2010

2010 Supplement Vol. 4

American Dental Association

ADA American Dental Association®

America's leading advocate for oral health

2010

Supplement to
Annual Reports and Resolutions
Volume 4

151st Annual Session

Orlando, Florida

October 9–13, 2010

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Legal, Legislative and Public Affairs Matters

Resolution No. 8-2009 New ☐ Substitute ☐ Amendment ☐

Report: NA Date Submitted: July 2010

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

EDITORIAL CHANGES TO THE ADA *CONSTITUTION*

Background: (*Reports* 2009:101)

Editorial Changes to the ADA *Constitution*: In conducting its review, the subcommittee further noted instances in the ADA *Constitution* where editorial revisions could be made to improve the syntax and readability of the document and render the *Constitution* more consistent in style to the ADA *Bylaws*. The full Council approved by unanimous vote the subcommittee-recommended revisions in the ADA *Constitution*. Accordingly, the following resolutions are introduced to the 2009 House of Delegates for consideration. According to the ADA *Constitution*, constitutional amendments proposed must lay over for one year or be approved by unanimous vote after having been considered at a previous meeting during the same session of the House of Delegates.

Resolution

8-2009. Resolved, that the ADA *Constitution* be amended by incorporating the changes indicated below (deletions stricken through):

ARTICLE III • ORGANIZATION

Section 50. CONSTITUENT SOCIETIES: Constituent societies of this Association shall be those dental societies or dental associations chartered ~~as such~~ in conformity with Chapter II of the *Bylaws.*

Section 60. COMPONENT SOCIETIES: Component societies of this Association shall be those dental societies or dental associations organized ~~as such~~ in conformity with Chapter III of the *Bylaws* of this Association and in conformity with the bylaws of their respective constituent societies.

Section 70. TRUSTEE DISTRICTS: The constituent societies of the Association and the federal dental services shall be grouped into seventeen (17) trustee districts~~, as provided in Chapter IV of the *Bylaws*~~.

ARTICLE IV • GOVERNMENT

Section 10. LEGISLATIVE BODY: The legislative and governing body of this Association shall be a House of Delegates which may be referred to as "the House" or "this House~~," as provided in Chapter V of the *Bylaws*~~."

Section 20. ADMINISTRATIVE BODY: The administrative body of this Association shall be a Board of Trustees, which may be referred to as "the Board" or "this Board~~" as provided in Chapter VII of the *Bylaws*~~."

ARTICLE V • OFFICERS

Section 10. ELECTIVE OFFICERS: The elective officers of this Association shall be a President, a President-elect, a First Vice President, a Second Vice President, a Treasurer and a Speaker of the House of Delegates, each of whom shall be elected by the House of Delegates ~~as provided in Chapter VIII of the *Bylaws*~~.

Section 20. APPOINTIVE OFFICER: The appointive officer of this Association shall be an Executive Director who shall be appointed by the Board of Trustees ~~as provided in Chapter IX of the *Bylaws*~~.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 15 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: July 2010

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Attain Excellence in Operations (Required)

PROCESS TO ADDRESS VIOLATIONS BY CANDIDATES FOR ELECTIVE OR APPOINTIVE OFFICE AND CURRENT ADA ELECTIVE AND APPOINTIVE OFFICERS

Background: *(Reports:*123*)*

Process to Address Violations by Candidates for Elective or Appointive Office and Current ADA Elective and Appointive Officers: The Council conducted a critical review of the governance issues addressed by these referred resolutions. Among the information reviewed was an overview of candidate credentialing procedures, procedures for nominating candidates and examining their eligibility from the floor of the House of Delegates, the legal definition of "due process" and the concepts of "for cause," "without cause," "fiduciary duty" and "duty of loyalty." The Council also discussed the fundamental question of whether the Council was the appropriate entity to develop candidate qualification or selection procedures. The meaning of attorney-client privilege, its importance to the ADA and the potential consequences flowing from a breach of such privilege were addressed and clarified.

During its deliberations, the Council determined that it would be more appropriate to use the word "discipline" rather than "sanction" since, as indicated in *Bylaws* Chapter XII, the word "discipline" is the customary language of the Association. With respect to general topics considered, the Council concluded as follows:

Candidate Review. The Council concluded that it would be appropriate to specify that one of the qualifications for elective or appointive office should be that a candidate must not be under active discipline for violating duties owed to the Association or to the constituent society within whose jurisdiction the candidate practices. It was noted that procedures would need to be in place to coordinate the reporting of constituent society discipline for this purpose. The Council further noted that, in the case of a member announcing his/her candidacy for elective office from the floor of the House, any alleged discipline would need to be disclosed during debate.

After considerable debate and consideration, the Council originally decided that the duties of the Committee on Credentials, Rules and Order (CCRO), currently responsible for reviewing the eligibility of a candidate for delegate or alternate delegate positions, should be expanded to include reviewing candidates for all elective or appointive Association offices or positions. Thereafter, the Council was contacted by the Speaker of the House of Delegates, who expressed reservations concerning the CCRO assuming that responsibility given that it is a body with parliamentary responsibilities. After conferring with the Speaker through the Council chair, the Council agreed to revise its recommendation to suggest that the Election Commission conduct the contemplated candidate review. The Election Commission would not be required to investigate allegations or conduct hearings, but would review a candidate's disciplinary record to verify whether he/she is under active

discipline, and, if so, rule the candidate ineligible. The Election Commission would also need to be available to conduct those reviews throughout the year rather than just 60 days prior to annual session.*

A flow chart, attached as Appendix 1, depicts in graphical form the Council's recommended steps in the candidate review process.

Hearing Entity. The Council began deliberations on the question of a system for addressing the issue of disciplining a current holder of an elected or appointed office or position by considering what person or agency of the Association would be appropriate for conducting hearings on allegations of impropriety. The Council determined that, because the resolutions under consideration each call for the potential imposition of discipline, it is imperative that the entity or entities charged with deciding whether such discipline is warranted be capable of addressing pertinent issues in a fair, impartial and judicious manner and should have knowledge or experience in processes employed in making such determinations.

The Council was unanimous in its support of its subcommittee's recommendation that the Council itself was the appropriate ADA agency to conduct hearings of allegations that Association delegates or elected or appointed office or position holders have violated duties owed to the Association (including alleged breaches of the attorney-client privilege and/or improperly divulging ADA confidential information). The Council based this determination on its responsibility under the ADA *Bylaws*, as set forth in Chapter XII, Section 20A, for hearing appeals arising from decisions of constituent societies and the Council's extensive experience in conducting those hearings. It was further agreed that all members of the Council should sit on the hearing panel with the exception of any member from the trustee district or districts of the delegate or office or position holder involved.

Hearing Procedure. A flow chart, attached as Appendix 2, illustrates the sequence and steps the Council recommends should comprise a judicial hearing process. Under the proposed process, 1) charges are submitted to Council director, 2) the Council conducts hearing and renders a decision, to include whether a violation has occurred and what type of discipline, if any, is warranted, and 4) Council reports its determinations to the Election Commission.

While the Council deliberated at length on whether it would be necessary for the Council to investigate the merits of a charge prior to convening a hearing, it determined that such a procedure should not be adopted in light of the time and expense such a procedure would involve. Moreover, given the nature of the alleged misconduct that would be subject to a hearing, the Council believes that a full and complete understanding of the events involved can be arrived at by reading submissions from the complaining party and accused and the opportunity to question the parties at a hearing. During the hearing, the Council would serve in an adjudicatory capacity and the Legal Division would appoint an attorney (from within or outside the Association) to serve in a prosecutorial role. Depending on the circumstances of the case and its impact on the Association's ability to function without interruption, the Council could convene to conduct a disciplinary hearing at times other than its regularly scheduled meetings.

The Council also debated whether the Executive Director should be subject to the outlined disciplinary process. The Council concluded that the Executive Director should not be included as the power to appoint

* The Election Commission would not, however, have any role in any review of candidates for the appointive office of Executive Director, as that responsibility for appointments for that office rests with the Board of Trustees pursuant to Chapter IX, Section 20 of the *Bylaws*.

(and thus inherently to remove) the Executive Director is vested in the Board of Trustees under Chapter IX, Section 20 of the ADA *Bylaws*.*

Opportunity for Appeal. The Council considered the advisability of incorporating an appeal to the House of Delegates into the proposed hearing process. The Council expressed concern that having the House of Delegates as a whole consider appeals would be impractical and that even if a smaller ad hoc committee of the House of Delegates were formed for this purpose, such an appeals process would present practical difficulties associated with, among other things, transmitting case records to each member, protecting against the inadvertent disclosure of confidential information, filtering out political considerations and the considerable financial costs involved in coordinating the deliberation of an appeal. Bearing these issues in mind, the Council felt it appropriate that the judicial decisions made by the Council should be considered final.

Disciplinary Penalties. The Council also discussed the need to list with specificity the offenses that could warrant the imposition of discipline. It was felt that any list would be unlikely to cover every possible situation but that it would be appropriate to provide examples of offenses within the official judicial procedures. Attached as Appendix 3 is a list of potential grounds for the imposition of discipline as adapted from the *Standing Rules for Councils and Commissions* as requested in the original resolution from the House of Delegates. The Council also addressed the impact of disciplinary penalties that do not have specific end dates or are simply a matter of record such as letters of reprimand, censure and stayed suspensions, on a member's qualifications to hold elective or appointive office. The Council concurred that the definition of each type of discipline would have to be carefully crafted, mindful of the possible consequences to a member's ability to qualify as a candidate for office. Council members also agreed that all hearings and decisions would have to be made public and reported to the Election Commission so that those responsible for making appointments and for judging the qualifications for elective or appointive would have access to this information.

Recommendation. Based upon the discussions and deliberations of the Council and its subcommittee respecting the matters raised by Resolutions 67, 67RC, 68, 70 and 70RC as summarized in this report, the Council recommends the adoption of the following resolution:

Resolution

15. Resolved, that anyone identified by the Election Commission to be under active discipline for violating his or her duties to the constituent society within whose jurisdiction the member practices or of this Association shall be disqualified from seeking elective or appointive office while under that active discipline, and be it further

Resolved, that any member holding an elective or appointive position, but excluding the Executive Director, charged with violating his or her fiduciary or legal duties to the Association shall be afforded a fair and impartial hearing conducted according to existing judicial procedures of the Council on Ethics, Bylaws and Judicial Affairs. The Council on Ethics, Bylaws and Judicial Affairs shall be the disciplinary body whose actions shall be final and not appealable, and may include, but are not limited to: censure, suspension, probation or expulsion, and be it further

Resolved, that the final results of such hearing process shall be a public record and shall be reported to the Election Commission, and be it further

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* The Council also noted that the Board of Trustees can request that the Council review any allegations of wrongdoing made against the Executive Director, and report in an advisory capacity to the Board with its findings.

Resolved, that the appropriate amendments the ADA *Bylaws* to effectuate the matters set forth in this resolution shall be prepared by the Council on Ethics, Bylaws and Judicial Affairs and submitted to the 2011 House of Delegates, and be it further

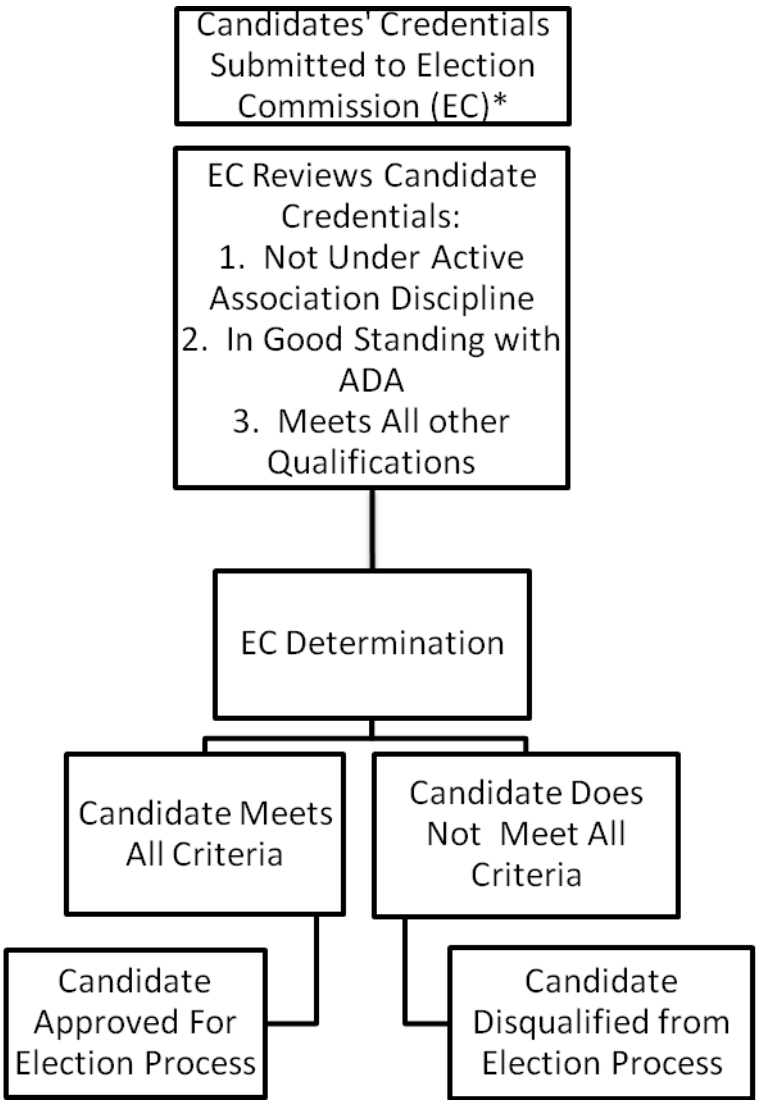
Resolved, that the financial implications, if any, of this resolution shall be investigated by the Council on Ethics, Bylaws and Judicial Affairs and reported to the 2011 House of Delegates with the suggested *Bylaws* revisions.

BOARD RECOMMENDATION: Vote Yes.

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

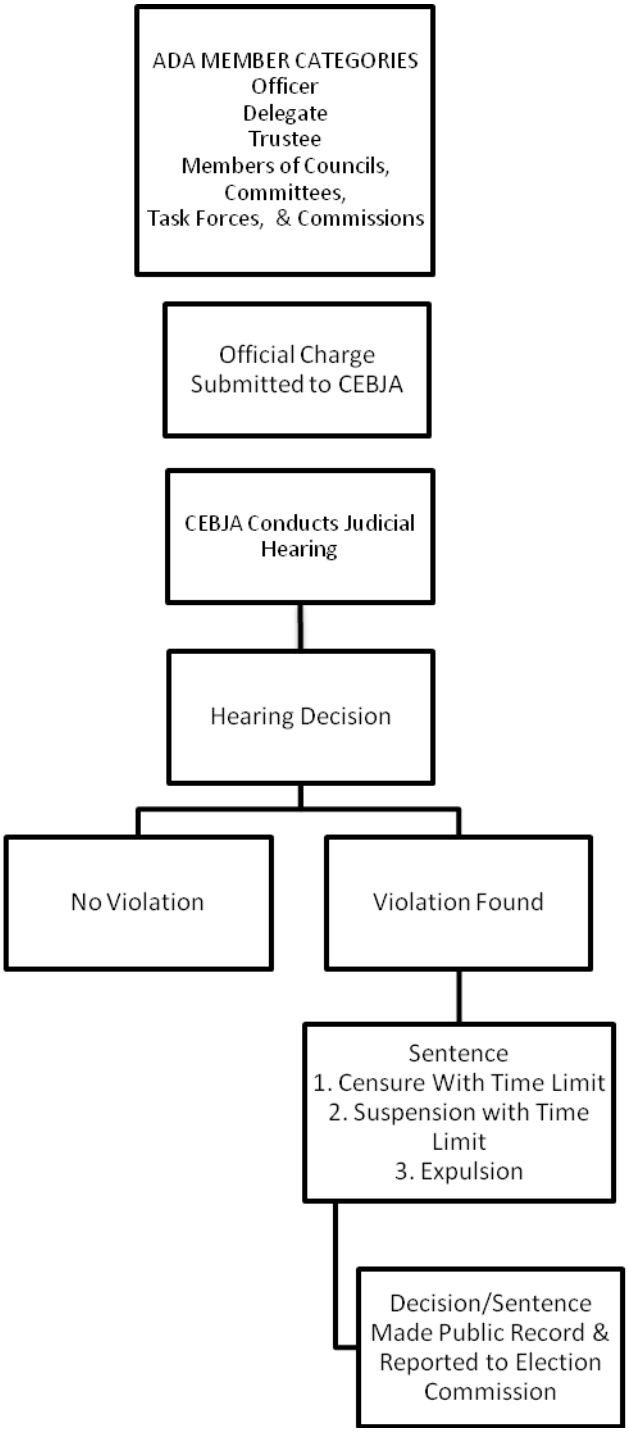
Appendix 1

Candidate Credential Review
Election of Officers, Delegates & Alternate Delegates



Appendix 2

Violations of Fiduciary Responsibility – Hearing Process



Appendix 3

Potential Grounds for Discipline or Removal from Office*

1. Continued, gross or willful neglect of the duties of the office.

2. Breach of fiduciary duty to the American Dental Association, its subsidiaries or related entities (collectively "Association"), including:

    a. Failure to comply with the Association's policies on conflict of interest or otherwise to act in the best interests of the Association, uninfluenced by personal or other considerations
    b. Failure or refusal to disclose necessary information on matters of Association business
    c. Failure to keep confidential any exclusive information of the Association protected by secrecy, including confidential information and information subject to the attorney-client privilege
    d. Failure to act in a fiscally responsible matter, including making unauthorized expenditures or misusing Association funds
    e. Failure to actively participate in meetings or adequately inform one's self of all reasonably available information necessary to make decisions in the best interests of the Association
    f. Failure to act in a manner reasonably calculated to protect the Association from violation of the law
    g. Failure to carry out directives of the House of Delegates or its policies

3. Failure to comply with the Association's Professional Conduct Policy and Prohibition Against Harassment.

4. Unwarranted attacks on the Association, any of its agencies or any person serving the Association in an elected, appointed or employed capacity.

5. Unwarranted refusal to cooperate with any officer, trustee, or council/commission member or staff.

6. Misrepresentation of the Association and any person serving the Association in an elected, appointed or employed capacity to outside persons.

7. Being found to have engaged in conduct subject to discipline pursuant to Chapter XII of the *Bylaws.*

8. Conviction of a felony.

* Adapted from the Standing Rules for Councils and Commissions.

Resolution No. 16 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: July 2010

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Attain Excellence in Operations (Required)

ADA MEMBER CONDUCT POLICY

Background: *(Reports:*125*)*

Member Code of Conduct: By referral of Resolution 82-2009, the Council was asked to develop a Member Code of Conduct, including investigation and enforcement procedures, using the principles outlined in the resolution as a guide. The Council members present during the discussion of the resolution at the House briefed the Council on the intent behind the proposed Member Code of Conduct and advised that the Member Code of Conduct is intended to serve as a guide for members of the Association in their interactions with other dentists, dentist members, and Association officers, trustees and staff that occur in the course of conducting the business of the Association. The Council is also cognizant that any procedures that are developed and adopted by the Association on this topic may serve as a template for the development of similar processes by constituent and component societies.

The Council considered suggesting that a Member Code of Conduct be appended to the ADA *Code* so that members would have a single reference source for their ethical and professional duties and obligations. However, since the strength of the ADA *Code* is its focus on the dentist-patient relationship resulting from the clinical practice of dentistry the Council believes this distinctive focus of the ADA *Code* should be maintained.

In addition, the Council discussed the possibility that confusion would result between the ADA *Code* and an intra-Association conduct code if the latter were called a “code,” and determined that such confusion would be a distinct possibility. To guard against possible confusion, the Council recommends that the word “Code” be removed from the title and that the title be revised to “ADA Member Conduct Policy.”

The Council recommends that the judicial procedures described in the ADA *Bylaws*, Chapter XII, Section 20C should be used to enforce the proposed policy. Section 20A of the same chapter, detailing conduct subject to discipline, should also be amended to include violations of the proposed conduct policy.

The Council agreed that such a policy merits consideration. It used the template provided in Resolution 82-2009 to formulate language, revised the sentence structure to adhere to phrasing commonly used in professional conduct documents, and proposes the following specific changes to the ADA Member Code of Conduct put forth in House Resolution 82-2009 (additions underlined; deletions stricken):

ADA Member ~~Code of~~ Conduct Policy

~~Members will maintain high standards of integrity and conduct their dealings as members of the Association in a professional manner.~~

1. Members should communicate respectfully in all interactions with ~~will treat~~ other members and Association officers, trustees and staff. ~~with courtesy and respect, and shall refrain from conduct that is unreasonably disruptive or is harassing.~~

2. Members ~~will~~ should respect the decisions and polices of the Association and ~~will~~ must not engage in ~~conduct that is~~ disruptive ~~to~~ behavior in interactions with other members, Association officers, trustees, or staff. ~~or causes the Association to expend an unreasonable amount of time or effort to address.~~

3. Members have an obligation to be informed about and use ~~are encouraged to use proper~~ Association policies for ~~channels of~~ communication and dispute resolution.~~to address differences.~~

4. Members ~~will~~ must comply with all applicable laws and regulations, including but not limited to antitrust laws and regulations.

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

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

   ~~Members will not use all or part of Association lists, including membership directory, online member listings, conference attendees, and education course participants for selling, prospecting or creating a directory or database~~.

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

8. Members must not violate the confidentiality of attorney-client sessions conducted within the Association's tripartite. Members ~~will~~ must make every effort to avoid conflicts of interest and the appearance of conflicts of interest.

Recommendation. Based on its consideration of Resolution 82-2009, the Council recommends adoption the following resolution:

Resolution

16. Resolved, that the ADA Member Conduct Policy set forth below be adopted as policy of the Association, effective at the close of the 2011 House of Delegates:

ADA Member Conduct Policy

1. Members should communicate respectfully in all interactions with other dentists, dentist members, Association officers, trustees and staff.

2. Members should respect the decisions and policies of the Association and must not engage in disruptive behavior in interactions with other members, Association officers, trustees, or staff.

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

4. Members must comply with all applicable laws and regulations, including but not limited to antitrust laws and regulations.

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

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

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

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

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

and be it further

Resolved, that this resolution be referred to the Council on Ethics, Bylaws and Judicial Affairs for the purpose of developing an enforcement procedure for the ADA Member Conduct Policy by modifying the judicial procedures described in Chapter XII, Section 20C of the ADA *Bylaws* as appropriate to harmonize with ADA Member Conduct Policy, and be it further

Resolved, that the resulting enforcement procedures for the ADA Member Code of Conduct be presented for consideration to the 2011 House of Delegates.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 17 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: July 2010

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Attain Excellence in Operations (Required)

AMENDMENT OF THE ADA *BYLAWS* REGARDING TERM OF DELEGATES AND ALTERNATE DELEGATES

Background: *(Reports:*127*)*

Tenure of the House of Delegates: In its referral of Resolution 102H-2009 (*Trans.*2009:494), the House of Delegates requested the Council to evaluate a proposed delineation of the tenure of members of the House of Delegates. The Council agreed that there is a need to address this issue and concurs with the intent of the resolution in its attempt to clarify the point at which delegates' duties and rights to confidential business and financial information between sessions of the House commence and conclude. In its deliberations, the Council recognized that the schedules used by constituent societies to select delegates and alternate delegates vary from state to state and contribute to the difficulty of defining specific tenure. As a consequence, the Council extensively discussed a number of possible options and their impact on the constituent societies' current procedures, including alternative tenure cycles, requiring every state society to utilize identical calendars for selecting delegates and alternate delegates, and the creation of a delegate-elect position.

As a result of its deliberations, the Council believes it appropriate that the term of a delegate or alternate delegate commence when such delegate or alternate delegate is certified and that such term run until a duly elected or appointed replacement delegate or alternate delegate is certified by the Association. To effectuate that recommendation, Chapter V, Section 10 of the ADA *Bylaws* should be amended by addition to define delegate tenure and Chapter V, Section 60 of the ADA *Bylaws* should be amended so that references to members of the House of Delegates are consistent with the proposed amendments to Section 10G. The Council recommends adoption of the following resolution:

Resolution

17. Resolved, that the ADA *Bylaws,* Chapter V, be amended to include a Section 10G, which shall read as follows (new language underscored):

> <u>G. TERM OF DELEGATES AND ALTERNATE DELEGATES. The term of a delegate or alternate delegate elected or selected pursuant to Section 20 of this Chapter commences from the time such delegate or alternate delegate is certified pursuant to Section 30 of this Chapter until another delegate or alternate delegate elected or selected in place of such delegate or alternate delegate is so certified.</u>

and be it further

Resolved, that the ADA *Bylaws,* Chapter V, Section 60 be amended as follows (new language underscored, deleted language stricken).

Section 60. TRANSFER OF POWERS AND DUTIES OF THE HOUSE OF DELEGATES: The powers and duties of the House of Delegates, except the power to amend, enact and repeal the *Constitution and Bylaws,* and the duty of electing the elective officers and the members of the Board of Trustees, may be transferred to the Board of Trustees of this Association in time of extraordinary emergency. The existence of a time of extraordinary emergency may be determined by unanimous consent of the members of the Board of Trustees present and voting at a regular or special session. Such extraordinary emergency may also be determined by mail vote of the last House of Delegates on recommendation of at least four (4) of the elective officers. A mail vote to be valid shall consist of ballots received from not less than one-fourth (1/4) of the current members of the ~~last~~ House of Delegates. A majority of the votes cast within thirty (30) days after the mailing of the ballot shall decide the vote.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 18 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: July 2010

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Attain Excellence in Operations (Required)

AMENDMENTS OF THE ADA *BYLAWS*—ADDITION OF AMERICAN STUDENT DENTAL ASSOCIATION DELEGATES IN DETERMINING A QUORUM OF THE HOUSE OF DELEGATES

Background: *(Reports:*129*)*

Addition of American Student Dental Association (ASDA) Delegates in Determining a Quorum: During the Council's discussions and consideration of Resolution 15-2009 referred by the House of Delegates, it was noted that the ASDA delegation of five delegates specified in Chapter V. HOUSE OF DELEGATES, Section 10. COMPOSITION, A. VOTING MEMBERS and D. DELEGATE ALLOCATION are not included in the calculation of a quorum set forth in Chapter V. HOUSE OF DELEGATES, Section 100. QUORUM. The Council believes that this apparent discrepancy should be rectified by an amendment to the ADA *Bylaws* and that the ASDA delegation should be included as a part of the calculation of a quorum of the House of Delegates, just as are the delegates from the constituent societies and the federal dental services. Therefore, the Council recommends adoption of the following resolution:

Resolution

18. Resolved, that ADA *Bylaws* Chapter V. HOUSE OF DELEGATES, Section 100. QUORUM, be amended by the addition by the addition of the following language (additions underscored):

Section 100. QUORUM: One-fourth (1/4) of the voting members of the House of Delegates, representing at least one-fourth (1/4) of the constituent societies, the American Student Dental Association and the federal dental services, shall constitute a quorum for the transaction of business at any meeting.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 19 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: July 2010

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Attain Excellence in Operations (Required)

AMENDMENT OF THE *ADA PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL C*ONDUCT-SECTION 3.F. PROFESSIONAL DEMEANOR IN THE WORKPLACE

Background: *(Reports:*130*)*

Proposed ADA *Code* Addition Section 3.F. Professional Demeanor in the Workplace: In response to a recent report from The Joint Commission, the Council investigated the issue of intimidating and disruptive behavior among health care professionals, particularly with respect to the potential effect that such behavior may have upon the care received by patients. The Council, in considering the report of a subcommittee convened to investigate the issue, felt strongly that instances of intimidating, disruptive and/or abusive behavior in the workplace could negatively affect care given patients by dental professionals. Consequently, the Council adopted the recommendation of the subcommittee that the ADA Code be amended by addition to include a section setting forth the obligation to provide a workplace environment conducive to providing professional care to patients, and recommends adoption of the following resolution:

Resolution

19. Resolved, that the ADA *Principles of Ethics and Code of Professional Conduct* be amended by the addition of the following code section, 3.F. Professional Demeanor in the Workplace (additions underlined):

> 3.F. PROFESSIONAL DEMEANOR IN THE WORKPLACE.
> Dentists have the obligation to provide a workplace environment that supports respectful and collaborative relationships for all those involved in oral health care.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 20 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: July 2010

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Attain Excellence in Operations (Required)

ADA CURRENT POLICY REVIEW

Background: *(Reports:*130*)*

ADA Current Policy Review: As required by Resolution 15H-1995 (*Trans.*1995:660), a subcommittee of the Council was charged with review of the *Current Policies* to identify those policies that impact the Council's duties under the ADA *Bylaws*. In reporting to the Council on that undertaking, the subcommittee reported that the task was found to be quite cumbersome in that the *Current Policies* contain policy statements in language that is outdated or no longer accurate. It was reported to the Council that numerous policy statements were found that had seemingly outlived their relevance or value. Finally, the report indicated that the process of merely identifying the policies relevant to the Council was unnecessarily tedious because there are no official indicators of which agency is responsible for each policy. As a result of the report, the Council deliberated on an approach that would keep ADA *Current Policies* relevant and consistently stated. As a result, the Council recommends the adoption of the following resolution to achieve that goal:

Resolution

20. Resolved, that the Association Board of Trustees appoint a task force charged with reviewing ADA *Current Policies* and, after consulting with Association councils, commissions and committees, or appropriate ADA entity assign each existing policy to a council, commission or committee or appropriate ADA entity for purposes of conducting periodic reviews of Association policies, and be it further

Resolved, that the task force report back to the Board of Trustees on the policy assignments, and be it further

Resolved, that each council, commission and committee or appropriate ADA entity to which a policy or policies are assigned by the task force review all policies assigned to it and determine if each policy should remain unchanged, be revised or rescinded or new policy submitted in resolution form to the House of Delegates, and be it further

Resolved, that each council, commission and committee or appropriate ADA entity to which a policy or policies are assigned by the task force report back to the Board of Trustees on its review of policies to it by June 2011, and be it further

Resolved, that any new Association policy proposed to the House of Delegates include a designation of the council, commission or committee or ADA entity responsible for the periodic review of that policy, and be it further

Resolved, that Resolution 15H-1995 be amended as follows (insertions underlined and deletions stricken):

Resolved, that commencing as of June 2011, each council, commission and committee or appropriate ADA entity of the Association review all policies assigned to it at least as often as every ~~seven~~ three years ~~after the adoption of a policy, that policy shall be reviewed by the appropriate ADA agency;~~ if ~~modification~~ revision or rescission is suggested, it shall be submitted to the House of Delegates for action.

so that the amended Resolution 15H-1995 reads as follows:

Resolved, that commencing as of June 2011, each council, commission and committee or appropriate ADA entity of the Association review all policies assigned to it at least as often as every three years; if revision or rescission is suggested, it shall be submitted to the House of Delegates for action.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 21 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: July 2010

Submitted By: Council on Government Affairs

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication:

Amount One-time Amount On-going $380,000

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

ADDITIONAL FEDERAL ADVOCACY RESOURCES

Background: *(Reports:*146*)*

Additional Federal Advocacy Resources: The implementation of the recently enacted health care reform law presents a series of potential opportunities and threats on a range of issues pertaining to oral health. A host of federal agencies within the Department of Health and Human Services will be developing regulations in the coming years to fully implement the law, and the next Congress may enact additional laws that alter the current law. While the Council on Government Affairs, ADA Washington staff and current outside consultants have done a very good job advocating on all the federal legislative and regulatory issues facing dentists and patients, the Council believes that the implementation of hundreds of provisions in the new health care reform law will require additional outside resources to maximize the ADA's ability to advocate on behalf of the profession.

The ADA currently contracts with three outside lobbying firms, and although they have assisted the ADA with regulatory issues and federal agency interactions, their primary purpose is to supplement the ADA lobbying staff in achieving legislative advocacy success. The Division has no budget for opinion research or advocacy advertising (either inside-the-Beltway or in congressional districts), and these and other tactics must become routine elements of the ADA's advocacy activities if the ADA is to remain effective in Washington, DC. While it is not expected that each activity will require funding each year, some mix of these tactics must be employed each year. Through the ADA's very successful State Public Affairs program, the ADA provides grants to state dental associations so that they can enlist the necessary outside lobbying and public affairs resources to be successful advocates for the profession with their state governments. This resolution seeks to assure that the ADA has access to the same resources at the federal level.

To provide some background on costs, the requested funding is based upon the following estimates: that an additional lobbying firm, with particular expertise in working with the federal agencies that are charged with implementing the new health care reform law, could cost $15,000 a month, opinion research on an issue can cost up to $100,000 (four focus groups and a nationwide poll) and full-page ads in Capitol Hill publications (such as Roll Call, The Hill and Politico) cost approximately $10,000 per day. Creative costs for an ad cost approximately $10,000.

The following resolution is presented for the House of Delegates' consideration:

Resolution

21. Resolved, that the ADA Division of Government and Public Affairs engage the services of at least one additional outside lobbying firm with particular expertise in working with the federal agencies that are charged with implementing the new health care reform law, and be it further

Resolved, that the Division be provided with $380,000 to conduct public opinion research, to run advocacy advertisements in Capitol Hill publications and to employ other related tactics in support of ADA federal advocacy goals.

BOARD COMMENT: The Board of Trustees supports this request. However, the original resolution was confusing in that it was not clear that the $380,000 funded the outside lobbying as well as the public opinion research and advocacy advertisements. Therefore, the Board recommends the following substitute resolution.

21B. Resolved, that the ADA Division of Government and Public Affairs engage the services of at least one additional outside lobbying firm with particular expertise in working with the federal agencies that are charged with implementing the new health care reform law, and be it further

Resolved, that the Division conduct public opinion research, run advocacy advertisements in Capitol Hill publications and employ other related tactics in support of ADA federal advocacy goals.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

BOARD VOTE: UNANIMOUS.

Resolution No. 26 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: May 20, 2010

Submitted By: Pennsylvania Dental Association

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Attain Excellence in Operations (Required)

AMENDMENT OF THE ADA *BYLAWS*: COMPOSITION OF VOTING MEMBERS OF THE HOUSE OF DELEGATES

The following resolution was adopted by the Pennsylvania Dental Association and submitted on May 20, 2010.

Background: The *Bylaws* do state in Chapter I that active, life and retired members have the privilege of serving as delegates or alternates. However, when we look at Chapter V, Section 10. A. VOTING MEMBERS, the only restriction for delegates is that they be officially certified by the constituent. Nothing contained in this section defines which classes of members can be officially certified by the constituent. Furthermore, Chapter V, Section 10. E, ALTERNATE DELEGATES states, "Each constituent dental society and each federal dental service may select **from among its active, life and retired members** the same number of alternate delegates as delegates." If we state this requirement for alternates, certainly we should state the same requirement for delegates.

Resolution

26. Resolved, that the ADA *Bylaws* Chapter V, Section 10 be amended as follows (new language underscored):

Section 10: COMPOSITION

A. VOTING MEMBERS. The House of Delegates shall be limited to four hundred sixty (460) voting members for the two years 2004 to 2005 inclusive. Thereafter, the number of voting members shall be determined by the methodologies set forth in Section 10C of this Chapter. It shall be composed of the officially certified delegates of the constituent dental societies, <u>who shall be active, life or retired members,</u> two (2) officially certified delegates from each of the five (5) federal dental services, <u>who shall be active, life or retired members</u> and five (5) student members of the American Student Dental Association who are officially certified delegates from the American Student Dental Association.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 28 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: May 17, 2010

Submitted By: South Dakota Dental Association

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

FUNDING FOR TREATMENT OF MEDICAID PATIENTS UNDER THE HEALTH CARE REFORM ACT (HCRA)

The following resolution was adopted by the South Dakota Dental Association and submitted on May 17, 2010.

Background: On March 24, 2010 the President signed the Health Care Reform Act (HCRA). The HCRA will add millions of previously uninsured children to the rolls of Medicaid and CHIP. It is critical that the American Dental Association take a leadership role in assuring that these patients receive high quality oral health care. The increase in patients seeking care under HCRA will increase the call for care to be provided by non-dentists at a lower level of quality. It is critical for the ADA to address the issues raised by other stake holders in this arena. The ADA must convince policy makers and legislators that if adequate resources are applied to this issue, all children can have high quality oral health care delivered by licensed dentists in the dental home. The concept of a stable high quality dental home delivering care to all patients must be the goal of all stake holders in this area. Every available study proves that dentists are uniquely qualified to deliver this care. Multiple examples have conclusively proven that if reimbursement for care provided is fair and adequate that access issues evaporate.

Resolution

28. Resolved, that the American Dental Association call for adequate Federal funding to be provided for the treatment of Medicaid patients under the Health Care Reform Act (HCRA), and be it further

Resolved, that the ADA pursue a Federal standard for reimbursement for dental care to be set at a minimum of the 75th percentile of the prevalent commercial insurer in each state, and be it further

Resolved, that the ADA pursue a plan whereby Medicaid-enrolled individuals will be able to access dental care at a rate comparable to that for individuals with commercial insurance.

BOARD COMMENT: The Board agrees with the intent of this resolution; however, a "vote no" is recommended in this case because current policy already directs the Association to make lobbying for adequate funds to provide oral health care to Medicaid-eligible individuals the highest priority (*Medicaid and Indigent Care Funding* (2006:338)) and existing policy expressly directs the Association to seek enactment of federal legislation to enhance the federal Medicaid match to 90/10 for dental care (*Increase Federal Medicaid Funding* (2002:409)). There is also older policy that urges constituent societies (with ADA assistance) to seek uniform benefits, adequacy of payments, voluntary practitioner participation, and ultimately expansion of Medicaid benefits for all segments of the indigent population (*Improvements in Medicaid Program* (1995:648)). To accomplish the above goals, the Association helped draft federal legislation, which was introduced as the "Essential Oral Health Care Act of 2009" (H.R. 2220) on April 30, 2009, by Representatives

Mike Ross (D-AR) and Mike Simpson (R-ID), which now has 33 co-sponsors. Among other things, H.R. 2220 offers states an increase in their federal medical assistance percentage (FMAP) of up to 90 percent if the states develop a plan approved by the Secretary of the Department of Health and Human Services that ensures individuals covered by the Medicaid plan have the same access to oral health care services as are available to the population in the state. As detailed in H.R. 2220, this must be accomplished through increasing fees to market-based rates, addressing administrative barriers and the demand for services, as well as other factors.

BOARD RECOMMENDATION: Vote No.

Board Vote:															
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		
☐	■	☐	☐	CALNON	☐	■	☐	☐	LOW	☐	■	☐	☐	SULLIVAN	
☐	■	☐	☐	ENGEL	■	☐	☐	☐	MANNING	☐	■	☐	☐	THOMPSON	
☐	■	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	☐	■	☐	☐	VERSMAN	
☐	■	☐	☐	FEINBERG	☐	■	☐	☐	RICH	■	☐	☐	☐	VIGNA	
☐	■	☐	☐	GIST	☐	■	☐	☐	SEAGO	☐	■	☐	☐	WEBB	
☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SMITH, A. J.	☐	■	☐	☐	WEBER	
☐	■	☐	☐	LONG	☐	■	☐	☐	STEFFEL					Res. 28	

Resolution No. 29 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: May 11, 2010

Submitted By: Eighth Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication:

Amount One-time $30 million Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

ADA PUBLIC RELATIONS CAMPAIGN

The following resolution was adopted by the Eighth Trustee District and submitted on May 11, 2010.

Background: As more outside groups are beginning to look toward mid-level dental providers to address the access to dental care issue, it is imperative that the message of the American Dental Association members be part of this growing public conversation. It is not enough for dentists to talk amongst themselves about the pros and cons of what the further development of mid-level dental provider could do to the existing dental care delivery system in the United States. On behalf of its members, the ADA needs to educate and engage the public about the extensive training that is required to become a dentist and the real barriers that exist in providing care to the underserved population in this country.

The ADA's brochure *Dentists: Doctors of Oral Health* explains the high level of education and training that is required to become a dentist in the United States. At a minimum, a general dentist has at least four years of highly specialized academics after obtaining an undergraduate bachelor's degree. The curricula during the first two years of dental and medical school are essentially the same, yet this standard is not commonly understood by the public at large.

This ADA brochure contains information that the ADA should disseminate to policymakers, media and the public to remind them that oral health care is being provided by "doctors" and that any new dental provider will have a dramatically lower level of education and clinical skill. A full national public relations campaign should be developed using multiple media formats to spread this message.

The ADA public relations campaign should discuss why an underserved population exists. The most common problem that created the underserved is that they are attempting to access dental care via the states' Medicaid program. In virtually every state, these programs have been underfunded for decades to a point that many dentists cannot afford to provide care to the Medicaid population. Any level of dental provider will face these same economic realities.

The campaign should also show that many in the underserved population are the ones most likely to have complicating medical conditions and are utilizing a higher number of medications. If this population is difficult for dentists to treat, how could someone with only two years of education beyond high school be expected to competently provide care to this group of patients.

The funding for the ADA public relations campaign should be funded by using any necessary means. Reserves are maintained for unforeseen matters that arise such as this and should also be considered. This recent wave of interest in mid-level dental providers by the W.K. Kellogg Foundation, Pew Charitable Trusts

and the Institute of Medicine will only get bigger and the American Dental Association needs to be on top of the wave and not be crushed by it.

As in the past, it will be the responsibility of the appropriate reference committee to determine the source of funding for this resolution which could include, but not be limited to, dues, special assessment, reserves or any other creative means.

Resolution

29. Resolved, that the ADA undertake a multi-media public relations campaign to educate the public on the level of education that dentists receive and how that would compare to any lower level of provider, and be it further

Resolved, that the ADA public relations campaign should also emphasize the difficulties that dentists face when treating the underserved population, and be it further

Resolved, that the ADA public relations campaign be funded up to $30 million through any necessary funding including using the reserves of the Association.

BOARD COMMENT: The Board recognizes the need to educate the public and other key audiences such as elected officials on the plight of underserved populations and the responses that the American Dental Association is making to ensure that the highest quality of care is provided. The Board also recognizes that conducting a major public relations campaign would require the allocation of considerable financial resources. The Board has supported the development and use of communications that reinforce the position of the dentist as the leader of the dental team and the most qualified professional to provide the best care to these underserved populations. There are numerous approaches to improving access to care which are being proposed which underscore the need to deliver this message to the public.

A major campaign to elevate the public's understanding of the unmatched educational experience and professional expertise of the dentist directly supports the goals of the Association and could elevate the public's awareness and perception of the profession. As the leader of the dental team, the dentist ensures that efforts to extend care to those in need are done so without compromising the safety and quality of care being provided. The Board notes that this message should be part of public communications and advocacy efforts.

The complexity of the access to care issue also requires that the Association address it on several levels. The Board further recognizes that the public perception of the training of the dentist, and that these doctors are providing the highest degree of oral health care, is one element. Advocating on both the national and state level to reinforce that the quality of the care to be provided must not be compromised by expedient solutions is also essential. Developing and supporting efforts to improve access to quality care therefore must be looked at in their entirety as does the use of the financial resources required. There is at this time no research the Association has conducted or evidence that the messages of such a public relations campaign would have the desired effect of changing public attitudes towards the increased use of non-dentists to resolve access to care for underserved populations.

The scope of the proposed resolution must be carefully evaluated within the context of the overall budget needs of the Association including a determination if the reserve funds available are sufficient to meet this need. Absent the availability of reserve funds the funding of up to $30 million would require a dues increase, special assessment, or some combination thereof, of up to $280 per member. The Board recommends referral of this resolution to the Council on Communications and other appropriate ADA agencies for study and recommendation. The Board notes that this is an issue of great interest to the profession and encourages the Council and appropriate ADA agencies to seek additional information from state executive directors and other dental associations that have engaged in similar campaigns.

BOARD RECOMMENDATION: Vote Yes on Referral to Council on Communications and other appropriate ADA agencies.

Board Vote:															
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		
■	☐	☐	☐	CALNON	■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN	
■	☐	☐	☐	ENGEL	■	☐	☐	☐	MANNING	■	☐	☐	☐	THOMPSON	
■	☐	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	☐	■	☐	☐	VERSMAN	
■	☐	☐	☐	FEINBERG	■	☐	☐	☐	RICH	■	☐	☐	☐	VIGNA	
■	☐	☐	☐	GIST	■	☐	☐	☐	SEAGO	■	☐	☐	☐	WEBB	
■	☐	☐	☐	KREMPASKY SMITH	■	☐	☐	☐	SMITH, A. J.	■	☐	☐	☐	WEBER	
■	☐	☐	☐	LONG	■	☐	☐	☐	STEFFEL					Res. 29	

Resolution No. 30 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: May 11, 2010

Submitted By: Eighth Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

PUBLIC DISCLOSURE OF DENTISTS PARTICIPATING IN MEDICAID AND SCHIP FEDERAL WEBSITE

The following resolution was adopted by the Eighth Trustee District and submitted on May 11, 2010.

Background: The Children's Health Insurance Programs Reauthorization Act (CHIPRA) requires the secretary of Health and Human Services to list on the www.InsureKidsNow.gov website all dentists that have enrolled to participate in Medicaid or SCHIP.

For over a decade, Illinois has worked with its state Medicaid agency and its dental program administrator to only promote and make public the names of enrolled dentists that were actually taking new patients. Dentists could be enrolled but their name never given out to the public.

Participating dentists could designate how many and which type of patients they would currently accept to treat. Dentists could chose to work closely with a local school, Head Start or religious organization and only take patients from them and not from the general public. This worked well and allowed some dentists to marginally participate in the program without their names being widely broadcast as taking new patients. This referral arrangement was overturned by the Center for Medicare and Medicaid Services (CMS) as not being in compliance since it did not list all enrolled dentists.

This has begun to cause some dentists to end their participation in the Medicaid program out of fear that they could no longer control referrals. The relationships that the dentist had with other organizations ended as they did not want their name on a list that was available to the general public.

How is the public served by being given the name of an enrolled dentist that is not taking new patients? It is upsetting to the patient as they believe they are being given correct information from the CMS website and it also is disruptive to a dentist's practice when it has to repeatedly tell patients that they are no longer taking new Medicaid or SCHIP patients.

The American Dental Association should seek a legislative solution to only list participating dentists that wish to have their name on this public website.

Resolution

30. Resolved, that the ADA, through legislation, seek to change the current requirement within CMS so that the www.Insurekidsnow.gov website would only list those dentists that choose to have their names made public and are taking new patients.

BOARD COMMENT: Soon after CHIPRA was reauthorized by Congress, the ADA contacted senior staff at the Centers for Medicare and Medicaid Services (CMS) to express concern about this website requirement.

The ADA received assurances that, in order to mitigate confusion and inconvenience to patients and doctors, only the names of practitioners who are accepting *new* patients and participating in Medicaid and the Children's Health Insurance Program (CHIP) are to be listed on the "Insure Kids Now" website. CMS partners with the Health Resources and Services Administration (HRSA) in administering the website, which is housed within HRSA. CMS is responsible for working with states to help them comply with the requirements for state reported information that is loaded onto the website. HRSA and CMS have issued Provider Data Submission Technical Information documents and held conference calls to discuss the data elements that a state is required to include on the website. Accordingly, The Board believes that the Association has already addressed the primary concern voiced in the resolution.

BOARD RECOMMENDATION: Vote No.

Board Vote:

Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
☐	■	☐	☐	CALNON	☐	■	☐	☐	LOW	■	☐	☐	☐	SULLIVAN
☐	■	☐	☐	ENGEL	■	☐	☐	☐	MANNING	☐	■	☐	☐	THOMPSON
☐	■	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	☐	■	☐	☐	VERSMAN
☐	■	☐	☐	FEINBERG	■	☐	☐	☐	RICH	■	☐	☐	☐	VIGNA
☐	■	☐	☐	GIST	☐	■	☐	☐	SEAGO	☐	■	☐	☐	WEBB
☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SMITH, A. J.	☐	■	☐	☐	WEBER
■	☐	☐	☐	LONG	☐	■	☐	☐	STEFFEL					Res. 30

Resolution No. 49 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: July 2010

Submitted By: Board of Trustees

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Attain Excellence in Operations (Required)

AMENDMENT TO THE ADA *BYLAWS*: CHAPTER V, HOUSE OF DELEGATES, SECTION 10. COMPOSITION, SUBSECTION A. VOTING MEMBERS PROHIBITION ON PROXY VOTING

Background: Changes In Illinois Law - Section 107.50 of the Illinois General Not For Profit Act was recently amended to provide that voting members (not a board of directors) may vote by proxy unless a not-for-profit corporation's articles of incorporation or bylaws explicitly *prohibit* proxy voting. Previously under Illinois law, proxy voting was not permitted unless it was expressly authorized in the articles of incorporation or bylaws. Thus, this change in Illinois law requires an examination of ADA governance rules and procedures.

ADA Voting Procedures: Under current ADA policies and procedures, ADA voting members of the House of Delegates are required to vote in person. An alternate delegate may vote where duly substituted for a voting delegate of the House of Delegates. Proxy voting is not permitted. These policies and procedures are memorialized in ADA documents as follows:

Voting Members and Alternate Delegates. The ADA *Bylaws* provide that each constituent dental society, federal dental service, and the American Student Dental Association may officially certify a specified number of delegates who shall be voting members of the House of Delegates, and that these same organizations may each select a specified number of alternate delegates. (Chapter V, Sections 10A and 10F)

Seating of Alternate Delegates. The ADA *Manual of the House of Delegates* provides for the seating of alternate delegates as follows (2009 edition, page 6):

> **Seating of Alternate Delegates**
> Delegates wishing to substitute alternate delegates from their delegation for themselves during a meeting of the House of Delegates must complete the appropriate delegate-alternate substitution form at the special registration desk. Delegates are required to sign the form and surrender their admission cards for the meeting or meetings not attended before admission cards will be issued to alternate delegates by the Committee on Credentials, Rules and Order. Substitution of alternate delegates may be made during all four meetings of the House of Delegates.
>
> Delegates representing the American Student Dental Association shall be seated as a single delegation along with the president and executive director of ASDA.

Voting Procedure. The August 2009 *Report of the Standing Committee on Credentials, Rules and Order* sets forth voting procedures in the House of Delegates as follows:

> **Voting Procedures in the House:** The method of voting in the House of Delegates is usually determined by the Speaker who may call for a voice vote, show of hands (voting cards), standing vote, roll call of the delegations, electronic voting or such other means that the Speaker deems

appropriate. The House may also, by majority vote, determine for itself the method of voting that it prefers.

Only votes cast by voting members of the House of Delegates either for or against a pending motion shall be counted. Abstentions shall only be counted in determining if a quorum is present. **The Committee wishes to remind the members of the House that there are no provisions for proxy voting in the ADA House of Delegates.** Delegates should not vote either electronically or by card vote for an absent delegate.

If the result of a vote is uncertain or if a division is called for, the Speaker may use the electronic voting method or may call for a standing vote. If a standing vote, the count will be made by tellers appointed by the Speaker and reported to the Secretary.

The Committee on Credentials, Rules and Order is charged with supervising the count of votes in the House of Delegates. The members of the Committee will remain in the voting area until all election results have been tabulated and finalized.

To codify the House of Delegates' long standing prohibition against proxy voting in the ADA *Bylaws*, the following Resolution is offered.

Resolution

49. Resolved, that Chapter V. HOUSE OF DELEGATES, SECTION 10. COMPOSITION, Subsection A. VOTING MEMBERS, of the ADA *Bylaws* be amended by addition of the following new fourth sentence*:*

> Proxy voting is explicitly prohibited; however, an alternate delegate may vote when substituted for a voting member in accordance with procedures established by the Committee on Credentials, Rules and Order.

so the amended Subsection reads (new language underscored)

> *Section 10*. COMPOSITION.
>
> A. VOTING MEMBERS. The House of Delegates shall be limited to four hundred sixty (460) voting members for the two years 2004 to 2005 inclusive. Thereafter, the number of voting members shall be determined by the methodologies set forth in Section 10C of this Chapter. It shall be composed of the officially certified delegates of the constituent dental societies, two (2) officially certified delegates from each of the five (5) federal dental services and five (5) student members of the American Student Dental Association who are officially certified delegates from the American Student Dental Association. <u>Proxy voting is explicitly prohibited; however, an alternate delegate may vote when substituted for a voting member in accordance with procedures established by the Committee on Credentials, Rules and Order</u>.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 50 New ■ Substitute ☐ Amendment ☐

Report: CGA Supplemental Report 1 Date Submitted: July 2010

Submitted By: Council on Government Affairs

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

COUNCIL ON GOVERNMENTAL AFFAIRS SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES: NEGOTIATED RULEMAKING PROCESS REGARDING A NATIONAL PRETREATMENT STANDARD FOR DENTAL OFFICE WASTEWATER

Summary: The Council on Government Affairs discussed at length possible regulatory action to mandate amalgam separators nationwide. It carefully reviewed the pressures favoring such regulation and how the Association can best represent the interests of its members in negotiations with the United States Environmental Protection Agency (EPA). As a result of its deliberations, the Council approved a resolution to be brought to the House favoring a negotiated rulemaking for the use of amalgam separators.

Background to Memorandum of Understanding: In 2007, the EPA announced plans for a "Study of a Pretreatment Requirement for Dental Offices" (EPA Docket ID No. EPA–HQ–OW–2006–0771). A national pretreatment standard for dental offices, while not readily apparent from the title, would have applied to dental office wastewater and would almost certainly have meant a national mandate for amalgam separators. On December 21, 2007, the ADA filed comments on this proposed study, forcefully arguing that a national pretreatment standard for dental offices was unnecessary because dentistry contributes less than 1% of the mercury generated from human activity in the environment and because dentistry was already acting voluntarily to address environmental impacts from dental amalgam and would accelerate its voluntary efforts. The Association was able to cite the then-recent addition of amalgam separators to its best management practices (http://www.ada.org/sections/publicResources/pdfs/topics_amalgamwaste.pdf) as strong evidence of this. Dental offices using the prior best management practices already captured about 80% of waste amalgam. Separators increase the amount of captured amalgam that otherwise would be captured downstream by municipal wastewater treatment plants. This material is then available for recycling. In 2008, the EPA agreed with the Association and concluded that no national standard was needed at that time.

In lieu of imposing a national pretreatment standard, the EPA proposed in February 2008 a memorandum of understanding (MOU) between itself, the Association and the National Association of Clean Water Agencies (NACWA). The MOU was signed in December 2008. The MOU committed all parties to promote adoption of the Association's best management practices for amalgam wastewater (including the use of amalgam separators). It also committed the parties to it to establish goals for progress toward universal compliance with the best management practices. An essential term of the MOU, insisted upon by the EPA and NACWA, was that nothing in it prevented the EPA or a state or a local authority from pursuing future regulation mandating the use of separators. Dental offices were not provided an exemption, EPA simply agreed to allow a voluntary program to be implemented and it would evaluate whether sufficient progress was being made by such a program.

Impact of MOU: The MOU, combined with the addition of separators to the Association's best management practices, greatly enhanced the Association's standing among regulators. The Association was able to credibly argue in support of its policy against mandates at numerous meetings. Since the end of 2008, no state (except Michigan, which moved forward with the support of the Michigan Dental Association) has enacted a state-wide separator mandate. While local requirements are more difficult to track, there seems to have been less pressure for mandates at that level too. In other words, for two years and counting, the Association has been able to prevail on its arguments in favor of voluntary separator use.

There has been another, indirect positive impact from the MOU and from the addition of separators to the best management practices. In the past, efforts to ban dental amalgam were often premised on both alleged health concerns and the environmental impact of dental amalgam. The 2009 favorable ruling on dental amalgam by the Food and Drug Administration has blunted the claims of a safety issue. At the same time, the use of separators, the Association's revised best management practices and the MOU have blunted, but not eliminated, the environmental argument in support of an amalgam ban.

Pressure for Greater Regulation: Despite the MOU and the fact that dentistry contributes a small percentage of mercury to the environment, pressure is now growing in favor of renewed separator mandates at both the state and national level. In general, the current Obama administration relies more on command and control regulation than the prior administration. This has been demonstrated through management of the Occupational Safety and Health Administration as well as other federal agencies. As a Senator, President Obama sponsored a bill banning the export of mercury, which was enacted. In addition, negotiations are underway through the State Department on a potential international mercury control treaty. While any such treaty is likely to be several years away, it will almost certainly address dental office wastewater and will likely call upon signatory nations to rely upon amalgam separators as the chosen control technology.

EPA is also moving forward with potential revisions to the way in which it regulates incineration and other disposal of wastewater treatment plant sludge or biosolids. Approximately 20% of the nation's treatment plant biosolids are incinerated. Most waste amalgam at treatment plants is caught in the biosolids. While separators have little impact on the level of mercury discharged from treatment plants to lakes and streams, they do prevent a significant amount of mercury in the form of amalgam from reaching the biosolids. These potential regulatory revisions will significantly increase pressure on treatment plants to minimize mercury levels in biosolids. To do so, the treatment plant operators will look primarily to dental offices because dental offices are often the largest contributor of mercury (albeit in the form of amalgam) to a treatment plant. EPA is also showing signs of tightening permitted mercury levels in surface waters. This too will increase pressure of treatment plants and, through them, on all who discharge into the treatment plants, especially dental offices.

The Environmental Council of States, an association of state environmental officials, has come out against the MOU and in favor of a nationwide separator mandate. Solmetex, the largest separator manufacturer in the country, has joined with ECOS in this request, arguing that dentists will not install separators in significant numbers voluntarily. Some in Congress are also being heard on this issue. In May 2010, Representative Kucinich held another in a series of hearings by the U.S. House Domestic Policy Subcommittee of the Oversight Committee on Government Operations and Reform focusing on dental amalgam. During the hearing, Representatives Dennis Kucinich (D), Dan Burton (R), Diane Watson (D) and Elijah Cummings (D) each criticized EPA for not mandating separators nationwide, and Representative Kucinich promised still more hearings.

Finally, it is difficult to overstate the overall concern among regulators and law makers over all matters relating to mercury, in whatever form. This concern, coupled with pressure from state officials, a large separator manufacturer, members of Congress, a potential treaty and EPA's own regulation of treatment plant biosolids and mercury levels in surface waters, all increase the pressure for nationwide or state and local separator mandates. Perhaps the best indication of this increasing pressure is that, later in 2010, EPA will again consider whether it should issue a national pretreatment standard for dental office wastewater. This will be

the first, but certainly not last, test of how EPA reacts to the growing pressure. Action at the state and local levels could likely also increase at any time.

Goals for Voluntary Separator Use Under the MOU: One of the requirements under the MOU is for the parties to set a goal for increased voluntary use of amalgam separators. Earlier this year, the EPA plainly expressed to the Association that there was a need for a very serious and aggressive goal. At the same time, the EPA informed the Association that it was considering a petition from the Environmental Council of States to establish a national pretreatment standard for dental offices. The EPA suggested a goal of a 25% gain in voluntary separator usage over the next 12 months (ending in June 2011) and additional 25% gains annually thereafter until full compliance was achieved. The Association and EPA agreed to an initial goal of 20% for the first year, followed by gains of 25% thereafter. To translate these percentages into actual separator sales, the Association provided data on the number of dentists in states without separator mandates (because the goals only apply to voluntary usage) and reduced this number by the number of specialists who typically do not place or remove amalgams and by a set percentage, based on survey data, for the number of other dentists who do not place or remove amalgams. While the exact calculations are still being reviewed, this will result in an initial 12 month goal of approximately 15,000 separators to be voluntarily installed.

Council Recommendation: The Council is very much aware that this is an extraordinarily ambitious goal and that, despite best efforts, it might not be met. But the Council believes that the Association must make every effort to meet it. This will be done through direct outreach via ADA.org and ADA News and, primarily, through programs initiated by constituent societies. Nevertheless, the Council recognizes that the Association could fall short of the goal and the likely consequence is regulatory action at the state or federal levels.

The Council believes that it is important for the Association to actively engage with EPA over any potential regulation. Should the Association fail to meet the MOU's goals, its bargaining position will be weakened and a national separator mandate may be issued without significant input from dentistry. For that reason, the Council believes that the Association should approach the EPA and propose a negotiated rulemaking for a national pretreatment standard now, prior to the expiration of the first 12 month period for the initial goal. This will best allow the Association to shape any such regulation in order to minimize the burden on dentists and to assure it is as reasonable and fair as is possible.

Benefits: Calling for negotiated rulemaking with EPA will further enhance the Association's standing with the agency and help to maximize its influence over any such rule. It will allow the Association to advocate forcefully for provisions to minimize the burden on individual dentists. For example, the Association could seek to assure that dental offices would not be subject to routine wastewater testing, a cumbersome and expensive process. Each of the listed items in the second proposed clause of the resolution contains terms helpful to dentistry and without which the Association should not support regulation. Pursuing negotiated rulemaking will also enhance the reputation of the Association and its members as good environmental stewards. Finally, such an action would continue to blunt, if not prevent, calls for amalgam bans based on environmental concerns.

Accordingly, the Council on Government Affairs proposes the following resolution:

Resolution

50. Resolved, that the appropriate agencies of the ADA engage the United States Environmental Protection Agency in a negotiated rulemaking process regarding a national pretreatment standard for dental office wastewater, and be it further

Resolved, that the following principles guide the Association's position in any negotiations with the United States Environmental Protection Agency:

1. Any regulation should require covered dental offices to comply with best management practices patterned on the ADA's best management practices (BMPs), including the installation of International Organization for Standardization (ISO) compliant amalgam separators or separators equally effective;
2. Any regulation should defer to existing state or local law or regulation requiring separators so that the regulation would not require replacement of existing separators compliant with existing applicable law;
3. Any regulation should exempt dental practices that place or remove no or only de minimis amounts of amalgams;
4. Any regulation should include an effective date or phase-in period of sufficient length to permit affected dentists a reasonable opportunity to comply;
5. Any regulation should provide for a reasonable opportunity for covered dentists to repair or replace defective separators without being deemed in violation of the regulation;
6. Any regulation should minimize the administrative burden on covered dental offices by (e.g.) primarily relying upon self certification (subject to verification or random inspection) and not requiring dental-office-specific permits;
7. Any regulation should not include a local numerical limit set by the local publicly owned treatment works (POTW);
8. Any regulation should not require wastewater monitoring at the dental office, although monitoring of the separators to assure proper operation may be required;
9. Any regulation should provide that compliance with it shall satisfy the requirements of the Clean Water Act unless a more stringent local requirement is needed.

BOARD COMMENT: The Board agrees with the Council that given the potential for unilateral action by the EPA, it is in the best interest of the profession and the public to engage in a negotiated rulemaking process with the agency in a manner consistent with the terms of this resolution.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 64 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: August 18, 2010

Submitted By: Third Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

AMENDMENT OF THE *MANUAL OF THE HOUSE OF DELEGATES*:
GUIDELINES GOVERNING THE CONDUCT OF CAMPAIGNS FOR ALL ADA OFFICES

The following resolution was submitted by the Third Trustee District and submitted on August 18, 2010, by Dr. Jeffrey B. Sameroff, secretary, Pennsylvania Dental Association.

Background: The cost of ADA President-elect's campaigns has become prohibitive for smaller trustee districts and state dental association constituents who finance a large portion of the campaigns. For the 2009 campaign, the three candidates spent approximately $100,000 each, for a total of about $300,000. The cost of the combined candidates' reception alone was $150,000. Campaign travel to the constituents cost the candidates about $30,000 combined.

Campaign travel undoubtedly diverts candidates' time, energy and attention from important ADA business during the campaign year. Especially in this challenging time for our Association, candidates need to be fully focused on Association business.

Resolution

64. Resolved, that the *Manual of the House of Delegates*, *Guidelines Governing the Conduct of Campaigns for All ADA Offices* be amended by substitution as follows: The current *Guidelines* are appended.

Guidelines Governing the Conduct of
Campaigns for ~~All~~ ADA Elective Offices (pg 23-24)

The following guidelines govern the announcement and conduct of campaigns for ADA elective offices. This document incorporates the various guidelines and policies related to campaign activities adopted by the House of Delegates over the years. These guidelines shall be distributed annually to all candidates, delegates, alternate delegates and other parties of interest.

1. An Election Commission, consisting of the Speaker, the Secretary of the House of Delegates, and the Second Vice President, shall oversee and adjudicate all issues of contested elections for ADA offices. The Speaker shall be the chair of the Election Commission. In the event the Speaker is running in a contested race for office, the ADA President shall replace the Speaker and serve as chair of the Election Commission. The Election Commission shall meet with all candidates to negotiate cost-effective agreements on campaign issues such as promotional activities and gifts (which are limited to campaign pins), campaign literature and electronic communications.

2. Candidates shall not formally announce their intent to run for office until the final day of the annual session immediately preceding their candidacy. Prior to this formal announcement, candidates may freely campaign within their own trustee districts. Campaign activities outside a candidate's own trustee district shall begin only after the official announcement at the above-mentioned annual session.

3. Candidates' campaign statements and profiles shall appear in the *ADA News* and shall be posted on the Association's Web site in a section dedicated to candidates for ADA elective offices.

4. No material shall be distributed in the House of Delegates without obtaining permission from the Secretary of the House. Materials to be distributed in the House of Delegates on behalf of any member's candidacy for office shall be limited to printed matter on paper only and nothing else. (A single distribution per candidate for each House of Delegates will be made. However, this distribution could consist of more than one piece of printed matter as long as the materials are secured together.)

5. Candidates for the **Offices of President-elect, Second Vice President and Speaker of the House** shall be additionally governed by the following:

   a. Candidates shall not hold campaign receptions or participate in campaign travel to other trustee districts or constituents.

   b. Candidates may, by invitation, visit district caucuses (or constituent societies as appropriate) held during the annual session at which they are standing for election. Caucuses issuing such invitations are requested to provide an appropriate opportunity for the candidates to meet with their members. It is recommended that such forum be structured to allow all candidates to make presentations, to allow caucuses freedom to assess candidates and to allow each candidate to respond to questions.

   c. Candidates may, during the annual session at which they are standing for election, use the hospitality suites of their own districts for the purpose of campaigning. Candidates may also hold campaign meetings in their own districts for the purpose of strategizing.

   d. No candidate shall knowingly accept campaign contributions which create the appearance of conflict of interest as reflected in Chapter VI of the ADA *Bylaws*.

   e. Candidates shall submit a summary of campaign revenues and expenses to the Election Commission at the end of the campaign.

6. Candidates for the **Office of Treasurer** shall be additionally governed by the following:

   a. Campaigns shall be limited to visiting the district caucus meetings during the annual session.

   b. Candidates shall not distribute any tangible election material, including but not limited to printed matter, CD-ROMs, audiovisual materials, pens, pins, stickers or other accessory items.

   c. Candidates shall not use signs, posters or any electronic means of communication including but not limited to telephones, television, radio, electronic and surface mail or the Internet.

   d. Candidates shall not attempt to raise funds to support a campaign, nor to conduct any social functions, hospitality suites or other electioneering activities.

e. Candidates' names and curriculum vitae shall be submitted to the House of Delegates in the first mailing in the year of the election.

7. Any questions regarding the Guidelines should be directed to the chair of the Election Commission for clarification.

BOARD COMMENT: The Board has empathy for the affordability challenges which smaller districts and constituents encounter with respect to campaigning expenses for running a candidate. However, the Board does not support the elimination of campaign travel because of the value it affords in allowing the members to get to know the candidates. There is a mechanism in place whereby the candidates have the ability to negotiate cost-effective agreements on campaign issues, so campaign receptions can be conservative as to their costs.

BOARD RECOMMENDATION: Vote No.

Board Vote:															
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		
☐	■	☐	☐	CALNON	☐	■	☐	☐	LOW	☐	■	☐	☐	SULLIVAN	
☐	■	☐	☐	ENGEL	☐	■	☐	☐	MANNING	☐	■	☐	☐	THOMPSON	
☐	■	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	☐	■	☐	☐	VERSMAN	
☐	■	☐	☐	FEINBERG	☐	■	☐	☐	RICH	☐	■	☐	☐	VIGNA	
☐	■	☐	☐	GIST	☐	■	☐	☐	SEAGO	☐	■	☐	☐	WEBB	
☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SMITH, A. J.	☐	■	☐	☐	WEBER	
☐	■	☐	☐	LONG	■	☐	☐	☐	STEFFEL					Res. 64	

APPENDIX

CURRENT

Guidelines Governing the Conduct of Campaigns for All ADA Offices

The following guidelines govern the announcement and conduct of campaigns for ADA elected offices. This document incorporates the various guidelines and policies related to campaign activities adopted by the House of Delegates over the years. These guidelines will be distributed annually to all candidates, delegates, alternate delegates and other parties of interest.

1. An Election Commission, consisting of the Speaker, Secretary of the House of Delegates, and the Second Vice President, shall oversee and adjudicate all issues of contested elections for ADA offices. The Speaker shall be the chair of the Election Commission. In the event the Speaker is running in a contested race for office, the ADA President shall replace the Speaker and serve as chair of the Election Commission.

The Election Commission shall meet with all candidates to negotiate cost-effective agreements on campaign issues such as promotional activities and gifts (which are limited to campaign pins), campaign literature, travel and electronic communications.

2. Candidates shall not formally announce their intent to run for office until the final day of the annual session immediately preceding their candidacy. Prior to this formal announcement, candidates may freely campaign within their own trustee districts. Campaign activities outside a candidate's own trustee district shall begin only after the official announcement at the annual session.
3. District caucuses (or constituent societies as appropriate) issuing invitations to candidates are requested to provide an appropriate opportunity for the candidates to meet with their members. It is recommended that such forum be structured:

   a. to allow all candidates to make presentations;
   b. to allow caucuses freedom to assess candidates; and
   c. to allow each candidate to respond to questions.
4. Candidates shall negotiate a mutually agreeable travel schedule.
5. Candidates shall not use social functions or hospitality suites/meeting rooms on behalf of their candidacy during the campaign year. (This is not intended, however, to limit candidates from holding campaign meetings for the purpose of strategizing.)
6. Only candidates for the **Office of President-elect** will host campaign receptions. These campaign social functions will be restricted to the candidate's reception at the annual session. Campaign receptions will be held the evening prior to the election. Receptions will be financed by each candidate's campaign fund and/or the district presenting the candidate for nomination. The president-elect candidates, in consultation with the Election Commission, will determine a dollar amount for the reception.
7. The display of campaign signs and posters at the campaign reception shall be limited to the immediate area of each candidate's respective reception room/area. (The ADA will provide a prominent directory of campaign receptions in the headquarters hotel.)
8. All candidates' campaign statements and profiles, which appear in the *ADA News*, will

be posted on the Association's Web site, ADA.org, in a section dedicated to candidates for ADA elected offices.

9. The election process for the **Office of Treasurer** may be preceded by a campaign strictly limited to visiting the district caucus meetings during the annual session. Candidates shall not be permitted to distribute any tangible election material, including but not limited to printed matter, CD-ROMs, audiovisual materials, pens, pins, stickers or other accessory items. Candidates shall not use signs, posters or any electronic means of communication including but not limited to telephones, television, radio, electronic and surface mail or the Internet. Candidates shall not attempt to raise funds to support a campaign, nor to conduct any social functions, hospitality suites or other electioneering activities. The candidates' names and curriculum vitae will be submitted to the House of Delegates in the first mailing in the year of the election.
10. No material may be distributed in the House of Delegates without obtaining permission from the Secretary of the House. Materials to be distributed in the House of Delegates on behalf of any member's candidacy for office shall be limited to printed matter on paper only and nothing else. (A single distribution per candidate for each House of Delegates will be made. However, this distribution could consist of more than one piece of printed matter as long as the materials are secured together.)
11. No candidate will knowingly accept campaign contributions which create the appearance of conflict of interest as reflected in Chapter VI of the ADA *Bylaws*.
12. Candidates for all ADA elective offices should submit a summary of campaign revenues and expenses to the Election Commission at the end of the campaign.
13. Any questions regarding the Guidelines should be directed to the chair of the Election Commission for clarification.

Resolution No. 79 New ■ Substitute ☐ Amendment ☐

Report: CGA Supplemental Report 2 Date Submitted: September 2010

Submitted By: Council on Government Affairs

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

COUNCIL ON GOVERNMENT AFFAIRS
SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES:
RECENT COUNCIL ACTIVITIES

Background: This report provides a response to 2009 House of Delegates resolutions not addressed or only partially addressed in the Council's annual report.

Chair and Vice-Chair: The Council forwarded the name of Dr. Matthew J. Neary to the Board of Trustees for approval as the Council's next chair and elected Dr. Richard A. Weinman as vice-chair.

The Strategic Plan of the American Dental Association: In support of Goal I, Advocacy, of the Strategic Plan, the Council submits the following supplemental report to the House of Delegates.

State Public Affairs Program: In 2010, a State Public Affairs Program (SPA) Oversight Committee was created to increase volunteer direction of the workings of the program. The committee, comprised of leaders from the ADA Board and relevant councils, meets every other week by conference call with ADA staff. One of the major issues supervised by the SPA Oversight Committee was the issuing of an RFP for the national SPA consulting contract, which entailed soliciting bids and ideas from public affairs firms from across the nation. The result of this process was that the committee opted to retain the current national consultant, Chlopak, Leonard Schechter and Associates (CLS). However, as a result of the RFP process, the duties and fees have been renegotiated to result in a savings of $240,000 annually, effective June 1, 2010.

Another new development with the program is that no state grants were paid in July (with rare exceptions permitted for timing purposes, although that did not change the number of months any given state is funded for over the year). The reason is that the vast majority of state legislative sessions were over by that time, and it's an ideal period for the Oversight Committee to assess the progress and program in each participating state and determine whether additional funding is warranted for the remainder of 2010 (or some period of the rest of the year). Each participating state was required to submit a self-assessment of their program which the Committee reviewed in June and July. No state program is automatically renewed.

Programming: Over the course of the first five months of 2010, the ADA SPA team and CLS have continued day-to-day oversight of public affairs campaigns in **more than 20 states**. Additionally, the program has provided strategic direction and executed projects around a number of issues that affect the profession on a national scale. Lastly, the program has begun to implement new initiatives and refine new resources to be shared across the states, in order to enhance learning and *further develop the SPA program.* During the third and fourth quarters of 2010, ADA and CLS are transitioning many of the

functions previously administered by CLS to the Department of State Government Affairs to achieve many of the cost savings reflected in the new national consulting contract.

Non-Covered Services: In the early part of 2010, the ADA SPA team and CLS supported the Virginia Dental Association's attempt to pass legislation preventing dental insurance companies from capping the fees a dentist participating in that plan can charge for non-covered services (NCS), as first passed in Rhode Island last year. Collectively, program staff provided strategic direction, media relations advice, and drafted a number of communications materials and print advertisements to support VDA's position. As legislative battles on this issue became prevalent in more and more states, the SPA staff monitored progress, coordinated strategy and shared resources across state lines. That effort continues.

Given the importance of this issue to the profession and the number of states pursing legislation, the program funded research to determine public perceptions and strong/weak messages on NCS. Focus groups were held in Chicago and Denver in March.

Pew Dental Care Report Card Response: In February, the Pew Research Center released the States Children's Dental Care Report Card in which every state was given a letter grade on the dental care provided to children. In advance of the report release, the SPA team held a conference call with state associations to preview the report and provide them with an opportunity to ask questions. CLS provided counsel on how best to publically respond to the report and how to use it as an opportunity to promote the state's proactive agenda for addressing these issues. Additionally, sample statements were provided to states as they prepared their response and counsel was provided to individual states on the most strategic ways to respond.

Foundations Work: When it became clear that the Kellogg Foundation was organizing in a group of states, the SPA team began a series of regular calls with the states targeted by the foundation. These calls have been an important tool in collecting information, sharing learning, and ensuring states are all on the same page about what is happening elsewhere in the country.

SPA Program Development: A webinar was held on June 4 with state associations, relevant ADA councils, their lobbyists and the SPA program consultants to explain the contents and applicability of newly generated SPA resources: the Legislative Bank and Case Studies (detailed below).

Legislative Bank. This was developed to promote information sharing across the state dental associations. It categorizes and provides details on a range of affirmative legislative solutions supported by dentistry on access to care issues and serves as a one-stop resource to help them develop their own dentist-centric legislative solutions.

Case Studies. These provide an in-depth look at where legislative solutions have worked the best and to map out successful campaign plans. Each case study contains an overview of the problem, identifies the challenges the state association faced, lays out the strategy, describes the media coverage and collateral development, and analyzes the results. SPA will create new case studies on NCS in the middle part of 2010. The case studies we have developed are as follows:

- Connecticut: Increasing Connecticut dentist participation in dental Medicaid
- Maryland: Recruiting dentists for the Maryland dental Medicaid program
- Missouri: Successfully obtaining budget increases for Medicaid reimbursements
- North Dakota: Strengthening dental Medicaid
- Illinois: Building a coalition centered around increasing access to dental care

- New Mexico: Positioning the Association as the source for oral health information
- Wyoming: Defeating denturism legislation and passing an Oral Health Initiative

Dentists: Doctors of Oral Health. To help the public understand that dentists are highly-skilled health-care professionals, the Association developed a booklet to provide state dental associations with easily implementable initiatives that can be used to strengthen their overall perception in the state. The document is designed to increase the understanding of the complexity of dentistry, the education required to become a dentist, and the importance of dentists in their community. Several states are now implementing suggestions from this document, including Idaho and Connecticut.

Native American Project. The purpose of the original Native American Oral Health Care Project funded through the SPA program was to identify workable solutions to dental care issues facing tribes in Arizona and New Mexico. State executive directors, volunteer leaders and local consultants have organized numerous meetings throughout Arizona and New Mexico with tribal leaders in order to engage Native Americans on access to care issues. From these meetings, the program has found that, while conditions vary from tribe to tribe and in some cases by location, access to consistent and quality dental health care services is often lacking.

Moving forward, the SPA Program is considering a research project to analyze the oral health needs of the Native American populations. Additionally, the SPA team is now working to replicate the program in North Dakota and South Dakota.

2011 Applications: Applications for participation in the program next year has been sent to each constituent society. The deadline for initial applications is the end of October. However, the program is structured to accept applications, as needs arise, throughout the year.

Response to Assignments from the 2009 House of Delegates

This section contains responses to 2009 House of Delegates resolutions not addressed or only partially addressed in the Council's annual report.

Deduction of Student Loan Interest. Resolution 34H requires the Association to support legislation that will increase the amount of interest from student loans that can be deducted from income taxes and seek the elimination of the cap. It also calls for the ADA to help draft legislation that would make interest rates more consistent with current market rates while allowing for consolidation of loans. The ADA worked with Representatives Brian Higgins (D-NY) and Carolyn McCarthy (D-NY) to introduce the "Higher Education Affordability and Equity Act of 2010", H.R. 5078, on April 20, 2010. Under current law, individuals who are paying back student loans can deduct up to $2,500 in interest on those loans annually. There are also income caps (from $40,000 to $60,000 for single filers and $60,000 to $150,000 for joint filers) that limit the availability of the deduction for many young dentists. H.R. 5078 would increase the income limits to $115,000 for single filers and $230,000 for joint filers, while also making permanent the elimination of the five-year limit. Finally, the bill eliminates the $2,500 cap on the amount of interest eligible for the deduction, allowing the full amount of interest to be deducted. Reintroduction of the bill was the focus of the American Student Dental Association's Lobby Day, as the ADA Washington Office staff provided key materials to lobby for this issue. This issue has also been a subject of discussion with the Organized Dentistry Coalition.

Maximum Fees for Non-Covered Services. The 2009 House of Delegates adopted Resolution 59H-2009 to provide policy directing the Association to seek legislative action to prevent dental plans from capping the amount dentists can charge for services a plan does not cover. This resolution was in response to actions taken by dental plans, which began implementing contract provisions holding dentists to maximum allowed fees for services for which no benefit is available or no reimbursement is provided with increasing frequency in 2008. In response to this resolution, the Association drafted and facilitated the introduction of federal

legislation ("Dental Coverage Value and Transparency Act of 2010", H.R. 5000) on April 13, 2010, by Rep. Andrews (D-NJ), which includes a provision prohibiting *all* group health plans (including stand alone dental plans, as well as medical plans with dental benefits) from applying the plan's fee schedule to services for which no benefit or reimbursement is provided.

In addition, the Association has assisted states that are addressing this issue. Twenty-nine states have filed bills in 2010 to prevent caps on non-covered services (NCS bills), and 14 have been enacted. With Rhode Island's law of 2009, there are a total of 15 states (Alaska, Arizona, Idaho, Iowa, Kansas, Louisiana, Mississippi, Nebraska, North Carolina, Oklahoma, Oregon, Rhode Island, South Dakota, Virginia and Washington) with an NCS law. One state has filed a lawsuit to block NCS contracts, and one has determined existing law sufficient to prohibit NCS contract provisions.

Dental benefit plans, under the new NCS laws, cannot set limits on what dentists may charge unless the service is a covered service under the plan contract. Therefore, a key component of the NCS bills is the definition of *covered services.* Most states' bills and laws generally define covered services as services that are reimbursable under the dental plan contract *except where contract limitations apply*—such as waiting periods, deductibles and annual maximums. It is important to recognize that any fee for a dental service defined in law as a "covered service" is eligible to be limited by the dental benefit plan.

The National Conference of Insurance Legislators' (NCOIL) Health, Long-Term Care and Health Retirement Issues committee met in July and considered model legislation to prevent dental benefit carriers from capping dental service fees they do not cover. However, no vote was taken because of the split among committee membership. Some members wanted to include services that exceed the annual maximum in the definition of a "cover service", others did not. NCOIL meets again from November 18-21 in Austin, TX.

The Council on Government Affairs and the Council on Dental Benefit Programs believe the Association's current policy (59H) does not provide sufficient guidance to enable the Association to take a position on what services should and should not be included under the definition of a "covered service." As a result, the Association is hampered in its efforts to support state and federal legislation that accurately reflect the desire of the House of Delegates. The following resolution is offered by the CGA and CDBP as a means of providing clear guidance to the Association in its advocacy efforts regarding maximum fees for non-covered services.

Resolution

79. Resolved, that the Association oppose any third party contract provisions that establish fee limits for non-covered services, and be it further

Resolved, that "non-covered service" is defined as any service for which the third party contract provides either no benefit or no reimbursement, including services that exceed the annual or lifetime maximums and services provided during waiting periods, and be further

Resolved, that "covered service" is defined as any service for which the third party contract provides a benefit and for which reimbursement would be provided but for the application of contractual limitations (such as deductibles and copayments), other than the application of annual and lifetime maximums and waiting periods, and be it further

Resolved, that the Association pursue passage of federal legislation to prohibit ERISA covered plans from applying such provisions, and be it further

Resolved, that the Association encourage constituent dental societies to work for the passage of state legislation to prohibit insurance plans from applying such provisions, and be it further

Resolved, that Resolution 59H, Maximum Fees for Non-Benefited Services, be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 83-84 New ■ Substitute ☐ Amendment ☐

Report: CC Supplemental Report 1 Date Submitted: September 2010

Submitted By: Council on Communications

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time _____ Amount On-going _____

ADA Strategic Plan Goal: Members (Required)

COUNCIL ON COMMUNICATIONS SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES: RECENT COUNCIL ACTIVITIES

Background: The following information is provided to update the House of Delegates on activities related to communications, which have occurred since the preparation of the Council on Communications' 2010 annual report.

This report presents the Council's proposed amendments of its *Bylaws* duties and a proposed amendment of the 1997 ADA Communications Policy Standards for Dental Society Publications (*Trans.*1997:303,660) for consideration by the 2010 House of Delegates.

This report also presents the Council's amended mission statement incumbent on House of Delegates approval to proposed revisions to its *Bylaws* duties; progress on the development of an Association-wide social media plan led by the Council; and an update on the ADA State Public Affairs Program managed by a joint committee which includes Council representatives.

Amendment of the ADA *Bylaws* Regarding Duties of the Council on Communications: At its June 18-19 meeting, the Council discussed issues related to its role as the primary ADA agency responsible for reputation management, providing strategic oversight and advising the Association on the image and brand implications of Association plans, programs, services and activities.

The Council requests that the 2010 House of Delegates adopt an amendment to the Council's *Bylaws* duties to more accurately reflect the expanded functions of the Council and the new Division of Communications and Marketing.

Council on Communications Mission Statement: The Council voted to amend its mission statement as follows, incumbent on the 2010 House of Delegates approval to proposed revisions to its *Bylaws* duties:

> The Council on Communications is the primary ADA agency <u>responsible for reputation management, providing strategic oversight and</u> ~~dedicated to~~ advising the Association on the ~~external~~ image and brand implications of Association plans, programs, services and activities ~~in order to preserve and enhance the trusted image of the Association and the profession~~. <u>Further, this Council shall advise the Association regarding integrated and strategic communications plans and policies between itself, the public, members and the profession.</u>

Amendment of the Policy, "Standards for Dental Society Publications": In accordance with House Resolution 15H-1995 (*Trans.*1995:660), which directs the review of ADA policy at least every seven years after adoption, ADA councils and commissions were reminded to review appropriate policies as part of their

assignment for 2010. The Council adopted a resolution recommending that the 2010 House of Delegates amend the 1997 policy "Standards for Dental Society Publications" (*Trans.*1997:303,660).

Proposed Oral Health Initiatives: The Council identified access to oral health care, oral health initiatives and programs that affect the image of dentistry as the communications priorities on which the ADA should focus in 2010 and that staff can implement on a tactical level.

In support of the ADA Strategic Plan 2011-2014, the Division of Communications and Marketing developed the following goal for 2010: Position the ADA as the leading advocate for oral health by promoting the value of good oral health to the public.

The Council selected oral health and overall health as the health initiative topic on which the division could create a multi-year initiative. The goal of this initiative would be to explain and demonstrate how oral health is integrally connected with general health and the call to action would be to follow ADA oral hygiene recommendations.

Social Media Strategy: In an effort to develop a framework for an ADA social media strategy, the Council requested the ADA Board of Trustees to review and adopt a Social Media statement of purpose and goals. The Council also requested that the Board adopt an implementation of social media for events such as the 2010 annual session to provide an additional communications channel and a platform for attendees to share their experiences and build a sense of community as well as for the ADA to communicate with attendees prior to the 2010 annual session.

The Council's Social Media Workgroup has developed a strategic plan outline, which details short-term and long-term recommendations for implementing social media in support of the ADA's communications strategy around key ADA initiatives. Currently, the Division of Communications and Marketing (with strategic input from the Council's Social Media Workgroup) is in the process of conducting focus group research with dentists (in-person and on-line) and survey research to confirm social media use and expectations with key audiences. The findings from this research will help in the development of a strategic plan for Association-wide social media.

Other Activities: In support of the ADA Strategic Plan goal "Achieve Effective Advocacy," ADA spokespersons were interviewed on a variety of oral health issues for major news outlets such as *USA Today*, Fox News, *The New York Times*, *The Wall Street Journal*, *Los Angeles Times* and *Money Magazine.* This year, Council leadership approved participation in a press event to raise public awareness of the value of the ADA Seal of Acceptance to consumers.

Dr. Clifford Whall, PhD, director of the ADA Seal of Acceptance program, joined Tom's of Maine representatives at an editors briefing in New York City in March. Tom's of Maine is a long-standing participant in the ADA Seal program. The company sponsored the press event and invited Dr. Whall to give a presentation to 31 health and beauty editors of national magazines and health blogs about the rigorous criteria products must meet to earn the ADA Seal. Dr. Whall also told editors that the ADA Seal program is part of the ADA's ongoing mission to promote oral health and helps consumers make informed decisions about dental products.

In August, an article about the ADA Seal of Acceptance program by Dr. Michael Rethman, chair of the ADA Council on Scientific Affairs, appeared on page 2 in a supplement to the *Chicago Tribune* (http://doc.mediaplanet.com/all_projects/5464.pdf). Approximately half a million supplements were produced creating an estimated 1.3 million reader impressions and 2 million online impressions.

ADA Strategic Communications Plan: In accordance with the Council's Bylaws duties, the Council maintains the strategic communications plan for the ADA. The Council created a Strategic Communications Plan Workgroup to provide strategic input for the Council to update the ADA Strategic Communications Plan to align with the new 2011-2014 ADA Strategic Plan.

State Public Affairs Program: Communications plays a critical role in the State Public Affairs (SPA) Program, which was established by Resolution 41H-2006, and detailed in Board Report 14: Protecting and Advancing Dentistry: A Strategic Path to a Nationally-Coordinated, State-Targeted Integrated Public Affairs Plan (*Supplement* 2006:3052). The Council, along with the Council on Government Affairs, provides volunteer oversight to the SPA program by having a representative chair the SPA Oversight Committee on a rotating basis with CGA.

The SPA Oversight Committee, after reviewing numerous proposals and presentations, elected to retain the SPA program's current national consultant, Chlopak, Leonard, Schechter and Associates (CLS) to manage the program through 2011.

Resolutions

(Resolution 83:Worksheet:5047)
(Resolution 84:Worksheet:5049)

BOARD COMMENT: The Board recognizes and appreciates the update on Council activities provided in this supplemental report including suggested amendment to its mission statement. The Board encourages the Council to review its mission statement to ensure it reflects the advisory and oversight responsibilities of the Council identified in Resolution 83 subsequent to action by the House.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS.

Resolution No. 83 New ■ Substitute ☐ Amendment ☐

Report: CC Supplemental Report 1 Date Submitted: September 2010

Submitted By: Council on Communications

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

AMENDMENT OF ADA *BYLAWS* REGARDING DUTIES OF THE COUNCIL ON COMMUNICATIONS

Background: (See CC Supplemental Report 1, Worksheet:5044)

Resolution

83. Resolved, that Chapter X. COUNCILS, Section 120. DUTIES, Subsection C. COUNCIL ON COMMUNICATIONS, of the ADA *Bylaws* be amended by revising subsections a through f (new language underscored and deletions stricken through):

C. COUNCIL ON COMMUNICATIONS. The duties of the Council shall be to:

a. Identify, recommend, and maintain a ~~an external~~ strategic communications plan for the Association. ~~to facilitate other work throughout and on behalf of the Association.~~
b. ~~advise~~ Manage the reputation of the Association, provide strategic oversight and advise the Association on the ~~external~~ image and brand implications of its plans, programs, services and activities.
c. Provide counsel to the Association on the priority and allocation of ~~externally focused~~ communication resources, to advise on their implications, and to identify the areas where the greatest strategic communications impact can be achieved.
d. Identify, recommend, articulate and maintain strategies for significant ~~external~~ communications campaigns across the Association.
e. Serve as a strategic communications and brand management resource to other Association agencies. ~~on communications to the profession~~
f. Serve as a resource and to support communications and reputation management strategies for the ~~create, implement, monitor and update an ongoing communication support strategy for the~~ constituent and component dental societies.

BOARD COMMENT: The Board appreciates the Council's diligence in the review and proposed updating of its duties and the role the Council plays in the oversight of the association's reputation. The Board also recognizes that the activities of other agencies have a direct effect on reputation. Therefore, the Board offers the following substitute resolution, which provides alternative language in line 8 of page 5048 for the originally proposed language reflected in line 15 on page 5047.

83B. Resolved, that Chapter X. COUNCILS, Section 120. DUTIES, Subsection C. COUNCIL ON COMMUNICATIONS, of the ADA *Bylaws* be amended by revising subsections a through f (new language underscored and deletions stricken through):

C. COUNCIL ON COMMUNICATIONS. The duties of the Council shall be to:

a. Identify, recommend, and maintain a ~~an external~~ strategic communications plan for the Association. ~~to facilitate other work throughout and on behalf of the Association.~~
b. Advise on the reputation management of the Association, provide strategic oversight and advise the Association on the ~~external~~ image and brand implications of its plans, programs, services and activities.
c. Provide counsel to the Association on the priority and allocation of ~~externally focused~~ communication resources, to advise on their implications, and to identify the areas where the greatest strategic communications impact can be achieved.
d. Identify, recommend, articulate and maintain strategies for significant ~~external~~ communications campaigns across the Association.
e. Serve as a strategic communications and brand management resource to other Association agencies. ~~on communications to the profession~~
f. Serve as a resource and to support communications and reputation management strategies for the ~~create, implement, monitor and update an ongoing communication support strategy for the~~ constituent and component dental societies.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

BOARD VOTE: UNANIMOUS.

Resolution No. 84 New ■ Substitute ☐ Amendment ☐

Report: CC Supplemental Report 1 Date Submitted: September 2010

Submitted By: Council on Communications

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

AMENDMENT OF THE POLICY, "STANDARDS FOR DENTAL SOCIETY PUBLICATIONS"

Background (See CC Supplemental Report 1, Worksheet:5044)

Proposed Resolution

84. Resolved, that the "Standards for Dental Society Publications" (*Trans.*1997:303,660) be amended in the first paragraph of the section entitled "Objective," by the addition of the following sentences:

> An increasing number of dental society publications are posted on the Internet and the content is potentially accessible by the general public. This fact should be taken into consideration during the editing process.

so that the amended section reads (additions are underscored)

> **Objective:** The dental society publication is both an educational tool and a channel of communication between the dental society and members. An increasing number of dental society publications are posted on the Internet and the content is potentially accessible by the general public. This fact should be taken into consideration during the editing process.
>
> While emphasis in content may vary, the objectives of the publication should be (1) to broaden the dentist's professional knowledge and improve his/her competence so he/she can provide better health service, and (2) to keep him/her informed on professional affairs. To accomplish these objectives, a society's publication should:
>
> 1. inform the dentist on issues of concern to the profession;
> 2. communicate the dental society's policies and actions on professional issues;
> 3. report the news and latest developments in the profession;
> 4. communicate government rules and regulations;
> 5. assist the dental society with membership recruitment and retention efforts;
> 6. inform and market to members available benefits and services;
> 7. provide a forum to address the needs and concerns of members, including the latest issues;
> 8. recognize the achievement and efforts of individuals who have worked hard for the advancement of the profession;
> 9. elicit the support and participation of the membership; and
> 10. maintain a balanced content with an attractive and interesting format.

The objectives of other dental publications, such as school, alumni, dental student, fraternity and commercial, should closely parallel those of dental society publications, namely education and communication, and the same standards should apply to all dental publications.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 85 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Fifteenth Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

CHIEF LEGAL COUNSEL

The following resolution was submitted by the Fifteenth Trustee District and transmitted on September 2, 2010, by Ms. Donna Cortez, executive affairs manager, Texas Dental Association.

Background: The Chief Legal Counsel provides legal advice, preventative legal guidance, and advice in all matters pertaining to the practice of law on behalf of the American Dental Association. Given the complexity of this position, and its importance in monitoring and controlling risks throughout the Association, it is imperative that the Chief Legal Counsel is accountable only to the Board of Trustees in the performance of his/her duties. The Board, in turn, must implement appropriate authority and chain of command to ensure impartial legal advice, and balance the complex roles of the Chief Legal Counsel, therefore, be it

Resolution

85. Resolved, that the ADA *Bylaws* Chapter VII. Board of Trustees, Section 100. DUTIES, B be amended by the addition of the words, "and Chief Legal Counsel" to read: "Appoint the Executive Director and Chief Legal Counsel of the Association", and be it further

Resolved, that the ADA *Bylaws* Chapter IX. Appointive Officer, Section 40, c, be amended by addition of the words "except the Chief Legal Counsel" to read "engage the staff of this Association, except the Chief Legal Counsel, and direct and coordinate their activities," and be it further

Resolved, that the Chief Legal Counsel is not an appointive officer of this Association.

BOARD COMMENT: The Board of Trustees believes that the Executive Director should remain in charge of all ADA staff, including the Chief Legal Counsel. Expanding the responsibilities of the Board members/volunteers could result in increased risk for the ADA on employment matters. If adopted, the resolution would create ambiguity in the reporting relationships of the Chief Legal Counsel as well as for the other ADA attorneys in employ of the ADA. The Chief Legal Counsel is accountable to the Association, not the Board**.**

BOARD RECOMMENDATION: Vote No.

Board Vote:															
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		
☐	■	☐	☐	CALNON	☐	■	☐	☐	LOW	☐	■	☐	☐	SULLIVAN	
☐	■	☐	☐	ENGEL	■	☐	☐	☐	MANNING	■	☐	☐	☐	THOMPSON	
☐	■	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	☐	■	☐	☐	VERSMAN	
☐	■	☐	☐	FEINBERG	☐	■	☐	☐	RICH	■	☐	☐	☐	VIGNA	
☐	■	☐	☐	GIST	☐	■	☐	☐	SEAGO	☐	■	☐	☐	WEBB	
☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SMITH, A. J.	☐	■	☐	☐	WEBER	
■	☐	☐	☐	LONG	☐	■	☐	☐	STEFFEL					Res. 85	

Resolution No. 86 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Fifteenth Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

COMMUNICATIONS

The following resolution was submitted by the Fifteenth Trustee District and transmitted on September 2, 2010, by Ms. Donna Cortez, executive affairs manager, Texas Dental Association.

Background: The members of the House of Delegates of the ADA must be free to communicate with other members of the House of Delegates, Association officers and Board members, and staff of the ADA. This communication is fundamental to a knowledge-based organization, and is essential for a deliberative and representative body, therefore, be it

Resolution

86. Resolved, that the Board of Trustees may not adopt any rule, policy, guideline, or authority, etc., that prohibits or restricts communications among members, members of the Board and members of the House of Delegates, and be it further

Resolved, that to facilitate communication within the House of Delegates, email addresses of all House members shall be shared with the entire House on a yearly basis. Any House member who does not wish his or her email address to be shared may, by request, not be included in the list.

BOARD COMMENT: The Board has taken some actions that have been implemented to enhance communications between the House of Delegates and Board of Trustees. The Board agrees that open communication should occur but recognizes that at times restrictions on that communication is necessary to protect the Association from legal and financial risk. As part of the $7 dues increase package in the base budget for the House consideration, we have included the software licenses to replace SiteScape with a new solution. We have found that we can also leverage this solution to enable a secure collaboration area for the HOD as well. This software will allow secure discussion forums, online chat, scheduling session, and a secure ecosystem for HOD collaboration. We recommend that, rather than utilizing electronic mail for this capability, that this collaboration software is leveraged.

As another point of consideration, the industry standard for Board level communications is to have a dual level of authentication (security). An email account does not provide that level of security, therefore opening the HOD to a risk that their communications could be compromised.

Assuming the approval of the HOD for the $7 dues increase, we can implement this new collaboration software in the first half of 2011.

BOARD RECOMMENDATION: Vote No.

Board Vote:															
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		
☐	■	☐	☐	CALNON	☐	■	☐	☐	LOW	☐	■	☐	☐	SULLIVAN	
☐	■	☐	☐	ENGEL	■	☐	☐	☐	MANNING	■	☐	☐	☐	THOMPSON	
☐	■	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	☐	■	☐	☐	VERSMAN	
☐	■	☐	☐	FEINBERG	☐	■	☐	☐	RICH	■	☐	☐	☐	VIGNA	
☐	■	☐	☐	GIST	☐	■	☐	☐	SEAGO	☐	■	☐	☐	WEBB	
☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SMITH, A. J.	☐	■	☐	☐	WEBER	
■	☐	☐	☐	LONG	☐	■	☐	☐	STEFFEL					Res. 86	

Resolution No. 88 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Third Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

NOMINATION AND ELECTION PROCEDURES FOR THE OFFICE OF SPEAKER OF THE HOUSE OF DELEGATES

The following resolution was submitted by the Third Trustee District and transmitted on September 8, 2010, by Dr. Jeffrey B. Sameroff, secretary, Pennsylvania Dental Association.

Background: The House of Delegates meets but once a year and sets policy for the Association. It is imperative that the business of the House be conducted in a legal and efficient manner. The office of Speaker of the House of Delegates requires special skills, training and experience to deal with procedure during the Annual Session. Each year, the delegates voting for this office need enough time to review any candidate's qualifications. If last-minute nominations are permitted, delegates may not have sufficient time to make an educated decision. In addition, an incumbent Speaker running for re-election is totally occupied with the business of the House during the Annual Session. Any campaign activities during this critical time may distract such a candidate and detract from time spent dealing with the necessary activities of the Speaker.

Resolution

88. Resolved, that the Council on Ethics, Bylaws and Judicial Affairs review the nomination and election procedures for the Office of Speaker of the House of Delegates and report back to the 2011 House of Delegates.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 89 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Board of Trustees

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

AMENDMENT TO THE ADA *BYLAWS*: CHAPTER X. COUNCILS. SECTION 110. COUNCIL ON SCIENTIFIC AFFAIRS, SUBSECTION K(e); AND CHAPTER XIII. AMERICAN DENTAL ASSOCIATION FOUNDATION. SECTION 10 AND SUBSECTIONS A AND C OF SECTION 30.

Background: At its September 3, 2010 meeting, the Board of Directors of the ADA Foundation approved Amended and Restated Bylaws ("Restated Bylaws"). A copy of the Restated Bylaws is attached hereto as Appendix 1. The Restated Bylaws were adopted by the ADA Foundation Board of Directors for the purpose of moving the Foundation forward. They are part of a number of steps towards addressing certain governance recommendations identified by the KPMG Report. The ADA Foundation Board of Directors submitted the Restated Bylaws to the ADA Board of Trustees for approval at its September 12-14, 2010 meeting. Approval of the Restated Bylaws by the ADA Board of Trustees, acting for the sole Member, necessitates an examination of and change in the ADA *Bylaws*.

Council on Scientific Affairs: Under the current ADA *Bylaws (*Chapter X, Section 110, Subsection K(e)), one of the duties of the Council on Scientific Affairs is to "Guide, assist and act as liaison to the American Dental Association Foundation and serve as its peer review body." A copy of Chapter X, Section 110, Subsection K is attached hereto as Appendix 2. The ADA Foundation will report directly to the ADA Board of Trustees and the sole Member regarding PRC and thus the referenced provision is unnecessary.

American Dental Association Foundation: Under the current ADA *Bylaws*, the entirety of Chapter XIII is devoted to the ADA Foundation. Section 10 addresses the Foundation's agencies and personnel, Section 20 addresses financial support from the Association, and Section 30 addresses the Duties of the Foundation. A copy of Chapter XIII is attached hereto as Appendix 3. Section 10 and Subsection A and C of Section 30 are no longer necessary because the Foundation is responsible for governing and managing its own internal business and affairs.

To codify the above-described changes in the ADA *Bylaws*, the following resolution is offered.

Resolution

89. Resolved, that Chapter X.COUNCILS, SECTION 110. COUNCIL ON SCIENTIFIC AFFAIRS, Subsection K(e), of the ADA *Bylaws* be amended by deleting said Chapter X, Section 110, Subsection K(e) in its entirety so that the amended Subsection reads as follows (deletions stricken):

K. COUNCIL ON SCIENTIFIC AFFAIRS. The duties of the Council shall be to:

a. Develop and promote an annual research agenda with appropriate means for funding.

b. Identify emergent issues and areas of research that require response from the research community.

c. Report results on the latest scientific developments to practicing dentists.

d. Evaluate and issue statements to the profession regarding the efficacy of concepts, procedures and techniques for use in the treatment of patients.

~~e. Guide, assist and act as liaison to the American Dental Association Foundation and serve as its peer review body.~~

f. Represent the Association on scientific and research matters and maintain liaison with related regulatory, research and professional organizations.

g. Encourage the development and improvement of materials, instruments and equipment for use in dental practice, and to coordinate development of national and international standardization programs.

h. Determine the safety and effectiveness of, and disseminate information on, materials, instruments and equipment that are offered to the public or the profession and further critically evaluate statements of efficacy and advertising claims.

i. Study, evaluate and disseminate information with regard to the proper use of dental therapeutic agents, their adjuncts and dental cosmetic agents that are offered to the public or the profession.

j. Award the American Dental Association Seal to dental products that meet the Association's requirements for acceptance.

k. Promote efforts to develop dental research workforce and to involve students in dental research.

l. Study, evaluate and disseminate information on those aspects of the dental practice environment related to the health of the public, dentists and dental auxiliaries.

m. Serve as the primary resource for scientific inquiries from the public and the profession.

and be it further

Resolved, that Chapter XIII. AMERICAN DENTAL ASSOCIATION FOUNDATION, be amended by deleting Section 10 and Subsections A and C of Subsection 30 so that the amended Article XIII reads as follows (new language is underscored, deletions stricken):

CHAPTER XIII • AMERICAN DENTAL ASSOCIATION FOUNDATION

Section 10. ~~AGENCIES AND PERSONNEL: The Research Institute and the Paffenbarger Research Center at the National Institute of Standards and Technology will be agencies of the American Dental Association Foundation and the personnel of these agencies shall be employees of the Foundation.~~

~~*Section 20.*~~ FINANCIAL SUPPORT: <u>The Association is the sole Member of the American Dental Association Foundation.</u> The Association shall annually furnish sufficient financial support, as an addition to generated non-Association funding, to assure the continued viability of the Foundation's research activities.

Section 30. DUTIES:

~~A. The Foundation, through its agencies, the Research Institute and the Paffenbarger Research Center at the National Institute of Standards and Technology shall:~~

~~a. Conduct basic and applied research for the utilization in and development of oral health.~~

~~b. Conduct training programs in research disciplines that relate to the basic and applied problems of oral health.~~

~~c. Submit, either through or in cooperation with the Council on Scientific Affairs, an annual report to the House of Delegates, interim reports on request to the Board of Trustees, and an annual budget to the Board of Trustees for such financial support allocations as the Board may deem necessary.~~

~~B. In addition,~~ t~~T~~he Foundation's Administrative/ Charitable group shall submit, through the ADA Board of Trustees acting as the Member, an annual report to the House of Delegates, interim reports on request to the Member, and an annual budget to the Board of Trustees for such financial support allocations as the Board may deem necessary.

~~C. The Foundation also may perform such other charitable and research functions as permitted under its articles of incorporation and bylaws and the laws of the State of Illinois.~~

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

APPENDIX 1

ADA FOUNDATION RESTATED BYLAWS

AMENDED AND RESTATED BYLAWS OF THE ADA FOUNDATION

(Adopted as of September __, 2010)

ARTICLE I

NAME

The name of the corporation is ADA Foundation, hereinafter referred to as "corporation."

ARTICLE II

PURPOSES

The corporation is both organized and operated exclusively for one or more of the purposes specified in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or the corresponding provisions of any subsequent federal tax law ("Code"). The specific purposes of the corporation are: (a) to be dentistry's premier philanthropic and charitable organization; and (b) to be a catalyst for uniting people and organizations to make a difference through better oral health by securing contributions and providing grants for sustainable programs in dental research, education, access to care and assistance for dentists and their families in need.

No part of the net earnings or assets of the corporation shall inure to the benefit of or be distributed to its member, or any director or officer of the corporation, or any private person (except that (1) reasonable compensation may be paid for personal services rendered to or for the corporation which are reasonable and necessary to carry out one or more of its exempt purposes, and (2) payments and distributions may be made in furtherance of one or more of its exempt purposes. No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements), any political campaign on behalf of or in opposition to any candidate for public office.

Notwithstanding any other provision of these *Bylaws*, the corporation shall not carry on any other activities not permitted to be carried on (a) by an organization exempt from federal income tax under Code Section 501(c)(3), (b) by an organization, contributions to which are deductible for federal income tax purposes under Code Section 170(c)(2), (c) by an organization, contributions to which are deductible for federal gift purposes under Code Section 2522(a), or (d) by an organization, contributions to which are deductible for federal estate tax purposes under Code Section 2055(a)(2).

Upon dissolution of the corporation or the winding up of its affairs, the Board of Directors shall, after paying or making provision for the payment of all the liabilities of the corporation, dispose of all of the assets of the corporation exclusively for the purposes of the corporation in such manner, or to such organization or organizations organized and operated exclusively for charitable, educational, literary, religious or scientific purposes as shall at the time qualify as an exempt organization or organizations under Code Section 501(c)(3), as the Board of Directors shall determine. Any such assets not so disposed of shall be disposed of by the

Circuit Court of the county in which the principal office of the corporation is then located, exclusively for such purposes or to such organization or organizations, as said Court shall determine, which are organized and operated exclusively for such purposes.

The corporation shall have such powers as are now or may hereinafter be granted by the General Not for Profit Corporation Act of the State of Illinois.

ARTICLE III

OFFICES

The principal office of the corporation in the State of Illinois shall be located in the City of Chicago, County of Cook. The corporation may have such other offices, either within or without the State of Illinois, as the Board of Directors may determine or as the affairs of the corporation my require from time to time.

The corporation shall have and continually maintain in the State of Illinois a registered office and a registered agent whose office is identical with such registered office. The registered office may, but need not, be identical with the principal office in the State of Illinois, and the address of the registered office may be changed from time to time by the Board of Directors.

ARTICLE IV

MEMBER

Section 1: Voting Rights. The sole Member of the corporation shall be the American Dental Association (the "Association") acting through its Board of Trustees on behalf of its House of Delegates. Subject to these *Bylaws*, the Member shall have the right to vote, as set forth in these *Bylaws*, on the following:

(a) amendment or repeal of the *Articles of Incorporation* of the corporation;

(b) amendment of these *Bylaws* as provided in Article XII below;

(c) the election and removal of ADA Directors (as defined herein) as provided in Article V below;

(d) the removal of directors as provided in 805 ICLS 105/108.35(d) of the Illinois Not For Profit Corporation Act;

(e) any merger of this corporation;

(f) the dissolution of this corporation; and

(g) the disposition of all or substantially all of the assets of this corporation

Section 2: Annual Meeting. The Member shall hold an annual meeting at a date, place, and time determined by the Association's Board of Trustees for the purpose of electing the ADA Directors and the transaction of such business as may come before the meeting. The Member shall report the name of the ADA

Director(s) it has elected to the President of the corporation's Board of Directors prior to the corporation's Annual Meeting.

Section 3: Special Meetings. Special meetings of the Member, for any purpose or purposes, unless otherwise prescribed by statute, may be called by the corporation's Board of Directors, by the President of the corporation's Board of Directors, or by the Member at the next regular or special meeting of the Association's Board of Trustees.

Section 4: Action by Written Consent. Any action required to be taken at a meeting of the Member, or any other action which may be taken at a meeting of the Member, may be taken without a meeting if a consent in writing setting forth the action so taken shall be signed on behalf of the Member by the President of the Association or his designee after obtaining the requisite consent of the Board of Trustees of the Association.

ARTICLE V

BOARD OF DIRECTORS

Section 1: General Powers, Number and Classification. The property and affairs of the corporation shall be managed by or under the direction of its Board of Directors. The number of directors shall be twenty (20); however at no time shall there be less than fifteen (15) directors. In addition, the President of the Foundation shall be an *ex officio* member of the Board without the right to vote, except that the President shall cast the deciding vote in case of a tie. The terms of directors shall be staggered, with directors divided as equally as possible between Class A, Class B, Class C, and Class D. At the time of his or her election, each director shall be assigned to Class A, Class B, Class C, or Class D, and an effort shall be made to keep each class of directors of approximately equal size. The Member shall have the right to elect four directors - one director in each of Class A, Class B, Class C, and Class D (each, an "ADA Director," and collectively, the "ADA Directors"). The Board of Directors of the corporation shall have the right to elect sixteen (16) directors – four (4) in each of Class A, Class B, Class C, and Class D (each, an "Independent Director," and collectively, the "Independent Directors"). Use of the term "director" or "directors" without designation shall refer to both ADA Directors and Independent Directors.

Section 2: Tenure. Each director shall hold office for a term of four (4) years and until his or her successor shall have been elected and qualified. Unless otherwise determined by the Board of Directors, the tenure of a director shall be limited to one (1) term. An individual who fills a vacancy in the office of director for a partial term shall be eligible for election to a full term or terms in his or her own right.

Section 3: Qualifications. Directors need not be residents of Illinois. The Board shall use its best efforts to recruit Independent Directors with broad and diverse backgrounds, age, experience and abilities, and with expertise in areas such as finance, accounting, law, business, education, management, fundraising, research, science, and public health. The Board of Directors may determine additional qualifications for Independent Directors consistent with these *Bylaws*. The powers and duties hereunder may be delegated to a Committee of the Board.

Section 4: ADA Directors. The Member shall be entitled to elect the four (4) ADA Directors, one in each of Class A, Class B, Class C, and Class D. At the time of election, each ADA Director who is a trustee of the American Dental Association shall have the number of years left on his or her term of office as

trustee that matches the number of years that he or she would be eligible to serve as a director of the corporation.

Section 5: Independent Directors. The Board shall be entitled to elect the sixteen (16) Independent Directors, four (4) in each of Class A, Class B, Class C, and Class D. Election of Board members shall occur at each annual meeting of the Board of Directors.

Section 6: Annual Meeting. Beginning in 2010, an Annual Meeting of the Board of Directors shall be held in the month of September (at such dates and times as provided in notices of such meetings) for the purpose of electing the number of Independent Directors equal to the number of directors in the Class whose term expires, electing all officers, and for the transaction of such other business as may come before the meeting. If the election of the Independent Directors and officers shall not be held on the date designated herein for any Annual Meeting, or at any adjournment thereof, the Board of Directors shall cause the election to be held at a Special Meeting of the Board of Directors as soon thereafter as conveniently may be.

Section 7: Regular Meetings. During each calendar year, in addition to the Annual Meeting, the Board of Directors shall hold not less than three (3) regular meetings, which shall be held on such dates and at such times as set by resolution of the Board of Directors, for the transaction of such business as may come before those meetings.

Section 8: Special Meetings. Special meetings of the Board of Directors may be called by or at the request of the President or any three (3) directors.

Section 9: Place of Meeting. The Annual Meeting and regular meetings of the Board of Directors may be held in a single geographic location (at the principal office of the corporation or at such other place, either within or without the State of Illinois, as may be designated by the Board of Directors) or from multiple remote locations through the use of a conference telephone or other communications equipment, or some combination thereof. Special meetings of the Board of Directors may be held in a single geographic location or from multiple remote locations through the use of a conference telephone or other communications equipment, or some combination thereof. The person or persons authorized to call any special meeting of the Board of Directors may fix the time and place, either within or without the State of Illinois, or via conference telephone, for holding any special meeting of the Board called by him or them. If no designation is made, the place of meeting shall be the principal office of the corporation in the State of Illinois.

Section 10: Notice. Unless otherwise specifically required by law, notice of any special meeting of the Board of Directors shall be given at least three (3) days prior thereto by written notice delivered personally or sent by regular mail, e-mail, fax or national overnight courier service to each director at the director's address as shown by the records of the corporation. If mailed, such notice shall be deemed to be delivered two days after deposit in the U.S. mail in a sealed envelope so addressed, with postage thereon prepaid. If notice be given by fax or e-mail, such notice shall be deemed to be delivered on the day the sending machine confirms delivery of the fax or e-mail or transmission. If notice is given by national overnight courier service, such notice shall be deemed delivered one day after the notice is delivered to such courier service. Any director may waive notice of any meeting. The attendance of a director at any meeting shall constitute a waiver of notice of such meeting, except where a director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. Neither the business to be transacted at, nor the purpose of, any special meeting of the Board of

Directors need be specified in the notice or waiver of notice of such meeting, unless specifically required by law or by these *Bylaws*.

Section 11: Quorum. A majority of the directors then in office shall constitute a quorum for the transaction of business at any meeting of the Board of Directors, provided, that if less than a majority of the directors are present at said meeting, a majority of the directors present may adjourn the meeting from time to time without further notice.

Section 12: Manner of Acting. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, except where otherwise provided by law, the *Articles of Incorporation* or these *Bylaws*.

Section 13: Resignation. A director may resign at any time upon written notice to the Board of Directors. The resignation of any director shall take effect at the time specified in such notice, and, unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

Section 14: Removal. An ADA Director may be removed by the Member, with or without cause, as specified by the Illinois Not For Profit Corporation Act. An Independent Director may be removed, with or without cause, by a two-thirds (2/3) vote of the Independent Directors at any regular or special meeting of the Board called expressly for that purpose. In addition, the position of a director with three unexcused absences from consecutive regular meetings shall be deemed immediately vacant, regardless of the classification of such director.

Section 15: Vacancies. Any vacancy occurring in the position of an ADA Director shall be filled by the Member. Any vacancy occurring in the position of an Independent Director shall be filled by the Board of Directors. A director elected to fill a vacancy shall be elected for the unexpired term of such director's predecessor in office.

Section 16: Executive Committee. There shall be an Executive Committee of four (4) members comprised of the four (4) Vice Presidents. In addition, the President shall be an *ex officio* member of the Executive Committee without the right to vote, except that the President shall cast the deciding vote in case of a tie. The Executive Committee shall be governed by rules established by the Board of Directors. The Executive Committee shall have and may exercise all the authority of the Board of Directors in the management of the corporation between meetings of the Board of Directors, provided the Executive Committee shall not have any authority of the Board of Directors in reference to (a) electing, appointing or removing any director or officer of the corporation or any member of the Executive Committee, or (b) amending these *Bylaws*. The Executive Committee shall keep minutes of each of its meetings and report the same at the next meeting of the Board of Directors. Unless otherwise provided by resolution of the Board of Directors, a majority of the Executive Committee shall constitute a quorum, and the act of a majority of the members shall constitute the act of the Executive Committee. Each member of the Executive Committee shall serve until the next annual meeting of the corporation and until a successor is appointed, unless such member has been sooner removed.

Section 17: Standing Committees. The Board of Directors shall have the following standing committees:

(a) Finance Committee. The Vice President - Finance shall be the Chair of the Finance Committee. The responsibilities of the Finance Committee shall include the following: to assist the Chief

Financial Officer in the review, development and administrative review of the annual budget for consideration by the Board of Directors; to review investment policies and performance of investment portfolio and develop recommendations for the Board of Directors; to serve as a resource for the Board of Directors; and to recommend selection of the auditor and work with the auditor when there is not a separate audit committee.

(b) Board Development/Governance/Nominating Committee. The President shall be the Chair of the Board Development/Governance/Nominating Committee. The responsibilities of the Governance/Nominating Committee shall include the following: review and make recommendations to the Board regarding the corporation's *Bylaws* and *Standing Rules* as necessary; study the leadership requirements of the corporation; ensure effective board processes, structures and roles, including retreat planning, committee development, and board evaluation; identify needed board member skills; review, interview, and select potential members, and orient new members; and suggest new, non-board individuals for committee membership as needed.

(c) Development and Fundraising Committee. The Vice President– Development and Fundraising shall be the Chair of the Development and Fundraising Committee. The responsibilities of the Development and Fundraising Committee shall include the following: work with staff to develop and implement an annual fundraising plan; work with fundraising staff in their efforts to raise money; be responsible for involvement of all board members in fundraising; and monitor fundraising efforts to be sure that ethical practices are in place, that donors are acknowledged appropriately, and that fundraising efforts are cost-effective.

(d) Programs Committee. The Vice President - Programs shall be the Chair of the Programs Committee. The responsibilities of the Programs Committee shall include the following to the extent not delegated to the Scientific Research Committee: to oversee new program development; to monitor, assess, and oversee existing programs; to make scholarship and grant decisions; to initiate and guide program evaluations; and to facilitate discussions about program priorities for the corporation.

(e) Scientific Research Committee. The Vice President - Scientific Research shall be the Chair of the Scientific Research Committee. The responsibilities of the Scientific Research Committee shall be to: monitor, assess, and oversee existing scientific research, fellowship, and internship programs; monitor, assess, and oversee scientific scholarship and scientific awards programs; initiate and guide scientific program evaluations; facilitate discussions about scientific program priorities for the corporation; and monitor, assess, and oversee Paffenbarger Research Center and Research Institute activities.

In addition, the Board may designate from time to time additional standing or special committees as set forth by resolution or in *Standing Rules* adopted by the Board of Directors. Rules not inconsistent with these *Bylaws* for the governance of standing committees, including but not limited to selecting members of such committees, selecting the name for each standing or special committee, usual duties, term of office and requirements for reports, may also be set forth in *Standing Rules* adopted by the Board, or if not so set forth, then by resolution of the Board. In the absence of *Standing Rules* or rules set forth in a resolution adopted by the Board, the committee may adopt such rules, including for the participation of non-Board member volunteers. Anything herein to the contrary notwithstanding, each committee shall have two or more directors, a majority of its membership shall be directors, and all committee members shall serve at the pleasure of the Board. In addition, members of any committee of the Board may participate in and act at any meeting via telephone or other communications equipment by means of which all persons participating in the meeting can communicate with each other. Participation in such meeting shall constitute attendance and presence in person at such meeting of the person or persons so participating.

Section 18: Special Committees. The President of the Board may from time to time establish other special committees to carry out tasks specifically referred to them. Such committees shall consist of members, including a chairperson, as appointed by the President, but each committee shall have at least one member who is a director of the corporation. Such committees will automatically terminate upon completion of the task assigned.

Section 19: Compensation: Directors and officers shall not receive any compensation for services rendered to the corporation as members of the Board unless otherwise determined by the Board, except that directors may be reimbursed for expenses incurred in the performance of their duties to the corporation, in reasonable amounts based on policies approved by the Board.

Section 20: Action by Written Consent. Any action required to be taken at a meeting of the Board of Directors, or any other action which may be taken at a meeting of the Board of Directors, may be taken without a meeting if a consent in writing setting forth the action so taken shall be signed on behalf of all members of the Board of Directors entitled to vote on the subject matter thereof.

ARTICLE VI

OFFICERS

Section 1: Officers. The elective officers of the corporation shall be a President; four (4) Vice Presidents as follows: Vice President – Finance, Vice President – Development and Fundraising, Vice President – Programs, and Vice President – Scientific Research; and such other officers as may be elected in accordance with the provisions of this article. While any qualified person may be elected President and any qualified director may be elected as a Vice President, no two offices may be held by the same person and neither the President nor a Vice President shall serve simultaneously as an elective or appointive officer or trustee of the Association. The Board of Directors may elect or appoint such other officers, as it shall deem desirable, such officers to have the authority and perform the duties prescribed, from time to time, by the Board of Directors.

Section 2: Election and Tenure. The officers of the corporation shall be elected by the Board of Directors at the Annual Meeting of the Board of Directors. If the election of officers shall not be held at such meeting, such election shall be held as soon thereafter as conveniently may be. Vacancies may be filled or new offices created and filled at any meeting of the Board of Directors. Officers shall be installed immediately following election. The President and each Vice President shall each serve for a term of two (2) years and until such officer's successor shall have been duly elected and shall have qualified, or until his death or until such officer shall resign or shall have been removed in the manner hereinafter provided. An individual who fills a vacancy in an office for a partial term shall be eligible for election to a full term or terms in his or her own right. Unless otherwise determined by the Board of Directors, the tenure of an officer shall be limited to one (1) term.

Section 3: Resignation. Any officer may resign at any time by giving written notice to the President of the Board. Such resignation shall take effect at the time specified in the notice, or if no time is specified, then immediately.

Section 4: Removal. Any officer may be removed from such office, with or without cause, by a two-thirds vote of the directors at any regular or special meeting of the Board called expressly for that purpose.

Section 5: Vacancy. A vacancy in any office shall be filled by the Board of Directors for the unexpired term.

Section 6: President. The President shall be the principal executive officer of the corporation and shall in general supervise and control all of the affairs of the corporation and in general shall perform all duties incident to the office of President (except such duties as may be delegated or assigned to the Executive Director from time to time by these *Bylaws*, the Board of Directors or the President) and such other duties as may be prescribed by the Board of Directors from time to time. He or she will also serve as the primary official representative of the corporation in its contacts with government, civic, business and professional organizations for the purpose of advancing the objectives of the corporation. The President shall serve as an *ex officio* member of the Board of Directors, as an *ex officio* member of the Executive Committee, and as Chair of the Board Development/Governance/Nominating Committee. He or she shall preside at the meeting of the Board of Directors; shall present an annual report of the corporation to the Member at a time to be determined by the Board of Directors; and in general shall perform all duties incident to the role of President.

Section 7: Vice President – Finance. The Vice President - Finance shall serve as Chair of the Finance Committee and as a member of the Executive Committee. In the absence of the President or in the event of the President's inability to act, the Vice President - Finance shall perform the duties of the President, and when so acting, shall have all the powers of and be subject to all the restrictions upon the President. The Vice President – Finance shall also perform such other duties as from time to time may be assigned by the President or by the Board of Directors.

Section 8: Vice President – Development and Fundraising. The Vice President – Development and Fundraising shall serve as Chair of the Development and Fundraising Committee and as a member of the Executive Committee. The Vice President –Development and Fundraising shall also perform such other duties as from time to time may be assigned by the President or by the Board of Directors.

Section 9: Vice President – Programs. The Vice President – Programs shall serve as Chair of the Programs Committee and as a member of the Executive Committee. The Vice President –Programs shall also perform such other duties as from time to time may be assigned by the President or by the Board of Directors.

Section 10: Vice President – Scientific Research. The Vice President –Scientific Research shall serve as Chair of the Scientific Research Committee and as a member of the Executive Committee. The Vice President –Scientific Research shall also perform such other duties as from time to time may be assigned by the President or by the Board of Directors.

Section 11: Executive Director. The Board of Directors may hire an Executive Director who shall have such duties as may be delegated or assigned to him or her from time to time by these *Bylaws*, the Board of Directors, the President, and/or as set forth in any job description or contract. The Executive Director shall supervise and be principally responsible for the day-to-day management of the corporation, including but not limited to, (1) working with the Chief Financial Officer on the financial reporting to the Board of Directors, budgeting, evaluating costs related to the corporation's programs, and insuring that all tax filings are complete and timely filed; and (2) evaluating each of the corporation's programs to determine whether such program fits within the corporation's charitable mission. In addition, the Executive Director shall work closely with the President to ensure that all routine corporate functions are carried out, and, in general, shall perform the duties incident to the office of Executive Director, but subject to such limitations and restrictions as may be imposed from time to time by these *Bylaws*, the Board of Directors, the President,

or any job description or contract. The Executive Director shall be responsible to the Board. The Executive Director shall employ and may terminate the employment of members of the staff (except the Chief Financial Officer) necessary to carry out the work of the corporation. The Executive Director shall also act as the Secretary of the Corporation and as such, shall keep minutes of the meetings of the members of the Board of Directors in one or more books provided for that purpose; see that all notices are duly given in accordance with the provisions of these *Bylaws* or as required by law; be custodian of the corporate records and of the seal of the corporation and see that the seal of the corporation is affixed to all documents the execution of which on behalf of the corporation under its seal is duly authorized in accordance with the provisions of these *Bylaws*.

Section 12: Chief Financial Officer. The Board of Directors may hire a Chief Financial Officer who shall have such duties as may be delegated or assigned to him or her from time to time by these *Bylaws*, the Board of Directors, the President, the Executive Director, and/or as set forth in any job description or contract. The Chief Financial Officer shall report to on a day to day basis on day-to-day financial matter to Executive Director. The Chief Financial Officer shall also have reporting responsibility to the Board of Directors at each Board meeting on the financial health of the corporation including but not limited to the financial implications of the corporation's programs, including fundraising costs. The Chief Financial Officer, in conjunction with the Executive Director, shall be responsible for developing a budget and the Chief Financial Officer shall have the responsibility to present such budget to the Board of Directors for its approval. The Chief Financial Officer shall have charge and custody of and be responsible for all funds and securities of the corporation; receive and give receipts for monies due and payable to the corporation from any source whatsoever, and deposit all such monies in the name of the corporation in such banks, trust companies or other depositaries as shall be selected in accordance with the provisions of Article VIII of these *Bylaws*; and in general perform all the duties incident to the office of Chief Financial Officer except for investment matters and such other limitations and restrictions as may be imposed from time to time by these *Bylaws*, the Board of Directors, the President, or any job description or contract. If required by the Board of Directors, the Chief Financial Officer shall give a bond for the faithful discharge of his or her duties in such sum and with such surety or sureties as the Board of Directors shall determine.

ARTICLE VII

CONTRACTS AND FINANCIAL AFFAIRS

Section 1: Contracts. The President, Vice President, and Executive Director (if there is one), shall be authorized to execute contracts. In addition, the Board of Directors may authorize any other officer or officers, agent or agents of the corporation, to enter into any contract or execute and deliver any instrument in the name of and on behalf of the corporation, and such authority may be general or confined to specific instances.

Section 2: Checks, Drafts, Etc. All checks, drafts or other orders for the payment of money, notes or other evidences of indebtedness issued in the name of the corporation, shall be signed by such officer or officers, agent or agents of the corporation and in such manner, as shall from time to time be determined by resolution of the Board of Directors. In the absence of such determination by the Board of Directors, such instruments shall be signed by the Chief Financial Officer and countersigned by the President or President-elect of the corporation.

Section 3: Loans and Indebtedness. No loans shall be contracted on behalf of the corporation and no evidence of indebtedness shall be issued in its name unless authorized by a resolution of the Board with such authority being either general or confined to specific instances.

Section 4: Deposits. All funds of the corporation shall be deposited from time to time to the credit of the corporation in such banks, trust companies or other depositories as the Board of Directors may select.

Section 5: Gifts. The Board of Directors may accept on behalf of the corporation any contribution, gift, bequest or devise for the general purposes or for any special purpose of the corporation. The powers hereunder may be delegated to a committee of the Board.

Section 6: Investments. The Board of Directors shall manage, invest, operate, deal in and with, and conserve the property of the corporation, and it may retain any or all of the stock or other assets transferred to the corporation by gift or bequest; provided, however, that the exercise of any such powers shall not in any way conflict with the purposes of the corporation as stated in its *Articles of Incorporation*, and such powers shall not be exercised so as to cause the corporation to lose its qualification as an exempt organization under Section 501(c)(3) of the Code as such provision now exists or may hereafter be amended. The powers hereunder may be delegated to a committee of the Board.

ARTICLE VIII

BOOKS AND RECORDS; MINUTES; REPORTS

Section 1: Books and Records; Minutes. The corporation shall keep correct and complete books and records of account and shall also keep minutes of the proceedings of the Board of Directors and committees having any authority of the Board of Directors.

Section 2: Annual Report. The corporation shall submit an annual report to the Member's House of Delegates, with a copy to the Association's Board of Trustees.

ARTICLE IX

SEAL

The Board of Directors may provide a corporate seal, but such seal shall not be required on any document, contract or other instrument of this corporation. Such seal, if any, shall be in the form of a circle and shall have inscribed thereon the name of the corporation and the words "Corporate Seal Illinois."

ARTICLE X

WAIVER OF NOTICE

Whenever any notice whatever is required to be given under the provisions of the General Not For Profit corporation Act of Illinois or under the provisions of the Articles of Incorporation or by the bylaws of

the corporation, a waiver thereof in writing signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

ARTICLE XI

INDEMNIFICATION

Each present or former director, officer, committee member, employee or other agent of the corporation, and each person who, at the request of the corporation, serves or served another corporation, partnership, joint venture, trust, employee benefit plan or other enterprise in any such capacity, and the heirs and personal representatives of each of the foregoing, shall be held harmless and indemnified by the corporation against all claims and liabilities and all costs and expenses, including attorney's fees, reasonably incurred or imposed upon such person in connection with or resulting from any action, suit or proceeding, or the settlement or compromise thereof, to which that person may be made a party by reason of any action taken or omitted to be taken by that person as a director, officer, committee member, employee or agent of the corporation or such other enterprise, in good faith; provided that the right of indemnification shall apply to a person acting as an agent for the corporation in a professional capacity for compensation only to the extent provided in an agreement between the corporation and such person. Such indemnification may include without limitation the purchase of insurance and advancement of any expenses, upon receipt of an undertaking by or on behalf of the director, officer, employee or agent to repay any such advance, unless it shall ultimately be determined that he is entitled to be indemnified as authorized in these *Bylaws*. The indemnification provided by these *Bylaws* shall not be deemed exclusive of any other rights to which those seeking indemnification may be entitled under any agreement, insurance policy or otherwise.

ARTICLE XII

AMENDMENTS

These *Bylaws* may be altered, amended, repealed, or new bylaws may be adopted, by two-thirds (2/3) of the entire Board of Directors at any regular or special meeting, *provided* that no such amendment, alteration, repeal or adoption of new bylaws shall in any way conflict with the purposes of the corporation as stated in these *Bylaws* or the Articles of Incorporation, or otherwise cause the corporation to lose its qualification as an exempt organization under Section 501(c)(3) of the Code as such provision now exists or as it may hereafter be amended; and *provided further* that prior written notice of the proposal to alter, amend or repeal the *Bylaws* or adopt new bylaws is given to each director of the corporation. Anything herein to the contrary notwithstanding, the following actions are subject to the approval by the Member (acting by a two-thirds (2/3) vote of the Association's Board of Trustees):

(a) Section 1 of Article IV;

(b) Sections 1-4 and Sections 14 and 15 of Article V; and

(c) This Article XII.

APPENDIX 2

CHAPTER X. COUNCILS. SECTION 110. COUNCIL ON SCIENTIFIC AFFAIRS, SUBSECTION K(e)

K. COUNCIL ON SCIENTIFIC AFFAIRS. The duties of the Council shall be to:

a. Develop and promote an annual research agenda with appropriate means for funding.

b. Identify emergent issues and areas of research that require response from the research community.

c. Report results on the latest scientific developments to practicing dentists.

d. Evaluate and issue statements to the profession regarding the efficacy of concepts, procedures and techniques for use in the treatment of patients.

e. Guide, assist and act as liaison to the American Dental Association Foundation and serve as its peer review body.

f. Represent the Association on scientific and research matters and maintain liaison with related regulatory, research and professional organizations.

g. Encourage the development and improvement of materials, instruments and equipment for use in dental practice, and to coordinate development of national and international standardization programs.

h. Determine the safety and effectiveness of, and disseminate information on, materials, instruments and equipment that are offered to the public or the profession and further critically evaluate statements of efficacy and advertising claims.

i. Study, evaluate and disseminate information with regard to the proper use of dental therapeutic agents, their adjuncts and dental cosmetic agents that are offered to the public or the profession.

j. Award the American Dental Association Seal to dental products that meet the Association's requirements for acceptance.

k. Promote efforts to develop dental research workforce and to involve students in dental research.

l. Study, evaluate and disseminate information on those aspects of the dental practice environment related to the health of the public, dentists and dental auxiliaries.

m. Serve as the primary resource for scientific inquiries from the public and the profession.

APPENDIX 3

CHAPTER XIII. AMERICAN DENTAL ASSOCIATION FOUNDATION.

CHAPTER XIII • AMERICAN DENTAL ASSOCIATION FOUNDATION

Section 10. AGENCIES AND PERSONNEL: The Research Institute and the Paffenbarger Research Center at the National Institute of Standards and Technology will be agencies of the American Dental Association Foundation and the personnel of these agencies shall be employees of the Foundation.

Section 20. FINANCIAL SUPPORT: The Association shall annually furnish sufficient financial support, as an addition to generated non-Association funding, to assure the continued viability of the Foundation's research activities.

Section 30. DUTIES:

A. The Foundation, through its agencies, the Research Institute and the Paffenbarger Research Center at the National Institute of Standards and Technology shall:

a. Conduct basic and applied research for the utilization in and development of oral health.

b. Conduct training programs in research disciplines that relate to the basic and applied problems of oral health.

c. Submit, either through or in cooperation with the Council on Scientific Affairs, an annual report to the House of Delegates, interim reports on request to the Board of Trustees, and an annual budget to the Board of Trustees for such financial support allocations as the Board may deem necessary.

B. In addition, the Foundation's Administrative/ Charitable group shall submit, through the ADA Board of Trustees acting as the Member, an annual report to the House of Delegates, interim reports on request to the Member, and an annual budget to the Board of Trustees for such financial support allocations as the Board may deem necessary.

C. The Foundation also may perform such other charitable and research functions as permitted under its articles of incorporation and bylaws and the laws of the State of Illinois.

Resolution No. 90 New ■ Substitute ☐ Amendment ☐

Report: Board Report 16 Date Submitted: September 2010

Submitted By: Board of Trustees

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Financial (Required)

REPORT 16 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:
BYLAWS REVIEW OF THE TREASURER NOMINATION PROCESS

Executive Summary: This report summarizes the consideration of the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) of the current procedures for nominations for the office of Treasurer contained in the ADA *Bylaws* pursuant to the initial request of the Board of Trustees (B-139-2009) and the Board's further request at its July 24-26, 2010 meeting. As a result of the Council's deliberations, changes in the nomination procedures are recommended by CEBJA, as set forth in the below resolution recommended by the Council.

Background: The Council on Ethics, Bylaws and Judicial Affairs received a request from the ADA Board of Trustees to review the ADA Bylaws in regard to the selection process for ADA Treasurer. A workgroup was formed for this review and consisted of Dr. Judith M. Fisch, Dr. Alan R. Stein, Dr. Thomas W. Gamba, Dr. Dwyte E. Brooks, and Dr, Walter I Chinoy. A proposal was submitted by the workgroup to the Council in July 2010 and approved by CEBJA by mail ballot. The Council submitted the proposal to the Board for consideration at its July 24-26, 2010 meeting, and the Board requested that the following points be included in the nomination procedures:

- That the revised nomination procedure not allow for comment on specific candidates by the Board of Trustees but provide a mechanism by which the House of Delegates can assess the credentials of candidates; and
- That the revised nomination procedure allow candidates to be nominated from the floor and to have the credentials of such candidates be available for review by the House of Delegates prior to voting.

Discussion: The Council's deliberations and study of the nomination process for the office of Treasurer focused on the areas of (1) determining the proper balance between allowing candidacies for the office of Treasurer to be voted on by the House of Delegates and (2) allowing the qualifications of candidates to be objectively considered and the results of that consideration being communicated to the House of Delegates.

Under the current Bylaws, if there are two or more eligible candidates for the office of Treasurer, the Board of Trustees nominates at least two, but no more than three candidates from the floor of the House. Those nominated candidates are then voted upon by the House of Delegates in accordance with the procedures set forth in Chapter V, HOUSE OF DELEGATES, Section 150, ELECTION PROCEDURE. During the course of CEBJA's review and deliberations on the nomination process, members of the Council expressed the sentiment that the selection process should be revised to give the House of Delegates the right to select the Treasurer from all candidates that have announced for the position rather than only those candidates nominated by the Board of Trustees. Consequently, under the recommendation being advanced by CEBJA, there would be no limit on the potential number of candidates in an election for the office of Treasurer, and the Board of Trustees would lose the power it now has to eliminate a potential Treasurer candidate from consideration by the House of Delegates.

However, CEBJA is aware that the office of Treasurer needs to be filled by an individual who has experience and skill in financial matters. Initially, CEBJA recommended that that the function of screening and review of the credentials of Treasurer candidates presently performed by the Board of Trustees be maintained. Upon receiving the Board's request that the nomination procedure not allow the Board to comment on specific candidates but rather to provide a mechanism for the House of Delegates to assess candidates' credentials, CEBJA has revised its recommendation to provide that the Board will establish recommended qualifications and review whether candidates satisfy those recommended qualifications. Regardless whether the Board determines individual candidates satisfy the recommended qualifications, all candidates would be nominated on the floor of the House of Delegates. As set forth below, CEBJA's recommended revisions to the *Bylaws* call for the Board to establish recommended qualifications for the office of Treasurer, for documentation supporting the candidacy of interested individuals to be submitted one hundred twenty (120) days prior to the convening of the House of Delegates. Following the Board's review of candidates' credentials, those credentials and the Board of Trustees' determination as to whether individual candidates satisfy the recommended qualifications would then be forwarded to delegates for their consideration at least sixty (60) days prior to the convening of the House of Delegates.

CEBJA also considered the Board's request that a revised nomination procedure allow candidates who had not previously announced their candidacy for the office of Treasurer to be nominated from the floor of the House of Delegates. CEBJA carefully considered this request, but respectfully recommends against the process, as it considers the office of Treasurer too critical to the Association's prudent business operations to permit candidates not thoroughly and thoughtfully vetted in advance to announce their candidacy at the eleventh hour.

During the review process, CEBJA also considered scenarios where there are either no eligible candidates for the position of Treasurer or when a vacancy occurs in that position, and provided proposed language that would allow the office of Treasurer to be filled by the existing Treasurer or, in cases of a vacancy or where the existing Treasurer is unable to serve another year, a former Treasurer in a Treasurer pro tem position.

Recommendation: Having considered the matters referred by the Board of Trustees as indicated above, the Council recommends the adoption of the following resolution:

Resolution

90. Resolved, that CHAPTER VIII, ELECTIVE OFFICERS, Section 30, NOMINATIONS, be amended as follows (additions underscored, deletions stricken):

B. Nominations for the office of Treasurer shall be made in accordance with the order of business. The search for Treasurer shall be announced in an official publication of the Association in November of the final year of the incumbent Treasurer's term, together with the recommended qualifications for that position as provided in Chapter VII, Section 100G of these Bylaws. ~~If there is only one (1) eligible c~~Candidates for the office of Treasurer~~, the Board of Trustees~~ shall apply by submitting a standardized Treasurer Curriculum Vitae form to the Executive Director at least one hundred twenty (120) days prior to the convening ~~nominate that individual from the floor~~ of the House of Delegates. Each candidate's application shall be reviewed by the Board of Trustees. The Executive Director shall provide all members of the House of Delegates, at least sixty (60) days prior to the convening of the House of Delegates, with each candidate's standardized Treasurer Curriculum Vitae and the determination of the Board of Trustees as to whether the candidate meets the recommended qualifications for the office of Treasurer. Only those candidates shall be nominated from the floor of the House of Delegates. The nominations may be followed by an acceptance speech not to exceed four (4) minutes by ~~the~~ each candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. ~~If there are two (2) or more eligible candidates for the office of Treasurer, the Board of Trustees shall nominate at least two (2) and not more than three (3) candidates from the floor of the House of Delegates by a~~

~~simple declaratory statement for each nominee, which may be followed by an acceptance speech not to exceed four (4) minutes by the candidate from the podium, according to the protocol established by the Speaker of the House of Delegates.~~ Seconding a nomination is not permitted. No further nominations for the office of Treasurer shall be accepted from the floor of the House of Delegates. If there are no eligible candidates for the office of Treasurer when the House of Delegates meets, the term of the incumbent Treasurer shall be extended by one (1) year. Should the incumbent Treasurer be unwilling or unable to serve an additional one (1) year term, the office of Treasurer shall be filled in the same manner as provided in Chapter VIII, Section 80 of these Bylaws. Under these circumstances, former Treasurers of this Association would be eligible to serve as Treasurer *pro tem* for one (1) additional year.

and be it further

Resolved, that CHAPTER VIII, ELECTIVE OFFICERS, Section 50., TERM OF OFFICE, be amended as follows (additions underscored, deletions stricken):

Section 50. TERM OF OFFICE: The President, President-elect, First Vice President, Second Vice President and Speaker of the House of Delegates shall serve for a term of one (1) year, except as otherwise provided in this chapter of the *Bylaws*, or until their successors are elected and installed. The term of office of the Treasurer shall be three (3) years, or until a successor is elected and installed. The Treasurer shall be limited to two (2) consecutive terms of three (3) years each~~.~~, excepting the case of a former Treasurer who has been elected Treasurer *pro tem* as provided in Chapter VIII, Section 30 of these Bylaws, who may serve one (1) additional year.

and be it further

Resolved, that CHAPTER VIII, ELECTIVE OFFICERS, Section 80. VACANCIES, Subsection A. VACANCY OF ELECTIVE OFFICE be amended as follows (additions underscored, deletions stricken):

A. VACANCY OF ELECTIVE OFFICE: In the event the office of President becomes vacant, the President-elect shall become President for the unexpired portion of the term. In the event the office of President becomes vacant for the second time in the same term or at a time when the office of President-elect is also vacant, the First Vice President shall become President for the unexpired portion of the term. In the event the office of First Vice President becomes vacant, the Second Vice President shall become the First Vice President for the unexpired portion of the term. A vacancy in the office of the Second Vice President shall be filled by a majority vote of the Board of Trustees. In the event of a vacancy in the office of Speaker of the House of Delegates, the President, with approval of the Board of Trustees, shall appoint a Speaker *pro tem*. In the event the office of President-elect becomes vacant by reason other than the President-elect succeeding to the office of the President earlier than the next annual session, the office of President for the ensuing year shall be filled at the next annual session of the House of Delegates in the same manner as that provided for the nomination and election of elective officers, except that the ballot shall read “President for the Ensuing Year.” A vacancy in the office of Treasurer shall be filled by a majority vote of the Board of Trustees until the process of inviting applications, screening and nominating candidates and electing a new Treasurer has been completed by the Board of Trustees and the House of Delegates. The Treasurer *pro tem* shall be eligible for election to a new consecutive three (3) year term. The newly elected Treasurer shall be limited to two (2) consecutive terms of three (3) years each~~.~~, excepting the case of a former Treasurer who has been elected Treasurer *pro tem* as provided in Chapter VIII, Section 30 of these Bylaws, who may serve one (1) additional year.

and be it further

Resolved, that CHAPTER VII, BOARD OF TRUSTEES, Section 100., DUTIES, Subsection G. be amended as follows (additions underscored, deletions stricken):

G. Establish recommended qualifications for the office of Treasurer.

so that the recited Sections of the *Bylaws* as amended read as appears in APPENDIX 1 appended to this report. A timeline of the process outlined in this report appears in APPENDIX 2 appended to this report.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

APPENDIX 1

PROPOSED AMENDED *BYLAWS* PROVISIONS

CHAPTER VIII, ELECTIVE OFFICERS, Section 30, NOMINATIONS:

B. Nominations for the office of Treasurer shall be made in accordance with the order of business. The search for Treasurer shall be announced in an official publication of the Association in November of the final year of the incumbent Treasurer's term, together with the recommended qualifications for that position as provided in Chapter VII, Section 100G of these Bylaws. Candidates for the office of Treasurer shall apply by submitting a standardized Treasurer Curriculum Vitae form to the Executive Director at least one hundred twenty (120) days prior to the convening of the House of Delegates. Each candidate's application shall be reviewed by the Board of Trustees. The Executive Director shall provide all members of the House of Delegates, at least sixty (60) days prior to the convening of the House of Delegates, with each candidate's standardized Treasurer Curriculum Vitae and the determination of the Board of Trustees as to whether the candidate meets the recommended qualifications for the office of Treasurer. Only those candidates shall be nominated from the floor of the House of Delegates. The nominations may be followed by an acceptance speech not to exceed four (4) minutes by each candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. Seconding a nomination is not permitted. No further nominations for the office of Treasurer shall be accepted from the floor of the House of Delegates. If there are no eligible candidates for the office of Treasurer when the House of Delegates meets, the term of the incumbent Treasurer shall be extended by one (1) year. Should the incumbent Treasurer be unwilling or unable to serve an additional one (1) year term, the office of Treasurer shall be filled in the same manner as provided in Chapter VIII, Section 80 of these Bylaws. Under these circumstances, former Treasurers of this Association would be eligible to serve as Treasurer *pro tem* for one (1) additional year.

CHAPTER VIII, ELECTIVE OFFICERS, Section 50, TERM OF OFFICE:

Section 50. TERM OF OFFICE: The President, President-elect, First Vice President, Second Vice President and Speaker of the House of Delegates shall serve for a term of one (1) year, except as otherwise provided in this chapter of the *Bylaws*, or until their successors are elected and installed. The term of office of the Treasurer shall be three (3) years, or until a successor is elected and installed. The Treasurer shall be limited to two (2) consecutive terms of three (3) years each, excepting the case of a former Treasurer who has been elected Treasurer *pro tem* as provided in Chapter VIII, Section 30 of these Bylaws, who may serve one (1) additional year.

CHAPTER VIII, ELECTIVE OFFICERS, Section 80. VACANCIES, Subsection A. VACANCY OF ELECTIVE OFFICE:

A. VACANCY OF ELECTIVE OFFICE: In the event the office of President becomes vacant, the President-elect shall become President for the unexpired portion of the term. In the event the office of President becomes vacant for the second time in the same term or at a time when the office of President-elect is also vacant, the First Vice President shall become President for the unexpired portion of the term. In the event the office of First Vice President becomes vacant, the Second Vice President shall become the First Vice President for the unexpired portion of the term. A vacancy in the office of the Second Vice President shall be filled by a majority vote of the Board of Trustees. In the event of a vacancy in the office of Speaker of the House of Delegates, the President, with approval of the Board of Trustees, shall appoint a Speaker *pro tem*. In the event the office of President-elect becomes vacant by reason other than the President-elect succeeding to the office of the President earlier than the next annual session, the office of President for the ensuing year shall be filled at the next annual session of the House of Delegates in the same manner as that provided

for the nomination and election of elective officers, except that the ballot shall read “President for the Ensuing Year.” A vacancy in the office of Treasurer shall be filled by a majority vote of the Board of Trustees until the process of inviting applications, screening and nominating candidates and electing a new Treasurer has been completed by the Board of Trustees and the House of Delegates. The Treasurer *pro tem* shall be eligible for election to a new consecutive three (3) year term. The newly elected Treasurer shall be limited to two (2) consecutive terms of three (3) years each, excepting the case of a former Treasurer who has been elected Treasurer *pro tem* as provided in Chapter VIII, Section 30 of these Bylaws, who may serve one (1) additional year.

CHAPTER VII, BOARD OF TRUSTEES, Section 100, DUTIES, Subsection G:

G. Establish recommended qualifications for the office of Treasurer.

APPENDIX 2

TREASURER NOMINATION TIMELINE

Prior to November of incumbent Treasurer's final year in office

Board prepares recommended qualifications for Treasurer position

November of final year of incumbent Treasurer's term

Search for Treasurer announced in official Association publication, including recommended qualifications set by Board

At least 120 days prior to time House of Delegates convenes

Candidates for Treasurer submit standardized Treasurer curriculum vitae

Upon receipt of standardized Treasurer curriculum vitae from Executive Director, and by no later than 60 days prior to time House of Delegates convenes

Board reviews and determines whether each candidate meets recommended qualifications

At least 60 days prior to time House of Delegates convenes

Executive Director transmits Treasurer candidates' standardized Treasurer curriculum vitae and Board's determination as to whether each candidate meets the recommended qualifications

House of Delegates in session

All candidates who submitted applications are nominated from the floor of the House (No other nominations from floor permitted)

Resolution No. 93 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Fifteenth Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

WHISTLEBLOWER

The following resolution was submitted by the Fifteenth Trustee District and transmitted on September 2, 2010, by Ms. Donna Cortez, executive affairs manager, Texas Dental Association.

Background: A Whistleblower action was filed at ADA and could pose a significant, ongoing liability for the American Dental Association.

The Board of Trustees has commissioned outside attorneys and consultants to investigate the Whistleblower charges; and whereas the Board, by a majority vote, has refused to release its investigative documents concerning this matter to the ADA House of Delegates; and whereas Article IV of the ADA Constitution states that the House of Delegates is the supreme authoritative and governing body of the American Dental Association, be it

Resolution

93. Resolved, that all reports produced by consultants or outside investigative firms relating to the Whistleblower action ("Browne report" and other reports that address the same subject matter), be released immediately to credentialed members of the 2010 ADA House of Delegates, and be it further

Resolved, that the 2010 House of Delegates, after review and debate of the investigative documents, shall direct the Board of Trustees to act immediately on this matter, in accordance with official actions adopted at the 2010 ADA House of Delegates.

BOARD COMMENT: This is a matter of importance to the ADA and the Board believes that the House needs to make an informed decision about the receipt of these reports. The Board is happy to provide the reports to the House of Delegates, provided that the House is fully informed of the risk, responsibility and the potential liability associated with receiving them. In consultation with Speaker, this will be decided by the House in the first session of the House of Delegates. The House will need to weigh the legal risks associated with the disclosure of privileged attorney-client material that, if disclosed, could put the ADA at risk from a legal perspective. If the House votes to not see the material, the Speaker advises that the entire resolution is moot. If the House votes to see the material, the Board, in consultation with the Speaker, has arranged to provide the reports in a secure modality that will minimize the risk of the Association and best protect the interests of ADA as an organization. The Board also wishes the House to know that it has not refused to make the reports available.

BOARD RECOMMENDATION: Vote No.

Board Vote:															
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		
☐	■	☐	☐	CALNON	☐	■	☐	☐	LOW	☐	■	☐	☐	SULLIVAN	
☐	■	☐	☐	ENGEL	■	☐	☐	☐	MANNING	■	☐	☐	☐	THOMPSON	
■	☐	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	☐	■	☐	☐	VERSMAN	
☐	■	☐	☐	FEINBERG	☐	■	☐	☐	RICH	■	☐	☐	☐	VIGNA	
☐	■	☐	☐	GIST	■	☐	☐	☐	SEAGO	■	☐	☐	☐	WEBB	
☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SMITH, A. J.	☐	■	☐	☐	WEBER	
■	☐	☐	☐	LONG	☐	☐	■	☐	STEFFEL					Res. 93	

File 12 Pages 5079-5080 (Res 93)

Resolution No. 94 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Fifteenth Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

CONDUCT OF MEETINGS AND MINUTES AND RECORDING OF MEETINGS

The following resolution was submitted by the Fifteenth Trustee District and transmitted on September 2, 2010, by Ms. Donna Cortez, executive affairs manager, Texas Dental Association.

Background: Actions of the ADA Board of Trustees should be transparent to members of the House of Delegates. Members of the House also deserve to know how members of the Board have voted on all issues before them. Therefore, let it be

Resolution

94. Resolved, that all business, actions, and votes of the Board of Trustees shall be made in an open session of the Board of Trustees meetings, except that when giving direction to the legal counsel in an attorney-client privileged communication. Votes may be taken in that attorney-client session to determine the will of the Board to direct legal counsel, and be it further,

Resolved, that minutes shall contain a record of all motions, votes, and actions by the Board of Trustees, and enough detail of the proceedings such that the reader of the minutes may understand the deliberations of the trustees; and how each trustee voted when the vote is not unanimous, or when substitute resolutions are introduced, and be it further

Resolved, that when attorney-client privileged information or other sensitive proprietary information should be conveyed to the members of the House of Delegates, an appropriate confidentiality agreement be obtained from the member, such agreement being a signed hard copy or a secure electronic confirmation of agreement.

BOARD COMMENT: The Board of Trustees is in favor of the intent of this resolution which is to support transparency and accountability. However, there are aspects about it that raise some concerns that the Board believes should be addressed by the Reference Committee and the House of Delegates. The Board has no hesitancy and very much supports recording in its minutes Board actions and votes, including how each trustee votes when a vote is not unanimous. The execution of confidentiality agreements by House members who receive privileged or confidential ADA documents helps to protect the interests of the ADA and helps members of the House to remain mindful of their fiduciary responsibilities. When the new web site for members of the House of Delegates is launched, the completion of appropriate “click through” confidentiality agreements will be required in order to gain access to privileged or confidential documents. It will also meet industry standards for dual authentication on Board matters. One concern identified is in the first resolving clause, which directs the Board to conduct all of its business in open session. This will encumber the Board’s ability to manage the affairs of the ADA. There should be a mechanism to allow the Board to have

discussions on and actions concerning confidential subject matter in a closed session to protect sensitive information the disclosure of which might result in financial harm to the Association. An example is the selection of future ADA annual sessions meeting sites and the related contract negotiations necessary to protect the ADA's interests. The exception articulated for attorney-client privileged communications is narrower than the traditional definition of an attorney-client privileged communications, which involves requesting or receiving legal advice. Thus, under the first resolving clause, matters that would be treated as privileged communications would be made in open session. This would waive the privilege accorded attorney-client communications and could potentially expose the Association to significant legal and financial risk. The resolution also calls for the recording of all motions, votes and actions. The Board recommends the level of detail be clarified to record action votes and not all procedural votes.

BOARD RECOMMENDATION: Vote Yes.

Board Vote:

Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
☐	■	☐	☐	CALNON	■	☐	☐	☐	LOW	☐	■	☐	☐	SULLIVAN
☐	■	☐	☐	ENGEL	■	☐	☐	☐	MANNING	■	☐	☐	☐	THOMPSON
■	☐	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	☐	■	☐	☐	VERSMAN
■	☐	☐	☐	FEINBERG	■	☐	☐	☐	RICH	■	☐	☐	☐	VIGNA
☐	■	☐	☐	GIST	■	☐	☐	☐	SEAGO	■	☐	☐	☐	WEBB
☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SMITH, A. J.	■	☐	☐	☐	WEBER
■	☐	☐	☐	LONG	☐	■	☐	☐	STEFFEL					Res. 94

Resolution No. 95 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Fifteenth Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

RELEASE OF REPORTS

The following resolution was submitted by the Fifteenth Trustee District and transmitted on September 2, 2010, by Ms. Donna Cortez, executive affairs manager, Texas Dental Association.

Background: Resolution 95H-2009 specifically addressed issues of transparency between the ADA Board of Trustees and House of Delegates. Yet, the Board has continued to receive or hear multiple reports and refused to release many of these reports to the House of Delegates, the Supreme Governing Body of the ADA. In the opinion of the 15th District delegation, this action has clearly violated both the spirit and intent of Resolution 95H-2009. Members of the House of Delegates deserve to see reports in a timely fashion, enabling the House to make clear and knowledge based decisions. Therefore, let it be

Resolution

95. Resolved, that all reports that are not specifically reports of committees or subcommittees of the Board, or attorney-client privileged reports between the Board and Legal Counsel for the purpose of giving or receiving advice or information on pending or potential legal proceedings, received by the Board of Trustees, are considered to be reports to the Association and shall be made available to members of the House of Delegates in their original form within ten (10) business days of receipt of that report. Board responses to the report may be sent separately and must not delay provision of the report to members of the House, and be it further

Resolved, that all reports received by the Board of Trustees and subsequently released to members of the ADA House of Delegates shall be marked "confidential" and shall contain a disclaimer to the effect that "This document does not reflect the policy of the ADA, the ADA House of Delegates or the opinion of the ADA Board of Trustees."

BOARD COMMENT: In light of the development of Resolution B-181, which called for the development of a secure communications protocol for the House of Delegates, and which will be implemented in part prior to the 2010 House of Delegates, in light of the roll out of a secure communication process which will enable the House to access all documents including reports, confidential and privileged documents within 10 to 14 business days of the receipt and review of the material by the Board, the Board felt the need for this resolution to be moot.

BOARD RECOMMENDATION: Vote No.

Board Vote:															
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		
☐	■	☐	☐	CALNON	☐	■	☐	☐	LOW	☐	■	☐	☐	SULLIVAN	
☐	■	☐	☐	ENGEL	☐	■	☐	☐	MANNING	☐	■	☐	☐	THOMPSON	
☐	■	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	☐	■	☐	☐	VERSMAN	
☐	■	☐	☐	FEINBERG	☐	■	☐	☐	RICH	☐	■	☐	☐	VIGNA	
☐	■	☐	☐	GIST	☐	■	☐	☐	SEAGO	☐	■	☐	☐	WEBB	
☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SMITH, A. J.	☐	■	☐	☐	WEBER	
■	☐	☐	☐	LONG	☐	■	☐	☐	STEFFEL					Res. 95	

File 14 Pages 5083-5084 (Res 95)

Resolution No. 96 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Fifteenth Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

CLARIFYING THE POWERS OF THE HOUSE OF DELEGATES

The following resolution was submitted by the Fifteenth Trustee District and transmitted on September 2, 2010, by Ms. Donna Cortez, executive affairs manager, Texas Dental Association.

Background: The American Dental Association has operated throughout its existence, as delineated in the ADA *Constitution and Bylaws*, with the knowledge certain that the House of Delegates is the supreme authoritative body of the organization. Recent events have indicated a lack of understanding and adherence by the ADA Board of Trustee. The ADA's House of Delegates takes the following action to reiterate the powers of the House.

Therefore, be it

Resolution

96. Resolved, that the ADA *Bylaws* be amended by the addition of a new subsection in Chapter VII, Section 100 to read:

- To support the House of Delegates in its role as the legislative and governing body, and the supreme authoritative body,

and be it further

Resolved, that the oath of office for members of the Board of Trustees, and Officers of the ADA shall include specific language that reiterates that the House of Delegates serves as the supreme authoritative body of the ADA.

BOARD COMMENT: The Board of Trustees believes it is well versed in its responsibilities to the House of Delegates under the governing documents of the Association and sees this as unnecessary.

BOARD RECOMMENDATION: Vote No.

Board Vote:															
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		
☐	■	☐	☐	CALNON	☐	■	☐	☐	LOW	☐	■	☐	☐	SULLIVAN	
☐	■	☐	☐	ENGEL	■	☐	☐	☐	MANNING	■	☐	☐	☐	THOMPSON	
■	☐	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	☐	■	☐	☐	VERSMAN	
☐	■	☐	☐	FEINBERG	☐	■	☐	☐	RICH	■	☐	☐	☐	VIGNA	
☐	■	☐	☐	GIST	■	☐	☐	☐	SEAGO	■	☐	☐	☐	WEBB	
☐	■	☐	☐	KREMPASKY SMITH	■	☐	☐	☐	SMITH, A. J.	☐	■	☐	☐	WEBER	
■	☐	☐	☐	LONG	■	☐	☐	☐	STEFFEL					Res. 96	

File 15 Pages 5085-5086 (Res 96)

Resolution No. 97 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Sixth Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication:

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Collaboration (Required)

SUPPORT OF CURRENT MEDICAID LAW AND REGULATIONS REGARDING DENTAL SERVICES

The following resolutions were adopted by the Sixth Trustee District and submitted on September 11, 2010, by Dr. W. Ken Rich, Sixth District Trustee.

Background: "Dental Services" as currently defined in Medicaid regulations at 42 CFR 440.100 means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his profession, including treatment of (1) The teeth and associated structures of the oral cavity; and (2) Disease, injury, or impairment that may affect the oral or general health of the recipient. "Dentist" means an individual licensed to practice dentistry or dental surgery.

The federal Omnibus Budget Reconciliation Act of 1989 (OBRA'89) also includes provisions related to dental services under Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT). It mandates "Dental services" (A) which are provided (i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and (B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

The same act establishes the reporting provision of EPSDT. The following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan is reported each fiscal year: (i) the number of children provided child health screening services, (ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services), (iii) the number of children receiving dental services, and (iv) the State's results in attaining the participation goals set for the State under section 1905(r).

As currently written, this federal act and accompanying regulation protect children because the dental care is comprehensive, medically necessary, provided at appropriate intervals, and must be provided by a licensed dentist or under the licensed dentist's supervision.

Some alternative models that utilize non-traditional dental providers who practice independently of dentists and who do not possess the education, training, and expertise of a licensed dentist, would be in violation of these provisions of federal law and potentially result in a lower quality of care for children at highest risk for oral diseases. Furthermore, these types of alternative dental care providers would create a two-tiered system of care, whereby affluent children would be treated by licensed dentists and Medicaid children would be treated by lesser educated dental care providers.

Resolution

97. Resolved, that the Association oppose attempts to alter federal statutes or regulations regarding the definition of "dental services" under the Medicaid program if such alterations would permit such services to be delivered in a manner other than by a dentist or under the supervision of a dentist, and be it further

Resolved, that Association constituent societies encourage their members to enroll in Medicaid programs and provide dental services helping to ensure that EPSDT guidelines are met.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 99 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: First Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication:

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

The following resolution was adopted by the First Trustee District and submitted on September 11, 2010, by Dr. Jeffrey Dow, caucus chair.

CONFLICT OF INTEREST POLICY

Background: Chapter IV of the *Bylaws* of the American Dental Association spells out the Conflict of Interest Policy for all individuals who serve in elective, appointive, or employed offices or positions at the ADA. A written disclosure is required annually to disclose any conflict of interest by those individuals. However, there is a lack of this disclosure when there is a formal discussion or debate on issues in councils, committees, the Board of Trustees and the House of Delegates. This presents an inherent risk of bias that could lead to ADA policy being influenced by undisclosed commercial interests or relationships.

Therefore, be it

Resolution

99. Resolved, that chairs of any meeting of the ADA, including Executive Committee, Board of Trustees, councils, committees and the House of Delegates read the following at the opening of each meeting:

> 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.

and be it further

Resolved, that all members of the House of Delegates must complete a written disclosure and that any noted conflicts of interest be transmitted to the House of Delegates if they have any such relationship that may present a conflict of interest, and be it further

Resolved, that when speaking on the floor of the House of Delegates or in Reference Committees, those individuals/members shall first identify those relationships before speaking on an issue related to such conflict of interest.

BOARD COMMENT: The Board appreciates the efforts of the First District to help foster compliance with ADA's conflict of interest policy, as set forth in Chapter VI of the ADA *Bylaws*. ADA does have other documents that speak to the conflict of interest policy. For example, the *Standing Rules for Councils and Commissions* addresses conflict of interest matters for volunteers on the councils, commissions and

committees. The ADA Executive Director indicates that the ADA's employment handbook addresses conflict of interest matters as to the ADA staff. She also points out that the staff are not the decision makers at such meetings. The Board of Trustees believes the Association would benefit by having the Council on Ethics, Bylaws and Judicial Affairs review this proposal with respect to volunteer activities in context with existing policies report on its finding to the Board and the 2011 House of Delegates.

BOARD RECOMMENDATION: Vote Yes on Referral.

BOARD VOTE: UNANIMOUS.

Resolution No. 100 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Fifth Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

ADA SUPPORT OF REPEAL OF HEALTH CARE REFORM LEGISLATION

The following resolution was submitted by the Fifth Trustee District and transmitted on September 13, 2010, by Ms. Connie Lane, executive director, Mississippi Dental Association.

Background: Legislators in 38 states have introduced legislation opposing the new health care reform law signed by President Obama, and attorneys general in 16 states have filed lawsuits against the federal government challenging its constitutionality -- particularly the constitutionality of the individual mandate.

- The recently enacted federal legislation on health care reform places mandates on the individual states to vastly expand entitlement programs like Medicaid, but does not provide the funding for the states to do so.
- The law places a mandate on individuals to purchase health insurance.
- The law does not include meaningful medical liability reform.
- The law does not improve funding for under- funded Medicaid dental programs.
- The law places restrictions on flexible spending accounts which many Americans use to pay for needed dental care.
- The law does not adequately address patient protections that should apply to group health plans offering dental benefits, such as prohibiting plans from limiting payments on services not covered by the plan.
- The law includes provisions to allow workforce pilot programs that may lead to non-dentists performing surgical dental procedures.
- The law places increased tax burdens on individuals, small businesses, and large businesses.
- The law cuts appropriations for Medicare by 500 billion dollars over the next ten years.

Therefore, be it

Resolution

100. Resolved, that the American Dental Association supports the repeal of the Federal Health Care Reform Legislation passed by Congress in 2010, and be it further

Resolved, that the American Dental Association House of Delegates directs the ADA Washington Office to engage in legislative efforts to repeal the Health Care Reform Legislation passed by Congress in 2010.

BOARD COMMENT: The Board believes that expending valuable lobbying resources on attempting to repeal the new health care law is not a wise approach based upon the low likelihood of success over the next two years. Even if Republicans attain control of the House and Senate, the President will oppose any repeal. In addition, there is a high likelihood that such advocacy would make it harder for the ADA to advocate successfully for legislative and regulatory changes to the new law. The Board believes that advocating for such changes is extremely important. Accordingly, the Board recommends adoption of the Board substitute.

100B. Resolved, that the ADA direct the Washington Office to make it a legislative and regulatory priority to advocate for changes in those provisions in the new health care reform law that deviate from current ADA policy.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

BOARD VOTE: UNANIMOUS.

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Board Report 9 Date Submitted: September 2010

Submitted By: Board of Trustees

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

REPORT 9 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:
RESPONSE TO RESOLUTION 35H-2009—STUDENT LOAN CONTRACT ANALYSIS

This is a progress report that describes the activities related to fulfilling the House resolution calling for a Student Loan Contract Analysis program.

Background: The 2009 House of Delegates adopted Resolution 35H-2009, which states as follows:

> **35H-2009. Resolved,** that as a member benefit, the ADA perform student loan contract analysis and help inform the students about the content of the contracts at the request of an ASDA chapter or a post-doctoral direct member, or a pre-doctoral student accepted into a dental school program.

Implementation of Student Loan Contract Analysis Program: The ADA Division of Legal Affairs has been working diligently to implement the student loan contract analysis program. Since the passage of Resolution 35H-2009, the Division has researched the most common types of student loans for dental students. That research identified seven loan programs administered or guaranteed by the federal government. The documentation for each type of loan was then analyzed and a standard contract analysis for each loan program has been prepared. Since those analyses were completed, two of the federal loan programs have been discontinued, leaving five current programs.

The Division has also collaborated with the Office of Student Affairs (OSA) and the American Student Dental Association (ASDA) to develop a process for receiving loan analysis requests and relevant information from dental students. ASDA members will submit requests and information through ASDA, while newly admitted dental school students and post-doctoral ADA members will send requests and information directly to the ADA via a new email address, studentloananalysis@ada.org, created for that purpose. Loan analyses will be sent from the Division of Legal Affairs directly to the requesting students.

The Division is preparing for a launch of the program in September 2010 and anticipates that it will begin processing requests at that time. The Division and OSA have been developing a FAQ sheet that will be distributed in September to dental students through their local ASDA chapters as a part of the launch of the program. The FAQ sheet will explain the mechanics of the program in an easy-to-read format. The Division has also been working with the Division of Communications to promote the launch of the program in various *ADA News* and information outlets.

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes Transmit.

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

Resolution No. 108 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Fourteenth Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Financial (Required)

DELINEATION OF DELEGATE FIDUCIARY DUTIES

The following resolution was adopted by the Fourteenth District Caucus on September 25, 2010, and transmitted on September 26, 2010, by Dr. Thomas J. Schripsema, chair, Fourteenth District Resolutions Committee.

Background: In recent sessions of the House of Delegates, delegates have been given information that is privileged by the attorney-client relationship, ostensibly because it was deemed necessary for our policy-making responsibilities. As a result, the House determined to have interim reports provided to the delegates more often than the usual annual reports of the Board, Officers and Councils. This raises questions regarding the responsibility, ability and potential liability of delegates to exercise certain fiduciary responsibilities to the organization, which were previously the exclusive purview of the Board of Trustees. Clarification of these responsibilities is necessary to avoid conflicts within the organization and to insure that those with the responsibility perform with due diligence. Equally important is the limitation of liability by the proper dissemination of appropriate information to those that need to know and can act correctly. The Council on Ethics, Bylaws and Judicial Affairs can review the relevant issues and bring the necessary clarification.

Resolution

108. Resolved, that the Council on Ethics, Bylaws and Judicial Affairs consider and delineate the fiduciary responsibilities and duties of individual delegates to the ADA House of Delegates, and be it further

Resolved, that the Council be encouraged to consult additional resources including, but not limited to, current delegates, comparable associations and the American Institute of Parliamentarians, and be it further

Resolved, that a report, including recommended bylaws changes, if necessary, be presented to the 2011 House of Delegates.

BOARD COMMENT: Received after this section had been reproduced for House distribution.

Resolution No. 109 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Fourteenth Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Financial (Required)

CLARIFYING THE ELECTION OF THE TREASURER

The following resolution was adopted by the Fourteenth District Caucus on September 25, 2010, and transmitted on September 26, 2010, by Dr. Thomas J. Schripsema, chair, Fourteenth District Resolutions Committee.

Background: The office of treasurer of the American Dental Association is unique from the other offices of the Association. It is elective because the Association recognizes the office requires someone with leadership and vision. It is selective because it requires someone with a particularly unique set of skills and experience. Wisely, we limit the campaigning for this office to keep the focus on credentials rather than a candidate's rhetorical or marketing skills. We also rely on the Board's due diligence to qualify them for the office, because without the benefit of a campaign, it is impossible for the delegates to adequately evaluate and verify a candidate's credentials. While the bylaws suggest that this is the process to be followed, they don't explicitly prevent nominations from the floor, which might entice a candidate with weaker credentials to avoid the Board's examination and exploit this loophole. Requiring all candidates to undergo the thorough vetting of the Board allows delegates to have confidence in the capabilities of the nominees and utilize the limited exposure they have to the candidates to discern those traits that a resume cannot adequately reveal.

Resolution

109. Resolved, that Chapter VIII. Section 20, be amended as follows (additions underscored):

Section 20. ELIGIBILITY: Only an active, life or retired member, in good standing, of this Association shall be eligible to serve as an elective officer. Trustees and elective officers may not apply for the office of Treasurer while serving in any of those offices, except that the Treasurer may apply for a second term pursuant to Chapter VIII, Section 50 of these *Bylaws*. Application for the office of Treasurer shall be made to the Board of Trustees not less than 30 days prior to the first session of the annual meeting of the House of Delegates at which a Treasurer is to be elected, in accordance with criteria determined by the Board to review a candidate's credentials for the purpose of selecting eligible nominees.

and be it further

Resolved, that Chapter VIII. Section 30 B., be amended as follows (additions underscored):

B. Nominations for the office of Treasurer shall be made only by a representative of the Board of Trustees in accordance with the order of business. If there is only one (1) applicant selected as an eligible candidate for the office of Treasurer, the Board of Trustees shall nominate that individual from the floor of the House of Delegates by a simple declaratory statement, which may be followed by an

acceptance speech not to exceed four (4) minutes by the candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. If there are two (2) or more eligible candidates for the office of Treasurer, the Board of Trustees shall nominate at least two (2) and not more than three (3) candidates from the floor of the House of Delegates by a simple declaratory statement for each nominee, which may be followed by an acceptance speech not to exceed four (4) minutes by the candidate from the podium, according to the protocol established by the Speaker of the House of Delegates. Seconding a nomination is not permitted.

BOARD COMMENT: Received after this section had been reproduced for House distribution.

Resolution No. 111 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Fourteenth Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

REGULAR COMPREHENSIVE POLICY REVIEW

The following resolution was adopted by the Fourteenth District Caucus on September 25, 2010, and transmitted on September 26, 2010, by Dr. Thomas J. Schripsema, chair, Fourteenth District Resolutions Committee.

Background: Association policies currently receive periodic review on a very sporadic basis. Although current policy requires that they be reviewed every seven years, there is no way for the House to know if the review actually takes place unless a revision or rescission is proposed. In fact, many policies become outdated or irrelevant and are only removed after much time passes. Keeping policies up-to-date is an essential responsibility as the House considers the Association's direction each year and really provides the parameters under which the Board and staff function. This resolution calls for the development of a regular protocol for the review and revision of Association policies.

Resolution

111. Resolved, that the Board of Trustees develop a timetable and protocol to allow the review of all Association policies every three years, and be it further

Resolved, that the Councils, committees, taskforce, or other Association agency assigned with the review consider the following in making recommendations:

- Relevance to current situation
- Continued need
- Consistency with other Association policies
- Appropriateness of language and terminology

and be it further

Resolved, that recommended rescissions and revisions will be brought to the House of Delegates in resolution form for debate and approval, and be it further

Resolved, that recommendations for maintaining policies unchanged will be assimilated into a single resolution, and if approved, unchanged policies will continue to carry the identifying information of their original adoption, and be it further

Resolved, that any policies that delegates remove from the reapproval consent calendar, and which after appropriate debate are amended or substituted, be automatically referred to the appropriate agency for reconsideration during the following year, and be it further

Resolved, that existing policy "Sunset Review of Association Policies" (*Trans.*1995:659), be rescinded.

BOARD COMMENT: Received after this section had been reproduced for House distribution.

Resolution No. 118 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Fourteenth Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

INVESTIGATING BREACHES OF CONFIDENTIALITY

The following resolution was adopted by the Fourteenth District Caucus on September 25, 2010, and transmitted on September 26, 2010, by Dr. Thomas J. Schripsema, chair, Fourteenth District Resolutions Committee.

Background: Confidential information takes on many different forms. It may be formal attorney-client communications. It may be discussion of strategic plans. It may be employment or salary matters, or it could simply be first draft brainstorming that has yet to be finally refined. In any case, we understand the importance of privileged information. All professions consider certain communications to be sacrosanct. As an organization our existence depends upon mutual trust between the staff and volunteers. Dissemination of confidential communications constitutes a violation of that trust and accepted organizational ethics. In the internet age, the dissemination of information is fast and easy, as is the damage which can result. Once information is out, it cannot be put back and the consequences must simply be lived with, therefore a reasonable deterrent is desirable. This resolution suggests a due process to hold those that might intentionally violate our trust, responsible.

Resolution

118. Resolved, that the appropriate amendments to the ADA *Bylaws* to effectuate the proposal below be prepared by the Council on Ethics, Bylaws and Judicial Affairs and submitted to the 2011 House of Delegates:

1. That the intentional distribution of confidential Association information to other than those for whom it was intended is a violation of professional ethics, except for communications whose sole purpose is the reporting of suspected wrongdoing in accordance with the Association's corporate "whistleblowing" policy;

2. That when there is an allegation that confidential Association information has been disseminated to others than it was intended, the President may appoint a committee of not more than five persons with sufficient diversity and skill to investigate the allegation to attempt to identify the source of the information and the manner in which it was disseminated;

3. That if the identified source is a member of the staff, they will immediately be restricted from access to Association communications until the validity of the accusation and reason can be determined and appropriate review of their employment and due process have been completed;

4. That if the identified source is a member volunteer, they will be charged with a violation of professional ethics and subject to a hearing before the Council on Ethics, Bylaws and Judicial Affairs

to determine the validity of the accusation, the reason dissemination may have taken place and if appropriate, a penalty commensurate with the violation;

5. That all activities of an investigative committee or subsequent due process are to be kept confidential except for the report of final outcomes and associated penalties;

6. That the investigative committee will immediately refer any matter to the legal division and suspend further activity, if evidence indicates that the dissemination of confidential information has resulted in either a potential liability or a recoverable damage for the Association, or is protected by corporate policy or applicable statute; and

7. That the ADA *Bylaws* Chapter X, Section 120G., relating to duties of the Council on Ethics, Bylaws and Judicial Affairs, be amended to allow the Council to discipline the officers, trustees, ADA members of councils, commissions, or appointed taskforces, or delegates to the House of Delegates of this Association that have been accused and found guilty of a violation of ethics related to their service.

BOARD COMMENT: Received after this section had been reproduced for House distribution.

Resolution No. 120 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: October 2010

Submitted By: Eleventh Trustee District

Reference Committee: Legal, Legislative and Public Affairs Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Collaboration (Required)

SUPPORTING QUALITY RELATED PERFORMANCE MEASURES IN HEALTH CENTERS

The following resolution was submitted by the Eleventh Trustee District and transmitted on October 1, 2010, by Mr. Jim Towle, executive director, Alaska Dental Society.

Background: Health Resources and Services Administration (HRSA) funded health centers are expected to have ongoing quality improvement and assessment programs in order to support the delivery of high quality, value-added health care. As such, HRSA requires that health centers report quality-related performance measures annually in the Uniform Data System (UDS)[i]. An example of a medical performance measure required in the UDS is the reporting of the **"**Percentage of pregnant women beginning prenatal care in the first trimester" within the health center. There are currently two very important performance measures that would if implemented greatly increase a health center's and HRSA's ability to measure quality and value as it relates to oral health[i].

Relative Value Units (RVU)[ii,iii]: RVU's are used to quantify the productivity of a dental program. The numerical value of a RVU for an individual Current Dental Terminology (CDT) code is based on the amount of time, skill, materials and level of complexity related to delivering a specific procedure code. Traditionally, health centers have measured the number of patients seen per day as a metric to determine productivity. However, the problem with measuring the number of patients seen per day is that it cannot be quantified to determine the amount of treatment completed. Measuring RVUs is superior to all other forms of productivity measurement because it allows a health center to quantify productivity and allows a health center to compare that productivity to other health centers across the nation despite regional difference in fee schedules and sliding fees. RVUs are currently used in some health centers[iv] across the nation and in Indian Health Services (IHS)[v]. Ultimately, the establishment of a HRSA defined and direct RVU oral health performance measure aligned with grant performance reporting (UDS) would greatly increase a health center's ability to accurately measure productivity.

Dental Treatment Plan Complete (DTPC) Rate: DTPC rate is a measurement of what percent of comprehensive care patient's within a health center have completed all dentist recommended essential dental care services within a one year period of time. This simple patient-centered measure has the ability to assist health centers and HRSA in evaluating the efficiency of management systems and treatment/prevention protocols. Multiple health centers across the nation currently use this measure including health centers in Washington and Montana[vi]. The establishment of a HRSA defined and directed DTPC rate oral health performance measure aligned with grant performance reporting (UDS) would greatly increase a health center's ability to accurately measure quality and value-added processes.

Considering the strong ability of these oral health performance measures to improve the quality and value of services delivered within health centers the following resolution is offered.

Resolution

120. Resolved, that the ADA advocate aggressively for HRSA to define and direct a RVU oral health performance measure aligned with grant performance reporting (UDS), and be it further

Resolved, that the ADA advocate aggressively for HRSA defined and directed DTPC rate oral health performance measure aligned with grant performance reporting (UDS).

BOARD COMMENT: Received after this section had been reproduced for House distribution.

[i] US Department of Health and Human Services. Health Resources and Services Administration. Health Care and Business Plan Performance Measures. http://bphc.hrsa.gov/about/performancemeasures.htm Accessed 27Sep10.
[ii] The Center for Health and Healthcare in Schools. Rosenthal. Management Information Systems. http://v5.healthinschools.org/static/sh/dental/manage.aspx Accessed 27Sep10.
[iii] National Maternal and Child Oral Health Resource Center. Safety Net Dental Clinic Manual. Dental Productivity Measures. http://www.dentalclinicmanual.com/docs/Productivity_measures.pdf Accessed 27Sep10
[iv] National Maternal and Child Oral Health Resource Center. Safety Net Dental Clinic Manual. Washington State Dental RVU Cookbook. http://www.dentalclinicmanual.com/docs/Rvu-cookbook.pdf Accessed 27Sep10.
[v] US Department of Health and Human Services. Indian Health Services. Relative Value Units. http://www.doh.ihs.gov/edr/documents/CDT%202009-2010_IH%20Codes_LOC_RVU_Complete.pdf Accessed 27Sep10.
[vi] National Maternal and Child Oral Health Resource Center. National Primary Oral Health Care Conference. Gillette J. http://www.mchoralhealth.org/Presentations/NOHPC2006/M_Gillette.pdf Accessed 27Sep10.

Membership and Planning

Resolution No. 40 New ■ Substitute ☐ Amendment ☐

Report: Board Report 4 Date Submitted: July 2010

Submitted By: Board of Trustees

Reference Committee: Membership and Planning

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Build Dynamic Communities (Required)

REPORT 4 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:
ANNUAL REPORT OF THE STANDING COMMITTEE ON THE NEW DENTIST

Background: The Committee on the New Dentist (CND), as a standing committee of the ADA Board of Trustees, is charged through the ADA *Bylaws* to accomplish the following: to provide the Board of Trustees with expertise on issues affecting new dentists less than ten years following graduation from dental school; to advocate to the Board of Trustees and other ADA agencies the perspectives of the new dentist in the development of policies, programs, benefits and services of the ADA; to identify the needs and concerns of new graduate dentists and make recommendations for any programs to assist with their transition to practice; to stimulate the increased involvement and active participation of new dentists in organized dentistry; to serve as *ex officio* members, without the power to vote, of councils and commissions of the ADA on issues affecting new dentists; and to enhance communications with constituent and component new/young dentist networks. Therefore, the Board of Trustees submits the following report to the 2010 House of Delegates.

Committee Composition: The following individuals served as members of the Standing Committee on the New Dentist in 2009-2010: Dr. Deepinder (Ruchi) Sahota, California, chair; Dr. Robert Leland, Massachusetts, vice-chair; Dr. Jeremy Albert, Florida; Dr. Jennifer Davis, Pennsylvania; Dr. Jennifer Enos, Arizona; Dr. Jennifer Jerome, Ohio; Dr. Eric Kosel, Illinois; Dr. Christopher Liang, Maryland; Dr. Garrick Lo, Washington; Dr. Keri Miller, Alabama; Dr. Matthew Niewald, Missouri; Dr. Sarah Poteet, Texas; Dr. Danielle Ruskin, Michigan; Dr. Christopher Salierno, New York; Dr. Stacey Swilling, Arkansas; Dr. Eric Unkenholz, South Dakota.

The Strategic Plan of the American Dental Association: Committee activities support many of the objectives of the *ADA Strategic Plan*, primarily those of Build Dynamic Communities. In 2009-2010, the Committee was very active in addressing the Strategic Plan, providing input to the 2011-2014 plan development and addressing the impact of the environmental scan relative to new dentists. This work is ongoing.

January Mega Issue Discussion: At its January 2010 meeting, the Committee on the New Dentist completed a mega issue discussion with the framing question, "How can the ADA get more timely, relevant and emerging oral health information to the public?" This addressed the 2007-2010 Strategic Plan goal to Create and Transfer Knowledge.

Background information about the current ADA initiatives to inform and educate the public was provided to the Committee, along with the Council on Communications' Strategic Communications Plan and CAPIR's Health Literacy in Dentistry Action Plan 2010-2015. A demonstration reel of ADA Public Service Announcements, Satellite Media Tours, and the video podcast for the public were shown. Committee director Karen Burgess presented the findings of both member and public surveys of ADA initiatives.

Panelists for the discussion included Dr. Sonja Boone, director, Physician Health and Healthcare Disparities, American Medical Association; Dr. Kimberly May, assistant director, Public and Professional Affairs, American Veterinary Medical Association; and Ms. Mary Kate Wilson, senior director, Consumer Marketing, Alzheimer's

Association. Each panelist provided an overview of public outreach efforts within their organizations including goals, strategies, communication tactics, challenges and successes. In addition, ADA staff from the Council on Communications, Council on Access, Prevention and Interprofessional Relations, Council on Scientific Affairs, Marketing, and Electronic Communication provided information for the Committee.

Following the panel discussion, the Committee conducted a brainstorming session to identify key issues and subsequently made several recommendations to the Council on Communications, advising that the Committee supports the concept of developing a social media strategy to reach the public and profession and Committee the implementation of piloting social media to meet the needs of new dentists and the New Dentist Committee Network. In addition, the Committee recommended that the Council on Communications consider messages such as "see your dentist" and "oral health is a part of overall health" as key messages in the strategic communications plan targeted to the public.

June Mega Issue Discussion: At its June 2010 meeting, the Committee on the New Dentist completed a megaissue discussion on the topic "How can the ADA be the organization of the future?" Between January and June, Committee members completed analysis of the 2009 Environmental Scan and the potential impact of each of the seven sections on new dentists. A report addressing this analysis and related discussion points as well as potential recommendations for consideration was prepared and discussion was utilized as background for the megaissue topic. The Committee took a long view and considered three potential future scenarios by breaking into three groups, each group addressing one of the following worlds:

1) The seamless healthcare world, where medical, oral, and mental health were all addressed in a holistic approach;

2) the technologically advanced world, where scientific advances has led to new diagnostic and treatment opportunities for oral and systemic health; and

3) the one-payer world, where all health care providers are employees, there is a single payer for care, and everyone has access to oral health care.

Each small group addressed the implications for the public, the profession, the membership and for the association, and then an overarching discussion identified key factors that were consistent across all three scenarios. The Committee will continue its work on this mega issue through a workgroup consisting of Dr. Ruchi Sahota, Dr. Rob Leland, and Dr. Keri Miller to develop specific recommendations for ADA action.

Metrics: At its January and June 2010 meetings, the Committee evaluated its current activities and evaluation criteria in keeping with the strategic planning process and prioritized its budgeted programs within the framework of the strategic plan. Of particular note, the Committee took action in 2010 to enhance revenue and reduce expenses related to the ADA New Dentist Conference. One such action was the recommendation to the Board of Trustees that a new array of sponsorship opportunities be offered to dental society and corporate sponsors beginning with the 2010 conference. This plan was approved and as a result, the 2010 conference sponsorship revenue totaled $133,500, exceeding the budgeted level of $125,000. Fee increases for the conference and a high level of attendance also resulted in registration revenue of $116,222.50, significantly higher than the $80,000 budgeted. The Committee will receive a final report on conference expenses and determine the net expense/revenue for the 2010 conference. In addition, the Committee plans to add an additional, non-exhibit sponsorship opportunity for the 2011 conference, which will celebrate the Committee's 25th year. The ADA 25th New Dentist Conference: Sweet Home Chicago Silver Jubilee will be held June 16-18, 2010 in Chicago.

The Committee addressed the 2007-2010 ADA Strategic Plan goals in the following ways:

Achieve Effective Advocacy. As described below, in January 2010 the Committee revised its subcommittee structure into more effectively address the broad range of issues of interest to new dentists. While the Committee has received reports on advocacy in the past, this has often focused primarily on licensure and

financial incentives for new dentists to practice in particular locations. With its June 2010 meeting, the Committee began receiving more comprehensive reports on advocacy issues at the federal and state level, and took action at that meeting to voice its support for the collaborative approach with the constituent societies through the State Public Affairs Initiative. In a related action, the Committee also directed the *ex officio* to the Council on Government Affairs to communicate the Committee's support of the priorities established for action through the ADA Advocacy Agenda.

The Committee is also working more closely with ADPAC to encourage ADPAC membership among new dentists. Committee staff work closely with ADPAC staff to evaluate the demographics of ADPAC members on an ongoing basis and to monitor growth in new dentist participation. In addition, the Committee monitors and works to increase the number of new dentists who join ADPAC on site at the New Dentist Conference.

Build Dynamic Communities. The Committee has an interest in facilitating new dentist membership and conversion of dental students to active membership. The Committee plans explore opportunities to use the 2012 New Dentist Conference to recruit nonmember dentists. The Committee also noted that the conference's Washington DC location should be used to highlight the value of ADA membership relative to professional advocacy. In addition, the Committee recommended that the quantitative survey of dental students and recent graduates to be conducted later in 2010 be utilized to evaluate the gap between new dentist and overall membership market share in the northeast section of the United States. The Committee receives a regular update on the Council on Membership's MC^2: Membership Contact and Connections and works to add value to membership by providing resources, information, and continuing education to new dentist members.

Create and Transfer Knowledge. The Committee provides support to outreach to the public through its *ex officio* to the Council on Communications; in addition, the Committee's chair, Dr. Ruchi Sahota, serves a co-host for the Council's video podcasts to the public. The Committee also supports transfer of practice and scientific knowledge to new dentists and dental students through its annual conference, audio podcasts, webinars, quarterly publication, as well as *ex officio* participation on councils including the Council on Dental Practice, Council on ADA Sessions and Council on Scientific Affairs. In December 2009, the ADA Board of Trustees delegated the responsibility for volunteer oversight for the Success Dental Student Programs to the Committee on the New Dentist, and the Committee most recently reviewed content changes with input from other ADA agencies (including the Council on Dental Education and Licensure, Council on Dental Practice, Council on Ethics, Bylaws and Judicial Affairs, Council on Scientific Affairs, and Council on Dental Benefits Programs), selected six new speakers, and will hold an in-person speaker training for new speakers and a training webinar for continuing speakers prior to the start of the 2010-2011 academic year.

Achieve Excellence in Operations. The ADA has the objective of implementing innovative means to support leadership development; the Committee on the New Dentist is noted for its development of the on-line basic leadership educational program, *Understanding the Association – the Series*. The Committee receives reports related to utilization, and has exceeded the metrics of 150 participants annually. In the most recent report, about half the participants were new dentists and half were established dentists.

New Dentist Membership: One key role for the Committee is the facilitation of new dentist involvement in organized dentistry. Membership among active licensed new dentists increased from 29,437 in 2008 to 29,793 at the end of 2009. However, due to growth in the market, there was a slight market share decrease from 69.0% to 68.4%. The market share gap between new dentists and members overall has narrowed to 0.7 percentage points, as the overall membership market share at end-of-year 2009 was 69.1%. As noted above in the section on strategic planning, the Committee sees opportunity to increase the level of membership participation through the New Dentist Conference and related activities and will be following up with increased outreach through the New Dentist Committee Network.

The Committee supports the goal of achieving a 75% membership market share for all dentists, including recent graduates, by enhancing the value of membership and communicating to dental students and new dentists.

The Committee provides targeted resources to meet new dentists' needs. One of these is the quarterly publication, *ADA New Dentist News*, which is distributed free of charge to member new dentists and dental students as a wrap on *ADA News*. Its purpose is to provide practical information to help new dentists succeed in practice. The publication is sponsored by Matsco, an ADA Business Resources provider offering practice acquisition, start-up and expansion loans; its focus is a particularly good fit with *ADA New Dentist News* readers. The May 2010 issue went to both members and nonmembers and addressed how new dentists are faring in this economy, the Dental Practice Hub Web site, peer review for new dentists, the value of ADA membership and information on the New Dentist Conference. Future issues in 2010 will include topics such as work-life balance, staying fit, life in a community health center, ergonomics, disability insurance, practice mobility and licensure updates, among others.

Another resource to meet new dentist needs is the ADA New Dentist Conference, which just finished its 24th year in June. The 2010 conference provided up to 15 hours of high quality continuing education at a low registration fee and was designed to facilitate peer sharing and social opportunities. Final registration was 409, the highest it's been in more than ten years. New this year, the Committee offered a full day of leadership development topics which were very well attended by both volunteer leaders and those looking to get involved in organized dentistry. Eighty-two leaders representing 25 states, as well as the Committee on the New Dentist and 13 members of the ADA Board were in attendance. Total participation for the day was strong, with over 200 attending the leadership day keynote by Cynthia D'Amour on *Exceptional Leadership Skills for your Personal, Professional and Community Life* and continuing through the morning breakout sessions and either the orientation program, "New Dentist Volunteers: How to Get Involved and Stay Involved" or the advanced leadership program "Demonstrating Value to the New Dentist." Following these programs was the popular "Network Idea Exchange and Hot Topics: Ask Your ADA Leaders," where attendees heard about programs and activities for new dentists, shared concerns affecting new dentists and participated in a Q & A session with the ADA Board of Trustees. A total of 135 people attended this session. Overall, evaluations of the leadership day and of the conference as a whole were positive.

Due to the high attendance, increase in registration fee rates, and success of the new sponsorship opportunities for dental societies and corporate sponsors, the conference is expected to come in $25,000-35,000 over budget from a revenue perspective. Evaluation of related expenses when the hotel bill is received will determine the net revenue for the conference, as some expenses, such as catering, will vary according to the attendance.

New Dentist Issues: There are several issues of special interest to new dentists and the Committee is active in monitoring those issues and providing insight and information.

Financial Issues. The Committee follows the ever-increasing level of student debt and serves as a resource to dental students, while also continuing to develop financial resources for new dentists and dental students. The Committee examined the 2009 American Dental Education Association Survey of Dental School Seniors and determined that the graduating debt among the Class of 2009 was down slightly compared to the previous year, at $163,535 from all schools, $140,831 from public schools, and $194,665 from private and private state-related schools. The Committee also tracks student loan repayment programs and other financial incentives to practice in a particular location and requested the ADA Office of Student Affairs to provide a resource for dental student on this topic, which was developed and made available to students in the spring of 2010.

The Committee is also interested in the career choices, financial pressures and income and benefits received by new dentists in various occupations, including private practice, federal services, graduate students, dental education, etc. Plus, with the recent economic downturn, the Committee requested and received regular reports from the Health Policy Resources Center's *Survey of Economic Confidence* comparing new dentists to established dentists. In general, younger dentists are reporting less negative impact on their gross billings and net income, and are also more confident than older dentists that future economic conditions will improve.

Practice Transition. The Committee is dedicated to helping dental students and new dentists make a successful transition to practice, recognizing the diversity of dental occupations that new dentists may choose. The Committee works to educate dental students and new dentists about practice options, including dental research, dental education, public health, federal services and alternative practice settings. The annual Survey of Dental School Seniors conducted by the American Dental Education Association noted above also provides information regarding trends in occupations immediately following dental school graduation; the percentage of new graduate going into private practice has remained relatively stable around 50%, but the percentage going directly into practice ownership has steadily declined. There has been an increase in the numbers of new graduates going into advanced dental education programs.

The ADA Health Policy Resources Center has also noted the growth in group practice among dentists, and in particular, new dentists. The Committee has discussed focus group research among dental students and new dentists which shows an interest in group practice, but particularly for small group practice. This qualitative information indicates that these young practitioners are attracted to the opportunity for control and ownership coupled with the ability to share responsibility and have a more flexible lifestyle in terms of work/life balance. A quantitative survey of junior and senior dental students and dentists in the first five years following dental school graduation is in development to address this and other practice and professional issues.

Dental Education. The Committee follows dental education issues, particularly as they impact dental students and new dentists, including dental school curriculum, the opening of new dental schools, the availability of general practice residencies and specialty programs.

Dental Licensure. Each year, the Committee continues to play an active role in educating dental students about the licensure process through the expanded publication *Dental Boards and Licensure Information for the New Graduate* which is produced by the Office of Student Affairs and distributed to all senior dental students and made available for download to members on ADA.org. Strongly supportive of a single national clinical licensure examination, the Committee requested and received a thorough report on ADA activities in this regard, which was prepared by staff of the Council on Dental Education and Licensure and presented at the Committee's January 2010 meeting.

The Voice of the New Dentist: The Committee seeks to accurately represent the views and needs of new dentists, including those in occupations other than private practice, such as federal service, graduate students and dental education. In order to do so, the Committee requests a consultant each year from each branch of the federal dental services, as well as a liaison to the American Student Dental Association (ASDA). Consultants this year included: Dr. Wesley Shute (ASDA), Lieutenant Barry Peterson (Navy), Colonel Amar Kosaraju (Air Force), Lieutenant Justin Sikes (Public Health Service), Captain Zachary Paukert (Army), and Dr. Stanislava Misci (Veterans Affairs).

Dr. Shute provided information to the Committee regarding dental student issues, and indicated that ASDA's Board of Trustees is focusing on the development of a strategic plan to guide ASDA over the next few years. Dr. Shute reported on dental education, professional issues, student advocacy, membership value development and awareness and leadership recruitment and training.

The consultants from the branches of the federal dental services provided insight into the concerns of new dentists in the military and other federal services, including loan repayment, membership dues, mentoring and training, continuing education, licensure issues and advocacy initiatives. Dr. Misci noted that the patient population of the VA Healthcare system has been shifting toward a much younger age group and there has been a shift in the types of dental restorations used which requires regular continuing education and implementation of the latest technologies and materials; therefore providing an educational source and building comprehensive dental treatment experience for new dentists.

Between the Air Force, Army, Navy, and US Public Health Service, several hundred new graduates enter federal service dentistry each year; new dentist participation in the Department of Veterans Affairs system is primarily through general practice residency and other advanced dental education programs. Lt. Sikes noted that there was difficulty in recruiting dentists to serve in geographically remote areas, so a new incentive pay

program has been authorized where the service agency awards anywhere from $0-$3000 per month. The U.S. Air Force Dental Corps assimilates, mentors, and trains junior dental officers. With this program, future dentists serve as second lieutenants during dental school and are then promoted to Captain once they enter the Air Force. Maintaining outreach to junior officers is important for ensuring their participation in organized dentistry.

The Committee was pleased to note that membership participation among dental students continues to be high, at 84.3%. Membership market share for new dentists in the federal services is also high, at 70.8%, compared to the overall FDS market share of 61.5%.

***Ex Officio* Participation:** The Committee currently participates as the voice of the new dentist to 12 ADA agencies, through its *ex officio* assignments. The agencies include: Council on Access, Prevention and Interprofessional Relations, Council on ADA Sessions, Council on Communications, Council on Dental Education and Licensure, Council on Dental Benefit Programs, Council on Dental Practice, Council on Ethics, Bylaws and Judicial Affairs, Council on Members Insurance and Retirement Programs, Council on Government Affairs, Council on Membership, Council on Scientific Affairs and the ADPAC Board. Through these *ex officio* assignments, committee members have provided insight on diverse topics: access to care; course offerings at the ADA annual session; legislative issues; membership outreach and conversion of dental students and new dentists to active tripartite membership; risk management; advocacy for dentists and patients; dental workforce issues; social media; evidence-based dentistry; and licensure issues.

Representatives of the Committee also serve on other committees and task forces for the ADA, including: ADA Strategic Planning Committee, Center for Education and Lifelong Learning (CELL) CE Online Advisory Group and the Social Media Workgroup through the Council on Communications. Recently, the Board of Trustees approved the funding for a Committee member to attend the 2010 Conference on Workforce Issues in July 2010.

Leadership Development: The Committee is dedicated to the development of ADA's future leaders. It supports the development of new dentist committees throughout the tripartite and the active involvement of new dentists in organized dentistry. There is new dentist representation by 45 constituent and 163 component societies in the New Dentist Committee Network. In February 2010, the Nevada Dental Association established a New Dentist Committee and hosted a basic new dentist committee workshop facilitated by ADA staff and Dr. Jennifer Enos, the Fourteenth District representative to the Committee on the New Dentist. The Arizona Dental Association is also in the process of establishing a new dentist committee and will be hosting a basic workshop in August this year. The Pennsylvania Dental Association and the Colorado Dental Association will be hosting the advanced workshop later this year which is also facilitated by staff.

The Committee's Network Communications Program helps new dentist volunteers across the country keep in touch with news in organized dentistry. From the Committee chair to all Network leaders and staff contacts, *Network Updates* are disseminated by e-mail six times throughout the year. Topics range from ADA awards programs and the ADA New Dentist Conference to resource availability and initiatives of interest to new dentists, such as legislative and licensure updates, financial issues, ADA Catalog products and ADA distance learning opportunities.

The ADA New Dentist Conference plays an important role in volunteer leadership development. In addition to offering continuing education for the general new dentist member, the 2010 conference offered a new full day of leadership programming with continuing education credit as pre-conference courses. The Committee monitors the number of leaders attending as well as the feedback they provide; 82 leaders representing 25 states, as well as the Committee on the New Dentist and 13 members of the ADA Board were in attendance. Including conference registrants who are interested in becoming more involved in leadership, over 200 conference attendees participated in the leadership development programming on site. The leadership programming included a keynote, morning breakout sessions and development programming for new and

experienced volunteers, as well as a session to facilitate networking and peer sharing for all Network leaders. Overall, evaluations of the leadership day and of the conference as a whole were positive.

The Committee offers leadership development opportunities outside of the New Dentist Conference as well. Several Web seminars are held throughout the year for leadership development outreach. On December 9, Dr. Cindy Lyon of the Arthur Dugoni School of Dentistry presented "Balancing Personal and Professional Responsibilities." Sixty-six attendees participated in the live event and an additional 37 members viewed the archived version which was available for 90 days following the event.

Due to the popularity of the practice management topics, a blend of leadership and practice topics are scheduled for the remainder of 2010. Upcoming web seminars include "Delegating for Outrageous Results" with Ms. Cynthia D'Amour and "Promoting Your Practice from the Inside Out" with Dr. Andy Doerfler.

Also, ADA CE Online offers a self-guided continuing education course, "Understanding the Association Series" designed to help members identify their leadership style, conduct effective meetings, set goals, and gain a better understanding of the association's role in the political process. This free course, developed by the Committee on the New Dentist, and offered exclusively to ADA members, includes a series of nine units to provide enhanced leadership development training for current and future tripartite volunteers by outlining key aspects for active members to strengthen leadership skills. Participants who successfully complete the course earn three continuing education credits.

To recognize and support individuals and programs that contribute significantly to the tripartite on issues of special interest to new dentists, the Committee sponsors several awards, including three for individual achievement, as well as two recognizing dental societies. This year, the Committee recognized Dr. Thomas Smyth of Minnesota with the Golden Apple Award for New Dentist Leadership; Dr. Brett Kessler of Colorado with the Golden Apple Award for Outstanding Leadership in Mentoring; and, in collaboration with ADPAC, Dr. Christopher Morgan of Michigan with the Golden Apple Award for New Dentist Legislative Leadership. The Committee selected the San Antonio District Dental Society New Dentist Committee as the 2010 recipient of the New Dentist Committee Outstanding Program Award of Excellence for its "CND Continuum for Excellence." The Committee, with the participation of the Council on Membership, selected the recipient of the Golden Apple Award for Dental School/Dental Student Involvement in Organized Dentistry in June 2010. The award winner will be announced in September 2010.

In order to make resources more conveniently available to the Network and dental society staff, many Committee resources are posted on the Dental Society Resources (DSR) Web site (www.adadentalsociety.org) for dental society staff and volunteers. Publicizing this site, and gaining feedback to enhance it, is an ongoing opportunity for the Committee. DSR is frequently highlighted in New Dentist Committee Network *Updates* and is included in the Basic and Advanced New Dentist Committee Workshops curriculum. Dental Society Resources was also demonstrated for the attendees at the orientation session for new Network leaders at the 2010 New Dentist Conference.

Response to Assignments from the 2009 House of Delegates: The House of Delegates adopted the following resolution:

> **18H-2009. Resolved,** that new dentists (defined as dentists graduating less than ten years previously) be encouraged to become involved as volunteers in organized dentistry, and be it further
>
> **Resolved,** that constituent dental societies be urged to include new dentists in the leadership development process, offer new dentists volunteer opportunities, and be inclusive of new dentists in the leadership education offered.

Subsequently, the Committee on the New Dentist has undertaken numerous initiatives to encourage new dentists to become involved with organized dentistry, particularly related to the 2010 conference and the increase in education and resources provided to current and potential new dentist volunteers. For example, attendees who are not current Network leaders who are registered for the leadership day have been

contacted about their reasons for doing so, and the information about those who are interesting in getting more involved will be provided to the CND district representatives for follow-up. There was also a flyer encouraging greater involvement in the registration packet for all attendees and at the membership booth. In addition, the CND will be a part of the Leadership Day at annual session in 2010 and staff a station at the open house there to help interested new dentists make connections with state or local new dentist committees in their area.

Regarding the second resolving clause, the Committee on the New Dentist took action at its June 2010 meeting to request that the 2010 survey of constituent dental societies, which will be undertaken in the third quarter of 2010, include appropriate questions to document the inclusion of new dentists in leadership opportunities. In addition, the Committee's New Dentist Committee Network Feedback Survey will include relevant questions.

Committee Self-Assessment: As part of its strategic planning process, the Committee undertook a self-assessment at its January 2010 meeting. A Web survey of Committee members was used to gather information prior to the meeting and develop a list of Committee priorities, which was reviewed and finalized at the meeting. Based on Committee priorities, the Committee reconfigured its subcommittees at its January 2010 meeting.

The Subcommittee on Continuing Education and Conference Activities was established to review and report to the full Committee on the New Dentist on issues and activities regarding ADA continuing education opportunities for new dentists and the ADA New Dentist Conference. Responsibilities include:

1. To monitor dental student and new dentist desires in continuing education and make recommendations to ensure relevance of ADA offerings regarding topics, speakers, formats, and other relevant issues.
2. To make recommendations regarding the ADA New Dentist Conference, including conference site locations, themes, programs and speakers and to establish metrics and monitor performance of the conference.
3. To make recommendations and monitor the performance of Webinars, podcasts, and other ADA-sponsored CE opportunities for dental students and new dentists.
4. To monitor new dentist attendance at ADA annual session and to provide recommendations to the Council on ADA Sessions regarding new dentist programming and other activities to encourage new dentist participation.

The Subcommittee on the New Dentist Committee Network and Leadership was established to review and report to the full Committee on issues and activities related to the New Dentist Committee Network, including workshops, *Network Update*, the online leadership education program (Understanding Associations) as well as the leadership programming at the New Dentist Conference and elsewhere. Responsibilities include:

1. To monitor and encourage leadership involvement of new dentists and develop leadership training programs for implementation by component and constituent societies.
2. To monitor legislative and political issues and encourage involvement of new dentists in legislative and political action activities through appropriate tripartite agencies.
3. To oversee the resources provided to the New Dentist Committee Network and to encourage the growth and development of state and local new dentist committees.
4. To plan the leadership programming at the New Dentist Conference.
5. To monitor the participation in the Understanding Associations online leadership program and identify and recommend the implementation of additional ADA leadership opportunities for new dentists.
6. To coordinate and award the New Dentist Committee Outstanding Program Award of Excellence and to select the recipients of the Committee-judged Golden Apple awards.

The Subcommittee on New Dentist Issues was established to review and report to the full Committee on issues of importance to new dentists, such as financial issues, dental education and licensure, advocacy and

legislation, conversion of dental students and new dentists to active membership, and practice-related issues, as well as to recommend the development of appropriate policy and resources. This subcommittee specifically addresses the *ADA New Dentist News* and the Success Dental Student Programs. Responsibilities include:

1. To develop recommendations for consideration by appropriate agencies of the Association to reflect the new dentist perspective related to the development of policy.
2. To develop recommendations related to ADA resources targeted to meet the needs of new dentists.
3. To evaluate trends and develop strategies to enhance the value of organized dentistry for new dentists and recommend strategies to enhance membership participation.
4. To review content, address speaker selection, and provide recommendations to enhance the effectiveness and success of the Success Dental Student Programs.
5. To establish the editorial calendar, provide feedback, and make recommendations to enhance the effectiveness of *ADA New Dentist News*

During its self-assessment, the Committee reviewed its activities in light of the priorities and its *Bylaws* responsibilities and took action to eliminate funding the *Little Dental Drug Book* from its 2011 budget. The book, which was funded by the CND and presented each year to the dental school seniors from the CND and the Council on Scientific Affairs, was seen as not closely tied to Committee priorities and it was noted that since the initiation of this program, new resources have become widely available to dental students. The Committee also discussed its mission, *Bylaws* responsibilities, and the criteria for nomination to the Committee on the New Dentist, and took action to continue work on these topics through a workgroup chaired by CND vice-chair Dr. Rob Leland and including Drs. Jeremy Albert, Shamik Vakil and Eric Kosel. In addition, the Committee discussed its unique role as a standing committee of the Board of Trustees and whether it could be more effective as a council, and decided that the current structure and reporting relationship was appropriate and important to preserve.

The Mission and Bylaws workgroup met by conference call and continued discussions via e-mail, and did recommend revisions to the Committee's mission, the criteria for nomination to the Committee, as well as to its *Bylaws* responsibilities, in order to more accurately reflect the Committee's priorities and related activities, as well as transparency around the Committee's unique role and the level of commitment required to serve.

The Committee on the New Dentist addressed the workgroup's report and recommendations at its June 2010 meeting, and took action to revise its mission and criteria for nomination, and to recommend appropriate Bylaws changes to the Board of Trustees for transmission to the House of Delegates.

One key change was the recommendation to change the name of the agency from the "Committee on the New Dentist" to "New Dentist Committee." The Committee noted that it is not an agency about new dentists, but made up of new dentists and representing new dentists. The Committee also noted that the existing mission was descriptive of its role within organized dentistry, but was not transparent enough – member dentists could not read the mission statement and clearly understand what it is the Committee does. Therefore, the Committee approved the following Mission Statement:

> The Mission of the ADA New Dentist Committee is to serve as the voice of the new dentist within the American Dental Association, representing new dentists' views to the ADA Board of Trustees and other agencies; to monitor and anticipate new dentist needs and advocate for the development of member benefits, services, and resources to facilitate professional and practice success; and to foster the next generation of leadership within organized dentistry by building community and facilitating new dentist leadership development at all three levels of the tripartite.

Just as the Committee desired transparency to the membership regarding its mission, the Committee also wanted the Board of Trustees and potential new district representatives on the Committee to have a clear idea of the requirements for serving. The Committee therefore took action to recommend revisions to its criteria to read as follows:

New Dentist Committee Criteria for Nomination

In light of the purpose and responsibilities of the ADA New Dentist Committee, the NDC recommends that the following criteria be used to select nominees for Committee appointment. The candidate must:

1. Be a new dentist, who shall have received their D.D.S. or D.M.D. degree less than ten (10) years before the time of selection.

2. Have a demonstrated commitment to increasing the involvement of new dentists in organized dentistry and addressing the professional, practice and leadership development needs of this membership segment.

3. Be willing and able to devote an adequate amount of time to:

a. attend a two- or three-day meeting and a five-day meeting/conference each year;

b. participate in subcommittee meetings by conference call of the NDC;

c. devote weekly time to reviewing and responding to committee material and communication via e-mail and internet, commitment to regular consultation with staff, and sharing information from district activities;

d. attend all meetings of another ADA council/commission as an *ex officio* member as appointed by the Board of Trustees, encompassing at least two additional in-person meetings of varying length annually as well as related preparation, subcommittee attendance, and other duties; and

e. prepare for and attend all meetings of any ADA task force or committee to which a Committee member may be appointed.

4. Be willing and able to provide hands-on assistance through telephone calls, letters, e-mail and fax transmission and public speaking or workshop engagements as necessary to strengthen the New Dentist Committee Network and to support the dental student outreach including but not limited to the Success Dental Student Programs.

When selecting nominees, the Board of Trustees is also encouraged to consider the representation of diversity with regard to the following groups: racial and/or ethnic minority, gender, military/government, faculty, private practice, associateship/employee, and graduate student.

Finally, the Committee addressed its *Bylaws* responsibilities, and made recommendations to reflect the new name (New Dentist Committee), to eliminate the reference to a two-year ineligibility for appointment to an ADA council upon completion of service on the Committee in order to give the Board of Trustees the option to nominate Committee alumni if desired, as well as changes to better reflect the Committee's focus on tripartite leadership development.

Resolution

40. Resolved, that the ADA *Bylaws, Chapter VII.* BOARD OF TRUSTEES*, Section 140.* COMMITTEES*,* be amended to revise the section relating to the Committee on the New Dentist, as follows: (new language underscored; deletions stricken through).

Section 140. COMMITTEES: The Board of Trustees shall have a standing ~~Committee on the~~ New Dentist <u>Committee</u>. The Committee shall consist of one (1) member from each trustee district who are active members selected by the Board of Trustees and confirmed by the House of Delegates. Members of the Committee shall have received their D.D.S. or D.M.D. degree less than ten (10)

years before the time of selection. The chair of the Committee shall be appointed annually by the Board of Trustees.

Members of the Committee shall serve one (1) term of four (4) years**.** ~~and shall not be eligible for appointment to a council or commission for a period of two (2) years after completing service on the Committee. However, the~~ The Board of Trustees shall stagger the terms of the members of the Committee in a manner so four (4) members will complete their terms each year, except every fourth year when five (5) members shall complete their terms.

The Board of Trustees shall have the power to remove a Committee member for cause in accordance with procedures established by the Board in its Rules. In the event of any vacancy on the Committee, the Board of Trustees shall select a member of this Association possessing the same qualifications as established by these *Bylaws* for the previous member, to fill such vacancy for the remainder of the unexpired term. If the term of the vacated Committee position has less than fifty percent (50%) of a full four-year term remaining at the time the successor member is selected, the successor member shall be eligible for selection to a new, consecutive four-year term. If fifty percent (50%) or more of the vacated term remains to be served at the time of selection, the successor member shall not be eligible for another term.

The New Dentist Committee's work shall be assigned by the Board of Trustees, and reports and proposals formulated by the Committee shall be referred to the Board for decision and action. The duties of the Committee shall be to:

a. Provide the Board of Trustees with expertise on issues affecting new dentists ~~less than ten years following graduation from dental school~~.

b. Advocate to the Board of Trustees**,** ~~and~~ other agencies of this Association and the tripartite dental societies the perspectives of the new dentist in the development of policies, programs, benefits and services of the Association.

c. Identify the needs and concerns of new graduate dentists and make recommendations for any programs to assist with their transition to practice.

d. ~~Stimulate the increased~~ Enhance member value, encourage involvement and active participation**,** and build a community of new dentists in organized dentistry.

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

f. ~~Enhance communications with~~ Facilitate the development of constituent and component new~~/young~~ dentist ~~networks~~ committees and provide resources to assist ~~them~~ constituent and component dental societies in meeting the needs of new dentists.

g. Enhance the development of future leaders by providing and promoting leadership development opportunities and training for new dentists.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 41 New ■ Substitute ☐ Amendment ☐

Report: CM Supplemental Report 3 Date Submitted: July 2010

Submitted By: Council on Membership

Reference Committee: Membership and Planning

Total Financial Implication: $62,500

Amount One-time $ Amount On-going $ 62,500

ADA Strategic Plan Goal: Attain Excellence in Operations (Required)

COUNCIL ON MEMBERSHIP SUPPLEMENTAL REPORT 3 TO THE HOUSE OF DELEGATES:
2011 ADA MEMBERSHIP RELATED MARKET RESEARCH ACTIVITIES

Background: Market research is a core function of knowledge based organizations. In order to make successful decisions, information about member needs, wants and interests is vital to providing benefits and services that are of value. In serving ADA member and prospective member dentists, understanding dentists' perceptions of what is critical to their success, what experiences are unique to dentists in an urban setting, and how the group practice of dentistry is impacting new and independently practicing dentists' decision-making are all critical to determining how best to improve ADA value and strategy.

Research has been used to guide many ADA business decisions, from what products to offer in the ADA Catalog to whether ADA members support a membership category for non-practicing dentists. At 53% of all revenues, membership represents the ADA's single largest revenue stream. It is vital that important membership initiatives are undertaken only after market research is completed.

Similarly, it is customary in any successful organization to evaluate opportunities to increase revenue against opportunities to reduce expenses. To that end, all divisions within the ADA, with input from the Administrative Review Committee, the executive director, and senior management have been asked to identify opportunities to reach a balanced budget that addresses the association's priorities consistent with the strategic plan. The finalized budget has been submitted to the Board of Trustees and, ultimately, will be provided to the ADA House of Delegates through Board Report 2.

One of the expenses identified to be removed from the budget in 2011 in order to balance the budget is $62,500 slated for member research projects addressing critical issues on dentistry, urban market needs and those of dentists in group practices.

Decision-making Using Market Research: Membership research has been of significant value to the Council on Membership and to other agencies of the ADA in identifying emerging issues, providing input from the general membership and from subgroups within membership on the development of policies, programs, benefits and services, and to help the ADA prioritize its activities in light of member needs and opinions. In addition, member research is critical to creating effective membership retention and recruitment communications. In recent years, member research has also helped the ADA gauge its success in terms of member satisfaction and loyalty and to identify actions that will increase these measures. Since 2001, the ADA has budgeted for both qualitative and quantitative member research on an annual basis, with expenses ranging from $70,000-$125,000 annually, depending upon the research agenda.

At its June 2010 meeting, the Council on Membership discussed the positive impact of member research, and in particular, the critical need to conduct research in an ongoing and timely manner. The main objectives of the eliminated 2011 research agenda include:

1. Critical Issues in Dentistry. A qualitative and quantitative study of member and nonmember dentists. This study will conduct focus group primary research with member and nonmember dentists (separately) to

explore current pressing issues in dentistry. Topics might include access to care, diversity, advocacy, and member value. Focus groups afford the opportunity to use skilled moderators to probe participant responses to explore the reasons behind perceptions, approaches the ADA might take to address issues, and provide comparative feedback. It is particularly useful for rich discussions and to identify relevant aspects of new or changing issues. The follow-up quantitative survey would allow the ADA to validate the focus group findings and determine how the ADA's efforts are having an impact on the profession. (Total cost $30,000)

2. Urban Markets. A qualitative study of member and nonmember dentists. It is clear through prior research that membership participation is lower in urban settings and previous research has identified key geographic areas of focus. This study will continue the ADA Council on Membership's efforts to identify relevant factors and opportunities to enhance membership value and participation in these areas. Issues to be explored include practice setting, competition, diversity, and engagement with the objective of understanding what separates urban dentists from their suburban and rural counterparts, and what makes ADA membership less compelling to them. This research is critical to increasing membership market share in these large markets. (Total cost $25,000)

3. Group Practice Impact. Health Policy Resource Center data shows that 8% of dentists now practice in a group setting and that this segment of the profession is growing quickly, while the percent of dentist in solo practice is decreasing. At the same time, it has been noted that membership is lower among dentists in group practice. The purpose of the research is to explore the tangible and intangible benefits provided by employers in the group practice setting and to identify opportunities to more effectively enhance member value for and communicate member value to these dentists. This research will guide ADA outreach efforts to this growing target market. (Total cost $7,500)

Resolution

41. Resolved, that funding for the Council on Membership's research projects on critical issues in dentistry, urban market needs and group dental practice needs be reinstated to the amount of $62,500 for the 2011 budget year.

BOARD COMMENT: The Board of Trustees realizes the value and importance of ongoing member and nonmember research; however, due to financial restraints it believes that deferring research in the 2011 year is prudent.

BOARD RECOMMENDATION: Vote No.

Board Vote:															
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		
☐	■	☐	☐	CALNON	■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN	
☐	■	☐	☐	ENGEL	■	☐	☐	☐	MANNING	☐	■	☐	☐	THOMPSON	
☐	■	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	☐	■	☐	☐	VERSMAN	
■	☐	☐	☐	FEINBERG	■	☐	☐	☐	RICH	☐	■	☐	☐	VIGNA	
☐	■	☐	☐	GIST	■	☐	☐	☐	SEAGO	☐	■	☐	☐	WEBB	
☐	■	☐	☐	KREMPASKY SMITH	■	☐	☐	☐	SMITH, A. J.	☐	■	☐	☐	WEBER	
■	☐	☐	☐	LONG	■	☐	☐	☐	STEFFEL					Res. 41	

Resolution No. 47 New ■ Substitute ☐ Amendment ☐

Report: CM Supplemental Report 1 Date Submitted: July 2010

Submitted By: Council on Membership

Reference Committee: Membership and Planning

Total Financial Implication: $80,000

Amount One-time $ Amount On-going $ 80,000

ADA Strategic Plan Goal: Build Dynamic Communities (Required)

COUNCIL ON MEMBERSHIP SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES: RECENT COUNCIL ACTIVITIES

Background: Since its annual report was submitted in 2010, the Council on Membership met once more in June. This report will address the subjects brought forth at that meeting as well as the response to a 2009 House of Delegates assignment, Resolution 76H-2009*, Promotion of Activities for Retired Members* (*Trans. 2009:487).*

Introduction: The American Dental Association continues to operate in challenging economic times. It is critical that ADA continue to provide value to its members. The Council on Membership is mindful of how the economic climate can shape both current and future ADA membership growth strategies. The Council reviewed the 2010 mid-year membership statistics and current efforts to bolster member value to specific ADA market segments and considered this information when making key decisions throughout its June 2010 Council meeting.

Membership Outreach: The Council continued its work on its 2010 membership goals. Since February 2010, Membership Outreach managers have had individual contact with each of the 53 constituent dental societies to support their membership recruitment and retention efforts and involvement in the marketing collaborative. In addition, Outreach Managers provided onsite consultation and assistance at the Arizona Dental Association, California Dental Association, Florida Dental Association, Georgia Dental Association, New Jersey Dental Association, Maryland State Dental Association and the Washington State Dental Society.

Continuing ADA efforts to personally reach out to dentists and be more inclusive, membership outreach managers exhibited at five conferences during 2010 prior to the Council meeting, including the following:

- California Dental Association Annual Meeting;
- Chicago Mid-Winter Meeting;
- Hinman Dental Meeting;
- National Oral Healthcare Conference; and
- Society of American Indian Dentists Annual Meeting.

In the few weeks following the Council meeting, membership outreach managers participated in three additional meetings:

- Colegio Summer Meeting in San Juan, Puerto Rico;
- New Dentist Conference in San Diego, California; and
- Academy of General Dentistry in New Orleans, Louisiana.

The Council focused its discussion in part on ways to work more closely with organizations that hold dental meetings in order for the ADA to gain more visibility and form stronger relationships among those in attendance and the organizations they represent.

Marketing Collaborative: "MC²: Membership Contact and Connections" is an evolution in approach to how the ADA recruits and retains its members. Utilizing all available resources, this membership growth and outreach strategy aims to reinforce the ADA brand, deliver consistent recruitment and retention messages and assist the dental societies by providing cost-effective resources and expertise that reinforces member value through outreach at all three membership levels. While a broad level of service and resources have been made available to all tripartite dental societies, additional effort has been provided to the 18 constituent dental societies identified by the Council on Membership as offering the greatest potential for membership growth, which include:

- Arizona Dental Association
- California Dental Association
- Colegio de Cirujanos Dentistas de Puerto Rico
- Florida Dental Association
- Georgia Dental Association
- Illinois State Dental Society
- Maryland State Dental Association
- Massachusetts Dental Society
- Michigan Dental Association
- New Jersey Dental Association
- New York State Dental Association
- North Carolina Dental Society
- Ohio Dental Association
- Pennsylvania Dental Association
- Tennessee Dental Association
- Texas Dental Association
- Virginia Dental Association
- Washington State Dental Association

In 2010, three national membership campaigns will be made available to constituent, and eventually component dental societies, through the marketing collaborative approach. The campaigns include a member reinstatement campaign in April, a half-year dues campaign in June, and a value-based renewal campaign in the fall. All constituent societies have the opportunity to participate in the three national campaigns and customize marketing materials with their state membership benefits, which will enhance the ADA national membership benefits highlighted in the marketing materials. Component dental societies will be introduced to the approach through ADA and constituent efforts in August and September of 2010.

In addition to two separate sessions offered at the 2010 ADA Annual Conference on Membership Recruitment and Retention, six web-based training webinars were offered in March and April to inform constituent dental society staff about MC^2, the marketing collaborative approach, the three national campaigns, additional blank marketing templates and how to use the Web-to-print tool. A Web-to-print training guide was also provided to states as a follow-up to their initial instruction.

The reinstatement campaign targets tripartite members who were members as of December 31, 2009, but have not paid their 2010 dues. The goal for this campaign is to reduce the number of TOTAL nonrenewed members by 10% (comparison July 1, 2009 to July 1, 2010). The results of the campaign will be compiled once the membership cutoff occurs the weekend of July 9, 2010. The reinstatement campaign included one direct mail postcard. A total of 7,828 postcards using customized messaging from the ADA and constituent dental societies were mailed on May 5, 2010.

The recruitment campaign will target nonmember dentists eligible for tripartite membership who were not members in 2009 or 2010. The recruitment campaign will include a brochure and letter as well as a follow-up postcard that will promote the half year (50%) dues promotion. The goal for the campaign is to increase the number of dentists (who pay rate 2) by 10% (comparison December 31, 2009 to December 31, 2010).

As of May 10, 2010, 31 states customized marketing copy and 13 others participated in the Reinstatement Campaign. As of this same date, 31 states customized marketing copy and 16 participated in the Recruitment Campaign.

The Council noted the success of the marketing collaborative approach and carefully considered timing, costs and benefit of expanding the collaborative moving forward. A resolution to expand the marketing collaborative approach will be submitted in a separate report.

Market Research Presentation: The Council received informational presentations on the topics of current membership research being undertaken by the ADA regarding the recently completed Seal of Acceptance research projects and the Composite Loyalty Score update as well as the current research in progress: Retirement Survey; New Dentist/Dental Student quantitative; Tripartite Program Review; Member Handbook survey; Committee on the New Dentist alumni survey; and the Nonmember Quantitative Survey.

It was identified that funds for market research activities for 2011 have been removed from the ADA's budget. The Council discussed the importance of making knowledge-based decisions and recommended restoring funding for 2011 market research projects. A resolution to reinstate funding for 2011 market research will be submitted in a separate report.

Ethics Presentation: The Council received a report on the ADA *Principles of Ethics and Code of Professional Conduct* (ADA *Code*) from a member of the Joint Subcommittee on Ethics and Integrity in Dental Education and Practice and discussed the importance of the *Code*. Based on this discussion the Council moved to encourage constituents and local components to incorporate an affirmation of the ADA *Code* with members at events when appropriate and/or possible.

Report on the National Summit on Diversity: The Council received an oral report on the National Summit on Diversity in Dentistry that convened June 11-12, 2010 with 36 presidents, past presidents, presidents-elect, trustees and former trustees and executives from National Dental Association, Hispanic Dental Association, Society of American Indian Dentists and the American Dental Association. Dr Joan Reede keynoted, Dr. Ashleigh Rosette facilitated. Representatives from each organization presented deeply personal testimonials on the history of exclusion/inclusion. Five presenters described current initiatives and 10 workgroups generated ideas for new initiatives. The full Summit developed promising ideas for strong collaboration among the four organizations. Summit representatives from the four organizations are now writing a joint report for their boards as prelude to commitments to specific joint action. The Presidents of the four organizations committed to continuing their dialogue through quarterly conference calls.

2010 ADA Annual Conference on Membership Recruitment and Retention: The theme of the 2010 ADA Annual Conference on Membership Recruitment and Retention was "Working Together for Membership Success—A New Era of Collaboration" and brought together nearly 150 attendees to secure solutions to membership challenges. Twenty-seven ADA constituents and 23 ADA components were represented as well as a number of organizations from outside the ADA tripartite structure, including the Alliance of the American Dental Association; the American Association of Oral and Maxillofacial Surgeons; the American College of Prosthodontists; and the Hispanic Dental Association.

The Conference was hosted by the Council on Membership, with its Chair, Dr. Terry L. Buckenheimer, serving as emcee. The Council provided attendees with flash drive ink pens as a thank you for their efforts throughout the year. Each pen's flash drive was pre-loaded with membership resources that attendees could access and share with their colleagues via their computers.

Ms. Patricia Fripp, a recognized expert on collaboration, provided a keynote address entitled "Collaborate for Membership Success: How to Build Rewarding and Productive Relationships;" and the closing session included Neil Dempster, a national speaker on higher performing organizations, discussed applying the information obtained through the conference in his presentation called "Grow with the Flow." The meeting also included a "Best Practices Idea Swap" and breakout sessions on a variety of topics such as social media, the marketing collaborative, how to use the Web-to-print tool and increasing member loyalty.

ADA Office of Student Affairs: The Council discussed the current activities of the ADA Office of Student affairs and committed to collaborate with the American Student Dental Association (ASDA) to work on student conversion as well as formed a workgroup to explore the feasibility of hosting a national "Signing Day" as a way to promote dental students conversion into tripartite ADA membership.

Federal Dental Services: The Council recommended that constituent and component dental societies be encouraged to assist dentists transitioning from federal dental practice into private practice, similar to the way graduating dental students are assisted in transitioning from dental school into private practice.

Workgroup on Faculty Issues: The Council's workgroup on faculty issues met via conference call in April 2010. The workgroup brought recommendations to the Council and the Council approved the following recommendations regarding faculty membership at its June meeting.

- That a telephone focus group and follow-up web survey be conducted among nonmember faculty to gain insight on their perspectives of ADA membership.

- That the Council collaborate with the Council on Dental Education and Licensure (CDEL) to explore development of an action plan to share with American Dental Education Association (ADEA) on the significance of ADA membership for dental school faculty and deans.

Dues Installment Programs: At its February 2010 meeting, the Council on Membership discussed the possibility of constituent dental societies using dues payment installment programs at the state level to increase membership. Following up on that discussion, at its June 2010 meeting, the Council formed a workgroup to conduct a feasibility study to see if a 12-month payment plan can be administered by the ADA and what effect that would have on current ADA resources and operations.

Student Block Grant Funding: One of the expenses identified to be removed from the 2011 budget included $180,000 for Student Block Grant funding. This funding was later reinstated by the Board of Trustees at the level of $100,000.

The Student Block Grant program has been in place in some capacity since 2003, was expanded in 2003 and has become a popular program for constituent societies who work with dental schools for dental school membership conversion into tripartite membership. The Council on Membership included $175,000 in its 2010 budget to reimburse constituent dental societies for student outreach this calendar year. The budgeted amount reflects the fact that not all eligible societies take advantage of the funding.

The 2010 Student Block Grant Program is underway. As of July 1, Tennessee, Kentucky, Pennsylvania, New Hampshire, South Carolina, Michigan, New Jersey and Rhode Island dental societies have submitted requests for reimbursement, totaling more than $19,000. Activities include a barbeque lunch and presentation, participation in a student dental convention, a spring social event with two dental schools, white coat ceremonies, vendor fair participation, exam goodie bags, lunch and learns, a panelist dinner in conjunction with the American Association of Women Dentists and a networking breakfast with ASDA students. The deadline for block grant reimbursement submission is December 31, 2010 and typically most dental societies submit requests in the fourth quarter. A "student block grant kit" is now posted on the Dental Society Resources Web site. The kit includes an FAQ, a report of block grant activities and tips targeted to constituent societies with and without dental schools.

The following table depicts the usage of block grant funds since 2003. (*Rounded up to nearest dollar.)

Student Block Grant History								
Grant year	Total No. schools participated	%	States w/o schools that participated	%	Total Number of States Participated	%	Total Amount Granted	Total Amt. Budgeted
2009	54	93%	8	50%	40	75%	$ 169,005.00	$ 195,000.00
2008	54	95%	N/A	N/A	33	92%	$ 142,038.00	$ 168,000.00
2007	52	93%	N/A	N/A	32	89%	$ 131,509.00	$ 168,000.00
2006	51	91%	N/A	N/A	33	92%	$ 133,856.00	$ 168,000.00
2005	52	93%	N/A	N/A	33	92%	$ 142,101.00	$ 168,000.00
2004	n/a	-	N/A	N/A	27	75%	$ 40,289.00	$ 50,000.00
2003	n/a	-	N/A	N/A	17	47%	$ 113,603.00	$ 156,000.00

No. schools reflects the schools that received program outreach in given year; % reflects participation rate.

No. reflects the number of states that participated in the program in given year; % reflect participation rate.

The Council discussed the positive feedback from constituent societies that participate in the block grant program as well as the pros and cons of eliminating the program. Ultimately, the Council decided that educating dental students on the purpose and the importance of organized dentistry is critical to converting students to ADA membership upon graduation. Relationships built early can forge lifelong membership engagement in organized dentistry. Therefore, the Council voted to maintain the original budget to cover the expense of the Student Block Grant program for 2011 and offers the following resolution for consideration:

47. Resolved, that funding for the Student Block Grant Program be increased to the amount of $180,000 for the 2011 budget year.

Addressing the topic of budget reductions was not an easy exercise. The overriding concern of the Council is that reducing funding that supports critical tripartite services and membership support may lead to a reduction in ADA's capacity to protect membership market share and undermine the largest revenue stream to the association. The ADA has been able to maintain membership levels during the current economy -- an extraordinary accomplishment. Ultimately, however, the ADA and the tripartite structure cannot exist without members.

Market Segmentation: In addition to addressing segmentation by geography (constituent and component, urban and rural), year in dental school and years as a new dentist, the Council continues to direct its attention to understanding additional ways that dentists perceive themselves and understand their relationship to the ADA. Using demographic characteristics such as age, gender, and race/ethnicity, as well as practice type and dental school faculty affiliation, the Council recognizes the increasing importance of offering unique member value that is responsive to unique member needs, Responding to the need that exists for inclusiveness within the ADA and across the profession, along with understanding the other unique needs of like-minded members will enhance the overall value of the ADA to the membership, the profession, and the public. No members, no ADA. No ADA, no profession. The Council also stated that moving forward, understanding more about the unique needs of these segments, then creating and communicating member value in response are fundamental to achieving overall membership growth and restoring ADA's market share.

ADA.org and the Find a Dentist Feature: On March 31, 2010, the ADA launched a completely redesigned and reorganized Web site featuring stronger content for dentists and their patients, easier navigation and a colorful, user-friendly new format. The revitalized Web site at www.ada.org represents the result of more than a year and a half of research, planning and development.

The new site offers improved tools and resources for both dentists and patients, including a newly created "Find-a-Dentist" function where dentists can show their photo, describe their academic history, identify the insurance they accept and communicate other details about their practice. The Council on Membership participated in the development and testing of the new "Find-a-Dentist" function. The Council also reviewed and approved guidelines for photo standards, practice description submissions and affiliation with other dental organization options. Patients accessing the "Find-a-Dentist" feature can search for a provider by practice location and dental specialty. In order to allow as many member dentists as possible to update their online ADA profile, the "Find-a-Dentist" feature will not be marketed to the public until later in the summer of 2010.

The same database used for "Find-a-Dentist" is also used for the ADA's member directory. As a result, a number of improvements were also made to the functionality of this important members' only section of ADA.org.

Nonmember Activities at Annual Session: The reduction of registration fees for nonmember dentists attending annual session continues to be a successful strategy for highlighting ADA membership to dentists who may be reluctant to join the Association. As of June 30, 2010, of the 258 nonmember attendees who took advantage of the nonmember reduced rate at the 2009 ADA annual session in Honolulu, 24 have joined the ADA. In 2008, 371 nonmember dentists took advantage of the one-time reduced nonmember rate to attend the 2008 ADA annual session in San Antonio and as of end-of-year 2009, 65 of them had joined the Association.

The Council on Membership, in concert with the Council on ADA Sessions, has chosen to re-focus the first time attendee orientation center at annual session to reach out to nonmember dentists in 2010. The center and its functions will then be absorbed fully into those of the ADA Pavilion in 2011 and moving forward.

ADA Strategic Plan: The Council received a presentation from its trustee liaison on the Board approved strategic plan for the Association for 2011-2014. He recognized the executive director has been instrumental in the development of the new strategic plan, that the plan includes metrics and is easily understood.

Self-Assessment: The Council conducted a routine self-assessment and answered questions on the group's relevance and impact.

Nomination of Chair and Election of Vice Chair: The Council nominated Dr. Virginia Hughson-Otte, Thirteenth District representative, Valencia, California, as chair of the Council on Membership for 2010-2011. The Council elected Dr. Nancy Rosenthal, Third District representative, Jenkintown, Pennsylvania, as vice chair of the Council on Membership for 2010-2011.

Meetings: The Council met on June 13-14, 2010 at the ADA Headquarters Building in Chicago.

Response to Assignments from the 2009 House of Delegates: The following Resolution 76H-2009, Promotion of Activities for Retired Members (*Trans. 2009:487)*, was referred to the Council on Membership.

> **76H-2009. Resolved,** that the Council on Membership consider and promote activities for members approaching retirement and retired members to increase retention, and be it further
>
> **Resolved,** that the Council report its findings to the 2010 House of Delegates.

The Council continued its study on the promotion of activities for members approaching retirement and retired members to increase retention, based on the 2009 referral from the House of Delegates Resolution 76H-2009. At its February meeting, the Council reviewed and discussed a report that outlined the Council's investigation of other membership associations and their strategies to recruit and retain retiring members; possible collaboration opportunities with the Council on Communications in order to provide the greatest

benefit to the retired dentist market; exploration of a print and/or electronic newsletter and/or a column in *ADA News* to target retired and/or retiring dentists; exploration of a possible collaboration with the Division of Communications to determine the most efficient and effective way to communicate to the retiring/retired market and the possible encouragement of state and local dental societies to focus on retention efforts among retired and retiring dentists. Through a thorough review and discussion of the report the Council determined that it will:

- continue its study of this market as well as explore the use of various forms of electronic media to promote existing benefits for the retired and near retiring dentist market that support their current and future retirement needs such as assistance with financial investment and practice transition activities;

- along with the Council and Divisions on Communications and ADA Publishing explore utilizing appropriate ADA publications in order to have a section devoted to retired and retiring members and/or create a specific retirement publication;

- develop best practices as a guideline for establishing activities for retired and retiring member dentists; and

- provide direction to the ADA to explore the feasibility of conducting a survey of retired dentists to capture information about their needs and opinions.

Resolution

47. Resolved, that funding for the Student Block Grant Program be increased to the amount of $180,000 for the 2011 budget year.

BOARD COMMENT: The Board of Trustees agrees that using the student block grant program to support conversion of new graduates to tripartite membership aligns with the new strategic plan and is viewed as a vital part of supporting ADA's core competency of growing membership. During the 2011 budget review process, the Board gave careful consideration to the merit of the program in light of the tight budget year. The Board also noted that the funds are typically not fully expended each year. With that in mind, the Board recommended funding the program at $100,000. The Board is concerned about the cost of increasing the program beyond the $100,000 level.

BOARD RECOMMENDATION: Vote No.

Board Vote:

Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
☐	■	☐	☐	CALNON	■	☐	☐	☐	LOW	☐	■	☐	☐	SULLIVAN
☐	■	☐	☐	ENGEL	■	☐	☐	☐	MANNING	■	☐	☐	☐	THOMPSON
☐	■	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	☐	■	☐	☐	VERSMAN
■	☐	☐	☐	FEINBERG	☐	■	☐	☐	RICH	☐	■	☐	☐	VIGNA
☐	■	☐	☐	GIST	■	☐	☐	☐	SEAGO	☐	■	☐	☐	WEBB
☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SMITH, A. J.	■	☐	☐	☐	WEBER
☐	■	☐	☐	LONG	☐	■	☐	☐	STEFFEL					Res. 47

Resolution No. 48 New ■ Substitute ☐ Amendment ☐

Report: CM Supplemental Report 2 Date Submitted: July 2010

Submitted By: Council on Membership

Reference Committee: Membership and Planning

Total Financial Implication: $500,000

Amount One-time $ Amount On-going $ 500,000

ADA Strategic Plan Goal: Build Dynamic Communities (Required)

COUNCIL ON MEMBERHSIP SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES: EXPANSION OF THE TRIPARTITE MARKETING COLLABORATIVE PROGRAM

Introduction: Increasing the number of ADA members is a core competency of the American Dental Association. This document outlines a request to expand the tripartite marketing collaborative approach originally approved by the House of Delegates in 2008 in order to further ADA membership growth. With an expanded collaborative marketing system in place, the tripartite could prioritize and dedicate financial and ADA staff resources in a more consistent, comprehensive and efficient way in order to reach existing and prospective members.

This document provides background on the program's establishment and its role in the MC^2: Membership Contact and Connections program created by the Council on Membership with input from the tripartite. It shares the Council's perspective on the importance of tripartite collaboration and market segmentation, so that the association pursues the best opportunities for membership growth that lead to an increase in market share. The document also describes the importance of and successes with the marketing collaborative approach thus far, and why now is the appropriate time to expand the program. Finally, it outlines the commitment of resources in time, human capital, and dollars that will be necessary, as well as the expected return on investment.

Background: In 2008, the House of Delegates approved a decision package to provide constituent and component dental societies with marketing expertise and customized resources in the form of a tripartite marketing collaborative approach. The program has since been successfully piloted and made available to constituent dental societies, and will be rolled out to the component dental societies in fall of 2010.

In 2009, the Council on Membership unveiled the MC^2: Membership Contact and Connections program (MC^2) to constituent and component dental societies. MC^2 is an evolution in approach to how the ADA recruits and retains its members. Utilizing all available resources, this membership growth and outreach strategy aims to reinforce the ADA brand, deliver consistent recruitment and retention messages and assist the dental societies by providing cost-effective resources and expertise that reinforces member value through outreach at all three membership levels.

The tripartite marketing collaborative approach has evolved into a key resource provided through the Council on Membership's MC^2: Membership Contact and Connections program. As such, it: helps:

- enhance ADA, constituent and component dental society membership growth efforts;
- elevate member value messages;
- reinforce the brand; and
- allow for a more targeted approach to reaching nonmembers.

This program gives the three levels of the tripartite the ability to work together to build upon membership growth as a core competency through development and implementation of customized membership marketing plans and campaigns. These plans and campaigns are then implemented collaboratively to create consistent messaging and supplement dental society efforts that may or may not be in place. Successful implementation drives increased recruitment and retention, which contributes to an increase in market share.

Building upon this solid foundation, this resolution outlines expansion of the collaborative approach using a model similar to the ADA's Public Affairs program. The result is a method that proactively establishes collaborative tripartite marketing plans, provides ADA assistance at a dental society level, creates access to membership campaign print and marketing resources, utilizes metrics to measure success, and recognizes and financially supports constituents and component dental societies that work collaboratively with the ADA to conduct successful membership growth strategies and tactics.

In doing so, the expansion of the Tripartite Marketing Collaborative would further support the following two ADA 2011 – 2014 strategic planning objectives:

- Help dentists succeed and excel throughout their careers; and
- Enhance ADA fiscal responsibility by delivering a balanced budget that includes increased non-dues revenue, cost savings and/or operational efficiencies while safeguarding all ADA assets through optimum compliance.

Membership Market Share: As indicated in the Council on Membership's annual report, the ADA continues to increase the number of active licensed members over time. However, because the market size continues to grow at a faster rate, ADA market share has dropped. To illustrate the point, the 69.1% ADA market share in 2009 is the lowest achieved since ADA began tracking market share in 1993. Concurrently, the number of active members (128,952) is the second largest membership count of active, licensed dentists achieved during this same period (Table 1). The highest count was achieved in 2007, just prior to the current economic recession. This demonstrates that ADA efforts to increase membership have been successful. However, new efforts to sustain market share growth may be required. Current activities generate incremental market share gains at best, largely due to the high market share the ADA enjoys. Through Council activity and the ADA's operational plan metrics, both market share and membership continue to be monitored and reported to the Board of Trustees and the House of Delegates

.**Table 1**
Membership Growth and Market Share from 1993 – 2009

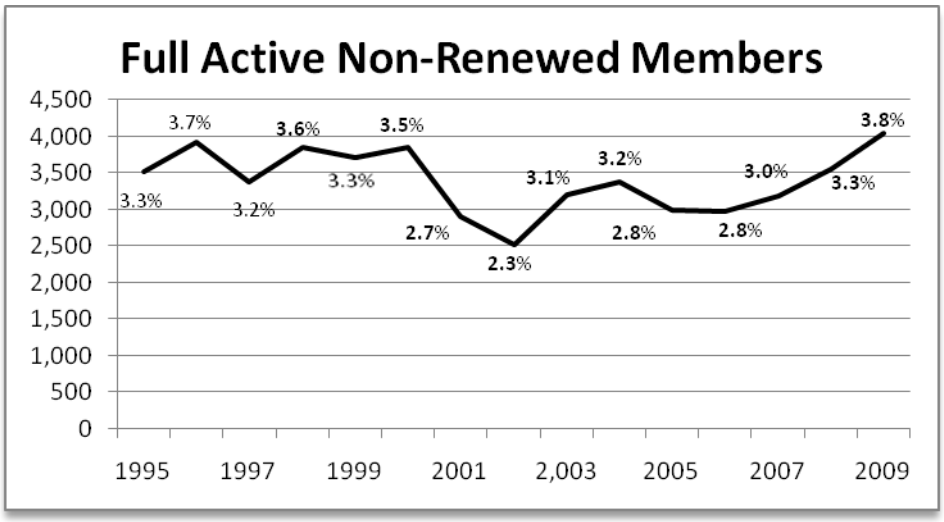
Year	Active Licensed Members	Change from Previous Year	Total Market of Active Licensed Dentists	Change from Previous Year	Market Share %	Change from Previous Year
2009	128,952	42	186,589	2,965	69.10%	-1.1%
2008	128,910	-382	183,624	1,618	70.20%	-0.8%
2007	129,292	1,272	182,006	3,814	71.00%	-0.8%
2006	128,020	1,458	178,192	613	71.80%	0.5%
2005	126,562	836	177,579	1,516	71.30%	0.3%
2004	125,726	2,581	176,063	2,538	71.00%	0.6%
2003	123,145	2,039	173,525	1,467	70.40%	0.0%
2002	121,106	3,828	172,058	5,447	70.40%	0.0%
2001	**117,278**	**685**	**166,611**	**1,058**	**70.40%**	**-1.0%**
2000	116,593	-2,414	165,553	-1,044	71.40%	0.0%
1999	119,007	-312	166,597	-483	71.40%	0.0%
1998	119,319	-465	167,080	2,140	71.40%	-1.2%
1997	119,784	928	164,940	1,918	72.60%	-0.3%
1996	118,856	1,289	163,022	2,939	72.90%	-0.5%
1995	117,567	2,139	160,083	3,012	73.40%	-0.1%
1994	115,428	-1,061	157,071	333	73.50%	-0.8%
1993	116,489	---	156,738	---	74.30%	---

Source: End-of-year ADA Active Licensed Market Share Reports

The membership goal set in ADA's 2010 Operational Plan is to maintain current membership levels in light of the economic climate; achieving 128,950 at year end 2010. This number has been shared with the Board and with Council Chairs. Achieving the 2010 membership goal, while factoring in an expected increase in market size of 3,000 active licensed dentists, it is anticipated that ADA's market share will be at 68.5% at the end of 2010 a change of -.0.6%.

The active nonrenew percentage rose half a percentage point from 3.3% to 3.8% at year end. There were 4,041 active nonrenews in 2009 compared to 3,548 in 2008, an increase of 493. Table 2 shows the percent of full active non-renewing members from 1995 through 2009.

Table 2
Full Active Nonrenewed Members



Source: 2009 ADA Dentist Masterfile

The expansion of the Tripartite Marketing Collaborative approach will help create a series of proactive, complementary activities across all three levels of the association and provide for prioritization of resources where they are needed most. Doing so gives the ADA, its constituent and component societies the greatest likelihood of achieving the highest ADA market share.

Market Segmentation: At the June 2009 meeting of the Council on Membership, nine constituent dental societies were identified as showing the greatest opportunity for membership growth. As a result, each constituent dental society and at least one of its component societies were selected to pilot the collaborative marketing approach in the fall of 2009. In addition, the Council directed that efforts move forward to provide assistance, training and support to expand the value of MC^2: Membership Contacts and Connections in all constituent societies, giving particular attention to the opportunities identified in the nine constituent societies.

In addition to those constituent societies noted, the Colegio de Cirujanos Dentistas de Puerto Rico represents a key opportunity (Puerto Rico has 1,154 ADA nonmember dentists which represents nearly two percent of all nonmember dentists in the U.S.). It has a total market of dentists that is larger than the total markets of 18 of the 52 constituents societies in the U.S. The ADA enjoys a positive and unique relationship with the Colegio, and continues to collaborate on membership growth activities. As such, discussions are underway to provide the benefits of the marketing collaborative approach to the Colegio given language, production and economic challenges.

Appendix 1 identifies the nine pilot state dental societies selected by the Council on Membership to participate in the collaborative pilot project. These nine and the Colegio individually represent the highest number of nonmembers qualified for ADA active, licensed membership as of December 31, 2009. These nine states and the Colegio account for 61%, or more than 30,000, of all nonmembers.

At the February 2010 meeting of the Council on Membership, a second group of constituent dental societies were identified as including the next highest proportion of all nonmembers (20%.) This group represents slightly more than 10,000 dentists. The remaining 35 states listed in Appendix 3 account for the balance (19%) of nonmembers.

In addition to its analysis of constituent dental society membership patterns, as part of the Council's June 2010 work in evaluating opportunities for membership growth in metropolitan areas, Appendix 4 shows the component dental societies identified as offering the greatest opportunity to reach the following market segments:

- Ethnically Diverse
- Faculty
- Federal Dental Service
- General Practitioner
- Graduate Student
- New Dentist
- Non – U.S. Trained
- Specialist
- Women

Overall, the Council has identified 19 key constituent dental societies that represent more than 80% of nonmember prospects and offer the greatest opportunity for membership growth.

Of the 545 component dental societies that make up the tripartite, the 11 noted in Appendix 4 represent approximately one-half of the 14,000 nonmember prospects in metropolitan areas with less than 70% market share. In addition, among these 6,669 dentists, approximately one-third are women, nine of every ten are a general practitioner, one in four indicates they are ethnically or racially diverse and one in five is new to the profession. However, while it is important to understand the size of these market segments and to create messaging for each one, the Council also recognizes that an individual dentist may represent several segments and, therefore, have unique needs. For example, the needs of a female general practitioner just out of dental school who is of African-American heritage are likely different than those of a male orthodontist 15 years out of dental school who is of Hispanic heritage. As a result, membership value means something different to each individual member dentist. The location of these dentists is also of significant importance (New York versus Nebraska, for example).

The Council envisions that resources to fuel membership growth can be allocated most efficiently by providing a high level of service to all constituent and component dental societies while distributing additional resources to those areas of the tripartite where the greatest impact can be achieved. In addition, these resources can be customized and their use monitored on an annual basis. Using this information, the impact of these resources on membership growth can be identified, effective approaches can be replicated, and an integrated collaborative membership growth effort can be orchestrated across all three levels of the tripartite system.

2010 Tripartite Marketing Collaborative Implementation: The phased rollout of the Tripartite Marketing Collaborative in 2010 offers constituents three collaborative campaigns. The constituent societies who participated in one or more of these campaigns worked with ADA staff to obtain the participation of their components (for targeted information at the component level) or using "generic" local level copy. The rollout has used the following three tactics.

First Tactic. Two customized national direct mail membership campaigns focusing on member renewal and offering a half year dues incentive to prospective members were conducted in April, May, June and July of 2010. These campaigns used national and constituent messaging. A third campaign will be conducted this fall focusing on member value and use national, state and local messaging. These campaigns will allow all states and components to do additional marketing locally but at the same time ensure that all members and nonmembers are contacted and invited to join or renew at least two times throughout the year. The cost of developing and mailing the direct mail pieces associated with each campaign are being paid for by the ADA (see funding section below).

Second Tactic. The second tactic gives constituent and components the opportunity to utilize a Web-to-print process to 1) conduct the national campaigns described in the first tactic, and 2) create additional customizable marketing pieces such as postcards, brochures, renewal forms, flyers, etc. using established templates. The Web-to-print process has been identified as an easy-to-use and cost effective process for constituent and component societies to customize their marketing resources while incorporating the ADA brand. This process allows for the following:

- online access to marketing materials from multiple locations;
- customization of design and copy elements of marketing material;
- legal review of pieces that represent the ADA;
- downloading of print files or placement of print orders;
- list management abilities; and
- the option to ship in bulk or mail to specific individuals.

Third Tactic. The third tactic fosters greater collaboration among the ADA and those constituents and components that represent markets with the greatest opportunity for membership growth. This includes those areas of the United States that have the most ADA nonmembers. The ADA membership outreach staff, in concert with marketing, membership information and member marketing staff will work with constituents and components to collaboratively develop strategic membership growth plans. With direction of the Council on Membership, and by focusing on those areas of the tripartite with the greatest opportunity for membership growth (overall and by market segment), ADA membership outreach managers, other ADA staff, and staff from constituent and component dental societies will work collaboratively with greater efficiency and effectiveness to grow tripartite membership.

Expansion of the Collaborative Strategy: To build upon the success of the pilot program and the 2010 national collaborative campaigns, the three existing tactics would be expanded by creating an application process to help underfunded constituents and components offset their costs to execute their collaborative marketing plans. With an expanded collaborative marketing system in place, through the Council, the ADA and the tripartite financial and staff resources would be prioritized and dedicated in a more consistent, comprehensive and efficient way in order to reach existing and prospective members. This approach also would support an interest of the dental societies that ADA further encourage innovation and testing of new ideas and approaches by capturing detailed information about tactics that are proven to be successful. As the needs of the market shift, so will the efforts of the tripartite dental societies that serve those markets.

The aforementioned application would be completed by the constituent and component dental societies and demonstrate their plans to strengthen membership through recruitment and/or retention strategies. Some of the key information required for submission would include:

- demonstration of membership growth opportunities;
- submission of an annual membership marketing plan;
- defined focus on specific target markets;
- detailed costs of implementation;
- description of metrics to be reported back to the Council on Membership to demonstrate campaign success, return on investment and lessons learned; and
- permission to replicate successful programs (best practices) in other constituent and component dental societies.

Each application would be submitted to an independent review committee established and appointed by the Board of Trustees based upon the recommendation of the Council on Membership. The independent review committee would be used to determine if application requests meet the requirements for the requested funds and would award the funding accordingly. With all three levels of the tripartite participating, funding would be allocated to each level, based upon their involvement. Again, to participate in the program accurate records

and quantified results would be required in order to evaluate the return on the committee's investment in these endeavors.

Resource Commitment: Additional activities to supplement the membership mailings currently conducted could include, but are not limited to, relationship-building meetings, events, study club creation or expansion, outings and receptions. These types of programs have been used successfully by dental societies to stimulate membership interest and generate applications.

These events provide opportunities for one-on-one interactions with members and prospective members as well as raise awareness of the value that the ADA tripartite offers. The success of these efforts, when used in tandem with direct mail and other marketing communications, have been demonstrated through the pilot study, district report surveys, and as part of the membership best practice information shared at the ADA's annual membership recruitment and retention conference. The original research to understand dental society membership growth needs also notes the value found by constituents and components in using these approaches.

The cost to conduct **current** Tripartite Marketing Collaborative activities as described in the three tactics noted above is approximately $105,000 annually. This expense is allocated as follows:

Type of Expense	**Expense**
Artwork and Photographic	$11,800.00
Outside Printing	$42,000.00
Postage, Mailings & Freight	$51,200.00
Total	$105,000.00

At its June 2010 meeting, the Council on Membership recommended that an additional $500,000 be allocated annually in order to **expand** the Tripartite Marketing Collaborative. The committee appointed by the Board at the Council on Membership's recommendation would have responsibility to allocate funding, in essence serving on ADA's behalf to invest in those collaborative membership growth plans that demonstrate the greatest merit and prospective return. As a result, if each of the 53 constituent dental societies in collaboration with the ADA and their components are able to generate 19 additional tripartite members each year, the overall additional dues revenue would exceed the overall cost of the expansion each year (i.e., 53 constituents x 19 members x $498 = $501,486) and increase ADA's market share penetration by an additional 1,007 members.

In order to keep administrative costs of the program to a minimum, the following approach will be taken:

- Some existing activities that are conducted by Council on Membership staff that support JADA and *ADA News* fulfillment will be re-assigned to free up existing staff for this activity;
- Dental society applications will be required to be completed and submitted in an electronic format for consideration, resulting in less labor intensive processing;
- Application review will be conducted via listserve; and
- The independent review committee established and appointed by the Board of Trustees would report to the Council on Membership and the House of Delegates as to the effectiveness and efficiency of the overall marketing collaborative approach.

Making funding available to dental societies through a controlled process requiring application submission, third-party evaluation, coordinated implementation at all three levels of the tripartite and effective monitoring and reporting of results would create a laboratory and a mechanism to encourage, reward, and recognize innovative ideas and successful membership growth efforts. Funds would be awarded based upon demonstrated need and opportunity, allowing for allocation of funds in those areas offering the greatest likelihood of success.

Resolution

48. Resolved, that the 2010 ADA House of Delegates approve funding in the amount of $500,000 for the purpose of expanding the Tripartite Marketing Collaborative Approach to positively impact tripartite membership in those areas and among those market segments that offer the greatest opportunity.

BOARD COMMENT: The Council on Membership contends that to further tripartite membership growth, an investment is necessary that builds capacity, aligns efforts and applies expertise at a national, state and local level would directly and positively impact the prospective and existing member. Further, that while the ADA has enjoyed continued membership growth, it has not kept pace with the growing market. It will be critical for the ADA to maintain and increase membership market share, which is becoming increasingly difficult given the changes in the profession and soft economic environment. The Board supports the plan to increase membership and believes that this approach, established through the work of the Council on Membership, aligns with the new strategic plan and is viewed as a vital part of supporting ADA's core competency of growing membership.

The Board understands that this request requires a significant investment at a time when other vital investments are being considered. Note that a collaborative commitment is required from the ADA, the constituent and their components who participate in the program, and that a demonstrated return on investment is required.

BOARD RECOMMENDATION: Vote Yes.

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN
■	☐	☐	☐	ENGEL	■	☐	☐	☐	MANNING	■	☐	☐	☐	THOMPSON
■	☐	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	☐	■	☐	☐	VERSMAN
☐	■	☐	☐	FEINBERG	■	☐	☐	☐	RICH	■	☐	☐	☐	VIGNA
■	☐	☐	☐	GIST	■	☐	☐	☐	SEAGO	☐	■	☐	☐	WEBB
☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SMITH, A. J.	☐	■	☐	☐	WEBER
■	☐	☐	☐	LONG	☐	■	☐	☐	STEFFEL				Res.	48

Appendices

Appendix 1: Nine ADA Constituent Dental Societies Representing 59% of All Nonmembers

District	State	Nonmembers
13	California Dental Association	8,636
2	New York State Dental Association	3,872
15	Texas Dental Association	3,451
17	Florida Dental Association	3,191
3	Pennsylvania Dental Association	2,763
4	New Jersey Dental Association	2,720
8	Illinois State Dental Society	2,381
4	Maryland State Dental Association	1,570
9	Michigan Dental Association	1,409
	Total	29,993

2009 ADA MasterFile

Appendix 2: Nine ADA Constituent Dental Societies Representing 19% of All Nonmembers

District	State	Nonmembers
16	Virginia Dental Association	1,354
7	Ohio Dental Association	1,344
5	Georgia Dental Association	1,241
14	Arizona Dental Association	1,149
16	North Carolina Dental Society	1,046
11	Washington State Dental Association	1,020
1	Massachusetts Dental Society	924
6	Tennessee Dental Association	869
6	Kentucky Dental Association	794
	Total	9,741

2009 ADA Masterfile

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Appendix 3: Thirty-Five ADA Constituent Dental Societies Representing 19% of All Nonmembers

District	State	Nonmembers
6	Missouri Dental Association	764
11	Oregon Dental Association	753
10	Minnesota Dental Association	617
14	Colorado Dental Association	596
7	Indiana Dental Association	563
9	Wisconsin Dental Association	562
1	Connecticut State Dental Association	531
5	Alabama Dental Association	478
12	Louisiana Dental Association	434
14	Nevada Dental Association	409
12	Oklahoma Dental Association	400
14	Utah Dental Association	379
16	South Carolina Dental Association	371
12	Kansas Dental Association	325
10	Nebraska Dental Association	250
5	Mississippi Dental Association	239
4	District Of Columbia Dental Society	233
14	New Mexico Dental Association	228
12	Arkansas State Dental Association	202
6	West Virginia Dental Association	196
10	Iowa Dental Association	170
11	Idaho State Dental Association	148
1	New Hampshire Dental Society	141
14	Hawaii Dental Association	128
11	Alaska Dental Society	117
1	Rhode Island Dental Association	106
1	Maine Dental Association	78
11	Montana Dental Association	65
1	Vermont State Dental Society	44
10	North Dakota Dental Association	39
4	Delaware State Dental Society	39
14	Wyoming Dental Association	35
10	South Dakota Dental Association	23
4	Virgin Islands Dental Association	5
	Total	9,668

2009 ADA Masterfile

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Appendix 4: Eleven Components Representing More Than 6,500 Nonmembers
From Ten Distinct Market Segments

Component	All Dentists	Women	All Faculty	Full Time Faculty	General Practitioners	Specialists	Federal Dental Service	Graduate Students	Foreign Trained	Ethnically or Racially Diverse	New Dentists
Los Angeles	1,060	329	48	39	949	111	2	11	386	355	185
Western Los Angeles	259	96	10	7	239	20	1	1	75	71	44
California	1,319	425	58	46	1,188	131	3	12	461	426	229
Philadelphia County	394	113	55	38	331	63	2	7	32	116	83
Pennsylvania	394	113	55	38	331	63	2	7	32	116	83
Greater Houston	1,113	431	58	30	973	140	5	5	64	497	259
Texas	1,113	431	58	30	973	140	5	5	64	497	259
Chicago	1,699	571	35	25	1,524	175	5	7	140	424	207
Illinois	1,699	571	35	25	1,524	175	5	7	140	424	207
Second District	623	197	21	5	564	59	2	13	52	103	163
Ninth District	462	157	15	9	394	68	0	2	50	114	76
Nassau District	495	144	19	5	425	70	0	4	46	83	60
Bronx County	154	49	2	1	130	24	0	3	13	50	57
Queens County	652	215	16	4	587	65	1	6	87	199	142
New York County	871	349	90	50	686	185	2	12	65	229	231
New York	3,257	1,111	163	74	2,786	471	5	40	313	778	729
Total Components	6,669	2,220	311	183	5,829	840	15	66	946	1,744	1,248

2009 ADA Masterfile

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: CM Supplemental Report 4 Date Submitted: July 2010

Submitted By: Council on Membership

Reference Committee: Membership and Planning

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Attain Excellent in Operations (Required)

COUNCIL ON MEMBERSHIP SUPPLEMENTAL REPORT 4 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 92H-2009—FIVE-YEAR PROJECTED DUES REVENUE IMPACT FROM MEMBERS TRANSITIONING TO LIFE MEMBERSHIP

Background: The Health Policy Resources Center, in conjunction with the Division of Membership, Tripartite Relations and Marketing, developed projections of the dues revenue impact from members' transition to life membership. The projections were developed through statistical modeling and extensive review of retirement trends among dentists. It should be noted that retirement rates among dentists have dropped slightly both as a result of the economic downturn and also as part of a longer term trend. The most significant component of the drop in retirement rates took place in 2009. Accordingly, the projections are more likely to overstate than understate the financial impact. Finally, these projections do not include the added dues revenues associated with new members and dental students transitioning from student status to member status and the associated dues increases.

Based on historical patterns and the current age and member longevity, it is estimated that the dues revenue impact from members transitioning to life membership will be as follows (Table 1):

Table 1

Year	Dues Impact From Members Transitioning to Life Membership
2010	($521,406)
2011	($610,926)
2012	($698,166)
2013	($658,742)
2014	($679,347)

At the end of 2009, there were 11,516 active life members and 22,539 retired life members. Although the ADA should be mindful about the anticipated transition of baby boom dentists into different membership categories and also into retirement, it also is appropriate for the ADA to recall that current workforce projections indicate that the dental workforce will continue to grow continuously through 2030, and this projection does not incorporate potential graduates from dental schools that have not opened their doors (Table 2).

Table 2: Census Counts and Projections, 1993-2030

Year	Professionally Active Dentists	Active Private Practitioners	Applicants to Dental School	Applicant Rate	First-Year Enrollment	Graduates	Applicants per Admission
1993	155,087	142,603	6,761	0.348	4,100	3,778	1.649
1994	157,228	144,581	7,713	0.399	4,121	3,875	1.872
1995	158,641	146,089	7,996	0.418	4,237	3,908	1.887
1996	160,388	147,247	8,598	0.458	4,255	3,810	2.021
1997	160,781	147,778	9,829	0.534	4,347	3,930	2.261
1998	163,291	151,309	9,447	0.526	4,268	4,041	2.213
1999	164,664	152,151	9,010	0.501	4,314	4,095	2.089
2000	166,383	152,798	7,770	0.426	4,327	4,171	1.796
2001	168,556	155,716	7,412	0.397	4,407	4,367	1.682
2002	169,894	156,921	7,538	0.394	4,448	4,349	1.695
2003	173,574	160,184	8,176	0.415	4,618	4,443	1.770
2004	175,709	162,184	9,433	0.469	4,612	4,350	2.045
2005	176,634	162,180	10,731	0.526	4,688	4,478	2.289
2006	179,594	164,864	12,463	0.604	4,733	4,515	2.633
2007	181,725[1]	166,837	13,742	0.663	4,770	4,714	2.881
2010	186,098	170,719	11,411	0.542	5,153	4,530	2.215
2015	191,620	175,970	12,343	0.548	5,691	5,041	2.169
2020	196,137	180,084	12,087	0.554	5,998	5,530	2.015
2025	199,230	182,789	12,655	0.561	6,186	5,774	2.046
2030	201,453	184,122	13,473	0.562	6,448	5,968	2.089

Source: American Dental Association, Health Policy Resources Center, 2009 ADA Dental Workforce Model: 2007-2030.

[1] At the time of this report, the *2007 Distribution of Dentists in the United States by Region and State* was not published; therefore, the 2007 numbers are considered preliminary.

The attached appendix file shows the number of projected members who will become eligible for life membership from 2010 to 2014. This projection assumes that there will be no dues increase during the next five years and that all members will retain membership. There is also an assumption that the retirement rate will remain the same during the same time period.

The number of members who begin paying in the life membership dues rates over the next five years is expected to increase from 2,381 in 2010 to 3,039 by 2014. It should be noted that the further out in the projection, the less accurate the forecast. The reduction in the amount of dues paid by members who moved into life membership in 2009 was reduced by $520,696. That amount is expected to increase to $521,406 in 2010 and by 2014 it is projected to be $679,347. The number of members attaining the life membership requirement is expected to grow over the next five years with 2,381 paying life membership dues rates in 2010, both active and retired life, and by 2014, 3,039 will reach life membership status. The total number of expected members to be impacted is within one-half of one percent on an annual basis over five years.

Appendix - Forecast to Become Life Members 2010-2014

Year Paying Life Dues for First Time	2010	2011	2012	2013	2014
Expected Retired Life	514	590	675	637	656
Expected Active Life	1,867	2,143	2,448	2,310	2,383
Total Projected to Become Life Members	**2,381**	**2,733**	**3,123**	**2,947**	**3,039**

Reduction from Prior Year	2010	Estimated Reduction from Prior Year	2011	Estimated Reduction from Prior Year	2012	Estimated Reduction from Prior Year	2013	Estimated Reduction from Prior Year	2014	Estimated Reduction from Prior Year
2.5% who paid full active dues ($498) to retired life($0)	61	($30,378)	68	($34,026)	78	($38,881)	74	($36,690)	76	($37,836)
12.7% who paid retired dues ($125) to retired life($0)	302	($37,350)	347	($43,375)	397	($49,625)	374	($46,750)	386	($48,250)
Paid full dues and expected to pay active life dues (76.5% of estimated total elected)($249)	1,822	($453,678)	2,143	($533,525)	2,448	($609,660)	2,310	($575,302)	2,383	($593,261)
Total estimated reduction in dues revenue		($521,406)		($610,926)		($698,166)		($658,742)		($679,347)

Note:

Total Estimate of number elected to life membership by year calculated on age and years in membership datamart as of 5-31-2010.

Assumes no dues increase or decrease.

Full dues in 2009 and 2010 are $498.

In 2010, 78.4% are active life with 76.5% paying the active life dues of $249 (50% of full dues) the rest on $0 waivers.

21.6% are retired life in 2010.

Assumes retired rate will remain the same in future years.

Assumes no deaths.

Numbers do not add up to total expected to pay life dues because some members paid $0 in the previous year and are expected to pay $0 the next year. Only dues payers were figured in these calculations.

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Board Report 3 Date Submitted: July 2010

Submitted By: Board of Trustees

Reference Committee: Membership and Planning

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Attain Excellence in Operations (Required)

REPORT 3 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTIONS 118H-2002 AND 119H-2002 – COUNCIL AND COMMISSION SELF-ASSESSMENT

Background: This report to the House of Delegates is in response to the adopted 2002 resolutions 118H-2002 and 119H-2002 (Trans.2002:373 and 418), which read:

118H-2002. Resolved, that the board of Trustees develop a sunset review process for each council and commission to occur on a regular rotational basis with a report describing the process to the 2003 House of Delegates, and be it further

Resolved, that this review process should include consultation with each council and commission and address each council and commission's relevancy, productivity, efficiency, mission and duties.

119H-2002. Resolved, that each ADA council and commission conduct a self-study to determine its relevance; address its efficiency, productivity; and examine its mission and duties, and be it further

Resolved, that the result of these studies be reported to the 2003 House of Delegates.

These Self-Assessments were reported to the ADA House of Delegates in 2003 and addressed 12 specific questions:

1. Report any proactive prior self-evaluation information
2. What are the trends in volunteer engagement in associations? Use data and information on governance trends and experiences of others.
3. What are the functions/duties of your specific council/commission? Address comprehensively (relevance, missions, duties et al) process and structure.
4. Examine ADA *Bylaws* for currency: still should be done? Should be done here/elsewhere?
5. What are the aims of having a council/commission (Volunteer oversight, member input, volunteer training and education?)
6. Is there a different way of structuring your council's/commission's volunteer involvement to satisfy all of the above in a different way? How can your council/commission be more effective?
7. How can you make your work more relevant to the grassroots members?
8. What are you still doing that is no longer sufficiently useful to the grassroots member?

9. Examine any sunset policies, etc.

10. What are the key issues/topics you address that grassroots members (others) care about?

11. If your agency stopped existing, would it matter/how/to whom/why?

12. Use metrics to evaluate where possible. What data and information supports your assessment?

In 2003, no agency found itself redundant or irrelevant, but some changes were made as a result of the process. All agency reports were made available to the House of Delegates by posting on ADA.org.

2010 Self-Assessments: ADA councils and commissions as well as the Committee on the New Dentist (CND) and the Committee on International Programs and Development (CIPD) completed a comprehensive self-assessment in 2010 addressing the same twelve questions utilized in 2003. As in 2003, no agency found itself to be unnecessary. Several agencies noted that their duties or the levels of their responsibility had changed in recent years, and cited either *Bylaws* changes since 2003 (such as the Council on Access, Prevention and Interprofessional Relations' changes approved in 2008 and the Council on Dental Benefits Programs changes approved in 2009) or anticipated *Bylaws* changes (such as the Committee on the New Dentist's proposed changed to be address by the Board of Trustees and House of Delegates in 2010). *Bylaws* clarifications are also being addressed. For example, the Council on Scientific Affairs (CSA) and the Council on Dental Practice (CDP) have drafted updates to their *Bylaws* duties that are concerned with standards development. It is anticipated that these agencies will forward appropriate resolutions to the 2010 House of Delegates for approval.

Many agencies noted that there had been a change in how they accomplished their work, with greater reliance on subcommittees and work groups that often met remotely (by conference call or web-enabled calls) or shared information by listserv or other electronic communications means in order to accomplish more work and more detailed work between meetings. For example, the Council on Communications appointed a workgroup to begin updating the ADA Strategic Communications Plan to align with the new 2011-2014 ADA Strategic Plan.

In addition, a review of the agency self-assessments shows a marked focus on member value and service to the profession and to the public. For example, the Council on Dental Practice developed the Dental Practice Hub on ADA.org as an exclusive, members-only resource to address key practice issues related to the economy. The Council on Government Affairs and Council on Communications anticipate continued collaboration to address the public's image of the dental profession. The Committee on International Programs and Development identified its unique role of providing a global context for the dental profession and its work in developing ADA membership among non-US dentists, which is also addressed by the Council on Membership.

Volunteer engagement is a key issue for the agencies. Overall, the Bureau of Labor Statistics reports that both the number of volunteers and the volunteer rate rose in the 12 months ending in September 2009. About 63.4 million people, or 26.8% of the population, volunteered at least once during that time period. This compares to 26.4% of the population in the previous 12 months. While volunteers include all demographic groups, women are more likely to volunteer, as are parents of children under 18 and people with higher levels of educational attainment. By age of volunteer, individuals 35-44 are most likely to volunteer at 31.5%, but younger people volunteer, as well – the rate for individuals 25 to 34 is 23.5% and for those 16-24 years of age, 22.0%. In general, religious organizations, schools or other youth-related organizations, or social/community service organizations are the most frequent recipients of volunteer activity.

According to a study completed by ASAE & the Center for Association Leadership in 2008, association members volunteer more than the national average and are motivated more by the greater good or by the opportunity to advance a cause they value than by career goals alone. No agencies reported any difficulty in recruiting qualified volunteers and enthusiasm for volunteer activities throughout the tripartite is strong, with continued strong support for access programs such as Give Kids A Smile and the National Foundation of

Dentistry's Donated Dental Services (DDS) Program for the handicapped. Reflecting the national averages, there is a strong network of dentists in the New Dentist Committee Network and early signs of greater broad participation among these young practitioners throughout the tripartite.

Overall, ADA agencies have a systemic approach to evaluating activities to identify those that are no longer relevant or as valuable as in the past, and many agencies have specific related metrics. Typically this is more a matter of improving or changing activities to better meet member needs, rather than outright sunsetting. For example, the Council on Dental Education and Licensure (CDEL) had produced a publication called the *Resource Guide for the International Dentist: the State Dental Licensure Process*. Upon review in 2008, CDEL recommended transitioning the Guide to become a salable item and since that time, 164 copies were sold and revenue to the income has totaled more than $3,000. Similarly, the Committee on the New Dentist had routinely funded copies of the *Little Dental Drug Booklet* for dental school seniors, which was given as a gift from the CND and the Council on Scientific Affairs, and this practice will be discontinued in 2011 as the resource is not tightly tied to the CND's duties and electronic options for pharmaceutical reference materials are widely available. Routine policy review is conducted by all agencies as appropriate.

Due to the size of the 2010 Council, Commission and Committee Self-Assessments, the document can be found on ADA.org, House of Delegates Page: www.ada.org/2010hodreports.aspx

Ongoing Self-Assessments: There was a high degree of volunteer engagement and thoughtful discussion related to the 2010 council and commission self-assessments. The opportunity to reflect on the broader picture, appreciate accomplishments and consider news ways to add more value was appreciated by many participants. It is anticipated that the Board of Trustees will continue to report self-assessments to the ADA House of Delegates every five years, with the next report in 2015.

Resolutions

This report is informational in nature and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Board Report 5 Date Submitted: July 2010

Submitted By: Board of Trustees

Reference Committee: Membership and Planning

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Attain Excellence in Operations (Required)

REPORT 5 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:
ANNUAL REPORT OF STRATEGIC PLANNING ACTIVITIES

Background: This report to the House of Delegates on the American Dental Association's (ADA) annual strategic planning activities is submitted as required by Resolution 104H-1990 (*Trans*.1990:570) that directs the Board and staff to establish and implement the ADA strategic planning process and to provide annual reports on its progress.

2010 Strategic Planning Committee: Dr. Teri Barichello, chair, Oregon; Dr. William Calnon, trustee, Second District; Dr. Dennis Engel, trustee, Ninth District; Dr. Raymond Gist, ADA President-elect; Dr. Daniel Klemmedson, Arizona; Dr. S. Jerry Long, trustee, Fifteenth District; Dr. Charles Norman, trustee, Sixteenth District; Dr. Kathleen O'Loughlin, ADA executive director; Dr. McKinley Price, Virginia; Dr. Ruchi Sahota, California; Dr. Carol Summerhays, California and Mr. Paul Sholty, ADA chief financial officer. Mr. Tom Elliott, Division of Legal Affairs, associate general counsel, and Ms. Diane Ward, senior manager, Strategic Planning and Special Projects provided staff support to the Committee.

Overview: The ADA began a new strategic planning process during 2009 which included clearly defined phases of the process (research, plan development and implementation) as well as clarifying the roles and responsibilities of the Board, Strategic Planning Committee (SPC) and staff. Phillip Lesser and Barton Tretheway of Bostrom Consulting assisted with developing the process and provided facilitation services during several key meetings including the strategic planning retreat of the Board.

During 2010 the SPC supported the Board by monitoring the implementation of the 2007-2010 Strategic Plan and the associated 2010 Operating Plan; contributed to the development and overview of the Operating Plan and Dashboard reporting; and assisted with drafting success measures, finalizing and communicating the new 2011-2014 ADA Strategic Plan throughout the ADA.

The SPC met by phone several times this year and held two in-person 2-day meetings on April 1-2 and July 8-9, 2010. Meetings this year focused on:

1. Implementation of the 2007-2010 ADA Strategic Plan by review and analysis of available 2010 quarterly dashboard results of the Operating Plan. During 2010 methods and mechanisms were developed to help track progress of the Strategic Plan goals, objectives and initiatives by capturing metrics of the Operating Plan through a dashboard tool. The dashboard results were successfully monitored and reported for first and second quarter 2010 and ADA staff anticipates providing reports as scheduled for the remainder of the year. This process is designed to link the ADA Strategic Plan, Operating Plan (dashboard reporting) and the budgeting cycle in a coordinated effort.

2. The Committee reviewed the *Organization and Rules of the Board of Trustees* and made several recommendations regarding its composition, terms and duties to the Board Workgroup on the

Organization and Rules, to improve succession planning as well as clarify the Committee's duties relative to the new Strategic Planning process instituted in 2009-2010. In addition, the Committee charged the ADA staff with developing a more comprehensive environmental scanning process. An internally developed Environmental Scan was delivered to the Board of Trustees and the Strategic Planning Committee in December 2009 and an update in July 2010.

3. The Committee supported the Board of Trustees through analysis of data, trends and gathering input from the communities of interest toward the development of the ADA Strategic Plan: 2011-2014. During the April Board meeting, a first draft of the Plan was presented by the Strategic Planning Committee Board member, Dr. William Calnon. The Board recommended a fourth goal related to financial stability and the SPC reconvened by conference calls to draft the goal, objectives and appropriate measures. The Committee recommends that the Board provide ongoing review of the Mission and Vision statements to ensure that they accurately reflect the Associations' purpose.

4. The SPC worked with the Board to finalize and communicate the new Plan with the membership. A revised draft of the ADA Strategic Plan: 2011-2014 was presented for discussion during the June Board of Trustees meeting. Following review and discussion, the revised Plan was adopted, Resolution B-55-2010. Communication to the membership and communities of interest was initiated through:

    - posting the Plan on ADA.org
    - ADA News article (June 21, 2010)
    - creation of talking points and PowerPoint presentation for Board of Trustees use within their districts
    - SPC phone conference with registered Constituent Executives, Council and Commission Chairs (July 9).
    - presentation at the July Management Conference

5. The SPC discussed and reviewed the draft 2011 Operating Plan and alignment with the draft 2011 budget and made recommendations to the staff. See Appendix 2 for the draft planning process chart that was developed with Committee input.

Results: The Board of Trustees and Strategic Planning Committee gratefully acknowledge the contributions of the various stakeholders and communities of interest that provided information and feedback to assist with drafting, finalizing and communicating the planning process. Initial feedback has been positive and our efforts toward socializing the new Plan throughout the ADA have been well received. The Board encourages and welcomes all feedback directly to the district trustees. A dedicated email address adastrategicplan@ada.org has been assigned to gather and monitor additional comments. We anticipate that the ADA Strategic Plan: 2011-2014, Operating Plan with dashboard results and the annual budget will be better coordinated and automated for greater efficiencies in future years.

The Board of Trustees adopted the *American Dental Association Strategic Plan: 2011-2014* during its June 2010 meeting and it is appended to this report (Appendix 1).

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Appendix 1

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

American Dental Association Strategic Plan: 2011-2014

June 14, 2010

Table of Contents

The ADA Strategic Plan is not a policy document. It is a management tool for the ADA Board of Trustees. All related actions will be interpreted in accordance with ADA policy, which is set by the ADA House of Delegates.

INTRODUCTION

The object of the American Dental Association is stated simply in the *Bylaws*: to improve the health of the public and to promote the art and science of dentistry. Dedicated members represented by hundreds of volunteer leaders are the directors of our work. The Association's decisions are informed by listening to the public, to devoted practitioners, and to the various communities of interest which serve, support or impact the health care environment and delivery of oral health care. Well informed members and volunteer leaders supported by valued ADA professional staff, all willing to engage the issues of our time, represent the way our Association will remain relevant under environmental conditions of constant change and extraordinary challenges.

The key environmental issues for the ADA now and in the future include; long standing economic recession and slow recovery, health care reform and the evolving health care marketplace, changing demographics, globalization and the redefinition of the role of associations in the information and social networking age. Associations are expected to operate transparently in a culture of trust and commitment. As health professionals, our members are expected to work together to solve common problems, meet common needs and accomplish agreed upon goals. Our youngest members push collaboration to a new height and embrace "green" as a lifestyle choice. Inclusivity is an expectation of the shifting demographics and the impact of advancing technology on patient care is profound. The growing number of women entering the profession has a significant impact on practice preferences in the future. The expectation for immediate access to information and virtual networking make for new models of collaboration, perhaps replacing face-to-face meetings. Our dental community is now global in reach, and the ADA is viewed by the world as a leader in oral health. In order to remain a relevant and vital organization, the ADA must address this rapidly changing environment and set our sights on the impact we, as a profession and as an association, will have on our members, our communities and our organization.

The four major 2011-2014 ADA goals and their respective objectives listed in this Plan represent the ADA's focused response to this environment and represent the future state to be achieved. Our belief statements set the stage for the translation of this strategic plan into an annual operating plan which identifies our key initiatives and drives our day to day work. If successfully implemented, the operating plan will lead to measureable achievements of our Strategic Plan goals and objectives. The ADA as an organization, its volunteer leaders, and its professional staff hold ourselves accountable for our success and our future as a professional organization.

Executive Summary

ADA Vision Statement: The American Dental Association: The oral health authority committed to the public and the profession.

ADA Mission Statement: The ADA is the professional association of dentists committed to the public's oral health, ethics, science and professional advancement; leading a unified profession through initiatives in advocacy, education, research and the development of standards.

ADA Goals: 2011-2014

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

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

3. Goal: Improve public health outcomes through a strong collaborative profession, and through effective collaboration across the spectrum of our external stakeholders

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

Beliefs

The American Dental Association believes that . . .

- optimal oral health is essential to the quality of life
- optimal oral health is an integral component of overall health
- the strength of the dental profession is intimately linked to demonstrable improvement of the public's oral health
- the *ADA Principles of Ethics* are the hallmarks of professionalism in dentistry
- the integrity of the patient-doctor relationship is sacrosanct
- oral health care must be based on scientific principles derived from high quality research, patient needs and expectations and sound clinical judgment
- prevention is the cornerstone of an effective and efficient health care delivery system
- oral health care is best provided by a coordinated dental team led by the dentist
- a properly educated, diverse, adequately sized and distributed dental workforce is critical to the delivery of quality oral health care
- quality care is safe, effective, efficient, timely, patient centered and equitable.
- excellence in dental education, research and lifelong learning is critical to the future of the profession
- ADA membership is the foundation of a successful dental professional, regardless of career choice and a healthy community

Core Competencies

In order to achieve these goals, there are certain core competencies that the ADA as an organization must possess. The ADA does not exist without members. A strong stable membership is critical to the Association's effectiveness. The tripartite organization's strong and vibrant relationship is vital to the ADA's ability to achieve its goals and objectives. Access to ADA leadership positions should be open to all members in accordance with their talents and interests.

In addition to the above, the ADA organization must have the ability to translate the ADA's Strategic Goals and Objectives into an efficient and effective implementation or operating plan, focused on achieving the desired results as stated in the strategic objectives.

In order to do this, the Association must attract, employ, retain, and recognize the most skillful and dedicated professional staff. It must optimize according to best practice, its business structures, processes and systems in order to deliver timely desired results. The ADA organization must be careful stewards of precious assets and scarce resources, including money, people, property and time. In order to achieve results and demonstrate value to the members, the ADA organization must be able to communicate effectively with internal and external stakeholders and especially with the public at large.

2011-2014 Goals and Objectives

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

A strong profession is best able to meet the needs of our communities.

Outcomes/objectives:

1. Professional competency and ethical standards

Intent: to ensure that every member achieves the highest level of professionalism, proficiency and ethics possible given each member's unique talents, interests and career path so that the profession of dentistry remains a true profession by embracing an expanding body of professional knowledge driven by high quality research and analysis.

a. Sustain the highest level of knowledge, skills and values for the dentist regardless of the chosen career path

b. Professional success regardless of the career path selected: clinical practice, academia, research, uniformed services, public health, informatics, industry

Measure: Member Survey - utilization of online and annual session CE

2. Professional autonomy

Intent: to ensure that every member achieves a desired state of professional autonomy that enables the improvement and maintenance of the patient's oral health. The doctor patient relationship is free from interference from all entities that lie outside of that relationship.

Preservation of the dentist as leader of the dental team is a critical component of this objective.

Measure: Member Survey - perception of professional autonomy

3. Financial health

Intent: to ensure that every member achieves a personally desired state of financial well-being and economic stability, so that the member is secure in the knowledge that success, as each member uniquely defines it, is achievable including; work life balance, career path, practice modality, community involvement and chosen lifestyle.

a. Sustainable business models for all members (small business owner, employee, academician, researcher, industry, etc) of the profession

Measure: Member perception of financial well being

4. Positive public image of the profession

Intent: to ensure that every member benefits from the public's positive perception of the profession of dentistry

a. Awareness of high level of dental credentials, and civic/community leadership
b. Environmentally responsible dental practices/best management practices

Measure: ADA consumer survey

5. Member health, wellness and professional satisfaction throughout their career(s)

Intent: to ensure that every member benefits from optimum health and wellness throughout their careers

and that opportunities exist to achieve a state of wellness for all generations of dentists from newly graduated to retirement.

Measure: Member survey: less than five years, mid career, retirement

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

ADA positions itself to be the most trusted source of consumer information regarding oral health.

Outcomes/objectives:

1. Oral health literacy

Intent: to ensure the public has easy access to evidence based, appropriate and timely oral health information to enable effective decision-making regarding oral health, including individual risk assessment and the need and/or demand for prevention and treatment services.

a. Creation and transfer of knowledge

Measure: ADA consumer survey

2. Shared responsibility

Intent: to ensure that both the individual and the dental professional understand their unique roles and responsibilities in managing an individual's, or a community's state of oral health. Be active participants in the doctor patient relationship in a culturally competent manner.

Measure: member survey-utilization rate of patient bill of rights

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

Outcomes/objectives:

1. Effective dental professional collaboration

Intent: to ensure that the entire profession of dentistry is working toward common goals of improving the public's health through strategies that include improved health literacy, efficient, effective delivery systems, adequate workforce (quantity and distribution) to meet the public's oral health care needs, and building the scientific body of knowledge related to oral and systemic health.

Measure: NRDC survey, external stakeholder survey, Access Summit group feedback

2. The public has access to effective prevention and to a quality focused delivery system

Intent: to ensure that the public benefits from effective and accessible preventive strategies so that the goal of the elimination of oral disease becomes a focal point for the public, the policy maker and the professional. In addition, the intent of this objective is to insure the public's access to a quality driven delivery system, for both government sponsored and private systems of care. *(Quality is care that is safe, effective, efficient, patient centered, equitable and timely - IOM Crossing the Quality Chasm 2001)*

a. Public delivery system mirrors the efficiencies of private system

Measure: To be determined.

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

Intent: to enable the House of Delegates and Boart of Trustees to fulfill their fiduciary responsibility, to achieve long-term financial stability for the Association.

Outcomes/objectives:

1. **Increase the reserves of the Association so that a reserve level of 50% of the Association's annual budgeted operating expenses is achieved, as urged by HOD Resolution 59-2007H-2008.**

Measure: Reserves as a percentage of the total operating expense

2. **Establish, as permitted by the ADA *Bylaws* Chapter XVII, Section 30, and annually fund a Capital Improvement Fund that can be carried over each year.**

Measure: Annual balance of Capital Improvement Fund

The Planning Process

The Strategic Plan of the American Dental Association charts the ADA's future as a strong and progressive organization. The Plan addresses issues that will affect the future of the profession and the ADA. It directs the ADA to allocate resources through the budgeting process to essential core initiatives. The Plan acknowledges that change is constant and that the Association must position itself to anticipate, take initiative and respond to these changes. For this reason, the Plan is a dynamic document, updated annually in the form of an annual operations plan. Members from the Board of Trustees, the Strategic Planning Committee and the general membership, guide that process of continual review, comparing the plan with the actual results on a quarterly basis. The planning process recognizes the importance of ongoing self-study through analysis of trends, member needs and Association accountability and performance.

Through its strategic plan, the Association communicates its purpose as expressed in its Vision and Mission Statements. The common convictions and heritage that unite the dental profession are presented in the Plan's Beliefs statements. Prioritized goals and objectives set future direction and the allocation of limited resources.

Meeting member needs and responding to key environmental trends are the underpinnings of the ADA Strategic Plan for the years 2011-2014.

In preparation for developing the strategic plan, an environmental assessment study [1]was completed in response to the ADA Board of Trustees' request. The study gathered relevant information from within the ADA as well as from the world at large—both within and outside of health care. In December 2009, the ADA distributed an environmental scan of resources utilized by staff. The analysis of this information is the basis for the ADA Strategic Plan: 2010-2014.

Implementation and Utilization of the ADA Strategic Plan

The ADA's Strategic Plan was developed to shape its future. It is paramount that the Plan be fully integrated into its operational structure and processes. To make certain that the Plan is utilized to the fullest possible extent, the following practices occur:

[1] The Institute for the Future

1. A strategic planning committee, made up of Board of Trustees members and other ADA members and staff, will continue to review the dental profession's environment by analyzing trends, assessing membership expectations and other valuable data. Based on their annual review, recommendations shall be made to the Board of Trustees annually regarding Plan action items for the year ahead. Further, the Committee will monitor the implementation of the Plan by the agencies of the ADA.

2. The Strategic Plan will be integrated throughout the ADA's agencies, councils, and programs by having an annual Operations Plan. Quarterly reports on progress regarding the implementation of the operating plan will be made available to the House of Delegates, the Board of Trustees, the membership and the staff. ADA programs, services, and projects must move the Association toward the established mission statement, goals and objectives.

3. The belief statements, goals and objectives contained in the Strategic Plan and its annual updates shall provide the primary basis for the annual budget development by agencies, staff and the Board of Trustees. Financial resources shall be shifted toward areas of greatest priority.

The above-stated practices make clear the intent of the Strategic Plan, and its annual updates shall be the statement of the strategic direction for the ADA. The successful implementation of this plan will be determined by the actual results achieved in both the Strategic Plan and the annual operating plan.

Acknowledgements

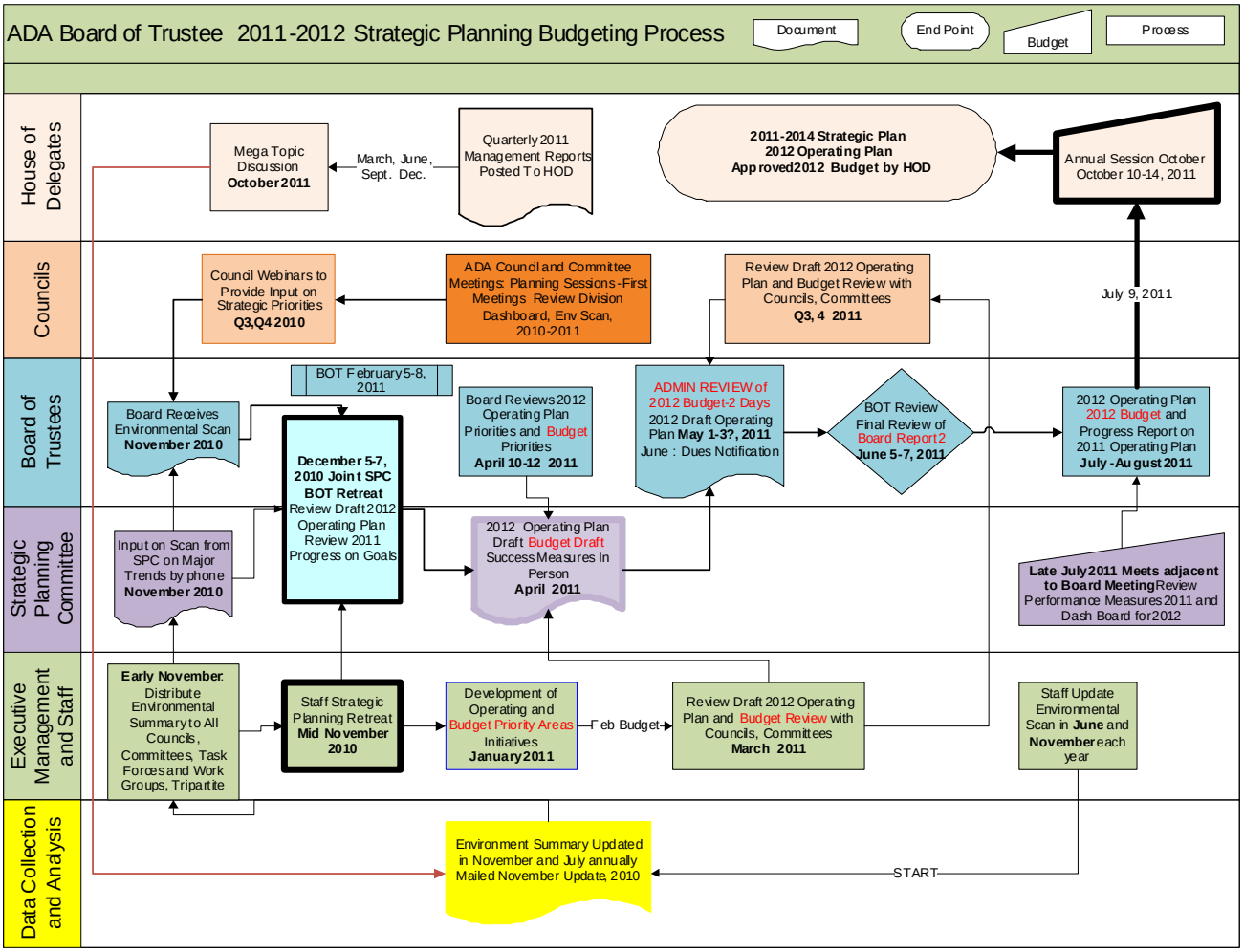
Strategic Planning Committee Members: 2010

Dr. Teri Barichello, chair, Oregon; Dr. William Calnon, trustee, Second District; Dr. Dennis Engel, trustee, Ninth District; Dr. Raymond Gist, ADA President-elect; Dr. Daniel Klemmedson, Arizona; Dr. S. Jerry Long, trustee, Fifteenth District; Dr. Charles Norman, trustee, Sixteenth District; Dr. Kathleen O'Loughlin, ADA executive director; Dr. McKinley Price, Virginia; Dr. Ruchi Sahota, California; Dr. Carol Summerhays, California.

Staff to the Committee: Dr. Kathleen O'Loughlin, Office of the Executive Director and Strategic Planning; Mr. Thomas Elliott, Esq., Division of Legal Affairs, associate general counsel; Mr. Paul Sholty, Chief Financial Officer; Ms. Diane L. Ward, senior manager, strategy planning and special projects.

The Committee gratefully acknowledges the contributions of various tripartite and ADA staff and agencies as well as communities of interest that provided information to the Committee for its deliberations and in the ongoing implementation of the ADA strategies.

Appendix 2 – Draft Planning Process Chart



Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Board Report 15 Date Submitted: September 2010

Submitted By: Board of Trustees

Reference Committee: Membership and Planning

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

REPORT 15 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:
2010 NATIONAL SUMMIT ON DIVERSITY IN DENTISTRY

Background: The 2010 National Summit on Diversity in Dentistry (Diversity Summit) convened at ADA Headquarters on June 11-12, 2010 with 36 representatives selected by the American Dental Association (ADA), the Hispanic Dental Association (HDA), the National Dental Association (NDA) and the Society of American Indian Dentists (SAID). Participants included presidents, past presidents, presidents-elect, current and former board members, executive directors and dental students. Dr. Joan Reede, Dean for Diversity and Community Partnership, and Associate Professor of Medicine, Harvard Medical School, delivered the keynote address "Diversity in Dentistry: Time for a New Beginning." Dr. Ashleigh Rosette, associate professor, Fuqua School of Business, Duke University facilitated the Diversity Summit. The Diversity Summit was developed through a fully collaborative process involving ADA, HDA, NDA and SAID leaders and volunteers.

At the Diversity Summit, representatives from each organization presented deeply personal testimonials on the history of exclusion/inclusion in organized dentistry. Five presenters described current initiatives to improve diversity in the profession and leadership, and to reduce population disparities in oral health status. Then ten workgroups generated ideas for new initiatives. The full Diversity Summit developed promising ideas for collaboration among the four organizations.

Presidents of the four organizations also committed to continuing their dialogue through quarterly conference calls. Their focus will be on oversight for the collaborative efforts and for the agenda for future collaboration.

Following the Diversity Summit, the four organizations collaborated on a report for their boards as a prelude to commitments to specific joint action. The report is appended and also will appear on a Diversity Summit Web page on ada.org.

At its July 2010 meeting, the ADA Board of Trustees adopted four resolutions proposed by the Diversity Committee regarding the Diversity Summit.

B-130-2010. Resolved, that the Board endorses the mutual commitment made by the presidents of the American Dental Association, the Hispanic Dental Association, the National Dental Association and the Society of American Indian Dentists at the 2010 National Summit on Diversity in Dentistry to begin a series of quarterly conference calls among the associations' presidents, and be it further

Resolved, that the Board recognizes the series of presidential calls as fundamental to sustained collaboration through the presidents' sharing oversight for current collaboration and planning how the associations can consider specific longer-term initiatives.

B-131-2010. Resolved, that the ADA invite a maximum of two representatives each from the Hispanic Dental Association, the National Dental Association and the Society of American Indian Dentists to attend the September and December 2010 programs of the Institute for Diversity in Leadership so they may observe and gain background for considering new collaboration in leadership development, and be it further

Resolved, that any expenses incurred by the invited individuals be assumed by their respective associations.

B-132-2010. Resolved, that the American Dental Association collaborate with the Hispanic Dental Association, the National Dental Association, and the Society of American Indian Dentists to familiarize current and potential corporate sponsors with general outcomes from the 2010 National Summit on Diversity in Dentistry and opportunities for supporting new initiatives that may emerge.

B-133-2010. Resolved, that the Diversity Committee of the ADA Board of Trustees consider and report by December 2010 on mechanisms for expanding collaboration from the National Summit on Diversity in Dentistry to a broadened representation of dental associations with memberships centered in diverse groups of dentists, including options involving the National Roundtable for Dental Collaboration established by the ADA in early 2010.

Since that time, the Diversity Committee met on Tuesday, August 10 via conference call. Additional resolutions emerged that will further position the ADA to meet heightened expectations and opportunities from the successful Diversity Summit.

Actions: The Diversity Summit Web page will serve as a source of ideas and ongoing information to a network of informed, committed, individuals and organizations. This network can look to the Institute for Diversity in Leadership as not only a training program, but also a learning laboratory that can benefit leadership program design in many associations. Also, the ADA Board's Strategic Planning Committee is encouraged to tap the network for ideas and insights from diverse associations to flow into its environmental scanning process.

Through the planning process for the Diversity Summit, it was clear that considering the perspectives of others is a key to effective collaboration. Consequently, cultural competency can be a vital part of initial orientation and ongoing learning by the ADA Board and other boards. The cost of an excellent program is benchmarked to having a top-flight diversity trainer such as Howard Ross from the Cook-Ross firm, who normally charges in the vicinity of $10,000 per day. Mr. Ross facilitated the Access Summit and is a frequent diversity speaker and consultant for major organizations.

Further, from the new perspectives that ADA leaders gained during planning for the Diversity Summit and the Diversity Summit itself, there is now perceived a need to strengthen and extend ADA's 2008 apology for not acting before 1965 to end all discriminatory membership practices in the tripartite, while also celebrating ADA today as a diverse association committed to collaboration with other associations for advancing the well being of patients, communities and the profession.

Quarterly calls of the Diversity Summit presidents plus strategies for a larger circle of collaborating associations and supportive corporate sponsors all help to sustain collaboration for the long term.

Together, the resolutions approved in July and in September will help to position ADA as a diverse association that can also serve as an "umbrella" organization for associations with memberships centered on diverse groups of dentists.

B-169-2010. Resolved, that ADA collaborate with the Hispanic Dental Association, National Dental Association and Society of American Indian Dentists to implement a communications strategy to alert members and volunteers to the Web page for the National Summit on Diversity in Dentistry as an

information resource on history, current efforts and potential collaboration for advancing diversity and inclusion in the profession, and for reducing disparities in oral health status across diverse populations.

B-170-2010. Resolved, that the Diversity Committee in consultation with the President, appropriate agencies, and other associations, develop and offer a cultural competency educational program as part of the Board orientation program for 2011, and be it further

Resolved, that a supplemental request for funding as needed will be presented to the Board of Trustees in 2011.

B-171-2010. Resolved, that the Strategic Planning Committee be encouraged to invite national associations with memberships centered in diverse populations of dentists to indentify and/or comment on key trends they observe among their members.

Resolutions

This report is informational in nature and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

Board Vote: Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN
☐	☐	☐	■	ENGEL	■	☐	☐	☐	MANNING	☐	☐	☐	■	THOMPSON
☐	☐	☐	■	FAIELLA	■	☐	☐	☐	NORMAN	■	☐	☐	☐	VERSMAN
☐	☐	☐	■	FEINBERG	■	☐	☐	☐	RICH	☐	☐	☐	■	VIGNA
☐	☐	☐	■	GIST	■	☐	☐	☐	SEAGO	■	☐	☐	☐	WEBB
☐	☐	☐	■	KREMPASKY SMITH	☐	☐	☐	■	SMITH, A. J.	■	☐	☐	☐	WEBER
■	☐	☐	☐	LONG	■	☐	☐	☐	STEFFEL					Report 15

Appendix

National Summit on Diversity in Dentistry
June 11-12, 2010
Final Report

Purpose of the National Summit on Diversity in Dentistry

National Summit Goal: To build trust, mutual respect, and seek consensus on objectives, basic strategies, concrete progress measures and continued collaboration for ongoing progress for diversity in dentistry.

On June 11-12, 2010, at the ADA Headquarters building in Chicago, a group of 36 presidents, president-elects, past-presidents, trustees, executive directors, dental students and volunteers from the Society of American Indian Dentists (SAID), National Dental Association (NDA), the Hispanic Dental Association (HDA) and the American Dental Association (ADA) convened the 2010 National Summit on Diversity in Dentistry. The National Summit was a historic opportunity for these leaders to meet and begin collaborating as to how the organizations they represent can better work together to support the profession and the public.

The recommendations generated during the National Summit were the product of idea-generating sessions held in workgroups comprised of leaders from each organization. They represent a starting point upon which further collaboration can build. The boards from the four respective organizations will decide which recommendations to pursue jointly with the other organizations through formal actions intended to endure beyond successive leadership changes.

ADA House of Delegates Funding with Respect to the National Summit

Funding for the National Summit planning, facilitation, keynote address and meals was approved by the ADA House of Delegates in 2008 and 2009, with additional support provided by Procter & Gamble. Travel and lodging for National Summit participants was funded by each organization.

Planning Process

The Joint Planning Team, comprised of leaders and executives from SAID, NDA, HDA, ADA, met twice in 2010 at the ADA Headquarters building in Chicago to plan for the 2010 National Summit on Diversity in Dentistry. The Joint Planning Team meetings were followed by a series of conference calls.

At the first meeting, the group's work focused on the value of diversity, the importance of perspective taking, building trust and developing superordinate goals for the organizations to work towards. At the second meeting, the focus was on collaborative leadership and the development of the agenda and work teams for the Summit. The Joint Planning Team agreed that the agenda for the National Summit would focus on three areas: History of Inclusion and Exclusion in Dentistry, Diversity in Leadership and Community/Oral Health Issues. Planning teams for these segments were led, respectively, by Dr. Nathan Fletcher, Dr. Ernest Garcia, and Dr. Samuel Low.

After establishing these three agenda teams, each team began designing and creating the content for its portion of the agenda. Collaboration occurred through monthly conference calls, with the end result being a robust agenda for the 2010 National Summit on Diversity in Dentistry.

National Summit

Participants: As agreed upon during the second Joint Planning Team meeting, each organization was allocated 10 spots to invite participants from its organization. Attending the National Summit were thirty-six participants, comprised of past-presidents, presidents, president-elects, trustees, dental students, volunteers and executive directors.

Format: To set the stage and provide context for the work to come out of the National Summit, the Summit opened with eight profound, deeply personal, but optimistic historical testimonials given as part of the "History of Inclusion and Exclusion in Dentistry" portion of the agenda. The History of each organization was also included. A list of the speakers for this portion of the agenda is available in the Appendix.

Dr. Joan Reede, Dean for Diversity and Community Partnership, and Associate Professor of Medicine, Harvard Medical School, presented the keynote address: "Diversity in Dentistry: Time for a New Beginning."

Across the agenda segments of "Diversity in Leadership" and "Community and Oral Health Issues" there were ten break-out workgroups. The workgroups generated recommendations that aimed to increase and focus collaboration among the four organizations. Recommendations were summarized and the summaries were then categorized as either short-term or longer-term. The National Summit conferees did not create a sharp distinction between "short term" and "longer term," in part reflecting their organizations' different decision processes and timetables for governance, strategic planning, and budgeting. There was a general sense that "short term" applies to objectives with a reasonable probability of successful collaboration during the rest of 2010 and 2011.

Promising Areas for Collaboration from the National Summit

Diversity in Leadership

- Quarterly conference calls for the presidents of SAID, NDA, HDA, ADA. (The presidents agreed to begin these in August 2010.)

- Explore possibilities for "cross representation" among governance bodies for SAID, NDA, HDA, ADA. Promising examples include:

  Short-Term:
  - Councils' engaging consultants from diverse organizations and possibly engaging outside consultants for cultural competency training. (Short-term).

  Longer-Term:
  - Exchanging liaison representatives with "a voice but not a vote."
  - Lateral movement by experienced leaders from one association to councils or committees in another.
  - Expanded organizational representation in each organization's respective House of Delegates.
  - Reciprocal membership options and new direct membership categories.

- Among members of all four organizations, increase awareness of leadership education and service opportunities. Potential initiatives include:

Short-Term:

- Marketing campaign that informs dentists about leadership training, e.g., existing programs in all the organizations.

Longer-Term:
- Forming a subcommittee of the ADA Board's Diversity Committee with representatives from organizations including SAID, NDA and HDA to explore strategies for increasing members' awareness of leadership education and service opportunities.
- Centralized leadership/diversity training program for the four organizations and others, drawing on best practices from the Institute for Diversity in Leadership.

- Actively engage and provide state and local-level leadership opportunities for diverse members from all age groups, genders, racial and ethnic categories, and practice settings. Potential strategies include:

Short-Term:
- Outreach by local and state associations for diverse volunteers for specific projects – diverse in terms of age, gender, race, ethnicity, and practice setting (e.g. community health centers). (Some approaches may be more for longer-term consideration.)
- Enhance connections to leadership roles for alumni of leadership institutes, including the Institute for Diversity in Leadership.

Longer-Term:
- State-level and local-level board liaison exchange among SAID, NDA, HDA and ADA affiliates and others, and reciprocal membership options.
- Explore social networking technologies for mutual support among leaders and emerging leaders at all levels.
- Establish local leadership training programs, after national assessment.
- Provide Web-based training in cultural competence and other training to foster association environments that are welcoming to a diverse range of dentists.

- Track progress and potential for improving diversity in dentistry and leadership, and for reducing oral health disparities across diverse populations.

Short-Term:
- Collaboratively develop information systems for tracking and reporting on governance diversity at the associations' local, state and national levels. (Short-term)
- SAID, NDA, HDA and ADA share rosters of related student organizations.

Longer-Term:
- Periodic National Summits on Diversity in Dentistry, with an expanding circle of organizations.
- ADA House of Delegates "Mega Topic" discussion on diversity in dentistry.

Toward a More Diverse Dental Profession

- Building on the multi-year "Pipeline" demonstration programs funded by the Robert Wood Johnson Foundation focused on dental schools, collaboratively identify the special roles for dental associations at all levels. Recommendations for further consideration include:

Short-Term:
- Identify and focus on common objectives among the associations' existing programs to encourage and support dental school matriculation and graduation for students from diverse backgrounds, retaining program ownership and identity.
  Extend this support to high school and college students of diverse backgrounds.
- Develop strategies to increase information sharing among dental associations (national, state and local) on workforce diversity strategies.
- Provide dental associations at all levels with research-based insights on career pathways and pilot programs, in order to encourage creative thinking on new strategies for increasing diversity among dental students and the profession.

Longer-Term
- Explore ways to increase financial support for students in need, especially as college and dental school debt loads grow.
- Consider standardizing and expanding existing mentoring programs for undergraduates, high school students or students even earlier in their school progression.
- Support continued exploration of a new dental school accreditation standard related to diversity of the student population. .
- Explore strategies for filling dental school faculty vacancies and – recognizing the influence of faculty as mentors and role models – for increasing faculty diversity.
- Explore new approaches to licensure for non-U.S.-trained dentists.

Reducing Disparities in Oral Health Status Across Diverse Populations

- Explore a collaborative communications strategy for the associations to advance key oral health messages grounded in solid research, with emphasis on prevention.

  Short-Term:
  - Reinforcing the public's understanding of the value of dentistry and oral health to general health.
  - Expanding oral health literacy of patients.

  Longer-Term:
  - Advance applied research agendas on the etiology of early childhood caries.

- Expanding cultural competence of professionals for prevention and treatment of oral health problems.

- Develop community health workers knowledgeable in oral health care to help people bridge access barriers related to such factors as transportation, child care, finances and other factors. (The ADA's Community Dental Health Coordinator model, for example.)

- Pursue collaborative advocacy strategies with a range of organizations to speak with one voice in addressing consumers, policy makers, and other health professionals on topics such as:

  Short-Term:
  - Form a cross-organizational team to pursue collaborative advocacy on such topics as:
    - Expanding Medicaid eligibility to oral health coverage for pregnant women, seniors, and adult emergency care.
    - More adequate Medicaid payment rates for dental care.
    - Streamlined Medicaid administration and information technology for provider relations.

- Increased efforts to recruit, train, encourage and assist dentists to establish practices in underserved areas through financial incentives, loan repayment programs and innovations in dental education.
- Eliminating any “red-lining” based on practice location by businesses supporting dental practices.
- Quality oral health care for all – the key elements

Next Steps:

This report will be forwarded to the board of each organization in order to initiate proper consideration of the National Summit’s outcomes within each organization’s governance, planning and budgeting processes. The National Summit participants hope that each organization will consider ideas from the Summit along with its own programs and plans, and share where it will be able to collaborate. Then the four organizations can collaborate on more detailed planning and implementation for their new joint efforts.

Examples of the kinds of short-term collaboration envisioned by the National Summit include:

- A project already underway in one organization includes new roles for volunteers and staff from other organizations.

- Similar projects in one or more organizations form liaison relationships to share insights and experiences.

- To accomplish one of the National Summit goals (short or longer-term), a team of volunteers and staff from our organizations forms to plan a joint project and proposal for funding by their organizations or foundations. The associations’ boards formally encourage the formation of such teams covering various objectives in this report.

- To address a National Summit goal, the four associations form a team to mobilize the rich pool of volunteer, member and staff talent and relationships throughout their networks of state and local affiliates. (Example: Connecting the career mentoring programs led by some dental societies and launching more such programs.)

- The National Summit notes that new data collection projects using electronic surveys require minimal if any cash outlays but plenty of organizational encouragement for respondents to complete surveys.)

- Certainly other examples are possible.

National Summit conferees also anticipate that successful short-term collaboration will form the foundation for longer-term collaboration.

In order to build on the spirit of collaboration and the goodwill generated by the National Summit, the four presidents of SAID, NDA, HDA and ADA agreed to hold quarterly conference calls. These calls will be used as an opportunity for the presidents to share oversight with respect to the emerging collaborative projects.

Note:

This report was prepared by the National Summit on Diversity in Dentistry editorial group, composed of Dr. Ruth Ball (SAID), Dr. Nathan Fletcher (NDA), Dr. Sarita Arteaga (HDA) and Dr. Sam Low (ADA).

Appendix

The following is a list of the presenters at the 2010 National Summit on Diversity in Dentistry:

Representing the Society of American Indian Dentists:
- Dr. George BlueSpruce
- Dr. Nancy Reifel

Representing the Hispanic Dental Association:
- Dr. Sarita Arteaga
- Dr. Ernest Garcia

Representing the National Dental Association
- Dr. Roy Irons
- Dr. Claude Williams

Representing the American Dental Association
- Dr. James Hupp
- Dr. Raymond Gist, president-elect

Keynote Speaker:
- Dr. Joan Reede

Facilitator:
- Dr. Ashleigh Rosette

National Summit on Diversity in Dentistry
Friday-Saturday, June 11-12, 2010
American Dental Association Headquarters
211 East Chicago Avenue, Chicago, Illinois

Summit Goal: To build trust, mutual respect, and seek consensus on objectives, basic strategies, concrete progress measures, and continued collaboration for ongoing progress for diversity in dentistry.

Agenda

Day 1: Friday, June 11, 2010

2:30 – 3:00 p.m. Outside Conference Room 2B	**Registration**
	Opening
3:00 – 3:30 p.m. Conference Rooms 2B-D	**Greetings, Goals and Introductions for the Summit** Dr. Ronald Tankersley, president and Dr. Raymond Gist, president-elect, American Dental Association **Dr. Ashleigh Rosette, National Summit Facilitator** Fuqua School of Business Duke University
	History of Inclusion and Exclusion in Dentistry
3:30 – 3:35 p.m.	**Preface** Dr. Nathan Fletcher, past president National Dental Association
3:35 – 5:25 p.m.	**Organizational Histories and Personal Testimonials** Facilitator: Dr. Ashleigh Rosette *Each organization has a total of 25 minutes to utilize at its discretion.* **Society of American Indian Dentists** Dr. George Blue Spruce (video message) and Dr. Nancy Reifel **Hispanic Dental Association** Dr. Sarita Arteaga and Dr. Ernest Garcia **National Dental Association** Dr. Roy Irons (video message) and Dr. Claude Williams **American Dental Association** Dr. Raymond Gist and Dr. James Hupp
5:25 – 5:30 p.m.	**Closing remarks for this agenda segment** Dr. Nathan Fletcher and Dr. Ashleigh Rosette
5:30 – 5:45 p.m.	**Break**

Keynote Address	
5:45 – 6:30 p.m.	**Diversity in Dentistry: Time for a New Beginning** Joan Y. Reede, MD, MS, MPH, MBA Dean for Diversity and Community Partnership Harvard Medical School Boston, Massachusetts
6:30 – 8:00 p.m. Executive Dining Room, 22nd Floor	**Group Dinner**

The associations coming together for National Summit express appreciation to Procter & Gamble for sponsoring this event.

Agenda

Day 2: Saturday, June 12, 2010

8:00 – 8:30 a.m. Conference Rooms 2B-D	**Breakfast**
Diversity in Leadership	
8:30 – 8:35 a.m.	**Preface** Dr. Ernest Garcia, past president Hispanic Dental Association
8:35 – 9:20 a.m.	**Background: Setting the Stage** Facilitator: Dr. Ashleigh Rosette *Each organization has a total of 11 minutes to present their perspective and processes on:* • Selecting members for governance roles (and diversity in ADA House) • Dimensions of diversity • Efforts to increase leadership diversity and diverse input to governance; best practices • Leadership development programs **Hispanic Dental Association** Dr. Victor Rodriguez **National Dental Association** Dr. Nathan Fletcher **American Dental Association** Dr. Carol Gomez Summerhays **Society of American Indian Dentists** Dr. Dave Smith
9:20 – 10:15 a.m.	**Workgroup Discussions: Diversity in Leadership** Facilitator: Dr. Ashleigh Rosette Discussion Questions: 1. Longer range, what ADA governance changes could be beneficial? Other associations' changes? 2. Shorter range, how can our associations and the Tripartite make dentists

	better aware of leadership education and volunteer involvement opportunities? 3. What could all of our associations do to strengthen leadership training programs, enroll more dentists, and offer more opportunities for input and volunteering? How could HDA, NDA and SAID leaders be encouraged to play leadership roles in ADA as well? 4. How can we track progress in diversity in leadership?
10:15 – 10:30 a.m.	**Break**
10:30 – 10:55 a.m.	**Workgroup Reports: Diversity in Leadership** Facilitator: Dr. Ashleigh Rosette
10:55 – 11:00 a.m.	**Closing remarks for this agenda segment** Dr. Ernest Garcia and Dr. Ashleigh Rosette
Oral Health Care Issues	
11:00 – 11:05 a.m.	**Preface** Dr. Samuel Low, trustee, 17th District American Dental Association
11:05 a.m. – 12:15 p.m.	**Current Initiatives: Workforce Diversity, Oral Health Disparities, and Policy/Advocacy** Facilitator: Dr. Ashleigh Rosette *Each organization has a total of 17 minutes to highlight their <u>current</u> initiatives for workforce diversity, reduced disparities, and related policy/advocacy.* **National Dental Association** Dr. Walter Owens **American Dental Association** Dr. William Calnon and Dr. Kenneth Versman **Society of American Indian Dentists** Dr. Ruth Bol **Hispanic Dental Association** Dr. Francisco Ramos-Gomez
12:15 – 1:15 p.m. Executive Dining Room, 22nd Floor	**Lunch with Greeting and Remarks** Dr. Ronald Tankersley, president, and Dr. Kathleen O'Loughlin, executive director, American Dental Association

1:15 – 3:30 p.m. Conference Rooms 2B-D	**Workgroup Discussions: Oral Health Care Issues** Facilitator: Dr. Ashleigh Rosette *Each workgroup will focus on finding common ground objectives and developing high level strategies.* Workgroup assignments (2 groups per topic): • Workforce Diversity • Oral Health Disparities • Related Policy/Advocacy Strategies
3:30 – 3:55 p.m.	**Workgroup Reports: Oral Health Care Issues** Facilitator: Dr. Ashleigh Rosette
3:55 – 4:00 p.m.	**Closing remarks for this agenda segment** Dr. Samuel Low and Dr. Ashleigh Rosette
Common Ground Objectives for Joint Actions	
4:00 – 4:55 p.m.	**Charting a Course Together** Facilitator: Dr. Ashleigh Rosette
4:55 – 5:00 p.m.	**Closing Remarks from each organization** Facilitator: Dr. Ashleigh Rosette *Each organization has a total of 1 minute.* **American Dental Association** Dr. Ron Tankersley **Society of American Indian Dentists** Dr. Dave Smith **Hispanic Dental Association** Dr. Victor Rodriguez **National Dental Association** Dr. Walter Owens

The associations coming together for National Summit express appreciation to Procter & Gamble for sponsoring this event.

National Summit on Diversity in Dentistry
Friday-Saturday, June 11-12, 2010
American Dental Association Headquarters
211 E. Chicago, Ave, Chicago, Illinois
Participant Roster

Hispanic Dental Association (HDA):
- Dr. Sarita Arteaga, past president
- Dr. Yolanda Bonta, executive director*
- Dr. Ernie Garcia, past president*
- Dr. Amarilis Jacobo, New York Hispanic Dental Association, board member
- Ms. Maria Martinez, student trustee
- Dr. Lauro Medrano-Saldana, New York Hispanic Dental Association, board member
- Ms. Margo Melchor, president-elect
- Dr. Maritza Morell, treasurer
- Dr. Francisco Ramos Gomez, immediate past president*
- Dr. Victor Rodriguez, president

National Dental Association (NDA):
- Dr. Michael Battle, immediate past president*
- Dr. Sheila R. Brown, president-elect
- Dr. Katrina Eagilen, chairman of the board
- Dr. Nathan Fletcher, past president*
- Dr. Roy Irons, vice president (video message)
- Mr. Robert Johns, executive director*
- Ms. Evelyn Lucas-Perry, SNDA board of trustees
- Dr. Walter Owens, president*
- Dr. Greg Stoute, past president
- Dr. Claude Williams, life member

Society of American Indian Dentists (SAID):
- Dr. George Blue Spruce, founder and past president (video message)
- Dr. Ruth Bol, vice president*
- Dr. Nancy Reifel, board member*
- Dr. Dave Smith, president*
- Ms. Danielle Stimson, student representative
- Dr. Sandra Wilson, board member

American Dental Association (ADA):
- Dr. Bill Calnon, trustee, 2nd District, Diversity Committee of the Board*
- Dr. Chad Gehani, Queens County Dental Society, New York*
- Dr. Ray Gist, president-elect*
- Dr. Jim Hupp, chair, Council on Dental Education and Licensure, Committee on Career Guidance and Diversity Activities*
- Dr. Sam Low, trustee, 17th District, Diversity Committee of the Board*
- Dr. Jeanne Sinkford, American Dental Education Association*
- Dr. Carol Gomez Summerhays, past president, California Dental Association*
- Dr. Ron Tankersley, president
- Dr. Ken Versman, trustee, 14th District, Diversity Committee of the Board*
- Dr. Charlie Weber, trustee, 3rd District, Diversity Committee of the Board

Procter & Gamble (P&G) – Event Sponsor:
- Dr. J. Leslie Winston, director, Professional and Scientific Relations, North America

**Member of the National Summit on Diversity in Dentistry Joint Planning Team*

Staff:

Ms. Megan Anshutz, publications coordinator, ADA Board and House Matters
Mr. Alan Bardauskis, manager, ADA Tripartite Data Relations
Ms. Kristi Gingrich, program coordinator, ADA Dental Society Services
Ms. Kim Howard, National Dental Association
Ms. Imelda Lemon, Society of American Indian Dentists
Mr. Joe Martin, director, ADA Dental Society Services
Mr. Ron Polaniecki, manager, ADA Dental Society Services
Ms. Bev Skoog, ADA Career Guidance Program Liaison
Ms. Stephanie Starsiak, manager, ADA Administrative Services
Ms. Wendy-Jo-Toyama, ADA senior vice president, Membership, Tripartite Relations and Marketing

National Summit on Diversity in Dentistry
Friday-Saturday, June 11-12, 2010
American Dental Association Headquarters
211 E. Chicago, Ave, Chicago, Illinois
Biographical Sketches

Facilitator: Dr. Ashleigh Shelby Rosette

Dr. Ashleigh Shelby Rosette is an Assistant Professor of Management and Center of Leadership and Ethics scholar at the Fuqua School of Business at Duke University. She is also a Fellow at the Center for the Study of Race, Ethnicity and Gender in the Social Sciences and a member of the Duke Corporate Education Global Learning Resource Network.

Dr. Rosette studies prototypical and subtypical characteristics of leadership, culture and emotions in negotiations and decision-making, systems of privilege in organizations, and covert interpersonal aggression in work groups. Her research has been published or is forthcoming in academic journals and books, such as *Organizational Behavior and Human Decision Processes; Journal of Applied Psychology; Gender, Ethnicity, and Race in the Workplace; Research on Managing Groups and Teams; Group Decision & Negotiation* and the *Duke Journal of Gender and Public Policy*.

Her research has been recognized with awards presented by the Academy of Management, State Farm, Kellogg Teams and Groups Center, the Ford Foundation, the International Association of Conflict Management and the Dispute Resolution Research Center. Dr. Rosette has conducted and presented her research in the United States, France, Spain, Portugal, Hong Kong, South Africa, The Netherlands, and Canada. In addition, she has provided consulting services to an array of clients in varied industries, such as banking, auditing services, automobile manufacturing, medical services, and the social/non-profit sector.

Dr. Rosette's teaching experience is varied and spans across a spectrum of courses that center around two primary areas: (1) Negotiations and (2) Leadership. She currently teaches two courses, *Negotiations* and *Leadership, Ethics, and Organizations* to MBAs and Executives. Her teaching philosophy is to empower and inspire. Empower students with the knowledge and learning that transforms classroom concepts into real world application. Inspire them to become better leaders, managers, professionals, and colleagues. She has received the Excellence in Teaching Award of the Year in the Cross-Continent Executive MBA program and the Duke Goethe Executive MBA program at Fuqua and the Outstanding Faculty Teaching Award at the Kellogg School.

She received her Bachelor in Business Administration degree and Master in Professional Accounting degree from the University of Texas at Austin. She received her Ph.D. in Management and Organizations from the Kellogg School of Management at Northwestern University.

September 2009

Keynote Speaker: Joan Y. Reede, MD, MS, MPH, MBA

Appointed as the first Dean for Diversity and Community Partnership in January 2002, Joan Y. Reede is responsible for the development and management of a comprehensive program that provides leadership, guidance, and support to promote the increased recruitment, retention, and advancement of under-represented minority faculty at Harvard Medical School (HMS). This charge includes oversight of all diversity activities at HMS as they relate to faculty, trainees, students, and staff.

Dr. Reede is director of the Minority Faculty Development Program and faculty director of Community Outreach Programs at Harvard Medical School. In addition, she holds the appointments of associate professor of medicine at HMS, associate professor of society, human development, and health at the Harvard School of Public Health, and assistant in health policy at Massachusetts General Hospital.

Prior to coming to HMS in 1989, Dr. Reede served as the medical director for a Boston community health center and for the Commonwealth of Massachusetts Department of Youth Services. Dr. Reede worked as a pediatrician in community and academic health centers, juvenile prisons, and public schools.

The impact of Dr. Reede's work is reflected in the numerous programs she has created to benefit minority students, residents, scientists, and physicians. Over the past fifteen years, Dr. Reede has created and developed more than 16 programs at HMS that aim to address pipeline and leadership issues for minorities and women who are interested in careers in medicine, academic and scientific research, and the healthcare professions. Supported by a dedicated staff, she has developed mentoring programs for under-represented minority students from the middle school through the graduate and medical school levels. Dr. Reede has also designed a training program for middle and high school teachers, developed science curricula for public schools, implemented research and exchange clerkship programs at HMS, and designed and implemented two innovative fellowships in minority health policy for physicians, dentists, and doctoral-level mental health professionals.

In addition, Dr. Reede founded the Biomedical Careers Program (BSCP) in collaboration with the Massachusetts Medical Society and the New England Board of Higher Education. BSCP is a collaborative, community-based organization involving academia, private industry, medical centers, public education, and professional societies. This organization is designed to identify, support, and provide mentoring for under-represented minority students, trainees, and professionals pursuing biomedical careers.

In recognition of her far-reaching accomplishments, Dr. Reede has received numerous awards, including the following four. In 1986, she received the Boston NAACP Health Award for contributions to the health of the Boston minority community. Dr. Reede received the Community Service Award from the Epilepsy Association of Massachusetts in recognition of her work for a live, five-part satellite series on neuroscience for New England high school teachers in 1993. In 1996, she received the American Association of University Administrators Exemplary Models of Administrative Leadership Award. Two years later, in 1998, Dr. Reede was named a Center for Disease Control and Prevention/University of California Public Health Leadership Institute Scholar. In 2005, Dr. Reede received the Herbert W. Nickens Award from the Society of General Internal Medicine and the Herbert W. Nickens Award from the Association of American Medical Colleges. She received the Academic Leadership in Primary Care Award from Morehouse School of Medicine. In 2006, she was recognized by *Modern Healthcare* magazine as one of “the top 25 minority executives in healthcare” and by *Ebony* magazine in their annual women’s health section as one of six “medical movers and shakers”. Dr. Reede was awarded the Riland Medal for Public Service from the New York College of Osteopathic Medicine and an honorary Doctor of Science degree from the New York Institute of Technology in 2007. Dr. Reede is the 2008 Homer G. Phillips Hospital Public Health Lecturer at Washington University in St. Louis School of Medicine.

At the national level, Dr. Reede was appointed to the Health and Human Services Advisory Committee on Minority Health by Donna E. Shalala, former Secretary of Health and Human Services, and she served on the Board of Governors for the Warren Grant Magnuson Clinical Center; the National Advisory Dental and Craniofacial Council; the Secretary's Advisory Committee on Genetics, Health, and Society at the National Institutes of Health (NIH); and as a Commissioner of The Sullivan Commission on Diversity in the Healthcare Workforce. Dr. Reede formerly served on the Secretary's Advisory Committee to the Director of NIH, and is currently on the Sullivan Alliance to Transform America's Health Professions. Dr. Reede serves as a member of the Continuing Education Committee of the American Public Health Association, The Satcher Health Leadership Institute of Morehouse School of Medicine Initiative National Advisory Board, The National Hispanic Medical Association Board of Directors, and recently she was elected to the Health Research & Trust Board of Directors of the American Hospital Association. In 2007, Dr. Reede was voted to the membership in the Medical Administrators Conference. In 2009, she was elected to the Health Research & Trust Board of Directors of the American Hospital Association. She presently serves on the National Children's Study Advisory Committee of the Eunice Kennedy Shriver National Institute of Child Health and Human Development, and as a Co-Chair for the Women in Science Work Group, "Moving Into The Future – New Dimensions in Women's Health Research", Office of Research on Women's Health at NIH. In 2009, Dr. Reede was elected as a Member in the Institute of Medicine of the National Academies.

Locally, former Massachusetts Governor Jane Swift appointed Dr. Reede to the Board of Directors of the John Adams Innovation Institute of the Massachusetts Technology Collaborative. Also in 2007, Dr. Reede was invited to join the Massachusetts Life Sciences Collaborative Task Force, one of several task forces charged with developing a statewide life sciences strategy. Dr. Reede is the 2009 John and Valerie Rowe Distinguished Lecturer of the John and Valerie Rowe Health Professions Scholars at the University of Connecticut School of Medicine.

Dr. Reede graduated from Brown University and Mount Sinai School of Medicine. She completed her pediatric residency at Johns Hopkins Hospital in Baltimore, Maryland, and a child psychiatry fellowship at The Children's Hospital Boston. She holds an MPH and MS in health policy and management from Harvard School of Public Health, and an MBA from Boston University.

Pre-Summit Background Readings and Resources

- *Trends in Oral Health Status: United States, 1988–1994 and 1999–2004*

  (Abstract through Conclusion only)
- *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*
- *Missing Persons: Minorities in the Health Professions* (Executive Summary)
- *Dental Enrollments in U.S. Dental Schools and Underrepresented Minorities*
- Diversity profiles of the ADA House of Delegates, from 2005, 2007 and 2009
- Web "portal" for information resources on disparities in oral health, available through the Division

  of Oral Health, Centers for Disease Control and Prevention, U.S. Department of Health and

  Human Services: http://www.cdc.gov/oralhealth/oral_health_disparities.htm#

Agenda Section Organizers

History of Exclusion and Inclusion in Dentistry - Dr. Nathan Fletcher, past president, National Dental Association
Diversity in Leadership - Dr. Ernest Garcia, past president, Hispanic Dental Association
Oral Healthcare Issues - Dr. Samuel Low, trustee, 17th District, American Dental Association

Resolution No. 115 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Fourteenth Trustee District

Reference Committee: Membership and Planning

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

HUMANITARIAN MEMBERSHIP CATEGORY

The following resolution was adopted by the Fourteenth District Caucus on September 25, 2010 and transmitted on September 26, 2010 by Dr. Thomas J. Schripsema, Fourteenth District Resolutions Committee Chair.

Background: Accepting a call to provide humanitarian aid in a remote area always entails personal sacrifices. One thing that should not have to be sacrificed is a professional affiliation with the American Dental Association. On very limited income it is nearly impossible to maintain professional memberships. While many of the benefits of membership may not be accessed abroad, the continued relationship with colleagues "back home" can provide needed support and inspiration to all. The benefit of continued affiliation to both the organization and the individual dentist certainly justifies a category of membership. Allowing members to maintain their continuous membership when they choose to devote a part of their lives to service, will give them the opportunity to become life members when they return.

Resolution

115. Resolved, that the Council on Membership consider a new category of membership for dentists that engage in full time international humanitarian relief and have been active members in good standing for at least five years immediately before leaving the country, and be it further

Resolved, that for purposes of determining eligibility for life membership, years as a member in this humanitarian category will be considered the same as active members, and be it further

Resolved, that, if appropriate, bylaws language be developed and submitted to the 2011 House of Delegates for consideration.

BOARD COMMENT: Received after this section had been reproduced for House distribution.

Resolution No. 116 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Fourteenth Trustee District

Reference Committee: Membership and Planning

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Collaboration (Required)

INTERNATIONAL SERVICE INSPIRED BY DR. THOMAS GRAMS

The following resolution was adopted by the Fourteenth District Caucus on September 25, 2010 and transmitted on September 26, 2010 by Dr. Thomas J. Schripsema, Fourteenth District Resolutions Committee Chair

Background: Violence in Afghanistan is such a regular feature of the news these days that it often gets no more than passing notice, but in July 2010 the world's attention was focused on the senseless murders of American relief workers by the Taliban. Among those killed was Dr. Thomas Grams, a leader in the group and a long-time ADA member from Durango, Colorado. Dr. Grams was an active and loyal member of the Colorado Dental Association before he closed his practice in Durango to devote his life to humanitarian efforts. In addition to his efforts in Afghanistan, Dr. Grams had treated children in South America and Asia, especially Nepal and India, for several years. His commitment to providing care to those that need it most superseded considerations of his own safety. His legacy, in addition to the tens of thousands of patients to whom he brought relief, should be the inspiration of his profession to carry on these efforts.

Resolution

116. Resolved, that the ADA urge the ADA Foundation to create a fund in memory of Dr. Thomas Grams, to benefit the delivery of dental care in international humanitarian relief efforts, and be it further

Resolved, that if such a fund is created, the ADA encourage member involvement in international humanitarian relief through contributions to the fund or participation in fund-supported projects.

BOARD COMMENT: Received after this section had been reproduced for House distribution.

Resolution No. 117 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Eleventh Trustee District

Reference Committee: Membership and Planning

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

FACULTY MEMBERSHIP PILOT PROJECTS

The following resolution was submitted by the Eleventh Trustee District and transmitted on September 28, 2010, by Dr. Mary Krempasky Smith, trustee.

Background: The WSDA House of Delegates proposed a resolution last year that would assess the issue of faculty involvement in organized dentistry as a means of providing leadership to those students and new graduates entering the profession. This resolution was referred to the Board of Directors for further study. The House also directed the Board to look at possible options for the payment of tripartite dues in order to recruit more dental school faculty into membership and a report back to this year's WSDA House of Delegates and propose any recommendations for action. The Board conducted a review of this question and concluded that the best way to gain meaningful information would be to survey the faculty at the University of Washington School of Dentistry. The survey results can be found in Appendix 1.

Faculty membership in organized dentistry is a multi-faceted concern that encompasses many issues. The survey results indicate that the majority of concern is focused on the financial disparity between faculty salaries and private practitioner income which may prevent faculty from continuing their membership in the ADA tripartite. Another strong theme expressed by faculty was that there may be a perceived lack of respect for what faculty members do to educate our future dentists. The Board agreed that this is cause for concern in light of our current faculty shortage nationally which appears to be growing rapidly to a catastrophic level. The survey also revealed that faculty members universally agreed that, as educators, they influence future dentists in becoming involved in organized dentistry.

With respect to asking the American Dental Association to become involved, it was felt that since there are so many differing considerations on this issue and since the focus by one state on membership of faculty may differ from other states, it was felt this should remain a state issue for the time being.

Additionally, during the survey period, it was discovered that another state dental association (Alabama) has recently initiated a pilot project to reduce faculty dues for the state and component dues by 50% for full time faculty members of their dental school. It was designed as a one year pilot project and at the end of one year the number of faculty is reported to have doubled. Because of this success, Alabama decided to extend the pilot for another year.

The survey results also show that even though the survey was small, ALL nonmember dentists who had been members in the past stated that they would consider rejoining the association if the dues level were reduced to a 50% level.

Therefore the Board recommended and the House passed a resolution to implement a similar pilot project as Alabama for the University of Washington full time faculty (80% time or greater). While this would result in a revenue neutral position if the number of faculty members were to double, it was felt that even if the number

of faculty were to increase by a lesser number, this effort would be advantageous to the association because of the additional advocacy for student involvement in WSDA membership and governance after dental school. It is also felt that this gesture may also signal to dental school faculty that the WSDA appreciates their dedication and efforts to dental education in light of the sacrifices made in faculty salaries. If these pilot projects are successful in recruiting more faculty it is felt that the ADA may wish to implement similar effort to attract more faculty into ADA membership.

Resolution

117. Resolved, that the ADA Council on Membership monitor the progress of any pilot projects for faculty recruitment and retention programs from the states of Alabama, Washington and any other states that may have similar programs, and be it further

Resolved, that the Council on Membership report its findings and results of these pilot projects and any recommendations to the 2011 or 2012 House of Delegates.

BOARD COMMENT: Received after this section had been reproduced for House distribution.

Appendix 1

Survey Comments of UW School of Dentistry Faculty on ADA Membership

1. Are you an ADA member? Yes No
"Yes-A reluctant member however-I think it's a waste of money. I don't recommend that junior faculty join. I think it's more important that they join their specialty association. Faculty salaries are so low and we haven't had increases in about 3 years, it simply doesn't add up."

2. Would an initiativeto reduce dues for full time faculty cause you to join? Yes No
"I would strongly consider; - I think this should have happened years ago when it was first brought up."

3. What is an appropriate reduction that would cause you to join? 15% 25% 50%
All answers were 50%
Comments: Faculty salaries are greater than 50% LESS than private practice income.

4. What could be done to encourage you to become a member?

---"There are two major issues, equally important: money and respect."
--- "The question of respect is really a question of give-and-take. Organized dentistry is asking me to spend a significant amount of time and money ($1,500/yr) to promote its programs, but what is it doing for full-time faculty and what is it doing to encourage quality dentists to make a career in education? I see nothing being done here that demonstrates any advantages of participation."
--- "Having been a public servant for most of my 37 year dental career, my income has been fixed. I have in the past had the opportunity to have a one day/week associated practice, but was forced to leave it 2 years ago due to increasing teaching commitments. Yes, as a full-time faculty member, I am at the school 5 days/week and 10 hours/day. I do not take a lunch hour in order to work with students. I am only able to take a real vacation in September. -I make less than $100,000 per year, and the budget of the State of Washington has not allowed a cost of living allowance for 2 years."
---"I did re-instate my membership several years ago when active in my associate practice."
--- "Why is it so difficult to understand why full-time faculty cannot afford the luxury of participation in organized dentistry?"
---"Recruiting new faculty is not easy because of the required commitment."
---"What is organized dentistry doing for us?"
---"A significant reduction in tripartite dues and equal "member status" for education would go a long way toward giving back to us all that we sacrifice in the name of educating new dentists."

5. Do you feel as an educator, you influence future dentists in being involved in organized dentistry?
Yes No

---"Schools that enjoy a strong relationship with ADA and its State Associations and District Societies in areas that directly relate to students are more successful in graduates becoming members. Witness the success of UOP (high) versus UCSF (low) in the same city. The example also emphasizes the importance of the State components. ADA at the National level is distant and relatively cold and often appears to do more harm than good from a student perspective."

6. Additional Comments: "Thank you very much for doing this survey. This is a very important issue. I have been a member of ADA before but couldn't afford renewing my membership due to the low

salary comparing to outside practitioners. I would consider re-joining ADA if the due is reduced more than 50% for full time faculty. Thank you very much again!"

---"I am a member, but I also believe the dues are too high. A 50% reduction (or more) would be a great incentive for faculty to be members."

--- "This is a hard time for all US dental schools, particularly the publics who depend heavily on State funding"

Resolution No. 119 New ■ Substitute ☐ Amendment ☐

Report: N/A Date Submitted: September 2010

Submitted By: Eleventh and Thirteenth Trustee Districts

Reference Committee: Membership and Planning

Total Financial Implication: TBD

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

PROVISION FOR 12 MONTH-CALENDAR YEAR ELECTRONIC DUES PAYMENT PROGRAM

The following resolution was submitted by the Eleventh and Thirteenth Trustee Districts and transmitted on September 30, 2010, by Diane Schaubach, secretary, Thirteenth District Caucus.

Background: ADA *Bylaws* (Chapter I, Section 50A) allow active and active life members to participate in an installment based dues payment plans if the current dues or special assessment amount is fully paid by June 30. In order to comply with the ADA *Bylaws* requiring a June 30 full dues paid status and to ensure the EFT participating dentists' membership did not lapse, it is necessary for states to advance 6 months' of ADA dues to the ADA (July – December payments) prior to actually receiving those funds from the members. This resolution would amend ADA *Bylaws* to remove the June 30 deadline and allow for a 12 Month-Calendar Year plan thereby allowing monthly installment plans to run from January 1 – December 31 of each year.

This amendment would provide greater flexibility for the sponsoring entities to offer a 6-month, a 12 month pre-payment, or a 12 month calendar year plan. Under the 12 month plan, members would be able to pay their membership dues throughout the membership calendar year.

Such a plan is consistent with other similar payments plans members are familiar with such as insurance premiums and health club memberships.

Finally, and perhaps most importantly, a 12 month calendar year installment payment plan has the potential to increase retention rates and enhance recruitment efforts. The following information is provided as a demonstration of members' receptiveness to a 12-month/calendar year plan.

The California Dental Association was an early advocate of installment payment plans or Electronic Fund Transfer (EFT) programs. Responding to members' concerns over the economy in 2009, CDA decided to provide a 12 month calendar year program from January to December.

The following represents CDA's experience with installment plans from 2006 – 2010.

- Participation levels for CDA's 6 month EFT programs for 2006, 2007 and 2008 respectively were 8.9%, 9.2% and 9.6% of the total membership. The program was growing annually but not at the pace demonstrated when a 12 month plan was implemented.
- The first year of the 12-month calendar year plan was 2009. There were 2,902 members enrolled (representing 12% of the total membership, a 2.4% increase in participation).
- The number of 12-month participants in 2010 continued to grow with a total of 3,678 members enrolled (representing 16.1% of the total members for an increase in membership participation of 4% with an overall increase of 27% in the number of members participating in the program in a one year period.)

- Because of being able to expand the time available for members to enroll in the program, the 12 month plan has become an effective **retention** tool allowing lapsed members to enroll in the program past the drop date by remitting the equivalent of the months missed and then paying the remainder on a monthly basis.
- Further, the plan is serving as an effective **recruitment** tool as new members have been allowed to participate in the plan for their first years' dues where in the past, dues would have been collected in full at the time of joining. Bearing the full cost of dues at one time was often a financial burden and prohibitive for prospective members. The ability to enroll new members in the EFT program lessens the immediate cost of membership and has been perceived as welcoming and user friendly.
- During 2008, 2009 and 2010 (to date) only 16 individuals have been dropped from the EFT program for insufficient funds or closed accounts.

In order to provide enhanced service to our members around payment of dues and enhance recruitment and retention efforts, adoption of the following resolution is requested.

Resolution

119. Resolved, that the ADA *Bylaws* Chapter I, Section 50A be amended by substitution of the words "December 30" for the words "June 30" where they appear (new language underscored, deletions stricken through).

> *Section 50A*. PAYMENT DATE AND INSTALLMENT PAYMENTS: Dues and any special assessment of all members are payable January 1 of each year, except for active and active life members who may participate in an installment payment plan. Such plan shall be sponsored by the members; respective constituent or component dental societies, or by this Association if the active or active life members are in the exclusive employ of, or are serving on active duty in, one of the federal dental services. The plan shall require monthly installment payments that conclude with the current dues and any special assessment amount fully paid by ~~June 30~~ December 30. Transactional costs may be imposed, prorated to this Association and the constituent or component dental society. The installment plan shall provide for the expeditious transfer of member dues and any special assessment to this Association and the applicable constituent or component dental society.

Note: This resolution does not address the issue of impacted cash flow for ADA, constituents, components as it is normally a one-year impact with subsequent years' cash flow being able to be accounted for through the budget process.

BOARD COMMENT: Received after this section had been reproduced for House distribution.

REPORT OF PRESIDENT

Before I begin, I would appreciate a moment of personal privilege. Obviously, this is a special Annual Session for me and I'd like to introduce those staff and family members who were able to attend today - Please stand when recognized...

First, my Practice Administrator, who has worked with me since my first day in practice, Susan Lee; my sister, from Spokane, Washington, Nancy Tankersley; my son and partner, Ken: his wife, Christy, and my granddaughters Ava and Zoe; last, but certainly not least, my wife, Gladys

Those who know me personally know that my family really is my greatest pride; and Gladys really is the "wind beneath my wings". Thank you.

Delegates, Alternate Delegates, Board Members, Professional Staff, and Guests:

Serving as your President has been the greatest professional honor of my life. I appreciate the opportunity to represent you during the past year.

Of course, this year turned out to be more tumultuous than anticipated. But, I want to assure you that your ADA volunteers and professional staff stayed on task.

As I reflect on the past year, I'd like to briefly share my perspectives on our legacy, today's profession, today's ADA, the past year, and our future:

First, Our Legacy

We have a proud 151-year history. We are dentists, not Saints. So, it's not untarnished. But, we can be proud of our legacy. We owe much of our credibility today to the vision and courage of dental leaders of yesterday.

Just imagine being those dentists who sat in the HOD in the 1950s:

- Extractions, amalgam restorations, and fabricating dentures constituted 85% of their practices
- The typical dental office had less than two employees
- Most patients thought that losing teeth was "normal" or "hereditary"
- Dental practices were thriving

Then, those dental leaders were confronted with scientific evidence that fluoridating drinking water would reduce caries almost 50% and that periodontal disease was preventable. What should they do? Should they protect their jobs like trade unions, or step up to the plate and respond like healthcare professionals? Of course, we know that they chose the latter.

The ADA's decision to advocate for fluoridated drinking water and change the focus of dental practice from disease management to prevention speaks volumes about our profession:

- Imagine accountants advocating for a flat tax
- Imagine trial attorneys advocating to cut litigation in half
- To put their courage into perspective, imagine us recommending that you advocate for a new technology that would reduce those services that you provide today by 50%. How would you feel?

We stand on the shoulders of giants – men and women who secured our transition from a trade to a highly respected profession. Everyone practicing today – and everyone receiving oral health care – benefit from the actions of those leaders.

Now, let's talk about Today's Dental Profession

We continue to be unique among health professions for a few reasons:

First, we are the last of the major health professions to be, primarily, market driven
- Our patients can choose their dentists … and their treatments …
- Our fees are value-driven, not part of a zero-sum rationing plan

The **second** thing that makes us unique is that most dental practices are solo or small group practices – we are the last of the cottage industries in health care
- We have autonomy in determining our hours of practice, scope of practice and fees
- Unlike many other professionals, we actually understand our business models and the value of our services...and
- The doctor-patient relationship remains a meaningful component of good dental care

The **third** thing that makes us unique is that most dentists are GPs
- There's no need for third parties or the government to designate the gatekeepers of dental care – the role of the GP is part of our culture
- Our GPs and specialists work collaboratively to provide good patient care...and
- As a result, we enjoy a cohesiveness that is the envy of other major health professions

Well, what about Today's ADA?

Today's ADA is unique among professional associations:

First, the ADA is the "umbrella" organization for the entire profession
- We represent all dentists: GPs, specialists, private practitioners, public health dentists, academicians, researchers, those working in industry, and those wearing the uniform
- We are in competition with no one; but we are a valuable resource to everyone
- We promote ADA policies; but, we also appreciate and respect the perspectives of members who disagree with those policies

Second, the ADA develops and maintains the standards for the dental profession
- That includes standards for education, accreditation, materials, practice, IT, and ethics
- Without the ADA, we would be a trade, not a self-regulating profession

Third, the ADA is exceptionally well positioned – let me explain why
- With the explosion of knowledge, it's essential that the ADA Professional Staff have the knowledge necessary to advise and inform us of developments in their respective areas of expertise. In today's complex environment, they also need the competence to help us attain our goals without sacrificing our professional values. No other dental organization on the planet possesses a staff and infrastructure that can address science, education, advocacy, standards, dental practice, communications, and outreach like ours. They make us proud; and I'd like those ADA professional staff members present to stand to be recognized.
- No other dental organization in the world has so many members so dedicated to the profession. Perhaps that's because our members are the ADA's owners, customers, and workers. As many of you have heard me say, "The reason that our volunteers are unpaid isn't because they're worthless; it's because they're priceless"
- Now, more than ever, the ADA brand is strong. Our long history, market share, and infrastructure are indisputable. Even those who misunderstand or disagree with us, recognize our relevance to oral health.

Of course, we still have challenges. As you know, we recently discovered significant problems with systems and processes at the ADA. Your Board recognized the problems, asked for the appropriate audits and

evaluations, and replaced the staff members responsible. This year, your new ED, new CFO, Professional Staff, and volunteers made substantial progress in implementing an aggressive corrective action plan to put this unfortunate situation behind us.

So, we can all be proud of today's ADA. But, today's ADA is actually an anachronism – a relic of a bygone era. We successfully preserved something wonderful...created by previous generations of leaders. Other organizations were unsuccessful. It's unlikely that we could recreate the ADA, as we know it, in today's culture. It's a prize worth protecting and defending.

Now, what about This Past Year?

You can be proud of what we accomplished this year:

- We advocated forcefully for improved oral health care, oral health literacy, and preventive programs for the underserved
- We continued our efforts for fluoridation of drinking water
- We defended the use of dental amalgam for situations in which it is the preferred material. In America, dentists don't need amalgam; but, some of our patients do
- We defended freedom to access the full range of acceptable healthcare options for patients with the means and desire
- We implored policy makers to step up to the plate and provide additional funding for dental care for the disadvantaged in their trillion-dollar healthcare reform legislation. Sadly, they didn't target any funding for this tragic situation. But, we aren't giving up.
- We vigorously tackled the Red Flags Rule, the 1099 tax form requirement, fee caps for non-covered services, McCarran Ferguson, and financial reform legislation. Patients' ability to access value-driven dental care is dependent upon dentists' ability to succeed in market-based practices.
- Finally, we increased our collaborative efforts with other groups concerned with oral health for the underserved:
    - We had many individual meetings with specialty groups, foundations, and oral health advocacy groups outside the dental family; and we hosted a Diversity Summit and Roundtable on Dental Collaboration
    - Improved relationships among the dental family and other oral health advocates will enhance our effectiveness as America's Leading Advocate for Oral Health

So, what about Our Future?

The internal and external challenges that we face are complex. We live in an ambiguous world, but we are often uncomfortable dealing with ambiguity. There are no easy solutions. As H.L. Mencken said, "For every complex problem, there is a simple solution that is elegant, easy to understand, and wrong."

American culture is increasingly tolerant of ethical misconduct, denial of accountability, dissemination of information that's un-vetted or out of context, and the politics of personal destruction. Ethical breaches in athletics, research, education, government, banking, and journalism are commonplace.

But, we represent a profession that performs irreversible procedures on fellow human beings on a regular basis. Our standards must be higher than those with less daunting responsibilities. That's our legacy of the past and should be our aspiration for the future.

The ADA House of Delegates is the supreme authoritative body of the Association. Our future reputation, credibility, and relevance are your responsibility. You will determine whether we surrender to current cultural trends...or sustain traditional values and best practices. Like those dental leaders in the 1950's who determined our legacy, you will determine the legacy for future generations. It's an honor to be in this House of Delegates. But, it's also an incredible responsibility.

To fulfill one of my final responsibilities, I will share five of my heartfelt beliefs about how you can best advance the ADA's reputation, credibility, and relevance:

First, I believe that you should insist that ADA policies be based on sound science and impeccable ethics

- There are persistent pressures from members, the public, and industry for the ADA to take positions that are intellectually and scientifically unsupportable
- But, the strength of the ADA is directly proportional to its credibility
- As a knowledge-based, self-regulating profession, if you subordinate science and ethics to self-interests, the ADA will lose its credibility

Second, I believe that you should insist that all information from the ADA be appropriate, vetted for accuracy, and presented in proper context

- Emerging technologies have overwhelmed society's ability to ethically regulate the dissemination of information. In the name of "transparency", we are increasingly exposed to information that has not been vetted for accuracy, is not in proper context, and violates basic principles of ethical journalism.
- Your standards should be higher
- As those responsible for the destiny of the dental profession, your decisions should be based on proper, valid, contextual information

Third, I believe that you should insist that your elected representatives in Chicago be properly vetted before being duly elected.

- Just think about it. Some trust their lives to complete strangers driving cabs in Chicago, but don't trust the judgment of their elected Officers and Trustees in Chicago. It's a fascinating commentary on behavioral dissonance.
- The governance structure of the ADA is your responsibility. But, regardless of that structure, it's impossible for a 460-member body to oversee the management of the ADA. Some designated group has to do that job. Without your trust, they can't do it.
- It's irresponsible to send representatives to Chicago with questionable ethics or competence; it's irrational to assume that their ethics and competence will miraculously change after they arrive. You should send representatives to Chicago that you trust.

Fourth, I believe that you should insist that debate be limited to relevant issues

- As I traveled around the country during the past few years, I never met anyone whose intent was to harm the ADA or oral health. Admittedly, there are conflicting perspectives. In fact, some vociferously disagree with the recommendations that I'm currently making.
- But, our perspectives are determined by our positions, not moral decadence.
- The politics of personal denigration is counterproductive, ignores the ethical principle of benevolence, and impugns the ADA's reputation. By focusing on issues, rather than perceived personal failings, you will make better decisions and protect our reputation.

Finally, I believe that you should insist that the ADA "tell its story better"

- The ADA and the dental profession have an incredible story to tell. But, we remain poorly understood by many
- Our collaborative efforts increase mutual respect and understanding. Our State Public Affairs program increases the effectiveness of our messaging. Our new Division of Communications and redesigned web site will act as springboards to better messaging in the future. But, we need to do more.
- To maintain market share with younger dentists, they must understand our relevance to their lives. They need to understand that our standards development activities give them their professional status. And, they need to understand the necessity of advocacy in today's society.
- To increase our relevance to others concerned with oral health, we must proactively demonstrate our concern for the public. I believe that the ADA should consider coordinating quarterly national volunteer events every year:

- First Quarter: To demonstrate our concern for the oral health of underserved children, continue our expanded "GKAS" project
- Second Quarter: To demonstrate our concern for the oral health of underserved adults, coordinate a national "Mission of Mercy" project
- Third Quarter: To demonstrate our concern for the oral health of underserved elderly, develop a national "elder care" project
- Fourth Quarter: To demonstrate our concern for the heartbreak and persistence of oral cancer, coordinate a national "oral cancer screening" project

These events will increase awareness of those oral health problems targeted...and offer opportunities for meaningful collaboration. In addition to helping patients, they will engender a renewed sense of professionalism in the students, dentists, lab technicians, and allied dental personnel who participate.

In addition, I believe that the ADA should establish a repository for collecting and collating data from the full array of dental outreach programs. This will be a powerful tool for educating policy makers about both the extent of the access problem and the philanthropic efforts of the dental profession.

In Closing

Unfortunately, the ADA is not invincible. Unless we resist cultural trends and psychosocial pressures, our reputation, credibility, and relevance are at risk.

Today's dental profession is unique among health professions and the ADA is unique among professional associations.

- The ADA has an extraordinary professional staff and infrastructure
- The commitment of our volunteer members is the envy of other professional organizations
- We are addressing our internal problems with an aggressive corrective action plan...and
- We are engaged in meaningful dialogue with others concerned with oral health

Ray Gist, your next President, is a gentle, quiet man, but resolute in his convictions. He's receptive to new ideas, but wise from vast personal experiences. He understands parochial challenges, but is global in perspective. His consensus-building skills will further advance our collaborative efforts.

Your Board is probably the hardest working and most knowledgeable in the history of the ADA. Our new, robust on-boarding protocol for new Trustees will make it even more effective.

The legendary power and wisdom of a knowledgeable and committed House of Delegates continues to be one of the ADA's greatest assets.

By sticking to our traditional values and insisting upon best practices, the ADA is well positioned to reach new heights in reputation, credibility and relevance. Based on our long history and my many years in the HOD, I'm confident that you will steer us on the right course and that our future is bright.

Thanks again for the honor of serving as your President.

Resolution No. 125 New ■ Substitute ☐ Amendment ☐

Report: N/A Date Submitted: October 2010

Submitted By: Fourth Trustee District

Reference Committee: Membership and Planning

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

AMENDMENT OF *ADA BYLAWS* REGARDING DUES OF ACTIVE LIFE MEMBERS

The following resolution was adopted by the Fourth Trustee District and transmitted on October 9, 2010 by Mr. Art Meisel, executive director, New Jersey Dental Association.

Resolution

125. Resolved, that the *ADA Bylaws*, Chapter I, Membership, Section 20, Qualifications, Privileges, Dues and Special Assessments, Subsection B (c) (1) be amended by the addition of the words, "until age 72 when dues will be the same as retired life members" after the word year on page 10, line 345 , so the amended subsection reads as follows:

c. DUES AND SPECIAL ASSESSMENTS

(1) ACTIVE LIFE MEMBERS. The dues of life members who have not fulfilled the qualifications of retired membership pursuant to Chapter 1, Section 20C of these *Bylaws* with regard to income related to dentistry shall be fifty percent (50%) of the dues of active members, due January of each year. In addition to their annual dues, active life members shall pay fifty percent (50%) of any active member special assessment, due January 1 of each year <u>until age 72 when dues will be the same as retired life members</u>.

and be it further

Resolved, that the amendment be referred to the Council on Membership for study and report to the 2011 House of Delegates.

BOARD COMMENT: Received after this section had been reproduced for House distribution.

Dental Workforce

Resolution No. 43-46 New ■ Substitute ☐ Amendment ☐

Report: CDP Supplemental Report 1 Date Submitted: July 2010

Submitted By: Council on Dental Practice

Reference Committee: Dental Workforce

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

COUNCIL ON DENTAL PRACTICE SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTIONS 27-30 (2009): WORKFORCE POLICIES

Background: The 2009 House of Delegates referred Resolutions 27-30 (*Trans*.2009:414, 425) to the Council on Dental Practice (CDP) for review and report to the 2010 House. These resolutions proposed amendments to the Comprehensive Policy Statement on Allied Dental Personnel (*Trans*.1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307); Dentist Administered Dental Assisting and Dental Hygiene Education Programs (*Trans*.1992:616); Opposition to Pilot Programs which Allow Nondentists to Diagnose Dental Needs or Perform Irreversible Procedures (*Trans*.2005:343); and Diagnosis or Performance of Irreversible Dental Procedures by Nondentists (*Trans*.2004:328).

CDP appointed a Subcommittee on Workforce Issues (SWI) during its May 2009 meeting in anticipation of performing its *Bylaws* responsibilities with respect to dental workforce issues. Following the assignments made at the 2009 meeting of the House of Delegates, additional Council members were appointed to the SWI during the Council's October 29-31, 2010, meeting in order to conduct a robust review of the resolutions. The 11 members of the SWI included Dr. Christopher Larsen, chair, Eighth District; Dr. Craig Armstrong, Fifteenth District; Dr. Charles D'Aiuto, Seventeenth District; Dr. Jerome DeSnyder, Second District; Dr. Stephen Glenn, Twelfth District; Dr. Jonathan Knapp, First District; Dr. Roger Newman, Eleventh District; Dr. Jamie Sledd, Tenth District; Dr. Judee Tippett-Whyte, Thirteenth District; Dr. Douglas Torbush, Fifth District; and Dr. Mark Zust, Sixth District.

SWI's adopted goals were to review existing policy to address dental team issues that incorporate both national and regional (state) differences and concerns relative to current practices and in preparation for the future; to review the assigned policies so as to be consistent and proactive; and to assure the maintenance of patient safety through proper education, supervision and scope of practice of team members.

Prior to discussion of the policies, the SWI reviewed many resource documents related to workforce. Many of these documents were included as appendices in a Council update report on workforce issues to the December 2009 meeting of the Board of Trustees. This report was also provided to the members of the House of Delegates (HOD), alternate delegates and ADA past presidents electronically on February 3, 2010. During the course of its deliberations, the Subcommittee reviewed many other resource documents, including the Institute of Medicine's report of "The US Oral Health Workforce in the Coming Decade," several reports from the *British Dental Journal* on dental therapists; Connecticut's proposed possible study of dental therapists; and updates on Minnesota's dental therapist legislation.

A follow-up survey of the HOD was taken to determine whether the report had been helpful, and that sought to determine what further information would be needed by the delegates in order to consider policy proposals brought to the next HOD.

Results of the first House of Delegates survey were sent to the HOD in July 2010. Also distributed were a status report on workforce initiatives in various states and an update on the therapist program in Minnesota.

Process: Ten conference calls were held during the course of the Subcommittee's deliberations, each being at least of two hours' duration. The first call was held on November 13, 2009, and the most recent was held May 10, 2010. In addition to the conference calls, one all-day meeting was held in Chicago by the Subcommittee. The SWI recommended proposed changes by consensus or by majority vote. Positions recommended could be revisited at a later time at the request of a Subcommittee member.

At times, following discussion, a clear consensus position was recommended. At other times, a straw poll of the members was held whenever a proposed change was not unanimous and the majority position was recommended. In yet other cases, sections of the policy were posted to Sitescape for ongoing discussion before a straw poll was conducted. Some new text was added to the referred policies; some of the changes proposed in the resolutions were agreed to and some were not; and some new deletions of text were recommended.

Policy Review: At the beginning of the policy review, the Subcommittee decided the Comprehensive Policy Statement on Allied Dental Personnel was the most significant policy assigned, because other policies flowed from it. SWI therefore decided that this policy would be discussed first while keeping in mind the stated goals of the Subcommittee.

Resolution 27-2009, Amendment to the "Comprehensive Policy Statement on Allied Dental Personnel" (Trans.1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307): The proposed changes to the policy as set forth in Resolution 27 were distributed and each Subcommittee member provided comments and/or suggestions of edits to the policy. These were collected by staff, and all edits or comments received were placed in a single document and distributed to all members of the Subcommittee. All comments/edits were discussed in the sequence of the original policy. Because of the complexity of the edits, staff sent a "clean copy" of the policy with all recommended edits together with the existing policy and a side by side comparison to the Subcommittee following each meeting.

Due to the robust discussion of the Comprehensive Policy Statement on Allied Dental Personnel, most of the conference calls subsequent to the planning calls were devoted to discussion of this policy. During the CDP May 13-15, 2010, meeting, some sections of the Subcommittee's proposed policy were modified by the full Council.

Because of the extensive modification of the original policy and in view of the many previous citations of policy changes, the Council recommends that a new Comprehensive Policy Statement on Allied Dental Personnel be adopted and that the existing ADA policy be rescinded (see Worksheet:7005).

Resolution 28-2009, Amendment to the Policy, "Dentist Administered Dental Assisting and Dental Hygiene Education Programs" (Trans.1992:616).

Resolution 28-2009 reads as follows.

> **28-2009. Resolved,** that the ADA policy on Dentist Administered Dental Assisting and Dental Hygiene Education Programs (*Trans*.1992:616) be amended by deletion of the first resolving clause, so that the amended policy reads as follows:
>
> > ~~**Resolved,** that dental assisting and dental hygiene educational programs should be administered or directed by a dentist, and be it further~~
> >
> > **Resolved,** that licensed or legally permitted dentists must be actively involved in the clinical supervision of dental assisting and dental hygiene educational programs.

The Council agreed that dentists should be involved in the education of dental assistants and dental hygienists, but that in some situations it might be difficult for a program to retain a dentist to oversee it. CDP also found that the existing policy would be better understood if the clauses were reversed. The policy amendment proposed by CDP (see Worksheet 7017) reflects this possibility and is consistent with language found in the proposed amendment of the Comprehensive Policy Statement on Allied Dental Personnel. Since this policy was directly concerned with education programs, the proposed amendment was circulated to the Council on Education and Licensure (CDEL) for comment. CDEL's comments were considered by the CDP during its deliberation of this resolution.

For these reasons, the CDP recommends that Resolution 28-2009 not be adopted. The Council further recommends that its proposed amendment to the policy, Dentist Administered Dental Assisting and Dental Hygiene Education Programs (Worksheet:7017) be adopted.

Resolution 29-2009, Amendment to the Policy, "Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform Irreversible Procedures" (Trans.2005:343).

Resolution 29-2009 reads as follows.

> **29-2009. Resolved,** that the ADA policy on Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform Irreversible Procedures (*Trans*.2005:343) be amended to read as follows (additions are shown by underscoring; deletions are shown by strikethroughs).
>
> ~~**Resolved,** that the American Dental Association opposes pilot programs that are in violation of the ADA policy stated in Resolution 24H-2004 (*Trans.*2004:291), no. 13 (stating that, "The ADA is opposed to non-dentists making diagnoses, or developing treatment plans or performing irreversible procedures.")~~
>
> **Resolved,** that the American Dental Association asserts that the dentist is the head of the dental team and is solely responsible for examination, evaluation, diagnosis, and development of the patient's treatment plan, and be it further
>
> **Resolved,** that the ADA encourages any new member of the dental team proposed in a pilot program be supervised by a dentist (as determined by the individual state dental practice act) and that new member be based upon determination of need, sufficient education and training, and a scope of practice that ensures the protection of the public's oral health.

Since the education, supervision and scope of practice are included in the Council's proposed revisions to the Comprehensive Policy Statement on Allied Dental Personnel, the Council recommends that Resolution 29-2009 not be adopted, and that the policy, Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform Irreversible Procedures, be rescinded (see Worksheet:7018).

Resolution 30-2009, Amendment to the Policy, "Diagnosis or Performance of Irreversible Dental Procedures by Nondentists" (Trans.2004:328).

Resolution 30-2009 reads as follows.

> **Resolved,** that the ADA policy on Diagnosis or Performance of Irreversible Dental Procedures by Nondentists (*Trans*.2004:328) be amended as follows (additions are shown by underscoring; deletions are shown by strikethroughs):
>
> **Resolved,** that the American Dental Association by ~~all appropriate~~ federal legislative and ~~judicial~~ any other appropriate means support ~~resist any~~ efforts to deliver ~~compromising the~~ quality ~~of~~ dental health care services provided by the dental team with the dentist as the head of the team, delegating duties to team members under

appropriate supervision as determined by the individual states. ~~allowing any nondentist to diagnose or perform irreversible dental procedures oral diseases except as otherwise authorized by state law with reference to physicians.~~

The definition of the term "irreversible" was not provided in existing policy. This was identified as a challenge for ADA staff when responding to questions from legislative bodies, the media or the public. In order to make the policy more understandable, the Council recommends that Resolution 30-2009 not be adopted and that the policy, Diagnosis or Performance of Irreversible Dental Procedures by Nondentists (*Trans*.2004:328), be amended (see Worksheet:7020).

Other Subcommittee Activities: At the request of the American Society of Constituent Dental Executives, the Divisions of Dental Practice/Professional Affairs and Membership, Tripartite Relations and Marketing collaborated on a plan related to workforce issues which will be implemented in the summer of 2010. A combination of conference calls, webinars and a face-to-face meeting will be held over the summer. The first webinar presented was a presentation developed by CDP staff entitled "The History of the Dental Team" on June 18. The webinar was intended to be an educational presentation only and was built upon the significant body of knowledge accumulated by the Subcommittee over the last several months. It was a retrospective perspective on the ebbs and flows of dental team iterations over the last hundred years and was meant to provide a historical context for the current discussion. The second webinar will be given in August as an educational presentation on various workforce models.

Members of the Subcommittee will attend and participate in the Conference on Workforce Issues to be held on July 18, 2010, at the ADA Headquarters Building in Chicago, immediately preceding the ADA Management Conference. In addition to the Subcommittee, three representatives from each constituent society, the Officers and members of the Board of Trustees, incoming trustees, and selected representatives of ADA councils, committees or commissions were invited to attend the conference. The purpose of the Conference is to engage volunteer leaders in a facilitated information-based dialogue related to workforce issues that will lead to a better understanding of workforce models, a better appreciation of regional differences and perspectives on workforce issues and a better understanding of the role that national foundations play regarding new dental team members.

Resolutions

See Resolution 43, Worksheet:7004
See Resolution 44, Worksheet:7017
See Resolution 45, Worksheet:7018
See Resolution 46, Worksheet:7020

Resolution No. 43 New ■ Substitute ☐ Amendment ☐

Report: CDP Supplemental Report 1 Date Submitted: July 2010

Submitted By: Council on Dental Practice

Reference Committee: Dental Workforce

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

AMENDMENT TO THE "COMPREHENSIVE POLICY STATEMENT ON ALLIED DENTAL PERSONNEL"

Background: (See Council on Dental Practice Supplemental Report 1, Worksheet:7000)

Resolution

43. Resolved, that the ADA policy, Comprehensive Policy Statement on Allied Dental Personnel be adopted, and be it further

Resolved, that the Comprehensive Policy Statement on Allied Dental Personnel (Trans.1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307) be rescinded.

Comprehensive Policy Statement on Allied Dental Personnel
General Principles

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

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

Three workforce categories are recognized by the ADA based on depth and breadth of education:

Dentists
The dentist and recognized dental specialists, by virtue of the depth and breadth of knowledge resulting from their advanced education, are the ultimate experts in all matters relating to oral health. This authority is paramount when considering delivery models or the delegation of duties to other dental team members.

Formally Trained Auxiliaries
Formally trained auxiliaries include team members such as Dental Hygienists, Certified Laboratory Technicians, Community Dental Health Coordinators and Dental Assistants with advanced training. Based on education and training, these team members provide a narrowly proscribed range of services that are duly authorized and delegated by the dentist. Because of their limited and focused training, these dental team members are not qualified to provide comprehensive diagnosis and treatment planning for dental patients.

Dental Support Staff
Dental support staff includes dental assistants (other than Dental Assistants with advanced training), laboratory workers, and administrative staff. With less specific training than that of formally trained auxiliaries, these individuals provide support services to dentists and formally trained auxiliaries.

Delegation of Functions

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

The American Dental Association has the responsibility to provide guidance to all agencies, organizations and governmental bodies, such as state dental boards and legislatures, that have an interest in, or responsibility and authority for, decisions on utilization, education, and supervision of allied dental personnel. In this context, the primary responsibility is to assure that decisions on allied dental personnel utilization are based upon only that which has been shown to be safe, effective and necessary to address a demonstrated and defined need and will not adversely affect the health and well-being of the public. In meeting these responsibilities, dentists must also identify those functions or procedures that require the knowledge and skill of the dentist and therefore must be performed only by a licensed dentist. Discharging this responsibility dictates that the dentist performs an examination/evaluation, renders a diagnosis and formulates a treatment plan.

Nothing in this statement should be interpreted to limit a dentist from delegating to a properly trained allied dental personnel responsibility for assisting the dentist in the performance of certain functions under the dentist's supervision and in accordance with state law, if, in the dentist's professional judgment, this is in the patient's best interest. Procedures that are delegated must have appropriate supervision (personal, indirect or direct~~)~~ as determined by the applicable jurisdictional authority. The transfer of permissible functions from the dentist to the allied dental personnel must not result in a reduced quality of patient care and must avoid fragmentation of the dental team. In all cases, the authority and responsibility of the dentist for the overall oral health of the patient must be maintained to assure cost-effective delivery of services to the patient.

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

Delegation of Expanded Functions

Provision for the delegation of intraoral expanded functions to allied dental personnel which are included in state dental practice acts and regulations should specify (1) education and training requirements by a nationally accredited program established by the Commission on Dental Accreditation; (2) level of supervision by the dentist; (3) assurance of quality; and (4) regulatory controls to assure protection of the public. Final decisions on delegation of expanded functions should

be made by the dentist, based on the best interests of the patient and in compliance with legal requirements in the jurisdiction. Because of the complexity of the procedures involved and the need to assure protection of the public, intraoral expanded functions as defined in state dental practice acts and regulations shall be performed by allied dental personnel only under the appropriate supervision of the dentist.

Supervision of Allied Dental Personnel

Supervision by the dentist is paramount in assuring the highest quality of care and the safety of the patient. The degree of supervision required to assure that treatment is appropriate and does not jeopardize the systemic or oral health of the patient varies with the nature of the procedure and the medical and dental history of the patient. The dentist, under appropriate jurisdictional authority, bears the responsibility for determining which aspects of each patient's treatment may be delegated, and to which qualified auxiliary the procedures may be delegated. The unauthorized and improperly supervised delivery of care by allied dental personnel is opposed by the American Dental Association.

The types of supervision are defined in the glossary of terminology at the end of this policy statement.

Personal, direct, and indirect supervision are appropriate for delegation of duties to allied dental personnel providing direct patient care. In some states, properly credentialed dental auxiliaries are permitted to perform some duties under either general supervision or public health supervision, as delegated by the supervising dentist. The following criteria should be followed whenever functions are performed under general supervision:

1. Any patient to be treated by a dental auxiliary must first become a patient of record of a dentist. A patient of record is defined as one who:
   a. has been examined by the dentist;
   b. has had a medical and dental history completed and evaluated by the dentist; and
   c. has had his/her oral condition diagnosed and a treatment plan developed by the dentist.

2. The dentist must provide to the dental auxiliary authorization to perform clinical dental services for that patient of record.

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

Appropriate Settings for Dental Auxiliary Services

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

Public oral health programs should utilize all appropriate dental team members in implementation of programs which have been endorsed by appropriate jurisdictional authority. The dental auxiliary, in this setting, may provide approved oral health services under an appropriate supervisory arrangement, as specified by relevant jurisdictional authorities. The federal dental services are urged to utilize allied dental personnel in compliance with policies of the American Dental Association.

Allied Dental Personnel Education, Credentialing & Licensure

There should be a single state board of dentistry in each state that serves as the sole licensing and regulatory authority for dentistry to include dentists and all other licensed and/or credentialed dental personnel. State dental boards are urged to require licensing and credentialing appropriate to the level of care that is provided by each dental auxiliary.

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

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

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

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

The dental hygiene education curriculum does not provide adequate preparation to enable graduates to provide comprehensive oral health care or to practice without the supervision of a dentist.

Constituent Legislative Activities

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

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

Glossary of Terminology Related to Allied Dental Personnel Utilization and Supervision

This Glossary is designed to assist in developing a common language for discussion of allied dental personnel issues by dental professionals and public policy makers. It should be noted that some of the terms included do not lend themselves to rigid definition and can only be described as to use and

meaning. Also, certain terms are defined in dental practice acts and regulations, which vary from state to state.

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

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

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

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

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

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

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

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

Dental Laboratory Technician/Certified Dental Technician: An individual who has the skill and knowledge in the fabrication of dental appliances, prostheses and devices in accordance with a

dentist's laboratory work authorization. To avoid misleading the public, no occupational title other than dental laboratory technician or certified dental technician (when appropriate) should be used to describe this allied team member.

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

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

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

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

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

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

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

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

Personal Supervision. The dentist is personally operating on a patient and authorizes the allied dental personnel to aid treatment by concurrently performing a supportive procedure.

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

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

General Supervision. A dentist is not required to be in the dental office or treatment facility when procedures are provided, but has personally diagnosed and treatment planned the condition to be

treated, has personally authorized the procedures, and will evaluate the performance of the allied dental personnel.

Public Health Supervision. A dentist who is designated by a state or local jurisdiction to oversee services provided as specified by state law or regulations, when such services are provided as part of an organized community program in various public health settings.

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

BOARD COMMENT: The Board of Trustees believes that the policy developed by the CDP was conceptually moving in the right direction. However, the majority of the Board noted that the removal of language defining surgical services as delivered only by a dentist was problematic. Additionally, the failure to remove the language in the current policy that allows state boards of dentistry to approve training programs for hygienists, as well as the inclusion of this language for other auxiliaries in the proposed policy, were of concern.

BOARD RECOMMENDATION: Vote No.

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	☐	■	☐	☐	LOW	■	☐	☐	☐	SULLIVAN
■	☐	☐	☐	ENGEL	☐	■	☐	☐	MANNING	■	☐	☐	☐	THOMPSON
☐	■	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	☐	■	☐	☐	VERSMAN
☐	■	☐	☐	FEINBERG	■	☐	☐	☐	RICH	☐	■	☐	☐	VIGNA
■	☐	☐	☐	GIST	☐	■	☐	☐	SEAGO	☐	■	☐	☐	WEBB
■	☐	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SMITH, A. J.	■	☐	☐	☐	WEBER
☐	■	☐	☐	LONG	☐	■	☐	☐	STEFFEL				Res.	43

WORKSHEET ADDENDUM
COUNCIL ON DENTAL PRACTICE
POLICY TO BE RESCINDED

Comprehensive Policy Statement on Allied Dental Personnel (1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307) (additions are shown by underscoring; deletions are shown by strikethroughs-CDP Resolution 43)

Comprehensive Policy Statement on Allied Dental Personnel
General Principles

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

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

Three workforce categories are recognized by the ADA based on depth and breadth of education: ~~The three recognized categories of allied dental personnel are dental hygienists, dental assistants and dental laboratory technicians. (See the glossary for definitions of each category.) A dental laboratory technician who is employed in the dental office is considered to allied dental personnel. A dental technician who performs a supportive function in an environment outside the dental office may be properly termed a supportive or allied member of the dental health team.~~

Dentists
The dentist and recognized dental specialists, by virtue of the depth and breadth of knowledge resulting from their advanced education, are the ultimate experts in all matters relating to oral health. This authority is paramount when considering delivery models or the delegation of duties to other dental team members.

Formally Trained Auxiliaries
Formally trained auxiliaries include team members such as Dental Hygienists, Certified Laboratory Technicians, Community Dental Health Coordinators and Dental Assistants with advanced training. Based on education and training, these team members provide a narrowly proscribed range of services that are duly authorized and delegated by the dentist. Because of their limited and focused training, these dental team members are not qualified to provide comprehensive diagnosis and treatment planning for dental patients.

Dental Support Staff
Dental support staff includes dental assistants (other than Dental Assistants with advanced training), laboratory workers, and administrative staff. With less specific training than that of formally trained auxiliaries, these individuals provide support services to dentists and formally trained auxiliaries.

Delegation of Functions

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

The American Dental Association ~~dental profession~~ has the responsibility to provide guidance to all agencies, organizations and governmental bodies, such as state dental boards and legislatures, that have an interest in, or responsibility and authority for, decisions on utilization, education, and supervision of allied dental personnel. In this context, the primary responsibility is to assure that decisions on allied dental personnel utilization are based upon only that which has been shown to be safe, effective and necessary to address a demonstrated and defined need and will not adversely affect the health and well-being of the public. ~~or cause an increased risk to the patient.~~ In meeting these responsibilities, dentists must also identify those functions or procedures that require the knowledge and skill of the dentist and therefore must be performed only by a licensed dentist. Discharging this responsibility dictates that the dentist performs an examination/evaluation, renders a diagnosis and formulates a treatment plan. ~~These functions and~~

~~procedures include, but are not limited to: examination, diagnosis and treatment planning; prescribing work authorizations; surgical or cutting procedures on hard or soft tissue; prescribing drugs and other medications; and administering local, parenteral, inhalational, or general anesthesia.~~

Nothing in this statement should be interpreted to limit a dentist from delegating to a properly trained allied dental personnel responsibility for assisting the dentist in the performance of certain ~~these~~ functions under the dentist's supervision and in accordance with state law, if, in the dentist's professional judgment, this is in the patient's best interest. Procedures that are delegated must have appropriate supervision (personal, indirect or direct) as determined by the applicable jurisdictional authority. The transfer of permissible functions from the dentist to the allied dental personnel must not result in a reduced quality of patient care and must avoid fragmentation of the dental team. In all cases, the authority and responsibility of the dentist for the overall oral health of the patient must be maintained to assure cost-effective delivery of services to the patient. ~~and avoid fragmentation of the dental team.~~

Utilization of ~~Constituent dental societies should advocate the functions which may be appropriately delegated to~~ allied dental personnel must be based on (1) the best interests of the patient; (2) the education, training and credentialing of the allied dental personnel; (3) considerations of cost-effectiveness and efficiency in delivery patterns; and (4) valid, independent, U.S. research demonstrating the feasibility, ~~and~~ practicality and appropriate quality of care utilizing ~~allied~~ dental personnel in such roles in actual practice settings.

Delegation of Expanded Functions

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

Supervision of Allied Dental Personnel

Supervision by the dentist is paramount in assuring the highest quality of care and the safety of the patient. ~~In all instances, a dentist assumes responsibility for determining, on the basis of diagnosis, the specific treatment patients will receive and which aspects of treatment may be delegated to qualified personnel.~~ The degree of supervision required to assure that treatment is appropriate and does not jeopardize the systemic or oral health of the patient varies with the nature of the procedure and the medical and dental history of the patient. The dentist, under appropriate jurisdictional authority, bears the responsibility for determining which aspects of each patient's treatment may be delegated, and to which qualified auxiliary the procedures may be delegated. The unauthorized and improperly supervised delivery of care by allied dental personnel is opposed by the American Dental Association.

The types of supervision are defined in the glossary of terminology at the end of this policy statement. ~~Supervision and coordination of treatment by a dentist are essential to comprehensive oral health care. Unsupervised practice by allied dental personnel reduces the quality of oral health care, fails to protect the dental health of the public and is opposed by the American Dental Association. The types of supervision are:~~

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

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

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

~~*General supervision.* A dentist is not required to be in the dental office or treatment facility when procedures are being performed by the allied dental personnel, but has personally diagnosed the condition to be treated, has personally authorized the procedures and will evaluate the performance of the allied dental personnel.~~

~~General supervision is not acceptable to the American Dental Association because it fails to protect the health of the public.~~ Personal, direct, and indirect supervision are appropriate for delegation of duties to allied dental personnel providing direct patient care. ~~However,~~ ~~i~~In some states, properly credentialed ~~licensed~~ dental auxiliaries ~~hygienists~~ are

permitted to perform some duties~~, except for intraoral expanded functions,~~ under either general supervision or public health supervision, as delegated by the supervising dentist. ~~In order to assure the safety of the patient, T~~the following criteria should ~~must~~ be followed whenever functions are performed under general supervision:

1. Any patient to be treated by a dental auxiliary ~~hygienist~~ must first become a patient of record of a dentist. A patient of record is defined as one who:
   d. has been examined by the dentist;
   e. has had a medical and dental history completed and evaluated by the dentist; and
   f. has had his/her oral condition diagnosed and a treatment plan developed by the dentist.
2. The dentist must provide to the dental auxiliary ~~hygienist prior written~~ authorization to perform clinical dental ~~hygiene~~ services for that patient of record. ~~Such authorization should remain in effect for a limited time period as specified by state law.~~
3. The dentist shall examine the patient following performance of clinical services by the dental auxiliary. ~~hygienist.~~ Such examination shall be performed within a reasonable time as determined by the nature of the services provided, the needs of the patient and the professional judgment of the dentist.

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

Appropriate Settings for Dental Auxiliary ~~Hygiene~~ Services

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

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

Public oral health programs should utilize all appropriate dental team members in implementation of programs which have been endorsed by ~~constituent dental societies~~ appropriate jurisdictional authority. The dental auxiliary,~~hygienist,~~ in this setting, may provide approved oral health ~~screening and preventive care~~ services under an appropriate supervisory arrangement, as specified by relevant jurisdictional authorities. The federal dental services are urged to utilize allied dental personnel in compliance with policies of ~~in state practice acts and regulations, as well as oral health education programs for groups within community served~~ the American Dental Association.

Allied Dental Personnel Education, Credentialing & Licensure

There should be a single state board of dentistry in each state that serves as the sole licensing and regulatory authority for dentistry to include dentists and all other licensed and/or credentialed dental personnel. State dental boards are urged to require licensing and credentialing appropriate to the level of care that is provided by each dental auxiliary. All personnel who participate in the provision of oral health care must have appropriate education and training and meet any additional criteria needed to assure competence. The type and length of education needed to prepare allied dental personnel to perform specific delegated patient care procedures should be specified in state dental practice acts and regulations.

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

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

Expanded functions education programs are designed to prepare dental auxiliaries to provide expanded dental services under the direction and appropriate supervision of a dentist. Programs accredited by the Commission on Dental

Accreditation (CODA) typically prepare the expanded functions auxiliary to perform legally permitted clinical services. However, other programs, CODA accredited or approved by the respective state's board of dental examiners, which utilize such methods as institutionally-based didactic course work, in-office clinical training, or electronic distance education can be an acceptable means to train expanded functions auxiliaries. Boards of dentistry are urged to review such innovative programs for acceptance. The dental hygiene education curriculum does not provide adequate preparation to enable graduates to provide comprehensive oral health care or to practice without the supervision of a dentist.

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

~~Licensure of Dental Hygienists~~

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

Constituent Legislative Activities

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

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

Glossary of Terminology Related to Allied Dental Personnel Utilization and Supervision

This Glossary is designed to assist in developing a common language for discussion of allied dental personnel issues by dental professionals and public policy makers. ~~The terms included were selected from the American Dental Association's policies on allied dental personnel education, utilization and supervision and are defined consistently with the intent of those policies.~~ It should be noted that some of the terms included do not lend themselves to rigid definition and can only be described as to use and meaning. Also, certain terms are defined in dental practice acts and regulations, which vary from state to state.

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

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

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

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

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

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

~~**Allied Dental Personnel:** Individuals who assist the dentist in the provision of oral health care services to patients, including dental assistants, dental hygienists and dental laboratory technicians who are employed in dental offices or other patient care facilities.~~

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

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

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

Evaluation/Examination, Comp~~lete~~prehensive: A dentist performs ~~thoroughly evaluates the state of health of the patient including~~ a thorough evaluation and recording of the extraoral and intraoral conditions ~~examination~~ of the hard and soft tissues. ~~of the oral cavity and contiguous structures.~~ This may require interpretation of ~~includes but is not limited to the use of diagnostic~~ information acquired through additional diagnostic procedures. It ~~interpretation of appropriate dental radiographs and may also include pulp vitality tests, transillumination, study models and laboratory tests, when indicated.~~ includes an evaluation for oral cancer where indicated, the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.

Evaluation/Examination, Limited: A dentist performs ~~thoroughly evaluates the state of health of the patient and includes~~ an evaluation ~~of the hard and soft tissues of a portion of the oral cavity. Includes but is not~~ limited to a specific oral health problem or complaint. This may require ~~the use of diagnostic information acquired through~~ interpretation of ~~selected dental radiographs; may also include diagnostic~~ information acquired through ~~interpretation of other~~ additional diagnostic procedures. ~~tests, as indicated.~~ Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.

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

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

Oral Diagnosis: The determination by a dentist of the oral health condition of an individual patient, achieved through the evaluation of data gathered by means of history taking, direct examination, patient conference, and such clinical aids and tests as may be necessary in the judgment of the dentist. ~~(*Trans.*1978:499).~~

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

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

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

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

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

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

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

Public Health Supervision. A dentist who is designated by ~~That oversight where~~ a state or local jurisdiction to oversee ~~licensed dental hygienist may provide dental hygiene~~ services provided, as specified by state law or regulations, when such services are provided as part of an organized community program in various public health settings. ~~settings, as designated by state law, and with general oversight of such programs by a licensed dentist designated by the state.~~

Treatment Plan: The sequential guide for the patient's care as determined by the dentist's diagnosis and used by the dentist for the restoration to and/or maintenance of optimal oral health. ~~(*Trans.*1978:499).~~

Resolution No. 44 New ■ Substitute ☐ Amendment ☐

Report: CDP Supplemental Report 1 Date Submitted: July 2010

Submitted By: Council on Dental Practice

Reference Committee: Dental Workforce

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

AMENDMENT TO THE POLICY, "DENTIST ADMINISTERED DENTAL ASSISTING AND DENTAL HYGIENE EDUCATION PROGRAMS"

Background: (Council on Dental Practice Supplemental Report 1, Worksheet:7000)

Resolution

44. Resolved, that the ADA policy on Dentist Administered Dental Assisting and Dental Hygiene Education Programs (*Trans*.1992:616) be amended by the deletion of the first resolving clause, and the addition of a new second resolving clause, so that the amended policy reads as follows (additions are shown by underscoring; deletions are shown by strikethroughs):

~~**Resolved,** that dental assisting and dental hygiene educational programs should be administered or directed by a dentist, and be it further~~

Resolved, that licensed or legally permitted dentists must be actively involved in the clinical supervision of dental assisting and dental hygiene educational programs, and be it further

Resolved, that dental assisting and dental hygiene educational programs should be administered or directed by a dentist whenever possible.

BOARD RECOMMENDATION: Vote Yes.

Board Vote: Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN
■	☐	☐	☐	ENGEL	☐	■	☐	☐	MANNING	■	☐	☐	☐	THOMPSON
■	☐	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	■	☐	☐	☐	VERSMAN
■	☐	☐	☐	FEINBERG	■	☐	☐	☐	RICH	■	☐	☐	☐	VIGNA
■	☐	☐	☐	GIST	☐	■	☐	☐	SEAGO	■	☐	☐	☐	WEBB
■	☐	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SMITH, A. J.	■	☐	☐	☐	WEBER
■	☐	☐	☐	LONG	■	☐	☐	☐	STEFFEL					Res. 44

Resolution No. 45 New ■ Substitute ☐ Amendment ☐

Report: CDP Supplemental Report 1 Date Submitted: July 2010

Submitted By: Council on Dental Practice

Reference Committee: Dental Workforce

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

RESCISSION OF THE POLICY, "OPPOSITION TO PILOT PROGRAMS WHICH ALLOW NONDENTISTS TO DIAGNOSE DENTAL NEEDS OR PERFORM IRREVERSIBLE PROCEDURES"

Background: (See Council on Dental Practice Supplemental Report 1, Worksheet:7000)

Resolution

45. Resolved, that Resolution 93H-2005 (*Trans*.2005:343), Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform Irreversible Procedures, be rescinded.

BOARD COMMENT: After thoughtful discussion, the Board of Trustees preferred the language in Resolution 92 (Worksheet:7062) which also rescinds this policy and affirmatively addresses pilot programs.

BOARD RECOMMENDATION: Vote No.

Board Vote: Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
☐	■	☐	☐	CALNON	☐	■	☐	☐	LOW	☐	■	☐	☐	SULLIVAN
☐	■	☐	☐	ENGEL	☐	■	☐	☐	MANNING	☐	■	☐	☐	THOMPSON
☐	■	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	☐	■	☐	☐	VERSMAN
☐	■	☐	☐	FEINBERG	■	☐	☐	☐	RICH	☐	■	☐	☐	VIGNA
■	☐	☐	☐	GIST	☐	■	☐	☐	SEAGO	☐	■	☐	☐	WEBB
■	☐	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SMITH, A. J.	☐	■	☐	☐	WEBER
☐	■	☐	☐	LONG	☐	■	☐	☐	STEFFEL					Res. 45

WORKSHEET ADDENDUM
COUNCIL ON DENTAL PRACTICE
POLICY TO BE RESCINDED

Opposition to Pilot Programs Which Allow Non-Dentists to Diagnose Dental Needs or Perform Irreversible Procedures (2005:343)

93H-2005. Resolved, that the American Dental Association opposes pilot programs that are in violation of the ADA policy stated in Resolution 24H-2004 (*Trans.*2004:291), no. 13 (stating that, "The ADA is opposed to non-dentists making diagnoses, or developing treatment plans or performing irreversible procedures.").

Resolution No. 46 New ■ Substitute ☐ Amendment ☐

Report: CDP Supplemental Report 1 Date Submitted: July 2010

Submitted By: Council on Dental Practice

Reference Committee: Dental Workforce

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

AMENDMENT TO THE POLICY, "DIAGNOSIS OR PERFORMANCE OF IRREVERSIBLE DENTAL PROCEDURES BY NONDENTISTS"

Background: (See Council on Dental Practice Supplemental Report 1, Worksheet:7000)

Resolution

46. Resolved, that the ADA policy on Diagnosis or Performance of Irreversible Dental Procedures by Nondentists (*Trans*.2004:328) be amended as follows (additions are shown by underscoring; deletions are shown by strikethroughs):

Resolved, that the American Dental Association by all appropriate federal ~~legislative~~ and judicial means ~~resist any effort compromising the quality of dental~~ strive to maintain the highest quality of oral health care ~~services~~ by maintaining that the dentist be the healthcare provider that performs evaluations/examinations, diagnoses, and treatment planning, and be it further ~~nondentist to diagnose or perform irreversible dental procedures except as otherwise authorized by state law with reference to physicians.~~

Resolved, that the dentist be the health care provider that performs surgical procedures, except as authorized by jurisdictional authority, and be it further

Resolved, that the definition of surgical procedures be defined as the cutting or removal of hard or soft tissue, and be it further

Resolved, that the word "irreversible" be replaced by the word "surgical" in all ADA Policy statements, with the exception of the World Medical Association Declaration of Helsinki, Ethical Principles for Medical Research Involving Human Subjects-2004 (*Trans.*2006:316).

BOARD COMMENT: The Board of Trustees supports this request. However, the Board concluded that modifications were needed to clarify a dentist's scope of practice with regard to surgical procedures. Therefore, the Board recommends the following substitute resolution.

46B. Resolved, that the ADA policy on Diagnosis or Performance of Irreversible Dental Procedures by Nondentists (*Trans*.2004:328) be amended as follows (additions are shown by underscoring; deletions are shown by strikethroughs):

Resolved, that the American Dental Association by all appropriate federal ~~legislative~~ and judicial means ~~resist any effort compromising the quality of dental~~ strive to maintain the highest quality of oral health care ~~services~~ by maintaining that the dentist be the healthcare provider that performs evaluations/examinations, diagnoses, and treatment planning, and be

it further ~~nondentist to diagnose or perform irreversible dental procedures except as otherwise authorized by state law with reference to physicians.~~

Resolved, that the dentist be the health care provider that performs surgical/irreversible procedures, and be it further

Resolved, that surgical procedures be defined as the cutting or removal of hard or soft tissue.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN
■	☐	☐	☐	ENGEL	☐	■	☐	☐	MANNING	■	☐	☐	☐	THOMPSON
■	☐	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	■	☐	☐	☐	VERSMAN
■	☐	☐	☐	FEINBERG	■	☐	☐	☐	RICH	■	☐	☐	☐	VIGNA
■	☐	☐	☐	GIST	■	☐	☐	☐	SEAGO	■	☐	☐	☐	WEBB
■	☐	☐	☐	KREMPASKY SMITH	■	☐	☐	☐	SMITH, A. J.	■	☐	☐	☐	WEBER
■	☐	☐	☐	LONG	■	☐	☐	☐	STEFFEL				Res.	46B

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Minority Report to CDP Supplemental Report 1 Date Submitted: July 2010

Submitted By: Drs. Craig S. Armstrong; Jeffrey M. Cole; Douglas Torbush; C. William D'Aiuto

Reference Committee: Dental Workforce

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

MINORITY REPORT TO COUNCIL ON DENTAL PRACTICE
SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES:
RESPONSE TO RESOLUTIONS 27-30 (2009): WORKFORCE POLICIES

Executive Summary: The 2009 American Dental Association (ADA) House of Delegates (HOD) assigned the Council on Dental Practice (CDP) to review Resolutions 27-30 (*Trans*.2009:415; 425; 432; 432; 433) (Appendix 1) which amend the ADA's current workforce policies. The CDP's subsequent report informs the Board of Trustees (BOT), and ultimately the HOD, about the CDP's recommendations to Resolutions 27, 28, 29, and 30 (see CDP Supplemental Report 1, Worksheets:7000-7004).

The CDP report is a valuable contribution to the continued discussion about allied dental personnel as it relates to the challenges facing dentistry in the delivery of care to historically underserved populations; however the minority disagrees considerably on many of the conclusions within it. It is traditional in such cases for those in the minority to express their disagreements in a minority report, which is customarily published at the end of the Council report.

Therefore, the undersigned, a minority of the CDP's Subcommittee on Workforce Issues (SWI), appointed to study ADA Resolutions 27-30 (2009), and a CDP member not agreeing with the CDP report, desire to express their views in this minority report.

Although the minority has serious reservations about the CDP's final recommendations regarding all the resolutions assigned to the Council—Resolutions 27, 28, 29, and 30—this minority report will focus upon Resolution 27, specifically the suggested amendments to the "Delegation of Functions" section of the ADA's "Comprehensive Policy Statement on Allied Dental Personnel" (Appendix 2).

Synopsis of Concerns: The issue is whether to retain the existing language in the "Delegation of Functions" section within the ADA's "Comprehensive Policy Statement on Allied Dental Personnel," or to amend the policy in ways that will allow allied dental personnel to perform irreversible surgical procedures.

The minority believes that the SWI failed to represent a balanced cross-section of ADA members' viewpoints and concerns about the assigned resolutions. When committees or other groups are appointed to present an objective report, the members are appointed with an attempt to balance the group as much as possible with those favorable and those opposed to the issue(s). Deliberative committees should be representative of all important elements and groups within the organization in order for its recommendations to be approved (Appendix 3).

While the SWI's membership was expanded to "allow for a robust discussion of the [workforce] issues," the minority does not feel that the addition of new members achieved the intended balance of view on the issues (Appendix 4).

Thus, the CDP's report which did not include the minority's concern that amending the ADA's policy on the "Delegation of Functions" to allow dental personnel to perform irreversible surgical procedures, may negatively affect patient safety by creating a two-tiered dental care delivery system.

History: Since 2005, the ADA BOT has reviewed numerous workforce reports from different internal sources leading to the current recommendations to revise workforce policies. The BOT received Board Report 8 in August 2009, which resulted in revisions of selected existing workforce policy, as well as a recommendation for a new policy to, "support states as they are challenged by emerging workforce issues."

During the 2009 ADA HOD, the Reference Committee on Dental Benefits, Practice, Science and Health listened to significant testimony in opposition to amending the ADA's Comprehensive Policy Statement on Allied Dental Personnel—Resolution 27—and recommended that the resolution amending policy not be adopted. The proposed amended language regarding the "Delegation of Functions" is provided below (Appendix 5).

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

The dental profession has the responsibility to provide guidance to all agencies, organizations and governmental bodies, such as state dental boards and legislatures, that have an interest in, or responsibility and authority for, decisions on utilization, education, and supervision of allied dental personnel. In this context, the primary responsibility is to assure that decisions on allied dental personnel utilization will not adversely affect the health and well-being of the public or cause an increased risk to the patient. In meeting these responsibilities, dentists must also identify those functions or procedures that require the knowledge and skill of the dentist and therefore must be performed only by a licensed dentist. These functions and procedures include, but are not limited to: examination, diagnosis and treatment planning; prescribing work authorizations; surgical or cutting procedures on hard or soft tissue; prescribing drugs and other medications; and administering local, parenteral, inhalational, or general anesthesia.

Nothing in this statement should be interpreted to limit a dentist from delegating to a properly trained allied dental personnel responsibility for assisting the dentist in the performance of these functions under the dentist's supervision and in accordance with state law, if, in the dentist's professional judgment, this is in the patient's best interest. The transfer of permissible functions from the dentist to the allied dental personnel must not result in a reduced quality of patient care. In all cases, the authority and responsibility of the dentist for the overall oral health of the patient must be maintained to assure cost-effective delivery of services to the patient and avoid fragmentation of the dental team. <u>Any surgical/irreversible procedures that are delegated should have appropriate supervision (personal, indirect, or direct) as determined by the individual state dental practice act.</u>

Constituent dental societies should advocate the functions which may be appropriately delegated to allied dental personnel based on (1) the best interests of the patient; (2) the education, training and credentialing of the allied dental personnel; (3) considerations of cost-effectiveness and efficiency in delivery patterns; and (4) valid research demonstrating the feasibility and practicality of utilizing allied dental personnel in such roles in actual practice settings.

Following floor debate wherein certain ADA members requested that the CDP review the resolution, the HOD ultimately voted to refer Resolution 27 to the CDP for additional study and comment (Appendix 6). Of particular concern to the minority, and not reflected in the Council report, is the CDP's proposal that the ADA **drastically** amend its current policy on the "Delegation of Functions" to remove the specific

reference stating that only a dentist has the knowledge and skill necessary to cut hard or soft tissue and **thus this procedure must be performed only by a licensed dentist.** The CDP's proposed new language, as compared to Resolution 27, is provided below (additions are shown by underscoring; deletions are shown by strikethroughs) (Appendix 7).

Delegation of Functions

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

The American Dental Association dental profession has the responsibility to provide guidance to all agencies, organizations and governmental bodies, such as state dental boards and legislatures, that have an interest in, or responsibility and authority for, decisions on utilization, education, and supervision of allied dental personnel. In this context, the primary responsibility is to assure that decisions on allied dental personnel utilization are based upon only that which has been shown to be safe, effective and necessary to address a demonstrated and defined need and will not adversely affect the health and well-being of the public. or cause an increased risk to the patient. In meeting these responsibilities, dentists must also identify those functions or procedures that require the knowledge and skill of the dentist and therefore must be performed only by a licensed dentist. Discharging this responsibility dictates that the dentist performs an examination/evaluation, renders a diagnosis and formulates a treatment plan. These functions and procedures include, but are not limited to: examination, diagnosis and treatment planning; prescribing work authorizations; surgical or cutting procedures on hard or soft tissue; prescribing drugs and other medications; and administering local, parenteral, inhalational, or general anesthesia.

Nothing in this statement should be interpreted to limit a dentist from delegating to a properly trained allied dental personnel responsibility for assisting the dentist in the performance of certain these functions under the dentist's supervision and in accordance with state law, if, in the dentist's professional judgment, this is in the patient's best interest. Procedures that are delegated must have appropriate supervision (personal, indirect or direct) as determined by the applicable jurisdictional authority. The transfer of permissible functions from the dentist to the allied dental personnel must not result in a reduced quality of patient care and must avoid fragmentation of the dental team. In all cases, the authority and responsibility of the dentist for the overall oral health of the patient must be maintained to assure cost-effective delivery of services to the patient, and avoid fragmentation of the dental team.

Utilization of Constituent dental societies should advocate the functions which may be appropriately delegated to allied dental personnel must be based on (1) the best interests of the patient; (2) the education, training and credentialing of the allied dental personnel; (3) considerations of cost-effectiveness and efficiency in delivery patterns; and (4) valid, independent, U.S. research demonstrating the feasibility, and practicality and appropriate quality of care utilizing allied dental personnel in such roles in actual practice settings.

Conclusion: Certain ADA leaders contend that the only way for the ADA to remain relevant in the workforce policy process is to concede to claims by other entities that lesser-trained, non-professional providers are capable of performing procedures previously limited only to the dentist, such as irreversible surgical procedures. By remaining silent on the prohibition against allied dental personnel performing these procedures, as stated in current ADA policy, the CDP report effectively condones this practice.

The public and the legislatures look to the ADA to establish the highest professional standards for the practice of dentistry. Conceding the most integral element of dental practice—surgical procedures—may create a perception that dentistry does not value patient safety.

The minority agrees that the ADA must offer policy-makers viable options to address access to care issues. However, the minority believes that all patients are entitled to a consistent and high standard of

dental care and that an effective team-based delivery model, headed by a dentist, is the key to delivering optimal oral health care services to the public. This team-based approach helps protect the public health by ensuring that everyone has access to the **same** comprehensive and competent oral health care wherein a licensed dentist is the only team member with the educational competence, knowledge and skill necessary to carry out irreversible surgical procedures.

Although the minority acknowledges that each state is contending with different workforce issues that make it impossible to have a "one-size-fits-all" workforce model, the ADA has the **duty and obligation** to preserve the doctor-patient relationship wherein the dentist determines customized care for each individual patient, and is the only member of the dental team performing irreversible surgical procedures.

In conclusion, the minority **strongly** disagrees with the decision in the CDP's report to remain silent on the delegation of irreversible procedures to non-dentists. **The ADA must maintain dentistry's standard of care and core values.** Preventing allied dental personnel from performing irreversible procedures does not constrict states from meaningfully addressing access to care issues while still preserving the dental team.

Amending the current policy unfairly handicaps constituent states wishing to guard against the creation of a non-professional provider that performs irreversible surgical procedures. Lawmakers may question why such state associations fight against the non-professional provider if the ADA policy's on the "Delegation of Functions" is amended to tacitly endorse it.

Changing ADA policy in a manner that creates a two-tiered dental care delivery system is not in the best interest of the **patients** we serve. Therefore, the minority respectfully requests that the "Delegation of Functions" section of the ADA's "Comprehensive Policy Statement on Allied Dental Personnel" remain unchanged.

Resolutions

This report is informational and no resolutions are presented.

BOARD COMMENT: The Board of Trustees recognizes the minority's right to file their report. The Board also recognizes that the House of Delegates will engage in a comprehensive discussion of these resolutions and, in its wisdom, may choose to modify them as needed. With this in mind, the Board is transmitting the report to the House without a recommendation. After all of the districts submit further related comments or resolutions for consideration by the Board at its September 12-14, 2010 session, the Board will forward its recommendations to the House for consideration.

Appendix 1

Resolution No. 27 New ■ Substitute ☐ Amendment ☐

Report: Board Report 8 Date Submitted: August 2009

Submitted By: Board of Trustees

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

AMENDMENT TO THE "COMPREHENSIVE POLICY STATEMENT ON ALLIED DENTAL PERSONNEL"

Background: (See Board Report 8, Workforce Policies, Worksheet:3014)

Resolution

27. Resolved, that the ADA policy on the Comprehensive Policy Statement on Allied Dental Personnel (*Trans*.1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307) be amended to read as follows (additions are shown by underscoring; deletions are shown by strikethroughs):

Comprehensive Policy Statement on Allied Dental Personnel

General Principles

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

The dentist is ultimately responsible, ethically and legally, for patient care. In carrying out that responsibility and to increase the capacity of the profession to provide patient care in the most cost-effective manner, the dentist may delegate to allied dental personnel certain patient care functions for which the allied dental personnel has been trained.

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

Delegation of Functions

The primary purpose of dentists delegating functions to allied dental personnel is to increase the capacity of the profession to provide patient care while retaining full responsibility for the quality of

care. This responsibility includes identification of the need for specific types of allied dental personnel and establishment of appropriate controls on the patient care services provided by allied dental personnel.

The dental profession has the responsibility to provide guidance to all agencies, organizations and governmental bodies, such as state dental boards and legislatures, that have an interest in, or responsibility and authority for, decisions on utilization, education, and supervision of allied dental personnel. In this context, the primary responsibility is to assure that decisions on allied dental personnel utilization will not adversely affect the health and well-being of the public or cause an increased risk to the patient. In meeting these responsibilities, dentists must also identify those functions or procedures that require the knowledge and skill of the dentist and therefore must be performed only by a licensed dentist. ~~These functions and procedures include, but are not limited to: examination, diagnosis and treatment planning; prescribing work authorizations; surgical or cutting procedures on hard or soft tissue; prescribing drugs and other medications; and administering local, parenteral, inhalational, or general anesthesia.~~

Nothing in this statement should be interpreted to limit a dentist from delegating to a properly trained allied dental personnel responsibility for assisting the dentist in the performance of these functions under the dentist's supervision and in accordance with state law, if, in the dentist's professional judgment, this is in the patient's best interest. The transfer of permissible functions from the dentist to the allied dental personnel must not result in a reduced quality of patient care. In all cases, the authority and responsibility of the dentist for the overall oral health of the patient must be maintained to assure cost-effective delivery of services to the patient and avoid fragmentation of the dental team. Any surgical/irreversible procedures that are delegated should have appropriate supervision (personal, indirect, or direct) as determined by the individual state dental practice act.

Constituent dental societies should advocate the functions which may be appropriately delegated to allied dental personnel based on (1) the best interests of the patient; (2) the education, training and credentialing of the allied dental personnel; (3) considerations of cost-effectiveness and efficiency in delivery patterns; and (4) valid research demonstrating the feasibility and practicality of utilizing allied dental personnel in such roles in actual practice settings.

Delegation of Expanded Functions

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

Supervision of Allied Dental Personnel

In all instances, a dentist assumes responsibility for determining, on the basis of diagnosis, the specific treatment patients will receive and which aspects of treatment may be delegated to qualified personnel. As the dentist is best educated and trained to provide the care and has the responsibility for patient care, supervision by the dentist is paramount in assuring the highest quality of care and the safety of the patient. The degree of supervision required to assure that treatment is appropriate and does not jeopardize the systemic or oral health of the patient varies

with the nature of the procedure and the medical and dental history of the patient, as determined with evaluation and examination by the dentist.
~~Supervision and coordination of treatment by a dentist are essential to comprehensive oral health care. Unsupervised practice by allied dental personnel reduces the quality of oral health care, fails to protect the dental health of the public and is opposed by the American Dental Association.~~
The types of supervision are:

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

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

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

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

~~General supervision is not acceptable to the American Dental Association because it fails to protect the health of the public. Personal, direct, and indirect supervision are appropriate for delegation of duties to allied dental personnel providing direct patient care. However, in some state licensed dental hygienists are permitted to perform duties, except for intraoral expanded functions, under general supervision, as delegated by the supervising dentist. In order to assure the safety of the patient, the following criteria must be followed whenever functions are performed under general supervision:~~

~~1. Any patient to be treated by a dental hygienist must first become a patient of record of a dentist. A patient of record is defined as one who:~~
~~a. has been examined by the dentist;~~
~~b. has had a medical and dental history completed and evaluated by the dentist; and~~
~~c. has had his/her oral condition diagnosed and a treatment plan developed by the dentist.~~

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

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

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

Appropriate Settings for Dental Hygiene Services

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

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

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

Allied Dental Personnel Education

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

~~Dental assisting and dental hygiene educational programs should be administered or directed by a dentist.~~ Further, licensed or legally permitted dentists must be involved in the clinical supervision of dental assisting and dental hygiene education programs, in accordance with state law.

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

The dental hygiene education curriculum does not provide adequate preparation to enable graduates to provide comprehensive oral health care or to practice without the supervision of a dentist.

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

Licensure of Dental Hygienists

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

during which patient care is provided, must be conducted under the supervision of a licensed dentist.

Constituent Legislative Activities

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

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

Glossary of Terminology Related to Allied Dental Personnel Utilization and Supervision

This Glossary is designed to assist in developing a common language for discussion of allied dental personnel issues by dental professionals and public policy makers. The terms included were selected from the American Dental Association's policies on allied dental personnel education, utilization and supervision and are defined consistently with the intent of those policies. It should be noted that some of the terms included do not lend themselves to rigid definition and can only be described as to use and meaning. Also, certain terms are defined in dental practice acts and regulations, which vary from state to state.

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

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

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

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

Allied Dental Personnel: Individuals who assist the dentist in the provision of oral health care services to patients, including, but not limited to, dental assistants, dental hygienists and dental laboratory technicians who are employed in dental offices or other patient care facilities.

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

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

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

Examination, Complete: A dentist thoroughly evaluates the state of health of the patient including a thorough examination of the hard and soft tissues of the oral cavity and contiguous structures. This includes but is not limited to the use of diagnostic information acquired through interpretation of appropriate dental radiographs and may also include pulp vitality tests, transillumination, study models and laboratory tests, when indicated.

Examination, Limited: A dentist thoroughly evaluates the state of health of the patient and includes an evaluation of the hard and soft tissues of a portion of the oral cavity. Includes but is not limited to the use of diagnostic information acquired through interpretation of selected dental radiographs; may also include diagnostic information acquired through interpretation of other diagnostic tests, as indicated.

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

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

Oral Diagnosis: The determination by a dentist of the oral health condition of an individual patient, achieved through the evaluation of data gathered by means of history taking, direct examination, patient conference, and such clinical aids and tests as may be necessary in the judgment of the dentist (*Trans.*1978:499).

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

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

Supervision: The authorization, direction, oversight and evaluation by a dentist of the activities performed by allied dental personnel.
Personal supervision. A type of supervision in which the dentist is personally operating on a patient and authorizes the allied dental personnel to aid treatment by concurrently performing a supportive procedure.

Direct supervision. A type of supervision in which a dentist is in the dental office or treatment facility, personally diagnoses the condition to be treated, personally authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by

the allied dental personnel, and, before dismissal of the patient, evaluates the performance of the allied dental personnel.

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

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

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

Treatment Plan: The sequential guide for the patient's care as determined by the dentist's diagnosis and used by the dentist for the restoration to and/or maintenance of optimal oral health (*Trans*.1978:499).

BOARD RECOMMENDATION: Vote Yes.

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LONG	■	☐	☐	☐	SYKES
☐	■	☐	☐	ELLIOTT	■	☐	☐	☐	MANNING	■	☐	☐	☐	TANKERSLEY
■	☐	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	■	☐	☐	☐	THOMPSON
■	☐	☐	☐	GIST	■	☐	☐	☐	RICH	■	☐	☐	☐	VERSMAN
■	☐	☐	☐	GLECOS	■	☐	☐	☐	SCHWEINEBRATEN	■	☐	☐	☐	VIGNA
■	☐	☐	☐	KREMPASKY SMITH	■	☐	☐	☐	STEFFEL	■	☐	☐	☐	WEBB
■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN					Res. 27

Resolution No. 28 New ■ Substitute ☐ Amendment ☐

Report: Board Report 8 Date Submitted: August 2009

Submitted By: Board of Trustees

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

AMENDMENT TO THE POLICY, "DENTIST ADMINISTERED DENTAL ASSISTING AND DENTAL HYGIENE EDUCATION PROGRAMS"

Background: (See Board Report 8, Workforce Policies, Worksheet:3014)

Resolution

28. Resolved, that the ADA policy on Dentist Administered Dental Assisting and Dental Hygiene Education Programs (*Trans.*1992:616) be amended by deletion of the first resolving clause, so that the amended policy reads as follows:

~~**Resolved,** that dental assisting and dental hygiene educational programs should be administered or directed by a dentist, and be it further~~

Resolved, that licensed or legally permitted dentists must be actively involved in the clinical supervision of dental assisting and dental hygiene educational programs.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 29 New ■ Substitute ☐ Amendment ☐

Report: Board Report 8 Date Submitted: August 2009

Submitted By: Board of Trustees

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

AMENDMENT TO THE POLICY, "OPPOSITION TO PILOT PROGRAMS WHICH ALLOW NONDENTISTS TO DIAGNOSE DENTAL NEEDS OR PERFORM IRREVERSIBLE PROCEDURES"

Background: (See Board Report 8, Workforce Policies, Worksheet:3014)

Resolution

29. Resolved, that the ADA policy on Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform Irreversible Procedures (*Trans.*2005:343) be amended to read as follows (additions are shown by underscoring; deletions are shown by strikethroughs).

~~Resolved, that the American Dental Association opposes pilot programs that are in violation of the ADA policy stated in Resolution 24H-2004 (*Trans.*2004:291), no. 13 (stating that, "The ADA is opposed to non-dentists making diagnoses, or developing treatment plans or performing irreversible procedures.")~~

Resolved, that the American Dental Association asserts that the dentist is the head of the dental team and is solely responsible for examination, evaluation, diagnosis, and development of the patient's treatment plan, and be it further

Resolved, that the ADA encourages any new member of the dental team proposed in a pilot program be supervised by a dentist (as determined by the individual state dental practice act) and that new member be based upon determination of need, sufficient education and training, and a scope of practice that ensures the protection of the public's oral health.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 30 New ■ Substitute ☐ Amendment ☐

Report: Board Report 8 Date Submitted: August 2009

Submitted By: Board of Trustees

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

AMENDMENT TO THE POLICY, "DIAGNOSIS OR PERFORMANCE OF IRREVERSIBLE DENTAL PROCEDURES BY NONDENTISTS"

Background: (See Board Report 8, Worksheet:3014)

Resolution

30. Resolved, that the ADA policy on Diagnosis or Performance of Irreversible Dental Procedures by Nondentists (*Trans*.2004:328) be amended as follows (additions are shown by underscoring; deletions are shown by strikethroughs):

Resolved, that the American Dental Association by ~~all appropriate~~ federal legislative and ~~judicial~~ any other appropriate means support ~~resist any~~ efforts to deliver ~~compromising the~~ quality ~~of~~ dental health care services provided by the dental team with the dentist as the head of the team, delegating duties to team members under appropriate supervision as determined by the individual states. ~~allowing any nondentist to diagnose or perform irreversible dental procedures oral diseases except as otherwise authorized by state law with reference to physicians.~~

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Appendix 2

Comprehensive Policy Statement on Allied Dental Personnel (1996:699; 1997:691; 1998:713; 2001:467;2002:400; 2006:307)

General Principles

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

The dentist is ultimately responsible, ethically and legally, for patient care. In carrying out that responsibility and to increase the capacity of the profession to provide patient care in the most cost-effective manner, the dentist may delegate to allied dental personnel certain patient care functions for which the allied dental personnel has been trained.

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

Delegation of Functions

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

The dental profession has the responsibility to provide guidance to all agencies, organizations and governmental bodies, such as state dental boards and legislatures, that have an interest in, or responsibility and authority for, decisions on utilization, education, and supervision of allied dental personnel. In this context, the primary responsibility is to assure that decisions on allied dental personnel utilization will not adversely affect the health and well-being of the public or cause an increased risk to the patient. In meeting these responsibilities, dentists must also identify those functions or procedures that require the knowledge and skill of the dentist and therefore must be performed only by a licensed dentist. These functions and procedures include, but are not limited to: examination, diagnosis and treatment planning; prescribing work authorizations; surgical or cutting procedures on hard or soft tissue; prescribing drugs and other medications; and administering local, parenteral, inhalational, or general anesthesia.

Nothing in this statement should be interpreted to limit a dentist from delegating to a properly trained allied dental personnel responsibility for assisting the dentist in the performance of these functions under the dentist's supervision and in accordance with state law, if, in the dentist's professional judgment, this is in the patient's best interest. The transfer of permissible functions from the dentist to the allied dental personnel must not result in a reduced quality of patient care. In all cases, the authority and responsibility of the dentist for the overall oral health of the patient must be maintained to assure cost-effective delivery of services to the patient and avoid fragmentation of the dental team.

Constituent dental societies should advocate the functions which may be appropriately delegated to allied dental personnel based on (1) the best interests of the patient; (2) the education, training and credentialing of the allied dental personnel; (3) considerations of cost-effectiveness and efficiency in delivery patterns; and (4) valid research demonstrating the feasibility and practicality of utilizing allied dental personnel in such roles in actual practice settings.

Appendix 3

Sturgis, Alice (2001), *The Standard Code of Parliamentary Procedure*, 4th ed., p. 177 (TSC).

Committees for Deliberation

Committees may be classified according to the nature of their assignments into committees primarily for deliberation and committees primarily for action. It is vital that a committee appointed for deliberation and investigation or one which performs discretionary duties be representative of all important elements and groups within the organization. The report of a representative committee will reflect the opinions of the whole organization and has a good chance of being approved. A nominating committee and a committee to determine the location for a new clubhouse are examples of committees that should be representative.

Appendix 4

REPORT OF THE COUNCIL ON DENTAL PRACTICE:
UPDATE ON WORKFORCE ISSUES

Supports ADA Strategic Plan (2007-2010) Goal: Achieve Effective Advocacy
Objective 1: Preserve the dentist as the leader of a team which provides comprehensive oral health care services in any health care system.

Executive Summary: Resolutions to change workforce policy were referred to the Council on Dental Practice by the 2009 House of Delegates. This report conveys the activities of the Council and background materials that will be used in their consideration of the House assignment. This report is informational and no action is requested of the Board of Trustees.

Overview: The Council on Dental Practice (CDP) received an assignment from the 2009 House of Delegates (HOD) to review Resolutions 27-30 which are concerned with workforce policy. At its October 2009 meeting, CDP's Subcommittee on Workforce Issues (SWI) was expanded to allow for robust discussion of issues. Members of the SWI are Drs. Christopher Larsen, chair; Bill D'Aiuto; Craig Armstrong; Jake DeSnyder, CDP *ad-interim* chair; Stephen Glenn, CDP vice-chair; Jonathon Knapp; Roger Newman; Jamie Sledd; Judee Tippett-Whyte; Douglas Torbush and Mark Zust.

SWI has met via conference call on November 11 and December 2, 2009. Resources have been posted on Sitescape to provide the SWI with a thorough background of the issues.

Four goals have been identified by the Subcommittee:

- to review existing policy to address dental team issues that incorporate both national and regional (state) differences and concerns relative to current practices and in preparation for the future
- to review existing policy to assure that patient safety is maintained through proper supervision, education and scope of practice of dental team members
- to review existing ADA policy to be consistent and proactive
- to report through the Board of Trustees to the 2010 HOD

SWI plans to continue to meet via conference call at regular intervals. The Council has submitted a request for funding to this Board meeting for a face to face meeting in February 2010.

Recent Events: The Task Force on the Dental Team made its final report to the June 2009 Board meeting. Several reports from Board working groups have been received since 2005, leading to the current recommendations to revise workforce policies (Appendix 1).

Recommendations on changes to current ADA workforce policy (Appendix 2) were made by the Workforce Policy Workgroup, appointed by the Board at its June 2009 meeting. Board Report 8 to the 2009 House of Delegates on Workforce Policies was presented to the House, as well as a recommendation for a new policy to support states as they are challenged by emerging workforce issues (Appendix 3).

The 2009 House of Delegates adopted Resolution 31H as editorially corrected and referred Resolutions 27-30 to the Council on Dental Practice for further review.

Background: The decision by the Alaska Native Tribal Health Consortium (ANTHC) to allow Dental Health Aide Therapists (DHATs) to deliver dental services to native Alaskans in remote areas touched off a series of events that culminated with the settlement of a lawsuit between the ADA and ANTHC (Appendix 4). Included in the settlement agreement with the ANTHC was an agreement that the ADA and ANTHC "will use their best efforts to preserve the language concerning the scope of dental health aide therapist practice and the [federal statutory] language limiting such practice to Alaska."

Adequate access to dental care continues to be a concern of local oral health coalitions, health foundations and policy-makers, in many states, and while state budgets continue to be challenged to provide financial resources to meet the dental needs of their citizens, some advocates have sought to increase access to care by proposing some form of mid-level dental provider similar to the Alaska DHAT to meet the local public oral health needs.

There have been several different proposals for new team member models to address the access to care issues. Some of these models are aimed at increasing preventive services, but most of them have been developed to allow the delivery of preventive, therapeutic and restorative services, including irreversible procedures, by an individual receiving less than the traditional education and training of a U.S. dentist. The amount of education for these new team members, the settings for delivery of services, and regulatory requirements vary widely (Appendix 5).

The majority of these models are based on one created in New Zealand in 1921, originally called the dental school nurse. Now known as dental therapists, these workforce members have been utilized worldwide. A study by Dr. David A. Nash that was published in 2008 and which is widely quoted, reported that 53 countries permit the use of dental therapists. Thirteen of these countries have fewer than ten therapists (Appendix 6). Information from the European Union Manual of Dental Practice contradicts the inclusion of two countries reported in the Nash review (Ireland and the Netherlands) and reports that two others stopped training therapists in the 1950s and 1960s (Estonia and Latvia) (Appendix 7).

There is a considerable amount of literature concerning the Dental Health Aide Therapist (Appendix 8). The articles can be categorized as:

- articles that describe a DHAT program and its feasibility to provide care (the most common)
- articles that report on studies that indicate that DHATs perform dental treatment at a level of quality that equals, or, exceeds that provided by dental students and/or dentists (the next most common)
- articles that describe limitations of these programs (rare).

State Activities: Alaska was the first state chosen by the federal government to utilize DHATs for the native Indian population. Minnesota is the first state to legislatively add a mid-level provider. Detailed information on the program instituted in Minnesota is provided in Appendix 9.

In November 2009, the Connecticut State Dental Association (CSDA) passed a resolution at its House of Delegates meeting that supports testing a pilot project of a two-year DHAT model, with the general supervision of a dentist. This is a development which CSDA may or may not ultimately pursue. Internal discussions are ongoing and may be affected by local political considerations. Workforce model information and resources that were provided to the CSDA's membership and various other information related to this resolution can be found in Appendix 10.

Other states will be facing challenges to existing workforce models. A recent ADA Department of State Government Affairs' report lists currently known activities regarding expansion of the dental work force (Appendix 11).

Dental Organizations: Other dental organizations have issued policy positions concerning mid level providers. The Academy of General Dentistry (AGD) published a white paper on "Increasing Access to and Utilization of Oral Health Care Services." With respect to ADHP mid-level providers, AGD found that this new provider would be economically unfeasible and would work against prevention (Appendix 12).

The American Academy of Pediatric Dentistry (AAPD) has issued their "Analysis and Policy Recommendations Concerning Mid-level Dental Providers." Several policy recommendations include further study of the Dental Therapist and CDHC (Community Dental Health Coordinator) models, and that the AAPD would support the use of mid-level dental providers under some circumstances, following a thorough evaluation of safety, efficiency and effectiveness (Appendix 13).

The American Association of Public Health Dentistry has published a policy position on "Access to Dental Care" that supports expanded use of new dental providers, specifically the Alaska Dental Health Aide Therapist. Their "Principles of Health Reform" call for regulation and licensure of oral health care personnel that would allow the most cost-effective use of the oral health workforce (Appendix 14).

The American Association of Oral and Maxillofacial Surgeons, the American Academy of Periodontology, American Academy of Oral and Maxillofacial Pathology, and American Association of Orthodontists do not have any policy positions on mid-level providers.

The status of policy position statements by the American Association of Endodontists, American College of Prosthodontists, and American Academy of Oral and Maxillofacial Radiology are pending.

Recent Events

Exclusion of ADA from Workforce Discussions: Since the meeting of the 2009 House of Delegates, several new issues have arisen. It has become apparent that several foundations who are seeking to increase access to dental care through the creation of new mid-level providers have said that the ADA will not be asked to join any discussions on workforce. Existing ADA policy prevents the ADA from studying various workforce models. A summary of the major foundations that fund dental projects and their activities related to oral health issues can be found in Appendix 15.

Dr. Tankersley, Dr. O'Loughlin, some members of the Board and ADA staff have had direct contact with representatives of foundations, governmental groups and the public health community. In general there is strong support for development of a DHAT to solve access issues. It has been reported by individuals within certain government agencies, that the Health Resources and Services Administration, the Institute of Medicine, and the National Academy of Science view the ADA as protectionist of its members and not concerned with the public's health.

Health Reform: The Senate's version of a health reform bill has re-opened the issue of DHATs working in the lower 48 states. An amendment to the Senate health reform bill would allow DHATs to work in any tribal area. ADA's agreement with ANTHC called for the ANTHC to support a "longitudinal study of the delivery of health care in remote areas of Alaska that reviews the use of dental health aides, dental health aide therapists, public health dentists, private sector dentists, community dental health coordinators and any other model that provides direct care to patients."

In cooperation with the ANTHC, ADA has approached Senator Dorgan (Democrat, North Dakota) to remove this portion of his amendment and limit DHATs to Alaska. This effort seems to have become a seminal event for those wishing to expand the use of DHATs in the dental workforce. The public health community circulated an e-mail call to action to block removal of this amendment from the Senate bill (Appendix 16). Fifteen grants of $4 million each are included in the bill for "alternative dental health care providers demonstration projects," which will be evaluated to "increase access to dental health care services in rural and other underserved communities." In a July 15, 2009 letter to Senators Kennedy (Democrat, Massachusetts) and Enzi (Republican, Wyoming) regarding the draft legislation on health care reform specific to this section, the ADA expressed its position that "The ADA believes this section should be deleted. Deleting this section would reduce the cost of the bill by $60 million or more over five years. Individual states are already assessing and addressing their unique dental access situations and producing a wide variance of solutions. States have worked to develop these new models by finding their own funding sources."

Existing ADA Policy: The existing policies that appear to have limited the ADA's scope of response to quickly moving events are:

Existing Policy	**Policy Changes Referred to CDP** (additions are shown by underscoring; deletions are shown by strikethroughs)
Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform Irreversible Procedures (2005:343)	
Resolved, that the American Dental Association opposes pilot programs that are in violation of the ADA policy stated in Resolution 24H-2004 (*Trans.*2004:291), no. 13 (stating that, "The ADA is opposed to non-dentists making diagnoses, developing treatment plans or performing irreversible procedures.")	~~**Resolved,** that the American Dental Association opposes pilot programs that are in violation of the ADA policy stated in Resolution 24H-2004 (*Trans.*2004:291), no. 13 (stating that, "The ADA is opposed to non-dentists making diagnoses, or developing treatment plans or performing irreversible procedures.")~~ **Resolved,** that the American Dental Association asserts that the dentist is the head of the dental team and is solely responsible for examination, evaluation, diagnosis, and development of the patient's treatment plan, and be it further **Resolved,** that the ADA encourages any new member of the dental team proposed in a pilot program be supervised by a dentist (as determined by the individual state dental practice act) and that new member be based upon determination of need, sufficient education and training, and a scope of practice that ensures the protection of the public's oral health.
Diagnosis or Performance of Irreversible Dental Procedures by Nondentists (2004:328)	
Resolved, that the American Dental Association by all appropriate federal legislative and judicial means resist any effort compromising the quality of dental health care services by allowing any nondentist to diagnose or perform irreversible dental procedures except as otherwise authorized by state law with reference to physicians.	**Resolved,** that the American Dental Association by ~~all appropriate~~ federal legislative and ~~judicial~~ any other appropriate means support ~~resist any~~ efforts to deliver ~~compromising the~~ quality ~~of~~ dental health care services provided by the dental team with the dentist as the head of the team, delegating duties to team members under appropriate supervision as determined by the individual states. ~~allowing any nondentist to diagnose or perform irreversible dental procedures oral diseases except as otherwise authorized by state law with reference to physicians.~~

Summary: The House of Delegates is the governing body of the ADA that adopts policy positions. The 2009 House chose to refer the workforce policy changes recommended by the Board of Trustees to the CDP for further review. This information is background material that will be used in consideration of policy review by CDP's SWI.

Appendix 5

American Dental Association House of Delegates Minutes: 2009, p. 426

Amendment to the "Comprehensive Policy Statement on Allied Dental Personnel" (Board of Trustees Resolution 27): The Reference Committee reported as follows.
The Reference Committee heard significant testimony in opposition to Resolution 27 and agrees with the testimony. Therefore, the Committee recommends that Resolution 27 not be adopted. This resolution supports the ADA Strategic Plan Goal: Achieve Effective Advocacy.

27. Resolved, that the ADA policy on the Comprehensive Policy Statement on Allied Dental Personnel (*Trans*.1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307) be amended to read as follows (additions are shown by underscoring; deletions are shown by strikethroughs):

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

The dentist is ultimately responsible, ethically and legally, for patient care. In carrying out that responsibility and to increase the capacity of the profession to provide patient care in the most cost-effective manner, the dentist may delegate to allied dental personnel certain patient care functions for which the allied dental personnel has been trained.

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

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

The dental profession has the responsibility to provide guidance to all agencies, organizations and governmental bodies, such as state dental boards and legislatures, that have an interest in, or responsibility and authority for, decisions on utilization, education, and supervision of allied dental personnel. In this context, the primary responsibility is to assure that decisions on allied dental personnel utilization will not adversely affect the health and well-being of the public or cause an increased risk to the patient. In meeting these responsibilities, dentists must also identify those functions or procedures that require the knowledge and skill of the dentist and therefore must be performed only by a licensed dentist~~. These functions and procedures include, but are not limited to: examination, diagnosis and treatment planning; prescribing work authorizations; surgical or cutting procedures on hard or soft tissue; prescribing drugs and other medications; and administering local, parenteral, inhalational, or general anesthesia.~~

Prepared by: Dr. Pamela Porembski, senior manager, Council on Dental Practice
Council Chair: Dr. Jerome DeSnyder
Division Director: Dr. Wayne P. Wendling, managing vice president, Health Policy Resources Center

Nothing in this statement should be interpreted to limit a dentist from delegating to a properly trained allied dental personnel responsibility for assisting the dentist in the performance of these functions under the dentist's supervision and in accordance with state law, if, in the dentist's professional judgment, this is in the patient's best interest. The transfer of permissible functions from the dentist to the allied dental personnel must not result in a reduced quality of patient care. In all cases, the authority and responsibility of the dentist for the overall oral health of the patient must be maintained to assure cost-effective delivery of services to the patient and avoid fragmentation of the dental team. Any surgical/irreversible procedures that are delegated should have appropriate supervision (personal, indirect, or direct) as determined by the individual state dental practice act.

Constituent dental societies should advocate the functions which may be appropriately delegated to allied dental personnel based on (1) the best interests of the patient; (2) the education, training and credentialing of the allied dental personnel; (3) considerations of cost-effectiveness and efficiency in delivery patterns; and (4) valid research demonstrating the feasibility and practicality of utilizing allied dental personnel in such roles in actual practice settings.

Appendix 6

America Dental Association House of Delegates Minutes: 2009, p. 431.

Dr. Carney moved Resolution 27 (*Supplement*:3016).

Dr. Frank J. Graham, New Jersey, moved to refer Resolution 27, saying "These resolutions … have not been reviewed by the Council, and I think they should have the Council's review first before we consider these. These came from the Board and from the Work Groups. So I'd prefer to go through the Council."

A delegate from the floor spoke in opposition to referral saying, "I rise to support not adopting this resolution. This was the recommendation of the Reference Committee, of which I was a member."

Dr. William T. Spruill, Pennsylvania, spoke in favor of referral saying, "At last year's House in San Antonio, we debated for more than an hour about funding our pilot programs. And the final vote was about 82% in favor, as I recall. Much of the testimony at the Reference Committee, which went on for more than an hour, was eerily similar to last year's House. … I speak in favor of referral because this resolution came from Board Report 8, and it did not go through the Council yet, and I would love to see them work on the language to see if we can achieve an 82% acceptance rate in this House."

Dr. James L. Ribary, Washington, spoke in support of referral saying, "[Resolution] 27 refers to the comprehensive policy statement. This statement, as it is, is very limiting. All who oppose this can keep your heads buried, but we in the Eleventh need the terminology and definitions and changes to protect us. ..."

Dr. Jamie L. Sledd, Minnesota, spoke in support of referral saying, "… It is critical that they have the opportunity to study this. It's important to all of us that language on supervision is appropriate and understood and that the dentist is the head of the dental team, the dentist always does the diagnosis and the treatment planning."

Dr. Robert L. Morrow, Colorado, spoke in opposition to referral saying, "I want to see this voted down completely. All of these amendments here together, we covered in, I think it was 34RC, but all of these amendments here, and particularly 27, seems to be giving the farm away and trying to make it appear that we haven't."

Dr. Jonathan B. Knapp, Connecticut, moved to vote immediately. The motion to vote immediately was adopted by a two-thirds (2/3) affirmative vote.

On vote, the motion to refer Resolution 27 to the Council on Dental Practice was adopted.

Appendix 7

American Dental Association Council on Dental Practice 2010 Supplemental Report 1 to the House of Delegates, Resolution 00.

Strike through version of the Council's recommended policy substitution for the policy, Comprehensive Policy Statement on Allied Dental Personnel: additions are shown by underscoring; deletions are shown by strikethroughs.

Comprehensive Policy Statement on Allied Dental Personnel ~~(1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307)~~

General Principles

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

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

Three workforce categories are recognized by the ADA based on depth and breadth of education: ~~The three recognized categories of allied dental personnel are dental hygienists, dental assistants and dental laboratory technicians. (See the glossary for definitions of each category.) A dental laboratory technician who is employed in the dental office is considered to allied dental personnel. A dental technician who performs a supportive function in an environment outside the dental office may be properly termed a supportive or allied member of the dental health team.~~

Dentists
The dentist and recognized dental specialists, by virtue of the depth and breadth of knowledge resulting from their advanced education, are the ultimate experts in all matters relating to oral health. This authority is paramount when considering delivery models or the delegation of duties to other dental team members.

Formally Trained Auxiliaries
Formally trained auxiliaries include team members such as Dental Hygienists, Certified Laboratory Technicians, Community Dental Health Coordinators and Dental Assistants with advanced training. Based on education and training, these team members provide a narrowly proscribed range of services that are duly authorized and delegated by the dentist. Because of their limited and focused training, these dental team members are not qualified to provide comprehensive diagnosis and treatment planning for dental patients.

Dental Support Staff
Dental support staff includes dental assistants (other than Dental Assistants with advanced training), laboratory workers, and administrative staff. With less specific training than that of formally trained auxiliaries, these individuals provide support services to dentists and formally trained auxiliaries.

Delegation of Functions

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

The American Dental Association ~~dental profession~~ has the responsibility to provide guidance to all agencies, organizations and governmental bodies, such as state dental boards and legislatures, that have an interest in, or responsibility and authority for, decisions on utilization, education, and supervision of allied dental personnel. In this context, the primary responsibility is to assure that decisions on allied dental personnel utilization are based upon only that which has been shown to be safe, effective and necessary to address a demonstrated and defined need and will not adversely affect the health and well-being of the public. ~~or cause an increased risk to the patient.~~ In meeting these responsibilities, dentists must also identify those functions or procedures that require the knowledge and skill of the dentist and therefore must be performed only by a licensed dentist. Discharging this responsibility dictates that the dentist performs an examination/evaluation, renders a diagnosis and formulates a treatment plan. ~~These functions and procedures include, but are not limited to: examination, diagnosis and treatment planning; prescribing work authorizations; surgical or cutting procedures on hard or soft tissue; prescribing drugs and other medications; and administering local, parenteral, inhalational, or general anesthesia.~~

Nothing in this statement should be interpreted to limit a dentist from delegating to a properly trained allied dental personnel responsibility for assisting the dentist in the performance of certain ~~these~~ functions under the dentist's supervision and in accordance with state law, if, in the dentist's professional judgment, this is in the patient's best interest. Procedures that are delegated must have appropriate supervision (personal, indirect or direct) as determined by the applicable jurisdictional authority. The transfer of permissible functions from the dentist to the allied dental personnel must not result in a reduced quality of patient care and must avoid fragmentation of the dental team. In all cases, the authority and responsibility of the dentist for the overall oral health of the patient must be maintained to assure cost-effective delivery of services to the patient. ~~and avoid fragmentation of the dental team.~~

Utilization of ~~Constituent dental societies should advocate the functions which may be appropriately delegated to~~ allied dental personnel must be based on (1) the best interests of the patient; (2) the education, training and credentialing of the allied dental personnel; (3) considerations of cost-effectiveness and efficiency in delivery patterns; and (4) valid, independent, U.S. research demonstrating the feasibility, ~~and~~ practicality and appropriate quality of care utilizing ~~allied~~ dental personnel in such roles in actual practice settings.

Delegation of Expanded Functions

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

Supervision of Allied Dental Personnel

Supervision by the dentist is paramount in assuring the highest quality of care and the safety of the patient. ~~In all instances, a dentist assumes responsibility for determining, on the basis of diagnosis, the specific treatment patients will receive and which aspects of treatment may be delegated to qualified personnel.~~ The degree of supervision required to assure that treatment is appropriate and does not jeopardize the systemic or oral health of the patient varies with the nature of the procedure and the medical and dental history of the patient. The dentist, under appropriate jurisdictional authority, bears the responsibility for determining which aspects of each patient's treatment may be delegated, and to which qualified auxiliary the procedures may be

delegated. The unauthorized and improperly supervised delivery of care by allied dental personnel is opposed by the American Dental Association.

The types of supervision are defined in the glossary of terminology at the end of this policy statement. ~~Supervision and coordination of treatment by a dentist are essential to comprehensive oral health care. Unsupervised practice by allied dental personnel reduces the quality of oral health care, fails to protect the dental health of the public and is opposed by the American Dental Association. The types of supervision are:~~

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

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

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

~~*General supervision.* A dentist is not required to be in the dental office or treatment facility when procedures are being performed by the allied dental personnel, but has personally diagnosed the condition to be treated, has personally authorized the procedures and will evaluate the performance of the allied dental personnel.~~

~~General supervision is not acceptable to the American Dental Association because it fails to protect the health of the public.~~ Personal, direct, and indirect supervision are appropriate for delegation of duties to allied dental personnel providing direct patient care. ~~However,~~ ~~i~~In some states, properly credentialed ~~licensed~~ dental auxiliaries ~~hygienists~~ are permitted to perform some duties~~, except for intraoral expanded functions,~~ under either general supervision or public health supervision, as delegated by the supervising dentist. ~~In order to assure the safety of the patient,~~ T~~t~~he following criteria should ~~must~~ be followed whenever functions are performed under general supervision:

1. Any patient to be treated by a dental auxiliary ~~hygienist~~ must first become a patient of record of a dentist. A patient of record is defined as one who:
   a. has been examined by the dentist;
   b. has had a medical and dental history completed and evaluated by the dentist; and
   c. has had his/her oral condition diagnosed and a treatment plan developed by the dentist.
2. The dentist must provide to the dental auxiliary ~~hygienist prior written~~ authorization to perform clinical dental ~~hygiene~~ services for that patient of record. ~~Such authorization should remain in effect for a limited time period as specified by state law.~~
3. The dentist shall examine the patient following performance of clinical services by the dental auxiliary. ~~hygienist.~~ Such examination shall be performed within a reasonable time as determined by the nature of the services provided, the needs of the patient and the professional judgment of the dentist.

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

Appropriate Settings for Dental Auxiliary ~~Hygiene~~ Services

The settings in which a dental auxiliary ~~hygienist~~ may perform legally delegated functions shall be limited to treatment facilities under the jurisdiction and supervision of a dentist~~. When the employer of the dental~~

~~hygienist is not a licensed dentist, t~~The method of compensation and other working conditions for the dental auxiliary ~~hygienist~~ must not interfere with the quality of dental care provided or the relationship between the responsible supervising dentist and the dental ~~hygienist~~ auxiliary.

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

Public oral health programs should utilize all appropriate dental team members in implementation of programs which have been endorsed by ~~constituent dental societies~~ appropriate jurisdictional authority. The dental auxiliary,~~hygienist,~~ in this setting, may provide approved oral health ~~screening and preventive care~~ services under an appropriate supervisory arrangement, as specified by relevant jurisdictional authorities. The federal dental services are urged to utilize allied dental personnel in compliance with policies of ~~in state practice acts and regulations, as well as oral health education programs for groups within community served~~ the American Dental Association.

Allied Dental Personnel Education, Credentialing & Licensure

There should be a single state board of dentistry in each state that serves as the sole licensing and regulatory authority for dentistry to include dentists and all other licensed and/or credentialed dental personnel. State dental boards are urged to require licensing and credentialing appropriate to the level of care that is provided by each dental auxiliary. All personnel who participate in the provision of oral health care must have appropriate education and training and meet any additional criteria needed to assure competence. The type and length of education needed to prepare allied dental personnel to perform specific delegated patient care procedures should be specified in state dental practice acts and regulations.

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

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

Expanded functions education programs are designed to prepare dental auxiliaries to provide expanded dental services under the direction and appropriate supervision of a dentist. Programs accredited by the Commission on Dental Accreditation (CODA) typically prepare the expanded functions auxiliary to perform legally permitted clinical services. However, other programs, CODA accredited or approved by the respective state's board of dental examiners, which utillize such methods as institutionally-based didactic course work, in-office clinical training, or electronic distance education can be an acceptable means to train expanded functions auxiliaries. Boards of dentistry are urged to review such innovative programs for acceptance. The dental hygiene education curriculum does not provide adequate preparation to enable graduates to provide comprehensive oral health care or to practice without the supervision of a dentist.

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

~~**Licensure of Dental Hygienists**~~

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

~~the dental hygiene licensure examination, during which patient care is provided, must be conducted under the supervision of a licensed dentist.~~

Constituent Legislative Activities

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

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

Glossary of Terminology Related to Allied Dental Personnel Utilization and Supervision

This Glossary is designed to assist in developing a common language for discussion of allied dental personnel issues by dental professionals and public policy makers. ~~The terms included were selected from the~~ American Dental Association's policies on allied dental personnel education, utilization and supervision ~~and are defined consistently with the intent of those policies.~~ It should be noted that some of the terms included do not lend themselves to rigid definition and can only be described as to use and meaning. Also, certain terms are defined in dental practice acts and regulations, which vary from state to state.

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

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

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

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

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

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

~~**Allied Dental Personnel:** Individuals who assist the dentist in the provision of oral health care services to patients, including dental assistants, dental hygienists and dental laboratory technicians who are employed in dental offices or other patient care facilities.~~

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

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

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

Evaluation/Examination, Completeprehensive: A dentist performs thoroughly evaluates the state of health of the patient including a thorough evaluation and recording of the extraoral and intraoral conditions examination of the hard and soft tissues. of the oral cavity and contiguous structures. This may require interpretation of includes but is not limited to the use of diagnostic information acquired through additional diagnostic procedures. It interpretation of appropriate dental radiographs and may also include pulp vitality tests, transillumination, study models and laboratory tests, when indicated. includes an evaluation for oral cancer where indicated, the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.

Evaluation/Examination, Limited: A dentist performs thoroughly evaluates the state of health of the patient and includes an evaluation of the hard and soft tissues of a portion of the oral cavity. Includes but is not limited to a specific oral health problem or complaint. This may require the use of diagnostic information acquired through interpretation of selected dental radiographs; may also include diagnostic information acquired through interpretation of other additional diagnostic procedures. tests, as indicated. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.

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

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

Oral Diagnosis: The determination by a dentist of the oral health condition of an individual patient, achieved through the evaluation of data gathered by means of history taking, direct examination, patient conference, and such clinical aids and tests as may be necessary in the judgment of the dentist. (*Trans.* 1978:499).

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

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

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

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

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

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

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

Public Health Supervision. A dentist who is designated by~~ That oversight where~~ a state or local jurisdiction to oversee ~~licensed dental hygienist may provide dental hygiene~~ services provided, as specified by state law or regulations, when such services are provided as part of an organized community program in various public health settings. ~~settings, as designated by state law, and with general oversight of such programs by a licensed dentist designated by the state.~~

Treatment Plan: The sequential guide for the patient's care as determined by the dentist's diagnosis and used by the dentist for the restoration to and/or maintenance of optimal oral health. ~~(*Trans.*1978:499).~~

Resolution No. 53 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: July 20, 2010

Submitted By: Sixteenth Trustee District

Reference Committee: Dental Workforce

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

AMENDMENTS TO THE "COMPREHENSIVE POLICY STATEMENT ON ALLIED DENTAL PERSONNEL"

The following resolution was adopted by the Sixteenth Trustee District and transmitted on July 20, 2010, by Mr. Phil Latham, executive director, South Carolina Dental Association.

Background: The current ADA policy needs to reflect the current environment. There are factions outside the ADA that want to be the spokesman for oral health care in this country and they will be successful in doing so if we allow some of our long standing policies to fragment our association.

Perhaps our greatest challenge that we face in dentistry today is to work together to take the necessary steps to control our own destiny and the destiny of oral health care in this country. It is to that end that we should try and amend our policy to accommodate our membership as a whole.

That being said, some of these policy changes may be difficult to accept, but they will benefit the association as a whole and hopefully bring us closer together. This is not compromise, but a solution to the problems we are facing.

Therefore, be it

Resolution

53. Resolved, that the ADA policy "Comprehensive Policy Statement on Allied Dental Personnel" (*Trans.*1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307) be amended to read as follows (additions are shown by underscoring; deletions are shown by strikethroughs):

Comprehensive Policy Statement on Allied Dental Personnel
General Principles

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

The dentist is ultimately responsible, ethically and legally, for patient care. In carrying out that responsibility and to increase the capacity of the profession to provide patient care in the most cost-effective manner, the dentist may delegate to allied dental personnel certain patient care functions which the allied dental personnel has been trained.

The three recognized categories of allied dental personnel but not limited to, are dental hygienists, dental assistants and dental laboratory technicians. (See the glossary for definitions of each category.) A dental laboratory technician who is employed in the dental office is considered to allied dental personnel. A dental technician who performs a supportive function in an environment outside the dental office may be properly termed a supportive or allied member of the dental health team.

Delegation of Functions

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

The dental profession has the responsibility to provide guidance to all agencies, organizations and governmental bodies, such as state dental boards and legislatures, that have an interest in, or responsibility and authority for, decisions on utilization, education, and supervision of allied dental personnel. In this context, the primary responsibility is to assure that decisions on allied dental personnel utilization will not adversely affect the health and well-being of the public or cause an increased risk to the patient. In meeting these responsibilities, dentists must also identify those functions or procedures that require the knowledge and skill of the dentist and therefore must be performed only by a licensed dentist in accordance with the proposed policy change in Resolution 54 (Worksheet:7058). ~~These functions and procedures include, but are not limited to: examination, diagnosis and treatment planning; prescribing work authorizations; surgical or cutting procedures on hard or soft tissue; prescribing drugs and other medications; and administering local, parenteral, inhalational, or general anesthesia.~~

Nothing in this statement should be interpreted to limit a dentist from delegating to a properly trained allied dental personnel responsibility for assisting the dentist in the performance of these functions under the dentist's supervision and in accordance with state law, if, in the dentist's professional judgment, this is in the patient's best interest. The transfer of permissible functions from the dentist to the allied dental personnel must not result in a reduced quality of patient care. In all cases, the authority and responsibility of the dentist for the overall oral health of the patient must be maintained to assure cost-effective delivery of services to the patient and avoid fragmentation of the dental team.

Constituent dental societies should advocate the functions which may be appropriately delegated to allied dental personnel based on (1) the best interests of the patient; (2) the education, training and credentialing of the allied dental personnel; (3) considerations of cost-effectiveness and efficiency in delivery patterns; and (4) valid research demonstrating the feasibility and practicality of utilizing allied dental personnel in such roles in actual practice settings.

Delegation of Expanded Functions

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

Supervision of Allied Dental Personnel

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

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

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

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

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

~~General supervision is not acceptable to the American Dental Association because it fails to protect the health of the public. Personal, direct, and indirect supervision are appropriate for delegation of duties to allied dental personnel providing direct patient care. However, in some state licensed dental hygienists are permitted to perform duties, except for intraoral expanded functions, under general supervision, as delegated by the supervising dentist. In order to assure the safety of the patient, the following criteria must be followed whenever functions are performed under general supervision.~~ The ADA has always promoted policy that protects the health of the public. Personal, direct and indirect supervision for the delegation of duties of allied personnel is the most appropriate means of promoting optimal patient care. However in some states licensed dental hygienists are permitted to perform duties, except for intraoral expanded functions, under general supervision, as delegated by the supervising dentist. In order to assure the safety of the patient the following criteria must be followed whenever functions are performed under general supervision.

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

   a. has been examined by the dentist;
   b. has had a medical and dental history completed and evaluated by the dentist; and
   c. has had his/her oral condition diagnosed and a treatment plan developed by the

dentist.

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

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

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

Appropriate Settings for Dental Hygiene Services

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

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

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

Allied Dental Personnel Education

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

Dental assisting and dental hygiene educational programs should be administered or directed by a dentist. Further, licensed or legally permitted dentists must be involved in the clinical supervision of dental assisting and dental hygiene education programs, in accordance with state law.

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

The dental hygiene education curriculum does not provide adequate preparation to enable graduates to provide comprehensive oral health care or to practice without the supervision of a dentist.

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

Licensure of Dental Hygienists

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

Constituent Legislative Activities

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

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

Glossary of Terminology Related to Allied Dental Personnel Utilization and Supervision

This Glossary is designed to assist in developing a common language for discussion of allied dental personnel issues by dental professionals and public policy makers. The terms included were selected from the American Dental Association's policies on allied dental personnel education, utilization and supervision and are defined consistently with the intent of those policies. It should be noted that some of the terms included do not lend themselves to rigid definition and can only be described as to use and meaning. Also, certain terms are defined in dental practice acts and regulations, which vary from state to state.

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

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

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

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

Allied Dental Personnel: Individuals who assist the dentist in the provision of oral health care services to patients, including, but not limited to, dental assistants, dental hygienists and dental laboratory technicians who are employed in dental offices or other patient care facilities.

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

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

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

Examination, Complete: A dentist thoroughly evaluates the state of health of the patient including a thorough examination of the hard and soft tissues of the oral cavity and contiguous structures. This includes but is not limited to the use of diagnostic information acquired through interpretation of appropriate dental radiographs and may also include pulp vitality tests, transillumination, study models and laboratory tests, when indicated.

Examination, Limited: A dentist thoroughly evaluates the state of health of the patient and includes an evaluation of the hard and soft tissues of a portion of the oral cavity. Includes but is not limited to the use of diagnostic information acquired through interpretation of selected dental radiographs; may also include diagnostic information acquired through interpretation of other diagnostic tests, as indicated.

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

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

Oral Diagnosis: The determination by a dentist of the oral health condition of an individual patient, achieved through the evaluation of data gathered by means of history taking, direct examination, patient conference, and such clinical aids and tests as may be necessary in the judgment of the dentist (*Trans.*1978:499).

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

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

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

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

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

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

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

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

Treatment Plan: The sequential guide for the patient's care as determined by the dentist's diagnosis and used by the dentist for the restoration to and/or maintenance of optimal oral health (*Trans*.1978:499).

BOARD COMMENT: Board of Trustees found the proposed policy makes positive statements regarding the *Comprehensive Policy Statement on Allied Personnel*. However, the lack of reference to surgical/irreversible procedures as outlined in Resolution 54 (Worksheet:7058), should Resolution 54 not be adopted, leaves a potential void in addressing this important policy matter. The Board has clarified its position on surgical/irreversible procedures in Resolution 46B (Worksheet:7020).

BOARD RECOMMENDATION: Vote No.

Board Vote: Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN
☐	■	☐	☐	ENGEL	☐	■	☐	☐	MANNING	■	☐	☐	☐	THOMPSON
☐	■	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	☐	■	☐	☐	VERSMAN
☐	■	☐	☐	FEINBERG	■	☐	☐	☐	RICH	☐	■	☐	☐	VIGNA
☐	■	☐	☐	GIST	☐	■	☐	☐	SEAGO	☐	■	☐	☐	WEBB
■	☐	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SMITH, A. J.	■	☐	☐	☐	WEBER
☐	■	☐	☐	LONG	■	☐	☐	☐	STEFFEL					Res. 53

Resolution No. 53S-1 New ☐ Substitute ■ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Sixteenth Trustee District

Reference Committee: Dental Workforce

Total Financial Implication:

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

AMENDMENTS TO THE "COMPREHENSIVE POLICY STATEMENT ON ALLIED DENTAL PERSONNEL"

The following substitute for Resolution 53 (Worksheet:7051 REVISED) was submitted on September 21, 2010, by the Sixteenth Trustee District and transmitted by Mr. Phil Latham, executive director, South Carolina Dental Association.

Background: The current ADA policy needs to reflect the current environment. There are factions outside the ADA that want to be the spokesman for oral health care in this country and they will be successful in doing so if we allow some of our long standing policies to fragment our association.

Perhaps our greatest challenge that we face in dentistry today is to work together to take the necessary steps to control our own destiny and the destiny of oral health care in this country. It is to that end that we should try and amend our policy to accommodate our membership as a whole.

That being said, some of these policy changes may be difficult to accept, but they will benefit the association as a whole and hopefully bring us closer together. This is not compromise, but a solution to the problems we are facing.

Therefore, be it

Resolution

53S-1. Resolved, that the ADA policy "Comprehensive Policy Statement on Allied Dental Personnel" (*Trans.*1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307) be amended to read as follows (original additions are shown by underscoring; new additions are double underscored; deletions are shown by strikethroughs):

Comprehensive Policy Statement on Allied Dental Personnel
General Principles

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

The dentist is ultimately responsible, ethically and legally, for patient care. In carrying out that responsibility and to increase the capacity of the profession to provide patient care in the most cost-effective manner, the dentist may delegate to allied dental personnel certain patient care functions which the allied dental personnel has been trained.

The three recognized categories of allied dental personnel include but are not limited to, dental hygienists, dental assistants and dental laboratory technicians. (See the glossary for definitions of each category.) A dental laboratory technician who is employed in the dental office is considered to allied dental personnel. A dental technician who performs a supportive function in an environment outside the dental office may be properly termed a supportive or allied member of the dental health team.

Delegation of Functions

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

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

~~These functions and procedures include, but are not limited to: examination, diagnosis and treatment planning; prescribing work authorizations; surgical or cutting procedures on hard or soft tissue; prescribing drugs and other medications; and administering local, parenteral, inhalational, or general anesthesia.~~

Nothing in this statement should be interpreted to limit a dentist from delegating to a properly trained allied dental personnel responsibility for assisting the dentist in the performance of these functions under the dentist's supervision and in accordance with state law, if, in the dentist's professional judgment, this is in the patient's best interest. The transfer of permissible functions from the dentist to the allied dental personnel must not result in a reduced quality of patient care. In all cases, the authority and responsibility of the dentist for the overall oral health of the patient must be maintained to assure cost-effective delivery of services to the patient and avoid fragmentation of the dental team.

Constituent dental societies should advocate the functions which may be appropriately delegated to allied dental personnel based on (1) the best interests of the patient; (2) the education, training and credentialing of the allied dental personnel; (3) considerations of cost-effectiveness and efficiency in delivery patterns; and (4) valid research demonstrating the feasibility and practicality of utilizing allied dental personnel in such roles in actual practice settings.

Delegation of Expanded Functions

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

Supervision of Allied Dental Personnel

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

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

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

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

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

~~General supervision is not acceptable to the American Dental Association because it fails to protect the health of the public. Personal, direct, and indirect supervision are appropriate for delegation of duties to allied dental personnel providing direct patient care. However, in some state licensed dental hygienists are permitted to perform duties, except for intraoral expanded functions, under general supervision, as delegated by the supervising dentist. In order to assure the safety of the patient, the following criteria must be followed whenever functions are performed under general supervision~~ The ADA has always promoted policy that protects the health of the public. Personal, direct and indirect supervision for the delegation of duties of allied personnel is the most appropriate means of promoting optimal patient care. However in some states licensed dental hygienists are permitted to perform duties, except for intraoral expanded functions, under general supervision, as delegated by the supervising dentist. In order to assure the safety of the patient the following criteria must be followed whenever functions are performed under general supervision.

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

   a. has been examined by the dentist;
   b. has had a medical and dental history completed and evaluated by the dentist; and
   c. has had his/her oral condition diagnosed and a treatment plan developed by the dentist.

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

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

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

Appropriate Settings for Dental Hygiene Services

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

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

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

Allied Dental Personnel Education

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

Dental assisting and dental hygiene educational programs should be administered or directed by a dentist. Further, licensed or legally permitted dentists must be involved in the clinical supervision of dental assisting and dental hygiene education programs, in accordance with state law.

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

The dental hygiene education curriculum does not provide adequate preparation to enable graduates to provide comprehensive oral health care or to practice without the supervision of a dentist.

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

Licensure of Dental Hygienists

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

Constituent Legislative Activities

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

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

Glossary of Terminology Related to Allied Dental Personnel Utilization and Supervision

This Glossary is designed to assist in developing a common language for discussion of allied dental personnel issues by dental professionals and public policy makers. The terms included were selected from the American Dental Association's policies on allied dental personnel education, utilization and supervision and are defined consistently with the intent of those policies. It should be noted that some of the terms included do not lend themselves to rigid definition and can only be described as to use and meaning. Also, certain terms are defined in dental practice acts and regulations, which vary from state to state.

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

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

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

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

Allied Dental Personnel: Individuals who assist the dentist in the provision of oral health care services to patients, including, but not limited to, dental assistants, dental hygienists and dental laboratory technicians who are employed in dental offices or other patient care facilities.

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

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

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

Examination, Complete: A dentist thoroughly evaluates the state of health of the patient including a thorough examination of the hard and soft tissues of the oral cavity and contiguous structures. This includes but is not limited to the use of diagnostic information acquired through interpretation of appropriate dental radiographs and may also include pulp vitality tests, transillumination, study models and laboratory tests, when indicated.

Examination, Limited: A dentist thoroughly evaluates the state of health of the patient and includes an evaluation of the hard and soft tissues of a portion of the oral cavity. Includes but is not limited to the use of diagnostic information acquired through interpretation of selected dental radiographs; may also include diagnostic information acquired through interpretation of other diagnostic tests, as indicated.

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

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

Oral Diagnosis: The determination by a dentist of the oral health condition of an individual patient, achieved through the evaluation of data gathered by means of history taking, direct examination, patient conference, and such clinical aids and tests as may be necessary in the judgment of the dentist (*Trans.*1978:499).

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

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

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

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

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

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

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

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

Treatment Plan: The sequential guide for the patient's care as determined by the dentist's diagnosis and used by the dentist for the restoration to and/or maintenance of optimal oral health (*Trans*.1978:499).

BOARD COMMENT: Received after this section had been reproduced for House distribution.

Resolution No. 54 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: July 20, 2010

Submitted By: Sixteenth Trustee District

Reference Committee: Dental Workforce

Total Financial Implication:

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Public Health (Required)

DIAGNOSIS OR PERFORMANCE OF SURGICAL DENTAL PROCEDURES BY NONDENTISTS

The following resolution was adopted by the Sixteenth Trustee District and transmitted on July 20, 2010, by Mr. Phil Latham, executive director, South Carolina Dental Association.

Background: At the 2009 House of Delegates in Honolulu, Board Report 8 and the resulting resolutions that it generated left the delegates having to choose between two seemingly conflicting issues. Both of these issues the House seems to want to support, but, to date, the issues have been presented as an "either/or" decision. The issues are:

1) the ADA should have policy that allows it to assist states who are faced with DHAT or midlevel provider legislation. The HOD was told that current policy was not flexible enough to allow assistance from the ADA in the face of such threats. And,

2) the ADA should preserve its current policies and one of its principal core values that only a dentist should be able to perform surgical procedures on hard or soft tissue.

The dilemma of having to choose between one of these two issues resulted in referral back to the CDP with the charge of suggesting amendments to ADA policies which supports both of these issues. The report that the CDP sent to the BOT in December, without question, satisfies issue #1. It could be easily argued that the report fell far short of supporting issue #2. In its present form, the HOD is likely to defeat it, or refer it back yet again.

After much discussion with many people the following resolution seems to accomplish what the HOD was asking for. It allows for assistance when needed as described in issue #1. But it still holds true to one of our fundamental core values described in issue #2.

The third resolving clause is necessary because no one can define the word "irreversible" and would bring ADA policy more in line with legislation that many states have already passed in particular as it deals with dental hygienist giving local anesthesia. Some would say that an EFDA that packs and carves amalgam is irreversible and there are many more examples. The word surgical and its definition are clean and clear.

Resolution

54. Resolved, that the ADA by all appropriate federal and judicial means strive to maintain the highest quality of oral health care by maintaining that the dentist be the healthcare provider that can perform examinations, diagnoses, treatment planning, and surgical procedures except as otherwise authorized by state law with reference to physicians, and be it further

Resolved, that the definition of surgical procedures be defined as the cutting or removal of hard or soft tissue, and be it further

Resolved, that the word "surgical" replace the word "irreversible" in all ADA Policy statements, with the exception of the World Medical Association Declaration of Helsinki Principles for Medical Research Involving Human Subjects and be it further

Resolved, that the policy "Diagnosis or Performance of Irreversible Dental Procedures by Nondentists" (*Trans*.2004:328), be rescinded.

BOARD COMMENT: The Board of Trustees is sympathetic to this request. However, replacement of the word 'irreversible' with 'surgical/irreversible' was preferred by the Board as more descriptive when used to explain this component of a dentist's scope of practice. This language was incorporated in Resolution 46B (Worksheet:7020), which contains language similar to this resolution.

BOARD RECOMMENDATION: Vote No.

Board Vote: Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LOW	☐	■	☐	☐	SULLIVAN
☐	■	☐	☐	ENGEL	☐	■	☐	☐	MANNING	■	☐	☐	☐	THOMPSON
☐	■	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	☐	■	☐	☐	VERSMAN
☐	■	☐	☐	FEINBERG	■	☐	☐	☐	RICH	☐	■	☐	☐	VIGNA
☐	■	☐	☐	GIST	☐	■	☐	☐	SEAGO	☐	■	☐	☐	WEBB
■	☐	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SMITH, A. J.	■	☐	☐	☐	WEBER
☐	■	☐	☐	LONG	☐	■	☐	☐	STEFFEL					Res. 54

Resolution No. 91 New ☐ Substitute ☐ Amendment ☐

Report: N/A Date Submitted: September 9, 2010

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Dental Workforce

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

AMENDMENT TO THE POLICY, "OPPOSITION TO PILOT PROGRAMS WHICH ALLOW NONDENTISTS TO DIAGNOSE DENTAL NEEDS OR PERFORM IRREVERSIBLE PROCEDURES"

The following resolution was adopted by the Council on Access, Prevention and Interprofessional Relations and transmitted on September 9, 2010, by Dr. Mark A. Crabtree, chair.

Background: The Council on Access, Prevention and Interprofessional Relations (CAPIR) recognizes the dedication of the Council on Dental Practice (CDP) in its thoughtful and thorough review of the resolutions assigned by the 2009 House of Delegates. CAPIR commends CDP for its dedication, energy, perseverance and determination in carrying out the responsibilities to a successful conclusion.

Just as the determinants associated with improving access to oral health services are many, diverse and complex, CAPIR acknowledges that multiple solutions will need to be considered in order to begin to address the access issue. As evidenced by the 2009 Access to Dental Care Summit, it is apparent that there are many oral health stakeholders outside of organized dentistry that are seeking such solutions. As America's leading advocate for oral health, it is important that the American Dental Association be at the table when possible solutions are brought forth.

CAPIR has become comfortable with the inherent contradictions that often arise when multiple perspectives are brought forward for discussion. It believes that interactions where differences of opinion are valued and actively pursued will strengthen the ADA and the profession, and provide a platform to refute allegations that the ADA is more concerned with its own self interest and protecting the status quo, rather than promoting and protecting the health of the public. The Council supports the active engagement and participation of the ADA in the development and/or evaluation of pilot programs that are focused on improving the oral health of all Americans.

Therefore, the Council recommends adoption of the following resolution.

Resolution

91. Resolved, that the ADA policy on Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform Irreversible Procedures (*Trans*.2005:343) be amended to read as follows (additions are shown by underscoring; deletions are shown by strikethroughs).

~~**Resolved,** that the American Dental Association opposes pilot programs that are in violation of the ADA policy stated in Resolution 24H-2004 (*Trans.*2004:291), no. 13 (stating that, "The ADA is opposed to non-dentists making diagnoses, or developing treatment plans or performing irreversible procedures.")~~

Resolved, that the American Dental Association asserts that the dentist is the head of the dental team and is solely responsible for examination, evaluation, diagnosis, and development of the patient's treatment plan, and be it further

Resolved, that the ADA encourages any new member of the dental team proposed in a pilot program be supervised by a dentist (as determined by the individual state dental practice act) and that new member be based upon determination of need, sufficient education and training, and a scope of practice that ensures the protection of the public's oral health, and be it further

Resolved, that the ADA actively engage and participate in the development and/or evaluation of pilots that are focused on improving the oral health of all Americans.

BOARD COMMENT: The Board appreciates the efforts of CAPIR in drafting this resolution. After thoughtful discussion, the Board of Trustees preferred the language in Resolution 92 (Worksheet:7062) which rescinds this policy and affirmatively addresses pilot programs.

BOARD RECOMMENDATION: Vote No.

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
☐	■	☐	☐	CALNON	☐	■	☐	☐	LOW	☐	■	☐	☐	SULLIVAN
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■	☐	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SMITH, A. J.	☐	■	☐	☐	WEBER
☐	■	☐	☐	LONG	☐	■	☐	☐	STEFFEL				Res.	91

Resolution No. 92 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2010

Submitted By: Seventh Trustee District

Reference Committee: Dental Workforce

Total Financial Implication:

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Public Health (Required)

ADA INVOLVEMENT IN PILOT PROGRAMS AND STUDIES

The following resolution was submitted on September 9, 2010, by the Seventh Trustee District and transmitted by Mr. Douglas Bush, executive director, Indiana Dental Association.

Background: In 2004 the ADA House of Delegates approved a response to the Alaska Native Oral Health Access Task Force recommendations that included 14 strategic initiatives in an effort to assure quality dental health care for Native Alaskans (*Trans.*2004:291). Item 13 of this initiative stated, "The ADA is opposed to nondentists making diagnoses, developing treatment plans or performing irreversible procedures."

In 2005, the ADA House of Delegates approved an additional resolution (Resolution 93H-2005; *Trans*.2005:343) which stated: "Resolved, that the American Dental Association opposes pilot programs that are in violation of the ADA policy stated in Resolution 24H-2004 (*Trans.*2004:291), no. 13.

The 2004 and 2005 House actions are deficient in two areas. First, they failed to properly define "nondentist," potentially opening the door to dentists who do not hold a valid license being included in the activities the resolutions intended to prohibit.

Second, the 2005 resolution failed to precisely define what it means to "oppose" pilot programs that are in violation of ADA policy. Does this simply mean that the ADA is to express opposition to the studies? Does it prohibit the ADA from participating on study panels? Does it prohibit the ADA from offering testimony to study panels? Does it prohibit the ADA from considering the findings of the studies? The term "oppose" is ambiguous and subject to broad interpretation. The ADA's reputation as a science-based organization could be harmed if it is perceived as opposing the results of a study before it is conducted. Instead, the ADA should be in a position to assure objective, evidence-based, peer reviewed research on any issue affecting the profession.

Resolution

92. Resolved, that Resolution 24H-2004, item number 13 (*Trans.*2004:291) be amended as follows (additions are underscored):

> The ADA is opposed to nondentists <u>or non-licensed dentists</u> making diagnoses, developing treatment plans or performing <u>surgical/</u>irreversible procedures, and be it further

Resolved, that Resolution 93H-2005 (*Trans.*2005:343) opposing pilot programs that are in violation of the existing ADA policy be rescinded, and be it further

Resolved, that the ADA critically review and seek opportunity for input into any pilot program or study that has potential for significant impact on the dental profession, and be it further

Resolved, that the policy of the ADA shall be to encourage discussions/dialogue with government, oral health care organizations or other agencies involved in dental workforce issues or oral health care issues, and be it further

Resolved, that the policy of the ADA shall be to seek funding for Association studies on dental workforce models or oral health care delivery issues or their evaluations, and be it further

Resolved, that the ADA encourages any new member of the dental team proposed in a pilot program be supervised by a dentist and that new member be based upon determination of need, sufficient education and training, and a scope of practice that ensures the protection of the public's oral health.

BOARD COMMENT: The Board supports Resolution 92, however decided an additional phrase referring to state dental practice acts should be included in the sixth resolving clause. Therefore, the Board recommends the following substitute resolution.

92B. Resolved, that Resolution 24H-2004, item number 13 (*Trans.*2004:291) be amended as follows (additions are underscored):

The ADA is opposed to nondentists <u>or non-licensed dentists</u> making diagnoses, developing treatment plans or performing <u>surgical/</u>irreversible procedures, and be it further

Resolved, that Resolution 93H-2005 (*Trans.*2995:343) opposing pilot programs that are in violation of the existing ADA policy be rescinded, and be it further

Resolved, that the ADA critically review and seek opportunity for input into any pilot program or study that has potential for significant impact on the dental profession, and be it further

Resolved, that the policy of the ADA shall be to encourage discussions/dialogue with government, oral health care organizations or other agencies involved in dental workforce issues or oral health care issues, and be it further

Resolved, that the policy of the ADA shall be to seek funding for Association studies on dental workforce models or oral health care delivery issues or their evaluations, and be it further

Resolved, that the ADA encourages any new member of the dental team proposed in a pilot program be supervised by a dentist (as determined by the individual state dental practice act) and that new member be based upon determination of need, sufficient education and training, and a scope of practice that ensures the protection of the public's oral health.

BOARD RECOMMENDATION: Vote Yes on Substitute.

Board Vote: Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN
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APPENDIX 1
WORKSHEET ADDENDUM
POLICY TO BE AMENDED

The Alaska Native Oral Health Access Task Force – Strategies to Assure Access to Quality Health Care for Native Alaskans (2004:291). (additions are underscored)

Resolved, that in response to the Alaska Native Oral Health Care Access Task Force's findings and recommendations and to the unique and separate challenges that Alaska presents, the following strategies to assure access to quality health care for Native Alaskans be approved:

1. The ADA encourage the establishment of a work group that includes tribal leaders and the Alaska Dental Society (ADS) to facilitate improved access to oral health care for the Alaskan village populations.

2. The ADA work with the ADS and tribal leaders to seek federal funding with the goal of placing a dental health aide (i.e., a Primary Dental Health Aide I or II) trained to provide oral health education, preventive services and palliative services (except irreversible procedures, including but not limited to tooth extractions, cavity and stainless steel crown preparation and pulpotomies) in every Alaska Native village that requests an aide.

3. The ADA support the use of Expanded Functions Dental Health Aides I and II where appropriate to improve the efficiency of delivering oral health care services to Alaska Natives within the Community Health Aide Program.

4. The ADA continue to support current federal policy that facilitates the entry of American Indians/Alaska Natives into the health professions, especially in the field of dentistry.

5. The ADA work to ensure that representatives of the ADS are included in oversight activities concerning the dental health aide program and other programs affecting the delivery of oral health care services to Alaska Natives.

6. The ADA offer, and the ADS be encouraged to offer, to work with the tribal leaders to increase the use of telecommunications to ensure the proper delivery of oral health care in the villages.

7. The ADA take actions that help to significantly increase the number of dentists and dental hygienists available to provide services to Alaska Natives in the rural villages through private contracts and volunteerism and to facilitate the placement of donated dental equipment, including encouraging the ADS to establish a volunteer position to coordinate these activities with the tribes.

8. The ADA offer, and the ADS be encouraged to offer, to explore ways of working with the Denali Commission and the tribes to expedite the building of dental clinics in rural Alaska villages.

9. The ADA offer to work with the ADS, Alaska Native Tribal Health Consortium, the Alaska Native Health Board and others to lobby for increased federal funding to help ensure that improvements in community water quality in the rural Alaska villages include fluoridation.

10. The ADA work with the ADS and tribes to help reduce the consumption of soft drinks and other cariogenic products.

11. Consistent with the needs and desires of tribal leaders, the ADA support the increased use and funding of military reservist dentists, including dental specialists, in delivering care to Alaska Natives in remote, rural villages.

12. The ADA through its agencies help to facilitate the placement of volunteer dentists and dental hygienists in tribal and Indian Health Service facilities nationwide.

13. The ADA is opposed to nondentists or non-licensed dentists making diagnoses, developing treatment plans or performing surgical/irreversible procedures, and be it further

14. The ADA will work to help tribes and tribal leaders understand the dangers and patient health risks of nondentists making diagnoses or performing irreversible dental procedures, including but not limited to tooth extractions, pulpotomies and cavity and stainless steel crown preparation.

APPENDIX 2
WORKSHEET ADDENDUM
POLICY TO BE RESCINDED

Opposition to Pilot Programs Which Allow Non-Dentists to Diagnose Dental Needs or Perform Irreversible Procedures (2005:343)

93H-2005. Resolved, that the American Dental Association opposes pilot programs that are in violation of the ADA policy stated in Resolution 24H-2004 (*Trans.*2004:291), no. 13 (stating that, "The ADA is opposed to non-dentists making diagnoses, or developing treatment plans or performing irreversible procedures.").

Resolution No. 132S-1 Citation for Original Resolution: 7069

Submitted By: Second Trustee District Date Submitted: October 2010

Substitute ☐ Amendment ■

Reference Committee Report On: Dental Workforce

Financial Implications (if different from original resolution): $

AMENDMENT TO THE "COMPREHENSIVE POLICY STATEMENT ON ALLIED DENTAL PERSONNEL"

The following amendment to Resolution 132 (Worksheet:7069) was submitted by the Second Trustee District and transmitted on October 11, 2010, by Dr. Mark Feldman, Executive Director New York State Dental Association.

Background: The proposed amendments to the *Comprehensive Policy Statement on Allied Dental Personnel* that were distributed to the House of Delegates appear flawed. Specifically, there is terminology used in the proposed amended *Policy Statement* that is inconsistent with current language appearing in the ADA Anesthesia Guidelines documents which were adopted by the House of Delegates in 2007. In addition, there are 27 states plus the District of Columbia that permit dental hygienists to administer nitrous oxide. Accordingly, the Second Trustee District is proposing the following amendment to the second paragraph of the section entitled Delegation of Functions contained within the proposed amended *Comprehensive Policy Statement on Allied Dental Personnel*:

Resolved, that the last sentence of the second paragraph of the section entitled Delegation of Functions contained within the proposed amended *Comprehensive Policy Statement on Allied Dental Personnel* be amended as follows: (new language double underscored; deletions double stricken through).

Addendum:
Comprehensive Policy Statement on Allied Dental Personnel Trans. 1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307) (additions are shown by underscoring; deletions are shown by strikethroughs- RC Resolution 132):

Comprehensive Policy Statement on Allied Dental Personnel
General Principles

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

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

The ~~three~~ recognized categories of allied dental personnel ~~include~~ are ~~but not limited to,~~ dental hygienists, dental assistants, community dental health coordinators and dental laboratory technicians. (See the glossary for definitions of each category.) A dental laboratory technician who is employed in the

dental office is considered to be allied dental personnel. A dental technician who performs a supportive function in an environment outside the dental office may be properly termed a supportive or allied member of the dental health team.

Delegation of Functions

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

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

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

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

Delegation of Expanded Functions

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

Supervision of Allied Dental Personnel

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

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

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

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

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

General supervision is not acceptable to the American Dental Association because it fails to protect the health of the public. The ADA has always promoted policy that protects the health of the public. Personal, direct and indirect supervision are the appropriate levels of supervision for the delegation of duties to allied dental personnel providing direct patient care. However, in some states licensed dental hygienists are permitted to perform duties, except for intraoral expanded functions, under general supervision, under general supervision or public health supervision, as delegated by the supervising dentist. In order to assure the safety of the patient the following criteria must be followed whenever functions are performed under general supervision:

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

   a. has been examined by the dentist;
   b. has had a medical and dental history completed and evaluated by the dentist; and
   c. has had his/her oral condition diagnosed and a treatment plan developed by the dentist.

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

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

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

Appropriate Settings for Dental Hygiene Services

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

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

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

Allied Dental Personnel Education

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

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

~~Dental assisting and dental hygiene educational programs should be administered or directed by a dentist. Further, licensed or legally permitted dentists must be involved in the clinical supervision of dental assisting and dental hygiene education programs, in accordance with state law.~~

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

Expanded functions education programs are designed to prepare dental auxiliaries to provide expanded dental services under the direction and appropriate supervision of a dentist. Programs accredited by the

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

Neither ~~T~~the dental hygiene education curriculum nor the expanded function education programs ~~does not~~ provides adequate preparation to enable graduates to provide comprehensive oral health care or to practice without the supervision of a dentist.

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

Licensure of Dental Hygienists

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

Constituent Legislative Activities

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

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

Glossary of Terminology Related to Allied Dental Personnel Utilization and Supervision

This Glossary is designed to assist in developing a common language for discussion of allied dental personnel issues by dental professionals and public policy makers. ~~The terms included were selected from the American Dental Association's policies on allied dental personnel education, utilization and supervision and are defined consistently with the intent of those policies.~~ It should be noted that some of the terms included do not lend themselves to rigid definition and can only be described as to use and meaning. Also, certain terms are defined in dental practice acts and regulations, which vary from state to state.

Allied Dental Personnel: ~~Individuals~~ Team members who assist the dentist in the provision of oral health care ~~services to patients, including, but not limited to, dental assistants, dental hygienists and dental laboratory technicians~~ and who are employed in dental offices or other patient care facilities.

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

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

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

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

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

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

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

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

Examination/Evaluation, Completeprehensive: A dentist performs thoroughly evaluates the state of health of the patient including a thorough evaluation and recording of the extraoral and intraoral conditions examination of the hard and soft tissues. of the oral cavity and contiguous structures. This may require interpretation of includes but is not limited to the use of diagnostic information acquired through additional diagnostic procedures. It interpretation of appropriate dental radiographs and may also include pulp vitality tests, transillumination, study models and laboratory tests, when indicated. includes

an evaluation for oral cancer where indicated, the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.

Examination/Evaluation, Limited: A dentist performs ~~thoroughly evaluates the state of health of the patient and includes~~ an evaluation ~~of the hard and soft tissues of a portion of the oral cavity. Includes but is not~~ limited to a specific oral health problem or complaint. This may require ~~the use of diagnostic information acquired through~~ interpretation of ~~selected dental radiographs; may also include diagnostic~~ information acquired through ~~interpretation of other~~ additional diagnostic procedures. ~~tests, as indicated.~~ Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.

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

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

Oral Diagnosis: The determination by a dentist of the oral health condition of an individual patient, achieved through the evaluation of data gathered by means of history taking, direct examination, patient conference, and such clinical aids and tests as may be necessary in the judgment of the dentist (~~*Trans.*1978:499~~).

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

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

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

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

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

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

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

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

Treatment Plan: The sequential guide for the patient's care as determined by the dentist's diagnosis and used by the dentist for the restoration to and/or maintenance of optimal oral health. ~~(*Trans.*1978:499)~~.

New Business

Resolution No. 133 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: October 11, 2010

Submitted By: Seventh Trustee District

Reference Committee: NA

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

TENURE OF THE HOUSE OF DELEGATES

The following resolution was submitted by the Seventh Trustee District and transmitted on October 11, 2010, by Dr. Mark Bronson, delegate.

Background: Resolution 17 (Worksheet:5012) addresses the tenure of Delegates and Alternate Delegates. With these being new members of the House of Delegates they may need background information to make informed decisions for our supreme governing body that may require attorney-client briefing.

Resolution

133. Resolved, that the Manual of the House of Delegates state that during any new delegate and alternate delegate orientation, that ADA legal counsel give an attorney-client briefing if necessary.

Resolution No. 134 New ■ Substitute ☐ Amendment ☐

Report: N/A Date Submitted: October 2010

Submitted By: Second, Fifth, Thirteenth and Seventeenth Trustee Districts

Reference Committee: N/A

Total Financial Implication: None

Amount One-time _____ Amount On-going $ _____

ADA Strategic Plan Goal: _____ (Required)

STUDY OF ADA EMPLOYEES' RETIREMENT PLANS

The following resolution was submitted by the Second, Fifth, Thirteenth and Seventeenth Trustee Districts and transmitted on October 11, 2010, by Dr. Jolene Paramore, delegate, Seventeenth Trustee District.

Background: Resolution 85H-2009 requested that the ADA undertake a study/analysis of the ADA employees' qualified retirement plans (Defined Benefit and 401K) and non-qualified retirement plan (Executive Pay Parity Plan), and that the study be reported to the 2010 House of Delegates. The Board provided a very detailed and informative report to the House but without any recommendations. We now request the Board use the study to provide the House with a recommendation on what action should be taken with respect to these retirement plans to best serve the Association, its members, and its staff. Therefore, we submit the following resolution.

Resolution

134. Resolved, that the study of the ADA Employees Retirement Plan as submitted in Board Report 12 (Worksheet:2164) be referred back to the Board of Trustees for evaluation and study by the Board and for submission of the Board's recommendations regarding these retirement plans to the 2011 House of Delegates.

Resolution No. 135 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: October 11, 2010

Submitted By: Fourth Trustee District

Reference Committee: NA

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

STUDY OF ADA RETIREMENT BENEFITS

The following resolution is submitted by the Fourth Trustee District and transmitted on October 11, 2010, by Dr. Frederic Sterritt, alternate delegate.

135. Resolved, that the Board of Trustees hire a pension analyst/financial planner to study all of the existing ADA retirement benefit programs and develop a report containing any recommendations concerning them, and be it further

Resolved, that the report be posted on the ADA House of Delegates web site prior to the 2011 House of Delegates meeting.

Resolution No. 136 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: October 12, 2010

Submitted By: Tenth Trustee District

Reference Committee:

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

COMMUNICATION TO STAKEHOLDERS REGARDING BARRIERS TO CARE

The following resolution was submitted by the Tenth Trustee District and transmitted on October 12, 2010 by Dr. Mel Thaler, South Dakota, Tenth District.

Resolution

136. Resolved, that the American Dental Association communicate to all stakeholders that the barriers to care are financial and not workforce related.

Resolution No. 137 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: October 12, 2010

Submitted By: Sixteenth Trustee District

Reference Committee: NA

Total Financial Implication:

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Members (Required)

AMENDMENT OF *ADA BYLAWS* REGARDING CANDIDATE ELECTION PROCESS

The following resolution was submitted by the Sixteenth Trustee District and transmitted on October 12, 2010 by Dr. Hal Fair, caucus secretary.

Background: The *ADA Bylaws* deals with the election of multiple candidates as follows:

Chapter V, Section 150a currently states:

> When one is to be elected and more than one has been nominated, the majority of the ballots cast shall elect. In the event no candidate receives a majority on the first ballot, the two (2) candidates receiving the greatest number of votes shall be balloted upon again.

This procedure works well when there are three (3) or fewer candidates, but becomes inherently unfair with every additional nominee on the ballot. Robert's Rules of Order recommends and Sturgis Standard Code of Parliamentary Procedures (Ed. 4) suggests a more equitable method, whereby the candidate with the fewest votes is dropped from the ballot and a new is taken. This process is repeated until one candidate receives a majority of the votes cast.

Resolution

137. Resolved, that the *ADA Bylaws*, Chapter V., Section 150a be amended as follows (deletions are stricken through and additions are underscored):

> When one is to be elected and more than one has been nominated, the majority of the ballots cast shall elect. In the event no candidate receives a majority on the first ballot, ~~the two (2) candidates receiving the greatest number of votes shall balloted upon again.~~ the candidate with the fewest votes shall be dropped and the remaining candidates shall be balloted upon again. This process shall be repeated until one (1) candidate receives a majority of the votes cast.

Resolution No. 138 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: October 12, 2010

Submitted By: Sixteenth Trustee District

Reference Committee: NA

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

RETROSPECTIVE STUDY ON WORKFORCE ISSUES

The following resolution was submitted by the Sixteenth Trustee District and transmitted on October 12, 2010 by Dr. David Anderson, Sixteenth Trustee District, delegate.

Resolution

138. Resolved, that the ADA, through the appropriate agencies, produce for the 2011 ADA House of Delegates, a critical retrospective study of workforce programs in New Zealand, Australia, Saskatchewan and Great Britain or any other sources that are available.

Addendum

ADA FOUNDATION

ANNUAL REPORT

TO THE ADA HOUSE OF DELEGATES

As of 8/24/2010

ANNUAL REPORT OF THE ADA FOUNDATION

The 2010 ADA Foundation (ADAF or Foundation) Annual Report to the ADA House of Delegates consists of the following four sections.

ADA Foundation

Dugoni, Arthur A., California, 2010, president
Sudzina, Michael R., South Carolina, 2011, vice president
Ellwein, Orin, South Dakota, 2011, director
Feldman, Cecile A., New Jersey, 2010, director
Fletcher, Kent W., Illinois, 2011, director
Garcia, Ernest L., Jr., California, 2011, director
Garcia, Raul I., Massachusetts, 2010, director
Grover, Jane S., Michigan, 2012, director
Henderson, Robert C., Illinois, 2010, director
Hopkins, Sheila, New York, 2011, director
Niessen, Linda C., Texas, 2011, director
Norman, Charles H., North Carolina, 2012, director
Rouse, Leo E., Maryland, 2011, director
Seago, Donald L., Mississippi, 2013, director
Simms, Richard A., California, 2010, director
Smith, Charles L., West Virginia, 2013, director
Sullivan, Timothy J., Wisconsin, 2010, director
Thompson, R. Wayne, Kansas, 2011, director
Walker, Lewis C., Florida, 2011, director
Warren, David D., New Mexico, 2010, director
Webb, Russell I., California, 2010, director
Beutler, Jeffery M., Interim Chief Executive Officer
Murphy, Emmett P., Interim Chief Financial Officer
Czarnecki, Robert N., director, administration and endowments
Jasek, Jane F., director, programs

*Composition reflects the date of submission, August 30, 2010

Status Update: ADA Foundation Corrective Action Plan

Background: The ADA Board, at its June, 2010 meeting, adopted the following resolutions with respect to the ADA Foundation and the related KPMG Tax and Financial Report (the "KPMG Report") and inquiry by the Illinois Attorney General.

> **Resolved,** that the ADA Board requests that the ADAF Board present a corrective action plan and associated timeline to the ADA Board of Trustees at the next ADA Board meeting (**B-96-2010)**;
>
> **Resolved,** that the ADA Board of Trustees urge the ADAF Board to immediately recruit and hire an interim CEO for the ADAF to facilitate the development and implementation of a comprehensive corrective action plan (**B-97-2010)**; and
>
> **Resolved,** that the ADAF Board report progress on the corrective action plan quarterly to the ADA Board of Trustees (**B-98-2010)**.

Corrective Actions and Corrective Action Plan: The ADA Foundation, through its Executive Committee comprised of Dr. Arthur Dugoni, Mr. Michael Sudzina, Mr. Kent Fletcher, and Dr. Robert Henderson, and with the assistance of ADAF Staff and both in-house and outside counsel retained to handle the Attorney General inquiry, has been hard at work on a detailed and comprehensive written Corrective Action Plan ("CAP") responsive to the KPMG Report. Much thought and work has already gone into the CAP, which the ADA Foundation hopes to have finalized in approximately the next 30 - 60 days. The CAP will be presented to the Illinois Attorney General when it is complete.

In addition to and as part of the larger written CAP that the Foundation is developing, the Foundation Board adopted a number of resolutions responsive to the KPMG Report for the purpose of moving the Foundation forward. The ADA Foundation Board views the resolutions as the first step towards addressing certain deficiencies identified by the KPMG Report. The Foundation Board's June 22-23, 2010 actions and status updates as of August 24, 2010 are listed below:

- Requested that the ADA Board of Trustees, acting for the Foundation's sole member, immediately direct the Legal Division to prepare, for submission to and approval by the ADA Board of Trustees, amended ADA Foundation Bylaws and Standing Rules which address the issues raised by the KPMG Report, and which, among other things, specifically eliminate the following provisions: (1) that the ADA Executive Director serve as the Secretary of the Foundation; (2) that the Secretary of the Foundation (a) serve as executive head of the central office of the Foundation and all its branches and engage all employees and (b) supervise, administer and coordinate the activities of the staff and committees of the Foundation in regard to their specific assignments and to systematize the preparation of their reports; (3) that the ADA Treasurer serve as Treasurer of the Foundation; and (4) that the Secretary of the Foundation be responsible to administer contracts entered into with the Foundation and that all contracts be signed by the President, Vice president or the Secretary and attested as appropriate by the ADA Chief Counsel or Senior Associate General Counsel or an Associate General Counsel of the American Dental Association.
    - After thoughtful consideration, the ADA Board of Trustees recommended to the ADA Foundation Board of Directors that they prepare ADAF Bylaws and Standing Rules which address all of the aforementioned issues identified in the KPMG report and present the draft documents for consideration to the ADA Board of Trustees acting as the Sole Member of the Foundation. These proposed Bylaws and Standing Rules revisions are in near complete form and will be reviewed and considered at the September 3, 2010 ADAF Board of Directors meeting. These draft documents are intended for presentation to the September ADA Board of Trustees meeting for consideration with an update to the ADA HOD in October, 2010.
    - In the mean time, actions have been taken to implement the intent of the ADAF resolutions as described in the following items.
    - The ADAF Nominating Committee will begin the process of nominations to replace directors whose terms are expiring in October 2010 and to nominate individuals to serve as officers for the Foundation.

- The Foundation: (1) respectfully accepted the resignation of Dr. Kathleen O'Loughlin, Executive Director of the ADA, as Secretary and executive head of the Foundation effective immediately; and (2) relieved her, immediately effective with such resignation, from performing all fiduciary duties and obligations under the Foundation's Bylaws, the Foundation's Standing Rules, and her employment contract as related to the Foundation.
    - This Item has been implemented as envisioned as part of the revised Foundation Bylaws.

- The Foundation: (1) respectfully accepted the resignation of Dr. Ed Leone, Treasurer of the ADA, as Treasurer of the Foundation effective immediately; and (2) relieved him, immediately effective with such resignation, from performing all fiduciary duties and obligations under the Foundation's Bylaws and the Foundation's Standing Rules.
    - This item has been implemented as envisioned as part of the revised Foundation Bylaws.

- Approved that, effective immediately, the Board, through its President, Vice President, and directors Robert Henderson and Kent Fletcher, assumes the responsibilities, power, and duties under the Bylaws and Standing Rules related to the executive head of the Foundation until such time as the Board deems it appropriate to relegate them back to staff.
    - This item has been implemented and responsibilities, power and duties have been so exercised; a position summary for the Interim Executive Director/CEO delineates any shared responsibility, accountability, authority and duties.

- Approved that, effective immediately, the Executive Director of the Foundation reports to the Foundation Board of Directors.
    - This Item has been implemented through the position summary as envisioned as part of the revised Foundation Bylaws

- Approved that, effective immediately, the positions of interim Chief Executive Officer of the Foundation and interim Chief Financial Officer of the Foundation report to the Foundation Board of Directors; and
    - This item has been implemented through the position summaries and/or contracts for services. The reporting relationships will be further revised as part of the revised Foundation Bylaws and position descriptions for each of these functions.

- Authorized and directed the President and Vice President of the Foundation, to immediately interview and hire an interim Chief Executive Officer and an interim Chief Financial Officer of the Foundation.
    - This item has been implemented as of June 28, 2010.
    - The Foundation Board retained the services of both an interim Chief Executive Officer and an interim Chief Financial Officer. Mr. Jeffery Beutler, who will serve as Interim Chief Executive Officer, has broad experience in

for-profit and not-for-profit organizations, including serving as the Executive Director of the American Association of Nurse Anesthetists. Mr. Emmett P. Murphy, CPA, assumes the role of Interim Chief Financial Officer. Mr. Murphy specializes in financial and administrative consulting for clients such as the American Student Dental Association, the American Academy of Orthopaedic Surgeons and DePaul University.

- After significant review of the Foundation's financial status, the Board is not aware of any embezzlement, theft, or fraud
- The ADAF has initiated a complete revision of its financial reporting with respect to its operations and budgeting process. Reporting and budgeting of business units will be based on management oversight and accountability. (See Section #4, Financial Overview)

- Directed that the ADA Legal Division, acting in conjunction with the interim Chief Executive Officer, the interim Chief Financial Officer, and two members of the Board selected by the Foundation's President, develop a clear and comprehensive Corrective Action Plan which addressed, among other things, (1) governance issues, (2) financial controls, (3) fundraising procedures and policies, (4) accountability controls, and (5) other key issues addressed in the KPMG Report; with a status report to be made to the Foundation Board at its July 28, 2010 meeting; and that the Legal Division be tasked with reconciling the Foundation's Corrective Action Plan with the ADA's Corrective Action Plan as necessary.
    - This group has worked closely with the Foundation Acting Executive Committee to address all related issues.
    - ADAF Staff have prepared background materials and participated with counsel and the Executive Committee members in the review of all ADAF program, activities and initiatives to ensure:
        - Alignment with mission and purpose
        - Compliance with federal and state statutes
        - Fundraising and financial best practices
        -
- Suspended the ADA Foundation fundraising activities until a Corrective Action Plan is approved by the Board and is in place.
    - This moratorium has been in effect since June 22, 2010.
    - All communities of interest have been notified.
    - Donors whose contributions were received after this date have been notified and either have been or will be offered the options of leaving the money in a segregated account until the moratorium is lifted, having the contributions returned to them, or directing the contributions to another qualified 501(c) (3) organization.
    - All contributions received since December 2009 have been placed in a separate and segregated fund until all 990 restatements have been completed for 2009, 2008, 2007, and 2006.

- Tasked the ADA Legal Division with reviewing each fundraising vendor contract to which the Foundation is a party to determine whether such contract should be terminated or amended, and that the Legal Division report its recommendations to the Foundation Board at its July 2010 meeting.
    - This item has been implemented and all related fundraising vendor contracts have been terminated; one exception is the vendor supporting the *Our Legacy — Our Future* (OLOF) initiative, which will be reviewed at the October meeting of the OLOF Steering Committee to recommend future involvement and activities. In addition, a list of all pending contracts has been developed for monitoring and tracking through the development and approval phases.

- Decided to terminate the employment relationship with Barkley Payne, Executive Director of the Foundation, effective immediately.
    - This item has been implemented, including a fully executed severance agreement.

- With respect to the Paffenbarger Research Center, (1) approved support of up to $545,273 from royalty funds to cover supplemental funding for staff at the PRC in 2010, as recommended by the PRC Workgroup; (2) approved a commitment up to $2.3 million dollars from royalties to fund actions through 2011 called for in the PRC Transition Plan; and (3) requested the ADA Human Resources Department develop an aggressive plan for search and recruitment of a senior director for PRC.
    - Item (1): has been implemented and PRC staff notified of this decision.
    - Item (2): PRC staff has been notified of this action.
    - Item (3): A draft position description has been developed and the ADAF President has initiated the process for appointment of a search committee. The Interim Executive Director has been directed to move forward to fill the PRC Business Manager position to assist in management of PRC activities in the interim and also directed to assist in the search process for the senior PRC administrative position.

- Approved the discontinuation of funding and oversight of the Hillenbrand Fellowship Program, effective June 23, 2010.
    - This item has been implemented, and the entire program, including governance, administration, staffing and funding, has been moved to the ADA effective August 1, 2010.

- Requested that appropriate staff (including attorneys) review the structure and member selection process of the GKAS National Advisory Board and submit any recommendations for improvement to the ADAF Board of Directors.
    - After multiple meetings of all stakeholders and communities of interest, the GKAS program (GKAS DAY and GKAS Expansion activities) is still under review; a final set of options will be going to the ADAF Executive Committee on August 30 and to the ADAF Board of Directors on September 3 for consideration.

- Approved the discontinuation of the Campaign for Innovation.
    - The ADA Foundation Board closely examined the Campaign for Innovation. Considering a number of factors, including the current economy, significant up-front campaign costs, the broader fundraising environment, and feedback from volunteers, donors and the dental schools, the ADAF Board reached the very difficult decision to reluctantly end the Campaign for Innovation.
    - The wrap-up phase is 80% completed and will take another 45-90 days to finalize: Follow-up letters and calls to donors are underway.
    - Staff positions associated with the Campaign for Innovation were eliminated in July, unfortunately affecting the employment of seven ADAF staff members who had been hired to support this initiative. The Board thanks all of these

dedicated staff members for their assistance and wishes them the best in all that they do in the future. One of the staff members has returned on an interim basis to help with related stewardship activities; one other laid off staff person has offered to help on a contract hourly basis if needed; the Foundation has hired a temporary technical support person to assist in data entry and management during this transition.

- The Foundation Board emphasized its strong support of dental education by reaffirming its support of the Dental Education: *Our Legacy — Our Future*.
  - The Foundation takes pride in the success of the *Our Legacy — Our Future* awareness and marketing campaign with 55% of the nation's dental schools reporting $550 million being either pledged or donated to support dental education throughout the United States. Applying this fundraising rate to 100% of U.S. dental schools, it is estimated that nearly $1 billion was pledged or donated to support dental education as a result of the *Our Legacy — Our Future* Campaign.
  - The OLOF Steering Committee will be meeting at the 2010 ADA annual session to continue to plan winning strategies in support of Dental Education.

- Directed that the ADA Legal Division and all other applicable staff be tasked with completing the Intercompany Services Agreement between the ADA and the Foundation by July 28, 2010.
  - The draft Intercompany Services Agreement is complete except for the financial methodology to be used for assigning costs for services rendered. A series of meetings are underway between the ADA and ADAF to finalize this process and codify it as part of the Agreement. The timeline for submission to both parties for approval is late September.

The Foundation has commenced an in-depth, staff, legal counsel, Executive Committee and Board of Directors examination and evaluation of each one of its 40+ programs and has also initiated a review of current and future staffing requirements to support the programs in each of its four primary missions.

The Foundation Board is committed to implementing KPMG's recommendations which will improve and strengthen the Foundation, and remains dedicated to its mission of dental education, access to care, research, and charitable assistance.

Resolutions: This section of the ADA Foundation Annual Report is informational and no resolutions are presented.

ADA Foundation Research Institute

Frantsve-Hawley, Julie, director

Located in the Division of Science at ADA Headquarters in Chicago, the Research Institute (RI) is supported by the ADA Foundation (ADAF). RI scientists address emerging and critical oral health issues through basic and applied research, often in collaboration with scientists at universities or other research institutions, including the ADAF Paffenbarger Research Center (PRC).

The RI conducts the popular research program assessing the occupational health of the dental team known as the Health Screening Program. Through a grant from the National Library of Medicine to the ADAF, the RI provided the financial resources to construct the Center for Evidence-Based Dentistry Web site (ebd.ada.org). The RI helps attract dental students toward careers in research by hosting research externs recommended and coordinated by the American Student Dental Association, conducting the annual Dental Students' Conference on Research, and judging awards sponsored by the ADA Foundation at the Intel Science and Engineering Fair.

The Research Institute Supports the Mission of the ADA Foundation: The Research Institute supports the ADAF's mission through practical scientific research on issues that impact the oral health of the public, the occupational health of the dental team, and everyday clinical practice. Examples are:

- Assessing the best available evidence on topics of concern to the dental profession and making the results available to dentists for use in their clinical decision-making (evidence-based dentistry).
- Monitoring the occupational health of the dental profession through the Health Screening Program.
- Responding to emerging and critical oral health issues (e.g., oral-systemic health interactions, and patient and provider safety issues).

ADAF Health Screening Program: The mission of the Health Screening Program (HSP) is to make the dental office safer for dental professionals and the patients they serve, and to expand scientific knowledge in areas of importance to dentists and their patients. The HSP also promotes scientific research by making the nation's largest database of aggregated information about the health of dental professionals available to scientific investigators.

The HSP has been offered for 40 years as an event at the ADA annual session. After a one year hiatus in 2008, the retooled 2009 Health Screening Program was held on October 1-3 at the ADA annual session in Honolulu, Hawaii. Approximately 950 individuals participated in 2009, with online appointments made using the pre-registration option. The no-show rate was variable and ranged from less than 10% for the most popular times (early morning) to 30-40% for the less popular times (late mornings). The HSP opened at 6:00 a.m. each morning to accommodate interest in early appointments.

Due to an off-site location and extreme space limitations in Honolulu, the HSP area was smaller than in previous years. Nevertheless, the space provided the opportunity to invite a limited number of collaborators to participate in the HSP. They included UCLA (Dr. David Wong, salivary diagnostics) and SmartPractice (patch test and delayed latex hypersensitivity). Also new this year was the first CE course offered in association with the HSP. The course was given by Dr. Michael Glick and Dr. Barbara Greenberg on conducting medical screenings in a dental setting. This course is part of a research program to evaluate changes in dentists' knowledge and attitudes toward conducting medical screenings in a dental setting. Data from this research has been submitted as an abstract to the 2010 AADR conference.

Screenings/services offered to participants included:

- HSP questionnaire
- Blood pressure and weight
- Comprehensive metabolic panel with differential cholesterol
- Hemoglobin A1c
- Hepatitis C
- Legionella pneumophila
- Flu shots

Optional screenings offered for a fee included:

- Prostate specific antigen
- Thyroid stimulating hormone
- VAP cholesterol
- Bone density

Looking ahead, the HSP will continue to be the leading source of longitudinal data on the occupational health and safety of the dental team and will provide the scientific basis for continuing to develop sound policies on emerging occupational health and safety issues affecting the dental team. The ADA Council on Scientific Affairs has proposed to the ADAF several new directions for the HSP in future years, including a forum for research and education on the role of dentistry in overall healthcare.

To address the funding needs for the HSP, the ADA Foundation developed an HSP task force to recommend short-term and long-term funding strategies. Dr. Dugoni and Dr. Findley appointed the following individuals to serve on this special taskforce.

Dr. Dominick DePaola, former dean, The Forsyth Institute
Mr. Kent Fletcher, ADAF Board member and Vice President, Public Relations, Sunstar
Dr. Michael Glick, editor, *The Journal of the American Dental Association*
Dr. Curtis Hamann, HSP screening sponsor and President and CEO, SmartPractice
Dr. Michael Rethman, chair, Council on Scientific Affairs
Dr. Marie Schweinebraten, ADA Board member, Fifth District Trustee

Dr. Anthony Volpe, former ADAF president and vice president, Global Oral Care, Colgate-Palmolive Company

The task force met in August, 2009 and prepared a report for the March 2010 ADAF Board of Directors meeting to review recommendations. Unfortunately, the task force was unable to present a confirmed and sustainable funding model for the HSP. The task force recommendations originally described a stable funding model for HSPs 2010 and beyond. However, due to funding, governance and administrative issues, the 2010 HSP was cancelled at the request of the ADAF Board of Directors. The ADA Board of Trustees has agreed to fund the 2011 HSP. The ADAF Board of Directors has agreed that the Foundation will consider requests for grants to support related research activities in the future. Planning functions for the 2010 HSP have halted and communications are under way to inform all interested parties of the cancellation and to reimburse registered participants.

Dentists' Attitudes toward Chair-side Screening for Medical Conditions: Through collaboration with Dr. Michael Glick (University at Buffalo) and Dr. Barbara Greenberg (New Jersey Dental School), the Research Institute was involved in a research project to assess dentists' attitudes, willingness and perceived barriers regarding chair-side medical screening in the dental office. A national, random sample of U.S. general dentists was surveyed by mail by means of an anonymous questionnaire. The results indicate that dentists considered medical screening important and were willing to incorporate it into their practices. Additional education and practical implementation strategies are necessary to address perceived barriers. This study was published in the January 2010 issue of *JADA*.

Barriers to Implementing Evidence-Based Clinical Guidelines: Through collaboration with Dr. Heiko Spallek (University of Pittsburgh), the Research Institute was involved in a research project to identify barriers that early-adopting dentists perceive as common and challenging when implementing recommendations from evidence-based (EB) clinical guidelines. In this cross-sectional study, dentists who attended the 2008 Evidence-Based Dentistry Champion Conference were asked to participate in an anonymous online questionnaire. Results indicate that the most common barriers to implementation are difficulty in changing current practice model, resistance and criticism from colleagues, and lack of trust in evidence or research. Barriers perceived as serious problems have to do with lack of up-to-date evidence, lack of clear answers to clinical questions, and contradictory information in the scientific literature. A manuscript pertaining to this study has been submitted to *The Journal of Evidence-Based Dental Practice.*

Intel International Science and Engineering Fair: *(This program is currently under review and the future status has not yet been determined.)* To stimulate interest in oral health research and recognize the work of young scientists, the ADA Foundation sponsors awards at the Intel International Science and Engineering Fair (ISEF). Judging and award presentations are coordinated by the Council on Scientific Affairs. The 2009 ISEF was held in Reno, Nevada. Dr. Sheila Strock, senior manager, Council on Access, Prevention and Interprofessional Relations, served as judge. The ADA Foundation sponsored three awards for projects that contribute to scientific research relevant to oral health ($2,000 for first place, $1,000 for second place and $500 for third place).

First prize at the 2009 ISEF went to David C. Evans for his project titled, “A Solution for Post-Surgical Pain Control: A Novel Sustained-Release Local Anesthetic Composed of Hyaluronan, Fibrinogen, and Marcaine.” Mr. Evans developed an effective and safe local anesthetic that provides a sustained release in excess of 30 hours, thereby eliminating pain for a longer period post-operatively.

Second prize was awarded to Catherine Yang Fan for her project titled, “Development of a Novel Antimicrobial Bone Graft Substitute for Cranioplasty.” Ms. Fan successfully produced silver nano-particles in situ by curing dental resin resulting in a biomaterial with antimicrobial properties.

The third place award went to Shannon Somer Stockton for her project titled, “The Down-Regulation of Sp1 Protein by Tolfenamic Acid in Head and Neck Cancer.” Ms. Stockton tested the effectiveness of Tolfenamic acid in down-regulation Sp proteins resulting in the inhibition of cancer cell proliferation.

Held each May, the Intel ISEF is the world's largest pre-college celebration of science, bringing together more than 1,200 high school students from 50 countries. The May 2010 ISEF will be held in San Jose, California.

45th Annual Dental Students’ Conference on Research: *(This program is currently under review and the future status has not yet been determined.)* Forty-two students representing dental schools in the United States and Canada attended the 2010 Dental Students’ Conference on Research in Gaithersburg, MD. This annual conference was held on May 2-4, 2010, with sponsorship from the ADA Foundation and Johnson & Johnson. Students toured facilities at the Paffenbarger Research Center. The students heard presentations about dental research career opportunities from scientists and representatives from the ADA Council on Scientific Affairs, the American/International Association for Dental Research, PRC, National Institute of Dental and Craniofacial Research and Johnson & Johnson. Students also had the opportunity to present results of their own research in a poster session at the conclusion of the conference.

Resolutions: This section of the ADA Foundation Annual Report is informational and no resolutions are presented.

ADA Foundation Paffenbarger Research Center at the National Institute of Standards and Technology

Schumacher, Gary E., associate director, chief research scientist, clinical research
Carey, Clifton M., director, independent research and grant administration
Bowen, Rafael L., distinguished scientist
Chow, Laurence C., assistant director and chief research scientist, dental chemistry
Dickens, Sabine H., chief research scientist emeritus, polymer chemistry
Vogel, Gerald L., chief research scientist, dental cariology

The Paffenbarger Research Center (PRC), which is located on the campus of the National Institute of Standards and Technology (NIST) in Gaithersburg, MD, is an agency of the American Dental Association Foundation (ADAF). PRC receives funding through the American Dental Association's (ADA) annual grant to the Foundation, from National Institutes of Health (NIH) grants, from industrial contracts and grants and from service contracts with NIST. NIST also provides PRC with substantial in-kind support. PRC generates royalty income for the ADA Foundation, some of which is returned to PRC to support its research programs. The licensing of patented inventions ensuing from scientific research at the PRC has resulted in 30 products currently available to practicing dentists.

PRC scientists conduct basic and applied studies in clinical research, dental chemistry, polymer chemistry and dental cariology. Projects further the scientific research mission of the ADA Foundation, and also respond to critical issues identified by the Association's Council on Scientific Affairs. In the past year, PRC scientists published or had accepted 41 peer-reviewed manuscripts and abstracts, and their work resulted in the issuance of four new United States patents. The researchers made 21 scientific presentations and lectures at scientific meetings or for dental continuing education, including invited talks both nationally and internationally to ADA affiliate societies, universities, academies, study clubs and other organizations. Seventeen PRC researchers presented their data at the 2010 American Association for Dental Research meeting in Washington, DC. Abstracts of PRC research presentations and publications, as well as reprints of published articles and manuscripts presented at scientific meetings, are available from PRC on request. Descriptions of the ongoing research projects are available on the ADAF Web site at http://www.ada.org/2919.aspx.

The PRC Supports the Foundation's Mission: The Foundation, through PRC, supports advancing the oral health of the public through basic and applied research and more specifically the development of improved dental materials and treatment technologies. Several examples of how PRC directly addresses the Foundation's mission are:

- Public Presence by responding to critical issues through the Division of Science and the Council on Scientific Affairs, through direct participation in national and international standards organizations. The news reports of lead in porcelain fused to metal crowns became a critical issue that received national media attention. The PRC rapidly mobilized to support the Division of Science and the CSA by participating in an ADA sponsored study to determine the extent and potential

toxicity of the problem. Publicity about PRC is often supported by the National Institute of Standards and Technology public relations office. PRC hosts the Dental Students' Conference on Research, which is sponsored by the ADAF and industry (Johnson & Johnson).

- Data and Information by researching issues that have direct impact on practice and public health, and the publication and dissemination of these research results. PRC serves the practitioner, the patient and manufacturers through involvement in and support of the national and international standards process. PRC researchers serve as an ISO subcommittee secretary, a working group convener and experts on working groups.

- Education and transfer of knowledge by providing quality continuing education programs for constituent and affiliate organizations. Topics discussed include dental materials, caries mechanisms and caries management for the at risk dental patient, fluoride therapies, remineralization therapy via calcium and phosphate, and issues involving lead in porcelain fused to metal crowns. The PRC hosted the 46th annual Dental Students' Conference on Research by providing lectures and tour stops that highlight areas of research interest.

- Professionalism by communicating PRC accomplishments directly to the profession through programs, presentations, and the public media. Included were press releases on PRC tooth remineralization technology, amorphous calcium phosphate, presentations to state dental associations and local societies, and publication of a compact disc highlighting PRC accomplishments. The compact disc is available by contacting Gretchen Duppins (301-975-6806) or by written request at: Paffenbarger Research Center, NIST, 100 Bureau Drive Stop 8546, Gaithersburg, MD 20899-8546. The PRC research highlights are also accessible online at the ADA Web site: http://www.ada.org/2919.aspx.

Plan to Reinvigorate PRC: In 2008 the PRC prepared a self-study for a committee of external reviewers that was commissioned to examine the scope, scientific program, operational aspects and funding of the Paffenbarger Research Center. The findings of the report were presented to the ADA Board of Trustees, which referred them to the Council on Scientific Affairs (CSA) to develop recommendations with an action plan and milestones. PRC staff worked with the CSA subcommittee that developed the report on the future of PRC that was adopted by the full Council and submitted to the Board of Trustees in April 2009. The Board of Trustees forwarded a modified version of CSA's report and recommendations to the 2009 House of Delegates for the House's information (Board Report 11).

One recommendation was to appoint a workgroup to begin implementation of priority actions needed to reinvigorate PRC's operations and research programs. The workgroup, originally created by the ADA Board, was subsequently transferred to the auspices of the ADA Foundation. Dr. Russell Webb has remained chair of the workgroup throughout. The workgroup's charge was expanded by the ADAF Board of Directors to include investigation of governance options for PRC. This, with work being done to clarify PRC financial

statements, has taken precedence over the plan to reinvigorate PRC. Hopefully, that plan, with any necessary modifications, can move forward again shortly. One aspect of the plan, creation of a PRC Emeritus Scientist Program, was implemented in March 2010, when emeritus status was offered and accepted by a retired PRC scientist.

Critical Issues Research and Standards:

- *Lead in crowns.* The porcelain of all-ceramic crowns and porcelain fused to metal crowns was examined to evaluate the existence of lead, the quantifiable amount and whether the lead leaches from the fired porcelain under acid attack. Porcelain powders from various manufacturers were examined to identify the existence of lead in the powder. Data collected from this research will be used to initiate the development of performance standards for porcelain.

- *Dental erosion.* PRC researchers are examining the effects of tooth whitening (bleaching) agents and dental erosion caused by beverages such as sports drinks, soft drinks and wine. Procedures developed would be incorporated into ANSI/ADA specifications as well as in International Standards.

- *Zinc in denture adhesives.* PRC scientists have planned experiments to measure the amount of zinc in denture adhesives as well as measurement of the amount of zinc released. This will aid in developing a performance standard.

Dental Chemistry: Progress continues on PRC-developed calcium phosphate bone cements with experiments currently being conducted to address uses, such as bone repair, endodontic procedures and ridge augmentation. A new, dual-paste, premixed cement is undergoing intensive developmental work in preparation for a new FDA 510k application in 2009. PRC scientists have synthesized the first alkaline pH calcium phosphate cement that forms fluorapatite as the main product. The material is being evaluated for antimicrobial and root canal sealing properties at The University of Maryland Baltimore College of Dental Surgery, and for non-resorptive properties using a rabbit model at Nihon University School of Dentistry, in Tokyo, Japan. An apparatus to synthesize nano-sized calcium phosphate and calcium fluoride particles, engineered and built by PRC scientists, has now been supplemented by a new commercial instrument that is more efficient and has greater output capacity. This new device was made possible by a $94,450 grant from the American Recovery and Reinvestment Act (ARRA) stimulus funds awarded by the NIDCR. Experiments to assess the efficacy of nano calcium fluoride particles in an oral rinse are continuing. In a collaborative effort with The University of Maryland Baltimore College of Dental Surgery, the materials are being used as sources of calcium, phosphate and fluoride ions released in smart restorative materials research. A newly discovered fluoride-calcium-phosphate complex is being studied for applications in fluoride rinses, dentifrices, gels and varnishes. Additional work has focused on incorporating calcium into fluoride prophylaxis pastes and varnishes, which leads to improved tooth fluoride uptake by these applications. In a collaborative study with the National Institute of Environmental Health Sciences (NIEHS), one of the institutes of the NIH, calcified specimens from patients suffering from juvenile dermatomyositis will be examined by Fourier transform infrared microspectroscopy and x-ray diffraction to determine their composition. A research project supported in part

by the U.S.-Egypt Science and Technology Joint Fund and in collaboration with the Egyptian National Research Centre provides PRC with a $30,000 grant to work jointly with Egyptian scientists. The goals of the Joint Fund are to strengthen the scientific and technological capabilities of both the United States and Egypt, and to broaden and expand relations between the scientific and technical communities. An Egyptian scientist spent three months at the PRC creating nano calcium fluoride powders for drug delivery systems. This collaboration permits the PRC to investigate new avenues of research.

Dental Cariology: A clinical research project, funded from a grant from the Wm. Wrigley Jr. Company was begun to evaluate the therapeutic nature of chewing gums. Gum will be formulated to release calcium and phosphate to determine its ability to prevent caries. Studies will also determine the remineralizing potential of therapeutic- releasing chewing gums compared to traditional sugar-free chewing gum. PRC laboratory techniques have attracted the interest of commercial manufacturers with resulting collaborative research. A new commercially available anti-caries varnish that contains both fluoride and amorphous calcium phosphate (ACP), which is a PRC licensed remineralizing technology, was launched. The use of ACP as a filler in a resin matrix is part of the ongoing "smart composite" research, and the current focus is on the effect of the size of the ACP particles. A study to evaluate the performance of ACP fillers in root canal sealers is ongoing and will continue through most of calendar year 2010. Additional goals for the Cariology group include development of international standards for assessing the abrasiveness of dentifrices and for assessing the erosive capacity of oral rinses. Studies to determine the amount of fluoride that is necessary to provide therapeutic efficacy are underway. These studies use a novel laboratory mouth model, and will begin validating the results in a clinical study.

Polymer Chemistry: Work continues on developing adhesive remineralizing resin composites for the ART technique. The areas of research for this material include improved strength by reinforcement with ceramic whiskers, evaluation of the calcium phosphate filler, variations in the resin formulation and assessment of wear characteristics. A patent application for a remineralizing dental composite material based upon calcium phosphate nano-fillers is currently under review. Extensive experiments and evaluation on the in vitro remineralization of artificial caries lesions in comparison to natural lesions has recently been completed. Several acidic monomer resin formulations have been tested for mechanical properties nondestructively, using a dynamic mechanical analyzer. Experiments were performed to determine the mechanical and physical properties of resin composites modified with silane oligomeric comonomers. It has been shown that these comonomers are able to reduce polymerization shrinkage stress in composite restorative materials. Research involving development of a new adhesive resin formulation based on one of the PRC-synthesized polymerizable cyclodextrin derivatives continue. Initial bond strength tests for bonding a composite material to dentin were encouraging. Basic research on scaffold materials and the effects of size and structure of the scaffold for optimized cell attachment has been started.

Clinical Research: Clinical studies involving human subjects are ongoing to evaluate the therapeutic nature of chewing gums in terms of their ability to form oral reservoirs of calcium and phosphate. A clinical study on a remineralizing chewing gum and a mouth

rinse based on a fluoride calcium phosphate complex has been initiated. The PRC has been active in assisting the Division of Science in the review of chewing gum guidelines for the ADA Seal of Acceptance program. PRC conducted its third annual *Dental Fractography Workshop,* co-sponsored by the ADA Foundation, NIST, Zeiss and 3M. Past courses were filled to capacity with a class of international dental researchers and the 2010 course is already sold out. Discussions have begun to develop research collaborations with dental schools to provide a larger volunteer base for clinical trials.

Resolutions: This section of the ADA Foundation Annual Report is informational and no resolutions are presented.

Financial Update

The ADAF Board of Directors has directed that an in-depth financial analysis of the Foundation be conducted. This analysis was initiated June 2010 and includes the review of all ADAF programs, cost centers, financial policies and procedures, financial systems and processes, reporting mechanisms and budgeting processes. This analysis will lead to recommendations for actions necessary to assure compliance with foundation financial and accounting best-practices. To date, this review has led to a major revision of the Foundation's budgeting process, financial operations and reporting processes, including oversight and accountability.

The new financial processes, systems and structure will more accurately track and report financial data that will be used both for better internal operations and accountability, and for external reporting as well.

The following financial summary is based on current available financial information, and projections are based on anticipated Foundation activities for the remainder of 2010. The assumptions used to estimate future expenditures are also partially based on historic information and the final results are likely to vary from the projections.

Table 1: Financial Position

		Mid Year		Est. Year End
Assets				
	Cash	$2,393,000*		$1,235,500
	Receivables	953,000		953,000
	Investments (no 2nd half change)	22,228,000**		22,228,000
	Property	595,000		595,000
	Other			
	Total Assets	$26,169,000		$25,011,500
Liabilities and Net Assets				
	Accounts Payable	$530,000		$530,000
	Due to Affiliates	2,903,000+		2,153,000+
	Deferred Revenues	118,000		118,000
	Net Assets	22,618,000		22,210,500
	Total Liabilities and Net Assets	$26,169,000		$25,011,500

Table 1.
*Cash is expected to be lower due to the suspension of fundraising June 22, 2010.
**Due to unstable market conditions, no Investment balance changes have been projected.
+Liability balances between the ADA and the Foundation will be addressed to reduce this number to more historical levels which are traditionally based on payment timing.

Table 2: Statement of Activities:

Statement of Activities	First Six Months	Second Six Months	
Revenues excluding investments	$4,064,000	$3,450,000	* +
Investment Activity	(581,101)	0	**
Expenses	3,594,000	3,857,500	=
	$(111,101)	$(407,500)	

Table 2.

Revenues

*The impact of the suspension of fundraising will have a significant impact on revenues.

**Investments changes are not projected so there is no change in the balance.

+Sponsorship of some programs may continue based on the analysis of each program and their charitable purpose.

Expenses

=Costs for the innovation campaign have ceased and will favorably impact the second half of the year. Additional costs will be incurred for severance of former employees, for the interim CEO and CFO, and for consulting involved in the cost, finance and budget system analysis.

Index of Resolutions

* Resolutions 126-132 will be indexed in *Transactions, 2010.*

2009 Resolution

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