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**ADA** American  
Dental  
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America's leading  
advocate for oral health

# 2013

Supplement to  
Annual Reports and Resolutions  
Volume 1

154th Annual Session  
New Orleans, Louisiana  
November 1–5, 2013

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211 East Chicago Avenue  
Chicago, Illinois 60611

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Board Report 1/  
Credentials, Rules and Order

Resolution No. 67 New

Report: Board Report 1 Date Submitted: August 2013

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

ADA Strategic Plan Goal: \_\_\_\_\_ (Required)

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

This is the first in a series of reports to be presented by the Board of Trustees to the House of Delegates at the 154<sup>th</sup> Annual Session of the American Dental Association.

**Appreciation to the Council on ADA Sessions and the 2013 Committee on Local Arrangements:** The American Dental Association is pleased to have its 154<sup>th</sup> Annual Session in New Orleans, Louisiana.

The Council on ADA Sessions has created a meeting that lives up to the ADA’s reputation for delivering an extraordinary education and exhibition experience. The Board of Trustees wishes to express its sincere gratitude to the Council, and the exceptional leadership of Dr. Michael M. Blicher, 2012-2013 council chair and Dr. Gregory J. Peppes, program chair. They have planned and produced not only an innovative continuing education program, but an exhibition that allows dental professionals to experience firsthand the latest in cutting edge dental materials, services and new technologies.

Council members: Dr. Hugo F. Bertagni, Dr. Barry I. Cohen, Dr. Joseph P. Crowley (Board of Trustees liaison), Dr. Grace A. Curcuru, Dr. James R. Foster, Dr. James E. Galati (2014 CAS chair-designate), Dr. T. Harold Lancaster, Dr. William E. Lee, Scott B. Levitz (ASDA liaison), Dr. Calbert M. Lum, Dr. Risé L. Martin (general chair, 2014 San Antonio Committee on Local Arrangements), Dr. Steven E. Parker, Dr. John P. Pietrasik, Dr. Robert E. Roesch, Dr. S. Shane Samy, Dr. Brian M. Schwab (New Dentist Committee liaison), Dr. Neil E. Torgerson, Dr. Sidney R. Tourial and Dr. James H. Van Sicklen, Jr. are all to be recognized for their commendable achievement.

The Board also extends its sincere thanks to those chairpersons who so capably assisted Dr. Robert E. Barsley, general chair of the 2013 New Orleans Committee on Local Arrangements: Dr. William A. Hadlock, vice chair; Dr. David C. DeGenova, registration co-chair; Dr. Peter L. Glaser, hospitality co-chair; Dr. Edward J. Hebert, program co-chair; Dr. David J. Hildebrandt, hospitality co-chair; Dr. Kay Jordan, program co-chair; Dr. Gerald A. Williams, registration co-chair.

Finally, the Board expresses tremendous appreciation to all of the volunteers on the Committee on Local Arrangements for the assistance they provide to the Council in the operation of this annual session. The Board recognizes and thanks the Louisiana Dental Association and the New Orleans Dental Association for their contributions to the success of the 2013 New Orleans Annual Session.

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



1 **Death of Former Officials:** Since the last meeting of the House of Delegates, the following ADA officers  
2 and trustees have passed away: Dr. Floyd E. Dewhirst, former thirteenth district trustee, 1972-1978; Dr.  
3 Curtis E. Gause, former vice president, 1993-1994; and Dr. Richard T. Grubb, former vice president,  
4 2000-2001.

5  
6 **Election of Honorary Membership:** In accordance with Resolution 78H-1980 (*Trans.980:590*), which  
7 empowers the Board of Trustees to elect members of the Association, the following individuals have been  
8 elected to Honorary Membership:

9  
10 Mr. Bruce Bergstrom  
11 Dr. Paul Warren  
12

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

16  
17 **Distinguished Service Award:** Established in 1970, the Distinguished Service Award is the highest  
18 honor conferred by the Association's Board of Trustees. Each year the Board may select one recipient  
19 for the Award. The Board is pleased to announce that the recipient of the 2013 Distinguished Service  
20 Award is Dr. Robert T. Ferris.

21 **Robert T. Ferris, D.D.S., M.Sc., Ph.D.:** Dr. Robert Ferris is an accomplished clinician, scholar,  
22 educator, examiner, leader in organized dentistry, and philanthropist who has served the  
23 profession and the American Dental Association with distinction for over 50 years.

24 Dr. Ferris received his dental education (D.D.S.) from Emory University in 1961, and received  
25 his post-doctoral Masters in Science (M.Sc.) in periodontology and Ph.D. in microbiology from  
26 the Ohio State University, and is a Diplomate of the American Board of Periodontology. Dr.  
27 Ferris has had a distinguished career in as both a clinician and scholar, maintaining a private  
28 practice in periodontics since 1967 while serving numerous academic appointments, including  
29 Associate Professor and Chair, Department of Periodontics at Case Western Reserve School  
30 of Dental Medicine (1968-71), and Clinical Professor of Periodontics, University of Florida  
31 College of Dentistry (1977 to present).

32 Among his many scholarly accomplishments, Dr. Ferris has lectured nationally and  
33 internationally on topics related to the surgical management of periodontal disease, the inter-  
34 relationships between oral and systemic diseases, and the role of occlusion and prosthetic  
35 treatment on the periodontium. He has published extensively on topics ranging from basic  
36 science, to clinical management of oral disease, to the impact of standards on the delivery of  
37 oral healthcare.

38 His role in organized dentistry is no less remarkable, having served as vice president of the  
39 American Dental Association, as well as president of the American Academy of Periodontology,  
40 the Florida Dental Association, and the American Association of Dental Examiners. He has  
41 also twice chaired the Florida Board of Dentistry, and has served as chair of the Florida section  
42 of the American College of Dentists. He is a Fellow of the American College of Dentists, the  
43 International College of Dentists, the Pierre Fauchard Academy, and has been twice awarded  
44 the Florida Dental Association Dentist of the Year. In addition, Dr. Ferris has served as a  
45 delegate or alternate delegate to the ADA House of Delegates for over 25 years.

46 Beyond his professional achievements, he has also served his community in several civic  
47 posts, including Rotary International and Maitland-South Seminole Chamber of Commerce.  
48 Most notably, he has exhibited exemplary personal philanthropy by his donation of \$1 million to  
49 benefit both the Florida Dental Health Foundation and the American Academy of  
50 Periodontology Foundation, a tribute to his commitment to the sustainability and future of our  
51 profession.

1 **Retiring Officers and Trustees:** The Board of Trustees wishes to express its gratitude to the following  
2 officers and trustees for services rendered to the Association during their tenure on the Board: Dr.  
3 Kenneth J. Versman, first vice president; Dr. Dennis W. Engel, trustee, Ninth District; Dr. Maxine  
4 Feinberg, trustee, Fourth District; Dr. Donald L. Seago, trustee, Fifth District; and Dr. Charles R. Weber,  
5 trustee, Third District.

6 **Appreciation to Employees:** The Board of Trustees is pleased to bring to the attention of the House of  
7 Delegates 35 members of the Association staff for their years of service.

8 *Forty Years:* Stephanie Starsiak, Membership, Tripartite Relations and Marketing

9 *Thirty-Five Years:* Elander Goins, Education/Professional Affairs; Craig Palmer, Publishing, ADA  
10 Washington Office; Carol Balabanow, Science/Professional Affairs

11 *Thirty Years:* Deborah Gorski, Membership, Tripartite Relations and Marketing; James Berry, Publishing;  
12 John Malone, Science/Professional Affairs; Judith Fleeks, Human Resources

13 *Twenty-Five Years:* Kathy Clary, Government Affairs, Washington Office; Regina Sligh, Membership,  
14 Tripartite Relations and Marketing

15 *Twenty Years:* Colleen Philbin, Publishing; Daniel Creed, Government Affairs; Kelly Bentley, John  
16 Fernandez and Christine Chico, Membership, Tripartite Relations and Marketing; Christine Dillon, ADA  
17 Foundation; Linda Pompey, Communications

18 *Fifteen Years:* Clayton Mickel, Corporate Relations; Alfredo Ovalle, Jr., Leonora Dempsey, and Kenneth  
19 Elliott, Information Technology; Kathleen Alexandrakis and Kristy Vogt, Science/Professional Affairs;  
20 Kathleen Hoffman, ADA Foundation; Patrick Cannady, Sabrina Collins and Jean Narcisi, Dental  
21 Practice/Professional Affairs; Marilu Alonso and Bradley Harmon, Membership, Tripartite Relations and  
22 Marketing; Fabian Perez, Conference Services and Meeting Planning; Diane Ward, Administrative  
23 Services; Kimberly Green, Finance and Operations; Jeffrey Gartman and Andrea Matlak,  
24 Education/Professional Affairs; Tracy Hollenbach, Communications

25 **Nominations to Councils and Commissions:** The Board of Trustees annually submits to the House of  
26 Delegates nominations for membership to the councils, commissions and New Dentist Committee. Based  
27 on the ADA *Bylaws*, the nominees for ADA open positions on the Commission on Dental Accreditation  
28 and Council on Scientific Affairs were selected by the Board from nominations open to all trustee districts.  
29 Additionally, in accordance with a long-standing House directive, the Board is providing a brief narrative  
30 comment on each nominee's qualifications. The *Bylaws*, Chapter VI, Conflict of Interest, requires  
31 nominees for Councils and Commissions to complete a conflict of interest statement and file such  
32 statements with the Secretary of the House of Delegates to be made available to the delegates prior to  
33 election. Copies are available upon request through the Office of the Executive Director.  
34

1 The qualifications of these nominees appear on Page 1007.

**ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS**

Shelly Fay Jones, Michigan  
Melanie S. Lang, AHA, Washington, D.C.  
Neil C. Nunokawa, Hawaii  
Todd A. Pankratz, M.D., AMA, Nebraska  
Valerie B. Peckosh, Iowa  
Andrew P. Soderstrom, California

**ADA SESSIONS**

Charles B. Foy, Jr., Louisiana  
David J. Fulton, Jr., Illinois  
Gregory La Morte, New Jersey  
Douglas A. Wyckoff, Missouri

**COMMUNICATIONS**

James R. Hight, Jr., Tennessee  
Craig W. Herre, Kansas  
Carolyn J. Malon, Connecticut  
James A. H. Tauberg, Pennsylvania

**DENTAL ACCREDITATION**

Patricia L. Blanton, Texas\*

**DENTAL BENEFIT PROGRAMS**

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

**DENTAL EDUCATION AND LICENSURE**

Prabu Raman, Missouri  
Jill M. Price, Oregon

**DENTAL PRACTICE**

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

**ETHICS, BYLAWS AND JUDICIAL AFFAIRS**

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

**GOVERNMENT AFFAIRS**

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

**MEMBERSHIP**

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

**MEMBERS INSURANCE AND RETIREMENT PROGRAMS**

J. Preston Coleman, Texas  
Larry J. Ferguson, South Carolina  
Bradley B. Kincheloe, Wyoming  
David E. McLean, Vermont

**NATIONAL DENTAL EXAMINATIONS**

Rhett L. Murray, Colorado

**NEW DENTIST**

J Emily R. Ishkanian, Nevada  
Jill C. McMahon, Illinois  
Justin R. Norbo, Virginia  
Kendra J. Zappia, New York

**SCIENTIFIC AFFAIRS**

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

\*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 to participate in CODA activities.

**Resolution**

**67. 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 and commission members.

**ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS**

John J. Hanck, Colorado  
Monica Hebl, Wisconsin  
Heather B. Heddens, Iowa

**ADA SESSIONS**

Hugo F. Bertagni, Illinois  
Michael M. Blicher, Washington, D.C.  
William E. Lee, Kentucky  
Gregory J. Peppes, Kansas

**COMMUNICATIONS**

J. Michael Johnson, Kentucky  
Krista M. Jones, Oklahoma  
John B. Nase, Pennsylvania  
Jonathan D. Shenkin, Maine

**DENTAL ACCREDITATION**

Kent L. Knoernschild, Illinois  
Michael E. Biermann, Oregon

**DENTAL BENEFIT PROGRAMS**

A. David May, Jr., Texas  
Bruce G. Toy, California

**DENTAL EDUCATION AND LICENSURE**

Michael D. Edwards, Alabama  
Ronald L. Rhea, Texas

**DENTAL PRACTICE**

Craig S. Armstrong, Texas  
Jeffrey M. Cole, Delaware  
Jonathan B. Knapp, Connecticut  
Jon J. Johnston, Pennsylvania

**ETHICS, BYLAWS AND JUDICIAL AFFAIRS**

Dwyte E. Brooks, Nevada  
Walter I. Chinoy, New Jersey  
Jeffrey C. Esterburg, Ohio  
Kevin A. Henner, New York

**GOVERNMENT AFFAIRS**

Ronald S. Bowen, Utah  
Amber A. Determan, South Dakota  
Henry W. Fields, Jr., Ohio  
Herbert L. Ray, Jr., Pennsylvania

**MEMBERSHIP**

Mark A. Bauman, New York  
Jean E. Bainbridge, Texas  
J. Dale Goad, New Mexico

**MEMBERS INSURANCE AND RETIREMENT PROGRAMS**

Jeffrey E. Dodge, Rhode Island  
Gregory W. Rashall, Texas  
Douglas S. Rawls, South Carolina  
George F. Rosenbaum, Nevada

**NATIONAL DENTAL EXAMINATIONS**

Peter S. Trager, Georgia

**NEW DENTIST**

Madalyn M. Davidson, Illinois  
Jennifer L. Enos, Arizona  
Christopher J. Salierno, New York  
Shamik S. Vakil, Virginia

**SCIENTIFIC AFFAIRS**

G. Garo Chalian, Colorado  
Stephen K. Harrel, Texas  
Jacqueline M. Plemons, Texas  
S. Bryan Whitaker, Arkansas

1 **ADA Institute for Diversity in Leadership:** The ADA Board of Trustees selected the following dentists  
2 to be the eleventh class of the ADA Institute for Diversity in Leadership, to begin the program in  
3 September 2013:

4  
5 Dau, Steven, Tampa, FL  
6 Davis, Andrea, Gulfport, MS  
7 Edwards, Maurice, New York, NY  
8 Frizzell, Felicia, Fort Defiance, AZ  
9 Harris-Beatty, Calysta, Rockford, IL  
10 Martinez, Maria, Middleton, ID  
11 Moronta, Ruben, Bronx, NY  
12 Patel, Nehal, Jenks, OK  
13 Rekhi, Princy, Renton, WA  
14 Rodriguez, Esperanza, Bronx, NY  
15 Thakkar, Nipa, Wyomissing, PA  
16 Torres, Daniel, Gainesville, FL  
17

18 **The Institute Program:** In proposing the Institute to the ADA 2002 House of Delegates, the ADA Board  
19 described the objectives of the Institute as: "... to build lifetime relationships with minority dentists; to  
20 mentor promising leaders with potential to impact diverse communities; and to strengthen alliances with  
21 stakeholder institutions, including dental leaders, industry, public and governmental communities of  
22 interest."  
23

24 Opened in 2003, the Institute is a one-year program in which 12 dentists participate by: (1) attending  
25 three leadership training seminars at the American Dental Association headquarters, Chicago, in a small  
26 group setting, (2) engaging in five conference calls with faculty, classmates, and staff, and (3) completing  
27 a self-selected personal leadership project. The participating dentists belong to racial, ethnic and/or  
28 gender groups that have been traditionally underrepresented in leadership roles. Each year, the ADA  
29 Board's Diversity and Inclusion Committee reviews applicants and recommends the new class for  
30 approval by the ADA Board. Overall program oversight is provided by the Diversity and Inclusion  
31 Committee of the ADA Board of Trustees. For 2012-2013, committee members are: Dr. Charles Weber,  
32 chair; Dr. Steven Gounardes; Dr. Gary Yonemoto; and, Dr. Terry Buckenheimer. In addition, three  
33 members of past or current Institute classes serve as consultants to the ADA Board's Diversity and  
34 Inclusion Committee, advising on a variety of topics as regular participants in the Committee meetings:  
35 Dr. Alejandro Aguirre (2006-2007), Maria Maranga (2012-2013) and Veronika Vazquez (2010-2011).  
36

37 Program faculty is from Northwestern University's Kellogg School of Management. Beginning in 2012,  
38 Professor Keith Murnighan, an award-winning Kellogg faculty member who has taught with the program  
39 since the beginning, has been Kellogg advisor and faculty liaison.  
40

41 The program is partially supported through generous contributions from two corporations: Procter &  
42 Gamble Oral Health and Henry Schein Dental.  
43

44 **Feedback from the Programs:** As in all prior years, both the September and December 2012 programs  
45 were rated positively by class members in terms of faculty, networking opportunities among the incoming  
46 and outgoing classes, and worth their time. Participants described the Institute as an invaluable  
47 experience with inspiring faculty.  
48

49 **Alumni Leadership Roles:** Institute alumni have been selected for positions as volunteers in ADA  
50 governance, serving on: the ADA Board's Strategic Planning Committee, the New Dentist Committee,  
51 and as delegates or alternates to the ADA House of Delegates over the past several years (with eight in  
52 the 2012 House).  
53

54 Institute alumni have filled volunteer leadership roles with constituent and component dental societies.  
55 From among those responding to the alumni surveys over the years, 46 (44%) of the respondents report

1 involvement in leadership roles with state or local dental societies. For example, alumni have held posts  
2 in governance including council and committee chairs, assistant editor, and foundation committee  
3 member at the state level. Further, Institute alumni have served as president, secretary, board member,  
4 journal editor and Give Kids A Smile chair at the local level.

5  
6 Institute participants have also served as board members and officers with the Hispanic Dental  
7 Association, the National Dental Association, the American Association of Women Dentists, and the  
8 Society of American Indian Dentists.

9  
10 In addition, alumni continue to report leadership roles with non-dental society organizations. These have  
11 included: state board of dentistry member; residency program director; associate dean of diversity and  
12 inclusion; community health center director; adoption center fund-raising leader; officer of a local medical  
13 society, and volunteer leadership positions in many community oriented organizations.

14 **Review of Association Policies:** In accord with Resolution 111H-2010, Regular Comprehensive Policy  
15 Review, the Board reviewed four policies. The Board voted to maintain the following three policies and  
16 proposed an amendment to one--ADA Disclosure Policy (See Res. 63: Worksheet:5045)

#### 17 **Policies to be Maintained**

18 59H-2008 (Hyperlink Embedding in Policy Statements)

19 **Resolved**, that where appropriate, electronic versions of policy statements should be embedded with  
20 hyperlinks to supporting documents, references and media, and be it further

21 **Resolved**, that such accompanying supporting material should be reviewed with the same care as  
22 the actual policy statement before publication by the appropriate ADA agencies.

23 95H-2009 (Transparency)

24 **95H-2009. Resolved**, that action items and approved minutes of all open meetings of ADA  
25 councils, committees and of the Board of Trustees be promptly posted in the Members Only  
26 section on ADA.org, and be it further

27 **Resolved**, that the ADA, as the sole shareholder of ADABEI, shall direct ADABEI and any other  
28 subsidiaries to post on the Members Only section of ADA.org all approved minutes of Board  
29 meetings, and be it further

30 **Resolved**, that security in the Members Only section on ADA.org be enhanced as may be  
31 necessary so as to ensure that members will have exclusive access to the information contained  
32 in this Web site area.

33 35H-2001 (Utilization of Multi-Council Task Forces)

34 **35H-2001. Resolved**, that the American Dental Association utilize multi-council task forces when  
35 rapid responses are required to address emerging issues, and include the necessary expertise  
36 from members of relevant councils on these task forces as provided in Chapter XI, Section 10 of  
37 the *Bylaws*, and be it further

38 **Resolved**, that Resolution 42-1970-H, Membership of American Dental Association Task Forces  
39 (*Trans.*1970:479), be rescinded.  
40

**STATEMENT OF QUALIFICATIONS OF NOMINEES TO COUNCILS AND COMMISSIONS****ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS**

*Jones, Shelly Fay, Michigan, 2017.* Dr. Shelly Jones has been very active in the Michigan Dental Association (MDA) over the past several years. She currently serves on the MDA's Committee on Government and Insurance Affairs (CGIA). Her input on the CGIA has been invaluable when it comes to access issues and protecting the integrity of the dental profession. Dr. Jones recently attended the ADA's Washington Leadership Conference where she met with and lobbied several members of Congress on ADA issues. Her ability to communicate effectively with the legislators was a key to getting several members of the Michigan congressional delegation to co-sponsor ADA legislative initiatives. In addition to the above, Dr. Jones recently served as the MDA's Mission of Mercy (MOM) local chair. This was the first MOM that the MDA conducted and it was a great success due in part to the hard work of Dr. Jones. The MOM served over 1,100 individuals and provided almost \$1 million in care to the underserved. Dr. Jones would be an excellent addition to the Council on Access, Prevention and Interprofessional Relations.

*Nunokawa, Neil C., Hawaii, 2017.* Dr. Neil Nunokawa is a former member to the Council on Membership (2005-09). He fully fulfills both the general eligibility and time commitment requirements. Dr. Nunokawa has served as president-elect and president of the Hawaii Dental Association twice (1998-99 and 2011-12). He has been involved legislatively in carrying out his leadership duties and has engaged in discussions with non-dentists regarding dental care of the underserved. He presently serves as the co-chair of the Maui Oral Health Task Force, an organization composed of advocacy groups and representatives of community clinics dedicated to the promotion of oral health among all sectors of the population of Maui, especially the underserved. Dr. Neil C. Nunokawa would be a definite asset to CAPIR.

*Pankratz, Todd; Hastings, M.D., Nebraska, 2014.* Dr. Pankratz is a partner with OB/GYN Associates in Hastings, Nebraska. He is a graduate of Hastings College, the University of Nebraska-College of Medicine, and completed his residency at Truman and St. Lukes's Hospitals in Kansas City, Missouri, where he served as chief resident.

Todd has served in numerous leadership roles in the medical community. Within the Nebraska Medical Association (NMA) his leadership positions include serving as a trustee, president of the Greater NE Caucus, the legislative committee, the maternal child health committee, and the Medicaid committee. He was also a director with the Nebraska Medical Insurance Services. Todd has been also been active within the Mary Lanning Memorial Hospital medical staff including chairing the credentials committee, chairing OB/pediatrics committee, and the executive committee. Todd is a member of the American College of Obstetricians and Gynecologists and serves as a Nebraska state officer. He has also been a delegate for the Young Physician's Society of the AMA. Dr. Pankratz has been recognized with numerous honors with the most prestigious one being the AMA's Foundation Leadership Award. Todd resides in Hastings, Nebraska with his wife, Jessica Meeske, a pediatric dentist and their two children. He is active within the community including serving as a director on the board of Five Points Bank and an advisor to Energy Pioneer Solutions. He enjoys watching Nebraska Husker games, coaching his daughter's basketball team, helping out with church youth, collecting wine, and following his kids' activities.

*Peckosh, Valerie B., Iowa, 2017.* Dr. Valerie Peckosh is a pedodontist in private practice in Dubuque since 1999. After graduation from Oregon School of Dental Medicine in 1993, Dr. Peckosh served in the USPHS, Indian Health Service at Pine Ridge Indian Reservation in South Dakota until 1997. She then completed her pediatric dental residency at Lutheran Medical Center in 1999. Dr. Peckosh has extensive background and passion in working in public health. She has a very diverse population in her practice and sees a large percentage of Medicaid patients including special needs adults. Her entire career, Dr. Peckosh has been involved in organized dentistry and very concerned with the issues of access to care and their impact on the public as well as the future of our profession. Dr. Peckosh believes with the future

1 changes in our healthcare system, our profession will face many challenges preserving the integrity of our  
2 profession. She is very concerned that the philosophy of “some care is better than no care” will take root  
3 in dentistry and those who will be hurt the most are the ones who cannot help themselves, children and  
4 the special needs population. Dentistry’s message of prevention and education must always be in the  
5 forefront of any of these conversations. Dr. Peckosh would like to be involved in CAPIR’s process of  
6 evaluating these issues and others that come before the Council, and be positioned to contribute to the  
7 recommendations and policies created.

8 *Soderstrom, Andrew P., California, 2017.* Dr. Andrew Soderstrom is a pediatric dentist from the California  
9 central valley, currently completing Dr. Brian Scott’s original term on CAPIR. Dr. Soderstrom strongly  
10 believes that prevention is the cornerstone of a successful pediatric dental practice, and strives to  
11 [provide] a realistic strategy to motivate the caregiver and patient to maintain good oral health through  
12 good communication (listening and presenting) skills. He will be able to provide leadership at CAPIR as  
13 the ADA develops their plan to advance the public awareness regarding the benefits of good oral health.  
14 He understands that while access issues tend to bring up connotations of children’s needs there are other  
15 groups (persons with special needs, the elderly and indigent adults) who also experience barriers to oral  
16 health care. His experience in leadership as CDA developed the “Phased Strategies” report has provided  
17 him with the insight into this complex issue. Leading the first CDA Cares event in Modesto and working in  
18 an FQHC has given him the real world insight into the access issue. This background will be beneficial as  
19 the ADA develops its strategy to address access from a national perspective.

20 Dr. Soderstrom’s pragmatic approach to dealing with complex or emotionally charged issues is an asset.  
21 As a servant-leader, he has always tried to be the voice of reason and foster collaboration when facing  
22 challenges, regardless of his personal opinion. As someone who values the facts, appreciates divergent  
23 views and supports consensus building, he will be a valuable asset to the CAPIR team.

#### 24 **ADA SESSIONS**

25 *Foy, Charles B., Jr., Louisiana, 2017.* Dr. Charles Foy is a practicing general dentist in Madisonville,  
26 Louisiana. He has held numerous positions in his local component and on the state level. He is past  
27 president of the Louisiana Dental Association (LDA). Dr. Foy has served on the LDA Council on Annual  
28 Sessions as Chairman and Exhibits Chairman. He is a Fellow of the Pierre Fauchard Academy, the  
29 International College of Dentists and the American College of Dentists. Dr. Foy will make an excellent  
30 member of the Council on ADA Sessions.

31 *Fulton, David J., Jr., Illinois, 2017.* Dr. David J. Fulton, Jr. has been a part of organized dentistry since his  
32 graduation from Dental School in 1987. For decades now he has experienced a whole host of various  
33 roles of service opportunities within the Illinois State Dental Society and the Chicago Dental Society  
34 (CDS). He has performed those vast and diverse roles in an exemplary manner and has been a truly  
35 extraordinary volunteer member-dentist. He is currently the president of the Chicago Dental Society. His  
36 work with all aspects of the Chicago Dental Society’s Midwinter Dental Meeting is nothing short of  
37 remarkable to say the least. His experiences and talents even encompass his being the very first  
38 individual in the CDS to set up and conduct a full virtual reality dental meeting, with a whole complement  
39 of program speakers and comprehensive array of exhibitors as well. In fact, he may have been the very  
40 first individual (dentist) in the nation to accomplish this remarkable achievement.

41 Dr. Fulton is a very bright, well-organized, knowledgeable and committed individual. He is a general  
42 dentist and shares a dental practice with his father, Dr. David J. Fulton, Sr., who was once also quite  
43 active in organized dentistry and, as a matter of fact, several years back served a four-year term on the  
44 ADA Council on Annual Sessions (now the Council on ADA Sessions). Both Dr. Fulton, Sr. and Dr.  
45 Fulton, Jr. have rather consummate dental service histories, each in their own right.

46 Dr. David J. Fulton, Jr. would serve in an exemplary manner and would most definitely be of tremendous  
47 value as a member volunteer-dentist on the Council on ADA Sessions.



1 *La Morte, Gregory, New Jersey, 2017.* Dr. Gregory La Morte is a past president of the Essex County  
2 Dental Society (ECDS). He presently is the vice president of the New Jersey Dental Association (NJDA)  
3 and has served as treasurer of NJDA and been both a trustee to the NJDA Board of Trustees and a  
4 Delegate to the NJDA House of Delegates for many years. Dr. La Morte has served on numerous  
5 councils and committees of the ECDS and the NJDA. He is a Fellow in the American College of Dentists.  
6 He presently is serving a second term as chair of the New Jersey section of the American College of  
7 Dentists. He is a past president of the Pierre Fauchard Society of New Jersey. Dr. La Morte served two  
8 terms on NJDA's Annual Sessions Council for a total of eight years. While his activities in organized  
9 dentistry are too numerous to list here, he has also found time to maintain an active role in his  
10 community. He has held numerous positions with the Boy Scouts of America and serves on the  
11 executive board of the Northern New Jersey Council of the Boy Scouts of America. Dr. La Morte's many  
12 years of experience at all levels of organized dentistry and his eight years of hands on experience serving  
13 on NJDA's Council on Annual Sessions make him an exceptional candidate for the Council on ADA  
14 Sessions.

15 *Wyckoff, Douglas A., Missouri, 2017.* Dr. Douglas Wyckoff graduated from the University of Missouri –  
16 Kansas City School of Dentistry in 1992. He has been extremely active in organized dentistry for his  
17 entire career. He has served organized dentistry in several capacities on all three levels of the tripartite.  
18 Dr. Wyckoff will serve the Council on ADA Sessions well, having gained experience as a member of  
19 several councils and committees including the ADA New Dentist Committee. He is in private practice in  
20 his home town of Cameron, Missouri.

## 21 **COMMUNICATIONS**

22 *Herre, Craig W., Kansas, 2017.* Dr. Herre is a practicing general dentist in Leawood, Kansas. He has  
23 served in many positions in his home district as well as secretary, treasurer and president of Kansas  
24 Dental Association. He is a Fellow of the American College of Dentistry. Dr. Herre has presented many  
25 seminars from marketing your dentistry to orofacial bioesthetic dentistry. He will make an excellent  
26 member of the Council on Communications.

27 *Hight, James, Jr., Tennessee, 2017.* Dr. James Hight graduated from the University of Tennessee  
28 College of Dentistry in 1978 where he also received his Masters in Orthodontics in 1980. He has had a  
29 distinguished career serving organized dentistry at all three levels of the tripartite. His accomplishments  
30 include serving as the president of the Tennessee Association of Orthodontists and serving on the Board  
31 of Trustees of the Tennessee Dental Association. His expertise in communications is evident in the  
32 lectures he has been invited to deliver. Dr. Hight practices orthodontics in Jackson, Tennessee.

33 *Malon, Carolyn J., Connecticut, 2017.* Dr. Carolyn Malon is the immediate past president of the  
34 Connecticut State Dental Association (CSDA). She has had active roles in government affairs and  
35 governance reform. She has helped the CSDA achieve the confidence of the Connecticut Legislature and  
36 has worked in their MOM's projects. Dr. Malon will bring a voice of reason and thoughtfulness to the  
37 council.

38 *Tauberg, James A.H., Pennsylvania, 2017.* Dr. James Tauberg owns an oral surgery practice and is very  
39 involved in both Pennsylvania Dental Association and American Association of Oral and Maxillofacial  
40 Surgeons. He has excellent communication skills and teaching experience.

## 41 **DENTAL ACCREDITATION**

42 *Blanton, Patricia L., Texas, 2017.* Dr. Patricia Blanton is the immediate past vice president of the  
43 American Dental Association. She has served as president of the Texas Dental Association (TDA), and  
44 the American College of Dentists. She is Professor Emeritus of the Department of Anatomy at Baylor  
45 College of Dentistry. As a full time faculty member, she was heavily involved in both the undergraduate  
46 and graduate curriculums. She has served as a consultant to the US Army and the TDA Council on  
47 Dental Education, Trade and Ancillaries Ancillary. She has also served on the ADA Council on Scientific

1 Affairs. She has over 100 scientific publications. From 2007 to 2008, Dr. Blanton served on the ADA  
2 Presidential Task Force on CODA giving her inside knowledge of how CODA worked. Based on her  
3 academic history and her close association with CODA she would serve the ADA well as the ADA  
4 member on CODA.

## 5 **DENTAL BENEFIT PROGRAMS**

6  
7 *Eder, B. Scott, West Virginia, 2017.* Dr. B. Scott Eder is a graduate of West Virginia University School of  
8 Dentistry. He established his practice in 1991, after having worked as an associate dentist in a local  
9 practice and as a staff dentist in a rural dental clinic. Dr. Eder has been an involved member of the West  
10 Virginia Dental Association since 1988, and has served on the executive council since 2004. In 2009, he  
11 was inducted into the International College of Dentistry. Dr. Scott is the current president of the Kanawha  
12 Valley Dental Association, co-chair of the West Virginia Oral Health Coalition, and an appointed member  
13 of the Kanawha County Patient Protection and Affordable Care Act (PPACA) Task Force and a rural  
14 committee for development of safety net clinics. He is a regular volunteer at the West Virginia Health Rite  
15 Dental Clinic and is an annual volunteer (this year's chairperson) at the local Give Kids A Smile event.

16 *Gordon, Douglas J., California, 2017.* Dr. Douglas Gordon is a very motivated leader who is passionate  
17 about the third party payer and governmental issues. He recognizes the value of the Council on Dental  
18 Benefits as the profession's key ADA conduit in code maintenance and modification. His passion for  
19 preserving the quality of care for our patients and the quality of life for new dentist is his focus. He  
20 believes that these issues tie directly to member service and value, predicting that ADA market share can  
21 increase if the ADA is successful in addressing these issues.

22 His experience includes eight years of serving on his component Peer Review Committee and being  
23 Ethics Chair, which will be useful in the Council's role of overseeing quality of care by dentist throughout  
24 the nation. His public speaking experience will be an asset as the Council is charged with peer review  
25 education. His additional experience serving as California Dental Association Trustee, and as a member  
26 of multiple committees, provides depth of knowledge of California dental issues. He also serves on the  
27 Western Regional Examination Board (WREB): traveling the nation, meeting and interacting with dentists  
28 and students, many of whom are just entering the profession. This cements his commitment and sense  
29 of responsibility to protect the profession for our newer colleagues. He has strong interpersonal skills,  
30 allowing him to identify common ground, be congenial, and most critically to be effective in consensus  
31 building.

32 *Hill, Steven J., Texas, 2017.* Dr. Steven Hill is an individual with high morals and ethics. He has served  
33 organized dentistry since the mid-90's and currently serves Texas as a second year member of the Texas  
34 Dental Association Board of Directors. He has an understanding of dental benefits and the significance of  
35 Medicaid and other insurance programs. He is a founding member of the "South Plain's Dental District  
36 Society" Employees Benefit trust which is a medical insurance program for West Texas dentists only and  
37 this gives him the needed knowledge and experience with insurance plans that will benefit the Council  
38 very much.

39 *Riggins, Ronald D., Illinois, 2017.* Within the Illinois State Dental Society (ISDS) membership, there are  
40 very few individual who are as knowledgeable, talented, committed and eager to serve as is Dr. Ronald  
41 Riggins. From his military service years and on into his transition to private dental practice, Dr. Riggins  
42 has been an outstanding example of what is good and correct about the dental profession and the level of  
43 care being provided to the citizens of this nation. Dr. Riggins is an active participant in organized  
44 dentistry and he excels in all aspects of it, as he has clearly demonstrated, time and again, with every  
45 task he has undertaken. He presently serves on the ISDS Oral Health Advisory Board and has chaired  
46 the ISDS Committee on Insurance for a good many years. In addition to these areas of service, he also  
47 has wide-ranging experience in quality assurance oversight and infection control expertise. Dr. Riggins  
48 has a strong interest in and commanding background relative to dental benefit matters. Indeed, his two  
49 years of experience on the Council already in completing the term of Dr. Tom Machnowski has  
50 undoubtedly galvanized his experience, understanding, expertise and preparedness for an uncertain

1 future. Dr. Riggins will make his next four years on CDBP successful beyond anyone's expectation. As  
2 the Eighth District's representative to the Council on Dental Benefit Programs, he has demonstrated time  
3 and again that he brings a unique and thoughtful perspective.

#### 4 **DENTAL PRACTICE**

5 *Cammarata, Rita M., Texas, 2017.* Dr. Cammarata currently serves as vice president on the Texas  
6 Dental Association Board of Directors. She has been involved in organized dentistry for many years.  
7 She is an individual with high morals and ethics. Dr. Cammarata was a hygienist prior to becoming a  
8 dentist and then specializing in pediatric dentistry. This pathway has given her the necessary experience  
9 in practice management. As a pediatric dentist she is very much interested in the electronic health record  
10 and will play an important role in working with this. She understands collaboration and will be a willing  
11 partner in working with other groups. She certainly represents all the other criteria needed as a member  
12 of this Council.

13  
14 *Mazur-Kary, Michelle L., Maine. 2017.* Dr. Michelle Mazur-Kary is the immediate past president of the  
15 Maine Dental Association. She practiced general dentistry for a number of years before returning to  
16 Harvard to get her certificate in Endodontics and an M.P.H.

17 *Landes, Christine M., Pennsylvania, 2017.* Dr. Christine Landes' credentials are impressive and they  
18 show how well qualified she is to provide the highest level of care. She is a graduate of the University of  
19 Pennsylvania School of Dental Medicine and she completed her specialty training at Albert Einstein  
20 College of Medicine for Pediatrics in New York. A past president of the Montgomery Bucks Dental  
21 Society, Dr. Landes is an active member of many professional groups, including the American Dental  
22 Association, the American Academy of Pediatric Dentistry and Pennsylvania Dental Association. She  
23 remains a member of the University of Pennsylvania Alumni Association, and the Second District Dental  
24 Society of the Pennsylvania Dental Association. Dr. Landes' commitment to the community started when  
25 she was a member of Psi Omega Fraternity. Dr. Landes has been recognized by her fellow dentists for  
26 her services to the profession. She has been a delegate and alternate delegate to the Pennsylvania  
27 Dental Association (2000 to present), the Chair of National Children's Dental Health Month (1997-2011),  
28 and elected to the International College of Dentists (2004). Dr. Landes has held the position of president  
29 and secretary to the Dental Society of Montgomery-Banks. She has been named one of America's Top  
30 Dentists from 2005 to the present. In addition, Dr. Landes is a National Speaker for Child Abuse  
31 Awareness and Protection.

32 *O'Toole, Terry G., Federal Dental Services, 2017.* Dr. Terry O'Toole graduated from the University of  
33 Missouri School of Dentistry in 1981 and went on to receive his certificate in General Practice Dentistry  
34 from the Veteran Affairs Medical Center in San Diego in 1982. His undergraduate degree was in  
35 business administration. As director, Dental Informatics and Analytics, he serves as a member of the  
36 Office of Dentistry primary leadership triad tasked with the development of strategic plans and  
37 implementation of national policy initiatives that govern the provision of dental care within the VA. He  
38 also serves as the VA's lead subject matter expert for electronic dental records/decision support systems  
39 to industry and other governmental organizations. His responsibilities include the continued  
40 development, implementation and maintenance of the VA's clinical dental electronic health record used at  
41 200+ sites in over 7,000 patient encounters daily. He is directly accountable for developing and  
42 maintaining accurate clinical reporting and business analytics systems. Dr. O'Toole's unique expertise in  
43 the area of dental informatics should be a valuable asset to the Council on Dental Practice as the  
44 Association continues to expand its efforts with regards to the electronic health record and continues to  
45 help educate its members in this area.

#### 46 **EDUCATION AND LICENSURE**

47 *Price, Jill M., Oregon, 2017.* Dr. Jill Price has been in private practice since 1993 in Portland, Oregon.  
48 She has been president of the Oregon Dental Association (ODA) and the speaker of the ODA House of  
49 Delegates. She has been a member of the Oregon Health and Science University (OHSU) Foundation

1 Board of Trustees, OHSU Alumni Board President, as well as a member of the search committee for the  
2 new dean at OHSU. She is a Fellow of the International and American College of Dentists and Pierre  
3 Fauchard Academy. She has been a part time clinical faculty at OHSU, and involved in many of the  
4 recent efforts to generate support for the expanded new dental school at OHSU. She has demonstrated  
5 a high level of professional service, first as a dental student leader at OHSU and then as a practicing  
6 dentist who has contributed to her community, state association and to multiple aspects of dental  
7 education efforts in Oregon.

8 *Raman, Prabu, Missouri, 2017.* Dr. Prabu Raman is a 1983 graduate of the University of Missouri  
9 Kansas City School of Dentistry. He has been very active in both academics and organized dentistry for  
10 his entire career. He is a Fellow of the American College of Dentistry and of the Pierre Fauchard  
11 Academy. He attained Fellowship in the International College of Cranio Mandibular Orthopedics in 2002  
12 and attained Master status in 2007. He is an accomplished speaker and has been published several  
13 times. Dr. Raman is in private practice in Kansas City, Missouri, where he concentrates on the treatment  
14 of headache and jaw pain.

#### 15 **ETHICS, BYLAWS AND JUDICIAL AFFAIRS**

16 *Edwards, Adam A., New York, 2017.* Dr. Adam Edwards is a proven leader in organized dentistry who is  
17 very much dedicated to his profession as well as being a very active community leader. He is  
18 knowledgeable, organized and a team player. He would be an asset to the Council on Ethics, Bylaws  
19 and Judicial Affairs. Some credentials include:

- 20 • Current Chairman of the New York State Dental Association (NYSDA) Council on Ethics;
- 21 • Council Chairman of the NYSDA Council on Ethics, 2009-10;
- 22 • Member, NYSDA Council on Ethics, 2001 to present;
- 23 • Hearing Officer, NYSDA Council on Ethics, 2007-08 and 2011-13;
- 24 • Chairman of the NYSDA – Third District Ethics Committee, 2002 to present;
- 25 • Fellow of the American College of Dentists;
- 26 • Delegate of the NYSDA House of Delegates, 2010 to present;
- 27 • Served on reference committees for the NYSDA House of Delegates; and
- 28 • Recipient of the William B. Smith Award “for continued involvement in organized dentistry,  
29 continuing education, and display of the highest ethical standards” – September 2011.

30 *Halasz, Michael H., Ohio, 2017.* Dr. Michael Halasz is a general dentist in private practice in Kettering,  
31 Ohio. At the American Dental Association, he has been a member of the ADA House of Delegates since  
32 2005 and currently serves as the District Seven Caucus Chair. He recently served on the Association’s  
33 Task Force on Governance, and is a past member of the Council on Dental Practice (2007-11), past chair  
34 of the subcommittee on economic issues, and past member of the subcommittee on green dentistry.

35 At the Ohio Dental Association, he currently serves as the Speaker of the House of Delegates and has  
36 served in this capacity since 2010. Prior to that, he served as the vice speaker of the House of Delegates  
37 since 2004. He also currently serves as the parliamentarian for the executive committee; and serves as a  
38 member of the Ad Interim Committee, ADA Leadership Nomination Committee, Credentials, Rules and  
39 Order Committee, Ethics and Judicial Affairs Committee, Strategic Planning Committee, and Task Force  
40 on Auxiliary Utilization and Access to Care. He has served as the chair of the Council on Dental Care  
41 Programs and Dental Practice; and as a member of the Finance Committee, Sub-council on New  
42 Dentists, Task Force on Governance, Ohio Dental Political Action Committee (ODPAC), and various  
43 reference committees.

44 Dr. Halasz is past president of the Dayton Dental Society and currently serves as the society’s  
45 parliamentarian and is a member of the Constitution and Bylaws Committee. Additionally, he served as  
46 the chair of the society’s Annual Clinic Meeting Committee and Past-Presidents’ Nominating Committee;  
47 and as a member of the Budget Committee, Long-Range Planning Committee, Program Committee and  
48 United Way Committee.

1 *Merritt, Kennedy W., New Mexico, 2017.* Dr. Kennedy Merritt has been a general practice dentist for 35  
2 years in Clovis, New Mexico. He has been involved at every level of the tripartite of organized dentistry.  
3 He has served 12 years on the New Mexico Board of Dentistry where he was charged with the writing of  
4 the state's By-Laws and Rules and Regulation for Dentistry/Dental Hygiene/Dental Assistant practice. He  
5 has been through all the chairs of the local, district and state dental associations. He is a delegate for  
6 New Mexico to the American Dental Association since 2002. He has served on two reference committees  
7 for the ADA. His latest project is the development of a Health and Well-Being Dentist program for the  
8 New Mexico Dental Association. He is committed to sharing appropriate Council information with the  
9 district membership and has been involved in and a proponent of the electronic communications in his  
10 office, local hospital medical staff membership, NMDA and the ADA. He is willing to serve on an ADA  
11 Council on Ethics, Bylaws and Judicial Affairs and is committed to meeting schedules and sub-committee  
12 assignments as necessary.

13 *Shekitka, Robert A., New Jersey, 2017.* Dr. Robert Shekitka is a past president of both the Essex County  
14 Dental Association and the New Jersey Dental Association. He has served on numerous councils and  
15 committees on both the state and component level. Dr. Shekitka is a Fellow in the International and  
16 American Colleges of Dentistry (ACD) and recently finished his term as Regent for the ACD. Dr. Shekitka  
17 has taught dental hygiene on a part-time basis for many years and recently retired from a full-time  
18 practice of general dentistry to become a full-time faculty member at the New Jersey Dental School now  
19 named Rutgers University College of Dentistry. Dr. Shekitka is an exceptional candidate for the Council  
20 on Ethics, Bylaws and Judicial Affairs in that he has devoted close 20 years developing curriculum and  
21 teaching ethics education to dental students and dentists alike. His enthusiasm and excellent  
22 communication skills will serve him well as I am certain he will be an engaged member of this Council.

### 23 **GOVERNMENT AFFAIRS**

24 *Bronson, Mark E., Ohio, 2017.* Dr. Mark Bronson is a general dentist in private practice in Cincinnati,  
25 Ohio. At the American Dental Association, he has been a member of the ADA House of Delegates since  
26 2004 and has served as the chair one time and as a member two times on the Reference Committee on  
27 Dental Benefits, Practice and Health. He also recently served on the ADA's Task Force on Governance.  
28 He currently serves as an ADA Action Team Leader for Senator Sherrod Brown and has regularly  
29 attended the Washington Leadership Conference since 2008.

30 At the Ohio Dental Association, Dr. Bronson is currently serving as the immediate past president, as the  
31 secretary to Ohio Dental Political Action Committee (ODPAC), as a member of the ODA's for-profit  
32 subsidiary, the Ohio Dental Association Services Corporation (ODASC), and as a member of the Task  
33 Force on Auxiliary Utilization and Access to Care. Previously, he has served as the chair of the Ad  
34 Interim Committee, ADA Leadership Nomination Committee, Council on Dental Care Programs and  
35 Dental Practice, Strategic Planning Committee, and Reference Committee on Dental Services and  
36 Governmental Affairs; and has served as a member of the Credentials, Rules and Order Committee,  
37 Ethics and Judicial Affairs Committee, Finance Committee and Governance Task Force.

38 He is a past president of the Cincinnati Dental Society and currently serves on the Society's Board of  
39 Trustees, Finance Committee Honors Committee and Investment Committee. Additionally, he has also  
40 served as the chair of the Cincinnati Dental Society's Children's Dental Health Committee, and Public  
41 Relation Committee; and as a member of the Membership Committee, Nomination Committee, and  
42 Program Committee.

43 *Cobb, Regina E., Arizona, 2017.* Dr. Regina Cobb is a practicing dentist in good standing with the ADA.  
44 She was president of the Arizona Dental Association from 2008 to 2009 and has been the chair of the  
45 Council on Government Affairs since 2009. Regina has been an ADA Delegate or Alternate for several  
46 years as well as an action team leader for the Washington Leadership Conference. She has served as a  
47 legislative liaison for the Kingman Area Chamber of Commerce for the last two years. She has also been  
48 a volunteer staff member for Congressman Paul Gosar since 2010. Dr. Cobb has a very strong

1 background and knowledge of the legislative process and would be a strong member for the Council on  
2 Government Affairs.

3 *Incalcaterra, Charles J., Pennsylvania, 2017.* Dr. Charles Incalcaterra qualifications include:

- 4 • Delegate to the Pennsylvania Dental Association (PDA), 1993-94, 1998, and 2011-13;
- 5 • Served on Government Relations Committee, PDA, 1997-2000;
- 6 • President, Lehigh Valley Dental Society, 2012-13;
- 7 • President, Second District Valley Forge Dental Association (Pennsylvania), 2012-13;
- 8 • Attended PDA's "Day on the Hill," 2012 and 2013; and
- 9 • Appointed Site Visitor for CODA, July 2013.

10 *Morrison, Scott L., Nebraska, 2017.* Dr. Morrison is in private practice specializing in periodontics in  
11 Omaha. He has been involved in organized dentistry since beginning his practice in 1991 and has a very  
12 strong background in the legislative process. Dr. Morrison has served as the Nebraska Dental  
13 Association Legislative Council Chairperson since 1997. During his leadership, the council introduced  
14 legislation dealing with community water fluoridation, legislation that was vetoed by the Governor and  
15 subsequently overridden through a grassroots effort. Dr. Morrison and the council also addressed  
16 legislation on the private practice of dental hygiene, licensure and expanded scope of practice  
17 opportunities for dental hygienists and dental assistants. Through his attendance at the ADA Grassroots  
18 Leadership and Lobbyist Conferences in Washington DC, Dr. Morrison has gained knowledge of the  
19 Association's policies and application to existing legislation. Dr. Morrison has a working relationship with  
20 ADPAC having had the opportunity to present funding various political candidates. He has excellent  
21 communication skills and will be able to develop relationships with members of congress as he works for  
22 the future of dentistry as a member of the Council on Government Affairs.

## 23 MEMBERSHIP

24 *Durbin, Michael G., Illinois, 2017.* The number of members within the Chicago Dental Society (CDS) a  
25 component of the Illinois State Dental Society (ISDS) is arguably larger than the membership numbers for  
26 many state dental associations and societies. While that is certainly an impressive fact, in terms of the  
27 sheer number of persons involved, it can present challenges to the huge numbers of gifted individuals  
28 within a large dental society who are eager to serve the society (on the component, state or national  
29 levels) as volunteers. After all, there are only a given number of opportunities. An individual who has  
30 demonstrated absolutely remarkable skill relative to organized dentistry matters, who has exhibited a  
31 dedication second to no one, and who has never shied away from any task, regardless of the difficulty or  
32 commitment, is Dr. Michael Durbin. Indeed, there are scarce individuals who are as well-informed,  
33 brilliant, devoted and enthusiastic to serve as is Dr. Durbin. Throughout dental school, during specialty  
34 training (Orthodontics) and now in private practice, Dr. Durbin has set the benchmark exceedingly high.  
35 His exemplary service, both as an orthodontist and organized dental leader are inspirational and well-  
36 recognized. Dr. Durbin is an active participant in CDS, ISDS, and ADA responsibilities, as well as with his  
37 specialty group He has taken his service in all the officer roles with the CDS Members Group seriously  
38 and has made meaningful strides to grow the membership. He excels in whatever capacity he  
39 undertakes. He currently serves on the ISDS Board of Trustees and chairs its Finance Committee. He  
40 also currently serves as a Trustee with the Illinois Society of Orthodontics. In addition to these areas of  
41 service, he also has comprehensive experience with the various aspects of running the CDS Annual Mid-  
42 Winter Meeting, Member Concerns and Sponsorship issues. His areas of expertise on the vast array of  
43 pertinent dental matters are measureless. Dr. Durbin has a strong interest in, a unique sensitivity for and  
44 a masterful background relative to membership matters. He quickly adjusted to the Council on  
45 Membership when in 2011 he assumed the duties as the Eighth District representative to the Council  
46 when he stepped up to finish the term relinquished by Dr. Ken Yonan. Dr. Durbin become fully effective  
47 as the Eighth District's representative to the Council on Membership within weeks of his appointment.  
48 Should his reappointment be successful, his service performance will most definitely exceed that of these  
49 past two years.

1 *Jones, Gary O., Arizona, 2017.* Dr. Gary Jones served as president and on the Board of the Arizona  
2 Dental Association. He also served as president of the Central Arizona Dental Society. While serving in  
3 these leadership positions, membership was an important priority to him. He presented to his district  
4 resolutions dealing with membership that have been adopted by the ADA House of Delegates.

5 *Maranga, Maria C, New York, 2017.* Dr. Maria Maranga is one of the most enthusiastic and energetic  
6 people I have ever known. She is a well-focused, creative, and a motivating individual. She will bring a  
7 wealth of knowledge and experience to the table. Some of her many accomplishments include:

- 8 • Chair of the New York State Dental Association (NYSDA) Council on Membership, 2012  
9 to present;
- 10 • President, New York State Dental Association of Endodontics, 2011-13;
- 11 • Voted one of the Top 50 Most Influential Women of Long Island by the Long Island Business  
12 News, 2012;
- 13 • Recipient of the Hallmark of Excellence Award from New York State Dental Association, 2010;
- 14 • Member of the ADA Diversity Institute – Class of 2012-13;
- 15 • Female Mentorship Group, Stony Brook School of Dental Medicine, 2011 to present; and
- 16 • President, Suffolk County Dental Society, 2011.

17 *Smith, Carmen P., Texas, 2017.* Dr. Carmen Smith has been involved in organized dentistry ever since  
18 she graduated from dental school. She has served on a number of committees for the Dallas County  
19 Dental Society including Membership, Finance, and is currently vice chair-elect of the Southwest Dental  
20 Conference on a path to be president of the Dallas County Dental Society. Dr. Smith will play an  
21 important role in her position in helping the Council with its recruitment and retention of new and current  
22 members.

### 23 **MEMBERS INSURANCE AND RETIREMENT PROGRAMS**

24 *Coleman, J. Preston, Texas, 2017.* Dr. J. Preston Coleman is a past president of the Texas Dental  
25 Association (TDA) and prior to that served as treasurer of the TDA and also on the Audit Committee. He  
26 understands finance and was heavily involved with decisions made concerning all the TDA's finances.

27 *Ferguson, Larry J., South Carolina, 2017.* Dr. Larry Ferguson has been in private practice in Charleston,  
28 South Carolina since 1980. He graduated from The Citadel Military College of South Carolina in 1973  
29 and from the MUSC College of Dental Medicine in 1979. He has distinguished himself at all levels of the  
30 tripartite serving as the first African-American president of the South Carolina Dental Association, 2006-  
31 07. He is a past member of the ADA Charitable Relief Commission and the ADA Foundation Board as  
32 well as the Medical University of South Carolina Foundation Board. He currently serves as a Board  
33 member for South Carolina for Delta Dental of Missouri Insurance Company and has previously served as  
34 a member of the Insurance Council of the South Carolina Dental Association. Dr. Ferguson has received  
35 numerous community and service awards including an Honorary Doctorate from the Gulf Coast  
36 Theological Seminary and The Citadel Man of the Year Award. He will bring incredible insight and  
37 knowledge to the Council and will be an invaluable asset.

38 *Kincheloe, Bradley B., Wyoming, 2017.* Dr. Bradley Kincheloe has been actively involved in reviewing  
39 401K retirement plans for employees and investment planning as part of annual budget planning while  
40 serving on the Laramie County United Way Board and the Cheyenne Family YMCA Board. As a member  
41 of the Executive Board of the Wyoming Dental Association, he has been a member of the Budget,  
42 Internal Audit, and Finance Committee for the past three years. This past experience as well as being a  
43 small business owner has given him a familiarity with retirement savings options and terminology. His  
44 experience with group insurance would be limited to mostly "small business" type plans, but he feels  
45 comfortable with insurance terminology and discussion of other larger type plans.

46 *McLean, David E., Vermont, 2017.* Dr. David Mclean graduated from Indiana University School of  
47 Dentistry and has practiced in Vermont since 2000. The current President of the Vermont Dental Society,

1 he is active in Special Smiles and access to dental care issues. As a young dentist he brings a needed  
2 perspective to the council.

### 3 **NATIONAL DENTAL EXAMINATIONS**

4 *Murray, Rhett L., Colorado, 2017.* Dr. Rhett Murray is an experienced restorative clinician. He has been  
5 in practice since 1977 and has focused his interest to prosthodontics. Dr. Murray has been a clinical  
6 instructor at the University of Colorado School of Dentistry. In addition, for many years he has been a  
7 consultant to the Colorado State Board of Dental Examiners. He was also an examiner for the Central  
8 Regional Testing Service. He is the past president for the Colorado Dental Association and just  
9 completed his term as the co-chair for the American Dental Political Action Committee. Dr. Murray has  
10 been a delegate or alternate to the American Dental Association House of Delegates since 2000.

### 11 **NEW DENTIST COMMITTEE**

12 *Ishkanian, Emily R., Nevada, 2017.* Dr. Emily Ishkanian is a 2010 graduate of the University of Nevada,  
13 Las Vegas School of Dental Medicine and has served as the Southern Nevada New Dentist Chair for the  
14 past two years. After attending the New Dentist Conference in 2011, she gained a new perspective on  
15 the significance of the ADA. As a result, she has committee the last two years to creating a local new  
16 dentist organization in southern Nevada. Her goal has been to increase the involvement of new dentists  
17 in organized dentistry and ease the transition of dental students from dental school to practice. In two  
18 years, the Southern Nevada New Dentists have grown to sixty members that comprise new dentists as  
19 well as dental students. Some of their accomplishments include: a continuing education series  
20 specifically designed to meet the needs of new dentists, volunteer opportunities (Give Kids A Smile and  
21 lunch for senior dental students during their board examinations), conversion of senior ASDA graduates  
22 to ADA members, and social events. The diversity of the group is broad as they seek members serving in  
23 military and government positions, UNLV faculty, senior dental students, residency programs (UNLV  
24 GPR, Nellis Air Force Base GPR, and UNLV Pediatric and Orthodontic residency programs) as well as  
25 corporate and private practice dentists.

26 *McMahon, Jill C., Illinois, 2017.* Dr. Jill McMahon is the current chair of the Illinois State Dental Society  
27 (ISDS) Committee on the New Dentist. She is a 2007 graduate of the Southern Illinois University College  
28 of Dental Medicine. She has already had significant experience in private practice dentistry and now has  
29 established her own dental practice. Dr. McMahon is acutely aware of what issues and concerns  
30 presently impact the new dentists, as well as being first-hand familiar with the professional and small  
31 business matters that are so uniquely important for the younger dentists with many years of dental  
32 practice ahead of them. She presently serves as the ISDS New Dentist Committee Liaison to both the  
33 ISDS Committee on Membership and ISDS Committee on Governmental Affairs. Dr. McMahon brings a  
34 whole host of knowledge, talent, experience and dedication to the table.

35 *Norbo, Justin R., Virginia, 2017.* Dr. Justin Norbo graduated from Hampden-Sydney College in 2006 and  
36 Virginia Commonwealth University (VCU) School of Dentistry in 2010. Dr. Norbo has quickly become  
37 involved in leadership roles in organized dentistry. He is presently chairman of both the Northern Virginia  
38 Dental Society New Dentist Committee and the Virginia Dental Association (VDA) New Dentist  
39 Committee. Dr. Norbo serves as a contributor to the VCU School of Dentistry Strategic Plan. He also  
40 serves as secretary of the Virginia Academy of General Dentistry. In addition, as a student, he  
41 established the Student Professionalism and Ethics Association at VCU and served as a student delegate  
42 to the VDA in 2009. His enthusiasm for the profession of dentistry will be contagious as he serves on the  
43 New Dentist Committee.

44 *Zappia, Kendra J., New York, 2017.* Dr. Kendra Zappia is a very energetic and enthusiastic new dentist.  
45 I first met Dr. Zappia at a New Dentist Conference 2011 and was impressed with her participation at the  
46 meeting. She is a hand on individual actively working in both the local and the state level with new dentist  
47 programs. Some of Dr. Zappia's activities include:  
48



- 1 • Chair of the New York State Dental Association (NYSDA) New Dentist Committee, 2010 to  
2 present;
- 3 • Chair of the NYSDA – Third District Dental Society New Dentist Committee, March 2010 to  
4 present; and
- 5 • Recipient of numerous grants from the ADA Membership Programs for Growth (MPG).  
6

## 7 **SCIENTIFIC AFFAIRS**

8  
9 *Dmytryk, John J., Oklahoma.* Dr. John Dmytryk received his D.M.D., General Practice Residency, and  
10 Certificate in Periodontology from the University of Florida. He also received a Certificate in Forensic  
11 Dentistry from the Armed Forces Institute of Pathology, Washington, DC. He is currently Associate Dean  
12 for Academic Affairs and Professor of Periodontics at the University of Oklahoma College of Dentistry and  
13 also has a private Intramural Faculty Practice. Dr. Dmytryk is a faculty advisor to student research for the  
14 American Association for Dental Research (AADR) and a council representative for AADR. He is on the  
15 Editorial Review Committee for the Journal of the American Dental Association and the Archives of Oral  
16 Biology.  
17

18 His research interests include Control and Guidance of Tissue Cell Locomotion, particularly in relation to  
19 wound healing, regeneration and tumor biology. He has received grant funding from NIH, Presbyterian  
20 Health Foundation, and several other sponsors. He is the author or co-author of 16 papers in peer-  
21 reviewed journals and 36 abstracts and has presented at several local, national, and international  
22 scientific and clinical meetings. Dr. Dmytryk possesses all of the attributes needed to be a premier  
23 member of the Council on Scientific Affairs. His varied and well-rounded educational and practice  
24 experiences suit him well for this position.  
25

26 *Platt, Jeffrey A., Indiana.* Dr. Jeffrey Platt received his M.S. degree in Dental Materials from the Indiana  
27 University Graduate School. He has been an active researcher in his field for 20 years with a lengthy list  
28 of publications and presentations and has mentored multiple students as they have learned to apply the  
29 scientific method to their research pursuits and communication. He has co-authored systematic reviews,  
30 laboratory research primarily in the area of polymer-based materials, and presented to clinicians around  
31 the world. Recent collaborations have resulted in several publications related to the impact of pulp  
32 regeneration methodologies on dentin.  
33

34 As either the primary investigator, or co-investigator, Dr. Platt has conducted several clinical research  
35 projects including Class V adhesive studies to meet ADA acceptance criteria, a dentin desensitizer  
36 evaluation and a 3.5 year evaluation of the ability of caries detection devices to monitor caries under clear  
37 pit and fissure sealants in a high caries-risk population. After 16 years of full-time practice, he brought  
38 significant clinical knowledge and experience into his academic career. Dr. Platt is fully aware of the time  
39 commitment that is expected by participation on this Council. The Dean of Indiana University School of  
40 Dentistry has stated that he is supportive of this nomination and that whatever can be reasonably done to  
41 facilitate Dr. Platt's availability to serve in this manner will be done.  
42

43 The Dental Materials curriculum at Indiana includes an exploration of the national and international  
44 standards to guide the use of materials within the profession. The graduate curriculum includes a  
45 semester course that focuses on standard testing and methods. Dr. Platt has been part of a team that  
46 has taught that course for the past 13 years and has a solid basic understanding of the standards  
47 process.  
48

49 Dr. Platt has 42 peer-reviewed publications, over 65 research abstract presentations and over 50  
50 continuing education presentations that have been given locally, regionally, and internationally. He  
51 serves as the editor of the international peer-reviewed publication *Operative Dentistry*. His record clearly  
52 supports his ability to participate in scientific analysis and communication at a high level.  
53

54 *Slayton, Rebecca L., Washington.* Dr. Rebecca L. Slayton has recently been appointed Chair of the  
55 Department of Pediatric Dentistry at the University of Washington. Prior to the appointment she was

1 professor of Pediatric Dentistry at the University of Iowa. The Council on Scientific Affairs reviewed which  
2 skills based positions were needed on the CSA at their December 2012 Council meeting. Dr. Ed  
3 Truelove, the current vice chair of CSA has forwarded Dr. Slayton's name for consideration after the  
4 Council reviewed her credentials and supported her nomination. The Council would like a Pediatric  
5 dentist to replace Dr. Tim Wright, a Pediatric dentist and last year's CSA chair. Dr. Slayton has an  
6 advanced degree in genetics, and an engineering degree in addition to her dental degree and specialty  
7 certificate. Her research background and experience is extensive. Dr. Slayton's would serve in an  
8 exceptional way on behalf of the ADA and Council on Scientific Affairs.

9  
10 *Weyant, Robert J., Pennsylvania.* Dr. Robert Weyant received his B.S., M.S., and D.M.D. from the  
11 University of Pittsburgh. He received his Ph.D. in epidemiology from the University of Michigan. He is a  
12 consultant to the ADA's Center for Evidence Based Dentistry and a presenter at the ADA's Champion  
13 Conference from 2008 to 2013. He has chaired the ADA Professional Topical Fluoride Recommendation  
14 Review Panel and has also been an advisor to several councils at the ADA.

15  
16 He is Editor of the *Journal of Public Health*, a member of the Institute of Medicine and has been teaching  
17 at the University of Pittsburgh for the past 20 years where he chairs the Department of Public Health and  
18 holds the title of Associate Dean, Public Health and Outreach.

19  
20 He has been involved in public health, epidemiological, and clinical research throughout his entire career.  
21 During his time in the Navy he conducted research on population-based prevention programs and  
22 developed clinical quality assurance programs. While employed by the VA, Dr. Weyant conducted  
23 implant research and was also engaged in health services research on dental care delivery and clinical  
24 outcomes. His doctoral dissertation (Michigan) was on dental implant survival employing a national  
25 registry of dental implants that he developed for over 170 VA dental clinics nationally. He has been at  
26 The University of Pittsburgh for the last 22 years, where he has continually been engaged in NIH-funded  
27 research, including studies in geriatrics (osteoporosis, healthy aging), health disparities, genetics,  
28 orthodontics, and prevention, particularly as it applies to early childhood caries. In addition, he has been  
29 involved with development of ADA's workforce initiatives (Community Dental Health Coordinator).

30

1       **ADDENDUM TO REPORT 1 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:**  
2       **ADDITIONAL RESPONSES TO RESOLUTIONS FROM THE 2012 HOUSE OF DELEGATES**

3       *Resolution 74H-2012—Transition to an Electronic House of Delegates.* In accordance with Resolution  
4       74H (*Trans.*2012:407), effective with the 2013 House of Delegates, all materials for the meetings will be  
5       provided in an electronic format only, discontinuing the practice of printing and mailing worksheets and  
6       House related materials. The exceptions will be Reference Committee Agendas, which will be printed  
7       and made available in the reference committee hearing rooms, Reference Committee Reports which will  
8       be printed and distributed to each district caucus, and new business resolutions, which will be distributed  
9       at the House as well as being made available on ADA Connect.

10       The elimination of paper represents a significant shift in how the House conducts business. To help  
11       facilitate this transition, a communications plan for frequent and consistent messaging was put in place.  
12       In January, the ADA began implementing this plan by placing reminders in delegate certification materials  
13       and Leadership Updates, that effective 2013, all materials of the House of Delegates will be provided in  
14       an electronic format only, on ADA Connect and ADA.org (with the exception of Reference Committee  
15       Reports and Agendas). As of August, seven messages were placed in the Leadership Update; in May,  
16       the Executive Director emailed constituent executive directors to reinforce the importance of regularly  
17       checking ADA Connect for announcements and recommended setting “Alerts” to receive notifications  
18       when new material is posted on ADA Connect. In addition, access to ADA Connect was expanded to  
19       include key constituent staff identified by their respective executive directors in order to assist delegates  
20       with the transition from paper. Support and Resources for ADA Connect are posted online at  
21       <http://connect.ada.org/Pages/contactus.aspx>. Recommended support documents include: *ADA Connect*  
22       *User Guide, ADA Connect User Hardware and Software Requirements, Alerts Guide for Site Members,*  
23       *Create/Reset ADA Connect Password, and Zip and Download Selected Files.*

24       *Resolution 76H-2012—ADAMember.Net Email Forwarding Service.* Resolution 76H (*Trans.*2012:407)  
25       called for the discontinuation of the @ADAMember.net electronic mail forwarding service due to low  
26       utilization effective 90 days after the close of the 2012 House of Delegates meeting. Work began to  
27       discontinue this service in late January 2013. IT staff developed a project task list, which included  
28       identifying all email forwarding applications that resided on ADA.org. IT and Membership staff worked  
29       together to develop a plan to communicate the service discontinuation to existing users. The information  
30       was sent to users the week of February 11, 2013. Once all users had been contacted, the system was  
31       officially shut down in April.

32       Resolution 76H also directed that remaining funds from the 2011 Special Assessment for IT Infrastructure  
33       be returned to the 2012 IT budget and used to resolve open audit points for Hyperion and Payment Card  
34       Industry standard compliance. These funds were transferred to operating funds in 2012 as specified in  
35       the resolution.

36       *Resolution 88H-2012—Composition of the Election Commission.* In 2012, the House of Delegates  
37       adopted Resolution 88H (*Trans.*2012:413) that changed the composition of the Election Commission.  
38       The new composition included: Dr. Charles Norman, president-elect; Dr. William Calnon, immediate past  
39       president; Dr. Kevin Henner, chair, Council on Ethics, Bylaws and Judicial Affairs and Commission Chair;  
40       with Dr. Glen Hall (speaker of the House of Delegates) serving as consultant to the Commission. In  
41       November, the Commission met, via conference call, to review its duties, discuss the campaign  
42       guidelines and update a draft candidate agreement for the President-elect candidate’s review. In  
43       December the Commission met with the president-elect candidates via conference call to review the  
44       campaign agreement and address any questions the candidates had. Throughout the year the  
45       Commission responded to questions raised by the candidates and others and provided rulings when  
46       appropriate.

1     *Resolution 89H-2012—Guidelines Governing the Conduct of Campaigns for All ADA Offices.* In 2012,  
2 the House adopted Resolution 89H (*Trans.2012:417*) that rescinded existing Guidelines Governing the  
3 Conduct of Campaigns for All ADA Offices with a new set of Guidelines. The new Guidelines were added  
4 in the ADA publication, Current Policies; posted on ADA.org; and included in the 2013 Manual of the  
5 House of Delegates and Supplemental Information that is available electronically on ADA Connect and  
6 ADA.org. The Guidelines were distributed to members of the Board of Trustees and 2013 president-elect  
7 and second vice president candidates and to any member upon request.

8     *Resolutions 90H-2012 and 91H-2012—Term Limits for Delegates and Alternate Delegates.* These  
9 resolutions (*Trans.2012:412*) urged constituencies to implement term limits for ADA delegates and  
10 alternates delegates. These resolutions were included in the recent Current Policies update, a copy of  
11 which is available on ADA Connect. In the future these policies will be noted in communications  
12 regarding delegate and alternate delegate certification.

13     *Resolution 111H-2012—Establishment of an ADA Educational Program to Assist Senior Dental Students*  
14 *in the Analysis and Evaluation of Employment Contracts.* In this resolution (*Trans.2012:457*), the House  
15 of Delegates instructed the ADA to provide resources to assist members (especially senior dental and  
16 postgraduate students) contemplating contracts of employment. The Division of Legal Affairs (Division)  
17 worked with both the Council on Dental Practice and the New Dentist Committee to obtain from members  
18 representative dentist employment agreements, so the Division could identify key contract provisions that  
19 commonly appear in such agreements. The Division is in the process of finalizing an educational manual,  
20 titled “*Dentist Employment Agreements: A Guide to Key Legal Provisions.*” This manual will highlight and  
21 explain employment contract provisions to which the parties may wish to give particular attention, and  
22 discuss issues to consider when confronted with these provisions. When the drafting is completed, the  
23 Division will engage ADA Communications to provide design and branding for the publication. Once all  
24 steps have been completed, which is anticipated to occur by year end, the manual will be shared with the  
25 New Dentist Committee and posted on the Center for Professional Success website.

26     *Resolution 170H-2012—Regular Comprehensive Policy Review.* Resolution 170H (*Trans.2010:603;*  
27 *2012:370*) amended a previous resolution that directed the establishment of a policy review timetable and  
28 protocol. Resolution 170H changed the review timeline—from three to five years—and eliminated the  
29 need to ratify existing policies by presenting a resolution to the House listing policies to be maintained.  
30 Councils were informed of the change in the policy review through the Unofficial Actions of the 2012  
31 House of Delegates and in the 2013 instructions for annual and supplemental reports to the House.  
32 Agencies were also requested to identify in the reports to the House any policies that the Council  
33 reviewed that were being maintained. Agencies will continue their policy review, and will only submit for  
34 House action resolutions to either amend or rescind existing policies.

Resolution No. 67 New

Report: Board Report 1 Date Submitted: August 2013

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 Goal: \_\_\_\_\_ (Required)

**NOMINATIONS TO ADA COUNCILS AND COMMISSIONS**

**Background:** (See Page 1007 for qualification of nominees)

**ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS**

Shelly Fay Jones, Michigan  
Melanie S. Lang, AHA, Washington, D.C.  
Neil C. Nunokawa, Hawaii  
Todd A. Pankratz, M.D., AMA, Nebraska  
Valerie B. Peckosh, Iowa  
Andrew P. Soderstrom, California

**ADA SESSIONS**

Charles B. Foy, Jr., Louisiana  
David J. Fulton, Jr., Illinois  
Gregory La Morte, New Jersey  
Douglas A. Wyckoff, Missouri

**COMMUNICATIONS**

James R. Hight, Jr., Tennessee  
Craig W. Herre, Kansas  
Carolyn J. Malon, Connecticut  
James A. H. Tauberg, Pennsylvania

**DENTAL ACCREDITATION**

Patricia L. Blanton, Texas\*

**DENTAL BENEFIT PROGRAMS**

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

**DENTAL EDUCATION AND LICENSURE**

Prabu Raman, Missouri  
Jill M. Price, Oregon

**DENTAL PRACTICE**

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

**ETHICS, BYLAWS AND JUDICIAL AFFAIRS**

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

**GOVERNMENT AFFAIRS**

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

**MEMBERSHIP**

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

**MEMBERS INSURANCE AND RETIREMENT PROGRAMS**

J. Preston Coleman, Texas  
Larry J. Ferguson, South Carolina  
Bradley B. Kincheloe, Wyoming  
David E. McLean, Vermont

**NATIONAL DENTAL EXAMINATIONS**

Rhett L. Murray, Colorado

**NEW DENTIST**

J Emily R. Ishkanian, Nevada  
Jill C. McMahon, Illinois  
Justin R. Norbo, Virginia  
Kendra J. Zappia, New York

**SCIENTIFIC AFFAIRS**

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

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

3 **Resolution**

4  
5 **67. Resolved**, that the nominees for membership on ADA councils, commissions and the New  
6 Dentist Committee submitted by the Board of Trustees in accordance with Chapter VII, Section  
7 100(H) of the Bylaws be elected.

8 **BOARD RECOMMENDATION: Vote Yes.**

9 **Vote: Resolution 67**

BUCKENHEIMER	Yes	FEINBERG	Yes	NORMAN	Yes	VERSMAN	Yes
CROWLEY	Yes	GOUNARDES	Yes	ROBERTS	Yes	WEBER	Yes
DOW	Yes	HAGENBRUCH	Yes	SCOTT	Yes	YONEMOTO	Yes
ENGEL	Absent	ISRAELSON	Yes	SEAGO	Yes	ZENK	Yes
FAIR	Yes	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	Yes

Resolution No. 47-49 New

Report: Credentials, Rules and Order Date Submitted: August 2013

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 Goal: \_\_\_\_\_ (Required)

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

2 **Background:** The Standing Committee on Credentials, Rules and Order of the House of Delegates is  
3 charged by the ADA Bylaws, Chapter V, HOUSE OF DELEGATES, Section 140Bb, with the following  
4 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 delegates 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 2012 Session of the House of Delegates:** The minutes of the 2012 session of the  
13 House of Delegates have been posted (*Trans.*2012:363-528) in the House of Delegates Community of  
14 ADA Connect and on ADA.org at <http://www.ada.org/members/1338.aspx>.

15 Questions or corrections regarding the minutes may be forwarded to Michelle Kruse, manager, House of  
16 Delegates at [krusem@ada.org](mailto:krusem@ada.org). The Committee presents the following resolution for House action.

17 **47. Resolved**, that the minutes of the 2012 session of the House of Delegates, as published in  
18 *Transactions, 2012* (pages 363-528), 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. Accordingly, the Committee recommends adopting the agenda as  
21 the official order of business for this session. The Committee also recommends that the Speaker of the  
22 House be allowed to rearrange the order of the agenda as deemed necessary to expedite the business of  
23 the House.

24 **48. Resolved**, that the agenda as presented in the *2013 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**, that with the consent of the House of Delegates, the Speaker is authorized to alter the  
28 order of the agenda as deemed necessary in order to expedite the business of the House.

29 **Referrals of Reports and Resolutions:** A standing rule of the House of Delegates directs that prior to  
30 each session of the House, the Speaker shall prepare a list of recommended referrals to reference

1 committees with the list to be available at the opening meeting of the House and be subject to  
2 amendment or approval on vote of the House of Delegates.

3 This preliminary list of referrals (circulated in the form of the Updated General Index to the resolution  
4 worksheets) will be provided with the second posting of resolution worksheets in mid-October. The  
5 Speaker will announce additional referrals during the first meeting of the House of Delegates. A complete  
6 list of referrals, in the form of an agenda, will be available in the reference committee hearing rooms on  
7 Saturday morning, November 2.

8 **49. Resolved**, that the preliminary and supplemental list of referrals submitted by the Speaker of the  
9 House of Delegates be approved.

10 ***The American Institute of Parliamentarians Standard Code of Parliamentary Procedure:*** In 2011,  
11 the House of Delegates adopted Resolution 56H-2011 (*Trans.*2011:541) that identifies the current edition  
12 of the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure (AIPSC)* as the  
13 document that governs the deliberations of the House of Delegates in all cases in which they are  
14 applicable and not in conflict with the standing rules or the *ADA Bylaws*. The current edition of the *AIPSC*  
15 *Standard Code* was released in May 2012.

16 **Annual Reports and Resolutions, Manual of the House of Delegates and Resolution Worksheets:**  
17 The publication, *Annual Reports and Resolutions 2013* was posted in July on ADA Connect and ADA.org  
18 and can be accessed through the following link: <http://www.ada.org/1391.aspx>.

19 In addition, the first set of resolution worksheets will be posted on ADA Connect and ADA.org by the end  
20 of day, Friday, August 9. Per 74H-2012, effective in 2013, all materials of the House of Delegates will be  
21 provided in an electronic format only (with the exception of reference committee reports and agendas).

22 The second set of resolution worksheets will become available shortly after the Board of Trustees'  
23 October 6-8 session. The second set of resolution worksheets will be posted on ADA Connect and  
24 ADA.org by end of day, Friday, October 11. Paper copies will not be provided.

25 The *Manual of the House of Delegates and Supplemental Information* has been developed to  
26 complement the resolution worksheets. This document incorporates the "Rules of the House of  
27 Delegates" and all pertinent meeting information (*i.e.*, House agendas, members of the Standing and  
28 Reference Committees, reference committee hearing schedule, and schedule of the district caucuses).  
29 Any modifications to the *Manual* and specifically the Rules of the House of Delegates reflect either  
30 actions of the previous House of Delegates, details regarding dates, times and locations of the 2013  
31 meeting, or editorial corrections.

32 *Supplement to Annual Reports and Resolutions* is prepared primarily for historical purposes only since it  
33 reprints in resolution worksheet form all the reports and resolutions presented to the House of Delegates.  
34 This publication will be available online in the first quarter of 2014.

35 **Hearing of Reference Committees:** The reference committees of the House of Delegates will hold  
36 hearings on Saturday, November 2, in various rooms of the Grand Ballroom and Grand Salon of the  
37 Hilton New Orleans Riverside. The list of reference committee hearing rooms appears in the *Manual of*  
38 *the House of Delegates and Supplemental Information*.

### 39 **Saturday, November 2**

40 7:00 a.m. to 9:00 a.m. Business, Budget and Administrative Matters

41 9:00 a.m. to 11:00 a.m. Legislative, Health, Governance and Related Matters

42 10:00 a.m. to Noon Dental Education, Science and Related Matters



1 11:00 a.m. to 1:00 p.m. Dental Benefits, Practice and Related Matters

2 Noon to 2:00 p.m. Membership and Related Matters

3 Hearings will continue beyond the scheduled hours if everyone has not had an opportunity to be heard or  
4 if the complete agenda has not been covered.

5 In accordance with the *Manual of the House of Delegates*, section "General Procedures for Reference  
6 Committees," any member of the Association, whether or not a member of the House of Delegates is  
7 privileged to attend and participate in the discussion during the reference committee hearings. Guests of  
8 the Association are also welcome to attend reference committee hearings provided they identify  
9 themselves to the committee. Nonmembers of the Association may participate at hearings only on the  
10 invitation of the majority of the reference committee. At reference committees, everyone  
11 (individuals/members) will be obligated to disclose any personal or business relationship that they or their  
12 immediate family may have with a company or individual doing business with the ADA, when such  
13 company is being discussed, prior to speaking on an issue related to such a conflict of interest.

14 Association staff is available at hearings to provide information requested by members of reference  
15 committees or through the Chair by those participating in the discussion.

16 **Reports of Reference Committees:** Printed copies of reference committee reports will be made  
17 available to the chair of record of each delegation on Sunday, November 3. A sufficient number of copies  
18 of each report will be provided for each delegation's delegates, alternate delegates, secretary, executive  
19 director, trustee and editor. Reference committee reports will also be posted on ADA Connect and will be  
20 available early morning on November 3.

21 Delegates must bring their copies of reference committee reports to the meetings of the House of  
22 Delegates since additional printed copies will be limited.

23 **Nominations of Officers:** The nominations of officers (president-elect and second vice president) will  
24 take place at the first meeting of the House on Friday afternoon, November 1. Candidates for elective  
25 office will be nominated from the floor of the House by a simple declaratory statement, which may be  
26 followed by an acceptance speech not to exceed four minutes by the candidate. Seconding nominations  
27 is not permitted.

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

29 **Nomination of Trustees:** Nominations of members of the Board of Trustees from Districts 3, 4, 5, and 9  
30 will take place at the first meeting of the House. Prior to such nominations, the delegates from each of  
31 the districts concerned must caucus for the purpose of determining their nominee or nominees in  
32 accordance with the provisions of Chapter VII, Section 40, of the *Bylaws*. A list of caucus meetings  
33 appears in the *Manual of the House of Delegates and Supplemental Information*.

34 The results of the caucus must be reported to the Secretary of the House of Delegates no later than the  
35 opening of the meeting on Friday. In the event of a contested trustee election, candidates for the office of  
36 trustee shall be nominated from the floor of the House of Delegates by a simple declaratory statement,  
37 which may be followed by an acceptance speech not to exceed four minutes by the candidates from the  
38 podium. Seconding nominations is not permitted.

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

43 **Voting Procedures in the House:** The method of voting in the House of Delegates is usually  
44 determined by the Speaker who may call for a voice vote, show of hands (voting cards), standing vote,

1 roll call of the delegations, electronic voting or such other means that the Speaker deems appropriate.  
2 The House may also, by majority vote, determine for itself the method of voting that it prefers.

3 Only votes cast by voting members of the House of Delegates either for or against a pending motion shall  
4 be counted. Abstentions shall only be counted in determining if a quorum is present. If the result of a  
5 vote is uncertain or if a division is called for, the Speaker may use the electronic voting method or may  
6 call for a standing vote. If a standing vote, the count will be made by tellers appointed by the Speaker  
7 and reported to the Secretary of the House.

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

11 **Election Procedures:** Voting for the offices of president-elect and second vice president will be  
12 conducted in a separate room located in the vicinity of the House of Delegates (Rivergate Room), from  
13 6:30 a.m. to 8:00 a.m. on Monday, November 4. Members should bring their number 6 meeting card and  
14 vote early in order to avoid a delay at the voting machines. If at all possible, delegation changes should  
15 be made by the end of the day Sunday, November 3, to expedite the check-in process for voting.

16 In the event a second balloting is necessary, the number 6 meeting card will be reused. The second  
17 balloting will be conducted on Monday, November 4, at a time announced by the Speaker.

18 The Standing Committee on Credentials, Rules and Order oversees the confirmation and reporting of  
19 election results. The Committee will verify the number of votes received by each candidate prior to the  
20 election results being placed in a sealed envelope and transmitted to the Secretary of the House. The  
21 Secretary will review and forward the results to the Speaker for announcement. CRO members present  
22 during the review of election results will remain in the voting area until the House is informed of the  
23 election results. If there are any delays in reporting the election results, the Committee chair will  
24 immediately notify the Secretary of the delay.

25 **Standing Order of Business—Installation of New Officers and Trustees:** The installation ceremony  
26 for new officers and trustees will take place on Tuesday, November 5, as the first item of business with  
27 the time to be specified by the Speaker of the House of Delegates.

28 **Introduction of New Business:** The Committee calls attention to the *Bylaws*, Chapter V, Section  
29 130(Ae) which provides that no new business shall be introduced into the House of Delegates less than  
30 15 days prior to the opening of the annual session, unless submitted by a Trustee District. No new  
31 business shall be introduced into the House of Delegates at the last meeting of a session except when  
32 such new business is submitted by a Trustee District and is permitted to be introduced by a two-thirds  
33 (2/3) affirmative vote of the delegates present and voting. The motion introducing such new business  
34 shall not be debatable. Approval of such new business shall require a majority vote except new business  
35 introduced at the last meeting of a session that would require a bylaw amendment cannot be adopted at  
36 such last meeting. Reference committee recommendations shall not be deemed new business.

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

41 **Explanation of Resolution Number System:** Original resolutions are numbered consecutively  
42 regardless of whether the source is a council, other Association agency, constituent society, delegate,  
43 Board of Trustees or House reference committee. Revisions made by the Board, reference committee or  
44 House are considered "amendments" to the original resolution. If amended by the Board, the suffix "B"  
45 follows the original resolution number (Res. 24B); if amended by a reference committee, the suffix "RC"  
46 follows (Res. 24RC).

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

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

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

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

8 If a Board (B) or reference committee (RC) resolution is a substitute for several original resolutions, the  
9 Board’s recommended substitute or the reference committee’s recommended substitute uses the number  
10 of the first resolution submitted and adds the proper suffix (B or RC). The report will clearly state that the  
11 other resolution or resolutions have been considered and are included in the “B” or “RC” resolution. A  
12 resolution submitted by an agency other than the Board or a reference committee as a substitute or  
13 amendment retains the original resolution number followed by the suffix “S-1” (Res. 24S-1). If two  
14 substitute resolutions are submitted for the same original resolution, the suffixes are “S-1” and “S-2” (Res.  
15 24S-1, Res. 24S-2).

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

19 **Dedicated Pro and Con Microphones:** The Speaker has advised that to ensure balanced opportunity  
20 for debate during all House discussions that microphones 1, 3, and 5 will be identified for pro testimony  
21 and microphones 2, 4, and 6 will be identified for con testimony throughout the session. To preserve the  
22 microphone queue for debate on the main motions the Speaker has indicated that two microphones at the  
23 front of the room labeled “A” and “B” will be used for debate on subsidiary motions. A third microphone  
24 will be placed front and center, labeled “P” for parliamentary inquiries, point of information or to appeal for  
25 a ruling from the chair. Microphone “P” may also be used for a question of privilege that has to do with  
26 the convenience, comfort, rights, or privileges of a member or of the assembly that is urgent and must be  
27 decided immediately. Offering to give information is debate and is not a point of information, and should  
28 be given at one of the six microphones in the queue.

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

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

42 **Access to Floor of House:** Access to the floor of the House of Delegates is limited to officers and  
43 members of the House of Delegates, the elective and appointive officers of the Association, the former  
44 presidents, the members of the Board of Trustees, the chairs of the councils and commissions, the  
45 secretaries and executive directors of constituent societies, the executive director and president of the  
46 American Student Dental Association, an officially designated representative from each of the American

1 Hospital Association and American Medical Association and members of the Headquarters Office staff.  
2 Council and commission chairs are responsible for requesting floor access for any non-delegate council or  
3 commission member who desires to speak during debate on the report of the council or commission  
4 consistent with the *Bylaws* and the Rules of the House of Delegates.

5 Alternate delegates, former officers and former trustees do not have the privilege of access to the  
6 floor but will be seated in a special area reserved for them.

7 Admission to the House will begin 30 minutes prior to the start of each meeting of the House and will not  
8 be granted without the display of the appropriate annual session badge. Every delegate must also hand  
9 the appropriately numbered card to the attendant at the door for each meeting so that the official  
10 attendance record may be maintained. Former officers and former trustees will also be admitted to the  
11 section reserved for alternate delegates and upon request will receive access to all reference committee  
12 reports available to delegates and alternates.

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

20 **Substitution of Alternate Delegates for Delegates:** Delegates wishing to substitute alternate delegates  
21 from their delegation for themselves during a meeting of the House of Delegates must complete the  
22 appropriate delegate-alternate substitution form. Delegates are required to sign the form and surrender  
23 their admission cards for the meeting or meetings not attended before admission cards will be issued to  
24 alternate delegates by the Committee on Credentials, Rules and Order. Substitution of alternate  
25 delegates may be made during all four meetings of the House of Delegates. In order for a complete and  
26 accurate attendance record for all meetings of the 2013 House of Delegates, submission of these  
27 completed substitution forms is essential.

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

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

42 **Attorney-Client Session:** An attorney-client session is a form of closed session during which an  
43 attorney acting in a professional capacity provides legal advice, or a request is made of the attorney for  
44 legal advice. During these sessions, the legal advice given by the attorney may be discussed at length,  
45 and such discussion is "privileged." The requests, advice, and any discussion of them are protected,  
46 which means that opponents in litigation, media representatives, or others cannot legally compel their  
47 disclosure. The purpose of the privilege is to encourage free and frank discussions between an attorney  
48 and those seeking or receiving legal advice. The privilege can be lost (waived) if details about the  
49 attorney-client session are revealed to their parties. Once the privilege has been waived, there is a

1 danger that all privileged communications on the issues covered in the attorney-client session, regardless  
 2 of when or where they took place, may become subject to disclosure. For attorney-client sessions, the  
 3 Speaker and Secretary shall consult with the General Counsel regarding attendance during the session.  
 4 No official action may be taken nor business conducted during an attorney-client session.

5 In accordance with the above information, all those participating in an attorney-client session shall refrain  
 6 from disclosing information about the discussion held during the attorney-client session. In certain cases,  
 7 a decision may be made to come out of the attorney-client session for purposes of conducting a non-  
 8 privileged discussion of the same or related subject matter. The difference will be that during the non-  
 9 privileged session there will be no discussion of any legal advice requested by attendees during the  
 10 attorney-client session or about any of the legal advice given by the legal counsel. It is such requests for  
 11 legal advice, legal advice given, and discussion of the legal advice during the attorney-client session that  
 12 are protected by the privilege and that shall not be disclosed or discussed outside of the attorney-client  
 13 session.

14 **Manual of the House of Delegates:** Each member of the House of Delegates has access to the *2013*  
 15 *Manual of the House of Delegates* through ADA Connect. The *Manual* contains the standing rules of the  
 16 House of Delegates and the pertinent provisions of the *Bylaws*.

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

19 **Distribution of Materials in the House of Delegates:** The Committee calls attention to the procedures  
 20 to be followed for distributing materials in the House of Delegates: (1) no material may be distributed in  
 21 the House without obtaining permission from the Secretary of the House; (2) material to be distributed  
 22 must relate to subjects and activities that are proposed for House action or information; and (3) material  
 23 to be distributed on behalf of any member's candidacy for office shall be limited to printed matter on paper  
 24 only and nothing else.

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

28 **House of Delegates Information and Resource Office:** An Information and Resource Office will be  
 29 open Thursday, October 31 through Sunday, November 3, and will be located in the Burgundy Room,  
 30 Hilton New Orleans Riverside, Level 1. This office will be open to delegates, alternates, constituent  
 31 society officers and staff. The office will be equipped with computers, a copier, resource materials for  
 32 researching issues; and general information about the meetings of the House of Delegates and related  
 33 activities. Everyone is urged to use the Information and Resources Office when drafting resolutions or  
 34 testimony.

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

### 37 **Resolutions**

38 Resolution 47 (Worksheet:1028)

39 Resolution 48 (Worksheet:1029)

40 Resolution 49 (Worksheet:1030)

Resolution No.  47  New

Report:  Credentials, Rules and Order  Date Submitted:  August 2013

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 Goal: \_\_\_\_\_ (Required)

1

**MINUTES OF THE HOUSE OF DELEGATES**

2

**Background:** The minutes of the 2012 session of the House of Delegates have been posted (*Trans.2012:363-528*) in the House of Delegates Community of ADA Connect and on ADA.org at <http://www.ada.org/members/1338.aspx>.

3

4

5

Questions or corrections regarding the minutes may be forwarded to Michelle Kruse, manager, House of Delegates at [krusem@ada.org](mailto:krusem@ada.org). The Committee presents the following resolution for House action.

6

**Resolution**

7

**47. Resolved**, that the minutes of the 2012 session of the House of Delegates, as published in *Transactions, 2012* (pages 363-528), be approved.

8

Resolution No.  48    New

Report:  Credentials, Rules and Order  Date Submitted:  August 2013

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 Goal:   (Required)

1

**ADOPTION OF AGENDA AND ORDER OF AGENDA ITEMS**

2

**Background:** The Committee has examined the agenda for the meeting of the House of Delegates.

3

Accordingly, the Committee recommends adopting the agenda as the official order of business for this session.

4

The Committee also recommends that the Speaker of the House be allowed to rearrange the

5

order of the agenda as deemed necessary to expedite the business of the House.

**Resolution**

6

**48. Resolved,** that the agenda as presented in the *2013 Manual of the House of Delegates and Supplemental Information* be adopted as the official order of business for this session, and be it further

7

8

**Resolved,** that with the consent of the House of Delegates, the Speaker is authorized to alter the order of the agenda as deemed necessary in order to expedite the business of the House.

9

10

Resolution No. 49 New

Report: Credentials, Rules and Order Date Submitted: August 2013

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 Goal: \_\_\_\_\_ (Required)

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 the Updated General Index to the resolution  
 7 worksheets) will be provided with the second posting of resolution worksheets in mid-October. The  
 8 Speaker will announce additional referrals during the first meeting of the House of Delegates. A complete  
 9 list of referrals, in the form of an agenda, will be available in the reference committee hearing rooms on  
 10 Saturday morning, November 2.

**Resolution**

11 **49. Resolved,** that the preliminary and supplemental list of referrals submitted by the Speaker of the  
 12 House of Delegates be approved.



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## Budget, Business and Administrative Matters

Resolution No. 3-4 New

Report: Board Report 2 Date Submitted: August 2013

Submitted By: Board of Trustees

Reference Committee: Budget, Business and Administrative Matters

Total Net Financial Implication: See Resolutions 3-4 Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE \_\_\_\_\_

ADA Strategic Plan Goal: Financial (Required)

1       **REPORT 2 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: 2014 BUDGET**

2       **Introduction:** *All dollar figures are in thousands with unfavorable variances in parentheses.*

3       In accordance with its *Bylaws* duties, the Board of Trustees presents the proposed 2014 operating  
4       budget for the Association. This report also provides the House of Delegates with background  
5       commentary and analysis of significant budget changes for 2014. The Board is recommending a 2014  
6       operating budget of \$122,244 in revenues and \$123,687 in expenses and income taxes, generating a  
7       deficit of \$(1,443) in net income before reserve spending. In arriving at this proposal, the Board of  
8       Trustees and the Administrative Review Committee analyzed budget requests relative to the  
9       Association’s strategic priorities, as directed by the 2011 House of Delegates in resolutions 44H-2011  
10      and 52H-2011 (*Trans.*2011:444;445). Resources were allocated between programs and divisions in  
11      an effort to maximize their effective use in executing the ADA’s Strategic Plan for 2011-2014.

12      Although Board Report 2 proposes a net deficit for 2014 based on information available at the time of  
13      this report’s submission, the board does not expect a 2014 deficit due to other changes expected prior  
14      to the Annual Session. In addition, 2012 actual and 2013 projected favorable results to budget would  
15      also offset this deficit.

16      The Board of Trustees also approved a resolution recommending no membership dues increase for  
17      2014.

18  
19      **Contents**

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## 1 **Overview of New Budget Improvements and Philosophy**

2  
3 This report is the result of significant efforts of many volunteers and staff over many months that built on  
4 initial progress made over the past few years. Many thanks are due to everyone who contributed to both  
5 the content as well as the processes which sometimes changed as new information was used to adapt  
6 and improve along the way. In the spirit of continuous improvement, constructive suggestions are  
7 welcomed to ensure that the best information is provided to support quality decision-making.  
8

9 This year, the 2014 budget process started earlier than ever before to ensure that each council could use  
10 Decision Lens, a collaborative, decision support software, to rank its own programs. This approach  
11 followed through on a promise from last year to involve all Councils, as representatives of the House.  
12 When inconsistent data from several councils precluded the consolidation of valid results using each  
13 Council's ratings of their own programs, a Council Budget Group ("CBG") of senior leaders from each  
14 Council was formed to rate all ADA programs. Decision Lens was an important software tool that helped  
15 fulfill 2011 House resolutions to rate all ADA programs using one set of universal assessment criteria but  
16 it was still only one of many inputs to the overall budget process. Councils of the House are uniquely  
17 positioned to aid the House in fulfillment of its fiduciary responsibilities and compare all programs within  
18 the Association against one set of universal assessment criteria. Councils are also best informed in their  
19 particular areas of bylaws authority and therefore worked in much more detail early in this budget  
20 process.  
21

22 Specifically, Resolution 44H-2011 asked that the Board develop a set of universal assessment criteria  
23 and that each council use the criteria to evaluate its programs and report to the Administrative Review  
24 Committee. Resolution 52H-2011 specifically directed the Board to develop and follow a set of short and  
25 long-term financial strategies that identify existing programs, services and products to be sunset so that  
26 existing finite human and financial resources may be redeployed for new initiatives that align with the  
27 Strategic Plan of the ADA and that deliver greater member value or public health impact.  
28

29 For the first time, council leaders agreed to form a separate group of senior representatives, one from  
30 each council, to rate all programs against the universal assessment criteria. These ratings were  
31 combined with Administrative Review Committee criteria weightings to generate the Decision Lens scores  
32 which resulted in program rankings. Consistent with last year's process, the Administrative Review  
33 Committee meeting was dedicated to taking input from council chairs and ADA staff to discuss their  
34 programs, including factors outside the universal assessment criteria. Although no programs were sunset  
35 through this year's budget process, mainly due to the significant changes made last year, ALL programs  
36 across the ADA were evaluated on a consistent basis by one group of representatives of the House and  
37 councils also had a forum for additional input beyond the program rankings.  
38

39 The 2014 budget prioritization of programs represents a process which is closer to an ideal "zero based"  
40 budget because all programs, new and old, were assessed together using one set of criteria. This is  
41 fundamentally different than past ADA presentations of base budgets, which included ongoing legacy  
42 programs, plus new programs. It should be noted that House resolutions passed after this budget  
43 process do not go through this new review and prioritization process.  
44

45 With this background, it should be noted that this 2014 budget represents the estimates of ADA revenue  
46 and expenses to deliver the listed programs and services based on the best information and assumptions  
47 available at the time these budgets were built in early 2013. As a result, it is very possible that some  
48 estimates or assumptions could change based on new information that becomes available closer to the  
49 start of the budget year. If that new information results in significant, quantifiable impacts to the 2014  
50 budget, then those will be reported by the Treasurer to that House at the annual session as possible  
51 amendments to the budget subject to the discretion of the House. Unfortunately, potential changes are  
52 an inherent risk of the ADA's current budget process due to its long timeline. Some budget estimates  
53 made a year before the start of the budget period are often less accurate than those that are built later.  
54

1 From a higher perspective, the ADA's 2014 budget is also a product driven by the ADA's program agenda  
2 which has been aligned as much as possible with the ADA's strategic plan goals as well as the core  
3 functions and services required to support a 400+ employee, \$120 million organization and all the  
4 supporting governance structures. This budget report is therefore focused more on programs and  
5 services being delivered and less on the accounting structures of the ADA already reviewed in detail by  
6 councils, the Administrative Review Committee, and the Board of Trustees.

7  
8 In the simplest terms, the most basic goal of the budget process is the prioritization of resources in  
9 alignment with the strategic plan. It is hoped that the House of Delegates, at its annual session, will share  
10 this high level view of the ADA and that all resolutions introduced will be reviewed and prioritized with  
11 consideration to the same criteria.

### 12 **Enhanced Format of this Report**

13  
14 In an effort to communicate in a more concise format, this report provides much new information (listed  
15 below) that has not been provided to the House of Delegates in prior years. At the same time some  
16 aspects have been streamlined to keep the report at a concise and readable length.

17  
18 For the first time, this report includes the following information for every ADA agency program:

- 19 • Number of Staff Working on Each Program: number of full time equivalent (FTE) employees.
- 20 • Revenue generated by the program.
- 21 • Expense: Includes both the cost of the staff time and non-staff expenses such as travel and  
22 consultants.
- 23 • Assessment Score by Council Budget Group (CBG): Council Budget Group's scoring of each  
24 program against the six Universal Assessment Criteria defined by the Board of Directors at the  
25 direction of the House of Delegates.

26  
27 In prior years, Board Report 2 presented budgets only in terms of accounting categories such as "salaries  
28 expense" and "office expenses." That approach did not disclose the activities on which the funds were  
29 being spent, except for new initiatives in "decision packages." The new program information in this  
30 report enables the following new insights:

- 31 1. Zero-based budgeting. No automatic grandfathering of old programs. All programs are  
32 evaluated together at one time.
- 33 2. Staff time allocations across programs. For example, 6 staff are working on Program A versus  
34 only 1 staff working on Program B.
- 35 3. Program assessment scores: How well does each ADA activity in every agency division align  
36 with the Strategic Plan Goals? These program assessments were a specific requirement of  
37 House resolutions 44H-2011 and 52H-2011.
- 38 4. Cross-division comparisons: How do activities in one division compare to those in another  
39 division, for revenue, cost, staffing effort, assessment score?

40  
41 For any delegate that would like to see more detail on the 22 ADA divisions, budget information on each  
42 division will be available on the secure Financial House of Delegates site of ADA connect. Two  
43 documents, 2014 Budgets for Agency Divisions and 2014 Budgets for Shared Services Divisions, include  
44 narrative overviews of each division, descriptions and financial information on each of the division's  
45 programs, and explanations of significant year-over year variances.

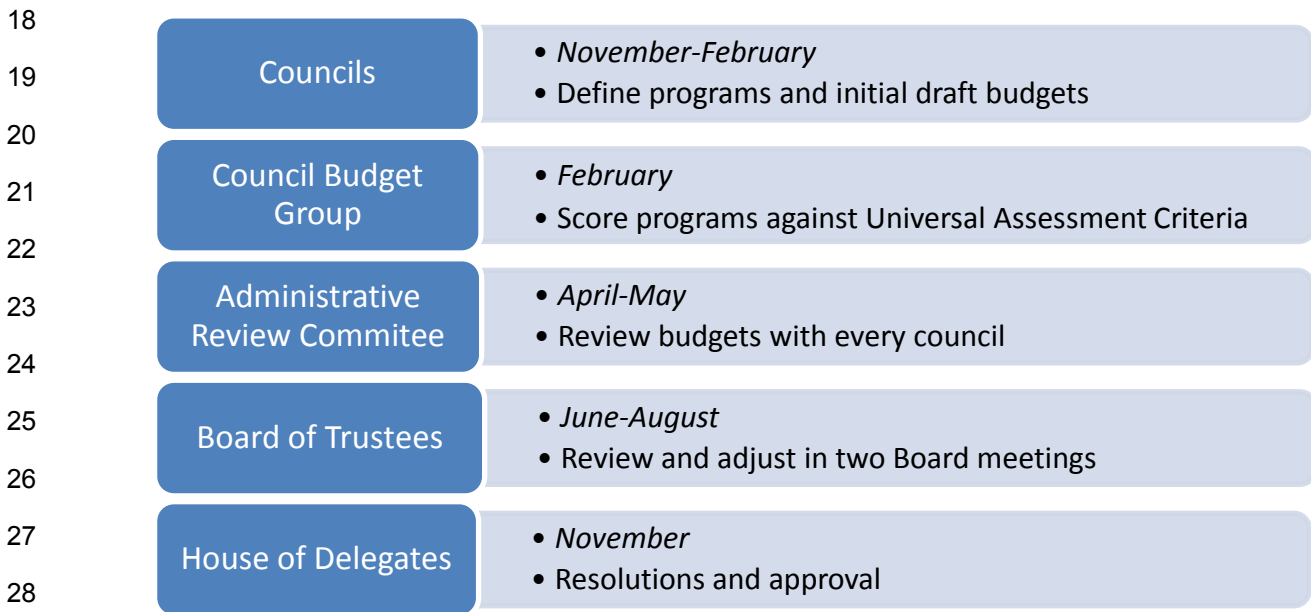
46  
47 Another change in format is the presentation of the ADA's operating surplus/deficit based on "net income  
48 before reserve spending." The change is the result of action by the 2012 House of Delegates to create  
49 and annually contribute to a capital replacement reserve fund as a means of reducing the likelihood of  
50 future special dues assessments. The ADA's annual budgets have historically included capital spending  
51  
52  
53

1 in the “net depreciation and capital add back.” Budgets from 2004 through 2012 included only “operating  
2 capital” spending and did not include contribution to a capital replacement reserve fund before the House  
3 approved this funding for the 2013 budget. As a result, the first two budget summary statements show a  
4 bottom line “net revenue / (expense) after taxes” while the next page shows the surplus/(deficit)  
5 consistent with prior budgets and includes the impact of new capital replacement reserve contributions  
6 budgeted in 2013 and 2014.

7 **Budget Process Overview**

8 The ADA *Bylaws* charge the Treasurer with design of the budgetary process in concert with the Board of  
9 Trustees and oversight of the Association finances and development of a budget for approval by the  
10 House of Delegates. The process now stretches over more than year due to: multiple layers of volunteer  
11 involvement; the timing of council, committee and Board meetings; and the *Bylaws* requirement that the  
12 House be informed of the membership dues 90 days before the annual session. Over the past few years,  
13 several changes to the budget process have been layered on top of this decades-old framework. In  
14 compliance with House resolution 44H-2011, ADA expenditures are now grouped by activity (aka  
15 “program”) and scored against a set of Universal Assessment Criteria.

16 The outline below illustrates the various volunteer oversight bodies that are involved with the budget  
17 during the year. Each step in the outline is explained below.



30 **Councils**

31 In the first stage of this process, ADA staff worked with over 200 council members to determine which  
32 programs should be included in the 2014 budget. Each agency division defined a list of programs that  
33 represent their work products, i.e., what the division accomplishes that creates member value. This  
34 provided councils with better visibility at a summary level of the planned activities and resources required.  
35 Most councils then also scored their programs against the Universal Assessment Criteria, further  
36 educating the councils on their programs.

37 Next, staff input the initial draft budgets for these programs into the Hyperion budget system. Every hour  
38 of staff time and every dollar of non-staff expense was planned against the programs. The sum of the

1 staff time in the programs equals the total staffing budget. As shown on page 2014, only the staffing in  
2 shared services divisions (such as Human Resources and Legal) are not included in program costs.

### 3 **Council Budget Group**

4 Next, a Council Budget Group (CBG) rated each program from every agency division against the  
5 Universal Assessment Criteria. The Council Budget Group includes one senior representative from each  
6 of 15 councils, commissions, and committees. The eight Universal Assessment Criteria listed below  
7 were created by the Board pursuant to House resolution 44H-2011.

- 8
- 9 1. **Strategic Goal # 1: Member Success / Practice Success:** Program alignment to the ADA's  
10 Strategic Goal # 1, Member Success. Program is intended to direct assist the dentist in their  
11 practice or career. (*Weighting = 25 %*)
- 12 2. **Strategic Goal # 2: Trusted Information Resource / Public Education:** Program alignment to the  
13 ADA's Strategic Goal # 2: Be the trusted resource for oral health information that will help people  
14 be good stewards of their own oral health. Program directly provides education to the public.  
15 (*Weighting = 9 %*)
- 16 3. **Strategic Goal # 3: Public Health Outcomes / Access to Care/Prevention/Collaboration:**  
17 Program alignment to the ADA's Strategic Goal # 3 Improve public health outcomes through a  
18 strong collaborative profession, and through effective collaboration across the spectrum of our  
19 external stakeholders. Goal of the program includes at least one of the following: improve  
20 access to care, increase prevention, or bring the dental profession together to work on common  
21 goals to improve public health. (*Weighting = 9 %*)
- 22 4. **Program Impact:** Number of members directly helped and the level to which members benefit  
23 from the program. For practice related programs, how many members use the program in their  
24 practice and how much does it help them? For programs that interface with third parties such as  
25 a benefits carrier, standards body, regulatory agency, state or federal legislative body: What  
26 impact will the program have on the policy makers position to the benefit of dentists or the public?  
27 (*Weighting = 14 %*)
- 28 5. **Competitive Advantage:** Extent to which program can be easily be duplicated by other  
29 organizations or other members of the tripartite. In some cases ADA market share can be one  
30 indication of competitive advantage. (*Weighting = 12 %*)
- 31 6. **Attracts or Retains Members:** Do members often cite this program as a reason why they join  
32 the ADA? Do members that would otherwise leave the ADA renew their membership in order to  
33 maintain the benefits of this program? (*Weighting = 31 %*)
- 34 7. **Intangible Benefits to the ADA Brand of Public Perception of Dentistry:** Examples of  
35 intangible benefits are general advancement of knowledge or enhancement to the brand  
36 equity/reputation of the ADA or Dentistry in the eyes of the public or policymaker.  
37 (*Weighting = 0 %*)
- 38 8. **Risk:** The likelihood and degree to which a program outcome could possible lead to adverse  
39 effects. Types of risk include reputational, legal/regulatory, strategic, operational, and  
40 organizational. (*Weighting = 0 %*)

41 The weightings shown above were determined by the Budget and Finance Committee after the CBG had  
42 completed their assessments. The Committee assigned a weighting of zero % to the last two criteria,  
43 effectively eliminating these criteria from the scores, because CBG score results for these two criteria  
44 were statistically inconsistent which indicated that these two criteria were too subjective and not  
45 consistently used.

46 The CBG scores were collected in a web-based software called Decision Lens, which enabled  
47 independent voting by each participant. This Decision Lens tool is not responsible for the program scores  
48 any more than a voting machine is responsible for the results of a public election.

- 1 Learning from the councils' experiences with program assessments, the subsequent CBG process  
2 reflected three improvements:
- 3 • Each member of the CBG was presented with explanations of the Universal Assessment Criteria  
4 and examples of how the criteria is applied to hypothetical programs.
  - 5 • CBG was provided with a one page overview of each program developed by program  
6 management which included program descriptions and notes on how each program relates to  
7 each of the Universal Assessment Criteria. The CBG was instructed to apply their own critical eye  
8 to this information, and did so as shown in the scores below.
  - 9 • CBG was allowed to enter scores at their own pace (typically taking 3-4 hours) rather than being  
10 rushed in a council meeting.

11 While the CBG was scoring programs, the Treasurer, Executive Director, and senior staff reviewed the  
12 initial draft financial budgets for errors, opportunities to improve operational efficiency, cross division  
13 synergies, or risks to goal achievement.

#### 14 **Administrative Review Committee**

16 Before the Administrative Review Committee met for its formal budget review, its chair, the ADA  
17 Treasurer, and the Executive Director, along with ADA Financial management reviewed all budget  
18 materials in detail. This helped to frame up some of the most substantive issues to be considered at the  
19 subsequent Committee meeting.

20 The full Administrative Review Committee was then provided with budgets including the following for  
21 every program: program description, notes on the program's alignment with each assessment criteria,  
22 CBG's assessment scores, revenue, staff full time equivalent employees (FTE), expense including staff  
23 time, as well as consolidated ADA budget financial statements versus prior year actual and budget. The  
24 Committee meeting included discussions with each council chair regarding the council's programs. The  
25 Committee typically asked the council chair about the expected outcomes of a program, or the strategies  
26 that the council is pursuing, or current status against goals mentioned in the program's budget materials.  
27 This dialog served as a two-way education—the council shared their knowledge of the programs while the  
28 Committee offered the perspectives of their broader view across the ADA.

#### 29 **Board of Trustees**

30 The Administrative Review Committee, led by the Treasurer, then made its final budget recommendation  
31 to the full Board of Trustees, first at the June Board session. The Board reviewed the Committee's report  
32 recommendations and asked questions and requested additional information as needed. Budget  
33 adjustments agreed upon by the Board were then reflected in the subsequent budget draft presented to  
34 the Board of Trustees at their second summer session, which this year occurred in early August.

#### 35 **House of Delegates**

36 The final budget will reflect any changes adopted by the House of Delegates, including any financial  
37 impact of all House resolutions.

#### 38 **Final Comments on 2014 Budget Targets**

39 For several years, the ADA has been challenged by falling market share and rising costs. In fact, initial  
40 budget submissions included lower dues revenue which continued the existing multi-year trend of  
41 declining membership market share. As a result, this 2014 budget was updated to include stretch goals  
42 for membership to serve as a catalyst for change to turnaround this trend. Alignment of the entire  
43 organization to drive value to attract and retain members and improve non-dues revenue is critical to the  
44 long term success and financial stability of the ADA.  
45

**American Dental Association Operating Fund**1 2014 Budget Summary by Natural Account  
\$ 000

	2,012 Actual	2,013 Budget	2,014 Budget	2014 B v 2013 B	
				Fav / (Unfav)	
				\$	%
<b>Revenues</b>					
Membership Dues	54,552	57,550	58,146	596	10%
Advertising	8,156	9,617	9,483	(134)	-14%
Rental Income	5,579	5,023	3,855	(1,688)	-23.3%
Publication & Product Sales	7,448	6,740	7,034	294	4.4%
Testing Fees & Accreditation	18,855	18,020	20,130	2,110	11.7%
Meeting & Seminar Income	11,315	10,225	9,429	(796)	-7.8%
Grants & Contributions	1,987	1,907	2,261	354	18.6%
Royalties	6,609	5,293	7,127	1,834	34.6%
Investment Income	2,362	2,085	1,476	(609)	-29.2%
Other Income	2,934	3,205	3,304	99	3.1%
<b>Total Revenues</b>	<b>119,797</b>	<b>119,664</b>	<b>122,244</b>	<b>2,580</b>	<b>2.2%</b>
<b>Expenses</b>					
<b>Salaries and Temporary Help</b>					
Salaries (Base Compensation)	37,522	38,653	40,840	(2,187)	-5.7%
Agency Compensation (Incl Severance)	1,575	1,300	700	600	46.2%
Temporary Help	1,158	258	284	(26)	-10.1%
<b>Total Salaries and Temporary Help</b>	<b>40,255</b>	<b>40,211</b>	<b>41,824</b>	<b>(1,613)</b>	<b>-4.0%</b>
<b>Fringe Benefits</b>					
Pension - Normal Cost	1,496	1,703	2,324	(621)	-36.5%
Pension - Catchup Supplemental Funding	5,065	5,492	5,252	240	4.4%
401k Contribution	1,843	1,718	1,737	(19)	-1.1%
All Other Benefit Costs	4,443	4,809	4,874	(65)	-1.4%
<b>Total Fringe Benefits</b>	<b>12,847</b>	<b>13,722</b>	<b>14,187</b>	<b>(465)</b>	<b>-3.4%</b>
Total Payroll Taxes	2,727	2,734	2,810	(76)	-2.8%
Total Travel Expenses	5,646	5,900	6,299	(399)	-6.8%
Printing, Publication & Marketing	9,668	11,027	11,764	(737)	-6.7%
Meeting Expenses	3,054	2,290	2,388	(98)	-4.3%
Consulting and Outside Services	7,586	5,973	6,981	(1,008)	-16.9%
Professional Services	8,688	9,465	9,654	(189)	-2.0%
Bank & Credit Card Fees	1,136	1,193	1,222	(29)	-2.4%
Office Expenses	4,781	5,151	5,270	(119)	-2.3%
Facility & Utility Costs	6,318	5,818	6,068	(250)	-4.3%
Grants and Awards	2,304	2,313	2,241	72	3.1%
Endorsement Costs	660	695	803	(108)	-15.5%
Depreciation/Amortization	6,563	6,358	6,342	16	0.3%
Other Expenses	1,352	2,577	2,634	(57)	-2.2%
ADA Health Foundation - Grant	1,907	1,900	1,900	0	0.0%
<b>Total Expenses</b>	<b>115,492</b>	<b>117,330</b>	<b>122,387</b>	<b>(5,060)</b>	<b>-4.3%</b>
<b>Net Income (Loss) before Income Tax</b>	<b>4,306</b>	<b>2,334</b>	<b>(143)</b>	<b>(2,477)</b>	<b>-106.1%</b>
<b>Income Taxes</b>	<b>(1,109)</b>	<b>(1,300)</b>	<b>(1,300)</b>	<b>0</b>	<b>0.0%</b>
<b>Net Revenue/(Expense) After Taxes</b>	<b>3,197</b>	<b>1,034</b>	<b>(1,443)</b>	<b>(2,477)</b>	<b>-239.6%</b>



**American Dental Association Operating Fund**

2014 Budget Summary by Division

\$ 000

2014 B v 2013 B

1 <b>Revenue</b>	2012	2013	2014	Fav / (Unfav)	
	Actual	Budget	Budget	\$	%
Legal Affairs	76	62	85	23	37.1%
Government & Public Affairs	55	32	30	(2)	-6.3%
Communications	90	692	688	(4)	-0.6%
Membership, Tripartite Relations & Marketing	1,931	1,742	2,205	463	26.6%
Division of Global Affairs	101	-	-	-	0.0%
Conference & Meeting Services	12,443	11,220	10,690	(530)	-4.7%
Headquarters Building	3,831	3,227	2,030	(1,197)	-37.1%
Washington Building	1,709	1,782	1,781	(1)	-0.1%
Product Development and Sales	9,019	8,214	8,586	372	4.5%
Finance and Operations	1,838	1,899	1,500	(399)	-21.0%
Central Administration	58,983	60,983	62,238	1,255	2.1%
Dental Practice	42	331	668	337	101.8%
Dental Benefits	5	77	-	(77)	-100.0%
Health Policy Resource Center	131	60	70	10	16.7%
Science	890	688	910	222	32.3%
Education	19,224	18,625	20,539	1,914	10.3%
ADA Publishing	9,222	10,020	10,034	14	0.1%
Corp. Rel & Strat. M kng Alliances	208	10	190	180	1800.0%
<b>Total Revenue</b>	<b>119,798</b>	<b>119,664</b>	<b>122,244</b>	<b>2,580</b>	<b>2.2%</b>
<b>Expense</b>					
Contingency General	216	1,000	1,000	-	0.0%
Administrative Services	5,522	5,558	5,721	(163)	-2.8%
Human Resources	1,666	1,996	2,055	(59)	-2.9%
Legal Affairs	4,005	4,149	3,938	211	5.4%
Government & Public Affairs	8,512	9,049	8,894	155	1.7%
Communications	4,197	5,621	5,884	(263)	-4.5%
Membership, Tripartite Relations & Marketing	8,648	8,736	9,145	(409)	-4.5%
Division of Global Affairs	1,332	1,355	1,464	(109)	-7.4%
Conference & Meeting Services	9,617	8,641	9,463	(822)	-8.7%
Headquarters Building	6,026	5,361	5,794	(433)	-7.5%
Washington Building	1,087	1,046	1,069	(23)	-2.2%
Product Development and Sales	4,205	4,042	4,464	(422)	-9.5%
Finance and Operations	4,353	4,070	4,126	(56)	-1.4%
Central Administration	10,396	10,144	9,156	988	10.8%
Information Technology	8,995	10,344	11,249	(905)	-8.0%
Dental Practice	1,266	1,475	2,109	(634)	-30.1%
Dental Benefits	2,140	2,036	1,997	39	2.0%
Health Policy Resource Center	2,507	2,526	2,720	(194)	-7.1%
Science	6,492	6,392	6,886	(494)	-7.2%
Education	14,361	13,833	15,148	(1,315)	-8.7%
ADA Publishing	8,901	9,092	9,199	(107)	-1.2%
Corp. Rel & Strat. M kng Alliances	1,048	864	906	(42)	-4.6%
<b>Total Expense</b>	<b>115,492</b>	<b>117,330</b>	<b>122,387</b>	<b>(5,057)</b>	<b>-4.3%</b>
Income Before Taxes	4,306	2,334	(143)	(2,477)	-106.1%
Income Taxes	(1,109)	(1,300)	(1,300)	-	0.0%
<b>Net Revenue/(Expense) After Taxes</b>	<b>3,197</b>	<b>1,034</b>	<b>(1,443)</b>	<b>(2,477)</b>	<b>-239.6%</b>

**Deficit/Surplus Reflecting Other Cash Items**

The table below builds on the two budget summary statements which end in Net Surplus/ (Deficit) after Taxes” and show the impact of adding back depreciation expense, a non-cash item, and adding in both operating capital spending plus the new capital replacement reserve contributions budgeted in 2013 and 2014. This presentation arrives at a bottom line consistent with prior budget reporting.

**ADA Operating  
Calculation of Surplus/Deficit**  
\$ 000

	2012 Actual	2013 Budget	2014 Budget
Net Revenue / (Expense) After Taxes	\$ 3,197	\$ 1,034	\$ (1,443)
Add Back Depreciation	6,563	6,358	6,342
Operating Capital Expenditures	(3,440)	(2,856)	(3,329)
Contribution to Capital Replacement Reserve Fund	0	(3,502)	(3,013)
<b>Total: Operating Surplus/(Deficit)</b>	<b>\$ 6,320</b>	<b>\$ 1,034</b>	<b>\$ (1,443)</b>

The House of Delegates created the capital replacement reserve fund beginning with the 2013 budget. For the 2013 and 2014 budgets, the amount of the contributions to the capital replacement reserve fund is determined by the excess of depreciation over the operating capital expenditures. This assumes that over a multi-year period depreciation is a rough indicator of the future capital expenditures that will be required to replace aging assets. This level of contributions should greatly reduce the risk of special membership dues assessments to fund replacements of aging assets.

The surplus/deficit including the contributions to the long term reserve fund (bottom row above) will equal the net revenue / (expense) (top row above) as long as the contributions to the capital replacement reserve fund are based on the excess of operating capital expenditures over depreciation.

**Key Assumptions**

The 2014 budget is based on the following key assumptions:

**1. Membership Dues Revenue** reflects no dues increase. However, non-renewals by full dues payers are assumed to fall to 1,500 in 2014 from the consistent trend over the past few years of ~ 4,000 per year. This favorable assumption adds \$ 1.3M to 2014 revenue.

**2. Great West Life Insurance:** The Council on Member Insurance and Retirement Programs CMIRP has identified and recommended opportunities for additional non-dues revenue from Great West Life Insurance. However, no additional revenue is reflected in this budget as decisions regarding Great West are being considered separate from this budget.

**3. Capital Expenditures and Depreciation:** Operating deficit is expressed including depreciation under the assumption that the non-cash depreciation charge to the operating surplus will fund both operating capital expenditures plus a contribution to the capital reserve fund. Contributions to capital reserve fund

1 equal the excess of depreciation over the current year operating capital expenditures. As shown on page  
2 2008, 2014 contributions to the capital replacement fund will be largely offset by capital expenditures  
3 against the fund.

4  
5 **4. Employee Salary Increase:** The 2014 budget includes provision for a 3.5% merit pool at a cost of  
6 \$1.4M. In addition, 10 FTEs (for Library, CPS, CMIRP, Science EBD, and IT Aptify) are included at a cost  
7 of \$0.7M.

8  
9 **5. Revenue from ADA Periodicals and Product Sales:** The 2014 budget is not as optimistic as the  
10 2013 budget because market migration to lower priced digital media will continue to present challenges,  
11 particularly as dentists less comfortable with the Internet retire. This budget goal also carries some risk to  
12 serve as a catalyst for change rather than being set at an ultra-safe level where achievement is 100%  
13 certain.

14  
15 **6. Headquarters Building Vacancy:** 5.5 floors are assumed to be vacant for most of 2014, with one floor  
16 planned to be leased by the end of 2014 to generate income in 2015 and future years. This vacancy  
17 results in a 2014 budget revenue decline versus 2013 budget of \$1.2M.

18  
19 **7. Employee Medical Costs:** 2014 budget of \$ 3.4 M is \$ 1.1 M or 45% higher than 2012 actual costs,  
20 due to uncertainty regarding rebates and the impact of health care reform.

21  
22 **8. Program Costs:** Every expense and employee headcount in agency divisions is allocated to 65  
23 agency programs. However:

- 24  
25 a. Some portion of program costs (perhaps ~ 20 %) is fixed overhead that would not necessarily be  
26 reduced if a program is sunset.  
27 b. Reduction of the "variable" ~ 80 % would in most cases require employment terminations and  
28 redistribution of work to the extent that separated employees also worked on programs that were not  
29 sunset.  
30 c. 4 of the 65 programs are internal, and therefore not assessed by the Council Budget Group.  
31 Foundation Grant is not managed by any agency division but was assessed by the CBG. Therefore,  
32 the CBG assessed 62 programs.  
33

### Revenues

34 Total revenues in the 2014 budget are \$ 122,244. Highlights of various revenue categories are provided  
35 below.

36  
37 **Membership Dues:** The Division of Membership, Tripartite Relations and Marketing estimates the future  
38 membership levels for each of 28 dues paying categories and multiplies by the 28 dues rates. The 2014  
39 budget anticipates 178,790 members, of which 93,648 will pay full dues of \$522 per year. The average  
40 dues rate per member is \$325 per year including discounts such as Active Life and Recent Graduate.  
41 These figures do not reflect any dues increase or assessment as no dues increase for 2014 has been put  
42 forth by the Board of Trustees.

43  
44 **Advertising:** This category primarily includes advertising sales in ADA publications, new initiatives in  
45 electronic media and secondarily at the ADA annual session. The 2014 revenue of \$9,483 is a (1.4) %  
46 decline from 2013 budget but a 16.3 % increase over 2012 actual. While traditional advertising in ADA  
47 News and JADA will decline in 2014, new sources of revenue such as the consumer website and digital  
48 advertising are assumed to contribute growth.

49  
50 **Rental Income:** This revenue category primarily includes rental income from the Headquarters Building  
51 and the Washington DC Building. Revenue of \$3,855 is a decrease of (23.3) % from 2013 budget. 5.5  
52 floors are assumed to be vacant for most of 2014, with one floor leased near the end of 2014.

1 **Publication and Product Sales:** The increase of \$294 or 4.4 % is largely related to continued growth in  
2 subscriptions and the introduction of the JADA Archive. Additionally, revenue associated with the newly  
3 launched Center for Professional Success (CPS) is expected to generate nearly \$50 in product sales  
4 revenue in 2014.

5  
6 **Testing Fees and Accreditation:** This has been the ADA's largest source of revenue growth over the  
7 last few years. Revenues from testing and accreditation fees are expected to rise by \$2,110 or 11.7 %  
8 versus 2013 budget due to growth in the number of candidates being tested and fees increases in both  
9 testing and accreditation. 2014 accreditation revenue is 58 % above 2013 budget, primarily due to fee  
10 increases that average 57 %. However, as shown below, accreditation revenue (program # 57) still falls  
11 short of costs by \$277 in 2014.

12  
13 **Meeting and Seminar Income:** Most of the \$ (796) decline is related to the location of the 2014 annual  
14 session versus the 2013 annual session. San Antonio is a significantly smaller and less profitable  
15 location than New Orleans.

16  
17 **Grants, Contributions, and Sponsorships:** Grants, contributions, and sponsorships are projected to  
18 increase by \$354 or 18.6%. The 2014 budget anticipates new grants and sponsorships related to the  
19 CPS program. Additionally, the GKAS budget now includes revenue to offset the associated expenses of  
20 this program.

21  
22 **Royalties:** Includes royalties received from the *ADA Business Resources* program, CDT licenses,  
23 domestic and international product licenses, and the selling of mailing lists. The growth of \$1,834 or  
24 34.6% is due to ongoing growth in CDT licenses and *ADA Business Resources* offerings, the latter of  
25 which also had a very conservative 2013 budget.

26  
27 **Investment Income:** A conservative projection for revenue of \$1,476 for 2014 includes both interest and  
28 dividends on reserve fund assets and investment earnings on cash in the operating account. The decline  
29 of \$ (609) in 2014 is primarily due to two factors:

30  
31 \$(300) due to an accounting change in which income from deferred compensation assets are no  
32 longer reported as ADA revenue. The associated equal expense is also no longer reported, and  
33 therefore this accounting change has no impact on ADA net surplus.

34 \$(309) due to the lower interest rate environment that reduces returns on cash. Most of the ADA's  
35 financial assets are held in equity securities in the reserve account and continue to generate strong  
36 returns. However, the much smaller cash assets that are reported in the operating account are  
37 affected by lower interest rates.

38  
39 **Other Income:** This category is composed of miscellaneous revenue, including such items as overhead  
40 revenue from subsidiaries and the Member Insurance Program, and Seal Program revenues. The \$99  
41 increase is mainly due to an increase in the reimbursement the ADA receives from the Member's  
42 Insurance Program, due to additional costs related to the external audit of the programs.

### Expenses

43 Total operating expenses are budgeted at \$122,387, an increase of \$(5,060) or (4.3) % versus the 2013  
44 budget.

45 Highlights of various expense categories are provided below.

46  
47  
48 **Salaries (Base Compensation):** Base salary expenses are budgeted at \$40,840 an increase of \$(2,187)  
49 or (5.7) % from the 2013 budget. This includes a 3.5% salary increase pool at a cost of \$ 1,353.  
50 Additionally, the 2013 budget assumed the Library staffing levels would be down to 1 person by the end

1 of the 2013 as most functions would be outsourced. After further study, the 2014 library budget includes  
2 5.2 FTE's to re-launch the library as a 21<sup>st</sup> century knowledge resource with digital information that  
3 members can efficiently search through electronic databases. Additionally, a net of 5 new hires are  
4 proposed in the 2014 budgets of other divisions.  
5

6 **Agency Compensation (includes Severance):** This category includes expense associated with  
7 severance pay, off cycle salary increases and service awards and is projected to be favorable by \$600 or  
8 46.2%. The decline is due to the 2013 budget including an increase in severance pay as a result of staff  
9 reductions related to program eliminations.  
10

11 **Temporary Help:** The ADA hires temporary staff for annual session and to assist divisions when staff  
12 positions are open during the year.  
13

14 **Pension – Normal Cost:** This category is to cover annual contributions to the scaled back new pension  
15 plan that went into effect January 1, 2012. The cost reflected in this category represents estimated plan  
16 contributions required by the IRS rules for current employees. While this increased by \$(621) or when  
17 compared to 2013, this cost is still over \$3 million less than they were before the plan changes. These  
18 amounts fluctuate on an annual basis and are based on actuarial assumptions.  
19

20 **Pension – Catch-up Supplemental Funding:** The ADA must continue to fund the liability of the full  
21 employee pension plan that was offered to employees prior to 2012. As of 12/31/2012, the ADA pension  
22 plan had a cash basis funded status of approximately 87% and all plan contributions add to net plan  
23 assets that are only used to pay future benefits.  
24

25 **401K Contribution:** No significant change is anticipated for 2014.  
26

27 **All Other Benefit Costs:** Expenses in this category include group medical premiums, dental direct  
28 reimbursement, life insurance, workers compensation, deferred compensation benefits and union dues  
29 for two building engineers. The expenses in this category are expected to increase by \$(65) or (1.4) %  
30 from 2013. Group medical costs are expected to increase in 2014. Partially offsetting the increase is an  
31 accounting change for appreciation of deferred compensation benefits. The 2013 budget included  
32 revenue and the offsetting expense, neither of which are included in the 2014 budget.  
33

34 **Payroll Taxes:** This category includes expense associated with employer related taxes such as FICA,  
35 SUI and FUI. The increase in the budget for this category is based on increased staffing levels.  
36

37 **Travel Expenses:** Travel expenses are usually comprised of about three quarters volunteer travel and  
38 one quarter staff travel. Budget expenses for travel are projected to increase by \$(399) or (6.8) % versus  
39 the 2013 budget. Airline and hotel costs are projected to increase in 2014.  
40

41 **Printing, Publications and Marketing:** This expense item increased Association-wide due to closure of  
42 the internal print services which generated savings offsets from significant staffing reductions. In addition,  
43 social media marketing has been added to the marketing plan for 2014.  
44

45 **Meeting Expenses:** The 2014 budget anticipates an unfavorable variance of \$ (98), largely attributable  
46 to expenses associated with the annual session site in 2014. Additionally, CDEL is budgeting for an  
47 additional meeting in 2014.  
48

49 **Consulting Fees and Outside Services:** Expenses in this area increase by \$(1,008) or (16.9) %. The  
50 increase is attributable to IT initiatives, funding for research priorities in HPRC and expenses related to  
51 annual session.  
52

53 **Professional Services:** Most of the \$(189) increase in this expense category are due to test  
54 administration fees that the ADA pays to the company that administers NBDE, DAT and OAT exams.

1 This increase is directly related to the increase in testing revenue. Also contributing to this increase are  
2 expenses related to JADA On-Line Seminar Series in the Publishing Division. In addition, this account  
3 also includes legal and audit fees managed by the Legal division.  
4

5 **Bank and Credit Card Fees:** This category represents transaction fees paid to financial institutions and  
6 reimbursements to state and local societies for credit card fees related to ADA membership dues  
7 collection.  
8

9 **Office Expenses:** The \$(119) increase versus 2013 budget in office expenses reflects increases in  
10 furniture and equipment due to adding and enhancing CE Hub components on the exhibit hall floor at  
11 annual session as well as a slight increase in the new contract with the annual session decorator. Audio  
12 visual costs have increased based on all the different components of the meeting we are introducing to  
13 enhance attendee experience and engagement. Additionally, enhancements to the ADA Library increase  
14 the budget in this category.  
15

16 **Facility and Utility Costs:** These expenses represent costs for building management and operations,  
17 maintenance, and real estate taxes for the ADA Headquarters and Washington DC buildings. The  
18 increase of \$(250) is the result of increased property taxes for the headquarters building, partially offset  
19 by savings in cleaning costs and building management fees.  
20

21 **Grants and Awards:** The ADA distributes grants to support various organizations for specific functions.  
22 The \$ 72 savings is largely due to a reduction in State Public Affairs grants of \$ 225.  
23

24 **Endorsement Costs:** This category represents monies paid to state societies that participate in the *ADA*  
25 *Business Resources* program and to the AMA for use of medical codes in *CDT* related products.  
26

27 **Depreciation and Amortization:** 2014 budget expense is nearly the same as the 2013 budget.  
28 Depreciation is calculated annually based on prior year and proposed current year capital acquisitions.  
29

30 **Other Expenses:** Other expenses include general insurance, recruiting costs, staff development,  
31 overhead recovery, and the contingency fund. No significant variance exists in this category. The ADA  
32 budgets \$ 1,000 per year in the contingency fund, against which spending during the year is approved by  
33 the Board of Trustees,  
34

35 **ADA Foundation Grant:** The Association's annual grant to the Foundation remains constant in 2014.  
36

### 37 **List of Programs Sorted by Decision Lens Ranking**

38

39 The listing below provides the rank order of all programs as well as the FTE's, revenue, expense and the  
40 net revenue/(expense) of each. This schedule captures every dollar of ADA expenses and every ADA  
41 staff member, so that the totals below equal the totals shown on the more traditional schedules included  
42 above.  
43

**List of Programs Sorted by Decision Lens Ranking**

Rank #	Program #	Division		Decision Lens Score	FTE	Revenue	Expense	Net Revenue / (Expense)
1	15	MTM	Office of Student Affairs	0.664	2.0	0	353	(353)
2	2	Govtmt	Advocacy Denal Practice -Fed Dental Serv	0.640	3.5	0	1,065	(1,065)
3	25	DCCE	ADA Session	0.628	13.1	9,873	7,995	1,878
4	26	Publish	JADA	0.605	9.2	3,477	3,791	(314)
5	16	MTM	Council on Mbr Insurance & Rtrmt Progra	0.603	3.3	1,529	1,135	394
6	34	Benefits	CDBP Third Party Issues	0.594	2.9	0	416	(416)
7	20	MTM	New Dent Committee & New Dentist Prog	0.590	2.8	310	746	(436)
8	44	Science	Center Evidence Based Dentistry	0.582	4.7	113	993	(880)
9	27	Publish	ADA News	0.576	10.6	4,802	4,421	382
10	45	Science	Scientific Literature Research Anal & Edu	0.565	7.8	12	1,197	(1,185)
11	1	Govtmt	Advocacy Sci Ed Appropriations,Wellness	0.550	2.8	0	535	(535)
12	46	Science	Product Evaluation	0.547	7.7	0	1,309	(1,309)
13	61	Comm	Professional Web and Digital	0.545	3.9	0	653	(653)
14	19	MTM	Success Prog--Speaker Dev & Dent Schor	0.542	0.6	132	197	(65)
15	42	Science	ADA Seal	0.542	4.5	705	781	(76)
16	37	Benefits	Dental Code Dev&Maint	0.537	2.9	0	472	(472)
17	50	Educat	CDEL ContEdRecProg(CERP)	0.535	3.5	273	556	(283)
18	30	Practice	Center for Professional Success (CPS)	0.534	4.8	635	1,127	(492)
19	6	Govtmt	State Public Affairs Prog. (SPA)	0.530	6.3	23	4,023	(4,000)
20	39	HPRC	Member Products & Services	0.530	2.8	20	471	(451)
21	48	Science	Exp Lab Research on Emerging & Critcl Is	0.523	5.3	0	760	(760)
22	8	Govtmt	Fluoridation & Prevention	0.504	2.8	0	450	(450)
23	29	PDS	Product Development and Sales	0.504	9.4	8,586	4,561	4,024
24	43	Science	Science Liaison & Advocacy	0.497	4.7	0	712	(712)
25	59	Comm	Public and Professional Communications	0.466	5.8	0	1,060	(1,060)
26	13	Govtmt	DMM Recruitment & Retntion Activities	0.464	5.3	8	1,173	(1,165)
27	62	Comm	Public Affairs	0.459	2.3	0	430	(430)
28	7	Govtmt	ADPAC Marketing Campaign	0.458	3.1	0	554	(554)
29	35	Benefits	Department Dental Informatics	0.458	3.3	0	641	(641)
30	47	Science	ANSI Standrds & Standrds Devlpmnt	0.456	5.3	80	1,071	(991)
31	49	DCCE	CDEL- Continuing Education Oversight	0.454	2.1	502	529	(27)
32	3	Govtmt	Advocacy Access and Dental Coverage	0.445	2.8	0	593	(593)
33	63	Comm	Public Relations Agency Programs	0.429	2.3	0	1,216	(1,216)
34	14	MTM	Membershship Contact & Connections	0.428	6.4	30	1,557	(1,527)
35	60	Comm	Consumer Outreach	0.425	4.2	688	1,392	(704)
36	5	Govtmt	Lobbyist Conference	0.421	0.3	0	64	(64)
37	33	Practice	Group Practice Models & Economics	0.419	1.9	0	282	(282)
38	4	Govtmt	Washington Leadership Conference	0.410	1.7	0	405	(405)
39	32	Practice	DentHealthWellness&Well-Being	0.409	1.8	33	286	(253)
40	36	Benefits	CDBP Quality Assess&Improvement	0.408	2.9	0	468	(468)
41	10	Govtmt	Access Community Oral Health Infra Capa	0.399	2.1	0	447	(447)
42	11	Govtmt	Geriatrics and Special Needs	0.397	1.8	0	356	(356)
43	52	Educat	CODA(Accreditation)	0.392	14.8	2,545	2,823	(277)
44	9	Govtmt	Interprofessional Relations	0.388	1.8	7	403	(395)
45	53	Educat	Joint Commission Natl Board JC-NBDE	0.369	21.3	10,750	7,201	3,548
46	55	Educat	Library Services	0.369	5.2	10	760	(750)

**List of Programs Sorted by Decision Lens Ranking (Page 2 of 2)**

Rank #	Program #	Division	Decision Lens Score	FTE	Revenue	Expense	Net Revenue / (Expense)	
47	38	HPRC	Policy Research	0.365	6.9	0	1,498	(1,498)
48	56	Educat	CDEL-Policy Management & Development	0.359	4.1	0	537	(537)
49	17	MTM	Dept Dental Society Svcs	0.356	8.4	78	1,310	(1,232)
50	24	Global	FDI Internt'l Activity	0.347	0.6	0	517	(517)
51	18	MTM	Inst for Divsty in Leadership	0.343	0.2	40	156	(116)
52	21	Global	International Collaboration	0.325	2.3	0	465	(465)
53	23	Global	Internt'l Business Dev	0.325	1.2	0	316	(316)
54	22	Global	Intnt'l Humanitarian Outreach	0.315	0.9	0	166	(166)
55	58	ADAF	Grant to ADA Foundation	0.295			1,900	(1,900)
56	31	Practice	Dental Team Liaison Relation	0.291	2.6	0	375	(375)
57	51	Educat	CDEL-Dental Aptitude Test; DAT-DTS	0.281	7.7	5,636	2,340	3,295
58	57	Educt	Internatl Consultation for Dental Educatn	0.278	0.6	108	133	(25)
59	28	Publish	Digital Advertising	0.235	4.8	1,754	890	864
60	41	HPRC	Research Services External Clients	0.204	1.4	0	247	(247)
61	40	HPRC	Research Serv Internal Clients	0.192	2.9	50	503	(453)
62	54	Educat	Outside Clients-Optometry Test(OAT)	0.174	2.7	1,217	797	421
<b>Total Programs Assessed by CBG</b>					<b>267.5</b>	<b>54,026</b>	<b>74,580</b>	<b>(20,553)</b>
<b>Internal Programs in Agency Divisions</b>								
		MTM	Department of Membership Information	N/A	10.0	78	1,224	(1,146)
		MTM	Member Service Center	N/A	14.0	0	1,294	(1,294)
		DCCE	Meeting Room Management	N/A	5.8	315	876	(561)
		Comm	Marketing Shared Services	N/A	7.5	0	1,134	(1,134)
		<b>Total</b>			<b>37.3</b>	<b>393</b>	<b>4,528</b>	<b>(4,135)</b>
<b>Non-Program Divisions:</b>								
			Contingency General		0.0	0	1,000	(1,000)
			Administrative Services		13.6	0	5,721	(5,721)
			Human_Resources		6.8	0	2,055	(2,055)
			Legal Affairs		15.6	85	3,938	(3,854)
			Finance and Operations		34.0	1,500	4,126	(2,626)
			Headquarters Building		1.0	2,030	5,794	(3,764)
			Washington Building		0.0	1,781	1,069	712
			Central Administration		0.0	62,238	9,156	53,082
			Information Technology		48.0	0	11,248	(11,248)
			Corp. Rel & Strat. Mkng Alliances		4.0	190	906	(716)
		<b>Subtotal</b>			<b>123.0</b>	<b>67,825</b>	<b>45,015</b>	<b>22,810</b>
			Income Taxes				1,300	(1,300)
			Add back Grant to Foundation already in Central Admin				(1,900)	1,900
			Depreciation in Agncy Divisions Not in Progr Costs				165	(165)
<b>Total ADA</b>					<b>427.8</b>	<b>122,244</b>	<b>123,688</b>	<b>(1,443)</b>



## 1 Council Budget Group (CBG) Program Assessments

2 The Administrative Review Committee and Board generally agreed with the CBG's program  
3 assessments. The only area of major difference between the Board assessment and the CBG score  
4 rankings were those for the Health Policy Resources Center programs on which, as shown above, the  
5 CBG had scored three of the four programs in the bottom quartile, including # 60 and # 61 out of 62  
6 programs. It appeared that the new direction and work products of the HPRC were not well-  
7 communicated to the CBG at the time they did their scoring. The HPRC staff subsequently provided the  
8 Board an additional narrative that better explains the HPRC work. That document is included in the  
9 supplemental division reports available to all delegates.

10 As shown in the table above, some of the lower ranked programs generate non-dues revenue and profit  
11 that enables funding of other, higher ranked programs. This is why the financial information is shown  
12 alongside the scores against the Universal Assessment Criteria.

13 Programs that ranked # 50, # 52, # 53, # 54, # 58 all relate to international activity. In these areas the  
14 Board requested more specific commitments to revenue growth. Several improvement actions were  
15 defined for these areas. The Budget and Finance Committee intends to monitor progress in this area  
16 more closely in the future.

17 The Committee also shared some of the CBG's apparent concerns about the ADA's grant to its  
18 Foundation, which the CBG had ranked # 55 out of 62. The ADAF has not yet been able to provide any  
19 multi-year financial projections and unexpectedly submitted emergency funding requests in both 2012  
20 and 2013. After considerable discussion, the Committee and Board agreed to maintain the grant to the  
21 Foundation at the same level as in the prior year, but with the understanding that the Foundation will  
22 submit a strategic plan. The plan will define the scope of ADAF activities and provide advance visibility to  
23 the ADAF's funding needs.

24 The CBG scored the Office of Student Affairs the highest of any program. An ADA study completed after  
25 the CBG scoring suggests that the CBG correctly identified a key driver of ADA market share. The study  
26 found that graduates of ADA-friendly dental schools are far more likely to remain ADA members over their  
27 full careers.

### Additional Detail on Divisions

For delegates that would like to review additional budget detail on each of the ADA's 22 divisions and 62 programs, two supplementary documents will also be available on the secure Financial House of Delegates site of ADA Connect.

- 2014 Budgets Agency Divisions: Overviews of each agency division, summary of each division's revenue and expense by program, program descriptions and explanation of any significant 2014 budget variances versus 2013 budgets.
- 2014 Budgets Shared Services Divisions: Overview of each Shared Services division, summary of revenue and expense by department, and explanation of any significant 2014 budget variances versus 2013 budgets.

**Capital Expenditures**

The ADA has two types of capital expenditures, each with its own procedures for reporting and approvals: Reserve Capital and Operating Capital. In order to ensure that funding is available to cover major capital replacement projects as well as “Operating Capital” projects which are included in annual operating budgets, the ADA defines each category as follows:

- 1
  - 2
  - 3
  - 4
  - 5
  - 6
  - 7
  - 8
  - 9
  - 10
  - 11
  - 12
  - 13
  - 14
  - 15
1. **Operating Capital** spending to add, upgrade, or replace more common and short-lived fixed assets. A good example of this would be the ongoing annual replacement of computer equipment which is done on a continuing annual basis with 1/3 of all PC equipment turned over each year such that every computer at the ADA is retired and replaced every 3 years. This category should include all items replaced within 5 years. Operating Capital Spending is included as a line item with detail support in the annual operating budget in Board Report 2.
  2. **Reserve Capital** spending is a separate category of larger and much less frequent building repairs, replacements, and renovations to ADA buildings. Such renovations will include the cost of tenant improvements (TI) and related one-time costs to secure long term leases. Because this type of major capital spending comes from a dedicated capital replacement reserve account, each actual project must be reviewed and approved by the Finance Committee and Board. Costs of tenant leasehold improvements must be justified as part of a complete capital authorization request (CAR) in a board report with appropriate economic analysis.

16  
17

**Capital Expenditure Summary**

\$ 000	2013 B	2014 B
Conferences and Continuing Education	(265)	(271)
Headquarters Building	(656)	(678)
Washington Building	(211)	(85)
Finance and Operations	(71)	(60)
Central Administration	(230)	-
Information Technology	(1,390)	(2,092)
Dental Practice		(95)
Science	(33)	(50)
<b>Total Operating Capital</b>	<b>(2,856)</b>	<b>(3,331)</b>
Headquarters Building:		
Tenant Improvements	(997)	(1,183)
Maintenance/Replacement	(200)	(1,045)
Washington DC Building:		
Tenant Improvements	(133)	(230)
Maintenance/Replacement	-	(108)
<b>Total Reserve Capital</b>	<b>(1,330)</b>	<b>(2,566)</b>
<b>Total Capital Expenditures</b>	<b>(4,186)</b>	<b>(5,897)</b>

**2014 Budget Operating Capital Expenditures**

<b>List of 2014 Capital Expenditures by Division</b>					
Thousands of Dollars					
<b>Division Name: Information Technology</b>					
	<b><u>Q1</u></b>	<b><u>Q2</u></b>	<b><u>Q3</u></b>	<b><u>Q4</u></b>	<b><u>2014</u></b>
Desktop Replacements (110)		132			132
Computer Monitors (150)				75	75
Network Printer Replacements (15)				45	45
Network Servers (1)				275	275
Network Infrastructure Upgrades				95	95
Annual Laptop Replacements - BOT (15)			29		29
Annual Laptop Replacements (115)				219	219
Board Room Upgrades			150		150
ArcServe Software Licenses				25	25
Microsoft Office 2013		250			250
Telephone System Upgrades (2)		20			20
Aptify EDUC Licenses (1)	99				99
MS SQL Licenses (1)			135		135
Hyperion System Upgrade (1)			50		50
Mobile Application Development (1)		13		12	25
Aptify Legislative & Peer Implementation (1)				50	50
FileWeb Replacement - Decision Package (1)	230			188	418
<b>Total Division</b>	<b>329</b>	<b>415</b>	<b>364</b>	<b>984</b>	<b>2,092</b>
<b>Division Name: Conferences &amp; Continuing Education</b>					
	<b><u>Q1</u></b>	<b><u>Q2</u></b>	<b><u>Q3</u></b>	<b><u>Q4</u></b>	<b><u>2014</u></b>
Exec Dining Room China Replacement			9		9
Exec Dining Room Catering Equipment			12		12
2nd Floor Conference Center Upkeep Furniture & Soft Goods	6				6
2 <sup>nd</sup> Floor Work Suite Renovation			244		244
<b>Total Division</b>	<b>6</b>	<b>0</b>	<b>265</b>	<b>0</b>	<b>271</b>
<b>Division Name: Dental Practice/Professional Affairs-CDP</b>					
	<b><u>Q1</u></b>	<b><u>Q2</u></b>	<b><u>Q3</u></b>	<b><u>Q4</u></b>	<b><u>2014</u></b>
Financial Analyzer Develop.	24	24	24	23	95
<b>Total Division</b>	<b>24</b>	<b>24</b>	<b>24</b>	<b>23</b>	<b>95</b>

<b>Division Name: Finance &amp; Operations</b>					
	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	<b>2014</b>
Association Wide Furniture			40		40
Postage Meter Machine	20				20
<b>Total Division</b>	<b>20</b>	<b>0</b>	<b>40</b>	<b>0</b>	<b>60</b>
<b>Division Name: Headquarters Building</b>					
<b>Operating Capital</b>					
	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	<b>2014</b>
Upgrade Common Area - 7th Floor (Leasing)	175				175
Painting Stairwells (Leasing) 3 Stairwells	77				77
New Lining - Condensate & Boiler Feed Tanks			200		200
Roof Replacement - Parking Garage			65		65
Sump Pumps - Replacement	60				60
Garage Exhaust Fans - Replacement		25			25
Install Floor Drain s- Mezzanine		6			6
Replace Drain Lines - Mezzanine/Garage (Cafe')		70			70
<b>Total Division</b>	<b>312</b>	<b>101</b>	<b>265</b>	<b>-</b>	<b>678</b>
<b>Division Name: Headquarters Building</b>					
<b>From Capital Replacement Fund</b>					
	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	<b>2014</b>
New Tenant - Improvement Suite 1300			140	140	280
Sidewalk Replacement			350		350
Water Proof Floor - 3rd Floor Mechanical				195	195
Re-Caulk All Glass Spandrel & Windows - North & South Sides		500			500
New Tenant - Improvement Suite 1500			903		903
<b>Total Division</b>	<b>-</b>	<b>500</b>	<b>1,393</b>	<b>335</b>	<b>2,228</b>
<b>Division Name: Washington DC Building</b>					
<b>Operating Capital</b>					
	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	<b>2014</b>
Façade Caulking		85			85
<b>Total Division</b>	<b>-</b>	<b>85</b>	<b>-</b>	<b>-</b>	<b>85</b>
<b>Division Name: Washington DC Building</b>					
<b>From Capital Replacement Fund</b>					
	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	<b>2014</b>
Common Corridor Renovation		108			108
New Tentant Improvements		180			180
ADA Space Improvements			50		50
<b>Total Division</b>	<b>-</b>	<b>288</b>	<b>50</b>	<b>-</b>	<b>338</b>

<b>Division Name: Science/Professional Affairs</b>					
	<b><u>Q1</u></b>	<b><u>Q2</u></b>	<b><u>Q3</u></b>	<b><u>Q4</u></b>	<b><u>2014</u></b>
EDS Detector for Neoscope2	50				50
<b>Total Division</b>	<b>50</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>50</b>
	<b><u>Q1</u></b>	<b><u>Q2</u></b>	<b><u>Q3</u></b>	<b><u>Q4</u></b>	<b><u>2014</u></b>
<b>Total ADA Operating Capital</b>	741	625	958	1,007	3,331
<b>Total ADA Capital Replacement Fund</b>	-	788	1,443	335	2,566
<b>Grand Total - 2014 Capital Requests</b>	<b>741</b>	<b>1,413</b>	<b>2,401</b>	<b>1,342</b>	<b>5,897</b>

1 **Projected Expenditures from the Capital Reserve Fund**

2 The 2012 House approved a 2013 budget that included a \$3,502 contribution to set up a new capital  
3 reserve account to fund foreseeable significant, but infrequent, capital replacement projects. The ultimate  
4 purpose of this capital reserve account is to avoid the need for future special assessments. Because this  
5 capital replacement reserve account was started from zero in 2013, good stewardship prompts us to  
6 introduce transparent reporting of recent activity as well as current estimates of future needs for this fund  
7 in the charts that follow.

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11

**Estimated Expenditures from The Capital Replacement Reserve Fund**

\$ 000

	2013P	2014P	2015P- 2017P
<b>Headquarters Building Projects</b>			
Tenant Improvement costs for new/renewals	\$997	\$1,183	\$4,083
Major Renovation or Replacements			
Reline Boiler Tanks	200		
Exterior - sidewalk replacement		350	
Exterior - Window Re-Caulking		500	
Electrical Switch Gear replacement			1,550
Chillers			2,550
Other Asset Replacements - 3rd Floor Waterproofing			
		195	
<b>Total Headquarters Building</b>	<b>\$1,197</b>	<b>\$2,228</b>	<b>\$8,183</b>
<b>Washington DC Building Projects</b>			
Tenant Improvement costs for new/renewals	\$133	\$230	\$673
Major Renovation or Replacements			
Common Area Renovations		108	
Exterior Façade Repairs			120
Window Replacement project			820
Variable Air Volume Boxes			740
Other Asset Replacements			
			91
<b>Total Washington DC Building</b>	<b>\$133</b>	<b>\$338</b>	<b>\$2,444</b>
<b>Total Capital Expenditures from Reserve Fund</b>	<b>\$1,330</b>	<b>\$2,566</b>	<b>\$10,627</b>

**Projected Reserve Fund Balances**

Beginning in 2013, the ADA effectively has two reserve funds: an operating reserve and a capital reserve. The schedules below show fund balances might trend based on future operating results, reserve spending, and capital expenditures. However, there is considerable uncertainty in variables over which the ADA and its leadership have limited control, such as pension liability valuation, reserve capital expenditures, non-dues revenue, and investment returns. Therefore, the projections below illustrate only one possible scenario.

**ADA Capital Replacement Reserve Fund**

\$ 000

	2013P	2014P	2015P- 2017P
Beginning of Year	-	2,216	2,861
Fund Contributions			
Cash from Depreciation	6,358	6,342	19,026
Operating Capital Expenditures	(2,856)	(3,329)	(9,988)
Investment Returns	43	199	420
Subtotal	3,546	3,211	9,458
Reserve Capital Expenditures	(1,330)	(2,566)	(10,627)
Total Changes	2,216	645	(1,169)
<b>End of Year</b>	<b>2,216</b>	<b>2,861</b>	<b>1,692</b>

**ADA Uncommitted Operating Reserves**

Assumes 2013 operating results equal 2013 budget

\$ 000

	2013P	2014P	2015P- 2017P
Beginning of Year	54,675	55,896	54,689
Changes:			
Operating Surplus / (Deficit)	1,034	(1,443)	3,000
Reserve Spending	(2,000)	(2,000)	(6,000)
Investment Appreciation	2,187	2,236	6,563
Total Changes	1,221	(1,208)	3,563
<b>End of Year</b>	<b>55,896</b>	<b>54,689</b>	<b>58,251</b>
Budget Expenses	117,330	122,387	127,283
Reserve % of Expenses	47.6%	44.7%	45.8%

*These reserve account activity and balance projections are based on very rough assumptions to show possible trends and are not intended to indicate long term targets.*

1 **Capital Replacement Reserve Fund (New as of 2013):** This was created by the 2012 House of  
2 Delegates to eliminate the need for special membership dues assessments to fund large asset  
3 replacements. In the long run, funding will be determined by the projected needs, but during the first few  
4 years the fund contributions are equal to depreciation less operating capital expenditures. In other words,  
5 in each year the excess of depreciation over operating capital is contributed to the capital reserve fund.  
6  
7 Under the assumptions shown above, by the end of 2017 the fund balance would be \$1,692. As shown  
8 in the capital expenditure schedule, significant assets are expected to reach the end of their useful lives  
9 and need replacement during this period.  
10  
11 **Uncommitted Operating Reserves:** As a reminder, this report does not include any new non-dues  
12 revenue from Great West Life Insurance, nor any member dues increase. Also, the 2013 result is  
13 assumed to be equal to the 2013 budget and the strong investment returns achieved through June 2013  
14 are not assumed to continue for the balance of 2013. Under these conservative assumptions, the  
15 reserve balance would remain below the 50% goal and show little change from 2013-2017.  
16



1 **ADA Operations**  
2 **2012 Actual Variances versus 2012 Budget**  
3 **\$ 000**  
4

			Variance	Subtotal	Total Surplus
2012 Budget					400
<u>Revenue variances</u>					
Favorable - Royalty revenue			1,054		
Favorable - Short-term investment earnings			299		
Unfavorable - Membership dues			(260)	1,093	
<u>Expense variances</u>					
Favorable - Open positions			1,105		
Favorable - Pension expense			1,341		
Favorable - Group medical costs			1,638		
Unfavorable - severance payments			(851)		
Unfavorable - 401k employer expense			(1,390)		
Favorable - Travel expenses			460		
Unfavorable - Depreciation expenses			(475)	1,828	
<u>Division variances (without salaries/travel - includes revenues)</u>					
Favorable - Government & Public Affairs	SPA grants		930		
Favorable - Contingency Fund	Did not request funds		774		
Favorable - Education	Testing revenues		942		
Unfavorable - Headquarters building	Property taxes		(946)		
Unfavorable - ADA Publishing	Advertising revenues		(1,803)		
Favoable - Membership			313		
Favorable - Conferences & Continuing Ed			328		
Favorable - Information Technology			262		
Favorable - Science			247		
Favorable - Dental Practice			275		
Remainder of variances			307	1,629	
<u>Cash item variances</u>					
Favorable - Capital expenditures			895		
Favorable - Depreciation expense			475	1,370	
<b>Total Variances</b>					<b>5,920</b>
<b>2012 Actual</b>					<b>6,320</b>

1 **Headquarters Building Valuation**

2  
3 The House adopted Resolution 69H-2002 (*Trans.2002:372*), directing that the estimated market value of  
4 the ADA headquarters building be included in Board Report 2. The two most likely uses of the ADA  
5 building by a purchaser would be as an office building or a conversion to a residential property. These are  
6 two very different uses and very different markets which yield different estimated valuations. Per  
7 discussion with real estate transaction professionals in Chicago, a rough estimate would be \$41 to \$48  
8 million but a more detailed evaluation of major capital projects and the release of pending vacancies  
9 could move those numbers. Furthermore, the value for office use assumes that the building would be  
10 occupied, meaning that for a sale, the ADA would need to commit to a long-term lease as a tenant at  
11 market rates (an expense not now incurred) or find a replacement tenant and rent space in a different  
12 building.

13  
14 These amounts represent gross selling price before any related sale and closing costs. Further, these  
15 valuations reflect current conditions in the Chicago real estate market.

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**Resolutions**

(See Resolution 3; Worksheet:2025)  
(See Resolution 4; Worksheet:2026)

Resolution No. 3 New

Report: Board Report 2 Date Submitted: August 2013

Submitted By: Board of Trustees

Reference Committee: Budget, Business and Administrative Matters

Total Net Financial Implication: \$122,244 (Revenue)  
\$123,687 (Ongoing Expense) Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE \_\_\_\_\_

ADA Strategic Plan Goal: Financial (Required)

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**APPROVAL OF 2014 BUDGET**

**Background:** (See Report 2 of the Board of Trustees to the House of Delegates: 2014 Budget, Worksheet:2000).

**Resolution**

**3. Resolved,** that the 2014 Annual Budget of revenues and expenses, including net capital requirements be approved.

**BOARD RECOMMENDATION: Vote Yes.**  
**BOARD VOTE: UNANIMOUS.**

Resolution No.  4  New

Report:  Board Report 2  Date Submitted:  August 2013

Submitted By:  Board of Trustees

Reference Committee:  Budget, Business and Administrative Matters

Total Net Financial Implication:  None  Net Dues Impact:

Amount One-time   Amount On-going   FTE  0

ADA Strategic Plan Goal:  Financial  (Required)

1  **ESTABLISHMENT OF DUES EFFECTIVE JANUARY 1, 2014**

2  **Background:** The Board of Trustees at its June 2013 meeting approved a preliminary budget with a net  
3 deficit of (\$1,443,000), based on the current dues rate of five hundred twenty-two dollars (\$522.00). A  
4 dues increase is not being sought. Notification of the proposed dues level was circulated to all  
5 constituent dental societies and announced in an official Association publication. The following resolution  
6 is submitted by the Board of Trustees.

**Resolution**

7  **4. Resolved,** that the dues of ADA active members shall be five hundred twenty-two dollars  
8 (\$522.00), effective January 1, 2014.

9  **BOARD RECOMMENDATION: Vote Yes.**

10  **Vote: Resolution 4**

BUCKENHEIMER	Yes	FEINBERG	Yes	NORMAN	Yes	VERSMAN	Yes
CROWLEY	Yes	GOUNARDES	Yes	ROBERTS	Yes	WEBER	Yes
DOW	Yes	HAGENBRUCH	Yes	SCOTT	Yes	YONEMOTO	Yes
ENGEL	No	ISRAELSON	Yes	SEAGO	Yes	ZENK	Yes
FAIR	Yes	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	No

Resolution No. None New  
 Report: Board Report 5 Date Submitted: June 2013  
 Submitted By: Board of Trustees  
 Reference Committee: Budget, Business and Administrative Matters  
 Total Net Financial Implication: TBD Net Dues Impact: TBD  
 Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0  
 ADA Strategic Plan Goal: Members and Financial (Required)

1 **REPORT 5 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: BOARD ACTION ON**  
 2 **ADA MEMBERS INSURANCE PLANS PURSUANT TO REPORT BY COUNCIL ON MEMBERS**  
 3 **INSURANCE AND RETIREMENT PLANS**

4 **Background:** The Council on Members Insurance and Retirement Programs (CMIRP or Council) has  
 5 provided the Board with a report recommending actions relating to ADA Members Insurance Plans  
 6 (Insurance Plans). The report is attached as an Appendix. The CMIRP report reviews a comprehensive  
 7 two-year financial audit and benchmarking study of the Insurance Plans utilizing actuarial consultants  
 8 from Milliman, Inc. The financial audit confirmed the best in class status of the Insurance Plans in pricing  
 9 and service, as well as their financial strength and stability.

10 Based on recommendations from CMIRP, the Board took the following actions:

- 11 • Approved a change in the interest credit formula;
- 12 • Approved changes to the risk and profit charges for two of the Insurance Plans;
- 13 • Approved a one-time payment to the ADA of the Board approved 2012 unallocated surplus set-
- 14 aside from the term life plan; and
- 15 • Approved a change in its Board rules.

16 Each of these actions is described in detail in the attached report to the Board by CMIRP.

17 The Board had considerable discussion on the change in the Board rules recommended by the Council.  
 18 The Board amended the Council’s proposed resolution to more clearly express the Board’s commitment  
 19 to protect policyholder value. Following the recommendation of the Council, the Board adopted the  
 20 following amended resolution:

21 **B-48-2013. Resolved**, that *The Organization and Rules of the Board of Trustees* be amended to  
 22 delete the following section in its entirety.

23 “POLICY ON SURPLUS FROM GROUP LIFE INSURANCE PROGRAM”

24 ~~Insurance Surplus: When a surplus is available from the Group Life Insurance Program,~~  
 25 ~~the Board of Trustees shall allocate this surplus either to improvement of the program,~~  
 26 ~~reduction of premium or refund to the certificate holders or to the ADA General fund.”~~

27 and be it further

1                 **Resolved**, that the following language be inserted in its place:

2                         **Insurance Surplus:** When a surplus is available from insurance programs, the surplus  
3                         should be used to ensure value for policyholders and financial stability of the Association.

4     This change permits the Board to allocate excess surplus as non-dues revenue, provided the interests of  
5     the policyholders are protected (i.e. the Insurance Plans remain best in class). In taking this action, the  
6     Board agreed with CMIRP that very positive, changed circumstances in the growth in the asset base  
7     provided the Board with an opportunity to take action to promote member value for *all* ADA members  
8     while at the same time preserving value for ADA policyholders.<sup>1</sup>

9     The Board thanks the Council for its efforts to enhance member value while maintaining unmatched value  
10    for our policyholders.

11   **Resolutions**

12    This report is informational and no resolutions are presented.

13  
14    **BOARD RECOMMENDATION: Vote Yes to Transmit.**

15  
16    **BOARD VOTE: UNANIMOUS.**

17

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<sup>1</sup> In particular, the Board draws the House's attention to the attached report in which CMIRP reviews efforts it will undertake to improve plan value for policyholders. For example, CMIRP will take up the development of an implementation plan for the proposed plan changes listed below:

- Gender rates for the Term Life, Disability Income Protection and Office Overhead Expense plans,
- A tobacco rate class for the Disability Income Protection and Office Overhead Expense Plans, and
- Developing a proposal for the ADA to derive annual non-dues revenue from the Insurance Plans of up to \$6-\$11 million as part of the annual financial calculations for the Insurance Plans.

1

## APPENDIX

## REPORT OF THE COUNCIL ON THE MEMBERS INSURANCE AND RETIREMENT PROGRAMS

*Goal #1: Provide support to dentists so they may succeed and excel throughout their careers.*  
*Goal #4: Ensure that the ADA is a financially stable organization that provides appropriate resources to enable operational and strategic initiatives.*

2 **Overview:** The Council on Members Insurance and Retirement Programs is asking the Board of  
 3 Trustees to rescind Board policy related to surpluses from the ADA Members Insurance Plans (Insurance  
 4 Plans). This philosophical paradigm shift and request has been debated by the Council over the last two  
 5 years with unanimous agreement to support the concept that the ADA should receive non-dues revenue  
 6 from the insurance plans. The genesis of this change comes from a comprehensive two year financial  
 7 audit and benchmarking study of the Insurance Plans conducted by actuarial consultants from Milliman,  
 8 Inc. The results of this financial audit confirmed the best in class status of the Insurance Plans in pricing  
 9 and service, as well as their financial strength and stability. While the philosophy of deriving non-dues  
 10 revenue from the Insurance Plans has changed, the priority of the Council to ensure member value while  
 11 maintaining best in class Plans and services with the lowest competitive pricing has not. The Council  
 12 firmly believes that these priorities are obtainable and are not mutually exclusive.

13 The Council believes this is a unique opportunity to continue to provide exceptional high value to our  
 14 current certificate holders and enhance member value for *all ADA members* through non-dues revenue  
 15 from the Insurance Plans. Through the financial audit and subsequent negotiations, the Council identified  
 16 \$38.7 million in excess surplus and reserves. The Council is considering maintaining the \$38.7 million to  
 17 fund additional plan benefit and rate changes as well as possibly fund new product development for a  
 18 level premium term plan and level premium disability plan through Great-West Financial (Great-West).

19 In September, the Board approved a Council resolution to set aside \$6.1 million in Term Life Plan 2012  
 20 unallocated surplus and report back with a proposal for its use. Based on the size of the excess surplus  
 21 and reserves available, the Council is recommending that the \$6.1 million be distributed to the ADA.

22 Based on recommendations by Milliman, Inc., the Council believes that, for the foreseeable future, the  
 23 plans can provide up to approximately \$6-11 million in non-dues revenue on a yearly basis *with no*  
 24 *compromise to the quality or pricing of the plans*. The Council feels it is time to leverage the strength of  
 25 the Insurance Plans to benefit *all members* by enhancing the financial condition of the ADA. This is a true  
 26 win-win situation.

27 **Background:**28 The ADA Members Insurance Plans

29 Under the oversight of the Council, in order to add to member value, the ADA offers our members a  
 30 portfolio of insurance and retirement plans. Membership is a requirement for continued participation in  
 31 the Insurance Plans and is a requirement to establish a retirement plan. This report addresses the  
 32 Insurance Plans only. The Insurance Plans are Term Life, Term Plus (universal life), Disability Income  
 33 Protection, Office Overhead Expense and MedCASH all of which are underwritten by Great-West.

34 The Council's efforts to increase member value have been very successful. Specifically regarding the  
 35 insurance plans, as of the end of 2012, over 62,000 dentists were participants in at least one of the five  
 36 Insurance Plans. Nearly 19,000 of those dentists participate in multiple plans. In addition, the Life and  
 37 MedCASH plans cover more than 20,000 spouses or domestic partners, along with 7,800 children.

1 In order to provide the Board with some context, the following summarizes each Insurance Plan, the  
2 number of certificate holders and the plan assets:  
3  
4

**Plan Overview; December 31, 2012**

<b>Plan Name</b>	<b>Plan Description</b>	<b>Insured Members</b>	<b>Plan Assets</b>
<b>Term Life</b>	The Term Life Plan can be used to collateralize loans, fund buy-sell agreements, and provide income to a member's family/beneficiaries in case of death.	50,195	\$318 million
<b>Term Plus (Universal Life)</b>	This is a Term Life Plan with a special Policy Value Account to accumulate savings on a tax-deferred basis.	1,466	Combined with Term Life
<b>Disability Income Protection</b>	Income Protection insurance helps cover personal expenses if disabled and unable to perform the duties of the profession.	19,314	\$318 million
<b>Office Overhead Expense</b>	Office Overhead Expense insurance helps cover practice expenses if disabled and unable to perform the duties of the profession.	10,726	\$60 million
<b>MedCASH</b>	MedCASH <sup>SM</sup> supplements primary health coverage. It pays a cash benefit for hospital confinement or outpatient visits; and a lump sum benefit for certain defined "critical conditions".	4,248	\$10 million

5 The ADA's Current Practice Regarding Insurance Plans Surplus

6 Currently all surpluses from the Insurance Plans must be used in one of three ways:

- 7
- 8 • improvements of the plans,
  - 9 • a reduction of premium,
  - or a refund of premium to certificate holders.

10 This restriction is based on a Board Rule passed by the Board which in turn is based on a House  
11 resolution urging the Board to do so. (Board Rule: "When a surplus is available from the Group Life  
12 Insurance Program, the Board of Trustees shall allocate this surplus either to improvement of the  
13 program, reduction of premium or refund to the certificate holders."<sup>2</sup>)

<sup>2</sup> The genesis of this Board policy regarding use of surplus comes from the following transactions:

At the October 15, 1969 meeting of the House of Delegates when the House adopted Resolution 7-1969-H (*Trans.*1969:280.) Resolution 7H-1969 recommended the Board to rescind its allocation of Group Life Insurance surplus funds to the ADA Research and Educational Foundation; requested that the Board allocate any future surpluses from the Group Life Insurance Program to improvements of the program, reduction of premium or refund to certificate holders; and that the Board consider rescinding the amendment of the Rules of the Board concerning surplus from the Group Life Insurance Program adopted at its October, 1969 meeting. The Board accepted the recommendation of the House and transferred the money back to the Life Insurance Program. Subsequently, at its March 1970 meeting, the Board formally amended its Organization and Rules to reflect that future surplus from the Group Life Insurance Program should be used for the improvement of the program, reduction of premium or as a refund to the certificate holders. (*Trans.*1970:296.) In 1993, it was suggested by the Strategic Planning Committee that the Association investigate "royalty income" from the member insurance programs. In response, the House passed Resolution 82H-1993 which urges the Board to continue to use surpluses generated by the insurance plans for benefit improvements, premium reductions and/or refunds for participating members (*Trans.*1993:697).



1 To provide the Board with context as to how the plan assets have grown while the Board policy has been  
2 in place, as of December 31, 1998 the insurance plan assets were approximately \$268 million, generating  
3 investment income of approximately \$15 million. As of December 31, 2012, the plan assets have grown  
4 to over \$700 million (an increase of 263% in the last 14 years) with generated investment income of \$24  
5 million.

6 During this same time period premium credits<sup>3</sup> have also continued to increase. Premium credits for the  
7 Term Life Plan have risen from approximately 40% of gross premium to 60% of 2012 gross premium (The  
8 actual 2012 term life premium credit was 54% after adjusting for the gross premium rate reduction  
9 approved in 2012.) The Milliman Inc. audit findings state that if the insurance premiums “are currently  
10 40% below the best rate in the market, it is questionable whether adjusting rates any further below the  
11 market will attract additional business or is necessary to retain current policyholders.”

#### 12 The ADA’s Relationship with Great-West Financial

13 The Insurance Plans are underwritten by Great-West based on a direct business model that excludes  
14 many common sales, marketing and other related expenses to the Plan. In the ADA direct business  
15 model no third party agent or broker is involved which eliminates payment of commissions or fees as an  
16 expense to the Plans. In the ADA’s model, Great-West is responsible for underwriting, plan  
17 administration, sales and marketing.

18 The ADA business relationship with the Great-West dates back to 1934 when the Term Life Plan was first  
19 introduced. The Council values this long-time and important relationship. Great-West has been a partner  
20 with the Council in protecting and increasing member value through the well-designed Insurance Plans  
21 available to our members.

22 At the same time, the Council recognized that it had been thirteen years since the last formal study of the  
23 Insurance Plans, which is unusual for a program of its size. The Council, along with new staff leadership,  
24 in recognizing that too much time elapsed since the last study, hired Milliman, Inc. to conduct an  
25 extensive financial audit and benchmarking study. The Council evaluated Milliman’s audit findings and  
26 proposed plan changes and developed a proposed plan of action related to benefit and plan design, rate  
27 structure and plan financials. At all times, enhancing member value and protecting certificate holder value  
28 was critical to the Council while developing the proposed plan of action.

29 The following section of this report will provide a recap of Milliman Inc.’s audit findings and the  
30 benchmarking study, which was previously reported to the Board at its September, 2012 meeting.  
31 Accordingly, the Council will merely restate key points from Milliman’s financial audit and benchmarking  
32 study.

#### 33 The Audit and Benchmarking Study

34 In 2012, the Council undertook a financial audit of the Great-West plans, hiring Milliman, Inc. to conduct  
35 the study. The purpose of the audit was:

---

<sup>3</sup> Premium credits are a discount off of gross premium rates. Premium credits operate as a “dividend in advance” whereby participants only pay the discounted net rate.

- 1 • to conduct a financial audit of the Insurance Plans to study the appropriateness and
- 2 reasonableness of the program expense factors;
- 3 • to study and understand Great-West's actuarial methodology and reserving practices;
- 4 • to evaluate Great-West's experience rating calculations and help define measurements for
- 5 benchmarking the competitiveness of the Insurance Plans.

6 The benchmarking study was structured to:

- 7 • to assess the competitiveness of the Insurance Plans both in terms of product design and pricing;
- 8 • to quantify the savings to the Insurance Plans inherent in the ADA "direct business" plan model
- 9 (e.g. no third party agent or broker eliminating payment of a commission or fees as an expense to
- 10 the Insurance Plans);
- 11 • to survey select national and state, dental and non-dental, associations to benchmark the
- 12 competitiveness of the ADA Plans against other professional association plans, and to compare the
- 13 ADA insurance model versus other associations.

14 The findings of the audit and benchmarking study provide the data and recommendations to help ensure  
15 the Insurance Plans are returning maximum value in terms of product design, pricing and administrative  
16 efficiency to the certificate holders. In addition, implementation of the audit recommendations will help  
17 enable transparent oversight and reporting of Insurance Plan performance to ensure compliance with  
18 ADA goals and help assess the financial stability of the member programs. Implementation of audit  
19 recommendations will also establish future performance standards that best position the member plans to  
20 align with the strategic goals of the Association.

#### 21 Review of Key Financial Audit Findings

22 As was noted earlier, the results of the financial audit and benchmarking study were previously reported  
23 to the Board. For purposes of this report, the key findings were:

- 24 • The policies offered by ADA are very competitively priced. Specifically the Milliman, Inc. audit  
25 report stated "*Having a low price compared to the market is obviously an advantage and will*  
26 *contribute to increased volume of sales. However we speculate that the program has reached a*  
27 *point where a lower price yields decreasing marginal opportunity of attracting new business and*  
28 *retaining current policyholders. For example, if the ADA premiums are currently 40% below the*  
29 *best rate in the market, it is questionable whether adjusting rates any further below the market will*  
30 *attract additional business or is necessary to retain current policyholders.*"
- 31 • The risk and profit charge paid to Great-West for the MedCASH plan is generally higher than  
32 seen in the industry and for the Term Life seems reasonable. Further study is needed to  
33 determine the appropriateness of risk and profit charge formulas for all plans.
- 34 • Surplus levels on all plans are above industry standards. (The surplus account represents the  
35 accumulated financial gains and losses that the Plans have experienced since the inception of  
36 the program.) Further analysis is needed regarding surplus practices to assess reasonableness  
37 and appropriateness for all plans.
- 38 • Reserve levels in general are adequate. (Reserves are set-up to offset the liabilities for each plan  
39 for known and unknown claims and other expenses to the plan.) Further analysis is needed  
40 regarding reserving practices to assess reasonableness and appropriateness for all plans.

- 1 • The vast majority of the 20 professional and trade associations (including state dental societies)  
2 that responded to a survey as part of the benchmarking study receive revenue from their member  
3 insurance programs.
- 4 • The interest credit rate should be re-evaluated with a possible change to the benchmark that is  
5 used. This is discussed later in the report.

#### 6 The Council's Conclusions Based on these Key Findings

7 Ultimately, the financial audit and benchmarking study strongly supports the Council's conclusion that the  
8 Insurance Plans remain very competitively priced and are well-positioned financially to continue to  
9 provide valuable benefits to the ADA membership. The audit further confirmed ADA has an opportunity to  
10 continue to offer quality Insurance Plans at very competitive premiums and, at the same time, reallocate  
11 some of the program value to members both through new Insurance Plans or member services and  
12 through general non-dues revenue to the ADA.

#### 13 Negotiations with Great-West

14 Based on the financial audit and benchmarking study, and the Council's conclusions based on the  
15 findings, the Council decided to begin negotiations with Great-West over a series of items.

16 ADA created two teams to aid in negotiations with Great-West: a negotiating team (Team A) and a  
17 steering committee (Team B). Members of Team A included Dr. Tom Paumier, CMIRP chair, Clark  
18 Slipher, Milliman, Inc., Kelly Abeles, director, CMIRP, Nancy Livingston, CMIRP legal counsel and Rita  
19 Tiernan, manager, CMIRP.

20 Members of Team B included Dr. Tom Paumier, CMIRP chair, Dr. Ron Lemmo, ADA treasurer, Dr. Gary  
21 Yonemoto, trustee, CMIRP board liaison, Clark Slipher, Milliman, Inc., Dr. Kathy O'Loughlin, ADA  
22 executive director, Paul Sholty, chief financial officer, Wendy-Jo Toyama, senior vice president,  
23 Membership, Tripartite Relations and Marketing, Karen Burgess, senior director, Membership Marketing  
24 and Member Services, Kelly Abeles, director, CMIRP, and Nancy Livingston, CMIRP legal counsel.

25 Team A held three separate negotiation meetings on February 14, March 1 and March 13, 2013. Prior to  
26 each negotiation meeting, the Council workgroup met to discuss Great-West's proposals and Milliman's  
27 counter proposals. The workgroup recommendations were then put forth to Team B for discussion and  
28 ratification. The workgroup and Team B were in alignment prior to Team A negotiations.

29 The key priority issues for the negotiations included establishing an interest crediting formula that  
30 provides increased investment return on assets of the Insurance Plans and determination of the  
31 appropriateness of Great-West's risk and profit charges in light of fully funded positions of the Plans and  
32 the actual insurance risk to Great-West. Both are discussed below.

#### 33 *Interest Crediting Formula*

34 The goal of the interest crediting formula negotiations with Great-West was to come to an agreement on a  
35 new formula that would provide a rate of return on ADA Plan assets that was more in-line with Great-  
36 West's earnings from their General Account (Corporate) portfolio.

37 The Insurance Plans receive investment income based on the total plan assets held in the Plans,  
38 including all premiums, reserves and surpluses. The Insurance Plans assets (approximately \$700 million)  
39 are held on deposit in Great-West's General Account and are not segregated or invested differently than  
40 the balance of the assets in their General Account. A source of profit to Great-West is the difference

1 between the credited interest paid on the Insurance Plan assets and the actual interest income Great-  
2 West receives on their General Account (Corporate) investments.

3 Contractually, Great-West provides the Insurance Plans with an investment return guarantee on the  
4 invested asset. The invested new money interest rate is determined each calendar year based on a  
5 formula utilizing a Guaranteed Investment Contract (GIC) Index. Milliman, Inc. noted that an interest credit  
6 formula based on the GIC Index is obsolete in today's investment environment.

7 ADA negotiated a new interest credit formula with Great-West that is no longer based on the obsolete  
8 GIC index. The new formula is based on the Barclays Intermediate Corporate Index. By changing to this  
9 new formula, investment income will increase by approximately \$3.1 million in year one (2014) to  
10 approximately \$8 million per year by year ten (2023).

#### 11 *Risk and Profit Charge*

12 The goal of the risk and profit charge negotiations with Great-West was to come to an agreement on new  
13 charges that would reduce expenses to the Insurance Plans.

14 The risk and profit charge is a Great-West expense to the Insurance Plans for their risk in underwriting the  
15 Insurance Plans plus a profit margin. The charge is established by contract as a declared percentage of  
16 earned premiums, and each plan's risk and profit charge is different. As an example, in 2011, Great-West  
17 earned a total of approximately \$3 million for risk and profit.

18 As noted earlier, the financial audit found that the risk and profit charge for the MedCASH plan is  
19 generally higher than seen in the industry and the charge for the Term Life seems reasonable. Based on  
20 these findings Milliman, Inc. recommended that further study was needed to determine the  
21 appropriateness of the risk and profit charge formulas for all plans.

22 ADA negotiated a reduction of \$116,000 in the risk and profit charge paid to Great West under the  
23 MedCASH and Office Overhead Expense Plans, which lessens the expense to these Insurance Plans by  
24 \$116,000.

#### 25 Council Recommendations

26 Following negotiations with Great-West, the Council now makes four recommendations to the Board:

##### 27 1. Approval of the New Interest Credit Formula

28 ADA negotiated a new interest credit formula with Great-West that is no longer based on the obsolete  
29 GIC index. The new formula is based on the Barclays Intermediate Corporate Index. By changing to this  
30 new formula, investment income will increase by approximately \$3.1 million in year one (2014) and  
31 approximately \$8 million by year ten (2023).

32 In addition, ADA is gaining additional transparency regarding investment income by having access to  
33 Great-West's General Account corporate bond purchases yield data. Great-West will also modify its  
34 annual report format to include a review of the investment returns on Insurance Plan assets and financial  
35 market conditions in response to ADA's request for greater transparency. ADA's expectation is that the  
36 agreed upon new interest crediting formula will continue unless there is a clear pattern of change in  
37 annual performance or the financial market environment.

1 2. Approval of the New Risk and Profit Charges

2 ADA negotiated new risk and profit charges as follows:

- 3 A. Decrease the MedCASH Plan risk and profit charge paid to Great-West from 2.5% to 1.5% of  
4 gross premium for an annual savings of approximately \$25,000.  
5 B. Decrease the Office Overhead Expense Plan risk and profit charge paid to Great-West from 2.5%  
6 to 2.0% of gross premium for an annual savings of approximately \$91,000.

7 3. Amendment of the Board Rules Restriction on Surplus from the Plans

8 As the Council has stated throughout this report, the proposals for change will protect the extraordinarily  
9 high value enjoyed by certificate holders for the foreseeable future. The Council sees no reason for the  
10 ADA to remain the exception to the common professional association practice of generating non-dues  
11 revenue from the Insurance Plans. Ultimately, the Council believes that non-dues revenue can be  
12 distributed to the ADA while at the same time having the ability to enhance the Insurance Plans and  
13 assuring that our Plans remain best in class.

14 The Council is recommending that the Board amend the Board Rules so as to enable distribution to the  
15 ADA of non-dues revenue. Amendment of the policy will permit implementation of a plan to annually  
16 distribute non-dues revenue to the ADA dependent on the overall financial health and premium credit  
17 analysis of the plans, as part of the annual financial calculations for the Insurance Plans.

18 4. Approval of Payment of the \$6.1 Million 2012 Term Life Plan Unallocated Surplus Set Aside

19 Subject to adoption of the preceding recommendation, the Council recommends payment to the ADA of  
20 the \$6.1 million 2012 term life plan unallocated surplus set-aside. (Unallocated surplus is that portion of  
21 the plan's total surplus that is not earmarked for Premium Credit.)

22 In 2012, Great-West Life proposed an increase in the premium credits for the Life plan for 2013 from 54%  
23 (2012 level) to 58%. (Premium credits are a discount off of gross premium rates.) At ADA's request,  
24 Milliman, Inc. reviewed the Great-West proposal and Milliman, Inc. responded with a letter and  
25 recommendation that the Council consider **not** increasing the Term Life Premium Credit percentage to  
26 participants from 54% to 58%.

27 Milliman, Inc. supported its recommendation to maintain the premium credit for Life Plan participants at  
28 54% with a statement from the audit report:

29 "The premium rates for all of the Plans offered by ADA are very competitive in the industry. The  
30 competitive rate levels are achieved through Premium Credits from the plan. The ADA and Great-  
31 West adjust the Premium Credits annually, which determine the amount of premium that  
32 members will actually pay the following year. Having a low price compared to the market is  
33 obviously an advantage and will contribute to increased volume of sales. However we speculate  
34 that the program has reached a point where a lower price yields decreasing marginal opportunity  
35 of attracting new business and retaining current policyholders. For example, if the ADA premiums  
36 are currently 40% below the best rate in the market, it is questionable whether adjusting rates any  
37 further below the market will attract additional business or is necessary to retain current  
38 policyholders. The ADA has an opportunity to continue offering quality insurance Plans at  
39 competitive rates and at the same time, reallocate some of the program value to members  
40 through new insurance benefits or non-insurance member services, perhaps through general  
41 revenue directly for the Association."

1 The Board approved at its September, 2012 meeting that the 2013 premium credit for participants in the  
2 Term Life Plan remain at the 2012 level of 54%, that the remaining 4% be set-aside and that the Council  
3 report back to the Board, for its consideration, the proposed use(s) of this approximately \$6.1 million (4%)  
4 2012 term life plan unallocated surplus set-aside.

5 To further support this recommendation, the Council has identified \$38.7 million in excess surplus and  
6 reserves through implementation of the financial audit recommendations and subsequent negotiations  
7 with Great-West. The Council is currently considering maintaining the \$38.7 million in excess surplus and  
8 reserves as plan assets to fund additional financial audit proposed plan benefit and rates changes as well  
9 as possibly to fund new product development for a level premium term plan and level premium disability  
10 plan through Great-West.

11 Due to the size of these excess surpluses and reserves, and the fact that they should be adequate to  
12 fund additional financial audit recommendations, the Council has determined that the best use of the  
13 approximately \$6.1 million 2012 term life plan unallocated surplus set-aside is as a distribution to the  
14 ADA.

#### 15 Future/Next Steps

16 Management of the Insurance Plans is a very complex matter. The Council's work is not complete with  
17 the filing of this report with the Board. The Council will continue to strive to protect certificate holder value  
18 and to enhance general member value all as ways to attract and retain ADA members. The Council  
19 wishes the Board to be aware of the next steps it will consider.

20 For example, the Council has received additional proposals from Great-West resulting from financial audit  
21 findings and recommendations. After careful consideration, the Council deferred decisions related to  
22 recommendations about these proposals until a final course of action is approved and implemented  
23 related to the interest credit formula for insurance plan assets, Great-West's risk and profit charges for the  
24 MedCASH and Office Overhead Expense Plan and until receipt of the Great-West June 2013 proposals.

25 The Council will discuss the following opportunities at its August 2013 meeting:

- 26 • a one-time release of surplus from the Office Overhead Expense Plan of \$18.5 million and the  
27 MedCASH Plan of \$4.0 million.
- 28 • a one-time reduction of \$1.2 million in the Disability Income Protection Plan incurred but not  
29 reported reserve (IBNR)
- 30 • removal of the continuation of insurance reserve for policies issued to future insureds only
- 31 • release of \$15 million from the Term Life and Disability Income Protection Plans claim fluctuation  
32 reserves (CFR) by a) reducing the CFR formula from 21% of earned premium to 18% of earned  
33 premium for Term Life; and b) reducing the CFR formula from 25% of earned premium + 5.5% of  
34 the Disabled Life Reserve (DLR) to 16% of earned premium + 5% of DLR for Disability Income  
35 Protection

36 The financial impact of these proposed changes, if implemented, is the reduction of approximately \$38.7  
37 million in excess surplus and reserves from the Insurance Plans. Implementation of the excess surplus  
38 and reserves from the Plans could be in the form of increased premium credits to participants, as a refund  
39 to certificate holders, to fund enhancements to the insurance plans or as non-dues income to the ADA.  
40 The Council is considering maintaining these excess surplus and reserves as plan assets to fund  
41 additional proposed plan benefit and rates changes as well as possibly fund new product development for  
42 a level premium term plan and level premium disability plan through Great-West. These proposed plan  
43 benefit and rate changes will enhance policy holder value by continuing to make the plans best in class

1 as well as competitively priced. The Council will report back to the Board with greater detail and, if called  
2 for, proposals for recommended changes.

3 The Council will also take up the development of an implementation plan for consideration at the August  
4 2013 meeting for each of the proposed plan changes listed below:

- 5 • Gender rates for the Term Life, Disability Income Protection and Office Overhead Expense plans
- 6 • A tobacco rate class for the Disability Income Protection and Office Overhead Expense Plans
- 7 • Developing a proposal for the ADA to derive annual non-dues revenue from the Insurance Plans  
8 of up to 3%-5% of gross premiums as part of the annual financial calculations for the Insurance  
9 Plans.

#### 10 Potential Non-dues Revenue Proposal

11 In connection with the proposal for the ADA to derive annual non-dues revenue from the Insurance Plans,  
12 Milliman, Inc. recommended that up to 3%-5% of total annualized gross premiums, dependent on the  
13 overall financial health and premium credit analysis of the plans, may be a reasonable formula to use as  
14 the basis for a proposal. Based on 12/31/12 total gross premiums for all plans, non-dues revenue could  
15 range between \$6.5 million (3%) to \$10.9 million (5%). The Council will develop a proposal for Board  
16 consideration regarding non-dues revenue with a clear focus on the Council's core value to maintain  
17 member value by providing best in class Insurance Plans at the most competitive price while striving to  
18 maintain current (historically high) premium credits.

#### 19 Legal and Finance Protection of ADA Tax Status

20 Staff from the Council, Finance Operations and the Division of Legal Affairs have been working together  
21 to assure that the non-dues revenue proposals offered are implemented in the most tax advantageous  
22 way possible to minimize unrelated business income (UBI) and to not jeopardize the Association's tax-  
23 exempt status. In order to accomplish this, it is anticipated that the revenue stream from the insurance  
24 plans will be structured as follows:

- 25 • A portion of the revenue would be a royalty for the use of ADA's intellectual property, which  
26 royalty would generally be excluded from UBI and would therefore be non-taxable; and
- 27 • The balance as a payment which would be considered UBI and would be taxable to ADA.

28 Even if a portion of the payments to the ADA are taxable, the benefits of receiving additional revenue  
29 outweigh any additional income tax payable by ADA.

30 As UBI grows, the risk is that too much gross revenue devoted to an unrelated business may cause the  
31 IRS or a court to conclude that the time devoted to the activity is substantial and unrelated to the tax-  
32 exempt function of the ADA's primary purpose, thereby jeopardizing its tax-exempt status.

33 Analysis shows that for the foreseeable future through at least 2016, the range of anticipated ADA non-  
34 dues revenue from the insurance plans and all other sources is not likely to approach levels that would  
35 endanger ADA's tax exemption. Staff from Finance Operations and the Division of Legal Affairs will  
36 continue to monitor UBI levels so as to insure that ADA's tax exemption is not in jeopardy. If the  
37 percentage of UBI begins to approach unacceptable levels (20% - 25% as advised by outside tax counsel  
38 and outside tax consultants, respectively), an alternative structure would have to be considered.  
39 However, it is the conclusion of Finance Operations and the Division of Legal Affairs that this is not  
40 currently necessary. The Board will be updated periodically as more information becomes available.

1 For all of the reasons discussed in this report, the Council proposes to the Board the following  
2 resolutions:

3 **Proposed Resolutions**

4 **B-46. Resolved**, that the new interest credit formula on the assets of the ADA Insurance Plans  
5 as described in the June 2013 Board Report at page 6007, lines 28-37 are approved.

6 **B-47. Resolved**, that the changes to Great-West Financial's risk and profit charge for the  
7 MedCASH and Office Overhead Expense Plans as described in the June 2013 Board Report are  
8 approved.

9 **B-48. Resolved**, that The *Organization and Rules of the Board of Trustees* be amended to  
10 delete the following section in its entirety:

11 "POLICY ON SURPLUS FROM GROUP LIFE INSURANCE PROGRAM  
12 Insurance Surplus: When a surplus is available from the Group Life  
13 Insurance Program, the Board of Trustees shall allocate this surplus either to  
14 improvement of the program, reduction of premium or refund to the certificate  
15 holders."

16 **B-49. Resolved**, that payment to the ADA of the 2012 \$6.1 million Term Life Plan unallocated  
17 surplus set-aside is hereby approved; subject to the Administrative Services and Experience  
18 Rating Agreement with Great-West being amended to authorize said payment to the ADA.



Resolution No. None N/A

Report: Board Report 8 Date Submitted: August 2013

Submitted By: Board of Trustees

Reference Committee: Budget, Business and Administrative Matters

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0

ADA Strategic Plan Goal: Members (Required)

1 **REPORT 8 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: DEVELOPMENT OF**  
 2 **ADA'S NEXT STRATEGIC PLAN - A CRITICAL TIME FOR DENTISTRY**

3 **Background:** President Robert A. Faiella appointed a group of a group of members of the Board of  
 4 Trustees and House of Delegates to oversee the development of the next strategic plan for the  
 5 Association. The committee members are: Trustees Drs. Hilton Israelson (chair), Roger Kiesling and  
 6 Mark Zust, and House of Delegate members Drs. James Antoon and Thomas Paumier. Ex officio: Drs.  
 7 Robert Faiella, Charles Norman and Kathleen O'Loughlin.

8 The Association is currently implementing the ADA Strategic Plan 2011-2014 and anticipates the new  
 9 five-year plan will take effect in 2015. Work on the next plan began following the 2012 House of  
 10 Delegates meeting. The following report will summarize work already completed and the process to be  
 11 followed to develop a new plan.

12 **WORK COMPLETED**

13  
 14 **Selection of a Strategic Planning Consultant:** The committee began its work by developing a request  
 15 for proposal. A number of highly qualified consultants responded to the RFP and the committee  
 16 personally interviewed four of them. Following extensive discussion of the respective qualifications of  
 17 these firms, the Committee selected OPIS, LLC, a nationally recognized consulting firm for associations.  
 18 The two principle consultants are Michael Gallery and Colin Rorrie.

19  
 20 **External Environmental Scanning:** An essential preliminary step to development of a new strategic plan  
 21 is external environmental scanning. The goal of environmental scanning is to alert decision makers to  
 22 potentially significant external changes before they crystallize, so that decision makers have sufficient  
 23 lead time to react and incorporate these factors into the strategic planning process. An environmental  
 24 scan focuses on the external environment and should:

- 25  
 26 • detect scientific, demographic, technical, economic, social, and political trends and events  
 27 important to the institution;  
 28 • identify the potential threats, opportunities, or changes for the institution implied by those  
 29 trends and events;  
 30 • promote a futuristic orientation in the thinking of leadership; and  
 31 • alert leadership to trends that are converging, diverging, speeding up, slowing down, or  
 32 interacting.

33 The Strategic Planning Steering Committee requested that the ADA's Health Policy Resources Center  
 34 lead the environmental scan. A full report on the scanning results may be found in Appendix 1. The

1 report addresses the external scanning efforts. The Board wishes this report to be disseminated as  
 2 widely as possible and encourages delegates to make full use of it.

3 **Scope of Work:** Under the guidance of the committee, the scanning consisted of two parts: a broad  
 4 macro view of the changing landscape in dentistry and deeper analysis on specific topics including:

5

Topic	Description
Dental Care Utilization	Analysis of recent trends in utilization of dental care by different segments of the population and factors driving trends.
Dental Care Expenditure	Analysis of recent trends in dental expenditure by different segments of the population and factors driving trends.
Population Demographics	Analysis of how population demographic shifts, mainly aging, will influence demand for dental care going forward.
Increased Dental School Capacity	Analysis of workforce projections based on current trajectory of increased enrolment and alternative scenarios.
The Affordable Care Act – Utilization of Dental Care	Analysis of how the ACA could influence dental benefits patterns, dental care utilization and expenditure.
The Affordable Care Act – Care Delivery Models	Analysis of how the ACA could influence dental care financing and delivery.
Consumer Dental-Care-Seeking Behavior	Analysis of changing attitudes toward oral health and dental care.
The Rising Cost of Dental Education	Analysis of cost of dental education, student debt, and implications for career choices of graduates.
Changing Dental Care Delivery Models	Analysis of group and corporate dentistry models and their potential implications on patients and dentists.
Key Factors in Membership Participation	Analysis of member satisfaction and factors influencing whether dentists join the ADA.

6 For the macro analysis, a request for proposal was sent out to over 15 consulting firms with experience in  
 7 doing environmental scans in the health care field. The consulting firm of Diringer & Associates was  
 8 selected. A copy of the report prepared by Diringer & Associates may be found on page 19 of Appendix  
 9 1.

10  
 11 For the specific issues research, the Health Policy Resources Center used a combination of external  
 12 consultants and internal researchers to complete the analyses. On certain topics, research had already  
 13 been commissioned through separate ADA efforts (e.g. education debt, the Affordable Care Act) and was  
 14 available to incorporate into the environmental scan. The Health Policy Resources Center was already  
 15 carrying out some of the research on the specific topics as part of its strategic research agenda.

16  
 17 **Intelligence Fair:** The broad macro analysis and the deeper specific issues researched were presented  
 18 at a 2-day Intelligence Fair held in Chicago in May. The objective of the Intelligence Fair was to distill,  
 19 synthesize and interpret all of the research findings in order to identify the most pressing environmental

1 factors that need to guide the strategic plan. This meeting was a chance to discuss ‘what does this all  
 2 mean for the ADA’ in an open, strategic setting.

3 To assist the Strategic Planning Steering Committee, a group of external thought leaders from outside of  
 4 the ADA with diverse background and perspectives were selected to lend their insights, contribute their  
 5 expertise, and assist in interpreting the findings. The thought leaders were:  
 6

Dr. Howard Bailit Professor Emeritus University of Connecticut Health Center Farmington, CT	Dr. Anthony LoSasso Professor and Senior Research Scientist Division of Health Policy and Administration University of Illinois at Chicago
Dr. Ira Lamster Dean & Professor of Dentistry Columbia University New York, NY	Dr. Matthew Messina Founder, Dentist Matthew Messina DDS., Inc. Fairview Park, OH
Dr. Roger Levin Chairman & CEO Levin Group, Inc. Owings Mills, MD	Mr. Steve Thorne Founder, President Pacific Dental Services Irvine, CA

7 **Key Findings:** Several important structural changes have occurred in the dental care sector in recent  
 8 years:

- 9 • Utilization of dental care has declined among working age adults, particularly the young and the  
 10 poor, a trend that is unrelated to the recent economic downturn.
- 11 • Dental benefits coverage for adults has steadily eroded the past decade, again particularly for  
 12 young and poor adults. Not surprisingly, more and more adults in all income groups are  
 13 experiencing financial barriers to care.
- 14 • Total dental spending in the U.S. slowed considerably in the early 2000s and has been flat since  
 15 2008, with public financing accounting for an increasing share.
- 16 • Trends for children are very different than for adults. Dental care utilization among children has  
 17 increased steadily the past decade, a trend driven entirely by gains among poor and near-poor  
 18 children. The percent of children who lack dental benefits has declined, driven by the expansion  
 19 of public programs.
- 20 • The shifting patterns of dental care utilization and spending have had a major impact on dentists.  
 21 Average net incomes declined considerably beginning in the mid-2000s. They have held steady  
 22 since 2009 but have not rebounded. Two out of five dentists indicate they are not busy enough  
 23 and can see more patients, a significant increase over past years.
- 24 • Most importantly, all of these trends were established well before the recent economic downturn.

25 The coming years will bring considerable change to the dental profession, significant challenges, but also  
 26 some new opportunities. Modeling results indicate that dental spending will remain flat in the coming  
 27 decades. This ‘new normal’ is a stark departure from decades of historically robust growth in the dental  
 28 economy. For a variety of reasons, dental benefits are likely to continue to erode for adults, which could  
 29 negatively influence dental care utilization. The Affordable Care Act will expand dental benefits coverage  
 30 for children, both public and private, but will not address many key access-to-care issues. It will not  
 31 reverse the decline in utilization among adults.

32 On the care delivery side, there will be pressure to increase value and reduce costs from all payers –  
 33 governments, employers, and individuals. This will be driven by a shift toward value-based payments  
 34 within both public and private plans and a new wave of health care consumerism among the population.  
 35 Commercial dental plans will increasingly use more selective networks, demanding increased  
 36 accountability through data and performance measures. The trend towards larger, consolidated multi-site

1 practices will continue, driven by changes in practice patterns of new dentists, a drive for efficiency, and  
2 increased competition for patients. The pressure to reduce costs will also drive innovation, including  
3 exploring alternative care delivery models. The Affordable Care Act will promote increased coordination of  
4 care, providing an opportunity to bridge the gap between oral and general health and to re-examine the  
5 role of oral care providers within the health care system. The immediate opportunities will be within the  
6 pediatric and Medicaid populations.

7 **Key Takeaway:** It is a critical moment for dentistry and a time for the profession to define its destiny.  
8 Given the significant environmental changes occurring and on the horizon, this is a watershed moment for  
9 the profession. It is not a time for complacency. Understanding the key forces at work will assist the  
10 profession in defining its own destiny. Ignoring what is happening in the health and consumer  
11 environment will mean ceding the future of the profession to others. This first step of scanning the  
12 environment through thoughtful, objective, empirical research has provided the ADA with key facts and  
13 information needed to help shape a strategy for navigating the challenges ahead and charting a course  
14 for the dental profession.

15 A comprehensive dissemination strategy has been developed to share the key findings with various target  
16 audiences, including leadership within state associations, districts, grassroots members, internal ADA  
17 councils, committees, commissions and external stakeholders.

18 **Internal Scan:** Similar to the external environmental scan, the internal scan informs the Association  
19 about the thoughts, priorities and concerns of internal stakeholders, including the Board, the House, Staff  
20 and general members. OPIS conducted confidential telephone and in person interviews with current  
21 Board officers, trustees, delegates, past presidents, state presidents and CEOs and ADA senior staff.  
22 Over 30 people were interviewed.

23 The purpose of the interviews was to get each leader's input on their perception of the mission of the  
24 organization, factors that help or hinder the achievement of that mission, the ADA's strengths and  
25 weaknesses and key issues facing the profession. A full report of the findings is attached as Appendix 2.  
26 The highlights of the report appear below.

27 **Summary of Findings:** Those interviewed had a good perspective on the mission of the ADA to support  
28 members and the profession while being the leader in oral health. As far as ADA strengths, the tripartite  
29 arrangement, membership numbers, volunteers and staff were often articulated. With regard to areas for  
30 improvement, right sizing the governance, more proactive communication and alignment of efforts with  
31 the tripartite were stressed.

32 As far as key issues facing the profession, the focus of the responses was reimbursement challenges,  
33 high cost of education and level of debt and meeting the needs of an increasing diverse membership.

34 When asked what members want from the ADA, advocacy with government and insurance companies,  
35 help in building practices and being the trusted source of information on oral health were often mentioned.

36 **Next Steps:** Internal scanning work is still underway. Additional interviews are being conducted,  
37 including from among the New Dentist Committee. In addition, the consultants will be at the ADA annual  
38 meeting later this year to conduct focus groups of general ADA members. The committee has also asked  
39 the consultants to observe some of the Annual Session and to take advantage of opportunities for  
40 informal interactions with delegates.

#### 41 **DEVELOPMENT PROCESS FOR NEW STRATEGIC PLAN**

42 **Preliminary Work of the Strategic Plan Steering Committee:** In addition to overseeing the internal and  
43 external scanning efforts, the committee has begun the process of constructing the next strategic plan.  
44 The following reports on those efforts, but the Board and the committee both wish to stress that this work  
45 is not yet final and will be further shaped by data and work of the volunteers and staff.

1 **Approach to Development of the Next Strategic Plan:** As was noted above, internal and external  
2 scanning are prerequisites to development of a successful strategic plan. While this work has been  
3 substantially completed, the committee has moved on to a different phase of plan development.

4 The Association is using a systematic strategic planning process to address the following critical strategic  
5 questions:

- 6
- 7 1. Why do we exist?
- 8 2. Whose needs will we meet?
- 9 3. Which needs?
- 10 4. How will we meet selected needs?
- 11 5. How must we be best structured to meet member needs?
- 12 6. How will we know if we have succeeded?

13 The consultants prepared the following diagram to present the process the Association is following:



14

15 The consultants are using a modified balanced scorecard approach to assist the ADA in developing its  
16 strategic plan. The balanced score card method is designed to enable an organization to align people,  
17 programs, and structure to achieve its mission. This approach allows for a logical connection between the  
18 organization’s mission, the goals it seeks to attain, and the activities it carries out. Moreover, this  
19 interconnection does not exist only at the top layer of the organization, but transcends all levels so that  
20 every person involved understands how his or her performance contributes to the ADA’s mission.

21 **Framework for the next strategic plan:** As noted above, the next strategic plan will be built around a  
22 mission statement, goals and objectives. The committee held a full-day, facilitated meeting, along with  
23 members of senior staff, to work on formulating a draft of a mission, goals and objectives. An  
24 understanding of these key elements is essential to development of a successful plan:

- 1 • A *mission statement* sets forth the ultimate ends an organization seeks to attain. It states, simply  
2 and directly, why the organization exists. An important purpose of the mission is to serve as an  
3 initial filter to be used by the House, the Board, Councils and staff when evaluating ADA  
4 programs and services. To be effective in that purpose, it must be brief and easily recalled by  
5 leaders and staff. A mission statement should be concise, realistic, feasible, and verifiable and  
6 have broad appeal to those whom the ADA serves.  
7
- 8 • The *goals* are the top-line goals of the final plan. The goals should address three primary areas:  
9 finance, membership, and organizational capacity. The goals assure that the Association has  
10 both the budget and the organizational capacity to meet the expectations and needs of the  
11 members.  
12
- 13 • *Objectives, or outcome statements*, are subsidiary to the goals. These are what the Association  
14 needs to achieve in order to meet the goals and further the ADA's mission. The committee  
15 focused on developing no more than two SMART outcomes for each of the three Goals. SMART  
16 outcome statements are **S**pecific, **M**easurable, **A**chievable, **R**elevant, and **T**imely.  
17

18 **Next Steps:** The Strategic Planning Steering Committee, along with senior staff, has developed a  
19 working draft of a mission statement, goals and objectives, but that is not the end of the process. The  
20 committee will revisit these issues and make changes to the drafts. Then, in December, the Board and  
21 Council chairs and co-chairs will meet in person for another full-day, facilitated session in order to review  
22 and finalize them. This will set the stage for the next step of developing strategies to meet the objectives.  
23

- 24 • Develop strategies: the ADA's objectives will serve as the basis for developing strategies to  
25 successfully meet identified targets. Strategies are broad statements of what the ADA will do to  
26 accomplish its objectives. Strategy development is the work of committees, task forces and staff.  
27 This step allows committees to become an integral part of the strategic plan by outlining what will  
28 be done to achieve ADA's mission.
- 29 • Review/revise programs and services: An organization's programs and services are the tactics it  
30 will use to carry out the strategies designed to achieve its objectives. Organizations often cannot  
31 come to agreement on whether to offer certain programs or services, or to embark on an  
32 advocacy initiative, because the leaders of the organization have not come to agreement on the  
33 purpose those activities are to serve. Armed with specific organizational objectives and well-  
34 articulated strategies to meet those objectives, wise organizations can have well-reasoned  
35 discussions of how a particular program or initiative meets the organization's intended outcomes.
- 36 • Review/modify Plan: Leaders and staff will review budgets and make final decisions on strategies  
37 and tactics, based on what the organization can afford to implement.
- 38 • Design evergreen process: Strategic planning is a verb – not a noun. It is an ongoing process of  
39 clarifying initiatives, specifying objectives and ensuring that performance and structure are in line  
40 with those objectives.
- 41 • Engage in regular reporting on strategic plan implementation: Association leaders often ask the  
42 question: "How do we know that the strategic plan is being effectively implemented in a timely  
43 fashion?" There will be regular reporting to the ADA Board of Trustees and House of Delegates  
44 on the strategic plan's implementation status. This will occur through a standard agenda item for  
45 each Board of Trustees and reports to the House of Delegates.
- 46 • Ongoing involvement and communication: Successful strategic planning requires the  
47 participation and "buy-in" of all those affected by the plan. The committee, of course, plays a key  
48 role in this process. It contains representatives of both the Board and the House. The scanning  
49 process, the interviews, the focus groups, ongoing interactions, the planned December planning  
50 meeting with Council leaders and the Board, and the planned stakeholder meeting discussed  
51 below are all examples of the participation of key stakeholders in this process. These tools also  
52 provide invaluable opportunities to communicate the work leading up to the new strategic plan, as  
53 do formal reports such as this one.

- 1 • Stakeholder meeting of 60-70 attendees prior to finalizing an initial draft Plan by the end of first
- 2 quarter 2014: As part of the ongoing goal of facilitating stakeholder involvement and enhancing
- 3 communication described above, our consultant will facilitate a key meeting next year with a goal
- 4 of finishing an initial draft of a full strategic plan. Planning for this meeting is underway but not yet
- 5 finalized.

6 **Conclusion:** This report is informational and no resolutions are being offered. The next strategic plan will

7 position the Association to face a changing world and will be key to its success. The Board, through the

8 Strategic Plan Steering Committee, will continue to involve volunteer leaders from the House of

9 Delegates and the Councils, as committees of the House, in the development of the next plan. The

10 Board will report back to the House of Delegates in 2014 with a new strategic plan developed through the

11 process outlined here.

12 **Resolutions**

13 This report is informational and no resolutions are presented.

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

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR)**

## APPENDIX 1

# **A Profession in Transition: Key Forces Reshaping the Dental Landscape**

**ADA Health Policy Resources Center**

**June 2013**



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## Executive Summary

**Background**

The American Dental Association (ADA) carried out a comprehensive analysis of the dental care sector to help inform the strategic planning process. The research was carried out by external consultants and the ADA's Health Policy Resources Center. A group of renowned thought leaders reviewed the findings and provided additional insights. This report is a summary of the findings.

**Key Findings**

**Several important structural changes have occurred in the dental care sector in recent years.** Utilization of dental care has declined among working age adults, particularly the young and the poor, a trend that is unrelated to the recent economic downturn. Dental benefits coverage for adults has steadily eroded the past decade, again particularly for young and poor adults. Not surprisingly, more and more adults in all income groups are experiencing financial barriers to care. Total dental spending in the U.S. slowed considerably in the early 2000s and has been flat since 2008, with public financing accounting for an increasing share. Trends for children are very different than for adults. Dental care utilization among children has increased steadily the past decade, a trend driven entirely by gains among poor and near-poor children. The percent of children who lack dental benefits has declined, driven by the expansion of public programs. The shifting patterns of dental care utilization and spending have had a major impact on dentists. Average net incomes declined considerably beginning in the mid-2000s. They have held steady since 2009 but have not rebounded. Two out of five dentists indicate they are not busy enough and can see more patients, a significant increase over past years. Most importantly, all of these trends were established well before the recent economic downturn.

**The coming years will bring considerable change to the dental profession, significant challenges, but also some new opportunities.** Modeling results indicate that dental spending will remain flat in the coming decades. This 'new normal' is a stark departure from decades of historically robust growth in the dental economy. For a variety of reasons, dental benefits are likely to continue to erode for adults, which could negatively influence dental care utilization. The Affordable Care Act will expand dental benefits coverage for children, both public and private, but will not address many key access to care issues. It will not reverse the decline in utilization among adults. On the care delivery side, there will be pressure to increase value and reduce costs from all payers – governments, employers, and individuals. This will be driven by a shift toward value-based payments within both public and private plans and a new wave of health care consumerism among the population. Commercial dental plans will increasingly use more selective networks, demanding increased accountability through data and performance measures. The trend towards larger, consolidated multi-site practices will continue, driven by changes in practice patterns of new dentists, a drive for efficiency, and increased competition for patients. The pressure to reduce costs will also drive innovation, including exploring alternative care delivery models. The Affordable Care Act will promote increased coordination of care, providing an opportunity to bridge the gap between oral and general health and to re-examine the role of oral care providers within the health care system. The immediate opportunities will be within the pediatric and Medicaid populations.

**Key Takeaway**

**It is a critical moment for dentistry and a time for the profession to define its destiny.** Given the significant environmental changes on the horizon, this is a watershed moment for the profession. It is not a time for complacency. Understanding the key forces at work will assist the profession in defining its own destiny. Ignoring what is happening in the health and consumer environment will mean ceding the future of the profession to others. This first step of scanning the environment through thoughtful, objective, empirical research has provided the ADA with key the facts and information needed to help shape a strategy for navigating the challenges ahead and charting a course for the dental profession.

## Critical Issue – Dental Care Utilization

## The Issue

Routine dental care is an important component of oral health. We examined dental care utilization for various sub-groups of the population over the past decade.

## Key Findings

**Dental care utilization for children increased more than 9% over the last decade.** The increase in utilization was driven entirely by low-income children. Children below the poverty line experienced a 38% increase in dental care utilization from 2000 to 2010, while those between 100-200% of poverty saw a 35% increase. Dental utilization by low-income children increased in 47 out of 50 states. By contrast, utilization rates among higher income children were relatively unchanged. While low-income children still lag behind upper-income children in dental care utilization, the gap is narrowing.

**Adult dental care utilization peaked in 2002-2003 before declining 10% over the remaining part of the decade.** The decline in utilization was consistent among all non-elderly adults, but was more pronounced for younger adults. Adults ages 19-34, who are the least likely age group to visit the dentist, experienced the largest decrease in utilization. Among seniors, dental care utilization held steady.

**The decline in adult utilization occurred across all income groups, but was particularly acute for low-income adults.** Adults below the poverty line experienced an almost 14% decline in utilization between 2003 and 2010. By contrast, high-income adults, who were more than twice as likely to have an annual dental visit as low-income adults, experienced a 6% decline in during that same period. As a result, the rich-poor gap in utilization is widening for adults.

## Key Policy Takeaways

**The reduction in financial barriers has been an important factor in increasing children's dental care utilization.** The enactment of the Children's Health Insurance Program (CHIP), expansion of the dental safety net, and increased participation of dentists in Medicaid programs are key factors not only in increasing utilization, but also in reducing the income disparity in dental care utilization among children.

**Low-income adults and young adults are seeing increased financial barriers to dental care, resulting in decreased utilization.** Adults do not have access to the same dental care safety net as children. The past decade has seen significant reductions and eliminations of adult dental benefits in Medicaid programs. Unlike dental benefits for children in Medicaid, adult dental benefits are optional and often subject to cuts during lean economic times. We are seeing the effect of a steady disinvestment in adult dental benefits within state Medicaid programs, along with a reduction in employer sponsored dental benefits.

**The Affordable Care Act includes pediatric oral care as an essential health benefit, but does not address adult dental care.** This omission will do little to change the decline in dental utilization among adults and is likely to have long-term consequences. Dental benefits are a major predictor of dental care utilization, and the Affordable Care Act represents a missed opportunity to address the financial barriers issue.

## Additional Materials

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## Critical Issue – Dental Care Expenditures

## The Issue

The dental economy is in transition. After decades of growth, dental expenditures have flattened. We explore recent trends in aggregate dental spending, as well as per-patient spending among those with a dental visit.

## Key Findings

**Dental expenditures are growing, but much more slowly than historical rates.** The growth in dental spending began to slow in the early 2000s, well before the recent economic downturn. From 1990-2002, dental expenditures grew an average of almost 4% per year. Between 2002 and 2008, that average growth rate fell to just under 2%. Between 2008 and 2011, the average annual growth rate declined 0.3%. On a per capita basis, dental expenditures actually declined slightly between 2008 and 2010. Overall, dental spending has experienced a much bigger slowdown than health care spending.

**Among people who had a dental visit, average annual expenditures grew steadily throughout the decade before leveling off in 2008.** Children who had a dental visit had a decline in per-patient expenses over the decade, while adults -- most significantly adults over the age of 65 -- had a significant increase. Per-patient expenses for adults have been largely unchanged since 2008, however. It is too early to tell whether the recession had a permanent effect on per-patient spending.

**Public programs are a small, but growing source of dental financing, while the percentage of out-of-pocket financing has declined.** In 1990, only 2% of dental expenditures were financed by public programs. By 2011, that number grew to 8%. The tradeoff for increased public spending has been reduced out-of-pocket spending. From 1990 to 2011, the rate of dental expenditures financed out-of-pocket declined from 48% to 42%.

## Key Policy Takeaways

**A decline in utilization is an important factor in the slowdown of the dental economy.** The percentage of adults with a dental visit in the past year has declined steadily since the early 2000s. While children have had an increase in annual dental visits over that time, it is not enough to offset the decline among adults. In addition, the growth in utilization is most prevalent among low-income children who are likely to be covered by public programs.

**The decline in utilization has not being offset by an increase in per-patient expenditures.** In order to make up for the decline in utilization, expenses for patients who visit the dentist must increase significantly if total expenditures are to hold steady. Since 2008, per-patient expenditures have been flat, contributing to the slowdown in national dental expenditures. Although there are only two years of post-recession data, a 'new normal' of dental spending may be upon us.

**The small, but growing shift in payer mix has likely contributed to the flattened growth in dental expenditures.** Public programs reimburse at a significantly lower rate than private insurance, although there is evidence private insurers are reducing payment rates as well. Both pay less than private-pay patients. If this trend in payer mix continues, the growth in dental expenditures is unlikely to rebound to earlier levels.

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## Critical Issue – Population Demographics

### The Issue

The U.S. population is growing and becoming more racially and ethnically diverse than ever before. Baby boomers are retiring at increasing rates, fueling the graying of America. Changing demographics play an important role in dental use as some groups are more likely than others to have dental needs, dental benefits and visit the dentist. We analyze trends in dental expenditures over the last two decades combined with population demographic changes to model future dental spending.

### Key Findings

***Per patient expenditures have been relatively flat over the last decade among children and working age adults, but have grown significantly for seniors.*** The growth in expenditures for seniors has leveled off over the last few years. Nevertheless, they have the highest per patient dental expenditures of any age group.

***Per capita expenditures are expected to grow over the coming decades, but at a very slow rate.*** In 2010 per-capita dental expenditures were \$269. Depending on the assumptions made, projections of future per-capita dental expenditures range from a conservative \$277 to an optimistic \$325 by 2040. Projected growth rates range from 0.22% to 1.25% over the next decade compared with a growth rate of almost 3.9% between 1996 and 2002. Between 2030 and 2040 the growth rate in dental expenditures is expected to be less than one-quarter of a percent.

***Older Americans are expected to account for a growing share of dental expenditures over the coming decades.*** Seniors ages 60-79 will account for about 32% of all dental expenditures by 2040, followed by children with about 24%. The largest growth will be in adults ages 70-79 whose proportion of total expenditures is expected to double between 2010 and 2040. Children account for such a large proportion of dental expenditures because they have high rates of dental benefits, primarily through a robust safety net system. More surprising, is the growth in dental expenditure among seniors, who traditionally have low rates of dental benefits.

***The growing racial and ethnic diversity of the population will likely have an effect on dental utilization trends.*** Racial and ethnic minorities are less likely to use dental care than whites. From 2000 to 2050, the percentage of the white population is projected to drop from 81% to 74%. The percentage of the population identifying themselves as Hispanic is expected to grow from 12.6% in 2000 to just over 30% in 2050. Hispanics are less likely than the general population to visit the dentist regularly and more likely to view regular dental care as unimportant. Hispanics are also more likely to be uninsured for dental benefits than whites. We did not model the effect of racial and ethnic shifts.

### Key Policy Takeaways

***We are unlikely to see a return to the fast growth in dental expenditures of previous decades.*** The growing number of adults without benefits, the growth in public financing at the expense of private insurance, and the increasing diversity of the population all point to very slow growth of expenditures over the coming decades. The near stagnant growth seen in the last few years may be the “new normal.”

***The growing share of dental expenditures from people over the age of 60 represents a bright spot in future projections.*** Overall rates of edentulism have decreased in among older adults and the incidence further decreases with each succeeding age cohort. Seniors are less likely to have dental benefits, primarily because Medicare has very little dental coverage, and are more likely to pay out-of-pocket for dental care. Seniors have the highest per-patient dental expenditures of any age group.

**Critical Issue – Population Demographics  
(Continued)**

**Additional Materials**

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### Critical Issue – The Impact of the Affordable Care Act on Dental Care Utilization

#### The Issue

The health care system is on the verge of major reform as the Affordable Care Act (ACA) is fully implemented. Dental benefits are included as an essential health benefit for children, but not for adults. We explore the likely impact of the ACA on the utilization of dental care.

#### Key Findings

**An estimated 8.7 million children are expected to gain comprehensive dental benefits by 2018 through the ACA.** This increase is split roughly evenly among those gaining access through Medicaid, the new health insurance exchanges, and employer sponsored insurance. This will reduce the number of children without dental benefits by about 55% relative to 2010 levels. Utilization of dental care is closely tied to the availability of dental benefits. The expansion of dental benefits is expected to generate an additional 13.8 million visits per year, about 20% of which will be financed by Medicaid.

**About 4.5 million adults are expected to gain 'extensive' dental benefits by 2018 through the ACA.** Although almost 17 million adults are expected to gain some level of dental benefits through the Medicaid expansion, only a small share of this will be 'extensive' coverage. Adult dental benefits are optional within Medicaid. Only 800,000 adults are expected to gain private dental benefits through purchases on health insurance exchanges. Taken together, this will reduce the number of adults without dental benefits by about 5% relative to 2010 levels. This expansion is expected to generate 9.2 million dental visits, more than 80% of which will be through Medicaid.

#### Key Policy Takeaways

**The increase in children and adults gaining dental benefits through Medicaid will put significant pressure on the safety net delivery system.** Along with other issues, Medicaid reimbursement for dental care in most states is inadequate to entice the majority of dentists to participate. Research shows that reforming Medicaid, including increasing reimbursement rates closer to market levels, is associated with an increase in dental care utilization. The ACA does not address the critical issues of dental care reimbursement and other program inefficiencies within Medicaid. The issue of low Medicaid reimbursement was addressed for primary medical care, but an important opportunity was missed for dentistry.

**The ACA will not help reverse the decline in dental care utilization among young adults and low-income adults.** The exception is in the few states that currently provide extensive Medicaid dental benefits and will continue to do so or in states that expand adult dental benefits.

**The implementation of the pediatric dental benefit in the essential health benefits regulation lessens its impact.** Because dental benefits are often provided separately from overall health insurance, the regulation allows health insurers in exchanges to comply with the pediatric oral health requirement as long as those benefits are offered as a standalone policy. There is no requirement that health insurers integrate pediatric oral health care or that parents purchase the dental policy on behalf of their children. This may result in children falling through the cracks.

#### Additional Materials

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### Critical Issue – Consumer Dental Care-Seeking Behavior

#### The Issue

Consumers are changing their attitudes on their role in managing their health and how they interact with the health care system. This trend has been called “consumerism.” Patients are no longer passive participants, but active members of a team helping making health care decisions. Less is known about the consumerism trend in dental care. We reviewed the available evidence to better understand consumer behaviors and attitudes on oral health.

#### Key Findings

***The degree of consumerism corresponds with income, education, age, and health status.*** Active consumers are more likely to have college diplomas and higher income than passive consumers. Age and health status are important factors, but in different ways. Millennials are more likely to have a casual attitude toward health care, but are also more likely to use health information technology and shop around for better prices than their older counterparts. Baby boomers and seniors, on the other hand, are more likely to be compliant with their providers' treatment decisions, but will take an active role if they have one or more chronic conditions.

***Dental-care seeking behavior is strongly associated with having dental benefits.*** Individuals with dental benefits are more likely to have visited the dentist in the last year and go to the dentist for preventive care than those without benefits. More than three-quarters of individuals without dental benefits report having gone to the dentist only once or not at all in the last 10 years. Individuals who lack dental coverage are three times as likely to go to the dentist only when they have a problem rather than for preventive care. Financial barriers and not knowing how much treatments cost are the two most common reasons for delaying dental care.

***Hispanics are less likely to visit the dentist regularly than the general population despite being more likely to experience oral health problems.*** Hispanics are less likely than the general population to see regular dental visits as important. About half of Hispanics do not feel dental visits are necessary as long as they take good care of their teeth. Knowledge gaps, cost, and language or cultural differences are the top barriers to Hispanics seeking regular dental care.

#### Key Policy Takeaways

***Dentists will increasingly encounter patients who proactively shop for value and quality.*** Compared with health care, more patients pay out-of-pocket for dental care, increasing the importance of savvy shopping. Young adults are the least likely to have dental insurance and most likely to use information technology to gather information, find providers, and compare prices. This will intensify as advances in health information technology make it easier for patients to access information on specific providers.

***Baby boomers are less likely to shop around for value than younger consumers, but this may change.*** Many experts believe the next generation of seniors will be less wealthy than the current generation and may be more cost conscious as a result. It is unclear how these two forces will interact going forward in the dental market.

***Dental practices can prepare for the growing consumerism trend by making information available online on treatments and prices.*** The heaviest users of health information technology also have the highest income, making them more able to pay out-of-pocket for their dental needs. Young adults, who have low rates of dental coverage, are also high users of technology and most likely to shop for a good bargain.

#### Additional Materials

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**Critical Issue – Consumer Dental Care-  
Seeking Behavior (Continued)**

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### Critical Issue – Key Factors in Membership Participation

#### The Issue

ADA membership has been relatively flat since 2007, while the number of dentists in practice has increased, resulting in a gradual erosion of the membership market share. We analyze membership satisfaction and explore the factors influencing whether dentists maintain ADA membership.

#### Key Findings

**Demographics and practice setting are correlated with decisions to maintain ADA membership.** Female dentists are about 8 percentage points less likely to be members than male dentists. The racial gap is even more striking. There is a 30 percentage point difference in dentist market share between African American and white dentists. On the plus side, the market share for new dentists is very similar to the overall market share indicating the ADA is doing a good job of engaging new dentists. Dentists in full-time private practice are more likely to maintain ADA membership than those who work part-time or have another occupation, such as federal service or dental education. For those in private practice, a higher percentage of owners are members than non-owners.

**The top reason for not belonging to the ADA is that membership is not perceived as a good value.** Nearly three-quarters of nonmembers said the dues are too high for the benefits received. An additional 37% said they could not afford the dues. Similarly, among members who did not renew their membership, the most common reasons given are affordability and value. Among current members, 80% believe the ADA is an excellent, very good, or good value.

**The top reasons members gave for belonging to the ADA are to support their profession, advocacy, and personal professional credibility.** Although these intangibles are the top three reasons, in terms of importance, members gave tangible benefits about equal weight. These tangible benefits include maintaining insurance, getting continuing education, accessing information, attending meetings, receiving publications, and professional networking opportunities. In general, members are looking for both types of benefits.

#### Key Policy Takeaways

**As the dental workforce becomes more diverse, ADA's market share of dentists may decline.** The decreased likelihood of women and non-whites to maintain ADA membership compared with white men may reduce ADA's market share going forward as these demographic groups make up a higher proportion of the profession. The ADA may wish to increase recruitment and retention efforts aimed at the subgroups less likely to be represented in its membership.

**In order to increase membership, the ADA may want to consider enhancing and communicating the tangible benefits of membership.** Nonmembers do not believe the dues are justified for the benefits received. It may be easier to place a value on tangible benefits like insurance and continuing education than intangible benefits such as advocacy.

**While the overall assessment of value among members is high, there is room for improvement.** Although 80% believe the ADA is a good value that leaves 20% who believe it is a fair or poor value. This segment of the membership may be less likely to renew their membership in the coming years. The value assessment was similar to that of the state societies, but somewhat lower among local societies.

### Critical Issue – Increased Dental School Capacity

#### The Issue

Dentist shortages are often seen as the root cause of access to dental care issues in the United States and elsewhere. Significant increases in dental school enrolment are planned or underway, in part due to this perceived shortage, but mainly due to the significant excess demand for dental education. We analyzed how the supply of dentists could evolve in the coming years and how this compares to expected demand for dental care under different scenarios.

#### Key Findings

***The supply of dentists, on a per capita basis, has been stable the past few decades.*** According to the most comprehensive data, the number of professionally active dentists in the United States was between 59 and 60 per 100,000 population since 1990. During this time, the profile of dentists has changed, with female and older dentists accounting for a larger share of supply.

***Under various modeling scenarios, the supply of dentists through 2030 is expected to decrease slightly.*** This is despite a projected increase in dental school enrolment in the coming years. The number of professionally active dentists is estimated to decrease from 60 per 100,000 population in 2010 to between 54 and 55 per 100,000 population in 2030. The major drivers of this slight decline in supply are a shrinking population of young people in the United States of post-secondary school age, and an increase in retirement and death rates due to an aging dentist population. The modeling is sensitive to various assumptions and further work is needed to confirm results. For example, some modeling scenarios predict stable numbers of graduates in the near term, resulting from a continued decline in dentists earnings (a major predictor of dental school applicants).

***The demand for dental care, measured as dental spending per capita, has slowed considerably in recent years and a 'new normal' could be emerging.*** Modeling of dental spending per capita under various scenarios suggests that, if anything, a very slight increase is expected through 2030. This is very different than the steady growth – about 4% per year in inflation adjusted per capita terms – of previous decades.

***Dentist earnings appear to be influenced by the growth of dental spending relative to the supply of dentists, as economic theory would predict.*** The period leading up to the mid-2000s saw robust growth in dental spending among the population and a relatively stable supply of dentists. Through 2010, however, demand for dental care has declined, resulting in decreased spending. At the same time, the supply of dentists has increased. This period corresponds with a significant decrease in dentist net incomes.

#### Key Policy Takeaways

***Looking forward, despite expanded dental school capacity, a major increase in the future supply of dentists is not anticipated.*** On a per capita basis, most scenarios actually predict a slight decrease in the number of dentist through 2030. Given the anticipated sluggish trajectory of dental spending, a major increase in the supply of dentists would have negative consequences for dentist earnings. It appears this type of 'glut' of dentists is not what is on the horizon.

***But various factors could result in fewer dentists being needed to deliver a fixed amount of dental care.*** The modeling does not take into account major increases in efficiency and changes in the dental care delivery system that could emerge in the coming years. If things like technological advancement, the emergence of new dental providers to take on some of the work dentists currently do, the growth of larger dental care organizations, and the incorporation of dental care within accountable care organizations, fewer dentists may be required to deliver the same amount of dental care to the population.

***Given the dental economy is expected to remain sluggish, any further major ramping up of the supply of dentists is likely to have negative effects on dentist earnings.*** As a result, careful consideration must be given to any further expansion of dental school capacity or increase in foreign dentists in the face of what appears to be decades of very modest growth in dental spending. Moreover, for various reasons, and pure economic reality is one of them, dentists could consider expanding their scope of practice beyond traditionally dentistry.

### Critical Issue – Changing Care Delivery Models

#### The Issue

New models of dental practice are emerging and there is considerable interest in understanding their implications for the public and practicing dentists. We provide an update on the ADA research program on large group practice. Only very preliminary findings are available at this stage.

#### Key Findings

**Multi-site practices are a small but growing segment of dentistry.** In 2011, approximately 6.4 percent of dentists across the nation report that their practice is part of a larger entity that delivers dental care at more than one location, up from 5.4 percent in 2008. This is a small, but growing, portion of practicing dentists in the United States. The youngest cohort, below thirty-five years of age, is most likely to be in this model, followed by those 65 and older. It would appear that multi-office firms seem to be a common method for entry into the dental care system for new and younger dentists, but also can be a viable option for a dental career for about 4 to 8 percent of dentists over 65.

**The dental market has seen gradual consolidation in recent years.** In the period 1992 through 2007, the number of firms decreased somewhat, while the number of establishments within these firms increased. The delivery system has concentrated through acquisitions and the development of de novo practices in a manner similarly seen in medicine. It would appear that the expansion of group practices occurs at the large, multi-office organizations level, where economies of scale emerge and can be significant.

**About 8,000 dentists are currently working in very large/corporate/DSMO-affiliated practices.** Across the 25 DGPA association practices the average number of dentists affiliated with the typical practice was 326. However, smaller practices are the norm, so the median number of 154 dentists is a better description of the size of the typical DGPA practice. An estimated 7,827 dentists are affiliated with the 25 DGPA practices.

#### Key Policy Takeaways

**The care delivery model is changing.** But it is unclear how fast and how prevalent the non-solo model will be or how prevalent non-ownership will be. The evolution of group practice to date has been gradual. Most dentists and dental students still intend to own their own dental practice one day. But this does not mean they do not want to affiliate with dental service management companies to 'outsource' significant functions.

**We do not know much about the implications of alternative care delivery models for patients and dentists.** The ADA's research agenda on group practice exactly tries to fill this knowledge gap. Results, however, are not yet available. The evidence that does exist suggests that there are no significant differences in treatments patterns between DGPA-type dental practices and traditional dental practices.

#### Additional Materials

Warren, M. Preliminary Analysis of Dental Group Practice Association Members: Selected Data and State Regulation and Classification of Group Dental Practice Findings. American Dental Association. Health Policy Resources Center. May 2013. Unpublished. Draft available upon request.

Understanding New Dental Care Delivery Models: A Research Agenda to Inform Policy and Advocacy. American Dental Association. Health Policy Resources Center. May 2013. Unpublished. Draft available upon request.

Pipes S. A Private Sector Healthcare Solution that we can Smile about. Forbes. October 15, 2012. Available from: <http://www.forbes.com/sites/sallypipes/2012/10/15/a-private-sector-healthcare-solution-that-we-can-smile-about/>.

Laffer A. Dental Service Organizations: A Comparative Review. Laffer Associates. September 2012. Available from: [http://heartland.org/sites/default/files/20120918\\_2012.09.19dsos.pdf](http://heartland.org/sites/default/files/20120918_2012.09.19dsos.pdf).

**Critical Issue – Changing Care Delivery  
Models (Continued)**

**Additional Materials (Continued)**

Guay A, Wall T, Petersen B, Lazar V. Evolving Trends in Size and Structure of Group Dental Practices in the United States. Journal of Dental Education. August 2012.

## Critical Issue – The Rising Cost of Dental Education

### The Issue

Educational debt can affect career choices, discouraging graduates from taking jobs in the public sector in favor of obtaining higher salaries in the private sector. We examined the trends in dental student debt, how they compare to other fields, and what affect educational debt has on career choices.

### Key Findings

**State financial support for public dental schools declined dramatically over the last decade and schools offset this loss with increases in revenue from tuition and fees.** Public dental schools have seen overall revenue increase of only 1% from 2004 to 2012. The low increase in revenue is primarily a result of a 17% reduction in public financing. The main reason overall revenue did increase slightly even as public support decreased is because of tuition revenue. In addition to increasing tuition, dental schools have also increased enrollment.

**The average debt for dental school graduates has increased over time, primarily due to increases in the cost of attending dental school.** Students graduating from private dental schools had an average debt of \$213,000 in 2011, while the average for private school graduates was \$161,000. Between 1994 and 2011, the 4-year cost of attending dental school increased at an average annual rate of 7.8% for public schools and 5.6% for private schools. Similarly, cumulative educational debt grew at an average annual rate of 7.0% and 5.9% for public and private dental schools, respectively. This indicates students are borrowing more to offset increasing tuition rates. Dental graduates are not unique in their increasing educational debt, however. The growth rate in debt for dental students is similar to that of graduates in other professions such as medicine, law, and pharmacy.

**The ratio of debt-to-income started increasing fairly rapidly in 2003, driven by a slow growth in dental salaries.** The debt-to-income ratio is a good measure of the feasibility of paying off educational debt. In 1990, the debt-to-income ratio was 76% for graduates from private dental schools and 46% from public schools. By 2011, those ratios had grown to 119% and 90%, respectively.

**Educational debt has an effect on some career decisions, but the effect is small, and not as large as gender or race.** When modeling the effect of an additional \$35,000 in educational debt (the actual increase for dental education between 2004 and 2011), graduates were more likely to enter private practice, less likely to pursue an advanced education and less likely to accept a faculty or government position. Graduates' choice in practice setting, however, is more heavily influenced by gender, race, ethnicity, and having a parent who is a dentist than by educational debt. Debt was not found to have an influence on owning a practice, going into public health, practicing in an underserved area, the percentage of poor patients seen or the number of hours worked.

### Key Policy Takeaways

**Dental schools are now more dependent financially on tuition and fees than in the past.** Schools have been able to pass increases in operating costs on to students in the form of higher tuition and fees, because of a large, well-qualified applicant pool. Now that growth in dentists' incomes is slowing, and student debt is at an all-time high, this financing strategy may come to an end. We could be seeing a dental education 'bubble'.

**Educational debt is not the main driver of career choices.** The analysis has shown clearly that while some career choices are influenced by debt, many are not. Other individual characteristics have a far greater impact on career choices.

**The steady increase in dental education costs and educational debt combined with the slow growth in dental salaries could make dental education less attractive to some students.** This may have a dampening effect on the applicant pool. Although two-thirds of dentists who graduated in 1996 are now debt free, they started with a much lower debt burden than today's graduates. Ninety percent of younger dentists are experiencing stress over educational debt and more than 60% describe their stress as "a lot" or "extreme." The growing educational debt is a problem for graduates in all professional fields, but the debt-to-income ratio for dentists is among the highest. Time will tell whether debt begins to play a larger role in graduates' career choices.

**Critical Issue – The Rising Cost of Dental Education (Continued)**

**Additional Materials**

Bailit H, Beazoglou T, Paturzo D, Robinette A, Tomlinson K. Trends in Dental School Finances: Report to the American Dental Association. May 2013. Unpublished. Draft available upon request.

### Critical Issue – Affordable Care Act: Care Delivery and Financing

#### The Issue

Most dental care is financed through out-of-pocket payments and standalone dental plans. Historically dentists have provided care primarily in small, independent, provider-owned practices although this is changing somewhat with the recent growth of large group practices. We analyzed how dental care financing and delivery may change with the implementation of the Affordable Care Act (ACA).

#### Key Findings

***The ACA changes the health care delivery system in important ways, primarily through Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs).*** An ACO is the integration of primary care clinicians, specialists, and hospitals providing coordinated care for patients. The ACO shares responsibility for treating a group of patients and its reimbursement is tied to performance measurement. The ACA provides incentives for ACOs to grow and expand through Medicare. PCMH is a practice model guided by a primary care clinician in which a team of health care providers deliver coordinated care to patients. Unlike ACOs, PCMHs do not have to move towards a financial risk sharing arrangement and their role in the ACA is limited to Medicare. In fact, PCMHs more commonly serve Medicaid patients.

***Dental care does not have an important role in today's ACOs.*** Existing ACOs under the ACA primarily serve Medicare patients and Medicare does not provide significant coverage for dental services. ACOs are focused on integrating their core medical services, particularly high-cost, high-risk procedures that have potential cost savings. Dental care is usually not viewed as a core service.

***PCMHs are more likely than ACOs to incorporate dental care, especially when serving a Medicaid population.*** Dental benefits for children are a mandatory benefit under Medicaid, creating a payment stream for at least some PCMH patients to receive dental services. PCMHs created by non-profit community health centers, which are likely to serve a predominantly low-income, Medicaid population, are particularly apt to include dental services. There are several ACOs in operation that include dental services for adults and children as part of their core basket of services. They tend to focus on Medicaid populations in states where Medicaid covers adult dental.

***The ACA includes pediatric dental benefits as an essential health benefit, but does little to integrate it with medical benefits in the private market.*** All health plans sold on the individual and small employer market, both inside and outside the exchange, are required to include the essential health benefits. Currently dental benefits are almost always sold as standalone products in both the employer and individual markets. The ACA does not change this structure. In fact, the ACA allows health plans on the exchange to satisfy the pediatric oral health requirement as long as a standalone dental plan is available which provides pediatric benefits. Health plans in the exchange are not required to integrate dental benefits for children and parents are not required to purchase the standalone plan for their kids. Health plans outside the exchange can be compliant with the pediatric oral health requirement if they can be "reasonably assured" that an individual has obtained that coverage through a standalone dental plan.

#### Key Policy Takeaways

***The ACA, both as written in law and in its implementation, continues the bifurcation of dental care and medical care.*** ACOs, because of their primary focus on Medicare, have little incentive today to include dental care, despite the research showing the link between poor oral health and some chronic diseases. In terms of financing, the implementation of the pediatric dental benefit mandate weakens considerably its status as a true essential health benefit and encourages the silo-ing of dental care financing from medical plans.

***ACOs outside the Medicare program present more opportunities to integrate medical and dental care.*** ACOs existed prior to the ACA, perhaps under a different name. ACOs in some states serve Medicaid beneficiaries and are more likely to include dental care than Medicare ACOs. This is especially true where Medicaid covers adult dental care. An additional opportunity that should be explored is ACOs that serve dual Medicare and Medicaid eligible beneficiaries in states that provide adult dental benefits through Medicaid.



**Critical Issue – Affordable Care Act: Care Delivery and Financing (Continued)**

***Primary Care Medical Homes offer the most promising delivery reform opportunity for dental care.***

Especially in PCMHs that serve Medicaid beneficiaries or dual eligible Medicare and Medicaid beneficiaries, including dental care makes sense. The states with the biggest opportunities for integrating dental care in PCMHs are those that provide adult dental benefits in their Medicaid program.

**Additional Materials**

Vujicic M, Nasseh K. Accountable care organizations present key opportunities for the dental profession. Health Policy Resources Center Research Brief. American Dental Association. April 2013. Available from:

[http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief\\_0413\\_2.pdf](http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_0413_2.pdf)

Vujicic M, Goodell S, Nasseh K. Dental benefits to expand for children, likely decrease for adults in coming years. Health Policy Resources Center Research Brief. American Dental Association. April 2013. Available from:

[http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief\\_0413\\_1.pdf](http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_0413_1.pdf).

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## CRITICAL TRENDS AFFECTING THE FUTURE OF DENTISTRY: Assessing the Shifting Landscape

Prepared for American Dental Association

### Executive Summary

Dentistry in the United States is in a period of transformation. The population is aging and becoming more diverse. The health care delivery system is changing rapidly with the implementation of the Affordable Care Act. Consumer habits are shifting with Americans increasingly relying on technology and seeking greater value from their spending. The nature of oral disease and the financing of dental care are in a state of flux.

To assist the American Dental Association in its strategic planning, Diring and Associates was retained in March 2013 to conduct an environmental scan of emerging trends that affect the future of dentistry. Consisting of a comprehensive literature review and key informant interviews, the scan found that:

### People

1. The population is getting older and more diverse, leading to different disease patterns, care-seeking behavior and ability to pay.
2. Consumers are becoming more astute purchasers of health care and seeking value for their spending.

### Providers

3. An increasing number of dentists are being trained, but mounting debt load and changing demographics are altering the practice choices for new dentists.
4. Pressures are growing for an expanded dental team to provide preventive and restorative services.
5. Care is being integrated within “patient centered medical homes” in medicine but there has been slow take up of dental care services.

### Payments

6. Payment for dental services is shifting from commercial dental insurance to public coverage and personal out of pocket payments.
7. Commercial dental plans are increasingly using more selective networks, demanding increased accountability through data and performance measures, and pressuring providers to reduce costs.

Research on the Macro Environment – Commissioned  
from Diringer and Associates (Continued)

**Policies**

8. The Affordable Care Act pediatric dental benefit will provide millions of additional children with dental coverage through the small group and individual markets and optional Medicaid expansions.
9. Public programs, with a growing number of participants, will demand increased accountability from dental providers.

**Practice Implications**

10. With the increased demand for value in dental care spending, practices will need to become more efficient.
11. The trend towards larger, multi-site practices will continue driven by dental plan pressures for smaller provider networks, practice patterns of new dentists and increased competition for patients.
12. Health care reform and Medicaid expansions with an increasing emphasis on outcomes and cost-effectiveness will encourage alternative models of dental care.

This is a critical moment in dentistry and not a time for complacency. Understanding the key forces at work will assist the profession in defining its own destiny. Ignoring what is happening in the health and consumer environments will mean ceding the future of the profession to others.

By commissioning this report and convening key thought leaders, the ADA has taken on the challenge of facing the new reality and charting a course for the dental profession and the oral health of America. (Full report available upon request.)

*Diringer and Associates is a California based health policy consulting firm founded in 2001. It has significant experience in oral health, public policy, evaluation and organizational development. This report was authored by Joel Diringer, JD, MPH, Kathy Phipps, MPH, DrPH, and Becca Carsel, MA.*

Description of Strategic Planning  
Environmental Scan Process

**Objective**

The goal of environmental scanning is to alert decision makers to potentially significant external changes before they crystallize so that decision makers have sufficient lead time to react and incorporate these factors into the strategic planning process. An environmental scan focuses on the external environment and should:

- detect scientific, demographic, technical, economic, social, and political trends and events important to the institution
- identify the potential threats, opportunities, or changes for the institution implied by those trends and events
- promote a futuristic orientation in the thinking of leadership
- alert leadership to trends that are converging, diverging, speeding up, slowing down, or interacting

The Strategic Planning Steering Committee requested that the ADA's Health Policy Resources Center lead the environmental scan.

**Scope of Work**

Two categories of research were needed: (i) a broad macro view of the changing landscape in dentistry (ii) deeper analysis on specific topics including:

Topic	Description
<b>Dental Care Utilization</b>	Analysis of recent trends in utilization of dental care by different segments of the population and factors driving trends.
<b>Dental Care Expenditure</b>	Analysis of recent trends in dental expenditure by different segments of the population and factors driving trends.
<b>Population Demographics</b>	Analysis of how population demographic shifts, mainly aging, will influence demand for dental care going forward.
<b>Increased Dental School Capacity</b>	Analysis of workforce projections based on current trajectory of increased enrolment and alternative scenarios.
<b>The Affordable Care Act – Utilization of Dental Care</b>	Analysis of how the ACA could influence dental benefits patterns, dental care utilization and expenditure.
<b>The Affordable Care Act – Care Delivery Models</b>	Analysis of how the ACA could influence dental care financing and delivery.
<b>Consumer Dental-Care-Seeking Behavior</b>	Analysis of changing attitudes toward oral health and dental care.
<b>The Rising Cost of Dental Education</b>	Analysis of cost of dental education, student debt, and implications for career choices of graduates.
<b>Changing Dental Care Delivery Models</b>	Analysis of group and corporate dentistry models and their potential implications on patients and dentists.
<b>Key Factors in Membership Participation</b>	Analysis of member satisfaction and factors influencing whether dentists join the ADA.

For the macro analysis a request for proposals was sent out to over 15 consulting firms with experience in doing environmental scans in the health care field. The consulting firm of Diringer & Associates was selected.

For the specific issues research, the Health Policy Resources Center used a combination of external consultants and internal researchers to complete the analyses. On certain topics, research had already been commissioned through separate ADA efforts (e.g. education debts, the Affordable Care Act) and was available to incorporate into the environmental scan. The Health Policy Resources Center was already carrying out some of the research on the specific topics as part of its strategic research agenda.

Description of Strategic Planning  
Environmental Scan Process (Continued)

**The Intelligence Fair**

The broad macro analysis and the deeper specific issues research were presented at a 2-day Intelligence Fair held in Chicago in May. The objective of the Intelligence Fair was to distill, synthesize and interpret all of the research findings in order to identify the most pressing environmental factors that need to guide the strategic plan. This meeting was a chance to discuss 'what does this all mean for the ADA' in an open, strategic setting.

To assist the Strategic Planning Committee, a group of external thought leaders from outside of the ADA with diverse background and perspectives were selected to lend their insights, contribute their expertise, and assist in interpreting the findings. The thought leaders were:

**Dr. Howard Bailit**

Professor Emeritus  
University of Connecticut Health Center  
Farmington CT

**Dr. Ira Lamster**

Dean & Professor of Dentistry  
Columbia University  
New York, NY

**Dr. Roger Levin**

Chairman & CEO  
Levin Group, Inc.  
Owings Mills, MD

**Dr. Anthony LoSasso**

Professor and Senior Research Scientist  
Division of Health Policy and Administration  
University of Illinois at Chicago  
Chicago, IL

**Dr. Matthew Messina**

Founder, Dentist  
Matthew Messina DDS., Inc.  
Fairview Park, OH

**Mr. Steve Thorne**

Founder, President  
Pacific Dental Services  
Irvine, CA

## **APPENDIX 2**

# **Summary of Key Interview Findings for ADA Strategic Planning Project**

**Submitted To:**

**The Strategic Plan Steering Committee**

**Submitted By:**

**Michael E. Gallery., PhD, FASAE, CAE  
Colin C. Rorrie, Jr., PhD, FASAE, CAE  
OPIS Consultants, LLC**

**June 28, 2013**

## **Introduction**

The American Dental Association has undertaken the development of a new strategic plan. As a part of this initiative, the association engaged Organizational Performance Improvement Systems (OPIS), a nationally recognized association consulting firm, to work with the ADA. A key part of the project design is to conduct confidential in person and telephone interviews by OPIS consultants with key leaders and staff.

The interview phase of the project was initiated in late April and continued through early June with the initial results presented to the ADA Strategic Planning Steering Committee on June 7. As of that date, thirty five interviews had been completed. The interviews included ADA officers, trustees, House of Delegate members, state presidents, state executive directors and ADA senior staff.

## **Findings**

What follows are the key responses from the interviews. What characterizes a key response is that it was mentioned multiple times in the interviews. The remainder of the report will set forth the questions followed by the key responses.

### **1. What, in your opinion, is the major mission and purpose of the ADA?**

- Advocate for patients and the profession
- Support members and advocate for the profession
- Help members improve their practice
- Be the voice of the dental profession on matters related to oral health

### **2. What external environmental factors help or hinder ADA's ability to meet its mission?**

#### **Help**

- Name recognition and branding which is viewed positively
- The intellectual property of the ADA represented by the staff
- The tripartite organization arrangement

#### **Hinder**

- Competing entities who promote self interest – for profit practice management companies
- Growing influence of third part payers and government
- Competing stakeholders represented by other dental organizations

### **3. What are the ADA's strengths?**

- Membership numbers

- Depth, breadth, expertise and dedication of ADA staff
- Advocacy of the ADA before legislative and regulatory bodies
- Tripartite arrangement
- Volunteer work force
- Brand – ADA is well recognized

**4. In what areas does the ADA need to improve?**

- Right sizing the governance and staffing to become a more nimble, transparent decision making organization
- More support for the needs of dentists at different stages of their career from young to older practicing dentists
- More attention to value and the programs and services that members feel drive value
- Need more proactive communication on the value of the ADA and its leadership on oral health issues as opposed to an organization that is simply reactive
- Alignment of efforts with the tripartite and other national dental organizations

**5. What is unique about the ADA?**

- Tripartite relationship
- Size and ability to leverage resources – program with Ad Council
- Has done a good job of maintaining the membership base although as a percentage of the profession is decreasing
- Communication efforts shifting to a member focus creating a sense that it is good to be a dentist
- The organization for oral health

**6. What in your mind do members want most from the ADA?**

- Advocacy with government and insurance companies
- Help in building/managing practices especially young dentists as the practice model changes
- Want ADA to be a more proactive leader for the profession like Call to Action efforts
- Make sure ADA programs and services are what the member sees as important to their practice
- Want the ADA to be the trusted source for information

**7. What is the most serious problem facing the profession?**

- Reimbursement challenges which could be increased with the Affordable Care Act
- Increasing movement from cottage industry of single dentists tied to ADA to group/corporate models that will not automatically mean ADA membership
- High cost of education and level of debt of graduating dentists
- Increasing diversity of the profession, women and minorities and the need to address their issues



- ADA is no longer the singular focus of dentistry with the emergence of ethnic and specialty associations

**8. Is there anything I haven't asked that you want to tell me?**

- Need to go back and review governance – structure, authority, layers and lack of representation like a young dentist on the Board. Challenges facing the profession require a nimble organization which the ADA is not
- Redouble efforts to represent all segments of the profession, women and ethnic, as well as organization settings, single practice and corporate entities

**Next Steps**

There have been some additional interviews that have been identified, for example, members of the Committee on the New Dentist, which will be scheduled. In addition, the consultants will be at the ADA annual meeting later this year to conduct focus groups of ADA members.

The results from these interviews, along with the work already completed, will be used with the Strategic Planning Steering Committee to develop the next ADA Strategic Plan.

Resolution No. None N/A  
 Report: Board Report 9 Date Submitted: August 2013  
 Submitted By: Board of Trustees  
 Reference Committee: Budget, Business and Administrative Matters  
 Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_  
 Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0  
 ADA Strategic Plan Goal: Members (Required)

1 **REPORT 9 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:**  
 2 **ANNUAL REPORT ON THE CURRENT ADA STRATEGIC PLAN**

3 **Background:** This report to the House of Delegates on the American Dental Association’s (ADA) current  
 4 strategic plan is submitted to the House as an informational report.

5 **Overview:** Since the 2012 House meeting, the Board monitored the implementation of the 2011-2014  
 6 Strategic Plan and the associated Operating Plan. The Strategic Plan may be found here  
 7 [https://www.ada.org/members/sections/about/doc\\_strategic\\_2011.pdf](https://www.ada.org/members/sections/about/doc_strategic_2011.pdf). The Association is moving from a  
 8 culture focusing on activities to one which will focus on results. This work is in progress and it is expected  
 9 that the new strategic plan which is under development (and is the subject of a separate report) will  
 10 continue this shift.

11 **Results:** The Association utilizes a combined quarterly management report that includes an executive  
 12 summary of divisional activity, the Strategic Dashboard, Operating Plans and financial statements. The  
 13 quarterly management report is available on ADA.org at <http://www.ada.org/4022.aspx>. The quarterly  
 14 management report allows delegates and the Board to quickly monitor ADA activities and performance  
 15 against the current strategic/operating plan. This report is intended to supplement the information  
 16 available through the quarterly management report.

17 The existing strategic plan includes a series of “outcomes/objectives” for each of the four strategic goals.  
 18 Of course, our ultimate objective is to create a unique and powerful value for members, nonmembers and  
 19 the public while creating a powerful and influential ADA brand. The remainder of this report will provide  
 20 information on progress towards reaching these desired outcomes. In the following section of the report,  
 21 the Goals and Outcomes/objectives are taken directly from the Strategic Plan.

22 **Goal 1: Provide support to dentists so they may succeed and excel throughout their careers**

23 Outcomes/objectives:

- 24 1. *Professional competency and ethical standards:* The “Measure” for this outcome as stated in  
 25 the strategic plan is utilization of online and annual session continuing education (CE). Limiting  
 26 success to these two areas does not reflect how effectively we are impacting professional  
 27 competency or ethical standards so additional information is included as well. It is important to  
 28 note that the Association has centralized CE delivery under one area and is reassessing all  
 29 products and delivery methods to remain the leader in dental continuing education.  
 30

31 Overall utilization of ADA CE: During 2012, the Association delivered 395 CE offerings, to 42,600  
 32 dentist and 20,004 dental team members awarding 163,799 continuing education units. During

1 2011, the Association delivered 453 CE offerings, to 46,248 dentists and 24,234 dental team  
2 members awarding 178,117 continuing education units.

3  
4 Additional Measures:

- 5  
6
- 7 • At the 2012 Annual Session, 21,455 dentists and dental professionals occupied 48,864  
8 individual seats or 2.28 courses per dental professional (5.7 hours of cutting edge dental  
9 continuing education on average per dentist/dental professional). This represents a slight  
10 decline in the number of courses taken per dental professional compared to 2011 where  
11 46,800 individual seats were occupied or 3 courses per attendee. In 2011, this  
12 represented an increase of .2 over 2010 and .8 over 2009.
  - 13 • ADA CE Online provided 10,023 users with ADA developed/owned online CE courses.  
14 By the end of 2012, CE Online had 35,404 users; 6,572 registered in 2012 (an increase  
15 of 26% from 2011) who took 14,294 total courses. In 2011, CE Online had more than  
16 28,000 users; 6,512 registered in 2011 (with an increase of 15% from 2010).
  - 17  
18 • The Association scheduled 100 Success Dental Student Programs at 43 dental schools,  
19 providing practice management, financial, ethics and other subjects to enrich the dental  
20 school experience and provide information on real world topics from practicing dentists.  
21 The greatest number of programs, 118, were presented in the 2008-2009 year, the first  
22 year all four programs were available for scheduling. After hitting a low of 87 programs in  
23 the 2009-2010 year, the numbers have increased and averaged out at about 100  
24 programs per year. We anticipate scheduling approximately 100 programs again for the  
25 2013-2014 year.
  - 26  
27 • The ADA Center for Evidence-Based Dentistry (EBD) offers individualized workshops to  
28 train dental school faculty in principles and practices of evidence-based dentistry. Three  
29 workshops have been provided since the program's inception in 2012. This is in addition  
30 to more than 100 members served by the Center's two annual educational programs: the  
31 EBD Champions' Conference and ADA/Forsyth EBD Course.
  - 32  
33 • JADA LIVE was successfully launched with three full-day sessions in three cities and  
34 provided CE to 275 attendees in areas including digital imaging, Council on Scientific  
35 Affairs recommendations for safe use of Cone Beam Computed Tomography (CBCT),  
36 ergonomics and the use of social media in practice.
  - 37  
38 • Through the Legal Division, the Association continues to provide members with  
39 informational and educational materials relating to their legal obligations in such areas as  
40 statutory and regulatory compliance, as for example HIPPA, compliance and federal  
41 employment law.
  - 42  
43 • Through the Division of Science/Professional Affairs, the Association provides members  
44 with evidence-based clinical recommendations and scientific reports that address critical  
45 and emerging issues such as the use of dental sealants, management and maintenance  
46 of periodontal disease and topics in infection control and radiation safety. Six clinical  
47 recommendations have been published to date and one new one is in progress. There  
48 have been 21,488 views of the clinical recommendations page in the past 12 months

- 49 2. *Professional autonomy*: This outcome focuses on keeping the doctor-patient relationship free  
50 from outside interference. The "Measure" for this outcome as stated in the strategic plan is a  
51 member survey on perception of professional autonomy. In retrospect, reliance on perception  
52 is a poor way to assess progress towards this outcome. Sources of potential interference are

1 well known: third-party payors and government regulation. The following summarizes  
2 achievements made toward reaching this objective, specifically with respect to these sources  
3 of potential interference.

#### 4 Federal Issues

- 5 • Health benefit exchanges or “marketplaces” as they are now called (essentially a web  
6 page that serves as a virtual marketplace in each state, D.C., and the territories to help  
7 individuals and small businesses buy private coverage) must be in place in time to begin  
8 enrolling beneficiaries by October 2013. They must be fully operational by January 1,  
9 2014. Since the implementation process began in earnest, the ADA and constituent  
10 dental societies have stressed in communications with federal and state authorities,  
11 respectively, the following key advocacy points.  
12
  - 13 ○ ADA Position: Exchanges must maximize competition among plans to ensure  
14 that the exchange marketplace is competitive on January 1, 2014 and beyond.  
15 To meet this goal plans must offer real value and provide consumers with an  
16 adequate network of providers. Status: Although regulators have been receptive  
17 to our message, only after the exchanges have been operational for some time  
18 will we know the true nature of the plan offerings and the adequacy of their  
19 networks.  
20
  - 21 ○ ADA Position: Stand-alone dental plans and medical plans with an embedded  
22 dental benefit must be able to compete on an equal footing inside and outside  
23 the exchange to ensure consumers have a robust selection of dental products.  
24 Status: HHS officials have made accommodations for stand-alone dental plans to  
25 compete inside the exchange by making it clear that medical QHPs do not have  
26 to offer the pediatric dental EHB if there is a stand-alone plan in the exchange.  
27 However, HHS does not require the medical QHPs inside the exchange offering  
28 an embedded pediatric dental EHB to separately price and offer that benefit.  
29 HHS’s February 20 rule also accommodated stand-alone dental plans operating  
30 outside the exchange in the individual and small group markets. The rule allows  
31 medical QHPs outside the exchange to offer plans without the pediatric dental  
32 EHB – if the medical QHP is “reasonably assured” that such coverage is sold  
33 only to consumers who have also purchased a pediatric dental EHB through an  
34 exchange-certified stand-alone plan.  
35
  - 36 ○ ADA Position: Children should be covered by a dental benefit that is “necessary  
37 to prevent disease and promote oral health, restore oral structures to health and  
38 function, and treat emergency conditions” and necessary to address a health  
39 condition where both medical and dental care is clinically required. Status: All  
40 states except Utah (which is offering only preventive services) have chosen  
41 either the state’s Children’s Health Insurance Program (CHIP) plan or the MetLife  
42 High Option plan from the Federal Employee Dental and Vision Insurance  
43 Program (FEDVIP) as their benchmark plan. Both plans provide an adequate  
44 array of dental services. HHS defined “pediatric services” as services for  
45 individuals under the age of 19, although states have the flexibility to extend such  
46 coverage beyond the 19-year-old baseline.  
47
  - 48 ○ ADA Position: There should be adult dental coverage for emergencies as part of  
49 the EHB package. Status: This recommendation was not adopted by any of the  
50 state or federal regulators. It is important to note that states expanding coverage  
51 in this fashion would have to pay 100 percent of the cost.  
52

- 1           ○ ADA Position: There should be cost sharing equitability to ensure consumers are  
2           treated fairly regardless of whether they select dental coverage as part of an  
3           embedded dental product or in a separate stand-alone plan. Status: We  
4           addressed this in comments submitted to relevant federal agencies on December  
5           19, 2012, and again on March 15, 2013. There is also an effort underway to  
6           bolster this advocacy through Congressional support.

- 7  
8           • Certification and Accreditation On February 26 – ADA staff spoke with officials at the  
9           Center for Consumer Information and Insurance Oversight (CCIIO) about the potential  
10          certification and accreditation of stand-alone dental plans. Status: The agency agrees  
11          with the ADA that certification standards do not apply to stand-alone dental plans at this  
12          time. Also, the agency agrees that there is currently no entity authorized to engage in  
13          such activity. Going forward, CCIIO will continue to work with the ADA. The Association  
14          explained that the ADA has taken the lead in developing the Dental Quality Alliance  
15          (DQA) to ensure that specific concerns of dentistry are adequately addressed and that  
16          we believe any entity designated as an accreditor for dental benefit plans should be  
17          required to use specific clinical quality measures developed by the DQA.  
18  
19          • Congressman Paul Gosar (R-AZ) authored H.R. 1798, the Dental Insurance Fairness Act  
20          of 2013 that will help consumers receive the full value of their dental coverage. Under  
21          H.R. 1798 all self-funded health plans that offer dental benefits will provide uniform  
22          coordination of benefits and will permit patients to assign the payment of benefits directly  
23          to their dentists. The bill enjoys bipartisan support with 8 Democrats and 7 Republicans  
24          co-sponsoring the bill.

25  
26       State Issues

- 27          • As the implementation of the Affordable Care Act (ACA) continues, along with the  
28          development of various state health insurance exchanges required under the ACA, the  
29          ADA Washington Office, Department of State Government Affairs staff and resources  
30          supported through the SPA program have all worked in unison to promote the oral health  
31          coverage in the ACA. All toolkits and resources have been updated and special  
32          emphasis has been geared to help states implement laws that require the purchase of  
33          pediatric dental coverage by families with dependents in the individual and small group  
34          markets after January 1, 2014. ADA's document "Potential Effects of the Affordable Care  
35          Act on Dentistry" has been updated to reflect new rules and developments. There are no  
36          outcomes from these efforts yet because the exchanges are still being developed.
- 37          • A total of 34 states now have laws or some other mechanism that restricts dental plans'  
38          ability to cap fees on non-covered services. Since 2009, 32 states have enacted specific  
39          laws to restrict fee capping, one state has existing laws that define non-covered services  
40          in a way so that they may not be capped. Another state has a legislative agreement  
41          crafted with the aid of the state legislature to prevent fee capping. These new laws were  
42          enacted in rapid succession since 2009 with the ADA serving to support the states by  
43          networking key advocacy points.
- 44          • Adult dental Medicaid has experienced a few improvements over the year-reversing a  
45          trend of dormant programming improvements. Colorado will add services for adult  
46          Medicaid enrollees this year, as will Minnesota as a result of new laws. Minnesota also  
47          enacted a 5 percent increase in Medicaid reimbursements for all populations.
- 48          • A few states have filed assignment of benefits and coordination of benefits legislation this  
49          year with the ADA providing advocacy assistance.

## 1 International Issues

- 2 • The ADA supported efforts to protect the availability of dental amalgam in the United  
3 Nations Environment Program proposed mercury treaty. The Association joined the FDI  
4 World Dental Federation, Food & Drug Administration, U.S. State Department,  
5 Environmental Protection Agency, World Health Organization and 130 countries in  
6 developing the globally binding treaty that calls for a phased-down approach to amalgam  
7 use through decreased disease and prevention strategies but does not place any  
8 restrictions or ban on use as a dental material.  
9
- 10 • Through its membership in the FDI World Dental Federation, the Association helped to  
11 successfully lobby for the inclusion of oral diseases within the World Health Organization  
12 global action plan for the prevention and control of non-communicable diseases 2013-  
13 2020. The plan recognizes that oral diseases share risk factors with the four major  
14 chronic diseases and thus benefit from a common approach. One of the preventive  
15 recommendations is also oral health cancer screenings.
- 16 3. *Financial health*: This outcome focuses on the financial health of members, as defined by each  
17 member. The “Measure” as stated in the strategic plan is member perception of well-being.  
18 Because the outcome explicitly recognizes that each member may define success under this  
19 outcome differently, the following actions are offered as key examples of action taken to meet  
20 this outcome:
- 21 • The Association launched the Center for Professional Success (CPS) in 2013. The CPS  
22 website is strategically aligned with the ADA’s priority to build member value. The soft  
23 launch and testing of the CPS practice management resource portal was completed in  
24 July 2013 and a CPS marketing plan was initially implemented in September. As of July  
25 1, 2013, two multi-year sponsorships totaling \$500,000 were secured for the project  
26 (sponsored by ADA Business Enterprises, Inc. (“ADABEI”) and ADA Insurance  
27 Plans). The formal launch of the CPS practice management project will occur at the 2013  
28 ADA annual session.  
29
- 30 • Through the Council on Members Insurance and Retirement Plans, the Association  
31 worked with an outside actuarial insurance consultant to conduct both an audit and a  
32 benchmarking study of the ADA Insurance Plans and an ADA Members Retirement  
33 Program. As a result of these reports, new products are under consideration.  
34
- 35 • The 2012 ADA Kellogg Executive Management Program was held with 26 participants,  
36 enhancing the understanding of customary business school curriculum of participating  
37 member dentists.
- 38 4. *Positive public image of the profession*: This outcome focuses on how the profession is viewed  
39 by the public. The Association has taken the following steps to improve public image of  
40 dentists:
- 41 • Resolution 75H-2012 approved by the House of Delegates provided funding for a public  
42 relations effort. The Association retained the services of Fleishman Hillard, as the  
43 national public relations agency to provide expertise in the development and execution of  
44 communications efforts.  
45
- 46 • The Association has developed and launched a public relations initiative through the  
47 Council on Communications with the addition of Fleishman Hillard as the national agency  
48 working with Communications. This initiative includes specific programs and media  
49 outreach centered on the Action for Dental Health: Dentists Making a Difference

1 campaign to address the leadership role of ADA dentists on access to care, safety net  
2 and prevention issues; it includes specific media efforts supporting the Science of  
3 Dentistry as the validation of our member's role in science-based healthcare delivery and  
4 patient care; and it includes support to position MouthHealthy.org as the most trusted and  
5 respected resource for public oral health information. The program's specific goals are  
6 set forth in greater detail in Appendix 1.

- 7
- 8 • Communication's proactive media relations efforts have included outreach to major  
9 national media and specific activities focused on the ADA role and positions relating to  
10 oral cancer detection and treatment, prenatal and early childhood dental health and  
11 support on press inquiries and engagement on elder care, the use of dental amalgam  
12 and infection control in the dental office. Through May 2013 media coverage has reached  
13 37.1 million newspaper and magazine readers, 33.5 million TV viewers and 691 million  
14 visitors to news and information websites. Comparative analytics from 2012 are not  
15 available.
- 16 • Association social media assets are fully functional with an aggregate of more than  
17 30,000 likes to Facebook pages and approximately 25,000 Twitter followers.  
18 MouthHealthy, launched in July 2012 is now at 1,331 Facebook followers and 1,850  
19 Twitter followers. The ADA Facebook wall was opened to followers as of April 2013 and  
20 now has 30,104 followers with @ADA Twitter followed by 10,296 people, up +69% in  
21 2013 and @ADANews with 19,380 followers, up 22% in 2013.
- 22
- 23 • The Association has issued a series of statements featuring solutions to "Breaking Down  
24 Barriers to Oral Health for All Americans" which articulates the profession's commitment  
25 to oral health leadership. These are being repositioned as Action for Dental Health  
26 resources.
- 27
- 28 • Over 41,600 dental team members, including more than 10,000 dentists participated in  
29 1,800 GKAS events throughout the nation.
- 30

31 5. *Member health, wellness and professional satisfaction throughout their career(s)*: This  
32 outcome focuses on the health and wellness of individual members. Many of the actions  
33 described elsewhere enhance member personal satisfaction. The following steps focus  
34 specifically on wellness.

- 35 • The Association produced four webinars on topics related to opioid analgesics, addiction  
36 and the prevention of prescription drug abuse. Over 500 ADA members participated in  
37 the 2013 webinars which are supported by a three-year grant sub-award received from  
38 the Substance Abuse and Mental Health Services Administration and the American  
39 Academy of Addictive Psychiatry.
- 40
- 41 • Content related to establishing healthy habits in the dental office, ergonomics, stress  
42 management, career burnout, disability support and promoting initiatives related to  
43 women's health is currently being developed and will be included in the future Center for  
44 Professional Success.

45 **Goal 2: Be the trusted resource for oral health information that will help people be good stewards**  
46 **of their own oral health.**

47 Outcomes/objectives:

1 1. *Oral health literacy*: This outcome focuses on the public's knowledge of oral health. The stated  
2 "Measure" is an ADA consumer survey. A consumer survey was fielded for the MouthHealthy  
3 communications and website initiative and as part of the Ad Council effort there is a baseline  
4 tracking study which will be followed by annual reports of selected oral health behavior changes  
5 and literacy measures. Both of these efforts will permit tracking over time, although they will rely  
6 on self-reported data. Another appropriate metric is measurement of how many members of the  
7 public are reached through various initiatives. In particular:

- 8
- 9 • MouthHealthy.org traffic continues to grow with over 680,000 visitors and 2.4 million page  
10 views since launch July 2012 through May 2013. As the ADA resource specifically  
11 directed to the public new features have been added including a dental symptom  
12 checker. The symptom checker is a mobile app which includes full integration with ADA  
13 Find A Dentist based on user GPS location.
- 14
- 15 • The Association is a leading partner in the Ad Council coalition to promote prevention  
16 efforts in the home. The target audience is at-risk kids and caregivers. Since the  
17 inception of the campaign several additional outreach efforts have been executed  
18 including retention of a national spokesperson for on-camera and digital appearances, an  
19 in-school program for the 2013/14 school year and extensive media coverage. Reporting  
20 on donated media lags due to the nature of the distribution but in the 10 months since  
21 inception through April 2013 the program has generated \$10.4 million in donated media  
22 and \$6.4 million in earned media exposure. There have been 1.3 million visits to the  
23 2min2x.org website with over 30,000 downloads of the "Brush Checklist" and 70,000  
24 views of the two minute videos.
- 25
- 26 • The ADA conducted a consumer outreach promotion involving 5,000 member dental  
27 offices and PopCap video games. 1 million oral health game cards were distributed and  
28 the custom video to "Stop Zombie Mouth" has generated 2,585,000 views on YouTube.  
29 The media coverage of this campaign generated 382 media stories with an audience of  
30 152 million.
- 31
- 32 • Work continues on revitalizing the ADA's trusted Seal of Acceptance brand by presenting  
33 new consumer friendly content on MouthHealthy.org and through social media channels.  
34 ADA is collaborating with Seal Program participants to link to MouthHealthy and increase  
35 traffic to the Seal content areas. Combined traffic to Seal pages on ADA.org and  
36 MouthHealthy is 15,000 visits and 33,000 page views each month. Compared to  
37 analytics for the same timeframe in the previous year, visits to Seal pages have nearly  
38 tripled while page views have increased by 41 percent. A new Seal video is planned for  
39 production this year, and the Seal is expected to play a prominent role in the national PR  
40 campaign.

41

42 2. *Shared responsibility*: The focus of this outcome is the respective roles of both the patient and  
43 doctor in managing oral health. The stated "Measures" largely focus on the data provided above  
44 with respect to oral health literacy.  
45

46 **Goal 3: Improve public health outcomes through a strong collaborative profession; including**  
47 **effective collaboration across the spectrum of stakeholders outside of dentistry**

48 Outcomes/objectives:

- 49 1. *Effective dental professional collaboration*: The focus of this outcome is the entire profession  
50 working together to improve oral health. This is an area of intense activity within the



1 Association, including:  
2

- 3 • The Association's "Action for Dental Health: Dentists Making a Difference" campaign  
4 launched in May. It features a comprehensive suite of solutions to improve access to  
5 oral health in which collaborations with constituent societies, allied dental  
6 organizations and interprofessional relationships play a key role. These include  
7 support from the American Hospital Association, American Association of Emergency  
8 Room Physicians, and the leadership of community health centers to mention just a  
9 few. Such collaborations are integral to the success of the campaign generally and to  
10 achieving demonstrable progress in addressing access issues specifically.  
11
- 12 • The Association partnered with over 35 other oral health organizations, resulting in  
13 the Ad Council campaign on prevention which continues this year. Results from that  
14 campaign are reported above.  
15
- 16 • Work is underway on the 5<sup>th</sup> annual conference in January 2014 of the National  
17 Roundtable for Dental Collaboration. This conference provides a venue for 23 dental  
18 associations and dental specialty organizations to identify and assess common  
19 challenges. The focus in 2014 will be on the future of the profession.  
20
- 21 • The Association will welcome the 11th Institute for Diversity in Leadership class in  
22 late September and participated in a Joint Leadership session with National Dental  
23 Association, Hispanic Dental Association and Society of American Indian Dentists.  
24
- 25 • Collaborating with the Health Resources and Services Administration (HRSA), the  
26 Association developed a perinatal consensus statement with American Congress of  
27 Obstetricians and Gynecologists (ACOG).  
28
- 29 • The Association entered into a formal partnership with the U.S. National Oral Health  
30 Alliance to provide a platform for a diverse network of stakeholders to harness  
31 opportunities and create viable solutions for improved oral health through prevention  
32 and treatment for vulnerable populations.  
33
- 34 • Through engagement with the American Academy of Pediatrics Section on Oral  
35 Health, the Association developed an oral health risk assessment tool and made  
36 available to 60,000 pediatric physicians.  
37
- 38 • The ADA is a member association of the FDI World Dental Federation, which  
39 represents the dental profession of the world and stimulates and facilitates the  
40 exchange of information across all borders with the aim of optimal oral health for all  
41 peoples. The FDI has nearly 200 Member Associations representing more than 1  
42 million dentists worldwide. By being a member of the ADA, dentists are also a  
43 member of the FDI. Several ADA members are on committees of the FDI and the  
44 ADA has a 10-person delegation to the FDI. The ADA helped lead the task team that  
45 developed Vision2020, a report that outlines five goals toward addressing urgent  
46 health care challenges.  
47
- 48 • The ADA sponsors the nine dentistry programs on four continents of Health  
49 Volunteers Overseas (HVO). HVO is a private, non-profit organization, committed to  
50 improving health care in developing countries through training and education. ADA  
51 members are able to and have actively participated in volunteering overseas through  
52 these programs.  
53

1           2. *The public has access to effective prevention and to a quality focused delivery system:* This  
2 outcome focuses on prevention strategies and availability of a quality driven delivery system,  
3 with the public system mirroring the efficiencies of the private system.  
4

- 5           • The ADA developed a tool kit titled “Fluoridation: Tap in to Your Health” which is  
6 available to dental societies via ADA Connect. The tool kit includes: 1) materials for  
7 building a fluoridation campaign; 2) materials for public distribution; 3) advocacy  
8 materials and 4) press statements and policies from the ADA. Launched at the ADA  
9 Management Conference in July 2012, the tool kit has been revised twice with the  
10 latest edition launched in July 2013. Demand for the kit from state/county/local  
11 health departments led to collaboration with the Association of State and Territorial  
12 Dental Directors who have also made the tool kit available via the members-only  
13 section of their Web site. As of Dec. 2012, the toolkit had been accessed 134 times  
14 and as of June 26, 2013, the toolkit has been accessed 253 times.  
15
- 16           • Requests for fluoridation technical assistance from members, constituent/component  
17 dental societies and local governments have increased steadily over the last five  
18 years. Since 2008, the annual number of phone and e-mail requests has doubled as  
19 many communities face economic challenges, anti-fluoridation activities have  
20 increased, and the uncertainty regarding the proposed HHS recommendation for the  
21 fluoride level in fluoridation at 0.7 mg/L remains unresolved. From 2010 to 2011, the  
22 number of requests for technical assistance spiked by 50 percent largely due to the  
23 HHS proposed recommendation. Requests for assistance continued to rise in 2012.  
24 It is anticipated the number of requests will increase significantly when the final HHS  
25 recommendation is made. Over the next several years, the trend of increased  
26 requests for technical assistance will continue as communities act on the HHS  
27 recommendation. From January 2011 through June of 2012, CAPIR provided  
28 fluoridation technical assistance to dentists, oral health coalitions and state/local  
29 dental societies in more than 35 states. On April 12, 2013, the ADA sponsored a six-  
30 hour fluoridation training course developed by CAPIR in collaboration with the  
31 Department of Continuing Education, Public/Professional Communications and State  
32 Government Affairs. Twenty-six participants representing their state dental societies  
33 received information on topics that ranged from the latest science supporting  
34 fluoridation to a discussion of campaign strategies to initiate and retain fluoridation  
35 programs.  
36
- 37           • As reported above, the ADA provided constituent dental societies with tools they  
38 need to effectively advocate for dentistry and dental patients with regard to the  
39 establishment of health benefit exchanges under the new health care reform law, the  
40 Affordable Care Act (ACA).  
41
- 42           • The Association obtained Centers for Medicaid and Medicaid Services (CMS)  
43 assistance in promotion of Incurred Medical Expense (IME) to state Medicaid  
44 agencies to facilitate dentist’s use of this reimbursement mechanism for dental care  
45 provided to nursing home residents on Medicaid. This year over 600 registered for  
46 the IME call, and approximately 325 participated in the live webinar. The recorded  
47 webinar was also made available as an archived version.

48 **Goal 4: Ensure that the ADA is a financially stable organization that provides appropriate**  
49 **resources to enable operational and strategic initiatives**

50 Outcomes/objectives:

- 1           1. *Increase the reserves of the Association so that a reserve level of 50% of the Association's*  
2           *annual budgeted operating expenses is achieved, as urged by HOD Resolution 59-2007H-*  
3           *2008: The purpose of this outcome is self-explanatory, as is the Measure. At present, the*  
4           *Association's reserve levels do not meet this outcome (as of March 31, 2013, reserves are at*  
5           *the 48% level).*

6 Additional information regarding the financial status of the Association can be found in the Quarterly  
7 Management Reports referenced at the beginning of this report at <http://www.ada.org/4022.aspx>. These  
8 reports include the following data on membership trends, dues revenue, non-dues revenue and  
9 expenses, all reported over time (Appendix 2.).

10 In addition, the following actions have been taken with respect to the financial status of the Association:

- 11
- 12           • The ADA increased its focus on business development by designating a senior vice  
13           president for business with responsibility for leading new business activities across the  
14           Association as well as for three of the largest non-dues-revenue-generating areas of the  
15           ADA – Publishing, Corporate Relations and Conferences and Continuing Education  
16           (formerly Conference and Meeting Services). Working in close collaboration with the  
17           Division of Membership, this position will oversee the ADA's annual product strategy and  
18           identify business opportunities for new and existing ADA products and services with high  
19           member value, dues revenue and/or non-dues revenue growth.  
20
  - 21           • The Manager, International Business, in the Division of Global Affairs, manages the  
22           Association's international business new growth activities. A business plan will be  
23           drafted by year end to lay out the strategy and tactics to grow non-dues revenue  
24           internationally.  
25
  - 26           • Membership trends 2007-2012 show flat membership numbers with a steady increase in  
27           the size of the profession, causing an annual decline in the membership market share;  
28           this trend is consistent across constituent dental societies. Building and maintaining a  
29           consistently strong membership market share is a priority for ADA's financial stability.  
30           Through mid-year 2013, new/reinstated member recruitment is slightly ahead of 2012  
31           while retention is lagging somewhat. As a result, 2013 active membership at mid-year is  
32           slightly under 2012 levels, and market share is also lower as a result of growth in the  
33           market. Recruitment and retention initiatives – including early implementation of the non-  
34           renew calling program conducted collaboratively by the ADA and the state dental  
35           societies – are underway.  
36
  - 37           • ADA membership recruitment and retention initiatives support a strong membership base  
38           and related dues revenue. The 2012 membership rolls included 3,907 members who  
39           were not members in 2011 and had either joined the ADA for the first time or reinstated  
40           their membership by the end of 2012. A final assessment of 2012 activities shows that  
41           two-thirds had received one or more recruitment communications. In general, dentists  
42           who did not receive communications were in transition from one location to another or  
43           between membership categories. In addition, 66.1% of new graduates had converted to  
44           active membership, and 100% of these dentists had received ADA communications.  
45
  - 46           • In 2012, the Membership Program for Growth (MPG) distributed \$497,500 in funding to  
47           support a total of 88 constituent and component membership recruitment and retention  
48           efforts, with new dentists, diverse dentists, and women dentists and dental students as  
49           priorities for outreach. Due to timing of the MPG reporting process, initial results for 2012  
50           will be reported later in 2013, but previous analysis shows a positive impact on  
51           membership numbers and dues revenue. The 2013 MPG process distributed \$488,000  
52           in funding to support a total of 74 constituent and component initiatives through June 1,

1 with results to be reported in 2014.  
2

- 3 • The 2012 House of Delegates took action to change the dues reduction offered to active  
4 life members from 50% to 25%. Through June 2013, the impact has been an apparent  
5 increase in the non-renew rate (from 6.3% to 8.9% comparing 2013 to 2012 as of May  
6 31). However, there are more members paying that dues rate due to an increase in the  
7 number of eligible members, and the positive impact on dues will be over \$2 million.  
8
- 9 • Increasing member value is an ADA priority. This year brought the launch of the Power of  
10 3, which includes several related strategies to increase tripartite alignment and  
11 collaboration, greater accountability and transparency, a tripartite focus on evaluating and  
12 building member value, and a more strategic and effective approach to recruitment and  
13 retention initiatives, including a greater focus on raising the “member value IQ” –  
14 especially for new members – in order to reduce the non-renew rate. The overall goal is  
15 to reverse the market share decline and ensure that ADA membership growth meets or  
16 exceeds the growth of the profession.  
17
- 18 • The Council on Members Insurance and Retirement Programs conducted a  
19 comprehensive two-year financial audit and benchmarking study of the ADA Members  
20 Insurance Plans utilizing actuarial consultants from Milliman, Inc. The study confirmed the  
21 ADA Members Insurance Plans continue to be best in class and offer a superior value for  
22 policyholders. In addition, the audit, and subsequent negotiation with the insurance  
23 company, have provided for significant new value for the plans. As a result, the Council  
24 made recommendations to the Board of Trustees and the Board approved changes to the  
25 interest crediting formula on ADA Members Insurance Plan’s assets, a reduction in the  
26 insurance company’s risk and profit charge for two of the Plans, revision to the Board  
27 policy related to utilization of excess surplus from the Term Life Plan, and also approved  
28 a distribution to the ADA of the previous Board-approved one-time unallocated 2012  
29 surplus set-aside from the term life plan.  
30
- 31 • Through a comprehensive evaluation of Association programs and services using a  
32 formal prioritization tool and the universal assessment criteria developed with the Board,  
33 several services were identified to be sunset by year end 2012. In conjunction with the  
34 change in programs and services, total ADA staffing levels were reduced by  
35 approximately 10%.  
36
- 37 • Through continued cost containment and revenue generation the Association generated  
38 the highest total net to date from annual session, \$4,154,087, and a net per attendee of  
39 \$118.44. This is down from \$145.80 per person in 2011 however the large payment to  
40 the California Dental Association (CDA) dramatically changed the cost structure of the  
41 meeting. Removing the payment to the CDA for comparative analysis produces an  
42 estimated average net per attendee of \$152.17, the highest to date. The Association  
43 also attracted one international pavilion (Germany) to participate in the World  
44 Marketplace Exhibition.

- 45 2. *Establish, as permitted by the ADA Bylaws Chapter XVII, Section 30, and annually fund a*  
46 *Capital Improvement Fund that can be carried over each year:* In 2012, the Board forwarded  
47 to the House a plan to create such a fund in the 2013 budget:  
48

- 49 • The final House-approved 2013 budget included a provision to fund a new Capital  
50 Replacement Reserve Account to be used to pay for larger and much less frequent  
51 building repairs, replacements, and renovations to ADA buildings. The goal of this

1 new capital reserve account is elimination of the need for future special assessments.

- 2
- 3 • The 2013 budget calls for \$3.5 million to be contributed to this new Capital
  - 4 Replacement Reserve Account and the actual balance of this account as of March
  - 5 31, 2013 was \$875,000.

6 **Resolutions**

7 This report is informational and no resolutions are presented.

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

9 **BOARD VOTE: UNANIMOUS.**

## Action for Dental Health: Dentists Making a Difference

### Progress Report Goals

#### OVERARCHING GOAL:

Reduce the proportion of adults and children with untreated dental decay through multiple interventions, early diagnosis and risk assessment, disease management and health education, and by preventing dental disease before it starts.

#### Initiative: Lead Collaborations to Achieve and Exceed the Healthy People 2020 goals

Dedicate resources to collaborations, public/private partnerships and community-based interventions defined locally to achieve and exceed the Healthy People 2020 oral health goals adopted by U.S. Department of Health and Human Services.

- Goal:** Reduce the proportion of adults with untreated dental decay 15% by 2020, exceeding the 10% HP 2020 goal by 50%
- Goal:** Reduce the number of children under 18 with untreated dental decay 15% by 2020, exceeding the 10% HP 2020 goal by 50%
- Goal:** Increase the proportion of low income children who received any preventive dental services during the past year by 15% by 2020, exceeding the 10% HP 2020 goal by 50%

#### Initiative: Get People the Right Care, in the Right Setting – Emergency Department to Dental Chair

The utilization of emergency departments for dental conditions burdens the hospital, drains resources and becomes a cycle of care that does not treat and solve the underlying patient problem.

**Baseline:** Total dental emergency room visits 2.1 million (2010). Estimated 830,000 visits for preventable dental conditions and 390,000 visits for caries (cavities) as primary diagnosis (2009).

- Goal:** Institute ER interception programs in 25 states by 2015 and 50 states and District of Columbia by 2020
- Goal:** Reduce ER dependency for patients with dental caries (cavities) and the pain associated with dental emergencies 50% by 2020
- Goal:** Reduce the total proportion of ER visits for dental-related issues by 35% by 2020



ADA American Dental Association®

## APPENDIX 1

### Initiative: Community Based Contracting Between Local Dentists and Federally Qualified Health Centers

Increase the capacity of the Federally Qualified Health Center (FQHC) Dental Programs through the contracting of private practices to accept publicly insured patients in the private practice setting, while the administrative burden of state insurance programs remains with the FQHC, reducing the barrier for private practice participation in public dental programs.

**Baseline:** 17.5% of FQHC patients received oral health services (2007)

**Goal:** Increase patients receiving oral health services 175% by 2020 - target 50% of all FQHC patients to receive oral health services, such as risk assessments, preventive measures, dental referrals and direct treatment

### Initiative: Dentists Providing Care to Nursing Home Residents - Establish the Long-term Care Dental Campaign

Dentists are to participate in nursing home care and prevention programs through local community outreach, continuing education and training to work in long-term care.

**Baseline:** Currently, there is insufficient data at a national level to accurately understand how many nursing home residents are receiving regular dental care. Therefore, one goal of this initiative is to gain a better understanding and measurement of the extent of the problem. Ultimately, our goal is to ensure every nursing home resident who wants and needs dental care is able to get it.

**Goal:** At least ten state dental associations committed to implementing a long-term care program to improve the oral health of nursing home residents by 2015.

**Goal:** Through ADA continuing education, train at least 1,000 dentists to provide care in nursing homes by 2020, and increase the number of dentists serving on advisory boards or as dental directors of long-term care facilities.

### Initiative: Expansion of Give Kids A Smile Local Community Screening and Treatment Efforts

The Give Kids A Smile mission is that as a public/private partnership, to serve as a catalyst for community-based children's oral health and wellness programs that are expandable, sustainable and innovative. Each year dentists and dental team members in communities around the country conduct free screenings and provide preventive care, such as fluoride varnish and sealant applications, as well as offer treatment to children in need while getting them into continuity of care.

**Baseline:** 400,000 children screened and treated in 2012. Fact: National Health and Nutrition Examination Survey reports 23.8% of children aged 3-5 years had untreated dental decay in at least one primary tooth.

**Goal:** The Vision Statement of Give Kids a Smile calls for the elimination of cavities in U.S. five year olds by 2020.

**Goal:** ADA supports the Healthy People 2020 objectives that call for a 10% increase in children 3-15 who receive sealants. Sealants have been proven effective in reducing dental decay on the chewing surfaces of children's teeth.

-continued-

### **Initiative: Expansion of Community Water Fluoridation – Tap Into Your Health**

The Centers for Disease Control and Prevention have proclaimed community water fluoridation as one of the 10 great public health achievements of the 20<sup>th</sup> Century. Community Water Fluoridation is one public health program that actually saves money. An individual can have a lifetime of fluoridated water for less than the typical cost of one dental filling.

**Baseline:** As of 2010, 74 percent of people on public water systems enjoy the cavity-prevention benefits of fluoridated water.

**Goal:** Provide fluoridated water to 80% of Americans on public water systems by 2020

### **Initiative: Improve Utilization of the Existing Safety Net Through the Use of Community Dental Health Coordinators: Working with Patients in 15 States by 2015**

Expand the number of community dental health coordinators (CDHC) working as patient navigators, preventive specialists, and oral health screening workforce within the community health center environment and the private practice environment to reduce barriers to access (socio-economic, cultural, geographic, educational and psychological), while increasing capacity of the community health center dental programs and private practices.

**Baseline:** As of April 2013, 34 Community Dental Health Coordinators are actively working in 7 states. A CDHC pilot project evaluation found 1 CDHC working just 1 day a week was able to provide services to 114 patients over a 9 month period.

**Goal:** Increase the number of states with active Community Dental Health Coordinators to 15 states by 2015

### **Initiative: Educating all Americans to be Mouth Healthy for Life**

Continue to provide public education outreach programs and to improve oral health literacy among the general public through direct investment and collaborations.

**Baseline:** The ADA's MouthHealthy.org website launched in July 2012. The ADA is a founding and executive member of the Partnership for Healthy Mouths, Healthy Lives and the Ad Council developed Children's Oral Health campaign.

**Goal:** Establish MouthHealthy.org as the most respected and trusted online resource for oral health information and as one of the top 5 most visited websites for oral health information.

**Goal:** Support and expand the efforts of the Partnership for Healthy Mouths, Healthy Lives and the Ad Council campaign through ADA member dentists in the local community





ADA American Dental Association®

## APPENDIX 1

### **Initiative: Reducing the Barriers to Provider Participation in Medicaid/CHIP through Reductions in Administrative Burdens and State Developed Solutions for Sustainable Reimbursement**

Many states are cutting adult dental Medicaid. Six states provide no adult dental benefits through Medicaid and 18 states provide benefits for emergency dental care only. There are no states providing full coverage at this time. Each year, only \$143 per Medicaid patient is spent on dental treatment. Across the U.S., Medicaid spending for dental care is approximately 1% of total Medicaid spending.

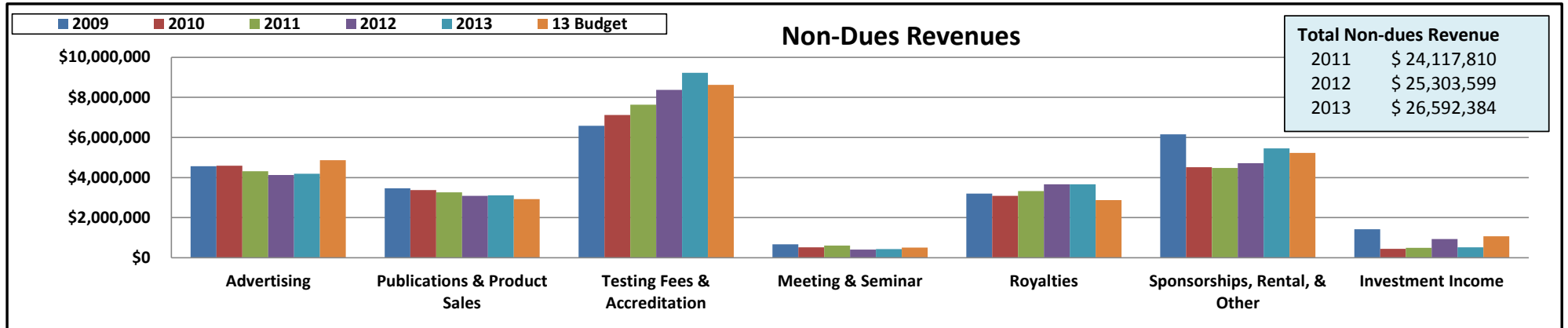
**Goal:** Increase the number of states that have streamlined their credentialing process to less than one month by 10%

**Goal:** Increase the number of states that have a dental Medicaid advisory committee by 25%

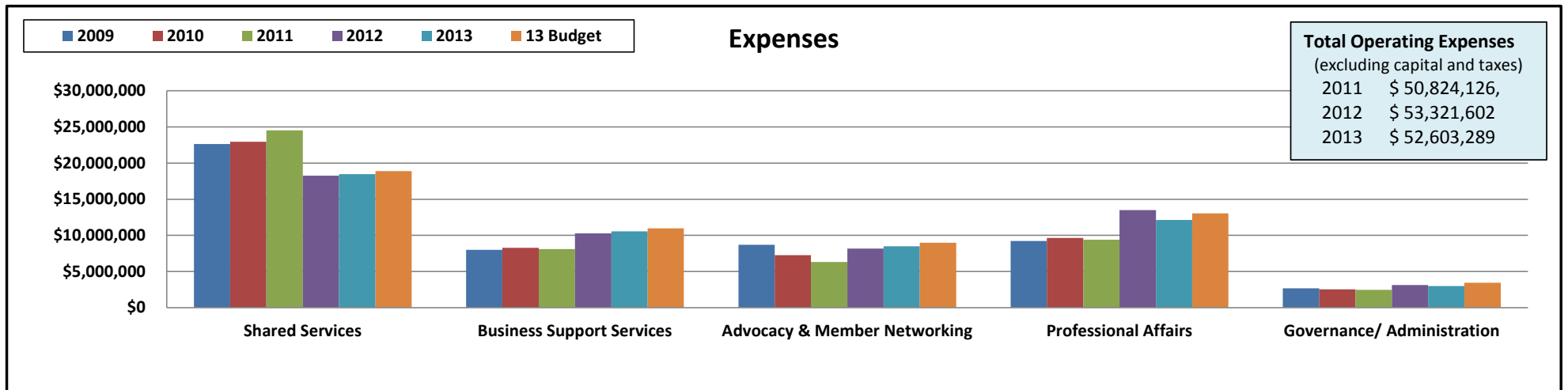
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**AMERICAN DENTAL ASSOCIATION (501(c) 6 only)**  
**ADA DIVISIONAL SUMMARY REPORT**  
**Month Ending: June 30, 2013**

Appendix 2

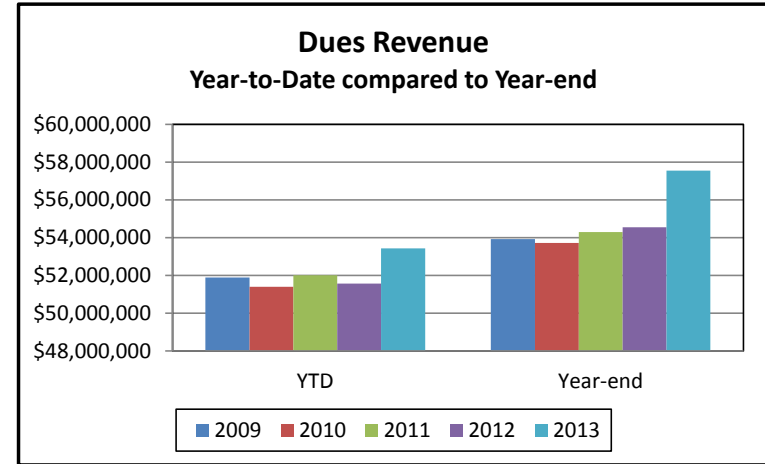
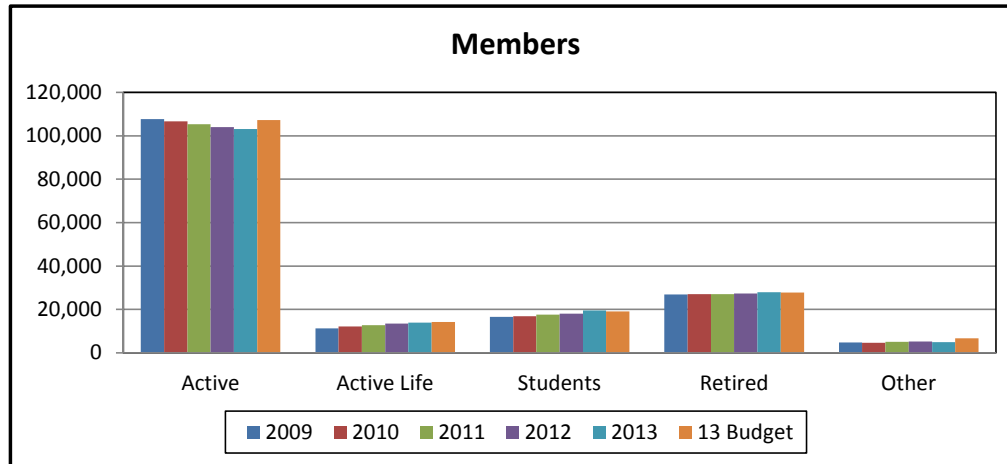


	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>13 Budget</u>
<i>Dues/Total Revenues</i>	50.90%	53.12%	51.51%	50.00%	49.61%	50.51%
<i>Total Revenue/FTEs</i>	\$124,100	\$117,300	\$116,600	\$123,500	\$134,700	\$126,200
<i>Annual Revenue Growth</i>		(4.96%)	(1.41%)	1.74%	4.27%	4.19%
<i>Staff Compensation &amp; Benefits/Total Expense</i>	49.88%	51.58%	53.53%	53.22%	51.84%	48.45%
<i>Benefits/Salaries</i>	46.99%	50.49%	53.42%	42.00%	42.13%	40.90%
<i>Number of FTEs</i>	428	430	427	410	392	418
<i>Annual Expense Growth</i>		(1.08%)	0.28%	4.91%	(1.35%)	3.76%



Decrease in Shared Services Expense is due to change in allocation of fringe benefits. Prior to 2012, 100% of fringe benefits were in Shared Services. For 2012 and following years, fringe benefits are allocated to all departments.

**AMERICAN DENTAL ASSOCIATION (501(c) 6 only)**  
**MEMBERSHIP ANALYSIS**  
**Month Ending: June 30, 2013**



	<b>Membership Totals</b>					
	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>13 Budget</u>
Active	107,660	106,623	105,373	103,958	103,051	107,217
Active Life	11,350	12,105	12,765	13,483	14,011	14,236
Students	16,624	16,936	17,648	18,100	19,567	19,067
Retired	26,897	27,040	27,102	27,409	27,970	27,826
Other	4,808	4,605	5,144	5,215	4,875	6,645
<b>Total Members</b>	<b>167,339</b>	<b>167,309</b>	<b>168,032</b>	<b>168,165</b>	<b>169,474</b>	<b>174,991</b>
<i>Dues/Total ADA Revenues</i>	50.9%	53.1%	51.5%	50.0%	49.6%	50.5%
<i>YTD dues collected/Total year-end</i>	96.3%	95.7%	95.8%	94.5%	92.9%	
<i>Full Dues Rate</i>	\$498	\$498	\$505	\$512	\$522	\$522
<i>Average Dues/Member</i>	\$310	\$307	\$309	\$307	\$315	\$329
<i>Full dues equivalent members</i>	104,212	103,220	102,979	100,702	102,367	110,249
<i>Membership growth/loss</i>		-0.02%	0.43%	0.08%	0.78%	
<i>Membership dues revenue increase</i>		-0.95%	1.17%	-0.86%	3.64%	
<i>Members per FTE</i>	391	389	394	410	432	419

	<b>Membership Dues per Tripartite</b>				
	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>13 Budget</u>
	\$47,854,333	\$48,055,299	\$47,567,978	\$47,494,211	\$50,557,171
	2,994,154	3,358,014	3,421,230	5,399,057	\$5,580,512
	84,680	88,290	90,500	97,835	\$95,335
	258,407	263,149	242,575	235,042	\$255,450
	212,036	239,844	237,028	209,250	\$1,061,594
	<b>\$51,403,610</b>	<b>\$52,004,596</b>	<b>\$51,559,311</b>	<b>\$53,435,395</b>	<b>\$57,550,062</b>

The numbers presented are as of month-end, not year-end except for 2012 Budget column. Special assessments are not included in the Membership Dues collected.

Resolution No. None N/A

Report: Board Report 11 Date Submitted: August 2013

Submitted By: Board of Trustees

Reference Committee: Budget, Business and Administrative Matters

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0

ADA Strategic Plan Goal: Members (Required)

1 **REPORT 11 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: INFORMATION**  
 2 **TECHNOLOGY INITIATIVES, EXPENDITURES AND ESTIMATED COSTS, AND ANTICIPATED**  
 3 **FUTURE PROJECTS**  
 4

5 **Background:** This report to the House of Delegates on the ADA’s Information Technology initiatives,  
 6 expenditures and future projects is submitted as required by Resolution 30H-2003 (*Trans.2003:334*),  
 7 which urged the Board to provide an annual report summarizing technology initiatives, expenditures,  
 8 estimated costs, anticipated projects and their sources of funding.

9 The Division of Information Technology (IT) uses an established plan to provide technology staff with the  
 10 goals and objectives necessary to support the ADA Strategic Plan. This plan allows the IT division to  
 11 address immediate issues and the opportunity to provide quality information technology operations to  
 12 service ADA members and the tripartite.

13 **Overview:** This executive summary provides an overview on IT-related projects that were completed in  
 14 2012, planned projects for 2013 and projected projects for 2014. Further details on all projects can be  
 15 found in the detailed report. This report is informational only; there are no resolutions.

16 **Year 2013 Projects and Expenditures:** In 2013, the IT division continues to move forward with projects  
 17 in its core areas. As of this report, the following projects are completed and others are currently in the  
 18 working stages with a completion goal by the end of the year.

- 19 • *Document Management (FileWeb).* The Association implemented Open Text Livelink as its  
 20 document management system in 2002. This system, which was branded “ADA FileWeb”, allows  
 21 ADA staff to efficiently store and share documents. An upgrade to improve the user interface as  
 22 well as provide new user functionalities and features was completed in March 2012. In 2013, an  
 23 outside IT consulting firm has been retained to assist staff with completing a planning effort for  
 24 the migration away from Open Text Livelink to Microsoft SharePoint. Cross-divisional Work  
 25 Teams have been established to define system requirements documentation and define business  
 26 processes. The information obtained in this phase will be used to select features and  
 27 functionality that will be implemented into the new system. The migration to the new environment  
 28 is planned for 2014.
- 29 • *Data Warehouse.* In 2012, work continued on enhancing and expanding the Electronic  
 30 Dashboard. Enhancement work also continued on existing data marts and new data marts were  
 31 implemented as needed upon request. In 2013, work is underway on developing a reporting  
 32 strategy for the ADA. This strategy will ensure data required for reporting is centrally located and  
 33 standardized methods for creating reports are developed and implemented across ADA. . Any  
 34 requests in 2014 for new data marts or enhancements to existing data marts will be completed  
 35 using existing IT staff

- 1       • *Internet.* The following outlines web-related projects that were completed in 2012 or are being  
2       completed in 2013:
- 3           ○ Evidence-Based Dentistry (EBD) website was enhanced in 2012 with new features and  
4           functionality and these enhancements continue in 2013. The EBD website, which was  
5           released a few years ago, needs to be rewritten and updated due to changes in the  
6           software platform that was used to develop the site and some underlying performance  
7           issues. A thorough site review to understand how the EBD workflows and processes  
8           work and what improvements are needed was conducted with staff from the Division of  
9           Science. System requirements are being written and development is scheduled to begin  
10          this summer. The formal launch of the site is scheduled for December 2013.
- 11          ○ SiteCore, the ADA's new web content management software was purchased and  
12          replaced OpenText RedDot. This new software launched with the new consumer  
13          website, [www.mouthhealthy.org](http://www.mouthhealthy.org). Work is currently underway to move ADA.org and  
14          related microsites from OpenText RedDot to the new SiteCore software. This  
15          reorganization will ensure that ADA.org matches the brand enhancements that exist on  
16          the Mouthhealthy and the Center for Professional Success (CPS) websites and improves  
17          the site navigation and content. This project is expected to be completed in early 2014.  
18          Additional end-user licenses were purchased in 2013 to ensure staff can update sites  
19          with the most current content. In 2014, outside IT consulting will be retained to provide  
20          software support as needed.
- 21          ○ *Consumer Website.* In June 2012, the new consumer website, [www.mouthhealthy.org](http://www.mouthhealthy.org)  
22          was launched. This new website is consumer-focused and provides consumers with a  
23          dedicated site to obtain dental information pertaining to their needs. The consumer-  
24          based content that resided on ADA.org was moved to this new website. It includes  
25          features such as a Symptom Checker Slideshow and a public-version of Find-A-Dentist.  
26          In January 2013, the Child Online Privacy Protection Act (COPPA), a law designed to  
27          protect young children from online predatory activities, was enacted. The law states that  
28          any website with material directed at children under the age of 12 has to either not track  
29          any of their activities on the site or has to have a complicated parental consent process.  
30          Mouthhealthy.org contains material directed at young children and tracks visitor activity.  
31          A decision was made with Communications and Legal staff to split the children's area of  
32          Mouthhealthy.org off to a separate non-tracking website ([www.mouthhealthykids.org](http://www.mouthhealthykids.org))  
33          instead of adding parental consent processes. Work is underway to meet the law's  
34          requirements and is planned to be in place by mid-July, 2013.
- 35       • *Center for Professional Success.* The Center for Professional Success (CPS) website is  
36       scheduled for a soft site launch in July and a full site launch in September 2013. This new web  
37       resource and member benefit provides dentists with an online tool to help with the day-to-day  
38       business management of their practices. The website is organized into three areas: Practice,  
39       Live, and Learn and is highly interactive with news feeds, trends trackers, research, quality of life,  
40       improved video capabilities and financial calculators. On-going content updates will occur  
41       throughout 2014 with no major changes or updates planned. Any programming changes will be  
42       completed using existing IT staff.
- 43       • *Mobility.* In 2012, the ADA continued to expand its mobile offerings and capabilities. Mobile  
44       applications for Annual Session and the New Dentists' Conference were deployed for the iPhone,  
45       Android and Blackberry platforms. These apps allow meeting attendees to locate exhibitors, find  
46       continuing education class times and locations and other relevant meeting information. Work is  
47       underway on both applications to expand features and functionality in 2013. As part of the  
48       consumer website project, the Symptom Checker mobile app was also released in 2012. In  
49       2013, the CDT code mobile app is being updated to provide new, revised and changed CDT  
50       codes as well as provide an auto-renewing subscription feature, which will allow users to

1 download and pay for updates as they are pushed out. A Toothflix Videos mobile application is  
2 currently under development and is scheduled for release in September. This product is currently  
3 sold in DVD format from the ADA Catalog and the Patient Smart web portal. Mobilizing this  
4 product will provide another format for ADA members to use this educational resource. A new  
5 Oral Pathologist mobile application has been developed and will deploy with the CPS website. In  
6 2014, updates and enhancements to existing apps will continue. The majority of this work will be  
7 done using existing IT staff with outside IT consulting will be retained if necessary.

- 8 • *ADA Connect.* The ADA Connect application was launched to the House of Delegates in 2011.  
9 Site enhancements were identified, developed, implemented and deployed prior to the 2012  
10 annual session. ADA Connect areas for ADA Councils, Committees and Standards Committees  
11 were deployed in June 2012. A Balloting and Voting system was also developed and deployed to  
12 administer voting activities for these groups. Enhancements are underway for the 2013 House of  
13 Delegates, which will make it easier for resolutions to be created and edited. A new Board of  
14 Trustees area has been added and was launched at the June 2013 Board meeting. In 2014, the  
15 MS SharePoint environment, which is the platform for ADA Connect will continue to be supported  
16 and updated as needed.
- 17 • *PeopleSoft.* The Human Resources Management System (HRMS) upgrade was completed in  
18 October 2012. Similar to the Financial System upgrade that was completed in 2011, this upgrade  
19 is necessary to maintain compliance with the software maintenance agreement and will ensure  
20 that updates and security patches are received and installed in a timely manner to keep the  
21 system current. In 2013, an upgrade to the latest version of PeopleTools will be completed.  
22 People Tools is the software development environment used by IT developers to create and  
23 customize PeopleSoft applications. This upgrade will ensure developers are using the most  
24 current software development environment that is compatible with most recent upgrades to the  
25 Finance and HRMS systems. Also in 2013, Oracle's Talent Management solution will be  
26 purchased and implemented. This solution tightly integrates with the PeopleSoft HRMS as they  
27 are both Oracle-owned products. This hosted software service will improve many aspects of the  
28 eRecruitment operation by providing HR recruiters the flexibility to have extra resources without  
29 hiring additional staff. It consolidates key activities such as posting jobs and searching for  
30 candidates into a single action and reduces the need for repetitive tasks. It reduces manual  
31 entries and time spent on reviewing resumes. This service provides features that quickly link  
32 applicants' skills to posted job descriptions. It also reduces the applicants' time filling out multiple  
33 pages of web forms thus giving them a more modern, less burdensome and more positive  
34 experience as they interact with the ADA and our technology for the first time. In 2014, any  
35 system updates or enhancements will be done using existing IT staff.
- 36 • *Hyperion Plan Tool.* In late 2012, outside IT consulting services were retained to redesign the  
37 budget cost centers and the program and project IDs to align the budget with the major programs  
38 within the ADA. While the project completed in time for the 2014 budget preparation cycle,  
39 additional consulting assistance was needed for more programming changes and system  
40 support. In 2013, additional system enhancements have been identified by Finance staff and are  
41 being implemented. In addition to ongoing system enhancement work, outside IT consultants  
42 were retained to complete a system audit and to interview budget administrators on their  
43 experiences with Hyperion. A system roadmap was developed and presented to appropriate  
44 senior staff. Work will be prioritized to determine what will be completed in 2013 in time for the  
45 2015 budget cycle and what can be done in 2014. A system upgrade is also scheduled for 2014,  
46 which will bring Hyperion to the most current version.
- 47 • *Tripartite System.* As of this report, 41 states, 69 components and the ADA are actively using the  
48 Tripartite System (TS). No additional funding has been requested for TS and all current work is  
49 completed by existing IT staff. In 2012, work began on transitioning from TS to Aptify. The  
50 system conversion will be completed in October 2013. Once the ADA conversion is completed, a  
51 plan will be developed to begin converting states and local societies currently using TS as their

1 membership management system to Aptify. The ADA purchased enterprise licensing, which  
2 allows all current TS sites to move to Aptify as well as any new sites to come on to Aptify if they  
3 so choose.

- 4 • *Infrastructure Hardware/Software Licenses.* The expenditures reflected in 2012, 2013 and 2014  
5 are primarily for hardware and software licenses to maintain the Association's network  
6 infrastructure as well as provide end-user equipment such as desktops, laptops and printers. In  
7 addition, funding is budgeted annually for a manufacturer-certified on-site technician. As part of  
8 the network server maintenance agreement, this technician is available on-site to fix hardware  
9 under warranty instead of depending on "depot warranty service." This on-site service minimizes  
10 downtime for users. In 2012, additional software licenses that provide updated functionality to  
11 backup data on the network servers were purchased. Updated Microsoft Project and Visio  
12 licenses were purchased for end-users as well as updated Microsoft Exchange software for the  
13 email servers. Microsoft changed its requirements for its System Center Configuration Manager  
14 (SCCM) software. This software allows IT staff to push updates and security patches to servers.  
15 Additional licenses were needed to ensure compliance with the new requirements. To address a  
16 Corrective Action Plan (CAP) audit point, software was purchased and implemented on some of  
17 the SQL database servers to audit database activity on these servers, what data is being looked  
18 at and if data is updated. Also in 2012, upgrades were completed on the Chicago and  
19 Washington DC telephone systems. These upgrades brought the system software to the latest  
20 version and will ensure continued maintenance and support. As part of the ADA's continued  
21 effort to maintain PCI compliance, a PCI Risk Assessment and Discovery is being done on the  
22 ADA's network infrastructure. This work will help IT staff assess the areas where potential PCI  
23 technology risks may occur. In 2014, software and hardware upgrades will be done in the ADA  
24 Board Room. Additional upgrades are planned for the Chicago and Washington DC telephone  
25 systems. Microsoft SQL licenses will be purchased to upgrade database servers and Microsoft  
26 Office 2013 will be purchased and deployed to ADA staff.
- 27 • *Aptify.* In 2012, work began to replace the Tripartite System (TS) at the ADA with Aptify. A  
28 cross-divisional Work Team was developed to gather system requirements and to complete the  
29 technical design. System development and configuration work began later in the year and  
30 continues into 2013. System testing will occur in September and implementation is planned to be  
31 completed in October. Along with the TS conversion, work is underway to develop and  
32 implement the Events module. This module will replace the many hard-coded online meeting  
33 registrations on ADA.org. ADA departments scheduling meetings will have the ability to develop  
34 their meeting registrations with this module, which will eliminate the need for IT staff to develop  
35 them. Once the TS conversion project is completed at the ADA, a plan will be developed to  
36 convert state and local societies currently using TS as their membership management system to  
37 Aptify. Throughout the remainder of 2013, the Aptify team will conduct TS/Aptify Awareness  
38 programs with current and non-current states to clarify Aptify's software capabilities for the  
39 Tripartite. Travel expenses have been funded in 2014 to complete these conversions. In 2014,  
40 Aptify's Legislative module will be implemented. This module will be used for grassroots efforts  
41 by the ADA, state and local societies. Additional Education licenses will be purchased to support  
42 two separate Education environments within Aptify. The current Education area allows for the  
43 Department of Testing Services (DTS) to manage test applications and scores. The second  
44 Education area will support Learning Management, which is currently under development. Aptify  
45 provided a temporary license while an evaluation was done on how to build and support these  
46 separate Education areas. The temporary license expires in January 2014.
- 47 ○ *Aptify/Learning Management System.* A third component of the Aptify/TS Conversion  
48 project is to implement the Aptify Education and eLearning/Learning Management  
49 System (LMS) modules to provide Continuing Education (CE) and Online Learning  
50 Management services that would replace the CE module within the Tripartite System.  
51 This system provides new functionality to allow online delivery of CE programs and to  
52 facilitate and manage the Tripartite's online CE activities and provide a variety of other

1 learning activities for ADA members, non-members and ADA staff. This program will  
2 provide a standardized software platform that leverages existing technology investments  
3 to create and distribute learning activities. Work is underway to develop and implement  
4 this system. It is scheduled to be deployed in October along with the Membership and  
5 Events modules. In 2014, system enhancements and fixes will be prioritized and  
6 implemented using existing IT staff with outside IT consulting services being retained to  
7 assist when needed.

- 8 ○ *SAS to Aptify Conversion.* In 2011, a project began to convert Statistical Analysis  
9 Software (SAS) applications used by the Department of Testing Services to a more  
10 current system. The applications used within SAS have been over-developed through  
11 the years and the system is slow and antiquated. The original plan was to convert these  
12 applications to a Microsoft .NET platform. However, since that solution was identified,  
13 Aptify was purchased. IT staff working with Aptify consultants determined that Aptify's  
14 Education module could be used to maintain these applications for DTS and thus  
15 leveraging an existing technology investment. The DTS Education system went live in  
16 April 2013. System fixes and enhancements are being completed using existing IT staff.  
17 Work is also underway to migrate outdated custom software applications that manage the  
18 online application and payment processes from ADA.org to Aptify's eBusiness module.  
19 This migration will eliminate custom application support, reduces credit card fees and  
20 removes custom integrations. It will also streamline operational efforts between DTS and  
21 Accounting for credit card and payment processing, which are currently done manually by  
22 both departments. In 2014, system enhancements and fixes will be prioritized and  
23 implemented using existing IT staff with outside IT consulting services being retained to  
24 assist when needed.

25 The table below outlines actual expenditures in the core areas in 2012; projected spending in 2013  
26 and planned spending in 2014. Also disclosed is spending related to infrastructure hardware and  
27 major projects.

	2012 Actual Spending	2013 Projected Spending	2014 Planned Spending
IT Core Area			
FileWeb	8,140	200,000	608,000
Data Warehouse	0	0	0
Internet/Mobility	379,045	639,073	87,400
ADA Connect	82,832	15,000	15,000
PeopleSoft	497,200	69,800	0
Hyperion Budgeting Plan Tool	229,259	59,140	106,000
Tripartite System	0	0	0
Infrastructure Hardware/Licenses	1,052,248	969,268	1,594,000
Aptify	400,212	551,378	239,000
Total Project Spending	2,648,936	2,503,659	2,649,400
Balance of IT Operating Budget	8,059,922	9,797,464	10,739,200
Total IT Spending	<u>\$10,708,858</u>	<u>12,301,123</u>	<u>13,388,600</u>



1 The tables below summarize the previous information based on the source of funding. The IT division  
 2 continues to maintain and upgrade its current core areas while also providing ongoing support and  
 3 completing various IT-related projects for ADA divisions.  
 4

IT Core Area

<b>2012 Actual Spending</b>	<u>Operating Budget</u>	<u>Capital Budget</u>	<u>Total</u>
FileWeb (1)	8,140	0	8,140
Data Warehouse	0	0	0
Internet/Mobility(2)	121,162	257,883	379,045
ADA Connect (3)	56,040	26,792	82,832
PeopleSoft (4)	185,280	311,920	497,200
Hyperion Budgeting Plan Tool (5)	194,259	35,000	229,259
Tripartite System	0	0	0
Infrastructure Hardware/Licenses (6)	122,761	929,487	1,052,248
Aptify (7)	247,868	152,344	400,212
Total Project Spending	935,510	1,713,426	2,648,936
Balance of IT Operating Budget	8,059,922	0	8,059,922
Total IT Spending	<u>\$8,995,432</u>	<u>\$1,713,426</u>	<u>\$10,708,858</u>

5

<b>2012 Consulting Projects</b>	<b>Operating Budget</b>	<b>Capital Budget</b>	<b>Total Actual Spending</b>
FileWeb Upgrade	8,140.00	0.00	8,140.00
FileWeb Replacement Planning	0.00	0.00	0.00
<b>FileWeb Totals (1)</b>	<b>8,140.00</b>	<b>0.00</b>	<b>8,140.00</b>
<b>Data Warehouse (DW) Totals</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
Mobile Application	3,000.00	0.00	3,000.00
Mobile Application	11,800.00	26,000.00	37,800.00
SiteCore Software	0.00	98,550.00	98,550.00
Consumer Website	84,000.00	112,000.00	196,000.00
Consumer Website	10,667.00	21,333.00	32,000.00
Evidence-Based Dentistry website	11,695.00	0.00	11,695.00
<b>Internet/Mobility Totals (2)</b>	<b>121,162.00</b>	<b>257,883.00</b>	<b>379,045.00</b>
ADA Connect	5,591.00	26,792.00	32,383.00
ADA Connect	10,849.00	0.00	10,849.00
ADA Connect	39,600.00	0.00	39,600.00
<b>ADA Connect Totals (3)</b>	<b>56,040.00</b>	<b>26,792.00</b>	<b>82,832.00</b>
HRMS Upgrade - Phase II	185,280.00	311,920.00	497,200.00
<b>PeopleSoft Totals (4)</b>	<b>185,280.00</b>	<b>311,920.00</b>	<b>497,200.00</b>
Hyperion Plan Tool Support	102,559.00	0.00	102,559.00
Hyperion Plan Tool Enhancements	91,700.00	35,000.00	126,700.00
<b>Hyperion Budgeting PlanTool Totals (5)</b>	<b>194,259.00</b>	<b>35,000.00</b>	<b>229,259.00</b>
<b>Tripartite System (TS) Totals</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
Warranty Technician	72,558.00	0.00	72,558.00
Telephone Upgrades	0.00	56,366.00	56,366.00
Network Infrastructure	0.00	147,147.00	147,147.00
Network Security	250.00	0.00	250.00
Operating Software	43,353.00	0.00	43,353.00
Capital Hardware	6,600.00	378,780.00	385,380.00
Capital Software	0.00	347,194.00	347,194.00
<b>Infrastructure Totals (6)</b>	<b>122,761.00</b>	<b>929,487.00</b>	<b>1,052,248.00</b>
Aptify Upgrade	45,000.00	81,600.00	126,600.00
Aptify/DTS Conversion	38,468.00	0.00	38,468.00
Aptify/TS Conversion/Events	164,400.00	70,744.00	235,144.00
<b>Aptify Totals (7)</b>	<b>247,868.00</b>	<b>152,344.00</b>	<b>400,212.00</b>
<b>Grand Totals</b>	<b>935,510.00</b>	<b>1,713,426.00</b>	<b>2,648,936.00</b>

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<b>2013 Projected Spending</b>	Operating Budget	Capital Budget	Total
FileWeb (1)	200,000	0	200,000
Data Warehouse	0	0	0
Internet/Mobility (2)	87,496	551,557	639,073
ADA Connect (3)	15,000	0	15,000
PeopleSoft (4)	29,800	40,000	69,800
Hyperion Budgeting PlanTool (5)	59,140	0	59,140
Tripartite System	0	0	0
Infrastructure Hardware/Licenses (6)	100,000	869,268	969,268
Aptify (7)	56,000	495,378	551,378
Total Project Spending	547,436	1,956,223	2,503,659
Balance of IT Operating Budget	9,797,464	0	9,797,464
Total IT Spending	<u>\$10,344,900</u>	<u>1,956,223</u>	<u>12,301,123</u>

3

<b>2013 Consulting Projects</b>	Operating Budget	Capital Budget	Total Actual Spending
FileWeb Upgrade	10,000.00	0.00	10,000.00
FileWeb Replacement Planning	190,000.00	0.00	190,000.00
<b>FileWeb Totals (1)</b>	<b>200,000.00</b>	<b>0.00</b>	<b>200,000.00</b>
<b>Data Warehouse (DW) Totals</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
Mobile Application	3,000.00	0.00	3,000.00
Mobile Application	0.00	12,000.00	12,000.00
Mobile Application	0.00	10,400.00	10,400.00
Mobile Application	0.00	18,510.00	18,510.00
SiteCore Content Management	0.00	22,000.00	22,000.00
Center for Professional Success (CPS)	2,500.00	187,500.00	190,000.00
Consumer Website	0.00	19,500.00	19,500.00
ADA.org Re-Organization	78,333.00	216,667.00	295,000.00
Evidence-Based Dentistry website	0.00	65,000.00	65,000.00
Evidence-Based Dentistry website	3,663.00	0.00	3,663.00
<b>Internet/Mobility Totals (2)</b>	<b>87,496.00</b>	<b>551,577.00</b>	<b>639,073.00</b>
ADA Connect	15,000.00	0.00	15,000.00
<b>ADA Connect Totals (3)</b>	<b>15,000.00</b>	<b>0.00</b>	<b>15,000.00</b>
PeopleSoft Tools Upgrade	16,800.00	40,000.00	56,800.00
Talent Management Service	13,000.00	0.00	13,000.00
<b>PeopleSoft Totals (4)</b>	<b>29,800.00</b>	<b>40,000.00</b>	<b>69,800.00</b>
Hyperion Plan Tool Support	20,000.00	0.00	20,000.00
Hyperion Plan Tool Audit	39,140.00	0.00	39,140.00

<b>Hyperion PlanTool Totals (5)</b>	<b>59,140.00</b>	<b>0.00</b>	<b>59,140.00</b>
<b>Tripartite System (TS) Totals</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
Warranty Technician	75,000.00	0.00	75,000.00
Network Infrastructure	0.00	370,000.00	370,000.00
Network Security	25,000.00	0.00	25,000.00
Operating Software	0.00	50,000.00	50,000.00
Capital Hardware	0.00	444,000.00	444,000.00
Capital Software	0.00	5,268.00	5,268.00
<b>Infrastructure Totals (6)</b>	<b>100,000.00</b>	<b>869,268.00</b>	<b>969,268.00</b>
Aptify Upgrade	0.00	25,000.00	25,000.00
Aptify/DTS Conversion	1,000.00	0.00	1,000.00
Aptify/TS Conversion/Events	40,000.00	425,378.00	465,378.00
Aptify LMS	15,000.00	45,000.00	60,000.00
<b>Aptify Totals (7)</b>	<b>56,000.00</b>	<b>495,378.00</b>	<b>551,378.00</b>
<b>Grand Totals</b>	<b>547,436.00</b>	<b>1,956,223.00</b>	<b>2,503,659.00</b>

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IT Core Area

<b>2014 Planned Spending</b>	<b>Operating Budget</b>	<b>Capital Budget</b>	<b>Total</b>
FileWeb (1)	190,400	417,600	608,000
Data Warehouse	0	0	0
Internet/Mobility(2)	62,400	25,000	87,400
ADA Connect (3)	15,000	0	15,000
PeopleSoft	0	0	0
Tripartite System	0	0	0
Hyperion Budgeting PlanTool (4)	56,000	50,000	106,000
Infrastructure Hardware/ Licenses (5)	95,000	1,499,000	1,594,000
Aptify (6)	90,000	149,000	239,000
Total Project Spending	508,800	2,140,600	2,649,400
Balance of IT Operating Budget	10,739,200	0	10,739,200
Total IT Spending	<u>\$11,248,000</u>	<u>2,140,600</u>	<u>13,388,600</u>

2

<b>2014 Consulting Projects</b>	<b>Operating Budget</b>	<b>Capital Budget</b>	<b>Total Actual Spending</b>
FileWeb Support	10,000.00	0.00	10,000.00
FileWeb Replacement	180,400.00	417,600.00	598,000.00
<b>FileWeb Totals (1)</b>	<b>190,400.00</b>	<b>417,600.00</b>	<b>608,000.00</b>
<b>Data Warehouse (DW) Totals</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
Mobile Application	32,400.00	25,000.00	57,400.00
SiteCore Content Management	30,000.00	0.00	30,000.00
<b>Internet/Mobility Totals (2)</b>	<b>62,400.00</b>	<b>25,000.00</b>	<b>87,400.00</b>
ADA Connect	15,000.00	0.00	15,000.00
<b>ADA Connect Totals (3)</b>	<b>15,000.00</b>	<b>0.00</b>	<b>15,000.00</b>
<b>PeopleSoft Totals</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
Hyperion Plan Tool Support	56,000.00	0.00	56,000.00
Hyperion System Upgrade	0.00	50,000.00	50,000.00
<b>Hyperion Budgeting PlanTool Totals (4)</b>	<b>56,000.00</b>	<b>50,000.00</b>	<b>106,000.00</b>
<b>Tripartite System (TS) Totals</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
Warranty Technician	75,000.00	0.00	75,000.00
Network Infrastructure	0.00	370,000.00	370,000.00
Network Security	20,000.00	0.00	20,000.00
Operating Software	0.00	50,000.00	50,000.00
Board Room Upgrades	0.00	150,000.00	150,000.00

Chicago Telephone System Upgrades	0.00	20,000.00	20,000.00
Capital Hardware	0.00	499,000.00	499,000.00
Capital Software	0.00	410,000.00	410,000.00
<b>Infrastructure Totals (5)</b>	<b>95,000.00</b>	<b>1,499,000.00</b>	<b>1,594,000.00</b>
Aptify Support	90,000.00	0.00	90,000.00
Aptify EDUC licenses	0.00	99,000.00	99,000.00
Aptify Legislative Module	0.00	50,000.00	50,000.00
<b>Aptify Totals (6)</b>	<b>90,000.00</b>	<b>149,000.00</b>	<b>239,000.00</b>
<b>Grand Totals</b>	<b>508,800.00</b>	<b>2,140,600.00</b>	<b>2,649,400.00</b>

- 1 **Resolutions**
- 2 This report is informational and no resolutions are presented.
- 3 **BOARD COMMENT: Vote Yes to Transmit.**
- 4 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**
- 5 **BOARD DISCUSSION).**

Resolution No. None New

Report: Board Report 14 Date Submitted: August 2013

Submitted By: Board of Trustees

Reference Committee: Budget, Business and Administrative Matters

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

1 **REPORT 14 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: COMPENSATION**  
 2 **AND CONTRACT RELATING TO THE EXECUTIVE DIRECTOR**

3 **Background:** In June, 2012, the Board of Trustees executed a second three-year employment  
 4 agreement with the current Executive Director, which expires on March 31, 2015. As in the initial  
 5 contract, either party may terminate the agreement without cause by giving the other party written notice  
 6 of termination at least 60 days prior to the termination date. The Executive Director is the only member of  
 7 the ADA staff with a written employment contract. The contract provides that the Executive Director's  
 8 performance is to be reviewed by the Board on an approximately annual basis or more frequently, as  
 9 deemed appropriate by the Board, at the Board's sole discretion.

10 **Compensation and Benefits:** The Executive Director's current annual base salary is \$450,000 and is  
 11 paid in accordance with the Association's standard payroll schedule and policies. The Board of Trustees  
 12 reviews the Executive Director's salary on an approximately annual basis, and may, in its sole discretion,  
 13 increase her compensation based upon a performance review by the Board. In addition, she is eligible to  
 14 receive an annual bonus ranging from 0%-3% of her base salary, as determined by the Board, based  
 15 upon criteria jointly approved by the Executive Director/COO and the Board, and subject to the availability  
 16 of funds. In April of 2013, the Executive Director/COO received a bonus in the amount of \$9,000 (2% of  
 17 base), which was directed to her deferred compensation account. The Executive Director is entitled to all  
 18 of the fringe benefits offered during the term of this Agreement to all other similarly situated Association  
 19 employees having her length of service in the employ of the Association; provided, however, that such  
 20 fringe benefits do not include "Severance Pay" under the ADA Employee Handbook or any other ADA  
 21 policy or procedure relating to severance pay.

22 The Executive Director participates in the soon-to-be closed Executive Parity Plan, a non-qualified  
 23 retirement plan that restores the value of lost benefits to senior ADA executives who otherwise would  
 24 suffer significant benefit reductions (20% to 60% reduction) because of the tax laws. This non-qualified  
 25 plan is funded via a specified cash amount the Board sets aside annually to be paid upon vesting. The  
 26 set asides are strictly restorative and are funded from the savings in the qualified pension plan  
 27 contributions which result because of the reduction in executive covered benefits under the qualified plan.  
 28 The Parity Plan will cease providing additional restoration benefits to the Executive Director and all other  
 29 current Plan participants effective December 31, 2013. The parity plan allocation for 2012 was \$35,492.  
 30 Because Dr. O'Loughlin is not yet vested in plan benefits, the allocation is booked to the ADA reserves as  
 31 a dedicated increase to reserve funds set aside for unvested participants to the Parity Plan.

32 The pension plan accrual for the Executive Director is estimated at \$39,818 for 2012. In addition, the  
 33 ADA employer contribution to the Executive Director's 401k plan was \$18,000.

1 The Executive Director also receives a \$5,000 annual contribution to the Great-West Variable Annuity  
2 Plan; a parking space in the Association Headquarters building; the reimbursement of reasonable,  
3 substantiated expenses incurred to purchase and maintain a membership in one city or athletic club in the  
4 Chicago area; one cellular telephone; spousal travel to the Association's annual session; and  
5 membership dues in professional associations (except the dues of the American Dental Association and  
6 its constituent and component dental societies). The Board collects data from outside consultants and  
7 various published reports in order to compare the compensation and benefits package of the Executive  
8 Director to other similarly sized non-profit organizations. The last data collection period was in 2011; at  
9 that time the range of total cash compensation (salary + any bonus paid) for CEO or Executive Director  
10 positions at national and regional not-for-profit individual membership organizations was reported as  
11 \$461,102 - \$472,950.

12  
13

### Resolutions

14 This report is informational and no resolutions are presented.

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

16 **BOARD VOTE: UNANIMOUS.**



Resolution No. None New

Report: Board Report 15 Date Submitted: August 2013

Submitted By: Board of Trustees

Reference Committee: Budget, Business and Administrative Matters

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE \_\_\_\_\_

ADA Strategic Plan Goal: Financial (Required)

1 **REPORT 15 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: RESPONSE TO**  
 2 **RESOLUTION 77H-2011: ADA PENSION PLANS**

3 **Background:** This report is in response to House of Delegates Resolution 77H-2011 (*Trans.2011:444*).

4 Resolution 77H-2011 reads as follows:

5 **77H-2011. Resolved,** that the Board of Trustees provide to the House of Delegates an annual  
 6 executive summary on the status of the Pension Plan as reflected in the annual ADA audit reports  
 7 and the annual actuarial certification of the pension plan funding status.

8 The ADA reviewed its employee benefits as part of a larger project to assess total compensation in 2011  
 9 and made significant changes to retiree benefits effective January 1, 2012 that reduced both future costs  
 10 and risks while still providing a market competitive total compensation package.

11 To summarize, that decision was based on the following facts which still apply to the plan:

- 12 • The new terms of the pension plan reduce future costs and risks by more than 60% compared to
- 13 the old plan terms.
- 14 • Supplemental pension funding is not optional and represents payment of prior service costs
- 15 under the old pension plan. This funding is the majority of the ADA's annual budget cost and is
- 16 required even if the plan is terminated.
- 17 • If the pension plan were terminated completely, the ADA would not have access to plan assets to
- 18 reduce costs in future periods.
- 19 • A "hard freeze" plan termination would come at a high price because conservative accounting
- 20 rules lock in the value of the liability based on an assumed liquidation of pension benefits as of
- 21 the termination date using current, historic low interest rates. This liability can only be reduced by
- 22 the future payment of those plan's liabilities.
- 23 • The long term economic costs of the plan are ultimately tied to the payout of future benefits over
- 24 many years, in fact, decades into the future. ADA contributions that go into the plan do not come
- 25 out except to pay plan benefits. Because pension benefits, since 1993, are only paid as a
- 26 monthly annuity to retirees, cash flows are predictable and plan assets are invested to balance
- 27 long term returns, risks, and costs in relation to the maturity of the long term pension liabilities.

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

- 31 a. the accrual basis liability included in the ADA's 12/31/12 balance sheet (based on FAS 158
- 32 accounting rules), and

- 1           b. the "cash basis" liability, percent funded status and funding requirements included in the ADA's  
2           1/1/13 Adjusted Funding Target Attainment Percentage ["AFTAP"] Range Certification Report  
3           (based on ERISA calculation rules).

4           Although these two liability calculation methods differ, in general terms the net Pension liability represents  
5           the amount of projected total pension funds needed to cover "100% funding" of future benefits less the  
6           value of actual funds invested in pension plan assets. In each case, this "100% funded" liability is an  
7           amount calculated by our actuary based on a formula that uses certain interest rates determined by either  
8           government or accounting rules. When interest rates go down the amount needed to reach 100% funded  
9           status goes up.

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

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

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

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

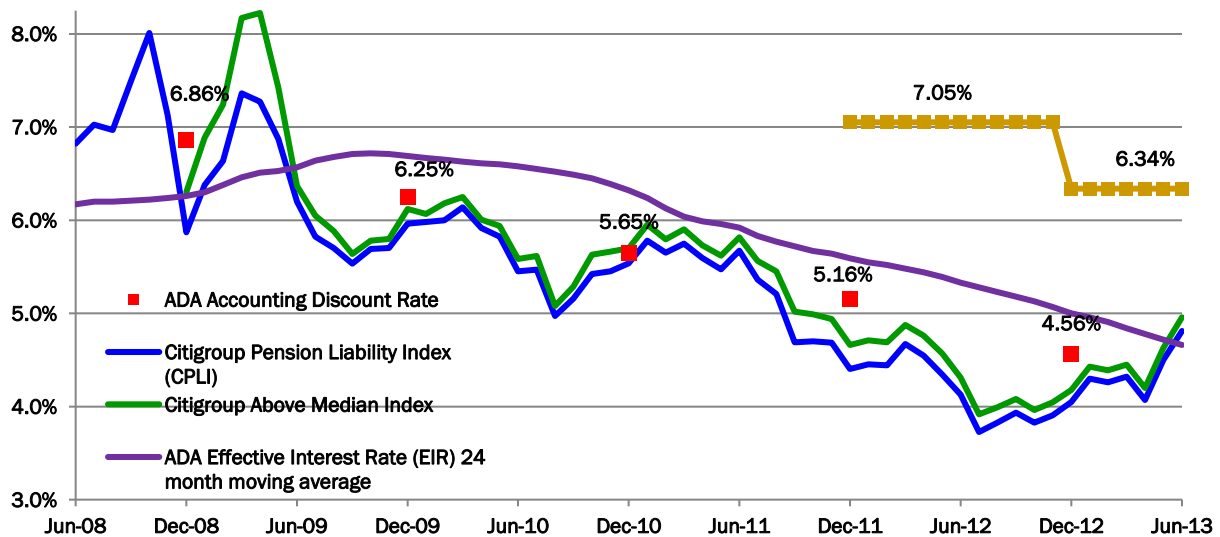
29          In addition to these changes to the pension liability, the ADA also made the "one time" change to future  
30          employee benefits effective January 1, 2012 that significantly reduced the ADA's accrual basis pension  
31          liability as well as its ongoing pension expense. This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

34          The following historical roll-forward analysis chart shows a three year history of the pension plan. The  
35          results for fiscal years 2010 and 2011 show normal service costs under the old plan while 2012 presents  
36          the actual results of the first year after plan changes. Beyond normal service costs and interest on the  
37          unfunded pension liability (i.e., Expected Obligation Increase), the biggest change to the 2012 accrual  
38          basis Net Pension Liability is the non-cash impact of a lower discount rate on the year end valuation,  
39          which was offset by favorable investment performance. The impacts of these falling "spot" interest rates  
40          have a big impact on the year end valuations of future benefit liabilities but, fortunately, are non-cash  
41          adjustments. For reference, the rates used for accounting purposes, and approved by our auditors, are  
42          shown at the bottom of the chart for each year.

<b>ADA Consolidated</b>				
<b>Net Pension Liability Analysis - Historical</b>				
Millions of Dollars; Increase/(Decrease) in Liability				
	Fiscal Year Ending			Notes
	2010 <sup>1</sup>	2011	2012	
Beginning Balance, December 31 of prior year	32.0	48.8	51.1	Net Liability, based on discount rate in effect at start of year less plan assets
Contributions (Cash):				
<i>Normal Service Cost Funding- current employees</i>	(4.7)	(5.2)	(1.7)	Actual cash cost to ADA in each plan year: Based on Old Plan formula in 2010 and 2011; New Plan formula in 2012
<i>Supplemental/Catch-up Funding of Prior Service</i>	(0.4)	(7.6)	(4.6)	Required contributions of prior service costs on path to 100% status
Expected Obligation Increase	11.8	13.4	10.0	Service Cost (benefit accrual) and Interest Cost (interest on prior obligation)
Net Investment (Gains)/Losses	(11.2)	(2.0)	(16.7)	Actual plan investment results based on market values at each year end
Actuarial (Gain)/Loss- incl. rate impact in 2010	21.3	2.1	4.5	Impact of updated participant population, salaries and mortality assumptions; 2010 also includes net impact of discount rate change
Reduction in Benefits	-	(8.9)	-	2011 net impact of Pension Plan design changes effective 1/1/2012.
Annual FAS 158 Actuarial Valuation Adjustment				
Discount Rate	Not available	10.0	14.1	Estimated non-cash impact of changing discount rate per accounting rules
Supplemental Benefit Trust	-	0.5	0.1	Net Change in supplemental plan liability as reported
<b>Ending Balance, December 31</b>	<b>48.8</b>	<b>51.1</b>	<b>56.8</b>	Net Liability, based on discount rate in effect at end of year less plan assets
<b>Discount Rate</b>				
Beginning of Year	6.25%	5.65%	5.16%	
End of Year	5.65%	5.16%	4.56%	
<sup>1</sup> Based on prior actuary's results.				

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3 Low interest rates, more than any other factor, have been increasing the year end valuations of  
4 Retirement Benefit Obligations. The next graph show the downward trend of the rates used to calculate  
5 these long term liabilities (although we are now seeing an increase in rates during 2013).



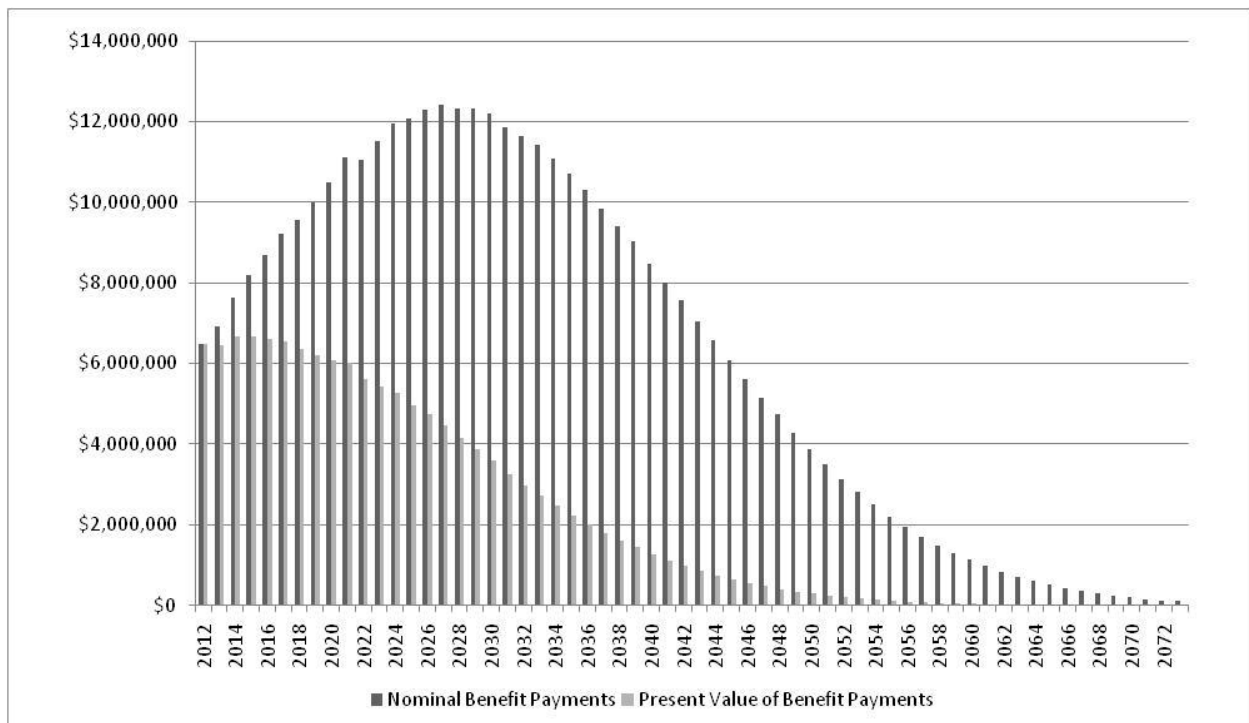
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7 The “ADA Accounting Discount Rate” shown in this graph reflects the rates used for the yearend financial  
8 statements. The “ADA Effective Interest Rate (EIR)” is a 24 month moving average of rates published by  
9 the IRS which would typically apply to funding requirements. However, the “MAP-21 Rates” reflect higher

1 rates based on a 25 year average to provide pension relief which reduced the Plan’s 2012 and 2013  
 2 funding requirements.

3 The Citigroup Indexes are also included as an indicator of current interest rate trends and, fortunately,  
 4 these show a recent turnaround in the long term trend which should lead to favorable impacts on future  
 5 pension liability valuations.

6 It is important to note that although the use of year end “spot rates” determines the value of the liabilities  
 7 for accounting purposes at year end, and while lower rates can also drive higher contribution rates to plan  
 8 assets, it is the actual cash payout of the retirement benefits that will only happen over many decades  
 9 that represents the true economic cost of the plan. Cash contributed to the plan to fund future benefits  
 10 stays in the plan until those benefits are paid. And the actual payout of the 12/31/12 pension plan liability  
 11 through monthly benefits to retirees will only happen over the next 30 to 40 years with the final payment  
 12 expected in the year 2073. The following graph shows these expected annual payments to plan  
 13 participants from plan assets:  
 14



15  
 16  
 17 This graph effectively shows that the maturity of the ADA’s pension liability is made up of predictable  
 18 annuities unlike many other plans that allow lump sum benefit payouts.

19 **Pension Relief:** Because so many actuaries for large pension plans questioned the use of “spot rates” to  
 20 value pension liabilities and lobbied legislators to use a longer 25 year average interest rate to calculate  
 21 the requirements for cash contributions to pension plans, “pension relief” was passed under MAP-21 last  
 22 year to reduce the funding burden on pension plan sponsors caused by the current, low interest rate  
 23 environment.

24 **Cash Basis Pension Liability (included in the annual actuarial certification of the pension plan**  
 25 **funding status):** The other pension liability recalculated by our actuary each year is the Cash Basis  
 26 Pension Liability which is published in the ADA’s annual Adjusted Funding Target Attainment Percentage  
 27 [“AFTAP”] Range Certification Report (based on ERISA calculation rules). This report is significant

1 because it includes the annual funded status of the plan. In addition, as this “cash basis” liability  
2 fluctuates, the amount of annual cash contributions required from the next year’s Operating Budget will  
3 also fluctuate.

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

American Dental Association Employees' Retirement Trust Adjusted Funding Target Attainment Percentage ("AFTAP") Funding Status as of January 1, 2013 (valuation date)							
(\$000s)	Year End 2010		Year End 2011		Year End 2012		
	amount	%	amount	%	amount	%	
<b>AFTAP Net Effective Interest Rate</b>	<b>6.32%</b>		<b>7.05%</b>		<b>6.35%</b>		
Cash Basis Target Liability (= 100% status)	\$ 133,828	100.0%	\$ 131,580	100.0%	\$ 146,710	100.0%	
Less: Plan Assets	(108,810)	81.3%	(112,255)	85.3%	(127,125)	86.7%	
Net AFTAP Report Unfunded Plan Liability	\$ 25,018	18.7%	\$ 19,325	14.7%	\$ 19,585	13.3%	

5  
6 The data in this chart also shows, in a simple format, how the year end valuation of investments also  
7 contributes to the funded status of the plan.

8 **Conclusions:** Although the use of “spot” rates of interest, in effect at the end of each year, determine the  
9 GAAP accounting basis of the liabilities and, although the annual cash basis valuation can drive higher  
10 contributions to the plan’s assets, the final cost of the plan is ultimately tied to the payment of these  
11 benefits to plan participants.

12 Because the ADA stopped lump sum payments for benefits earned after 1993, the pension plan operates  
13 as a simple annuity plan which greatly reduces transactions other than normal portfolio management and  
14 the payment of monthly benefits to participants. This results in very predictable cash flows.

15 Once the ADA contributes cash into the plan, it stays in plan investments to generate long term returns  
16 until benefits are paid out. Under this plan structure, the ADA’s actuaries and investment advisors have  
17 explained that temporary investment valuation and interest rate volatility have minimal impact on the long  
18 term economics of the pension plan.

19 Board changes to retirement benefit plans helped reduce total pension liabilities by over \$7 million at  
20 12/31/11 (all plan changes actually account for \$21.8 million of direct reduction which was partially offset  
21 by the impact of interest and investment).

22 In addition, the significant cut in pension plan benefits reduced “normal” pension costs, for 1 year of  
23 service, from \$5.2 million in 2011 to \$1.7 million in 2012.

24 Although the historic low “point in time” interest rates at year end have resulted in higher pension liability  
25 valuations, expected long term higher interest rates will turn this liability into an asset in the future.  
26 Pension relief intended to reduce the funding burdens on pension plan sponsors caused by the current,  
27 low interest rate environment was signed into law in 2012 as part of the MAP-21 Act is expected to  
28 reduce ADA contributions.

29 The continuation of the pension plan at reduced levels is expected to pay for itself with limited risk once  
30 100% funded status is reached.

31 While the impact of low interest rates has increased the amount of retirement liabilities measured at  
32 December 31, 2012, over the long term the plan will provide the ADA with a valuable benefit to attract and

1 retain employees critical to its mission based on an asset that will eventually pay for itself once 100%  
2 funded status is reached.

3 Without any continuing pension plan in place, there would be a long term risk of an overfunded pension  
4 plan, with the ADA being unable to utilize any portion of the resulting overfunded asset balance.

5 With a continuing pension plan, any overfunding that may occur due to fluctuating interest rates can be  
6 used to help minimize annual plan contributions going forward.

7 On a related topic, the Board's action in 2011 to reduce retiree health benefits resulted in an immediate  
8 \$10 million improvement in the ADA's financial position at December 31, 2011. That reduction also  
9 eliminated the ADA's exposure to escalating health care costs by capping the future maximum annual  
10 cost per retiree.

11 **Resolutions**

12 This report is informational and no resolutions are presented.

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

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

16

Resolution No. 84 New

Report: CMIRP Supplemental Report 1 Date Submitted: October 2013

Submitted By: Council on Members Insurance and Retirement Programs

Reference Committee: Budget, Business and Administrative Matters

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0

ADA Strategic Plan Goal: Members and Financial (Required)

1 **COUNCIL ON MEMBERS INSURANCE AND RETIREMENT PROGRAMS**  
 2 **SUPPLEMENTAL REPORT 1 TO HOUSE OF DELEGATES: ADA MEMBERS INSURANCE PLANS**  
 3 **RECOMMENDED STUDY OF A POTENTIAL APPROACH TO ON-GOING ROYALTY REVENUE**

4 **Background:** The first priority of the Council on Members Insurance and Retirement Programs is to  
 5 protect member value by protecting the quality and pricing of the insurance plans offered to members (the  
 6 ADA Members Insurance Plans or the "Plans"). While fully meeting this commitment, the Council (with  
 7 the advice and assistance of expert outside consultants) has concluded that the ADA is entitled to  
 8 significant non-dues revenue in form of royalty payments for ongoing use of the ADA name, logo,  
 9 goodwill and other intangible assets. The Council expects that the ADA will receive these royalty  
 10 payments into the foreseeable future. The Council emphasizes this will be done without compromise to  
 11 the quality or pricing of our insurance plans.

12 In the course of its work, the Council discussed the best disposition for this new non-dues revenue.  
 13 Recognizing that this is a question which belongs to the Board, which is better positioned to understand  
 14 and foresee Association-wide finances, the Council nevertheless decided to share with the House and the  
 15 Board one way to deal with this revenue. The Council is asking the House of Delegates to urge the  
 16 Board of Trustees to consider this potential approach to on-going royalty revenue, both its benefits and  
 17 drawbacks, and to report to the 2014 House of Delegates with its findings.

18 **Royalty Revenue:** The ADA is entitled to a royalty for use of its member list, name, logo, goodwill, and  
 19 other intangibles in marketing the Plans. These intangibles have contributed significantly to the success  
 20 of the Plans. As an example, since 1998, the assets of the Plans have grown from \$268 million,  
 21 generating investment income of approximately \$15 million annually, to more than \$700 million with  
 22 generated investment income of approximately \$24 million in 2012.<sup>1</sup> Over this time period, the ADA  
 23 never sought payment of royalties. Now, the Council has concluded, based on a comprehensive financial  
 24 audit by an outside actuarial consultant, Milliman, Inc., that the Plans are sufficiently strong to allow  
 25 payment of royalties to the ADA. This can be done while still maintaining competitive, best-in-class Plans  
 26 to maximize member value.

27 **Royalty Levels:** Based on recommendations by Milliman, Inc., the Council believes that, for the  
 28 foreseeable future, the Plans can provide between approximately \$6-11 million in non-dues revenue on a  
 29 yearly basis *with no compromise to the quality or pricing of the Plans*. In June, the ADA Board of  
 30 Trustees approved the Council's recommendation to distribute \$6.1 million in Term Life Plan 2012

---

<sup>1</sup> Resolution 82H-1993 urges the Board to continue to use surpluses generated by the insurance plans for benefit improvements, premium reductions and/or refunds for participating members (Trans.1993:697). As is discussed in this report, the Council feels strongly that some surpluses should be taken as royalty and this will not in any way compromise the quality or pricing of the Plans. After consultation with the Speaker of the House, it was determined that it is unnecessary to rescind the 1993 "urge" resolution.

1 unallocated surplus as a royalty for the 2013 year. In addition, the Council submitted a report to the  
2 Board of Trustees for consideration at the Board's October 2013 meeting recommending an additional  
3 royalty distribution totaling \$5.951 million for 2014 and 2015, as recommended by Great-West, and  
4 validated by Milliman, Inc.

5 **Determining Available Royalty Revenue:** The audit by Milliman, Inc. confirmed the financial strength of  
6 the Plans. Previous Council discussions identified maintaining the financial stability of the Plans,  
7 maintaining a competitive position relative to quality and price, and developing an appropriate process for  
8 the delivery of royalty revenue to the ADA to support member value overall as key Council goals in  
9 overseeing the Plans.

10 In furtherance of these goals, the Council developed guidelines for its own use in developing  
11 recommendations to the Board of Trustees relative to acceptance of royalty payments. Each year at its  
12 August meeting, the Council will determine (as validated by an outside actuarial consultant), and then  
13 recommend to the ADA Board of Trustees, the amount of royalty revenue, if any, to be distributed from  
14 the Plans based on seven considerations:

- 15 1. the primary priority of the Council is to maintain member value by providing best in class
- 16 Insurance Plans at competitive prices while striving to maintain their historically high
- 17 premium credits;
- 18 2. the plan financial results for the previous calendar year as well as the plan financial results
- 19 as of Q2 of the current year;
- 20 3. the three-year projected financials results for each Plan;
- 21 4. the Risk Based Capital Company Action Level ("CAL") calculated by the insurer<sup>2</sup>;
- 22 5. investment earnings on plan assets from the prior calendar year;
- 23 6. the amount of accrued royalties; and
- 24 7. the recommendations in any relevant audit or benchmarking study conducted<sup>3</sup>.

25 **Potential Approach to On-going Royalty Revenue:** Finally, in the course of its work, the Council had  
26 the opportunity to consider and discuss how the additional revenue to the ADA would benefit members.  
27 As part of those discussions, the Council recognized that the disposition of on-going royalty revenue is  
28 the Board's responsibility and that the Board is best positioned to understand the overall finances of the  
29 ADA. Similarly, the Council expressed confidence in the Board's ability to carry out this responsibility  
30 effectively. The Council developed one concept for disposition of additional revenue to aid in dues  
31 stabilization. Recognizing that the Board would be open to ideas for it to consider, the Council decided to  
32 present this concept to the House and ask the House of Delegates to urge the Board of Trustees to  
33 consider it in the course of its work over the coming year.

34  
35 The concept offered by the Council for consideration is to set aside some or all of the royalty revenue  
36 received from the Plans in a designated reserve which would be allowed to accumulate. Each year, the  
37 income from this fund would be used for the purpose of dues stabilization.

38 The Council noted that the proposed course of action would require patience with a vision for a  
39 predictable, sustainable, long-term approach. The Council also noted that the proposal could provide a

---

<sup>2</sup> The Risk Based Capital Company Action Level is calculated by GWF utilizing a formula to provide an insurance industry capital adequacy standard that is related to risk. Milliman has recommended, and GWF has agreed, that the target level will be between 400% and 500% of the regulatory minimum capital requirement.

<sup>3</sup> The Council recognized the need for regular on-going audits of the insurance plans by an outside consulting firm and approved the following schedule for on-going audits of the plan:

- an in-depth financial audit of the plans will be conducted every four years; and
- benchmarking of the rates and benefits of the plans will be conducted every two to three years.



1 financial benefit to future ADA members in terms of possible dues stabilization or other program support  
2 from the income that would be generated from the designated reserve.

3 The Council sees merit in this approach but recognizes that the Board will have a broader perspective of  
4 ADA finances and the responsibility to address the disposition of royalty income. Further, the Council  
5 realizes that this concept would need to be fully developed by the Board before it could be responsibly  
6 implemented. For example, the Board would need to consider:

- 7 • What portion of the royalty income should be set aside in a segregated fund?
- 8 • Should this portion vary from year to year based on ADA finances and how would that be done?
- 9 • How do current needs for income compare to the benefits of future dues stabilization?
- 10 • What form should such a segregated fund take and how would it relate to the existing reserve
- 11 funds and House policy on appropriate reserve levels?

12 Accordingly, the Council is not offering the House a resolution with a final plan for disposition of royalty  
13 income. The Council feels strongly that the Board is best positioned to consider its approach and the  
14 issues surrounding it. The Council recognizes that the Board may, after study and due diligence, accept  
15 its approach, modify it or reject it. The Council is comfortable placing the process to study this concept in  
16 the hands of the Board of Trustees.

17 For all of these reasons, the Council offers the following resolution for the consideration by the ADA  
18 House of Delegates.

**Resolution**

19 **84. Resolved**, that the Board of Trustees is urged to explore the benefits and drawbacks of  
20 maintaining all or some portion of the royalties received from the ADA Members Insurance  
21 Programs in a fund for purposes of dues stabilization, and be it further

22 **Resolved**, that the Board report to the 2014 House of Delegates on its findings.

23 **BOARD RECOMMENDATION: Vote Yes.**

24 **Vote: Resolution 84**

BUCKENHEIMER	Yes	FEINBERG	Yes	NORMAN	Yes	VERSMAN	Yes
CROWLEY	Yes	GOUNARDES	Yes	ROBERTS	Yes	WEBER	Yes
DOW	Yes	HAGENBRUCH	Yes	SCOTT	Yes	YONEMOTO	Yes
ENGEL	No	ISRAELSON	Yes	SEAGO	No	ZENK	Yes
FAIR	Yes	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	Yes

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# Dental Education, Science and Related Matters



- 1 • Lack of current electronic resources seriously affects the library's availability to deliver current  
2 information to ADA members. Each of the electronic resources to be acquired will enable the  
3 ADA member to have greater accessibility to online databases and information, with no  
4 restrictions on the time and place where they choose to access the services.  
5
- 6 • The ADA archives, the national authority on dental historic topics, is the official repository of the  
7 organization's historical publications and records of enduring value. Enhanced resources are  
8 needed in order for the archives to align with best practices for archival function and  
9 management. ADA members will gain online access to these important historic resources.  
10
- 11 • Strategies are proposed to promote, market and publicize library resources and services,  
12 including library and archives presence in the monthly edition of *ADA News*; information on ADA  
13 library new resources and services sent as a mass email to all ADA members; online and print  
14 promotion of the digitized collection of artifacts and photos; and literacy training classes on using  
15 new library resources online and in-person at the library.  
16
- 17 • ADA library budget projections for 2014 anticipate maintaining current staffing at four full-time  
18 library staff and one full-time director. Operational budget expenses of approximately \$202,000  
19 for annual renewal of licenses for use of enhanced software products and database access have  
20 been included. Digitation of archives and subsequent online purchases have the potential to be a  
21 future revenue stream for the library. Reconfiguration of library space is to be done in conjunction  
22 with restacking of entire building.  
23
- 24 • Enhanced member value through implementation of the transition plan includes expansion of  
25 ADA member access to electronic journals and research databases; increased ADA member  
26 capabilities in employing EBD; maintenance of the ADA leadership role as the source for EBD;  
27 and new links to on-demand, clinical dentistry tools that can be accessed daily to enhance the  
28 treatment of patients.

29 The Board carefully considered the report and recommendations of the Taskforce and adopted the  
30 following resolutions at it June 2013 meeting:

- 31
- 32 **B-52-2013. Resolved**, that the ADA Library and Archives Transition Plan be transmitted to the  
33 2013 House of Delegates in response to Resolution 159H-2012.  
34
- 35 **B-53-2013. Resolved**, that an ADA Library and Archives Advisory Board be established as an  
36 advisory committee to the ADA Board of Trustees, with duties and obligations as outlined in the  
37 Report of the Board of Trustees Taskforce on the ADA Library Transition Plan, and be it further  
38
- 39 **Resolved**, that the ADA Library and Archives Advisory Board be comprised of two members of  
40 the ADA Board of Trustees and two at-large members of the ADA appointed by the ADA  
41 President; two members of the Council on Dental Education and Licensure (CDEL) appointed by  
42 the Chair of CDEL (one should be an ADEA appointee); and two members of the Council on  
43 Scientific Affairs (CSA) appointed by the Chair of CSA; for two-year, renewable terms consistent  
44 with the member's appointment on the respective Council or Board of Trustees, and be it further  
45
- 46 **Resolved**, that the senior ADA Board of Trustees member serve as the Chair of the Advisory  
47 Board, and be it further  
48
- 49 **Resolved**, that the ADA Library and Archives Advisory Board report on an annual basis to the  
50 ADA Board of Trustees.  
51

1           **B-54-2013. Resolved,** that the Memorandum of Understanding between the ADA and the  
2           University of Illinois at Chicago be considered by the Board of Trustees at its December 2013  
3           meeting.  
4

5           The Board thanks the Taskforce for its fine work in developing this plan. The Board is convinced that this  
6           plan will move the Association forward and enhance member value.  
7

8

**Resolutions**

9

10          This report is informational and no resolutions are presented.

11

12          **BOARD RECOMMENDATION: Vote Yes.**

13          **BOARD VOTE: UNANIMOUS.**

14

# ADA LIBRARY & ARCHIVES TRANSITION PLAN

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## ADA LIBRARY TRANSITION PLAN TASKFORCE

June 2013

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## REPORT OF THE ADA LIBRARY TRANSITION PLAN TASKFORCE

### Resolution 159H-2012

#### Adopted by the 2012 ADA House of Delegates:

**159H-2012. Resolved**, that the library collections and physical space be maintained without disposition in 2013 and that appropriate agencies develop a transition plan for the library to be reported to the 2013 House of Delegates.

Following the action by the ADA House of Delegates, ADA President Dr. Robert Faiella appointed the following members of the Board of Trustees to the ADA Library Transition Plan Taskforce: Dr. Joseph Hagenbruch (8<sup>th</sup> District)-chair; Dr. Joseph Crowley (7<sup>th</sup> District); Dr. Julian (Hal) Fair III (16<sup>th</sup> District); and Dr. Gary Roberts (12<sup>th</sup> District). ADA staff support was provided by the interim director, ADA Library, Mr. Jeff Gartman; ADA Library Transition Plan Project Manager, Ms. Grazyna Langguth; and ADA SVP for Education and Professional Affairs, Dr. Anthony J. Ziebert. The Taskforce met via conference calls on January 8th and 15th, March 25th, and April 30<sup>th</sup>. In addition, meetings were held on January 25th-26<sup>th</sup> and March 12<sup>th</sup> at ADA Headquarters (see Appendix 1 for all meeting minutes.) The purpose of the January meeting was to solicit input and recommendations from ADA members who are frequent users of the library; ADA staff from the various divisions who are frequent users of the library; and directors of medical and dental libraries that have made the transition to primarily digital resources. The directors of the medical and dental libraries confirmed for the Taskforce that there are fundamental changes taking place in how information is delivered. All libraries are going through the process of maximizing resources through expanded use of electronic and digital means of conveying information. The ADA library is not immune from these changes; indeed, the ADA must make the same changes in order to stay relevant for ADA members and the profession. In addition, Dr. Hagenbruch, Mr. Gartman, and Dr. Ziebert made two trips to the University of Illinois at Chicago Regional Medical Center Library on February 5 and April 3 for the purpose of initiating a dialogue on services that the UIC Library is willing to provide to ADA members. The results of those discussions are outlined in the section of the report on the "Transition Plan for the Disposition of the Book Collection."

The Task Force believes that not only are they charged with developing a transition plan for the disposition of the print book collection, but also in a broader sense, they have been charged with ensuring that the resources for evidence-based dentistry are maintained and updated as a valuable member benefit, so that the library can enter the 21<sup>st</sup> century. The future lies in the efficient searching for knowledge through electronic databases, where the library serves as a knowledge resource center. The ADA Library Transition Plan makes a commitment to develop and maintain and develop a comprehensive collection of information resources for ADA members in various formats and makes a commitment to remain the focal point for support of evidence-based dentistry. Finally, as the ADA library looks to the future, the ADA Library Transition Plan makes a commitment to the preservation of the vital records of the Association through the ADA archives, and the provision of historical documentation and context relating to the Association, its members, activities, and accomplishments.

### I. ADA Library and Archives Mission Statement and Goals

*The mission of the ADA Library is to support the American Dental Association in its quest to provide oral health care that is based on scientific principles and to support lifelong learning for its members. (Strategic Plan, 2011-2014, Beliefs, Goals and Objectives)*

#### Library Goals and Objectives:

The Library seeks to fulfill the ADA's aspirations through the following goals and objectives which support the dental profession directly and the public through the profession.

#### Goal 1 Objectives: Information Resources.

- 1 1. Resources:  
2 To develop and maintain a comprehensive collection of information resources, in various formats, on  
3 clinical dentistry, oral health research, dental practice management, and related subject areas.
- 4 2. Archives:  
5 To preserve the vital records of the Association, and provide historical documentation and context  
6 relating to the Association, its members, activities, and accomplishments.
- 7 3. Access:  
8 To provide and facilitate user access to the collection and other dental information resources, using  
9 the most up-to-date technology where available and applicable.

## 10 **Goal 2 Objectives: Information Services to Members.**

- 11 1. To provide member dentists with professional information services by library staff, including fact-  
12 finding, verification, reference, online searching, internet searching assistance, recommendations of  
13 information resources, and referrals to other contacts and sources of information
- 14 2. Information Support for Staff  
15 To assist ADA staff to locate and utilize the information necessary to perform their jobs and respond  
16 to member needs, including instruction in the use of relevant information resources.
- 17 3. Archival and Historical Services  
18 To provide archival and historical services to support and enhance Association activities.
- 19 4. Service to Others  
20 To provide select oral health resources and services to other libraries, other health professionals, and  
21 government and social agencies as needed.  
22  
23  
24

## 25 **II. Background of World's Trend of Libraries Transition from Analog** 26 **to Digital Format (1)** 27

28 All libraries have been affected by the changes related to information and technology that have happened  
29 in the past decades. The most effective and efficient library experts recognize the need to make changes  
30 in traditional boundaries. The library's traditional role as a repository for physical books and periodicals is  
31 quickly fading, with important implications for space utilization, resource acquisition, and staffing. These  
32 changes are outlined as follows:  
33

- 34 1. Collection Size Rapidly Losing Importance.  
35 Even the wealthiest academic libraries are abandoning the "collection arms race" as the value of  
36 physical resources declines. Increasingly, libraries must adapt to a world in which providing access to  
37 scholarly resources is their primary role (rather than ownership of resources).  
38
- 39 2. Traditional Library Metrics Fail to Capture Value to Academic Mission.  
40 Libraries can no longer demonstrate their educational and scholarly impact via traditional input  
41 measures such as the number of volumes and serial titles held, expenditures on monographs and  
42 staff, gate count, and reference requests. New measures of success will emphasize impact on policy  
43 outcomes, impact on clinical practice, and research productivity of ADA members and staff.  
44
- 45 3. Viable Alternatives to the Library Now Boast Fastest Growth and Easiest Access.  
46 With the rise of nonprofits like PubMed and Cochrane, users now meet most of their information  
47 needs through sources outside of the library. The collections of articles, monographs, and e-books  
48 made available through these organizations dwarf library collections in size and scope, and content is  
49 increasingly accessed virtually through web- and cloud-based distribution portals.  
50
- 51 4. Demand Declining for Traditional Library Services.  
52 Very few members start research in the library or via the library website, opting instead for search  
53 engines and discipline-specific research resources. Circulation and reference requests have been



- 1 steadily declining for years, driving the library's traditional core (providing access to books and  
2 guiding patrons through research) to the periphery.  
3
- 4 5. New Patron Demands Stretch Budget and Organizational Culture.  
5 The modern library is caught between its historical role in managing print materials and new demand  
6 for digital resources and services, and it cannot afford to invest indefinitely in both. Today's users  
7 require a new set of services and accommodations from the academic library that necessitate a  
8 strategic paradigm shift: from building and maintaining a collection to engaging with members.  
9
- 10 6. E-book Adoption Reaching a Tipping Point.  
11 In April 2011, e-books began to outsell all print books on Amazon.com. Surveys of academic library  
12 directors indicate plans to substantially increase spending on e-books within the next five years.  
13 Growing investments by publishers, interactive functionality, and the advent of tablet PCs are building  
14 substantial momentum toward adoption. As more books are either scanned and made available  
15 digitally or published as e-books, libraries will need to adapt by diverting funds toward licensed digital  
16 access, rather than physical ownership and storage. New patron-driven costing models will finally  
17 allow libraries to avoid the risk and inefficiency associated with prospective collection-building and  
18 pay only for what patrons use, at the moment they use it. A new business model for e-book delivery,  
19 commonly referred to as patron- or demand-driven acquisition, allows libraries to shift from a  
20 prospective, "just in case" purchasing strategy to a "just in time" approach in which the library pays  
21 only for books actually used by patrons. Via a mix of free access, short-term rentals, and loans of  
22 purchased items, patron-driven acquisition more effectively calibrates the library's investment to  
23 demand, while significantly expanding the universe of available titles in the local catalog.  
24
- 25 7. Large-Scale Digital Collections Offer Promise of Widespread, Low-Cost Access.  
26 Google Books, HathiTrust, Internet Archive, and other efforts have digitized millions of volumes and  
27 have made them fully searchable and browsable online. While legal barriers and publisher resistance  
28 currently prevent full access to these collections, a growing corpus of material is being made  
29 available to the public at little to no cost.  
30
- 31 8. Technological Constraints Unlikely to Prevent Digital Transition.  
32 The breakneck pace of technological innovation will ensure that most usability limitations involved in  
33 the consumption of digital information and text will be addressed before patrons are aware of them.  
34 Format incompatibility, missing functionalities, and hard-to-read displays are likely to give way to  
35 better, less expensive reading technologies as publishing continues its digital migration.  
36
- 37 9. Local Print Collections Are Large, Expensive, and Rarely Used.  
38 At many institutions, less than half of the library's collection has ever circulated. Despite the steadily  
39 declining usage of print collections, they continue to occupy extensive (and typically central, and thus  
40 quite valuable) space. Books housed in open stacks are five times as expensive to store as those  
41 kept in off-site, high-density storage. As library budgets tighten, need for space rises, and circulation  
42 continues to decline, more and more libraries will consider moving print materials off-site.  
43
- 44 10. Leverage Data on Usage, Electronic Access, and Local Holdings to Prioritize Local Collections. There  
45 are now a variety of resources designed to aid libraries in the process of determining which volumes  
46 to relocate or remove. Librarians can prioritize resources and streamline decisions about collection  
47 management using objective data on usage, access to electronic alternatives, holdings by consortia  
48 partners, and preservation agreements.

#### **Limits of the Ownership Model**

"Given these potent trends, the Harvard libraries can no longer harbor delusions of being a completely comprehensive collection, but instead must develop their holdings more strategically.

To do so, Harvard will need to embrace a model that ensures access to—not necessarily ownership of—scholarly materials needed by faculty, students, and other library users, now and in the future."

### 1 III. The Digital Library(1)

#### 2 Libraries: An American Value

4 Libraries are a legacy to each generation, offering the heritage of the past and the promise  
5 of the future.

6 TRUSTEE FACTS FILE. 3<sup>rd</sup> edition; Robert P. Doyle and Robert N. Knight, editors  
7 *Illinois Library Association and Illinois State Library, Appendix D*

8  
9 Digital libraries provide the resources to access, interpret, distribute, preserve the integrity of, and ensure  
10 the persistence over time of collections of digital work so that they are readily and economically available  
11 for use by a defined community or set of communities. The digital library requires technology to link to  
12 resources of many libraries and information services.

13  
14 Libraries act as intermediaries between info consumers and publishers.  
15 Migrating from print to electronic collections, retiring legacy print collections, and moving from purchasing  
16 to curating collections represents a change in how the collecting activity is conceived. There are  
17 interdependencies between the parts of transition.

18  
19 **The very purpose of the ADA Library and Archives transformation to incorporate a digital**  
20 **information center is to achieve a goal of being shaped simultaneously by tradition and by**  
21 **technological innovation, transforming the library into a 21<sup>st</sup> century center of dentistry's**  
22 **knowledge and history. Just as the respected and state-of-the-art library facilities with which the**  
23 **Transition Plan Taskforce and ADA staff consulted in this careful progression, the ADA must also**  
24 **embrace a metamorphosis to a hybrid library format if it expects to keep pace with the growing**  
25 **demands of our members for information, crucial scientific intelligence requests, as well as a**  
26 **whole host of anticipated communication obligations.**

#### 27 Characteristics of a digital library

- 28 • **No physical boundary.** Users of a digital library need not go to a physical library; can use  
29 resources remotely.
- 30 • **Round-the-clock availability.** People can gain access to the information at any time, from any  
31 place, as long as the Internet connection is available.
- 32 • **Multiple Accesses.** The same resources can be used at the same time by multiple users.
- 33 • **Structured approach.** A digital library provides access to much richer content in a more  
34 structured manner, that is, we can easily move from the catalog to the particular book, then to a  
35 chapter, and so on.
- 36 • **Information retrieval.** There is flexibility in the use of search terms (key words). A digital library  
37 provides user-friendly interfaces, and clickable access to resources.
- 38 • **Preservation and conservation.** Exact copies can be made without compromising the quality.
- 39 • **Space.** A digital library can function in a smaller space.
- 40 • **Networking.** A digital library can provide links to resources of other digital libraries, achieving  
41 integration of resources.
- 42 • **Cost.** A digital library can cut a physical library's cost of paying for staff, but the higher cost of  
43 electronic resources balances the cost. The cost of maintaining a digital library is not lower than  
44 that of a traditional library.
- 45
- 46

#### IV. Current Description and Metrics of the ADA Library

##### A. Current library services status:

1. Books purchasing procedure stopped in the middle of 2012.
2. Journal subscriptions are being maintained at 2012 levels.
3. Books do not circulate out of the library.
4. Reference and research services are still delivered to the members and ADA staff.
5. Walk-in service is available to ADA members on an appointment basis.

##### B. Existing electronic services and resources

Access to existing online resources /databases for ADA members and ADA staff:

1. PubMed / Medline-PubMed comprises more than 22 million citations for biomedical literature from Medline, life science journals, and online books. Citations may include links to full text content from PubMed Central and publisher websites. Medline is the National Library of Medicine's on-line bibliographic database and is an index to the world's biomedical literature. It is the primary component of PubMed. Fee for ADA members requesting full-text articles through the ADA library: \$10.00 per article (1-14 pages), and \$20.00 (for 15 and more pages). This is a valuable ADA member service, as articles that are purchased directly from the PubMed website must be purchased through the publisher's link, with an average cost of \$45.00 per article. In addition, not all publishers offer the link directly from PubMed. (e.g., Quintessence)
2. FirstSearch- FirstSearch provides access to a core collection of reference databases, including WorldCat as well as other databases such as CAMIO, Electronic Books and OAlster. Users of WorldCat.org and WorldCat Local can access these FirstSearch databases through a single-search box. Available only for library staff, could be made available to ADA members through link on ADA website. The ADA Library pays \$3,458 for FirstSearch membership, renewed annually with current operating budget funds. This is absolutely necessary for library activities and services
3. Cochrane Library access has been renewed with current operating budget funds (April 2013).
  - The Cochrane Library is a collection of [databases](#) in [medicine](#) and other [healthcare](#) specialties provided by the [Cochrane Collaboration](#) and other organizations. At its core is the collection of Cochrane Reviews, a database of [systematic reviews](#) and [meta-analyses](#) which summarize and interpret the results of medical research.
  - The ADA Library Transition Plan Taskforce learned, through interviews with ADA members and ADA staff from the Division of Science, that access to the Cochrane databases is a key tool for evidence-based dentistry.
  - Searchable, full text articles can be obtained directly by the individual ADA member, or through the ADA library, for a fee.
  - In the past, the Cochrane database subscription renewal was not part of the annual operating budget of the ADA Library. Resolutions from the House of Delegates floor, along with adequate funding for purchase of the subscription, had been introduced and adopted by the House of Delegates in 2010 and 2011.

1 In 2012, the subscription was not renewed, as there was no resolution adopted  
2 by the House of Delegates.

- 3 • The annual subscription price has decreased dramatically over the past year. In  
4 2011, the cost of unlimited access for ADA members and staff to the database  
5 was \$18,000. For 2013, the cost for access of up to 1,000 ADA members  
6 and/or ADA staff is \$2,558. Based on past ADA usage statistics, 1,000 “seats”  
7 will be more than adequate to meet the needs of the ADA members and ADA  
8 staff that use the Cochrane database on a regular basis.

- 9  
10 4. ADA archives-no electronic archival management product currently being used, nor  
11 is there electronic access for ADA members and ADA staff.

## 12 **C. Description of Current Collection**

### 13 FACILITY

14  
15  
16 The ADA library and archives occupies approximately 5,000 square feet, half of the 6<sup>th</sup> floor, in  
17 the ADA Headquarters Building in Chicago. The library has occupied this space for the past  
18 eleven years. In 2002, the library and archives moved from the 19<sup>th</sup> floor of the ADA Building,  
19 where it occupied 75% of the square footage of that floor. The rationale for the move was to make  
20 the library more accessible to the ADA members and the public by placing it on a floor that was  
21 more adjacent to the lobby. In conjunction with the move to the 6<sup>th</sup> floor, approximately 25,000  
22 documents were de-accessioned from the collection, which was done with little (or no) volunteer  
23 oversight or scrutiny. Further de-accession of the collection has not occurred since the move to  
24 the 6<sup>th</sup> floor.

### 25 BOOK COLLECTION

26  
27 The ADA Library has an extensive print book collection which is composed of approximately 8000  
28 volumes. The collection covers 34 dental subject areas including strong and unique collections in  
29 practice management, dental implants, dental materials, dental history, dental radiography, and  
30 pediatric dentistry. Books are classified using the Black Classification System and are accessed  
31 via ADA library catalog. Books can be further classified as follows:

- 32 1. Historic and/or unique texts: the ADA library has several special collections useful  
33 for dental history research. Although used by the archivist, they are considered part  
34 of the ADA Library. This is a grey area between library & archives in terms of  
35 services and usage; it is a very valuable and unique collection. There are a total of  
36 668 books in this collection, which include facsimiles of early dental texts (including  
37 Pierre Fauchard's first text from 1727), with a range from 1727 to the 1960's.  
38 Foreign language texts (174 total) are considered a part of this collection, due to the  
39 uniqueness of these texts. The historic book collection is further classified as  
40 follows:

- 41 • The Rare Book Collection (called “Case” books in the catalog) is a separate  
42 collection that comprises antique books (books from the 16-19th centuries). All  
43 books have call numbers and are accessed via the online catalog.
  - 44 • The Legacy Book Collection is part of the main library book collection and  
45 comprises 20th century books printed prior to 1980. All books have call numbers  
46 and are accessed via the online catalog.
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2. Historic and available at other libraries (e.g. early editions of common texts): 770 total, ranging in dates from the 1920's to 1980.
  3. Current and unique: 991 total, a compilation of ADA publications, surveys, white papers, statements, etc.
  4. Current (post 1980) and available at other libraries: 1,888 total.
  5. Sub-collections of the general books collection:
    - Children's books collection ("Tooth Fairy" books, visiting a dentist, etc.).
    - Collection of books written by dentist's (i.e., Zane Grey).
    - New books (within 6-12 months after purchasing, a book has the status of a "New Book") .
    - Reference Books Collection is composed of medical-dental dictionaries, dental drug references, and ADA Survey reports.
  6. Miscellaneous collections
    - ADA Library Vertical Files-pamphlet files of past publications produced by dental organizations and institutions including patient education brochures, member directories, constitutions/bylaws, marketing literature, etc. Arranged alphabetically by name of organization and some topics. No call number assigned and not in the online ADA Library catalog. Digitized inventory of the names is available on FileWeb.
    - Dental School Catalogs -A representative collection of 19<sup>th</sup>-20th century dental school academic catalogs which list the school's curriculum and describe its facilities, faculty, etc. Arranged alphabetically by state and then by name of school. Collection is not assigned call numbers and not in the online ADA Library catalog. Digitized inventory of the names is available on FileWeb.
    - Constituent Meeting Programs-A representative collection of mostly 20th century meeting programs of constituent dental societies. Arranged alphabetically by state and then by name of dental society. Collection is not assigned call numbers and not in the online ADA Library catalog. Digitized inventory of the names is available on FileWeb.
    - Package Libraries-Clipped articles from dental journals on clinical topics 1900-2012. Arranged by topic and year. Inventory of the topics is available on FileWeb

## 38 JOURNAL COLLECTION

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The journal collection is the most heavily used of all the library's collections. ADA members, library staff, and the ADA Divisions of Science; Dental Practice; and Publishing regularly require access to and consult articles from this collection. The ADA library has an extensive journal collection of 531 journal titles. In addition, there are approximately 409 defunct journals in the collection, a few of which are considered historically significant (i.e., Dental Cosmos). Journal collection is composed of clinical journals, practice management journals, dental association journals and state/constituent society journals. This collection is set up in alphabetic order and approximately 85% of the journals have been bound with hardcover. One hundred and two journals are received through paid subscriptions, the remaining are received on a complimentary basis, either from the JADA exchange, ADA components, or other arrangements.

51 The paid subscriptions include:

- 52  
53
- 3 online e-journals (online access only)
  - 69 journals in electronic & print format

- 33 journals in print format only.

## ARCHIVES

The ADA Archives, the national authority on dental historic topics, is the official repository of the organization's historical publications and records of enduring value. Materials in the archives, arranged by department of origin, are preserved for future reference by the organization, regardless of organizational change or staff turnover.

1. ADA Records & Publications -Records of the organization such as annual meeting transactions or proceedings, minutes of ADA councils and committees, correspondence and memoranda, fiscal records and documentations, legal papers, etc. Currently arranged by department of origin. Assigned a unique archives call number based on the organizational structure of the ADA. Access via the archives card catalog
2. Archives Biography File-Files of biographical information on individual dentists, past and current ADA officers, and other people involved in the dental profession and important to the history of dentistry and the organization (6,000+ names); arranged by last name (no call number assigned); digitized inventory of the names is available on FileWeb; not in the Archives card catalog
3. Photographs of the ADA-Photos of Annual Sessions, ADA sponsored events, past ADA officers, staff members at work, etc.; collection arrangement mirrors the ADA Records and Publications collection; access via the archives card catalog
4. Audiovisual materials of the ADA-Film, tape, discs, other recording media produced by the ADA or that document ADA sponsored events (e.g. conferences, meetings, etc.)-collection arrangement mostly mirrors the ADA Records & Publications collection; access via the archives card catalog; some items have accession numbers; digitized inventory available on FileWeb.
5. Historic artifacts and gifts-over the years, individuals and national/international organizations have donated historic artifacts or have given gifts to the ADA. Many of these items have been displayed on the 22nd floor common areas of the ADA Building or in display cases at the entrance to the library. Other artifacts and gifts have been stored on the shelving within the archives. These items have been assigned unique accession numbers based on year acquired; digitized inventory is available on FileWeb; not currently in the archives card catalog. Criteria regarding the historic relevance and/or artistic value of the artifacts has not been established.
6. Archives of Other Dental Organizations-records of 9 smaller dental organizations stored in the ADA library; there are agreements on file for most of these concerning handling, accommodation, and disposition.

## D. ADA member Usage:

Annual on-site usage (estimated 2011)-ADA members and ADA staff

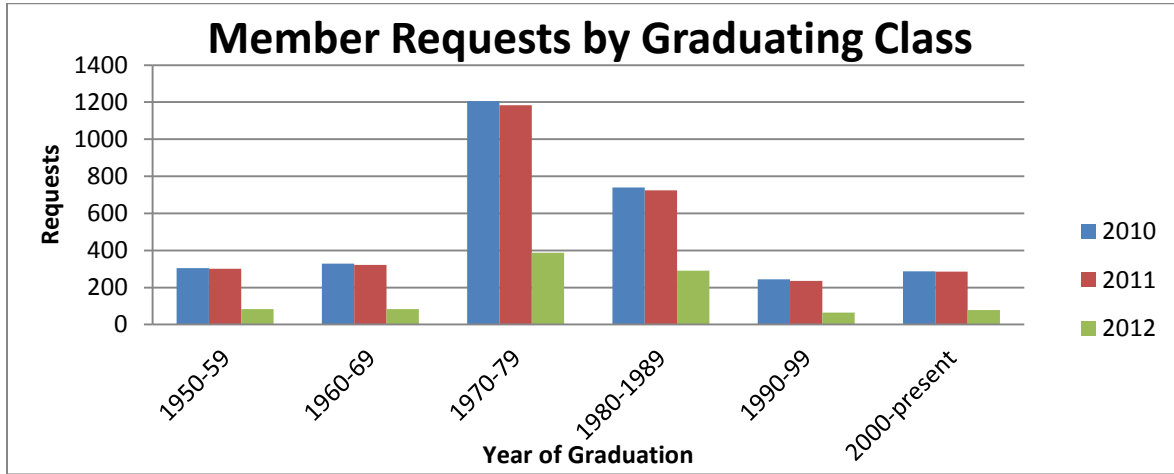
- 1,200 total visits on-site, with ADA staff estimated at 60% of on-site total visits.
- 285 unique on-site visits; 250 ADA members and 35 ADA staff, primarily from the ADA Division of Science and Professional Affairs and the ADA Division of Publishing.

Recorded transactions on-site and remote (estimated 2011)-

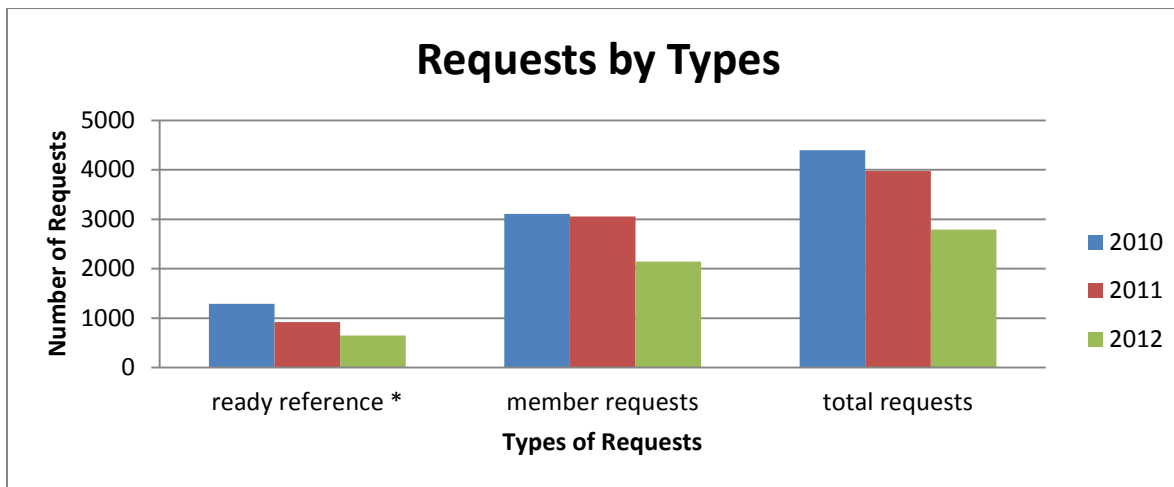
- 94 ADA members used the services of the ADA Library five times or more

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- 615 ADA members were one-time users



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7

\* Includes members, other professionals, and other libraries

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9

**E. Budget**

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The ADA Library does not generate any appreciable amount of revenue. Many of the fees charged for services do not cover the cost of providing those services. ADA Library expenses are related primarily to library staff salaries and benefits, journal subscriptions, and new book purchasing. The ADA library occupies approximately 50% of the sixth floor at the ADA Building in Chicago (5,500 square feet) and approximately 80% of this space is used for book, journal, and archives shelving and storage.

16

Through 2012, there were nine full-time professional library staff and one full-time library director, along with three part-time staff. The annual budget for 2012 was \$1.043 million. The annual budget for 2013 is \$405, 424, due to staff and service changes implemented January 1, 2013 (see Appendix 2).

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19  
20

## V. ADA Library Transition Plan

### A. Transition Plan for Governance of the ADA Library

1. What has been implemented to date: The plan of library transformation began in 2012. The goals and objectives of the restructuring plan were outlined to envision the required and necessary changes from a traditional, print based library to a digital library, with electronic-based resources.
  - a. ADA Library Staff reduction (January 2013): 5 FT positions remain, out of 10 FT; 3 PT; library staff reduction was implemented in January 2013, as best evidence suggests that a digital library can operate with a smaller staff. It also brought significant savings in the library budget. Current library staff need to undergo training in new software and electronic resources, and also need refresher training for existing products, as new products will be necessary and existing products will be used in a different way. The goal is to have library staff cross-trained to substitute each other's position/tasks, similar to the need for cross-training that is found in many ADA member dental offices.
  - b. Updating Mission and Goals for the ADA Library: The new library mission and goals were presented to the Board of Trustees Taskforce on ADA Library Transition Plan and accepted by the Taskforce in January 2013.
  - c. Implementation of the **ADA Library Resource Relevance and Vitality Policy**

All libraries routinely evaluate their collections to insure currency and vitality and to facilitate current use/access to the collection. Every library needs basic operational policies and procedures, and while creation of a library policy is a major task, it is absolutely necessary for library activities. The de-accession (weeding or culling) process is typically an annual library routine. The process is considered "best practices" in library management; however, this basic management function has been performed inconsistently, if at all, in the last eleven years at the ADA library. ADA library staff, with input from the ADA Library Transition Plan Taskforce, developed a policy regarding the routine evaluation of the current print collection and this has been an on-going process since the Taskforce approved the criteria (see Appendix 3 for the **ADA Library Resource Relevance and Vitality Policy** and associated de-accession criteria). This is not a time sensitive process, as the library can provide services regardless of the stage of de-accession process. ADA library staff estimate that this process will be completed by October 2013.
2. Proposed changes:
  - a. An engaged and functioning advisory board is considered "best practices" for library management. Accordingly, the ADA Library Transition Plan Task Force recommends the establishment of an advisory committee to the ADA Board of Trustees, known as the ADA Library and Archives Advisory Board.

#### **ADA Library and Archives Advisory Board**

##### RESPONSIBILITIES:

- Create and develop the mission of the ADA library and a strategic plan for the ADA Library
- Ensure the ADA library remains relevant to the ADA strategic plan.



- 1 • Provide input on the selection and hiring of a qualified library director, whenever
- 2 the position becomes available.
- 3 • Provide input during the annual ADA budgeting process on library funding,
- 4 priorities, and needs.
- 5 • Adopt policies and rules regarding library governance, assets and use;
- 6 develops, approves, and codifies all policies, based on input from the library
- 7 director and library staff; delegate procedural work to the library director and
- 8 library staff.
- 9 • Regularly plan and evaluate the library's service program.
- 10 • Evaluate annually the library facility to ensure it continues to meet ADA member
- 11 and ADA staff needs.
- 12 • Develop marketing plans for promotion of the ADA library to ADA members; ADA
- 13 component and constituent societies; the local dental and medical communities;
- 14 and affiliated dental organizations.
- 15 • Conduct the business of the library in an open and ethical manner in compliance
- 16 with all applicable laws and regulations and with respect for the institution, staff
- 17 and public
- 18 • Report on an annual basis to the ADA Board of Trustees.

#### 20 COMPOSITION:

21 The ADA Library Transition Plan Task Force makes the following recommendation on the  
 22 composition of the ADA Library and Archives Advisory Board: Two members of the ADA  
 23 Board of Trustees and two at-large members of the ADA appointed by the ADA  
 24 President; two members of the Council on Dental Education and Licensure (CDEL)  
 25 appointed by the Chair of CDEL (one should be an ADEA appointee); and two members  
 26 of the Council on Scientific Affairs (CSA) appointed by the Chair of CSA; Ex-officio  
 27 members: Director of the ADA Library and Archives; a member of the Division of Science  
 28 staff appointed by the SVP of Science and Professional Affairs; and the SVP of Education  
 29 and Professional Affairs. The senior Board member serves as the Chair of the Advisory  
 30 Board.

#### 32 CRITERIA FOR SELECTION OF MEMBERS:

- 33 • An interest in, and/or knowledge of, the operational aspects of libraries.
- 34 • Regular user of the ADA library, or academic medical center library.
- 35 • Interest in and/or familiarity with peer-reviewed dental literature and journals.
- 36 • Knowledge of the resources required for EBD.
- 37 • Interest in the history of dentistry and the history of the Association.
- 38 • Familiarity with the electronic resources and databases used in academic
- 39 libraries.

#### 41 TERM OF SERVICE:

42 Staggered, two-year renewable terms consistent with the member's appointment on the  
 43 respective Council or Board of

#### 45 MEETINGS:

46 In-house meeting annually (one day); conference call/webinar meetings on an as-needed  
 47 basis

48 ESTIMATED COST: \$12,000/year for travel

- 51 b. Changing the name to the ADA Library and Archives (for archives visibility)
- 52 The ADA library and the archives are two inseparable parts, which complement each
- 53 other. The resources and services of the library and archives mesh and overlap, so they

cannot function separately, as they create unity. The suggested change of the name to include the archives would expose the national authority on dental history.

ESTIMATED COST: none

- c. Development of a **Collection Development Policy** before digitization begins, clearly defining characteristics of the collection, scope, format, restriction on access, and ownership.
- d. Development of a **Gift and Historic Artifact Policy**
  - criteria regarding the historic relevance and/or artistic value of the gifts/artifacts
  - criteria for public display and locations of displays
  - regular evaluation of current collection of gifts/artifacts
- e. Development of a **Library Electronic Resources Policy** (i.e., type of resources to support, user access, license issues).
- f. Copyright Clearance Center-Library & Archives need to follow Copyright rules. In the past, the ADA library managed the Copyright Clearance Center license (see Appendix 4–Annual Copyright License Agreement.)
  - Currently the CCC license is paid until June 2013
  - Yearly cost of renewal is \$13,800.
  - The ADA Library Transition Plan Taskforce recommends annual renewal be paid by the ADA Division of Legal Affairs.

## B. Transition Plan for Disposition of the Print Book Collection

### 1. Library de-accession process of existing, outdated materials:

De-accession will leave the books collection smaller, but large enough for library to provide continuously excellent services and research. The de-accession process is a much needed inventory procedure and “best practices” for library management. It has not been performed at the ADA library on a consistent basis. All items taken for de-accession from shelves are also taken out from the library online catalog.

The implementation of the de-accession process has led simultaneously to an unexpected and positive side-effect of finding archives books inter-shelved with library books. Duplicates are being removed, and the archives collection is being supplemented by missing items. In addition, the ADA Library Transition Plan Taskforce determined that many of the print sub-collections of the library are rarely, if ever, utilized by ADA members or ADA staff. The sub-collections are not central to the primary mission and purpose of the ADA library and take up significant shelf space. Unless otherwise noted, any printed texts slated for removal from library will be first offered to ADA members (and/or affiliated organizations) at no charge (except for shipping cost). Any remaining texts will be handled through donations or sent to BetterWorldBooks for possible resale:

BetterWorldBooks.com:

- Resell ADA library de-accessioned texts on over 53 market places online
- No cost for the ADA library. All supplies and shipping covered by BWB.
- BWB returns 15% commission to ADA library and donates 5% to non-profit literacy groups
- If BWB cannot sell books, then donated to a non-profit literacy group to be reused

- 1                   • If BWB cannot resell or donate a book, it will be recycled so nothing ends up in  
2                   the landfill.
- 3
- 4           a. Print collections to be maintained on-site at ADA Library:
- 5           • Rare book collection (historic collection).
- 6           • Legacy book collection (historic collection).
- 7           • Regularly utilized foreign language books.
- 8           • ADA published books will be added to the archive.
- 9           • Biographies/Autobiographies about dentists will be evaluated for addition to the  
10           archives.
- 11           • Materials for which the ADA is the unique holder.
- 12           • Reference books, including medical-dental dictionaries; dental drug reference;  
13           ADA Surveys and Reports; and classic texts.
- 14               o newest editions retained and reference books in print format retained, if  
15               the e-format is not available.
- 16               o classic texts are important to keep as they are often consulted by the  
17               ADA Divisions of Publishing, Science and Dental Practice for article  
18               verification, and creation of reports. Library reference staff also refers to  
19               these texts in answering ADA member questions.
- 20
- 21           b. Print collections to be removed from ADA library:
- 22           • Multiple copies.
- 23           • Materials in a language other than English (dictionaries, yearbooks,  
24           transactions).
- 25           • Books from international publishers, if not used in last 3 years.
- 26           • Materials that have circulated infrequently (or never).
- 27           • Materials with dated or incorrect information.
- 28           • Worn out material.
- 29           • Children's book collection-books from this collection will be donated to the Ann &  
30           Robert H. Lurie Children's Hospital of Chicago and Kohl Children's Museum in  
31           Wilmette.
- 32           • Collection of books written by dentists (fiction; non-professional in nature)-books  
33           from this collection will be offered free on employee reading rack at the ADA  
34           lower level lounge, and to public libraries.
- 35           • Archives of other dental organizations-archives will be returned to originating  
36           organizations.
- 37           • Package library, except for history sub-topic files that will move to archives as a  
38           dental history resource.
- 39           • Vertical file.
- 40           • Dental school catalogues-offered to dental schools.
- 41           • Constituent meeting programs-offered to constituent societies.
- 42           • Current and new book collections
- 43
- 44   **2. Continued ADA member access to a print collection and onsite library facility usage-**  
45   **development of a Memorandum of Understanding (MOU) between the ADA and the**  
46   **University of Illinois at Chicago (UIC) Medical Center Library (see Appendix 5-proposed**  
47   **MOU between ADA and UIC).**

48

49           The UIC library is centrally-located in Chicago's south loop, with convenient freeway  
50           access and public transportation access. Inexpensive public parking is located within  
51           two blocks of the facility. The library itself is a comfortable, modern, and spacious  
52           facility:

53

- 1 a. ADA library staff have cross-indexed the ADA collection and the UIC collection. The ADA  
2 collection is stronger in older editions of classic texts and practice management texts,  
3 while the UIC collection is stronger in offering an increased quantity of the latest print  
4 texts. In recent years, the ADA collection has added an average of 55 new books a year,  
5 while the UIC library has added an average of 156 texts a year. Approximately 2,500  
6 texts would be transferred to UIC in order to complement and complete the UIC  
7 collection. The ADA would retain ownership of these texts and would be able to retrieve  
8 the collection intact; however, the texts would be integrated and catalogued with the UIC  
9 collection.
- 10
- 11 b. New books: The UIC library continues to have a robust acquisition budget, and it is  
12 anticipated that this will not change in the near future. This is due to that fact that it is  
13 identified as the regional medical center library and it has an obligation to maintain and  
14 expand the collections to service health care facilities throughout the region. Proposed  
15 annual acquisitions are circulated by the UIC Library "dental liaison" for input from the  
16 UIC School of Dentistry. The annual acquisition list can also be circulated to the ADA  
17 Library and Archives Advisory Board for input. The ADA library staff has the capability to  
18 publish the list of new texts on an annual basis to the ADA members, which would not be  
19 a change from the current "new book list" practice. This is a service that the ADA library  
20 provided which was viewed as valuable to the members who used the ADA library on a  
21 regular basis.
- 22
- 23 c. ADA library staff would be able to obtain any book requested by an ADA member through  
24 the inter-library loan program.
- 25
- 26 d. ADA members would also have access to a comprehensive collection of medical texts  
27 and journals.
- 28
- 29 e. ADA members would not need to call ahead to access the collection. The UIC library is  
30 open to the public during regular business hours, and during the evening and on  
31 weekends with card access. ADA members will have card access for the extended hours.  
32 In contrast, ADA members can access the ADA library only from 8AM-5PM during the  
33 week.
- 34
- 35 f. UIC to set an annual fee for the ADA which provides for unlimited access to the UIC/ADA  
36 collection for any ADA member, renewed by the ADA on an annual basis. This includes  
37 checking out texts and related materials

38 ESTIMATED COST: \$10,000/year

- 39
- 40
- 41 3. **New books (purchased within last 6-12 months)**-the ADA library will no longer purchase any  
42 new print texts, unless it is deemed necessary due to absence of said texts from all other  
43 available sources.
- 44
- 45 4. **New reference books**-purchased only in electronic format, unless a fundamental work on  
46 dentistry is available in print format only. Many reference e-books will be available from the  
47 database that the library is planning to acquire (see section on enhanced electronic resources).
- 48

### 49 **C. Transition Plan and Enhanced Resources for Print and Electronic Journal** 50 **Collection**

51

52 De-accession will leave the journal collection smaller; however, many of the print journals are non-peer  
53 reviewed and of no value for EBD or research. The ADA library has a large collection of hardcover-bound

1 journals and in the past, the library operating budget typically allocated approximately \$2,600 annually to  
2 bind in hardcover all previous years of print journals. Included in the bound journals collection is a large  
3 number of state and constituent society journals/newsletters and historically significant journals that are  
4 no longer published. The ADA library typically had past issues of these journals also bound on an annual  
5 basis. These journals have been reviewed for clinical content, and if such is contained and they are  
6 indexed in electronic databases, these journals are slated to be retained. All other state and constituent  
7 society journals will be removed from the collection and offered to the originating state/constituent  
8 societies. Short-run newsletters and publications, if non-clinical, non-comprehensive, or non-peer  
9 reviewed, will be removed. As more journals move to exclusive electronic availability, it is anticipated that  
10 binding expenses will no longer be incurred.

11  
12 Selection of journals for continued subscription has been finalized based on the following criteria:

- 13
- 14 • Peer-reviewed to US standards.
  - 15 • English language.
  - 16 • Foreign language-if peer-reviewed to US standards and considered an important resource for  
17 EBD.
  - 18 • Indexed in PubMed/Medline/Cochrane.
  - 19 • Content is primarily:
    - 20 ○ clinical dentistry.
    - 21 ○ biomedical/basic sciences related to dentistry.
    - 22 ○ biomaterials science related to dentistry.
    - 23 ○ dental-medical interrelationship.
    - 24 ○ medical, peer-reviewed journals that regularly feature topics of interest to clinical  
25 dentistry or EBD.
  - 26 • All journal holdings annually reviewed by the ADA Library and Archives Advisory Board to  
27 determine if the criteria are met.
  - 28 • All proposed journal additions (new journals) to the holdings reviewed by the ADA Library  
29 Advisory Board to determine if criteria are met.
  - 30 • E-journal exclusively (if possible). This is also the only option for born-digital journals
  - 31 • Print subscription to be discontinued when digital edition becomes available; hybrid  
32 (electronic & print format) only if there is no exclusively electronic version.
  - 33 • Usage statistics-it must be demonstrated that the journals selected are accessed by ADA  
34 members and ADA staff on a regular basis.

35  
36 Selection, of journals that library is purchasing, to be continued (see Appendix 6 for complete list of titles):

- 37 • 67 journal titles selected for paid subscription continuation (out of previously 102 titles)
- 38 • 43 journals are in electronic format only
- 39 • 9 journals are print and electronic formats (which makes 52 journals in electronic format),
- 40 • 17 journals are in print only (not available in electronic format),
- 41 • 1 journal is CD-ROM
- 42 • 1 journal is delivered in e-mail format

43  
44 Lack of current electronic resources seriously affects the library's ability to deliver current information to  
45 ADA members. The resources exist at other institutions' information centers, so it is vital for library's  
46 existence to offer ADA members at least an equal level of resources.

47 Inter-library Loan (ILL) lending and borrowing service will continue. The ADA library is using OCLC and  
48 Docline for the ILL. OCLC membership is an annual fee (\$3,483.00) paid in September to the Illinois  
49 State Library as part of annual operating budget. It is recommended that the ADA library become an  
50 institutional member of the Medical Library Association (\$485.00 annual fee) and that the archives should  
51 become an institutional member of the American Academy of the History of Dentistry (\$125.00 annual  
52 fee).

1 Selection of new electronic information resources is essential for increasing usability and functionality of  
2 the library from the ADA website. ADA members would gain remote access to all the resources by using  
3 the library website and would need to authenticate themselves just once using their member credentials.  
4 The selection process involves three-steps, which includes identification/discovery, evaluation and finally  
5 the decision to select the product.  
6

- 7 1. Identification/discovery-research for the best available resources.
- 8 2. Evaluation of electronic resources-after resources identification, evaluation is the most critical  
9 step of selection.
- 10 3. Evaluation criteria considered:
  - 11 a. Content
  - 12 b. Currency
  - 13 c. Reputation
  - 14 d. Indexing
  - 15 e. Impact Factor
  - 16 f. Ease of access
  - 17 g. Cost
  - 18 h. Technical support
  - 19 i. Licensing agreement

- 20
- 21
- 22 4. Negotiations with vendors: access for specific number of simultaneous users is a basic  
23 criterion for price. The following three options were given to vendors (when possible):
  - 24 a. library staff only,
  - 25 b. 1000 users,
  - 26 c. 10,000-15,000 users (12% of the total number of ADA members)

27  
28 Other factors include price and conditions of the resource and limitations imposed by  
29 licensing.  
30

- 31 5. Proposed enhanced and new electronic resources: each of these proposed electronic  
32 resources will enable the ADA member to have greater accessibility to online databases and  
33 information, with no restrictions on the time and place where they choose to access the  
34 services. A further description of the individual enhancements that each product is provided  
35 below:  
36

- 37 a. EbscoHost - e-journals subscription package  
38 This is a customized e-journal package available to ADA members via library website.  
39 Library staff has carefully reviewed existing list of journals. The list was compared to the  
40 list of e-journals provided by new databases library is planning to acquire, to avoid double  
41 purchase of the same title.  
42

43 This tool will allow ADA members to locate full-text articles from 69 online dental journals.  
44 It provides a single site for end users to search and access the library's collection of  
45 electronic journals, regardless of publisher, instead of having to go to multiple sites. In  
46 addition, the majority of library journal article purchases by ADA members are from  
47 journals that are embargoed by vendors, which means only abstract is available without  
48 this tool, with the full text only available after 12-18 months from the journal publication  
49 date. EbscoHost avoids charges for buying the full text of articles from different sources  
50 within the 12-18 month embargo period.  
51

52 The final cost of the e-journal package is \$37,938.42, with a potential usage up to 1,000  
53 Members/users. Three journal titles were already purchased in 2013, in 2014 the

1 subscription will be approximately \$40,000. As a comparison, ProQuest, another vendor,  
2 provided a price of \$199,066 for similar service.

3  
4 b. Ebsco A-to-Z

5 Ebsco A-to-Z list is the industry complete web-based tool for organizing and providing  
6 links to all of library's e-resources, including e-journals, titles in full-text databases and e-  
7 journal packages, and e-books. The A-to-Z list offers a 'one-stop' search of library e-  
8 collection, with easy, user-friendly navigation to full-text content.

9  
10 EBSCO A-to-Z locator tool will give ADA members an easy-to-navigate, comprehensive  
11 and searchable listing of all the full-text journals, magazines, and newspapers that the  
12 library has access to through the various EbscoHost databases to which the library  
13 subscribes. EBSCO A-to-Z is accessible without passwords from any location.

14  
15 The final cost is \$1,000.

16  
17 c. EbscoHost - *DynaMed™*

18 *DynaMed™* provides clinically-organized summaries for more than 3,000 topics.  
19 *DynaMed™* is updated daily and monitors the content of over 500 medical journals and  
20 systematic evidence review databases directly and indirectly. The new evidence is then  
21 integrated with existing content, and overall conclusions are changed as appropriate,  
22 representing a synthesis of the best available evidence. Through this process of  
23 systematic literature surveillance, the best available evidence determines the content of  
24 *DynaMed™*

25  
26 *DynaMed™* is a clinical reference tool for use at the point-of-care and provides access to  
27 clinically-organized summaries for more than 3,200 topics.

28 This is a collection of prominent industry journals, magazines, books and monographs,  
29 including a strong international coverage. This resource has a high-quality full-text  
30 content covering most fields of dentistry

31  
32 d. *Dentistry & Oral Sciences Source*

33 *Dentistry & Oral Sciences Source* is an extensive collection of full-text journals, which  
34 includes access to an additional 91 full-text journals that are not available through  
35 EbscoHost. ***Dentistry & Oral Sciences Source (DOSS)*** covers all facets of dentistry  
36 including dental public health, endodontics, facial pain & surgery, odontology, oral &  
37 maxillofacial pathology/surgery/radiology, orthodontics, pediatric dentistry, periodontics,  
38 and prosthodontics. As a part of this initiative, EBSCO has created backfiles of indexing,  
39 abstracts and full text spanning dozens of years for many publications. Searchable cited  
40 references are also included for 120 journals, with links to the complete text of many of  
41 the original works.

42  
43 The final cost for the combined two above resources is \$54,075 with a potential usage up  
44 to 1,000 members/users. There is no other source of this kind of dentistry information  
45 services.

46  
47 Note: All Ebsco products use *LinkSource* – vendor-neutral OpenURL link resolver  
48 providing better access to full text, and increasing the likely match between the citation  
49 and the full-text source.

50  
51 e. Wolters Kluwer Pharmaceutical Dental db: *Lexi-Comp*

52  
53 *Lexi-Comp Online for Dentistry* provides ADA members with dental-specific  
54 pharmacology information and drug interaction analysis tools to help ensure medication

1 safety. This resource also features a complete dental reference library of information  
2 addressing dental conditions, clinical procedures including oral surgery videos,  
3 management of dental emergencies, and information regarding diagnosis, planning, and  
4 therapy for dental disciplines. Forty-eight U.S. dental schools currently have this tool  
5 available in their clinics for dental student and faculty use.  
6

7 ADA library received a free trial for one year. The final price for annual license fee is  
8 \$20,000. Negotiations brought down the price from usual \$100,000.  
9 The \$20,000/year price is an advance credit for 105 users/year. For each additional user  
10 the price will be \$192 (1-500 users), or \$133 (501-2000 users).  
11

- 12 f. Redesign and simplified navigation to library & archives page from the ADA  
13 external website. The main goal is to improve the functions and ease of navigation of the  
14 electronic library through a website redesign. Information about the library and archives  
15 transition should be present on the first ADA web page:
- 16 i. Adding link to library & archives onto the first page.
  - 17 ii. Library link/existence must be visible, easy to notice, no additional layers to  
18 navigate through - Internet/Intranet ADA Website >Professional Research> ADA  
19 Library and Archives.
  - 20 iii. Link to the library and archives searchable database from ADA website
  - 21 iv. No hover function over tabs; no drop down menu.
  - 22 v. Information about archives (and in the future, access to archives repository), and  
23 link to the archives searchable database on ADA library external website.
  - 24 vi. Adding free resources to the library website (FirstSearch), and info about other  
25 products: *Lexi-comp*, *DynaMed™* and *Dentistry & Oral Sciences Source*.  
26

## 27 **D. Transition Plan and Enhanced Resources for the Archives and Special** 28 **Collections**

29  
30 The development of basic archives policies and procedures is the first step in the transition of the ADA  
31 archives to a more electronic basis. In addition, archives de-accession policy needs to be created and in  
32 written format. Currently, archive retrieval is manual and print only, there is no electronic database, nor  
33 electronic retrieval system. The archive catalogue is exclusive to the ADA and in print form. There is no  
34 self-service access to public documents available for ADA members and ADA staff through the ADA  
35 website. Archival documents could be a potential source of income.  
36

37 Proposed enhanced resources are needed in order for the archives to align with best practices for  
38 archival function and management. ADA members would gain online access to these important historic  
39 resources:  
40

- 41 1. Cuadra / STAR Knowledge Center for Archives (SKCA)  
42 This is a powerful solution for making archival collections visible and accessible.  
43 SKCA complies with the DACS, EAD, MARC, ISAD (g), and Dublin Core archival standards.  
44 It also provides flexible support within the full hierarchical model—collections, series,  
45 containers, and items. SKCA also includes a secure public access module that makes it easy  
46 for users to search within and across collections and to access both descriptions and relevant  
47 digital files. Archival collection is not retrievable without the archival management system.  
48 The system will allow for linking to local, archives material, and also from other departments  
49

50 The cost, for the first year is \$8,100.00.

- 51  
52 2. Data Conversion Laboratory.  
53 Budgetary estimate for the ADA in digitizing archives for import to content management  
54 system. Estimated number - 2,000 documents totaling approximately 10,000 pages.



1  
2 Cost: \$ 22,500.00  
3

- 4 3. Kenamore & Klinkow. Archives & Library Consultants  
5 Consultation services to help with development of schema and hierarchical organization of  
6 archives' documents. Recommendations for cataloging to strict archival standards, and  
7 providing alternative ways to adhere to the principles of archival cataloging, while preserving  
8 the current arrangements. Includes development of criteria for evaluation of historic artifacts.  
9

10 Cost: \$3,840.00  
11

12 **E. Strategies to Promote, Market and Publicize Library & Archives Resources**  
13 **and Services**  
14

- 15 1. All the promotion activities should start prior to activation of new library services and resources.  
16 2. Library presence at each quarterly and yearly ADA employees' meeting.  
17 3. Marketing ADA library's strong collection on specific specialized subjects to ADA members to  
18 make the library unique:  
19 i. Practice Management  
20 ii. Dental Implant  
21 iii. Dental Materials  
22 iv. Radiology  
23 v. Resources for EBD  
24 4. Promote library's historic book collection.  
25 5. Library and archives presence in the monthly edition of ADA News (no articles about the ADA  
26 library since 2011).  
27 6. "150 Reasons to Be a Member" should mention the Library (currently does not).  
28 7. Library presence in the yearly "Member Benefits" brochure (currently does not).  
29 8. Information on ADA library new resources and services mailed to all active library patrons.  
30 9. Information on ADA library new resources and services sent as a mass email to all ADA  
31 members.  
32 10. Information on library new resources and services sent to all other dental associations,  
33 organizations, virtual groups to spread the word about existence of transformed ADA library  
34 (and to correct obsolete information and links).  
35 11. Online and print promotion of the digitized collection of artifacts and photos.  
36 12. Literacy training classes on using new library resources online and in-person at the library.  
37 13. Request promotional material from vendors; any 'freebies' available for ADA  
38 members/patrons of ADA library and archives.  
39 14. Social media:  
40 i. Starting library blog (for example, post interesting research results)  
41 ii. Starting archives blog (for example, post interesting research results)  
42 iii. Facebook presence (and control over people who use ADA logo for  
43 advertisement)  
44 iv. "Ask a librarian" feature  
45 15. Director of ADA library attends the ADA Annual Session to provide information on ADA library  
46 resources and database usage training to ADA members.  
47

48 **F. ADA Library and Archives Staff**  
49

- 50 1. Change in responsibilities for all library and archives staff members, as workload shifts from  
51 step-by-step processes to more dynamic, complex tasks.  
52 2. Incorporate standards for providing continued prompt, accurate service to ADA members in  
53 job descriptions and performance reviews.

- 1 3. Training in all new purchased resources and services, as a key to successful e-journal  
2 management is proper staffing and proper training.
- 3 4. Refresher training in existing products, as the resources and their usage/maintenance  
4 change.
- 5 5. Cross-trained staff as a goal for uninterrupted library and archives services delivery.
- 6 6. Each library and archives electronic software product needs to have a trained back-up  
7 system administrator (library staff). One staff member – electronic resources librarian -  
8 dedicated to unique electronic resources management (technical issues, vendor  
9 communication, licensing, different workflow functions, access set-up, troubleshooting, usage  
10 statistics for services renewals, etc.).
- 11 7. Participation of all library and archives staff in demos of all new purchased resources and  
12 services.
- 13 8. Library staff delivers instructional services of information literacy training to patrons/ADA  
14 members.
- 15 9. Library staff will create resource guides for specific topics.
- 16 10. Library culture should reflect each individual's role as a contributor to the new library mission  
17 and goals.  
18

## 19 F. Other

- 20 1. Anticipated reference books and e-books annual expenses - \$3,000
- 21 2. Archives will benefit greatly from having an additional, temporary part-time position (for  
22 approximately 2 years) to aid in digitization of the collection. After data is entered into the  
23 archival management system anybody can use it, retrieve documents/information. Without  
24 transferring the archival collection in a hierarchical and systematic way to the electronic  
25 system, the retrieval and finding documents may not be possible-\$85,000 salary and benefits  
26 for two years.
- 27 3. Purchasing new products-purchase of new resources and services in 2013 will require  
28 contingency funding. All the quotes have a deadline for purchasing after which the quoted  
29 prices will no longer be applicable. Extension of expiration date for all the quotes was  
30 requested, with the expiration date of June 15, 2013, from all the vendors received (see  
31 Appendix 7 for list of upgraded products and costs for 2013.)
- 32 4. ADA library proforma budget for 2011-2015 (Appendix 8)-anticipate maintaining current  
33 staffing at four full-time and one full-time director. Reconfiguration of library space to be done  
34 in conjunction with restacking of entire building. The Taskforce has also submitted a  
35 contingency funds request to the Board of Trustee's Finance Committee (June 2013 Board of  
36 Trustees meeting) for the initial purchases of licenses, software, and database access of  
37 \$129,300.
- 38 5. The Taskforce recommends that pertinent historic artifacts, historic texts, and certain unique  
39 and artistic gifts be displayed in a public location (preferably the ADA Building lobby), or a  
40 "traveling display" of unique ADA possessions that could be offered to state and/or  
41 constituent dental societies for display at their annual meetings, etc.  
42

## 48 VI. Summary of Enhanced Member Value through Implementation of the 49 Transition Plan

- 50 • Expansion of ADA member access to electronic journals and research databases, increasing  
51 ADA member capabilities in employing EBD.  
52

- 1 • Maintenance of the ADA leadership role as the source for EBD.
- 2 • New links to on-demand, clinical dentistry tools that can be accessed daily to enhance the
- 3 treatment of patients.
- 4 • Digitation of the ADA archives, allowing for direct member access of materials through the ADA
- 5 website. Potential revenue source through purchasing of digitized materials.
- 6 • Redesign and simplified navigation to library & archives page from the ADA mainpage, along with
- 7 improved functions and ease of navigation of the electronic library through a website redesign.
- 8 • ADA library print book collection supplemented and enhanced by the UIC Medical Center Library
- 9 print book collection, with increased access to the print collection on evenings and weekends at
- 10 the UIC Medical Center Library.
- 11 • Access to the print medical literature and journal collection at the UIC Medical Center Library.
- 12 • Operational policies and procedures in place to assure that library resources are evaluated and
- 13 up-graded on a regular basis.
- 14 • Library staff development and cross-training to ensure continued excellent service to the ADA
- 15 member. ADA library staff will be able to provide services in a more effective and efficient
- 16 manner.
- 17 • Efficient use of space within the ADA Headquarters Building.

18

**List of Appendices**

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- Appendix 1-Minutes of Taskforce Meetings
  - Appendix 2- ADA Library Budget 2012-2013
  - Appendix 3-ADA Library Resource Relevance and Vitality Policy
  - Appendix 4-Annual Copyright License Agreement
  - Appendix 5-Proposed MOU between ADA and UIC
  - Appendix 6-Journal Title List
  - Appendix 7-New Products List
  - Appendix 8-ADA Library Budget 2011- 2015
- (1) From Redefining the Academic Library-*Managing the Migration to Digital Information Services*, University Leadership Council • Education Advisory Board  
2445 M Street, NW • Washington, DC 20037  
Telephone: 202-266-6400 • Facsimile: 202-266-5700 • [www.educationadvisoryboard.com](http://www.educationadvisoryboard.com)

## APPENDIX 1

### MINUTES

#### Board of Trustees Taskforce on ADA Library Transition Plan (Resolutions 159H-2012)

Tuesday, January 8, 2013, Conference Call

**Call to Order:** The Chair, Dr. Joseph Hagenbruch, called a meeting of the Board of Trustees Taskforce on ADA Library Transition Plan to order at 5:06 P.M. (central time) on Tuesday, January 8, 2013, via conference call.

**Roll Call:** Taskforce Members: Dr. Joseph Hagenbruch, 8<sup>th</sup> District Trustee, chair; Dr. Joseph Crowley (7<sup>th</sup> District); Dr. Julian (Hal) Fair III (16<sup>th</sup> District); and Dr. Gary Roberts (12<sup>th</sup> District). ADA Staff: Dr. Anthony J. Ziebert, senior vice president, Education/Professional Affairs; and Mary Kreinbring, director, ADA Library.

**Conflict of Interest Reminder:** Dr. Hagenbruch read the following statement: “In accordance with the ADA Disclosure Policy, at this time anyone present at this meeting is obligated to disclose any personal or business relationship that they or their immediate family may have with a company or individual doing business with the ADA, when such company is being discussed. This includes, but is not limited to insurance companies, sponsors, exhibitors, vendors and contractors.” No conflicts were noted.

**Review of the Taskforce’s Charge:** Dr. Hagenbruch noted the Task Force’s charge, reviewing House of Delegates Resolution 159H-2012.

**Review of the Mission of the ADA Library:** The Taskforce members reviewed the mission statement and the operational goals/objective of the ADA Library and noted that it has not been revised since the previous ADA strategic plan (2007-2010)(Appendix 1). The Task Force came to the consensus that the mission statement and goals/objectives need to be updated to reflect the current ADA Strategic Plan (2011-2014). Staff was directed to provide updated language for review at the next meeting of the Task Force.

**Review of Goals and Objectives of the Library Transition Plan:** The Task Force members reviewed the goals and objectives of the Library Transition Plan (Appendix 2) and came to the consensus that they were appropriate and can serve as a guideline for the transition planning. Staff then reviewed for the Task Force the library services that will continue to be provided in 2013, and those services that have been discontinued due to the House of Delegates decision to fund library expenses at approximately 50% of the 2012 level. The vast majority of library expenses go to salary and benefits for employees. The library staffing level has been reduced from 10 full-time employees and three part-time employees, to five full-time employees. Continuing services for 2013 include:

- Reference services and online literature searches.

- Journal subscriptions, although the current, full complement of journals will not be available due to the budget cutbacks. There is a question as to whether the current list of journals, while comprehensive, is actually necessary to meet the article requests that are received, as some journals are never utilized. Staff acknowledged that an analysis of the most relevant and appropriate journal subscriptions has not been completed.
- Requested journal articles will continue to be sent to members, either as a mailed paper copy, or as a PDF document.
- Inter-library loans.
- Online requests for articles.
- ADA archives and all ADA publications.
- On-site usage and access to the book collection will be for ADA members only, and by appointment.

ADA staff from other divisions (Science, in particular) will continue to have access to library resources.

**Services that have been discontinued in 2013 include:**

- The buying of new books.
- Lending of books, except in the instance of on-site member usage.
- Cataloguing and binding of books.
- On-site usage for the public.
- Direct access to the Cochrane database for members, although in the past, the funds for Cochrane have not been part of the operating budget of the library. At the 2012 House of Delegates, there was no resolution presented to restore funding for member access to the Cochrane database.

Finally, staff reported that some services may take longer to provide and some fees will possibly need to be raised slightly.

**Review of the List of Internal (ADA Staff) and External (ADA Member and Public)**

**Stakeholders Invited to January 25-26, 2013 Meeting:** The Task Force reviewed the list of guests invited to discuss ADA library resources. Most guests have been confirmed as attending either in-person, or via conference call. Staff is generating a set of questions for each guest which will be tailored to their area of expertise and these questions will be reviewed by the Task Force prior to sending to the guests.

**Next Steps:** The Task Force scheduled a follow-up conference call for January 15, 2013 at 5:30 PM, central time. The Task Force also requested staff to compile supplemental information related to the library budget; the nature of the library book collection; electronic resources; copyright; and patron/ADA member comments related to library services.

**Adjournment:** The meeting was adjourned at 6:00 pm.

## Appendix 1

### Mission of the ADA Library

The mission of the ADA Library is to support the ADA in the quest to provide oral health care that is based on scientific principles and to support life-long learning for its members (Strategic Plan 2007-2010, Guiding Principle, Values, and Beliefs)

## Appendix 2

### Goals and Objectives-Library Transition Planning

1. Determine the most significant, unique member value services that can be provided in the short term (2013) within the 2013 budget and staff size.
2. Develop a plan for long term delivery of services for both ADA members and ADA staff in support of ADA members, EBD and ADA policy.
3. Maintain the information resources necessary to the success of the ADA as the leading oral health care authority:
  - Clinical dentistry
  - Oral health research
  - National oral health care policy
  - Historical records of the association
  - Evidence-based Dentistry
  - Development of Clinical Guidelines
4. Provide ADA members with professional information services:
  - Fact-finding
  - Verification
  - Reference
  - Online and internet assistance
  - Recommendations on outside sources of information
5. Determine the extent of technological upgrades and additional services needed to be relevant into the future and identify sources of funding.
6. Determine the disposition of the book collection which allows for member access.

## MINUTES

### Board of Trustees Taskforce on ADA Library Transition Plan (Resolutions 159H-2012)

Tuesday, January 15, 2013, Conference Call

**Call to Order:** The Chair, Dr. Joseph Hagenbruch, called a meeting of the Board of Trustees Taskforce on ADA Library Transition Plan to order at 5:30 P.M. (central time) on Tuesday, January 15, 2013, via conference call.

**Roll Call:** Taskforce Members: Dr. Joseph Hagenbruch, 8<sup>th</sup> District Trustee, chair; Dr. Joseph Crowley (7<sup>th</sup> District); Dr. Julian (Hal) Fair III (16<sup>th</sup> District); and Dr. Gary Roberts (12<sup>th</sup> District). ADA Staff: Dr. Anthony J. Ziebert, senior vice president, Education/Professional Affairs; and Mary Kreinbring, director, ADA Library.

**Conflict of Interest Reminder:** Dr. Hagenbruch read the following statement: “In accordance with the ADA Disclosure Policy, at this time anyone present at this meeting is obligated to disclose any personal or business relationship that they or their immediate family may have with a company or individual doing business with the ADA, when such company is being discussed. This includes, but is not limited to insurance companies, sponsors, exhibitors, vendors and contractors.” No conflicts were noted.

**Discussion of Draft Mission Statement:** The Task Force reviewed the mission statement that was updated by staff to reflect the current ADA strategic plan (Appendix 1). The Task Force approved the mission statement with no further revisions.

**Discussion of Supplemental Documents:** The Taskforce members reviewed the documents provided by ADA staff related to the library budget; the nature of the library book collection; electronic resources; copyright; and patron/ADA member comments related to library services.

**Review Updated List of Internal (ADA Staff) and External (ADA Member and Public) Stakeholders Invited to January 25-26, 2013 Meeting:** The Task Force reviewed the list of guests invited to discuss ADA library resources. Ms. Kreinbring reported that all the guests have been confirmed as attending either in-person, or via conference call, although the exact time on the schedule for a few of the guests still needs to be confirmed (Appendix 2-Final Schedule). Ms. Kreinbring expressed that she will notify the Work Group via e-mail with any updates on the schedule as they occur. Staff generated a set of questions for each guest and the Task Force approved sending the questionnaires to the guests prior to the meeting. The Task Force discussed keeping everyone focused on the questions during the meeting, in particular the questions about library service utilization and recommendations on how to transition the library to more electronic resources (Appendix 3).

**Next Steps:** Task Force meeting in Chicago on January 25-26, 2013.

**Adjournment:** The meeting was adjourned at 6:10 pm.



## Appendix 1

### Mission of the ADA Library

The mission of the ADA Library is to support the American Dental Association in its quest to provide oral health care that is based on scientific principles and to support lifelong learning for its members. (Strategic Plan, 2011-2014, Beliefs, Goals and Objectives)

The **Strategic Plan, 2011-2014** expresses the **Belief** that “oral health care must be based on scientific principles derived from high quality research”, and that “excellence in dental education, research and lifelong learning is critical to the future of the profession.”

#### **ADA Goals and Objectives:**

As the Strategic Plan indicates, the Association seeks to

- 1) “...provide support to dentists...throughout their career” (Strategic Plan, Goal 1). The Association believes that a true profession:
  - a) Embraces “an expanding body of professional knowledge driven by high quality research and analysis” (Goal 1, Objective 1)
  - b) Sustains “the highest level of knowledge, skills and values for the dentist” (Goal 1, Objective 1a)
- 2) “Be the trusted resource for oral health information” (Strategic Plan, Goal 2). The Association promotes oral health literacy by:
  - a) Providing “easy access to evidence based, appropriate and timely oral health information” (Goal 2, Objective 1)
  - b) Fostering the “creation and transfer of knowledge” (Goal 2, Objective 1a)

#### **Library Goals and Objectives:**

The Library seeks to fulfill the ADA’s aspirations through the following goals and objectives which support the dental profession directly and the public through the profession.

#### **Goal # 1. Resources:**

##### **Objectives**

##### ***Information Sources***

To maintain and develop a comprehensive collection of information resources, in various formats, on clinical dentistry, oral health research, dental practice management, and related subject areas.

##### ***Archives***

To preserve the vital records of the Association, and provide historical documentation and context relating to the Association, its members, activities, and accomplishments.

### ***Access***

To provide and facilitate user access to the collection and other dental information resources, using new technology where available and applicable.

### **Goal # 2. Services:**

#### **Objectives**

##### ***Information Services to Members***

To provide member dentists with professional information services by library staff, including fact-finding, verification, reference, online searching, internet searching assistance, recommendations of information resources, and referrals to other contacts and sources of information.

##### ***Information Support for Staff***

To assist ADA staff to locate and utilize the information necessary to perform their jobs and respond to member needs, including instruction in the use of relevant information resources.

##### ***Archival and Historical Services***

To provide archival and historical services to support and enhance Association activities.

##### ***Service to Others***

To provide select oral health resources and services to other libraries, other health professionals, and government and social agencies as needed.

Appendix 2

**BOT Work Team on Library Transition  
Schedule--1/25-1/26--Video Conference Room--22nd Floor**

	FRIDAY			SATURDAY		
TIME	Name	Affiliation	Method	Name	Affiliation	Method
8:00				BOT Work Team	BREAKFAST Executive Dining Room	
8:30	BOT Work Team	BREAKFAST Executive Dining Room				
9:00	BOT Work Team	Pre-Meeting Discussion		Julie Schiavo	Dental Librarian, LSU Chair of Med Lib Assn Dental Section	By phone
10:00	Jim Shedlock Heidi Nickisch Duggan	Director, Associate Director, Northwestern Univ Galter Health Sciences Library	In-person	Dr. Steve Chan, CA	President, Calif Soc of Pedr Dent /Past HOD member /Former President, Calif Dent Assn	By phone
11:00	Jim Berry Liz Maxwell Judy Jakush	ADA Staff, Publishing Division	In-person	Dr. Mary Hayes, IL	Former HOD Member ADA Spokesperson Degreed Librarian	In-person
12:00	BOT Work Team	LUNCH Executive Dining Room		Austin Booth	Vice-Provost, Libraries, SUNY, Buffalo	Work team discussion of submitted PDF
12:30				BOT Work Team	LUNCH Executive Dining Room Discussion & Wrap-up	
1:00	Liz Bronson Tera Lavick	ADA Staff, Membership Division	In-person			
2:00	Julie Frantsve- Hawley Helen Ristic John Malone	ADA Staff, Science Division, Center for EBD, Dept of Scientific Information	In-person	<i>Afternoon refreshments will be delivered before 3 pm</i>		

<b>3:00</b>	Dr. Warren Jesek, IL Dr. Harvey Mahler, IL	Members On-site users	By phone In-person
<b>4:00</b>	Dr. Jane Gillette, MT Dr. Elliot Davis, NY Dr. George Priest, SC Dr. Michael Scheidt, CO	Members Remote Users	By phone
<b>5:00</b>	BOT Work Team	Post-meeting Discussion	

Appendix 3

**Questions—ADA Library Transition Sessions**

*Health Science Librarians*

**Jim Shedlock and Heidi Nickisch Duggan, Northwestern Univ**

How does digital vs. print compare in customer service, convenience, and cost? How easily did your users adapt to digital?

Please address “owning vs. licensing” as the latter may not include access to journal backfiles. How do you ensure access to older literature that may be needed for research?

Please describe Northwestern University’s new storage facility. What access issues exist, if any, with such remote storage of materials?

What access issues exist with providing digital content to remote patrons? (Either technical or legal)

What is your library’s experience with e-books?

How do you develop health professionals’ information literacy, search skills, and understanding of copyright limitations?

Please provide a brief summary of your library’s experience with clinical chair-side tools such as DynaMed and UpToDate.

## Questions—ADA Library Transition Session

### *Dental Librarian*

**Julie Schiavo, LSU**

How does digital vs. print compare in customer service, convenience, and cost? How easily did your users adapt to digital?

Please address “owning vs. licensing” as the latter may not include access to journal backfiles. How do you ensure access to older literature that may be needed for research?

What is your library’s experience with e-books?

From your perspective, what information resources and services are (or were) available to dentists and dental libraries only through the ADA Library?

How might the recent changes in ADA library services affect dentists and the dental library community?

What alternative information resources and services might dental school libraries provide for non-affiliated dentists, both local and remote, and at what cost?

You have previously written about studies showing that information professionals provide crucial support to health researchers and clinicians. Could you summarize that evidence for us?

What information resource and services should the ADA Library offer in the future to support information delivery to the dental profession and the dental library community?

### **Questions—Library Transition Sessions—Staff**

What ADA Library resources and services do you or did you use the most?

How will the recent changes affect your work or the services of your division? Other ADA divisions as well?

From your perspective, what information resources and services are (or were) available only through the ADA Library?

With the recent changes to the ADA Library, what alternative sources are you using or do you expect to use? How do the alternatives compare in resources, service, convenience, and cost?

What information resource and service enhancements should the ADA Library offer to provide the greatest value to staff in your division and others? To fill members' needs and enhance perceptions of value?

### **Question—Library Transition Sessions—ADA Members**

What ADA Library resources and services do you or did you use the most?

How will the recent changes affect your practice, research, scholarship, etc.?

From your perspective, what information resources and services are (or were) available only through the ADA Library?

With the recent changes to the ADA Library, what alternative sources are you using or do you expect to use? How do the alternatives compare in resources, service, convenience, and cost?

What information resource and service enhancements should the ADA Library offer to provide the greatest member value?

Would you be willing to pay more for direct access to electronic resources?

## MINUTES

### Board of Trustees Taskforce on ADA Library Transition Plan (Resolutions 159H-2012)

Friday and Saturday, January 25-26, 2013  
ADA Headquarters Building

**Call to Order:** The Chair, Dr. Joseph Hagenbruch, called a meeting of the Board of Trustees Taskforce on ADA Library Transition Plan to order at 8:34 A.M. (central time) on Friday, January 25, 2013, at the ADA Headquarters Building in Chicago.

**Roll Call:** Taskforce Members: Dr. Joseph Hagenbruch, 8<sup>th</sup> District Trustee, chair; Dr. Joseph Crowley (7<sup>th</sup> District); Dr. Julian (Hal) Fair III (16<sup>th</sup> District); and Dr. Gary Roberts (12<sup>th</sup> District). ADA Staff: Dr. Anthony J. Ziebert, senior vice president, Education/Professional Affairs; and Mary Kreinbring, director, ADA Library.

**Conflict of Interest Reminder:** Dr. Hagenbruch read the following statement: “In accordance with the ADA Disclosure Policy, at this time anyone present at this meeting is obligated to disclose any personal or business relationship that they or their immediate family may have with a company or individual doing business with the ADA, when such company is being discussed. This includes, but is not limited to insurance companies, sponsors, exhibitors, vendors and contractors.” No conflicts were noted.

**Pre-meeting Discussion:** The Chair asked Dr. Ziebert to provide a summary of the goals of the transition plan for the library. Dr. Ziebert stated that there are fundamental changes taking place in how information is delivered. All libraries are going through the process of maximizing resources through expanded use of electronic and digital means of conveying information. The ADA library is being affected by these same changes. The Task Force has been charged with ensuring that the resources for evidence-based dentistry are not only maintained as a valuable member benefit, but also updated so that the library can enter the 21<sup>st</sup> century. In addition, the Task Force has been charged with developing a plan that addresses the concerns of those members that still utilize the book collection. The challenge is to find a place to house the book collection so that it remains intact, with continued member access. The future, however, lies in the efficient searching for knowledge through electronic databases, where the library serves as a knowledge resource center. Dr. Ziebert concluded by stating that several guests over the next two days will be talking about how they transitioned their traditional libraries to knowledge resource centers. For example, Galter Library at the Northwestern University Medical Center is moving all their texts to an off-site storage facility, and at the same time enhancing electronic resources. Ms. Kreinbring clarified the difference between the archives and the historic book collection. The archives are the official historic documents of the association, while historic book collection is probably the most comprehensive collection of historically relevant texts in the world, some of which date to the 1700’s. Some dental schools still have libraries dedicated solely to dentistry, as opposed to medical center libraries that house dental texts. Strong dental school libraries are located at the University of Southern California, University of Missouri at Kansas City, Louisiana State University, Eastman in Rochester, and the University of Michigan. The current ADA collection is approximately 40% books, and 60% journals, with approximately 50,000 total



titles. The reference librarians still have the capacity to help members with PubMed and Medline searches. Some members do the search themselves and request articles from the library staff, while other members do not have experience in searching databases, and in those cases, the library staff will help with the search itself. Dr. Crowley stated that he agreed that the Task Force needs to find a way to keep the book collection intact, but at the same time, the Task Force needs to determine what needs to be enhanced in order to serve the members. The Task Force was provided pre-meeting information relative to the ADA Library, in terms of the Library Budget, ADA Library practices already curtailed or eliminated and staff details regarding number of employees, whether part-time or full-time and their designated duties. It was acknowledged that There has been no volunteer oversight for the ADA Library. Ten years ago (give or take a few months) the ADA Library was moved down to the 6<sup>th</sup> floor of the ADA Building from the 19<sup>th</sup> floor. The 6<sup>th</sup> floor was purposefully reinforced to sustain the unusually excessive weight of the ADA Library collection of material. The space for the library was downsized to about one half of the 6<sup>th</sup> floor. It was noted that the library had more space (three-fourths of the floor) when it was located on the 19<sup>th</sup> floor. Over 25,000 volumes were eliminated. These thousands of documents were deemed as redundant or unnecessary and were either sold off at bargain-basement prices, given away or, if not sold or given away, were destroyed. Many were in not written in English.

### **Summary of Guest Comments:**

**Mr. Jeff Gartman** (Reference and Online Services Librarian, ADA Library):

- Dentists have not been trained in the use of PubMed like physicians.
- In the past, he has conducted seminars at the ADA Annual Session on how to do a literature search with PubMed.
- He has found that he needs to spend time teaching members how to find information.
- He assists dentists that do not have access to a local dental school or health center library and the scope of their requirements for information needs to be determined.
- Electronic licensing is thorough but expensive as well

**Mr. Jim Shedlock** (Former Director (retired), Northwestern University Galter Health Sciences Library)

**Ms. Heidi Nickisch Duggan** (Associate Director, Northwestern University Galter Health Sciences Library):

- Mr. Shedlock has been a medical librarian in academic libraries since 1977.
- The print collection for all Northwestern Libraries has been put into storage. No one designated to manage this information at this time. Current materials are only available in a digital format.
- The collection is driven by basic science research.
- 98% of the acquisition budget is for electronic resources
- Northwestern is only digitizing their special collections and small collections. Digitization of existing print materials is very expensive. It is more cost-effective to purchase electronic back-files of existing periodicals from publishers, although the cost can vary considerably.
- The biggest challenge for the Galter Library will be electronic storage.

- The rare book collection will remain intact; however, the library is not the place that people go to view the collection. Increasingly, people want electronic access.
- Expectations and duties of librarians have changed considerably. At the Northwestern Medical School, librarians are now attending patient rounds with physicians providing on-demand answers.
- E-books/texts are acquired differently than written texts have been acquired in the past. The e-book is not bought and then provided for unlimited access for everyone. Now, access to a pool of e-books is purchased, and pricing also depends on the number of “clicks” an e-book receives. This is on-demand pricing.
- Other ways to mitigate the costs of acquisitions is through consortium purchasing (for instance, Northwestern is in a consortium of Big 10 Universities). There can also be local consortiums, and inter-library loan. However, the issue with inter-library loan is that if the library will not or cannot lend to other libraries, then the library would not be able to borrow from other libraries. This implies that you have some resources that other people do not have and that they want your resources.
- Another suggestion to mitigate costs is the creation of a subscription library and charging members for access to the collection and reference services. A potential model of a private science library that the ADA may wish to investigate is the Linda Hall Library.
- The Galter Library budget is approximately five million dollars.
- It was Ms. Duggan’s impression that the American Medical Association dispersed their entire print collection last year.
- There is an oversight group that aids the librarians allocating resources for acquisitions.
- Northwestern’s Library related budget is \$5,000,000
- These individuals do not have an accurate monetary figure established that accurately determines what the expense is relative to a “per person” use of their library system.
- Other library models were mentioned such as the Linda Hall Library in Kansas City, a private science library that is run off of an economic model

**Mr. Jim Berry** (Associate Publisher, *JADA*)

**Ms. Judy Jakush** (Editor, *ADA News*)

**Ms. Elizabeth Maxwell** (Editorial Director, *JADA*):

- The ADA staff from the Division of Publishing reported that they use the ADA library for the following services: fact-checking for brochures and *ADA News* “My View” articles; confirmation of proper citations for scientific papers published in *JADA*; the WorldCAT database; and access to specialty organization journals.
- Concern was expressed that access to all resources would become unavailable once the budget reductions took effect. The Task Force members responded that resources will still be available and that electronic resources will be enhanced.

**Ms. Elizabeth Bronson** (ADA Manager, Membership Outreach and Council on Membership) **Ms. Tera Lavick** (ADA Director, New Dentist Committee and Office of Student Affairs):

- The ADA staff from the Division of Membership includes working with the American Student Dental Association (ASDA); the New Dentist Committee; and the Council on Membership.

- The staff reported that they use the ADA Library mostly for reference information contained within the ADA archives; marketing as one of several member benefits; and as a stop on tours of the ADA Headquarters Building. Over 600 people were given tours of the building in 2012, and most people were unaware that there was an ADA library. The ADA Library tours have been suspended. A lifting of the suspension and a date selected to once again resume library tours has not been determined at this time. The staff stated that the presence of the ADA Library tended to impress international visitors in particular.
- Staff stated that they felt they could still obtain necessary information from the Library, even with some of the announced changes in offered services.
- Ms. Lavick expressed that it was her impression, from her years of experience, that once out of school, former students often lose access to their respective school libraries
- Virtual Reality Programs for library access are not only expensive, but are also a rather new concept and are thus still undergoing development enhancements.

**Dr. Julie Frantsve-Hawley** (Director, ADA Center of Evidence-based Dentistry)

**Mr. John Malone** (ADA Manager, Scientific Information)

**Dr. Helen Ristic** (ADA Director, Scientific Information)

- The ADA staff from the Division of Science reported that they must work remotely on a regular basis, so virtual access is the most valuable service to them. They do not want paper copies of anything and the written texts in the collection are rarely, if ever, used.
- The staff expressed concern that the changes will affect their ability to efficiently get the resources they need; however, they have come to the conclusion that the changes are not as all-encompassing as originally thought.
- Dr. Ristic expressed that she relies on staff assistance when she needs to search for documents.
- A name change for the Library was mentioned as a plausible option in this section of the interviews. Suggestion surfaces such as ADA Resource Center and ADA Media Center

**Dr. Warren Jesek** (General Dentist, Decatur IL, via conference call)

**Dr. Harvey Mahler** (General Dentist, Chicago, in-person):

- Dr. Jesek utilizes the library for journal articles. He prefers paper copies. He stated he is bitter about the library budget decrease.
- Dr. Mahler is a heavy user of the library, at least two-three times per month. He is an inventor and is on the speaker circuit. He is concerned about the legacy of the ADA if the library is no longer available for member use. He stated that he does not believe members take full advantage of the ADA librarian's knowledge of dental literature. He is also bitter about the library decision. He did not agree with the idea of charging user fees to raise revenue. He felt it is a member benefit that is included in the dues.
- Both members felt the library should be promoted as a resource or member value. A suggestion was made to create a web page called "Ask a Librarian." They were also very concerned about losing the physical space. Both admitted that they were not "tech savvy" regarding utilizing electronic library sources.

**Dr. Elliot Davis** (General Dentist, New York)

**Dr. Jane Gillette** (General Dentist, Montana)

**Dr. George Priest** (Prosthodontist, South Carolina): These ADA member dentists all participated via conference call.

- Dr. Davis emphasized that reference librarians are the key to the service offered by the library. He has had problems utilizing Google Scholar and PubMed. The proper number of reference librarians is needed to ensure that members get the best possible service. He has attempted to use the NYU dental library, but in his opinion, they do not have the skill set to develop successful searches like the ADA librarians. He admitted he has not utilized the NYU dental library since he was a student thirty years ago.
- Dr. Gillette emphasized that the librarians teach research/search strategies and reliable evidence. She uses the ADA library mostly for copies of manuscripts and access to for the Cochrane Library. She stated that EBD cannot be promoted by the ADA without the ability to utilize the Cochrane database.
- Dr. Priest does his own PubMed searches and utilizes the library to get copies of articles. He does not personally utilize the reference librarians, but believes reference librarians need to be maintained. He suggested that electronic resources need to be increased. He has no experience with the Cochrane database.

#### **General Task Force Discussion prior to recess**

- In general, staff utilization of ADA Library varied considerably depending on the Department and the particular needs of each individual
- Suggestion presented to send out a questionnaire/survey to each ADA Department for each member of the staff to complete so as to more closely determine staff use of the library services
- ADA Library expenses can be determined, but what cannot be assessed is what the costs would be to members and staff if they had to gather their information and conduct their research without the benefit of the ADA Library
- Ms. Kreinbring stated that about 100 ADA staff use the ADA Library on a regularly repeated basis related to their job, for support and information

**Meeting Recess:** The meeting was recessed at 5:15 P.M. until Saturday, January 26, 2013 at 8:30A.M.

Board of Trustees Taskforce on ADA Library Transition Plan  
(Resolutions 159H-2012)

Friday and Saturday, January 25-26, 2013  
ADA Headquarters Building

**Meeting Reconvened**

**Call to Order:** The Chair, Dr. Joseph Hagenbruch, called a meeting of the Board of Trustees Taskforce on ADA Library Transition Plan to order at 8:30 A.M. (central time) on Saturday, January 26, 2013, at the ADA Headquarters Building in Chicago.

**Roll Call:** Taskforce Members: Dr. Joseph Hagenbruch, 8<sup>th</sup> District Trustee, chair; Dr. Joseph Crowley (7<sup>th</sup> District); Dr. Julian (Hal) Fair III (16<sup>th</sup> District); and Dr. Gary Roberts (12<sup>th</sup> District). ADA Staff: Dr. Anthony J. Ziebert, senior vice president, Education/Professional Affairs; and Mary Kreinbring, director, ADA Library.

**Conflict of Interest Reminder:** Affirmed from the Friday, January 25, 2013 meeting.

Ms. Kreinbring requested a moment or two to offer information on Cochrane. Yesterday her testimony on the Cochrane Library, relative to the ADA's utilization, was in her own words rather sketchy. She expressed that she had done some checking since the meeting recess yesterday. She expressed that the ADA's fee for Cochrane usage covers about 1,000 people and the approximate annual charge is \$2,558.00. Very brief discussion followed on this information. Ms. Kreinbring then put forth somewhat of a rhetorical query: "What is the cost for being a relevant library?" There was concurrence, among those assembled, that the work of the ADA Library Task Force expects to shed some very meaningful light on this question.

**Summary of Guest Comments:**

**Ms. Julie Schiavo** (Assistant Professor, LSU School of Dentistry Library and 2012-2013 Chair, Dental Section, Medical Library Association): Ms. Schiavo participated via conference call.

- Ms. Schiavo stated that the dental library at LSU School of Dentistry is mostly digital. After hurricane Katrina, the library had no option but to go in the electronic collection due to the irreparable damage to the print collection. At the medical center, they are not quite at the "virtual" library stage yet, although they are working in that direction. Approximately 40% of the journal collection is not back-filed.
- Younger users expect to be able to access library resources from home. Older faculty members prefer hard copies of documents.
- E-books are not as plentiful in dental area compared to medical/nursing.

- StatRef is a collection of e-books. They are a good company to work with.
- Practicing dentists who are alumni can access the LSU collection. Fees for each article are \$11.00.
- Ms. Schiavo believes that the ADA is considered the national authority on historical questions.
- She recommended marketing the libraries expertise in evidence-based dentistry to new dentists. They are graduating from school expecting to use EBD to make clinical decisions. The experience at LSU is that students who use the Cochrane database have had success with it.

**Dr. Steven D. Chan** (President, California Society of Pediatric Dentistry; Former President, CDA; Former Member, California Library Commission): Dr. Chan participated via conference call.

- Dr. Chan has had significant experience with public libraries. He was involved with his local city library, which had a service area of three million people; 750,000 volumes; 5000 audio/visual titles; and 500 periodicals. The budget was 31 million dollars per year and 5 million dollars per year was spent on book purchases.
- The ADA historic collection is very important to him, although he knows he can get the information from other sources.
- He views the importance of the ADA library from the reputation management perspective of the Association and the profession. He does not agree that user fees should be charged.
- He is not a regular user of the library, but his intent was to bring a big picture perspective to the discussion.

**Dr. Mary Hayes** (Pediatric Dentist, Chicago; Past CDEL Member; Master's Degree in Library Science): Dr. Hayes participated in-person.

- Dr. Hayes stated that a library is an efficient way to organize information. She is disappointed that the ADA library is not buying books and she maintained that ADA internal departments rely on books to perform their job functions.
- Expressed that the library needs a strategic plan and a study of the types of information services that will be needed in the future.
- She is not a regular library user.

**Review of Meeting:** The Task Force discussed their overall impressions of the two days of interviews. The Task Force felt a strong consensus that a volunteer oversight group, similar to what was described by Ms. Duggan at the Galter Library, is necessary. The library has been conspicuous in its absence from the ADA Strategic Plan and must be included when the new plan is formulated. A library marketing plan is also crucially needed. As is happening with many

libraries, the ADA library should be viewed as an ADA resource center. Library metrics need to be tracked more closely, especially for the internal ADA staff users. Overall, the Task Force felt the meetings were valuable, and while this input should have been solicited before the budget decision, the interviews confirmed that it is time for the ADA library to enhance electronic and digital resources. Aspects of the book collection (historical) may be important to retain on-site; however, there are advantages to reallocating resources away from traditional texts. The Task Force would like to further consult on the transition planning with Ms. Schiavo from LSU.

**Next Steps:**

1. Dr. Hagenbruch and Dr. Ziebert will be visiting the UIC Medical Center Library at the invitation of Dental School Dean Bruce Graham. The UIC library has extensive dental resources and has offered to discuss the possibilities of making access available to any ADA member for a fee similar to what alumni of the school might pay an annual alumni fee (for example ~\$50.00).
2. A written plan must be completed in March, with final budget numbers completed in May, for a final report to the June Board of Trustees.
3. A follow-up conference will be arranged.

**Adjournment:** The meeting was adjourned at 2:15 P.M.

Meeting with Kate Carpenter (Professor & Assistant University Librarian (LHS) & Associate Dean Director, Greater Midwest Region, National Network of Libraries of Medicine) and Kevin O'Brien (Clinical Asst Professor & Asst Special Collections & Access Services Librarian) at UIC Medical Center Library

### **Meeting with UIC Health Sciences Library Staff**

**Wednesday, February 5, 2013**

**Second Floor, East Reference Room, UIC Health Sciences Library**

Dr. Bruce Graham, Dental College Dean at University of Illinois Chicago College of Dentistry, facilitated a meeting between Ms. Kathryn Carpenter and another of her colleagues at the UIC Health Sciences Library (M/C 763, 1750 West Polk Street, Chicago, Illinois 60612) and Drs. Anthony Ziebert and Joseph Hagenbruch. Dr. Graham also attended the meeting in its entirety.

The essential substance of the meeting was discussion on the possibilities and potential for the Health Sciences Library to partner with the ADA Library in housing some of the ADA Library book volumes and select other library related materials. A leading objective of this meeting was the discussion to bringing about a valued, potentially advantageous and mutual benefit in having ADA Library documents and materials housed at the UIC Health Sciences Library site for display, meaningful use and edification, while at the same time permitting ADA members and staff an ease of access to the material and information. After seeing the UIC facility, it became readily apparent that the facility does have a remarkable amount of space.

The entire meeting was exceedingly amiable and the conversation was most pleasant and very much encouraging. The members of the UIC Health Sciences Library were clearly very knowledgeable and impeccably professional in their demeanor. They immediately exhibited an interest in the concept. They expressed that they have no interest in duplication of documents, but expressed that new, unique and especially distinctive items would likely be of interest to them. Discussion on the subject of access revealed that all UIC Dental graduates have full admittance to the complete UIC Library System. The possibility of formulating a circumstance whereby ADA member dentists and ADA staff, regardless of whether they were graduates of the UIC College of Dentistry, could utilize the UIC Health Sciences Library was discussed with some favorable preliminary thought. However, this and other particulars will need to be investigated further during future discussion between the two parties. Further meetings between the ADA Library Task Force and the UIC Health Sciences Library are pending at this time and hinge upon the ADA Library Work Force deliberation as well as possible ADA BOT interests and concerns.

Respectfully,

Joseph F. Hagenbruch, D.M.D.



## MINUTES

### Board of Trustees Taskforce on ADA Library Transition Plan (Resolutions 159H-2012)

Tuesday, March 12, 2013  
ADA Headquarters Building

**Call to Order:** The Chair, Dr. Joseph Hagenbruch, called a meeting of the Board of Trustees Taskforce on ADA Library Transition Plan to order at the ADA Headquarters Building, Chicago, at 8:10 a.m. on Tuesday, March 12, 2013.

**Roll Call:** Taskforce Members: Dr. Joseph Hagenbruch, 8<sup>th</sup> District Trustee, chair; Dr. Joseph Crowley (7<sup>th</sup> District); Dr. Julian (Hal) Fair III (16<sup>th</sup> District); and Dr. Gary Roberts (12<sup>th</sup> District). ADA Staff: Dr. Anthony J. Ziebert, senior vice president, Education/Professional Affairs; Mr. Jeffrey Gartman, interim director, ADA Library; Ms. Grazyna T. Langguth, project manager, Library Transition Plan; and Ms. Katherine Barbush, administrative manager, Division of Education. Guests included Dr. Charles H. Norman, ADA president-elect; Dr. James K. Zenk (10<sup>th</sup> District); Dr. Terry L. Buckenheimer (17<sup>th</sup> District) and Dr. Kathleen T. O’Laughlin, executive director. Ms. Andrea Matlak, archivist and reference librarian, and Ms. Judy Jakush, editor ADA News, attended portions of the meeting.

**Conflict of Interest Reminder:** Dr. Hagenbruch read the following statement: *“In accordance with the ADA Disclosure Policy, at this time anyone present at this meeting is obligated to disclose any personal or business relationship that they or their immediate family may have with a company or individual doing business with the ADA, when such company is being discussed. This includes, but is not limited to insurance companies, sponsors, exhibitors, vendors and contractors.”* No conflicts were noted.

**Review of the Taskforce’s Charge:** Dr. Hagenbruch noted the Task Force’s charge, reviewing House of Delegates Resolution 159H-2012 , which states:

**159H-2012. Resolved,** that the library collections and physical space be maintained without disposition in 2013 and that appropriate agencies develop a transition plan for the library to be reported to the 2013 House of Delegates.

Dr. Hagenbruch reminded the Task Force that the report of the transition plan is due for the June 2013 Board of Trustees meeting, and the report will subsequently be submitted to the 2013 House of Delegates.

**Approval of Meeting Minutes:** Minutes from the following meetings were approved: January 8, 2013; January 15, 2013; and January 25-26, 2013.

**Metrics, categorization, and disposition of Books/Texts:** Dr. Ziebert reported that Mr. Jeff Gartman has assumed the position of *interim* director, ADA library services. Mr. Gartman reviewed the metrics and categorization of books/texts at the ADA Library:

1. Historic and unique
2. Historic and available at other libraries (eg., early editions of common textbooks)
3. Current and unique (e.g., ADA publications)
4. Current and available at other libraries
5. Product catalogues (historic)
6. Dental School Information Pamphlets/Booklets (descriptions of dental school academic programs-historic and current)

Most of the paper files and textbooks housed in the ADA library are used by ADA Publications and Science Divisions to confirm references in scientific articles and to document changes that have occurred in dental science through the different editions of the same textbook. In addition, the textbooks are utilized by the ADA Departments as reference texts. There are approximately 1200 member dentists who either check out textbooks on-site, or utilize the Library service of sending textbooks directly to the member (The ADA Library has an online catalogue). The member must then send the textbook(s) back within a specified amount of time. The ADA pays the postage for sending and returning the texts; however, there is a \$25.00 fee charged to the member, irrespective of the number of textbooks sent. Most of the time, the Library is sending out at least two textbooks for each mail order. Many times, this fee does not cover the postage. Mr. Gartman reported that ADA Library currently has no written policy on the management of the textbook collection. This has become problematic, with multiple copies of out-of-date editions of texts taking up significant space, along with texts that have limited or no usefulness for research or EBD. Mr. Gartman stated that two-thirds of the current textbook collection could be culled, with no loss of important reference texts for the ADA departments. The Task Force concurred that ADA Library staff should dedicate one full day per week to “right-sizing” the textbook collection. Mr. Gartman felt this could be accomplished within a year by dedicating every Friday to this task. Fridays tend to have a low call volume, and Library phones could be managed on this day by the ADA Call Center or by part-time staff as needed. The Taskforce came to consensus that if funding is needed for part-time staff to support this activity, this request for funds should be submitted to the Board of Trustees. Disposition of non-essential books could be accomplished by availing them to members for the cost of shipping. Constituent and component piecemeal journal collections can be returned to them; any contracts for book

storage with outside entities will be reviewed to ensure that the ADA is following its legal obligations. Donations of materials to the Library with no historic value can be offered to the members for the cost of shipping. The product catalogues and dental school catalogues are rarely, if ever, accessed by members or ADA staff and are of very little scientific value. The Task Force agreed that the product catalogs could be offered to the Dental Trade Alliance, while that the school catalogues could be offered to each school. Otherwise, there seemed to be little value in keeping them in the collection.

Ms. Langguth projected that 25% of the ADA Library collection can be digitized. Dr. Crowley volunteered to contact Head Librarian, Ms. Julie Schiavo, at the LSU Dental School Library, to get further information on the costs of digitization.

**Congruence of ADA Book Collection and UIC Medical Center Book Collection:** Mr. Gartman reported that he made a title-by-title comparison of both the historic and current texts in the ADA collection and the UIC Medical Center collection. In 2013, the UIC Medical Center contained more in its collection of current/new texts than the ADA Library. He made a comparison of book holdings by 12 subject areas (ADA vs. UIC) and found that the ADA Library has 4,697 titles and UIC has 1,926 titles of which 1,206 titles or 31% match the ADA holdings (Appendix 5). The ADA Library collection is stronger for older titles while UIC is stronger on current or new titles. It appears that those members who would like to continue to check out current textbooks on-site would have the opportunity to do so through a proposal by the Dean of the UIC School of Dentistry, Dr. Bruce Graham (Appendix 6). For an annual \$50 “alumni fee,” ADA members could have access to the entire UIC Medical Center collection. In addition, those members who request texts through the mail could still do so through interlibrary loan. Finally, the UIC text library could be filled in with texts from the ADA Library to make a more comprehensive collection housed at the UIC Library. Dr. Hagenbruch noted that the UIC Medical Center Library has convenient, adjacent parking and is served well by public transportation.

**Introduction and Update from Project Manager:** The Task Force was introduced to Ms. Grazyna Langguth, MLIS, Project Manager, hired to help formulate *the ADA Library Transition Plan*. Ms. Langguth presented for the Taskforce’s consideration the strategy and steps of library transition to a digital library as follows:

1. Changing the ADA library functional structure, maintaining the current five (5) staff positions;
2. Establishing library policies:
  - Establish criteria/policy and a regular timeline for evaluating existing library collection; including retiring the legacy print (books and journals) collection.
  - Establish a collection development policy for the future use of members

3. Restructuring library services to deliver networked information/resources
4. Selecting electronic resources/databases:
  - Negotiations with vendors
  - Getting price for a customized list of journals from one source instead of individual publishers to cut total cost of subscription(s)
5. Making the Archives collection visible:
  - Collection development policy
  - Weeding policy
  - Material selection for digitizing part of archival collection
6. Promoting and publicizing the Library & Archives to include:
  - Improvement of website for promotion of the new library services-locating information about the ADA Library and its services on the intranet is counterintuitive. The ADA is in the process of creating a more user-friendly web structure that will allow for easier access to ADA Library services.
  - Library presence in monthly edition of the ADA news
  - Library presence in the yearly Member's benefit brochure
  - Library newsletter
  - Library presence at the yearly ADA Annual Session, starting 2013 in New Orleans
7. Consistent and regular evaluation of potential new services to fulfill members' expectations and needs.

**ADA Library Visibility on ADA.org and at this year's ADA Annual Session:** Ms. Langguth noted that in her review of the ADA annual report, there was no mention of the ADA Library in the list of 150 member benefits of the ADA. In trying to access the ADA Library on ADA.org, it was not user-friendly, and not intuitive. It was discussed that the ADA.org will undergo reformatting to a user-friendly "Mouth Healthy" format, so that the ADA Library is visible as a valuable member resource.

**Action Item:** The Taskforce requested that an ADA Library staff member, Mr. Gartman, attend this year's annual session to serve as a Library representative and resource; and to attend the open hearing of the Reference Committee on Dental Education and Science Matters when this report is discussed and recommendations are prepared for the ADA House of Delegates.

## Proposed Resolution

**Resolved**, that after a critical review and comparison of text holdings, ADA texts be combined with UIC texts to provide one more comprehensive collection located at the UIC library and available for ADA members' use, and be it further

**Resolved**, that the ADA support its members' use of this more comprehensive collection by funding ADA membership for those members who will use the UIC library texts and services. (Cost Implication: \$10,000/year)

**Taskforce Discussion on Use of Vacated ADA Library Space:** Dr. O'Loughlin reported that in 2014, approximately six floors of space within the ADA building will open with the expiration of several long-term leases. The preliminary plan is to consolidate ADA divisions on adjacent floors, although the exact details have not been worked out yet. The Task Force came to consensus that strong consideration should be given to moving Division of Education staff currently housed on the 19<sup>th</sup> floor (CDEL and CODA) to the 6<sup>th</sup> floor in the library space that will become available, once a right-sizing of the collection is completed. The Task Force further learned that the 6<sup>th</sup> floor was strengthened when the Library was moved from the 19<sup>th</sup> floor fifteen years ago, so moving the library to another floor may not be cost-effective.

**ADA Lobby Renovation Option:** The Task force learned that there are preliminary discussions underway for utilization of the ADA Building lobby space which may include retail space. The Task Force came to the consensus that if there is additional space available in the lobby, that consideration be given to display some of the valuable artifacts that have been stored in the library. Dr. O'Loughlin reported that the ADA is waiting to hear back from a museum display expert at the University of Maryland.

**Journal Collections:** Mr. Gartman reported that eighty-five percent (85%) of ADA members' use of the ADA Library is for journals. The ADA Library receives 491 journals, fifteen of which are "open access." Three are electronic only, and the rest are a combination of print and electronic. The ADA Library also has 209 state and constituent society journals that are newsletter only, while five have clinical content. There is a need to cull the journals that do not have clinical or research content. Mr. Gartman and Ms. Langguth have been in contact with journal publishers and are in the process of soliciting estimated costs for enhancing electronic access and availability.

**Cochrane Library Use:** ADA received Cochrane's bid of \$8,500 minimum for internal use for 1,000 seats. There are no more 5-seat packages. The Council on Scientific Affairs (CSA) will pay for use of the Cochrane Library out of its operating budget. Mr. Gartman reported that Ms. Langguth is having further discussion related to direct member access to Cochrane.

**ADA News Article:** Judy Jakush, editor, *ADA News*, joined the Taskforce and confirmed that she is preparing an article to be published in the *ADA News* to reconfirm to members that the

ADA Library is not closing, but rather, in transition. Members' needs will be better met by a financially stable, better managed ADA Library that will allow members to have access to everything they always had, other than to be physically seated at the ADA Headquarters location.

**ADA Library Oversight:** To facilitate a formal reporting of the ADA Library's activities, the Taskforce believes that ADA library oversight should be added to the Bylaws duties of the Council on Dental Education and Licensure (CDEL). CDEL would then report ADA Library activities through its annual report to the House of Delegates.

### **Proposed Resolution**

**Resolved,** that oversight of the ADA Library be added to the duties of the Council on Dental Education and Licensure as stated in the *ADA Bylaws*, and be it further

**Resolved,** that a standing committee of the Council on Dental Education and Licensure, comprised of three (3) ADA-appointed members of the Council on Dental Education and Licensure; two (2) members of the Council on Scientific Affairs and the CDEL trustee liaison be appointed to oversee the ongoing activities of the ADA Library and report annually in CDEL's annual report to the ADA House of Delegates.

**NOTE:** There was further Taskforce discussion during the writing of the draft Task Force Report regarding the composition and reporting mechanism of the proposed library oversight committee. The Taskforce came to consensus that there were important communities of interest not represented on the oversight board as proposed above. Therefore, the library oversight committee as outlined in the Taskforce Report ("ADA Library and Archives Advisory Board") is the proposed governance mechanism for volunteer oversight of the library.

**ADA Archives:** Ms. Andrea Matlak, archivist and reference librarian, presented to the Taskforce details on the Library's archives. The Archives consist of the historical publications and records of the ADA. The records collection consists mostly of the minutes and agenda books of the BOT, HOD and councils/commissions/committees. Publications include pamphlets, brochures, reports, surveys, and standards, essentially anything printed, produced and distributed by the ADA. The Archives collection is kept separately and has its own call numbering scheme and arrangement. This is different from the Library's and is based on the ADA's organizational structure. Materials are kept together by the name of the council, department, office or division which produced it. The Archives also includes: 1) a large biographical file arranged by name (6000+ names) of people important to the ADA and the history of dentistry (consisting of biographical articles, resumes, photos, etc.); 2) a small collection of photographs (produced mainly by the publishing and/or editorial departments of the ADA through the years and some of which are filed in the biography file by name); 3) a small collection of audio-visual materials (video and audio tapes, film, and other audio recordings) produced and distributed by various departments of the ADA.

The Library also houses the archives of several other smaller dental organizations. These were collected by an earlier library director, interested in documenting the history of organized dentistry, who felt that they should be saved in one place to preserve them. They are not connected or related to the ADA's archives or organization. There are agreements on file for some of them regarding the rights and responsibilities of both parties. The Task Force came to the consensus that the archives should be returned to originating organization. They have no bearing on the main mission of the ADA archives, which is to collect and preserve the historic records and publications of the ADA and to make them accessible to ADA staff and members.

There are also historical collections within the ADA Library overseen by the archivist. This material is not part of the ADA archives, but can be considered archival in nature, as it was collected because it helps document the history of dental institutions and organizations. These collections were started by previous librarians interested in documenting dental history and the history of organized dentistry. They are not comprehensive collections and have been collected piecemeal through the years. The material was gathered from many different sources including ADA offices and donations. These collections include: 1) a small collection of dental school catalogs including many dating to the 19<sup>th</sup> century and those of both opened and closed dental schools; 2) meeting programs of state dental organizations; 3) the Library Vertical File, dating mostly to 20<sup>th</sup> century, consisting of pamphlets, brochures, directories, publications, reports, studies, and histories. These are all arranged by name of dental organization, institution and topics important to the history of dentistry, e.g. fluoridation, dental materials, etc.; 4) dental trade and manufacturing catalogs which help document the history of dental materials and equipment.

The Library also includes books on the history of dentistry and its institutions, biographies and autobiographies of dentists and other dental professionals, books written by dentists and children's books on dentistry. These books have been both purchased by the Library and donated by members and others. They have been collected because they are of interest to dentists and also help document the history of dentistry and the people involved in dentistry.

The archivist's duties include answering questions from staff, members and the public on the history of the ADA and all aspects of the dental profession. She generally answers 200-300 questions a year (average 225). In the past, questions have come from these three constituents equally; lately questions have come less from the public and more from staff and members. Ms. Matlack stated that she tends to answer more questions on the history of dentistry than the history of the ADA, since there is more of a general interest in dental history. Staff is more likely to ask for a copy of a specific historical document or photograph, but they also ask questions on the history of dentistry and information on individuals such as past ADA officers. Both members and the public ask about ancestors or family members as well as general dental history. The archivist has been answering genealogical/family history questions less and less, as this type of information has become more available online on sites such as Ancestry.com. General dental history can also be found on the Internet, and many articles on the history of dentistry have been published and can be searched for on PubMed. In depth information on

specific aspects of dental history or specific questions having to do with ADA policies is harder to come by on the Internet.

Ms. Matlack stated that the aforementioned special Library collections could be culled without affecting her ability to answer questions of members and staff.

**Board Directive on Staff Supply of Essentials and Web Access:** Ms. Matlak stated that she has been mandated by the ADA Board of Trustees to collect, catalogue and store all Council/Commission minutes and meeting information and ADA publications. However, she currently receives this information piecemeal and much is housed in multiple electronic locations, including on ADA.Connect and in File Web. She requested that the Task Force support her request to access the appropriate files on File Web and ADA.Connect, and future electronic ADA filing systems.

**Action Item:** The Taskforce urges the SVP for Education and Professional Affairs formally request the ADA IT Department grant the ADA Library archivist access to the appropriate electronic storage areas on ADA Connect and Fileweb so that a central repository of all ADA council/commission minutes, meeting information, and ADA publications can be maintained.

**Library Director Search:** Dr. Ziebert reported that a search will be conducted to replace the recently vacated position of Director, Library Services. Ms. Langguth, Mr. Gartman, and Dr. Ziebert have reviewed the position description and have made some revisions to reflect changes in expectations and duties of the director position in light of library transition (Appendix 7). It will be highly desirable that the new director have online/electronic reference experience. The library budget includes funding for five full-time staff members in 2013. Funding for five staff will be requested for the 2014 budget, with the understanding that addition funds may be needed to support the transition plan.

**Next Conference Call:** The ADA Library Taskforce will meet next by conference call on Monday, March 25, 2013, at 5:00 p.m. Central Time.

**Adjournment:** The meeting was adjourned at 1:40 pm.



## MINUTES

### Board of Trustees Taskforce on ADA Library Transition Plan (Resolutions 159H-2012)

Monday, March 25, 2013, Conference Call

**Call to Order:** Dr. Gary Roberts called a meeting of the Board of Trustees Taskforce on ADA Library Transition Plan to order at 5:30 P.M. (central time) on March 25, 2013 via conference call.

**Roll Call:** Taskforce Members: Dr. Joseph Crowley (7<sup>th</sup> District); Dr. Julian (Hal) Fair III (16<sup>th</sup> District); and Dr. Gary Roberts (12<sup>th</sup> District). ADA Staff: Dr. Anthony J. Ziebert, senior vice president, Education/Professional Affairs; Mr. Jeffrey Gartman, interim director, ADA Library; and Ms. Grazyna T. Langguth, project manager, Library Transition Plan. Dr. Joseph Hagenbruch, 8<sup>th</sup> District Trustee and chair was unable to join the call due to technical difficulties. As a quorum was present, Dr. Hagenbruch approved moving forward with the conference call as planned.

**Conflict of Interest Reminder:** Dr. Roberts read the following statement: *“In accordance with the ADA Disclosure Policy, at this time anyone present at this meeting is obligated to disclose any personal or business relationship that they or their immediate family may have with a company or individual doing business with the ADA, when such company is being discussed. This includes, but is not limited to insurance companies, sponsors, exhibitors, vendors and contractors.”* No conflicts were noted.

**Approval of March 12, 2013 meeting minutes:** The minutes from the March 12, 2013 meeting were approved.

**Status of negotiations with journal publishers and estimated costs for enhanced electronic resources:** Ms. Langguth reviewed the list of vendors and electronic enhancements proposed for both the ADA library and archives. In addition, annual costs for the resources were presented. The vendors have agreed to honor their fee quotes through June 15, 2013, to allow the Taskforce to make a contingency fund request at the June Board of Trustees meeting. The Taskforce came to the consensus that the proposed electronic enhancements were appropriate and necessary. Staff were instructed to prepare a contingency fund request based on the quoted fees.

**Review of first draft of the ADA Library Transition Plan:** Members of the Taskforce made several suggestions regarding the content of the first draft of the transition plan. Dr. Ziebert will incorporate the suggested revisions and re-circulate the draft to the Taskforce for further input.

**Review of proposed library “weeding” policy:** The Taskforce reviewed the ADA Library Relevance and Vitality Policy and determined that library staff should continue to cull through the existing print collection as outlined in the policy.

**New Business/Next Steps-proposed visit to UIC Medical Center Library:** Dr. Hagenbruch, Mr. Gartman, and Dr. Ziebert will be meeting with UIC Medical Center Library officials on April 3, 2013 to discuss the broad outlines of a Memorandum of Understanding (MOU) between UIC and the ADA on the disposition of the ADA print book collection. A conference call is scheduled for April 30, 2013 with the Taskforce to discuss the results of this meeting, and to further review the draft Taskforce Report.

**Adjournment:** The meeting adjourned at 6 p.m.

## MINUTES

### Board of Trustees Taskforce on ADA Library Transition Plan (Resolutions 159H-2012)

Tuesday, April 30, 2013, Conference Call

**Call to Order:** The Chair, Dr. Joseph Hagenbruch, called a meeting of the Board of Trustees Taskforce on ADA Library Transition Plan to order at 5:00 P.M. (central time) on Tuesday, April 30, 2013, via conference call.

**Roll Call:** Taskforce Members: Dr. Joseph Hagenbruch, 8<sup>th</sup> District Trustee, chair; Dr. Joseph Crowley (7<sup>th</sup> District); Dr. Julian (Hal) Fair III (16<sup>th</sup> District); and Dr. Gary Roberts (12<sup>th</sup> District). ADA Staff: Dr. Anthony J. Ziebert, senior vice president, Education/Professional Affairs; Mr. Jeffrey Gartman, interim director, ADA Library; and Ms. Grazyna T. Langguth, project manager, Library Transition Plan.

**Conflict of Interest Reminder:** Dr. Hagenbruch read the following statement: *“In accordance with the ADA Disclosure Policy, at this time anyone present at this meeting is obligated to disclose any personal or business relationship that they or their immediate family may have with a company or individual doing business with the ADA, when such company is being discussed. This includes, but is not limited to insurance companies, sponsors, exhibitors, vendors and contractors.”* No conflicts were noted.

**Discussion of Visit to UIC Medical Center Library:** Dr. Hagenbruch reviewed the meeting held on April 3, 2013 with staff of the UIC Medical Center Library (Appendix 1). UIC Library staff responded positively to a proposal to supplement the UIC print collection with the ADA print collection. UIC is amenable to signing a Memorandum of Understanding (MOU) with the ADA outlining the rights and responsibilities of each party. Under the agreement, ADA members would have full access to the entire UIC collection, along with all the services provided by UIC. While integrated with the UIC collection, the ADA collection would still be “owned” by the ADA. The ADA would pay an annual fee that would allow ADA member access to the facility. This fee would be similar to the fee charged for “corporate sponsorship” and is anticipated to be less than \$10,000 annually. The Taskforce came to the consensus that this plan for the disposition of the print book collection should be presented at the House of Delegates for its approval at the 2013 Annual Session.

**Review of Draft of the Transition Plan Report:** The Taskforce requested staff make further changes to the draft document. Once the changes have been incorporated, the Taskforce will complete the final editing of the report.

**Adjournment:** The meeting adjourned at 5:35 p.m.

## Appendix 1

**Dr. Hagenbruch, Mr. Gartman, Dr. Ziebert**

**Wednesday, April 3<sup>rd</sup>, 2013, 3:30PM**

**At the UIC Health Sciences Library on Polk Street**

### **UIC Library Questions**

- Is UIC willing to house the non-duplicative ADA books in their collection?
  - Jeff Gartman estimated that there are approximately 2,500 texts that could be transferred to UIC in order to complement and complete the UIC collection. The ADA would retain “ownership” of these texts; however, they would be integrated and catalogued with the UIC collection. If the ADA would subsequently want the texts returned, it would take some effort, but it could be done. UIC is willing and able to take the additional texts, there is shelf space in the current facility.
  
- Is UIC willing to set an annual fee for the ADA which provides for unlimited access to the UIC collection for any ADA member? Can UIC give assurances that this is a long-term option/solution for ADA members?
  - Kate Carpenter stated that UIC has a “corporate membership” category which may apply to the ADA. She stated that UIC needs to revisit this membership category, but felt that something in this regard can be worked out. Jeff Gartman emphasized that there would be approximately 100 unique ADA member users, most of whom would use the UIC facility multiple times within a year. Kate Carpenter thought that the number of ADA members that would use the UIC facility would not strain UIC library staff or services and both she and Kevin O’Brien expressed that the additional utilization and boosting of the clientele numbers might be look upon as a favorable development to those measuring the usage of the facility. There was a discussion that the ADA is looking for a long-term commitment, and it was suggested that a Memorandum of Understanding (MOU) between UIC and the ADA could address this issue. It was explained that a MOU could not be signed until after the ADA House of Delegates approved the transition plan; however, all the details could be worked out prior to the HOD meeting in November. UIC will get back to the ADA with an annual fee proposal within the next few weeks.
  
- What is the process for selection of new books for the dental collection? What role could the ADA Library play in this process, if a part of the ADA collection is housed at UIC?
  - There is a “dental liaison” from the library that proposes new text acquisition and asks for input from the UIC School of Dentistry. Kate Carpenter felt it would not

be an issue to circulate proposed dental acquisitions to the ADA for its input. The UIC library continues to have a robust acquisition budget, and they do not see that changing in the near future. This is due to that fact that they are identified as the regional medical center library and have an obligation to maintain and expand their collections to service health care facilities throughout the region. In addition, Jeff Gartman felt he could work with the liaison to publish the list of new texts on an annual basis to the ADA members. The “new book list” was a service that the ADA Library provided which was viewed as valuable to the members who used the ADA Library on a regular basis.

- What exactly will ADA members have access to? Do they need to call ahead (appointment)?
  - ADA members would have access to the entire UIC medical center collection. They would not need to call ahead. The UIC library is also open during the evening hours and weekends with card access. The ADA Library is (and, even prior to the call for change last year, was) only available from 8AM-5PM during the week, so this would enhance member access to information.
  
- Will there be some sort of orientation offered to interested ADA members? (e.g. how to find, how to use, etc.)
  - Kate Carpenter stated that the staff at the UIC library would be more than willing and able to provide orientation to ADA members who wish to utilize the UIC facility. Jeff Gartman stated that he did not think an extensive orientation would be needed for ADA members, as those members who use the ADA library on a regular basis are very familiar with the functioning of libraries in general.
  
- Will ADA members have the ability to check-out books from the UIC library?
  - Kate Carpenter stated that a provision could likely be put into play that would permit ADA members (through their inclusion in the soon-to-be proposed mutual plan between UIC and the ADA policy), where there would be a provision for them to have the benefit of check-out privileges for books and related material as a consequence of the UIC Library already being an integral part of the Regional Library Exchange System which includes, among other things, the advantage of the exchange policy.

# American Dental Association

Divisional Budget Summary - Library Services

	2011 Annual Actual	2012 Annual Actual	2013 Annual Budget
<b>Revenues</b>			
490004 Service Income - Other	30,059	33,188	32,000
490700 Miscellaneous Income	469	(75)	0
<b>Revenue</b>	<b>30,528</b>	<b>33,113</b>	<b>32,000</b>
<b>Expenses</b>			
Salaries and Temporary Help			
501001 Salaries	656,554	627,483	262,380
501002 Salaries-Part Time	29,145	23,468	0
501009 Salary Adjustments	0	0	7,871
501400 Temporary Help	0	0	8,424
<b>Total Salaries and Temporary Help</b>	<b>685,700</b>	<b>650,952</b>	<b>278,675</b>
Payroll Taxes			
501150 FICA Payroll Tax	48,107	45,977	17,994
501151 SUI Payroll Tax	0	0	1,177
501152 FUI Payroll Tax	0	0	280
501153 FUTA & SUTA Payroll Tax	5,931	5,668	0
<b>Total Payroll Taxes</b>	<b>54,038</b>	<b>51,645</b>	<b>19,451</b>
Fringe Benefits			
501200 Pension Fund	140,696	134,466	49,691
501201 Life Insurance - Disability	15,483	14,797	5,675
501202 Group Medical Cost	60,732	58,043	23,649
501203 Dental Insurance Cost	8,455	8,081	3,380
501204 401K	35,550	33,976	3,250
<b>Total Fringe Benefits</b>	<b>260,916</b>	<b>249,363</b>	<b>85,646</b>
Travel Expenses			
515103 Staff Airfare	1,180	439	2,125
515153 Staff Checked Baggage Fees	50	0	125
515203 Staff Ground Transportation	155	46	500
515403 Staff Lodging	1,135	1,593	3,477
515503 Staff Meals	180	77	825
515700 Miscellaneous Travel	0	20	0
<b>Total Travel Expenses</b>	<b>2,700</b>	<b>2,176</b>	<b>7,052</b>
Program/Activity			
505001 Inside Printing	8	126	200
505002 Outside Printing	1,234	0	0
505350 Book Binding	2,544	1,922	2,700
510002 Exhibit Preparation Costs	51	1,412	0
510200 Registration Fees Expense	1,370	510	2,000
520020 Outside Services	13,728	7,652	0
Consulting Fees (Advisory Board+ MOU UIC)	0	0	0
520300 Bank Fees	125	100	200
520450 Credit Card Fees	779	753	900
525001 Publications & Subscriptions	50,446	76,981	0
525003 Library Books	14,309	7,064	0
525004 Database Access Fees	16,500	0	19,050
525005 Membership Dues Expense	995	1,070	1,200
525006 Interlibrary loan	600	3,300	500
525010 Telephone	388	341	350
525020 Postage, Mailings & Freight	4,614	3,699	4,500
525200 Office Photocopy	1,718	1,346	1,800
525205 Stationery & Supplies	2,549	2,061	2,700
570002 Functional Training	0	120	0
570700 Miscellaneous Expense	989	13,880	10,500
<b>Total Program/Activity</b>	<b>112,947</b>	<b>122,339</b>	<b>46,600</b>
<b>Expense</b>	<b>1,116,301</b>	<b>1,076,474</b>	<b>437,424</b>
<b>Net Revenue/(Expense)</b>	<b>(1,085,773)</b>	<b>(1,043,361)</b>	<b>(405,424)</b>
<b>Net Revenue/(Expense) After Taxes</b>	<b>(1,085,773)</b>	<b>(1,043,361)</b>	<b>(405,424)</b>

## APPENDIX 3

### ADA Library Resource Relevance and Vitality Policy

All libraries routinely evaluate their collections to insure currency and vitality, and to facilitate current use/access to the collection. The ADA Library is committed to maintaining and developing a comprehensive collection of information resources for dentistry in various formats. In particular, the ADA Library is the focal point for support of evidence-based dentistry. The ADA Library is also charged with preserving the vital records of the Association and to provide historical documentation and context relating to the Association, its members, activities, and accomplishments. An applicable policy is necessary to review the current collection (books & journals), so that the best information materials are available to ADA members, staff, other libraries, and other health professionals.

#### *I. De-accession of the print book collection:*

1. All multiple copies.
2. All foreign language materials (dictionaries, yearbooks, transactions, etc).
3. All books from foreign publishers if they haven't been used in 3 years or never used.
4. Reference texts that are out of date.
5. Materials that can be found elsewhere: on the web, or digitally, or easily borrowed from another source.
6. Materials that have no discernible scientific merit; which may be trivial; or do not meet the needs and interests of Library users.
7. Current materials that have not circulated for the past three years, or have never circulated.
8. Materials related to library science.
9. Biographies/autobiographies about dentists, pending evaluation by ADA archivist.
10. Worn out volumes with dirty, brittle, yellow or missing pages; and those with extremely frayed bindings, broken spines, or dingy, torn, or dirty covers
11. Materials with dated or incorrect information; poorly written; or items which have been superseded by newer, improved editions, unless considered historically relevant.

**II. Print collections to be maintained on-site at the ADA library:**

1. Rare book collection.
2. Legacy book collection.
3. Regularly utilized foreign language books.
4. Materials for which the ADA is the unique holder.
5. Reference books, including medical-dental dictionaries; dental drug reference; and ADA Surveys and Reports and classic current editions of texts in the various, heavily-used dental subject areas.
6. Practice management texts.

**III. Print collections to be relocated within ADA library:**

1. ADA published books, add to the ADA archives.
2. Biographies/autobiographies about dentists, forwarded to the archives, pending evaluation by ADA archivist.
3. Historically relevant texts forwarded to historic collection.
4. Older editions of classic texts forwarded to the historic collection.

**IV. Books: criteria for selection of books available in the collection:**

1. New print or e-books will be added to the collection if the University of Illinois at Chicago Medical Center Library will not acquire the book; the book is not accessible through inter-library loan; and the Library Oversight Committee has determined that the book is essential for EBD research. In this case, the ADA library will purchase the book and add to the ADA collection housed at the UICMCL.
2. Updated reference texts.
3. Maintenance of the collection in practice management.
4. ADA published texts.
5. Usage statistics: must demonstrate that the books selected are accessed by ADA members and ADA staff on a regular basis.
6. All book current holdings annually reviewed by the ADA Library Oversight Committee to determine if the criteria are met.



**V. Journals: criteria for selection of journals available in the collection:**

1. Exclusively e-journals, except if the journal is only available in print. Print subscription to be discontinued when electronic access becomes available. Hybrid (print and electronic formats) only if there is no exclusive electronic version.
2. Peer-reviewed to US standards.
3. English language.
4. Foreign language-if peer-reviewed to US standards and considered an Important resource for EBD.
5. Indexed in Medline/Cochrane.
6. Content is primarily:
  - a. clinical dentistry.
  - b. biomedical/basic sciences related to dentistry.
  - c. biomaterials science related to dentistry.
  - d. dental-medical interrelationship.
  - e. medical, peer-reviewed journals that regularly feature topics of interest to clinical dentistry or EBD.
7. Usage statistics: must demonstrate that the journals selected are accessed by ADA members and ADA staff on a regular basis.
8. All journal current holdings annually reviewed by the ADA Library Oversight Committee to determine if the criteria are met.
9. All proposed journal additions (new journals) to the holdings reviewed by the ADA Library Oversight Committee to determine if criteria are met.

# ANNUAL COPYRIGHT LICENSE AGREEMENT

## SMALL TO MEDIUM SIZED BUSINESSES

This Annual Copyright License Agreement (the Agreement) is entered into between Copyright Clearance Center, Inc. ("CCC") and the undersigned firm and its majority-owned subsidiaries, if any (collectively referred to as "User"), to allow User, upon payment of a License Fee and subject to the Terms and Conditions set forth below, to make an unlimited number of uses of portions of the works listed in CCC's current Annual Copyright License repertory (the "Repertory" of "Works") for a period of one year.

### TERMS AND CONDITIONS

#### 1. Grant of License—Photocopying.

CCC, as agent for the Rightsholders (those persons who have granted CCC the authority to license their works hereunder), hereby grants to User a non-exclusive license to reproduce by photocopying in the United States articles or chapters (or portions thereof) from any of the Works which are marked in the Repertory as including Photocopy Rights. Photocopies may be used and distributed by User solely for User's Internal Purposes. Photocopies are visually identical reproductions, made on paper or a paper equivalent (such as film or acetate), of individual articles or chapters (or portions thereof) from works as originally published or paper copies thereof, including reproductions which involve only incidental, transitory electronic reproduction or storage, such as facsimile transmissions, when made for Internal Purposes. "Internal Purposes" means the ordinary business purposes of User, except that Internal Purposes do not include (i) fee-for-service copying, (ii) the sale of copies, (iii) the systematic reproduction and distribution of copies outside of User, or (iv) the bulk reproduction and distribution of copies outside of User.

#### 2. Grant of License—Electronic Uses.

CCC, as agent for the Rightsholders, hereby grants to User a non-exclusive right for User's employees (and those of User's contractors who have authorized access to User's intranet ("Contractors")) to make the following electronic uses of articles and other portions (and only portions) of any of the Works which are marked in the Repertory as including Electronic Rights ("Electronic-Rights Works"):

- (a) to select portions from Electronic-Rights Works lawfully obtained from a Rightsholder (or an authorized representative of a Rightsholder) already in digital form and to treat each such portion as an Authorized Electronic Reproduction under the terms of this Agreement;
- (b) only where the desired portion of an Electronic-Rights Work is not available in accordance with the provisions of Section 2(a) above, to convert portions of Electronic-Rights Works, lawfully obtained in paper form, to digital form in PDF format or other image-capture format that produces a faithful and accurate representation of such portion and to treat each such portion as an Authorized Electronic Reproduction under the terms of this Agreement;
- (c) to store Authorized Electronic Reproductions within User's electronic network;
- (d) to distribute, by means of User's intranet (or similar internal electronic network), Authorized Electronic Reproductions to any employee or Contractor of User for reading and electronic "marking up" by such employee or Contractor and for other uses within the scope of this Agreement;
- (e) to print out, on User printing equipment, paper copies of the Authorized Electronic Reproductions on paper or paper equivalents (for example, film or acetate);
- (f) to distribute such paper copies of Authorized Electronic Reproductions for the Internal Purposes of User;
- (g) to preserve Authorized Electronic Reproductions as part of the storage of the work product of a workgroup for as long as such storage may be maintained (regardless of the termination of this Agreement) if such Authorized Electronic Reproductions were created pursuant to this license and were a necessary part of such work product (provided, however, that such Authorized Electronic Reproductions may be used by User after the termination of this Agreement only to the extent necessary to prove that they were in fact a part of such work product);
- (h) to transmit electronic copies of Authorized Electronic Reproductions, each of them a faithful and accurate representation of the applicable Electronic-Rights Work portion, to an agency of a government if required by such government for regulatory purposes (such as for new drug application or securities regulation purposes), provided that such electronic copy carries the copyright notice attached to the Work and is marked to the effect of "This Electronic Copy of Copyrighted Material Was Made and Delivered to the Government Under License from Copyright Clearance Center, Inc.—No Further Reproduction is Permitted";
- (i) to reactively provide single electronic copies of individual Authorized Electronic Reproductions of applicable Electronic-Rights Works (as such Works shall be identified in publicly-accessible electronic form at [www.copyright.com](http://www.copyright.com) or otherwise by CCC in writing) to prospects, clients or customers of User upon request for informational purposes in connection with a product or service of User; and
- (j) to continue to use the applicable Electronic-Rights Work portion in accordance with subsections (c) to (i) above even after termination of this Agreement (but in that case without the payment of additional royalty), provided that both such Electronic-Rights Work portion and such use were covered by this Agreement, or a similar license from CCC, continuously for no less than three years prior to termination.

**3. Contents of Repertory.** The Repertory is available in publicly-accessible electronic form (at [www.copyright.com](http://www.copyright.com)); the included rights to any Work listed in the Repertory on the first day of this Agreement, together with the included rights to any Work added during the term of this Agreement, are included within this license from the day such rights are first listed until the end of the term (even if such rights are removed during the term).

**4. Special Conditions on Rights Granted.** The rights granted under this Agreement do not include any right to reproduce or otherwise use all or substantially all of a Work. (For purposes hereof, each issue of a journal or periodical shall be considered a separate Work—articles within a journal or periodical, therefore, may be reproduced or otherwise used in their entirety.) Photographs, illustrations, graphs and similar materials which are identified as included in a Work by permission may not be photocopied or otherwise used within the scope of Sections 1 or 2 except in the context of the Work. The rights granted under this Agreement do not extend to User's request for or receipt of photocopies or, except as provided in Section 2(a) above, Authorized Electronic Reproductions from outside User (authorizations for which User must obtain through other means, such as through payment of the prescribed royalty under one of CCC's transactional licensing services).

The rights granted under this Agreement (a) do not include any right to manipulate or change an individual Work portion in any way, (b) except as provided in Sections 2(h) and (i) above, do not include any right for a User to distribute an electronic copy of an Authorized Electronic Reproduction to any person other than an employee or Contractor of User for his or her own use within the scope of User's business, and (c) do not include any right to create a library or collection intended to substantially replace User's need for a particular Work.

The rights granted under Section 2 extend only to those employees and Contractors of User ordinarily located in the United States. An employee or Contractor of User ordinarily located outside the United States may not exercise any of the rights described in Section 2; provided, however, that this prohibition does not extend to the act by an employee or Contractor of User ordinarily located outside the United States of reading an Authorized Electronic Reproduction sent by electronic mail or posted on User's intranet if such employee or Contractor has authorized access to that intranet.

**5. License Fee.** The License Fee is determined by CCC on the basis of market information relating to the extent of authorized uses of Works by users similarly situated to User and other information derived from CCC's extensive database of employee configurations and average photocopying and electronic-use behavior among corporate licensees. Because it is based on access to the Repertory, the License Fee is net of all factors that might otherwise be considered deductions, including fair use. User acknowledges and agrees that the effectiveness of this Agreement is contingent upon timely clearance of funds remitted in payment of the License Fee. User's License Fee can be determined from the matrix on the signature page of this Agreement.

**6. Protection from Litigation.** Each Rightsholder has warranted that it will automatically waive any and all of its previously unasserted claims for copyright infringement of Works falling within the scope of the rights granted by Section 1 of this Agreement if the Work is participating in that Section, and/or within the scope of the rights granted by Section 2 if the Work is participating in that Section, provided in either case that User adheres to the terms and conditions of this Agreement for one year after the beginning of such participation and then executes and pays for a first one-year renewal of this Agreement.

**7. Term.** The term of this Agreement is one year, commencing on the date of acceptance by CCC, as marked at the bottom of this page. CCC may, in its sole discretion, offer one-year renewals of this Agreement to User at prices then in effect, and User may, in its sole discretion, elect to accept such renewal each year on the terms offered.

**8. Governing Law.** This Agreement shall be interpreted, construed, governed and enforced in accordance with and under the laws of the State of New York, without regard to the principles thereof of conflicts of law. Any case, controversy, suit, action or proceeding arising out of, in connection with, or related to this Agreement shall be brought in any federal or state court located in the County of New York, State of New York, to the personal jurisdiction and venue of which both User and CCC expressly submit.

**9. Miscellaneous Provisions.** CCC may from time to time make tools available for use in connection with the Agreement; if User chooses to avail itself of such tools, User agrees to the applicable terms of use, current versions of which will be made available here: [www.copyright.com/rightspherebasic/terms.html](http://www.copyright.com/rightspherebasic/terms.html) and <http://www.copyright.com>. Neither party to this Agreement shall have the right to assign or sublicense any of its rights or obligations hereunder without the prior written consent of the other party. This Agreement constitutes the entire agreement between the parties with respect to the subject matter hereof and may not be modified or amended except in a writing signed by the parties hereto. CCC certifies that the Rightsholders have warranted that they are authorized to license the rights granted herein; the license granted by this Agreement is given without any other warranty or recourse.



## LICENSE FEE CALCULATION, PAYMENT SELECTION AND AUTHORIZED SIGNATURES

Using the table provided on page four, identify the industry tier for your primary business. Then locate on the grid under the appropriate tier, the row that represents the number of employees in your company to determine the fee for your Annual Copyright License. Fill in the boxes in the lines below

- Lines 1-4: Circle the number of years your company would like to license, then circle the appropriate Industry Tier, then list the number of employees in your company and the appropriate License Fee amount from the grid on Page 4.
- Line 5: Multiply Line 4 by 35% (or .35) and list the amount in the box to the right.
- Line 6: Add line 4 and Line 5 and list the total in the box to the right.
- Line 7: Multiply the amount in Line 6 by the total number of years you've selected in Line 1
- Proceed to select your payment option and method below.

User represents that the number of employees identified below in Number 3 is correct to the best of its knowledge.

### SELECT YOUR OPTIONS, CALCULATE THE APPROPRIATE FEES AND SIGN BELOW (1-10)

1. Circle number of years for this license or renewal up to a maximum of 5 years							1	2	3	4	5		
2. Circle your Industry Tier selected from the table on page 4							1	2	3	4	5	6	7
3. List the number of employees in your company													
4. List the annual license fee (from grid on page 4)										A:	\$		
5. General and Administrative Charge (35% of annual fee)										B:	\$ Waived		
6. Total Annual Amount										(A + B):	\$		
7. Multiple Year License Amount										(A + B) X ( # of Years):	\$		
<b>8. SELECT ONE OF THE TWO PAYMENT OPTIONS-Check one of the options listed below</b>													
Option 1	User selects to Pay in Full Now for a Single or Multiple Year Renewal	The Annual License Fee will remain fixed for the number of Licensed Years selected above upon CCC's receipt of payment in full of the Multiple Year License Amount indicated above. Use one of the payment methods set forth below.											
Option 2	User selects to pay annually (One or Multiple Years)	If you select to pay annually, CCC will invoice once a year on the basis of the current number of employees, which you agree to revise each year as necessary. The License Amount will be at CCC's then-current rate, but will increase by no more than 2% each year. Failure to pay any such invoice on or before the annual renewal date will result in automatic termination of the license as of the end of the last paid-up annual term.											
<b>9. CHOOSE TO MAKE PAYMENT BY ONE OF THE METHODS BELOW</b>													
Make a Check payable to:	Copyright Clearance Center, Inc.	Send check to:	Copyright Clearance Center, Inc. PO Box 843006 Boston, MA 02284-3006										
Make a Credit Card Payment	Provide complete credit card information on Page 4												

**10. SIGN BELOW TO AGREE TO THE TERMS AND CONDITIONS OF THIS LICENSE (YOU WILL RECEIVE A COUNTERSIGNED AGREEMENT UPON PAYMENT)**  
**SCAN AND EMAIL TO: [accountmanagement@copyright.com](mailto:accountmanagement@copyright.com) OR FAX THIS DOCUMENT TO: 978-750-4250**

Organization Name \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Authorized Signature \_\_\_\_\_ Name (Print) \_\_\_\_\_

E-mail address (PRINT IN SPACES PROVIDED BELOW) \_\_\_\_\_ Signatory Title \_\_\_\_\_

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_____/_____/_____ CCC Officer's Signature		_____ Name		_____ Title of CCC Signatory			_____/_____/_____ Date	
Org #	I Code	Eff Date		Rec'd Date				
Account #	SIC	Sales Rep						

## TIERS BY INDUSTRY

Agriculture	Tier 6	General Hospital	Tier 7
Aircraft and Aerospace	Tier 6	Holding Companies	Tier 6
Associations	Tier 7	Insurance	Tier 6
Banks	Tier 6	Lumber	Tier 6
Biotechnology	Tier 1	Machinery	Tier 6
Broadcasting & Telecommunications	Tier 4	Medical and Dental Labs	Tier 5
Brokerages	Tier 6	Medical Equipment	Tier 1
Business Services/Advertising Agencies	Tier 7	Navigation and Guidance Equipment	Tier 5
Chemicals	Tier 4	Pharmaceuticals	Tier 1
Computers	Tier 6	Primary Metals	Tier 6
Construction	Tier 7	Publishing	Tier 5
Consulting	Tier 3	Radio and TV Equipment	Tier 7
Consumer Services	Tier 7	Research, other than Scientific	Tier 3
Doctor's Offices	Tier 7	Rubber and Plastics	Tier 7
Electronic and Electric Equipment	Tier 7	Scientific Instruments	Tier 4
Electronic Components	Tier 7	Scientific Research	Tier 1
Engineering	Tier 3	Software/Systems Design	Tier 2
Fabricated Metal	Tier 6	Stone, Clay and Glass	Tier 7
Fishing, Forestry and Hunting	Tier 6	Teaching and Research Hospitals	Tier 5
Food and Tobacco	Tier 7	Textiles and Apparel	Tier 7
Fuels	Tier 4	Transportation Equipment and Services	Tier 7
Gas Utilities	Tier 7	Water and Electric Utilities	Tier 7

Number of employees	TIER 1	TIER 2	TIER 3	TIER 4	TIER 5	TIER 6	TIER 7
751-1000	26,190	22,230	19,740	18,430	15,460	14,180	13,800
600-750	20,120	17,080	15,170	14,160	11,880	10,900	10,600
500-599	16,760	14,230	12,640	11,800	9,900	9,080	8,830
400-499	13,410	11,380	10,110	9,440	7,920	7,260	7,070
300-399	10,060	8,540	7,580	7,080	5,940	5,450	5,300
200-299	6,710	5,690	5,060	4,720	3,960	3,630	3,530
130-199	4,360	3,700	3,290	3,070	2,570	2,360	2,300
80-129	2,680	2,280	2,020	1,890	1,780	1,500	1,500
Minimum License Fee	1,680	1,500	1,500	1,500	1,500	1,500	1,500

Fees effective as of January 1, 2013

ADA  
price

### CREDIT CARD INFORMATION

Credit Card Type	Mastercard _____ VISA _____ American Express _____
Credit Card Number	
Expiration Date	
Name on card	
Name of Company	
Amount to be charged to the card	\$ _____
Authorized Signature	

## **MEMORANDUM OF UNDERSTANDING**

THIS MEMORANDUM OF UNDERSTANDING (the "Agreement") is made and entered into effective as of \_\_\_\_\_, 2013 (the "Effective Date") by and between the American Dental Association ("ADA"), an Illinois not for profit corporation having an office and place of business at 211 East Chicago Avenue, Chicago, Illinois 60611 and the Board of Trustees of the University of Illinois for the benefit of the University of Illinois at Chicago ("UIC"), having an office and place of business at 352 Henry Administration Building, MC350, 506 South Wright Street, Urbana, Illinois 61801. ADA and the Board of Trustees of the University of Illinois are sometimes hereinafter referred to collectively as the "Parties" and individually as a "Party."

### **RECITALS**

WHEREAS, the ADA has acquired and owns approximately two thousand five hundred (2,500) hard copy texts related to the art and science of dentistry and oral health ("the ADA Dental Texts"); and

WHEREAS, the ADA library facility fundamentally poses circumstances which present perceptible constraints regarding the accessibility of ADA Dental Texts for members, researchers, scholars and the public; and

WEREREAS, the ADA desires for the ADA Dental Texts to remain accessible to members, researchers, scholars and the public; and

WHEREAS, UIC maintains a health sciences library the main branch of which is located on the Chicago campus of UIC and ancillary branches of which are located at other University of Illinois locations in Illinois ("the UICLHS"); and

WHEREAS, UIC desires to receive texts relating to dentistry and oral health to complement the collection of health sciences texts in the UICLHS; and

WHEREAS, UIC is amenable to accepting the ADA Dental Texts and integrating the ADA Texts into the UICLHS pursuant to the terms and conditions outlined in this Memorandum of Understanding; and

WHEREAS, the ADA is amenable to transferring the ADA Dental Texts to UIC for integration into the UICLHS pursuant to the terms and conditions outlined in this Memorandum of Understanding.

NOW, THEREFORE, in consideration of the foregoing and the mutual covenants contained in this Agreement, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and intending to be legally bound hereby, the parties hereto agree as follows:

1. At its own expense, ADA shall deliver the ADA Dental Texts to the UICLHS facility located at 1750 West Polk Street, Chicago, Illinois on a date and time to be mutually agreed upon by the parties, together with a written or electronic inventory of the individual texts transferred.

2. Within sixty (60) days of its receipt of the ADA Dental Texts, UIC shall, in writing, indicate its acceptance of the inventory of individual texts received from ADA. Should UIC believe there to be any discrepancy between the inventory list and the volumes of the ADA Dental Texts received, it shall so notify the ADA and the parties will cooperate to arrive an agreed to inventory list.

3. Following receipt of the ADA Dental Texts, UIC will integrate the ADA Dental Texts into its cataloguing system and the UICLHS book collection located at 1750 West Polk Street, Chicago Illinois so that the ADA Dental Texts are accessible to patrons of the UICLHS.

4. From time to time during the period that this Memorandum of Understanding is in force, UIC shall provide ADA with summaries of its proposed annual acquisitions in sufficient time for the ADA to have input into the acquisitions being proposed, it being understood, however, that the final authority respecting library acquisitions rests solely with UIC. ADA shall have thirty (30) days from receipt of the annual acquisition summary from UIC to provide any input or suggestions it may wish to give UIC concerning the acquisition of material relating to the subjects of dentistry and oral health.

5. Should the ADA propose an acquisition that is either of no interest to UIC, exceeds the approved UIC budget for a given period, or UIC otherwise declines to obtain the proposed acquisition, the ADA may choose to make the acquisition and deliver the item to the UIC whereupon UIC will assimilate the acquisition into the UICLHS system. Any item acquired by ADA pursuant to this paragraph of the Memorandum of Understanding will be added to the inventory of ADA Dental Texts and will be treated as part of the ADA Dental Texts.

6. During the period that this Memorandum of Understanding is in force, the ADA shall pay annually to UIC the sum of ten thousand dollars (\$10,000.00) in exchange for UIC providing ADA members the same rights and privileges of UIC library usage as UIC grants to any regular library patron authorized by UIC, including rights and privileges to the UICLHS. Such rights and privileges granted to ADA members shall include, without limitation, checking out printed texts, use of library catalogues and databases, use of publicly accessible computers located at UIC library facilities and UIC library staff support. In addition, UIC shall provide ADA members with card access to UIC libraries, including the UICLHS, during any regular and extended hours for such libraries that from time to time may be announced and implemented by UIC.

7. Ownership of the ADA Dental Texts shall remain with ADA and shall not transfer to the Board of Trustees of the University of Illinois, UIC or UICLHS. The parties acknowledge and agree that risk of loss of the ADA Dental Texts rests with ADA during the period that the ADA Dental Texts are housed in the UICLHS facility located at 1750 West Polk Street, Chicago Illinois, provided that the ADA Dental Texts are treated with the same procedures and protocols for protection and preservation by which UICLHS treats its own library collection.

8. This Memorandum of Understanding shall take effect as of the Effective Date set forth above, and shall continue until \_\_\_\_\_, 2014 [one year], unless terminated earlier by either party as set forth herein. This Agreement may be renewed for additional one-year terms upon the written consent of both Parties.

9. Either party may terminate this Memorandum, with or without cause, upon thirty (30) days written notice to the other party or as otherwise agreed between the parties hereto.

10. Upon termination or expiration of this Memorandum of Understanding, UIC shall, at its own expense and within ninety days of the effective date of termination or expiration, retrieve

the ADA Dental Texts from the UICLHS book collection and assemble the ADA Dental Texts for shipping. Once so assembled, ADA shall, at its own expense, retrieve the ADA Dental Texts from UIC. ADA shall have sixty (60) days to compare the volumes of the ADA Dental Texts retrieved from UICLHS against the agreed upon inventory and report any discrepancy to UICLHS which will then undertake a search for any missing volumes. Absent a report to UICLHS of any discrepancy within the sixty (60) day period, it shall be presumed that the complete collection of ADA Dental Texts was delivered to ADA.

11. Upon termination or expiration of this Memorandum of Understanding, the rights and privileges granted to ADA members to use UIC library facilities under this Memorandum of Understanding shall be revoked. Should this Memorandum of Understanding be terminated by either party with or without cause before its date of expiration, UIC shall remit to ADA the portion of the payment made by ADA to UIC pursuant to paragraph 5, above that is proportional to the period during which ADA members would have had access to UIC libraries had the Memorandum of Understanding not been terminated.

12. Any notice that may or must be given by any party under this Agreement will be delivered (i) personally, (ii) by certified mail, return receipt requested, or (iii) by a nationally recognized overnight courier, addressed to the party to whom it is intended. Any notice given to a party shall be sent to that party's address as set forth below, or to such other address as that party may designate for service of notice by a notice given in accordance with the provisions of this paragraph. A notice sent pursuant to the terms of this paragraph shall be deemed delivered (i) when delivery is actually made, if delivered personally, (ii) three (3) business days after deposit into the United States mail, or (iii) the day following deposit with a nationally recognized overnight courier.

If to ADA:                   Attn: Senior Vice President, Education/Professional Affairs  
American Dental Association  
211 East Chicago Avenue  
Chicago, Illinois 60611

With a copy to:           "General Counsel" at the above address

If to Board of Directors of the University of Illinois:

Attn. University Librarian  
University of Illinois at Chicago  
Richard J Daley Library  
MC 234, 801 South Morgan Street  
Chicago, Illinois 60607

With a copy to:           "University Counsel"  
258 Henry Administration Building  
506 South Wright Street  
Urbana Illinois 61801



13. This Memorandum of Understanding embodies the entire understanding between the parties pertaining to the subject matter contained in it; supersedes any and all prior negotiations, correspondence, understandings, or agreements of the parties; and may be amended, modified, or revised, in whole or in part, only on the written consent of the parties to this memorandum. For the purpose of this subsection, an e-mail shall not be deemed a writing.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the dates shown below.

AMERICAN DENTAL ASSOCIATION

Dated: \_\_\_\_\_, 2013

By: \_\_\_\_\_  
Dr. Kathleen T. O'Loughlin  
Executive Director / COO

BOARD OF DIRECTORS OF THE  
UNIVERSITY OF ILLINOIS

Dated: \_\_\_\_\_, 2013

By: \_\_\_\_\_  
Christopher G. Kennedy  
Chairman

Serials Subscriptions Requested for Purchase from Ebsco

Acta odontologica scandinavica. (Paid 2013)
Advances in dental research [e-subscription; part of J of Dental Research]
American journal of dentistry.
American journal of orthodontics and dentofacial orthopedics.
Anesthesia progress.
Annals of the Royal Australasian College of Dental Surgeons.
British dental journal.
British journal of oral & maxillofacial surgery
Caries research.
Clinical implant dentistry and related research.
Clinical oral implants research.
Clinical oral investigations.
Community dentistry and oral epidemiology.
Cranio: the journal of craniomandibular practice.
Dental clinics of North America.
Dental historian. (Paid 2013)
Dental materials.
Dento maxillo facial radiology : DMFR
European journal of dental education.
European journal of esthetic dentistry
European journal of oral implantology.
European journal of oral sciences.
Evidence-based dentistry.
Explorer: official journal of the National Association of Dental Assistants
Fluoride: journal of the International Society for Fluoride Research.
Gerodontology.
Gordon J. Christensen Clinicians report.
Implant dentistry.
International journal of computerized dentistry.
International journal of dental hygiene.
International journal of oral & maxillofacial implants
International journal of oral and maxillofacial surgery.
International journal of paediatric dentistry
International journal of periodontics & restorative dentistry (English edition)
International journal of prosthodontics The.
International orthodontics / Collège européen d'orthodontie.
Journal of adhesive dentistry The.
Journal of clinical pediatric dentistry The.
Journal of clinical periodontology.
Journal of dental research.
Journal of disability and oral health.
Journal of endodontics.
Journal of esthetic and restorative dentistry.
Journal of evidence-based dental practice The.
Journal of oral and maxillofacial surgery
Journal of oral pathology & medicine
Journal of oral rehabilitation.
Journal of orofacial pain.
Journal of periodontal research.
Journal of prosthetic dentistry
Journal of prosthodontics: implant, esthetic and reconstructive dentistry
Journal of the history of dentistry
McGill advisory The.
Minerva stomatologica. (Paid 2013)
Operative dentistry.
Oral and maxillofacial surgery clinics of North America.
Oral diseases.
Oral health & preventive dentistry.
Oral surgery, oral medicine, oral pathology and oral radiology.
Periodontology 2000.
Primary dental journal (formerly Primary dental care)
Quintessence international (English edition).
Reality
Reality Now
Swedish dental journal.

<b>ACTION</b>	<b>INITIAL EXPENSE 2013 (Need contingency funds)</b>	<b>ONGOING EXPENSE 2014 (operating budget)</b>	<b>REVENUE AND/OR SAVINGS</b>
Appointment of ADA Library and Archive Advisory Board	none	\$12,000 for annual meeting on-site at ADA Headquarters	
Change Name: ADA Library and Archives	none	none	
Implementation of ADA Resource Relevance and Vitality Policy	none	none	Reduction of 60% in occupied library square footage
Copyright Clearance Center-ADA Division of Legal Affairs pays annual renewal fee	Paid utilizing existing funds from 2013 operating budget	Payment to be made through ADA Division of Legal Affairs operating budget	\$13,800
MOU between ADA and UIC for member access to UIC Library	If approved by HOD, would take effect January 1, 2014	\$10,000	
Cochrane Database	Paid utilizing existing funds from 2013 operating budget	\$2,558 annual expense by headcount and up to 1000 users	
FirstSearch-access to reference databases	Paid utilizing existing funds from 2013 operating budget	\$3,458	
Purchase of Updated Reference e-Books	none	\$3,000	
Interlibrary Loan	Paid utilizing existing funds from 2013 operating budget	\$3,483	
Institutional Membership-Medical Library Association	\$485	\$485	
Institutional Membership-American Academy of the History of Dentistry	\$125	\$125	
EbscoHost-Subscription e-journal Package	\$37,938	\$40,000	
Ebsco A to Z	\$1,000	\$1000 up to 1000 users annually	
Ebsco Dynamed and Dentistry and Oral Sciences Source	\$54,075	\$54,075 annual expense by headcount and up to	

		1000 users	
Lexicomp-online pharmaceutical database for dentistry	Free Trial	\$20,000 up to 105 users, if more than 105 then additional \$ 195 for each.	
Cuadra / STAR Knowledge Center for Archives (SKCA)- makes archival collections visible and accessible.	\$8,100	\$5350 Annual license fee; \$2650 for usage estimated similar to 2013 Total: \$8000	
Data Conversion Laboratory -digitizing archives for import to content management system	\$22,500 one-time		
Kenamore & Klinkow. Archives & Library Consultants- Consultation services to help with development of schema and hierarchical organization of archives' documents.	\$3,840 one-time		
IT upgrades to support enhanced electronic resources	none	none	
Library director to attend ADA Annual Session	\$1,800	\$1,800	
Binding fees	none	none	\$2,600
Purchase of New Print Texts	none	none	\$20,000
Part-time help for Archives Conversion to Digital	None in 2013	\$42,500 salary and expenses(\$85,000 for two years)	
TOTAL	\$128,063	\$ 202,526	

## American Dental Association

Divisional Budget Summary - Library Services

	2011 Annual Actual	2012 Annual Actual	2013 Annual Budget	2014 Annual Budget Proposed	2,015 Annual Budget Proposed
<b>Revenues</b>					
490004 Service Income - Other	30,059	33,188	32,000	10,000	10,000
490700 Miscellaneous Income	469	(75)	0	0	0
<b>Revenue</b>	<b>30,528</b>	<b>33,113</b>	<b>32,000</b>	<b>10,000</b>	<b>10,000</b>
<b>Expenses</b>					
Salaries and Temporary Help					
501001 Salaries	656,554	627,483	262,380	352,874	363,460
501002 Salaries-Part Time	29,145	23,468	0	0	0
501009 Salary Adjustments	0	0	7,871	0	0
501400 Temporary Help	0	0	8,424	0	0
<b>Total Salaries and Temporary Help</b>	<b>685,700</b>	<b>650,952</b>	<b>278,675</b>	<b>352,874</b>	<b>363,460</b>
Payroll Taxes					
501150 FICA Payroll Tax	48,107	45,977	17,994	25,407	26,169
501151 SUI Payroll Tax	0	0	1,177	0	0
501152 FUI Payroll Tax	0	0	280	0	0
501153 FLITA & SJITA Payroll Tax	5,931	5,668	0	2,830	2,915
<b>Total Payroll Taxes</b>	<b>54,038</b>	<b>51,645</b>	<b>19,451</b>	<b>28,237</b>	<b>29,084</b>
Fringe Benefits					
501200 Pension Fund	140,696	134,466	49,691	66,764	68,767
501201 Life Insurance - Disability	15,483	14,797	5,675	7,057	7,269
501202 Group Medical Cost	60,732	58,043	23,649	40,020	41,221
501203 Dental Insurance Cost	8,455	8,081	3,380	6,250	6,438
501204 401K	35,550	33,976	3,250	20,375	20,986
<b>Total Fringe Benefits</b>	<b>260,916</b>	<b>249,363</b>	<b>85,646</b>	<b>140,466</b>	<b>144,680</b>
Travel Expenses					
515101 Volunteer/Nonstaff Airfare	0	0	0	2,982	3,071
515103 Staff Airfare	1,180	439	2,125	426	439
515151 Volunteer Nonstaff Checked Baggage Fees	0	0	0	175	180
515153 Staff Checked Baggage Fees	50	0	125	25	26
515201 Volunteer/Nonstaff Grnd Trnsport	0	0	0	700	721
515203 Staff Ground Transportation	155	46	500	100	103
515301 Volunteer Per Diem	0	0	0	1,050	1,082
515403 Staff Lodging	1,135	1,593	3,477	482	496
515401 Volunteer/Nonstaff Lodging	0	0	0	3,374	3,475
515503 Staff Meals	180	77	825	130	134
515501 Volunteer/Nonstaff Meals	0	0	0	630	649
515700 Miscellaneous Travel	0	20	0	403	415
<b>Total Travel Expenses</b>	<b>2,700</b>	<b>2,176</b>	<b>7,052</b>	<b>10,477</b>	<b>10,791</b>
Program/Activity					
505001 Inside Printing	8	126	200	200	215
505002 Outside Printing	1,234	0	0	0	0
505350 Book Binding	2,544	1,922	2,700	0	0
510002 Exhibit Preparation Costs	51	1,412	0	0	0
510200 Registration Fees Expense	1,370	510	2,000	0	0
<b>520020 Outside Services (MOU UIC + Part Time Help)</b>	<b>13,728</b>	<b>7,652</b>	<b>0</b>	<b>52,500</b>	<b>53,500</b>
520300 Bank Fees	125	100	200	200	200
520450 Credit Card Fees	779	753	900	850	850
<b>525001 Publications &amp; Subscriptions</b>	<b>50,446</b>	<b>76,981</b>	<b>0</b>	<b>46,600</b>	<b>47,998</b>
525003 Library Books	14,309	7,064	0	0	0
<b>525004 Database Access Fees</b>	<b>16,500</b>	<b>0</b>	<b>19,050</b>	<b>82,075</b>	<b>84,537</b>
<b>525005 Membership Dues Expense</b>	<b>995</b>	<b>1,070</b>	<b>1,200</b>	<b>4,093</b>	<b>4,257</b>
<b>525006 Interlibrary loan</b>	<b>600</b>	<b>3,300</b>	<b>500</b>	<b>3,480</b>	<b>3,584</b>
525010 Telephone	388	341	350	350	361
525020 Postage, Mailings & Freight	4,614	3,699	4,500	800	824
525200 Office Photocopy	1,718	1,346	1,800	500	515
525205 Stationery & Supplies	2,549	2,061	2,700	400	412
570002 Functional Training	0	120	0	0	0
570700 Miscellaneous Expense	989	13,880	10,500	0	0
<b>Total Program/Activity</b>	<b>112,947</b>	<b>122,339</b>	<b>46,600</b>	<b>192,048</b>	<b>197,253</b>
<b>Expense</b>	<b>1,116,301</b>	<b>1,076,474</b>	<b>437,424</b>	<b>724,102</b>	<b>745,268</b>
<b>Net Revenue/(Expense)</b>	<b>(1,085,773)</b>	<b>(1,043,361)</b>	<b>(405,424)</b>	<b>(714,102)</b>	<b>(735,268)</b>

Note : For 2015 3% increase is assumed over 2014 Expenses

Resolution No. 33 New  
 Report: N/A Date Submitted: August 2013  
 Submitted By: Council on Dental Education and Licensure  
 Reference Committee: Dental Education, Science and Related Matters  
 Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_  
 Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0  
 ADA Strategic Plan Goal: Public Health (Required)

1 **AMENDMENT TO THE REQUIREMENTS FOR RECOGNITION OF DENTAL SPECIALTIES AND**  
 2 **NATIONAL CERTIFYING BOARDS FOR DENTAL SPECIALISTS**

3 **Background:** (*Reports:52*) The following is the pertinent information excerpted from the Council on  
 4 Dental Education and Licensure’s annual report. The current Requirements for Recognition of Dental  
 5 Specialties were adopted by the House of Delegates in 2009 (Appendix).

6 **Responses to House of Delegates Resolutions**

7 *17-2012. Amendment to the Requirements for Recognition of Dental Specialties and National Certifying*  
 8 *Boards for Dental Specialists (Trans.2012:473)*

9 In 2011, the ADA House of Delegates adopted Resolution 48H-2011, directing the Council to review  
 10 the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental*  
 11 *Specialists (Trans.2011:478)*. The Council was requested to consider Requirement 1(a) in the  
 12 *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental*  
 13 *Specialists* which states that a recognized specialty sponsoring organization’s membership should be  
 14 reflective of the special area of dental practice (as defined by the *ADA Code of Ethics*, Section 55.H.,  
 15 General Standards, for announcing specialization or limitation of practice), and consider interpreting  
 16 “reflective” to mean that only specialist dentist members be able to vote and to hold office. In  
 17 response, the Council transmitted Resolution 17 to the 2012 ADA House of Delegates:

18 **Resolution 17-2012 —Amendment to the Requirements for Recognition of Dental Specialties**  
 19 **and National Certifying Boards for Dental Specialists**

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

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

28 and be it further

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

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

and be it further

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

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

and be it further

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

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

As a result on considerable testimony presented at the Reference Committee Hearing as well as in the House of Delegates meeting, the 2012 House of Delegates referred Resolution 17 back to the appropriate ADA agency(ies) for further consideration. In recommending this referral, the Reference Committee on Dental Education, Science and Related Matters offered the following guidance:

*The Reference Committee heard testimony from many members on Resolution 17. The Reference Committee believes that there will be unintended consequences if the Requirements for Recognition are amended as proposed. The Committee concluded that the Council on Dental Education and Licensure; the Council on Access, Prevention and Interprofessional Relations; the Board of Trustees and the American Association of Public Health Dentistry should be given the opportunity to further explore options to define the term "reflective" and to arrive at a procedure to bring the sponsoring organization of public health dentistry into alignment with the other dental specialty organizations regarding this policy without disenfranchising dentists in the public health community. Accordingly the Reference Committee supports referral of Resolution 17 to the appropriate ADA agency(ies) for further study with a report to the 2013 House of Delegates.*

Council Chair, Dr. Ronald Venezie, established and chaired an ad hoc workgroup to make recommendations to the Council. Workgroup members included Dr. Teresa Dolan, vice chair of CDEL, Dr. Donald L. Seago, ADA Board of Trustees liaison to CDEL, Dr. Jane Gillette, CAPIR member and Dr. Catherine Hayes, president-elect, American Association of Public Health Dentistry (AAPHD). The workgroup as well as the Council unanimously supported the following key principles:

- 1 • The recognized specialties of dentistry are a vital part of the profession and must be
- 2 maintained at the highest standards.
- 3 • The sponsoring organization of a recognized dental specialty serves as the voice of that
- 4 specialty and must be governed by dentists who either have completed advanced dental
- 5 specialty education or have substantially comparable experience in that dental specialty.
- 6 • The specialty sponsoring organization and its certifying board must determine jointly whether
- 7 a dentist is appropriately experienced in that dental specialty in order to be eligible to hold
- 8 office in the specialty sponsoring organization or to vote on any issue related to the specialty.
- 9 • The sponsoring organization of a dental specialty has the right to offer one or more affiliate
- 10 membership categories to non-dentists—provided that such membership categories do not
- 11 include the privileges to hold office in the specialty sponsoring organization or to vote on any
- 12 issue related to the specialty.
- 13 • At present, the sponsoring organizations of the dental specialties, with the exception of the
- 14 AAPHD, meet Requirement 1(a) as proposed.
- 15 • All sponsoring organizations should be given until July 2015 to demonstrate/confirm
- 16 compliance with the amended Requirement 1(a).
- 17 • The Council on Dental Education and Licensure should then confirm that all sponsoring
- 18 organizations are in compliance with the amended Requirement 1(a) and report its findings to
- 19 the 2015 House of Delegates.

20 Thus, the Council on Dental Education and Licensure recommends that the following resolution be  
 21 adopted by the 2013 House of Delegates:

22  
 23 **Resolution**  
 24

25 **33. Resolved**, that Requirement (1) of the Requirements for Recognition of Dental Specialties be  
 26 revised as follows (additions are underscored; deletions are ~~stricken~~):  
 27

28 (1) In order for an area to ~~be~~ become and/or remain recognized as a dental specialty, it must  
 29 be represented by a sponsoring organization: (a) whose membership is reflective of ~~the~~  
 30 ~~special area of that proposed or recognized dental specialty practice~~; (b) in which the  
 31 ~~privileges to hold office and to vote on any issue related to the specialty are reserved for~~  
 32 dentists who either have completed a CODA-accredited advanced education program in that  
 33 proposed or recognized specialty or have sufficient experience in that specialty as deemed  
 34 appropriate by the sponsoring organization and its certifying board; and ~~(b)c~~ that  
 35 demonstrates the ability to establish a certifying board.  
 36

37 and be it further  
 38

39 **Resolved**, that the introductory paragraph of the Requirements for Recognition of National  
 40 Certifying Boards for Dental Specialists be revised as follows (additions are underlined; deletions  
 41 are ~~stricken~~):  
 42

43 In order to become, and remain, eligible for recognition by the American Dental Association  
 44 as a national certifying board for a ~~special area of practice~~ dental specialty, the ~~area~~ specialty  
 45 shall have a sponsoring or parent organization ~~whose membership is reflective of the~~  
 46 ~~recognized special area of dental practice~~ that meets all the elements of Requirement (1) of  
 47 the Requirements for Recognition of Dental Specialties. A close working relationship shall be  
 48 maintained between the parent organization and the board. Additionally, the following  
 49 requirements must be fulfilled.  
 50

51 and be it further



1  
2 **Resolved**, that requirement (2) in the section on Organization of Boards be revised as follows  
3 (additions are underscored; deletions are ~~stricken~~):  
4

5 (2) Each board shall submit in writing to the Council on Dental Education and Licensure a  
6 program sufficiently comprehensive in scope to meet the requirements established by the  
7 American Dental Association for the operation of a certifying board. This statement should  
8 include evidence of sponsorship of the board by a national organization ~~representing dental~~  
9 ~~practitioners interested in that special area of practice~~ that meets all the elements of  
10 Requirement (1) of the Requirements for Recognition of Dental Specialties.  
11

12 and be it further  
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14 **Resolved**, that the sponsoring organizations representing the currently recognized dental  
15 specialties be given until July 1, 2015, to demonstrate compliance with this revised requirement,  
16 and be it further  
17

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

21 **BOARD RECOMMENDATION: Vote Yes.**

22 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION- NO BOARD**  
23 **DISCUSSION)**

**WORKSHEET ADDENDUM  
COUNCIL ON DENTAL EDUCATION AND LICENSURE  
POLICY TO BE AMENDED**

**Requirements for Recognition of Dental Specialties and National Certifying boards for Dental Specialists**

Adopted by as amended by the ADA House of Delegates, October 2009

**Introduction**

A specialty is an area of dentistry that has been formally recognized by the American Dental Association as meeting the "Requirements for Recognition of Dental Specialists" specified in this document. Dental specialties are recognized by the Association to protect the public, nurture the art and science of dentistry, and improve the quality of care. It is the Association's belief that the needs of the public are best served if the profession is oriented primarily to general practice. Specialties are recognized in those areas where advanced knowledge and skills are essential to maintain or restore oral health.\*

Not all areas in dentistry will satisfy the requirements for specialty recognition. However, the public and profession benefit substantially when non-specialty groups develop and advance areas of interest through education, practice and research. The contributions of such groups are acknowledged by the profession and their endeavors are encouraged.

The sponsoring organization must submit to the Council on Dental Education and Licensure a formal application which demonstrates compliance with all the requirements for specialty recognition. The Council will submit its recommendation for approval or denial of the proposed specialty to the Association's House of Delegates.

Following approval by the House of Delegates, the sponsoring organization must establish a national board for certifying diplomates in accordance with the "Requirements for National Certifying Boards for Dental Specialists" as specified in this document. Additionally, the Commission on Dental Accreditation develops educational requirements and establishes an accreditation program for advanced educational programs in the specialty. The Council on Dental Education and Licensure and the sponsoring organization monitors the administrative standards and operation of the certifying board.

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\* Association policies regarding ethical announcement of specialization and limitation of practice are contained in the ADA Principles of Ethics and Code of Professional Conduct.

**Requirements for Recognition of Dental Specialties**

A sponsoring organization seeking specialty recognition for an area must document that the discipline satisfies all the requirements specified in this section.

- (1) In order for an area to be recognized as a specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.
- (2) A proposed specialty must be a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards. \*
- (3) The scope of the proposed specialty requires advanced knowledge and skills that: (a) are separate and distinct from any recognized dental specialty or combination of recognized dental specialties; and (b) cannot be accommodated through minimal modification of a recognized dental specialty or combination of recognized dental specialties.
- (4) The specialty applicant must document scientifically, by valid and reliable statistical evidence/studies, that it: (a) actively contributes to new knowledge in the field; (b) actively contributes to professional education; (c) actively contributes to research needs of the profession; and (d) provides oral health services for the public; all of which are currently not being met by general practitioners or dental specialists.
- (5) A proposed specialty must directly benefit some aspect of clinical patient care.
- (6) Formal advanced education programs of at least two years beyond the predoctoral dental curriculum as defined by the Commission on Dental Accreditation must exist to provide the special knowledge and skills required for practice of the proposed specialty.

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\* *Predoctoral accreditation standards are contained in the Commission on Dental Accreditation's document Accreditation Standards for Dental Education Programs.*

**Requirements for Recognition of National Certifying Boards for Dental Specialists**

In order to become, and remain, eligible for recognition by the American Dental Association as a national certifying board for a special area of practice, the area shall have a sponsoring or parent organization whose membership is reflective of the recognized special area of dental practice. A close working relationship shall be maintained between the parent organization and the board. Additionally, the following requirements must be fulfilled.

**Organization of Boards:**

- (1) Each Board shall have no less than five or more than 12 voting directors designated on a rotation basis in accordance with a method approved by the Council on Dental Education and Licensure. Although the Council does not prescribe a single method for selecting directors of boards, members may not serve for more than a total of nine years. Membership on the board shall be in accordance with a prescribed method endorsed by the sponsoring organization. All board directors shall be diplomates of that board and only the parent organizations of boards may establish additional qualifications if they so desire.
- (2) Each board shall submit in writing to the Council on Dental Education and Licensure a program sufficiently comprehensive in scope to meet the requirements established by the American Dental Association for the operation of a certifying board. This statement should include evidence of sponsorship of the board by a national organization representing dental practitioners interested in that special area of practice.
- (3) Each board shall submit to the Council on Dental Education and Licensure evidence of adequate financial support to conduct its program of certification.
- (4) Each board may select suitable consultants or agencies to assist in its operations, such as the preparation and administration of examinations and the evaluation of records and examinations of candidates. Consultants who participate in clinical examinations should be diplomates.

**Operation of Boards:**

- (1) Each board shall certify qualified dentists as diplomates only in the special area of dental practice approved by the American Dental Association for such certification. No more than one board shall be recognized by the Association for the certification of diplomates in a single area of practice.
- (2) Each board, except by waiver of the Council on Dental Education and Licensure, shall give at least one examination in each calendar year and shall announce such examination at least six months in advance.
- (3) Each board shall maintain a current list of its diplomates.
- (4) Each board shall submit annually to the Council on Dental Education and Licensure data relative to its financial operations, applicant admission and examination procedures, and results thereof. A diplomate may, upon request, obtain a copy of the annual financial report of the board.
- (5) Each board shall encourage its diplomates engage in lifelong learning and continuous quality improvement.
- (6) Each board shall provide periodically to the Council on Dental Education and Licensure evidence of its examination and certification of a significant number of additional dentists in order to

1 warrant its continuing approval by the American Dental Association.

- 2
- 3 (7) Each board shall bear full responsibility for the conduct of its program, the evaluation of the
- 4 qualifications and competence of those it certifies as diplomates, and the issuance of certificates.
- 5
- 6 (8) Each board shall require an annual registration fee from each of its diplomates intended to assist
- 7 in supporting financially the continued program of the board.
- 8

9 **Certification Requirements:**

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- 11 (1) Each board shall use, in the evaluation of its candidates, standards of education and experience
- 12 approved by the Commission on Dental Accreditation.
- 13
- 14 (2) Each board shall require, for eligibility for certification as a diplomate, the successful completion
- 15 of an educational program accredited by the Commission on Dental Accreditation of two or more
- 16 academic years in length, as specified by the Commission.\*
- 17

18 Although desirable, the period of advanced study need not be continuous, nor completed within  
19 successive calendar years. An advanced educational program equivalent to two academic years  
20 in length, successfully completed on a part-time basis over an extended period of time as a  
21 graduated sequence of educational experience not exceeding four calendar years, may be  
22 considered acceptable in satisfying this requirement. Short continuation and refresher courses  
23 and teaching experience in specialty departments in dental schools will not be accepted in  
24 meeting any portion of this requirement.

25  
26 Each board may establish an exception to the qualification requirement of completion of an  
27 advanced specialty education program accredited by the Commission on Dental Accreditation for  
28 the unique candidate who has not met this requirement per se, but can demonstrate to the  
29 satisfaction of the certifying board, equivalent advanced specialty education. A certifying board  
30 must petition the Council on Dental Education and Licensure for permission to establish such a  
31 policy. If granted, the provisions of the certifying board's policy shall be reported to the House of  
32 Delegates in the Annual Report of the Council on Dental Education and Licensure.

33  
34 \*The following interpretation for educational eligibility was provided by the 1975 House of  
35 Delegates of the American Dental Association (*Trans.* 1975: 690).

36  
37 Candidates for board certification who graduated after January 1, 1967, must have  
38 successfully completed an accredited advanced specialty program. Candidates for board  
39 certification who completed the prescribed length of education for board certification in a  
40 program of an institution then listed by the Council on Dental Education and Licensure  
41 prior to 1967, and who have announced ethically limitation of practice in one of the  
42 recognized dental specialties, are considered educationally qualified.

- 43
- 44 (3) Each board shall establish its minimum requirements for years of practice in the area for which it
- 45 grants certificates. The years of advanced education in this area may be accepted toward
- 46 fulfillment of this requirement.
- 47
- 48 (4) Each board, in cooperation with its parent organization, shall prepare and publicize its
- 49 recommendations on the educational program and experience requirements which candidates
- 50 will be expected to meet.

Resolution No. 50 New

Report: Board Report 10 Date Submitted: August 2013

Submitted By: Board of Trustees

Reference Committee: Dental Education, Science and Related Matters

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0

ADA Strategic Plan Goal: Members (Required)

1 **REPORT 10 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: RESPONSE TO**  
 2 **RESOLUTION 110H-2012 MONITORING THE DENTAL BOARD OF CALIFORNIA'S DEVELOPMENT**  
 3 **OF A PORTFOLIO EXAMINATION**  
 4

5 **Background:** The 2010 ADA House of Delegates adopted Resolution 42H-2010:

6 **42H-2010. Resolved,** that a Request for Proposals (RFP) process be initiated calling for the  
 7 development of a portfolio-style examination for licensure purposes designed to assess a  
 8 candidate's clinical competence with a third-party assessment that is valid and reliable  
 9 psychometrically, including a complementary written/interactive examination to assess issues not  
 10 deemed adequately addressed in the portfolio model, such as ethics and professionalism, and be  
 11 it further

12 **Resolved,** that a new workgroup composed of two representatives from the Board of Trustees,  
 13 three from the Council on Dental Education and Licensure (one appointee each from the ADA,  
 14 ADEA and AADB), one from the Committee on the New Dentist, and one from the American  
 15 Student Dental Association be appointed to oversee the development and announcement of the  
 16 RFP process in 2011 and consideration of the received proposals in 2012, and be it further

17 **Resolved,** that appropriate progress reports be made available to both the 2011 and 2012 House  
 18 of Delegates.  
 19

20 The Resolution 42H-2010 Workgroup was chaired by Dr. Samuel Low. Members included Dr. Edward  
 21 Vigna, Tenth District Trustee; Dr. Brian Kennedy (CDEL-ADA); Dr. Patrick Lloyd (CDEL-ADEA); Dr. David  
 22 Perkins (CDEL-AADB); Dr. Chris Salierno (NDC), and Ms. Brittany Bensch (ASDA). The Workgroup  
 23 reported its conclusions to the 2012 House of Delegates, noting that it is possible to develop a valid and  
 24 reliable portfolio-style examination designed to evaluate a candidate's clinical competency using third  
 25 party assessment. The Workgroup further believed that a portfolio-style clinical examination should be an  
 26 option available to candidates for initial licensure, but that the Association should continue to monitor  
 27 California's progress and learn from that experience. In addition, due to a projected financial commitment  
 28 of almost \$500,000 to develop the model, the 42H-2010 Workgroup was reluctant to recommend that the  
 29 House pursue development of the portfolio style examination model in 2013. Consequently, the 2012  
 30 House of Delegates adopted Resolution 110H-2012:

31 **110H-2012. Resolved,** that the ADA continue to monitor the Dental Board of California's  
 32 development of the portfolio examination option and provide a report back to the 2013 House of  
 33 Delegates.

1

2 The Resolution 110H-2012 Workgroup was chaired by Dr. Carol Gomez Summerhays, Thirteenth District  
3 Trustee. Members included Dr. Charles R. Weber (Third District Trustee); Dr. Cecile Feldman (CDEL  
4 Representative); Ms. Keri M. Jamison (American Student Dental Association Representative to CDEL);  
5 and Dr. Chris J. Salierno (New Dentist Committee Representative). Mr. Bill Lewis, Manager of Regulatory  
6 Affairs, California Dental Association, provided technical assistance to the Workgroup at the request of  
7 the Chair.

8

**9 Key Issues:**

10

- 11 • The California Dental Association (CDA) has been involved with the Dental Board of California's  
12 development of a portfolio style examination for several years. In the early 2000's, CDA sponsored  
13 task forces to examine a variety of pathways to licensure; the portfolio model appeared to be a  
14 promising model. Legislation was introduced in 2009 to authorize the portfolio style examination  
15 process as one pathway to dental licensure. This was authorizing legislation only and basic details  
16 on the process were included in the statute, with the remainder to be developed via the regulatory  
17 process. While the legislation was being developed and considered, stakeholders met to develop  
18 conceptual regulations in an effort to provide dental schools with preliminary details of the model and  
19 legislators with conceptual regulations. To seek licensure via the portfolio format, candidates will be  
20 required to complete specified numbers/types of clinical experiences and pass student-initiated  
21 competency examinations conducted in the dental school by calibrated, board-sanctioned faculty.  
22 The bill easily passed the California legislature, was signed into law in 2010 and became effective  
23 January 1, 2011. The legislation phased out the traditional one-time clinical examination. Today, the  
24 pathways to initial dental licensure in the State of California are 1) completion of an accredited one-  
25 year Post-doctoral General Dentistry (PGY-1) program; 2) passing the Western Regional Board  
26 Examination; or 3) completing the Portfolio-style examination process.
- 27  
28 • The California "Hybrid Portfolio" is an initial licensure pathway based upon the synthesis of the  
29 traditional portfolio model plus test cases (or competency cases) used in the dental schools for  
30 competency evaluations. Dental school faculty is responsible for evaluating the students'  
31 competencies. Per the regulations, the faculty is specially trained and calibrated to conduct these  
32 evaluations. Also by regulation, the Dental Board retains oversight and the right to conduct regular  
33 paper and on-site audits of the competency examinations. Because students decide during their final  
34 year of school when they are ready to have their competency assessed, the Dental Board determined  
35 it was most practical for faculty to complete these evaluations, rather than having examiners travel to  
36 the six dental schools on an unscheduled basis for every candidate.
- 37  
38 • Dentists licensed in California via the portfolio-style process may have limited opportunities for  
39 licensure by credentials in other states. Licensing by credentials (aka endorsement) varies by state.  
40 Currently, 46 states have provisions for licensure by credentials, but many states require applicants to  
41 have passed a clinical examination offered by a dental board or testing agency.
- 42  
43 • In April 2013, a special meeting of stakeholders was held in California to discuss and share more  
44 details about the portfolio format. The Dental Board of California shared with stakeholders an  
45 overview of the process including drafts of the candidate's handbook, grading schema, auditor's  
46 handbook and examiner's handbook. Stakeholder invitees included dental students, California dental  
47 school deans, CDA representatives and Dr. Summerhays.
- 48  
49 • At its May 2013 meeting, the Dental Board of California received a report on the portfolio style  
50 examination structure and function similar to the information provided during the April 2013  
51 stakeholders meeting. It is anticipated that the Dental Board will consider and perhaps take action on  
52 proposed regulations at its August 2013 meeting. Following approval of the draft regulations, the  
53 public vetting period including written comments and public hearings, will take at least year.

- 1  
2 • The Association should continue to monitor the Dental Board of California's progress in implementing  
3 the portfolio style examination process and its outcomes. Progress on this initiative should be  
4 reported to the House of Delegates annually. Because a duty of the Council on Dental Education and  
5 Licensure is to study, formulate and make recommendations on licensure policy, the Workgroup  
6 recommended and the Board concurred that future monitoring of California's progress should be  
7 assigned to the Council. Accordingly, the following resolution is presented:  
8

9 **Resolution**

10 **50. Resolved**, that the Council on Dental Education and Licensure continue to monitor  
11 the Dental Board of California's development and implementation of a portfolio-style  
12 licensure examination and report findings annually to the House of Delegates.  
13

14 **BOARD RECOMMENDATION: Vote Yes.**

15 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION- NO BOARD**  
16 **DISCUSSION)**  
17  
18



Resolution No. 53-57 New

Report: Board Report 13 Date Submitted: August 2013

Submitted By: Board of Trustees

Reference Committee: Dental Education, Science and Related Matters

Total Net Financial Implication: See Individual Resolution Worksheets Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE \_\_\_\_\_

ADA Strategic Plan Goal: Members (Required)

**REPORT 13 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTIONS 66H-2011, 91H-2011, B-204-2011, AND 113H-2012 DEFLATING THE DENTAL EDUCATION BUBBLE**

**Background:** In response to resolutions 66H-2011, 91H-2011, and B-204-2011, Dr. William R. Calnon, ADA president, appointed members to a workgroup on dental education as follows: Dr. Ken Rich, chair (6<sup>th</sup> district), Dr. Maxine Feinberg (4<sup>th</sup> district), Dr. Gary S. Yonemoto (14<sup>th</sup> district), Dr. James M. Boyle (CDEL Representative); Dr. Teresa A. Dolan (CDEL Representative); and Dr. Brian M. Schwab (New Dentist Committee Representative). Due to the complexity of the research requested by the House of Delegates, and the need to generate data not currently collected by the ADA through the HPRC, the project was extended into 2013 for a report to the 2013 House of Delegates (Resolution 113H-2012). Subsequently, ADA President Dr. Robert Faiella appointed Dr. Feinberg to replace Dr. Rich as chair, while Dr. Julian (Hal) Fair III (16<sup>th</sup> District) was appointed to serve on the Taskforce. In addition, the Taskforce invited a representative from the American Student Dental Association (ASDA), Mr. Martin Smallidge, to attend the meetings held in April 2013.

The Taskforce learned that student debt is perceived as a national higher education problem at all levels; however, the existing data on the issue of student debt is sparse, making analysis of trends and implications for the dental profession difficult to determine. At the April 2012 meeting, the Taskforce developed eight research foci to serve as a basis for data collection and analysis on the current financial state of dental schools; the rapidly increasing average debt load that dental students incur throughout their education; the potential impact dental student debt has on the way dentistry is commonly practiced in the United States; and the potential impact all these factors have on access to care in underserved communities. Two outside consultants were hired with expertise in the field of higher education financing: Howard Bailit, DDS, PhD, professor emeritus, University of Connecticut School of Medicine and Director, University of Connecticut Health Center Health Policy & Primary Care Research Center (1996-2005); and Sean Nicholson, PhD, professor, Cornell University, Department of Policy Analysis and Management (PAM) and a research associate at the National Bureau of Economic Research. The research questions generated by the Taskforce and the subsequent analysis of the data have resulted in the most comprehensive information available, to date, on dental student debt, dental school finances, and the dental "safety net."

**Key Issues:** The research questions and main findings are summarized as follows:

- What are the trends in dental student debt? How does this compare to higher education in general? Dentistry is experiencing the same trends in student loan debt as most other high-income professions. Dental school debt has increased over time due to increases in the cost of attending dental school. The rates of increase are in line with those experienced by other professional

1 students (e.g., physicians, veterinarians). The debt-to-income ratio for dentists has increased  
2 over time, as it has for most occupations/degrees.

- 3  
4 • What are the operating costs of a dental school? Does institutional setting matter? How are the  
5 operating costs financed (e.g., tuition, government) and how has the financing pattern changed  
6 over time?

7  
8 There is great variation in operating costs among schools, which can be attributed mostly to  
9 expenses associated with the number of full-time faculty and staff. As long as the “return on  
10 investment” allows students to pay off educational debt in a “reasonable” amount of time, the  
11 profession will continue to attract a large number of qualified applicants to fill the total number of  
12 available positions. Institutional setting (public versus private) does not seem to matter as a driver  
13 of overall revenue and overall expenses, particularly in recent years when financial support from  
14 states to their public universities has diminished.

- 15  
16 • What innovations have dental schools pursued to reduce operating costs?

17  
18 There have not been significant innovations in dental school models that significantly reduce  
19 operating costs. The increased number and quality of applicants over the past 15 years has  
20 allowed dental schools to increase tuition without adversely affecting enrollment. In addition,  
21 dental schools have been able to increase enrollment without substantially increasing expenses.  
22 Overall, dental schools are currently financially sound.

- 23  
24 • What is the role of educational institutions, students, residents and new graduates in the dental  
25 “safety net” and what innovations are there in recent years?

26  
27 Due to the limited number of students and residents available to provide treatment, compared to  
28 the estimated total number of underserved patients, dental schools cannot solely solve the  
29 access-to-care problem. In addition, students/residents are not as efficient in providing treatment  
30 compared to an experienced private practitioner. Innovations have centered around sending  
31 students to off-campus clinical sites such as Federally Qualified Health Centers (FQHC) for a  
32 portion of their clinical education.

- 33  
34 • What impact does student debt have on graduates’ employment choices?

35  
36 Debt appears to have a small effect on some of dentists’ career decisions. The magnitude of the  
37 effect is very small compared to other factors such as gender and race. In regression models,  
38 students graduating with relatively large amounts of debt are more likely to plan on entering  
39 private practice, less likely to plan on completing advanced education, and less likely to plan on  
40 pursuing a government position. Debt levels do not have an impact on the likelihood of owning a  
41 practice.

- 42  
43 • How many loan forgiveness programs are available to dental students? How effective are these  
44 programs in reducing student debt and improving access to care for the underserved?

45  
46 As of May 2013, there are a total of 1,732 dentists participating in loan repayment programs  
47 across the country, excluding active-duty military and the Army National Guard. The majority of  
48 programs (92.3%) do not have debt level requirements for participation, but 41.2% of programs  
49 consider debt level when determining the amount of support provided. The majority of programs  
50 have specific practice location requirements (e.g., federal or state HPSA, rural, etc.; 81.8%).  
51 Additionally, most programs require treatment of specific populations (e.g., Medicaid; 76.8%).  
52 There are more applications for positions than there are positions available. The programs seem  
53 to be effective in improving access to care; however, the improvement is limited by the small  
54 number of positions available.

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- What are dental schools doing in regards to teaching debt management and student loans?

Eighty percent of surveyed dental school deans reported that the dental school offers student debt or personal financial management information. In addition, the majority of dental school deans reported that student debt or personal financial management information is part of the dental school curriculum. This was closely correlated with survey results of recent graduates. More than 70% of surveyed recent graduates and current students believe that the dental school should provide more student debt or personal financial management information than is currently offered.

- What innovations could dental schools do in collaboration with the American Dental Association to reduce student debt?

The Taskforce came to the conclusion that the ADA can be most effective in addressing the student debt issue through a defined program of advocacy at the federal level and through development of a robust information portal to help current and prospective students be fully informed, financially literate consumers about a career in dentistry, including workforce forecasting reports, student debt, expected income, and life-long financial planning.

The Board carefully considered the report of the ADA Taskforce on Dental Education Economics and Student Debt (Appendix) and thanked the Taskforce for its fine work in developing the report. The Board believes that the ADA has a professional interest and obligation to support dental education and dental students by leading a collaborative effort in addressing the cost of dental education, the dental student debt burden, and the access to care issue. The Board supported the Taskforce recommendation calling for the ADA Success Program to be reviewed and revised to include more content on debt management and financial planning for students. Because the ADA Success Program is managed by the New Dentist Committee (a Standing Committee of the Board), the Board adopted Resolution B-102-2013 at its August meeting directing the New Dentist Committee to pursue the enhancements to the Success Program as outlined by the Taskforce.

The Board also concurred with the other recommendations presented by the Taskforce, noting that advocacy efforts on behalf of dental education and students must be strengthened, research efforts in dental education financing and student debt must be expanded, and the accreditation standards for predoctoral programs must be revised to emphasize the need for instruction in personal debt management and financial planning.

The Taskforce Report suggests and the Board agrees that a re-examination of the “dental education model” must be conducted to better prepare for the future, perhaps similar to the study conducted by the Institute of Medicine’s Committee on the Future of Dental Education in 1995. Such a study would require participation by dentistry’s broad communities of interest, with ADA and ADEA providing the most current data/analysis of dental education economics. On behalf of current and future members, ADA should have a leadership role, becoming a thought leader in the area of dental school financing, dental student debt, student loan interest rate reform, and the rate of return to a dental education. Recognizing that a study of this magnitude will be costly (estimated to be \$1.156 million), the Board recommends that the House take the first step by allocating \$80,000 to research potential funding sources for the study, write grant proposals; conduct literature reviews, and convene one in-person meeting for stakeholders and that funding from outside sources be secured by fall of 2015 in order for the study to proceed.

Accordingly, the Board presents the following resolutions to the 2013 House of Delegates.

1

**Resolutions**

2

(Resolution 53:Worksheet:3078)

3

(Resolution 54:Worksheet:3079)

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(Resolution 55:Worksheet:3080)

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(Resolution 56:Worksheet:3081)

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(Resolution 57:Worksheet:3083)

1 Appendix

2  
3 REPORT OF THE ADA TASKFORCE ON

4 DENTAL EDUCATION ECONOMICS AND STUDENT DEBT

5  
6 **Resolutions 66H-2011 and 91H-2011**

7 **Adopted by the 2011 ADA House of Delegates:**

8 **66H-2011. Resolved**, that the Board of Trustees with the assistance of appropriate councils and  
9 expert consultants, study, document and analyze the current and future economics of dental  
10 education, student debt and the impact on dental practice and access to care, utilizing existing  
11 environmental scan and other available data, and be it further

12  
13 **Resolved**, that the Board with the assistance of CDEL and consultants with expertise in dental  
14 education identify innovations in dental education that reduce costs without diminishing quality  
15 and recognize barriers to broader implementation, and be it further

16  
17 **Resolved**, that the Board, with the assistance of consultants with expertise in practice economics  
18 and subsidized care, consider the role educational institutions, students, residents and new  
19 graduates have played in the dental "safety net," and innovative ideas to improve that function  
20 while reducing student debt, and be it further

21  
22 **Resolved**, that the Board prepare a detailed report including short term and long range action  
23 recommendations to reduce dental student debt for consideration at the 2012 House of  
24 Delegates.

25  
26 **91H-2011. Resolved**, that the appropriate councils and ADA agencies investigate the  
27 development and implementation of a student loan repayment grant program for dentists working  
28 in a non-profit community dental clinic, and report to the 2012 House of Delegates.

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30  
31 **Resolution B-204-2011**

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33 **Adopted at the December, 2011 Board of Trustees meeting in support of 66H-2011:**

34  
35 **B-204-2011. Resolved**, that per the HOD Directive 66H-2011, the ADA President appoint a  
36 Taskforce made up of three members of the Board of Trustees; two members of the Council on  
37 Dental Education and Licensure; one member of the Committee on the New Dentist; and other  
38 appropriate councils and expert consultants, which the Taskforce may engage external  
39 consultants as deemed necessary for the study outlined in Res. 66H, and monitor the study's  
40 progress, and be it further

41  
42 **Resolved**, that the Board prepare a detailed report including short term and long range action  
43 recommendations to reduce dental student debt for consideration by the 2012 House of  
44 Delegates.

**Resolution 113H-2012****Adopted by the 2012 ADA House of Delegates:**

**Resolved**, that the Taskforce on Dental Education Economics and Student Debt conduct the research as outlined in this report and report findings to the 2013 House of Delegates, and be it further

**Resolved**, that the \$230,000 be returned to the General Fund and allocated in the 2013 budget for completion of the study.

**INTRODUCTION AND BACKGROUND**

In response to resolutions 66H-2011, 91H-2011, and B-204-2011, Dr. William R. Calnon, ADA president, appointed members to the workgroup as follows: Dr. Ken Rich, chair (6<sup>th</sup> district), Dr. Maxine Feinberg (4<sup>th</sup> district), Dr. Gary S. Yonemoto (14<sup>th</sup> district), Dr. James M. Boyle (CDEL Representative); Dr. Teresa A. Dolan (CDEL Representative); and Dr. Brian M. Schwab (New Dentist Committee Representative). Ms. Karen Hart, director of CDEL, Marko Vujicic, Ph.D., managing vice president, Health Policy Resources Center (HPRC), and Dr. Anthony J. Ziebert, senior vice president, Education/Professional Affairs provided staff support for the workgroup. Due to the complexity of the research requested by the House of Delegates, and the need to generate data not currently collected by the ADA through the HPRC, the project was extended into 2013 for a report to the 2013 House of Delegates (resolution 113H-2012). Subsequently, ADA President Dr. Robert Faiella appointed Dr. Feinberg to replace Dr. Rich as chair, while Dr. Julian (Hal) Fair III (16<sup>th</sup> District) was appointed to serve on the Taskforce. In addition, the Taskforce invited a representative from the American Student Dental Association (ASDA), Mr. Martin Smallidge, to attend the meetings held in April 2013.

The Taskforce met via conference calls on April 18, 2012, January 16, 2013, and July 15, 2013. Meetings were held at the ADA Headquarters Building on January 5, 2013, April 14-15, 2013 and June 7, 2013. Two outside consultants were hired with expertise in the field of higher education financing: Howard Bailit, DDS, PhD, professor emeritus, University of Connecticut School of Medicine and Director, University of Connecticut Health Center Health Policy & Primary Care Research Center (1996-2005); and Sean Nicholson, PhD, professor, Cornell University, Department of Policy Analysis and Management (PAM) and a research associate at the National Bureau of Economic Research.

The Taskforce learned that student debt is perceived as a national higher education problem at all levels; however, the existing data on the issue of student debt is sparse, making analysis of trends and implications for the dental profession difficult to determine. At the April 2012 meeting, the Taskforce developed eight research foci to serve as a basis for data collection and analysis on the current financial state of dental schools; the rapidly increasing average debt load that dental students incur throughout their education; the potential impact dental student debt has on the way dentistry is commonly practiced in the United States; and the potential impact all these factors have on access to care in underserved communities. The research questions, along with the methodology for collecting relevant data and the individual or group responsible for data collection and analysis, are outlined below in Table 1.

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2

**TABLE 1**

Research Foci and Question(s)	Methodology	Primary Researcher
What are the trends in dental student debt? How does this compare to higher education in general?	Analysis of ADEA senior survey data; various micro data sets with income and education debt data; Association reports; literature review.	Dr. Nicholson
What are the operating costs of a dental school? How are these operating costs financed (e.g. tuition, government) and how has the financing pattern changed over time? Does institutional setting (public vs. private) matter?	Analysis of CODA surveys of dental schools (2004-2011); literature review; key informant interviews.	Dr. Bailit
What innovations have dental schools pursued to reduce operating costs?	Analysis of CODA surveys of dental schools (2004-2011); literature review; key informant interviews.	Dr. Bailit
What is the role of educational institutions, students, residents and new graduates in the dental "safety net" and what innovations are there in recent years?	Analysis of CODA surveys of dental schools (2004-2011); Literature review; Key informant interviews.	Dr. Bailit
What impact does student debt have on graduates' employment choices?	Analysis of ADEA senior survey data (2004-2011) for intended choices; survey of 1996, 2001, 2006, 2011 graduate cohorts for actual choices.	Dr. Nicholson
How many loan forgiveness programs are available to dental students? How effective are these programs in reducing student debt and improving access to care for the underserved?	Web search to augment ADA Division of Government Affairs inventory of loan forgiveness programs; survey of heads of the loan forgiveness programs.	ADA staff from the Health Policy Resources Center and the ADA Division of Government Affairs
What are dental schools doing in regards to teaching debt management and student loans?	Survey of dental students (ASDA reps); Survey of 2011 graduates; Survey of dental school deans.	ADA staff from the Health Policy Resources Center

What innovations could dental schools do in collaboration with the American Dental Association to reduce student debt?	Suggested resolutions for action by the HOD submitted by the Taskforce outlined in this report	Taskforce
--	--	-----------

1 The research questions generated by the Taskforce and the subsequent analysis of the data have  
 2 resulted in the most comprehensive information available, to date, on dental student debt, dental school  
 3 finances, and the dental “safety net.”  
 4

5 **Data and Methods, Key Findings, and Policy Implications**

6  
 7 **1. What are the trends in dental student debt? How does this compare to higher education in**  
 8 **general?**  
 9

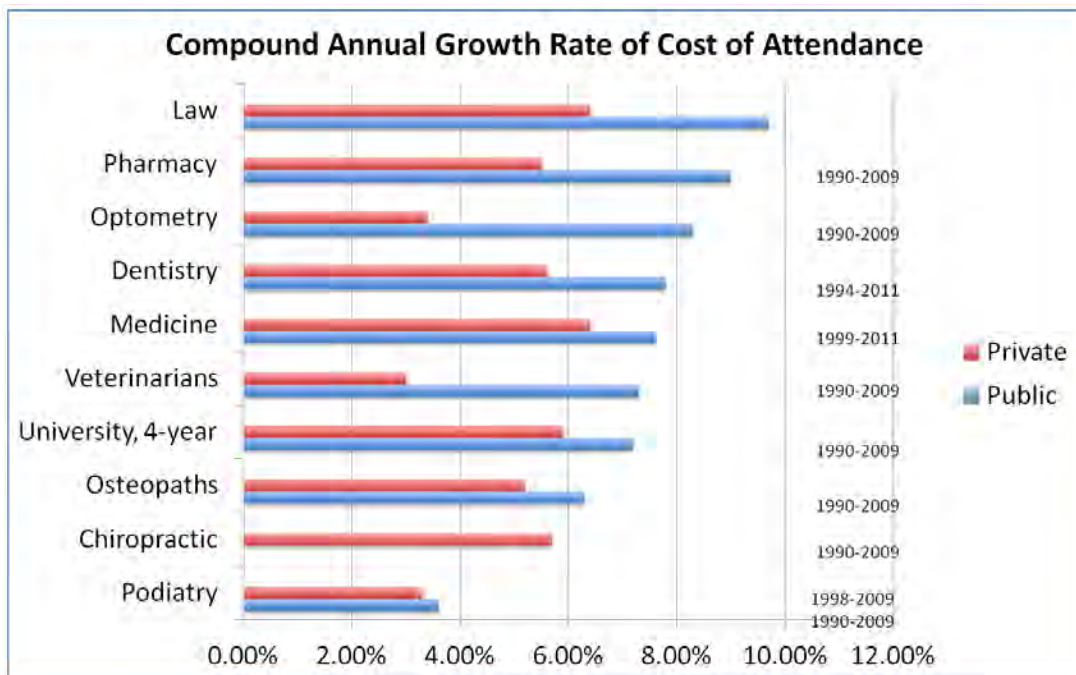
10 **Methods and Data**

11  
 12 Data for this study were obtained from the annual ADEA Survey of Dental School Seniors . The dataset  
 13 obtained was from 2004 through 2011. The average age of the seniors surveyed was 28 years old.  
 14 Observations with age less than 24 years old or greater than 50 years were excluded to remove  
 15 observations with inaccurate entries. Additional information was drawn from a variety of government  
 16 databases, a literature review, and various associations using proprietary data (See Appendix A-Debt  
 17 Trend Literature Review).  
 18

19 **Key Findings**

20  
 21 Cost of attendance (tuition and fees) for professional degrees is rising much faster than inflation. Dentistry  
 22 is by no means an outlier. Between 1994 and 2011, the 4-year cost of attending a public dental school  
 23 increased at an average annual rate of 7.8%. The cost of attending a private dental school increased at a  
 24 slightly slower rate of 5.6%. The rates represent a compounded annual growth rate and are similar to the  
 25 rates of increase at medical schools and four year undergraduate programs (Figure 1). The rates are  
 26 significantly higher than the rate of inflation over this period, which was 2.5%.  
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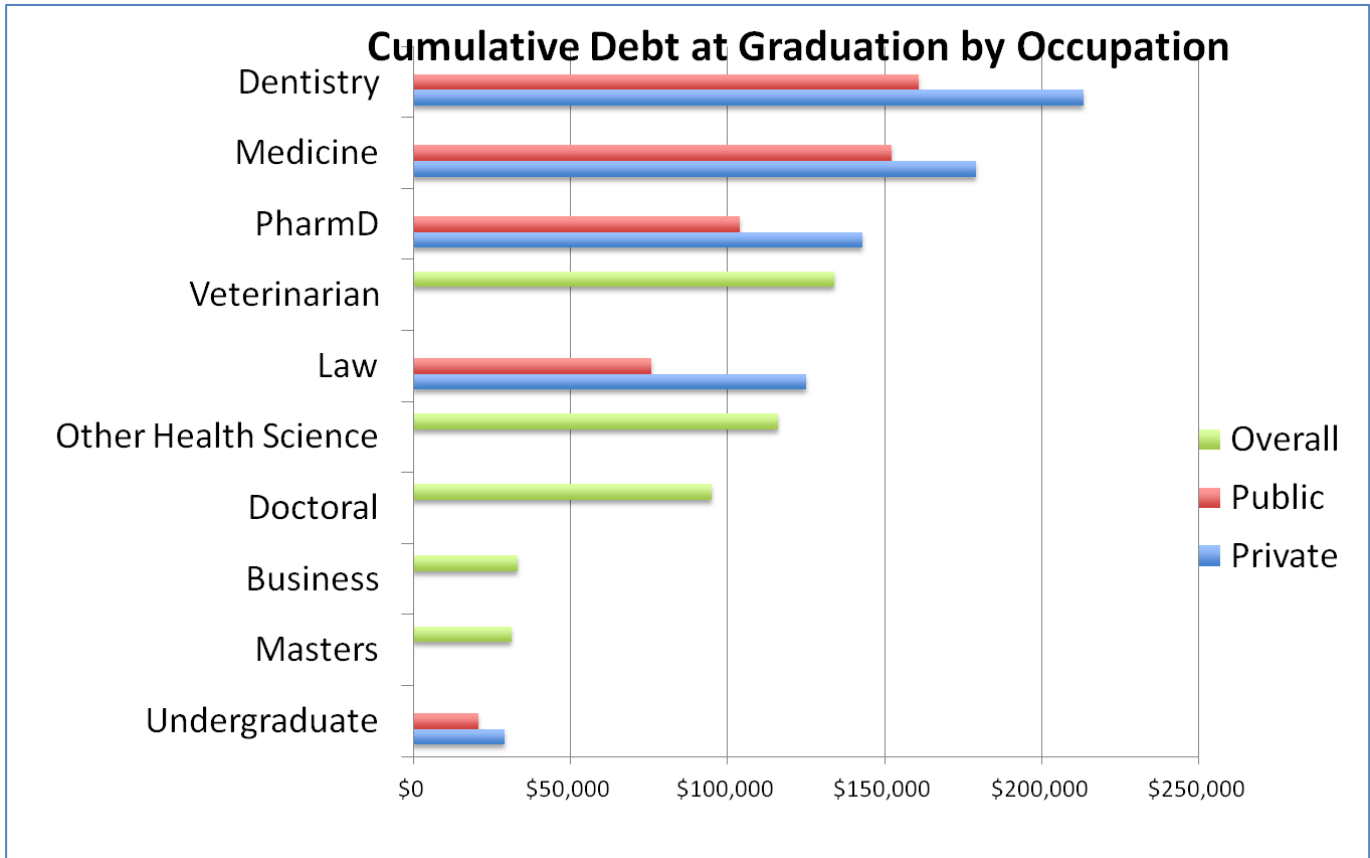
**Figure 1: Growth Rate of Dental Education Relative to Other Programs**





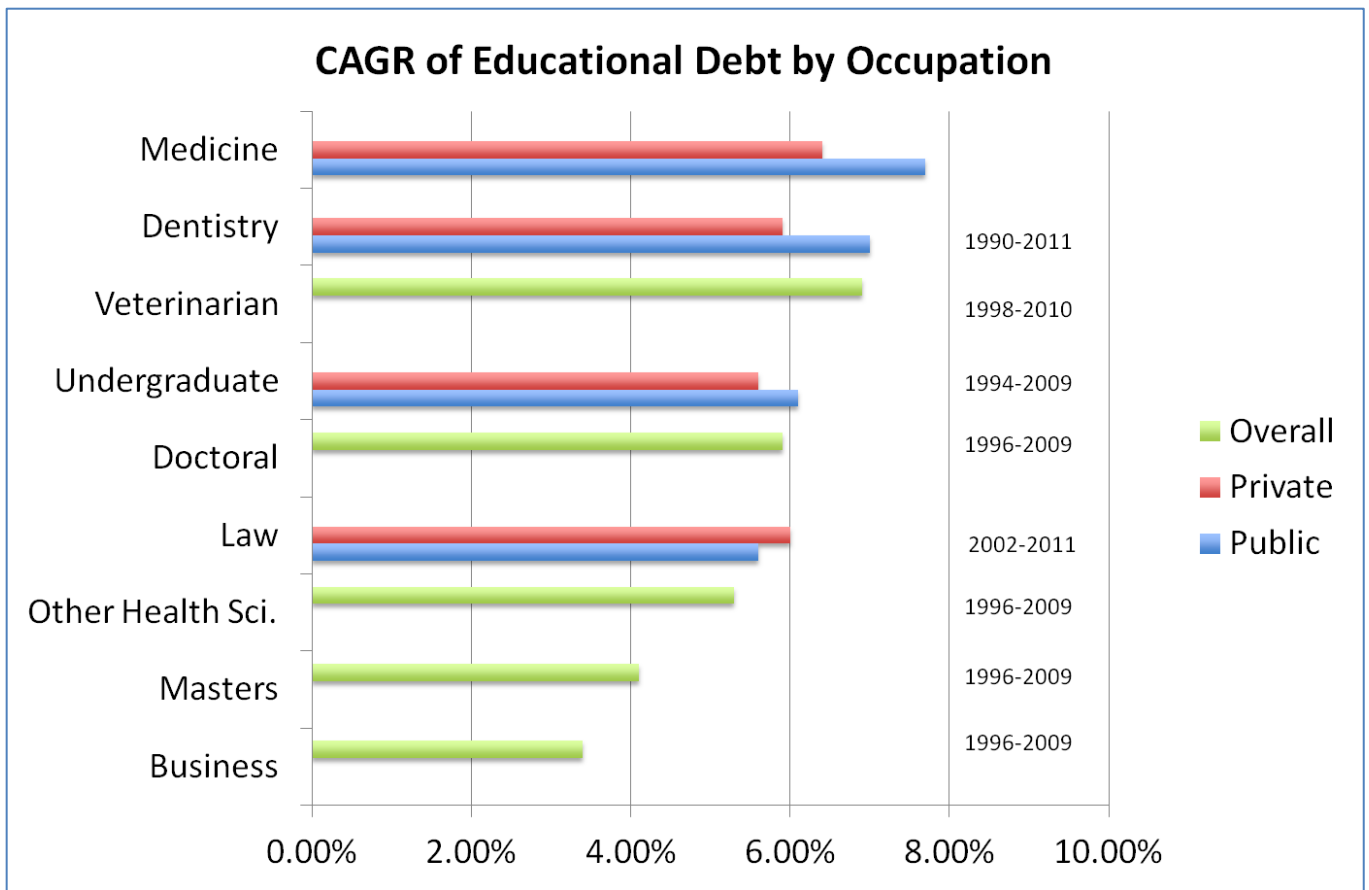
1 In addition, dental school graduates have higher than average debt loads. In 2011, the average total  
2 educational debt was \$213,000 for those who graduated from private schools and \$161,000 for those  
3 who graduated from public schools. According to the best available data for various occupations, dental  
4 students have more educational debt, on average, than any of the other high-income professions for  
5 which data could be found (Figure 2). As with other occupations, debt levels are higher for graduates of  
6 private dental schools.  
7

8 **Figure 2:** Cumulative Debt of Dental Students Relative to Other Professional Students  
9



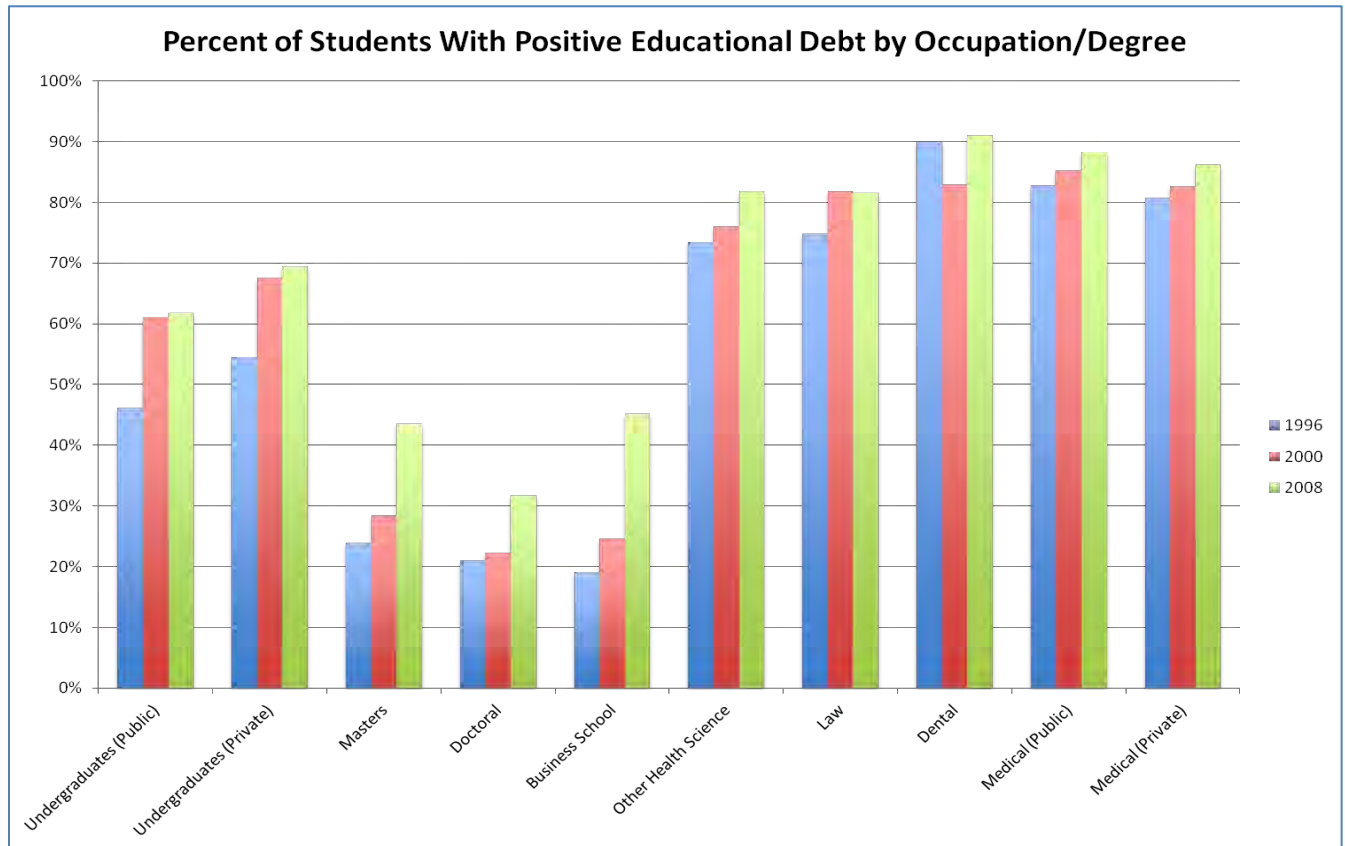
1 The increase in dental education debt is being driven by increases in cost of attendance. Cumulative  
 2 educational debt at the time of graduation grew at an average annual rate of 7.0% and 5.9% for students  
 3 attending public and private dental schools, respectively, between 1990 and 2011 (Figure 3). These rates  
 4 of increase are very close to the growth rates in the cost of attendance reported in Figure 1. This  
 5 indicates students are borrowing more in order to offset increasing tuition rates. Dental student debt is  
 6 growing at rates similar to those of medical and veterinary students, and slightly faster than in other high-  
 7 income occupations.  
 8

9 **Figure 3: Cumulative Average Growth Rate (CAGR) of Debt**  
 10 **for Dental Students Relative to Other Students**



1 More than 90% of dental students who graduated in 2008 had some educational debt. This percentage  
2 has not changed much since 1996. In fact, more than 70% of law, medical, dental, and other health  
3 sciences students have educational debt since the 1990s (Figure 4). Undergraduates and students in  
4 business school, as well as masters and doctoral programs, have experienced larger increases in the  
5 percentage of students with educational debt than dental students. However, these students started from  
6 a lower base in the mid-1990s.  
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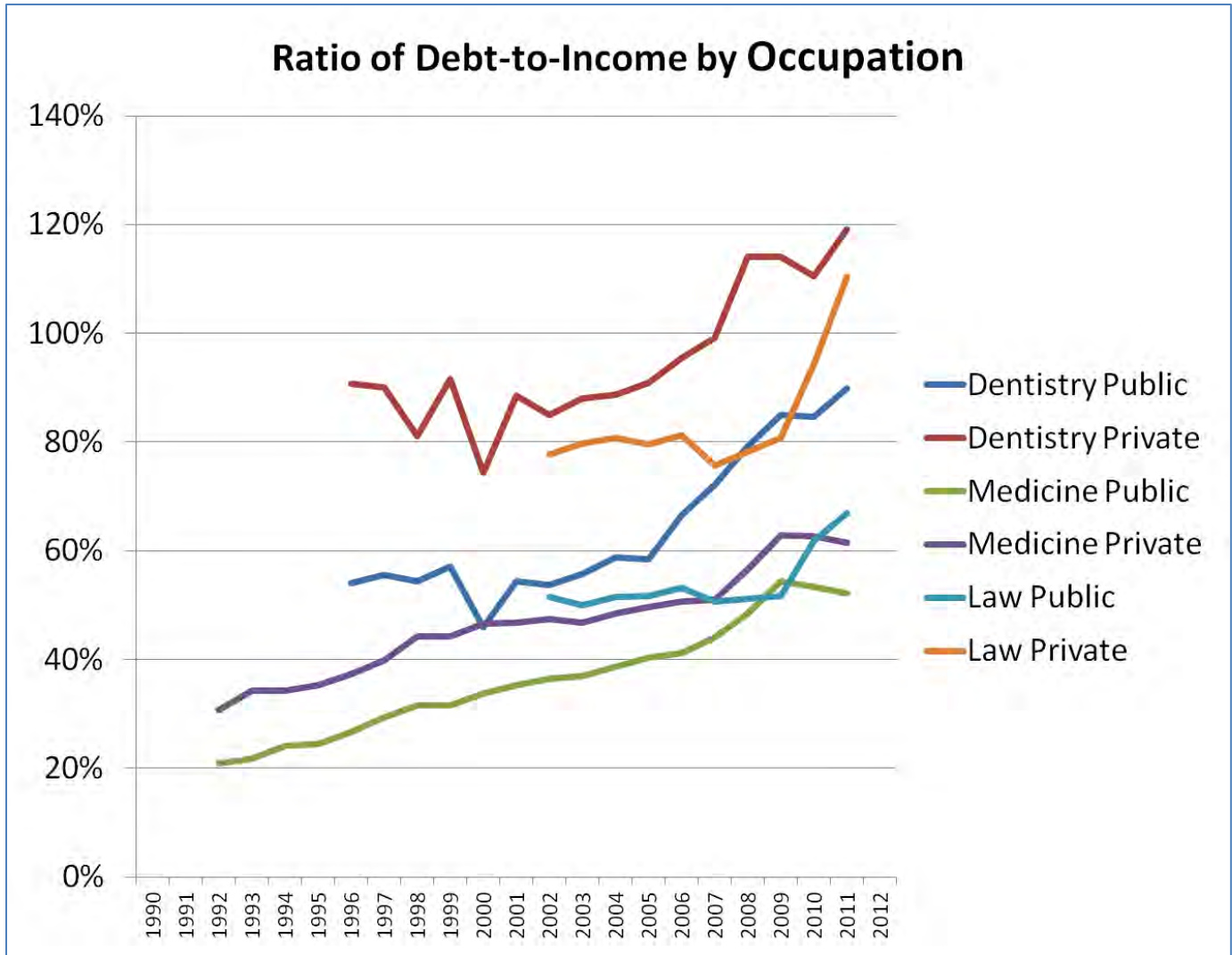
**Figure 4: Educational Debt for Dental Students Relative to Other Students**



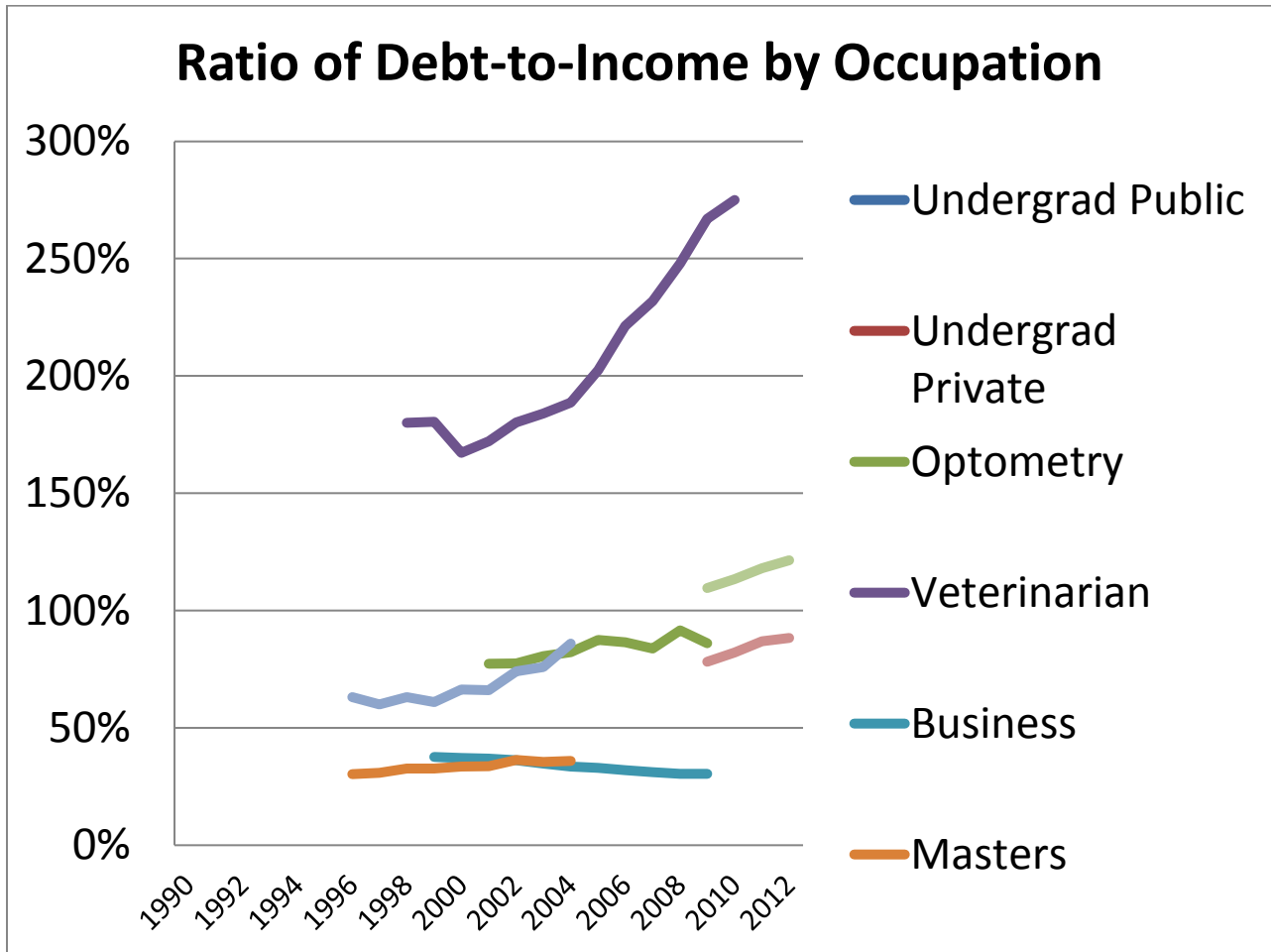
10  
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12 The debt to income ratio (total average debt at graduation divided by average annual net income) – a  
13 standard and widely-accepted measure of cost versus benefit – has increased substantially for dental  
14 students but also for other occupations over the last decade. Dentistry is not an outlier. Students  
15 graduating from private dental schools in 2011 had cumulative educational debt that was 119% of the  
16 median dentist’s income in that year. For graduates of public dental schools, the ratio of debt-to-income  
17 was 90% in 2011. In 1990, these figures were 76% and 46%, respectively, so the debt burden has  
18 increased over time. One major reason for the increase is that median dental income, which grew steadily  
19 between 1990 and 2003, started growing more slowly between 2003 and 2006, and then actually declines  
20 beginning in 2006. Dental graduates are not alone, however, as these trends in debt to income are the  
21 same for other occupations. The debt-to-income ratio has increased for most occupations and degrees,  
22 with business students and other masters students being the exceptions (Figure 5). The dental debt-to-  
23 income ratio in 2011 was similar to that of private law school graduates. Veterinarian graduates (Figure 6)  
24 have the highest ratio by far, approximately 275%, two to three times higher than dental graduates.

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**Figure 5:** Debt-to-income Ratio of Dental Graduates Relative to Other Graduates



**Figure 6: Debt-to-income Ratio of Undergraduates and Other Professional Graduates**



**Policy Implications**

- The trends in student debt for dental school graduates are also occurring for other occupations, to varying degrees. Debt levels have increased steadily since the early 2000’s for most higher education occupations. However, the sharp slowdown and decrease in dentist earnings since the mid-2000’s has led to a sharp increase in the debt to income ratio, a key measure of the “attractiveness” of the profession.
- Tuition increases have driven increases in student debt. If tuition increases continue and dentist incomes remain flat, the rate of return for a dental education will be dramatically reduced. Schools have been able to pass increases in operating costs on to students in the form of higher tuition and fees, because of a large, well-qualified applicant pool. Now that growth in dentists’ incomes is slowing, and student debt is at an all-time high, this financing strategy may come to an end. However, the fact that debt to income ratios are increasing for a wide variety of occupations will reduce the rate of return to these other occupations as well. This interplay will be one of the key factors driving the future dental school applicant pool. In a sense, the professions who experience the smallest decrease in the rate of return to education investment will likely be successful in maintaining significant numbers of qualified applicants.

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- The growth in dental income has slowed substantially over the last decade whereas tuition and educational debt have not. This may make dental school less appealing to qualified applicants compared with business school or medical school, for example. Although two-thirds of dentists who graduated in 1996 are now debt free, they started with a much lower debt burden than today's graduates. Ninety percent of younger dentists are experiencing stress over educational debt and more than 60% describe their stress as "a lot" or "extreme." As demonstrated in the ratio of debt to income by occupation figures, growing educational debt is a problem for graduates in all professional fields, but the debt-to-income ratio for dentists is among the highest.

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11 **Recommended Actions by Taskforce**

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- Develop a robust information program to help students become fully informed consumers about a career in dentistry, including workforce reports, debt, expected income and financial planning.
  - Pursue research efforts to collect better data on dental school applicants' knowledge about the economics of the profession and their career choices. One source of these data could be the candidate application survey associated with the Dental Admissions Test.
  - Advocate for more loan forgiveness programs for dentists at the state and federal levels.
  - Advocate for dentists to be eligible for all health professions loan forgiveness programs.

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**2. What are the operating costs of a dental school? Does institutional setting matter? How are these operating costs financed and how has the financing pattern changed over time?**

28 **Methods and Data**

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The data comes from the annual financial survey of all dental schools carried out by the ADA Health Policy Resources Center on behalf of CODA and a literature review (see Appendix B-Dental School Finances). The information in the survey is self-reported annually by the dental schools. The study covers all dental schools from 2000-2001 to 2011-2012. Due to changes in the survey format, some analyses focus on the 2004-2005 to 2011-2012 time-frame. The data were examined for all schools, then separately for both public and private schools. For each revenue and expense category, the mean and standard deviation and percent nominal and real mean changes were calculated. The characteristics of schools with the lowest expenditures per student were examined. Multivariate analyses investigated the factors that explain variation in the cost of educating students and residents. All the percent changes in revenues and expenses presented are in real dollars (i.e., adjusted for inflation).

41 **Key Findings**

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The number of dental school students and residents grew almost twice as fast as the U.S. population over the last decade. From 2000 to 2011, the average growth rate of the number of dental students was 1.6% (from 17,242 to 20,547 students). Specialty residents grew even faster, 2.1% per year (from 2,447 to 3,061 residents). The number of residents in postdoctoral general dentistry programs (AEGD and GPR) increased 3.5% per year, but this was from a very low base. At the same time, schools decreased enrollment of allied health students 1.1% per year. The U.S. population grew an average of 0.9% per year during that time. While the 1980's and 1990's saw a decrease in enrollment compared to the 1970's, in the 2000's, enrollment has been expanding significantly. According to the data, total revenues per year increased faster than total expenses per year and the average school ran a surplus for all years except 2000-2001. From 2000-2001 to 2011-2012, revenue increased faster than total expenses (4.3% vs. 3.4%) across all schools. In 2011-2012, the surplus across all schools combined was \$265 million (8% margin).

1 This resulted from greater revenues from tuition and fees, patient care, and university indirect subsidies.  
2 Revenues and expenditures differed by type of school. For public schools, total revenues increased only  
3 1.0% from 2004-2005 to 2011-2012 (Table 1). Most of the increase resulted from a large expansion of  
4 revenues from tuition and fees as well as patient care. At the same time, state support for dental schools  
5 declined substantially. Private dental schools, on the other hand, increased total revenues 21.1% and,  
6 similar to public dental schools, some of this increase was from higher tuition and fees as well as patient  
7 care. The size of endowments varies considerably among all schools and remains a relatively small  
8 proportion of operating revenue. Increasing dental school endowments could be a strategy for schools to  
9 pursue for enhancement of revenue.

10 **Table 1:**

11 Total Change in Real Revenue, 2004-2005 to 2011-2012,  
12 By Type of School

Revenue Source	Public	Private
Tuition/fees	68.5%	38.9%
Patient care	25.0%	15.3%
State support	-17.2%	N/A
Endowment	-2.3%	55.5%
<b>Total Revenue</b>	<b>1.0%</b>	<b>21.1%</b>

16 Public schools were more successful at controlling their expenses than private schools. Total public  
17 school expenses increased 11.8% compared with a 17.3% increase at private schools (Table 2). Private  
18 school expenses for libraries, technology, and facilities were much higher than similar expenses for public  
19 schools. The changes in expenses do not account for the age of the facility (i.e., equipment, technology,  
20 renovations and/or new construction).  
21  
22

23 **Table 2:**

24 Changes in Expenses, 2004-2005 to 2011-2012  
25 By Type of School

Expense	Public	Private
Education	4.6%	15.7%
Patients	16.2%	17.1%
Library/computers	- 8.4%	29.5%
Facilities	-19.2%	15.6%
<b>Total Expenses</b>	<b>11.8%</b>	<b>17.3%</b>

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31 The breakdown of revenues and expenses clearly shows the main difference in financial health between  
32 public and private schools is the decline in state support.  
33

34 The schools with the lowest expenses per “full-time equivalent student” (FTE) were mainly private, but  
35 there was no simple explanation for their lower costs. A better measure of financial health than total  
36 revenues and expenses is the revenue and expenses per FTE, which controls for school enrollment.

1 While there is no simple answer as to why schools had low expenditures, they tended to have fewer  
2 curriculum hours, smaller research programs, and fewer full-time clinical faculty. There were large  
3 differences in revenues per FTE among schools. The school with the highest revenues had revenues that  
4 are more than three times greater than the school with the lowest revenues. The five schools with the  
5 highest revenues had average revenues that were more than twice the average of the lowest five (Table  
6 3). Further, the nominal increase in revenues over the seven years was much greater in the highest  
7 revenue schools.  
8

9 **Table 3:**

10 Revenues per FTE for Five Schools Ranked by the  
11 Highest and Lowest Values in 2011/12  
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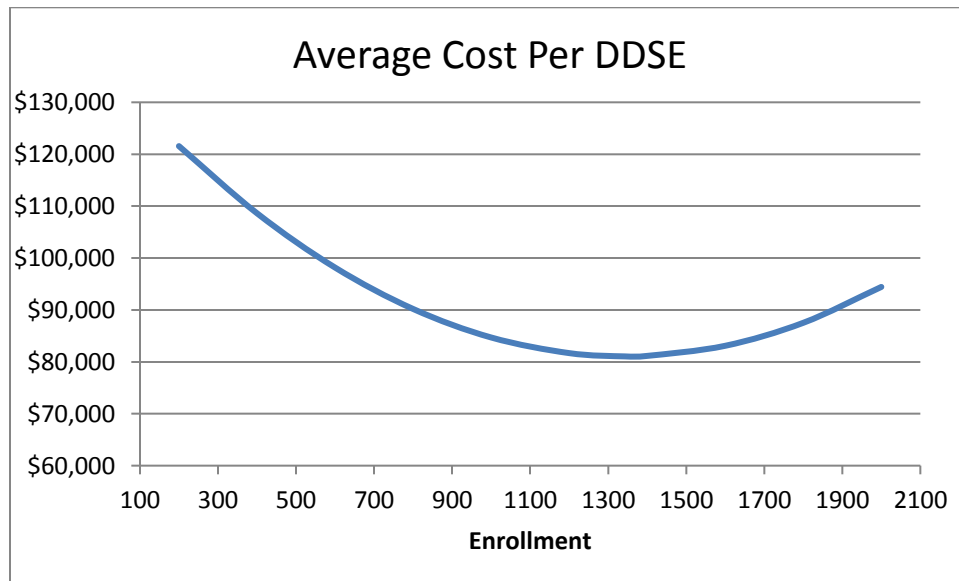
Type	Rank H Vs. L	Revenues per FTE		Nominal Difference
		2004/05	2011/12	
Public	H	\$178,872	\$212,224	\$33,352
Private	H	125,359	186,495	61,136
Public	H	142,732	180,857	38,125
Public	H	115,283	168,694	53,411
Public	H	123,260	165,525	42,265
Public	L	\$81,233	\$65,278	-\$15,955
Private	L	56,834	84,360	27,526
Public	L	67,431	84,644	17,213
Private	L	65,575	90,244	24,669
Public	L	103,496	99,361	-4,135

14  
15  
16 The average cost per “dental student equivalent” (DDSE=1.0 X undergraduate DDS enrollment + 1.7 X  
17 advanced specialty enrollment + 0.5 X allied enrollment + 1.0 X post-doctoral general dentistry  
18 enrollment) varies based on school size. The average cost per DDSE decreases as DDSE (i.e., the size  
19 of dental school) increases from 200 to 1,343, and then increases as the size exceeds 1,343 (Figure 1).  
20 With existing educational technology, 1,343 DDSE represents the most efficient size based on  
21 econometric analysis. Increasing the size of a small dental school can lower average costs markedly.  
22 Average costs decrease or increase slowly between 1,000 and 1,600 DDSE, but more rapidly outside this  
23 range. In 2010, the average DDSE was 460.2 per school. The largest DDSE is 1,577.5, while the smallest  
24 is 169.6.



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**Figure 1:** Estimated Average Cost Curve, 2011-2012, holding all variables other than DDSE constant



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More than 90 percent of the variation in total expenditures across dental schools over multiple time periods can be attributed to the size of the school's enrollment; personnel; faculty practice and research activities; and whether a school was public or private. The technology of dental education has changed with the internet, electronic records, computerized management systems, and new simulation methods. These technical innovations may have affected the cost structure of dental schools. To test for this possibility, similar cost functions were estimated for the years 1990-1991, 1995-1996, and 2010-2011. The results indicate that, while marginal changes occurred in the cost structure of dental education, the factors that are important now were also important in earlier years.

There is a critical need to reassess the method of collecting financial data from dental schools for both accreditation and research purposes, and to assess its overall reliability and value. There were many concerns with various data elements, and this raises some caution in interpreting the results of the analysis.

**Policy Implications**

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- The financial trends seen in the last 11 years (2000-2011) were already evident in the previous 11 years (1990-2001) based on previously published analyses. For public schools, state support started to decline 20 years ago and schools responded by increasing tuition and fees for students and advanced specialty residents. They also kept investments in the basic medical sciences, libraries, and physical plants below the inflation rate. Private schools also raised tuition and fees faster than the rate of inflation, even though they did not have the problem of declining public support. Overall, private schools appear to be in better financial shape than public schools and some private schools appear to have run surpluses.
- Both public and private schools were able to raise tuition and fees above the rate of inflation because the number and quality of dental students increased significantly. In large part, the increase in applicants was related to the expected return on an investment in a dental education. The assumption was graduates would be able to pay off their debt in a reasonable length of time and go on to have productive and well-paid careers in dentistry. Until recently, this was a sound

1 assumption. This may no longer be the case, as the rate of increase in dentists' incomes has  
2 slowed and even declined.

- 3
- 4 • Thus far, the number and quality of dental school applicants has not declined, and new dental  
5 schools are under development; however, there are significant concerns about the future. This  
6 suggests that the market signals are not obvious to large numbers of applicants and new schools.  
7 Schools may not be able to support traditional clinical dental education programs if they are  
8 unable to increase tuition and fees at the same rate as in the past.  
9
  - 10 • The following are potential revenue-enhancements/expense offsets for consideration:  
11
    - 12 ○ **Graduate Medical Education Funds** - One approach is to obtain federal (Center for  
13 Medicare and Medicaid Services) approval for dental school eligibility for Graduate  
14 Medical Education (GME) funds. At this time, only hospitals and community clinics can  
15 obtain GME funds. Most hospitals are not interested in funding dental residency  
16 programs, except for Oral and Maxillofacial Surgery and Pediatric Dentistry. Even when  
17 hospitals form joint residency programs with dental schools, they usually keep all or most  
18 of the indirect GME support. These indirect funds cover the cost of administering the  
19 program and paying the additional clinical expenses associated with residency training.  
20 The reality is that dental schools, rather than hospitals, cover most clinical training  
21 expenses. Hospitals are able to keep these indirect GME funds, because of their superior  
22 negotiating leverage compared to dental schools. The GME direct payments provide  
23 residents a stipend and fringe benefits. Depending on the number of residents, dental  
24 schools may receive partial funding for a faculty member to supervise residents. If dental  
25 schools could obtain federal GME approval for dental residency programs, it would be a  
26 major source of new revenue. It is difficult to judge the political feasibility of obtaining  
27 federal GME approval for dental schools. There is a growing national concern about  
28 hospital costs and the large sums of money spent on GME. The federal government may  
29 reduce hospital-based GME support, making it difficult to obtain GME funds for dental  
30 school-based residents.  
31
    - 32 ○ **Safety Net Clinics** - Patients treated by dental students are often underserved;  
33 however, due to the dental school clinics' educational mission,(for example, the nature of  
34 the teaching environment; the pace of dental care delivered; the patient populations that  
35 are treated; and the patients limited ability to afford comprehensive treatment), relatively  
36 few patients receive care compared to the estimated total number of underserved  
37 patients in the general population. There is a national concern about the large disparities  
38 in dental care, and approximately \$10 billion dollars have been allocated to expand  
39 Federally Qualified Health Centers (FQHCs) in the Affordable Care Act legislation. A  
40 strong case can be made to use some of these funds to provide dental schools additional  
41 resources to care for Medicaid and other underserved patients. In other words, the idea is  
42 to make dental schools part of the national dental safety net system and provide them  
43 similar levels of funding as FQHCs. The latter organizations are paid per visit for treating  
44 Medicaid eligible patients, and they receive a grant from the federal government to cover  
45 non-Medicaid eligible indigent patients.  
46
    - 47 ○ **Larger but Fewer Schools** - The analysis shows that most dental schools are too small  
48 to operate at maximum efficiency. Schools with approximately 1,300 DDSEs (students  
49 and residents) would operate more efficiently than schools with 500 DDSEs – the size of  
50 many dental schools. The potential savings from having fewer but larger schools are  
51 significant. If all schools had 1,300 DDSEs, the cost of dental education could be reduced  
52 20% or more and fewer schools would be needed to educate the current numbers of  
53 dental and auxiliary students and residents. While this strategy is compelling, it has little  
54 practical feasibility. Each public and private school operates independently. It is unlikely

1 that specific states or universities would close their dental schools based on a national  
2 voluntary plan for dental education.

- 3
- 4 ○ ***New Clinical Education Models*** - About 80 percent of dental school expenditures are  
5 for patient care programs, so substantial reductions in school operating expenses must  
6 come from clinical programs. Dental schools are the only health professional schools that  
7 own and operate their own patient care clinics. These clinics are run as teaching  
8 laboratories, with the primary goal of dental student education. Medical, nursing, and  
9 pharmacy education use a fundamentally different clinical education model. Students  
10 and residents are trained in clinical settings that are not owned or operated by the  
11 schools. In this sense, the schools pass the cost of clinical education on to these delivery  
12 sites (e.g., hospitals, outpatient clinics, pharmacies). Medicine also requires several  
13 years of clinical training after graduation to become eligible for licensure and specialty  
14 certification. This allows medical schools to focus on the basic and clinical sciences  
15 rather than technical skills which are learned after graduation. This is in direct contrast to  
16 dental schools which focus on technical skills, since graduates are expected to be ready  
17 to enter practice after four years.
- 18
- 19 ○ ***“Medical” model of clinical education***- This is no longer a new idea, and the  
20 transformation is already underway. Many schools are increasing the time that senior  
21 dental students spend in “community rotations,” receiving clinical training in community  
22 clinics, hospitals, and other patient care settings that are not owned or operated by dental  
23 schools. Known as community-based dental education (CBDE), at some schools senior  
24 students now spend over half the year providing care in community facilities (see  
25 Appendix C-Community-Based Dental Education). The available evidence suggests that  
26 students are much more productive in community settings, because they have the  
27 support of a professional clinical and administrative staff. In this model, community-  
28 based faculty continue to practice as they supervise one or two students, so large  
29 numbers of underserved patients receive care.
- 30

### 31 **Recommended Actions by Taskforce**

- 32 • Encourage the ADA/CODA/ADEA Liaison Committee for Surveys and Reports to continue the  
33 process of refining the dental school finance survey. Outside consultants should establish 5-6  
34 efficiency measures for benchmarking.
- 35
- 36 • Advocacy for dental schools to be approved FQHCs or partner with FQHCs.
- 37
- 38 • Encourage increased use of community clinics for the clinical education of dental students and  
39 residents.
- 40

### 41 **3. What innovations have dental schools pursued to reduce operational costs?**

#### 42 **Methods and Data**

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44

45 The data comes from the annual financial survey of all dental schools carried out by the ADA Health  
46 Policy Resources Center on behalf of CODA. The study covers all dental schools from 2000-2001 to  
47 2011-2012. Because of changes in the survey format, some analyses focus on the 2004-2005 to 2011-  
48 2012 period. The data were examined for all schools, then separately for both public and private schools.  
49 For each revenue and expense category, the mean and standard deviation and percent nominal and real  
50 mean changes were calculated. The characteristics of schools with the lowest expenditures per student  
51 were examined. Multivariate analyses investigated the factors that explain variation in the cost of  
52 educating students and residents. All the percent changes in revenues and expenses presented are in  
53 real dollars (i.e., adjusted for inflation).

54

**Key Findings**

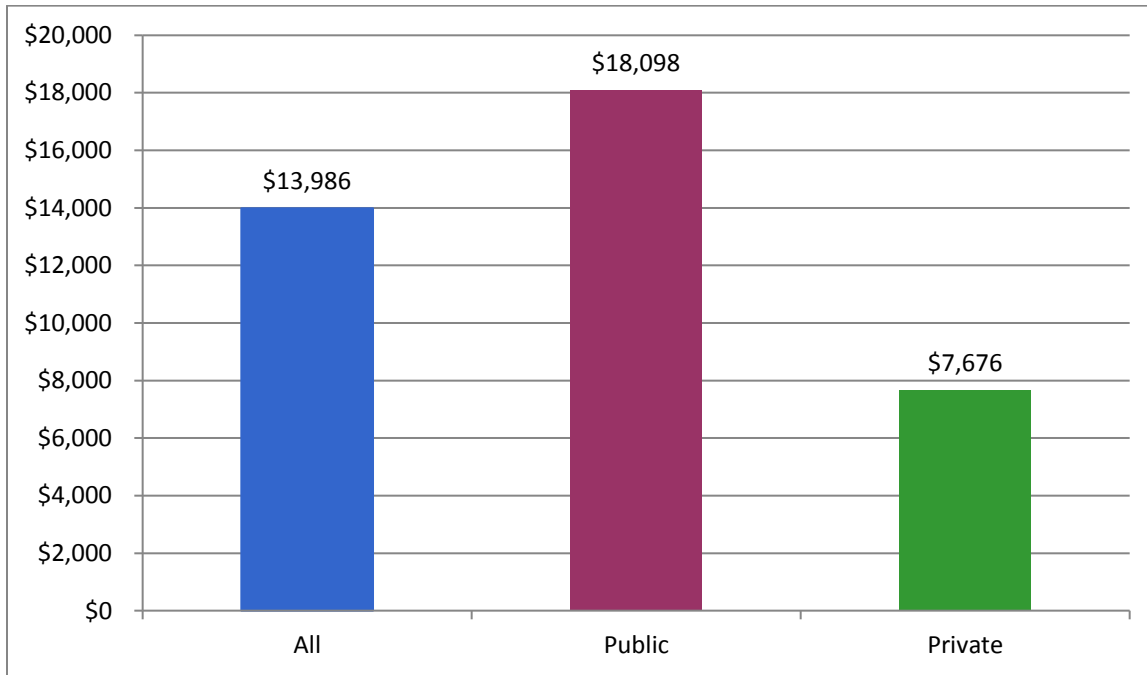
It is questionable as to whether there have been any large scale major innovations to reduce dental school costs, most likely because schools have not been “forced” to innovate. Schools have been able to raise tuition and fees as well as patient care revenues in order to compensate for increasing expenses and reduced public funding. Nevertheless, there are large differences between high cost and low cost schools in terms of costs per full time equivalent student (FTE). High cost schools tend to have larger research programs, more curriculum hours and more full-time faculty. Reductions in expenses per FTE student come mainly from economies of scale – increased enrolments rather than innovations. While state funding has declined for most public schools, a few still receive a substantial direct subsidy from state government. Some universities protected their dental schools from severe state budget reductions by making “hard” decisions on which academic units to support or close. Other schools came from states that had the resources to provide public universities adequate funding.

Many universities assisted their dental schools by increasing cross-subsidies and/or reducing overhead charges. Thus, the direct state allocation to dental schools is only part of the story. Universities have the flexibility to allocate public funds, endowment dollars, and other support differently among their academic units. All dental schools are part of universities and academic health centers, and there are many opportunities of universities to cross-subsidize the operations of dental schools. The average public school received \$8.9 million in university support in 2011-2012 and the average private university \$2.8 million in university support in 2011-2012. In real dollars, this support decreased in public dental schools, but increased substantially in private schools since 2004-2005. At the same time, universities also charge dental schools for certain services. Public schools paid universities an average of \$3.5 million, much less than the \$8.9 million in subsidies they received from the university. Further, the university charges declined about 10% in real dollars from 2004-2005 to 2011-2012. It appears that universities recognized the financial problems of public dental schools and made an effort to assist with fewer overhead charges. The situation with private schools is much different. University overhead charges averaged \$6.3 million in 2011-2012, much more than the average \$2.8 million received. Yet, from 2004-2005 these charges declined 20.7 percent in real dollars. Since private school universities increased the value of their services to dental schools and decreased overhead charges, it is evident that universities tried to assist private dental schools financially.

Looking at university indirect support on a revenue/FTE student basis reveals the differences between public and private dental schools (Figure 1). Across all schools, the average indirect support was almost \$14,000/FTE student. Public schools averaged over \$18,000/FTE student in indirect support from their universities, while private schools averaged just over \$7,600/FTE student. In addition, 12 of 19 private schools provided no indirect support, while just one of 38 public schools did not provide indirect support.

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**Figure 1: University Indirect Support for Dental Schools, Average Revenues/FTE**

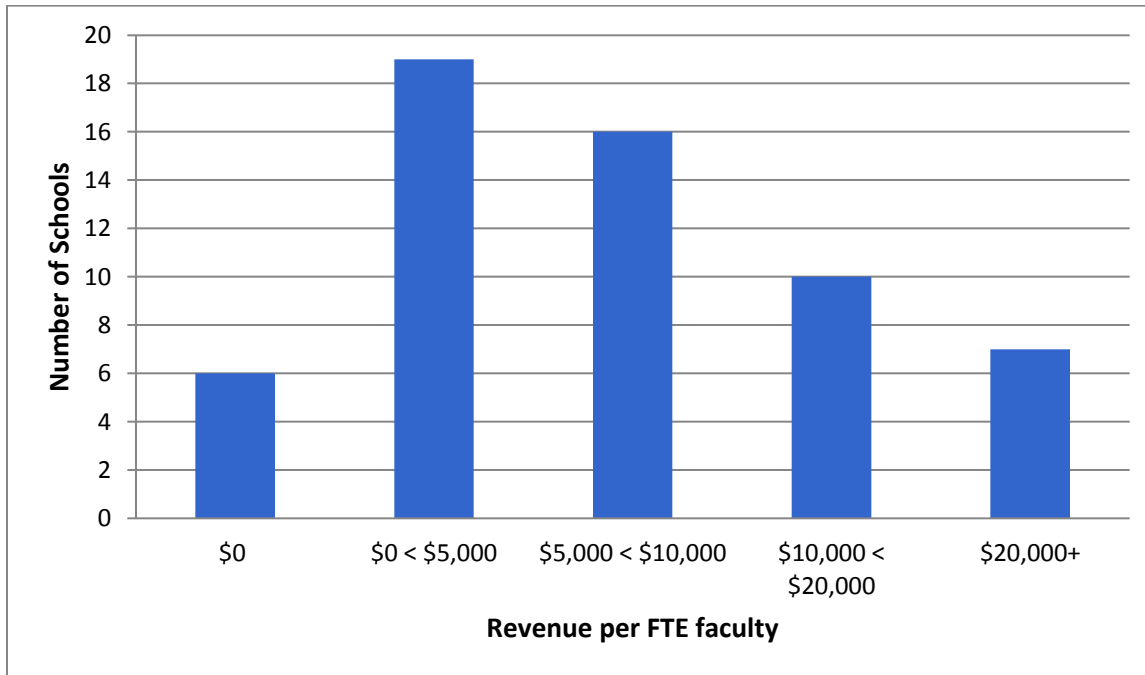


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Many dental schools increased the market value of their endowments. The average dental school endowment is about \$22 million, which generates about one million dollars annually in available operating funds. If schools continue to increase endowments at the same rate as the past ten years, this will generate additional operating funds and disposable income.

Schools varied substantially on the amount of revenue generated by full time equivalent faculty (see Figure 2). As schools are hard-pressed to pay clinical faculty competitive salaries, an effective faculty practice has considerable potential to provide schools additional resources. Most schools provide full-time faculty the opportunity to generate additional income by providing care to private patients in school-owned faculty practices, with schools keeping a certain percentage of gross faculty practice revenues to cover overhead expenses. In addition, some schools “tax” the faculty practice, with the dean retaining a percentage of net revenues to cover school operating costs. The amount of the tax varied widely among schools, but the modal tax was about five percent. Most schools generated less than four million dollars in faculty practice gross revenues.

**Figure 2: Variation in Faculty Practice Revenue, 2011-2012**



There are numerous issues with the quality of the financial data on dental schools. There is a critical need to reassess the method of collecting financial data from dental schools for both accreditation and research purposes, and to assess its overall reliability and value. There were many concerns with various data elements, and this raises some caution in interpreting the results of the analysis.

**Policy Implications**

Strategies that are successful in one school may not be easily transferred to other schools with different local environments. Dental education is “a local business,” and schools use different strategies to adapt to their local environments. The primary analysis looked at changes in total and average revenues and expenditures over time, but it masked large differences among dental schools. To address this issue, an analysis of the variation in selected critical variables was done. These analyses point to the great variation among schools as they try to adapt to local environmental conditions. Opportunities for schools to generate substantial new net revenues from patient care appear limited. As a result, schools need to look for other revenue-generating innovations or innovations that reduce expenses. Some possibilities include:

- Cooperation among schools - Most dental schools are too small to operate efficiently. One way to deal with this problem is to have schools located in the same city, state, or region share resources such as faculty, staff, and facilities. There are huge potential savings if schools would cooperate, and this is especially true for graduate specialty programs. It makes little economic sense for small schools to run these programs with just a few residents. This is also true in regards to specialized faculty in areas, such as oral and maxillofacial pathology and oral and maxillofacial radiology, along with interest areas in general dentistry, such as dental materials and oral medicine. Currently, there are almost no organized cooperative programs among geographically-related schools. Most likely, it will have to take a great deal more financial hardship before schools seriously consider giving up some of their autonomy to improve their financial situations.

- Closer Integration with Medical Education - It has been more than 150 years since the professions of medicine and dentistry separated in the United States. In large part, this separation explains why most dental schools are small, and why there are so many dentists (e.g., 185,000 dentists versus 115,000 internists). In the future, a stronger background in the basic and clinical sciences for dentists may be necessary, due to an anticipated increase in geriatric patients that have complex medical issues; new prevention and treatment technologies; and a shortage of primary care physicians. A case can be made for fewer but better trained dentists; however, this is a large, complex issue and cannot be fully explored in this paper.

#### Recommended Actions by Taskforce

- Encourage the ADA/CODA/ADEA Liaison Committee for Surveys and Reports to continue the process of refining the dental school finance survey.
4. **What is the role of educational institutions, students, residents and new graduates in the dental “safety net” and what innovations have there been in recent years?**

#### Methods and Data

The data comes from the annual survey of all dental schools carried out by the ADA Health Policy Resources Center on behalf of CODA; the Medical Expenditure Panel Survey (MEPS) (data on access disparities); and the annual ADEA Survey of Dental Seniors. An extensive literature review was conducted (see Appendix D-Dental Safety Net).

#### Key Findings

Dental schools account for relatively little of the total care provided to the underserved population. To attract patients, dental student clinic fees are usually set 40-60% below usual and customary market fees. As a result, students mainly treat patients from lower-income families. Students and residents are not as efficient in providing treatment compared with an experienced private practitioner. In addition, dental student clinics are not organized to maximize efficiency. Although dental student patients are often low income and underserved, relatively few patients receive care within dental school settings. Combining student and resident patients, an upper bound estimate is that dental schools treat about 1.3 million low income patients annually, only a small fraction of the estimated 30 million underserved people in the United States with a dental visit. Currently, the majority of low income patients receive dental care in private treatment settings. Two studies came to similar conclusions, estimating that between 65% and 75% of low income patients received care in private practice settings. In large part, this is because the overall capacity of the safety net system is only about 10 million patients. Dental school graduates from underrepresented minority (URM) backgrounds (i.e., African American, Hispanic, and Native American) are more likely to care for minority and underserved patients than graduates from other racial/ethnic groups.<sup>1</sup> Likewise, dental school graduates from rural areas are six times more likely to practice in rural areas than urban areas.<sup>2</sup> Based on the ADEA survey completed by graduating seniors, twice as many seniors from URM (45%) vs. White (23%) backgrounds agreed that dentists have an ethical and professional obligation to provide care to underserved patients. Likewise, a much higher percentage of URM (25%) vs. White (10%) seniors expect to have at least 30% of their patients from disadvantaged backgrounds. It also appears that relatively more URM graduates work in dental safety net clinics and that minority private practice dentists have relatively more minority patients.

There is a national concern about the large disparities in access to dental care. To partially address this issue, approximately \$10 billion have been allocated to expand Federally Qualified Health Centers (FQHCs) in the Affordable Care Act (ACA). FQHCs are paid per visit for treating Medicaid eligible patients and they receive a grant from the federal government to cover non-Medicaid eligible indigent patients.

## 1 **Policy Implications**

2  
3 While dental schools cannot solve the access problem, they can have a major impact if the payment and  
4 delivery strategies discussed are implemented. Importantly, these strategies will also improve the quality  
5 of dental education and provide schools with additional revenues that they can invest in slowing the  
6 growth of tuition and improving academic and research programs. There are several strategies that dental  
7 schools and the profession can use to decrease access disparities and expand the role of students and  
8 residents in the dental safety net, including:

- 9
- 10 • Increase the number of community-based dental education programs and increase the amount of  
11 time dental students and residents spend in these programs for clinical education-Instead of  
12 treating two patients a day (as is common in dental school clinics), students tend to treat more  
13 than two patients a day in the community-based clinics, due to increased numbers of allied dental  
14 staff in these clinics. If all schools had seniors spend 70 days in community sites, such as  
15 FQHCs, an additional 1.2 million patients could receive dental care. In addition to helping reduce  
16 disparities, community-based dental education can have a significant and positive effect on dental  
17 school finances.
  - 18
  - 19 • Encourage increases in enrollment and number of residency programs- Approximately 50% of  
20 dental school graduates enroll in advanced education programs in the dental specialties and  
21 general dentistry. Since most postdoctoral general dentistry education programs provide care to  
22 large numbers of underserved patients, an increased number of residency programs would still  
23 have a small impact on access disparities due to the significant underserved population.  
24 Assuming all these programs took place in efficiently run clinics and practices, another two million  
25 patients could receive dental treatment.
  - 26
  - 27 • Increased fees for treating low income patients - Medicaid reimbursement rates for dental care  
28 are generally very low in most states. In at least two states (North Carolina and New York) dental  
29 schools have negotiated an enhanced reimbursement rate for treating Medicaid patients. Dental  
30 schools could advocate for cost-based reimbursement on par with what FQHCs receive. With  
31 adequate Medicaid fees, dental students, residents, and faculty would have an incentive to care  
32 for Medicaid patients. Although this will have some effect on both access disparities and dental  
33 school finances, the reality is that while dental students mainly treat low-income patients, only  
34 about 13% are covered by Medicaid. This is because many states do not cover adult dental care.
  - 35
  - 36 • Recruit more students from underserved areas – research has shown that students from under-  
37 served areas are more likely to return to those areas and practice than other students; however,  
38 their overall impact on reducing access disparities is limited.

## 39 **Recommended Actions by Taskforce**

- 40
- 41 • Advocate for increased Medicaid fees and cost-based reimbursement for dental schools.
  - 42
  - 43 • Advocate for dental schools to be approved FQHCs or partner with FQHCs as an example of  
44 community-based education for dental students and residents.
  - 45
  - 46 • Encourage increased use of community clinics for clinical education of dental students and  
47 residents.
  - 48



## 5. What impact does student debt have on graduates' employment choices?

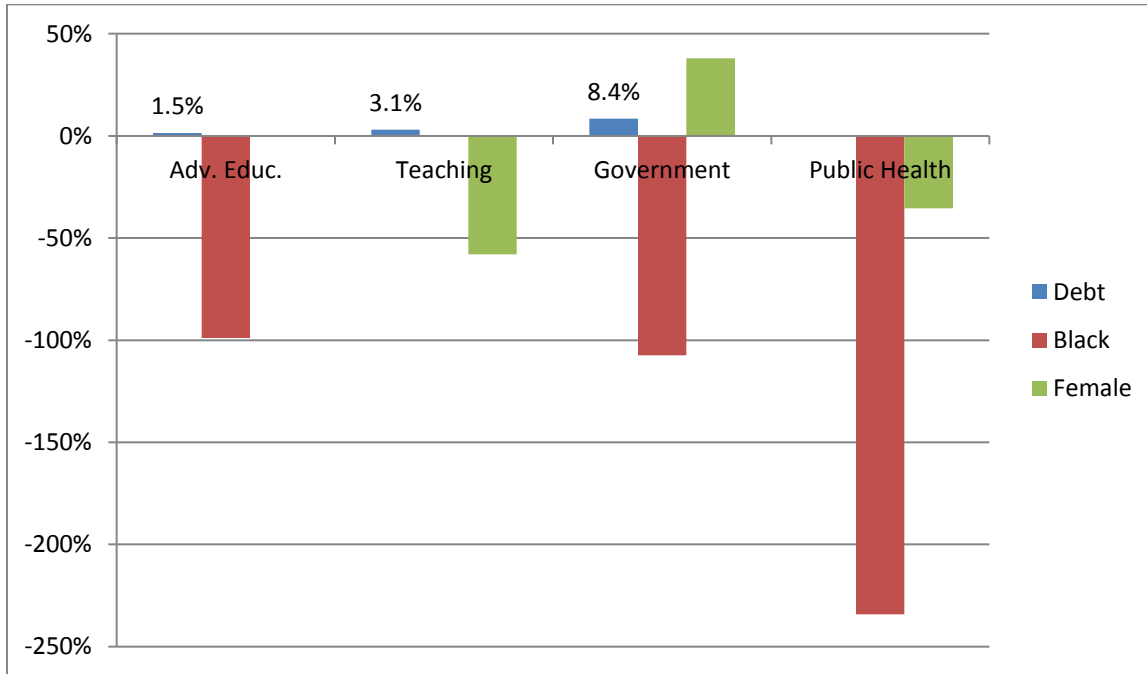
### Methods and Data

Data for this study came from three sources. First, historical data were obtained from the ADEA Annual Survey of Dental School Seniors, which is self-reported data collected at the time of graduation on expected post-graduate employment and/or education plans. The dataset obtained was from 2004 through 2011. The average age of the seniors surveyed was 28 years old. Observations with age less than 24 years old or greater than 50 years were excluded to remove observations with inaccurate entries. Second, new data were collected by the ADA. The methods consisted of surveying dental students who graduated in 1996, 2001, 2006, and 2011. More than 1,800 dental graduates completed the survey, which was conducted in January and February of 2013. The survey collected information regarding how much educational debt a dentist had upon completion of dental school, the current debt balance, the current practice situation, including annual income, average weekly hours worked, patient characteristics, attitudes toward debt, and other information. Regression analysis was performed to determine whether there is an association between the amount of a debt a student had when completing dental school and their actual career choices, such as whether they are in private practice, whether they own their practice, and whether they practice in an underserved area. The survey also asked how many dentists have paid off their educational loans, and the balance of those who are still paying off their loans. Unlike prior studies that focus on simple bivariate correlations between debt and career choices and outcomes, this new research use multivariate regression analysis to control for a variety of co-founding factors influencing career choice. The key career choices examined were: willingness to pursue specialty training, willingness to work in faculty settings, willingness to work in underserved areas, willingness to treat Medicaid patients, willingness to work in public health settings, hours worked per week, and practice ownership. Finally, a literature review was done (see Appendix E-Employment Choices).

### Key Findings

Students graduating with relatively large amounts of debt are more likely to plan on entering private practice, less likely to pursue advanced education, and less likely to plan on a government position, but, the magnitude of these effects is small. For each \$10,000 increase in debt, the model predicts a student's likelihood of choosing advanced education relative to private sector employment was lowered by 1.5%, choosing teaching was lowered by 3.1% and choosing a government career was lowered by 8.4% (Figure 1). While all these results were statistically significant, race and gender played a much larger role in career decisions than educational debt. Blacks were approximately twice as likely as whites to enter advanced education or government careers relative to private practice, and over three times more likely to choose public health. Females are 58% more likely to choose teaching, 38% less likely to enter government, and 35% more likely to enter public health than their male counterparts.

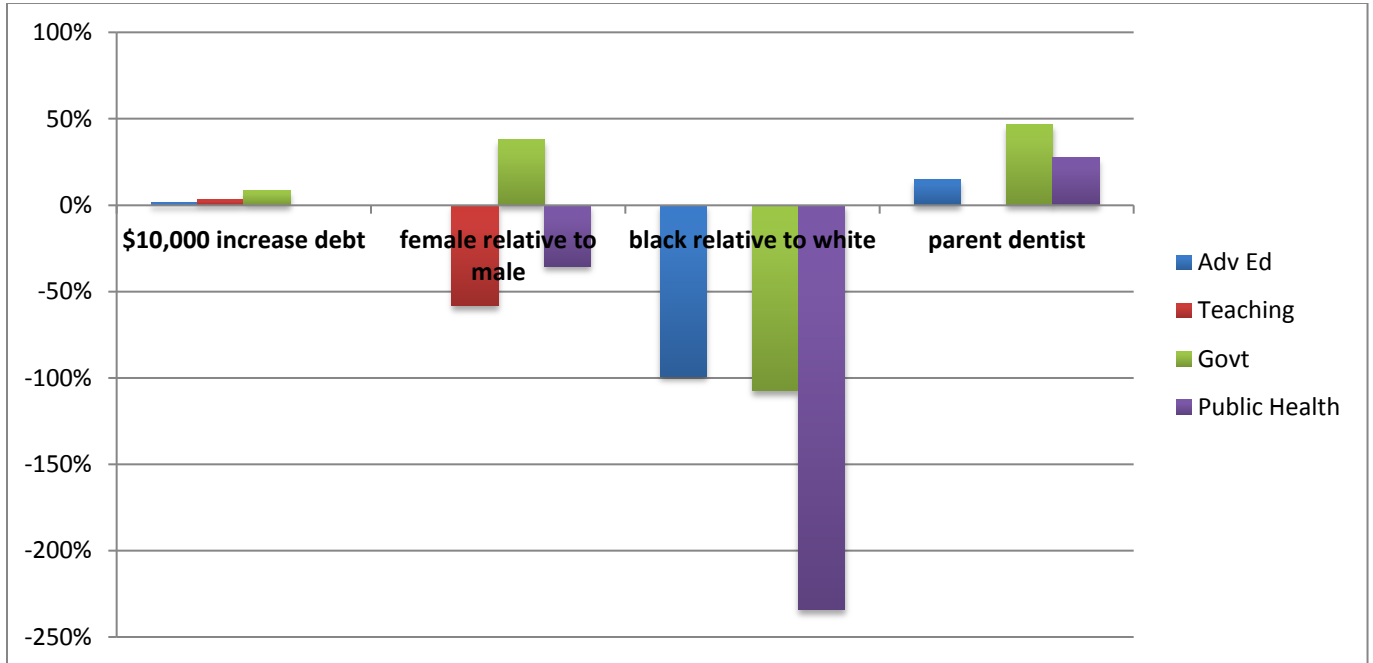
1 **Figure 1: Effect of Debt, Race, and Gender on Intended Career Choice Relative to Private Practice,**  
2 **Among Dental School Seniors (regression-adjusted)**  
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6 Note: Values > 0% mean private practice is more likely relative to other options,  
7 Values < 0% mean private practice is less likely relative to other options  
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9 The study modeled the change in career choice when debt increased \$35,000 (Figure 2). The \$35,000  
10 amount was chosen because this is the amount average debt loads actually increased from 2004 to  
11 2011. Extrapolating the effect of a \$35,000 increase in debt over the total number of graduates between  
12 2004 through 2011, the analysis indicates there would be 1,140 (8.4%) more individuals in private  
13 practice, 551 (5.3%) fewer in advanced education, 17 fewer teaching (10.9%), and 572 (2.9%) fewer in  
14 government over the eight year period. Factors other than debt have a dramatic impact on career  
15 intentions. The magnitude of the influence of different control variables on anticipated employment is  
16 seen in Figure 2. For a \$10,000 increase in debt, there is a small increase in probability that a student will  
17 choose private employment over advanced education, teaching or government. Female students are  
18 more likely to choose teaching and public health over private employment, but less likely to choose  
19 government. Black students are much more likely to choose advanced education, government and public  
20 health over private employment. Finally, if a parent is a dentist, the student is more likely to choose  
21 private employment over advanced education, government and public health.

1 **Figure 2.** Comparison of the Effect of Various Factors on the Probability of Dental School Seniors  
2 Wanting to Enter Private Practice Versus Other Career Choices (greater than 0% means  
3 private practice more likely; less than 0% means private practice less likely)  
4



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6  
7 Educational debt is not a deterrent to treating underserved patients. Contrary to conventional wisdom,  
8 educational debt had a small, but positive correlation with the likelihood of working with low-income  
9 patients in the regression analysis. This means that students with debt were actually more likely to treat  
10 underserved patients than those with less debt. A student is considered to have plans to work with the  
11 underserved if the student answered “definitely” or “probably” when asked if at least 25 percent of  
12 patients are expected to be underrepresented minorities, rural, or special needs. The control variables  
13 include whether a parent is a dentist, race, age, gender, father’s and mother’s education, and public or  
14 private school. Analysis of actual career choices provides very similar conclusions on the relatively small  
15 impact of debt levels on some career choices. For example, 86% of the 1991, 1996, 2001, and 2011  
16 graduating classes were in private practice. Controlling for various factors, debt did have an impact on the  
17 likelihood of entering private practice, holding a government position (e.g. working in an FQHC or the  
18 military) and pursuing advanced education; however, the magnitude of the effect is small compared to  
19 other factors, such as gender and race. The table below shows that, for example, there is a 0.4  
20 percentage point increase in the likelihood of being in private practice for every \$10,000 in educational  
21 debt, compared to a 20 percentage point effect due to race. The results are summarized in Table 1.

1  
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TABLE 1

Factor	Entering Private Practice	Accepting a Government Position	Advanced Education/ Specialization
\$10,000 increase in educational debt	+0.4	-0.3	-0.5
Female (vs. male)	-3.6	N/S	-11.1
Black (vs. white)	-19.8	+15.0	N/S
Father went to grad school (vs. not)	N/S	N/S	+4.7
Baseline % making this decision	86.3%	8.8%	18.4%

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Educational debt levels do not have an impact on practice ownership, hours worked, treating the underserved, or working in public health settings, once confounding factors are controlled. Even for career choices where debt does have an impact, the magnitude is small. This is summarized in Table 2. The multivariate modeling demonstrates that a \$35,000 increase in debt increases the probability of choosing private practice relative to other career choices from a baseline of 86.3% to 87.6%.

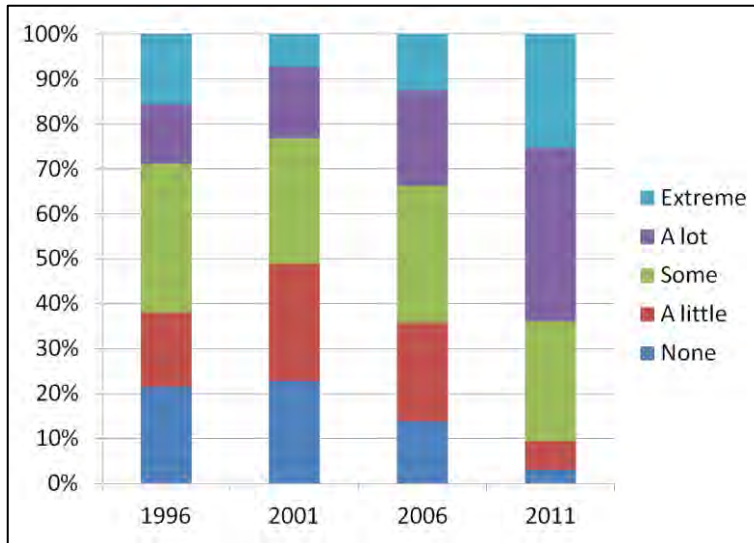
TABLE 2

Career Decision	Baseline Percent/Avg.	With \$35,000 more debt	Percent Change
• Private practice	86.3%	87.6%	+1.5%
• Own practice	59.2%	N/S	
• Faculty position	2.2%	2.0%	-7.9%
• Government position	8.8%	7.9%	-10.2%
• Public health	2.3%	N/S	
• Advanced education	18.4%	16.6%	-10.0%
• Underserved area	13.8%	N/S	
• Poor patients %	16.4%	N/S	
• Hours worked/year	1,641	N/S	

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Younger dentists are experiencing more stress about educational debt than older dentists. More than 60% of dentists who graduated in 2011 reported “extreme” or “a lot” of stress when it came to their educational debt compared with less than 30% of 1996 graduates (Figure 3).

**Figure 3: Stress Over Educational Debt by Graduating Cohort, Among Dentists with a Positive Debt Balance in 2013**



**Policy Implications**

- Debt is correlated with career choices, but the magnitude of the effect of debt on private employment is not as large as prior studies have implied. Previous studies did not control for other factors that influence career choice such as gender and race. The results of this study run counter to the conventional wisdom that debt has a major influence on pushing students toward private employment and away from specialization and public health. Rather, the most important factor influencing the decision to pursue advanced education or government was race, not debt. The most important factors influencing those pursuing public health were gender and race, regardless of debt level.
- The significance of educational debt as a factor in career choice could grow if debt continues to increase while salaries stagnate. The increase in dental salaries has flattened over the last decade, but educational debt continues to increase significantly. At some point, graduates may give more weight to their educational debt when making career decisions, although the point at which this begins to happen is extremely difficult to predict. Over the past five years, applications to law schools have decreased significantly, as it has become common knowledge that the job market for lawyers has been significantly affected by the recent recession.<sup>3,4</sup> In contrast, more than 94% of 2012 graduates of dental education programs report that they obtained a position within the field of dentistry at the time of graduation.<sup>5</sup> If this number begins a downward trend, it may be an indication that a critical threshold has been reached and that further increases in dental school enrollment may not be advisable.

**Recommended Actions by Taskforce**

- Develop a robust information program by the ADA to help students be fully informed consumers about a career in dentistry, including workforce reports, debt, expected income, and financial planning.
- Continue with research efforts to better understand the factors affecting career choices, and collect better data (via the DAT, for example) on dental school applicants' knowledge about the

economics of the profession and their intended career choices, and track actual career choices using the DENTPIN as the identifier.

**6. How many loan forgiveness programs are available to dental students? How effective are these programs in reducing student debt and improving access to care for the underserved?**

**Methods and Data**

In an ADA interdivisional effort, the Health Policy Resources Center, the Office of Student Affairs, and the Division of Government and Public Affairs staff identified 59 loan repayment programs by combining resources from previous research initiatives with primary data collection (see Appendix E-List of Loan Repayment Programs). Telephone interviews were conducted with program representatives. Loan repayment programs were included if it was known that dentists were eligible. Thus, programs that only target other health professionals were not included in this research. Calls were placed in March and April 2013. Complete information for 52 of the 59 programs and partial information for all programs was gathered. Descriptive statistics were calculated for all program characteristics. These programs offer funds to offset student loan costs after graduation from dental school and are distinct from scholarship programs, which offer funding during education.

The loan repayment programs were classified into seven funding categories:

	Description
<b>Military</b>	Dentists working for the military, active-duty or Reserves.
<b>Federal</b>	Funded with federal dollars.
<b>State</b>	Funded with state dollars.
<b>NHSC/State</b>	Funded with a combination of National Health Service Corps and state dollars.
<b>State with federal funding</b>	Funded with a combination of state and federal dollars.
<b>State with local matching</b>	Funded with a combination of state and local/site dollars.
<b>Private</b>	Funded through private organizations.

At the time of analysis, complete data were not available from military programs. These are not included in the results below.

1 **Key Findings**

2  
3 Overall, 59 programs offer loan repayment for dentists, with 1,615 dentist participants. Fifteen programs  
4 are for dentists only, and 44 are open to other health professions as well. The largest funding source  
5 category was NHSC/state (n=24). On average, these programs provide participants with \$97,278 in loan  
6 repayment funds over the course of their service. The breakdown of programs by funding source is seen  
7 in Table 1.  
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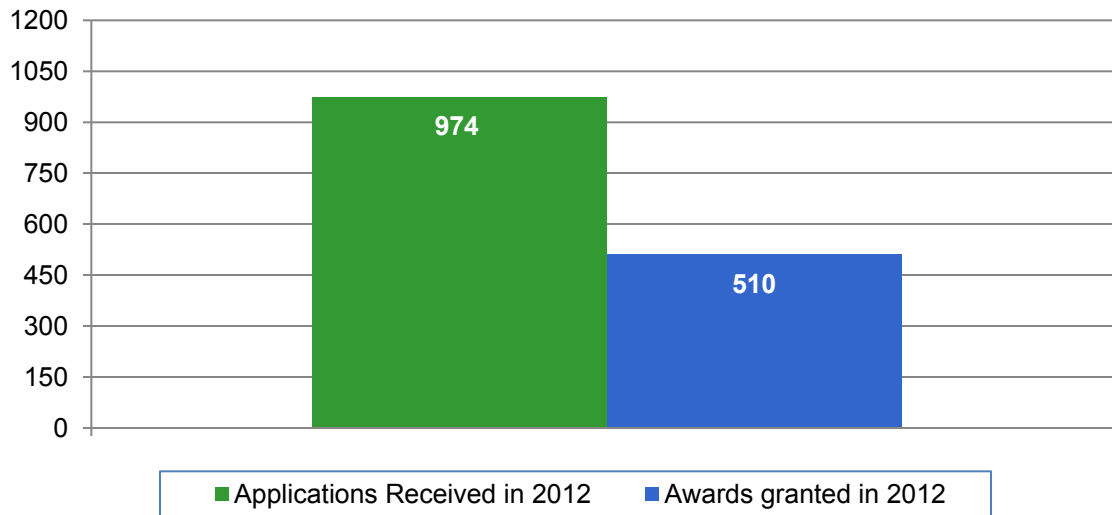
9 **TABLE 1-Key Program Characteristics**

10

	Number of programs	Number of dentists participating	Average maximum loan repayment
<b>Military</b>	5	NA	\$80,000
<b>Federal</b>	5	1,180	\$110,000
<b>State</b>	13	74	\$113,851
<b>NHSC/State</b>	24	141	\$87,158
<b>State with federal funding</b>	4	33	\$92,500
<b>State with local matching</b>	3	31	\$120,000
<b>Private</b>	5	156	\$101,667
<b>TOTAL</b>	59	1,615	\$97,278

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12  
13 The programs have more applications than accepted dentists. However, it is not clear if this indicated that  
14 programs are oversubscribed. There is no system in place to track multiple applications by the same  
15 dentists. For programs where data were available, the programs received a total of 974 applications from  
16 dentists in 2012 (46 programs) and accepted 510 dentists (48 programs) (See Table 2). There are two  
17 outliers with an unusually large number of applications: the Indian Health Services Loan Repayment  
18 Program (107 applications, all accepted) and the National Health Service Corps Loan Repayment  
19 Program (556 applications, 252 dentists accepted). Without including these outliers, seven applications  
20 per year are received per program and three dentists per year are accepted per program, on average.  
21 However, many program representatives commented that they were not overburdened with dentist  
22 applications and they would be happy to have more dentists apply. Indeed, many programs admitted all  
23 the dentists who applied in 2012. Representatives did not express opinions regarding reasons for low  
24 dentist application rates. In addition, further research is needed to determine whether dentists apply to  
25 multiple programs at the same time.

1 **TABLE 2-Dentist Applications across Program Types**



2  
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 4 The majority of programs cannot predictably quantify the number of openings per application cycle.  
 5 Typically, number of openings varies based on applications received and/or funding. However, for the 19  
 6 programs that do quantify openings, there were 263 spots available in 2012. There are three outliers with  
 7 an unusually large number of openings: Alaska’s Support-for-Service to Healthcare Practitioners – II (90  
 8 positions), the Michigan State Loan Repayment Program (33 positions), and the New York Primary Care  
 9 Service Corps (30 positions). Without including these outliers, there are seven openings per program on  
 10 average. Again, these are total openings, since openings are not earmarked for dentists. Obligations and  
 11 repayment terms vary widely. The average service commitment is a minimum of 2 years and a maximum  
 12 of 4 years. The average annual payment ranges from \$20,701 to \$35,809. The average maximum total  
 13 compensation across the entire service obligation is \$97,278. Most programs do not allow participation  
 14 after total debt is repaid and will not pay any amount greater than total debt. The majority of programs  
 15 (92.3%) do not have debt level requirements for participation, but 41.2% of programs consider debt level  
 16 when determining the amount of support provided. Method of payment was split evenly between direct  
 17 payment against loan (48%) and payment to beneficiary with a requirement to document loan repayment  
 18 (52%). Most programs require participants to take steps towards improving access to care for certain  
 19 populations. The majority of programs have specific practice location requirements (e.g., federal or state  
 20 HPSA, rural, etc.; 81.8%). Additionally, most programs require treatment of specific populations (e.g.,  
 21 Medicaid; 76.8%). Military programs are not included in these statistics, but military dentists are required  
 22 to treat service members and their families, and they must be willing to re-locate.

23  
 24 **Policy Implications**

- 25
- 26 • There are approximately 1,700 dentists participating in loan forgiveness programs, most of which
- 27 involve underserved areas or populations. This is less than 1% of practicing dentists, and is far
- 28 below the estimate of almost 10,000 dentists needed in health professional shortage areas
- 29 designated by HRSA. There is considerable opportunity to scale up loan repayment programs for
- 30 dentists. The average annual amount of loan repayment ranges from a minimum of \$20,701 to a
- 31 maximum of \$35,809.
- 32
- 33 • The existing slots could be oversubscribed – i.e. more dentists apply than are accepted – but the
- 34 data do not allow for a full analysis. Nationally, there were 974 applications for 510 accepted
- 35 dentists into various programs. This suggests that dentists are interested in taking up these



1 programs; however, further research is needed to determine whether the same dentist applies to  
2 multiple programs.

- 3
- 4 • If more positions were allocated to dentists, this could increase the number of dentists working in
- 5 underserved areas. Many program administrators expressed eagerness to enroll dentists into
- 6 loan forgiveness programs. There is opportunity to expand the reach, potentially earmark more
- 7 resources for dental slots within programs, and advocate for dentists to be eligible for programs
- 8 for which they currently are not eligible.
- 9

10 **Recommended Actions by Taskforce**

- 11
- 12 • Advocate for more loan forgiveness programs for dentists at the state and federal levels
- 13
- 14 • Advocate for dentists to be eligible for all health professions loan forgiveness programs
- 15
- 16 • Advise existing loan repayment programs to increase dentist outreach and recruitment efforts
- 17
- 18 • Include information about loan repayment programs in educational efforts to help students be fully
- 19 informed consumers about a career in dentistry.
- 20

21 **7. What are dental schools doing in regards to teaching debt management and student**  
22 **loans?**

23 **Methods and Data:**

24 To learn more about the student debt and personal financial management information that students  
25 receive while in schools, the ADA's Health Policy Resources Center conducted a web-based survey  
26 among three groups: all 2012 dental school graduates, all dental school deans, and all ASDA chapter  
27 leaders (see Appendix G-Web-based survey). E-mail invitations were sent to individuals in the sample  
28 (as described in Table 1 below) on April 8, 2013. Reminders were sent to non-respondents on April 11  
29 and April 17. Data collection was cut off on May 2, 2013.

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TABLE 1-Response Rate

	Sample size	Number of respondents	Adjusted response rate
<b>2012 dental school graduates</b>	4,957	681	15.0%
<b>Dental school deans</b>	64	30	46.9%
<b>ASDA chapter leaders</b>	63	23	36.5%

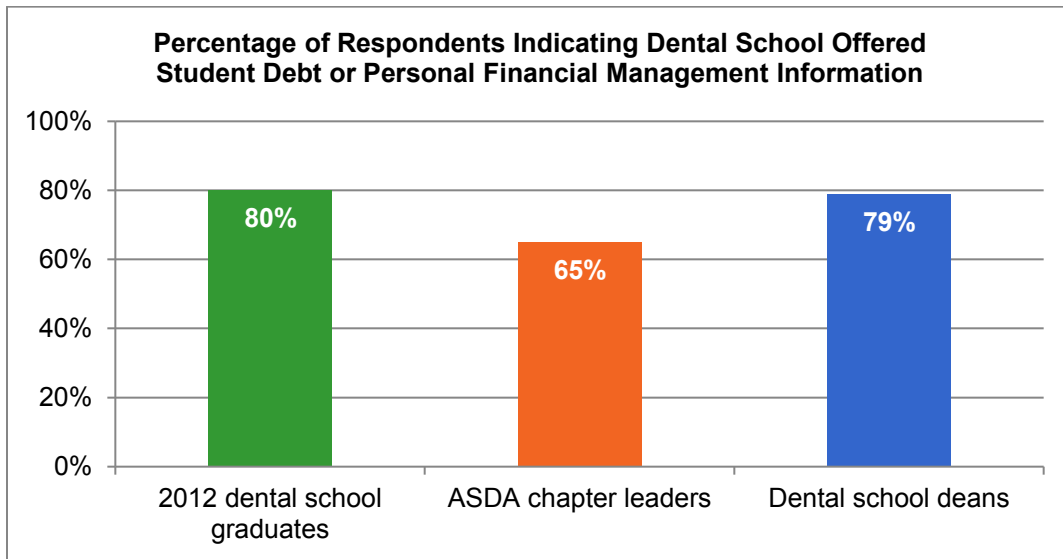
35  
36  
37 Please note that, while the response rate for dental school deans and ASDA chapter leaders was high,  
38 the low number of actual respondents invites caution when interpreting the results, as any additional  
39 response could have had a substantial impact on the final calculation. Nevertheless, the response rates  
40 are in the acceptable range for web-based surveys.

41  
42 **Key Findings:**

43  
44 Most dental schools offer student debt or personal financial management information; however, views  
45 varied widely among the three responding groups. Four in five 2012 dental school graduates (80%)  
46 indicated that their dental school offered student debt or personal financial management information.

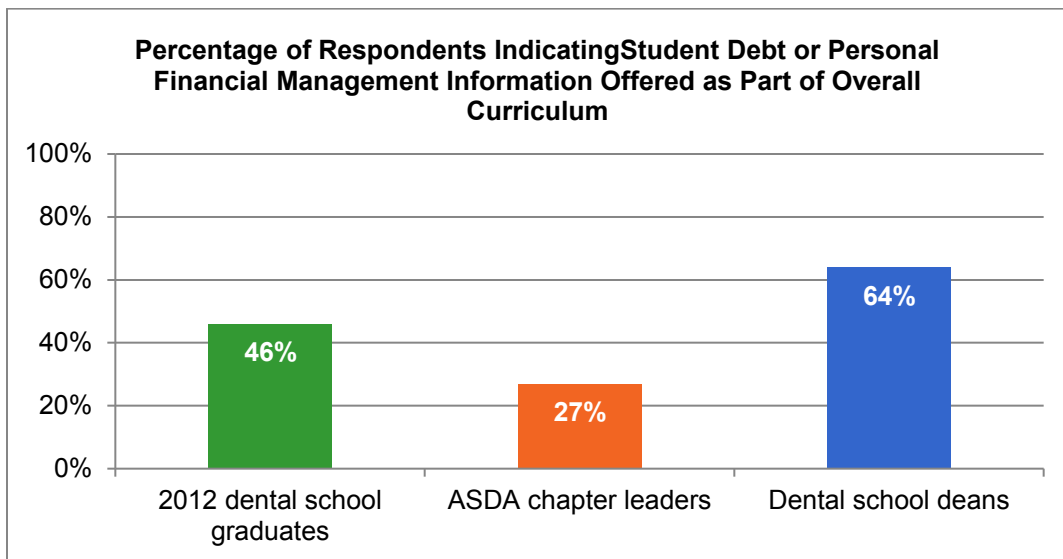
1 About the same percentage of responding dental school deans (79%) indicated so, while the percentage  
 2 of responding ASDA chapter leaders was lower, 65% (See Table 2).  
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TABLE 2



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 8 Student debt or personal financial management information is not usually part of the curriculum, although  
 9 views varied by group. While about two-thirds of responding dental school deans (64%) indicated so, a  
 10 smaller proportion of 2012 dental school graduates (46%) and ASDA chapter leaders (27%) believed that  
 11 the information was offered as part of the overall curriculum. This could be a true disconnect, or a result  
 12 of the sampling, or a combination (See Table 3).  
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TABLE 3

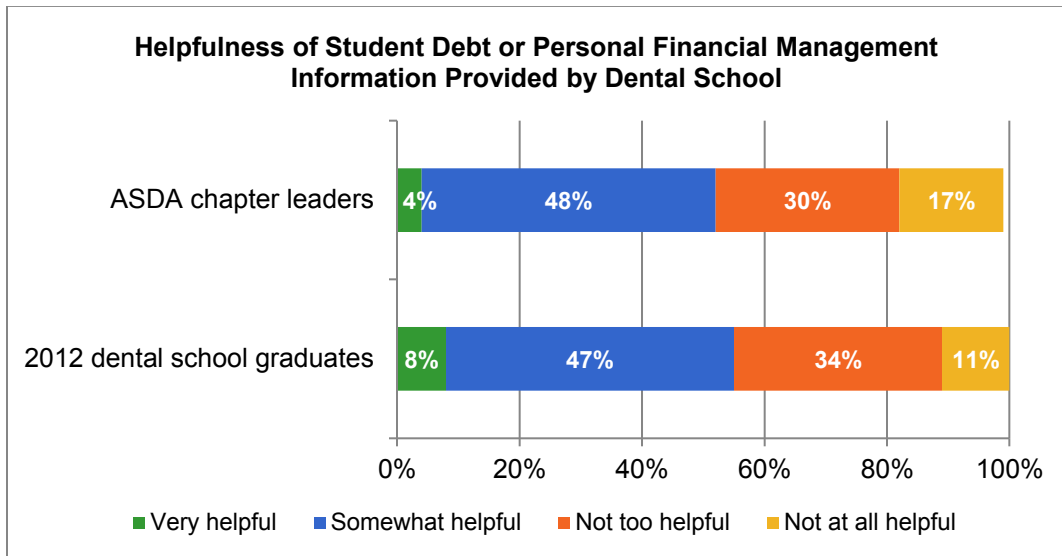


16  
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 19 Among respondents who indicated that the information offered was part of the curriculum, between half  
 20 and four-fifths, depending on the group of respondents, stated it was specifically part of a practice

1 management curriculum (66% of 2012 dental school graduates, 50% of ASDA chapter leaders, and 79%  
2 of dental school deans.) Dental school students want student debt or personal financial management to  
3 be part of the curriculum. Respondents who indicated that the student debt or personal financial  
4 management information provided was not part of the school’s overall curriculum were then asked, “Do  
5 you think your school should offer student debt or personal financial management information as part of  
6 the curriculum?” A majority of respondents in the group, 74% of 2012 graduates and 82% of ASDA  
7 chapter leaders, indicated that they thought student debt or personal financial management information  
8 should be part of the curriculum.

9  
10 The majority of dental schools offer student debt or personal financial management support outside their  
11 curricula. Two-thirds of 2012 dental school graduates (67%) indicated so, compared to 4 in 5 ASDA  
12 chapter leaders (80%) and 73% of responding dental school deans. The most often cited examples of  
13 support offered outside the curriculum were lunch and learns, one-on-one discussions with a financial  
14 adviser, counseling provided by the financial aid department, and guest speakers. About half of 2012  
15 dental school graduates and ASDA chapter leaders found the information provided by their dental school  
16 to be helpful (see Table 4). While just over half of 2012 dental school graduates (55%) and responding  
17 ASDA chapter leaders (52%) indicated the information was either “very” or “somewhat helpful,” the  
18 remaining respondents (45% of 2012 graduates and 47% of ASDA chapter leaders) thought the  
19 information was either “not too helpful” or “not at all helpful.”

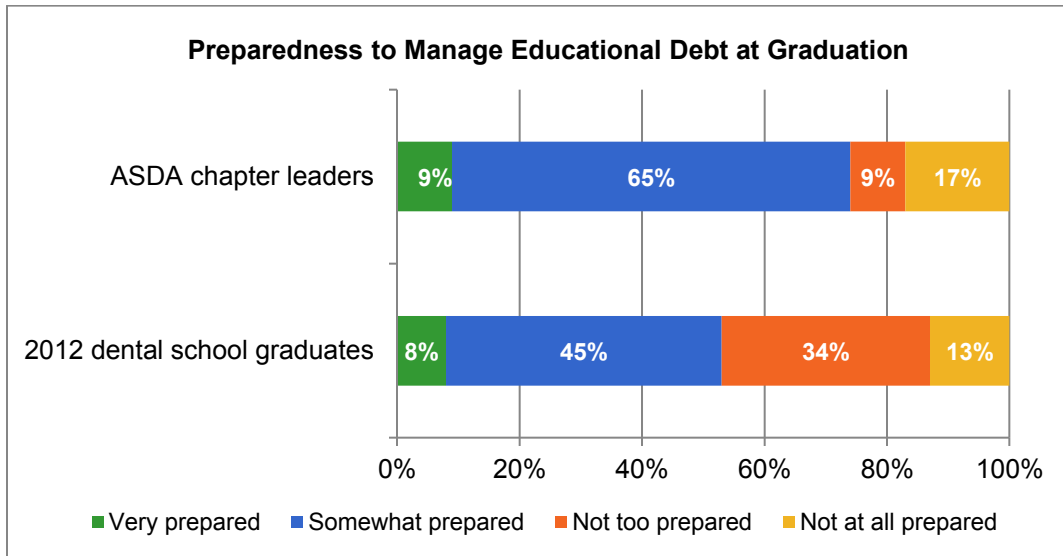
20  
21 TABLE 4  
22



23  
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25  
26 Almost half of 2012 dental school graduates (47%) did not feel prepared to manage their educational debt  
27 at graduation. Responding ASDA chapter leaders felt more positively, with only a quarter indicating they  
28 felt “not too prepared” or “not at all prepared” (please note that ASDA chapter leaders had not yet  
29 graduated at the time of the survey.) This could suggest a disconnect between how dental students feel in  
30 terms of their preparedness to manage their student debt, and how new graduates feel once they leave  
31 dental school and enter the profession (See Table 5).

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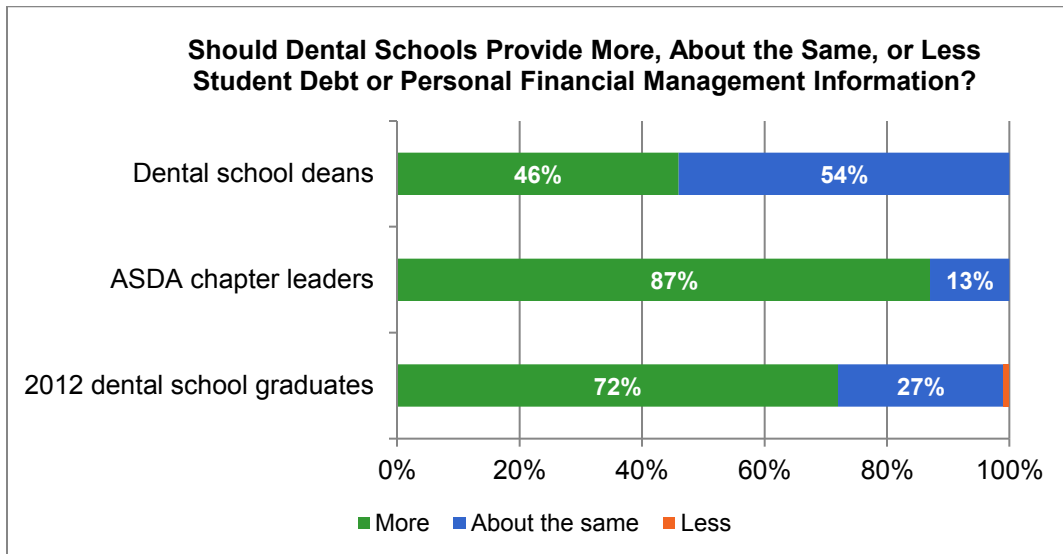
TABLE 5



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Dental school students want much more information on managing student debt and personal financial management. Deans' opinions on whether the school should provide more, about the same or less student debt or personal financial management information was different than that of 2012 dental school graduates and ASDA chapter leaders. While 46% of responding deans stated that the amount of information provided should increase, that percentage was much higher among 2012 dental school graduates (72%) and ASDA chapter leaders (87%) (See Table 6).

TABLE 6



14  
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16

1 Based on the survey findings, it appears that dental students and new graduates feel they need more  
2 information on the cost, expected debt load, and expected income of a dental career. Approximately 25%  
3 of 2012 dental school graduates provided further comments about the student debt or personal financial  
4 management information that they received from their dental school. This is a very high response rate for  
5 written comments, indicating that this is a major issue of interest among students and recent graduates.  
6 Most of the comments were on the high cost of dental education and the lack of information for making  
7 good decisions on managing their debt. There were also numerous comments on the attractiveness and  
8 rate of return to a dental education, and the disconnect between faculty and students. Below are a few  
9 examples:

10  
11 *“A time is coming when the cost versus benefits of entering this profession won't be in balance in  
12 the future. While in dental school, I didn't need the school to tell me to be financially responsible. I  
13 lived frugally but it was a drop in the bucket compared to the total cost of tuition and all the  
14 additional fees that I had no say over. The cost of educating a new dentist is way too high and  
15 new grads have to shoulder the burden of a bloated and overpriced educational program.”*

16  
17 *“After paying off loans for a year now, I realize how little I truly knew about the payback process.  
18 The school provided little information on payoff strategies. [The loan providers] have been  
19 horrible to work with. My husband (a dental classmate of mine) and I have been misled  
20 numerous times by them with 'policy changes,' payment plan selection, and more. The amount of  
21 student debt owed has postponed our practice purchase options.”*

22  
23 *“All we received was a 15-minute interview telling us how much we owed and IBR vs. traditional.  
24 Really? I just sunk \$300K into your institution and my education, and you give me 15 minutes?!  
25 A class on financial management should be offered by dental schools. We graduate drowning in  
26 debt, in a poor economy, and are then placed into high tax brackets for the rest of my life. Fifteen  
27 minutes hardly seems to be enough to prepare me for financial success. I am grateful for my  
28 education and love dentistry, but more financial education should be offered either from schools  
29 or from the ADA.”*

30  
31 *“Dental education is becoming horrendously expensive. Starting out, I had no CLUE how much  
32 debt I would have, or how it should be handled. More personalized financial outlook planning  
33 should be required at the outset of dental school. For example, any student who wants to borrow  
34 money should have to sit down with a human being and review real prospective numbers  
35 regarding how much he will borrow. The required 'financial counseling' offered by the government  
36 isn't informative enough.”*

37  
38 *“Reducing the cost of education is the solution. Mediocre advice from dental educators whom  
39 themselves have not suffered the burden of hundreds of thousands of dollars of debt is teetering  
40 on disrespectful.”*

41  
42 *“The cost of education for dental schools is out of control and still keeps climbing yearly. If this  
43 continues, students should be informed, by using the curriculum, about ways to manage their  
44 debt, so that they are prepared when they leave school. Students should be aware of their  
45 options so that no matter what job or continuing education avenue they pursue, they should be  
46 prepared and ready with numerous ways to handle their debt.”*

47  
48 *“This information should be made available to the students before they begin dental school. That  
49 way, they will know what they are getting themselves into financially. \$200,000.00+ in student  
50 loan debt is very difficult to manage and had I known the implications this debt was going to have  
51 on my life once I graduated I would have explored alternative means of paying for school. Now I  
52 find myself having to do a stint of public health for several years in order to make my student loan  
53 debt from dental school more manageable.”*

54

1 *"While my school provides classes on how to deal with the educational debt, it doesn't change the*  
2 *fact that the amount of debt new dentists have is outrageous! Too many speakers and financial*  
3 *professionals over inflate the earning potential of new graduates. The amount of debt is*  
4 *unsustainable. The schools do not promote how severe it is to have that much debt when you get*  
5 *out of school."*  
6

7 **Policy Implications:**  
8

- 9
- 10 • There is a need to make information on the rate of return of a dental career accessible to current  
11 and prospective students. Many dental students and new graduates do not have accurate  
12 information on the total cost, expected debt, and expected earnings associated with a career in  
13 dentistry. As a result, they are graduating and entering practice to find their expectations are not  
14 in line with reality.
  - 15 • There is a difference in perception between dental school deans and students regarding the need  
16 for more personal financial management resources. Dental school deans were much less likely to  
17 feel an urgent need for additional resources provided to students on how to manage student debt,  
18 and personal financial management in general. Dental students and new graduates felt that the  
19 resources provided to them were inadequate.  
20

21 **Recommended Actions by the Taskforce:**  
22

- 23
- 24 • The ADA Health Policy Resources Center (HPRC), the Liaison Committee for Surveys and  
25 Reports, and the Center for Professional Success (CPS) develop a robust information portal via  
26 ADA.org to help students and prospective students be fully informed, financially literate  
27 consumers about a career in dentistry, including workforce forecasting reports, student debt,  
28 expected income, and life-long financial planning.
  - 29 • Encourage the ADA New Dentist Committee to continue to develop, expand, and market the ADA  
30 "SUCCESS" program to all dental schools. In addition, the Taskforce suggests that modules  
31 related to financial management be enhanced to address student concerns for more information  
32 in this subject area.
  - 33 • Urge the Commission on Dental Accreditation to revise the accreditation standards for dental  
34 education programs in the area of practice management to require debt and financial  
35 management information be included in all dental school curricula.  
36

## SUMMARY

1  
2  
3 Dentistry is experiencing the same trends in student loan debt as most other high-income professions.  
4 Dental school debt has increased over time due to increases in the cost of attending dental school. The  
5 rates of increase are in line with those experienced by other professional students (e.g., physicians,  
6 veterinarians). There is great variation in operating costs among schools, which can be attributed mostly  
7 to expenses associated with the number of full-time faculty and staff. As long as the “return on  
8 investment” allows students to pay off educational debt in a “reasonable” amount of time, the profession  
9 will continue to attract a large number of qualified applicants to fill the total number of available positions.  
10 Institutional setting (public versus private) does not seem to matter as a driver of overall revenue and  
11 overall expenses, particularly in recent years when financial support from states to their public universities  
12 has diminished. There have not been significant innovations in dental school models that notably reduce  
13 operating costs. The increased number and quality of applicants over the past fifteen years has allowed  
14 dental schools to increase tuition without adversely affecting enrollment. In addition, to some extent,  
15 dental schools have been able to increase enrollment without substantially increasing expenses. Overall,  
16 dental schools are currently financially sound.

17  
18 Debt appears to have a small effect on some of dentists’ career decisions. The magnitude of the effect is  
19 very small compared to other factors such as gender and race. In regression models, students graduating  
20 with relatively large amounts of debt are more likely to plan on entering private practice, less likely to plan  
21 on completing advanced education, and less likely to plan on pursuing a government position. Debt levels  
22 do not have an impact on the likelihood of owning a practice. There is a difference in perception between  
23 dental school deans and students regarding the need for more personal financial management resources.  
24 Dental students and new graduates felt that the resources provided to them were inadequate.

25  
26 Due to the limited number of students and residents available to provide treatment compared to the  
27 estimated total number of underserved patients, dental schools alone cannot “solve” the access-to-care  
28 problem, but they can be part of the solution. Most dental schools currently include off-campus clinical  
29 rotation sites such as Federally Qualified Health Centers (FQHC) for a portion of students’ clinical  
30 education. There are approximately 1,700 dentists participating in loan forgiveness programs, most of  
31 which involve underserved areas or populations. This is far below the estimate of almost 10,000 dentists  
32 needed in health professional shortage areas designated by HRSA. There are more applications for  
33 positions than there are positions available. The programs seem to be an effective strategy to improve  
34 access to care; however, the impact is limited by the small number of positions available.

35  
36 The Taskforce concluded that the ADA can be most effective in addressing the student debt issue  
37 through a defined program of advocacy at the federal level and through development of a robust  
38 information portal to help current and prospective students be fully informed, financially literate  
39 consumers about a career in dentistry, including workforce forecasting reports, student debt, expected  
40 income, and life-long financial planning. Further, the results of this study suggest that a re-examination of  
41 the “dental education model” must be conducted to better prepare for the future, perhaps similar to the  
42 study conducted by the Institute of Medicine’s Committee on the Future of Dental Education in 1995.  
43 The Taskforce believes that such a study would require participation by dentistry’s broad communities of  
44 interest, with ADA and ADEA providing the most current data/analysis of dental education economics.  
45 On behalf of current and future members, ADA should have a leadership role, becoming a thought leader  
46 in the area of dental school financing, dental student debt, student loan interest rate reform, and the rate  
47 of return to a dental education.

## RECOMMENDATIONS

**8. What innovations could dental schools do, in collaboration with the American Dental Association, to reduce student debt?**

The results of this report suggest that there are limited opportunities for dental school innovation that can directly decrease the cost of dental education, decrease the dental student debt burden, and solve the access to care issue. Innovations explored to reduce student debt loads included admitting students to dental education programs after the third year of undergraduate education; requiring the vast majority of basic sciences courses as prerequisites; and condensing the dental curriculum to less than four years. The limitations of each of these strategies (for instance, student maturity and readiness issues; difficulties in assessing the quality and rigor of prerequisite courses) outweigh the minor impact that might be realized through national implementation at all dental schools. None the less, the Taskforce believes that the ADA has a professional interest and obligation to support dental education and dental students by leading a collaborative effort in the following initiatives:

- The ADA advocacy agenda on behalf of dental education, dental students, and recent dental school graduates include:
  1. Dental school approval as Federally Qualified Health Centers (FQHC) or ability to partner with FQHC's.
  2. Graduate Medical Education (GME) funding for non-hospital-based programs (i.e., dental schools).
  3. Increased Medicaid fees and cost-based reimbursement for dental schools.
  4. Increased number of loan forgiveness programs at the state and national level, including additional debt relief programs targeting rural/underserved areas.
  5. Financial incentives to practice permanently in underserved areas through supplemental payments or tax credits.
  6. Increased eligibility for dental graduates for all health profession loan forgiveness programs
  7. Student loan interest rate reform.
- The ADA Health Policy Resources Center (HPRC), the ADA/ADEA/CODA Liaison Committee for Surveys and Reports, and the Center for Professional Success (CPS), in collaboration with the communities of interest, develop a robust information portal via ADA.org to help current and prospective students be fully informed, financially literate consumers about a career in dentistry, including workforce forecasting reports, student debt, expected income, life-long financial planning, and a central registry of all loan/tuition relief programs.
- The ADA Health Policy Resources Center (HPRC), in preparation for the future of the profession and reexamination of the dental education model, expand its research efforts in the area of dental education financing, the impact of student debt and other factors on career choices in order to better position the ADA as a thought leader and knowledge broker in this area and to strengthen advocacy efforts.
- The ADA, in collaboration with the broad communities of interest, conduct a comprehensive study of the current dental education model, to include:
  1. Evaluation of the sustainability of dental school finances.
  2. Evaluation of all the current dental school curricula.
  3. Analysis of the competency and outcomes-based educational model.
  4. Analysis of dental school outcomes data.
  5. Analysis on the impact of student debt on career and practice choices.



- 1                   6. A determination of whether students are being adequately prepared for the practice
- 2                   of dentistry.
- 3                   7. A determination of whether dental schools that are opening in non-traditional
- 4                   academic health centers are meeting the appropriate level of scholarship to ensure
- 5                   that dentistry continues to be a learned profession.
- 6
- 7                   • The New Dentist Committee enhance the ADA Success Program to include more content
- 8                   related to personal debt management and financial planning.
- 9
- 10                  • The Commission on Dental Accreditation be urged to revise the Accreditation Standards
- 11                  for Dental Education Programs related to practice management to include instruction on
- 12                  personal debt management and financial planning.
- 13

APPENDICES

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- 17
- 18 Appendix A-Debt Trend Literature Review
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9 <sup>3</sup> Harper Steven J. Pop Goes the Law. The Chronicle Review; March 15, 2013.  
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Appendix C

Program Length and Experience in Extramural Facilities/Community-Based Dental Education (CBDE)(in weeks), 2011-12

	1st Yr Total	1st Yr CBDE	2nd Yr Total	2nd Yr CBDE	3rd Yr Total	3rd Yr CBDE	4th Yr Total	4th Yr CBDE	Total Length	Total CBDE
National Average	39.6	0.4	42.1	0.4	43.8	1.7	39.0	5.9	163.5	8.2
<i>Percentage</i>		<i>0.9%</i>		<i>1.0%</i>		<i>3.8%</i>		<i>15.1%</i>		<i>5.0%</i>
Maximum	50	8	48	8	52	8	48	33	192	33
Minimum	30	0	30	0	36	0	28	0	132	0
Median	40	0	43	0	44	1	40.5	4	164	6

Source: American Dental Association, Survey Center, *Surveys of Dental Education 2011-2012* (Group I)

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Health of program	Name of Program	Funding source	Are only dentists eligible (years)	How many openings per application cycle?	How many dentists applied to the program in 2012	How many dentists were accepted into the program in 2012	How many health care professionals are currently in the program	How many dentists are currently in the program	Minimum length of service for dentists: # yrs	Maximum length of service for dentists: # yrs	Minimum amount of financial support per year for dentists: \$	Maximum amount of financial support per year for dentists: \$	Maximum total support across service obligation	Average amount of financial support per year for dentists: \$	Is there a retention obligation for the program (yes/no)	Does the program require an educational debt level (yes/no)	Is there a requirement to locate in a specific geographic area of need (e.g. HPSA) (yes/no)	Is there a requirement to provide care to specific population groups (e.g. Medicaid) (yes/no)	Are payments made directly against an education loan account or is cash paid directly to the beneficiary (loan account) (yes/no)	Contact person	Email	Phone	NOTES	Center	
	Active Duty Health Professions Loan Repayment Program (ADHPLRP)																								
	ARMY	Military	No	varies					2	8	\$40,000	\$120,000			No	No	No	No	Agential loan				Must be active-duty	AO	
	ARMY FORCE	Military	No	varies											No	No	No	No	Agential loan	Patricia Faustner	Patricia.Faustner@army.mil			AO	
	NAVY	Military	No	varies					2	4	\$40,000	\$100,000			No	No	No	No	Agential loan	David Hartel, Sandra Yerkes	david.hartel@med.navy.mil, sandra.yerkes@med.navy.mil			AO	
	Reserve HPLRP	Military	No	varies by state	6	6	18	117	2	4	Balance	\$40,000	\$160,000	NA	NA	No	No	No	Agential loan	Ken Klaus	kenklaus@med.af.mil			AO	
	Army National Guard SLRP	Military	No	varies by state					8			\$50,000							Agential loan			1-800-454-6273	National Guard version of ADHPLRP	AO	
	Indian Health Service Loan Repayment Program (IHSLRP)	Federal	No	varies	107	107	1227	143	2	Unli repayment	Balance	\$24,000	Total debt	NA	No	No	Yes	Yes	Beneficiary	Timothy Luton	Timothy.Luton@hhs.gov	(201) 443-2486	Get dental info from ADA statement re: HIS	AO	
	National Health Service Corps Loan Repayment Program (NHSLRP)	Federal	No	varies	556	252	8634	1037	2	4	\$10,000	\$60,000	\$100,000	NA	No	No	No	Yes	Yes	NA	Renee Joslow	rjoslow@hhs.gov	301-443-6769	Must be general or pediatric dentist. Payment amount is tied to the HPSA "score" (two-tier system, sites with lower scores pay less). May not receive more funds than debt.	AO
	Veterans Affairs Education Debt Reduction Program (EDRP)	Federal	No	varies															Beneficiary	Byzka Delia	byzka.delia@va.gov	501-297-4056	Must be working at a VA facility. Details available through VA facility HR departments.	AO	
	VVA Student Loan Repayment Program (VSLRP)	Federal	No	varies															Beneficiary	Byzka Delia	byzka.delia@va.gov	501-297-4056	Specifically for RESEARCH (at least 20 hours per week) in any of the following areas: clinical, pediatric, health disparities, or clinical research for individuals from disadvantaged backgrounds. you must have total qualified educational debt equal to or in excess of 25 percent of your institutional base salary at the time of award.	AO	
	NHI Loan Repayment Program	Federal	No	varies	NA	NA	NA	NA	2	Unli repayment	Balance	\$35,000	Total debt	NA	Yes	Yes			Agential loan	Shelly Tragan	shelly.tragan@hhs.gov	866-849-4547		AO	
	Support for Service to Healthcare Practitioners (SHARP) SHARP-I	NHSC/State	No	3	3	2	74	8	2	NA	NA	NA	NA	NA	No	No	No	Yes	Yes	Agential Loan	Robert Sewell	robert.sewell@hhs.gov	507-465-4565	SHARP II is a new program with solicitations now in progress therefore most of this information is not available	SZ
	SHARP-I	State	No	90	12	2	13	2	3	6	NA	\$47,000	\$141,000	NA	No	NA	Yes	No	Either	Robert Sewell	robert.sewell@hhs.gov	507-465-4566		SZ	
	Arizona Loan Repayment Program	NHSC/State	No	varies	2	2	3	3	2	4	\$22,000	\$60,000	NA	NA	No	NA	Yes	Agential loan	Anna Reynolds	anna.reynolds@azdhs.gov	602-645-1086		SZ		
	California Health Professions Loan Repayment Program	State	No	varies	1	0	29	0	2	2	\$10,000	\$10,000	NA	NA	No	NA	Yes	Agential loan	Meaghan Harrington	meaghan.harrington@oahp.ca.gov	(916) 326-3654		SZ		
	California State Loan Repayment Program	NHSC/State	No	NA	NA	2	204	13	2	NA	NA	\$60,000	\$140,000	NA	No	Yes	Yes	Beneficiary	Monique Voss	monique.voss@oahp.ca.gov	916-326-3745		SZ		
	Coburn Health Service Corps	NHSC/State	No	varies	38	9	148	15	3	4	NA	\$33,333	\$100,000	NA	No	No	Yes	Yes	Beneficiary	Rich Marquez	Wendy.Planer	richmarquez@state.co.us	303-691-4916	Must work at least 40 hours per week	SZ
	Equilateral Dental Loan Repayment Program	State	Yes	varies	NA	3	3	3	2	2	NA				No	No	No	Yes	Beneficiary	Rich Marquez	Wendy.Planer	richmarquez@state.co.us	303-691-4916	No limited work hours	SZ
	Delaware State Loan Repayment Program	NHSC/State	No	unlimited	4	0	24	5	1	3	\$21,000	\$36,000	\$100,000	NA	No	NA	Yes	Yes	Agential loan	Rubin Lawrence	Rubin.Lawrence@state.de.us	302-759-2730		SZ	
	DC Health Professional Loan Repayment Program	NHSC/State	No	varies	2	2	39	5	2	4	NA	\$61,229	NA	NA	No	Yes	Yes	Agential loan	Lauren Rater	lauren.rater@dc.gov	202-442-6930		SZ		
	Dillon State Loan Repayment Program	NHSC/State	No	varies	NA	NA	NA	10	2	4	\$25,000	\$25,000	\$50,000	NA	No	No	Yes	Yes	Beneficiary	Jake Casper	jake.casper@mt.gov	406-833-8300		SZ	
	Iowa Loan Repayment Program	State	No	varies	3	0	11	1	2	Unli repayment	NA	\$50,000	\$50,000	NA	No	No	Yes	Agential loan	Sara Richert	sara.richert@iowadhs.gov	515-281-7630		SZ		
	Kansas State Loan Repayment Program	NHSC/State	No	varies	1	1	17	4	2	Unli repayment	NA	\$30,000	Total debt	\$30,000	No	No	Yes	Yes	Beneficiary	Barbara Huske	bhuske@ksdhs.gov	785-296-2742	Employment must be with a public or nonprofit private agency or facility.	SZ	
	Kentucky State Loan Repayment Program	NHSC/State	No	varies	0	0	10	2	2	Unli repayment	NA	\$35,000	Varies	NA	No	No	Yes	Yes	Beneficiary	Larry Allen	laal@ky.edu	606-493-3987	50/50 match loan requirement for qualified educational loans	SZ	
	Louisiana State Loan Repayment Program	NHSC/State	No	varies	2	1	6	5	2	7	NA	\$20,000	NA	NA	No	No	Yes	Yes	Beneficiary	Dore Toulouy	dore.toulouy@ls.gov	225-542-1583	Must have a sliding fee scale for low income patients	SZ	
	Maine Dental Education Loan Repayment Program	State	Yes	varies	4	4	13	13	2	4	\$20,000	\$80,000	NA	Yes	NA	Yes	Yes	Beneficiary	Claude Frey	cfr@maine.gov	NA		SZ		
	Maryland Dent Care Loan Assistance Repayment Program (MDC-LARP) for Dentists	State	Yes	5	22	5	14	14	3	NA	\$23,470	\$71,220	\$213,660	NA	No	Yes	NA	Yes	Beneficiary	Herry Goodman	herry.goodman@mdva.gov	410-767-5842	Must treat a minimum 30% Medicaid recipients as a portion of the total patient population	SZ	
	Massachusetts State Loan Repayment Program (MSLRP) for Dental Professionals	NHSC/State	Yes	varies	5	5	66	8	2	4	NA	\$50,000	\$100,000	\$50,000	Yes	Yes	Yes	Beneficiary	Julia Dyck/Noelle Watson	julia.dyck@state.ma.us/noelle.watson@state.ma.us	617-624-5224	May not receive more funding than debt	SZ		
	Michigan State Loan Repayment Program (MSLRP)	NHSC/State	No	30	3	1	60	2	4	\$25,000	\$35,000	\$140,000	\$20,000	No	No	Yes	Yes	Beneficiary	Kent Miller	kentmiller@mtchs.gov	(517) 341-6446		SZ		
	Minnesota State Loan Repayment Program (SLRP)	NHSC/State	No	5	1	2	11	2	4	NA	\$20,000	\$20,000	\$20,000	No	Yes	Yes	Beneficiary	Dave Jantke	dave.jantke@state.mn.us	651-261-3865	Award cannot exceed debt	AO			
	Minnesota Dental Loan Forgiveness Program	State	Yes	1	7	1	6	6	3	4	NA	\$20,000	\$100,000	NA	NA	No	NA	Yes	Beneficiary	Monet Samaha	monet.samaha@state.mn.us	651-261-3870	Scaled dental who are seeing 25 percent public program patients are eligible to apply. students and residents in their first year of training receive highest preference.	AO	
	Dental Loan Repayment Program	State w/federal	No	10	12	9	9	9	3	6	NA	\$40,000	\$120,000	\$40,000	Yes	No	Yes	Yes	Beneficiary	Myrtle Smith	msmith@nps.gov	601-661-1817	Contact person	AO	
	Missouri Health Professional Loan Repayment Program	NHSC/State	No	10	3	1	19	2	2	Unli repayment	NA	\$25,000	\$50,000	NA	No	No	Yes	Yes	Beneficiary	Tony Wetherston	tony.wetherston@health.mo.gov	606-891-7415	May not receive more funding than debt	AO	
	Montana State Loan Repayment Program	NHSC/State	No	15	0	0	15	0	2	2	Balance	\$15,000	\$30,000	NA	No	No	Yes	Yes	Agential loan	Lisa Berard	lberard@mt.gov	(406) 683-2790	No funding available at this time but they do have a stack of allocations that they will use through ongoing funding. They are hopeful that they will get re-funded.	AO	
	Nevada Loan Repayment Programs	State w/ local matching	No	NA	NA	9	87	9	3	3	NA	\$40,000	\$120,000	NA	No	Yes	Yes	Agential loan	Melrose Jarman	melrose.jarman@nevada.gov	402-471-0148	Award varies based on debt load and available funds. Blank spaces were refused by Ms. Jarman	AO		
	Nevada Health Service Corps	NHSC/State	No	varies	1	1	0	0	2	2	NA	\$40,000	NA	NA	No	No	Yes	Yes	Beneficiary	Keith Clark	keith.clark@nevada.gov	775-738-3828		AO	
	New Hampshire State Loan Repayment Program	State	No	unlimited	3	3			2	5	\$13,750	\$25,000	\$110,000	NA	No	NA	Yes	Beneficiary	Dave Roberts	daveroberts@state.nh.us	603-271-2275	\$75,000 for three years full time also possible 2-year extension at \$40,000; \$27,500 for two years part-time also possible 1-yr extension at \$10,000	AO		
	Primary Care Loan Repayment Program	State	No	unliing	16	10	24	2	4	\$26,000	\$33,600	\$125,000	NA	No	Yes	Yes	Agential loan	Sharon Bryant	sbryant@nd.gov	972-872-4605	Support varies by year, see email	AO			
	Health Professional Loan Repayment Program	State	No	varies	15	4	7	2	2	Unli repayment	NA	\$35,000	Total debt		Yes	Yes	Yes	Agential loan	Heather Romero	heather.romero@state.nm.us	505-476-8410		AO		
	Primary Care Service Corps	NHSC/State	No	33	new	new	new	new	2	5	50% of total debt	\$32,500	\$150,000	NA	No	Yes	Yes	Beneficiary	Caleb Wistar	cawis1@health.state.nv.us	516-473-7919	New program this year.	AO		
	The Dental Loan Repayment Program	NHSC/State	Yes	3	9	3	12	12	4	4	NA	\$20,000	\$60,000	NA	No	Yes	Yes	Beneficiary	Gary Cleard	gcleard@state.oh.us	751-249-4459	Amount paid will not exceed debt level	AO		
	Oro Dental Loan Repayment Program	State	Yes	varies	12	5	5	5	2	4	\$25,000	\$35,000	\$120,000	NA	No	No	Yes	Yes	Agential loan	Sandy Brado	sandy.brado@oro.ohio.gov	330-643-1301		AO	
	Oklahoma Dental Loan Repayment Program	State	Yes	5	7	5	15	15	2	5	NA	\$25,000	\$125,000	\$25,000	No	Yes	Yes	Yes	Agential loan	Susan Pater	OSP@okdhs.gov	405-271-5952	May not receive more funding than debt	AO	
	Oregon Partnership Loan Repayment Program	State w/ local matching	No	varies	1	1	8	1	2	5	25% of total debt	\$35,000	\$50,000	NA	No	Yes	Yes	Beneficiary	John Heller	jheller@oru.edu	503-464-4400		AO		
	Pennsylvania Primary Health Care Practitioner Loan Repayment Program	NHSC/State	No	10	0	0	39	4	3	4	Balance	Varies	\$40,000	NA	No	Yes	Yes	Agential loan	Jacqueline Hallett	jhallett@pa.gov	717-752-0268	May not receive more funding than debt. different amounts paid per year (see fundin)	AO		
	Rhode Island Dental Education Loan Repayment Program	NHSC/State	No	6	12	4	5	4	2	2	NA	\$25,000	\$50,000	NA	No	Yes	Yes	Agential Loan	Col Walker	colwalker@ri.gov	401-488-1737	May not receive more funding than debt	AO		
	Recruitment Assistance Program	State	Yes	5	1	1	3	3	3	25% of total contract	75% of total contract	Varies	NA	NA	NA	NA	No	Yes	Beneficiary	Jose Peterson	jose.peterson@state.sd.us	605-773-3517	Technically this is a RECRUITMENT program, not a loan repayment program.	AO	
	Tennessee State Loan Repayment Program	NHSC/State	No						2	5	\$30,000	\$40,000	\$100,000	NA	No	Yes	Yes	Beneficiary	Angie Allen	angie.allen@tn.gov	615-543-0228	Maximum loan repayment amounts are \$60,000 for an initial two-year award and \$40,000 for extensions	AO		
	Vermont Educational Loan Repayment Program for Dentists	State w/ local matching	Yes	varies	30	4	21	21	1	6	NA	\$20,000	\$125,000	NA	No	NA	Yes	Yes	Agential loan	Eliabeth Cole	elizabethcole@state.vt.us	(802) 656-0630		AO	
	Virginia Dental Loan Repayment Program	State w/federal	Yes	4	13	13	13	13	1	2	Balance	\$20,000	\$40,000	NA	No	No	Yes	No	Beneficiary	Tonya Adches	tonya.adches@oh.virginia.gov	804-864-7764		AO	
	Federal Virginia State Loan Repayment Program	Federal	No	varies	0	0	8	0	2	4	Balance	\$40,000	\$140,000	NA	No	No	Yes	Yes	Beneficiary	Diana Schulz	diana.schulz@oh.virginia.gov	804-864-7421		AO	
	Federal Public State Loan Repayment Program	Federal	No	varies	5	5	84	11	2	Unli repayment	NA	\$35,000	\$70,000	NA	No	Yes	Yes	No	Beneficiary	Cristina Wilens	health@va.gov	360-793-7647	May not receive more funding than debt	AO	
	West Virginia State Loan Repayment Program	NHSC/State	No	varies	0	0	26	0	2	4	Balance	\$40,000	\$50,000	NA	No	Yes	Yes	Agential loan	Karen Pauley	karen.pauley@wv.gov	304-556-4382	Pays 54% in exchange for two years of service, with another \$25k/yr for two more yrs with recoupation	AO		
	Health Professions Loan Assistance Program (HPLAP)	NHSC/State	No	17	8	8	54	16	3	3	\$10,000	\$20,000	\$50,000	NA	No	Yes	Yes	Agential loan	Kevin Jackson	kevinjackson@wyo.edu	608-281-1893	Loan payments are made in different amounts by year: 40%/40%/20%; award may not exceed 75% of loan balance	AO		
	Wyoming Healthcare Provider Loan Repayment Program	State	No																						

## Appendix G

### **2013 Student Debt Management Survey**

Did/does your dental school offer students debt or personal financial management information (that goes above and beyond federal requirements for student loans)?

Was/is the student debt or personal financial management information provided part of the school's overall curriculum?

More specifically, was/is the student debt or personal financial management information provided part of your practice management curriculum?

Do you think your school should/does your school offer student debt or personal financial management information as part of the curriculum?

Did/does your school offer student debt or practice financial management support outside the curriculum?

Please describe what type of additional student debt or personal financial management support was/is offered (outside the curriculum):

How helpful was/is the information provided by your dental school on student debt or personal financial management? (grads and ASDA only)

How prepared did/do you feel to manage your educational debt when you graduate(d)? (grads and ASDA only)

Do you believe your dental school should provide more, about the same, or less student debt or personal financial management information than it currently offers/offered to you and your classmates?

Any comments about the student debt or personal financial management information your dental school provided to its students/you and your classmates?

## REFERENCES

- <sup>1</sup> Montoya, R, Hayes-Bautista, D, Gonzales, L, Smeloff, E. Minority dental graduates: do they serve minority communities? *Am. J. Publ. Hlth.* 1978; 68(10):860-868.
- <sup>2</sup> McFarland, K, Reinhardt, J, Yaseen, M. Rural dentists: Does growing up in a small community matter? *JADA* 2012; 143(9):1013-1019.
- <sup>3</sup> Harper Steven J. Pop Goes the Law. *The Chronicle Review*; March 15, 2013.
- <sup>4</sup> Mangan, Katherine. Law Schools Confront "New Normal" in Job Market. *The Chronicle of Higher Education*; January 6, 2013.
- <sup>5</sup> 2011-2012 Survey of Dental Education-Academic Programs, Enrollment, and Graduates-Volume 1; unpublished data.

Resolution No. 53 New  
 Report: Board Report 13 Date Submitted: August 2013  
 Submitted By: Board of Trustees  
 Reference Committee: Dental Education, Science and Related Matters  
 Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_  
 Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0  
 ADA Strategic Plan Goal: Collaboration (Required)

1 **ADA ADVOCACY AGENDA**

2 **Background:** (Board Report 13, Worksheet: 3036)

3 **Resolution**

4 **53. Resolved**, that the ADA advocacy agenda on behalf of dental education, dental students,  
 5 and recent dental school graduates include:

- 6 1. Dental school approval as Federally Qualified Health Centers (FQHC) or ability to  
 7 partner with FQHC's.
- 8 2. Graduate Medical Education (GME) funding for non-hospital-based programs (i.e.,  
 9 dental schools).
- 10 3. Increased Medicaid fees and cost-based reimbursement for dental schools.
- 11 4. Increased number of loan forgiveness programs at the state and national level,  
 12 including additional debt relief programs targeting rural/underserved areas.
- 13 5. Financial incentives to practice permanently in underserved areas through  
 14 supplemental payments or tax credits.
- 15 6. Increased eligibility for dental graduates for all health profession loan forgiveness  
 16 programs
- 17 7. Student loan interest rate reform.

18  
 19 **BOARD RECOMMENDATION: Vote Yes.**

20 **BOARD VOTE: UNANIMOUS**

Resolution No. 53S-1 New

Report: NA Date Submitted: October 2013

Submitted By: Ninth District

Reference Committee: Dental Education, Science and Related Matters

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0

ADA Strategic Plan Goal: Members (Required)

**SUBSTITUTE FOR RESOLUTION 53:  
ADA ADVOCACY AGENDA**

The following substitute for Resolution 53 (Worksheet: 3078) was submitted by the Ninth Trustee District and transmitted on October 17, 2013, by Ms. Michelle Nichols-Cruz, Board and House Administrator, Michigan Dental Association.

**Background:** Substitute Resolution 53S-1 is being proposed to best position ADA advocacy efforts in areas most likely to achieve success.

Bullet 1

By current guidelines, dental school approval as a Federally Qualified Health Center cannot be accomplished. FQHC guidelines require an institution to provide the full scope of services - scope including medical, dental, and mental health services. Dental schools, by definition, do not provide the full scope of FQHC services.

Bullet 2

HRSA makes grants to organizations to improve and expand health care access and services for the underserved, focusing on the following program areas: Health Professions | HIV/AIDS | Maternal & Child Health | Office of the Administrator | Primary Health Care/Health Centers | Rural Health | Healthcare Systems | Organ Donation.

The addition of HRSA as a funding agency, in addition to the Centers for Medicaid and Medicare Services (CMS) which provides the GME funding, is most appropriate due to the fact that subsequent to health care reform, increasingly greater numbers of community based clinical funding opportunities will be offered through HRSA.

Bullet 3

Intergovernmental transfers (IGTs) are tools used to increase state Medicaid reimbursement rates by enhancing federal financial participation. Many states (Arizona, California, Colorado, Florida, Iowa, Kansas, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Washington, Wisconsin) have turned to IGTs as the best strategy to raise their state Medicaid shares.

IGTs are exchanges of public funds between different levels of government and are a common feature in state finance. In the early 1990s, many states began to use IGTs as a way to leverage federal Medicaid dollars to continue or expand coverage of services or to pay higher reimbursement rates to providers. The transfer of funds may take place from one level of government to another (i.e., counties to states) or

1 within the same level of government (i.e., from a state university hospital to the state Medicaid agency).  
2 Thus, states can use county or state expenditures to generate a federal match for enhanced support.

3  
4 In some cases, states have required local government providers (e.g., county-run nursing homes or  
5 municipal hospitals) to transfer back to the state some or all of the enhanced federal Medicaid funds  
6 originally paid to those providers. States have used these transferred funds for Medicaid or for other  
7 purposes such as to fill state budget shortfalls for other programs or to draw down additional federal  
8 Medicaid dollars.

9 **Resolution**

10 (Additions underscored; deletions stricken through)

11 **53S-1. Resolved**, that the ADA advocacy agenda on behalf of dental education, dental students,  
12 and recent dental school graduates include:

- 13 • ~~Dental school approval as Federally Qualified Health Centers (FQHC) or~~ The ability  
14 of dental schools to partner with FQHC's.
- 15 • Graduate Medical Education (GME) and Health Resources and Services  
16 Administration (HRSA) funding for non-hospital-based programs (i.e., dental  
17 schools).
- 18 • Increased Medicaid fees and cost-based reimbursement for dental schools, and the  
19 use of intergovernmental transfers for enhanced Medicaid reimbursement.
- 20 • Increased number of, and funding levels for, loan forgiveness programs at the state  
21 and national level, including additional debt relief programs targeting  
22 rural/underserved areas.
- 23 • Financial incentives to practice ~~permanently~~ long term in underserved areas through  
24 supplemental payments or tax credits.
- 25 • Increased eligibility for dental graduates for all health profession loan forgiveness  
26 programs
- 27 • Student loan interest rate reform.

28 **BOARD RECOMMENDATION: Received after the October Board of Trustees session.**

Resolution No. 54 New  
 Report: Board Report 13 Date Submitted: August 2013  
 Submitted By: Board of Trustees  
 Reference Committee: Dental Education, Science and Related Matters  
 Total Net Financial Implication: \$25,000 + \$64,000 Net Dues Impact: \_\_\_\_\_  
 Amount One-time \$25,000 Amount On-going \$64,000 FTE Total .5  
 ADA Strategic Plan Goal: Collaboration (Required)

1 **DEVELOPMENT OF A ROBUST INFORMATION PORTAL**

2 **Background:** (Board Report 13, Worksheet: 3036)

3 **Resolution**

4 **54. Resolved,** that the ADA Health Policy Resources Center (HPRC), the ADA/ADEA/CODA Liaison  
 5 Committee for Surveys and Reports, and the Center for Professional Success (CPS) in collaboration  
 6 with the communities of interest develop and promote a robust information portal via ADA.org to help  
 7 current and prospective students be fully informed, financially literate consumers about a career in  
 8 dentistry, including workforce forecasting reports, student debt, expected income, life-long financial  
 9 planning, and a central registry of all loan/tuition relief programs.

10

11 **BOARD RECOMMENDATION: Vote Yes.**

12 **Vote: Resolution 54**

BUCKENHEIMER	No	FEINBERG	Yes	NORMAN	Yes	VERSMAN	Yes
CROWLEY	Yes	GOUNARDES	Yes	ROBERTS	Yes	WEBER	Yes
DOW	Yes	HAGENBRUCH	Yes	SCOTT	Yes	YONEMOTO	Yes
ENGEL	Yes	ISRAELSON	Yes	SEAGO	Yes	ZENK	Yes
FAIR	Yes	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	Yes

Resolution No. 54S-1 Substitute

Report: Board Report 13 Date Submitted: October 2013

Submitted By: First Trustee District

Reference Committee: Dental Education, Science and Related Matters

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

1  
2

**SUBSTITUTE FOR RESOLUTION 54:  
DEVELOPMENT OF A ROBUST INFORMATION PORTAL**

3  
4

The following substitute to Resolution 54 (Worksheet: 3079) was submitted by the First Trustee District and transmitted on October 23, 2013, by Dr. Judith M. Fisch, First District Caucus Chair.

5

**Resolution**

6

(Additions underscored; deletions stricken through)

7  
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**54S-1. Resolved**, that the ~~ADA Health Policy Resources Center (HPRC), the ADA/ADEA/CODA Liaison Committee for Surveys and Reports, and the Center for Professional Success (CPS)~~ appropriate agencies of the ADA in collaboration with the communities of interest develop and promote a robust information portal via ADA.org to help current and prospective students be fully informed, ~~financially literate consumers about a career in dentistry, including workforce forecasting reports, student debt, expected income, life-long financial planning, and a central registry of all loan/tuition relief programs.~~

14

**BOARD RECOMMENDATION: Received after the October Board of Trustees session.**



Resolution No. 55 New

Report: Board Report 13 Date Submitted: August 2013

Submitted By: Board of Trustees

Reference Committee: Dental Education, Science and Related Matters

Total Net Financial Implication: \$112,000 Net Dues Impact: \$1.02

Amount One-time 0 Amount On-going \$112,000 FTE 1

ADA Strategic Plan Goal: Collaboration (Required)

1 **EXPANDING RESEARCH EFFORTS IN THE AREA OF DENTAL EDUCATION FINANCING**

2 **Background:** (Board Report 13, Worksheet: 3036)

3 **Resolution**

4 **55. Resolved,** that the ADA Health Policy Resources Center (HPRC), in preparation for the future of  
 5 the profession and reexamination of the dental education model, expand its research efforts in the  
 6 area of dental education financing, the impact of student debt and other factors on career choices in  
 7 order to better position the ADA as a thought leader and knowledge broker in this area and to  
 8 strengthen advocacy efforts.

9

10 **BOARD RECOMMENDATION: Vote Yes.**

11 **Vote: Resolution 55**

BUCKENHEIMER	No	FEINBERG	Yes	NORMAN	Yes	VERSMAN	Yes
CROWLEY	Yes	GOUNARDES	Yes	ROBERTS	Yes	WEBER	No
DOW	No	HAGENBRUCH	Yes	SCOTT	Yes	YONEMOTO	Yes
ENGEL	Yes	ISRAELSON	No	SEAGO	No	ZENK	Yes
FAIR	Yes	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	No

Resolution No. 56 New  
 Report: Board Report 13 Date Submitted: August 2013  
 Submitted By: Board of Trustees  
 Reference Committee: Dental Education, Science and Related Matters  
 Total Net Financial Implication: \$80,000 Net Dues Impact: .80  
 Amount One-time \_\_\_\_\_ Amount On-going 0 FTE 0  
 ADA Strategic Plan Goal: Collaboration (Required)

1 **A COMPREHENSIVE STUDY OF THE CURRENT DENTAL EDUCATION MODEL**

2 **Background:** (Board Report 13, Worksheet: 3036)

3 **Resolution**

4 **56. Resolved**, that the ADA seek collaboration with the broad communities of interest to conduct a  
5 comprehensive study of the current dental education model, to include:

- 6
- 7 1. Evaluation of the sustainability of dental school finances.
- 8 2. Evaluation of all the current dental school curricula.
- 9 3. Analysis of the competency and outcomes-based educational model.
- 10 4. Analysis of dental school outcomes data.
- 11 5. Analysis on the impact of student debt on career and practice choices.
- 12 6. A determination of whether students are being adequately prepared for the practice
- 13 of dentistry.
- 14 7. A determination of whether dental schools that are opening in non-traditional
- 15 academic health centers are meeting the appropriate level of scholarship to ensure
- 16 that dentistry continues to be a learned profession;
- 17

18 and be it further

19  
20 **Resolved**, that the ADA's financial implication for this resolution shall not exceed \$80,000, to be used  
21 to identify funding sources for the study; write grant proposals; coordinate conference calls; hire a  
22 consultant to do a literature review; and provide funds for one in-person stakeholder meeting, and be  
23 it further

24  
25 **Resolved**, that funding (estimated to be \$1,156,000) be raised from outside sources within a two year  
26 period in order for the study to proceed.  
27

1 **BOARD RECOMMENDATION: Vote Yes.**

2 **Vote: Resolution 56**

BUCKENHEIMER	Yes	FEINBERG	Yes	NORMAN	Yes	VERSMAN	Yes
CROWLEY	Yes	GOUNARDES	Yes	ROBERTS	No	WEBER	Yes
DOW	No	HAGENBRUCH	No	SCOTT	Yes	YONEMOTO	Yes
ENGEL	Yes	ISRAELSON	Yes	SEAGO	No	ZENK	No
FAIR	Yes	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	Yes

Resolution No. 56S-1 Substitute

Report: Board Report 13 Date Submitted: October 2013

Submitted By: Sixteenth Trustee District

Reference Committee: Dental Education, Science and Related Matters

Total Net Financial Implication: \$80,000 Net Dues Impact: .80

Amount One-time \_\_\_\_\_ Amount On-going 0 FTE 0

ADA Strategic Plan Goal: Collaboration (Required)

1 **SUBSTITUTE FOR RESOLUTION 56:**  
2 **A COMPREHENSIVE STUDY OF THE CURRENT DENTAL EDUCATION MODEL**

3 The following substitute for Resolution 56 (Worksheet: 3081) was submitted by the Sixteenth Trustee  
4 District and transmitted on October 16, 2013, by Mr. Phil Latham, executive director, South Carolina  
5 Dental Association.

6 **Resolution**

7 (Additions underscored; deletions stricken through)

8 **56S-1. Resolved**, that the ADA seek collaboration with ~~the~~ broad communities of interest, including  
9 dental educators, students, practicing dentists, health economists, and others with appropriate  
10 expertise to conduct a define the scope and specific aims of a comprehensive study of the current  
11 dental education models, to include:

- 12 1. Evaluation of the long-term sustainability of dental schools finances.
- 13 2. Evaluation of ~~all~~ the efficiency of the current dental school curricula and delivery
- 14 methods.
- 15 3. Analysis of the impact of student debt on dentistry as a career choice and subsequent
- 16 practice choices competency and outcomes based educational model.
- 17 4. ~~Analysis of dental school outcomes data.~~
- 18 5. ~~Analysis on the impact of student debt on career and practice choices.~~
- 19 6. ~~A determination of whether students are being adequately prepared for the practice~~
- 20 ~~of dentistry.~~
- 21 7. 4. A determination of whether dental schools that are opening in non-traditional
- 22 academic health centers are meeting the appropriate level of scholarship to ensure
- 23 that dentistry continues to be a learned profession;

24 and be it further

25  
26  
27 **Resolved**, that the ADA's financial implication for this resolution shall not exceed \$80,000, to be  
28 used to define the scope and specific aims of the study, to determine the estimated cost of the  
29 study, to identify potential funding sources for the study, and to report to the 2014 ADA House of  
30 Delegates identify funding sources for the study; write grant proposals; coordinate conference  
31 calls; hire a consultant to do a literature review; and provide funds for one in-person stakeholder  
32 meeting, and be it further

33  
34 **Resolved**, that funding (estimated to be \$1,156,000) be raised from outside sources within a two  
35 year period in order for the study to proceed.  
36

37  
38 **BOARD RECOMMENDATION: Received after the October Board of Trustees session.**



Resolution No. 58 New

Report: JCNDE Supplemental Report 1 Date Submitted: August 2013

Submitted By: Joint Commission on National Dental Examinations

Reference Committee: Dental Education, Science and Related Matters

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0

ADA Strategic Plan Goal: Public Health (Required)

1 **JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS SUPPLEMENTAL REPORT 1 TO**  
2 **THE HOUSE OF DELEGATES: JCNDE STANDING RULES REVISIONS**

3 **Background:** At its April 2012 meeting, members of the Joint Commission on National Dental  
4 Examinations' Committee on Dental Hygiene met and reviewed applications to fill vacancies on National  
5 Board Dental Hygiene Examination (NBDHE) Test Construction Committees. Criteria for filling these  
6 vacancies appear within the JCNDE Standing Rules (*Rules*), in a section entitled "Criteria for Dental  
7 Hygiene Test Constructors." In applying the criteria, the Committee encountered issues with the current  
8 set of applicants. More specifically, several members of the Committee noted that particular applicants  
9 seemed well-qualified to fill a vacancy, but existing criteria were perhaps too narrowly defined, and failed  
10 to recognize that the career path for dental hygienists is often quite varied. Additionally, it was not clear  
11 to members whether the criteria in place must be strictly adhered to or whether they could employ some  
12 discretionary judgment in their decision making process. Strict adherence to the criteria meant that  
13 applicants who some viewed as most qualified might not be eligible for Committee membership. Given  
14 these challenges, the Committee directed staff to review the criteria for selecting dental hygiene test  
15 constructors, for consideration by the Joint Commission at a future meeting.

16  
17 At its April 2013 meeting, members of the Committee on Dental Hygiene and the full Joint Commission  
18 revisited the issue, thoroughly discussed the available options, and issued a resolution to modify the  
19 selection criteria for NBDHE Test Constructors in the area of Clinical Dental Hygiene. This revision was  
20 intended to provide greater flexibility in selecting qualified test constructors, in accordance with the  
21 sentiments expressed above. The specific criteria language selected by the Joint Commission was as  
22 follows:

23 At least three years' experience, preferably within the last five years, teaching and  
24 practicing clinical dental hygiene; full-time or part-time in private practice or faculty  
25 practice.  
26

27 Relative to the original text, the updated text includes the word 'preferably,' thereby permitting Committee  
28 members additional flexibility as to when the experience in teaching and practicing clinical dental hygiene  
29 occurred. From the Joint Commission's perspective, the above change was sufficient to address the  
30 issue. The change to the *Rules* that corresponds to this issue appears under the section entitled "Criteria  
31 for Dental Hygiene Test Constructors" (Worksheet: 3097, lines 13, 21, 26, and 47). The above text also  
32 incorporates a grammatical correction ("years' experience" now includes an apostrophe), which was  
33 similarly applied to several other criteria within the *Rules* to improve language consistency (Worksheet:  
34 3098, lines 5 and 13).

35 According to the ADA *Bylaws*, Chapter XIV. COMMISSIONS, Section 120. Power to Adopt Rules and  
36 Section 130, Duties, amendments to the *Rules* must be submitted to the ADA House of Delegates for

1 approval by majority vote. In accordance with the *Bylaws*, the following resolution is forwarded to the  
2 2013 ADA House of Delegates, recommending approval of the revised *Rules*.

3

4 The Joint Commission recommends adoption of the following resolution.

5

6

#### Resolution

7 **58. Resolved**, that the criteria for Dental Hygiene Test Constructors in the area of Clinical Dental  
8 Hygiene, as stated in the *Standing Rules of the Joint Commission on National Dental Examinations*,  
9 be amended as follows (deletions stricken through, additions underscored):

10 c. At least three years' experience, preferably within the last five years, teaching and  
11 practicing clinical dental hygiene; full-time or part-time in private practice or faculty practice.

12 and be it further

13 **Resolved**, that lines 13, 21, 26, 47, on worksheet: 3097; and lines 5 and 13 on worksheet 3098, be  
14 amended as follows:

15 At least three years' experience within the last five years ...

16

17 **BOARD RECOMMENDATION: Vote Yes.**

18 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION- NO BOARD**  
19 **DISCUSSION)**

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Appendix

**STANDING RULES**

**PROPOSED CHANGES TO DOCUMENT**

Underline indicates text that has been inserted.

~~Strikeout~~ indicates text that has been deleted.

April ~~2012~~2013

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



1

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

4

5 1. Bylaws of the American Dental Association

6 2. Bylaws of the Joint Commission on National Dental Examinations

7 3. Standing Rules for Councils and Commissions

8

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

12

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## ELECTION OF A PUBLIC MEMBER

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

### Qualifications

The public member shall not be a(n):

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

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

It is suggested that the public member not be employed by a firm with a substantial interest in dentistry or dental hygiene, and that the public member be experienced in health issues, testing, credentialing, or advocating the interest of the public.

### Term

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

### Identification of Nominees

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

## ROLES OF COMMITTEES

Four standing committees meet in conjunction with the annual meeting of the Joint Commission. They are:

- a. Committee on Administration
- b. Committee on Dental Hygiene
- c. Committee on Examination Development
- d. Committee on Research and Development

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

#### 4 5 **Assignments**

6  
7 Assignment of topics to specific committees is the responsibility of the Joint Commission Chair,  
8 but this responsibility may be delegated in part or in total to the Secretary. Listed and discussed  
9 below are examples of topics that are typically assigned to each committee.

10  
11 A topic may be assigned to more than one committee. In addition, provided that it completes its  
12 assigned items, a committee may consider a topic assigned to a different committee.

#### 13 14 **Committee on Administration**

15  
16 This committee's responsibility relates to both National Board Dental Examinations and  
17 the National Board Dental Hygiene Examination. The committee deals with operations.  
18 Specific topics to be considered include:

- 19  
20 a. Examination security, including procedures for examination administration  
21 b. Examination regulations  
22 c. Joint Commission Bylaws and Standing Rules  
23 d. Finances, including an annual comparison of income and expenses  
24

#### 25 **Committee on Dental Hygiene**

26  
27 This committee's responsibility relates primarily to the National Board Dental Hygiene  
28 Examination. Specific topics to be considered include:

- 29  
30 a. Examination content and specifications  
31 b. Test construction procedures, including nomination of test constructors  
32 c. Information circulated to publicize or explain the testing program  
33 d. Portions of Examination Regulations that affect dental hygiene candidates  
34 e. Matters pertaining to finances, ADA and Joint Commission Bylaws, and Joint  
35 Commission Standing Rules that affect the National Board Dental Hygiene  
36 Examination  
37

#### 38 **Committee on Examination Development**

39  
40 This committee's responsibility relates primarily to National Board Dental Examinations.  
41 Specific topics to be considered include:

- 42  
43 a. Examination content and specifications  
44 b. Test construction procedures, including nomination of test constructors  
45 c. Information circulated to publicize or explain the testing program

## 1        **Committee on Research and Development**

2  
3        This committee's responsibility relates to both the National Board Dental Examinations  
4        and the National Board Dental Hygiene Examination. Topics considered by this  
5        Committee include any research or developmental activities related to the Examinations.  
6

## 7        **Committee Actions**

8  
9        A committee is expected to consider and report on all assigned topics. For most topics,  
10       committee actions are to be presented in the form of recommendations for Joint Commission  
11       action. Following are three exceptions:

- 12
- 13        a. A decision about the manner in which a committee approaches its assignment - for  
14        example, a change in the personal data form for potential test constructors - need not  
15        be reported.
  - 16
  - 17        b. Identification of background requested for future deliberations may be reported as  
18        information without an accompanying recommendation. If compilation of needed  
19        background requires substantial resources, however, a specific recommendation for  
20        action is appropriate.
  - 21
  - 22        c. A decision not to act may be reported as an informational item. If the topic has  
23        generated substantial outside interest, however, a recommendation not to act is  
24        appropriate so as to allow the Joint Commission to affirm the committee's decision.  
25

## 26       **Reporting**

27  
28       Background information prepared for Committee deliberations is circulated to all Commissioners  
29       and all Committee members. Exceptions are: information about a nominee to a test  
30       construction committee provided only to the committee charged with screening nominees and  
31       technical reports provided as background for the Committee on Research and Development.  
32

33       Committee reports are provided to the Joint Commission in written or electronic form. Topics  
34       are discussed in the order they are listed on the Joint Commission's agenda, and background  
35       information related to each topic is identified. For each recommendation, a report should  
36       include a brief summary or rationale. An exception is made in that no rationale is expected for  
37       appointment of a test constructor. Instead, an alternate is named for each newly proposed test  
38       constructor.  
39

40       Preparation and presentation of a committee's report is the responsibility of each committee's  
41       Chair. Preparation may be delegated to a staff secretary assigned to the committee. If the  
42       committee Chair is not a commissioner or if, for some other reason, the committee Chair is not  
43       present at the Joint Commission's annual meeting, responsibility for presenting the report may  
44       be delegated to a commissioner who has served on that committee.  
45

46       Committee reports are presented orally, stopping for action as needed. At each stop for action,  
47       the presenter represents the committee's views through his or her answers to questions. Only  
48       after ensuring that the committee's views have been represented adequately may the presenter  
49       impart any personal views.  
50

## CRITERIA FOR DENTAL TEST CONSTRUCTORS

The Joint Commission selects consultants to serve on its Dental and Dental Hygiene Test Construction Committees. A test constructor is appointed for a one-year term and may be reappointed to four consecutive terms. To be considered for appointment, a person must possess appropriate qualifications and must submit a completed personal data form. Someone who has completed five years of service on a committee will not be considered for reappointment to the same committee.

The following are the criteria for test constructors on Anatomic Sciences, Biochemistry-Physiology, Microbiology-Pathology, Dental Materials, Pharmacology, Patient Management, and Testlet Development Committees:

- a. Dentist with a masters degree in that biomedical science OR a professional with a doctoral degree in that biomedical science.
- b. Three years of experience within the last five years teaching or in research in that biomedical science.

The following are the criteria for test constructors on Dental Anatomy and Occlusion, Operative Dentistry, Prosthodontics, Oral and Maxillofacial Surgery-Pain Control, Orthodontics-Pediatric Dentistry, Endodontics, Periodontics, and Oral Diagnosis Committees:

- a. Dentist
- b. In the case of special areas of dentistry, graduation from an accredited advanced education program in that specialty.

### Part I (Component A) Test Construction Committees

#### Anatomic Sciences

This five member committee includes the following. At least one of the four subject-matter experts must be a dentist.

- a. Gross anatomists (2)
- b. Histologists (2); including one whose expertise is embryology and one whose expertise is neuroanatomy
- c. Full-time practitioner (1)

#### Biochemistry/Physiology

This five member committee includes the following. At least one of the four subject-matter experts must be a dentist.

- a. Biochemists (2)
- b. Physiologists (1)
- c. Full-time practitioner (1)

**Microbiology/Pathology**

This five member committee includes the following. At least one of the four subject-matter experts must be a dentist.

- a. Microbiologists (2); including one whose expertise is immunology
- b. Pathologists (2)
- c. Full-time practitioner (1)

**Dental Anatomy and Occlusion**

This four member committee consists of 4 dentists who are:

- a. Dental anatomists (3)
- b. Full-time practitioner (1)

**Part I (Component B) Test Construction Committees****Testlet Development**

This nine member committee consists of:

- a. Dental educators representing the various discipline areas, and all of who should already have served on a Part I discipline-based committee. (5)
- b. Dental practitioners representing each of the discipline-based Part I committees. (4)

**Consultant Review**

This committee is responsible for reviewing the discipline-based (Component A) and testlet-based (Component B) components of the Comprehensive Part I examinations to ensure the examinations adhere to test specifications and item guidelines outlined by the Joint Commission. The composition of this two member committee varies between the dental discipline experts and practitioners. Members of this committee should already have served on a Component A committee.

**Part II (Component A) Test Construction Committees****Operative Dentistry**

This five member committee consists of:

- a. Restorative/operative dentists (3)
- b. Expert in dental materials (1)
- c. Full-time practitioner (1)

**Pharmacology**

This four member committee consists of:

- a. Pharmacologists (3), one who is a dentist



- 1           b. Full-time practitioner (1)  
2

3           **Prosthodontics**  
4

5           This six member committee consists of:  
6

- 7           a. Prosthodontists (4), two with expertise in fixed prosthodontics and two with expertise  
8           in removable partial/complete prosthodontics  
9           b. Expert in dental materials (1)  
10           c. Full-time practitioner (1)  
11

12           **Oral and Maxillofacial Surgery/Pain Control**  
13

14           This four member committee consists of:  
15

- 16           a. Oral and maxillofacial surgeons (3), at least one with expertise in pain control  
17           b. Full-time practitioner (1)  
18

19           **Orthodontics/Pediatric Dentistry**  
20

21           This six member committee consists of:  
22

- 23           a. Orthodontists (3)  
24           b. Pediatric dentists (2)  
25           c. Full-time practitioner (1)  
26

27           **Endodontics**  
28

29           This four member committee consists of:  
30

- 31           a. Endodontists (3)  
32           b. Full-time practitioner (1)  
33

34           **Periodontics**  
35

36           This four member committee consists of:  
37

- 38           a. Periodontists (3)  
39           b. Full-time practitioner (1)  
40

41           **Oral Diagnosis**  
42

43           This six member committee consists of:  
44

- 45           a. Oral pathologists (2)  
46           b. Oral and maxillofacial radiologists (2)  
47           c. Dentist with advanced education in oral diagnosis (1)  
48           d. Full-time practitioner (1)  
49

**Patient Management**

This eight member committee consists of:

- a. Dental public health specialists (2)
- b. Dentist with advanced education in special needs (1)
- c. Behavioral scientists (3), at least one who must be a dentist
- d. Full-time practitioners (2)

**Full-time Practitioners**

A full-time practitioner is a currently licensed dentist (not necessarily a specialist) in the United States, practicing dentistry full-time (30 to 40 hours per week) for at least 10 years.

**Part II (Component B) Test Construction Committee****Component B**

This committee develops the case-based items for the Comprehensive Part II examination. This thirteen member committee consists of:

- a. Members representing the dental disciplines, all of who have served on a Part II Component A committee (10)
- b. General practitioners with experience in preparing educational or licensure examinations (2)
- c. Behavioral scientist (1)

**Case Selection**

As an adjunct to the Component B committee, this committee does the preliminary work of screening new patient cases, and identifying suitable cases. This committee drafts and reviews the patient histories, dental charts, and treatment plans associated with the cases. The composition of this 4-member committee varies between dental discipline experts and practitioners.

**Consultant Review**

This committee is responsible for reviewing the discipline-based (Component A) and case-based (Component B) components of the Comprehensive Part II examinations to ensure the examinations adhere to test specifications and item guidelines outlined by the Joint Commission. The composition of this two member committee varies between the dental discipline experts and practitioners. Members of this committee should already have served on a Component A committee.

## CRITERIA FOR DENTAL HYGIENE TEST CONSTRUCTORS

The National Board Dental Hygiene Examination is constructed by committees of consultants with subject matter expertise in the following eight areas.

### **Basic Sciences**

The basic sciences include anatomy, histology, biochemistry and nutrition, physiology, microbiology and immunology, pathology, pharmacology, and oral biology.

- a. Doctoral degree in a biomedical science, or a dentist or dental hygienist with an advanced degree in a biomedical or dental science.
- b. At least three years' experience within the last five years teaching a biomedical or dental science to dental hygiene students.

### **Radiology**

- a. Dentist or dental hygienist with a baccalaureate degree from an accredited program.
- b. An oral and maxillofacial radiologist or a dental hygienist with formal education in dental radiology beyond what was provided in dental hygiene program.
- c. At least three years' experience within the last five years teaching radiology.

### **Periodontics**

- a. Graduate of an accredited dental or dental hygiene program with advanced formal education or training in periodontics.
- b. At least three years' experience within the last five years teaching or practicing periodontics.

### **Oral Medicine/Oral Diagnosis**

- a. Dentist with advanced clinical training.
- b. At least three years of experience within the last five years teaching oral medicine/oral diagnosis.

### **Special Needs Professional**

- a. Dentist or dental hygienist with advanced clinical training.
- b. At least three years of experience within the last five years teaching a clinical science.

### **Dental Hygiene Curriculum**

- a. Dental hygienist who has graduated from an accredited program.
- b. Advanced degree, preferably in dental hygiene.
- c. Experience in curriculum design as a dental hygiene program director, member of a dental hygiene curriculum committee, or accreditation consultant for dental hygiene.
- d. At least three years' experience within the last five years teaching to dental hygiene students.

**Clinical Dental Hygiene**

- a. Dental hygienist who has graduated from an accredited program.
- b. Baccalaureate degree in dental hygiene, education, or a biomedical science.
- c. At least three years' experience, preferably within the last five years, teaching and practicing clinical dental hygiene; full-time or part-time in private practice or faculty practice.

**Community Dental Health**

- a. Dentist or dental hygienist who has graduated from an accredited program.
- b. Advanced degree in public health or related field.
- c. At least three years' experience within the last five years in a public health position or teaching community and public health courses to dental or dental hygiene students.

**Dental Hygiene Test Construction Committees**

Three dental hygiene Component A committees (total of 15 members) and a dental hygiene Component B committee (8 members) construct the National Board Dental Hygiene Examination.

**Component A Committees****Dental Hygiene I**

- a. Basic science experts (3)
- b. Dental hygiene curriculum expert (1)

**Dental Hygiene II**

- a. Periodontists (3), at least one who must be a dentist
- b. Dental hygiene curriculum expert (1)
- c. Clinical dental hygiene experts (2)
- d. Oral and Maxillofacial Radiologist or dental hygienist with formal education in radiology (1)

**Dental Hygiene III**

- a. Dental Hygiene Curriculum expert (1)
- b. Clinical Dental Hygiene expert (1)
- c. Community Dental Health experts (2)

**Component B Committees****Component B**

- a. Basic science expert (1)
- b. Dental hygiene curriculum expert (1)
- c. Clinical dental hygiene expert (1)
- d. Community dental health expert (1)
- e. Oral medicine/oral diagnosis expert (1)

- 1 f. Periodontist (1)  
2 g. Oral and Maxillofacial radiologist or dental hygienist with formal education in  
3 radiology (1)  
4 h. Special needs expert (1)  
5

#### 6 **Case Selection**

7  
8 Members from various dental hygiene disciplines (4)  
9

#### 10 **Consultant Review**

11  
12 Members from the various dental hygiene disciplines, one of which must be a dentist (4)  
13

14 Members on these Component B committees should have already served on a Dental Hygiene  
15 Component A committee.  
16

### 17 **DETECTION OF IRREGULARITIES BASED ON FORENSIC ANALYSES**

#### 18 **Definitions**

19  
20  
21 The Joint Commission is responsible for protecting the integrity of National Board Examination  
22 scores. One method used is to withhold scores that reflect unrealistic response patterns.  
23 Procedures for withholding scores are listed in the Examination Regulations for National Board  
24 Examinations.  
25

26 Statistical criteria for withholding scores are based on the response patterns of candidates or  
27 the performance of candidates on the overall examination. Potential irregularities may include,  
28 but are not limited to, the following:  
29

30 **Aberrant results:** Inconsistent response patterns as measured by response aberrance  
31 index (e.g., answering difficult questions correctly and missing easy questions).  
32

33 **Latency aberrance:** Candidates with inconsistent or inappropriate use of time in  
34 responding to items.  
35

36 **Perfect tests:** Two or more candidates with identical test results or perfect tests.  
37

38 **Unrealistic similarity:** Two or more candidates who have more identical wrong answers  
39 than different wrong answers.  
40

41 **Unusual gain in scores:** Candidates with unusual or artificial gains in scores in  
42 comparison to previous testing attempts.  
43

#### 44 **Criteria for Withholding Scores**

45  
46 Candidate's scores may be withheld or, as circumstances may warrant, reported when aberrant  
47 response patterns or aberrant examination performance is detected through forensic analyses  
48 or other information that supports the possibility that the candidate has given or received  
49 confidential information concerning examination content during or prior to the examination.

1 Similarly, scores may be withheld or reported if compelling information is available that suggests  
2 that the candidate was not testing for the intended purpose.

### 4 **LIMITED RIGHT OF APPEALS FOR EXAMINATION CANDIDATES**

6 The Joint Commission recognizes that strict application of the Examination Regulations for  
7 National Board Examinations may, because of unusual circumstances, impose an unusual  
8 burden on one or more candidates. In these situations, the Joint Commission may consider an  
9 appeal for special consideration.

11 Requests for an appeal pertaining to test results must be initiated within 30 days of receiving  
12 test results or, in the case of withheld scores, within 30 days of receiving written notice that  
13 scores are being withheld. In the event that the Joint Commission has given notice that  
14 previously released scores are to be invalidated or voided, the request for appeal must be  
15 submitted within 30 days. In this case, a request for appeal will stay the action to invalidate or  
16 void the score until such time as the appeal is decided or the time for submitting a request for  
17 appeal has expired. A request for an appeal must be submitted in writing and must include  
18 adequate documentation. The request for an appeal must indicate the specific relief requested.

19 A request for an appeal will first be screened by the Chair. The Chair, in his/her sole  
20 discretion, may 1) allow an appeal (if the Chair believes that there is a reasonable basis  
21 for the review of the facts of the case and the procedures applied thereto), 2) deny an  
22 appeal, or 3) recommend, in consultation with the secretary, to release scores.

24 When considering an appeal, the Joint Commission will strive to ensure that the candidates  
25 have an opportunity to gain National Board certification equal to, but not greater than, the  
26 opportunity provided other candidates.

28 If the issue presented in an appeal is likely to recur, the Joint Commission may consider a  
29 change in regulations. Granting of an appeal will be considered a precedent only if a change in  
30 regulations is also adopted. The candidate will be notified of the Joint Commission action within  
31 60 days after receipt of the written request for the appeal.

33 The Chair of the JCNDE, in consultation with the secretary of the JCNDE, may grant an appeal  
34 when additional, convincing information becomes available early in the appeal process that  
35 indicates an error was made in the decision to withhold scores.

### 37 **CONFLICT OF INTEREST POLICY**

39 Policies and procedures used in National Board testing programs should provide for fairness  
40 and impartiality in the conduct of examinations and treatment of all candidates. Central to the  
41 fairness of the JNCDE's operations and the impartiality of its decision-making process is an  
42 organizational and personal duty to avoid real or perceived conflicts of interest. The potential  
43 for a conflict of interest arises when one's duty to make decisions in the public's interest is  
44 compromised by competing interest of a personal or private nature, including but not limited to  
45 pecuniary interests.

47 Conflict of interest is considered to be:

- 49 1) Any relationship with a candidate for National Board certification, or



Resolution No. 85 New  
 Report: NA Date Submitted: September 2013  
 Submitted By: Sixth Trustee District  
 Reference Committee: Dental Education, Science and Related Matters  
 Total Net Financial Implication: Res. 85--\$75,000; Res. 85B--\$0 Net Dues Impact: \_\_\_\_\_  
 Amount One-time \$75,000 Amount On-going \_\_\_\_\_ FTE 0.2  
 ADA Strategic Plan Goal: Collaboration (Required)

**1 INVESTIGATE DENTAL INSTRUMENT PURCHASE AND LEASING PLANS OFFERED TO**  
**2 STUDENTS BY DENTAL SCHOOLS**

3  
 4 The following resolution was adopted by the Sixth Trustee District and submitted on September 17, 2013,  
 5 by Ms. Meg Shannon, executive director.  
 6

7 **Background:** In the last few years there has been, and continues to be, new dental schools opening and  
 8 the size of the student body varies from the 50's to 125+/- . Tuition varies from the lower \$20,000 to above  
 9 \$70,000 each year. In some schools the students buy their instruments and in others they lease them,  
 10 beginning with the first year. This is also true of established schools. The sterilization of contaminated  
 11 instruments is less complicated for the school if the students lease instruments since they may be  
 12 returned in a generic manner rather than to individual owners.  
 13

14 However, let's look at the purchase vs. leasing. Beginning with the freshmen year, the schools purchase  
 15 50 to over 100 sets of instruments. Surely the school is offered and can bargain for a substantial discount,  
 16 is this discount passed on to the students? Breakage and lost instruments are replaced by the individual  
 17 student so the sets remain complete. For those schools that lease instruments, when the first class  
 18 graduates new instruments need not be purchased, these used instruments are again leased. What is the  
 19 effective life of these instruments and is this longevity considered in the pricing of leasing for all student  
 20 populations?  
 21

22 Then, look at the fact that most students obtain loans and the President has just signed a bill that sets the  
 23 interest rate at 2% to 4% above the ten years Treasury note. At the present time that rate is about 2.58%.  
 24 The long term average for the note is about 6%. The question arises, are the rates variable each year are  
 25 they fixed?  
 26

27 If we consider the present rate of 2.58% plus 2% the totals 4.58% for the Stafford and 6.58% for those  
 28 who maxed out their Stafford. If we look at the Rule of 72, which when divided by the interest rate  
 29 approximates the intervals where the interest equals the loan value. At 4.58% interest the loan doubles at  
 30 15.7 years and triples at 31.4 years. At 6.58% the loan doubles at 10.9 years and triples at 21.8 years.  
 31 For leased instruments. If they purchase the instruments the cost does not change but at least they have  
 32 possession of the instruments and will be available when they open their office.  
 33

**34 Resolution**

35  
 36 **85. Resolved,** that the Council on Dental Education and Licensure, together with any other  
 37 appropriate ADA agencies, investigate dental instrument purchase and leasing plans offered to  
 38 students by dental schools, and be it further



1  
 2 **Resolved**, that a report to the 2014 House of Delegates be presented on this investigation, together  
 3 with any recommendations for cost savings measures and, if appropriate, model dental instrument  
 4 purchase and leasing plans that would be economically beneficial to students.

5 **BOARD COMMENT:** The Board appreciates the concern over the costs associated with obtaining a  
 6 predoctoral dental education that is the basis for this resolution; however, the Board believes that not only  
 7 is this type of study an opportunity for collaboration with the American Dental Education Association, but  
 8 will also require ADEA's expertise to generate a report with actionable items. It is imperative that CDEL  
 9 investigate whether ADEA has any interest in collaborating with the ADA before ADA funds are  
 10 committed to conduct a study. Finally, the Board believes the American Student Dental Association  
 11 should also be invited to collaborate, as this issue directly affects dental students. Therefore, the Board  
 12 urges a yes vote on the following substitute resolution.

13  
 14 **85B. Resolved**, that the Council on Dental Education and Licensure explore the feasibility of  
 15 collaborating with the American Dental Education Association and the American Student Dental  
 16 Association on an investigation of dental instrument purchase and leasing plans offered to students  
 17 by dental schools, and be it further

18  
 19 **Resolved**, that the Council also explore the financial implications of conducting this study, and be it  
 20 further

21  
 22 **Resolved**, that the Council report on the feasibility of the study to the 2014 House of Delegates.

23  
 24 **BOARD RECOMMENDATION: Vote Yes on the Substitute.**

25  
 26 **Vote: Resolution 85B**

BUCKENHEIMER	No	FEINBERG	Yes	NORMAN	No	VERSMAN	Yes
CROWLEY	Yes	GOUNARDES	Yes	ROBERTS	Yes	WEBER	Yes
DOW	Yes	HAGENBRUCH	Yes	SCOTT	Yes	YONEMOTO	Yes
ENGEL	Yes	ISRAELSON	No	SEAGO	Yes	ZENK	Yes
FAIR	No	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	Yes

Resolution No. 88 New

Report: NA Date Submitted: October 2013

Submitted By: Sixteenth Trustee District

Reference Committee: Dental Education, Science and Related Matters

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0

ADA Strategic Plan Goal: Members (Required)

1 **REQUIREMENTS IN DENTAL SCHOOL EDUCATION PROGRAMS**

2 The following resolution was submitted by the Sixteenth Trustee District and transmitted on October 16,  
3 2013, by Mr. Phil Latham, executive director, South Carolina Dental Association.

4 **Background:** Since 1997, 13 new dental schools have opened or have announced they will open with a  
5 planned date for enrollment of the first class of dental students. This wave of new dental schools came  
6 just after closure of seven dentals schools between 1986 and 2001. National concerns on access to  
7 dental care, the aging dental workforce, and a robust applicant pool that can support increased  
8 enrollment have been cited as reasons to open new dental schools. In 1990 the annual number of dental  
9 graduates per year nationally was 4,233. This declined to a low of 3,778 in 1993 and has risen to 4,996  
10 in 2010. With the opening of new and planned dental schools, first year enrollment in dental schools will  
11 rise to 5,500 to 6,000 by 2020. Applicants to dental school nationally have risen from 7,412 in 2001 to a  
12 high of 13,742 in 2007. Since 2007, the number of dental school applicants has declined to 12,039 in  
13 2011. Dental student debt has risen steeply from an average of \$84,247 in 1996 to \$203,374 in 2011  
14 while expenditures on dental services declined in the early 2000s and has remained flat since 2008.  
15 Average net income of dentists has declined since the mid-2000s. Recently, reports of greatly reduced  
16 applicants to law school have demonstrated how rapidly a shift in demand for seats in professional school  
17 can take place when the real or perceived return on educational investment declines. It is prudent to  
18 consider standards that would assess the demand for additional providers prior to issuing initial  
19 accreditation of new dental education programs or the expansion of existing programs. Currently, as  
20 outlined in the Evaluation & Operational Policies & Procedures (August, 2013) the Commission on Dental  
21 Accreditation (CODA) requires that to establish new allied dental education areas or disciplines elements  
22 to be addressed include:

- 23 • evidence of the potential for graduates to obtain gainful employment
- 24 • average student loan indebtedness
- 25 • average salary new graduates can expect to earn
- 26 • employment placement rates (when available)
- 27 • documentation of employment/practice opportunities/settings evidence from a feasibility  
28 study and/or needs assessment (where available) showing career opportunities, student  
29 interest, an appropriate patient base

30 Currently, the CODA standards for new and existing dental education programs do not require that a  
31 program meet a standard that demonstrates the true need for a new dental education program or  
32 increase in enrollment of a current program.

- 1 **Resolution**
- 2 **88. Resolved**, that the Commission on Dental Accreditation be urged to adopt and implement a new
- 3 accreditation standard for predoctoral dental education programs which requires new programs and
- 4 existing programs that wish to increase enrollment to conduct a needs assessment, and be it further
- 5 **Resolved**, that the new accreditation standard require programs to conduct a feasibility study that
- 6 includes but is not limited to: student interest in the profession, societal need, the availability and
- 7 appropriate patient base, the projected student loan indebtedness, employment opportunities and
- 8 expected salaries of the new graduates.
- 9 **BOARD RECOMMENDATION: Received after the October Board of Trustees session.**

Resolution No. 91 New

Report: NA Date Submitted: October 2013

Submitted By: Fourteenth Trustee District

Reference Committee: Dental Education, Science and Related Matters

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE 0

ADA Strategic Plan Goal: Members (Required)

1 **DISCLOSURE OF COSTS INCURRED BY DENTAL STUDENTS**

2 The following resolution was submitted by the Fourteenth Trustee District and transmitted on October 24,  
3 2013, by Dr. J. Jerald Boseman, chairman, Fourteenth District Resolutions Committee.

4 **Background:** In their interview process dental schools generally include a cursory financial presentation  
5 containing disclosure of current tuition, fees and the average cost of living in their communities.  
6 Applicants deserve the most accurate current information as they compare the financial obligations they  
7 will potentially incur by attending a particular dental school. Website posting of average costs and listing  
8 the maximum which can be borrowed from federal guaranteed loan programs is insufficient.

9 Comprehensive exit surveys of the past two graduating classes, including actual indebtedness and loan  
10 payback strategies would provide prospective students with the most accurate information. Disclosing this  
11 information to prospective students in detail during the application and interview process is in the best  
12 interest of the students and the dental profession.

13

14 **Resolution**

15 **91. Resolved,** that the ADA encourage dental schools, as part of their application and interview  
16 process, to disclose the actual costs incurred by their students to complete their degrees based  
17 on exit data collected for the two most recent classes.

18

19 **BOARD RECOMMENDATION: Received after the October Board of Trustees session.**

20



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# Dental Benefits, Practice and Health

Resolution No. 5 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

**AMENDMENT OF THE POLICY, TOOTH DESIGNATION SYSTEMS**

**Background:** (Reports:25)

**Tooth Designation Systems:** The CDBP believes that the policy "Tooth Designation Systems" should be amended to better reflect ADA agencies responsible for maintaining these systems.

The Universal/National Tooth Numbering System has been maintained by the ADA through adoption and amendment of policy by the House of Delegates. The Council on Dental Benefit Programs is the lead agency for maintenance and recommendations for amendment. This enumeration schema is well known and used within the domestic dental community. Its last amendment (2002:394) incorporated enumeration of supernumerary teeth.

Reference to the International Standards Organization (ISO) TC 106 Designation System for Teeth and Areas of the Oral Cavity is obsolete and misleading. This international standard is the basis for the ISO/ANSI/ADA Standard No. 3950, which is the ADA enumeration standard maintained by the ADA Standard's Committee on Dental Informatics (SCDI). The ADA is an accredited ANSI standards development organization and Standard No. 3950 maintenance is in accordance with ANSI protocols, which do not provide for House of Delegates approval of any changes.

Both the Universal/National Tooth Numbering System and the ISO/ANSI/ADA Specification No. 3950 for Designation System for Teeth and Areas of the Oral Cavity are incorporated by reference in the HIPAA standard electronic dental claim transaction. This reference states that the ADA is the source of both schemas.

**Resolution**

**5. Resolved**, that the ADA policy on Tooth Designation Systems (*Trans.* 1994:652; 2002:394) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that the American Dental Association accepts the ~~following definitions of the~~ Universal/National Tooth Designation System and the ~~International Standards Organization (ISO) TC 106 ISO/ANSI/ADA Specification No. 3950 for~~ Designation System for Teeth and Areas of the Oral Cavity as the human tooth and oral cavity enumeration schemas, and be it further **Resolved**, that the Universal/National Tooth Designation System is defined as follows:

*Permanent Dentition*

Teeth are numbered 1-32, starting with the third molar (1) on the right side of the upper arch, following around the arch to the third molar (16) on the left side, and descending to the lower third molar (17) on the left side, and following that arch to the terminus of the lower jaw, the lower right third molar (32).

Supernumerary teeth are identified by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar (e.g., supernumerary #51 is adjacent to the upper right molar #1; supernumerary #82 is adjacent to the lower right third molar #32).

*Primary Dentition*

Consecutive upper case letters (A-T), in the same order as described for permanent dentition should be used to identify the primary dentition.

Supernumerary teeth are identified by the placement of the letter "S" following the letter identifying the adjacent primary tooth (e.g., supernumerary "AS" is adjacent to "A"; supernumerary "TS" is adjacent to "T").

and be it further

**Resolved**, that ISO/ANSI/ADA Specification No. 3950 for International Standards Organization (ISO) TC 406 Designation System for Teeth and Areas of the Oral Cavity is defined as in standards documents prepared and published by the ADA Standards Committee on Dental Informatics.

*Designation of Areas of the Oral Cavity*

The oral cavity is designated by a two digit number where at least one of the two digits is zero, as follows:

00 designates the whole of the oral cavity  
 01 designates the maxillary area  
 02 designates the mandibular area  
 10 designates the upper right quadrant  
 20 designates the upper left quadrant  
 30 designates the lower left quadrant  
 40 designates the lower right quadrant  
 03 designates the upper right sextant  
 04 designates the upper anterior sextant  
 05 designates the upper left sextant  
 06 designates the lower left sextant  
 07 designates the lower anterior sextant  
 08 designates the lower right sextant

*Designation of Teeth*

Teeth are designated by using a two digit code. The first digit of the code indicates the quadrant and the second indicates the tooth in this quadrant:

a. First digit (quadrant)



1 ~~Digits 1-4 are used for quadrants in the permanent dentition and digits 5-8 for those in the~~  
2 ~~deciduous dentition, clockwise from the upper right quadrant.~~

3  
4 ~~b. Second digit (tooth)~~

5  
6 ~~Teeth in the same quadrant are designated by the second digit 1-8 (1-5 in the deciduous~~  
7 ~~dentition); this designation is from the median line in a distal direction.~~

8 **BOARD RECOMMENDATION: Vote Yes.**

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

11

12

Resolution No. 6 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, REPORTING OF DENTAL PROCEDURES TO THIRD PARTIES**

2 **Background:** (*Reports:27*)

3 **Reporting of Dental Procedures to Third Parties:** The CDBP believes that the policy "Reporting of  
4 Dental Procedures to Third Parties" should be amended to reflect the *CDT Code* as a named national  
5 standard by federal regulation.

6  
7 HIPAA regulations that name the *CDT Code* as the national standard for reporting dental services is a  
8 notable accomplishment that establishes a regulatory basis for use of this ADA intellectual property. Use  
9 of the *CDT Code* is required on all HIPAA standard electronic dental claim transactions and use of any  
10 other taxonomy on paper claims or those submitted by other means is contrary to the expanding use of  
11 electronic data interchange by dentists. Use of proprietary code sets on paper claims or other means is  
12 likely to result in claim rejection and reimbursement delay.

13  
14 The HIPAA requirement for *CDT Code* use is well established in all sectors of the dental community and  
15 ADA continued promotion of its use is redundant effort. Federal regulations require all HIPAA covered  
16 entities to only send or accept the *CDT Code*.

17  
18 The remaining changes simplify language for clarity.  
19

20 **Resolution**

21  
22 **6. Resolved**, that the ADA policy on Reporting of Dental Procedures to Third Parties  
23 (*Trans.*1991:637; 2009:418) be amended through text additions and deletions, so that the amended  
24 policy reads as follows (additions are underscored; deletions are ~~stricken~~):

25  
26 **Resolved**, that the ADA acknowledges the specification of the *CDT Code* as the sole taxonomy  
27 for reporting dental services on HIPAA standard electronic dental claims, and be it further  
28 **Resolved**, that when reporting dental treatment under dental plans, the method used by dentists  
29 for submitting claims to third-party payers and for filing fees ~~should~~ must be the American Dental  
30 Association's *Code on Dental Procedures and Nomenclature*, ~~as contained in the ADA's~~  
31 ~~publication, *Current Dental Terminology* (*CDT Code*)~~, and be it further  
32 **Resolved**, that third-party payers and their agents who process dental claims should not require  
33 the reporting of dental treatment or filing fees by any other coding taxonomies, and be it further  
34 **Resolved**, that ~~the Association formally contact commercial carriers, service corporations, any~~  
35 ~~and all other third-party payers and their agents who process dental claims, and vendors of~~

1 ~~electronic claims processing, to request that the ADA's *Code on Dental Procedures and*~~  
2 ~~*Nomenclature* be used as the code taxonomy for their claims adjudication process, and be it~~  
3 ~~further~~  
4 **Resolved**, that when an unusual procedure, or a procedure that is accompanied by unusual  
5 circumstances, is reported with a procedure code that includes "by report" in its nomenclature,  
6 that procedure code and its accompanying by a narrative description, that may or may not include  
7 a reference to an appropriate unspecified (- 999) code, it should be accepted by the third-party  
8 payer to assist in benefit determination.

9 **BOARD RECOMMENDATION: Vote Yes.**

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

12 Resolution 06

Resolution No. 7 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, RECOGNITION OF TOOTH DESIGNATION SYSTEMS FOR**  
 2 **ELECTRONIC DATA INTERCHANGE**

3 **Background:** (*Reports:28*)

4 **Recognition of Tooth Designation Systems for Electronic Data Interchange:** The CDBP believes  
 5 that the policy "Recognition of Tooth Designation Systems for Electronic Data Interchange" should be  
 6 amended for consistency with proposed revision to ADA policy "Tooth Designation Systems" and to  
 7 reflect the HIPAA standard electronic dental claim transaction.

8  
 9 Changes to the first resolving clause are consistent with proposed amendments to Tooth Designation  
 10 Systems (*Trans.*1994:652; 2002:394). Reference to the "International Standards Organization (ISO) TC  
 11 106..." is obsolete and misleading. This international standard is the basis for the ISO/ANSI/ADA  
 12 Standard No. 3950, which is the ADA enumeration standard maintained by the ADA Standard's  
 13 Committee on Dental Informatics (SCDI).

14  
 15 The HIPAA standard electronic dental claim transaction recognizes both the Universal/National system  
 16 (given identifier "JP") and the Standard No. 3950 (given identifier "JO"), and notes the ADA as the source  
 17 for each taxonomy.

18  
 19 The sixth resolving clause of the policy is proposed for deletion as it addresses mounting radiographs, not  
 20 electronic data interchange.

21  
 22 These amendments clarify and update the current policy text.

23 **Resolution**

24 **7. Resolved,** that the ADA policy on Recognition of Tooth Designation Systems for Electronic Data  
 25 Interchange (*Trans.*1994:675) be amended through text additions and deletions, so that the amended  
 26 policy reads as follows (additions are underscored; deletions are ~~stricken~~):

27  
 28 **Resolved,** that the American Dental Association recognizes that the two major systems used in  
 29 the United States for tooth designation are the Universal/National Tooth Designation System  
 30 ~~used primarily in the United States~~ and the ISO/ANSI/ADA Specification No. 3950 for Designation  
 31 System for Teeth and Areas of the Oral Cavity International Standards Organization (ISO) TC  
 32 ~~106 method used in most other countries,~~ and be it further

33 **Resolved,** that electronic oral health records should be designed to provide dentists the flexibility  
 34 to select which tooth designation system best suits his or her office, and be it further



Resolution No. 8 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, STATEMENT ON CAPITATION DENTAL BENEFIT PROGRAMS**

2 **Background:** (*Reports:28*)

3 **Statement on Capitation Dental Benefit Programs:** The CDBP believes that the policy "Statement on  
4 Capitation Dental Benefit Programs" should be maintained with the recommended syntax and other  
5 changes necessary to bring this policy up to date and to make it clearer and easier to understand based  
6 on similar changes made to related policies on capitated programs. Sections of the policy that appear to  
7 blame benefit plan design for unethical practices by a dentist have been removed.

8

9

**Resolution**

10

11 **8. Resolved,** that the ADA policy on Statement on Capitation Dental Benefit Programs  
12 (*Trans.1985:582; 1993:689*) be amended through text additions and deletions, so that the amended  
13 policy reads as follows (additions are underscored; deletions are ~~stricken~~):

14

15

A capitation dental benefit program is one in which a dentist or dentists contract with the  
program's sponsor or administrator to provide all or most of the dental services covered under the  
program to subscribers in return for payment on a per capita basis.

16

17

18

19

~~Because the contracting dentist's compensation in these programs is entirely or largely unrelated  
to the services actually provided, a circumstance is created in which the possibility of needed  
treatment being delayed or withheld by the contracting dentist, compelled by financial exigencies  
of maintaining a practice, must be acknowledged.~~

20

21

22

23

~~Because the financial responsibility of the capitation program subscriber for the payment from  
treatment provided is wholly or largely removed by this system of "prepaying" the contracting  
dentist, the subscriber patient's participation in decisions about his treatment is likewise reduced  
or eliminated.~~

24

25

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29

~~Because it is a practical certainty that not all dentists in a given community will choose to  
contract with will participate in a given capitation program, even if invited to do so, Therefore, the  
opportunity for capitation program subscribers to freely choose their receive treatment from any  
dentist in their community is necessarily restricted.~~

30

31

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~~Because in capitation dental benefit programs payment for covered services by specialists must  
be paid for in whole or part by the contracting general dentist or the program itself, a  
circumstance is created in which the possibility of the contracting general dentist's undertaking~~

1 ~~treatment beyond his or her capabilities or referring patients to a specialist of the program's rather~~  
2 ~~than the dentist's choice must be recognized.~~

3  
4 These inherent design limitations in capitation dental benefit programs make it incumbent upon  
5 the American Dental Association to provide the following recommendations to group benefit  
6 purchasers considering such programs:  
7

8 1. Capitation dental benefit programs should be offered only as an additional alternative to a  
9 benefit program which does not restrict the subscriber's opportunity to receive treatment from  
10 the dentist of his or her choice on a fee-for-service basis.

11 2. The scope of services covered in the ~~unrestricted~~ freedom of choice and capitation  
12 programs should be equal.

13 3. Each employee (or group member) should be provided comprehensive, unbiased  
14 information about the programs being offered and should be given a reasonable opportunity  
15 to select the program which ~~he~~ the employee believes best suits his or her needs, as well as  
16 periodic opportunities thereafter to choose to continue ~~his~~ enrollment in the program of ~~his~~  
17 the employee's initial selection or to enroll in a different program.

18 4. All dentists willing to abide by the terms of the capitation program's provider contract  
19 should be eligible to participate in the program.

20 5. There should be no automatic enrollment in capitation dental benefit programs.

21 6. A system of monitoring the dental needs and treatment provided under a capitation dental  
22 benefit program should be required of the administrator by the group purchaser. In this  
23 regard, the dental needs and procedures performed should be reported, not merely on an  
24 aggregate, but on an individual patient basis.

25 7. ~~Additionally, a~~ All services provided by specialists should be separately reported on both  
26 an aggregate and individual patient basis.

27 8. ~~Finally, all~~ Patients treated under a capitation dental benefit program should be provided  
28 in writing a list of their overall dental needs and the dental procedures rendered at each  
29 treatment visit.

30 9. Questions regarding the quality, appropriateness or thoroughness of treatment provided  
31 under capitation dental benefit programs should be resolved through the peer review system  
32 of the appropriate dental society.

33 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 9 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

**AMENDMENT OF THE POLICY, GUIDELINES FOR DENTAL COMPONENTS OF HEALTH MAINTENANCE ORGANIZATIONS**

**Background:** (Reports:29)

**Dental Health Maintenance Organizations:** The CDBP feels that the two current ADA policies on dental health maintenance organizations (DHMOs), "Closed Panel Dental Benefit Plans" (*Trans.*1989:545) and "Guidelines for Dental Components of Health Maintenance Organizations" (*Trans.*1988:476; 1993:689; 1995:610), should be combined into one easy to locate policy titled "Guidelines for Components of Dental Health Maintenance Organizations" with redundant statements deleted and appropriate updates included.

**Resolution**

**9. Resolved**, that the ADA policy on Guidelines for Dental Components of Health Maintenance Organizations (*Trans.*1988:476; 1993:689; 1995:610) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Guidelines for ~~Dental~~ Components of Dental Health Maintenance Organizations**

~~The A dental health maintenance organization (DHMO) concept has been defined as an organized system for health care~~ is a dental benefits plan that is a legal entity that accepts the responsibility to provide or otherwise ensure the delivery of an agreed upon set of comprehensive oral health care services for a voluntarily enrolled group of persons in a geographic area, and is reimbursed through a pre-negotiated and fixed periodic payment made by or on behalf of each person or family unit enrolled in the plan. with dental care provided by a limited number of dentists having contracts with the DHMO to provide these services.

The American Dental Association ~~recognized the HMO concept~~ (*Trans.*1971:501) but opposes ~~this approach as the only one~~ DHMOs as the sole benefit plan available to subscribers. Rather, such plans a DHMO should be presented to consumers as an alternative mode of financing and delivering oral health services, along with a comparable program that permits free choice of health provider dentist.

The ~~HMO concept has not demonstrated itself to be more economical, efficient or otherwise better in the delivery of dental services. Therefore, the ADA maintains that~~ DHMOs should not receive preferential treatment and ~~The Association suggests the following guidelines for DHMOs dental components:~~



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- 1. The DHMO should be recognized as only one of many alternatives to ~~deliver~~ finance oral health care.
- 2. A complete description of benefits provided under each plan should be given to all eligible individuals prior to each enrollment period. Benefit limitations and exclusions of each plan should be clearly described, and a complete and current list of dentists who participate in the closed panel plan should be provided.~~The subscriber should be made aware of limitations on choice of dentist and treatment location prior to enrollment.~~
- 3. Development and administration of a ~~dental component of an~~ DHMO should be under the control of a dentist.
- 4. Dental subscribers in an DHMO setting should be made fully aware of, and have access to, the profession's peer review mechanism.
- 5. A dental health education program with emphasis on prevention should be provided to all enrolled in an DHMO dental program.
- 6. The utilization of dental personnel should be consistent with American Dental Association policy.
- 7. Benefit programs offering dental care through an DHMO should also offer a ~~comparable dental plan~~ with equal or comparable benefits that permits free choice of dentist under a fee-for-service arrangement. Under this dual choice system, the individual consumers should also have periodic options to change plans and there should be equal premium dollars per subscriber available to both dental ~~delivery systems plans.~~
- 8. The freedom of choice plan should be designated the primary enrollment plan, i.e., eligible individuals who fail to enroll in any plan should be enrolled in the freedom of choice plan.
- 89. Administration should assure maximum benefits in dental care and minimum expenditures for administration.
- 910. When requested by the patient, the DHMO should pay for a second opinion from a dentist outside the DHMO network.
- ~~10. Dental services available from HMOs should be limited to HMO subscribers.~~
- 11. A broad range of dental services should be available to subscribers.
- 12. There should be no economic deterrent imposed that would discourage the utilization of diagnostic, preventive and emergency services.

33 **BOARD RECOMMENDATION: Vote Yes.**

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

36

Resolution No. 10 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **RESCISSION OF THE POLICY, CLOSED PANEL DENTAL BENEFIT PLANS**

2 **Background:** (*Reports:30*)

3 **Closed Panel Dental Benefit Plans:** The CDBP reviewed the policy “Closed Panel Dental Benefit

4 Plans” and recommends rescission because it closely resembles Guidelines for Dental Components of

5 Health Maintenance Organizations (*Trans.* 1988:476; 1993:689; 1995:610) which is being amended and

6 will include information from this policy. Basically, it is recommended that these two policies be combined

7 into one easy to understand policy.

8 **Resolution**

9

10 **10. Resolved,** that Resolution 6H-1989, “Closed Panel Dental Benefit Plans” (*Trans.* 1989:545), be

11 rescinded.

12 **BOARD RECOMMENDATION: Vote Yes.**

13 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**

14 **BOARD DISCUSSION)**

WORKSHEET ADDENDUM  
COUNCIL ON DENTAL BENEFIT PROGRAMS  
POLICY TO BE RESCINDED

1 **Closed Panel Dental Benefit Plans (*Trans.1989:545*)**

2 A closed panel dental benefit plan exists when patients eligible to receive benefits can receive them only  
3 if services are provided by dentists who have signed an agreement with the benefit plan to provide  
4 treatment to eligible patients. As a result of the dentist reimbursement methods characteristic of a closed  
5 panel plan, only a small percentage of practicing dentists in a given geographical area are typically  
6 contracted by the plan to provide dental services.

7 While the Association recognizes this concept as one way of providing benefits for dental services, closed  
8 panel plans have not demonstrated themselves to be more economical, efficient or otherwise better than  
9 other forms of benefit plans in effectively providing dental benefits to patients. Further, due to the  
10 overwhelming economic incentive for patients to choose a personal dentist from a limited number of  
11 available dentists, this benefit concept has the potential to reduce the patient's access to comprehensive  
12 dental care.

13 In view of these concerns, the Association opposes this approach as the only dental benefit plan available  
14 to subscribers. To protect the patient's freedom to receive benefits for dental services provided by any  
15 legally qualified dentist of his or her choice, the Association suggests the following guidelines for dental  
16 benefit plan sponsors who choose to offer a closed panel dental benefit plan:

- 17
- 18 1. Benefit programs that offer dental benefits through a closed panel should also offer a plan with
  - 19 equal or comparable benefits that permits free choice of dentist.
  - 20 2. Equal premium dollars should be allocated between the freedom of choice plan and the closed
  - 21 panel plan.
  - 22 3. A complete description of benefits provided under each plan should be given to all eligible
  - 23 individuals prior to each enrollment period. Benefit limitations and exclusions of each plan should
  - 24 be clearly described, and a complete and current list of dentists who participate in the closed
  - 25 panel plan should be provided.
  - 26 4. The freedom of choice plan should be designated the primary enrollment plan, i.e., eligible
  - 27 individuals who fail to enroll in any plan should be enrolled in the freedom of choice plan.
  - 28 5. Subscribers should have periodic options to change plans.
  - 29 6. When requested by the patient, the closed panel plan should provide benefits for a second
  - 30 opinion provided by a dentist who does not participate in the closed panel plan.
  - 31

Resolution No. 11 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

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**AMENDMENT OF THE POLICY, STATEMENT ON DENTAL BENEFIT PLANS**

**Background:** (*Reports:31*)

**Statement on Dental Benefit Plans:** The CDBP believes that the policy "Statement on Dental Benefit Plans" should be amended because dental benefit plans have not demonstrated an ability to keep pace with the economy; therefore, it is recommended that this statement be removed from policy.

In addition, the Purchaser Information Service is now the Dental Benefit Information Service and the ADA continues to promote fee-for-service freedom of choice dental plans, e.g., Direct Reimbursement on ADA.org.

**Resolution**

**11. Resolved,** that the ADA policy on Statement on Dental Benefit Plans (*Trans.1988:481*) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

From their inception, dental benefit plans have had the support of the American Dental Association on the premise that they can increase the availability of dental care and consequently foster better oral health in the United States. Research confirms that utilization of dental services increases proportionately with the availability of dental benefits.

In the interest of assuring that the best level of dental care possible is available under dental benefit plans, the following guidelines are offered for reference in the establishment and growth of dental benefit plans.

*Mechanisms for Third-Party Payment.* The Association believes that the dental benefit programs administered by commercial insurance companies, dental service corporations, other service corporations and similar organizations offering dental plans are an effective means of assisting patients in obtaining dental care. Conventional dental benefit plans are usually structured in ways that encourage prevention. Health maintenance organizations have followed dentistry's example and represent a similar approach in their preventive orientation. Direct reimbursement dental plans reimburse patients based on dollars spent, rather than on category of treatment received, and provide maximum flexibility to their specific dental needs.

The Association also believes that if dental plans restricting patients' freedom of choice are offered to subscribers, a plan that offers free choice of dentist should be offered as an option.

1 This approach should include periodic options to change plans and equal premium dollars per  
2 subscriber for each option.

3  
4 *Standards for Dental Benefit Plans.* The Association urges all purchasers and third parties  
5 involved with dental benefit plans to review the “Standards for Dental Benefit Plans.” These  
6 “Standards” have been developed to reflect the profession’s views on all types of dental benefit  
7 plans and will be a useful benchmark in reviewing the many options that are available.

8  
9 *Dental Society Review Mechanisms.* The Association urges patients, plan purchasers and third-  
10 party payers to make use of the peer review committees that have been established by the  
11 constituent dental societies. The Association believes that it is important to use review  
12 mechanisms as established by organized dentistry, in order to obtain objective and impartial  
13 professional review. Third-party review is recognized as an important first step in the screening  
14 process for clarification and resolution of disputes which arise out of pretreatment or post-  
15 treatment review. However, it is not equivalent to, nor is it a substitute for, the constituent or  
16 component peer review process.

17 *Statement on Areas Needing Improvement.* ~~Dental benefit plans have demonstrated an ability to~~  
18 ~~keep pace with the economy without contributing significantly to inflation of dental care costs.~~  
19 ~~However, the~~ The American Dental Association believes that dental benefit plans should be  
20 expanded in several areas, as follows:

21  
22 1. Most dental benefit plans limit preventive services to topical fluoride applications, regular  
23 prophylaxes, the application of pit and fissure sealants and space maintainers for children.  
24 The inclusion of broader prevention benefits, such as oral health risk assessments, the  
25 ~~application of pit and fissure sealants~~ application of adult fluoride, screening for oral cancer  
26 and other dental/medical related conditions, ~~and~~ oral hygiene instruction and ~~or~~ dietary  
27 counseling, is encouraged.

28  
29 2. ~~Experience~~ Research has shown that substantial numbers of covered individuals do not  
30 utilize their dental benefit plans. The Association supports a dental benefit plan design which  
31 encourages utilization of diagnostic and preventive services, such as a plan that covers these  
32 services at 100%, without a deductible.

33  
34 ~~To help dental benefit decision makers, the Council maintains a dynamic Purchaser Information~~  
35 ~~Service. The Service conducts research on the factors which influence a purchaser’s dental benefit~~  
36 ~~decisions. This knowledge equips the Service to carry out a full-time program to reach plan~~  
37 ~~purchasers to promote the Association’s policies of traditional fee-for-service dentistry and freedom of~~  
38 ~~choice of provider. It is also able to clarify the plans and options available to those purchasers, so that~~  
39 ~~they may make a more qualified dental benefit decision.~~

40  
41 The Association and its constituent and component societies should maintain active communication  
42 with all groups and individuals interested in the development and operation of dental benefit plans.  
43 Because of this activity, a great deal of knowledge about all aspects of dental benefits has been  
44 acquired. The dental profession is eager to share this knowledge with all interested parties.

45 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 11S-1 Substitute

Report: N/A Date Submitted: October 2013

Submitted By: Fifth Trustee District

Reference Committee: 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 Goal: Members (Required)

**SUBSTITUTE FOR RESOLUTION 11: AMENDMENT OF THE POLICY, STATEMENT ON DENTAL BENEFIT PLANS**

The following substitute for Resolution 11 (Worksheet: 4013) was submitted by the Fifth Trustee District and transmitted on October 16, 2013, by Dr. Mark Donald, chairman of the Fifth Trustee District.

**Background:** Most of the proposed changes from the Council on Dental Benefit Programs concerning the "Statement on Dental Benefit Plans" are appropriate and amplify the policy. However, the language on page 4014 of Resolution 11, lines 22-27 does not necessarily reflect the current policies of many third party payers. For instance, many times insurance companies do not allow for the application of pit and fissure sealants as part of their preventive benefits. Therefore, a more complete listing of preventive treatment services should be listed within the Statement on Dental Benefit Plans.

**Resolution**

**11S-1. Resolved,** that the ADA policy on Statement on Dental Benefit Plans (*Trans.*1988:481) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

From their inception, dental benefit plans have had the support of the American Dental Association on the premise that they can increase the availability of dental care and consequently foster better oral health in the United States. Research confirms that utilization of dental services increases proportionately with the availability of dental benefits.

In the interest of assuring that the best level of dental care possible is available under dental benefit plans, the following guidelines are offered for reference in the establishment and growth of dental benefit plans.

*Mechanisms for Third-Party Payment.* The Association believes that the dental benefit programs administered by commercial insurance companies, dental service corporations, other service corporations and similar organizations offering dental plans are an effective means of assisting patients in obtaining dental care. Conventional dental benefit plans are usually structured in ways that encourage prevention. Health maintenance organizations have followed dentistry's example and represent a similar approach in their preventive orientation. Direct reimbursement dental plans reimburse patients based on dollars spent, rather than on category of treatment received, and provide maximum flexibility to their specific dental needs.

1 The Association also believes that if dental plans restricting patients' freedom of choice  
2 are offered to subscribers, a plan that offers free choice of dentist should be offered as an  
3 option.

4 This approach should include periodic options to change plans and equal premium dollars per  
5 subscriber for each option.  
6

7 *Standards for Dental Benefit Plans.* The Association urges all purchasers and third parties  
8 involved with dental benefit plans to review the "Standards for Dental Benefit Plans." These  
9 "Standards" have been developed to reflect the profession's views on all types of dental benefit  
10 plans and will be a useful benchmark in reviewing the many options that are available.  
11

12 *Dental Society Review Mechanisms.* The Association urges patients, plan purchasers and third-  
13 party payers to make use of the peer review committees that have been established by the  
14 constituent dental societies. The Association believes that it is important to use review  
15 mechanisms as established by organized dentistry, in order to obtain objective and impartial  
16 professional review. Third-party review is recognized as an important first step in the screening  
17 process for clarification and resolution of disputes which arise out of pretreatment or post-  
18 treatment review. However, it is not equivalent to, nor is it a substitute for, the constituent or  
19 component peer review process.  
20

21 *Statement on Areas Needing Improvement.* ~~Dental benefit plans have demonstrated an ability to~~  
22 ~~keep pace with the economy without contributing significantly to inflation of dental care costs.~~  
23 ~~However, the~~ The American Dental Association believes that dental benefit plans should be  
24 ~~expanded in several areas, as follows~~ include, but not be limited to, the following preventative  
25 services:  
26

27 ~~1. Most dental benefit plans limit preventive services to topical fluoride applications,~~  
28 ~~regular prophylaxes, and space maintainers for children. The inclusion of broader~~  
29 ~~prevention benefits, such as the application of pit and fissure sealants and oral hygiene~~  
30 ~~instruction and or dietary counseling, is encouraged.~~  
31

- 32 1. Topical fluoride applications for children and all at risk populations
- 33 2. Prophylaxis as indicated by a healthcare provider
- 34 3. Application of pit and fissure sealants at any age as warranted
- 35 4. Space maintainers
- 36 5. Oral health risk assessments
- 37 6. Screening for oral cancer and other dental/medical related conditions
- 38 7. Oral hygiene instruction
- 39 8. Dietary consultation  
40

41 ~~2. Experience~~ Research has shown that substantial numbers of covered individuals do not  
42 utilize their dental benefit plans. The Association supports a dental benefit plan design  
43 which encourages utilization of diagnostic and preventive services, such as a plan that  
44 covers these services at 100%, without a deductible.  
45

46 ~~To help dental benefit decision makers, the Council maintains a dynamic Purchaser Information~~  
47 ~~Service. The Service conducts research on the factors which influence a purchaser's dental~~  
48 ~~benefit decisions. This knowledge equips the Service to carry out a full time program to reach~~  
49 ~~plan purchasers to promote the Association's policies of traditional fee for service dentistry and~~  
50 ~~freedom of choice of provider. It is also able to clarify the plans and options available to those~~  
51 ~~purchasers, so that they may make a more qualified dental benefit decision.~~  
52

53 The Association and its constituent and component societies should maintain active  
54 communication with all groups and individuals interested in the development and

1 operation of dental benefit plans. Because of this activity, a great deal of knowledge  
2 about all aspects of dental benefits has been acquired. The dental profession is eager to  
3 share this knowledge with all interested parties.

4 **BOARD RECOMMENDATION: Received after the October 2013 Board of Trustees session.**

5 Resolution 11S-1

6



## NOTES

Resolution No. 12 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, SUPPORT FOR INDIVIDUAL PRACTICE ASSOCIATIONS (IPAS)**

2 **Background:** (*Reports:32*)

3 **Support for Individual Practice Associations:** The CDBP originally recommended that the policy  
4 "Support for Individual Practice Associations (IPAs)" be rescinded. The Reference Committee heard  
5 testimony that this policy has continued relevance and should be referred back to the Council for revision,  
6 study and report to the 2013 House of Delegates.

7  
8 The Council determined that information regarding IPAs should be made available on ADA.org,  
9 particularly to clarify the legal and regulatory limitations on the use of IPAs, as a service to dentists that  
10 may wish to consider the creation of an IPA in the future.

11  
12 **Resolution**

13  
14 **12. Resolved,** that the ADA policy on Support for Individual Practice Associations (IPAs)  
15 (*Trans.* 1988:475; 1994:655; 2000:458) be amended through text additions and deletions, so that the  
16 amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

17  
18 **Resolved,** that the American Dental Association provide information to members and plan  
19 purchasers about dental individual practice associations (IPAs) that includes legal and regulatory  
20 limitations on the uses of IPAs. ~~are established and/or directed by organized dentistry and that~~  
21 ~~conform to Association policy, and be it further~~

22 ~~**Resolved,** that discussion of IPAs be included in the Purchaser Information Service Program~~

23 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 13 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, GOVERNMENT REPORTS ON PAYMENTS TO DENTISTS**

2 **Background:** (*Reports:33*)

3 **Government Reports on Payments to Dentists:** The CDBP notes that the policy “Government Reports  
4 on Payments to Dentists” concerns government reporting of gross reimbursements for services delivered  
5 under government programs. Changes to the first resolving clause now state this clearly, as well as  
6 noting specific information needed to establish the payment context. Reporting should include overhead  
7 expense, including the salary of the dentist as a legitimate aspect of overhead. The ADA’s Washington  
8 office also reviewed this proposed amendment and notes that this policy will have no practical application  
9 as it is not aware of any federal agency reports of dental reimbursements for government programs.

10  
11 The second resolving clause’s reference to overhead costs duplicates content in the first clause. Also the  
12 second and third resolving clauses date back to 1976 and are not currently on the ADA’s advocacy  
13 agenda.

14  
15 **Resolution**

16  
17 **13. Resolved,** that the ADA policy on Government Reports on Payments to Dentists  
18 (*Trans. 1976:858*) be amended through text additions and deletions, so that the amended policy reads  
19 as follows (additions are underscored; deletions are ~~stricken~~):

20  
21 **Resolved,** that government agencies issuing reports on reimbursements ~~income amounts~~ paid to  
22 dentists for services rendered under public programs be strongly urged to release such  
23 information in a clear context accompanied by such facts as:

- 24  
25 • the number of practitioners dentists represented in the payment
- 26 • the number of patients cared for, and the fact that these payments are gross receipts  
27 from which the dentist(s) ~~or dentists~~ must pay all overhead costs, ~~and be it further~~

28  
29 **Resolved,** that the American Dental Association ~~exhort governmental agencies that there is yet~~  
30 ~~other expense incurred by these public dental care programs. This expense includes pro rata~~  
31 ~~governmental administrative expense and pro rata overhead expense of the facilities they use. In~~  
32 ~~total fairness these additional expenses must be included in releases to the news media to reflect~~  
33 ~~actual cost to the public, and be it further~~

1 **Resolved,** that the Washington Office of the Association bring this matter forcefully to the  
2 attention of all federal agencies involved in such programs.

3 **BOARD RECOMMENDATION: Vote Yes.**

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

6 Resolution 13

Resolution No. 14 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, USE OF DEA NUMBERS FOR IDENTIFICATION**

2 **Background:** *(Reports:33)*

3

4 **Use of DEA Numbers for Identification:** The CDBP notes that shortly after the policy on “Use of DEA  
 5 Numbers for Identification” was adopted, the National Provider Identifier (NPI) was implemented. An NPI  
 6 is a unique, government-issued, standard identification number for individual health care practitioners  
 7 such as dentists, and practitioner organizations such as an incorporated dental practice. Federal law  
 8 requires use of an NPI by a dentist or practice that uses a HIPAA standard electronic transaction such as  
 9 the dental claim. Some state laws and some participating provider contracts also require a dentist or  
 10 practice to use their NPI on paper claims. Benefit plans and pharmacies should not require the DEA  
 11 registration number for any purpose other than the prescribing of controlled substances, consistent with  
 12 the DEA’s position.

13  
14 **Resolution**

15 **14. Resolved,** that the ADA policy on Use of DEA Numbers for Identification (*Trans.2000:454*) be  
 16 amended through text additions and deletions, so that the amended policy reads as follows (additions  
 17 are underscored; deletions are ~~stricken~~):

18 **Resolved,** that the ADA agrees with the Drug Enforcement Administration (DEA) that the DEA  
 19 number is to be used solely for purposes of prescribing controlled substances. take steps to  
 20 assure that unauthorized and non-discretionary use by the insurance industry and other entities  
 21 regarding the DEA number cease as promptly as prudence and reality permit, and be it further

22 **Resolved,** that ~~health care insurance providers be urged to immediately discontinue the use of~~  
 23 ~~the Drug Enforcement Administration (DEA) Registration Numbers as a means of identification~~  
 24 ~~and instead, voluntarily switch to a more appropriate and safer method of identifying health care~~  
 25 ~~providers who prescribe medications to insured patients such as the national health care provider~~  
 26 ~~identifier currently under development by the Health Care Financing Administration (HCFA), and~~  
 27 ~~be it further~~

1           ~~**Resolved**, that the ADA contact the HCFA and the DEA by the end of year 2000 to offer input for~~  
2           ~~the expeditious development and implementation of the alternative number currently being~~  
3           ~~considered.~~

4           **BOARD RECOMMENDATION: Vote Yes.**

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

7           Resolution 14

Resolution No. 15 New  
 Report: N/A Date Submitted: August 2013  
 Submitted By: Council on Dental Benefit Programs  
 Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, AUTHORIZATION OF BENEFITS**

2 **Background:** (Reports:34)

3 **Authorization of Benefits:** The CDBP believes that the policy "Authorization of Benefits" is an important  
4 policy and should be maintained with necessary changes to make the policy clearer.

5  
6 **Resolution**

7  
8 **15. Resolved,** that the ADA policy on Authorization of Benefits (*Trans.*1994:665) be amended  
9 through text additions and deletions, so that the amended policy reads as follows (additions are  
10 underscored; deletions are ~~stricken~~):

11 **Resolved,** that the American Dental Association supports the right of each dentist to accept or  
12 reject authorized benefits from any dental benefits plan, and be it further

13 **Resolved,** that the Association supports the right of every patient to authorize that his or her  
14 benefits be paid to the treating dentist and to have the authorization honored by the third-party  
15 payer, and be it further

16 **Resolved,** that when a third-party payer ~~inadvertently~~ submits payment directly to the patient,  
17 contrary to the patient's authorized preference, it is the third-party payer's responsibility ~~of the~~  
18 ~~third-party payer: first, to~~ submit the correct payment to the dentist and ~~second, to~~ reclaim the  
19 erroneously submitted payment from the patient, and be it further

20 **Resolved,** that in those states where dentists are not notified of the rescission of a prior  
21 authorization of benefits, the Association encourage state dental societies to seek legislative  
22 relief.

23 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 16 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, STATEMENT ON PREVENTIVE COVERAGE IN DENTAL BENEFITS**  
 2 **PLANS**

3 **Background:** (Reports:34)

4  
 5 **Statement on Preventive Coverage in Dental Benefits Plans:** The CDBP feels that the policy  
 6 "Statement on Preventive Coverage in Dental Benefits Plans" is important and that is it necessary to  
 7 clarify and update this policy to reflect current practice.

8  
 9 **Resolution**

10  
 11 **16. Resolved,** that the ADA policy on Statement on Preventive Coverage in Dental Benefits Plans  
 12 (*Trans.* 1992:602; 1994:656) be amended through text additions and deletions, so that the amended  
 13 policy reads as follows (additions are underscored; deletions are ~~stricken~~):

14 **Resolved,** that preventive dentistry refers to the procedures in dental practice and health  
 15 programs which, ~~in conjunction with clinical and radiographic examinations,~~ aid in the prevention  
 16 of oral diseases, and be it further

17 **Resolved,** that the American Dental Association recognizes the importance of implementing  
 18 preventive oral health practices as an effective means of promoting ~~affording~~ optimal oral health  
 19 to all individuals, and be it further

20 **Resolved,** that the ADA urges that all dental benefit plans include the following ~~preventive~~  
 21 procedures as covered services:

- 22
- 23 • prophylaxis ~~(at least twice in a calendar [contract] year);~~
  - 24 • topical fluoride applications for all patients ~~(at least twice in a calendar [contract] year);~~
  - 25 • application of pit and fissure sealants and reapplication as necessary;
  - 26 • oral health risk assessment;
  - 27 • screening for oral cancer and other dental/medical related conditions;
  - 28 • preventive resin restorations;
  - 29 • resin infiltrations;
  - 30 • fixed and removable appliances to prevent malocclusion ~~in the developing dentition;~~
  - 31 • ~~construction of athletic mouth protectors for use in sports guards;~~
  - 32 • prescription or use of supplemental dietary or topical fluoride for home use; and



- 1 • in-office patient education, i.e., oral hygiene instruction, ~~and~~ dietary counseling, and  
2 tobacco cessation counseling with regard to the promotion of good oral and overall  
3 health.

4 and be it further

5 **Resolved**, that the Council on Dental Benefit Programs continue to recommend to third-party  
6 payers, service plans, prospective purchasers and policyholders that, ~~where considered~~  
7 ~~necessary and appropriate~~, contract limitations on frequency of providing benefits allow for  
8 certain services to be stated coverage of preventive services as at least “twice in a calendar (or  
9 contract) year” and more frequently if risk factors are identified that warrant increased frequency  
10 ~~rather than “once in every six months.”~~

11 **BOARD RECOMMENDATION: Vote Yes.**

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

14 Resolution 16

Resolution No. 17 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

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**AMENDMENT OF THE POLICY, AGE OF “CHILD”**

**Background:** *(Reports:35)*

**Age of Child:** The CDBP believes that the ADA policy “Age of Child” is very important and that there are two distinct issues regarding age of child in dental benefit plans. For specific procedures, it is appropriate for the ADA to support determination based on the development of the dentition.

For eligibility issues, the ADA has supported the use of age 21 for adult status, specifically for purposes of interpreting federal legislation.

**Resolution**

**17. Resolved,** that the ADA policy on Age of “Child” (*Trans.1991:635*) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved,** that when dental plans differentiate coverage of specific procedures based on the child or adult status of the patient, this determination be based on the clinical development of the patient’s dentition, and be it further

**Resolved,** that for the sole purpose of eligibility for coverage, chronological age of 21 be used to determine enrollment status. ~~where administrative constraints of a dental plan preclude the use of clinical development so that chronological age must be used to determine child or adult status, the plan defines a patient as an adult beginning at age 12 with the exclusion of treatment for orthodontics and sealants.~~

**BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 18 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, ADA'S DENTAL CLAIM FORM**

2 **Background:** (*Reports:35*)

3 **ADA's Dental Claim Form:** The CDBP believes that the ADA policy "ADA's Dental Claim Form" should  
4 be amended with editorial changes that reflect current status of the claim form and the *CDT Code* as the  
5 approved vocabulary for use in electronic transactions and electronic health records.

6 **Resolution**

7 **18. Resolved,** that the ADA policy on ADA's Dental Claim Form (*Trans.1991:633; 2001:428*) be  
8 amended through text additions and deletions, so that the amended policy reads as follows (additions  
9 are underscored; deletions are ~~stricken~~):

10 **Resolved,** that the Council on Dental Benefit Programs, with the approval of the Board of  
11 Trustees, have the authority to evaluate and effect all changes to the American Dental  
12 Association's Dental Claim Form in consultation with the dental benefits and electronic data  
13 interchange industries, and be it further

14 ~~**Resolved,** that the American Dental Association urge universal use and acceptance of the ADA's  
15 Dental Claim Form and *Code on Dental Procedures and Nomenclature* by third-party payers,  
16 third-party payer organizations, and electronic data interchange agencies, and be it further~~

17 **Resolved,** that the constituent dental societies be encouraged to work with third-party payers ~~and~~  
18 ~~third-party payer organizations~~ to take whatever steps are necessary to influence dentists and  
19 third parties in their respective states to use and accept the most current approved Dental Claim  
20 Form.

21 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 19 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, BULK BENEFIT PAYMENT STATEMENTS**

2 **Background:** (*Reports:36*)

3 **Bulk Benefit Payment Statements:** The CDBP believes that the ADA policy "Bulk Benefit Payment  
4 Statements" is an important policy and should be amended with necessary changes to make the policy  
5 language current and clearer.

**Resolution**

6 **19. Resolved,** that the ADA policy on Bulk Benefit Payment Statements (*Trans.1990:536*) be  
7 amended through text additions and deletions, so that the amended policy reads as follows (additions  
8 are underscored; deletions are ~~stricken~~):  
9

10 **Resolved,** that although the ADA goes on record as being opposed to bulk payments by a third-  
11 party payer, in the interest of facilitating prompt settlement of patients' accounts, bulk benefit  
12 payments may be made by a third-party but should include a statement containing, at a minimum,  
13 the following information for each claim payment represented in the bulk ~~benefit check payment~~:  
14

- 15 1. Subscriber (employee) name;
- 16 2. Patient name;
- 17 3. Dates of service;
- 18 4. Specific ~~treatment service~~ reported on the submitted claim, by ~~ADA procedure code~~ CDT  
19 Code number and nomenclature;
- 20 5. Total fee charged;
- 21 6. Specific ~~ADA e-CDT Code~~ Code number and nomenclature on which benefits were determined;
- 22 7. Total covered expense;
- 23 8. Total benefits paid; and
- 24 9. In instances where benefits are reduced or denied, an explanation of the reason(s) ~~that~~  
25 why the total covered expense differs from the total fee charged, consistent with Association  
26 policy on Explanation of Benefits Statements.  
27

28 and be it further

29  
30 **Resolved,** that insurance companies should not withhold funds from current bulk benefit  
31 payments as a means of settling disputes over prior claims experience with the dentist and that  
32 constituent dental societies be encouraged to seek legislation to resolve this problem, and be it  
33 further

1  
2 **Resolved**, that bulk ~~benefit~~-payments should be issued to dentists at intervals of not longer than  
3 every ten business days, and be it further

4  
5 **Resolved**, that the Council on Dental Benefit Programs work with the insurance industry and  
6 dental service plans to incorporate this policy into their administrative procedures.

7 **BOARD RECOMMENDATION: Vote Yes.**

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

10

Resolution 19

Resolution No. 20 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, MEDICALLY NECESSARY CARE**

2 **Background:** (Reports:36)

3 **Medically Necessary Care:** The CDBP believes that the policy “Medically Necessary Care” should be  
4 amended to reflect the ADA’s position on benefit plans and their dental consultants making  
5 determinations of medical necessity without the complete information needed for a definitive diagnosis.  
6

7 In addition, the second resolving clause was changed to reflect that contacting plan purchasers directly is  
8 not currently a tactic utilized by CDBP.

9 **Resolution**

10  
11 **20. Resolved,** that the ADA policy on Medically Necessary Care (*Trans.*1988:474; 1996:686) be  
12 amended through text additions and deletions, so that the amended policy reads as follows (additions  
13 are underscored; deletions are ~~stricken~~):

14  
15 **Resolved,** that the American Dental Association make every effort on behalf of patients to see  
16 that the language specifying treatment coverage in health insurance plans be clarified so that  
17 medically necessary care, essential to the successful treatment of a medical or dental condition  
18 ~~being treated by a multidisciplinary health care team,~~ is available to the patient, and be it further  
19 **Resolved,** that ~~third-party payers and their consultants should appropriately limit their benefit~~  
20 ~~determinations to plan design and not make benefit determinations based on medical necessity~~  
21 ~~without the complete information that would be required for a definitive diagnosis. when the ADA~~  
22 ~~is notified of a situation in which a patient’s treatment is jeopardized by the narrow interpretation~~  
23 ~~of language contained in a medical benefit policy, the Association, with the assistance of its legal~~  
24 ~~advisor, shall contact the plan purchaser directly in an effort to see that the employer’s intentions~~  
25 ~~regarding the benefit purchased for the employee are conveyed to 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. 20S-1 Substitute

Report: N/A Date Submitted: October 2013

Submitted By: Fifth Trustee District

Reference Committee: 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 Goal: Members (Required)

**SUBSTITUTE FOR RESOLUTION 20: AMENDMENT OF THE POLICY, MEDICALLY NECESSARY CARE**

The following substitute for Resolution 20 (Worksheet: 4027) was submitted by the Fifth Trustee District and transmitted on October 16, 2013, by Dr. Mark Donald, chairman of the Fifth Trustee District.

**Background:** The Council on Dental Benefit Programs proposed to amend the ADA policy on Medically Necessary Care. The Fifth Trustee District’s proposed substitute strives to strengthen the current policy and places proposed deleted language back into the policy and include a few wordsmithing changes. On line 23, the word ‘ensure’ replaces ‘see that’ to convey more urgency. In lines 28-30 the proposed changes state the policy utilizing positive language rather than negative, which strengthens the statements. Finally, we contend that the language contained in lines 21-25 of the original resolution should be retained and not deleted. Even though the Council reports that contacting plan purchasers directly is not currently a tactic utilized by the ADA, it should be a policy which assists the ADA member dentist as well as patients.

**Resolution**

**20S-1. Resolved**, that the ADA policy on Medically Necessary Care (*Trans.*1988:474; 1996:686) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that the American Dental Association make every effort on behalf of patients to ~~see that~~ ensure the language specifying treatment coverage in health insurance plans be clarified so that medically necessary care, essential to the successful treatment of a medical or dental condition being treated by a multidisciplinary health care team is available to the patient, and be it further

**Resolved**, that third-party payers and their consultants should appropriately limit their benefit determinations to plan design and ~~not~~ make benefit determinations based on medical necessity ~~withou~~ with the complete information that would be required for a definitive diagnosis, and be it further

**Resolved**, that when the ADA is notified of a situation in which a patient’s treatment is jeopardized by the narrow interpretation of language contained in a medical benefit policy, the Association, with the assistance of its legal advisor, shall contact the plan purchaser directly in an effort to see that the employer’s intentions regarding the benefit purchased for the employee are conveyed to the third-party payer.

1 **BOARD RECOMMENDATION: Received after the October 2013 Board of Trustees session.**

2

Resolution 20S-1



## NOTES

Resolution No. 21 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, THIRD-PARTY ACCEPTANCE OF DESCRIPTIVE INFORMATION ON**  
 2 **DENTAL CLAIM FORM**

3 **Background:** (Reports:37)

4 **Third-Party Acceptance of Descriptive Information on Dental Claim Form:** The CDBP believes that  
 5 the ADA policy “Third-Party Acceptance of Descriptive Information on Dental Claim Form” is an important  
 6 policy and should be amended with necessary changes to make the policy language current and clearer.

7 **Resolution**

8 **21. Resolved**, that the ADA policy on Third-Party Acceptance of Descriptive Information on Dental  
 9 Claim Form (*Trans.*1978:507) be amended through text additions and deletions, so that the amended  
 10 policy reads as follows (additions are underscored; deletions are ~~stricken~~):

11 **Resolved**, that the descriptive narrative included on a claim submission when the *CDT Code*  
 12 nomenclature includes “...by report” in its nomenclature, of a dental procedure claim form be  
 13 given professionally appropriate consideration during adjudication to the procedure codes which  
 14 are used by third-party payers carriers for administrative purposes, and be it further  
 15 **Resolved**, that ~~the any~~ descriptive narrative or ~~any information~~ voluntarily submitted by the  
 16 dentist to assist in benefit determination should be considered during claim adjudication ~~accepted~~  
 17 by the third-party payer.  
 18

19 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 22 New  
 Report: N/A Date Submitted: August 2013  
 Submitted By: Council on Dental Benefit Programs  
 Reference Committee: 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 Goal: Members (Required)

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**AMENDMENT OF THE POLICY, CHARGE FOR ADMINISTRATIVE COSTS**

**Background:** (*Reports:37*)

**Charge for Administrative Costs:** The CDBP believes that the ADA policy “Charge for Administrative Costs” is an important policy and should be amended with necessary changes to make the policy language current and clearer.

**Resolution**

**22. Resolved**, that the ADA policy on Charge for Administrative Costs (*Trans.1974:656; 1989:553*) be amended through text additions and deletions, so that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that when ~~administration~~ costs are incurred by dental providers for non-clinical services such as filling out a claim form, an administrative charge ~~separate fees~~ may be charged for ~~this~~ such services.

**BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 23 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, DEVELOPMENT OF ADA DIAGNOSTIC CODING**

2 **Background:** (Reports:37)

3 **Development of ADA Diagnostic Coding:** The CDBP believes that the ADA policy “Development of  
 4 ADA Diagnostic Coding” is an important policy and should be amended with necessary changes to  
 5 indicate that development of the ADA’s diagnostic coding should be referred to as SNODENT clinical  
 6 terminology and maintenance of the terminology is performed in conjunction with the National Library of  
 7 Medicine (NLM) and the International Health Terminology Standards Development Organization  
 8 (IHTSDO). Also, the list of organizations that should be encouraged to adopt SNODENT has been  
 9 updated.

10 **Resolution**

11

12 **23. Resolved,** that the ADA policy on Development of ADA Diagnostic Coding (*Trans.* 1995:619) be  
 13 amended through text additions and deletions, so that the amended policy reads as follows (additions  
 14 are underscored; deletions are ~~stricken~~):

15 **Development of ADA Diagnostic Coding SNODENT Clinical Terminology**

16 **Resolved,** that the Council on Dental Benefit Programs, acting within its *Bylaws* authority, ~~with~~  
 17 ~~the approval of the Board of Trustees,~~ shall continue to develop and maintain the a diagnostic  
 18 ~~coding SNODENT clinical terminology system for the dental profession, in conjunction with the~~  
 19 ~~National Library of Medicine and the International Health Terminology Standards Development~~  
 20 ~~Organization,~~ and be it further

21 **Resolved,** that the American Dental Association ~~urge~~ encourage ~~universal use and acceptance~~  
 22 ~~adoption of the ADA’s diagnostic coding SNODENT clinical terminology system by:~~ public and  
 23 ~~private healthcare organizations; national and international standards developing development~~  
 24 ~~organizations; national quality measurement initiatives; dental schools; computer practice~~  
 25 ~~management dental information technology vendors, including but not limited to developers of~~  
 26 ~~Electronic Health Records (EHR) systems, digital imaging systems, and peripheral devices that~~

1 capture clinical data; health information databases and networks; electronic data interchange  
 2 organizations; plan purchasers; third-party payers and third-party organizations.  
 3

4 **BOARD COMMENT:** The Board appreciates the expertise of the Council on Dental Benefit Programs  
 5 and understands the intent of its policy update in Resolution 23. The reason for this Board substitute is to  
 6 distinguish development of SNODENT and maintaining SNODENT. The amended wording provides for  
 7 development of SNODENT to continue to be the exclusive purview of the Council, while recognizing that  
 8 maintenance will be performed in conjunction with the National Library of Medicine and the International  
 9 Health Terminology Standards Development Organization. Therefore, the Board recommends adoption  
 10 of Resolution 23B.

11 **23B. Resolved,** that the ADA policy on Development of ADA Diagnostic Coding (*Trans.*1995:619) be  
 12 amended through text additions and deletions, so the amended policy reads as follows (additions are  
 13 underscored; deletions are ~~stricken~~):

14 **Development of ADA Diagnostic Coding SNODENT Clinical Terminology**

15 **Resolved,** that the Council on Dental Benefit Programs, acting within its Bylaws authority, with  
 16 ~~the approval of the Board of Trustees~~, shall continue to develop and, in conjunction with the  
 17 National Library of Medicine and International Health Terminology Standards Development  
 18 Organization, to maintain the SNODENT clinical terminology system, ~~maintain a diagnostic~~  
 19 ~~coding system for the dental profession~~, and be it further

20 **Resolved,** that the American Dental Association ~~urge~~ encourage universal use and acceptance  
 21 adoption of the ADA's ~~diagnostic coding~~ SNODENT clinical terminology system by: public and  
 22 private healthcare organizations; national and international standards ~~developing~~ development  
 23 organizations; national quality measurement initiatives; dental schools; ~~computer practice~~  
 24 ~~management~~ dental information technology vendors, including but not limited to developers of  
 25 Electronic Health Records (EHR) systems, digital imaging systems, and peripheral devices that  
 26 capture clinical data; health information databases and networks; electronic data interchange  
 27 organizations; plan purchasers; third-party payers and third-party organizations.

28 **BOARD RECOMMENDATION: Vote Yes on the Substitute.**

29 **Vote: Resolution 23B**

BUCKENHEIMER	Yes	FEINBERG	Yes	NORMAN	Yes	VERSMAN	Yes
CROWLEY	Yes	GOUNARDES	Yes	ROBERTS	Yes	WEBER	Yes
DOW	Yes	HAGENBRUCH	Yes	SCOTT	Yes	YONEMOTO	Absent
ENGEL	Yes	ISRAELSON	Yes	SEAGO	Yes	ZENK	Yes
FAIR	Yes	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	Yes

Resolution No. 24 New  
 Report: N/A Date Submitted: August 2013  
 Submitted By: Council on Dental Benefit Programs  
 Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, POLICY ON FEES**

2 **Background:** (Reports:38)

3 **Policy on Fees:** The CDBP believes that the ADA “Policy on Fees” should be amended to more  
4 accurately reflect the manner in which these issues are handled.

5 **Resolution**

6  
7 **24. Resolved,** that the ADA Policy on Fees (*Trans.* 1990:540) be amended through text additions and  
8 deletions, so that the amended policy reads as follows (additions are underscored; deletions are  
9 ~~stricken~~):

10  
11 **Policy on Fees for Dental Services**

12  
13 **Resolved,** that the fiscal and health interests of patients are best served by the existence of an  
14 economic climate within which a dentist and his or her patient are able to freely arrive at a mutual  
15 agreement with respect to fees for service, and be it further

16  
17 **Resolved,** that the American Dental Association considers third-party intervention in fee  
18 determination to be potentially anticompetitive in nature and to be a disservice to the public,  
19 which is interested in securing the best possible dental care for themselves and their families, and  
20 be it further

21  
22 **Resolved,** that the Association is opposed to any law, regulation or third-party intervention that  
23 disrupts the relationship between the dentist and patient, including, but not limited to, encouraging  
24 patients to select dentists principally on the basis of cost, and be it further

25  
26 **Resolved,** that if a disagreement with regard to fees arises between a dentist, a patient and/or  
27 third-party, the ~~American Dental Association should transmit the complaint~~ should be transmitted  
28 to the appropriate constituent and component dental society peer review program, which should  
29 then be available to assist in resolving the disagreement within the limitations of applicable law.

30 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 25 New  
 Report: N/A Date Submitted: August 2013  
 Submitted By: Council on Dental Program Benefits  
 Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, FEE PROFILES**

2 **Background:** (Reports:38)

3 **Fee Profiles:** The CDBP believes that the ADA policy "Fee Profiles" should be amended as changes are  
4 needed to update this policy, make it clearer and to provide timely information on the ADA Legal  
5 Division's contract analysis service.

6  
7 **Resolution**

8  
9 **25. Resolved,** that the ADA policy on Fee Profiles (*Trans.*1987:502) be amended through text  
10 additions and deletions, so that the amended policy reads as follows (additions are underscored;  
11 deletions are ~~stricken~~):

12 **Resolved,** that when a dentist is employed and then leaves for new employment or to open his or  
13 her own practice, all insurance companies and/or dental service corporations shall allow said  
14 dentist to establish a new fee profile, and be it further

15 **Resolved,** that dentists beginning practice ~~should be advised~~ made aware of this policy on the  
16 development of individual fee profiles and also ~~be advised~~ made aware of the ~~potential limitations~~  
17 ~~due to methodologies used by the insurance industry and service corporations to develop fee~~  
18 ~~profiles for individual practitioners~~ ADA's contract analysis service which is authorized to analyze  
19 various types of dental provider contracts at no charge to members who request a review through  
20 their constituent dental society, and be it further

21 **Resolved,** that the Council on Dental Benefit Programs work with the insurance industry, dental  
22 service corporations and other appropriate agencies to ~~solve this problem for~~ assist dentists  
23 beginning practice.

24 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 26 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, HOSPITALIZATION INSURANCE FOR DENTAL TREATMENT**

2 **Background:** *(Reports:39)*

3 **Hospitalization Insurance for Dental Treatment:** The CDBP believes that the ADA policy  
4 "Hospitalization Insurance for Dental Treatment" is still relevant today and should be amended by  
5 updating the term "hospital insurance carriers" to "medical plans."  
6

7 **Resolution**

8  
9 **26. Resolved**, that the ADA policy on Hospitalization Insurance for Dental Treatment  
10 (*Trans.* 1972:674) be amended through text additions and deletions, so that the amended policy reads  
11 as follows (additions are underscored; deletions are ~~stricken~~):  
12

13 **Resolved**, that the Association actively urge ~~hospital insurance carriers~~ medical plans to include  
14 hospitalization benefits for dental treatment in public and private insurance programs so that the  
15 resources of a hospital are available to those dental patients whose condition, in the professional  
16 judgment of the dentist, makes hospitalization necessary.

17 **BOARD RECOMMENDATION: Vote Yes.**

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



Resolution No. 27 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, ALTERATION OF DENTAL TREATMENT PLANS BY THIRD-PARTY**  
 2 **CLAIMS ANALYSIS**

3 **Background:** *(Reports:39)*

4 **Alteration of Dental Treatment Plans by Third-Party Claims Analysis:** The CDBP believes that the  
 5 ADA policy "Alteration of Dental Treatment Plans by Third-Party Claims Analysis" is still relevant today  
 6 and should be maintained with these appropriate updates.

7  
 8 **Resolution**

9  
 10 **27. Resolved**, that the ADA policy on Alteration of Dental Treatment Plans by Third-Party Claims  
 11 Analysis (*Trans.* 1999:929) be amended through text additions and deletions, so that the amended  
 12 policy reads as follows (additions are underscored; deletions are ~~stricken~~):

13  
 14 **Resolved**, that in consideration of existing policy on standards for dental benefit plans  
 15 (*Trans.* 1988:478; 1989:547; 1993:696; 2000:458; 2001:428; 2008:453; 2010:546)  
 16 (~~*Trans.* 1993:696~~), the challenge of a dental treatment plan by a third-party claims analysis is  
 17 considered diagnosis and thereby constitutes the practice of dentistry, which can only be  
 18 performed by a dentist licensed in the state in which the procedures are being performed, who  
 19 has equivalent training with that of the ~~submitting~~ treating dentist, and carries with it full liability,  
 20 and be it further

21  
 22 **Resolved**, that the ADA encourage the adoption of this position by the American Association of  
 23 Dental Consultants ~~Examiners~~, all state dental associations, and all states' boards of dentistry,  
 24 and be it further

25  
 26 **Resolved**, that the ADA urges ~~the American Association of Dental Examiners~~, all state dental  
 27 associations and all states' boards of dentistry to pursue legislation and/or regulations to meet  
 28 this end.

29 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 28 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, PRINCIPLES FOR PAY-FOR-PERFORMANCE OR OTHER THIRD-**  
 2 **PARTY FINANCIAL INCENTIVE PROGRAMS**

3 **Background:** (*Reports:39*)

4 **Principles for Pay-for-Performance or Other Third-Party Financial Incentive Programs:** The CDBP  
 5 believes that the ADA policy “Principles for Pay-for-Performance or Other Third-Party Financial Incentive  
 6 Programs” should be amended to provide clarity to the intent of the policy and update the wording to  
 7 reflect advancements in this field. Additionally, the word “must” has been changed to “should” to more  
 8 accurately reflect the aspirational nature of ADA policy.

9  
 10 **Resolution**

11  
 12 **28. Resolved,** that the ADA policy on Principles for Pay-for-Performance or Other Third-Party  
 13 Financial Incentive Programs (*Trans.2006:328*) be amended through text additions and deletions, so  
 14 that the amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

15  
 16 **Principles for Pay-for-Performance or Other Third-Party Financial Incentive Programs**

- 17  
 18 1. The primary objective of Pay-for-Performance (P4P) or other third-party financial incentive  
 19 programs must be improvement in the quality of oral health care, so performance measures in  
 20 those ~~plans programs shall~~ should be valid measures of healthcare quality, quality-related.  
 21 2. The provisions of P4P or other third-party financial incentive programs ~~should must~~ not  
 22 interfere with the patient-doctor relationship by injecting factors unrelated to the patient’s needs  
 23 into treatment decisions. Treatment plans can vary based on a clinician’s sound judgment,  
 24 available evidence and the patient’s needs and preferences. Benchmarks to judge performance  
 25 should allow for such variations in treatment plans.  
 26 3. The incentives in P4P or other third-party financial incentive programs ~~should must~~ reward both  
 27 the progressive quality improvement as well as attainment of achievement of desired quality  
 28 metrics, levels and significant improvement in quality directed toward meeting the desired quality  
 29 levels.  
 30 4. P4P or other third-party financial incentive programs ~~should must~~ not limit access to care for  
 31 patients requiring extraordinary levels or types of care-, nor provide a disincentive for practitioners  
 32 to treat complex or difficult cases because of concern about performance ratings. There should  
 33 be a system of risk adjustments for difficult or complex cases.  
 34 5. ~~The incentives in a P4P or other third-party financial incentive program must be positive and of~~  
 35 ~~a type and magnitude that will drive improvement in the quality of care or support consistently~~  
 36 ~~high quality care.~~

- 1           65. The measures upon which incentive payments are based:
- 2           • ~~should~~ must be valid, reliable and feasible ~~exact, clear, measurable~~ and based on valid
- 3           science
- 4           • ~~should~~ must be standardized and have broad acceptance within the dental community
- 5           6. Before comparing measure scores between two entities the results should ~~must~~ be risk-
- 6           adjusted to account for patient differences.
- 7           • ~~must factor in patient compliance~~
- 8           • ~~must require a minimum of measurements~~
- 9           7. Reporting of quality to the public ~~should~~ must be fair and provide an opportunity for dentists to
- 10          comment on ratings. Payers ~~should~~ must discuss quality problems they identify with dentists
- 11          before any public ~~action is taken~~ reporting of ratings.
- 12          8. Participation by dentists ~~should~~ must be voluntary, with no financial penalties for not
- 13          participating.
- 14          9. Savings in costs ~~should~~ must not accrue to plans but ~~should~~ must be returned to patients in
- 15          reduced co-payments or expansion of benefits.
- 16          10. Development and subsequent ~~Regular~~-reassessment of P4P or other third-party financial
- 17          incentive programs ~~should~~ must be done, with input from participating dentists.

18  
19          and be it further

20  
21          **Resolved**, that the American Dental Association use these principles in discussions with  
22          organizations designing P4P or other third-party financial incentive programs and also monitor and  
23          continue to evaluate Pay-for-Performance or other third-party financial incentive programs being  
24          implemented in dental benefit plans, and be it further

25  
26          **Resolved**, that the ADA advocacy efforts with respect for P4P or other third-party financial incentive  
27          programs be guided by these principles.

**BOARD COMMENT: See Council Substitute Resolution 28S-1 (Worksheet:4038)**

Resolution No. 28S-1 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: Dental Benefits, Practice and Related Matters

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_ FTE \_\_\_\_\_

ADA Strategic Plan Goal: Members (Required)

1 **SUBSTITUTE FOR RESOLUTION 28: AMENDMENT OF THE POLICY, PRINCIPLES FOR PAY-FOR-**  
 2 **PERFORMANCE OR OTHER THIRD-PARTY FINANCIAL INCENTIVE PROGRAMS**

3 The following substitute for Resolution 28 (Worksheet:4055) was submitted by the Council on Dental  
 4 Benefit Programs and transmitted on July 31, 2013 by Dr. A. David May, chair.

5 **Background:** The Council agrees with all the proposed revisions to ADA policy in Resolution 28 except  
 6 one. The statement “must factor in patient compliance” should be retained in the policy statement to add  
 7 clarity and emphasis to that aspect of the policy. The statement “results should be risk-adjusted to  
 8 account for patient differences” is not clear enough to convey this essential message. (In the policy  
 9 revision first bullet under number 6 was to be deleted. The Council now believes it should be retained).

10 **Resolution**

12 **28S-1. Resolved,** that the ADA policy on Principles for Pay-for-Performance or Other Third-Party  
 13 Financial Incentive Programs (*Trans.*2006:328) be amended through text additions and deletions, so  
 14 that the amended policy reads as follows:

15 **Principles for Pay-for-Performance or Other Third-Party Financial Incentive Programs**

- 16
- 17
- 18 1. The primary objective of Pay-for-Performance (P4P) or other third-party financial incentive  
 19 programs must be improvement in the quality of oral health care, so performance measures in  
 20 those ~~plans programs shall~~ should be valid measures of healthcare quality, quality-related.
- 21 2. The provisions of P4P or other third-party financial incentive programs ~~should must~~ not  
 22 interfere with the patient-doctor relationship by injecting factors unrelated to the patient’s needs  
 23 into treatment decisions. Treatment plans can vary based on a clinician’s sound judgment,  
 24 available evidence and the patient’s needs and preferences. Benchmarks to judge performance  
 25 should allow for such variations in treatment plans.
- 26 3. The incentives in P4P or other third-party financial incentive programs ~~should must~~ reward both  
 27 the progressive quality improvement as well as attainment of achievement of desired quality  
 28 metrics. levels and significant improvement in quality directed toward meeting the desired quality  
 29 levels.
- 30 4. P4P or other third-party financial incentive programs ~~should must~~ not limit access to care for  
 31 patients requiring extraordinary levels or types of care-, nor provide a disincentive for practitioners  
 32 to treat complex or difficult cases because of concern about performance ratings. There should  
 33 be a system of risk adjustments for difficult or complex cases.

- 1 5. ~~The incentives in a P4P or other third-party financial incentive program must be positive and of~~  
 2 ~~a type and magnitude that will drive improvement in the quality of care or support consistently~~  
 3 ~~high quality care.~~
- 4 6. The measures upon which incentive payments are based:
  - 5 • ~~should must be valid, reliable and feasible exact, clear, measurable and based on valid~~  
 6 ~~science~~
  - 7 • ~~should must be standardized and have broad acceptance within the dental community~~
- 8 6. ~~Before comparing measure scores between two entities the results should must be risk-~~  
 9 ~~adjusted to account for patient differences.~~
  - 10 • ~~must factor in patient compliance~~
  - 11 • ~~must require a minimum of measurements~~
- 12 7. Reporting of quality to the public ~~should must be fair and provide an opportunity for dentists to~~  
 13 ~~comment on ratings. Payers should must discuss quality problems they identify with dentists~~  
 14 ~~before any public action is taken-reporting of ratings.~~
- 15 8. Participation by dentists ~~should must be voluntary, with no financial penalties for not~~  
 16 ~~participating.~~
- 17 9. Savings in costs ~~should must not accrue to plans but should must be returned to patients in~~  
 18 ~~reduced co-payments or expansion of benefits.~~
- 19 10. ~~Development and subsequent Regular-reassessment of P4P or other third-party financial~~  
 20 ~~incentive programs should must be done, with input from participating dentists.~~

21 and be it further

22  
 23  
 24 **Resolved**, that the American Dental Association use these principles in discussions with  
 25 organizations designing P4P or other third-party financial incentive programs and also monitor and  
 26 continue to evaluate Pay-for-Performance or other third-party financial incentive programs being  
 27 implemented in dental benefit plans, and be it further

28  
 29 **Resolved**, that the ADA advocacy efforts with respect for P4P or other third-party financial incentive  
 30 programs be guided by these principles.  
 31

32 **BOARD RECOMMENDATION: Vote Yes on the Substitute.**

33 **Vote: Resolution 28S-1**

BUCKENHEIMER	Yes	FEINBERG	Yes	NORMAN	Yes	VERSMAN	Yes
CROWLEY	Yes	GOUNARDES	Yes	ROBERTS	Yes	WEBER	Yes
DOW	Absent	HAGENBRUCH	Yes	SCOTT	Yes	YONEMOTO	Yes
ENGEL	Yes	ISRAELSON	Yes	SEAGO	Yes	ZENK	Yes
FAIR	Yes	KIESLING	Yes	SUMMERHAYS	Yes	ZUST	Yes

Resolution No. 29 New  
 Report: N/A Date Submitted: August 2013  
 Submitted By: Council on Dental Benefit Programs  
 Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, QUALITY HEALTH CARE**

2 **Background:** (Reports:40)

3 **Quality Health Care:** The CDBP believes that the ADA policy "Quality Health Care" should be amended  
4 to include the definition of quality of care which is now standard in the field.

5 **Resolution**

6  
7 **29. Resolved,** that the ADA policy on Quality Health Care (*Trans.* 1995:609) be amended through text  
8 additions and deletions, so that the amended policy reads as follows (additions are underscored;  
9 deletions are ~~stricken~~):

10 Oral health care is an integral component of health care. The Association promotes the public's  
11 oral health through commitment of member dentists to provide quality dental care.

12  
13 ~~Historically, the quality of dental care and the level of oral health care enjoyed by citizens of the~~  
14 ~~United States have been significantly enhanced by freedom of choice, fee-for-service dentistry.~~

15 Quality of care is the degree to which healthcare services for individuals and populations increase  
16 the likelihood of desired health outcomes and are consistent with current professional knowledge  
17 (Institute of Medicine).

18 *Quality oral health care* is characterized by the effective integration of multiple components of  
19 care consisting of prevention, acceptable treatment modalities, access, availability, utilization,  
20 patient management, patient autonomy, practice management, dental ethics and professionalism.

21 *Quality oral health care* is only possible when treatment decisions and planning are determined  
22 by the dentist and the patient, based on the patient's oral health needs and health status.

23 Any entity which seeks to participate in the managed dental benefit marketplace should be  
24 required by federal and state legislation to design and fund managed care dental plans that  
25 emphasize the value and importance of prevention, utilization, access, availability, cost

1 effectiveness, acceptable treatment modalities, specialist referrals, the profession's peer review  
2 system and an efficient administrative process.

3 **BOARD RECOMMENDATION: Vote Yes.**

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

6 Resolution 29

Resolution No. 30 N/A

Report: New Date Submitted: August 2013

Submitted By: Council on Dental Benefits

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, POSITION STATEMENT ON THE APPROPRIATE USE OF**  
 2 **ASSESSMENT DATA**

3 **Background:** (Reports:41)

4 **Position Statement on the Appropriate Use of Assessment Data:** The CDBP believes that the ADA  
 5 policy "Position Statement on the Appropriate Use of Assessment Data" should be amended to improve  
 6 clarity and reflect the current terminology used in this field. Additionally, the word "must" has been  
 7 changed to "should" to more accurately reflect the aspirational nature of ADA policy.

8 **Resolution**

9 **30. Resolved,** that the ADA policy on Position Statement on the Appropriate Use of Assessment  
 10 Data (*Trans.* 1998:701) be amended through text additions and deletions, so that the amended policy  
 11 reads as follows (additions are underscored; deletions are ~~stricken~~):

12 **Position Statement on the Appropriate Use of ~~Assessment Data~~**  
 13 **From Quality Measurement**  
 14

15 ~~It is widely recognized that assessment data~~ Data from quality measurement can provide very  
 16 useful information when ~~dealing with~~ addressing the many different issues confronting the health  
 17 care system, from improving the quality and effectiveness of patient care, to improving the  
 18 efficiency of care, to designing health benefit plans, based on the value of care. ~~However, as~~  
 19 ~~productively as~~ While data from quality measurement can be used productively, it can also be  
 20 misused and counterproductive. ~~Measurement instruments~~ Measure specifications must be  
 21 precisely designed to address specific concerns. One set of data cannot appropriately fit all  
 22 purposes. ~~To try to fit one set of data to meet all purposes is a major pitfall that should be~~  
 23 ~~avoided.~~

24 ~~Assessment data~~ Quality measures, are used today, ~~is used~~ for three ~~basic~~ quite distinct  
 25 purposes: ~~to improve the quality of direct patient care~~ delivery improvement, ~~to demonstrate~~  
 26 ~~accountability in the delivery of health care,~~ and ~~to conduct research~~ on the effectiveness of  
 27 ~~direct health care or on the efficiency of different delivery and financing structures.~~ Quality  
 28 ~~improvement, accountability and research are three quite distinct purposes and one~~ One set of  
 29 ~~data~~ uniform measures ~~should~~ does not satisfy the discrete needs of each purpose, e.g.: improve  
 30 the quality of care; demonstrate accountability in the delivery of health care; and conduct  
 31 research on the effectiveness of health care, or on the efficiency of different delivery and  
 32 financing structures ~~be used to meet these three purposes, uniformly.~~



1 Practitioners and health care institutions, such as hospitals, frequently use data from  
2 measurement for internal quality improvement, where the objective is:

- 3 • to understand the process of care and how it varies
- 4 • to understand how the process of care relates to the effectiveness of care for patients
- 5 • to clarify the clinician's perspective on the process of care and the need to change
- 6 • to plan and test changes in the process of care

7 The data collected for *quality improvement* is used in planning and implementing change. Thus, it  
8 should not be used prematurely as a conclusive or absolute statement about the quality of care.  
9 Because internal quality improvement requires that practitioners identify potential quality of care  
10 concerns, critique the process of care and test change, the practitioner must know that the data  
11 will remain confidential and will not be used as a premature judgment of either the practitioner or  
12 the process of care. Thus, internal improvement data should not be used for purposes of public  
13 accountability.

14 Accountability is distinct from internal quality improvement. Accountability data is intended to be  
15 publicly reported information. ~~For example, although the specific data from the internal quality~~  
16 ~~improvement program would not be suitable for accountability purposes, the fact that a~~  
17 ~~practitioner has a quality improvement program in place could be an indication of accountability.~~  
18 Accountability data is generally focused on the results or outcomes of care, and is often (but not  
19 exclusively) used to compare institutions, practitioners and health plans. In using such data for  
20 comparison, the sample must be large and the data measures must be adjusted for the different  
21 populations, environments and markets within which the practitioners, health plans and  
22 institutions operate. For example, ~~there the measures must be risk-adjusted~~ must be adjustments  
23 for severity of illness or demographic factors.

24 ~~Research is also distinct in its use of assessment data.~~ Quality of care research is often focused  
25 on examining the outcomes of care or the effectiveness of care. Measures should be specified in  
26 a manner that yields very precise results. Identifying and controlling variables that can influence  
27 the results is a more precise and extensive part of the data collection process than it is in either  
28 internal assessment or accountability.

29 There are, ~~however,~~ overlaps among the data measures used for internal quality improvement,  
30 public accountability and research. The results of research can be applied to identifying the best  
31 practices for quality improvement. Likewise, the need for accountability can set agendas for  
32 outcomes research and internal quality improvement. Internal quality improvement can define  
33 reasonable expectations for public accountability and the need for specific outcomes research.  
34 However, the feedback that will occur among internal quality improvement, accountability and  
35 research, should not be confused with the distinct purposes of each and the need for different  
36 ~~measurements~~ measures for each. The limits of the data ~~that is~~ collected from each sphere of  
37 assessment ~~should~~ must be recognized. Caution ~~should~~ must be used in ~~applying~~ interpreting  
38 ~~assessment~~ measurement data.

39 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 31 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, PRINCIPLES FOR THE APPLICATION OF RISK ASSESSMENT IN**  
 2 **DENTAL BENEFIT PLANS**

3 **Background:** *(Reports:42)*

4 **Principles for the Application of Risk Assessment in Dental Benefit Plans:** The CDBP believes that  
 5 the ADA policy “Principles for the Application of Risk Assessment in Dental Benefit Plans” should be  
 6 amended to provide clarity and better distinguish between individual and population level risk  
 7 assessment.

8 **Resolution**

9 **31. Resolved,** that the ADA policy on Principles for the Application of Risk Assessment in Dental  
 10 Benefit Plans (*Trans.*2009:424) be amended through text additions and deletions, so that the  
 11 amended policy reads as follows (additions are underscored; deletions are ~~stricken~~):

12 **Individual Risk Assessment:**

- 14 1. The assessment of the risk for the development of oral diseases, the progress of existing
- 15 disease or the adverse outcomes of treatment of oral disease for an individual patient is a
- 16 professional matter that is the sole responsibility of the attending dentist.
- 17 2. Individual risk assessment is an important consideration in developing a complete diagnosis
- 18 and treatment recommendations for each patient, the complexity of which is influenced
- 19 ~~determined~~ by the oral health status, goals and desires of the individual patient. The assessment
- 20 should be scientifically based, clinically relevant and continually refined through outcomes
- 21 studies.
- 22 3. There should be no interference by outside parties in the patient-doctor relationship by injecting
- 23 factors unrelated to the patient’s needs in any aspect of the diagnosis of the patient’s oral health
- 24 status or the attending dentist’s treatment recommendations.
- 25 ~~4. Risk assessments should not limit access to care for patients, including individuals who require~~
- 26 ~~extraordinary levels or type of care, nor provide a disincentive for practitioners to treat complex or~~
- 27 ~~difficult cases because of concern about performance ratings. There should be a system of risk~~
- 28 ~~adjustments for difficult or complex cases.~~
- 29 ~~5.~~ 4. Risk assessments should be conducted periodically on a schedule determined by the
- 30 attending dentist based upon the needs and medical status of the individual patient, since risk
- 31 can change over time due to application of preventive measures, changes in science, the effects
- 32 of therapy and changes in patient behaviors.

1           65. Self-administered patient questionnaires provided by third-party payers used for risk  
2 assessment purposes should contain the admonition that they are not to be considered as a  
3 substitute for a clinical evaluation performed by a dentist.

4           **Population Risk Assessment:**

5           ~~17. Risk assessment for communities or groups populations within a community~~ is a science  
6 separate from individual patient risk assessment, one that requires different skills and techniques  
7 than those used in the assessment of individual patients.

8           ~~2. If dental plans develop models to categorize their members based on risk, this should be~~  
9 ~~accomplished through a scientifically validated method.~~

10           ~~3. At no time should these risk assessment models be applied to design benefit packages for the~~  
11 ~~purpose of cost savings.~~

12           ~~4. Eligibility for preventive services within a dental benefit plan should not be limited based on~~  
13 ~~population level risk assessment.~~

14           ~~8. When a disease is present in a community and its prevalence is low because of the~~  
15 ~~effectiveness of preventive efforts, third-party payers should continue those preventive services~~  
16 ~~as benefits of a dental plan.~~

17           **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 32 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Benefit Programs

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, THIRD-PARTY PAYERS OVERPAYMENT RECOVERY PRACTICES**

2 **Background:** *(Reports:43)*

3 **Third-Party Payers Overpayment Recovery Practices:** The CDBP believes that the ADA policy “Third-  
4 Party Payers Overpayment Recovery Practices” should be amended to delete the second resolving  
5 clause as it basically says the same thing as the first resolving clause except that the first clause now  
6 includes constituent societies.

7 **Resolution**

8  
9 **32. Resolved**, that the ADA policy on Third-Party Payers Overpayment Recovery Practices  
10 (*Trans.* 1999:930) be amended through text additions and deletions, so that the amended policy reads  
11 as follows (additions are underscoring; deletions are ~~stricken~~):

12 **Resolved**, that the American Dental Association shall and its constituent societies are urged to  
13 seek or support legislation to prevent opposing all in appropriate third-party payers from  
14 withholding assigned benefits when an incorrect payment has been made on behalf of a different  
15 patient covered by the same third-party payer overpayment recovery practices, and be it further

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

20 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 34 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Practice

Reference Committee: 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 Goal: Members (Required)

1 **RESCISSION OF THE NATIONAL HEALTHCARE INFRASTRUCTURE (NHII) TASK FORCE**

2 **Background:** (*Reports:65*)

3 **Recommendation—Policy to be Rescinded:** The Council reviewed the policy, “The National  
4 Healthcare Information Infrastructure (NHII) Task Force” (*Trans.2005:338*) and recommends rescission  
5 because the objectives of the resolved clauses were completed and the Task Force was dissolved by the  
6 Board of Trustees in 2007 when the Electronic Health Record Working Group was established.

7 **Resolution**

8 **34. Resolved,** that Resolution 58H-2005 “The National Healthcare Information Infrastructure (NHII)  
9 Task Force” (*Trans.2005:338*), be rescinded.

10

11 **BOARD RECOMMENDATION: Vote Yes.**

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

14

1 WORKSHEET ADDENDUM  
2 COUNCIL ON DENTAL PRACTICE  
3 POLICY TO BE RESCINDED

4 **The National Healthcare Information Infrastructure (NHII) Task Force (*Trans.2005:338*)**

5 **Resolved**, that the ADA acknowledges President Bush's NHII initiative for the healthcare environment  
6 that provides interoperable patient information will impact the future of dentistry, and be it further  
7 **Resolved**, that the ADA position itself as the advocate for dentistry in all appropriate NHII activities, and  
8 be it further

9 **Resolved**, that the NHII Task Force provide an annual progress report on its activities to the 2006 House  
10 of Delegates, with appropriate recommendations for future years.

Resolution No. 35 New  
 Report: NA Date Submitted: August 2013  
 Submitted By: Council on Dental Practice  
 Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, RECOMMENDATIONS OF FUTURE OF DENTISTRY REPORT**

2 **Background:** (*Reports:65*)

3 **Recommendations of Future of Dentistry Report:** The Council believes that the policy  
4 "Recommendations of Future of Dentistry Report" should be amended because the last two resolved  
5 clauses are no longer relevant.

6 **Resolution**

7  
8 **35. Resolved,** that the ADA policy, "Recommendations of Future of Dentistry Report"  
9 (*Trans.1983:552*) be amended as follows (deletions are ~~stricken~~):

10 **Resolved,** that the Association accept the following five principal recommendations of the Future  
11 of Dentistry Report as priority guidelines for the ADA to prepare the profession for the challenges  
12 of the future.

- 13 • Convert public unmet need into demand for dental services;
- 14 • prepare the practitioners (existing and future) to be more patient/market oriented;
- 15 • broaden the practitioner's clinical skills and mix of services offered to the public;
- 16 • influence the quality and quantity of the manpower supply; and
- 17 • stimulate research and development.

18 ~~and be if further~~  
 19 ~~**Resolved,** that all appropriate Association agencies be directed to reassess their current~~  
 20 ~~programs and use these guidelines in formulating their future program activities, and be it further~~  
 21 ~~**Resolved,** that a report be forwarded annually by the Board of Trustees to the House of~~  
 22 ~~Delegates describing to what extent these guidelines have been incorporated.~~

23  
24 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 36 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Practice

Reference Committee: 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 Goal: Members (Required)

1 **AMENDMENT OF THE POLICY, ELECTRONIC TECHNOLOGY ACTIVITIES**

2 **Background:** (*Reports:65*)

3 **Electronic Technology Activities:** The Council believes that the policy "Electronic Technology  
4 Activities" (*Trans.1993:695*) should be amended because the ADA activity in the area of electronic  
5 technology has been intense for several years as seen by the activities of the Department of Dental  
6 Informatics and the Standards Committee for Dental Informatics and the first resolved clause should be  
7 changed to reflect this activity and to acknowledge that more intensity is not possible.

8 **36. Resolved,** that the ADA policy "Electronic Technology Activities" (*Trans.1993:695*) be  
9 amended as follows (additions are underscored; deletions are ~~stricken~~):

10 ~~**Resolved,** that the American Dental Association intensify its efforts~~ in the field of  
11 electronic technology ~~and that such efforts be established as is~~ a high priority for the  
12 American Dental Association, and be it further  
13 **Resolved,** that appropriate agencies of the Association are encouraged to provide full  
14 services  
15 in the areas of information science and dental electronic technology, and report  
16 developments and trends in these fields on a regular basis to the Board of Trustees, and  
17 be it further  
18 **Resolved,** that the Association is opposed to mandatory participation in electronic data  
19 interchange for dental claims processing.

20 **BOARD RECOMMENDATION: Vote Yes.**

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



Resolution No. 37 New

Report: N/A Date Submitted: August 2013

Submitted By: Council on Dental Practice

Reference Committee: 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 Goal: Collaboration (Required)

1 **STATEMENT SUPPORTING THE DENTAL TEAM CONCEPT**

2 **Background:** (*Reports:66*)

3 **Statement Supporting the Dental Team Concept:** The Council believes that the policy "Statement  
4 Opposing Unsupervised Practice by Dental Auxiliaries" should be replaced with new policy because a  
5 positive statement would better serve the ADA, while preserving the concept of supervision of auxiliaries  
6 by dentists.

7 **Resolution**

8 **37. Resolved,** that constituent dental societies, dental educators and dental examiners are  
9 encouraged to work closely and cooperatively with the ADA to support the dental team concept to  
10 prevent fragmentation of the dental team, and be it further

11 **Resolved,** that these parties are urged to support ADA policies on supervision of dental auxiliaries in  
12 all settings including, but not limited to, educational institutions, skilled nursing facilities and public  
13 health clinics, and be it further

14 **Resolved,** that Resolution 68H-1987, "Statement Opposing Unsupervised Practice by Dental  
15 Auxiliaries" (*Trans.1987:514*), be rescinded.

16 **BOARD RECOMMENDATION: Vote Yes.**

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

1 WORKSHEET ADDENDUM  
2 COUNCIL ON DENTAL PRACTICE  
3 POLICY TO BE RESCINDED

4 **Statement Opposing Unsupervised Practice by Dental Auxiliaries (*Trans.1987:514*)**

5 **Resolved**, that constituent dental societies, dental educators and dental examiners work closely and  
6 cooperatively to oppose any legislation that would allow unsupervised practice or the fragmentation of the  
7 dental team concept, and be it further

8 **Resolved**, that in conjunction with these legislative efforts these parties support ADA policies on  
9 supervision of dental auxiliaries in all settings including, but not limited to, educational institutions, skilled  
10 nursing facilities and public health clinics.



1 WORKSHEET ADDENDUM

2 COUNCIL ON DENTAL PRACTICE

3 POLICY TO BE RESCINDED

4

5 **Use of Biodegradable Materials in Manufacture and Packaging of Disposal Dental Products**  
6 **(*Trans.1991:585*)**

7 **Resolved**, that the American Dental Association seek to require manufacturers of disposable dental  
8 products to use wherever possible materials that are biodegradable in both the manufacture and  
9 packaging of such products.

Resolution No. 51 New

Report: CDP Supplemental Report 1 Date Submitted: August 2013

Submitted By: Council on Dental Practice

Reference Committee: 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 Goal: Financial (Required)

1 **COUNCIL ON DENTAL PRACTICE SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES:**  
 2 **RESPONSE TO RESOLUTION 46-2012: RESCISSION OF THE POLICY, SALE OF DENTAL**  
 3 **EQUIPMENT TO ILLEGAL PRACTITIONERS**  
 4

5 **Background:** As part of its policy review activity, the policy “Sale of Dental Equipment to Illegal  
 6 Practitioners” was recommended for rescission to the 2012 House of Delegates by the Council on Dental  
 7 Practice (CDP), because there appeared to be little or no benefit derived to the ADA from it and the policy  
 8 carries a degree of legal risk. Resolution 46-2012 (*Trans.*2012:450) reads:  
 9

10 **46-2012. Resolved,** that Resolution 33H-2001(*Trans.*2001:436), “Sale of Dental Equipment to  
 11 Illegal Practitioners”, be rescinded.  
 12

13 Resolution 33H-2001(*Trans.*2001:436) reads:  
 14

15 **Sale of Dental Equipment to Illegal Practitioners**  
 16

17 **Resolved,** that the ADA strongly urges dental equipment manufacturers and  
 18 suppliers to develop and implement guidelines which preclude the sale, transfer or  
 19 conveyance of new and used dental equipment and supplies (except “over the  
 20 counter” consumer care products) to illegal practitioners of dentistry, and be it further  
 21

22 **Resolved,** that the guidelines include the requirement that before manufacturers or  
 23 suppliers sell, transfer or convey dental equipment and supplies to persons they  
 24 believe plan to use the products in the practice of dentistry, the manufacturers and  
 25 suppliers first verify that the purchaser is licensed to practice dentistry in the state  
 26 where the products will be delivered, and be it further  
 27

28 **Resolved,** that the guidelines also include a requirement that contracts, purchase  
 29 orders, and invoices used to sell, transfer or convey dental equipment and supplies  
 30 require purchasers intending to use the equipment or supplies to provide dental care  
 31 to include their dental license number, and be it further  
 32

33 **Resolved,** that in the case of as yet unlicensed dental students or recent graduates,  
 34 the guidelines allow for the sale, transfer or conveyance of dental equipment and  
 35 supplies, provided that the student or recent graduate supplies verification of current  
 36 attendance in or graduation from an accredited dental school.  
 37

1 The House of Delegates referred Resolution 46-2012 to the appropriate ADA agency for study and report  
2 back to the 2013 House of Delegates. Resolution 46 was subsequently assigned to the CDP.

3 **Council Findings:** The CDP understands that anti-trust laws promote competition in the delivery of all  
4 manner of products and services in the American economy, and that these laws prohibit concerted  
5 actions that produce unreasonable restraints of trade. ADA's Division of Legal Affairs produced a  
6 publication, *The Antitrust Laws in Dentistry: A Primer of "Do's, Don'ts, and How To's" For Dentists and*  
7 *Dental Societies* that explains the impact of antitrust laws on dentistry. This publication is available to  
8 members at [https://www.ada.org/members/sections/professionalResources/antitrust\\_booklet\\_full.pdf](https://www.ada.org/members/sections/professionalResources/antitrust_booklet_full.pdf).

9 With this background, the Council reviewed this policy. An ADA resolution urging dental suppliers and  
10 manufacturers to take actions such as ascertaining the intended use of products and equipment, and/or  
11 verifying that the purchaser is licensed to practice dentistry, while well intentioned, is burdensome and  
12 impractical to implement, while suggestions to restrict sales accordingly may be viewed as inviting  
13 suppliers and manufacturers to engage in activities that might be perceived as an inappropriate restraint  
14 of trade in dental equipment.

15 Protection of the public from illegal dental practitioners is a responsibility of regulatory bodies, and not  
16 private parties such as the ADA and equipment manufacturers and suppliers. Actions to discourage or  
17 prohibit the unauthorized practice of dentistry, whether in this manner or others, should best be left to the  
18 states.

19 The CDP considered amending the policy to minimize or remove any potential risk. However, CDP  
20 ultimately concluded that any efforts to encourage non-governmental restriction on dental equipment  
21 sales would be both ineffective and subject to possible legal scrutiny under both federal and state  
22 antitrust laws. Following discussion of the risk to the ADA as measured against any perceived benefit of  
23 maintaining this policy, the CDP recommended rescission of this policy. Therefore, the Council  
24 recommends adoption of the following resolution.

### 25 **Resolution**

26  
27 **51. Resolved**, that the policy, "Sale of Dental Equipment to Illegal Practitioners" (*Trans.2001:436*), be  
28 rescinded.  
29

30 **BOARD RECOMMENDATION: Vote Yes.**

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

Resolution No. 52 New

Report: CDP Supplemental Report 2 Date Submitted: August 2013

Submitted By: Council on Dental Practice

Reference Committee: 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 Goal: Public Health (Required)

1 **COUNCIL ON DENTAL PRACTICE SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES:**  
 2 **REGISTRATION OF DENTAL LABORATORIES**

3 **Background:** Dental laboratory technicians were among the first dental team members. They were  
 4 trained on the job and worked in dental offices in the latter half of the nineteenth century. In 1917, 97% of  
 5 prosthetic work was done in the dental office under the direct supervision of a dentist. The first  
 6 commercial dental laboratory was opened in 1887. In a remarkable transformation, 95% of dental  
 7 prosthetic work was done in commercial dental laboratory settings by 1944. Dentists provided written  
 8 instructions for dental prosthetics, but were no longer training or overseeing the dental laboratory  
 9 technician. Dental laboratory technicians became isolated from the dental team during this period. In  
 10 2010, 4.7% of dentists reported employment (and oversight) of dental laboratory technicians to fabricate  
 11 custom appliances for their patients (*2010 Survey of Dental Practice*).

12 Challenges facing the dental laboratory industry have been of concern to the Council since its inception  
 13 and continue to be of concern. The Council on Dental Practice (the Council) was originally formed in  
 14 1948 as the Council on Dental Trade and Laboratory Relations to foster better relations between  
 15 laboratory technicians and dentists. In 2008, the ADA's House of Delegates directed the Council to  
 16 convene a meeting to discuss the state of dental laboratory services and to consider actions to insure that  
 17 the quality of prosthetic services remains high in the future. In 2009, the Council convened the Future of  
 18 Dental Laboratory Technology (FDLT) Conference. A diverse group of stakeholders discussed the state  
 19 of dental laboratory services and training in the U.S. Key issues discussed included the impact of off-  
 20 shore laboratories, safety and regulatory concerns related to dental laboratories and the marked  
 21 decrease in educational programs for dental laboratory technicians.

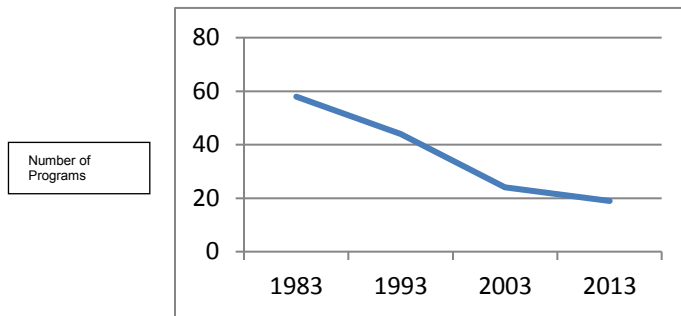
22 **Safety:** Patient safety is of paramount concern to individual dentists and to the ADA as an organization.  
 23 Recent reports from Oklahoma, Rhode Island and Pennsylvania have described inadequate infection  
 24 control procedures in dental offices that placed patients at risk for several infectious diseases. Dentists  
 25 are under the regulatory authority of their state boards, and the actions taken by the state boards in these  
 26 cases have served to protect the public by sanctioning the dentist's license to practice. The owner-  
 27 dentists have oversight responsibility for actions taken by his or her staffs, some of whom may not be  
 28 licensed or registered with the state.

29 The laboratory industry in contrast, in the U.S. is largely unregulated, even though the prosthetics or  
 30 appliances that are custom manufactured according to a dentist's order are delivered to patients. ADA  
 31 policy recommends that laboratories use current infection control standards, including personal protective  
 32 equipment and disinfection of prosthesis, appliances and materials. Laboratories can voluntarily obtain a  
 33 Certified Dental Laboratory certification (CDL) from the National Board for Certification in Dental  
 34 Laboratory Technology (NBC). Standards related to quality, safety and good manufacturing practices

1 must be met. Of an estimated 13,000 laboratories in the United States, only 200 have obtained this  
2 certification.

3 Documentation of the materials used in the manufacture of a dental prosthetic was approached  
4 proactively by the dental materials manufacturers through voluntary programs, IdentAlloy and  
5 IdentCeram. Certificates verifying the materials used in the dental prosthetic can be placed in the  
6 patient's chart and/or given to the patient. IdentAlloy and IdentCeram certificates may be used by both  
7 domestic and off-shore laboratories. As reported in the *2008 Survey on the Use of Dental Labs (SUDL)*,  
8 only 54.7% of laboratories provided IdentAlloy information to dental offices. Several years ago, the  
9 infamous "lead in a crown" case in Ohio underscored the lack of verification that materials ordered by a  
10 dentist for a dental prosthetic are actually used.

11 **Education:** Most non third-world countries require a minimum of a three-year degree to become a  
12 certified dental laboratory technician. This is not true in the U.S., where training of dental laboratory techs  
13 ranges from on-the-job training to associate degree programs. Educational programs for dental  
14 laboratory technicians have decreased since 1983, while dental hygiene and dental assistant programs  
15 have flourished. There are only 19 accredited dental laboratory technician programs in 2013. Fifty-eight  
16 were in existence in 1983, 44 in 1993, and 24 in 2003.



17  
18 Recognition of professional certification or registration plays a role in career choice. Hygienists are  
19 licensed to practice dental hygiene; dental assistants are increasingly becoming more regulated. The  
20 Dental Assistant National Board (DANB) found that currently, 38 states recognize or require that dental  
21 assistants pass one of the DANB national exams in order to perform dental assisting functions. Twenty-  
22 four states are considering or have implemented new rules and regulations related to dental assisting.  
23 Only six states require dental laboratory registration; lack of professional recognition is a perceived barrier  
24 to the success of these dental laboratory educational programs.

25 **Change in Enrollment of Allied Dental Educational Programs, 2001-2011**

	NUMBER ENROLLED		% CHANGE
	2001	2011	
Dental Hygiene	6,537	8,007	+22.5
Dental Assisting	6,433	10,390	+61.5
Dental Laboratory Technology	495	431	-12.9

2010-11 Survey of Allied Dental Education

26  
27 The decrease in the number of programs and enrollment of dental laboratory technicians is attributed to  
28 other factors as well. High costs of acquiring current technology for students, low entry wages, lack of  
29 programs in certain geographic areas, and a lack of visibility as a career option for students have all  
30 contributed to this decline. A 2010 reclassification of the dental laboratory technician to an unskilled



1 category by the U.S. Bureau of Labor Statistics has prevented students from obtaining training or  
2 retraining funding from state workforce agencies. It is necessary to effect positive changes to attract  
3 students to the career and assure a high quality workforce, since the number of graduates of these  
4 programs is below the number of laboratory technicians retiring.

5 **Globalization:** There are increasing trends toward the globalization of the dental laboratory industry. In  
6 2005, five million dental crowns were manufactured by foreign dental laboratories for patients in the U.S.  
7 (10% of the market at the time). Between 2008 and 2012, outsourcing of dental prosthetics grew by 27%.  
8 Between 2011-12, the rate of growth was 9.9%. China, Spain, Germany, Canada and Costa Rica are the  
9 top five exporters of dental prosthetics, with China far surpassing any other country in volume of products.  
10 An individual practitioner has a limited or no ability to determine what safety and manufacturing processes  
11 were followed.

12 While the number of prosthetics manufactured outside of the U.S. has increased, 77.3% of dentists  
13 reported that using a domestic laboratory was an important criterion when selecting a dental laboratory  
14 according to the *SUDL*, published in 2009. The same survey reported only 2.9% of dentists knew they  
15 were using a foreign laboratory, suggesting complete disclosure of the manufacturing process had not  
16 occurred. Existing ADA policy (*Trans.* 1990:543; 1995:623; 1999:933; 2000:454; 2003:365; 2005:327;  
17 2007:430) urges constituent societies to pursue legislation or voluntary agreements that dentists are  
18 notified in advance when a dental laboratory subcontracts a dental prosthetic to be manufactured,  
19 partially or entirely, by a foreign dental laboratory or any ancillary domestic laboratory.

20 **Current ADA Policy Positions on Safety and Regulation of Dental Laboratories:** The *Statement on*  
21 *Prosthetic Care and Dental Laboratories* (*Trans.* 1990:543, 1995:623; 1999:933; 2000:454; 2003:365;  
22 2005:327; 2007:430) contains provisions related to the safety of patients and laboratory technicians.  
23 Infection control issues, the use of personal protective equipment, and identification of materials are  
24 included in the section on the Laboratory/Technician (Items 6, 7, 8, and 9).

- 25 6. The laboratory should follow current infection control standards with respect to the personal  
26 protective equipment and disinfection of prostheses/appliances and materials. All materials  
27 should be checked for breakage and immediately reported if found.
- 28 7. The laboratory/technician should inform the dentist of the materials present in the case and  
29 may suggest methods on how to properly handle and adjust these materials.
- 30 8. The laboratory/technician should clean and disinfect all incoming items from the dentist's  
31 office; e.g., impressions, occlusal registrations, prostheses, etc., according to current  
32 infection control standards. All prostheses and related items which are returned to the dentist  
33 should be cleaned and disinfected, according to current infection control standards, placed in  
34 an appropriate container, packed properly to prevent damage, and transported.
- 35 9. The laboratory/technician should inform the dentist of any subcontracting  
36 laboratory/technician employed for preparation of the case. The laboratory/technician should  
37 furnish a written order to the dental laboratory which has been engaged to perform some or  
38 all of the services on the original written instructions.

39 Regulation of dental laboratories is also addressed. The policy recognizes that some states have  
40 instituted registration, certification, licensure or some variation of these for dental laboratories.  
41 Additionally, the policy notes that the ADA recognizes that the basic tenet of regulation by any  
42 governmental agency is to protect the health and welfare of the public. The policy states that the ADA is  
43 opposed to any form of governmental regulation or licensure of dental laboratories that is not under the  
44 auspices of the state board of dentistry. Protection of the health and welfare of the public through  
45 registration of dental laboratories under the state dental board is not opposed by current policy.

46 All ADA policies related to dental laboratories are listed in Appendix 1.

1 **Current State Regulation of Dental Laboratories:** Statutes in six states (FL, KY, OK, SC, TX, and MN)  
 2 currently require certification or registration of dental technicians and/or dental laboratories under the  
 3 state's dental board or its umbrella licensing agency. Pennsylvania requires registration with the state's  
 4 Department of Health. A detailed summary of the state regulations, prepared by the Department of State  
 5 Government Affairs, can be found in Appendix 2.  
 6

State	Year Enacted	Registration Fee
Florida	1990	\$200 every two years
Kentucky	1974	\$50 annually
Oklahoma	1959	\$200 annually
South Carolina	1942	\$102 annually
Texas	1987	\$105 annually
Minnesota	2012	\$50; \$25 renewal annually
Pennsylvania	1987	\$200 annually

7 The cost of laboratory registration in these states is relatively low. According to a survey conducted by  
 8 the National Association of Dental Laboratories (NADL), the registration fees have not increased costs to  
 9 dentists or caused marketplace restrictions or disruptions. In 2010, the cost of Porcelain fused to metal  
 10 (PFM) unit in SC, TX and FL, three states which have required laboratory registration for many years, is  
 11 below the national average cost of a PFM Crown (\$155). It was reported at the FDLT that 76% of dental  
 12 laboratories supported required registration of laboratories through state dental practice acts. (Valmont  
 13 Research, June 2009). The boards of both the NBC and NADL also support registration of dental  
 14 laboratories.

15 **Council Findings:** The Council carefully considered the advantages and disadvantages of promoting  
 16 registration of dental laboratories and found it would be beneficial for both dentists and the public for  
 17 states to require registration of dental laboratories. The Council considered:

- 18 • Protection of the health and welfare of the public is a basic tenet of the profession, and the ADA.
- 19 • A state-maintained registry would provide assurance to a dentist and the public that the  
 20 laboratory is compliant with minimum standards should a state require such standards.
- 21 • Registration would elevate the profession by recognizing dental laboratory technicians as an  
 22 integral part of the dental practice team. This recognition could lead to increased interest in DLT  
 23 programs, minimal education requirements and an assurance that high quality dental laboratories  
 24 will be available in the future.
- 25 • Laboratory registration is the most cost effective way to establish compliance with minimum  
 26 standards, including infection control or required continuing education, should a state require  
 27 such standards.
- 28 • A registry would allow for clear communication channels between dental laboratories, dental  
 29 manufacturers and the U.S. Food and Drug Administration (FDA) should there be a recall on a  
 30 dental material or equipment related to a health or safety issue.
- 31 • NADL, NBC and 76% of surveyed dental laboratories support registration of dental laboratories.



## APPENDIX 1

# Laboratories and Technicians 1954-2012

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## **Statement to Encourage U.S. Dental Schools to Interact With U.S. Dental Laboratories (*Trans.2010:547*)**

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**Resolved**, that the ADA encourage all U.S. dental schools to use U.S. dental laboratories for fabrication of undergraduate and graduate dental students' restorative prostheses, in lieu of sending the prescription for these medical devices abroad, and that the ADA believes that the educational process of U.S. dental students would be enhanced by interaction with local dental laboratories, and be it further

**Resolved**, that the ADA encourage U.S. dental schools to use their own in-house dental laboratories wherever possible in order to facilitate the valuable interaction between dental students and certified dental laboratory technicians as this will afford the dental students with the valuable experience necessary to facilitate the successful fulfillment of a prescription for fabrication of dental prostheses, and be it further

**Resolved**, that the ADA encourage U.S. dental schools to combine dental education programs with dental laboratory technology programs wherever dental laboratory technology programs are located within commuting distance of the dental school, and that these programs/curricula could include, but are not limited to, dental morphology/occlusion, prosthetic design and fabrication, waxing, casting, surveying of study casts, and incorporation of CAD/CAM technology.

## **National Board for Certification of Dental Laboratory Technicians' Continued Recognition (*Trans.2002:400*)**

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**Resolved**, that the National Board for Certification of Dental Laboratory Technicians' request for continued recognition as the certification board for dental laboratory technicians be approved.

## **Criteria for Approval of a Certification Board for Dental Laboratory Technicians (*Trans.1998:92, 713*)**

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One of the duties of the Council on Dental Education and Licensure indicated in the *Bylaws* of the American Dental Association is 'to study and make recommendations including the formulation and recommendation of policy on: (4) The approval or disapproval of national certifying boards for special areas of dental practice and for dental auxiliaries. (5) The educational and administrative standards of the certifying boards for special areas of dental practice and for dental auxiliaries.' The Council on Dental Education and Licensure believes that the examination and certification of dental laboratory technicians is necessary to provide the dental profession with an indication of those persons who have demonstrated their ability to fulfill the dental laboratory work authorization. Such a certification program should be based on the educational requirements for dental laboratory technicians approved by the Commission on Dental Accreditation.

The following basic requirements are prescribed by the Council on Dental Education and Licensure for the evaluation of an agency which seeks approval of the American Dental Association for a program to certify dental laboratory technicians on the basis of educational standards approved by the dental profession.

**I. Organization:** An agency that seeks approval as a Certification Board for Dental Laboratory Technicians should be representative of or affiliated with a national organization of the dental laboratory industry and have authority to speak officially for that organization. It is required that each dental laboratory technician member of the Certification Board hold a certificate in one of the areas of the dental laboratory technology.

**II. Authority and Purpose:** The rules and regulations established by the Certification Board of Dental Laboratory Technicians will be considered for approval by the Council on Dental Education and Licensure

1 on the basis of these requirements. Changes that are planned in the rules and regulations of the  
2 Certification Board should be reported to the Council before they are put into effect. The Board shall submit  
3 data annually to the Council on Dental Education and Licensure relative to its financial operations,  
4 applicant admission and examination procedures, and results thereof.

5 The principal functions of the Certification Board shall be:

- 6 a. to determine the levels of education and experience of candidates applying for certification examination  
7 within the requirements for education established by the Commission on Dental Accreditation;  
8 b. to prepare and administer comprehensive examinations to determine the qualifications of those persons  
9 who apply for certification; and  
10 c. to issue certificates to those persons who qualify for certification and to prepare and maintain a roster of  
11 certifees.

12 **III. Qualifications of Candidates:** It will be expected that the minimum requirements established by the  
13 Certification Board for the issuance of a certificate will include the following:

- 14 a. satisfactory legal and ethical standing in the dental laboratory industry;  
15 b. graduation from high school or an equivalent acceptable to the Certification Board;  
16 c. a period of study and training as outlined in the Accreditation Standards for Dental Laboratory  
17 Technology Education Programs, plus an additional period of at least two years of working experience as  
18 a dental laboratory technician; or, five years of education and/or experience in dental technology; and  
19 d. satisfactory performance on examination(s) prescribed by the Certification Board.

20 **Support of the Dental Laboratory Technician Certification Program and Continuing Education Activities**  
21 **(Trans.1997:682; 2010:547)**

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22 **Resolved**, that the American Dental Association encourage dental laboratory technicians to achieve  
23 certification status and pursue the continuing education that is required to provide dentists with technical  
24 support that will contribute to high standards of restorative dental care, and be it further

25 **Resolved**, that the American Dental Association encourage efforts by those engaged in dental laboratory  
26 technology and dental laboratory technology education to ensure that the future workforce in dental laboratory  
27 technology is adequately educated and skilled in the art and science of dental laboratory technology by  
28 promoting pursuit of certification, and be it further

29 **Resolved**, that the American Dental Association encourage constituent and component dental societies to  
30 recognize the continuing education needs of certified dental technicians by inviting their attendance at  
31 appropriate continuing education seminars and encouraging their attendance as presenters.

32 **Statement on Prosthetic Care and Dental Laboratories (Trans.1990:543; 1995:623; 1999:933; 2000:454;**  
33 **2003:365; 2005:327; 2007:430)**

---

34 **Introduction:** Patient care in dentistry often involves the restoration or reconstruction of oral and peri-oral  
35 tissues. The dentist may elect to use various types of prostheses to treat the patient and may utilize the  
36 supportive services of a dental laboratory and its technical staff to custom manufacture the prostheses  
37 according to specifications determined by the dentist.

38 Since the dentist-provider is ultimately responsible for the patient's care, the Association believes that he or  
39 she is the only individual qualified to accept responsibility for prosthetic care. At the same time, the dental  
40 profession recognizes and acknowledges with gratitude and respect the significant contributions of dental  
41 laboratory technicians to the health, function and aesthetics of dental patients.

42 This statement outlines the Association's policy on the optimal working relationship between dentist and  
43 dental laboratory, the regulation of dental laboratories and issues regarding the provision of prosthetic care. A  
44 glossary of terms is a part of this statement.

45 Because of the dentist's primary role in providing prosthetic dental care, the Association, through its  
46 Department of State Government Affairs and the Council on Dental Practice, provides upon request assistance  
47 to state dental societies in dealing with issues addressed in this statement.

1 **Diagnosis and Prosthetic Dental Treatment:** It is the position of the American Dental Association that  
2 diagnosis and treatment of complete and partial denture patients must be provided only by licensed dentists  
3 and only within the greater context of evaluating, treating and monitoring the patient's overall oral health. The  
4 Association believes that the dentist, by virtue of education, experience and licensure, is best qualified to  
5 provide denture treatment to the public with the highest degree of quality. As a result of its belief that dental  
6 care is the responsibility of a licensed dentist, the Association opposes prosthetic dental treatment by any other  
7 individuals. Further, the Association will actively work to prevent the enactment of any legislation or regulation  
8 allowing such activity or programs, on the grounds that it would be dangerous and detrimental to the public's  
9 health.

10 **Working Relationships between Dentists and Dental Laboratories:** The current high standard of prosthetic  
11 dental care is directly related to, and remains dependent upon, mutual respect within the dental team for the  
12 abilities and contributions of each member. The following guidelines are designed to foster good relations  
13 between dental laboratories, dental laboratory technicians and the dental profession.

14 Applicable laws shall take precedence if they are inconsistent with any of the following guidelines.

#### 15 **The Dentist:**

- 16 1. The dentist should provide written instructions to the laboratory or dental technician. The written  
17 instructions should detail the work which is to be performed, describe the materials which are to be used  
18 and be written in a clear and understandable fashion. A duplicate copy of the written instructions should be  
19 retained for a period of time as may be required by law.
- 20 2. The dentist should provide the laboratory/technician with accurate impressions, casts, occlusal  
21 registrations and/or mounted casts. Materials submitted should be identified.
- 22 3. The dentist should identify, as appropriate, the crown margins, post palatal seal, denture borders, any  
23 areas to be relieved and design of the removable partial dentures on all cases.
- 24 4. The dentist should furnish instruction regarding preferred materials, coloration, description of prosthetic  
25 tooth/teeth to be utilized for fixed or removable prostheses which may include, but not be limited to a  
26 written description, photograph, drawing or shade button.
- 27 5. The dentist should provide verbal or written approval to proceed with a laboratory procedure, or make any  
28 appropriate change(s) to the written instructions as the dentist deems necessary, when notified by a  
29 laboratory/dental technician that a case may have a questionable area with respect to paragraphs 2-4.
- 30 6. The dentist should clean and disinfect all items according to current infection control standards prior to  
31 sending them to the laboratory/technician. All prostheses and other materials that are forwarded to the  
32 laboratory/technician should be prepared for transport utilizing an appropriate container and packaged  
33 adequately to prevent damage and maintain accuracy.
- 34 7. The dentist should return all casts, registration and prostheses/appliances to the laboratory/technician if a  
35 prosthesis/appliance does not fit properly, or if shade selection is incorrect.

#### 36 **The Laboratory/Technician:**

- 37 1. The laboratory/technician should custom manufacture dental prostheses/appliances which follow the  
38 guidelines set forth in the written instructions provided by the dentist, and should fit properly on the casts  
39 and mounting provided by the dentist. Original written instructions should be retained for a period of time  
40 as may be required by law.  
41 When a laboratory provides custom-printed written instruction forms to a dentist, the laboratory  
42 document should include the name of the laboratory and its address, provide ample space for the doctor's  
43 written instruction, areas to indicate the desired delivery date, the patient's name, a location for the doctor  
44 to provide his/her name and address, as well as to designate a site for the doctor to provide a signature.  
45 The form should also allow for other information which the laboratory may deem pertinent or which may be  
46 mandated by law.
- 47 2. The laboratory/technician should return the case to the dentist to check the mounting if there is any  
48 question of its accuracy or of the bite registration furnished by the dentist.
- 49 3. The laboratory/technician should match the shade which was described in the original written instructions.
- 50 4. The laboratory/technician should notify the dentist within two (2) working days after receipt of the case, if  
51 there is a reason for not proceeding with the work. Any changes or additions to the written instructions

- 1 must be agreed to by the dentist and must be initialed by authorized laboratory personnel. A record of any  
2 changes shall be sent to the dentist upon completion of the case.
- 3 5. After acceptance of the written instructions, the laboratory/technician should custom manufacture and  
4 return the prostheses/appliances in a timely manner in accordance with the customary manner and with  
5 consideration of the doctor's request. If written instructions are not accepted, the laboratory/technician  
6 should return the work in a timely manner and include a reason for denial.
- 7 6. The laboratory should follow current infection control standards with respect to the personal protective  
8 equipment and disinfection of prostheses/appliances and materials. All materials should be checked for  
9 breakage and immediately reported if found.
- 10 7. The laboratory/technician should inform the dentist of the materials present in the case and may suggest  
11 methods on how to properly handle and adjust these materials.
- 12 8. The laboratory/technician should clean and disinfect all incoming items from the dentist's office; e.g.,  
13 impressions, occlusal registrations, prostheses, etc., according to current infection control standards.  
14 All prostheses and related items which are returned to the dentist should be cleaned and disinfected,  
15 according to current infection control standards, placed in an appropriate container, packed properly to  
16 prevent damage, and transported.
- 17 9. The laboratory/technician should inform the dentist of any subcontracting laboratory/technician employed  
18 for preparation of the case. The laboratory/technician should furnish a written order to the dental laboratory  
19 which has been engaged to perform some or all of the services on the original written instructions.
- 20 10. The laboratory/technician should not bill the patient directly unless permitted by the applicable law. The  
21 laboratory should not discuss or divulge any business arrangements between the dentist and the  
22 laboratory with the patient.

23 **Instructions to Dental Laboratories:** Complete and clearly written instructions foster improved  
24 communication and working relationships between dentists and dental laboratories and can prevent  
25 misunderstanding. State dental practice acts may specify the extent and scope of written instructions that are  
26 provided to dental laboratories for the custom manufacture of dental prostheses. These acts may describe the  
27 written instructions from the dentists to the dental laboratory as a "prescription" while other states refer to the  
28 instructions as a "work authorization" or "laboratory work order." Realizing that terminology in state dental  
29 practice acts differ, constituent dental societies are urged to investigate appropriate terminology for their dental  
30 practice acts regarding the term(s) used to describe the written instructions between a dentist and a dental  
31 laboratory and between dental laboratories for subcontract work, since the term selected may have tax  
32 implications depending on state tax revenue codes.

33 **Identification of Dental Prostheses:** The Association urges members of the dental profession to mark, or  
34 request the dental laboratory to mark, all removable dental prostheses for patient identification. Properly  
35 marked dental prostheses assist in identifying victims in mass disaster, may be useful in police investigations  
36 and help prevent loss of the prostheses in institutional settings.

37 **Shade Selection by Laboratory Personnel:** Selection of the appropriate shade is a critical step in the custom  
38 manufacture of an aesthetically pleasing prosthesis. The Association believes that when a dentist requests the  
39 assistance of the dental laboratory technician in the shade selection process, that assistance on the part of the  
40 dental laboratory technician does not constitute the practice of dentistry, providing the activity is undertaken in  
41 consultation with the dentist and that it complies with the express written instructions of the dentist. The shade  
42 selection site, whether dental office or laboratory (where lawful), should be determined by the professional  
43 judgment of the dentist in the best interest of the patient and where communication between dentist, patient  
44 and technician is enhanced. When taking the shade in the laboratory, the dental technician should follow the  
45 appropriate clinical infection control protocol as outlined in the ADA's infection control guidelines when dealing  
46 with the patient.

47 **Regulation of Laboratories:** The relationship between a dentist and a dental laboratory requires professional  
48 communication and business interaction. The dental laboratory staff may serve as a useful resource, providing  
49 product and technical information that will help the dentist in the overall planning of treatment to meet each  
50 patient's needs. The dental laboratory staff may also consult with the dentist about new materials and their  
51 suggested uses. The Association applauds such cooperative efforts so long as the roles of the parties remain  
52 clear; the dentist must be responsible for the overall treatment of the patient and the dental laboratory is

1 responsible for constructing high quality prosthetic appliances to meet the specifications determined by the  
2 dentist.

3 Some dentists may choose to own or operate a dental laboratory for the custom manufacture of dental  
4 prostheses for their patients or those patients of other dentists. The Association opposes any policy that  
5 prevents, restricts, or precludes dentists from acquiring ownership in dental laboratories.

6 In some states the issue of dental laboratory regulation has been addressed through requirements for  
7 registration, certification, licensure bills and some hybrids thereof. The Association believes the basic tenet of  
8 regulation by any governmental agency is the protection of the public's health and welfare. In the delivery of  
9 dental care, that collective welfare is monitored and protected by state dental boards that have the jurisdictional  
10 power, as legislated under the state dental practice act, to issue licenses to dentists. These boards also have  
11 the power to suspend or revoke such licenses if such action is deemed warranted.

12 For decades, the public health and welfare has proven to be adequately protected under the current system  
13 of dental licensure. The dentist carries the ultimate responsibility for all aspects of the patient's dental care,  
14 including prosthetic treatment. In a free market society, dentists select dental laboratories that provide the best  
15 quality services and prostheses. The Association opposes the creation of additional regulatory boards to  
16 oversee dental care and therefore, opposes any form of governmental regulation or licensure of dental  
17 laboratories not promulgated under the auspices of the state board of dentistry. The Association believes that a  
18 single state board of dentistry in each state is the most effective and cost-efficient means to protect the public's  
19 dental welfare.

#### 20 21 **Notification of Prosthetic Cases Sent to Foreign or Ancillary Domestic Labs for Custom Manufacture:**

22 Constituent dental societies are urged to pursue legislation or voluntary agreements to require that a domestic  
23 dental laboratory which subcontracts the manufacture of dental prostheses notify the dentist in advance when  
24 such prostheses, components or materials indicated in the dentist's prescription are to be manufactured or  
25 provided, either partially or entirely, by a foreign dental laboratory or any domestic ancillary dental laboratory.

#### 26 **Glossary of Terms Relating to Dental Laboratories**

27 **Introduction:** This glossary is designed to assist in developing a common language for discussion of  
28 laboratory issues by dental professionals and public policy makers. Certain terms may also be defined in state  
29 dental practice acts, which may vary from state to state.

30 **Must:** Indicates an imperative need or duty; an essential or indispensable item, mandatory.

31 **Should:** Indicates a suggested way to meet the standard; highly desirable.

32 **May or Could:** Indicates a freedom or liberty to follow suggested alternatives.

33 **Dental Appliance:** A device that is custom manufactured to provide a functional, protective, esthetic and/or  
34 therapeutic effect, usually as a part of oro-facial treatment.

35 **Dental Laboratory:** An entity that engages in the custom manufacture or repair of dental  
36 prostheses/appliances prostheses as directed by the written prescription or work authorization form from a  
37 licensed dentist.

38  
39 **Dental Prosthesis:** An artificial appliance custom manufactured to replace one or more teeth or other oral or  
40 peri-oral structures in order to restore or alter function and aesthetics.

41  
42 **Laboratory Certification:** A form of voluntary self-advancement in which a recognized, nongovernmental  
43 agency verifies that a dental laboratory technician or a dental laboratory has met certain predetermined  
44 qualifications and is granted recognition.

45 **Laboratory Registration:** A form of regulation in which a governmental agency requires a dental laboratory or  
46 dental laboratory technician to meet certain predetermined requirements and also requires registration with the  
47 agency and payment of a fee to conduct business within that jurisdiction.

48 **Laboratory Licensure:** A form of regulation in which a governmental agency, empowered by legislative fiat,  
49 grants permission to a dental laboratory technician or dental laboratory to provide services to dentists following



1 verification of certain educational requirements and a testing or on-site review procedure to ensure that a  
2 minimal degree of competency is attained. This form of regulation requires payment of a licensing fee to  
3 conduct business within a jurisdiction and may mandate continuing education requirements.

4 **Work Authorization/Laboratory Work Order:** Written directions or instructions from a licensed dentist to a  
5 dental laboratory authorizing the construction of a prosthesis. The directions or instructions included often vary  
6 from state to state but typically include: (1) the name and address of the dental laboratory, (2) the name and  
7 identification number, if needed, of the patient, (3) date, (4) a description of the work necessary and a diagram  
8 of the design, if appropriate for the appliance, (5) the specific type of the materials to be used in the  
9 construction of the appliance, (6) identification of materials used and submitted to the laboratory, and (7) the  
10 signature and license number of the requesting dentist. In those states where the term "prescription" is used in  
11 place of the term "work authorization" or "laboratory work order," prescription is defined as written instructions  
12 from a licensed dentist to a dental laboratory authorizing the construction of a prosthesis to be completed and  
13 returned to the dentist.

14 **Recognition Program for Meritorious Service by Certified Dental Technologists (*Trans.1987:496;***  
15 ***1999:922*)**

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16 **Resolved,** that the American Dental Association endorse and support a program, conducted by the state and  
17 local dental societies, recognizing the meritorious service performed by individual Certified Dental  
18 Technologists on appropriate anniversaries of service to the dental profession, as determined by the Council on  
19 Dental Practice.

1 **APPENDIX 2**2 **STATE REGULATION OF DENTAL LABORATORIES AND TECHNICIANS, details**

3 The American Dental Association, Department of State Government Affairs is aware of statutes in six states  
4 that currently require certification or registration of dental technicians and/or dental laboratories under the  
5 dental board or its umbrella licensing agency. Summaries of these statutes follow.

6 **FLORIDA** (1957, amended 1979, 1986, 1989). Florida law requires dental laboratory operators to register  
7 every two years with the Department of Professional Regulation (DPR) and pay a registration fee not to  
8 exceed \$300.00. DPR is empowered to promulgate rules governing dental laboratories, in consultation with  
9 the dental board and industry representatives. Periodic inspection of all dental labs operating in the state is  
10 required. DPR may bring an action to enjoin those who fail to register from continuing to operate. FL Stat.  
11 Ann. sections 466.031, et seq.

12 In 2008 Florida's new law, S 2760, requires that a dental lab located in Florida and registered as required with  
13 the board of dentistry disclose where a dental prosthesis is manufacture and the materials used. Florida is  
14 the first state to require both of these provisions. The owner of a dental lab or at least one employee must  
15 complete 18 hours of continuing education every two years.

16 In 2009, the **Florida** Board of Dentistry adopted a rule that changes the title of the rule to "Prescription  
17 Forms" from Prescription Work Order Forms; adds new language to clarify the original prescription must  
18 be retained in a file by the dental laboratory for a period of four (4) years; provides language detailing  
19 requirements for a registered dental laboratory to perform work for another registered dental laboratory.

20 **Illinois** 225 ILCS 25/48 (a) (1) (c) requires dental labs to provide point of origin and material used list (per  
21 ISDS). A laboratory that doesn't allow the inspection of its prescriptions and orders guilty of a class A  
22 misdemeanor. (225 ILCS 25/48)(e)(4) per NADL.

23  
24 **KENTUCKY** (2010). Prior to an amendment in 2010, every dental laboratory and dental technician were  
25 required to register annually and pay a registration fee established by the Board of Dentistry. This is no longer  
26 required. In 2010 a law was enacted requiring that all commercial labs hire either a licensed dentist or a  
27 certified dental lab technician and that prostheses are to be fabricated pursuant to written orders of the  
28 referring dentist. An advisory commission, composed of dental laboratory owners/managers and technicians,  
29 advises the Board on all matters relating to their regulation.

30 **Minnesota** law section 150A.24 et seq enacted in 2012 that requires all dental laboratories located within  
31 Minnesota to register with the Board of Dentistry every two years. Dentists must use a dental laboratory  
32 registered in Minnesota.

33 Registered dental labs may subcontract fabrication of the dental prosthetic device to another lab that provides  
34 the registered lab with a material content notice and the country of origin of the dental device.

35 All dental technological work must be done pursuant to a "work order" from a dentist. Dental labs must inform  
36 the dentist of the country of origin where the work was performed and a material content notice for each  
37 dental prosthetic device. The dentist must include this information in the patient's record.

38 **OKLAHOMA** (1959, amend 1981). Oklahoma requires all persons, firms, corporations or partnerships that  
39 engage in the dental laboratory business to obtain an operating permit from the board of Governors of  
40 Registered Dentists. The application for a permit must include the name and address of every owner and  
41 operator of the laboratory. The permit is renewable annually. Dentists may, however, own and operate a  
42 private, non-commercial dental lab in their own office for their own use. Okla. Stat. Ann. sections 328.36 and  
43 .37.

1 **Pennsylvania** - The State Board of Dentistry does not regulate dental labs in Pennsylvania. Dental  
2 laboratories which are located within the Commonwealth of Pennsylvania and which are not operating under  
3 the immediate supervision of a licensed dentist must be registered with the Pennsylvania Department of  
4 Health and adhere to requirements under the Pennsylvania Controlled Substance, Drug, Device, and  
5 Cosmetic Act and the Pennsylvania Code of Regulations Title 28, Chapter 25, Controlled Substances, Drug,  
6 Devices, and Cosmetics.

7 **SOUTH CAROLINA** (1946, amended 1986). South Carolina prohibits anyone but a registered dental  
8 technician or a person working under the supervision of a registered technician or a licensed dentist from  
9 performing dental technological work. The Board of Dentistry is responsible for regulation of dental  
10 technicians. Requirements for registration are:

11 1) Evidence of a good moral character;

12 2) A high school diploma or its equivalent;

13 3) Successful completion of a two-year course of study in dental technology at a Board-approved school or  
14 three years experience performing dental technological work under the direct supervision of a registered  
15 technician or a licensed dentist;

16 4) Successful completion of an examination administered by the Board; and

17 5) Evidence that the applicant has not violated the practice laws of any other jurisdiction where he or she is  
18 licensed or certified. S.C. Code Ann. section 40-15-120, et seq.

19 In 2008 the South Carolina Dental Association was successful in convincing the legislature to overwhelmingly  
20 override the governor's veto of the SCDA's dental lab bill, H 3906. The new law requires that dental labs  
21 inform the prescribing dentist the name of the country of origin in which any part of the dental prostheses was  
22 manufactured and a list of the materials used, by percentage of ingredients. The new law also requires that  
23 the employee of the dental lab authorizing the work be registered with the SC state board of dentistry.

24 **TEXAS** (1973, amended 1981, 1987, 2004). Owners or managers of dental laboratories must register their  
25 laboratories and each dental technician they employ with the Board of Dental Examiners on an annual basis.  
26 The dental board is assisted by a Dental Laboratory Certification Council in evaluating the eligibility of  
27 applicants for registration.

28 Applications for a certificate of registration must include proof that at least one technician working on the  
29 premises is certified by a nationally-recognized board. Applications for renewal of registration must provide  
30 evidence that at least one employee has completed a minimum of 12 hours of continuing education during  
31 the preceding 12 months, but the dental board will accept evidence that one employee is currently certified as  
32 a dental technician in lieu of continuing education.

33 Fees are set by the Board. Lapsed certificates may be renewed anytime within two years upon payment of  
34 all fees and penalties. After two years, a lapsed certificate can only be reinstated by complying with the  
35 requirements for obtaining the original certificate.

36 Only registered dental laboratories and technicians may fill prescriptions for the preparation or repair of dental  
37 prosthetic appliances. Dentists who perform laboratory services are exempt from the requirements of the act.  
38 Dentists who knowingly deal with an unregistered laboratory are subject to sanctions. Tex. Stat. Ann. Title 3,  
39 subtitle D, chapter 266, section 266.001; Title 22, Part 5, Chapter 116 of the Texas Administrative Code.

40 In 2009, the Texas State Board of Dental Examiners adopted a rule that requires a Texas registered dental  
41 laboratory to certify in writing to the prescribing dentist that the prosthesis was either:

42 (1) Manufactured entirely by a dental laboratory registered with the Texas State Board of Dental

1           Examiners;

2           (2) Manufactured in part or whole by a domestic laboratory inside of the United States; or,

3           (3) Manufactured in part or whole by a foreign laboratory outside of the United States.

4 Virginia - VA Code 54.1-2719 (D) allows for inspection of dental labs (per NADL)

5 Please note that this summary of state regulations pertaining to dental laboratories and technicians is offered  
6 as information only and not as practice, financial, accounting, legal or other professional advice. Readers  
7 need to consult their own professional advisors for such advice.

8 ADA Policy – excerpt regarding state regulation of dental laboratories.

9 Statement on Prosthetic Care and Dental Laboratories (Trans.1990:543; 1995:623; 1999:933; 2000:454;  
10 2003:365; 2005:327; 2007:430)

11 In some states the issue of dental laboratory regulation has been addressed through requirements for  
12 registration, certification, licensure bills and some hybrids thereof. The Association believes the basic tenet of  
13 regulation by any governmental agency is the protection of the public's health and welfare. In the delivery of  
14 dental care, that collective welfare is monitored and protected by state dental boards that have the  
15 jurisdictional power, as legislated under the state dental practice act, to issue licenses to dentists. These  
16 boards also have the power to suspend or revoke such licenses if such action is deemed warranted.

17 For decades, the public health and welfare has proven to be adequately protected under the current system  
18 of dental licensure. The dentist carries the ultimate responsibility for all aspects of the patient's dental care,  
19 including prosthetic treatment. In a free market society, dentists select dental laboratories that provide the  
20 best quality services and prostheses. The Association opposes the creation of additional regulatory boards to  
21 oversee dental care and therefore, opposes any form of governmental regulation or licensure of dental  
22 laboratories not promulgated under the auspices of the state board of dentistry.

Resolution No. 90 New

Report: NA Date Submitted: October 2013

Submitted By: Fifth Trustee District

Reference Committee: 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 Goal: Financial (Required)

1 **SALE OF DENTAL EQUIPMENT TO ILLEGAL PRACTITIONERS**

2 The following resolution was submitted by the Fifth Trustee District on October 16, 2013, and transmitted  
3 by Dr. Mark Donald, Chairman of the Fifth Trustee District.

4 **Background:** Each year many patients are harmed by individuals illegally practicing dentistry without a  
5 license. These unlicensed individuals purchase dental equipment and supplies and proceed to treat  
6 patients in garages, warehouses, and other unsanitary environments. Often the procedures performed by  
7 these individuals leave patients with infections and permanent bodily injuries. To help ensure the safety  
8 and wellbeing of all patients, dental equipment and supplies should only be available for purchase to  
9 licensed health care providers who are permitted by law to perform dental treatment. The only reason  
10 that one would purchase dental equipment and supplies is to provide dental treatment. Therefore, an  
11 appropriate approach to ensuring the safety of patients is to require those purchasing such equipment  
12 and supplies to validate that they are a licensed health care provider who is legally permitted to provide  
13 dental care to patients.

14 **Resolution**

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17 **90. Resolved,** that for the safety and welfare of people receiving dental care, the ADA  
18 encourages dental equipment manufacturers and suppliers, to the extent legally acceptable, to  
19 develop and implement guidelines which ensure that the sale, transfer or conveyance of new and  
20 used dental equipment and supplies (except "over the counter" consumer care products) is made  
21 to licensed and legally practicing health care providers, and be it further

22  
23 **Resolved,** that the guidelines include a mechanism by which manufacturers or suppliers can  
24 verify that the purchaser is a bona fide dental clinic or a licensed health care provider that legally  
25 is permitted to provide dental care in the state where the products will be delivered, and be it  
26 further

27  
28 **Resolved,** that the guidelines also include a requirement that contracts, purchase orders, and  
29 invoices used to sell, transfer or convey dental equipment and supplies require purchasers  
30 intending to use the equipment or supplies to provide dental care to include their professional  
31 license number, and be it further

32  
33 **Resolved,** that in the case of as yet unlicensed dental students or recent graduates, the  
34 guidelines allow for the sale, transfer or conveyance of dental equipment and supplies, provided  
35 that the student or recent graduate supplies verification of current attendance in or graduation

1 from an accredited dental school or other graduate program after which the student would be  
2 eligible to provide dental care, and be it further

3 **Resolved**, that the policy, "Sale of Dental Equipment to Illegal Practitioners" (*Trans.*2001:436), be  
4 rescinded.

5

6 **BOARD RECOMMENDATION: Received after the October Board of Trustees session.**

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Resolution 90

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WORKSHEET ADDENDUM  
FIFTH TRUSTEE DISTRICT  
POLICY TO BE RESCINDED

**Sale of Dental Equipment to Illegal Practitioners**

**Resolved**, that the ADA strongly urges dental equipment manufacturers and suppliers to develop and implement guidelines which preclude the sale, transfer or conveyance of new and used dental equipment and supplies (except “over the counter” consumer care products) to illegal practitioners of dentistry, and be it further

**Resolved**, that the guidelines include the requirement that before manufacturers or suppliers sell, transfer or convey dental equipment and supplies to persons they believe plan to use the products in the practice of dentistry, the manufacturers and suppliers first verify that the purchaser is licensed to practice dentistry in the state where the products will be delivered, and be it further

**Resolved**, that the guidelines also include a requirement that contracts, purchase orders, and invoices used to sell, transfer or convey dental equipment and supplies require purchasers intending to use the equipment or supplies to provide dental care to include their dental license number, and be it further

**Resolved**, that in the case of as yet unlicensed dental students or recent graduates, the guidelines allow for the sale, transfer or conveyance of dental equipment and supplies, provided that the student or recent graduate supplies verification of current attendance in or graduation from an accredited dental school.