting of methods.	Among patients with obstructive sleep apnea, both CPAP and MADs were associated with reductions in BP. Network meta-analysis did not identify a statistically significant difference between the BP outcomes associated with these therapies.
Bratton et al. ⁵⁰ (2015b)	Y	To compare using network meta-analysis and quantify the effects of CPAP and MADs on ESS and to establish predictors of response to CPAP in adult (>18y) pts with OSA	MEDLINE and the Cochrane Library from inception to 5/31/15 using the Cochrane Highly Sensitive Search Strategy	English	RCTs (67)	In adult patients with OSA, what is the effect of MADs compared with CPAP on daytime sleepiness?	Cochrane Collaboration RoB tool: "The risk of selection bias was unclear in most studies because they did not adequately describe their methods of randomisation and allocation concealment. Additionally, most studies were deemed to be at high risk of performance and detection bias because they compared treatments that could not be masked (eg, continuous positive airway pressure vs no treatment or mandibular advancement devices)."	[CPAP] and [MADs] are effective treatments for reducing daytime sleepiness in patients with [OSA]. [CPAP] seemed to be a more effective treatment than [MADs], and had an increasingly larger effect in more severe or sleeper OSA patients when compared with inactive controls. However, [MADs] are an effective alternative treatment should [CPAP] not be tolerated.

Table 3. Systematic Reviews and Meta-Analyses Published in 2015/2016 on Oral Appliance Therapy for SRBD (cont'd)

Review	MA	Objective	Search Sources	Language Restriction	Study Designs (n)	PICO	RoB/Quality Rating(s) Used in Report: Findings	Conclusions
<i>Adult Populations (cont'd)</i>								
Sharples et al. ⁵¹	Y	To update systematic reviews of the effects of MAD and CPAP, compared with each other and with conservative management, and to estimate the effect on AHI and ESS of both treatments in adult (>16y) pts with OSA	MEDLINE, Embase and the Science Citation Index searched from 6/08 through 8/13. Reference lists of papers were searched; the research team's experts were asked to identify other trials missed in updated searches	English	RCTs (71 trials, 77 separate comparisons)	In adult patients with OSAHS, what is the effect of MADs compared to CPAP or either to conservative management on AHI and sleepiness?	The Jadad score (0 [poor] to 5 [rigorous]) was calculated as a measure of quality for consistency with previously published reviews: the Jadad score was available for 69/71 trials, with average score "close to three" for comparisons against CM. The mean Jadad score "was 2.9 in MAD-CM trials, 2.3 in MAD-CPAP comparisons and 3.1 in CPAP-CM trials, with the lower mean scores in MAD-CPAP comparisons mainly attributable to the difficulty in blinding the two active treatments."	Both MAD and CPAP are clinically effective in the treatment of OSAHS. Although CPAP has a greater treatment effect, MAD is an appropriate treatment for patients who are intolerant of CPAP and may be comparable to CPAP in mild disease.
Serra-Torres et al. ²⁶	N	To assess the effectiveness of [MADs] in treating adults with OSAHS, based on polysomnographic measurements such as the AHI and oxygen saturation, and on changes in the upper airway and improvements in snoring and somnolence; adverse effects were also noted	MEDLINE, Scopus, and Cochrane Library databases were searched for studies published between 2004 and 2014	None	SRs and MAs, RCTs, cohort studies, and case-control studies, prospective and retrospective (22)	In adult patients with OSAHS, do MADs compared to placebo devices or no treatment have an effect on AHI, changes in the upper airway, sleepiness, or snoring, and what is the adverse effect profile of MADs?	Modified CONSORT: Of the 25 studies, 3 were excluded because they were considered to be of low quality. Of the remaining 22 articles, quality was considered to be high in 16 cases and medium in 6.	Using [MADs] during the hours of sleep helps to prevent snoring and excessive daytime sleepiness, reduce the AHI significantly, and bring about beneficial changes in the upper airway. Adjustable and custom-made [MADs] give better results than fixed and prefabricated appliances. Monobloc devices give rise to more adverse events, although these are generally mild and transient.

Table 3. Systematic Reviews and Meta-Analyses Published in 2015/2016 on Oral Appliance Therapy for SRBD (cont'd)

Review	MA	Objective	Search Sources	Language Restriction	Study Designs (n)	PICO	RoB/Quality Rating(s) Used in Report: Findings	Conclusions
<i>Adult Populations (cont'd)</i>								
Zhu et al. ⁵²	Y	To evaluate the effectiveness of oral appliances for managing adult patients with OSA.	PubMed, Web of Science, Embase, Cochrane Central Register of Controlled Trials, and SIGLE were searched from 1/80 to 9/15	None	RCTs and nonrandomized trials of oral appliances compared to placebo devices or untreated controls (17)	In adult patients with OSAS, do oral appliances compared to placebo devices or no treatment have an effect on AHI, respiratory arousal index, minimum oxygen saturation, rapid eye movement sleep, sleep efficiency and ESS?	Cochrane Collaboration RoB tool for individual studies: 13 were high RoB, 3 were medium RoB, and one was low RoB GRADE to assess the quality of each outcome evaluated: quality of evidence of outcomes in this MA was assessed to be low	The available evidence indicates benefits in respiration and sleep quality with oral appliances as compared to placebo devices or blank control , while we cannot determine its effectiveness in sleep efficiency and sleep architecture alterations. However, due to low evidence quality as revealed by GRADE, this finding should be interpreted with caution.
<i>Pediatric Populations</i>								
Huynh et al. ⁵³	Y	To investigate the efficacy of orthopedic mandibular advancement and/or rapid maxillary expansion in the treatment of pediatric (<18y) obstructive sleep apnea	MEDLINE (1946-4/14), and Embase (1974-4/14). Google and Google scholar were searched for eligible studies published until 4/14.	English	Treatment arms of RCTs and nonrandomized controlled designs and before-after studies (8)	In pediatric patients (<18y) with OSAS, do MADs or rapid maxillary expansion devices have an effect on AHI, oxygen saturation (%), arousal index, increase in upper airway volume, or sleep quality?	Modified criteria from ARRIVE guidelines for human experimental studies. An intraclass correlation coefficient evaluated agreement between reviewers. Although no quality assignments were reported, the intraclass correlation coefficient was reported to be 0.85, indicating “almost a perfect” agreement among the three reviewers concerning the designated articles.	Although the included studies were limited, these orthodontic treatments may be effective in managing pediatric snoring and obstructive sleep apnea. Other related health outcomes, such as neurocognitive and cardiovascular functions have not yet been systematically addressed.

Table 3. Systematic Reviews and Meta-Analyses Published in 2015/2016 on Oral Appliance Therapy for SRBD (cont'd)

Review	MA	Objective	Search Sources	Language Restriction	Study Designs (n)	PICO	RoB/Quality Rating(s) Used in Report: Findings	Conclusions
<i>Pediatric Populations (cont'd)</i>								
Nazarali et al. ⁵⁴	N	To evaluate the effectiveness of mandibular advancement appliances (MAAs) for treatment of pediatric (<16y) OSA.	PubMed, EMBASE, MEDLINE, Healthstar, Cochrane Central Register of Controlled Trials, and Cochrane Database of Systematic Reviews (inception to 8/14). Hand searches of relevant article reference lists and limited grey literature and Google Scholar searches	English	RCTs or nonrandomized clinical trials, prospective or retrospective (4)	In pediatric (<16y) patients with OSAS, does treatment with a MAA compared with control or before/after have an effect on AHI, oxygen desaturation, daytime/nocturnal symptoms, or dental/skeletal changes?	Cochrane RoB tool: All included studies were found to have high RoB potential. Common weaknesses identified were nonrandomized allocation and small sample sizes. Further, two studies did not include a non-treated control group A meta-analysis was not possible due to the heterogeneity in study designs and collected information. Therefore, assessment of the RoB across studies was not feasible (GRADE framework).	The current limited evidence may be suggestive that MAAs result in short-term improvements in AHI scores, but it is not possible to conclude that MAAs are effective to treat pediatric OSA. Medium- and long-term assessments are still required.

AHI: apnea-hypopnea index; ARRIVE: Animal Research: Reporting In Vivo Experiments; BP: blood pressure; CM: conservative management; CPAP: continuous positive airway pressure; DBP: diastolic blood pressure; ESS: Epworth Sleepiness Scale; LILACS: Latin American and Caribbean Health Sciences; MA: meta-analysis; MAA: mandibular advancement appliance; MAD: mandibular advancement device; N: no; N/A: Not available; OSA: obstructive sleep apnea; OSAHS: obstructive sleep apnea hypopnea syndrome; PICO: patients; interventions, comparator, outcome; pt(s): patient(s); RCT(s): randomized, controlled trial(s); RoB: risk of bias; SBP: systolic blood pressure; SIGLE: System for Information on Grey Literature in Europe; SR: systematic review; SRBD: sleep-related breathing disorder; Y: yes; y: years

1 Summary/Discussion

2 The evidence reviewed in this brief consists of a 2015 clinical practice guideline from the American
3 Academy of Sleep Medicine/American Academy of Dental Sleep Medicine (AASM/AADSM, based on a
4 systematic review and meta-analysis),¹ as well as a 2015 consensus guideline co-authored by dental
5 sleep medicine societies in Italy;² 6 randomized trials of oral appliances published since the last literature
6 search date of the 2015 AASM/AADSM guideline and that were not already included in the guideline;³⁴⁻³⁹
7 a 2015 review of systematic reviews;⁴⁰ and 8 systematic reviews/meta-analyses published in
8 2015/2016,^{26, 48-54} two of which were focused on pediatric populations.^{53, 54}

9 The evidence shows that oral appliances, specifically custom-made, titratable devices, can improve OSA
10 in adult patients compared to no therapy or placebo devices. OAs are generally less effective than
11 CPAP, but have a role in patients who are intolerant of or refuse CPAP. The AASM/AADSM guideline
12 found that patient adherence with OAs was better than that for CPAP and that OAs have fewer adverse
13 effects that result in discontinuation of therapy, compared with CPAP.

14 Gaps

15 The two systematic reviews^{53, 54} evaluating the data for oral appliances in pediatric OSA found very limited
16 evidence for their use and called for additional short- and long-term evidence, especially for health
17 outcomes, such as neurocognitive and cardiovascular function.

18 Another gap identified is the lack of published comparative evidence evaluating comprehensive
19 management of oral appliance therapy for OSA (i.e., diagnosis, treatment, and monitoring/titrating
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1 **Appendix**

2 **Appendix Table 1. ADA Council on Scientific Affairs (CSA) Oral Appliances Evidence Workgroup**

3

Workgroup Member	Affiliation
Angelo J. Mariotti, D.D.S., Ph.D. Workgroup Chair Member, CSA	<ul style="list-style-type: none"> • Chair, Division of Periodontology and Professor • The Ohio State University College of Dentistry • Columbus, OH
Henry A. Gremillion, D.D.S., M.A.G.D.	<ul style="list-style-type: none"> • Dean, Louisiana State University School of Dentistry • E.E. Jeansonne Endowed Professor in Continuing Dental Education • New Orleans, LA
Gary D. Klasser, D.M.D.	<ul style="list-style-type: none"> • Faculty Dental Practice, Louisiana State University School of Dentistry • Private practice (one day/week) • New Orleans, LA
Paul McLornan, D.D.S.	<ul style="list-style-type: none"> • Board-certified prosthodontist in private practice in San Antonio • Assistant professor at University of Texas San Antonio Dental School and on the graduate faculty of the UTHSCSA Graduate School of Biomedical Sciences • San Antonio, TX
James E. Metz, D.D.S.	<ul style="list-style-type: none"> • Diplomate of the American Board of Dental Sleep Medicine • General dental practice in Columbus, Ohio, with an emphasis on dental sleep medicine and restorative dentistry • Affiliate director of The Ohio State University Medical Center Sleep Medicine Fellowship Program • Columbus, OH
Julia Mikell, D.D.S.	<ul style="list-style-type: none"> • Member, ADA Council on Dental Practice • Private practice • Columbia, SC
Craig S. Ratner, D.M.D.	<ul style="list-style-type: none"> • Member, ADA Council on Dental Practice • Private practice • Staten Island, NY
David B. Schwartz, D.D.S.	<ul style="list-style-type: none"> • Diplomate of the American Board of Dental Sleep Medicine • Private practice • Skokie, IL
J. Christopher Smith, D.D.S.	<ul style="list-style-type: none"> • Member, ADA Council on Dental Practice • Private practice • Charleston, WV
Harold Smith, D.D.S.	<ul style="list-style-type: none"> • Diplomate of the American Board of Dental Sleep Medicine • Clinical Director, Dental Sleep Medicine of Indiana • President-Elect of the American Academy of Dental Sleep Medicine • Indianapolis, IN

4

1 **Appendix Table 2. PICO Questions Developed for the 2015 AASM/AADSM Guideline¹**

PICO Question 1	In adult patients with primary snoring, do oral appliances (OAs) improve snoring, sleep quality, including the bed partner's sleep quality, and/or quality of life measures compared to other therapies or no treatment?
PICO Question 2	In adult patients with obstructive sleep apnea (OSA) (irrespective of underlying severity of OSA, and for each mild, moderate, or severe OSA), do oral appliances improve the apnea hypopnea index (AHI)/respiratory disturbance index (RDI)/respiratory event index (REI), oxygen saturation, arousal index, and/or sleep architecture compared to other therapies or no treatment?
PICO Question 3	In adult patients with OSA, do OAs improve cardiovascular endpoints, such as hypertension, coronary artery disease, myocardial infarction, and/or arrhythmias, as compared to other therapies or no treatment?
PICO Question 4	In adult patients with OSA, do OAs improve quality of life measures, and/or objective and subjective daytime sleepiness, as compared to other therapies or no treatment?
PICO Question 5	In adult patients with OSA, do titratable OAs improve AHI/RDI/REI, oxygen saturation, arousal index, and/or sleep architecture and do they improve long-term management of OSA with outcome measures such as AHI/RDI/REI, sleep quality, quality of life measures, cardiovascular endpoints, and/or subjective/objective measures of sleepiness compared to non-titratable OAs?)
PICO Question 6	In adult patients with OSA, do OAs lead to mild or serious side effects compared to those treated with other therapies or no treatment?
PICO Question 7	In adult patients with OSA, do follow-up oximetry, home sleep apnea tests, polysomnograms, or follow-up with a sleep physician improve long-term management with OAs as compared to no follow-up?
PICO Question 8	In adult patients with OSA, does follow-up with dentists/sleep specialists improve adherence and reduce side effects associated with OAs compared to those who do not have follow-up?
PICO Question 9	In adult patients with OSA, does OA use show better adherence than that reported by subjective or objective measures for PAP therapy?
PICO Question 10	In adult patients with OSA, do different types of OAs have variable effectiveness in controlling sleep-disordered breathing as measured by the AHI/RDI/REI and/or other outcome measures such as sleep quality, quality of life measures, cardiovascular endpoints, and/or objective/subjective daytime sleepiness?
PICO Question 11	In adult patients with OSA, what are the factors that predict success with OAs compared to other therapies or no treatment?

1 **Appendix Table 3. AASM Strengths of Recommendations¹**

Assessment of Benefits versus Harms/Burdens	Overall Quality of Evidence			
	High	Moderate	Low	Very Low
Benefits clearly outweigh harms/burdens	Standard	Standard	Guideline	Option
Benefits closely balanced with harms/burdens OR Uncertainty in the estimates of benefits versus harms/burdens	Guideline	Guideline	Option	Option
Harms/burdens clearly outweigh benefits	Standard	Standard	Standard	Standard

2 **Appendix Table 4. AMSTAR Criteria⁵⁵ for Assessing Quality of Systematic Reviews**

Provision of a priori design
Duplicate study selection and data extraction
Comprehensive literature search
Publication status used as inclusion criterion
Listing of included and excluded studies
Provision of characteristics of included studies
Assessment and documentation of scientific quality of included studies
Appropriate use of scientific quality of included studies to formulate conclusions
Appropriate methods used to combine findings
Assessment of publication bias
Stated conflict of interest

APPENDIX 2

AIP Round 2 Comments

GENERAL COMMENTS

1
2
3
4
5 **1. First Name: Shah**
6 Last Name: Dipika
7 Occupation: Dentist

8 Comments: Dentists are the first and may be the only one to diagnose with proper training (as patients
9 may not see their physicians and physicians may not check for sleep apnea) on time, should be
10 diagnosing, should be allowed to administer test (test should be read by MD specialist) and treat with
11 proper training, should get reimbursed by med/ dental/ Medicare insurance.
12

13 **2. First Name: Christopher**
14 Last Name: Sprout
15 Occupation: Dentist
16

17 Comments: I have treated many (~30) patients who have been moderate to severe apnea cases with the
18 Micro O2 appliance according to the guidelines taught at the Las Vegas Institute. All of them were titrates
19 to within 3mm of an end to end position and some of these are patients were previously treated by other
20 dentists using a George gauge with poor results. I believe it is imperative to understand the underlying
21 anatomical and physiological guidelines before treating patients. If not, some dentists and unsuccessful
22 outcomes will continue to tarnish the treatment as a whole.

23
24 **3. First Name: Deborah**
25 Last Name: Ziwot
26 Occupation: Dentist in Sleep Disorder Center Industry

27 Comments: Two issues that you might consider mentioning in the policy on the role of dentistry in the
28 treatment of sleep are:

29 1. Dentists are not permitted to write prescriptions for oral appliance therapy or PAP therapy; only
30 physicians may write the prescriptions.

31 2. In addition to oral appliances, dentists are allowed to sell CPAP devices. Dentists may not write the
32 prescription for the PAP device, but they may sell the device. If the patient is a Medicare patient, the
33 dentist would be subject to additional requirements to sell the PAP device than that which is required for
34 oral appliances.

35
36 **4. First Name: Kent**
37 Last Name: Smith
38 Occupation: Dentist

39 Comments: I believe that testing for sleep disordered breathing is no different than testing for high blood
40 pressure, which we as dentists are encouraged to do. As long as we get a prescription to treat from an
41 MD, tests for sleep apnea using the equipment at our disposal should also be encouraged.

1 **5. First Name: McHenry**
2 Last Name: Lee
3 Occupation: Dentist

4 Comments: I have been a dentist for 44 years.
5 Dentist should be one of the first in line in recognizing and treating sleep disorders.
6 It only makes sense.
7 Dr Mac Lee

8
9 **6. First Name: Erika**
10 Last Name: Mason
11 Occupation: Dentist exclusively treating patients with OSA

12 Comments: I commend the ADA for finally acknowledging that DSM exists. AND for the first time since
13 the inception of the American Academy of Dental Sleep Medicine (AADSM) the ADA has taken an active
14 role in the policy fabrication for dentists who are members of the ADA. The proposed policy begins to
15 challenge the status quo with regards to treatment of these medical disorders by dentists. It also
16 endorses member dentists treating patients ubiquitously, but in my opinion the policy falls short in a few
17 ways.

18 I would have liked the policy to take a stronger stance on the need for continuing education in dental
19 sleep medicine. The fact that dentists coming out of school and even those who have been practicing
20 general dentistry for years are bundled together with those of us who have studied extensively and
21 committed to passing the Diplomate examination of the American Board of Dental Sleep Medicine
22 (ABDSM) is myopic. The proposed policy says that "Dentists should continually update their knowledge
23 and training of dental sleep medicine with related continuing education" which naively assumes that they
24 have any knowledge or education of sleep-related breathing disorders to begin with. Dental schools and
25 even weekend courses cannot adequately begin to shed the needed light on the vast amount of material
26 that one needs to properly treat our sleep patients. It is my opinion that to condone the practice of dental
27 sleep medicine without adequate training is setting up these doctors for potential liability as well as the
28 patients for failure. Continued education in dental sleep medicine is an absolute mandate and just joining
29 an organization is not enough. Dentists must commit to attending meetings, shadowing sleep physicians
30 and even shadowing dentists already skilled in dental sleep medicine to augment their knowledge.

31 The ultimate goal should be credentialing by the ABDSM and other organizations that have very good
32 standards of credentialing as well. (I am a double diplomat with ABDSM and the ACSDD) Until dental
33 school education incorporates comprehensive dental sleep medicine curricula, neophytes matriculating
34 from our dental institutions should be cautioned about the intricacies of dental sleep medicine and the
35 relationships that are required to adequately prepare for this expertise.

36 As dentists we are able to treat myriad maladies of the teeth, head and related oral structures. We
37 routinely screen our patients for hypertension we look for signs and symptoms of diabetes, oral cancer,
38 thyroid cancer, viral and bacterial infections, anemia, and other medical conditions. When we are placed
39 in a position to diagnose obstructive sleep apnea we are told to put the brakes on as it might be out of our
40 scope of practice.

41 The ADA has the opportunity to put forth a major campaign to treat a very large public health problem and
42 at this juncture we don't have the authority to do so. I would like the ADA to be bold enough to confront
43 this issue in the future policy statement regarding sleep-related breathing disorders. We should be
44 permitted to screen our patients and refer them for appropriate treatment just as we would if we screened
45 a patient for cancer and found a lump. We would be co-diagnosing and treating patients, based on the
46 appropriateness of the therapy we could provide. I would no sooner remove a lump in a patient's neck
47 than I would provide a CPAP or an oral appliance without the proper communication, co-diagnosis and

1 recommendations from my medical colleagues. The mutual respect of our medical colleagues will be
2 earned and we will no longer be simply technicians. We should be considered Oral Health Providers.

3 We are asked to act like physicians while treating these patients with an oral appliance; we bill medical
4 insurance and Medicare; and keep records that are like our medical colleagues; however, we are told to
5 refrain from anything that might resemble a diagnosis because that is out of our dental scope of practice
6 and jurisdiction. But is it really out of our scope and jurisdiction? That discussion is far too complicated to
7 entertain in this short comment.

8 I commend the ADA on beginning the long and arduous task of creating a policy on the treatment of
9 obstructive sleep apnea and sleep-related breathing disorders. I will continue to offer my
10 recommendations in any way I can.

11 The number of undiagnosed patients with OSA is far too large of a public health concern to not have
12 dentists included in the overall health screening and treatment of these patients. I believe that we have
13 made great strides in treating these patients diagnosed with sleep-related breathing disorders. With more
14 comprehensive dialogue with the ADA we have the ability to play a major role in managing this health
15 concern.

16 I am confident that the future of our role in this will benefit patients overall care, hone the relationship with
17 our medical colleagues, and provide another area of expertise within the scope of dentistry. I believe that
18 the education provided by the dental schools with the guidance of the AADSM and the ADA will be
19 comprehensive and universally disseminated which will continue to foster ideal overall therapy as
20 dentists.

21 This is a good start but we have much further to go.

22 **7. From: James E. Sweeney, DDS**

23 **Policy Statement on the Scope of Dentistry in the Treatment of Sleep-Related Breathing Disorders**

24 As a member of the ADA and a concerned sleep medicine clinician I am anxious for the ADA to take a
25 policy position regarding the dental roll in the public health crisis that is SRBD. I see some flaws in the
26 recent iteration:

27 1. Although I agree that it should be stressed that every adult patient be screened for SRBD the success
28 of any dental intervention in identification, diagnosis, and ultimate treatment and maintenance of the
29 SRBD patient requires knowledge, training and experience to which most of ADA members have not
30 been exposed.

31 For those desirous of adopting a sleep medicine program several educational opportunities are available.
32 Off-line CE courses and on-line courses can be pursued

33 (ACSDD and AASDM offer excellent CE courses leading to credentialing).

34 Offices choosing to not offer the service should form a referral relationship as is normal in dental
35 referrals.

36 2. Adult SRBD and childhood SRBD are different modalities with differing risk factors and treatment
37 protocols. A separate policy for childhood SRBD would be in order in a later resolution.

38 **SUGGESTIONS:**

39 A. Make a case for SRBD---use the precedent of the excellent ADA white paper

1 "Oral and Pharyngeal Cancer". Using the same format a compelling case can be made regarding the
2 public health crisis that SRBD is becoming. This awareness should stimulate a general response across
3 the dental community to join with other health care providers in controlling this major disease and offering
4 more wellness options to our patient population

5 B. Stress the importance of screening all adult patients for SRBD as we are mandated to do for oral
6 cancer.

7 C. Urge CE for all dental staff regarding SRBD

8 D. Policy statement regarding education for pre-doctoral dental students.

9 I appreciate the opportunity to offer my thoughts regarding this issue and applaud the committee in your
10 effort.
11

12 **8.** First Name: Jo
13 Last Name: Lloyd
14 Occupation: Sleep Care Coordinator
15

16 Comments: I would like to see Dentists be able to order the sleep studies and go through medical
17 insurance for that service. If the Dentists and the sleep care coordinator can be trained to evaluate a
18 patient for the risk of sleep disordered breathing, I think it is a natural progression to be able to order the
19 sleep study. Doing so will be more efficient for the patient and shorten the time of diagnosis to treatment,
20 which is really what we all want. I think it is equally important for the Sleep Care Coordinator to have
21 focused training. As a licensed Respiratory Care practitioner who has been in sleep medicine for 8 years,
22 I feel that my specialized training gives me and my Dentists an edge.
23

24 **9.** First Name: Adrienne
25 Last Name: Elwood-Cowan
26 Occupation: General Dentist

27 Comments: I want to thank the ADA for recognizing that we are an integral part of our patient's overall
28 health, not just their dental health. It is time for our profession to stand up and let our medical colleagues
29 know that we all play a role in the care of our patients. We can be instrumental in identifying patients who
30 suffer from this. By working with the appropriately trained medical community we can get our patients
31 treated thereby improving the quality of their lives and their health.

32 I just completed a mini residency at UNC-Chapel Hill School of Dentistry in Dental Sleep Medicine. I can
33 testify that we as dental professional, once properly trained, can offer our patients a treatment modality
34 that is effective and easy for the patient to use and comply with.

35 Again, thank you for allowing us to provide our patients with a high quality of care.

36 **10.** First Name: Bob
37 Last Name: Stanton
38 Occupation: Truck driver- volunteer patient advocate

39 Comments: In evaluating any new patient the dentist should inquire if they work in a safety sensitive
40 position which has fitness for duty requirements for sleep disorders.

41 Examples would be commercial motor vehicle operators subject to Department of Transportation medical
42 examiner requirements, Pilots and air traffic controllers subject to Federal Aviation Administration flight

1 physicals, Master Mariners subject to U S Coast Guard credentialing, or rail operators subject to Federal
2 Rail Authority safety circular 2016-03.

3 If yes, the oral appliance used must be capable of monitoring and reporting use via currently available
4 compliance chip technology.

5 **11. First Name: Arthur**
6 Last Name: Strauss
7 Occupation: Dentist

8 Comments: I am co-founder of the American Academy of Dental Sleep Medicine (AADSM). Obstructive
9 Sleep Apnea is a symptom of full or partial airway obstruction during sleep. The major player in this is the
10 relationship of the tongue to the throat.

11 If one looks at the relationships here it is easy to see that anatomically the area defined in the definition of
12 dentistry is intimately related to the tongue, its posture and position in the mouth and throat both statically
13 and dynamically.

14 The awake symptom of this full or partial airway obstruction is the "stress" response at both conscious
15 and unconscious levels. Loss of tongue muscle tone while awake is from distraction (psychology) while
16 asleep it is from relaxation and insomnia is from transition between both.

17 Dental anatomy is the controller of the posture and position of the tongue and how stable the structures
18 are.

19 In fabricating full dentures numerous variables that alter the internal anatomy of the oral cavity impact the
20 tongue position and stability as seen in ease of swallowing and speaking because it controls our airway
21 and "ability to breath or ease of breathing which takes priority over the swallowing and speaking. Only
22 after learning about obstructive sleep apnea did this easy observation become apparent.

23 All basic literature and clinical experience in dentistry and anatomy confirms this! I will email a few copies
24 of articles I have written if you are predisposed to inquire further with my input.

25 The AADSM came out of the OSA as a sleep disorder so to remain congruent with the name of the
26 organization and the structure in place within the medical community, The focus and conclusions attempt
27 to ignore that it is an anatomical condition that manifests differently while awake, asleep and in between.
28 The ADA is not entangled in this and can follow the scientific trail. If the ADA does, the results will show
29 how dentistry controls the tip of the pyramid in human survival. CPR following Airway-Breathing-
30 Circulation is the key as this is how the human body prioritizes within.

31 **12. First Name: Paul**
32 Last Name: Levine
33 Occupation: Dentist/Assistant Professor UTHSC Houston School of Dentistry

34 Comments: I am very pleased with the updated version of the revised policy on the treatment of sleep
35 disordered breathing by dentists. I feel the updated version has clear and concise language without much
36 ambiguity. I am for the acceptance of this new version as it is written. Paul Levine.

37 **13. First Name: Stephen**
38 Last Name: Rubinkan
39 Occupation: Dentist

1 Comments: I have had OSA for many years and have used a CPAP now for over 15 years. I am well
2 informed about the negative effect of OSA and have in the past tried to implement treating this condition
3 in my practice. Around 6 years ago I joined the American Academy of Dental Sleep Medicine and went
4 through their initial course. I was discourage to continue because of the difficulty in dentist having to get
5 involved with medical billing and the need to have a physician do the diagnosing of the condition.

6 I am still interested in pursuing having this part of my practice and have a dental associate how has found
7 a company who can help with the problem of medical billing. My interest was further heightened last week
8 when I worked on one of my patients. He was overweight and in the age group where OSA is common.
9 During the procedure I had him reclined about 50 degrees and was surprised at the difficulty he was
10 having breathing. He also is a cardiac patient who is on Coumadin and is about to have stints put in by
11 his cardiologist. I asked him after I was finished if he had a CPAP or been diagnosed with OSA. He said
12 no. I then asked him if any of his physicians had talked to him about OSA. He again said no and then said
13 that his brother uses a CPAP. I told him that since I am a dentist and only a physician can diagnose OSA,
14 he should talk to his cardiologist before the stint procedure about this, and that I was very sure that he
15 had the condition. I also told him of my wife's stepbrother who had OSA and used a CPAP. He had
16 problems with kidney stones and was given a narcotic for the pain. Unfortunately, he took the medication
17 before bed and was so groggy from it he neglected to use his CPAP, and stopped breathing during the
18 night. He was in his late 50's and had several young children.

19 I was very surprised that none of his physicians had check him or asked some simple questions to see if
20 he could possibly have OSA. I also feel the average dentists is probably as or better qualified to at least
21 suspect the presence of OSA especially we are always looking in or patients mouth and can observe the
22 anatomical conditions that would predispose a person to OSA. I therefore, strongly recommend that
23 dentists be allowed to be legally better involved with the diagnosis of OSA and would be more than happy
24 to be involved in accomplishing this.

25 **14. First Name:** David
26 **Last Name:** Schwartz
27 **Occupation:** Dentist

28 Comments: I do not see anything in the "Role of Dentistry in the Treatment of Sleep" PDF that mentions
29 children. SBD in children is common and is not always screened for by dentists and/or the pediatricians. It
30 negatively effects facial and brain growth and development, is a risk for ADHD, as well as a risk for the
31 same health issues as an adult.

32 Since we typically see children when they are not sick, we are positioned to view the size of the tonsils
33 and the allergic shiners when the child is at their best. We also are the only ones qualified to see narrow
34 arches, high palates, lack of spacing, just to name a few.

35 I would be happy to give more. Read the late James F. Gary, DDS work on airway, development, children
36 and more if you want to know more evidence.

37 **15. First Name:** Mickey
38 **Last Name:** Harrison
39 **Occupation:** Dentist

40 Comments: Please consider the following concerning dentistry's role in the care of SRBD patients: The
41 vast majority of Americans with SRBD remain undiagnosed (up to 90% of those afflicted); based on the
42 information that many folks visit their dentist regularly and do not see a physician, combined with Glick
43 and Vujicic's work showing that dentists, patients, and physicians are amenable to dentists screening for
44 chronic diseases, the dental office should be an important entry point into the medical care system for
45 those in need, especially in the case of SRBDs. A careful review of the patient's medical history can

1 reveal suspected SRBD, if the patient has (or has a family history of): hypertension, high cholesterol, type
2 2 diabetes, atrial fibrillation, myocardial infarction, stroke, coronary artery disease, and congestive heart
3 failure. Dental examination that is suspicious for SRBD includes a high Mallampati score, large tonsils,
4 narrow dental arches, especially a high narrow palatal vault, extraction orthodontics (retractive
5 orthodontics diminish oral cavity volume and force the tongue into the posterior airway space), large tori
6 and exostoses, and tooth wear. Patients exhibiting sleep bruxism and TMD are very likely airway patients,
7 and may be suffering from upper airway resistance syndrome, which is not typically addressed medically,
8 but which can contribute to sympathetic activation, elevate blood pressure and lead to excessive daytime
9 sleepiness and symptoms consistent with the functional somatic syndromes. Dentists are well-suited to
10 screen these patients with physical examination, surveys such as Epworth and STOP-Bang, among
11 others, and can utilize high-resolution pulse oximetry to perform screening sleep studies that are
12 incredibly accurate, and relatively cost- and time-efficient for the patient as compared to an in-lab
13 polysomnogram. Also note that more and more literature is supportive for oral appliance therapy as a first
14 line treatment for severe OSA, despite what the sleep medicine physicians would like everyone to
15 believe. Dentistry is poised to really become an integral part of sleep medicine, and we cannot limit
16 ourselves by mimicking and adhering to the AASM's guidelines. It is important to note that the executive
17 director of the AADSM, Jerry Barrett, is also the executive director of the AASM; it is obvious that given
18 this arrangement, the AADSM is a puppet institution beholden to the desires of the AASM. Dentistry
19 needs to stand up for itself and let its voice be heard, and if the ADA chooses wisely, can be a leader in
20 guiding the future of dentistry. Please consider the Special Interest Group on Dental Sleep Medicine
21 within the American Thoracic Society; they are a group of tens of thousands of physicians, and are
22 research and truth-based and driven, and are embracing dentists as an integral part of the sleep medicine
23 team. References are available for that which I have discussed upon request. Thank you for your
24 consideration.

25 **16.** First Name: Robert
26 Last Name: Oro
27 Occupation: Dentist

28 Comments: Have been using restorative dentistry to improve airway and sleep issues for over 10 years.
29 Have done the restorative on each other, relatives and our staff. Over 300 documented cases.
30 We are not in the occupation of treating breathing issues. We present to the patient what it will feel like
31 and look like to have optimum restorative dentistry like we have in our own and our staffs' mouths.
32 Once the patient feels what their breathing will be like with dental rehabilitation it becomes their educated
33 decision.

34 Sleep is one of the basic parts of healthy aging. We model healthy aging and oral health to our patients.
35 Enjoy the Journey.

36 Bob and Debbie
37 Robert J. Oro DMD MAGD
38 Debra A. Oro DMD FAGD

39 **17.** First Name: James
40 Last Name: Kearney
41 Occupation: General Dentist

42 Comments: As a general dentist, I have been providing oral sleep appliances for my patients that need it
43 since 2013. I believe that a prescription must come from a patient's medical doctor before I will construct
44 an oral appliance for them. I believe that a dentist should be able to write a prescription, after proper
45 screening, for a sleep test to be done through the discretion of a sleep lab or the patient's doctor as to
46 what sleep test (home or lab) is best for any particular patient. If an oral appliance is constructed for a

1 patient, a dentist should then be able to do follow up screening (not diagnostic) tests such as high
2 frequency pulse oximetry to determine and attain optimal efficacy of that appliance before referring the
3 patient back to a sleep lab or the patient's doctor for a follow up sleep test (PSG) which is diagnostic.

4 **18.** First Name: Ann
5 Last Name: Milar
6 Occupation: Manager, Policy

7 Comments: Thank you for the opportunity to review the proposed Policy Statement on the Role of
8 Dentistry in the Treatment of Sleep-Related Breathing Disorders. The revised policy aligns well with the
9 policy of the California Dental Association and reflects the proposed changes previously submitted.

10 **19.** First Name: Kimberly
11 Last Name: Hubenette
12 Occupation: Dentist

13 Comments: I'm glad the ADA finally created this. It's a step in the right direction.

14 **SPECIFIC COMMENTS**

15 **20.** First Name: David
16 Last Name: Barr
17 Occupation: Dentist

18 Comments: I am pleased with overall scope of the Policy Statement. My only suggestion is to include or
19 change the language in #11:

20 Proposed Changes: [Proposed Change(s):

21 11. Follow-up sleep testing by a physician should be conducted to evaluate the improvement or confirm
22 treatment efficacy for the OSA, especially if the patient develops recurring OSA relevant symptoms or
23 comorbidities.

24 While I believe it is imperative for a physician to be involved in the diagnosis of Obstructive sleep apnea,
25 the treating dentist should be allowed to order the efficacy testing for the oral appliance. If type 3 devices
26 are allowable to be used to help with the titration process AND one of the tests shows the obstructive
27 sleep apnea is sufficiently managed, that test should be allowed to be read by an appropriate sleep
28 physician for efficacy. As is, it is unclear if dentists are allowed to order the efficacy test.

29 **21.** First Name: David
30 Last Name: Bitonti

31 SRBD Committee,

32 Thank you very much for your efforts and work on this important topic. I appreciate the opportunity to
33 provide input to the material. Following please find my suggested input on the Proposed Policy
34 Statement on the Role of Dentistry in the Treatment of Sleep-Related Breathing Disorders. Please feel
35 free to contact me if I can be of further assistance.

Proposed Policy Statement on the Role of Dentistry in the Treatment of Sleep-Related Breathing Disorders

Sleep related breathing disorders (SRBD) are characterized by disruptions in normal breathing patterns associated with sleep. SRBDs are potentially serious medical conditions caused by anatomical airway collapse and altered respiratory control mechanisms. Common SRBDs include snoring and obstructive sleep apnea (OSA). OSA has been associated with metabolic, cardiovascular, respiratory, dental and other diseases.

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Oral appliances, specifically custom-made, titratable devices, can improve OSA in adult patients compared to no therapy or placebo devices. Oral appliance therapy (OAT) can improve OSA in adult patients, especially those who are intolerant of continuous positive airway pressure (CPAP). Dentists are the only health care provider with the knowledge and expertise to provide OAT.

The dentist's role in the treatment of SRBDs includes:

1. Dentists should screen patients for OSA, as part of a comprehensive medical and dental history, to recognize symptoms such as sleepiness, choking, snoring or witnessed apneas. These patients should be referred, as needed, to the appropriate physicians/sleep laboratory for proper diagnosis.

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2. Oral appliance therapy is an appropriate treatment for mild and moderate sleep apnea, and may improve severe sleep apnea when CPAP is not tolerated by the patient.

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3. When oral appliance therapy is prescribed by a physician through written or electronic order for an adult patient with obstructive sleep apnea, a dentist should fabricate an appropriate mandibular advancement device.

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4. Dentists should obtain appropriate patient consent for treatment, including the potential side effects of using OAT and appliance longevity. Dentists treating SRBDs with OAT should be capable of recognizing and managing the potential side effects.

5. Dentists who provide OAT to patients should monitor and adjust the Oral Appliance (OA) for treatment efficacy as needed, or at least annually. As titration of OAs has been shown to affect the final treatment outcome and overall OA success, the use of unattended cardiorespiratory (Type 3) or (Type 4) portable monitors may be used by the dentist to help define the optimal target position of the mandible. A dentist trained in the use of these portable monitoring devices may assess interim results of OA titration.

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6. Surgical procedures may also be considered as a necessary treatment for OSA when the CPAP or OAT is inadequate, not tolerated, or depending upon the severity of the disease.

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7. Dentists should continually update their knowledge of and training in dental sleep medicine with related continuing education.

8. Dentists should maintain regular communications with the referring physician as to the patient's treatment, progress and any recommended follow up treatment.

9. Follow-up sleep testing by a physician should be performed to evaluate treatment efficacy for the OSA, especially if the patient develops recurring OSA relevant symptoms or comorbidities.

Deleted: considered

1 **22.** First Name: Nancy
2 Last Name: Addy
3 Occupation: Dentist - practice limited to Dental Sleep Medicine

4 Comments: I have been an ADA member since 1988 and practicing Dental Sleep Medicine (DSM) since
5 1999. I am a diplomat of the American Board of Dental Sleep Medicine. My office is site accredited by the
6 American Academy of Dental Sleep Medicine. In 2006 I limited my practice to DSM and do no general
7 dentistry. I believe you have done an excel job with your Proposed Policy Statement on the Role of
8 Dentistry in the Treatment of Sleep-Related Breathing Disorders.

9 Proposed Changes:

10 1. In addition to following all the mentioned recognizable screening symptoms, I routinely use Home
11 Sleep Apnea Screening (HSAT) as an additional tool to encourage patients (pt) to see their physician for
12 a diagnosis of Obstructive Sleep Apnea (OSA) which may then be treated by CPAP, Oral Appliance
13 Therapy (OAT), surgery or whatever the physician and pt deem to be the appropriate course of action. I
14 NEVER make an oral appliance (OA) without a written Rx from a physician and whenever possible a
15 board certified sleep physician.

16 2. Children with OSA are particularly unique and in my opinion need special training to treat. A DDS can
17 easily screen for potential OSA and refer the child to the appropriate physician/orthodontist. I generally do
18 not treat pts younger than 18 years of age with OAT.

19 3. Completely agree with this statement.

20 4. Completely agree with this statement.

21 5. Completely agree with this statement.

22 6. I agree with this, but feel a weekend course does not train a DDS to be proficient in DSM.

23 7. I agree with this statement but feel some things should be added:

24 - It is imperative that a local treating MD be part of the overall tx plan for the pt

25 - This might perhaps include the MD to also give DDS a written Rx requesting DDS use HSAT for titration
26 of the OA.

27 - Without the DDS using HSAT it takes a significantly longer period to have the OA titrated, costs more to
28 the pt and the payer each time they go back to the MD for further titration of the oral appliance.

29 - Without the DDS using HSAT to titrate a huge bottle neck will occur as there are not enough MD's to be
30 able to easily, quickly and efficiently titrate the OA

31 - It is significantly important that once the patient is titrated to a "ball park" OA position, the pt is then
32 referred back to the treating MD for verification of effectiveness of OAT. In my opinion this cannot be
33 done by a DDS as it is out of the scope of practice. It must be verified by the local treating MD.

34 8. Completely agree with this statement

35 9. Completely agree. This is a field that is rapidly changing. Current CE is vitally important.

36 10. Completely agree. This is one reason why I do not believe that HSAT should be read by MD's who
37 are not the treating physician, who have not had a face to face with the pt and who may possibly be
38 located in another city or state. The best care for pt is a team made up of the local physician, other care
39 providers and the DDS. DSM is most definitely team approach.

1 11. I believe that the word "on going follow-up, at least yearly" should be added. Anyone who has done
2 DSM for any time knows that OSA does not get better with time and needs to be routinely followed by
3 both the DDS and the MD.

4 **23.** First Name: William
5 Last Name: Gerlach
6 Occupation: GP

7 Comments: Dear Council on Dental Practice, As the original maker of the ADA Resolution 96 at the 2015
8 HOD, I am grateful for your continuing efforts to get the wording correct.

9 My comments are limited to two items.

10 1) In #1, the final sentence is too broad and, in my opinion, dangerous to our profession. The current
11 language is directly out of the AASM, who has obviously influenced the ADA's thinking to a large extent.
12 Please take a hard look at this and recognize the damage that can be done to dentistry - what it says is
13 any patient with any sign or symptom of SRBD should be referred to a physician.

14 A sign or symptom could be observed gasping and apneic events. A sign or symptom could also be worn
15 dentition, periodontal disease, recession, a cracked tooth, scalloped tongue, etc. This statement could
16 conceivably stop patient flow in dental offices and become a torrent of patient flow into MD's offices for
17 unnecessary testing as most people have at least one sign or symptom of SRBD.

18 I'd like to offer a simple solution - use the final sentence in #2 twice. The final sentence in #2 could
19 adequately fit as the concluding sentence for items #1 and #2. It allows the dentist to use clinical
20 judgment based on his/her experiential level, to ask more questions, and to get the patient to the correct
21 treatment, either medical or dental, without promoting needless medical office visits and excessive costs.
22 As you have already approved of the wording for statement #2, this change could be made with limited
23 resistance.

24 Proposed Changes:

25 Therefore, #1 and #2 would read:

26 1. Dentists are encouraged to screen patients for SRBD as part of a comprehensive medical and dental
27 history to recognize symptoms such as sleepiness, choking, snoring or witnessed apneas and an
28 evaluation for risk factors such as obesity, retrognathia, or hypertension. If risk for SRBD is determined,
29 intervention through medical/dental referral or evidenced based treatment may be appropriate to help
30 treat the SRBD and/or develop an optimal physiologic airway and breathing pattern.

31 2. In children, screening through history and clinical examination may identify signs and symptoms of
32 deficient growth and development, or other risk factors that may lead to airway issues. If risk for SRBD is
33 determined, intervention through medical/dental referral or evidenced based treatment may be
34 appropriate to help treat the SRBD and/or develop an optimal physiologic airway and breathing pattern.

35 My final suggestion involves statement #11, which reads, "Follow-up sleep testing by a physician should
36 be conducted to evaluate the improvement or confirm treatment efficacy for the OSA, especially if the
37 patient develops recurring OSA relevant symptoms or comorbidities." Please consider eliminating the
38 phrase, "by a physician". This allows more experienced dentists, who already work hand-in-hand with
39 physicians, to make the determination based on the patient's history regarding the best means of follow-
40 up testing. Once again, thank you for your incredible efforts on our patients' behalf, and you are saving
41 lives because of those efforts.

1 **24. First Name: Steven**
2 **Last Name: Bender**

3 Please note suggested edits to the "Proposed Policy Statement on the Role of Dentistry in the Treatment
4 of Sleep-Related Breathing Disorders" document. Additions are noted in red. Verbiage suggested to be
5 eliminated is represented with a strike through.

6 Sleep related breathing disorders (SRBD) are disorders characterized by disruptions in normal breathing
7 patterns **during sleep**. SRBDs are potentially serious medical conditions caused by anatomical airway
8 collapse and/or altered respiratory control mechanisms. Common SRBDs include snoring, upper airway
9 resistance syndrome (UARS) and obstructive sleep apnea (OSA). **OSA SRBD have** been associated with
10 metabolic, cardiovascular, respiratory, dental and other diseases. In children, undiagnosed and/or
11 untreated ~~OSA~~ SRBD can be associated with cardiovascular problems, impaired growth as well as
12 learning and behavioral problems.

13 Dentists can and do play an essential role in the multidisciplinary care of patients with certain ~~sleep-related~~
14 ~~breathing disorders~~ **SRBD** and are well positioned to identify patients at ~~greater risk of SRBD~~. SRBD can
15 be caused by **and result in** a number of ~~multifactorial~~ medical issues and are therefore best treated
16 through a collaborative model. Working in conjunction with our colleagues in medicine, dentists have
17 various methods of **identifying and** mitigating these disorders. In children, the dentist's recognition of
18 suboptimal early craniofacial growth and development or other risk factors may lead to medical referral or
19 orthodontic/orthopedic intervention to treat and/or prevent SRBD. Various surgical modalities exist to treat
20 SRBD. Oral appliances, specifically custom-made, titratable devices, can improve SRBD in adult patients
21 compared to no therapy or placebo devices. Oral appliance therapy (OAT) can improve OSA in adult
22 patients, especially those who are intolerant of continuous positive airway pressure (CPAP). Dentists are
23 the only health care provider with the knowledge and expertise to **appropriately** provide OAT.

24 The dentist's role in the treatment of SRBDs includes the following:

25 1. Dentists are encouraged to screen **all** patients for SRBD as part of a comprehensive medical and
26 dental history to ~~recognize~~ **identify** symptoms such as **excessive daytime** sleepiness, choking **during**
27 **sleep or upon awakening**, snoring or witnessed apneas ~~and an evaluation~~ as well as ~~for~~ risk factors such
28 as obesity, retrognathia, ~~or~~ **and** hypertension, **among others**. These patients should **then** be referred, as
29 needed, to the appropriate physician for ~~proper~~ diagnosis.

30 2. In children, screening through history and clinical examination may identify signs and symptoms of
31 deficient growth and development, or other risk factors ~~for that may lead to airway issues~~ **SRBD**. If risk for
32 ~~SRBD is determined~~ **these factors are identified**, intervention through medical/dental referral or **via**
33 evidenced based ~~treatment~~ **therapy** may be appropriate to ~~help treat~~ **manage** the SRBD and/or develop
34 an optimal physiologic airway. ~~and breathing pattern.~~

35 3. Oral appliance therapy is an appropriate treatment **option** for mild and moderate sleep apnea, and for
36 severe sleep apnea when ~~a CPAP~~ **positive airway pressure (CPAP)** is not tolerated by the patient, **the**
37 **patient fails CPAP or if they prefer OAT. (AASM guidelines)**

38 4. When oral appliance therapy is prescribed **or recommended** by a physician through written or
39 electronic ~~order~~ means for ~~a an adult patient with obstructive sleep apnea,~~ **SRBD**, If deemed appropriate
40 **by the dentist**, ~~a dentist should fabricate~~ an oral appliance may be fabricated by the dentist.

41 5. Dentists should obtain appropriate patient consent for treatment that reviews the **proposed** treatment
42 plan, **all available options**, and any potential side effects of using OAT ~~and~~ as well as expected appliance
43 longevity.

44 6. Dentists treating SRBD with OAT should be capable of recognizing and managing the potential side
45 effects through **appropriate** treatment or proper referral.

1 7. Dentists who provide OAT to patients should monitor and adjust the Oral Appliance (OA) for treatment
2 efficacy as needed, or at least annually. As titration of OAs has been shown to affect the final treatment
3 outcome and overall OA success, the use of unattended cardiorespiratory (Type 3) or (Type portable
4 monitors may be used by the dentist to help define the optimal target position of the mandible. A dentist
5 trained in the use of these portable monitoring devices may assess the objective interim results for the
6 purposes of OA titration.

7 8. Surgical procedures may be considered as a secondary treatment for OSA when CPAP or OAT is
8 inadequate or not tolerated. In selected cases, such as patients with concomitant dentofacial deformities,
9 surgical intervention may be considered as a primary treatment.

10 9. Dentists treating SRBD should continually update their knowledge and training of dental sleep
11 medicine with related continuing education.

12 10. Dentists should maintain regular communications with the patient's referring physician and other
13 healthcare providers as to the patient's treatment progress and any recommended follow up treatment.

14 11. Follow-up sleep testing by a physician should be conducted as per the discretion of the patient's
15 physician who is overseeing the management of their SRBD to evaluate the improvement or confirm
16 treatment efficacy for the SRBD, especially if the patient develops recurring OSA-relevant symptoms or
17 associated comorbidities.

18 **25.** First Name: Barbara
19 Last Name: Mallonee DDS
20 Occupation: Dentist

21 Comments: In item 1 of the Dentist's Role in the Treatment of SRBD's, I would add the dental related
22 signs and symptoms we see every day that are HIGHLY correlated with SRBD's, specifically bruxism,
23 excessive tooth wear/fracture, tori, cervical abfraction lesions, restricted lingual/labial frenum, high palate,
24 narrow arches and scalloped tongue to name but a few. Dentists are the only ones to observe these very
25 important signs and symptoms and interpret them correctly.

26 In item 2 I would add infants as well as children as very EARLY detection of risk factors is crucial to a
27 positive outcome.

28 I like the collaborative wording throughout the policy statement. Now we just need to get our medical
29 colleagues on the same page, and I believe dentistry is tasked to be a leader in this regard.

30 **26.** First Name: Peter
31 Last Name: Chase
32 Occupation: Dentist

33 Comments: Your two PDF files are comprehensive and well done. However, you have not included a
34 number of items.

35 1. The critical interface between OSA and TMD conditions which often coexist and may, in fact, be
36 different manifestations of the same maxillomandibular imbalance. Treatment should be complimentary.

37 2. The need for the general practitioner to more comprehensively understand complex orthodontic and
38 prosthodontic therapy in relationship to changes in jaw posture as a primary side effect of treatment for
39 OSA.

40 3. As the dentist adopts oral appliance therapy for OSA, they must be advised they are taking

1 responsibility for the effects of their treatment on critical functions of not only breathing, but also chewing,
2 speaking, swallowing and hearing.

3 4. Understand that a planographic x-ray is inadequate diagnostic study to support oral appliance therapy
4 for OSA or TMD.

5 Please take the time to review the collaborative work...
6 Sleep Medicine and Oral Appliance Therapy (available on Amazon).

7 **27.** First Name: Steven

8 Last Name: Lamberg

9 Occupation: Dentist

10 Comments: Dear Committee Members,

11 As an Addendum of Paragraph 2 "In children, screening through history and clinical examination may
12 identify signs and symptoms of deficient growth and development, or other risk factors that may lead to
13 airway issues. If risk for SRBD is determined, intervention through medical/dental referral or evidenced-
14 based treatment may be appropriate to help treat the SRBD and/or develop an optimal physiologic airway
15 and breathing pattern."

16 There should be some recommended collaborative effort from the dentist to the pediatricians so that
17 earlier intervention can be realized rather than inheriting the child who has already developed
18 compensations which have already impacted growth and development.

19 There should be a responsibility for the dentist to understand when it is appropriate to collaborate with
20 myofunctional therapists, oral surgeons, pediatric neurologists, pediatric ENTs, dietitians, and many other
21 specialties.

22 SDB is an end stage disease. As dentists we must recognize that there is usually evidence that the child
23 has incompetency's before the age of 3 when we get to see them.

24 So I believe there should be a paragraph urging collaboration with not just MDs when we are treating
25 "road kill"...but rather with pediatricians and others who may see the child earlier in their development.
26 Additionally orthodontists should recognize that airway is a more significant contribution to the patient's
27 health and wellness than straight teeth.

28 **28.** First Name: James

29 Last Name: DuHamel

30 Occupation: Dentist

31 Comments: Thank you for your efforts to clarify this important discipline. I am a diplomat of the AADSM
32 and have been treating OSA with OAT for over 20 years. I have also been treating TMJ symptoms with
33 OAs for over 35 years. I strongly suggest that you include headaches, bruxism, and TMJ problems as
34 symptoms related to OSA. Mandibular advancement appliances have been used for decades for
35 correcting TMJ disorders and retruded mandibles. We now find a majority of our TMJ cases are resolved
36 with OAT for sleep apnea.

37 I find that it is imperative that dentists have TMJ training along with the sleep apnea training. With proper
38 training a dentist can improve a patients' TMJ function. Without training dentists can cause harm to the
39 TMJ. I have trained hundreds of dentists the past 10 years and have found that the lack of TMJ training is
40 a major cause of dentists not wanting to pursue treating OSA.

1 Also please emphasize that patients must be referred back to the physician after OAT for a titration sleep
2 study.

3 **29.** First Name: Paul
4 Last Name: Miller
5 Occupation: Orthodontist

6 Comments: With respect to your document entitled "Evidence Brief: Oral Appliances for Sleep-Related
7 Breathing Disorders"

8 I believe the following paragraph on page 1,

9 "The two recent systematic reviews evaluating the data for oral appliances in pediatric OSA found very
10 limited published evidence for their use and called for additional short and long-term evidence, especially
11 for health outcomes, such as neurocognitive and cardiovascular function."

12 Would better serve the public if the words "oral appliances" would be replaced by the words "mandibular
13 advancement appliance" or "OAT"

14 Your document ADA document entitled "Proposed Policy Statement on the Role of Dentistry in the
15 Treatment of Sleep-Related Breathing Disorders" states the following;

16 Paragraph 2. "In children, screening through history and clinical examination may identify signs and
17 symptoms of deficient growth and development, or other risk factors that may lead to airway issues. If risk
18 for SRBD is determined, intervention through medical/dental referral or evidenced based treatment may
19 be appropriate to help treat the SRBD and/or develop an optimal physiologic airway and breathing
20 pattern."

21 Suggests and implies which is valid that pediatric patients suffering from SRBD may benefit from
22 orthodontic dentofacial orthopedic procedures which would reduce upper airway resistance.

23 The phrase oral appliances in many instances is synonymous with orthodontic appliances which are oral
24 appliances. Leaving the phrase "oral appliances" could create confusion since orthodontic oral appliances
25 is the preferred modality in resolving dentofacial orthopedic orthodontic procedures that could resolve
26 airway issues.

27 **30.** Srinivasan Varadarajan, Esq.
28 Director, Dental Practice & Policy
29 Academy of General Dentistry

30 ***Following is a letter with AGD's comments to the revised policy.***

31 Council on Dental Practice
32 211 E. Chicago Avenue Chicago, IL 60611

33 Attn: Dentistry's Role in Sleep Related Breathing Disorders

34 Dear Dr. Porembski:

35 On behalf of the Academy of General Dentistry (AGD), thank you for the opportunity to comment on the
36 ADA's revised Proposed Policy Statement on the Role of Dentistry in the Treatment of Sleep-Related
37 Breathing Disorders (the "Revised Policy Statement"). The AGD executed review of the Revised Policy
38 Statement through its Dental Practice Council and Legislative & Governmental Affairs Council (the "AGD

1 councils"). The AGD councils reviewed the Policy Statement along with the ADA's Evidence- Brief: Oral
2 Appliances for Sleep-Related Breathing Disorders (the "Evidence Brief").

3 The following comments reflect the findings and recommendations of the AGD councils.

4 Policy Statement, 1: Dentists are encouraged to screen patients for SRBD as part of a comprehensive
5 medical and dental history to recognize symptoms such as sleepiness, choking, snoring or witnessed
6 apneas and an evaluation for risk factors such as obesity, retrognathia, or hypertension. These patients
7 should be referred, as needed, to the appropriate physicians for proper diagnosis.

8 The AGD Councils reiterate the need for the use of the word, "may," instead of either "should" or
9 "encouraged to." While "encouraged to" may be less prescriptive than "should," it may nonetheless
10 suggest a standard of care. "May" is permissive rather than prescriptive. Given that the Evidence Brief did
11 not include any evidentiary review or recommendation on screening for OSA, it would be inappropriate to
12 provide such firm policy prescription as "encouraged to."

13 Moreover, the AGD Councils are concerned that, by characterizing screening for SRBD "as part of a
14 comprehensive medical and dental history," it places a requirement that, if SRBD screening is performed,
15 a "medical" history must also be taken by the dentist and that this medical history must be
16 "comprehensive." The concern here is that it is vague as to what constitutes "comprehensive" and as to
17 what extent the health history recorded by the dentist must be "medical." In order to avoid the implication
18 that dentists who screen for SRBD are required to take comprehensive medical histories, the AGD
19 Councils recommend either deletion of the respective clause or replacement of the clause with "as part of
20 a dental history" or "as part of a health history." Note, again, the evidentiary brief relied upon by the ADA
21 CDP in drafting its policy statement offers no guidance in this area.

22 Accordingly, the following revision would be acceptable to the AGD:

23 Dentists are encouraged to may screen patients for SRBD as part of a comprehensive medical and dental
24 health [or dental] history to recognize symptoms such as sleepiness, choking, snoring or witnessed
25 apneas and an evaluation for risk factors such as obesity, retrognathia, or hypertension. These patients
26 should be referred, as needed, to the appropriate physicians for proper diagnosis.

27 Policy Statement, 8: Surgical procedures may be considered as a secondary treatment for OSA when
28 CPAP or OAT is inadequate or not tolerated. In selected cases, such as patients with concomitant
29 dentofacial deformities, surgical intervention may be considered as a primary treatment.

30 Given that the Evidence Brief does not include review of surgical procedures as either primary or
31 secondary treatment, the AGD Councils renew their recommendation that the ADA CDP refrain from
32 inclusion of this policy statement unless and until evidence has been provided.

33 Thank you again for the opportunity to provide comment on this matter. I strongly believe that
34 collaboration between our organizations on such matters that affect the practice of dentistry shall only
35 make our profession stronger.

36 Sincerely,
37 Maria A. Smith, DMD, MAGD
38 President, Academy of General Dentistry

39 **31.** First Name: Rebecca
40 Last Name: Layhe
41 Occupation: Dental Sleep Medicine Care Coordinator

1 Comments: The role of dentists in patient airway care is critical. Let me give you my personal experience.
2 My son, from the 3rd grade forward, has always struggled. Struggled with depression, poor school
3 performance, anxiety disorder, and with allergies. He has seen pediatricians, psychologists, ENT
4 specialists, and family practitioners. Not one ever screened his sleep. Our dentist asked if he had ever
5 had his sleep evaluated and offered us home sleep testing through his office - and strongly emphasized
6 that the study was read and interpreted by a board certified sleep MD - that it was a service he offered to
7 help more patients be screened a life-threatening disease because airway issues show up in a patient's
8 mouth and dentition. My son has severe OSA. A dentist saved his life. Period. Please include in your
9 standing that the dispensing of home HST units by dentists to facilitate screening by a board certified
10 sleep MD is a life-saving protocol we need to embrace. One life saved is worth it all. Thank you for your
11 consideration.

12 As an additional comment about the verbiage in this proposal, oral appliances are being referred to as
13 Mandibular Advancement Devices - which is not really appropriate. These are mandibular repositioning
14 devices, as advancement does not take into account the need for vertical change to open airway in cases
15 of high oropharyngeal collapse. I suggest the use of "Mandibular Repositioning Devices" to be more
16 accurate.

17 **32.** First Name: Sherene
18 Last Name: Thomas

19 Dear Dr. O'Toole,

20 Following is a letter and comments jointly prepared by the American Academy of Sleep Medicine (AASM)
21 and American Academy of Dental Sleep Medicine (AADSM) in regards to the second draft of the
22 Proposed Policy Statement on the Role of Dentistry in the Treatment of Sleep-Related Breathing
23 Disorders (SRBDs) Please let me know if you have any questions or need any additional information.

24 Thank you,
25 Sherene

26 Sherene Thomas, PhD
27 Senior Director - Communications, Science & Health Policy
28 American Academy of Sleep Medicine

Appendix 1



American Academy of Sleep Medicine

American Academy of Dental Sleep Medicine



April 18, 2017

Terry G. O'Toole, DDS
Chair, Council on Dental Practice
Attn: Sleep-Related Breathing Disorders
211 E. Chicago Avenue
Chicago, IL 60611

Dear Dr. O'Toole:

The American Academy of Sleep Medicine (AASM) and American Academy of Dental Sleep Medicine (AADSM) appreciate the opportunity to provide comments to the American Dental Association (ADA) Council on Dental Practice (CDP) regarding the second draft of the Proposed Policy Statement on the Role of Dentistry in the Treatment of Sleep-Related Breathing Disorders (SRBDs).

The AASM and AADSM recognize the role qualified dentists can play in the provision of custom-fabricated, titratable oral appliances for select patients with obstructive sleep apnea (OSA) when oral appliance therapy (OAT) has been prescribed by a physician. However, to ensure that the proposed policy promotes the highest quality of care for patients who have OSA, we request that the changes that are delineated in the attached policy draft and summarized below be made.

Dentists should not take comprehensive medical histories, which are taught in medical school, as proposed in recommendation #1. This recommendation should be revised to reflect that dentists should perform SRBD-specific histories and oral exams.

Recommendation #2 should be revised to state that, after risk is determined from screening, referral to an appropriate physician is the next step for evaluation and diagnosis of SRBDs. Based on existing evidence, treatment should not be the next step.

It should be specified in recommendation #3 that OAT is an appropriate treatment "option." Although OAs have been shown to improve physiologic sleep parameters, continuous positive airway pressure (CPAP), is still generally the first-line option for treating OSA. These options should be discussed with a patient before the physician prescribes the recommended course of treatment. It is also important to note in this recommendation that OAT is an appropriate treatment option for mild and moderate "obstructive" sleep apnea since OAT is not appropriate for SRBDs such as central sleep apnea.

Because training in dental sleep medicine is uncommon, not all dentists have the training or experience required to deliver knowledgeable care to patients with sleep-disordered breathing. Therefore, as physicians diagnose and subsequently refer patients with OSA for OAT, they should seek dentists who possess the requisite training or experience to be considered a "qualified dentist."¹ The proposed policy should be revised throughout to indicate that "qualified" dentists should provide OAT to ensure that OSA patients receive care from a dentist knowledgeable about dental sleep medicine. It should be specified in recommendation #4 that dentists without adequate, specific training; dental hygienists; physicians; and other clinicians should not fit or fabricate oral appliances for treatment of OSA.

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www.aasmnet.org

The AASM and AADSM disagree with recommendation #7 in the proposed policy:

Dentists who provide OAT to patients should monitor and adjust the Oral Appliance (OA) for treatment efficacy as needed, or at least annually. As titration of OAs has been shown to affect the final treatment outcome and overall OA success, the use of unattended cardiorespiratory (Type 3) or (Type 4) portable monitors may be used by the dentist to help define the optimal target position of the mandible. A dentist trained in the use of these portable monitoring devices may assess the objective interim results for the purposes of OA titration.

Dentists should **not** use home sleep apnea tests to objectively assess the effectiveness of OA titration. Although a qualified dentist should fit and adjust an oral appliance, it is outside a dentist's scope of practice to order, conduct and/or interpret objective tests, such as pulse oximetry or home sleep apnea testing (HSAT), to adjust or titrate an OA. HSAT should be administered by an AASM-accredited sleep facility or independent sleep practice under the supervision of a board-certified or board-eligible sleep medicine physician.² Once the qualified dentist has adjusted the oral appliance based on the patient's subjective report, the dentist must refer the patient back to the sleep physician, who will conduct any further objective tests necessary to confirm the effectiveness of OA treatment. The sleep physician should convey test results to the dentist, who can then make further adjustments to the oral appliance as needed.

Furthermore, dentists are not specifically trained to use home sleep apnea testing devices, and utilizing them to adjust, titrate or assess the effectiveness of an OA amounts to the assessment of a medical condition (i.e., OSA), which exposes dentists to medical malpractice liability. Professional liability insurance policies for dentists and their dental practices do not provide coverage for practicing outside the scope of dental licensure. Therefore, dentists who practice medicine by assessing objective HSAT results for the purpose of adjusting an oral appliance, are susceptible to considerable financial risk when caring for sleep-disordered breathing patients, who often have or can develop serious comorbid conditions such as systemic hypertension, coronary artery disease, atrial fibrillation and stroke.

Lastly, recommendation #7 should be clarified to state that follow-up objective testing by a physician should only be performed *when indicated*, because not all patients given OAT require follow-up objective testing. The decision to perform follow-up objective testing is one that a board-certified sleep medicine physician should make on re-evaluating symptom response in the context of the original polysomnography or HSAT results. If indicated, the objective testing should be performed by a sleep physician.

If you have any questions about the above joint comments of the AASM and AADSM, please direct them to Executive Director Jerome A. Barrett at 630-737-9700. I thank you for taking these comments into consideration, and I urge you to revise the proposed policy statement as advised.

Sincerely,
Ronald D. Chervin, MD, MS
AASM President

Harold A. Smith, DDS
AADSM President

References

1. Ramar K, Dort LC, Katz SG, Lettieri CJ, Harrod CG, Thomas SM, Chervin RD. Clinical practice guideline for the treatment of obstructive sleep apnea and snoring with oral appliance therapy: an update for 2015. *J Clin Sleep Med* 2015;11(7):773–827.
2. Kapur VK, Auckley DH, Chowdhuri S, Kuhlmann DC, Mehra R, Ramar K, Harrod CG. Clinical practice guideline for diagnostic testing for adult obstructive sleep apnea: An American Academy of Sleep Medicine clinical practice guideline. *J Clin Sleep Med*. 2017;13(3):479–504.

Proposed Policy Statement on the Role of Dentistry in the Treatment of Sleep-Related Breathing Disorders

Sleep related breathing disorders (SRBD) are disorders characterized by disruptions in normal breathing patterns. SRBDs are potentially serious medical conditions caused by anatomical airway collapse and altered respiratory control mechanisms. Common SRBDs include snoring, upper airway resistance syndrome (UARS) and obstructive sleep apnea (OSA). OSA has been associated with metabolic, cardiovascular, respiratory, dental and other diseases. In children, undiagnosed and/or untreated OSA can be associated with cardiovascular problems, impaired growth as well as learning and behavioral problems.

Dentists can and do play an essential role in the multidisciplinary care of patients with certain sleep related breathing disorders and are well positioned to identify patients at greater risk of SRBD. SRBD can be caused by a number of multifactorial medical issues and are therefore best treated through a collaborative model. Working in conjunction with our colleagues in medicine, dentists have various methods of mitigating these disorders. In children, the dentist's recognition of suboptimal early craniofacial growth and development or other risk factors may lead to medical referral or orthodontic/orthopedic intervention to treat and/or prevent SRBD. Various surgical modalities exist to treat SRBD. Oral appliances, specifically custom-made, titratable devices can improve SRBD in adult patients compared to no therapy or placebo devices. Oral appliance therapy (OAT) can improve OSA in adult patients, especially those who are intolerant of continuous positive airway pressure (CPAP). Qualified dentists with adequate, specific training and experience are the only health care provider with the knowledge and expertise to provide OAT.

The roles for dentists and qualified dentists in the treatment of SRBDs include the following:

1. All dentists are encouraged to screen patients for SRBD as part of a directed history and examination to recognize symptoms such as sleepiness, choking, snoring or witnessed apneas, and signs or risk factors such as obesity, retrognathia, or hypertension. These patients should be referred, as needed, to the appropriate physicians for proper diagnosis.

2. In children, screening through history and clinical examination may identify signs and symptoms of deficient growth and development, or other risk factors that may lead to airway issues. If risk for SRBD is determined, intervention through initial medical referral may be appropriate, followed by treatment for any diagnosed SRBD and efforts to guide development of an optimal physiologic airway and breathing pattern.

3. Oral appliance therapy is an appropriate treatment option for mild and moderate obstructive sleep apnea, and for severe sleep apnea when a CPAP is not tolerated by the patient.

4. When oral appliance therapy is prescribed by a physician through written or electronic order for an adult patient with obstructive sleep apnea, a qualified dentist should evaluate the patient for the appropriateness of fabricating a suitable oral appliance. If deemed appropriate, only a qualified dentist should fabricate an oral appliance. Dentists without adequate, specific training: dental hygienists: physicians: and other clinicians should not fit or fabricate oral appliances.

5. Qualified dentists should obtain appropriate patient consent for treatment that reviews the treatment plan and any potential side effects of using OAT and expected appliance longevity.

6. Qualified dentists treating SRBD with OAT should be capable of recognizing and managing the potential side effects through treatment or proper referral.

7. Qualified dentists who provide OAT to patients should monitor and adjust the Oral Appliance (OA) for treatment efficacy as judged by symptoms and side effects as needed, or at least annually. As titration of OAs through use of unattended cardiorespiratory (Type 3) or (Type 4) portable monitors, especially by dentists, has NOT been shown to affect the final treatment outcome and overall OA success, the use of these medical

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Commented [RDC3]: This is an important word to add. Otherwise, clinicians could feel completely comfortable giving a patient OAT without discussing other options, such as CPAP, that are provided to the majority of OSA patients.

Commented [RDC4]: Important to note, because OAT is not appropriate for central sleep apnea

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assessment tools by dentists to help define the optimal target position of the mandible is not appropriate. A dentist should collaborate with a board-certified sleep medicine physician and accredited sleep disorders center if and when objective interim results are desired for the purposes of OAT [titration].

8. Surgical procedures may be considered as a secondary treatment for OSA when CPAP and/or OAT is inadequate or not tolerated. In selected cases, such as patients with concomitant dentofacial deformities, surgical intervention may be considered as a primary treatment.

9. Qualified dentists treating SRBD should continually update their knowledge and training of dental sleep medicine with related continuing education.

10. Qualified dentists should maintain regular communications with the patient's referring physician and other healthcare providers to the patient's treatment progress and any recommended follow up treatment.

11. Follow-up assessment by a physician, with sleep laboratory testing when indicated, should be conducted to evaluate the improvement or confirm treatment efficacy for the OSA, especially if the patient develops recurring OSA relevant symptoms or comorbidities.

CR **Chervin, Ronald (Ron)**
This proposed article 7 is the most concerning. It contains "facts" that are not true, gives guidance that would not be appropriate for dentists or physicians, and encourages dentists to practice medicine, outside the legal scope of the practice of dentistry.

Chervin, Ronald (Ron)
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CR **Chervin, Ronald (Ron)**
Inaccurate as originally written, in that NOT all patients given OAT require follow-up testing. That is a decision that a board-certified sleep medicine physician should make on re-evaluating symptom response in the context of original PSG or HSAT results. For example, a symptomatic patient with an AHI of 7, treated with OAT, and reporting resolution of all symptoms is UNLIKELY to need any follow-up testing, as an AHI that is better or at worst similar to the original would lead to no further action.

Chervin, Ronald (Ron)
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Chervin, Ronald (Ron)
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1
2 **33.** Jackie Hittner, MA, MBA
3 Librarian
4 Charles R. Baker Memorial Library

5 Below are the AAO comments on the revised draft of the ADA Policy on Dentistry's Role in SRBD. The
6 AAO put together a task force to review the draft policy and their comments are in blue below. The BOT
7 has approved the task force comments and requested me to send the comments to the ADA.

8 Literature Cited

9 ADA document provides a comprehensive review of the current literature and is a useful reference for
10 regulatory bodies and the dental profession at large.

11 Adequacy of the policy with respect to gold standards for interdisciplinary management

12 1. Dentists are encouraged to screen patients for SRBD as part of a comprehensive medical and dental
13 history to recognize symptoms such as sleepiness, choking, snoring or witnessed apneas and an
14 evaluation for risk factors such as obesity, retrognathia, or hypertension. These patients should be
15 referred, as needed, to the appropriate physicians for proper diagnosis.

16 *The task force approves point 1 as stated.*

17 2. In children, screening through history and clinical examination may identify signs and symptoms of
18 deficient growth and development, or other risk factors that may lead to airway issues. If risk for SRBD is
19 determined, intervention through medical/dental referral or evidenced based treatment may be
20 appropriate to help treat the SRBD and/or develop an optimal physiologic airway and breathing pattern.

21 *The task force approves point 2 as stated.*

22 3. Oral appliance therapy is an appropriate treatment for mild and moderate sleep apnea, and for severe
23 sleep apnea when a CPAP is not tolerated by the patient.

24 *The task force approves point 3 as stated.*

1 4. When oral appliance therapy is prescribed by a physician through written or electronic order for an
2 adult patient with obstructive sleep apnea, a dentist should evaluate the patient for the appropriateness of
3 fabricating a suitable oral appliance. If deemed appropriate, a dentist should fabricate an oral appliance.

4 *The task force approves point 4 as stated.*

5 5. Dentists should must obtain appropriate patient consent for treatment that reviews the treatment plan
6 and any potential side effects of using OAT and expected appliance longevity.

7 *The task force: Informed consent it a legal requirement and standard of care. To leave point 5 as should*
8 *is too weak.*

9 6. Dentists treating SRSD with OAT should must be capable of recognizing and managing the potential
10 side effects through treatment or proper referral.

11 *The task force: Dentists must be capable of recognizing and managing potential side effects. If they*
12 *cannot they should not be treating.*

13 7. Dentists who provide OAT to patients should monitor and adjust the Oral Appliance (OA) for treatment
14 efficacy as needed, or at least annually. As titration of OAs has been shown to affect the final treatment
15 outcome and overall OA success, the use of unattended cardiorespiratory (Type 3) or (Type 4) portable
16 monitors may be used by the dentist to help define the optimal target position of the mandible. A dentist
17 trained in the use of these portable monitoring devices may assess the objective interim results for the
18 purposes of OA titration.

19 *The task force is divided on point 7. One viewpoint is: Given the medical diagnosis, physicians must*
20 *assess efficacy. Dentists should titrate and ask subjective questions and then refer back to the sleep*
21 *team or sleep doctors. The other viewpoint is: the point is fine as stated and does not need to be*
22 *changed.*

23 8. Surgical procedures may be considered as a secondary treatment for OSA when CPAP or OAT is
24 inadequate or not tolerated. In selected cases, such as patients with concomitant dentofacial deformities,
25 surgical intervention may be considered as a primary treatment.

26 *The task force approves point 8 as stated.*

27 9. Dentists treating SRBD should must continually update their knowledge and training of dental sleep
28 medicine with related continuing education.

29 *The task force approves that should be deleted and replaced with must in point 9.*

30 10. Dentists should must maintain regular communications with the patient's referring physician and
31 other healthcare providers to the patient's treatment progress and any recommended follow up treatment.

32 *The task force approves that should be deleted and replaced with must in point 10.*

33 11. Follow-up sleep testing by a physician should be conducted to evaluate the improvement or confirm
34 treatment efficacy for the OSA, especially if the patient develops recurring OSA relevant symptoms or
35 comorbidities.

36 *The task force is divided on point 11. Evidence exists to show that long-term efficacy is different from*
37 *short term. Tissues are compliant and stretch which may result in decreased effectiveness. However,*
38 *follow-up visits with a physician can get costly, especially if the patient does not have adequate insurance*
39 *coverage.*

1 Scope of Care

2 The policy statement should define the scope of education needed for dentists who provide OSA
3 treatment. Also lacking is the dentist should work with an interprofessional management group to provide
4 care to the OSA patient.

5 *The task force is divided on the Scope of Care section. Two members think the ADA policy should have a*
6 *statement regarding the scope of education needed for dentists who are going to treat SRDB and a*
7 *statement regarding the need to work as part of an interprofessional management group when treating*
8 *patients with SRBD. Two members of the task force do not think this section needs to be part of the*
9 *policy.*

10 In the accompanying Evidence Brief for the proposed policy, the AAO is requesting the following changes
11 be made:

12 1. Page 4: needs to be modified. Snoring in and of itself has no negative medical consequence unless or
13 until it becomes gasping and OSA.

14 2. Page 4 5th paragraph: remove "ultimately". A physician can ONLY diagnose OSA. A dentist
15 diagnosing OSA is practicing medicine without a license.

16 3. Page 6 oral appliance from snoring: For snoring, nothing is needed medically. Must also restate
17 "following diagnosis by a physician a prescription for an oral appliance is made to the dentist"

18 4. Page 6 box 4: "suggest" leaves open the possibility of a physician providing an oral appliance, which
19 would be outside their scope of care.

20 5. Page 6 box 6 remove "suggest" and replace with "require". Oversight is critical to assure use and to
21 avoid side effects.

22 6. Page 6 box 7 remove "suggest" and replace with "require". Objective follow up is critical to assure
23 effective treatment and to avoid side effects.

24 7. Page 6 box 8 remove "suggest" and replace with "require". Objective follow up is critical to assure
25 effective treatment and to avoid side effects.

26 *The task force approves the above edits to the Evidence Brief.*

27 **34.** First Name: Barry
28 Last Name: Freyberg
29 Occupation: Dentist

30 Comments: Two things stand out:

31 1. "Mandibular advancement device" to me is misleading. I'd strongly prefer "mandibular repositioning
32 device" The reason is that sometimes vertical changes alone work. So a less trained dentist might believe
33 advancement is all that needs to be considered. And I see this often. "Advance more and patient will do
34 better." Sometimes they get worse when protruded more. And have other complications.

35 2. I am impressed that the statement recognizes a DDS can use a sleep study to check on titration. I also
36 agree a sleep MD and MD's should direct diagnosis and treatment. On occasion, I let a reluctant patient
37 take home an HST (I use for titration) I own. And then a sleep tech scores the data and sleep MD
38 diagnoses and orders treatment (which might be a CPAP), which sometimes includes a visit to a sleep
39 MD or to their Primary care. What is the "position" on that?

1 Thanks, I tried to make it brief

2 **35.** First Name: Scott
3 Last Name: Craig
4 Occupation: CEO - Midwest Dental Sleep Center

5 Comments: #3 should say Oral Appliance Therapy is indicated for mild to moderate patients and for
6 severe patients where PAP is contraindicated or the patient is intolerant to or refuses PAP. This
7 statement is in line with the newest guidelines from the AASM and the AADSM.

8 **36.** First Name: Erik
9 Last Name: Wipf
10 Occupation: Dentist and Board Certified ABDSM Diplomate

11 Comments: In regards to paragraph number four in the proposed policy statement, it is not clear that a
12 dentist requires a prescription for fabrication of an oral appliance. I think that it should be emphasized that
13 the diagnosis and differentiation of OSA should only be made by a physician, and thus, a dentist can only
14 provide OAT with the written or electronic order from a physician.

15 **HOME SLEEP TEST COMMENTS**

16 **37.** First Name: Deborah Starr
17 Last Name: Lake
18 Occupation: General Dentist, ADA member

19 Comments: As a dentist who was Pankey and Dawson trained and a graduate of Georgetown when it
20 was a school of Gnathology, I was greatly relieved to find the source of most of our nocturnal bruxism
21 patients was a diminished airway. I've been working with patients in this area since 2006 and am in the
22 Study Club @ UCLA with Dr. Dennis Bailey. When we work with patients in rural areas as I do, we need
23 the ability to work with their PCP to assist in oral appliance therapy, if appropriate, and we should be able
24 to order a HST which may be read by a distant Sleep Specialist for at least a baseline to know if the case
25 is appropriately handled at the PCP level. Otherwise, patients are ordering CPAP and appliances online
26 with no professional input. We take blood pressures, perform MMAs, palatal expansion -- all affecting the
27 airway -- and that's good practice parameters.

28 **38.** First Name: Thomas
29 Last Name: Schell
30 Occupation: dentist

31 Comments: I would like to emphasize that the diagnosis of sleep disordered breathing is difficult; even by
32 the sleep trained MD using a full PSG.

33 The use of HSAT for the diagnosis of sleep disordered breathing is even more difficult/unreliable than
34 with a PSG and as such:

35 The use of HSAT is contraindicated in mild and moderate OSA. (which most patients with OSA using oral
36 appliances should have, particularly if it is being used for titration?)

37 The diagnosis of sleep disordered breathing is outside the defensible realm of a dentists training and
38 expertise. Liability for accident and disease (acute and chronic) should be seriously considered by the
39 ADA if there is any recommendation through them that it is appropriate.

1 The use of HSAT is diagnosing sleep disordered breathing presence and severity.

2 The use of HSAT by dentists divides an already deepening rift between dentists and their patients'
3 physicians when in collaborative efforts the best level of care can be achieved. In cooperative care the
4 success of care is maximized, the liability is minimized and the divide between dentists and physicians is
5 alleviated. (or at least not unnecessarily antagonized)

6 There is a strong push by the private sector to encourage the use of HSAT by dentists and to encourage
7 the increased, independent treatment of sleep disordered breathing by dentists. This is being driven by
8 profit and should be strongly discouraged by those responsible for the well-being of both patients and
9 dentists alike.

10 **39.** First Name: John

11 Last Name: Nadeau

12 Occupation: Dental Sleep Medicine Expert

13 Comments: I applaud the ADA for looking to issue a positive statement and stance about dentistry's role
14 in the management of sleep related breathing problems. I've worked in this space my whole life and have
15 trained thousands of dentists on processes and procedures necessary to successfully implement a dental
16 sleep protocol in their practices. Many state dental boards are looking to create policy for this as well and
17 I'm sure will be looking at the ADA position for guidance.

18 My single concern in your statement relates to the dental use of home sleep testing. You mention that this
19 is acceptable to use for oral appliance titration but make no mention of the diagnostic abilities of HST
20 devices. Please note that home sleep testing is accepted nationwide as a diagnostic test for obstructive
21 sleep apnea. It has been made available to dentists, ENT's, Primary Care Physicians and other non-sleep
22 specialists which has greatly increased access to diagnosis for many patients. Your statement that
23 patients at risk should be "referred to an appropriate physician for diagnosis" is insufficient. This is one
24 option. Another option would be for the dental office to dispense the FDA approved home sleep testing
25 equipment and then work with a board certified sleep MD for interpretation/diagnosis of that test. This is
26 standard practice nationwide in many dental and primary care medical practices. Including in your policy
27 that dentists can and should use home sleep testing in collaboration with a board certified sleep MD for
28 diagnosis is a best practice and will ensure continued success of many dental sleep practices nationwide.

29 **40.** First Name: Raymond

30 Last Name: Champ

31 Occupation: Dental Hygienist

32 Comments: I think the guidelines make some really great recommendations with appropriate diction. The
33 current statement states "as needed" in regards to referring for proper diagnosis. I think that may need
34 further clarification for dentists' recommendation with certain patients. I'm sure all parties are aware that
35 dentists are working with HST devices. They are not making the diagnosis on their own, which would be
36 completely inappropriate. However, I do strongly believe that all dentists are capable of screening and
37 identifying patients in their community. They should be allowed to help patients by using home testing
38 devices to identify SRBDs. Patients have shown their preference to be tested with HST(s) rather than
39 PSG(s). There are cost issues to consider here as well; it is much more expensive for the patient and the
40 insurance company to administer a PSG. To clarify, I am in no way saying PSG testing is obsolete. It is
41 completely necessary in some cases. The patient's choice should be considered during this process for
42 many reasons. The collaborative approach of working with sleep physicians remotely does in fact open
43 the door to more patients receiving a definitive diagnosis. That is the main goal here; to help patients
44 identify if they have SRBDs. Once they have that clarification, a treatment consultation must occur within

1 the guidelines of the AASM and ADA, with consideration to patient preference depending on the
2 diagnosis severity or previous therapeutic attempts.

3 **41.** First Name: Robert
4 Last Name: Booher
5 Occupation: Dentist

6 Comments: I am D, ABDSM and D, BASAB dual boarded and have been to hundreds of CE courses on
7 Sleep. I work with a number of sleep doctors and always refer my patients to them or their family
8 physician who are diagnosed with OSA by a physician. I find the patients I screen would like a sleep test
9 mailed to them vs. having to go to their doctor the majority of the time and we use EZ sleep for that
10 service. We have a unit for titration studies but do not use it for diagnosis and always send a copy of final
11 titration to their MD.

12 **42.** First Name: Lori
13 Last Name: Schmidt
14 Occupation: Dental asst., Sleep care coordinator and medical biller

15 Comments: I believe that there need to be guidelines in place and applaud you for looking at this.

16 My biggest concern is access to care for patients in rural areas as it seems most of the big decisions are
17 made without taking those folks into consideration.

18 I feel strongly that a dentist should be able to dispense a sleep test ONLY if it will be interpreted and
19 signed for diagnosis by a board certified sleep physician.

20 There will never be harm done to a patient by getting this deadly disease diagnosed, wherever it may be.

21 **43.** First Name: Troy
22 Last Name: Patterson
23 Occupation: General Dentist

24 Comments: Very excited about doing this in my dental practice and I support the fact that test can be run
25 by a dentist but referred to a certified sleep MD to provide interpretation and diagnosis.

26 **44.** First Name: Srujal
27 Last Name: Shah
28 Occupation: Dentist

29 Comments: I strongly believe the requirements should list something regarding the use of Home Sleep
30 Tests by dentists and that if dispensed by the dentist require review and signing by a Board Certified
31 Sleep Physician.

32 Also, that a diagnosis of sleep apnea or ruling out sleep apnea is urged for patients prior to making a
33 custom or temporary sleep appliance.

34 Also, dentists should be appropriately trained by the respective dental sleep medicine bodies prior to
35 treating a patient or refer to a dentist who is.

36 Dentists should communicate prior to, during and after treatment with the patient's physician (PCP, Sleep,
37 Cardiologist, Neurologist, Pulmonologist), when treating a patient.

1 **45.** First Name: Damian
2 Last Name: Blum
3 Occupation: Dentist

4 Comments: Dentists being involved in caring for patients with obstructive sleep apnea has significantly
5 enhanced the public's awareness of this highly destructive condition. Additionally, many more primary
6 care physicians are now evaluating their patients for this condition, in large part due to dentists being
7 involved in educating and increasing the physicians' awareness.

8 Without the dentists' evaluation and risk assessment, a large population of patients would not be aware of
9 the root cause of their current problems.

10 In many cases, early intervention can even prevent the appearance of this potentially deadly disorder.
11 This intervention is, in a large number of cases, is possible because an astute and trained dentist was
12 able to evaluate the upper airway obstruction early in the patient's life.

13 A dentist providing the equipment for a home sleep study is no different than an outside DME company
14 doing the same thing.

15 In either case, the study is still read, evaluated and diagnosed by a board certified sleep physician. The
16 resulting therapy, in either case, still requires a letter of medical necessity and a prescription from the
17 PCP, sleep physician or other treating physician.

18 I urge to consider that without the dentist's involvement in this process, a significant number of patients
19 would probably never be diagnosed, nor efficiently treated for this devastating condition.

20 **46.** First Name: Jerry
21 Last Name: Hu
22 Occupation: Dentist

23 Comments: I am a dentist in Alaska who works closely with a board certified sleep physician to treat
24 patients with OSA. The role of HSTs for thorough treatment is paramount, especially for patients living in
25 rural areas. Together with the physician who does the diagnosis, the HSTs are critical for titration,
26 advancements, and post OAT delivery efficacy results.

27 **47.** Michael Simmons resubmitted his original comments from AIP 2

Resolution No. 34 New
Report: N/A Date Submitted: September 2017
Submitted By: Council on Dental Benefit Programs

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None Net Dues Impact:

Amount One-time Amount On-going FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 **RESPONSE TO RESOLUTION 85H-2016: THIRD PARTY PAYMENT CHOICES**

2 **Background:** 2016 House of Delegates adopted Resolution 85H-2016-Third Party Payment Choices that
3 called for the Council on Dental Benefit Programs (CDBP) to develop draft policy regarding methods of
4 claims payment. In response, CDBP drafted the following policy for submission to the 2017 House.

5 **Proposed Resolution**

6 **34. Resolved,** that the American Dental Association adopt the following statement on third-party
7 payment choices.

8 **THIRD PARTY PAYMENT CHOICES**

9 The American Dental Association urges third party payers to support a dentist’s right to receive a
10 traditional paper check in lieu of alternative payment methods as payment for services rendered
11 to a beneficiary of a dental benefits program. The ADA opposes third party payer payment
12 methodologies that require a dentist to accept virtual credit card payments, electronic funds
13 transfer (EFT) payments or any other payment options as the only payment option without an
14 opportunity to choose a paper check.

15 Virtual credit cards may apply processing fees and these fees can be much higher than the
16 fees agreed upon by the dentist when signing the original credit card agreement.

17 While EFT improves efficiency for the payers and may, in the long-term, be beneficial for
18 dental practices, there are some dental offices that may incur problems due to their current
19 patient management systems not being fully equipped to handle end-to-end electronic claims
20 processing in particular bulk claim payments. Under current circumstances dentists are
21 simply left with having to deal with bank charges levied to adopt EFT or paying to get
22 upgraded to new software simply to handle EFT and electronic remittance advice (ERA)
23 transactions seamlessly. This results in little to no improvement in practice efficiency.

24 In addition, the ADA believes dental claims should be reimbursed within fifteen (15) business
25 days from receipt of the claim by the third party payer.

26 **BOARD RECOMMENDATION: Vote Yes**

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

Resolution No. 36 NewReport: None Date Submitted: September 2017Submitted By: Fourteenth Trustee DistrictReference Committee: B (Dental Benefits, Practice and Related Matters)Total Net Financial Implication: \$98,631 Net Dues Impact: \$.95Amount One-time _____ Amount On-going _____ FTE 1

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 STUDY ON HOW DENTAL BENEFIT COMPANIES AFFECT THE DOCTOR-PATIENT RELATIONSHIP

2 The following resolution was adopted by the Fourteenth Trustee District and transmitted on August 20,
3 2017, by Dr. Carol Morrow, Fourteenth District caucus chair.

4 **Background:** The dental benefit industry has many positive and negative effects on patient care. The
5 positives, among other things, include increased utilization of dental services, employee's access to care
6 for themselves and their families, a robust network of dentists and a reasonable cost for procedures.

7 However, some of their operating policies (i.e. disallow clauses, alternative treatment planning, down-
8 coding, predetermination requirements, etc.), can greatly interfere with the doctor patient relationship. The
9 American Medical Association has previously developed similar studies to educate consumer. These
10 policies may directly increase out of pocket expenses to patients who subscribe to these plans, which
11 potentially decreases access to care.

12 Proposed Resolution

13 **36. Resolved**, that the appropriate ADA agency conduct a study of dental benefit companies'
14 policies and contracts. Compile and evaluate this information to develop a scoring system to
15 dental benefit companies' impact on the doctor-patient relationship and the delivery of appropriate
16 care, and be it further

17 **Resolved**, that the ADA make available to its members and the public, the results of these
18 findings ranking the quality of these networks, and be it further

19 **Resolved**, that this scoring be examined and updated on a semi-annual basis.

20 **BOARD COMMENT:** The Council on Dental Benefit Programs (CDBP) has pursued similar efforts in the
21 past; however, feasibility, expense and data limitations have been recurrent concerns. In 2010 CDBP
22 compiled a comprehensive list of metrics to rate payers. The project was not feasible due to lack of data
23 to rate payers objectively. In 2014, the Council put together a satisfaction survey seeking data from
24 dentists to develop ratings for different payers. After significant exploration of survey methodology,
25 required sample sizes and survey burden on dentists to gather meaningful data at the payer level, this
26 effort was not pursued. In 2016, the Council investigated the feasibility of acquiring data on write-offs for
27 various plans as a means to rate plans. Meaningful data collection continues to be a barrier.

1 Qualitative review of processing policies (i.e. provider handbook) from various carriers to determine
2 which payers may have the most appropriate policies could form the basis for payer rating. However
3 these processing policies are sometimes plan specific (a carrier/payer supports numerous plans/group
4 policies) and change annually making the information gathered meaningless quickly.

5 With regards to contracts, in some cases, the contract stipulates confidentiality posing a risk to dentists
6 disclosing this information.

7 The decision to contract with a payer is largely driven by the market-share of beneficiaries in the locality
8 of the dental office. The ADA has provided several resources to assist members in making an informed
9 decision about participation in dental plans available at <http://ada.org/dentalplans>. In addition, the ADA
10 legal department provides a contract analysis service to further assist individual dentists who seek to
11 better understand their contracts before signing.

12 **BOARD RECOMMENDATION: Vote No.**

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

Resolution No. 44 New

Report: N/A Date Submitted: September 2017

Submitted By: Council on Dental Practice

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: One year Net Dues Impact: \$.41

Amount One-time \$42,170 Amount On-going _____ FTE .25

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 **RESPONSE TO RESOLUTION 91-2016: DEVELOPMENT OF SAMPLE CLINICAL CHART ENTRIES**
 2 **TO INCREASE QUALITY IN DOCUMENTATION**

3 **Background:** In 2016, the House of Delegates referred Resolution 91-2016 Development of Sample
 4 Clinical Chart Entries to Increase Quality in Documentation (*Trans.2016:287*) to the appropriate ADA
 5 agency for further study and report back to the 2017 House of Delegates. That resolution reads:

6 **91-2016. Resolved**, that the appropriate ADA agencies develop a resource guide which contains
 7 sample chart entries for the 30 most common procedure codes and additional guidance on best
 8 practices which relates to documentation which supports Medicaid Compliance for use by dentist
 9 members, and be it further

10 **Resolved**, that this benefit be maintained within the Members Only section of ADA.org, and be it
 11 further

12 **Resolved**, that this resource be shared with auditing units of state Medicaid programs so as to
 13 inform auditors of the best practices of clinical documentation.

14 The resolution was referred to the Council on Dental Practice (CDP) which met and discussed the
 15 background of the referral, the related issues of concerns, and possible responses to the referral to be
 16 provided to the 2017 House of Delegates.

17 The CDP noted testimony during the 2016 Reference Committee hearing elicited both positive and
 18 negative comments, and the opinion that any interest in developing templates for documenting frequently
 19 performed procedures should be balanced with an awareness of the possible negative implications of
 20 creating such a resource for members. The Reference Committee therefore referred the resolution to
 21 evaluate the feasibility of developing a resource; assess the potential risks of using this type of resource;
 22 and conduct a review of any similar projects in progress.

23 Before addressing these specific directives, CDP members discussed broader concepts relating to
 24 accurate, individualized charting and the maintenance of appropriate and complete patient records. The
 25 group unanimously agreed that a patient's record is proof of clinical findings, what was said to a patient,
 26 what was done for the patient, why a procedure was performed, how the patient responded as well as
 27 consent for treatment. They also agreed that best management practices called for this information to be
 28 recorded for every patient and for every procedure. The Council noted that proper charting and
 29 documentation might offer risk management protections to members in the event of an audit or other
 30 review. In addition, the Practice Institute is often asked by members and member's office staffs questions
 31 about record keeping in general and notably there is an increasing need to satisfy regulatory
 32 requirements documentation to minimize professional risk.

1 In their discussion of the feasibility of developing a resource that provided sample chart entries for
2 Medicaid audits and best practices on documentation, members of the Council determined that, while
3 such a resource could be developed, it would be too limited in scope to provide any meaningful member
4 benefit and could even put members, and the Association, at risk.

5 The discussion of potential risks associated with developing this type of resource revealed significant
6 concern that developing a template to help dentists chart specific information for certain procedures,
7 strictly for the purposes of satisfying Medicaid audits, would be too limited to be a viable and valuable
8 member benefit. A template could not assist the dentist in detailing essential, unique information specific
9 to each patient which could be critical in the event of an audit. CDP members also expressed concern
10 that overuse of the same phrases in multiple charts could be a red flag in any practice selected for an
11 audit. Relying on the same phrasing in multiple records could make it appear as though the dentist
12 neglected to document a patient's unique presentations and needs. It was also noted that differences in
13 state regulations regarding audits made it unlikely that any sample language for clinical charting
14 documentation would satisfy every states' requirements.

15 All patients, not only those receiving Medicaid benefits, should have the same level of comprehensive
16 documentation. The CDP determined that educating members and offering them a resource that
17 addressed chart entries including medical necessity, procedure documentation, and other related
18 encounter records maintained by the practice would be of greater benefit to members than simply
19 templated chart entries.

20 Discussions among ADA staff confirmed that no other agency within the ADA was currently involved in
21 developing sample chart entries or comparable resources.

22 The CDP agreed to recommend that the 2017 House of Delegates support the creation of an original
23 resource that would benefit all members with information on appropriate patient charting, documentation
24 and the maintenance of other practice-related records. There is no current resource available that
25 provides the member with information needed to navigate the regulatory requirements for record keeping.
26 This educational tool would be developed and available as a member benefit in 2018 through a
27 collaborative effort of three Councils: CDP, Council on Members Insurance and Retirement Plans
28 (CMIRP) and Council on Advocacy for Access and Prevention (CAAP)) with an estimated cost of
29 \$42,170, excluding staff time. CDP has *Bylaws* responsibility for monitoring and communicating to
30 members on topics relating to dental practice management¹; CMIRP has *Bylaws* responsibility for
31 maintaining activities in the area of risk management education programs and resources²; and CAAP
32 maintains activities in the areas of access to oral healthcare and community oral health advocacy³. CDP
33 would manage the content development process based on collaboration with the Councils and external
34 content authorities on the topics to be covered by the resource.

35 Therefore, the Council recommends the following resolution be adopted.

36 **Proposed Resolution**

37 **44. Resolved**, that the 2017 ADA House of Delegates approve the development of a practice
38 management resource that will provide guidance on a variety of risk management topics,
39 including properly charting clinical entries and documenting medical necessity, to be completed in
40 2018.

41 **BOARD RECOMMENDATION: Vote Yes.**

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

¹ http://www.ada.org/~media/ADA/Member%20Center/Files/ADA_2017_Bylaws.pdf?la=en page 62

² http://www.ada.org/~media/ADA/Member%20Center/Files/ADA_2017_Bylaws.pdf?la=en page 63

³ http://www.ada.org/~media/ADA/Member%20Center/Files/ADA_2017_Bylaws.pdf?la=en page 61

Resolution No. 50 New
 Report: N/A Date Submitted: September 2017
 Submitted By: Ninth Trustee District
 Reference Committee: B (Dental Benefits, Practice and Related Matters)
 Total Net Financial Implication: None Net Dues Impact: _____
 Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 **DO-IT-YOURSELF TEETH STRAIGHTENING**

2 The following resolution was submitted by the Ninth Trustee District and transmitted on September 12,
3 2017, by Ms. Michelle Nichols-Cruz, governance manager, Michigan Dental Association.

4 **Background:** Members of the American Dental Association are concerned with do-it-yourself (DIY) oral
5 treatments. Direct-to-consumer marketing of Internet-based teeth straightening programs have become
6 particularly aggressive with online and television network advertising. The sponsors of this resolution
7 believe that such self-delivered, unsupervised treatments have the potential to cause damage and
8 irreversible complications.

9 Rather than a clinical examination, some programs only request a “selfie” photograph and completion of a
10 questionnaire for treatment initiation. Clients may take impressions of themselves or they can visit
11 storefront centers where employees scan a client’s mouth.

12 Patients are also advised that their service may be eligible for reimbursement through dental benefit
13 plans. This further concerns the sponsors of this resolution, as benefiting such services will consume
14 limited plan resources.

15 The sponsors of this resolution contend that circumventing the involvement of a licensed dentist in the
16 provision of teeth straightening services eliminates the intellectual contribution of the dentist to diagnose,
17 treatment plan and manage treatment needs throughout the course of care, adversely impacting patient
18 safety and treatment outcomes.

19 **Proposed Resolution**

20 **50. Resolved**, that for the health and well-being of the public, the American Dental Association
21 believes that supervision by a licensed dentist is necessary for all phases of orthodontic treatment
22 including:

- 23 • oral examination
- 24 • periodontal examination
- 25 • radiographic examination
- 26 • study models or scans of the mouth
- 27 • treatment planning and prescriptions

- 1 • periodic progress assessments and
- 2 • final assessment with stabilizing measures

3 and be it further

4 **Resolved**, that the ADA strongly discourages the practice of do-it-yourself orthodontics because of
5 the potential for harm to patients.

6 **BOARD RECOMMENDATION: Vote Yes.**

7 **BOARD VOTE: UNANIMOUS.**

Resolution No. None N/A

Report: Council on Dental Practice Report 1 Date Submitted: September 2017

Submitted By: Council on Dental Practice

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

RESPONSE TO RESOLUTION 87H-2016: REVIEW OF RECOMMENDATIONS FOR CONE BEAM COMPUTED TOMOGRAPHY INSPECTIONS

Background: Recognizing the myriad of technological advances in radiographic imaging and other imaging modalities, the 2016 House of Delegates adopted Resolution 87H-2016 (*Trans.287:2016*) as follows:

87H-2016. Resolved, that the appropriate ADA agencies review the recommendations for the quality assurance inspection of dental radiographic equipment, including but not limited to, intra-oral, panoramic, cephalometric and cone beam computed tomography devices and recommend inspection protocols that would include the appropriate method and interval for inspection.

Following assignment as the lead agency, the Council on Dental Practice invited subject matter authorities, representatives of specialties and Council members from the Council on Dental Practice (CDP) and the Council on Scientific Affairs (CSA) to develop the recommendations (Appendix 1). Resources were collected, reviewed and discussed. An in-person meeting was held on March 20-21, 2017 to facilitate discussion. Through a consensus process, ethical and scientifically based protocols for quality assurance inspection of dental radiographic equipment to help ensure that the risk to patients from dental x-rays is as low as reasonably achievable (ALARA) while ensuring diagnostic acceptability were developed.

The appended report is a summary of the findings (Appendix 2). Recommendations for periodic testing are included, as well as inspection intervals. The recommendations will be published by the appropriate ADA agencies.

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

ORGANIZATION	REPRESENTATIVE
Academy of General Dentistry	Dr. Joseph Hagenbruch
American Academy of Oral and Maxillofacial Radiology	Dr. Veeratrishul Allareddy
American Academy of Oral and Maxillofacial Radiology	Dr. Ender Ozgul
American Academy of Pediatric Dentistry	Dr. Juan Yepes
American Association of Oral and Maxillofacial Surgeons	Dr. James Mercer
American Association of Orthodontists	Dr. Carla Evans
American Association of Physicists in Medicine	Joel Gray, Ph.D.
American Association of Physicists in Medicine	Mr. Robert Pizzutiello Jr.
American College of Prosthodontists	Dr. Gerald Grant
Council on Dental Practice	Dr. Terry O'Toole, chair
Council on Dental Practice	Dr. Michelle Mazur-Kary
Council on Dental Practice	Dr. Craig Ratner
Council on Dental Practice	Dr. Stacey Van Scoyoc
Council on Dental Practice	Dr. Michael Wojcik
Council on Scientific Affairs	Dr. Sharon Brooks
Council on Scientific Affairs	Dr. Paul Eleazer
Radiological Society of North America	Dr. Prabu Raman
Standards Committee on Dental Informatics/CDP consultant	Dr. Brent Dove
Standards Committee on Dental Informatics/CDP consultant	Dr. Peter Mah
Trade Industry Representative	Mr. Joel Karafin

APPENDIX 2

QUALITY ASSURANCE TESTING OF DIGITAL DENTAL RADIOGRAPHIC EQUIPMENT

Background: In 1972, the National Academy of Sciences National Research Council's Committee on Biological Effects of Ionizing Radiation reported that diagnostic radiology accounted for about 90 percent of the total man-made radiation exposure to the U.S. population. According to the U.S. Food and Drug Administration, seven of every ten Americans undergo some type of radiologic procedure annually, and dental examinations are the most frequent type of radiological procedure. Intra-oral radiographic exposures account for 95% of all dental radiographic exposures. Panoramic exposures are 3% of the total, cephalometric exposures are less than 1% of the total and cone beam computed tomography (CBCT) exposures are 2% and are expected to increase. Dental facilities account for approximately 40% of the state radiation registrants.

The dental profession is committed to providing the highest quality of care. Diagnosis and treatment decisions require a clinical examination and often a radiological examination. Accurate and reliable diagnostic information requires optimally functioning radiological equipment. Recognizing the myriad of technological advances in radiographic imaging and other imaging modalities, the 2016 House of Delegates (HOD) directed "that the appropriate American Dental Association (ADA) agencies review the recommendations for the quality assurance inspection of dental radiographic equipment including, but not limited to, intra-oral, panoramic, cephalometric and CBCT devices and recommend inspection protocols that would include the appropriate method and interval for inspection."

In response to the 2016 HOD resolution 87H, the Council on Dental Practice (CDP) formed an Ad Hoc Advisory Committee (AHAC) of subject matter authorities, representatives of specialties, and members of the CDP and the Council on Scientific Affairs (CSA). Resources were collected, reviewed and discussed. An in-person meeting was held on March 20-21, 2017 to facilitate discussion. The AHAC's purpose was to recommend ethical and, to the extent possible, scientifically based protocols for the quality assurance of the dental radiographic imaging process. Critical in this process is the quality control of dental radiographic equipment, to help ensure that the risk to patients from dental x-rays is as low as reasonably achievable (ALARA).

The 'Digital Issue': The generation of a radiographic image involves a series of steps and the quality of the final image is dependent on what occurs during each step in the process. While with film based radiography poor control of exposure is generally evident, digital radiography technology allows for a greater range of exposures that will still produce a diagnostically acceptable radiograph.¹ The operator may electronically manipulate the digital radiographic image with post-processing software to enhance contrast and brightness to an esthetically acceptable level, however diagnostic information not captured correctly will not be retrieved or restored. It is important that exposure times are adjusted and optimized to give adequate radiation to obtain a diagnostic image, as too low a value can result in loss of critical detail. However, overexposure of a digital detector is unlikely to result in a noticeable difference in the radiograph, yet produces an excess radiation dose which will not comply with the ALARA or as low as diagnostically acceptable (ALADA) principles of good radiation hygiene.

Quality Assurance, Quality Control and Inspection: Quality assurance, quality control and the inspection of radiographic equipment represent three distinct concepts. Each concept has differing basic principles and requirements. Each may therefore require different types of personnel to accomplish its goals.

Quality Assurance (QA) is the broad, overarching program that assures the quality of a product or service. This includes such issues as personnel education and certification, physical and environmental controls, as well as the measurement of quantitative and qualitative outcomes.

1 Dentists are required to maintain a standard of care for their patients which would include ensuring that the
2 radiographic imaging systems that are utilized on their patients are functioning correctly and producing
3 diagnostic radiographic images congruent with good radiation practices of ALARA and ALADA.

4 The licensed dentist or the registered x-ray machine owner is responsible for the implementation of the
5 quality assurance program of a dental facility. It is the responsibility of the licensed dentist and the
6 registered owner to ensure that x-ray producing equipment (radiographic and CBCT) complies with all
7 applicable state or local regulations and takes reasonable adequate safety measures to protect individuals
8 subject to radiation exposure. This consists of the training of dental healthcare personnel, including
9 documentation of their competency, on the basic principles of radiation safety and practices for operation
10 and maintenance of the x-ray equipment. In situations where there are multiple practitioners, one licensed
11 dental practitioner should be designated the radiation safety officer who oversees and ensures
12 compliance with the QA protocol established in the office. Written procedures, policies and training
13 records should be maintained by the licensed dentist or the registered x-ray machine owner. The QA
14 records should record the date and time that a quality control procedure was performed and by whom and
15 if any corrective action was required. A follow-up evaluation using the quality control protocol should then
16 be conducted to ensure that the product or procedure is functioning correctly before its use on a patient.

17 **Quality Control (QC)** is the distinct planning, implementation, and evaluation of procedures used to
18 produce high-quality radiographs with maximum diagnostic information while minimizing radiation
19 exposure. QC procedures include regular monitoring and scheduled maintenance of x-ray equipment, or
20 imaging systems, and periodic evaluations performed by trained staff or other personnel.

21 The purpose of QC is to set standards according to the available evidence for best practices, to
22 regularly audit these standards, and to ensure they are being met and to record compliance.
23 Implementation of QC procedures allows identification of equipment problems that can then be
24 corrected.

25 Properly trained staff members may be assigned duties of equipment monitoring, record keeping and
26 quality control operations. It is essential that the level of responsibilities and involvement of the licensed
27 dentist or owner and staff be defined and understood. Some states have training requirements for dental
28 office personnel that are stated in each state's Dental Practice Act or are limited by the radiographer
29 license or permit to practice radiography. The Dental Assisting National Board, Inc. and the American
30 Association of Dental Boards maintain a state Dental Practice Act data base for state statutes, regulation
31 and administrative rules governing the practice of each member of the dental team. Information regarding
32 state regulations relative to the operation of x-ray equipment, x-ray safety requirements for facilities, or
33 regulatory requirements for quality control are found in state's regulations. These regulations can be
34 obtained by contacting the state's radiation protection or control offices.

35 Radiographic systems can be quite complex with varied equipment and imaging software systems. If
36 dental offices are unsure of, or lack sufficient training on the proper use of any radiographic imaging
37 equipment due to new technology, additional training should be obtained from an oral maxillofacial
38 radiologist (OMR), the device manufacturer or another qualified expert familiar with the product.

39 A qualified expert for purposes here is generally accepted as an individual, by possession of a
40 recognized degree, certificate, or professional standing, or who by extensive knowledge, training and
41 experience, can perform dependable radiation surveys, estimate the degree of radiation hazard and
42 assist in developing monitoring protocols. This generally includes oral and maxillofacial radiologists,
43 most medical physicists and can include original equipment installers as certified or authorized by the
44 state of jurisdiction. When a qualified expert visits a dental facility, it is to perform an independent
45 evaluation of the radiographic equipment's performance relative to image quality, patient dose, and
46 manufacturer's specification. In addition, the qualified expert, in conjunction with the dentist, may also
47 determine if the image quality and patient dose have been appropriately optimized.

1 **Inspection** is a separate regulatory function by an employee or agent of a regulatory body to determine if
2 there is compliance with existing regulations. In some jurisdictions, a medical physicist or qualified expert
3 may visit a dental facility to evaluate regulatory compliance. In other jurisdictions, an employee of the
4 state or county regulatory agency performs this regulatory compliance function. Most states have
5 radiation safety compliance requirements, along with a state agency, to oversee compliance.

6 **Imaging Assessment Types:** The concept of radiographic monitoring may be divided into two distinct
7 categories—initial acceptance testing and periodic constancy testing. These two concepts must be applied
8 to every aspect of the radiographic imaging “chain” that leads to the production and display of a
9 radiographic image. The “chain” begins with the radiographic source, i.e. the x-ray tube and generator. It
10 continues on to the medium of image capture, whether that be digital x-ray sensor, photostimulable
11 phosphorus (PSP) plate or film. Digital radiography then continues through processing software. Finally,
12 the chain culminates where the image is displayed.

13 1. **Initial Acceptance Testing** is an essential element of a QC program and required for new
14 installations of all radiographic equipment. The purpose of Initial Acceptance Testing is to
15 assure that the radiographic system is operating correctly and will provide baseline data for
16 comparison during periodic constancy testing.^{2,3}

17 2. **Periodic Constancy Testing** is that element of the QC program that is recommended to
18 establish that the equipment continues to operate optimally with respect to image quality and
19 radiation safety.

20 **Digital Intraoral Radiography X-ray Source:** Initial acceptance testing should be performed upon initial
21 installation of the x-ray source. The tube potential, exposure time accuracy and reproducibility, x-ray
22 filtration, half-value layer, tube output and reproducibility, x-ray beam collimation or alignment and beam
23 stability should be evaluated by a qualified expert or the original equipment installer as part of the initial
24 equipment acceptance testing. All parameters should be within the manufacturer’s allowed variance from
25 the nominal specification. A written report should be provided by the qualified expert or original equipment
26 installer and should be included as part of the QC records.

27 Periodic constancy testing of x-ray source output should be performed annually by any person in the
28 dental staff with training on how to make the measurements of x-ray tube output and compare them
29 with the results obtained during initial acceptance testing. In addition, periodic constancy testing
30 should include evaluation of image quality using an appropriate phantom. The same tests for image
31 quality and radiation output should be repeated any time a major change has been made to the
32 imaging system, e.g., replacement of the x-ray tube, or any time the system software is upgraded or
33 changed.

34 Periodic verification of constancy testing including the tube potential, exposure time accuracy and
35 reproducibility, x-ray filtration, half-value layer, tube output and reproducibility, x-ray beam collimation
36 and alignment and beam stability should be evaluated every four years by a qualified expert
37 recognized by the state to ensure that the device is performing to the manufacturer’s specifications.
38 A written report should be provided by the qualified expert or original equipment installer.

39 **X-ray Sensor or Receptor:** Initial acceptance testing should be performed upon initial installation of any
40 new x-ray sensor or receptor by any person in the dental staff trained to use a dental radiographic
41 phantom to objectively evaluate critical parameters such as dynamic range, spatial resolution, and
42 contrast detail detectability over a wide range of clinically acceptable exposures. Using this method, an
43 optimal exposure can be determined for each image acquisition device and x-ray source combination. A
44 radiographic exposure technique chart should be developed based on the optimal exposure and the
45 range of exposures.

1 Periodic constancy testing of each x-ray sensor or receptor and x-ray source combination should be
2 performed annually by any person in the dental staff with training on how to use a dental radiographic
3 phantom to objectively evaluate critical parameters such as dynamic range, spatial resolution, and
4 contrast detail detectability and compare them with the result obtained during initial acceptance testing.
5 This same testing should be performed whenever a sensor is replaced or changed or when software is
6 upgraded or changed. PSP plates should be continuously evaluated for physical damage to the surface of
7 the imaging plate, often evidenced by artifacts discernable within the image, and taken out of service
8 when the damage affects the resultant image.

9 **Digital Panoramic Radiography:** Initial acceptance testing should be done upon initial installation of the
10 x-ray source. The tube potential, exposure time accuracy and reproducibility, x-ray filtration, half-value
11 layer, tube output and reproducibility, x-ray beam collimation, and focal trough or image layer alignment
12 should be evaluated by a qualified expert or the original equipment installer as part of the initial
13 equipment acceptance testing. A manufacturer's specific radiographic phantom should be used to verify
14 image layer alignment. All parameters should be within the manufacturer's allowed variance from the
15 nominal specification. A written report should be provided by the qualified expert or original equipment
16 installer.

17 Periodic constancy testing of x-ray source output should be performed annually by any person in the
18 dental staff with training on how to make the measurements of x-ray tube output and compare them
19 with the results obtained during initial acceptance testing. The same tests for image quality and
20 radiation output should be repeated any time a major change has been made to the imaging system,
21 e.g., replacement of the x-ray tube, or any time the system software is upgraded or changed.

22 Periodic verification of constancy testing should be performed every four years by a qualified expert
23 recognized by the state to ensure that the device is performing up to the manufacturer's
24 specifications.

25 **Digital Cephalometric Radiography:** Initial acceptance testing should be done upon initial installation of
26 the x-ray source. The tube potential, exposure time accuracy and reproducibility, x-ray filtration, half-value
27 layer, tube output and reproducibility, x-ray beam collimation and alignment should be evaluated by a
28 qualified expert or the original equipment installer as part of the initial equipment acceptance testing. All
29 parameters should be within the manufacturer's allowed variance from the nominal specification. A written
30 report should be provided by the qualified expert or original equipment installer.

31 Periodic constancy testing of x-ray source output should be performed annually by any person in the
32 dental staff with training on how to make the measurements of x-ray tube output and compare them
33 with the results obtained during initial acceptance testing. The same tests for image quality and
34 radiation output should be repeated any time a major change has been made to the imaging system,
35 e.g., replacement of the x-ray tube, or any time the system software is upgraded or changed.

36 Periodic verification of constancy testing should be performed every four years by an expert
37 recognized by the state to ensure that the device is performing up to the manufacturer's
38 specifications.

39 **Cone Beam Computed Tomography (CBCT):** Dental CBCT is a variation of traditional computed
40 tomography (CT) systems. The CBCT systems used by dental professionals rotate around the patient with
41 a flat panel digital detector capturing data from the cone-shaped x-ray beam. The data is used to construct
42 a three-dimensional (3-D) image of the mouth, teeth, jaw, nose and throat. Dental CBCT provides non-
43 invasive 3-D diagnostic information rather than the two-dimensional information provided by intra-oral,
44 panoramic, or cephalometric images.

45 Initial acceptance testing should be done upon initial installation and before patient use of the CBCT. The
46 tube potential, exposure time accuracy and reproducibility, x-ray filtration, half-value layer, tube output and

1 reproducibility, x-ray beam collimation and alignment should be evaluated by a qualified expert or the
2 original equipment installer as part of the initial equipment acceptance testing. CBCT image quality testing
3 should be performed using the manufacturer's specific radiographic phantom by a qualified expert or the
4 original equipment installer as part of the initial equipment acceptance testing. A written report should be
5 provided by the qualified expert or original equipment installer.

6 Periodic CBCT image constancy testing should be performed monthly using the manufacturer's
7 specific radiographic phantom by any person in the dental staff with training on how to make images
8 of the phantom and compare them with the results obtained during initial acceptance testing. Federal
9 regulations require the manufacturer of CBCT equipment to provide a phantom for evaluating image
10 quality of the CBCT system and instructions for quality control testing, including recommended
11 frequencies of such tests. The same tests for image quality and radiation output should be repeated
12 any time that a major change has been made to the imaging system, e.g., replacement of the x-ray
13 tube, or any time the system software is upgraded or changed.

14 Periodic verification of constancy testing should be performed two years after initial testing, graduating
15 to every four years if no significant deficiencies are identified, by a qualified expert recognized by the
16 state to ensure that the system performance is consistent with manufacturer's specifications. A written
17 report should be provided by the qualified expert.

18 **Diagnostic Display:** Initial acceptance testing of the diagnostic display should be performed upon initial
19 installation by any person in the dental staff with training on how to use the Society of Motion Picture &
20 Television Engineers (SMPTE) Diagnostic Imaging Test Pattern. The display device should be evaluated
21 for brightness, contrast, sharpness, geometric distortion and field uniformity.

22 Periodic constancy testing can be performed by any person in the dental staff with training on how to
23 use the SMPTE Diagnostic Imaging Test Pattern for evaluation of display performance. The display
24 device should be evaluated monthly for brightness, contrast, sharpness, geometric distortion and
25 field uniformity using the SMPTE Diagnostic Imaging test pattern and compared with the result
26 obtained during initial acceptance testing. The same tests should be repeated any time a major
27 change has been made to the imaging system such as when the display is replaced or the system
28 software is upgraded or changed.

29 **Conclusion:** Quality Assurance (QA) is the broad, overarching program that assures the quality of
30 images produced at the facility. Quality control procedures include the regular monitoring and
31 scheduled maintenance of x-ray imaging systems with periodic evaluations performed by trained
32 staff or other personnel to ensure operational constancy. Inspection is a separate regulatory function
33 by an agent of the regulatory body to determine if regulations are being met as compliant or
34 noncompliant and may be performed on-site or through a validated verification process.

35 Best practices for radiographic equipment include a qualified expert or equipment installer who is
36 recognized by the state to perform initial quality acceptance testing with written reporting at the time of
37 installation. This is then followed by periodic constancy testing by a competent staff member to perform
38 the indicated evaluation(s) of the imaging system components.

39 Periodic testing is recommended to establish that the equipment continues to operate optimally with
40 respect to image quality, healthcare provider, staff, and patient safety as determined at the initial
41 acceptance testing in accordance with the manufacturer's recommendations and with state regulations.

1 The following chart summarizes the recommendations by imaging modalities and components of the
 2 imaging chain. The suggested time in the following chart between periodic tests are the maximum amount
 3 of time allowed between intervals. State regulations may vary.

Assessment Type	Diagnostic Display	Intra-Oral Radiography X-Ray System	Intra-Oral Radiography Sensor or Receptor	Panoramic and Cephalometric Radiography	Cone Beam Computed Tomography
Initial Acceptance Testing	Performed by trained dental staff at the time of installation, or when changes are made.	Performed by a qualified expert or equipment installer who is recognized by the state at the time of installation, and repeated when significant changes are made.	Performed by a qualified expert or equipment installer who is recognized by the state at the time of installation, and repeated when significant changes are made.	Performed by a qualified expert or equipment installer who is recognized by the state at the time of installation, and repeated when significant changes are made.	Performed by a qualified expert or equipment installer who is recognized by the state at the time of installation, and repeated when significant changes are made.
Periodic Constancy Testing	Performed by trained dental staff on a monthly schedule.	Performed by trained dental staff on an annual schedule or at the interval recommended by the manufacturer.	Performed by trained dental staff on an annual schedule or at the interval recommended by the manufacturer.	Performed by trained dental staff on an annual schedule or at the interval recommended by the manufacturer.	Performed by trained dental staff on a monthly schedule or at the interval recommended by the manufacturer.
Periodic Verification Testing	No verification of constancy testing is required.	At four year intervals, verification performed by a qualified expert recognized by the state.	No verification of constancy testing is required.	At four year intervals, verification performed by a qualified expert recognized by the state.	Verification performed by a qualified expert recognized by the state two years after initial testing; advancing to every four years if no issues are detected.

References

American Dental Associations Technical Report 1094, Quality Assurance for Digital Intra-Oral Radiographic Systems.

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<http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?FR=1020.33>

(d) *Quality assurance.* The manufacturer of any CT x-ray system shall provide the following with each system. All information required by this subsection shall be provided in a separate section of the user's instructional manual.

(1) A phantom(s) capable of providing an indication of contrast scale, noise, nominal tomographic section thickness, the spatial resolution capability of the system for low and high contrast objects, and measuring the mean CT number of water or a reference material.

(2) Instructions on the use of the phantom(s) including a schedule of testing appropriate for the system, allowable variations for the indicated parameters, and a method to store as records, quality assurance data.

(3) Representative images obtained with the phantom(s) using the same processing mode and CT conditions of operation as in paragraph (c)(3) of this section for a properly functioning system of the same model. The representative images shall be of two forms as follows:

(i) Photographic copies of the images obtained from the image display device.

(ii) Images stored in digital form on a storage medium compatible with the CT x-ray system. The CT x-ray system shall be provided with the means to display these images on the image display device.

Resolution No. 53 New

Report: None Date Submitted: September 2017

Submitted By: Ninth Trustee District

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 **GENETIC TESTING FOR RISK ASSESSMENT**

2 The following resolution was submitted by the Ninth Trustee District and transmitted on September 19,
3 2017, by Ms. Michelle Nichols-Cruz, governance manager, Michigan Dental Association.

4 **Background:** Risk-based benefit plan design is growing in popularity with plan administrators, plan
5 purchasers and dental care providers. It allows for targeting benefits for care and thus access to care, for
6 those individuals at greatest health risk and it assures optimal use of limited plan resources to provide for
7 the best outcomes.

8 Typically a patient’s level of risk is assessed through generally accepted clinical markers or risk
9 assessment tools that have validity and reliability. This is important because inaccurate assignment of a
10 patient’s risk status or that of an entire population within a plan could result in adverse health outcomes if
11 access to needed care is restricted by the plan benefit allowances based on faulty conclusions.

12 Such was the case with a risk-based plan promoted by Delta Dental Plan of Michigan (DDPM), called
13 RightSize. This plan used a genetic test called PerioPredict to determine a patient’s risk for periodontitis.

14 DDPM supported a study by the University of Michigan and hailed its findings to assert that the
15 PerioPredict genetic test identifies the “periodontal gene.” The Michigan study was cited in literature
16 introducing Delta Dental’s new risk plan that limited dental cleanings to one annually and allowed access
17 to additional cleanings if the patient tested positive to the genetic test or had other risk markers such as a
18 history of diabetes or history of periodontal care. Additionally, the University of Michigan study concluded
19 that using this genetic test in such a plan design would save the dental plan roughly \$37 per patient
20 annually.

21 Instituting such a plan responds to marketplace pressures to contain plan costs and promotes an
22 impression of integrated health plan design. Delta Dental was the only payer known to use this genetic
23 test within a benefit plan design. In fact, other payers chose not to benefit the test or recognize its
24 conclusions. United Healthcare’s 2017 Dental Clinical Policy stated “The clinical utility of genetic testing
25 for susceptibility to periodontal diseases has not been established. Additionally, there is a lack of
26 objective, high quality clinical evidence to support these tests.”

27 It should also be noted that DDPM’s parent organization was an investor in the test’s manufacturer
28 Interleukin Genetics Inc., creating what could be viewed as a conflict of interest to promote adoption of
29 this test.

1 In March of 2015, *JADA* published an article by Dr. Scott Diehl et al that reanalyzed the data used in the
2 University of Michigan study and concluded that the genetic test was not useful in identifying individuals
3 at risk for periodontitis. Earlier this year, the ADA published "[Oral Health Topics](#)" on ADA.org that
4 concluded that no genetic test currently exists to assess risk for a patient developing periodontitis, yet
5 DDPM continued to use the test within its risk-based plan to ration access to benefits for preventive care.

6 The genetic testing community has also taken notice of this test. Recently the publication [GenomeWeb](#)
7 [published that there are serious concerns with the marketing and science behind this product](#). Recently,
8 the makers of the test, Interleukin Genetics Inc., announced its [liquidation](#) and it is assumed that their test
9 is no longer available.

10 The sponsors of this resolution recognize the value of risk-based benefit plan design and its promise of
11 appropriately directing benefit plan resources to those most in need of care. We are also hopeful that
12 genetic testing will emerge to aid in this goal. However, the sponsors of this resolution find it concerning
13 that a genetic test that had at best conflicting evidence for its validity and reliability, was used by a benefit
14 plan to restrict access to benefits for care and potentially negatively impact health outcomes.

15 Dentistry is not alone. Health professions will experience a growth of such products and tests in the
16 coming years and we will need a mechanism to assess the claims and counter claims so that we may
17 best serve our patients and advocate for the needs of the public.

18 For guidance on this issue, we may need only to look to the Centers for Medicare and Medicaid Services,
19 the largest payer of health benefits in America and a driver of trends for the benefit industry. As detailed
20 in this link, Medicare contractor Palmetto has implemented a strategy that places the burden of proof (and
21 cost) onto the manufacturer:

22 [https://www.palmettogba.com/palmetto/MolDX.nsf/DocsCat/MolDx%20Website~MolDx~Browse%20By%
23 20Topic~Technical%20Assessment~8PKRZF3404?open](https://www.palmettogba.com/palmetto/MolDX.nsf/DocsCat/MolDx%20Website~MolDx~Browse%20By%20Topic~Technical%20Assessment~8PKRZF3404?open)

24 To provide a mechanism where genetic test manufacturers and benefit plans using such tests can
25 provide assurances on validity and reliability for their program, ADA staff has suggested pursuing
26 development of standards through the American National Standards Institute (ANSI). Doing so would
27 provide needed credibility beyond that achieved through ADA policy alone, however; such a process is
28 estimated to take over two years to achieve. Thus the sponsors of this resolution would recommend a two
29 phase approach to first have Association policy on the expectations the profession would have on this
30 topic for the protection of our patients and also that the ADA would work through ANSI to have standards
31 developed through that organization.

32 **Resolution**

33 **53. Resolved**, that for the health and well-being of the public, the American Dental Association
34 believes that any payer organization using a genetic test to determine eligibility for benefit coverage
35 for specific oral healthcare services and any manufacturer of a test(s) used in such an effort must
36 publish specific information on:

- 37 • Confirmation from an independent third party agency of test validity and reliability for the
38 intended purpose
- 39 • Analysis on how this specific plan design will impact health outcomes and plan costs
- 40 • Disclosure of financial relationships between the manufacturer and payer
- 41 • Disclosure of bias and conflict of interest between the test manufacturer, investigators
42 providing evidence and literature used to promote the test and plan design and with the
43 payer organization

44 and be it further

- 1 **Resolved**, that the American Dental Association should work with the American National Standards
- 2 Institute (ANSI) to develop industry standards for these tests.

- 3 **BOARD RECOMMENDATION: Received after the September 2017 Board of Trustees meeting.**

- 1 **Resolved**, that the dental benefit plan rating tool be made available online as a free resource for
- 2 consumers and purchasers of such plans, and be it further
- 3 **Resolved**, that progress on this rating system tool be reported to the 2018 House of Delegates.

- 4 **BOARD RECOMMENDATION: Received after the September 2017 Board of Trustees meeting.**

Resolution No. 56 New

Report: N/A Date Submitted: October 2017

Submitted By: Minnesota Dental Association

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: \$812,000 Net Dues Impact: \$7.85

Amount One-time \$494,000 Amount On-going \$318,000 FTE 1.5

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 **ESTABLISHMENT OF A COMPREHENSIVE DENTAL DISEASE CLINICAL REGISTRY**

2 The following resolution was submitted by the Minnesota Dental Association and transmitted October 4,
3 2017, by Carmelo Cinqueonce, executive director, Minnesota Dental Association.

4 **Background:** Today, the dental benefits marketplace and the dental care delivery system is experiencing
5 significant change. Dental insurers have implemented Preferred Provider Organizations (PPO's) and
6 various risk sharing arrangements with dental clinicians. Traditional fee for service and non-network
7 delivery systems are now relatively rare. At the same time, dentistry is seeing substantial growth of Dental
8 Service Organizations (DSO's) and an increasing percentage of all dental care delivery is being provided
9 by dental clinicians in these organizations. Common strengths for both the dental insurers and the DSO's
10 is their access to large volumes of patient data.

11 Use of large volumes of patient data to understand population demographics, population health, cost of
12 care, patients' preferences, and the increasingly complex payment mechanisms has been commonplace
13 in the medical community. Medical care systems are embracing the use of data and analytics. Medical
14 care systems such as Mayo Clinic, John's Hopkins, the Cleveland Clinic, Intermountain Health, Kaiser
15 and so many others have invested heavily in Electronic Health Records (EHRs) systems, data analytics
16 and smart clinical decision support systems. Hospitals, large physician groups and others have
17 necessarily had to do the same to remain competitive in this market.

18 Dentistry is seriously behind in adoption of sophisticated EHRs, analytics, and clinical decision support
19 tools. For the most part, dentists have been "shielded" from changing payment mechanisms. However,
20 this has allowed payers to willingly take all the financial risk up front and control their costs through the
21 development of heavily discounted PPO's with ever lowering payment levels. Dental plans and their
22 supporting organizations are reviewing and researching how to integrate data and associate treatment
23 with disease in an effort to be the owners of the evidence to support care and to identify best practices.
24 Some dental plans are buying practices and beginning to better understand various correlations as they
25 improve their internal data gathering to include diagnosis, as well as observables and other findings that
26 lead us to a diagnosis. They are also beginning to develop coordinated care methodology with health
27 care plans to account for how medical conditions impact dental health and vice versa. The ability to
28 exchange this information between medical and dental plans and clinicians is becoming increasingly
29 important for what is perceived to be the best available patient care and for sound financial performance.

30 More important, when "standards" or acceptable treatment protocol are developed there is the possibility
31 that a very small set of dentists (and possibly not practicing dentists) will be determining and interpreting
32 the data to develop the evidence that supports treatment protocols because dental insurers control the

1 vast majority of real-world information available to understand treatment approaches to improve
2 outcomes. There may also be financial incentives that may not be in the interest of the best long-term
3 outcomes for patients.

4 Because of the much smaller (financial) size of dentistry, as compared to medicine and the expense of
5 Information Technology, data analytics and artificial intelligence, dentistry may be at greater risk than
6 medicine in responding to the developing marketplace. In this context, DSO's are in a better position than
7 the solo and small group practitioners who are not able to afford individual investments in sophisticated
8 technology.

9 Dentistry may not be able to develop strong enough negotiating alliances to provide for best patient care
10 and a reasonable financial arrangement. Dentistry needs to respond and be able to harness data to
11 inform our practice for the betterment of the patients we serve. As a profession, we must have greater
12 input into the developing evidence and treatment protocols to best serve our patients. The American
13 Dental Association (ADA) may be the best organization to broadly represent dentistry and house our
14 source of big data to help negotiate better policies for our patients.

15

Resolution

16 **56. Resolved**, that the ADA Council on Dental Benefit Programs establish a comprehensive dental
17 disease clinical registry with patient level clinical data to empower practitioners to understand care
18 patterns and generate evidence to improve oral health outcomes in lieu of relying on third-party
19 payers for such determinations.

20 **BOARD RECOMMENDATION: Received after the September 2017 Board of Trustees meeting.**

Resolution No. 57 New

Report: N/A Date Submitted: October 2017

Submitted By: Seventh Trustee District

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____

Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 **REVISION OF ADA POLICY STATEMENT ON INAPPROPRIATE OR INTRUSIVE PROVISIONS AND**
2 **PRACTICES BY THIRD PARTY PAYERS**

3 The following resolution as submitted by the Seventh Trustee District and transmitted on October 2, 2017
4 by Mr. Doug Bush, executive director, Indiana Dental Association.

5 **Background:** The American Dental Association has communicated to its members concern about the
6 overuse and potential abuse of opioid pain and antibiotic prescriptions.

7 Recently, Dr. Vivek Murphy, M.D., M.B.A., the Surgeon General of the United States, contacted health
8 care providers about concerns of abuse of opioid pain prescriptions. Congress has overwhelmingly
9 expressed similar concern by passing the Comprehensive Addiction and Recovery Act of 2016.

10 Additionally, the Center for Disease Control, along with other health care agencies and scientific entities,
11 have expressed concerns for the overuse and potential abuse of antibiotics. The world has recently seen
12 the development of strains of resistant bacteria that have become non-treatable and life threatening.

13 Some third-party payers, however, have established treatment policies that contribute to the overuse and
14 abuse of antibiotics and opioids. A specific example is one that restricts the clinician from providing more
15 than one soft tissue graft for a patient in any quadrant during a single surgical visit. Some third-party
16 payers require that these procedures be performed at separate visits in order for all procedures to be a
17 covered benefit. Not only does this require the patient to miss twice as much time from work, double the
18 occurrence of anxiety, have twice as much discomfort, but this policy requires the use of antibiotics and
19 pain medication to literally double. Our professional obligation is to protect our patients and in these
20 situations protect the greater good of the public at large.

21 **Resolution**

22 **57. Resolved**, that the Comprehensive ADA Policy on Inappropriate or Intrusive Provisions and
23 Practices by Third Party Payers (*Trans.2016:290*) be amended under the section titled **Disallowed**
24 **Clauses** by the addition of a third example as follows:

25 3. Surgical procedures to multiple sites when performed on the same day of service

26 and be it further

27 **Resolved**, that the ADA communicate its change to the Policy on Inappropriate or Intrusive
28 Provisions and Practices by Third Party Payers to all Third Party Payers, and request changes that

1 address the inappropriate disallowance of surgical procedures to multiple sites on the same day of
2 service, and be it further

3 **Resolved**, that the American Dental Association, as needed, seek legislation and/or regulations to
4 address these inappropriate third party payer provisions and practices, and be it further

5 **Resolved**, that constituent dental societies be urged to seek legislation or regulation in their individual
6 states to address these inappropriate third party payer provisions and practices.

7 **BOARD RECOMMENDATION: Received after the September 2017 Board of Trustees meeting.**

WORKSHEET ADDENDUM**1 Comprehensive ADA Policy Statement on Inappropriate or Intrusive Provisions and Practices by
2 Third Party Payers**

3 The American Dental Association opposes interference in the treatment decisions made between doctor
4 and patient. Plans which contain inappropriate and intrusive provisions substitute business decisions for
5 treatment decisions made through a patient-doctor dialogue. Such provisions and practices deny patients
6 their purchased benefits and robs them of their rights as informed consumers of healthcare.

7 Plans which contain provisions, such as those listed below, should disclose them to the plan purchasers
8 and to patients. Dentists should be made aware of these practices when offered a contract.

9 The ADA is of the opinion that a list of practices by third-party payers that are inappropriate or intrusive
10 and interfere with the doctor-patient relationship includes but is not limited to the following:

11
12 **Bad Faith Practices:** Not treating a beneficiary of a dental benefit plan fairly and in good faith; or a
13 practice which impairs the right of a beneficiary to either receive the appropriate benefit of a dental
14 benefits plan, or to receive the benefit in a timely manner.

15 Some examples of potential bad faith practices include, but are not limited to:

- 16 1. failure to properly investigate the information in a submitted claim
- 17 2. unreasonably and purposely delaying or withholding payment of a claim
- 18 3. withholding funds from bulk benefit payments for services rendered to unrelated patients as a
19 means of settling disputes over prior claims experienced with the dentist either from an alleged
20 past overpayment by the plan or retroactive ineligibility of benefits for a patient

21 **Inappropriate Fee Discounting Practices:** Requiring a dentist, who does not have a participating
22 provider agreement, to accept discounted fees or be bound by the terms and conditions set forth in the
23 participating provider contracts signed by other dentists.

24 Some examples of inappropriate fee discounting practices include, but are not limited to:

- 25 1. issuing reimbursement checks which, upon signing, result in the dentist accepting the amount as
26 payment in full
- 27 2. using claim forms which, upon signing, require the dentist to accept the terms of the plan's
28 contract
- 29 3. issuing documentation that states the submittal of a claim by a dentist means that he or she
30 accepts all terms and conditions set forth in the participating provider contract
- 31 4. sending communications to patients of nonparticipating dentists which state the patient is not
32 responsible for any amount above the maximum plan benefit

33 **Lowering Patient Benefits and Claims Payment Abuse:** Intentionally lowering the benefit to the
34 beneficiary and/or lowering the allowable amount to the dentist negating the code for the actual services
35 performed by the dentist. These practices, coupled with contractual clauses that require the dentist to
36 accept the plan payment as payment in full, compound the problem.

37 Some examples of claims payment abuse include, but are not limited to:

- 38 1. **Downcoding:** using a procedure code different from the one submitted in order to determine a
39 benefit in an amount less than that which would be allowed for the submitted code
- 40 2. **Bundling of Procedures:** the systematic combining of procedures resulting in a reduced benefit
41 for the patient/beneficiary

- 1 3. **Limiting Benefits for Non-Covered Services:** mandating a discounted fee for procedures for
- 2 which the plan pays no benefit
- 3 4. **Least Expensive Alternative Treatment Clauses:** contractual language that allows a plan to
- 4 only pay for the least expensive treatment if there is more than one way to treat a condition
- 5 5. **Most Favored Nation Clauses:** contractual language that requires a dentist to give the
- 6 beneficiaries of a dental plan the same lower fee that the dentist may have charged another
- 7 patient

8 **Disallowed Clauses:** Contractual language that prohibits a dentist from charging a patient for a covered
9 procedure not paid for by the benefit plan.

10 Some examples of disallowed procedures include, but are not limited to:

- 11 1. direct and indirect pulp caps when provided in conjunction with the final restoration or sedative
- 12 filling for the same tooth
- 13 2. frequency limitations such as sealants, which are repaired or replaced by the same dentist within
- 14 two years of initial placement

15 **Using Non-Dentist Personnel for Adjudication of Benefit:** A practice where a non-dentist determines
16 the medical necessity for benefit adjudication. Any determination of medical necessity for the purposes of
17 benefit adjudication should only be made by a dentist licensed in the state in which the procedures are
18 being performed.

19 **Restricting Dialogue between Dentists and Patients or Public Agencies:** Contractual language that
20 restricts dentists from fulfilling their legal and ethical duties to appropriately discuss with patients, other
21 health care providers, public officials or public agencies, any matter relating to treatment of patients,
22 treatment options, payment policies, grievance procedures, appeal processes, and financial incentives
23 between any health plan and the dentist.

24 **Automatic Assignment of Participating Dentist Agreements:** Contractual language which allows PPO
25 leasing companies and third-party payers to obligate the dentist to participate in any other third party
26 payer or managed care network without full disclosure of fees, processing policies and written consent
27 from the dentist. This is typically accomplished by selling or providing the discount rate information to any
28 other third-party payers and/or other managed care networks.

29 **Non-Disclosure of fee schedules and processing policies prior to contracting:** Requiring a dentist to
30 evaluate a contract with a carrier without full disclosure of the fee-schedules and processing policies as it
31 applies to all plans administered by the carrier.

32 and be it further

33 **Resolved,** that this policy be communicated to the National Association of Dental Plans (NADP) and
34 dental benefit companies to encourage consideration of this policy in the design and revision of each
35 carrier's dental plan products.

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5H-2006. Resolved, that the following strategies to address oral health issues of vulnerable elders be adopted (additions are shown by underscoring; deletions are shown by strikethroughs):

Advocacy to Address Elders' Health Care. The ADA, ~~with input constituent and component dental societies using input~~ from key stakeholders will develop strategies that will persuade legislators and regulators at all levels to make vulnerable elders' oral health a priority, and that these strategies may include but not be limited to the following:

- at least three new supportive programs to be implemented in 2008 (e.g., loan forgiveness, loan repayment, tax treatments, scholarships, grants, service opportunities) for dentists who provide care to vulnerable elders
- at least two new advocacy strategies that will result in 2010 compliance by all institutional settings with the minimum federal standards for daily mouth care for vulnerable elders
- at least two new strategies to educate and seek the support of key senators, representatives and agency officials within a year on key legislation, and the critical need for advanced general dentistry programs in geriatric dentistry and those programs with an emphasis in geriatrics
- at least three legislative, regulatory and market-based initiatives to improve the oral health of vulnerable elders developed in collaboration with stakeholders in the aging network and health communities
- a plan developed with key stakeholders by 2007 to influence and persuade those who fund and approve clinical trials in dental research to include people over 65 in study populations
- the ADA to encourage constituent and component dental societies to join in these advocacy efforts

Education of Health Care Workers to Support Elders' Oral Health Care. The following strategies will facilitate education of health care workers on issues related to oral health of the vulnerable elderly population:

- ADA collaborating with key stakeholders to develop a plan with strategies designed to expand opportunities for advanced general dentistry programs in geriatric dentistry and those programs with an emphasis in geriatrics that will commence within three years
- Appropriate ADA agencies developing and implementing by 2008 approved continuing education programs for certified nursing assistants in oral health and daily mouth care for vulnerable elderly
- ADA collaborating with stakeholders to create for implementation in 2008 a Web-based clearinghouse of community-based outreach programs, practice resources, continuing education opportunities and consensus reports related to providing oral health care to vulnerable elders

1 Additional strategies will include:

- 2 • ~~the ADA and state and local dental societies redoubling redoubling~~ efforts to provide
3 enhanced educational content on the oral health needs of vulnerable elders at national,
4 regional, state and local dental meetings, as well as online and for study groups
- 5 • the ADA encouraging constituent and component dental societies to join in efforts to provide
6 enhanced educational content on the oral health needs of vulnerable elders
- 7 • the ADA working collaboratively with key stakeholders to enhance undergraduate dental
8 education to better prepare dental and allied dental students for caring for the growing elderly
9 population, and to find additional ways to include dentistry in interdisciplinary and other
10 special geriatric training programs
- 11 • appropriate ADA agencies collaborating with key stakeholders and investigating the need for
12 a non-specialty interest area in general dentistry for geriatric dentistry
- 13 • appropriate ADA agencies developing elder care programming and obtaining staff support to
14 carry out the vision set forth in the white paper of the Task Force on Elder Care.

15 *Education of the Public and Policymakers to Enhance Elders' Oral Health.*

- 16 • the ADA will collaborate with appropriate stakeholders to develop a proposal for the 2007
17 ADA House of Delegates to build the public's awareness on how good oral health enhances
18 overall health and quality of life in vulnerable elders
- 19 • the ADA in 2007, in collaboration with stakeholders, will develop educational material (e.g.,
20 FAQs and three articles) for elders and their families for the public side of ADA.org to
21 increase awareness about how oral health impacts overall health and quality of life within a
22 year
- 23 • the ADA will develop position papers and supporting materials in 2007 (including talking
24 points) to educate policymakers on oral health issues relating to vulnerable elders
- 25 • the ADA will seek opportunities to educate policymakers and others that funding advanced
26 general dentistry programs in geriatric dentistry and those programs with an emphasis in
27 geriatrics is critical to improving the health of vulnerable elders
- 28 • the ADA will initiate or support key pieces of legislation that would improve the health of
29 vulnerable elders
- 30 • the ADA will develop educational tools on oral health issues of residents in long term care
31 facilities and assisted living facilities

32 *Exploring New Types of Dental Insurance for Elders.* The appropriate agencies of the ADA will
33 develop a plan for convening a 2008 meeting of key stakeholders to discuss new insurance plan
34 models for people over age 65, with an interim report to the 2007 House of Delegates and a final
35 report, with recommendations, to the 2008 House.

36 *Exploring Dental Workforce Needs to Support Elders' Oral Health Care.* Appropriate agencies of
37 the ADA will investigate new dental workforce roles specifically for the geriatric population
38 including appropriate functions for dental assistants and dental hygienists to support care for the
39 vulnerable elderly population.

1 *Research to Support Oral Health for Elders.* The ADA in 2007 will develop with key stakeholders
2 a plan to aggregate, identify, collect and synthesize existing research on the oral health of the
3 vulnerable elderly in order to identify knowledge gaps, including:

- 4 • mechanisms designed to ensure consistent and comprehensive data generation on the oral
5 health of vulnerable elderly populations through regular gap analyses of existing research
- 6 • mechanisms to identify and secure funding for at least three oral health care research
7 projects within three years that have the potential to prevent oral disease and improve the
8 oral health status of vulnerable elders
- 9 • mechanisms for urging and finding funding for 2008-10 research for therapeutic trials
10 designed to prevent, reduce and/or eliminate oral diseases affecting vulnerable elders; and
11 research that investigates the relationship between oral health and general health in
12 vulnerable elders
- 13 • mechanisms for disseminating research findings that impact vulnerable elders' oral health to
14 health care workers, the public and policymakers

15 Furthermore, the ADA will

- 16 • conduct in 2007 a 'Survey of Current Issues in Dentistry' devoted to vulnerable elders to
17 collect current data from general dentists and specialists on the care they are providing for
18 vulnerable elders in a variety of practice settings
- 19 • develop in 2007 an ADA Health Policy Resources Center analysis of vulnerable elders' oral
20 health issues to increase the understanding of age-associated and disease-associated oral
21 disorders and their impact on clinical care.
22

23 and be it further

24 **Resolved,** that the Board of Trustees report to the 2007 House of Delegates on the status of these elder
25 care initiatives.

Resolution No. 58S-1 Substitute
Report: N/A Date Submitted: October 2017
Submitted By: Eleventh Trustee District

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: \$119,398 Net Dues Impact: \$1.15

Amount One-time \$119,398 Amount On-going _____ FTE 1

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 **STRATEGIES FOR ELDER CARE**

2 The following substitute for Resolution 58 (Worksheet:3089 CORRECTED) was submitted by the
3 Eleventh Trustee District and transmitted on October 20, 2017, by Bracken Killpack, executive director,
4 Washington State Dental Association.

5 **Background:** The Eleventh District is proposing an amendment to Resolution 58 (additions are
6 underscored; deletions are ~~stricken~~):

7 **Resolution**

8 **58S-1. Resolved**, that the appropriate council of the American Dental Association ~~review~~ summarize
9 ~~the strategies for elder care adopted in Resolution 5H-2006 and any subsequent reports pertaining to~~
10 ~~the resolution provide a~~ report to the 2018 House of Delegates, ~~on progress made within each of the~~
11 ~~strategies~~, and be it further

12 **Resolved**, that this report include successes, failures and ~~what~~ actions the ADA can do ~~now~~ to meet
13 the elder care challenge of the future utilizing the latest research, products and technology.

Resolution No. 59 New
Report: None Date Submitted: October 2017
Submitted By: Seventeenth Trustee District

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None Net Dues Impact: _____
Amount One-time _____ Amount On-going _____ FTE 0

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 **PROTECTION OF PATIENTS' RIGHTS TO SELECT TREATMENT OPTIONS**

2 The following resolution was submitted by the Seventeenth Trustee District and submitted on October 9,
3 2017, by Mr. Drew Eason, executive director, Florida Dental Association.

4 **Background:** As a multitude of stakeholders are currently engaged in discussions regarding a
5 comprehensive dental benefit in Medicare, the American Dental Association (ADA), America's leading
6 oral health advocate, has the opportunity to guide deliberations on the various strategies for improving
7 oral health of elders.

8 While stakeholders develop various possible models of a prospective Medicare dental benefit program to
9 consider as an alternative to, or in conjunction with, other elder care benefit options fundamental patient
10 protection principles must be maintained. Such principles facilitate a sustainable care delivery model
11 prioritizing favorable health outcomes.

12 Of specific concern, is the preservation of the patient's opportunity to be presented with all treatment
13 options by and in consultation with his/her dentist. Furthermore, the limitations of any prospective
14 Medicare dental benefit should not restrict patients' access to care that is not covered by the plan.
15 Medicare provider contracts must allow patient payment for non-covered treatment options selected by
16 the patient. In order to preserve treatment options in a free market, the value of services not covered by
17 the benefit plan must not be dictated by the benefit plan.

18 Ultimately, any dental benefit plans developed for elder care either in Medicare or in any other format,
19 must be designed to be sustainably effective in helping patients obtain positive health outcomes.

20 **Resolution**

21 **59. Resolved**, the ADA must advocate for the protection of patients' rights to select treatment
22 options for optimal health through consultation with their dentist in any dental benefit plan that
23 may be developed in any future Medicare programs.

24 **BOARD RECOMMENDATION: Received after the September 2017 Board of Trustees meeting.**