2007

2007 Supplement Vol. 1

American Dental Association

ADA American Dental Association®

America's leading advocate for oral health

2007

Supplement to
Annual Reports and Resolutions
Volume 1

148th Annual Session

San Francisco, California

September 28 – October 2, 2007

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Report: Board Report 1 Date Submitted: July 2007

Submitted By: Board of Trustees

Reference Committee: NA

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: None (Required)

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

This is the first in a series of reports to be presented by the Board of Trustees to the House of Delegates at the 148th Annual Session of the American Dental Association.

Appreciation to the Council on ADA Sessions and the 2007 Committee on Local Arrangements: The American Dental Association is pleased to return to San Francisco, California, for the 148th Annual Session.

The Council on ADA Sessions has created a meeting that lives up to the ADA's reputation for delivering an extraordinary education and exhibition experience. The Board of Trustees wishes to express its sincere gratitude to the Council, and the exceptional leadership of Dr. Kenneth McDougall, 2006-2007 Council Chair, and Dr. Chad R. Leighty, program director. They have planned and produced not only an innovative continuing education program, but an exhibition that allows dental professionals to experience firsthand the latest in cutting edge dental materials, services and new technologies. Council members: Dr. Pamela S. Berlanga, Dr. Jeff J. Brucia, Dr. Stephen W. Carstensen, Dr. Gary K. Dubin, Dr. Mary Beth Dunn, Dr. James K. Feldman, Dr. John T. Frey, Dr. John R. Jordan, Jr., Dr. Risé L. Lyman, Dr. Michael Medovic, Dr. Edward H,. Mohme, Dr. Dennis D. Shinbori, Dr. Robert L. Skinner, Dr. Charles L. Smith (Board of Trustees Liaison), Dr. Philip E. Smith, Dr. A. Ted Twesme, Dr. Charles R. Weber, Dr. John R. Williams, Dr. Stephen J. Zuknick (CND Liaison) and Bradley D. Harrelson (ASDA Liaison) are all to be recognized for their commendable achievement.

The Board also extends its sincere thanks to those chairpersons who so capably assisted Dr. Jeff J. Brucia, general chair of the 2007 Committee on Local Arrangements: Dr. Dennis D. Shinbori, vice chair; Dr. Harvey J. Barish, program co-chair; Dr. Dudley Cheu, registration co-chair; Dr. Stafford J. Duhn, program co-chair; Dr. Nava Fathi, hospitality co-chair; Dr. Michael Fox, hospitality co-chair; Dr. Nader A. Nadershahi, registration co-chair; and Dr. James H. Van Sicklen, Jr., program co-chair.

Finally, the Board expresses tremendous appreciation to all of the volunteers on the Committee on Local Arrangements for the assistance they provide to the Council in the operation of this annual session. The Board recognizes and thanks to the California Dental Association for their contributions to the success of ADA07SanFrancisco Annual Session.

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

Death of Former ADA Officials: Since the 2006 session of the House of Delegates, the following former officials have passed away: Felix C. Crawford, ADA Vice President (2001-2002); Lawrence H. Meskin, *JADA* Editor, (1990-2001); John H. Mosteller, ADA Vice President (1977-1978); Gary J. Newman, ADA Trustee (1991-1995); and Michael T. Rainwater, ADA Trustee (2005-2006).

The Board also acknowledges the passing of a great friend to dentistry, Dr. Charles Norwood, Member of Congress from Georgia.

Election to Honorary Membership: In accordance with Resolution 79H-1980 (*Trans.*1980:590), which empowers the Board of Trustees to elect honorary members of the Association, the following individuals have been elected to Honorary Membership.

Dr. Stephen Hancocks
Mr. Fred Herbst
Ms. Faye K. Marley
Ms. Patricia M. Newton
Professor Lakshman Samaranayake
Professor Xing Wang
Professor Zhenkang Zhang

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

Distinguished Service Award: Established in 1970, the Distinguished Service Award is the highest honor conferred by the Association's Board of Trustees. Each year the Board may select one recipient for the Award. The Board is pleased to announce that the recipient of the 2007 Distinguished Service Award is Dr. Dushanka Kleinman.

Dushanka Kleinman, D.D.S., MScD: Dr. Kleinman served for 26 years at the National Institute of Dental and Craniofacial Research, joining the (then) NIDR in 1980, she was named deputy director in 1991 and served as acting director twice.

A rear admiral in the U.S. Public Health Services (USPHS) Commissioned Corps, Dr. Kleinman spearheaded the first-ever Surgeon General's report on oral health, which was published in 2000. In 2001 she was named Chief Dental Officer, USPHS, the first woman to hold that position since it was established in 1923. As Chief Dental Officer, she coordinated dental programs for the Office of the Surgeon General and advised the Surgeon General on issues related to dental practice and personnel in the Public Health Services.

Currently the associate dean for research and academic affairs, College of Health and Human Performance, University of Maryland-College Park; Dr. Kleinman also has an appointment as professor in the Epidemiology and Biostatistics Department of the College, which is transitioning to a School of Public Health.

Dr. Kleinman earned a B.S. in zoology from the University of Wisconsin and a D.D.S. from the College of Dentistry at the University of Illinois. She interned at the University of Chicago's Zoller Dental Clinic prior to studying at the Henry M. Goldman School of Graduate Dentistry at Boston University, where she received a M.Sc.D. in dental public health.

Dr. Kleinman is the recipient of many honors including the PFA Gold Medal (2005); the USPHS Distinguished Service Medal for exemplary and innovative leadership in contributing and directing the development of the first-ever Surgeon General's Report on Oral Health; the USPHS Outstanding Service Medal; the USPHS Surgeon General's Exemplary Service Medal; the American Public Health Association's John W. Knutson Distinguished Service Award in Dental Public Health; and the 2003 Carl A. Schlack Award from the Association of Military Surgeons of the United States.

She is a Diplomat of the American Board of Dental Public Health. She has been President of the American Association of Women Dentists, the American Board of Dental Public Health, and the American Association of Public Health Dentistry. As a member of the American Dental Association, Dr. Kleinman has served in the ADA House of Delegates representing the Public Health Service and participated as a member of the Oversight Committee in the development of the ADA's most recent Future of Dentistry Report.

Retiring Officers and Trustees: The Board of Trustees wishes to express its gratitude to the following officers and trustees for services rendered to the Association during their tenure on the Board: Dr. Stephen F. Schwartz, first vice president; Dr. John S. Findley, trustee, Fifteenth District; Dr. Joel F. Glover, trustee, Fourteenth District; Dr. Frank C. Grammer, trustee, Twelfth District; and Dr. Jeanne P. Strathearn, trustee, First District.

Appreciation to Employees: The Board of Trustees is pleased to bring to the attention of the House of Delegates 33 members of the Association staff for their years of service.

Thirty-five Years

Linda J. Hastings, Administrative Services

Thirty Years

Carrie Woodford-Dawson, Education and Professional Affairs; Patricia Schranz, Membership, Marketing and Tripartite Relations; and Chakwan Siew, Science and Professional Affairs.

Twenty-five Years

Charles Bermingham, Information Technology; Josielen Calloway, Finance and Operations; Anthony Giuseppetti, Paffenbarger Research Center; Corazon Lapuz, Education and Professional Affairs; Vivian Slack, Administrative Services; and Rita Tiernan-Stoterau, Finance and Operations.

Twenty Years

Pamela Fryer, Government and Public Affairs; Shirley Ji, Information Technology; Kathy Pujol, Conference and Meeting Services; Marsha Stiegel, Practice and Professional Affairs.

Fifteen Years

Rosemary Brandt, Finance and Operations; Anthony Gardner, Conference and Meeting Services; Albert Guay, Chief Policy Advisor; Laura Kosden, Publishing; and Ferdinand Villas, Finance and Operations.

Nominations to Councils and Commissions: The Board of Trustees annually submits to the House of Delegates nominations for membership to the councils, commissions and Committee on the New Dentists. Based on the ADA *Bylaws*, the nominees for ADA open positions on the Commission on Dental Accreditation and Council on Scientific Affairs were selected by the Board from nominations open to all

trustee districts. Additionally, in accordance with a long-standing House directive, the Board is providing a brief narrative comment on each nominee's qualifications.

The qualifications of these nominees for membership appear on page 1010.

Access, Prevention and Interprofessional Relations
Gary S. Davis, PA
A. J. Homicz, NH
Melanie S. Lang, WA
David J. Miller, NY
AMA Representative (To be Determined)
AHA Representative (To be Determined)

ADA Sessions
Stephen Carstensen, WA, *ad interim*
Ronald K. Heier, PA
Kevin M. Laing, OH
Hutson E. McCorkle, FL
Michael C. Remes, MN

Communications
Jonathan R. Gellert, NY
Eugene T. Giannini, DC
Josef N. Kolling, MI
Mary A. Starsiak, IL

Dental Accreditation
Reuben N. Pelot, III, TN

Dental Benefits
Philip J. Eversman, IN
Harry C. Futrell, FL
Daniel J. Klemmedson, AZ
Christopher J. Smiley, MI

Dental Education and Licensure
Brian T. Kennedy, NY
James L. Schmidt, ME

Dental Practice
H. Lee Gardner, Jr., SC
Stephen O. Glenn, OK
Michael H. Halasz, OH
Christopher C. Larsen, IL

Ethics, Bylaws and Judicial Affairs
Thomas W. Gamba, PA
Carl L. Sebelius, Jr., TN
Terri S. Tiersky, IL
Rodney B. Wentworth, WA

Government Affairs
James D. Condrey, TX
Rodney J. Klima, VA
Matthew J. Neary, NY
Donald M. Schinnerer, CA

Membership
Rex B. Card, NC
Todd R. Christy, MI
Virginia A. Hughson-Otte, CA
William F. Martin, III, MD

Members Insurance and Retirement Programs
Philip M. Abshere, OK
Edmund Cassella, HI, *ad interim*
D. Douglas Cassat, CA
C. Richard Gerber, WV
Louis A. Imburgia, IL

National Dental Examinations
Stephen T. Radack, III, PA

New Dentist
Jeremy M. Albert, FL
Jennifer Davis, PA, *ad interim*
Jennifer J. Jerome, OH
Robert S. Leland, MA
Stacey E. Swilling, AR

Scientific Affairs
Steven R. Armstrong, IA
Robert J. Buhite, NY
John O. Burgess, AL
George W. Taylor, III, MI

Resolution

23. Resolved, that the nominees for membership on ADA Councils, Commissions, and the Committee on the New Dentist submitted by the Board of Trustees in accordance with Chapter VII, Section 110(H) of the *Bylaws* be elected.

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

Access, Prevention and Interprofessional Relations
Vincent Filanova, NY
Lisa P. Howard, MA
Philip T. Siegel, PA
Henry C. Windell, OR

ADA Sessions
Kenneth McDougall, ND
John R. Jordon, Jr., FL
Chad R. Leighty, IN
Charles R. Weber, PA

Communications
Sally J. Cram, DC
Bradley W. Barnes, IL
Dennis W. Engel, WI
Douglas B. Smail, NY

Dental Accreditation
Joan M. Gillespie, VA

Dental Benefits
Alan E. Friedel, FL
Patricia I. Boyle, MI
Thomas J. Schripsema, NM
Stephen P. Simpson, OH

Dental Practice
Billie Sue Kyger, OH
Richard F. Hunt, III, NC
Teri Steinberg, IL
Jon W. Tilton, KS

Ethics, Bylaws and Judicial Affairs
Rickland G. Asai, OR
Dennis J. Charlton, PA
Keith W. Dickey, IL
Beverly A. Largent, KY

Government Affairs
S. Jerry Long, TX
Robert B. Raiber, NY
Gerald Gelfand, CA
Gary D. Oyster, NC

Membership
Debra A. Peters, MI
Charles A. Doring, MD
Anthony G. Mollica, Jr., SC
John D. Williams, CA

Members Insurance and Retirement Programs
Charles R. Bocks, III, CA
Gary O. Baker, MO
William J. Simpson, IL
Harry W. Whitis, AR

National Dental Examinations
Donald K. Keeter, OK

New Dentist
Matthew F. Krische, KS
Jennifer A. McConathy, NH
Shiva V. Shanker, OH
Stephen J. Suknick, FL

Scientific Affairs
Clark Stanford, IA
Jack E. Gotcher, Jr., TN
Michael K. McGuire, TX
Valerie A. Murrah, NC

ADA Election Commission Activities: The ADA Election Commission, which includes the Speaker of the House of Delegates, as chair, the Secretary of the House, and the Second Vice President, continues to meet with candidates for elective offices to oversee and adjudicate all issues of contested elections and to negotiate cost-effective agreements on campaign issues such as promotional activities and gifts, campaign literature, travel and electronic communications.

During these meetings, the Commission is often times asked for clarification of the Guidelines Governing the Conduct of Campaigns for All ADA Offices, the document that incorporates various guidelines and House policies related to campaign activities. This year, for clarification, the Commission modified the wording of item 5 to indicate that it was not intended to limit candidates from holding campaign meetings for the purpose of strategizing. Additionally, the words "prior to the first meeting of the House of Delegates" were replaced with "during the campaign year" to clarify that even after the first meeting of the House, social functions or hospitality suites are not permitted, unless otherwise specified in the Guidelines. The original item 5 states:

> 5. Candidates shall not use social functions or hospitality suites/meeting rooms on behalf of their candidacy prior to the first meeting of the House of Delegates.

The modified item 5 reads:

> 5. Candidates shall not use social functions or hospitality suites/meeting rooms on behalf of their candidacy <u>during the campaign year. (This is not intended, however, to limit candidates from holding campaign meetings for the purpose of strategizing.)</u>

Additionally, for clarification, the words "for each House of Delegates" were added to item 10, which now reads:

> 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 <u>for each House of Delegates</u> will be made. However, this distribution could consist of more than one piece of printed matter as long as the materials are secured together.

The Guidelines, with these clarifications, are included in the *2007 Manual of the House of Delegates* and are available on the House of Delegates page of ADA.org. If more substantive changes to the Guidelines are needed, the Commission will submit a report and resolution to the House of Delegates for its consideration.

ADA Institute for Diversity in Leadership: Resolution 101H-2002 (*Trans*.2002:386) approved the implementation of the ADA Institute for Diversity in Leadership and development of appropriate metrics to ensure the program is meeting its objectives. The objectives are to build lifetime relationships with diverse dentists; to mentor promising leaders with potential to impact diverse communities; and to strengthen alliances with stakeholder institutions, including dental leaders, industry, public and governmental communities of interest. The three corporate sponsors have renewed their commitment, providing $60,000

for the Institute's upcoming year. Sponsoring the Institute for 2006 are: GlaxoSmithKline, Procter & Gamble and Sullivan Schein Dental.

The Board of Trustees oversees this program and reports that the fourth class of 12 dentists representing diverse ethnic backgrounds, practice settings and interests will present their leadership projects to the incoming class of 12 participants in September 2007. Leadership project goals focus on oral health education, access, association involvement, career guidance, multi-site practices and dental health workforce. The Kellogg School of Management, Northwestern University, is continuing to provide an outstanding cadre of faculty and advisors for the Institute.

Currently, the Board's metrics for the ADA Institute for Diversity in Leadership are:

1. number of qualified applicants
2. all 12 participants meet requirements
3. ADA membership involvement (100% prior to or after Institute participation)
4. Institute class is itself diverse
5. positive participant evaluations of faculty
6. participant ratings of Institute experience as a whole (4 out of 5 on a 5.0 scale)
7. participants' qualitative evaluations of Institute's impact over time
8. actual leadership accomplishments demonstrated by participants over time
9. $60,000 in corporate sponsorship in 2006

This reports that the program has already met or is anticipated to meet its objectives. There were 35 applicants for the 2007-2008 class; all 12 of the candidates selected meet requirements; all are ADA members; ADA membership involvement is being tracked; the Institute class is itself diverse; faculty evaluations have been positive; participants' evaluations of the Institute have been positive; some alumni have already reported new community leadership experience; participants are progressing with their leadership projects; and corporate sponsorship goals have been achieved.

The Board selected the following participants for the 2007-2008 class of the ADA Institute for Diversity in Leadership:

Babo, Evis, Atlanta, Georgia
Diaz, Friz, Sacramento, California
Fatunde, Adejoke, Grapevine, Texas,
Fiocchi, Maria, Beaumont, Texas
Mayberry, Melanie, Rochester Hills, Michigan
McCants, Jennifer, Louisville, Kentucky
Ross, Ruth, Nashville, Tennessee
Satuito, Mary, Rolling Hills Estates, California
Sery, Laetitia, Huntersville, North Carolina
Sheikh, Aamir, Baltimore, Maryland
Verceles, Robert, Mountain View, California
Wakeem, Jehan, Saint Clair Shores, Michigan

Constituents and component dental societies take special pride in members who are selected for the Institute. For example, the California Dental Association invites Institute dentists from California to attend a meeting of the CDA Executive Committee and present their project work. CDA also provided a mobile dental van for an

alumni's ongoing leadership project, enabling definitive dental care for homeless veterans. Experience so far suggests that dentists' connections with organized dentistry can grow stronger from their Institute experience. Alumni of the Institute are playing a variety of leadership roles. Some are continuing or expanding their Institute leadership. From contact with dental societies during their Institute projects, some now serve as component and constituent volunteers. Three Institute alumni joined tripartite officers and executive directors at ADA's March 2007 Leadership Team Workshop. A number of alumni have launched a Career Pathways Network to link dentists who want to work together on ideas for smoothing the pathways from all neighborhoods to college and then to dental school.

The ambitious projects undertaken by the current class bode well for future contributions from this set of emerging leaders. The dentists and their project areas appear below:

Dr. Alejandro Aguirre, Plymouth, Minnesota: Developing a mentoring program through which Minnesota dentists can help foreign-trained dentists adapt to practice in Minnesota as they move through the dental school's advance standing program, earn licenses and enter practice; also, developing low-cost videos to encourage dentists to consider practicing in rural Minnesota and to become involved with the Minnesota Dental Association.

Dr. Willie Beasley, Vienna, Virginia. Working with families, dentists, churches, educators and others to enable more Northern Virginia dentists to serve special needs patients, including creating a new continuing education program for dentists.

Dr. Oshmi Dutta, Portland, Oregon. Opening a Web site for knowledge-sharing among dentists on the special challenges and decisions for successfully developing and leading multi-site practices.

Dr. Alex Gutierrez, Tampa, Florida: Building an oral health education Web site tailored to parents, teachers, teens, teachers and others in the Tampa area.

Dr. Lisa Jacob, Millinocket, Maine. Working to help underserved communities benefit from National Health Services Corp (NHSC) programs for mentoring dentists and repaying dental school loans. Also promoting careers in dentistry to local high school students and telling them about loan repayment programs such as through NHSC to help fund their dental education.

Dr. Conrad Journee, Liberty, Missouri. Approaching each of his county's 135 dentists to help increase access for low-income seniors by joining with Missouri's Donated Dental Services program.

Dr. Marilyn Virgil Ketcham, Farmington, New Mexico. Bringing together a college, regional medical center, non-profit agency and dental society to improve access to dental care for severely handicapped individuals.

Dr. Sandeep Mammen, Bloomfield, Connecticut. Communicating the mission of Connecticut's community health centers to the state's wider dental community, informing the state's dental students of career opportunities in the health centers and increasing access to care by those with limited or no access.

Dr. Karen Mays, Columbia, Missouri. Educating the community and dental professionals about the harmful effects of methamphetamine abuse and encouraging strategies for prevention and early intervention.

Dr. Celia Mendoza, Montebello, California. Designing and testing an oral hygiene education program to resonate with elementary school children for healthy behavior lifelong.

Dr. Karen Stewart, Ann Arbor, Michigan. Working with the public library systems to offer "stories-to-go" bags including books and DVDs on first dental visits, oral hygiene, dental conditions and dentistry as a career.

Dr. Grace Su, New York, New York. Designing and implementing an exchange program for dentists from Taiwan to study at NYU College of Dentistry and to earn a certificate and to return to Taiwan with a personal commitment to teach dentistry.

National Healthcare Information Infrastructure (NHII) Task Force: A key element that was anticipated to be addressed by the NHII Task Force was to provide staff with the strategic direction and give meaningful leadership for the profession, with measurable goals and objectives. The 2006 activities of the NHII Task Force and Electronic Health Record (EHR) have made it clear that the ADA needed to improve inter-agency coordination and control to ensure that EHR activities meet the national goals set for the implementation of the NHII which include an interoperable EHR. A combination of challenges in the NHII Task Force activities, representation on the committee and ownership of ADA intellectual property has brought this issue to the forefront.

To address these concerns, a recommendation was submitted and approved at the June BOT meeting to disband the current NHII Task Force and replace it with an EHR work group. It was effective immediately following the June BOT meeting. The composition of the new ADA work group is: Dr. Joel Glover, chair; Dr. William Glecos, vice-chair; Dr. Robert Ahlstrom (CDP); Dr, Joseph Crowley, (CGA); Dr. Mark J. Feldman, ADA president-elect; Dr. Joseph Hagenbruch, (CDBP); Dr. Mary Krempasky-Smith,; Dr. Scott A. Trapp (Chair, SCDI); Dr. Kathleen Roth, ADA President, *ex official*; and primary staff support from the Mr. Robert Owens, chief information officer, Dr. John Luther, senior vice president for Practice, and additional staff support from the General Counsel and the Chief Operating Officer.

It is anticipated that the EHR work group will benefit from the work already done by the NHII Task Force and will be able to move the agenda forward without jeopardizing the goals of staying patient centered and provider driven.

Responses to Resolutions from the 2006 House of Delegates

Principles for Pay-for Performance or Other Third-Party Financial Incentive Programs: Resolution 24H-2006 (*Trans.*2006:326), enumerates the principles that the ADA believes should guide the development and implementation of pay-for-performance (P4P) and other financial incentive programs if they are implemented in dental benefit plans. It also directs that these principles direct any discussions between the ADA and third parties on this subject and that the ADA monitor and evaluate developments in this area. On April 3, 2007, ADA representatives met for the second time with officials at the Center for Medicare and Medicaid Services (CMS) to discuss the ADA Principles and received a commitment on the part of CMS to consult with the ADA when 4P4 programs are considered for Medicaid. On April 18, representatives of the ADA met with the leadership of Delta Dental Plans Association and presented the Principles to them for dissemination to the Delta Plans across the nation. The Council on Dental Benefit Programs will assist in the dissemination of the Principles to the private insurance industry. An educational article on pay-for-performance was published for the membership in the February 5, 2007, *ADA News*. An ADA representative attended the National Pay-For-Performance Summit to monitor developments in this area and experiences of carriers that have instituted P4P programs in their medical plans.

Foreign Aid Assistance: Resolution 56-2006 (*Trans.*2006:313), called for the ADA to purchase $50,000 worth of dental supplies to be distributed in Iraq and Afghanistan as a gift from the dentists of the American Dental Association; to seek industry support to help magnify this effort; and seek assistance from the U.S. military to transport and distribute these materials.

This resolution was referred by the 2006 House of Delegates to the appropriate agency. As recommended by the Board of Trustees in its comment on Resolution 56, the resolution was referred to its standing Committee on International Programs and Development to review and evaluate the proposal.

The Committee on International Programs and Development (CIPD) evaluated the proposal and reported to the Board of Trustees at its April 2007 session. The Committee indicated that it sought comments from the ADA/HVO Dentistry Overseas Steering Committee, a subcommittee that manages the ADA international volunteer programs. The Steering Committee reviewed this resolution and acknowledged that although the sentiments behind providing humanitarian aid to the dentists and people of Iraq and Afghanistan are commendable, there are very real problems with its implementation. The following are the major concerns with implementation of the resolution:

- Although the U.S. military may indirectly be utilized to transport goods to developing countries, they cannot receive nor distribute the goods once they arrive.

- USAID, the State Department's agency for international development, supports the Denton Program, allowing shipments of humanitarian supplies on military transports, but this is done on a space-available basis, so the timeframe is, therefore, unknown as to when these supplies might be sent. Also, the Denton Program requires that a group within the country make a formal request for the supplies prior to their shipment.

- For the USAID to ship humanitarian supplies, there must be a reliable and active non-governmental organization or local agency that can safely receive and distribute the materials within the country. At this time, the ADA does not know of any groups that will be available to provide this support.

- The national dental associations of both countries no longer viably exist through which the Association might otherwise funnel donations, while direct donations to dental personnel could serve to target these professionals for reprisals and potential violence under the current political climate.

- Further, donations could very well end up being sold on the black market to support insurgencies and, with much certainty, donations would not be fairly distributed nor fulfill the true intent of the ADA's purpose at this time.

- Due to the political destabilization at this time, most USAID health projects in Iraq have ended as of the summer of 2006, according to their Web site.

Upon review of these concerns the CIPD recommended to the Board of Trustees that Resolution 56-2006 not be adopted. The Committee suggested that the Board could reconsider this request in the future, should the region stabilize and if the materials could be monitored and safely received and delivered by a qualified agency in Afghanistan and Iraq. The Board accepted the evaluation and recommendation of the Committee on International Programs and Development.

Sesquicentennial Anniversary of the American Dental Association: The American Dental Association historically recognizes milestones in its history, one of the most important being the 1959

Centennial Anniversary of its founding. In 2009, the ADA will celebrate its 150th Anniversary. To recognize this significant event, a special committee was appointed by the ADA President in 2005 to assist the Board in defining the appropriate commemorative celebration, with a vision, scope and theme. This planning committee is chaired by Dr. Walter Lamacki, Illinois. The committee members include: Dr. Jack Conley, California; Dr. Jack Gottschalk, Ohio; Dr. Brandon Maddox, Illinois; Ms. Martha Phillips, Georgia; and Dr. Jeanne Sinkford, Washington, D.C. The committee's goal is to create a fiscally responsible and significant commemoration of the ADA sesquicentennial anniversary that targets five major audiences (ADA members, ADA leadership, dental societies, ADA staff and the public/media/legislators) through the use of a combination of existing activities and unique celebratory events. The Board looks forward to the activities being developed by the committee and extends it appreciation to the committee members for their contributions.

STATEMENT OF QUALIFICATIONS

ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS

Davis, Gary S., Pennsylvania, 2011. Dr. Gary Davis is a graduate of Georgetown University School of Dentistry and is a general dentist in private practice. Dr. Davis has been involved in a number of professional and civic organizations. He is a Fellow of the International College of Dentists; the Pierre Fauchard Academy; and is on the Board of Directors of the Pennsylvania Academy of General Dentistry. He is involved with the Ecuadent Mission, having served as their dental director; the Rotary Club of Shippensburg, serving in a number of positions and as its president; and was a founding member, and chair, of the Drop-the-Anchor Committee. Dr. Davis has been an active participant with Our Lady of Visitation Parrish, a Cub Scout Webelos Leader, an AYSO soccer coach and Corpus Christi basketball coach. Dr. Davis has been very active in organized dentistry. He has been president of Cumberland Valley Dental Society, president and on the board of directors of the Fifth District Dental Society. At the state level, Dr. Davis has been involved with a number of councils: Administrative Affairs, Membership, Government Relations, New Dentist Committee, and the Diversity Task Force. Currently, Dr. Davis is the secretary of the Pennsylvania Dental Association and member of its Bylaws Committee. Dr. Davis has been a delegate and alternate delegate to the ADA House of Delegates, has served on the ADA's Council on Membership, and has served as chair on the ADA's Ad Hoc Committee on Diversity. With this background and experience Dr. Davis will be a positive addition to CAPIR.

Homicz, A. J., New Hampshire, 2011. Dr. A. J. Homicz believes we must continue to press for change that will keep the dentist at the head of the oral health team while addressing both real and received need and demand that is not being met. Dr. Homicz represented New Hampshire Dental Society on the 40 member coalition that wrote the state oral health plan and chairs that coalition. He testifies frequently before legislative committee on F+, independent hygiene and various funding issues. Dr. Homicz initiated New Hampshire's entry in Give Kids A Smile and is a consultant on several workforces.

Lang, Melanie S., Washington, 2011. Dr. Melanie Lang has served as the co-chair for the Spokane District Dental Society (SDDS) Public Relations Committee for the past two years. She has been instrumental in setting up their access program, Smile Spokane. This program treats children and senior/disabled adults. The senior/disabled adult program also includes an "Adopt a Senior" aspect so the patient receives comprehensive care. The success of Smile Spokane has lead to the formation of the SDDS Foundation. Dr. Lang has dual degrees. She received her dental degree from the University of Nebraska and received her degree in medicine from the University of Florida. She continues her dual involvement by serving on not only the SDDS Public Relations Committee, but also the Continuing Educational Committee for the Spokane County Medical Society. Dr. Lang's strong background in hospital dentistry and surgery will be valuable as the broadening scope of oral health awareness continues. The ability to work with a variety of health care settings while promoting oral health care as an important element of total well being is crucial in the development of public payer dental programs. Dr. Lang exemplifies the standards and qualities necessary for appointment to CAPIR and will be an excellent addition to the Council.

Miller, David J., New York, 2011. Dr. David Miller is a graduate of St. John's University and received his D.D.S. degree from Georgetown University School of Dentistry in 1984. Upon graduation he successfully completed a general practice residency at Woodhull Hospital in Brooklyn, New York. Dr. Miller currently serves as director of General Practice Residency Programs at Saint Vincent Catholic Medical Center in the burroughs of Queens and Brooklyn. He is an assistant clinical professor of dentistry at Columbia University School of Dental Medicine and an assistant professor of clinical dentistry at New York Medical College. He also maintains a part-time practice of general dentistry in East Meadow, New York. Dr. Miller has been very

involved in all aspects of organized dentistry, including service as president of the Nassau County Dental Society, chair of the Greater Long Island Dental Meeting and as a member of the New York State Dental Association (NYSDA) Board of Governors. He also has been a member, and chair, of the Council on Dental Health Planning and Hospital Dentistry of NYSDA. Dr. Miller was a major force in the development of, and served as chair of, the NYSDA subcommittee on Bioterrorism and Emergency Preparedness. He as been very instrumental in Give Kids A Smile programs and has served as his component coordinator since 2004. He also participated as a member of the Dental Identification Unit at the September 11, 2001, World Trade Center Tragedy. Dr. Miller is an active member of the American Association of Hospital Dentists, the Academy of Dentistry for the Handicapped and the American Society for Geriatric Dentistry. He is uniquely positioned to lend abundant experience and expertise to Council activities.

ADA SESSIONS

Carstensen, Stephen W., Washington, 2010, ad interim. Dr. Stephen Carstensen is a graduate of Baylor College of Dentistry. He served the Washington State Dental Association on the Committee for the Pacific Northwest Conference for four years, with on year as chair of the Committee.

Heier, Ronald K., Pennsylvania, 2011. Dr. Ronald Heier graduated from the Temple University School of Dentistry and completed a general practice residency at Emily P. Bissell Hospital. He is a general dentist in private practice. Dr. Heier has been active in fraternal and professional organizations from OKU Honor Society, to Academy of General Dentistry, the Pierre Fauchard Academy, the American College, and International College of Dentists. Dr. Heier has served organized dentistry at the local, district, state and national level. He has served on the Board of Governors and as president of the Dental Society of Chester County and Delaware County. Dr. Heier has been a district director and president of the Valley Forge Second District Dental Association. He has been vice president of the Pennsylvania Dental Association and has served on its Environmental Task Force. Dr. Heier worked on the ADA annual session in Philadelphia in 2005 as co-chair of registration and served as a member of the CLA Planning Committee. He has been on the Planning and Steering Committee of the Valley Forge Dental Conference for a number of years. Dr. Heier was also exhibitor chair twice and general chair for the Valley Forge Conference. With his background and strong work ethic, Dr. Heier will make an excellent addition to CAS.

Laing, Kevin M., Ohio, 2011. Dr. Kevin Laing is the current secretary of the Ohio Dental Association (ODA) and serves on its Finance Committee. He was a member of the ODA's Annual Sessions Committee from 1997 to 2005 and was chair in 2004-05. Dr. Laing is well versed and skilled in the process of meeting development, having led the committee in continuing education planning, exhibitor relationship development and sponsorship development. He currently serves as chair of the Conference of Dental Meeting Planners, the national organization for dentists and staff members involved in planning dental meetings at local, state and national levels.

McCorkle, Hutson E., Florida, 2011. Dr. Hutson McCorkle is a 1957 graduate of the University of Tennessee Dental School. After graduation, Dr. McCorkle served with the North Carolina Public Health Department and then with the United States Air Force. He has practiced general dentistry in Orlando since 1964 and has been a member of the ADA since that time. He has served as program chair and as president of the Dental Society of Greater Orlando. Dr. McCorkle has also served as a member of the Florida Dental Association (FDA) Board of Trustees and as a member of the FDA's Council on Dental Care. He has served as a member of the Academy One Hundred of the University of Florida. Dr. McCorkle is a Fellow of the International College of Dentists, the American College of Dentists and a member of the Florida Academy of Dental Practice Administration. He has served as a host dentist for the ADA meetings in 1992 and 1995. In 1996, Dr. McCorkle was the Local Arrangements Chair for Programs at the ADA/FDI meeting in Orlando, Florida,

and in 2004, he was the Local General Chair for the ADA meeting in Orlando. In addition to his dental service, Dr. McCorkle has been president of his local chapter of Sertoma and received his life member status. Dr. McCorkle will bring considerable experience to the Council from his service in the dental profession as well as from his experiences in civic and business endeavors.

Remes, Michael C., Minnesota, 2011. Dr. Michael Remes grew up in New Prague, Minnesota. After graduating from the University of St. Thomas in 1971 with a B.A. in Economics, he attended the University of Minnesota and received a B.S. in Dental Sciences in 1975. Dr. Remes received his dental degree from the University of Minnesota in 1976, he then, moved to Northfield, Minnesota and joined Heritage Dental Care and taught at the University of Minnesota part-time from 1977 to 1981. From 1999 to 2006, Dr. Remes served as a member of the Scientific Sessions Committee of the Minnesota Dental Association, which is responsible for its annual Star of the North dental convention. During this time he had responsibilities involving speaker selection, exhibits, budget, and promotional activities. In 2006, Dr. Remes served as chair of this convention.

COMMUNICATIONS

Gellert, Jonathan R., New York, 2011. Dr. Jonathan Gellert received his dental education at the University at Buffalo School of Dental Medicine. Dr. Gellert maintains a general dentistry practice in rural upstate New York. Upon starting his practice, he immediately became very involved in both organized dental and community affairs. He served as president of the Jefferson-Lewis Dental Society and then rose through the chairs of the Fifth District Dental Society of the New York State Dental Association (NYSDA), assuming the responsibilities of president in 2003. In that role he was intimately involved in both strategic planning and media relations. Dr. Gellert currently serves as a member of the NYSDA Council on Dental Benefits. Dr. Gellert serves on the Board of Managers of the Lewis County General Hospital and is very involved in public relations for the population it serves. He often is called upon as a spokesperson for the local press and community events. The Council on Communication's redefined roles will provide a natural position for Dr. Gellert to share his communication and public relations background. The first hand knowledge he has gained by living and practicing in a rural, underserved area will lend an authentic perspective to access to care issues faced by the Council.

Giannini, Eugene T., Washington, D.C., 2011. Dr. Giannini is the current president of the District of Columbia Dental Society. Dr. Gianinni is a member of the District of Columbia's Public Relations Committee and has considerable media experience with interviews for radio, television, and print media. His comfort with current communications technology makes him uniquely qualified for this Council position.

Kolling, Josef N., Michigan, 2011. Dr. Josef Kolling graduated from the University of Michigan with a D.D.S. degree in 1981, and a M.S. degree in restorative dentistry, crown and bridge, in 1984. He maintains a private practice in Ann Arbor, Michigan, and is an educator, teaching prosthodontics part-time (30 %) in the undergraduate clinic at the University of Michigan School of Dentistry. Dr. Kolling has been active at all levels of organized dentistry, serving on a variety of state and local committees. He is a past president of the F. B. Vedder Society of Crown and Bridge Prosthodontics, the Washtenaw District Dental Society, and the Michigan Dental Association (MDA). He has been an active member of the Michigan delegation to the ADA House of Delegates since 1995, and served as chair of the Michigan delegation in 2004. Dr. Kolling has been a spokesperson for the MDA and is frequently invited by various student groups to speak at their events. His understanding of the issues that face dentistry, combined with his ability to communicate them to members of the profession and the public, make him an excellent candidate for the Council on Communications.

Starsiak, Mary A., Illinois, 2011. Dr. Mary Starsiak obtained a bachelor of science degree in nursing from the College of Saint Teresa in Winona, Minnesota. In 1984, she graduated from Loyola University School of

Dentistry in Maywood, Illinois. Dr. Starsiak has been active in organized dentistry for many years at both the constituent and component level. At the state level, she served as trustee on the board of the Illinois State Dental Society. She has been a member of the ADA House of Delegates, as a delegate and alternate delegate. She has been a member of the Illinois State Dental Society (ISDS) House of Delegates since 1994 and has served on their Dental Education Committee and Membership Task Force. Dr. Starsiak will chair the 2009 ISDS annual meeting. At the component level, Dr. Starsiak is currently serving as a member of the Board of Directors of the Chicago Dental Society. She has served as chair of the Special Events and Membership Committees. She served as a member of the Access to Care Committee and the ADA Taskforce on Membership. Dr. Starsiak has been a spokesperson for the Chicago and Illinois State Dental Societies. She has served in all offices including that of president of the Northwest Side Branch of the Chicago Dental Society. She is a Fellow of the American College of Dentists, the International College of Dentists, the Academy of Dentistry International, the Pierre Fauchard Academy, the Academy of General Dentistry, and the Odontographic Society of Chicago. She has served in all offices of the Dental Arts Club of Chicago and the Illinois Association of Women Dentists.

DENTAL ACCREDITATION

Pelot, Reuben N., III, Tennessee, 2011. Dr. Reuben Pelot, III, is a general dentist from Knoxville, Tennessee. Dr. Pelot has been involved in dentistry in many different delivery models. He was a captain in the U.S. Army Dental Corps stationed at Fort Meade, Maryland, and he worked for the U.S. Department of Health in Knoxville. Dr. Pelot has been in private practice since 1961 and has been an attending faculty member with the University of Tennessee Hospital General Residency Program, a member of the Tennessee Board of Dentistry, and is a dental examiner for the Southern Regional Testing Association. He has served as president of the Tennessee Dental Association (TDA) Second District Dental Society, and he has served as the chair of the Committee on Education, a member of the Peer Review Committee, and chair of the Constitution and Bylaws Committee. He is a delegate to the TDA House of Delegates, a member of the TDA Committee on Continuing Education, Public Education, and Professional Relations. He serves as a member of the Advisory Council for the University of Tennessee General Practice Residency Program. Dr. Pelot is a Fellow in the American and International Colleges and the Pierre Fauchard Academy. He is a past president of the Tennessee Academy of General Dentistry and serves on the TAGD Board of Directors. Dr. Pelot would be a valuable member of the Commission because he has participated in many of the duties of the Commission dealing with education, curriculum design, and licensing examinations. He brings more than 46 years of private practice experience along with the experiences of being a faculty member at the University of Tennessee, serving on the Tennessee State Board of Dentistry, and currently serving as a regional board examiner.

DENTAL BENEFIT PROGRAMS

Eversman, Philip J., Indiana, 2011. Dr. Philip Eversman has more than 17 years experience on the Indiana Dental Association Council on Dental Benefits and Practice and has served as its chair. He is a past president of the Indianapolis District Dental Society, and a member of its Peer Review Committee. Dr. Eversman has also served as chair of the Access to Care Task Force in Indiana, and served in both the Indiana and ADA House of Delegates.

Futrell, Harry C., Florida, 2011. Dr. Harry Futrell is a 1972 graduate of the University of Louisville School of Dentistry. After dental school, Dr. Futrell completed a general practice residency at Moncrief Army Hospital and then served in the United States Army in Bangkok, Thailand. Dr. Futrell has practiced general dentistry in Panama City, Florida, since 1977. He has served as president of the Bay County Dental Society and the Northwest District Dental Association. Dr. Futrell is currently a trustee to the Florida Dental

Association and has served on the Florida Dental Association Council on Communications and the Florida National Dental Convention where he was the chair of exhibits. Dr. Futrell is a Fellow of the American College of Dentists and has served on the Statewide Health Council, the State Clinical Laboratory Advisory Council and the Dental Advisory Council of Gulf Coast Community College. In addition to his dental service, Dr. Futrell has been involved with Rotary International and Panama City Music Association. He is on the Board of Directors of Peoples First Community Bank in Panama City. Additionally, Dr. Futrell has participated in two missions to Costa Rica. Dr. Futrell brings a wide range of experience and will be a true asset to the Council.

Klemmedson, Daniel J., Arizona, 2011. Dr. Daniel Klemmedson has been in private practice of oral and maxillofacial surgery in Tucson, Arizona, since 1986. He holds dental and medical degrees from the University of Southern California, OMS residency at LAC/USC Medical Center. Dr. Klemmedson has been a member of the ADA for 20 years. He is the past president of Southern Arizona Dental Society, Arizona Dental Association, and Arizona Society of Oral and Maxillofacial Surgeons. Dr. Klemmedson is the current Speaker of the House for the Arizona Dental Association and has been an ADA delegate from 2002 to the present. He has also served as an AAOMS delegate from 2000 to the present and is a member of the AAOMS OMSPAC Committee. Dr. Klemmedson is a very bright and organized individual. He is a good thinker and evaluates issues thoroughly prior to making statements or taking actions which could have adverse consequences. Dr. Klemmedson is highly recommended to serve on the Council on Dental Benefit Programs.

Smiley, Christopher J., Michigan, 2011. Dr. Christopher J. Smiley is a 1986 graduate of Marquette University School of Dentistry and maintains a general dental practice with his wife, Dr. Colette Smiley, in Grand Rapids, Michigan. Dr. Smiley has been active in organized dentistry on both the local and state level, serving as president of the West Michigan District Dental Society (WMDDS) and as a trustee of the Michigan Dental Association (MDA) as well as the vice chair of the Michigan Dental Association's Insurance and Financial Group subsidiary. Dr. Smiley currently serves on the Dental PAC of Michigan's Board of Governors and he is chair of the WMDDS Committee on Legislation and the WMDDS Task Force on Hospital Based Dentistry. He is a past chair of the MDA's Committee on Marketplace Issues and has lectured on dental benefit plan issues at the MDA's annual session and at several local society meetings throughout Michigan. In 1995 he organized a symposium that brought benefit plan purchasers and health care providers together to discuss dental benefit plan design. Dr. Smiley continues to meet periodically with benefit plan decision makers to share dentistry's position on the choices they make. Dr. Smiley's knowledge and experience with dental plan issues will greatly benefit the Council on Dental Benefit Programs.

DENTAL EDUCATION AND LICENSURE

Kennedy, Brian T., New York, 2011. Dr. Brian Kennedy received his dental education at Georgetown University. Prior to dental school, he served four years active duty in the U.S. Army. Upon graduation, Dr. Kennedy transferred to the U.S. Army Reserve. He currently holds the rank of Colonel. Dr. Kennedy has been very active in many civic organizations in the Albany, New York Capitol district. His list of accomplishments in organized dentistry is impressive. He served his component, the Third District Dental Society of the New York State Dental Association (NYSDA) in many capacities including as president. Dr. Kennedy has been a member of the Board of Governors of the NYSDA and served as President of that organization in 2004. He also acted as a delegate to the ADA House of Delegates for several years. During his term as NYSDA president, Dr. Kennedy was intimately involved in New York's landmark PGY-1 movement. He has an intense passion for innovation in dental education and will contribute greatly to the important deliberations of CDEL.

Schmidt, James L., Maine, 2011. Dr. Schmidt's position at the Togus VA Medical Center in Augusta, Maine, and his relationships with the dental residents that have come through that program have had an enormous influence in Maine. He is regarded as a "great educator" and has encouraged many to take on leadership positions. Dr. Schmidt is a natural mentor and has been a great force in creating Maine's CE Program that serves this largely rural state and at the same time dovetails with the VA's mission to provide educational outreach for the community at large.

DENTAL PRACTICE

Gardner, H. Lee, South Carolina, 2011. Dr. Lee Gardner has practiced general dentistry since his graduation from the Medical College of South Carolina School of Dental Medicine in 1973. Dr. Gardner has been active in organized dentistry for many years. He served as president to both his local component society and the South Carolina Dental Association. He also served on South Carolina's ADA delegation. He has a long standing interest in the area of dental practice and is an honorary member of the South Carolina Dental Laboratory Association. Dr. Gardner's honors include membership in OKU in recognition of his high academic achievement and leadership potential and Fellowship in the American College of Dentists, International College of Dentists, and the Pierre Fauchard Academy. Dr. Gardner's background, work ethic, and thoughtful consideration will make him a valuable member of the Council on Dental Practice.

Glenn, Stephen O., Oklahoma, 2011. Dr. Stephen Glenn graduated with honors from the University of Tennessee College of Dentistry in 1974 and has practiced general dentistry in Tulsa, Oklahoma since that time. He has served as a forensic dental consultant to the Chief Medical Examiner of Oklahoma since 1977 and as an adjunct instructor in forensic science at Oklahoma State University since 2005. Dr. Glenn has been secretary treasurer, vice president, and president of the Tulsa County Dental Society, and has served Oklahoma Dental Association as vice president, president-elect, president and speaker of the House of Delegates. He is a Fellow of the American and International Colleges, the Pierre Fauchard Academy, and is a diplomat of the American Board of Forensic Dentistry. Dr. Glenn has served as president of Oklahoma DENPAC and chair of the Board of Delta Dental Plan of Oklahoma. He has been both a delegate and alternate delegate to the ADA House of Delegates and served on the Standing Committee on Credentials, Rules and Order. Dr. Glenn has been president of the Southside Rotary Club of Tulsa, and is a Paul Harris Fellow. His broad, varied, and extensive experience will make him a valuable addition to the Council on Dental Practice.

Halasz, Michael H., Ohio, 2011. Dr. Michael Halasz served on the Ohio Dental Association's Council on Dental Care Programs and Dental Practice from 2000 to 2004 and as its chair in 2003-04. He has been actively involved and is a dedicated member of the tripartite, is a past president of his component society, and has served on multiple committees and councils at both the state and local level. Dr. Halasz is a registered parliamentarian and has been a member of the National Association of Parliamentarians since 2002. He is the current vice speaker of Ohio's House of Delegates.

Larsen, Christopher C., Illinois, 2011. Dr. Christopher Larsen is a 1988 graduate of Southern Illinois University School of Dental Medicine and practices general dentistry in Moline, Illinois. Dr. Larsen completed a general practice residency program affiliated with Southern Illinois University in 1989. He is an active member of organized dentistry and he has served in all offices of the Rock Island Dental Society. At the state level, Dr. Larsen has served on the Legislative Committee and has been the Action Team Leader of the seventeenth district for the ADA's grass roots network. He currently serves on the Board of Trustees of the Illinois State Dental Society. In his community, Dr. Larsen was instrumental in establishing the Scott County Community College Dental Assisting Program. Dr. Larsen has also served four years as a director for the Dental Dash, which is a fun run for children in the Quad City area. He was the initial organizer of the

Give Kids A Smile day for the Quad City area. He has also been involved for several years in the Job Shadowing Program to promote careers in dentistry.

ETHICS, BYLAWS AND JUDICIAL AFFAIRS

Gamba, Thomas W., Pennsylvania, 2011. Dr. Thomas Gamba graduated from Temple University School of Dentistry and is a general dentist in private practice. He was clinical instructor of restorative dentistry at University of Pennsylvania School of Dental Medicine and course director for experiencing private practice at Temple. Dr. Gamba is the consulting dentist to the Philadelphia Phillies Baseball Club. He has been active with a number of professional organizations from ASDA, the Academy of General Dentistry, the Pierre Fauchard Academy, to past deputy regent for the International College. He is involved with the Temple Alumni Association, an instructor for the American Heart Association and on the board of directors and past president of the local American Cancer Society. Dr. Gamba has been very active at all levels of organized dentistry. At the ADA, he has served on the Council on ADA Sessions, Special Committee to Study the Separation of the Annual Session, and a delegate and alternate delegate to the House of Delegates. At the state level he has served on the councils of Professional Affairs, Insurance, and Membership. Dr. Gamba has been vice president, chair of the Credentials Committee to the House of Delegates, a trustee, speaker of the house, and is now president-elect of the Pennsylvania Dental Association. As speaker for four years, Dr. Gamba was involved with the evaluation and updating of the PDA's bylaws. With this type of experience Dr. Gamba will be an excellent addition to CEBJA.

Sebelius, Carl L., Jr., Tennessee, 2011. Dr. Carl Sebelius, Jr., is an oral and maxillofacial surgeon from Memphis, Tennessee. Dr. Sebelius is currently serving as professor emeritus, College of Dentistry, University of Tennessee, where he has been a member of the Department of Oral and Maxillofacial Surgery since 1968. Dr. Sebelius is the current speaker of the House of Delegates for the Tennessee Dental Association (TDA). He has served as the chair of the Memphis Dental Society Committee on Constitution and Bylaws, secretary, president-elect, and president. Dr. Sebelius has been a delegate and alternate delegate to the TDS House of Delegates, vice president of the TDA, and chair of the TDA Council on Annual Sessions. Dr. Sebelius is a Fellow in the American and International Colleges of Dentists and has an interest in ethics. His experience as speaker of the TDA House of Delegates also indicates that he is actively involved in bylaws and has helped guide the TDA through significant changes in their governance structure and bylaws revision in 2007.

Tiersky, Terri S., Illinois, 2011. Dr. Terri Tiersky graduated from Loyola University School of Dentistry in 1986 and John Marshall Law School in 1991. She maintains a general dental practice in Chicago. Active in organized dentistry since her graduation from dental school, Dr. Tiersky served as president of the North Side Branch of the Chicago Dental Society (CDS), as well as a member of the CDS Board of Directors, and the Illinois State Dental Society (ISDS) Board of Trustees. She is a Fellow of the American College of Dentists, the International College of Dentists and the Odontographic Society of Chicago. Dr. Tiersky has an extensive background dealing with issues of ethics and fairness. She has chaired numerous committees including the CDS Ethics and Special Issues and Communications Committees, CDS/ISDS Governance Advisory Panel, and currently serves on the CDS Mediation Committee, of which she was vice chair in 2003. Dr. Tiersky has also served on the Policy Manual Committees for the CDS, the North Side Branch, and the Members Group. In this capacity she reviewed and revised the Constitution, Bylaws and Policy of all three groups. Dr. Tiersky served as a member of the ADA House of Delegates, and was chair of the Eighth District Caucus Reference Committee on Legal and Legislative Matters. She was a delegate to the ISDS House of Delegates, having served a chair of the Legal and Legislative Affairs; Communications, and Membership Reference Committees. Dr. Tiersky's sense of fairness and integrity coupled with her experience and diverse education will enable her to serve as a valued member of the ADA Council on Ethics, Bylaws and Judicial Affairs.

Wentworth, Rodney B., Washington, 2011. Dr. Rodney Wentworth currently serves on the Washington State Dental Association's Board of Directors and he is a member of the Washington State Department of Health's Dental Anesthesia Committee. Dr. Wentworth's earliest involvement in organized dentistry began with an appointment to the Seattle King County Society Ethics Committee in 1989. Dr. Wentworth spent nine years on the SKCDS Ethics Committee (1989-98), and served as chair from 1992 to 1994. Dr. Wentworth served on the WSDA Committee on Judicial Affairs, Ethics, and Peer Review (1993-99) and served as chair the final two years of his term. His interest in ethics continues as he works as an affiliate instructor at the University of Washington School of Dentistry. Outside of organized dentistry, he has served on the Northwest Dentists Insurance Company, Claims Committee since 1992. He is a Fellow in the Pierre Fauchard Academy and the International College of Dentistry. Dr. Wenthworth's ability to analyze details and to communicate astute opinions will serve the Council well. Dr. Wentworth is sincere, thoughtful, and reasonable and it is with great pleasure that I nominate him to the Council on Ethics, Bylaws and Judicial Affairs.

GOVERNMENT AFFAIRS

Condrey, James D., Texas, 2011. Dr. James Condrey received his dental degree at the University of Texas Dental Branch-Houston in 1975 and has been in private practice since that time. He served on the ADPAC Board of Directors from 2001 to 2005 and has been the Legislative Action Team Leader for U.S. Representative Nick Lampson since 2006. Dr. Condrey is a Fellow of the American College of Dentists, the International College of Dentists and the Pierre Fauchard Academy.

Klima, Rodney J., Virginia, 2011. Dr. Rodney Klima received both his dental education and his orthodontic training at the Medical College of Virginia and has practiced orthodontics in Burke, Virginia, since completing his two-year military service in Fort Hood, Texas. Dr. Klima is past president of the Virginia Association of Orthodontists, the Northern Virginia Dental Society and the Virginia Dental Association (VDA) and is a current member of the ADA House of Delegates. He is also active in several capacities with the Medical College of Virginia School of Dentistry. Dr. Klima's other professional activities are too numerous to mention in the format. Importantly, however, he is past chair of the Virginia Political Action Committee, past member of the ADPAC Board, and is currently Virginia state co-coordinator of the American Dental Association Grassroots Action Team Network. Dr. Klima's honors include OKU and Fellowship in the VDA, the American College of Dentists, the International College of Dentists, and the Pierre Fauchard Academy. He is a recipient of the Alumni Star Award from the Virginia Commonwealth University School of Dentistry. Dr. Klima's unique and diverse background will make him a valuable member of the Council on Government Affairs.

Neary, Matthew J., New York, 2011. Dr. Matthew Neary is a graduate of Dartmouth College and received his dental education at Columbia University School of Dental and Oral Surgery. Following completion of his graduate studies at Columbia, he was granted a Certificate in Periodontics. Dr. Neary continues his association with Columbia University today as an adjunct associate professor and facilitator of their ethics program. Dr. Neary is in a private group practice of periodontics in New York City. He has been extremely active in many aspects of organized dentistry and in 2003 served as president of the New York County Dental Society, one of the largest component societies within the ADA tripartite structure. The New York Academy of Dentistry and the New York Society of Forensic Dentistry both elected him to the role of president within the last three years. Following the September 11, 2001, World Trade Center tragedy, Dr. Neary acted as a tour commander of the Dental Identification Team of the Office of the Chief Medical Examiner of the City of New York. For this service, he received a Certificate of Appreciation from the American Academy of Periodontics and the Humanitarian Award from the New York Academy of Medicine

Schinnerer, Donald M., California, 2011. Dr. Donald Schinnerer received is dental degree from Northwestern University Dental School in Chicago. He served in the U.S. Coast Guard and in the Reserve Commission as Dental Director, United States Public Health Service for 40 years. Dr. Schinnerer has served his local community as an elected public official for many years. Currently, he serves as treasurer of the California Dental Association (CDA) and chair of the Finance Committee. He is a delegate of the ADA House of Delegates and chaired the ADA's Reference Committee on Budget, Business and Administrative Matters in 2006. His volunteer activities with CDA also include director, 1201 Insurance Solutions, board of directors, and past chair of the American College of Dentists Executive Committee. Dr. Schinnerer will be an excellent addition to the ADA's Council on Government Affairs.

MEMBERSHIP

Card, Rex B., North Carolina, 2011. Dr. Rex Card has practiced general dentistry since his graduation from the University of North Carolina (UNC) in 1980 and has practiced in Raleigh for more than 20 years. Dr. Card has been president of the UNC Dental Alumni Association. His long service to organized dentistry include being president of the North Carolina AGD, a member of the AGD House of Delegates, and membership of the AGD's Council on Dental Care. Within the ADA tripartite, Dr. Card has been president of his component dental society; he also served as president of the North Carolina Dental Society (NCDS) and was a member of it's delegation to the ADA. He has also been active with "Into the Mouths of Babes," Mission of Mercy, Wake Smiles Open Door Clinic, Special Olympic Special Smiles, and Smart Start projects. He was a board member for Caring Dental Professionals. Dr. Card is also a deputy examiner for the North Carolina Board of Dental Examiners. His honors include Fellowship in the Academy of General Dentistry, the Academy of Dentistry International, the American College of Dentists, and the Pierre Fauchard Academy. Dr. Card's broad spectrum involvement in dentistry and his recognition of those aspects of organized dentistry that offer intangible awards for membership will make him a valuable member of the ADA Council on Membership.

Christy, Todd R., Michigan, 2011. Dr. Todd Christy is a general dentist, graduating in 1996 from the University of Detroit-Mercy. He currently serves on the Board of Trustees to the Michigan Dental Association. He has served as delegate and alternate delegate to the ADA House of Delegates for the past five years, and has played an active role in membership, serving both the state and local component committees. Dr. Christy was awarded the Michigan Dental Association's New Dentist Leadership Award in 2003 and the ADA Golden Apple for New Dentist Leadership in 2004. He continues to be active in recruitment for non-member dentists and for attracting future dentists to our association. He has worked with the Professional Health Careers Academy, mentoring the top math and science high school seniors, and has invited college students into his office and the MDA annual sessions to learn more about dentistry as a career. Dr. Christy has also hosted dental students during the MDA annual session mentor program, providing funding so dental students could attend, as well as host, during the meeting. Dr. Christy has served as a board member of the Michigan Dental Association Insurance and Financial Group, the MDA for profit subsidiary, for the past three years. Dr. Christy is a Fellow of the Pierre Fauchard Academy, the International College of Dentists, and the American College of Dentists. He believes that a person will be a better dentist through membership in the ADA, and will bring this passion for membership to the Council.

Hughson-Otte, Virginia A., California, 2011. Dr. Virginia Hughson-Otte received her dental degree from Creighton University. Dr. Hughson-Otte completed a clinical general practice residency, trauma rehabilitation, at Ranch Los Amigos Medical Center and served a hospital dentistry externship at Henry Mayo Newhall Memorial Hospital. Dr. Hughson-Otte is also an active diplomat of the American Boards of Forensic Dentistry and Examiners. She currently serves on the California Dental Association's Leadership Development Committee (presidential appointment), chairs the Council on Membership, and is a delegate to

the ADA House of Delegates. Dr. Hughson-Otte previously served as a member of the ADA's Reference Committee on Communications and Membership Services. Dr. Hughson-Otte's leadership and experience in membership issues makes her an excellent choice for this Council.

Martin, William F., III, Maryland, 2011. Dr. William Martin is a trustee to Maryland State Dental Association (MSDA) from Baltimore County, Maryland. His background gives evidence to the desire and skills looked for in members of the Council on Membership. Dr. Martin served as chair of the MSDA Committee on the New Dentist in 1996-97 when Maryland won the Outstanding New Dentist Committee Award from the ADA. He has served on the MSDA Membership Committee since 1994 and has been chair since 2001. Dr. Martin has worked extensively with the membership department of the ADA and has served as liaison to the students at the University of Maryland Dental School and has co-authored their Mentorship Program. Dr. Martin will be an outstanding addition to the Council.

MEMBERS INSURANCE AND RETIREMENT PROGRAMS

Abshere, Philip M., Oklahoma, 2011. Dr. Philip Abshere graduated from the University of Oklahoma College of Dentistry with honors after a distinguished career as a pilot in the United States Air Force. He is currently a Colonel in the Air National Guard and recently returned from a deployment to Afghanistan. Dr. Abshere has been involved in organized dentistry since 1992. He has served as president of the Oklahoma Dental Association and is currently on the Oklahoma Board of Dentistry. He is a Fellow of the American and International College, and the Pierre Fauchard Academy, as well as having served as president of the Academy of Air National Guard Dentists, and as Dental Advisor to the chief Medical Examiner of the state of Oklahoma. His extensive and varied experience in many fields make him an ideal candidate for appointment to the Council on Members Insurance and Retirement Programs.

Cassat, D. Douglas, California, 2011. Dr. Douglas Cassat received his D.D.S. degree from Georgetown University School of Dentistry and his B.A. in chemistry/biology from the United States International University, San Diego. Dr. Cassat has a long history of community service and as a volunteer with the California Dental Association, serving as a member, and then chair, of the Council on Legislation, serving on the CalDPAC Board of Directors, the TDIC Board of Directors, chair of the Underwriting and Finance Committees, and as secretary/treasurer, TDIC. He is currently a delegate to the ADA House of Delegates. Additionally, Dr. Cassat is a Fellow of the Pierre Fauchard Academy and American College of Dentists. Dr. Cassat comes highly recommended by the out-going chair of the ADA Council on Members Insurance and Retirement Programs. His expertise in finance and investments makes him a solid representative for this Council.

Gerber, C. Richard, West Virginia, 2011. Dr. Richard Gerber is a general dentist in St. Marys, West Virginia. Dr. Gerber is a past president on the West Virginia Dental Association (WVDA) Executive Council, Budget and Finance Committee, WestVADPAC, and has chaired the WVDA Committee on the Young Dentist, the Committee to Evaluate Independent Practice, the Committee to Evaluate Expanded Functions for Auxiliaries, and the Committee to Evaluate WestVADPAC. Dr. Gerber has served as the WVDA legislative chair, chair of the ADA Sixth District Caucus, and chair of the WVDA Delegation to the ADA House of Delegates. He has served as a delegate and alternate delegate to the ADA House of Delegates, and has served on the ADA Reference Committee on Communications and Member Services. Dr. Gerber is a Fellow of the American College of Dentists and the International College of Dentists.

Imburgia, Louis A., Illinois, 2011. Dr. Louis Imburgia, a 1984 graduate of Loyola University School of Dentistry, Maywood, Illinois, has been actively involved in organized dentistry from the day he graduated. Dr. Imburgia served in all offices including that of president of the Northwest Side Branch of the Chicago

Dental Society. He served on numerous standing and Chicago Dental Society Midwinter meeting committees including the Mediation/Peer Review Committee; the Legislative Interest Committee of Illinois Dentists; the Chicago Dental Society Review Book Review Committee; chair of the Public Aid Committee; chair of the course Division Program of the Midwinter Meeting; and has been selected to be the Midwinter Meeting general chair. Dr. Imburgia has served as a member of the Board of Trustees of the Illinois State Dental Society where he served as chair of the Finance and Planning Committee; member of the Publications Committee; the Judicial Affairs Committee; and the Allied Personnel Committee. Dr. Imburgia has served as a member of the Illinois State Dental Society and American Dental Association House of Delegates. He is a Fellow of the Academy of General Dentists, the International College of Dentists, the American College of Dentists, and the Odontographic Society of Chicago. Dr. Imburgia is a past president of the Arcolian Dental Arts Society. He was an educator in the Chicago City College teaching in the Dental Assisting Program. He is a dental consultant for NADENT, and independent dental consulting company reviewing dental benefits claims relating to traumatic dental injuries. Dr. Imburgia's vast experience in organized dentistry and his desire to participate will make him a valuable addition to the Council on Members Insurance and Retirement Programs.

NATIONAL DENTAL EXAMINATIONS

Radack, Stephen T., III, Pennsylvania, 2011. Dr. Stephen Radack, III, is a graduate from the University of Pittsburgh School of Dental Medicine and a general dentist in private practice. Dr. Radack has been involved in a number of professional and civic organizations including: the American Society of Dentistry for Children; Pennsylvania Academy of General Dentistry; St. Paul's Free Clinic; School District of Erie, School Dentist; and the United Way of Erie and St. Luke Catholic Church and School. Dr. Radack is also a Fellow of the Academy of General Dentistry, the American College of Dentists, the International College of Dentists, and the Pierre Fauchard Academy. He has held many positions in organized dentistry on the local and state level. Dr. Radack served as president of Erie County Dental Association and the Ninth District Dental Society. At the state level Dr. Radack has a wide range of experience as a member of numerous councils and committees including Insurance, Membership, and Dental Education and Practice. He has served as trustee and treasurer for the Pennsylvania Dental Association where he was on the Strategic Planning and Executive Committees and chair of the Budget, Finance and Property Committee. Dr. Radack is also a consultant examiner for the Northeast Regional Board of Dental Examiners. With this diverse background Dr. Radack will be an excellent addition to the Joint Commission on National Dental Examinations.

NEW DENTIST

Albert, Jeremy M., Florida, 2011. Dr. Jeremy Albert earned his dental degree from the University of Florida College of Dentistry in 2000. After dental school he completed an orthodontic residency at the University of Florida College of Dentistry Department of Orthodontics where he earned an M.S. degree. Dr. Albert is a board certified diplomat of the American Board of Orthodontics and currently practices orthodontics in Clearwater and Trinity, Florida. In addition to his tripartite ADA membership, Dr. Albert is a member of the American Association of Orthodontists, Southern Association of Orthodontists and Florida Association of Orthodontists. He serves as editor of the Florida Association of Orthodontist and is on the Editorial Committee of the Southern Association of Orthodontists. Dr. Albert is vice president of West Pasco Dental Association and is in line to become president. Dr. Albert is also a member of the Trinity Rotary Club where he serves as director of Community Service. He will bring enthusiasm and excitement to the Committee and is a fine example of the leadership our new dentists can possess.

Davis, Jennifer, Pennsylvania, 2010, ad interim. Dr. Jennifer Davis graduated from the University of Pennsylvania School of Dental Medicine in 2002. She received a Certificate of Dental Hygiene from the

University of Pittsburgh in 1988. Dr. Davis is an alumna of the Pankey Institute. She has been involved in research at the University of Pennsylvania and Lebanon Valley College. She received a grant from the National Institute of Health Grant for Health Professionals in 2000. Dr. Davis was also a participant in a publication in the Journal of Organic Chemistry; 1995. Jennifer is an associate dentist in the practice of Dr. Fredrick Johnson in Cleona, Pennsylvania. Dr. Davis will bring a wide range of experience to the ADA Committee on the New Dentist. She has served on the Pennsylvania Dental Association's New Dentist Committee since 2003 and served as the Committee's vice chair in 2005. In 2006 she attended an ADA training session through the Tripartite Grass Roots Initiative. In addition to serving as the school dentist for the Annville Cleona School District, Dr. Davis is active with the Lebanon County Chamber of Commerce and President of the Annville Rotary Club.

Jerome, Jennifer J., Ohio, 2011. Dr. Jennifer Jerome graduated from the Ohio State University College of Dentistry in 2001. She currently serves on the sub-council on New Dentists for the Ohio Dental Association. While in dental school Dr. Jerome was a member of ASDA and the Psi Omega Fraternity, and served as president of Psi Omega from 1999 to 2001. Dr. Jerome received numerous awards as a dental student including Outstanding Achievement Awards from the International Congress of Oral Implantologists and from the American Academy of Oral and Maxillofacial Radiology for Greatest Interest and Accomplishment. As a new dentist, she has already served as a council member and secretary of her local dental society, and as an alternate delegate to the Ohio Dental Association House of Delegates.

Leland, Robert S., Massachusetts, 2011. Dr. Robert Leland is a 2001 graduate from the Tufts University School on Dental Medicine and the current chair of the Massachusetts Council on Membership. He continues to be an advisor to the Massachusetts Dental Committee on the New Dentist. He is a 2007 recipient of the ADA Golden Apple Award for New Dentist Leadership.

Swilling, Stacey E., Arkansas, 2011. Dr. Stacy Swilling is a 1999 graduate of the University of Tennessee College of Dentistry. Dr. Swilling is licensed in both California and Arkansas, and has been very active in both organized dentistry and continuing education since her graduation. She has been a member of the Arkansas State Dental Association New Dentist Committee since 2000, and has served as chair since 2005. Dr. Swilling is also editor of the Southeast District Dental Society. She was chosen Arkansas New Dentist of the Year in 2004. Her intelligence, drive, and commitment make her an ideal candidate for the ADA Committee on the New Dentist.

SCIENTIFIC AFFAIRS

Armstrong, Steven R., Iowa, 2011. Dr. Steven Armstrong joined the University of Iowa College of Dentistry faculty in 1999 after completing post-doctoral work at the college as an NIDCR dentist-scientist. Dr. Armstrong’s education includes a D.D.S., Certificate of Operative Dentistry and Ph.D. in Oral Science from the University of Iowa as well as a GPR as USAF Langley AFB and serving in the Air Force for four years post-graduation. He is an associate professor in the Department of Operative Dentistry. Dr. Armstrong’s current primary teaching responsibilities include directorship of junior seminars, directorship of graduate dental materials, and lecturer in various other courses throughout the college. He also is an instructor in the sophomore and junior clinical operative clerkship and maintains a private intramural practice. Dr. Armstrong’s current research includes various projects investigating the biodurability of the dentin adhesive bond, including mechanical, ultrastructural, chemical, and thermal properties. Dr. Armstrong has more than ten projects under investigation in these areas and has been the principal investigator on numerous grants from the NIDCR, various institutions and industry. He has received numerous awards including the NIH Dentist-Scientist Award and the Paffenbarger Award for the Academy of Dental Materials. Dr. Armstrong serves on the board or is a reviewer for 11 journals including the *Journal of Prosthetic Dentistry and*

Operative Dentistry. He has published numerous articles and abstracts, lectures at the University and other organizations, mentored numerous students in their projects, and been involved in many teaching activities. He is a current member of the ADA, the American Dental Education Association, the Academy of Operative Dentistry, the International Association for Dental Research, the Dental Materials Group of the IADR, and the Academy of Dental Materials.

Buhite, Robert J., New York, 2011. Dr. Robert Buhite graduated from Sienna College in Loudonville, New York. He then completed a Fellowship in the Department of Biology at St. Louis University. Dr. Buhite's studies concentrated in comparative anatomy, comparative embryology and biophysics. Following his Fellowship, Dr. Buhite attended dental school at St. Louis University where he was president of the student government. He served as a division officer in the U.S. Navy Dental Corps. Dr. Buhite maintains a private practice in Rochester, with emphasis on implants and comprehensive restorative care. His son shares similar responsibilities in the same practice. Dr. Buhite has been intimately involved in implant research and in many ways has helped establish the discipline as part of contemporary dental practice. From 1986 to 1992 he held the position of clinical assistant professor at Harvard University School of Dental Medicine, with emphasis on dental implants. He currently is clinical associate professor and director of implant dentistry at the University at Buffalo School of Dental Medicine. Dr. Buhite is a diplomat of the American Board of Oral Implantology/Implant Dentistry and served as president of that organization in 2005. He is an Honored Fellow of the American Academy of Implant Dentistry. Dr. Buhite has lectured extensively both nationally and internationally. He will add a wealth of knowledge and experience to the deliberations of the Council.

Burgess, John O., Alabama, 2011. Dr. John Burgess is the assistant dean for clinical research and the director of the Biomaterials Graduate Program at the University of Alabama in Birmingham. He graduated from Emory University School of Dentistry and completed graduate training at the University of Texas Health Science Center in Houston. Dr. Burgess completed a general practice residency and a general dentistry residency in the Air Force. He served as military consultant to the Surgeon General in General Dentistry and was chair of Dental Research and Dental Materials at Wilford Hall Medical Center before retiring from the USAF. Dr. Burgess is a diplomat of the Federal Services Board in General Dentistry and the American Board of General Dentistry. He is a Fellow of the Academy of Dental Materials and the American College of Dentists, as well as an elected member of the American Academy of Esthetic Dentistry and the American Restorative Academy. He is a member of the Academy of Operative Dentistry, the American and International Associations for Dental Research, the Alabama Dental Association and the ADA. A dedicated researcher, Dr. Burgess has served as the principal investigator on industrial, foundation, state and national grants. Dr. Burgess reviews for four dental journals, is the author of more than 300 journal articles, textbook chapters and abstracts and has presented more than 800 continuing education programs nationally and internationally. He is an active investigator on clinical trials evaluating posterior composites, adhesives, fluoride releasing materials, impression materials and class 5 restorations. He maintains a part-time practice in general dentistry.

Taylor, George W., III, Michigan, 2011. Dr. George Taylor is an associate professor at the University of Michigan with joint appointments in the Department of Cariology, Restorative Sciences and Endodontics in the School of Dentistry, and in the Department of Epidemiology in the School of Public Health. He received his D.M.D. from Harvard School of Dental Medicine and completed a general practice residency at Brookdale Hospital Medical Center in Brooklyn, New York. Dr. Taylor was also a National Research Service Award Fellow in oral epidemiology and received his Dr.P.H. from the University of Michigan School of Public Health, Program in Dental Public Health, in 1994. He is a diplomat of the American Board of Dental Public Health and a director of the American Board of Dental Public Health. His research activities involve observational and intervention studies of relationships between oral diseases and other systemic diseases, particularly the role of oral infections in diabetes mellitus, oral health and pneumonia in older adults and other

adverse medical outcomes; and observational studies of factors affecting oral health status and dental care utilization of underrepresented minority populations. His research encompasses active involvement in clinical research (observational studies and clinical trials) as well as secondary data analyses of complex survey data. Dr. Taylor has had continuous NIH funding as principal or co-investigator since 1994. He practices and teaches clinical general dentistry and actively mentors students in the School of Dentistry's student research program and other faculty locally at the University of Michigan and at other institutions. His other professional activities include serving on the Oral Health Subcommittee of the Michigan Diabetes Policy Advisory Committee and the Pharmacy, Podiatry, Optometry, and Dentistry Workgroup of the National Diabetes Education Program. He is also a member of the National Advisory Dental and Craniofacial Research Council at NIH/NIDCR.

Resolution No. 23 New ■ Substitute □ Amendment □

Report: Board Report 1 Date Submitted: July 2007

Submitted By: Board of Trustees

Reference Committee: NA

Total Financial Implication:

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Create and Transfer Knowledge (Required)

NOMINATIONS TO ADA COUNCILS AND COMMISSIONS

Background: (See pages 1010-1023 for qualification of nominees)

Access, Prevention and Interprofessional Relations
Gary S. Davis, PA
A. J. Homicz, NH
Melanie S. Lang, WA
David J. Miller, NY
AMA Representative (TBD)
AHA Representative (TBD)

ADA Sessions
Stephen Carstensen, WA, *ad interim*
Ronald K. Heier, PA
Kevin M. Laing, OH
Hutson E. McCorkle, FL
Michael C. Remes, MN

Communications
Jonathan R. Gellert, NY
Eugene T. Giannini, DC
Josef N. Kolling, MI
Mary A. Starsiak, IL

Dental Accreditation
Reuben N. Pelot, III, TN

Dental Benefits
Philip J. Eversman, IN
Harry C. Futrell, FL
Daniel J. Klemmedson, AZ
Christopher J. Smiley, MI

Dental Education and Licensure
Brian T. Kennedy, NY
James L. Schmidt, ME

Dental Practice
H. Lee Gardner, Jr., SC
Stephen O. Glenn, OK
Michael H. Halasz, OH
Christopher C. Larsen, IL

Ethics, Bylaws and Judicial Affairs
Thomas W. Gamba, PA
Carl L. Sebelius, Jr., TN
Terri S. Tiersky, IL
Rodney B. Wentworth, WA

Government Affairs
James D. Condrey, TX
Rodney J. Klima, VA
Matthew J. Neary, NY
Donald M. Schinnerer, CA

Membership
Rex B. Card, NC
Todd R. Christy, MI
Virginia A. Hughson-Otte, CA
William F. Martin, III, MD

Members Insurance and Retirement Programs
Philip M. Abshere, OK
Edmund Cassella, HI, *ad interim*
D. Douglas Cassat, CA
C. Richard Gerber, WV
Louis A. Imburgia, IL

National Dental Examinations
Stephen T. Radack, III, PA

New Dentist
Jeremy M. Albert, FL
Jennifer Davis, PA, *ad interim*
Jennifer J. Jerome, OH
Robert S. Leland, MA
Stacey E. Swilling, AR

Scientific Affairs
Steven R. Armstrong, IA
Robert J. Buhite, NY
John O. Burgess, AL
George W. Taylor, III, MI

Resolution

23. Resolved, that the nominees for membership on ADA Councils, Commissions, and the Committee on the New Dentist submitted by the Board of Trustees in accordance with Chapter VII, Section 110(H) of the *Bylaws* be elected.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 24, 25 and 26 New ■ Substitute □ Amendment □

Report: Credentials, Rules and Order Date Submitted: July 2007

Submitted By: Standing Committee on Credentials, Rules and Order

Reference Committee: NA

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

REPORT OF THE STANDING COMMITTEE ON CREDENTIALS, RULES AND ORDER

Minutes of 2006 Session of the House of Delegates: The minutes of the 2006 session of the House of Delegates have been published (*Trans.*2006, pages 299-349) and circulated to the members of the House of Delegates and the officers of constituent and component dental societies. The minutes have also been posted in the House of Delegates section of ADA.org. To date, no formal requests for corrections or amendments have been received.

24. Resolved, that the minutes of the 2006 annual session of the House of Delegates, as published in *Transactions 2006*, pages 299-349, be approved.

The Chair moves the adoption of this resolution.

Minutes of Previous Meetings: If minutes of a previous meeting are required during this session of the House of Delegates for reference, the verbatim record shall constitute the minutes of that meeting.

Adoption of Agenda and Order of Agenda Items: The Committee has examined the agenda for the meetings of the House of Delegates. Accordingly, the Committee recommends adopting the agenda as the official order of business for this session. The Committee also recommends that the Speaker of the House be allowed to rearrange the order of the agenda as deemed necessary to expedite the business of the House.

25. Resolved, that the agenda as printed in the *2007 Manual of the House of Delegates and Supplemental Information* be adopted as the official order of business for this session, and be it further

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

The Chair moves the adoption of this resolution.

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

This preliminary list of referrals (circulated in the form of the Updated General Index to the resolution worksheets) will be provided with the second distribution of resolution worksheets. The Speaker will

announce additional referrals during the first meeting of the House of Delegates. A complete list of referrals, in the form of an agenda, will be available in the reference committee hearing rooms on Saturday morning, September 29.

26. Resolved, that the preliminary and supplemental list of referrals submitted by the Speaker of the House of Delegates be approved.

The Chair moves the adoption of this resolution.

Annual Reports and Resolutions, Manual of the House of Delegates **and Resolution Worksheets:** As customary *Annual Reports and Resolutions 2007* were posted in mid-June on ADA.org and were also mailed to delegates and alternate delegates in late July. In addition, the first set of resolution worksheets was mailed to delegates and alternate delegates in mid-August. A limited quantity of *Annual Reports* and the first set of resolution worksheets will be available in the House of Delegates Information and Resources Office, located in the Laurel Room of the Marriott San Francisco (Golden Gate Foyer, B2 Level). Appropriate announcements were included in *Annual Reports and Resolutions 2007,* in the cover letter transmitting the worksheets as well as in the *ADA News*.

The *Manual of the House of Delegates and Supplemental Information* has been developed to complement the resolution worksheets. This booklet incorporates the "Rules of the House of Delegates" and all pertinent meeting information (i.e., House agendas, listing of members of the standing and reference committees, reference committee hearing schedule, and schedule of district caucuses). This booklet was mailed with the first set of resolution worksheets in August.

Supplement to Annual Reports and Resolutions is prepared primarily for historical purposes only since it reprints in resolution worksheet from all the reports and resolutions presented to the House of Delegates. This publication will be available in the first quarter of 2008.

Hearing of Reference Committees: The reference committees will hold hearings on Saturday, September 29, in various rooms of the Marriott San Francisco. The list of reference committee hearing rooms appears in the *Manual of the House of Delegates and Supplemental Information*.

SATURDAY, SEPTEMBER 29, 2007

10:00 a.m. to Noon	Dental Education and Related Matters
10:30 a.m. to 12:30 p.m.	Communications and Membership Services
11:00 a.m. to 1:00 p.m.	Dental Benefits, Practice, Science and Health
11:30 a.m. to 1:30 p.m.	Legal and Legislative Matters
Noon to 2:00 p.m.	Budget, Business and Administrative Matters

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

In accordance with the *Manual of the House of Delegates*, section "General Procedures for Reference Committees," any member of the Association, whether or not a member of the House of Delegates, is privileged to attend and participate in the discussion during the reference committee hearings. Guests of the Association are also welcome to attend reference committee hearings provided they identify themselves to the

committee. Nonmembers of the Association may participate at hearings only on the invitation of a majority of the reference committee.

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

Reports of Reference Committees: Completed reference committee reports will be made available to the Chair of record of each delegation on Sunday morning. A sufficient number of copies of each report will be provided for each delegation's delegates, alternate delegates, secretary, executive secretary, trustee and editor.

All delegates must bring their copies of reference committee reports to the meetings of the House of Delegates since additional copies will be limited.

Nominations of Officers: The nominations of officers (president-elect, second vice president, and speaker of the House of Delegates) will take place at the meeting on Friday afternoon, September 28. Candidates for elective office will be nominated from the floor of the House by a simple declaratory statement, which may be followed by an acceptance speech not to exceed four minutes by the candidate from the podium. Seconding the nomination is not permitted.

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

Nominations of Trustees: Nominations of members of the Board of Trustees from Districts 1, 12, 14 and 15 will take place at the first meeting of the House. Prior to such nominations, the delegates from each of the districts concerned must caucus for the purpose of determining their nominee or nominees in accordance with the provisions of Chapter VII, Section 40, of the *Bylaws*. A list of caucus meetings will be found in the *Manual of the House of Delegates and Supplemental Information*. This listing constitutes official notice of caucus.

The results of the caucus must be reported to the Secretary of the House of Delegates no later than the opening of the meeting on Friday. In the event of a contested trustee election, candidates for the office of trustee shall be nominated 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 minutes by the candidate from the podium. Seconding a nomination is not permitted.

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

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 determination 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.

Election Procedures: Ballots will be used in this year's contested elections. Voting will be conducted in the Moscone Convention Center, West Building, Level 3, Room 3022, Monday, October 1, from 7:00 a.m. to 8:30 a.m. for the balloting for the offices of president-elect and second vice president, and any other contested election. Members should bring their number 6 meeting card and vote early in order to avoid a delay at the voting machines.

In the event a second balloting is necessary, the number 6 meeting card will be reused. The second balloting will be conducted on Monday, October 1, from 9:00 a.m. to 10:30 a.m.

The Standing Committee on Credentials, Rules and Order oversees the tabulation, confirmation and reporting of election results. The Committee will verify the number of votes received by each candidate and the number of spoiled ballots that could not be counted prior to the election results being placed in a sealed envelope and transmitted to the Secretary of the House. The Secretary will review and forward the results to the Speaker for announcement. Committee members present during the tallying of the ballots will remain in the voting area until the Speaker informs the House of the election results. If there are any delays in reporting election results, the Committee Chair will immediately notify the Secretary of the delay.

Standing Order of Business—Installation of New Officers and Trustees: The installation ceremony for new officers and trustees will take place on Tuesday, October 2, as the first item of business with the time to be specified by the Speaker of the House of Delegates.

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

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

Explanation of Resolution Numbering System for New Delegates and Alternate Delegates: Original resolutions are numbered consecutively regardless of whether the source is a council, other Association agency, constituent society, delegate, Board of Trustees or House reference committee. Revisions made by the Board, reference committee or House are considered "amendments" to the original resolution. If amended by the Board, the suffix "B" follows the resolution number (Res. 24B); if amended by a reference committee, the suffix "RC" follows (Res. 24RC).

If a resolution is adopted by the House, the suffix "H" follows the resolution's number (Res. 24H). The "H" always indicates that the resolution was adopted.

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

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

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

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

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

Recognition of Those Waiting to Speak: When a member wishes to address the House, the individual should approach the microphone, secure the attention of the Speaker through the attendant at the microphone and wait to speak until recognized by the Speaker. The member should then state his or her name, district and state for the benefit of the official reporter. If all members of the House follow this procedure, work will be expedited and all who wish to will be given an opportunity to be heard.

When an electronic vote is taken, the Speaker will allow sufficient time for members at the microphones to return to their places before taking the vote. In the event debate continues on the same issue, the Speaker will honor the microphone sequence prior to taking the electronic vote. Therefore, a member who was at the microphone and did not have an opportunity to speak before that vote was called and who wishes to continue debate on the same issue should return to the microphone they were at prior to the electronic vote.

Access to Floor of House: Access to the floor of the House of Delegates is limited to the officers and members of the House of Delegates, the elective and appointive officers of the Association, the former presidents, the members of the Board of Trustees, the chairs of councils and commissions, the members of councils and commissions when requested by the chair, the secretaries and executive secretaries of constituent societies, the executive director and president of the American Student Dental Association, an officially designated representative from each of the American Hospital Association and the American Medical Association, and members of the Headquarters Office staff.

Admission to the floor will not be granted without the display of the appropriate annual session badge. Every delegate must also hand an appropriately numbered card to the attendant at the door for each meeting so that the official attendance record may be maintained. Former officers and former trustees will also be admitted to the section reserved for alternate delegates. Former trustees, former officers and editors will receive all worksheet materials distributed to delegates and alternate delegates.

Secretaries and Executive Secretaries of Constituent Societies: In accordance with the standing rule of the House, "The secretary and executive secretary of a constituent society may be seated with the constituent

society delegation on the floor of the House of Delegates even though they are not official delegates." Under the standing rule, it is not permissible to designate an "acting" secretary or executive secretary of a constituent society so that he or she may be seated on the floor of the House, unless that person is designated as "acting" secretary or executive secretary for the remaining portion of the annual session.

Substitution of Alternate Delegates for 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. 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. In order for a complete and accurate attendance record for all meetings of the 2007 House of Delegates, submission of these completed substitution forms is essential.

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

Attorney-Client Session. An attorney-client session is a form of closed session during which legal advice of any kind is sought from an attorney acting in a professional capacity and the communications relating to that purpose are made in confidence by the client or attorney. For attorney-client sessions, the Speaker and Secretary shall consult with the Chief Legal Counsel regarding attendance during the session. No official action may be taken nor business conducted during an attorney-client session.

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

Manual of the House of Delegates: Each member of the House of Delegates has received a copy of the *2007 Manual of the House of Delegates*. The Manual contains the standing rules of the House of Delegates and the pertinent provisions of the *Bylaws*.

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

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

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

House of Delegates Information and Resource Office: An information and Resource Office will be open Thursday, September 27 through Sunday, September 30, and will be located in the Laurel Room of the Marriott San Francisco (Golden Gate Foyer, B2 Level). This office will be open to delegates, alternates, constituent society officers and staff. The office will be equipped with computers; a copying machine; resource materials for researching issues; and general information about the meetings of the House of Delegates and related activities. Everyone is urged to use the Information and Resource Office when drafting resolutions or testimony. Individuals having resolutions for submission to the House of Delegates will be directed to the Headquarters Office where final resolution processing will occur.

Resolution No. 24 New ■ Substitute ☐ Amendment ☐

Report: Credentials, Rules and order Date Submitted: July 2007

Submitted By: Standing Committee on Credentials, Rules and Order

Reference Committee: NA

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: None (Required)

APPROVAL OF MINUTES OF THE 2006 SESSION OF THE HOUSE OF DELEGATES

Minutes of 2006 Session of the House of Delegates: The minutes of the 2006 session of the House of Delegates have been published (*Trans.*2006, pages 299-349) and circulated to the members of the House of Delegates and the officers of constituent and component dental societies. The minutes have also been posted in the House of Delegates section of ADA.org. To date, no formal requests for corrections or amendments have been received.

Resolution

24. Resolved, that the minutes of the 2006 annual session of the House of Delegates, as published in *Transactions 2006*, pages 299-349, be approved.

Resolution No. 25 New ■ Substitute ☐ Amendment ☐

Report: Credentials, Rules and Order Date Submitted: July 2007

Submitted By: Standing Committee on Credentials, Rules and Order

Reference Committee: NA

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: None (Required)

ADOPTION OF AGENDA AND ORDER OF AGENDA ITEMS

Adoption of Agenda and Order of Agenda Items: The Committee has examined the agenda for the meetings of the House of Delegates. Accordingly, the Committee recommends adopting the agenda as the official order of business for this session. The Committee also recommends that the Speaker of the House be allowed to rearrange the order of the agenda as deemed necessary to expedite the business of the House.

Resolution

25. Resolved, that the agenda as printed in the *2007 Manual of the House of Delegates and Supplemental Information* be adopted as the official order of business for this session, and be it further

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

Resolution No. 26 New ■ Substitute ☐ Amendment ☐

Report: Credentials, Rules and Order Date Submitted: July 2007

Submitted By: Standing Committee on Credentials, Rules and Order

Reference Committee: NA

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: None (Required)

REFERRAL OF REPORTS AND RESOLUTIONS

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

This preliminary list of referrals (circulated in the form of the Updated General Index to the resolution worksheets) will be provided with the second distribution of resolution worksheets. The Speaker will announce additional referrals during the first meeting of the House of Delegates. A complete list of referrals, in the form of an agenda, will be available in the reference committee hearing rooms on Saturday morning, September 29.

Resolution

26. Resolved, that the preliminary and supplemental list of referrals submitted by the Speaker of the House of Delegates be approved.

Notes

Budget, Business and Administrative Matters

Resolution No. 12-13 New ☐ Substitute ☐ Amendment ☐

Report: Board Report 2 Date Submitted: July 2007

Submitted By: Board of Trustees

Reference Committee: Budget, Business and Administrative Matters

Total Financial Implication:

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Supports achievement of all five-strategic goals (Required)

REPORT 2 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ADA OPERATING ACCOUNTING FINANCIAL AFFAIRS AND RECOMMENDED BUDGET FISCAL YEAR 2008

Introduction: In accordance with its *Bylaws* duties, the Board of Trustees presents the proposed 2008 operating budget for the Association. This report also provides the House of Delegates with comparative financial data over a three-year period. Finally, it includes background commentary and an analysis of significant budget changes for 2008. The Board is recommending a 2008 operating budget of $113,089,500 in revenues and $114,082,300 in expenses, income taxes, and cash flow items, generating a net deficit of ($992,800). The 2008 budget again seeks to use the ADA's strong reserve position in a manner consistent with the long-term financial strategy of dues stabilization. In arriving at this proposal, the Board of Trustees analyzed budget requests relative to the Association's strategic priorities. Resources were reallocated between programs and divisions in an effort to maximize their effective use in executing the ADA's Strategic Plan for 2007-2010. Additionally, non-dues revenue sources were carefully examined to determine whether they were estimated at appropriate amounts.

Key comments concerning the 2008 budget follow:

- Membership dues revenues are expected to increase as a result of an increase in full dues paying equivalents (FTE's) of 986 members when comparing the 2008 budget to the 2007 budget. The increase is largely due to the 2003 House resolution reducing dues for the first four years after graduation. 2008 is the first year that members who were in the fourth year out of dental school go from the reduced rate categories to the full dues paying category. 2007 projected dues revenues are expected to be approximately $230,000 below budget due mainly to dues waivers for Hurricane Katrina victims. It is projected that half of the members that requested waivers in 2006 will request waivers in 2007. The increase in (FTE's) when comparing the 2008 budget to the 2007 current projection is 1,289.

- Non-dues revenues are budgeted to grow 5%, with the most significant growth being in Publication & Product Sales, Testing Fees and Accreditation, Sponsorship Income, Investment Income, and Royalties. A new version of *CDT* is expected to be released in 2008 which accounts for the increase in Publication & Product Sales. Fee increases and growth in the number of testing candidates account for the growth in Testing Fees and Accreditation. The increase in Investment Income is due to higher short-term interest rates and higher asset levels in the Reserve Fund. The increase in Corporate Sponsorship revenue is due to the 2008 annual session in San Antonio offering four additional evening/special events compared to two for the 2007 annual session in San Francisco. Additionally, continued growth in sponsorship of the educational programs at annual session is expected in 2008. The increase in royalties is due to increased member utilization of, and the addition of new products to the *ADA Member Advantage* program. Meeting and Seminar Income is expected to decrease 12% due to the location of the 2008 annual session being in San Antonio compared to the 2007 annual session being in San Francisco. The San Antonio meeting is not expected to draw as many attendees as San Francisco.

- Operating expenses are budgeted to increase by 5%. The increase is largely attributable to the increase in Depreciation expense and Staff Compensation. The increase in Depreciation is due to the Capital Improvement Program and ADA Headquarters Renovation Funds being closed and consolidated into the ADA as of December 31, 2007. The assets that were being depreciated in these funds will be transferred to the ADA in 2008. With the completion of the lobby renovation in 2007, the renovation of the entire headquarters building will be completed. The increase in Staff Compensation is due to annual performance-based merit increases and costs of employer paid taxes and fringe benefits. Partially offsetting these expense increases is a reduction in Meeting and Seminar expenses due to costs of hosting the annual session in San Antonio being significantly less than San Francisco.

- The 2008 budget adds value to membership with new program decision packages totaling nearly $553,700 in operating expenses and $75,500 in capital spending.

Budget Process

The Board continued to utilize the same very thorough budget process. The process started by giving the staff a benchmark to develop the base budget with a goal of having a balanced budget with an inflationary dues increase. The 2008 benchmark included the effect of a 4% compensation increase. Staff was directed to present new proposed activities in new program packages that could be reviewed, evaluated and ranked. Proposals for new activities from all divisions were considered in a pool and competed against each other for funding. This process facilitated consideration of strategic priorities at an organizational level.

Again this year, councils and commissions were encouraged to focus on establishing priorities, assess the relationship of activities to the ADA Strategic Plan, and sunset or curtail programs that are of lesser importance to the membership or the public. The Administrative Review Committee, which is comprised of the Finance Committee of the Board of Trustees, the President-elect, the Treasurer, the Executive Director, the Chief Operating Officer, and the Chief Financial Officer, closely reviewed and analyzed all budget requests.

2008 BUDGET SUMMARY WORKSHEET
FINANCIAL IMPLICATIONS RECAP

	2006 ACTUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
Dues Revenue	47,687,798	53,526,750	53,944,350	1%
Non-Dues Revenue	53,003,436	56,428,900	59,145,150	5%
Total Revenues	100,691,234	109,955,650	113,089,500	3%
Total Expenses	100,085,702	111,317,750	116,668,450	(5%)
Net Operating Results Before Taxes	605,532	(1,362,100)	(3,578,950)	(>100%)
Income Taxes	(971,055)	(1,200,000)	(1,200,000)	0%
Net Operating Results After Taxes	(365,523)	(2,562,100)	(4,778,950)	(87%)
Cash Flow Items				
Net Capital Requirements	700,621	517,250	3,786,150	>100%
Renovation Program Funding	(1,000,000)	0	0	0%
Net Surplus/(Deficit)	**(664,902)**	**(2,044,850)**	**(992,800)**	**51%**

AMERICAN DENTAL ASSOCIATION
NATURAL ACCOUNT SUMMARY WORKSHEET

	2006 ACTUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
Membership Dues	47,387,798	53,526,750	53,944,350	**<1%**
Advertising	6,741,551	7,856,400	7,981,100	**2%**
Rental Income	4,642,697	4,956,650	5,072,550	**2%**
Publication and Product Sales	8,190,546	7,738,200	9,011,850	**16%**
Testing Fees & Accreditation	10,012,917	10,901,200	11,820,450	**8%**
Meeting & Seminar Income	9,359,735	11,582,650	10,225,100	**(12%)**
Grants, Contributions, Sprship	2,151,143	1,856,500	2,422,100	**30%**
Royalties	5,913,842	6,056,950	6,489,950	**7%**
Investment Income	1,761,183	1,350,000	1,780,000	**32%**
Other Income	4,529,822	4,130,350	4,342,050	**5%**
Total Revenues	**100,691,234**	**109,955,650**	**113,089,500**	**3%**
EXPENSE				
Staff Compensation	47,195,075	50,202,100	52,960,850	**(5%)**
Print., Publicat. & Marketing	13,129,194	12,520,100	12,537,250	**(<1%)**
Meeting Expenses	3,092,967	4,638,050	3,361,400	**28%**
Travel Expenses	5,693,124	6,344,700	6,519,860	**(3%)**
Professional Services	11,320,957	16,239,750	16,183,730	**<1%**
Office Expenses	4,749,908	5,501,300	5,888,160	**(7%)**
Facility and Utility Costs	4,377,216	4,411,550	4,662,850	**(6%)**
Grants and Awards	341,304	339,000	356,000	**(5%)**
ADA Foundation Grant	3,202,523	3,215,800	3,529,050	**(10%)**
Endorsement Costs	763,479	761,200	805,600	**(6%)**
Depreciation and Amortization	4,065,591	4,047,100	6,751,900	**(67%)**
Bank & Credit Card Fees	718,711	721,000	750,100	**(4%)**
Other Expenses	1,435,653	2,376,100	2,361,700	**<1%**
Total Expenses	**100,085,702**	**111,317,750**	**116,668,450**	**(5%)**
Net Before Income Taxes	605,532	(1,362,100)	(3,578,950)	(>100%)
Income Taxes	(971,055)	(1,200,000)	(1,200,000)	0%
Net Revenue/(Expense) After Income Taxes	(365,523)	(2,562,100)	(4,778,950)	(87%)
Cash Flow Items				
Net Capital Expenditures	700,621	517,250	3,786,150	>100%
Renovation Program Funding	(1,000,000)	0	0	0%
Net Surplus/(Deficit)	**(664,902)**	**(2,044,850)**	**(992,800)**	**51%**

Revenues

Total revenues in the 2008 budget are being forecast at $113,089,500. Membership dues represent 47.7% of total revenue. The 2008 budget anticipates $59,145,150 in non-dues revenue, a 4.8% increase from 2007. Highlights of various revenue categories are provided below.

Membership Dues: In order to arrive at the overall budget for dues, the Division of Membership and Dental Society Services estimates the future membership levels for each dues paying category and multiplies those numbers by the various dues rates. For informational purposes and ease of comparison between years, the number of full-time equivalent members can be calculated by dividing the budgeted dues amount before dues rebates by the full dues rate of $489, which translates to approximately 109,450 and 110,400 full-time equivalent members for the 2007 and 2008 budgets, respectively. Final 2006 membership FTE's were 109,208. In comparing these numbers, it has to be noted that dues revenues for 2007 are expected to be $230,000 less than budget mainly because of dues waivers related to Hurricane Katrina. Also 2008 is the first year that members who were in the fourth year out of dental school go from the reduced rate categories to the full dues paying category.

The 2008 budget forecasts dues revenues of $54,079,350 before rebates and $53,944,350 net of rebates offered to state societies as an incentive to encourage prompt payment of member monies to the Association.

Advertising: This category primarily includes revenue from advertising in ADA publications and at annual session. Advertising income is expected to increase from $7,856,400 to $7,981,100. The increase is primarily due to a steady growth in classified advertising sales.

Rental Income: This revenue category primarily includes rental income from the Headquarters Building and the Washington D.C. Building. Rental income increased by 2%, from $4,956,650 to $5,072,550 due to the Headquarters and Washington D.C. Buildings projecting additional tenant revenue in 2008. The increase is due to lease renewals at higher rates and annual rent escalations in existing leases.

Publication and Product Sales: Projected 2008 sales total $9,011,850 compared to $7,738,200 in 2007. The 16% increase is due to 2008 being a year that generates significant *CDT* book revenue because a new release is scheduled. In 2007, *CDT* book sales will be minimal.

Testing Fees and Accreditation: Revenues from testing and accreditation fees are expected to rise from $10,901,200 in 2007 to $11,820,450 in 2008. The increase is mainly due to higher fees for Accreditation, National Board exams and Admission tests. Additionally, in 2008 the National Board exam is only offered using the computerized format which carries a higher fee. The National Board Dental Hygiene exam offers the option of taking a written or computerized format. It should be noted that expenses associated with computerized exams are also higher, which is explained under Professional Services.

Meeting and Seminar Income: Projected income from 2008 meeting and seminar fees of $10,225,100 is $1,357,550 less than the 2007 budget. The decline is primarily due to the location of the 2008 annual session. San Antonio is a less optimum convention location than San Francisco, which reduces the number of projected attendees and exhibit revenue. Additionally, the 2008 budget includes a reduction in the number of continuing education seminars being offered due to demand.

Grants and Contributions: Income from grants and contributions is expected to increase by $565,600. The increase is largely the result of continued growth in sponsorship of educational programs at annual session. Also contributing to the increase is the ADA launching a new sponsorship program that will offer various sponsorship programs for companies to choose from.

Royalties: Projected revenue represents royalties received from the *ADA Member Advantage* program, *CDT* licenses, and the selling of mailing lists. Royalty revenue is projected to increase by $433,000. The increase is largely related to the *ADA Member Advantage* program and anticipated royalties from *CDT* licensing.

Investment Income: Projected revenue of $1,780,000 for 2008 includes both interest and dividends on Reserve Fund assets and investment earnings on operating cash. The cash yield on the assets of the Reserve Fund is included in the operating budget as a key component of the dues stabilization financial strategy, which seeks to maintain annual dues revenues at or below inflation over a continuum of time. The inclusion of such investment revenues in the operating budget is a direct benefit of the ADA's strong reserve position. Budgeted interest and dividends on operating cash is projected to increase by $150,000 due to higher short-term interest rates, and earnings on reserve assets are expected to increase by $280,000 due mainly to higher asset levels.

Other Income: This category is composed of miscellaneous revenue, including such items as overhead costs recouped under federal grants and the members insurance program, and Seal Program revenues. 2008 is the fourth of five years in which a $1.4 million distribution of excess surplus of the MedCash Insurance Plan will be received. Projected revenue in 2008 represents a 5% increase when compared to 2007.

Expenses

Total expenses in the operating budget are being forecast at $116,668,450 for 2008. This represents a 4.8% increase. New programs represent $553,700 of the increase in expenses for 2008. Highlights of various expense categories are provided below.

Staff Compensation and Benefits: Staff compensation expenses are budgeted at $52,960,850. The 5.5% increase is mainly attributable to the 4% budgeted performance-based compensation increases and increased costs of payroll taxes and benefits. New programs added $10,000 to this category for 2007.

Printing, Publications and Marketing: The 2008 budget for this category reflects an increase of $17,150 or less than 1%. The increase in budgeted spending is due to the increased cost of paper, printing, marketing materials and postage related to publication and catalog sales. Partially offsetting the increase is a decline in funding is due to a reduction in the marketing budget of the Direct Reimbursement program. The House of Delegates approved a one-time decision package in 2006 that added an additional $250,000 to support dental societies in marketing the program.

Certain decision packages included printing and postage costs, which added $59,800 in expenses to this category.

Meeting Expenses: Expenses for meetings decreased by $1,276,650 or 28% when comparing 2007 and 2008. The anticipated decline in base budget funding is mainly due to a nearly $1.1 million reduction in site distribution expense. Typically, the host state and or local societies cancel their annual meetings and the ADA attempts to compensate them for any lost net revenue. Additionally, meeting room rental expenses are less in San Antonio. Rental fees for their convention center and the Alamo Dome are less expensive than the Moscone Center in San Francisco. Partially offsetting these decreases in expenses is an increase in shuttle bus expenses in San Antonio versus San Francisco due to the greater distance between the headquarters hotel and the convention center in San Antonio.

Decision packages Association-wide added $24,300 in meeting expenses.

Travel Expenses: Budgeted expenses for travel are projected to be $6,519,860 compared to $6,344,700 in 2007. The 3% increase is primarily due to decision packages adding $162,200 in additional expenses. Additionally, trips related to the "2010 Task Force" were added to the 2008 budget.

Professional Services: The budget in this category decreased from $16,239,750 in 2007 to $16,183,750 in 2008. The decrease in budgeted spending is partially due to the NCI Oral Cancer Grant ending in 2007. Additional savings will be realized due to the restructuring of the Members Retirement Plan which will eliminate outside consulting fees. Finally, three one-time decision packages in 2007 contained consulting expenses. These one-time expenses were backed out of the 2008 budget. Partially offsetting these decreases is an increase in test administration expenses as a result of most of the National Board exams, Admission tests, and Optometry tests being administered electronically, which results in higher exam costs. These higher costs is more than offset by higher test revenues. Additionally, fulfillment expenses for catalog products are projected to increase in 2008 as a result of higher product sales. Also, additional consulting, training and orientation expenses are required to assist with implementation of major advocacy recommendations. Decision packages added an additional $193,150 in professional service expenses.

Office Expenses: Expenses in this category are budgeted to increase 7% from $5,501,300 in 2007 to $5,888,160 in 2008. Several factors led to the increase: realignment of expenses from other expense categories, projected increases in postage rates, and the division of Conference Services sending out follow-up annual session reminders first class instead of bulk rate. Offsetting most of the increases are reductions in lab supplies and telephone costs, and postage savings because the National Boards, Admission, and Optometry tests are computerized. Several decision packages added $43,500 in expenses.

Facility and Utility Costs: These expenses represent costs for building management oversight, operations, maintenance, and real estate taxes for the ADA Headquarters and Washington buildings. The 2008 budget of $4,662,850 anticipates a 6% increase as a result of higher property taxes, cleaning costs, and general building repairs.

Grants and Awards: The ADA distributes grants to support various organizations. Expenses in this category increased from $339,000 in 2007 to $356,000 in 2008. The ADA grant to the National Foundation of Dentistry for the Handicapped will be increased in 2008.

ADA Foundation Grant: The Association's annual grant to the Foundation increased by $313,250 from $3,215,800 in 2007 to $3,529,050 in 2008. The increase in the ADA Foundation grant is due to merit increases, increased benefit costs, and an increase in audit and legal fees.

Endorsement Costs: This category represents monies paid to state societies that participate in the *ADA Member Advantage* program. This category increased from $761,200 in 2007 to $805,600 in 2008. The increase is directly related to the increase in royalty income generated by the *ADA Member Advantage* program.

Depreciation and Amortization: This category shows a 67% increase from $4,047,100 to $6,751,900. The significant increase is directly related to consolidating the CIP and Renovation Funds assets into the ADA in 2008. The renovation of the ADA building will be completed in 2007 and the assets transferred at the end of 2007.

Bank and Credit Card Fees: This category represents transaction fees paid to financial institutions and reimbursements to state and local societies for credit card fees related to collection of ADA membership dues. Expenses increased from $721,000 in 2007 to $750,100 in 2008. The increase is largely due to the ADA anticipating more state and local societies will accept payment of membership dues via credit cards. The ADA budgeted $280,000 in 2007 versus $310,000 in 2008.

Other Expenses: Other expenses include general insurance, recruiting costs, staff development, overhead recovery, and the contingency fund. Budgeted expenses not categorized elsewhere are expected to decrease from $2,376,100 in 2007 to $2,361,700 in 2008. The reduction is due to lower overhead costs as a result of the restructuring of the Members Retirement Plans, and a reduction in bad debt expense in Salable Materials. Decision packages added $60,750 to this category.

Cash Items

Net Capital Expenditures: The depreciation budget in Central Administration exceeds the capital budget of $2,890,250 by $3,861,650 before decision packages, and $3,786,150 with proposed decision packages requiring capital spending of $75,500. This $3,786,150 is added back to the operating budget and offsets expenses.

Building Renovation Project: 2007 is the final year of the building renovation project. The $1 million annual funding ended at the conclusion of 2006, as did the related $30 member assessment.

AMERICAN DENTAL ASSOCIATION
DIVISIONAL SUMMARY WORKSHEET

DIVISION	2006 ACTUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUES				
Administrative Services	21,000	0	0	0%
Legal Affairs	66,123	74,150	76,900	4%
Government Affairs	24,650	17,700	18,200	3%
Communications & Corp Rel	214,442	86,900	329,500	>100%
Membership & Den Soc. Serv	522,022	627,600	862,300	37%
Conference & Meeting Serv	10,250,551	11,903,400	11,181,500	(6%)
Headquarters Building	3,069,497	3,500,100	3,576,750	2%
Washington D.C. Building	1,429,948	1,437,550	1,472,200	2%
Finance & Operations	2,608,011	2,289,650	2,757,750	20%
Central Administration	54,126,954	60,098,450	60,844,750	1%
Information Technology	38,653	56,100	52,400	(7%)
Salable Materials	8,630,067	8,092,650	9,460,700	17%
Dental Practice	971,630	1,385,400	880,350	(36%)
Health Policy Resource Ctr	270,879	329,300	280,000	(15%)
Education	10,286,816	11,160,100	12,112,950	9%
Science	627,041	481,500	565,200	17%
ADA Publishing	7,532,950	8,415,100	8,618,050	2%
Total Revenues	**100,691,234**	**109,955,650**	**113,089,500**	**3%**
EXPENSES				
Administrative Services	6,508,573	7,121,800	7,365,050	(3%)
Legal Affairs	2,276,440	2,439,050	2,403,900	1%
Government Affairs	3,224,973	4,184,500	4,297,250	(3%)
Communications & Corp Rel	3,775,418	7,799,850	7,689,050	1%
Membership & Den Soc. Serv	5,783,745	6,298,350	6,749,050	(7%)
Conference & Meeting Serv	8,142,441	10,347,700	9,721,900	6%
Headquarters Building	4,161,991	4,205,100	4,493,700	(7%)
Washington D.C. Building	733,084	753,650	761,200	(1%)
Finance & Operations	3,464,404	3,848,250	3,854,700	(<1%)
Central Administration	24,069,765	22,791,650	27,706,900	(22%)
Information Technology	5,732,342	7,065,050	7,087,100	(<1%)
Salable Materials	4,583,792	4,469,800	4,613,150	(3%)
Dental Practice	5,365,159	5,959,050	5,213,100	13%
Health Policy Resource Ctr	2,009,764	2,105,350	2,104,700	<1%
Education	9,236,533	9,921,800	10,171,450	(3%)
Science	3,671,219	4,354,200	4,572,800	(5%)
ADA Publishing	7,346,059	7,652,600	7,863,450	(3%)
Total Expenses	**100,085,702**	**111,317,750**	**116,668,450**	**(5%)**
Net Revenue(Expense) Before Income Taxes	**605,532**	**(1,362,100)**	**(3,578,950)**	**(>100%)**

- Programs and activities in divisional/departmental budgets in this report do not include allocations of payroll taxes, fringe benefits, occupancy or general and administrative expenses. Payroll taxes, fringe benefits, and depreciation are aggregated in the Division of Central Administration. Occupancy costs are reflected in the Headquarters Building and indirect costs (e.g. accounting, human resources etc) are budgeted in separate departments. Therefore, the expenses specifically reflected in the budget for a particular program/activity are not all-inclusive, meaning the total cost of a program/activity would be higher if all the indirect costs were factored in.

Division of Administration and Policy

The division serves primarily as administrative infrastructure to the Association through implementation of actions and policies of the House of Delegates and the Board of Trustees; supervision of activities of Association staff and agencies by the Office of the Executive Director; coordination of meetings of the Board of Trustees and House of Delegates by the Department of Board and House Matters; support of the Chief Policy Advisor in regard to publications and policy statements; establishment, implementation and coordination of strategic planning activities by the Department of Strategic Planning and Consulting; recruitment and retention of staff and administration of personnel policies and practices through the Department of Human Resources; the coordination of travel activities, schedules and correspondence for the President, President-elect and Executive Director through the Department of Officer Services.

DIVISIONAL SUMMARY WORKSHEET
ADMINISTRATIVE SERVICES

	2006 ACTUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
Kellogg Exec Mgmnt Program	21,000	0	0	0%
Administrative Services				
Total Revenues	**21,000**	**0**	**0**	**0%**
EXPENSE				
Office of the Exec. Director	1,238,739	1,404,550	1,203,000	14%
Ex Dir. Advocacy Activities	0	287,000	212,100	26%
Office Quality/Strategic Plan	250,080	253,750	419,550	(65%)
Board of Trustees	1,805,897	1,849,150	1,896,250	(3%)
Office of the President	418,991	407,000	543,100	(33%)
Office of the President-Elect	305,320	300,850	309,500	(3%)
Office Immediate Past Pres	21,648	22,000	22,900	(4%)
Office of the Treasurer	94,854	100,100	103,000	(3%)
House of Delegates	888,572	868,200	877,800	(1%)
Human Resources	1,234,012	1,364,300	1,453,250	(7%)
Office of the Chief Policy Adv	250,460	264,900	324,600	(23%)
Administrative Services				
Total Expenses	**6,508,573**	**7,121,800**	**7,365,050**	**(3%)**
Net Revenue/(Expense)	**(6,487,573)**	**(7,121,800)**	**(7,365,050)**	**(3%)**

In comparing 2008 to 2007, the budget for this division shows an increase in net expenses of $243,250 or 3%. The increase is funding is attributable to an increase in Board of Trustee stipends, and travel costs. In the Office of the Executive Director a position was eliminated and a portion of those salary dollars were used to fund a new

position in the Department of Strategic Planning and Consulting. Also contributing to the increase in funding following are the decision packages listed below:

- $18,300 to fund the Sesquicentennial Celebration activities. To fund the initial promotion to commemorate, celebrate and communicate the ADA's 150 year commitment to the public's health. Funds will be used to effectively promote this event starting at annual session in San Antonio. The celebration itself will take place during 2009, which will require additional funding.
- $113,700 to fund the Commission on Dental Accreditation Task Force. This package funds a 12 member task force appointed by the president. The objectives of the task force will be to: (1) determine whether the structure, governance, policies, operating procedures and functionality of the CODA adequately meet the accreditation needs of the dental profession and whether CODA is using best practices in accreditation, (2) determine whether it is in the profession's best interest for CODA to maintain its affiliation with the U.S. Department of Education, and (3) make recommendations, accordingly, on how the dental accreditation process can be improved to preserve the high standards needed for the future of dental education as a profession. Funds are being requested for two meetings of the task force and to retain a consulting firm with specific expertise in the professional education arena to staff and support the task force's work.

- $60,000 to implement E-Recruit module in PeopleSoft. Currently applicants send either a paper resume or a file attached to an e-mail in order to respond to job postings with an employment application. The application is reviewed and the application information is manually entered into the PeopleSoft system. The purpose of e-recruit is to automate the process so applicants can apply to a job posting on the Web (or on a computer set up for applicant self service at the ADA for walk in candidates). Currently 1,600 to 1,800 applicants are entered manually in the system, taking 3 to 5 minutes to enter the data for each new applicant. There is also additional data entry for applicants re-applying for multiple positions. The data entry would be done as an applicant self service with the e-recruit module.

Division of Legal Affairs

The Division of Legal Affairs provides services in three principal areas: advice on legal issues to all areas of the Association and subsidiaries; handling the day-to-day legal work to protect the rights and interests of the Association and subsidiaries; and legal advocacy on behalf of the dental profession. In regard to advice and daily legal work, the division serves as counsel to the ADA House of Delegates, Board of Trustees, Executive Director, councils, commissions, committees and other agencies. It provides these same services to the governing bodies, officers and staff of ADA's for-profit and not-for-profit subsidiaries. The division reviews and/or drafts virtually all legal instruments including contracts, leases, corporate filings and bylaw provisions. It monitors and handles compliance with federal, state and local laws. In the event of suit, it also oversees the progress of litigation and settlement negotiations, helps develop strategies with outside counsel, controls costs, produces documents and helps prepare witnesses.

The division supports the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) that oversees and enforces the Code of Ethics and reviews proposed changes to the ADA *Constitution* and *Bylaws*.

In addition, the division answers hundreds of member inquiries each month, and provides information on a range of areas including professional practice and dental care.

This division now oversees the International Use of the Seal. This activity was previously part of the Product Evaluations department in the Division of Science. This activity was transferred because most of the work involved registering the ADA Seal in numerous countries which was being done by Legal staff.

DIVISIONAL SUMMARY WORKSHEET
LEGAL AFFAIRS

	2006 ACTUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
Office of AED - Legal Affairs	65,403	36,800	37,900	3%
Council Ethics Bylaws & Judic	720	5,750	5,900	3%
International Use of the Seal	0	31,600	33,100	5%
Legal Affairs Total Revenues	**66,123**	**74,150**	**76,900**	**4%**
EXPENSE				
Office of AED - Legal Affairs	1,973,306	1,984,200	1,923,100	3%
Council Ethics Bylaws & Judic	223,019	264,150	266,600	(<1%)
Contract Analysis Services	80,115	148,700	171,700	(15%)
International Use of the Seal	0	42,000	42,500	(1%)
Legal Affairs Total Expenses	**2,276,440**	**2,439,050**	**2,403,900**	**1%**
Net Revenue/(Expense)	**(2,210,317)**	**(2,364,900)**	**(2,327,000)**	**2%**

The overall net expense budget for the Division of Legal Affairs in 2008 declined by 1.6% or a net of $37,900. The decline in expenses is the result of staff turnover and a reduction in travel costs to bring budget more in line with historical spending.

Division of Government Affairs

The Division of Government Affairs oversees the federal and state political and legislative advocacy activities of the ADA and ADPAC on behalf of the dental profession.

The division is organized in several departments to accomplish its mission with the Council on Government Affairs providing input and proposing policy. The Department of State Government Affairs assists state and local dental societies to achieve their regulatory and legislative goals. The Congressional Affairs and Federal Affairs areas function as liaisons and advocates with Congress and the Executive branch via testimony, personal meetings and communications. The budget supports the administrative expenses of ADPAC, an organization that allows member dentists to support candidates who have positive views toward dentistry and involves dentists in political issues important to the profession. A majority of the Strengthening Our Advocacy initiative is funded within the Division of Government Affairs. This program allows the ADA to continue its momentum toward achieving a more aggressive, better informed advocacy posture into 2008 and beyond.

DIVISIONAL SUMMARY WORKSHEET
GOVERNMENT AFFAIRS

	2006 ACTUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
State Government Affairs	24,650	17,700	18,200	3%
Government Affairs Total Revenues	**24,650**	**17,700**	**18,200**	**3%**
EXPENSE				
Office AED-Government Affairs	705,630	783,350	848,900	(8%)
Council Government Affairs	375,810	411,550	421,200	(2%)
State Government Affairs	717,776	831,550	838,900	(<1%)
ADPAC	802,807	879,600	868,100	1%
Congressional Affairs	437,982	591,900	662,550	(12%)
Federal Affairs	184,968	264,850	225,700	15%
Strengthening Our Advocacy	0	421,700	431,900	(2%)
Government Affairs Total Expenses	**3,224,973**	**4,184,500**	**4,297,250**	**(3%)**
Net Revenue/(Expense)	**(3,200,323)**	**(4,166,800)**	**(4,279,050)**	**(3%)**

The 2008 budget for this division shows an increase in net expenses of $112,750 or 2.7%. This increase is primarily due to annual merit increases. Additionally, 25% of a staff position in this division was allocated to the Publishing division in prior years but is now allocated 100% in the department of Congressional Affairs.

Division of Communications and Corporate Relations

The Division of Communications and Corporate Relations formulates and implements the ADA's communication strategy and tactics including ADA.org, directs and coordinates communications programs for the public, profession and media, and oversees public relations initiatives. The division also serves as ADA's coordinating link for corporate sponsorships. Its Production Services Department serves as a centralized clearinghouse for Association print materials to assist in creative strategies and managing the print process with vendors.

Public awareness of dental topics is enhanced by generating media coverage for significant dental health issues, developing patient education materials, distributing Video News Releases, producing Public Service Announcements and creating television and radio programs. The promotion of campaigns such as National Children's Dental Health Month, the dentist's role in prevention of oral cancer, and Adult Oral Health Awareness, enhances the image of the profession and provides a service to the public.

The division coordinates the annual Give Kids A Smile National Children's Dental Access Day. By any measure, the ADA's relatively small financial investment in this program continues to pay huge PR and image dividends.

The ADA Pavilion department coordinates all ADA Pavilion activities for annual session and exhibits at other dental related trade shows.

The Public Affairs Advocacy initiative is a nationally coordinated, state-targeted integrated public affairs plan to help states lay out strategies to preempt negative consequences that troublesome issues may pose for dentistry and to position themselves to better control the policy environment that in turn controls the practice of dentistry.

DIVISIONAL SUMMARY WORKSHEET
COMMUNICATIONS AND CORPORATE RELATIONS

	2006 ACTUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
Office of AED - Communications	212,696	77,300	319,600	>100%
Give Kids a Smile	16	0	0	0%
Media Relations	1,730	9,600	9,900	3%
Communications & Corporate Rel	**214,442**	**86,900**	**329,500**	**>100%**
Total Revenues				
EXPENSE				
Office of AED - Communications	892,013	741,800	772,500	(4%)
Give Kids a Smile	173,300	151,600	151,600	0%
Marketing Communications	572,934	595,100	619,500	(4%)
Media Relations	563,011	643,000	580,700	10%
Public Info/Education-Programs	484,297	694,400	542,900	22%
Creative Services	689,951	719,500	724,100	(<1%)
Production Services	131,675	145,350	148,700	(2%)
Council on Communications	56,947	71,100	140,850	(98%)
ADA Pavilion/Trade Shows	211,290	258,000	228,200	12%
Public Advocacy Initiative	0	3,780,000	3,780,000	0%
Communications & Corporate Rel				
Total Expenses	**3,775,418**	**7,799,850**	**7,689,050**	**1%**
Net Revenue/(Expense)	**(3,560,976)**	**(7,712,950)**	**(7,359,550)**	**5%**

Net expenses for the Division of Communications and Corporate Relations have decreased $353,400 or 4.6% in 2008. The decrease in net budgeted funding is partially due to the ADA projecting additional corporate sponsorship monies. The ADA is launching a new corporate sponsorship program that will offer companies various levels of sponsorship opportunities. Additionally, the 2007 budget included a one-time decision package totaling $98,850 for the Teen Oral Health program.

An inter-divisional staff reallocation was budgeted in 2008. One employee will be transferred from the Department of Media Relations to the Council on Communications.

Division of Membership and Dental Society Services

The Division of Membership and Dental Society Services focuses on conveying the value of membership throughout the tripartite including: development of benefits resources providing support to constituent and component leaders, volunteers and staff through the Membership Services Outreach Program, the Annual Membership Conference, the Transition Program, and the Getting Off to a Smart Start Program, which carry the message of organized dentistry to dental students from new dentists, tripartite leaders and staff.

Continuing the successful Membership Initiative supported by the 2001 House is another key focus of the division. The goal of the program is to increase membership by relying on personal contact with potential members at a grassroots level. Additionally, this division's activities lend support of the Association's international presence at the FDI World Dental Congress coordinated by the Center for International Development

The division's strategic activities also include: dental society user support for the Tripartite System; maintenance and integrity of the Association's membership data on the Tripartite System; recruitment and retention programs; membership service strategies; development of dental society membership resources; liaison and communications with tripartite and other dental organizations; leadership and management forums for dental society leaders and staff; recognition of dental society activities through the Golden Apple Awards and other programs; and evaluation of current membership administrative procedures to ensure that these procedures continue to meet member and Association needs. To respond to membership needs as articulated in the Memberships Needs and Opinions Survey 2000, the division has a member service center that is meant to provide members with increased access, as well as high quality and efficient servicing.

This division created a new department titled Dental School Programs which reflects the new strategy for the ADA which consolidates all programs under the SUCCESS brand name and offers continuum of programs, one for each class, to every school per year. This new strategy was recommended by the Dental School Programs Advisory Group in 2006. The SUCCESS activities included in this department were previously housed in the Division of Dental Practice. This program also consolidated activities from the Committee on the New Dentist and a Success Ethics component from CEBJA in the Division of Legal Affairs.

DIVISIONAL SUMMARY WORKSHEET
MEMBERSHIP & DENTAL SOCIETY SERVICES

	2006 ACTUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
Federation Dentaire Int'l	30,000	40,000	40,000	0%
Office of AED-MDSS	80,000	80,000	80,000	0%
Membership Initiative	72,000	81,500	81,000	(<1%)
Dept Dental Society Svcs Core	30,510	59,500	47,150	(21%)
Committee on New Dentist	211,512	272,600	272,150	(<1%)
Dept of Membership Marketing	36,000	30,000	36,000	20%
Department of Membership Info	62,000	64,000	66,000	3%
Dental School Programs	0	0	240,000	100%
Membership & Dent. Society Svc				
Total Revenues	**522,022**	**627,600**	**862,300**	**37%**
EXPENSE				
Office of AED-MDSS	420,040	448,950	443,500	1%
Membership Initiative	639,163	838,200	808,350	4%
Dept Dental Society Svcs Core	711,755	778,200	799,900	(3%)
Council on Membership Admin	287,381	298,100	310,950	(4%)
Member Service Center	769,919	712,500	740,300	(4%)
Committee on New Dentist	493,617	493,600	467,450	5%
Dept of Membership Marketing	852,502	950,600	955,700	(<1%)
Department of Membership Info	789,589	820,500	841,300	(3%)
Dental School Programs	0	0	302,200	(100%)
Center for Int'l Development	285,857	314,500	331,400	(5%)
Federation Dentaire Int'l	498,641	511,600	583,500	(14%)
ADA/HVO Dental Overseas Prog	35,281	32,300	32,300	0%
Internt'l Business Development	0	99,300	132,200	(33%)
Membership & Dent. Society Svc				
Total Expenses	5,783,745	6,298,350	6,749,050	(7%)
Net Revenue/(Expense)	**(5,261,723)**	**(5,670,750)**	**(5,886,750)**	**(4%)**

The proposed 2008 budget for the Division of Membership and Dental Society Services reflects an increase in net expenses versus 2007 $216,000 or 3.8%. The increase in net expenses is partially due to the creation of the Dental School Program. The SUCCESS portion of this budget in 2007 resides in the Division of Dental Practice. Also contributing to the increase in net expenses is the decision package is listed below:

- $100,750 in net expense to provide additional funding (over what was consolidated into the Dental School Programs base budget from CDP, CND and CEBJA budgets) to fully implement the strategy recommended by the Dental School Advisory Group. This program will offer a comprehensive continuum of dental school programs targeted to meet the needs of freshman, sophomore, junior and senior dental students, with every class offered at every school on an annual basis.

Division of Conference and Meeting Services

The Division of Conference and Meeting Services plans and coordinates the annual session, provides meeting and event services across the Association, coordinates the use of in-house conference facilities, oversees operations of in-house food services, and coordinates travel and accommodations for volunteers and staff. The greatest proportion of divisional activity is directed toward the annual session with the Council on ADA Sessions. The annual session provides the dental community with a broad spectrum of professional, educational and social activities, connecting grassroots members with the ADA in one of the most tangible ways. Planning and production of this event is a collaborative effort of staff, volunteers, and contractors, and includes a myriad of activities such as marketing, promotion, registration, ticket sales, exhibit booth sales, sponsorship, program coordination and publication production.

DIVISIONAL SUMMARY WORKSHEET
CONFERENCE & MEETING SERVICES

	2006 ACTUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
Council on ADA Session	9,576,244	11,286,600	10,524,200	(7%)
Annual Session Staff Travel	75,630	0	0	0%
AS Presidential Gala	249,345	235,000	235,000	0%
Intl Annual Session Hosting	30,000	16,000	16,500	3%
Management Conf Reception	15,000	15,000	15,000	0%
Conference Services	211,030	227,200	250,400	10%
Meeting Room Management	93,302	123,600	115,400	(7%)
Citibank Foundation Reception	0	0	25,000	100%
Conference & Meeting Services Total Revenues	**10,250,551**	**11,903,400**	**11,181,500**	**(6%)**
EXPENSE				
Office Asst Exec Director-CMS	276,715	289,100	253,100	12%
Council on ADA Session	6,596,040	8,835,200	8,187,550	7%
Annual Session Staff Travel	266,745	187,000	187,000	0%
Annual Session Hosting	29,990	27,100	27,100	0%
AS Presidential Gala	270,701	213,400	213,400	0%
Intl Annual Session Hosting	48,009	36,200	36,200	0%
Management Conf Reception	12,885	15,000	15,000	0%
Conference Services	606,937	657,500	694,600	(6%)
Meeting Room Management	34,419	87,200	82,950	5%
Citibank Foundation Reception	0	0	25,000	(100%)
Conference & Meeting Services Total Expenses	**8,142,441**	**10,347,700**	**9,721,900**	**6%**
Net Revenue/(Expense)	**2,108,110**	**1,555,700**	**1,459,600**	**(6%)**

The Division of Conference and Meeting Services budget for 2008 reflects a decrease of $96,100 or 6.2% in net revenue. Revenue declined by $721,900 and expenses declined by $625,800. The decline in net revenue is largely due to the 2008 annual session in San Antonio being a smaller conference when compared to San Francisco. Attendance is projected to be significantly lower in San Antonio versus San Francisco.

The 6.1% decline in revenue is the result of lower exhibit rental fees and projected lower paid attendance in San Antonio. Partially offsetting the decline is an increase in corporate sponsorships for educational programs offered at annual session.

The 6.1% decline in expenses is due to the site distribution expense being significantly lower for San Antonio versus San Francisco. Additionally, the cost of the convention center rental is less in San Antonio than in San Francisco. The two evening events, casual barbecue and one other yet to be planned event, are revenue neutral. Partially offsetting the decline in expenses is an increase in the cost of shuttle bus service to the headquarters hotel and convention center in San Antonio. In San Antonio, hotels are much more scattered and many are a considerable distance from the convention center.

One employee was transferred from the Office of the Assistant Executive Director to the Council on ADA Sessions.

Headquarters Building

The Headquarters Building houses the majority of ADA staff in a premier location in Chicago. Approximately half of the building is rented to outside tenants. Jones Lang LaSalle provides day-to-day building management services as well as providing or coordinating property construction management, janitorial, security and leasing services.

DIVISIONAL SUMMARY WORKSHEET
HEADQUARTERS BUILDING

	2006 ACTUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
Headquarters Building	3,069,497	3,500,100	3,576,750	2%
Headquarters Building				
Total Revenues	**3,069,497**	**3,500,100**	**3,576,750**	**2%**
EXPENSE				
Headquarters Building	4,161,991	4,205,100	4,493,700	(7%)
Headquarters Building	**4,161,991**	**4,205,100**	**4,493,700**	**(7%)**
Net Revenue/(Expense)	**(1,092,494)**	**(705,000)**	**(916,950)**	**(30%)**

Projected revenues for the Headquarters Building are expected to increase by 2.2% due to higher rental rates for tenant lease renewals in 2008. Additionally, property tax and operating expense escalations are projected to increase by $100,000 in 2008. The increases in expenses are the result of higher property taxes, cleaning costs, porter costs for tenants, general building expenses, and inflationary increases in many line items.

The net expense of $916,950 for the headquarters building is misleading since no rental income is realized on the space occupied by the ADA, which is slightly more than half of the building. The current value of the annual rent for this ADA space is approximately $3.9 million.

Washington D.C. Building

The Washington D.C. Building houses the majority of the ADA Government Affairs staff. Ten of the twelve floors are rented to outside tenants. Borger Management provides day-to-day building management services as well as providing or coordinating property construction management, janitorial, security and leasing services.

DIVISIONAL SUMMARY WORKSHEET
WASHINGTON D.C. BUILDING

	2006 ACTUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
Washington D.C. Building	1,429,948	1,437,550	1,472,200	2%
Washington D.C. Building Total Revenues	**1,429,948**	**1,437,550**	**1,472,200**	**2%**
EXPENSE				
Washington D.C. Building	733,084	753,650	761,200	(1%)
Washington D.C. Building Total Expenses	**733,084**	**753,650**	**761,200**	**(1%)**
Net Revenue/(Expense)	**696,864**	**683,900**	**711,000**	**4%**

The Washington D.C. Building budget added an additional $27,100 in net revenue to the ADA's 2008 operating budget when compared to 2007, with revenues of $1,472,200 and expenses of $761,200. There were no significant changes in revenues or expenses in 2008.

Similar to the ADA Headquarters building, the net revenue shown for the Washington building is misleading since no rental income is realized on the two floors occupied by the ADA. The current market value of that rent is approximately $400,000, and represents a significant benefit of owning this property.

The ADA continuously monitors the real estate market in Washington D.C. to gauge potential changes in the market value of the ADA's Washington property. The market value of this property is impacted by not only the general real estate market conditions in Washington, but also by the conditions in the neighborhood in which the building is located. Current market intelligence indicates that the value of the Washington building has increased to approximately $17.5 million, although the ADA vacating its current space could negatively impact realization of that value.

Division of Finance and Operations

Finance and Operations supports the financial, accounting, investing and budgeting activities within the Association. These efforts are supported by volunteers who serve on the Finance and Audit Committees, as well as the Board of Trustees. Finance also assists the Board and House in fulfilling their fiduciary responsibilities through audited financial statements and other reports, as well as financial oversight.

The Internal Audit function was outsourced beginning in 2005. Central Services, Duplicating, Shipping and Receiving provide administrative support services to the Association through centralized purchasing, processing of mail, managing the receiving dock, providing in-house photocopying and printing services. The Council on

Members' Insurance and Retirement Programs, included in this division, provides valuable member benefits through its insurance and retirement products. Database licensing activities were transferred to the Department of Salable Materials in 2007.

DIVISIONAL SUMMARY WORKSHEET
FINANCE & OPERATIONS

	2006 ACTUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
Chief Financial Officer	1,761,184	1,350,000	1,780,000	32%
Council on Mbr Ins & Rtrmt Prg	795,670	906,550	933,650	3%
Central Services	156	0	0	0%
Duplicating Department	47,067	30,900	41,800	35%
Shipping & Receiving Dept	3,934	2,200	2,300	5%
Finance and Operations				
Total Revenues	**2,608,011**	**2,289,650**	**2,757,750**	**20%**
EXPENSE				
Chief Financial Officer	346,655	373,300	355,750	5%
Accounting Department	1,425,464	1,610,500	1,762,700	(9%)
Internal Audit	103,308	127,500	131,500	(3%)
Council on Mbr Ins & Rtrmt Prg	759,129	866,550	684,650	21%
Central Services	180,487	184,100	205,500	(12%)
Duplicating Department	344,002	369,700	385,200	(4%)
Shipping & Receiving Dept	305,359	316,600	329,400	(4%)
Finance and Operations				
Total Expenses	**3,464,404**	**3,848,250**	**3,854,700**	**(<1%)**
Net Revenue/(Expense)	**(856,393)**	**(1,558,600)**	**(1,096,950)**	**30%**

The net expense for the Division of Finance and Operations declined by $461,650 from $1,558,600 in 2007 to $1,096,950 in 2008. The improvement in net expense is due to an increase in interest and dividends on Operating Cash and Reserve Fund assets due to higher short-term interest rates and higher asset levels in the Reserve Fund. Additionally, restructuring of the Members Insurance and Retirement Plan added approximately $200,000 in net revenue. Partially offsetting these improvements in revenues is an increase in salaries due to merit increases and the transfer of an employee position from ADA Publishing to Accounting.

Central Administration

Central Administration combines into one area those revenue and expense activities that do not directly relate to any one division but rather reflect upon the Association in its entirety. These include membership dues revenue, royalty income, fringe benefits, endorsement costs, depreciation, grants and the like. Additionally, travel and compensation savings are also budgeted in Central Administration and are explained below.

Travel Savings: For 2008, Association-wide travel savings are projected to be $350,000, which is consistent with 2007. Invariably, actual travel costs incurred and trips taken do not coincide with budgeted levels due to various factors. Since these events are difficult to project on a divisional basis, an estimate has been developed for the organization as a whole based upon historical experience.

Compensation Savings: In 2008, compensation savings of $1,500,000 are projected as a result of normal staff turnover. This amount was increased by $55,000 compared to the 2007 budget of $1,445,000. The increase in compensation savings was based upon actual results in 2006. Similar to travel savings above, an estimate has been developed for the organization as a whole since projections at a divisional level would be difficult.

NATURAL CATEGORY ANALYSIS
CENTRAL ADMINISTRATION

	2006 ACTUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
Membership Dues	47,387,798	53,526,750	53,944,350	**<1%**
Royalties	3,971,566	4,219,700	4,530,300	**7%**
Other Income	2,767,590	2,352,000	2,370,100	**<1%**
Total Revenues	**54,126,954**	**60,098,450**	**60,844,750**	**1%**
EXPENSE				
Staff Compensation	14,187,478	13,125,950	14,858,750	**(13%)**
Print., Publicat. & Marketing	62,206	0	0	**0%**
Meeting Expenses	7,674	0	0	**0%**
Travel Expenses	135,567	(350,000)	(350,000)	**0%**
Professional Services	448,589	44,000	50,000	**(14%)**
Office Expenses	91,318	56,500	71,500	**(27%)**
Facility and Utility Costs	14,106	16,000	14,000	**13%**
Grants and Awards	230,000	145,000	170,000	**(17%)**
ADA Foundation Grant	3,202,523	3,215,800	3,529,050	**(10%)**
Endorsement Costs	758,479	756,000	797,000	**(5%)**
Depreciation and Amortization	4,065,591	4,047,100	6,751,900	**(67%)**
Bank & Credit Card Fees	296,940	320,800	329,450	**(3%)**
Other Expenses	569,294	1,414,500	1,485,250	**(5%)**
Total Expenses	**24,069,765**	**22,791,650**	**27,706,900**	**(22%)**
Net Revenue/(Expense)	**30,057,189**	**37,306,800**	**33,137,850**	**(11%)**

Revenues are expected to increase from $60,098,450 in 2007 to $60,844,750 in 2008, partially due to an increase in membership dues. The increase in dues revenue is explained on Page 2001, Lines 15-18. Also contributing to the increase in revenue is an increase in royalty income stemming from ADA's share of *Member Advantage* program royalties.

For 2008, total expenses are $27,706,900, which represent an increase of $4,915,250. Depreciation expense increased by $2,704,800 due to the assets of the Capital Improvement Project (CIP) and the ADA Renovation Funds being consolidated into the ADA as previously explained on Page 2001, Lines 38-41. These projects will be completed in 2007. Payroll taxes and benefits increased by approximately $1.8 million largely due to increases in pension funding and group medical premiums. The grant to the ADA Foundation increased by $313,250.

Membership Dues: Since membership dues are the result of all activities of the Association, they are recorded in this area. The explanation of the 2008 budget for membership dues is presented on Page 2004, Lines 5-14.

Dividing this budgeted dues amount by the full dues rate arrives at a number for full dues equivalent members. This data is presented for informational purposes only.

	2007	2008
Membership dues budget (before dues rebate & prior year dues)	$53,513,750	53,989,350
Dues Rate	$ 489	489
Full dues equivalent members	109,435	110,408
Rounded	109,450	110,400

In comparing the above numbers, it has to be noted that dues revenues for 2007 are expected to be nearly $230,000 less than budget due mainly to dues waivers related to Hurricane Katrina. It is currently projected that the dues waivers will be approximately half of the waivers granted in 2006.

Dues revenue includes an offset for the dues rebate paid to constituent dental societies that submit their dues to the Association in December, January or February. This rebate is expected to increase to $135,000 in 2008 from $70,000 in 2007. 2008 rebates on dues are significantly higher due to the dramatic rise in short term interest rates during 2006.

Royalties: Royalty income is derived from monies received through the *ADA Member Advantage* program. The ADA receives approximately 55% of the gross program royalties. Such income is expected to increase from $4,219,700 in 2007 to $4,530,300 in 2008 due to increased utilization of *ADA Member Advantage* products and services by members and new product offerings.

Other Income: The largest component of this category is the Med Cash Surplus distribution of $1.4 million dollars, which is consistent with 2007. Additional revenue is realized from overhead recovery from federal research activities, ADABEI, and the ADA members' insurance programs. No significant changes in the budget for overhead income is anticipated.

Expenses

Expenses in Central Administration are largely compensation and benefits related and significant budgetary changes in that area are explained below. Other costs pertain to program activities within the Association, as well as grants to various organizations.

Staff Compensation and Benefits: This category primarily includes Association-wide payroll taxes and benefit costs with an offset of $1,500,000 for compensation savings compared to $1,455,000 in 2007. The overall net increase from 2007 is related to increases in group medical premiums, pension plan funding, and life insurance premiums. The ADA, like most associations and corporations, has experienced significant increases in group medical premiums over the last few years as a result of rapidly rising healthcare costs. The ADA annually looks at alternatives to mitigate these huge cost increases through plan changes, changes in premium-cost sharing with employees, or a combination of the two. The higher pension costs are the result of the negative effect of continued low long-term interest rates and higher funding requirements based on legislation passed by Congress in 2006.

Professional Services: This category funds miscellaneous fees for outside services. The increase in professional services is meant to bring budgeted expenses in line with actual expenditures.

Grants and Awards: This category shows an increase in budgeted expenditures due to the ADA increasing its grant to the National Foundation of Dentistry for the Handicapped by $25,000.

ADA Foundation Grant: The ADA grant to the Foundation is budgeted at $3,529,050 compared to the 2007 budget of $3,215,800. The increase in funding is due to annual merit increases for the ADA Foundation staff and increases in cost of fringe benefits.

Endorsement Costs: This category represents revenue sharing monies paid to state societies that participate in the *ADA Member Advantage* program. The increase is a direct result of the increase in royalty revenue earned through the program.

Depreciation and Amortization: This category shows an increase in funding from $4,047,100 in 2007 to $6,751,900. The explanation for the increased is explained on Page 2006, Lines 31-34.

Bank & Credit Card Fees: This category includes expenses for bank and credit card transaction fees and reimbursements to state and local societies for credit card fees incurred from the collection of ADA membership dues. Expenses in this category increased by $8,650 to $329,450 in 2008. The increase is based on projections that additional state and local societies will allow members to pay their dues via credit cards.

Other Expenses: The largest components of this category are the contingency fund and general insurance. The increase of $70,750 in 2008 is due to premium increases for general insurance and an increase in other miscellaneous expenses.

Division of Information Technology and Standards

The Division of Information Technology and Standards (IT) provides cost-effective technology and telephone support to the Association and its divisions in Chicago, Washington D.C. and PRC through a number of PC, Web and LAN-based application systems, office automation, and network services. In addition, IT provides support to the tripartite through the Tripartite System and directly to members and the public through ADA.org on the Internet. IT also provides technology support to the Association's revenue-generating programs and for-profit activities.

The IT budget is meant to fund ongoing daily operations. Although cost saving measures are important in managing this functional area, it is critical that periodic upgrades and replacements occur to maintain and enhance service levels. If the technology environment is not kept relatively current, eventual replacement would come at a much higher cost in the future.

The Department of Standards Administration supports the administration, travel, meetings and staffing for the Association's standards activities. This includes participation in ADA standards committees accredited by the American National Standards Institute (ANSI), U.S. participation in the development of international dental standards, as well as participation in non-dental organizations that develop standards that affect dentistry (i.e., American Society of Heating, Refrigeration and Air-Conditioning Engineers (ASHRAE) that develop standards on indoor air quality.)

DIVISIONAL SUMMARY WORKSHEET
INFORMATION TECHNOLOGY & STANDARDS

	2006 ACUTAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
Department of Standards Admin	15,250	19,200	19,800	3%
U.S. Sub-Tags	23,403	36,900	32,600	(12%)
Info Technology and Standards				
Total Revenues	**38,653**	**56,100**	**52,400**	**(7%)**
EXPENSE				
Office of AED-Info Technology	519,964	643,250	699,600	(9%)
Dept of Information Technology	1,869,619	2,411,850	2,374,200	2%
Dept Application Development	1,976,247	2,524,800	2,467,300	2%
Internet & Intranet Services	893,772	987,800	1,041,000	(5%)
U.S. Sub-Tags	23,403	36,900	32,600	12%
Department of Standards Admin	449,337	460,450	472,400	(3%)
Info Technology and Standards				
Total Expenses	**5,732,342**	**7,065,050**	**7,087,100**	**(<1%)**
Net Revenue/(Expense)	**(5,693,689)**	**(7,008,950)**	**(7,034,700)**	**(<1%)**

The 2008 net expense budget for the Division of Information Technology and Standards increased by $25,750 or less than 1% when compared to 2007. The minor increase in funding is the result of the annual merit increases and funding of the following decision packages:

- $6,400 in operating expenses and $35,500 in the capital budget to purchase a COBOL complier required for the continued maintenance of the PeopleSoft Financial and Human Resources systems.

- $40,000 in the capital budget to upgrade the PeopleSoft Financial system to maintain software support. This upgrade allows for system fixes, patches, and upgrading of scripts to move to the next version and support third-party applications used to develop existing interfaces to existing applications, such as Siebel, TS, Accreditation, ExpoCad and for future interfaces with AdManager Pro and Raiser's Edge.

Largely offsetting the increase in spending are three 2007 decision packages totaling $160,900 that were considered one-time expenses and are thus not included in the 2008 budget.

Department of Salable Materials

The Department of Salable Materials, in conjunction with other Association divisions, develops, markets and administers products that support practicing dentists and the general dental community. The Database Licensing department was transferred to this area from the Division of Finance in 2007.

This program is responsible for product specifications such as design, layout, quality control, packaging, inventory management, pricing, planning, merchandising, database licensing, etc. Marketing programs are developed to most effectively reach target audiences and announce product availability.

DIVISIONAL SUMMARY WORKSHEET
SALABLE MATERIALS

	2006 ACTUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
Salable Materials	8,630,067	8,092,650	9,460,700	17%
Salable Materials Total Revenues	**8,630,067**	**8,092,650**	**9,460,700**	**17%**
EXPENSE				
Salable Materials	4,583,792	4,469,800	4,613,150	(3%)
Salable Materials Total Expenses	**4,583,792**	**4,469,800**	**4,613,150**	**(3%)**
Net Revenue/(Expense)	**4,046,275**	**3,622,850**	**4,847,550**	**34%**

This 2008 budget reflects a 33.8% or $1,224,700 increase in net revenue when compared to the 2007 budget. The increase is largely due to the release of a new version of the *CDT* book. Additionally, the Personalized Product line is projected to show significant growth in sales. The increase in expenses is directly tied to the increase in revenue.

Division of Dental Practice

The Division of Dental Practice houses the Council on Dental Practice (CDP), the Council on Dental Benefit Programs (CDBP), the Council on Access, Prevention and Interprofessional Relations (CAPIR), and the Department on Dental Informatics.

Several subcommittees support the Council on Dental Practice, including the Dentists Well-Being Advisory Committee and the Ergonomics and Disability Advisory Committee, which are included in the Council's budget. The main thrusts of Council activities involve developing and disseminating dental practice management information to assist dentists in the efficient operation of their dental practices. Also, in separate agencies are the Seminar Series, and Dental Practice Marketing. The Seminar Series provides high-quality, economical educational programs that present proven practice-building strategies and tactics. The Marketing program provides dental marketing techniques and resources mainly distributed through the Department of Salable Materials. The Success Program presents one-day practice management seminars at selected dental schools. Materials and program expenses are underwritten by corporate sponsors. Beginning in 2008, several programs are being consolidated under the SUCCESS brand name and this activity will be managed in the Division of Membership and Dental Society Services.

The Council on Dental Benefit Programs is supported by the Code and Third-Party Issues, Dental Benefit Information Service (DBIS) and the Office of Quality Assessment and Improvement, which are displayed as separate budgets within the Division. This Council focuses on dental benefit design, problem solving for members regarding dental insurance, maintenance of the procedure code and uniform claim form, and providing peer review program guidelines and workshops. Code and Third-Party Issues is concerned with maintaining the Association's Code on Dental Procedures and Nomenclature, interacting with third party payers and monitoring publicly funded programs such as Medicaid. The DBIS area provides a resource on the vast array of dental benefit plans. Promotion of Direct Reimbursement is a function of this department.

The Council on Access, Prevention and Interprofessional Relations' programs are separated into fluoridation and preventive health activities, including support for the National Fluoride Advisory Committee; access and community affairs activities; and interprofessional relations activities.

The Center for Continuing Education and Lifelong Learning (CELL) primary purpose is to develop and implement a business strategy for lifelong learning opportunities for ADA members.

The Direct Reimbursement Campaign purpose is to raise awareness and to promote DR to employers and brokers nationwide.

The NCI Oral Cancer Grant will conclude in 2007. The SUCCESS Program was transferred from the Division of Dental Practice to the Department of Dental School Programs within the Division of Membership and Dental Society Services.

DIVISIONAL SUMMARY WORKSHEET
DENTAL PRACTICE

	2006 ACTUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
CDP – Administration	9,785	10,000	9,000	(10%)
ADA CE ONLINE	0	0	18,050	100%
CELL Seminar Series Admin	541,046	893,500	852,000	(5%)
Success Seminars	152,000	182,000	0	(100%)
Dental Ben Inf Ser and Third	800	0	0	0%
Quality Assess Improvement	293	0	0	0%
CAPIR - Administrative	1,226	3,100	1,300	(58%)
NCI Grant	266,480	126,600	0	(100%)
Dentist Health and Wellness	0	110,650	0	(100%)
Ctr Contin Ed & Lifelong Learn	0	59,550	0	(100%)
Dental Practice Total Revenues	**971,630**	**1,385,400**	**880,350**	**(36%)**
EXPENSE				
Office of AED-Dental Practice	327,743	348,400	352,350	(1%)
CDP – Administration	537,656	545,450	563,800	(3%)
ADA CE ONLINE	43,052	43,400	106,400	(>100%)
CELL Seminar Series Admin	472,862	696,050	642,100	8%
Success Seminars	98,096	119,300	0	(100%)
CDBP - Administrative	240,383	323,100	426,100	(32%)
Dental Codes Standards and Adm	234,144	355,250	261,300	26%
Dental Ben Inf Ser and Third	464,611	477,700	299,800	37%
Quality Assess Improvement	110,446	115,700	122,700	(6%)
CAPIR - Administrative	192,873	238,750	271,600	(14%)
Fluoridation Preventive Health	200,011	178,100	204,100	(15%)
Interprofessional Relations	121,287	143,200	141,700	1%
Access and Community Health	126,858	144,200	146,450	(2%)
Alaska Dntl Placmnt Program	73,207	325,950	328,950	(<1%)
Geriatric Oral Health Program	0	311,100	296,100	5%
Department Dental Informatics	163,209	185,650	254,450	(37%)
NCI Grant	266,480	126,600	0	(100%)
Dentist Health and Wellness	115,401	233,000	137,300	41%
Ctr Contin Ed & Lifelong Learn	70,528	198,150	157,900	20%
Direct Reimb Mrkting Campaign	1,506,312	850,000	500,000	41%
Dental Practice Total Expenses	**5,365,159**	**5,959,050**	**5,213,100**	**13%**
Net Revenue/(Expense)	**(4,393,529)**	**(4,573,650)**	**(4,332,750)**	**5%**

2008 budgeted net expenses decreased by $240,900. The decline in funding is due to the 2007 budget including Resolution 30H which was a one-time activity for the Direct Reimbursement Marketing Campaign. This activity added $350,000 to the 2007 budget. Additional savings were realized as a result of staff reductions in the Department of Dental Benefits Information Services (DBIS). The savings are partially offset by merit increases and the transfer of the SUCCESS Program to the Division of Membership and Dental Society Services. One decision package is included in this division and is listed below:

- $61,550 to update the clinical descriptors in SNODENT, which is a vocabulary that was designed for use in electronic dental records. SNODENT has not been updated in ten years. Funds are requested for travel and meeting expenses for a nine-member SNODENT ADA Editorial Panel to review and maintain the clinical content of the SNODENT coding system. In addition, funds are necessary for the use of an outside vendor of medical terminology software and services to assist with the technology architecture update so that the SNODENT system will work within a computer system.

Health Policy Resources Center

The Health Policy Resources Center (HPRC) is a central repository for information relating to the health policy of the Association. The main purpose of this area is to strengthen and contribute to ADA's policy and advocacy on economic and technical issues. This is accomplished by identifying critical policy position development needs of the Association in economic and technical areas for use by ADA councils, commissions and the Board; by providing unbiased, scientifically valid information and analysis on priority economic issues of the Association for staff and policy-making bodies; by determining and prioritizing the objective, and economic/technical research needed for effective positioning and advocacy; by being responsible for oversight of activities of the Dental Economic Advisory Group; and by providing management and interpretation of survey results published by the Survey Center.

The Survey Center is the central ADA source for collection, analysis, and publication of up to date statistics on dentistry. Surveys are conducted in response to mandates of the House of Delegates and directives of the Board of Trustees, as well as requests from the Association's councils and commissions. In addition to making the reports available as salable materials and providing internal survey research assistance, the Survey Center provides survey research consultation to tripartite members, industry, dental organizations, and other related agencies (e.g., hospitals, educational institutions).

DIVISIONAL SUMMARY WORKSHEET
HEALTH POLICY RESOURCES CENTER

	2006 ANNUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
Health Policy Resource Center	39,542	80,000	45,000	(44%)
Survey Center	231,337	249,300	235,000	(6%)
Health Policy Resources Center				
Total Revenues	**270,879**	**329,300**	**280,000**	**(15%)**
EXPENSE				
Health Policy Resource Center	817,420	741,350	747,300	(<1%)
Survey Center	1,192,344	1,364,000	1,357,400	<1%
Health Policy Resources Center				
Total Expenses	**2,009,764**	**2,105,350**	**2,104,700**	**<1%**
Net Revenue/(Expense)	**(1,738,885)**	**(1,776,050)**	**(1,824,700)**	**(3%)**

HPRC's 2008 net expense is projected to decline by $48,650 or 2.7%. The decline in net revenue is attributable to the division bringing budgeted revenue more in line with historical totals. The decline in base expenses is due to the 2007 budget including two decision packages which were one-time activities.

A minimal percentage of several staff in this division were allocated to the NCI Oral Cancer grant for the last five years. In 2008, the above mentioned staff are now allocated 100% within the Division of Health Policy Resources Center.

Division of Education

The Division of Education is made up of three agencies with *Bylaws* authority: the Council on Dental Education and Licensure, the Commission on Dental Accreditation and the Joint Commission on National Dental Examinations; and two departments: the Department of Testing Services and the Department of Library Services. Among its responsibilities, the Council on Dental Education and Licensure provides oversight for the Continuing Education Recognition Program (CERP) that evaluates and recognizes providers of continuing dental education and the Dental Admission Testing Program (DAT). Major areas of responsibility include the promotion of excellence and consistency in education, improving the quality of dental education and the quality and uniformity of licensure examinations. The Department of Library Services supports the Association's role as a vital information source.

DIVISIONAL SUMMARY WORKSHEET
EDUCATION

	2006 ACTUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
Council Dentl Educ & Licensure	193,410	185,000	201,000	9%
Commission Dentl Accreditation	1,000,639	999,000	1,065,300	7%
International Consult & Accred	0	301,150	359,050	19%
Nat'l Board Dental Examination	4,996,647	5,354,500	5,725,750	7%
Admission Tests	3,436,917	3,403,750	3,873,000	14%
Outside Client Services	615,588	852,800	833,350	(2%)
Library Services	43,615	63,900	55,500	(13%)
Education Total Revenues	**10,286,816**	**11,160,100**	**12,112,950**	**9%**
EXPENSE				
Office of AED-Education	317,845	340,200	353,200	(4%)
Council Dentl Educ & Licensure	729,516	826,300	819,900	<1%
Commission Dentl Accreditation	1,879,421	1,808,250	1,869,050	(3%)
International Consult & Accred	0	233,150	234,150	(<1%)
Nat'l Board Dental Examination	3,510,609	3,679,700	3,733,550	(1%)
Admission Tests	1,607,760	1,670,450	1,818,800	(9%)
Outside Client Services	469,852	562,950	518,950	8%
Library Services	721,530	800,800	823,850	(3%)
Education Total Expenses	**9,236,533**	**9,921,800**	**10,171,450**	**(3%)**
Net Revenue/(Expense)	**1,050,283**	**1,238,300**	**1,941,500**	**57%**

Division of Education revenues and expenses for 2008 increased $952,850 and $249,650, respectively. The increase is mainly due to higher fees for Accreditation, National Board exams, and Admission tests. Additionally, in 2008 the National Board exam is only offered using the computerized format which carries a higher fee. The National Board Dental Hygiene exam offers the option of taking a written or computerized format.

Expenses for test administration fees are higher as a result of the National Board, Admission tests and Optometry tests now only being offered electronically, which results in higher exam costs. Credit card fees also increased as a result of more candidates paying by credit card when registering for exams. The increase in expenses is partially offset by the 2007 budget including two decision packages and one House resolution which were one-time activities.

Division of Science

The Division of Science administers the activities of the Council on Scientific Affairs, the Research Institute, the Paffenbarger Research Center, and the Association laboratories. The division also staffs and coordinates the ADA Foundation's annual Health Screening Program. This program provides a vital service to the profession through research, data collection, and information dissemination on health issues of practicing dentists and auxiliaries. In addition, the Division of Science monitors emerging dental science and responds to critical issues that could potentially affect professional policies and decisions. The Association provides member dentists, the dental healthcare team, and the public with timely and relevant information based upon sound scientific principles and evidence-based research. Through its Research Laboratory, the division assures the accuracy and reproducibility of safety and efficacy data submitted to the ADA Acceptance Program to gain the Seal of Acceptance. The lab also engages in practice-based research with emphasis on critical issues facing the profession.

The International Use of the Seal activities was transferred from the Product Evaluations department to the Division of Legal Affairs because most of the work involved registering the ADA Seal in numerous countries which was being done by Legal staff.

DIVISIONAL SUMMARY WORKSHEET
SCIENCE

	2006 ACTUAL	2007 ANNAUL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
Office of AED-Science	12,339	0	0	0%
Council on Scientific Affairs	50,640	37,100	0	(100%)
Product Evaluations	564,062	444,400	565,200	27%
Science Total Revenues	**627,041**	**481,500**	**565,200**	**17%**
EXPENSE				
Office of AED-Science	609,308	636,250	658,200	(3%)
Council on Scientific Affairs	1,281,828	1,133,600	1,276,800	(13%)
Research and Laboratory	1,322,032	1,640,400	1,667,900	(2%)
Product Evaluations	458,051	943,950	969,900	(3%)
Science Total Expenses	**3,671,219**	**4,354,200**	**4,572,800**	**(5%)**
Net Revenue/(Expense)	**(3,044,178)**	**(3,872,700)**	**(4,007,600)**	**(3%)**

The 2008 budgeted net expenses increased by $134,900 when compared to the 2007 budget. The increase is largely due to the funding of the following decision packages:

- $73,050 to enhance the House-mandated evidence-based dentistry program (Resolution 107H-2001). At its 2006 meeting, the ADA Advisory Committee on EBD held a strategic discussion on EBD implementation and directed interagency staff/volunteer workgroup to develop a business plan for a new more effective organizational structure. Representatives from CSA, CAPIR, CDBP, CDEL, CDP and CEBJA were members of the workgroup. The decision package requests funding to expand activities tied to member needs and issues, and will enable the ADA to develop three sets of clinical recommendations in 2008 and conduct at least three systematic reviews (vs. two sets of clinical recommendations and two systematic reviews currently funded in CSA's 2007/proposed 2008 base budget).

- $67,450 to obtain consensus on caries lesion classification developed by the ADA to replace the outdated G.V. Black classification of caries and cavity preparations. Early diagnosis of caries a more descriptive classification on the location and size of caries lesions is highly desirable for treatment planning and record keeping as well as to provide data that could be used in practice-based research. This will be accomplished by holding a consensus development conference with internal ADA participation from science, dental practice, dental benefit plans, dental education, health policy research and information technology. External participation will also include selected dental specialties such as radiology, public health pediatric dentistry and operative dentistry as well as experts in caries diagnosis and researchers in caries lesion classification. Other interested parties will also be invited to attend.

Partially offsetting the increase in net expenses is fee increases for the Seal of Acceptance program, an increase in Seal maintenance revenue to be more in line with actuals, and anticipating more companies will submit products for evaluation.

ADA Publishing

The Publishing division's mission is to produce credible, high quality, profitable ADA publications that inform the dental profession (in the U.S. and abroad) about the latest scientific, socioeconomic, and political issues affecting oral health care.

The division is responsible for the management of the editorial, business, and financial operations of ADA publications in print and electronic media—primarily *JADA* and *ADA News*, and their spin-off products. Publishing is also responsible for product and content development, production, design, marketing, distribution and fulfillment, as well as oversight and coordination of the activities of *JADA*'s scientific editor, editorial board, industry advisory board, and advertising sales representatives.

DIVISIONAL SUMMARY WORKSHEET
PUBLISHING

	2006 ACTUAL	2007 ANNUAL BUDGET	2008 BUDGET	PERCENT CHANGE FAV(UNFAV)
REVENUE				
JADA	3,455,317	3,806,900	3,896,350	2%
ADA News	3,719,873	4,154,150	4,317,250	4%
AS ADA News Daily	256,260	316,950	257,550	(19%)
Annual Session Official Guide	34,375	106,500	112,900	6%
Dental Therapeutics	27,887	0	0	0%
ADA.org Publishing Section	39,238	30,600	34,000	11%
ADA Publishing Total Revenues	**7,532,950**	**8,415,100**	**8,618,050**	**2%**
EXPENSE				
Pub General & Administrative	535,207	475,450	394,750	17%
JADA	2,966,812	2,827,000	3,060,150	(8%)
ADA News	2,863,400	3,304,100	3,353,400	(1%)
AS ADA News Daily	115,474	133,400	132,850	<1%
Sales & Marketing	471,315	480,200	485,050	(1%)
Annual Session Official Guide	69,464	124,350	125,150	(<1%)
Editorial Office	207,775	221,600	222,100	(<1%)
Dental Therapeutics	22,378	0	0	0%
ADA.org Publishing Section	94,233	86,500	90,000	(4%)
ADA Publishing Total Expenses	**7,346,059**	**7,652,600**	**7,863,450**	**(3%)**
Net Revenue/(Expense)	**186,891**	**762,500**	**754,600**	**(1%)**

Division of Publishing revenues and expenses for 2008 increased $202,950 and $210,850, respectively. The increase in revenue is primarily due to a steady growth in classified advertising sales. Partially offsetting the increase is a reduction in the number of advertisements in ADA publications as advertisers continue to shift their spending from print to other media and from industry mergers.

The increase in expenses is due to an increase in postage, sales commissions, and paper costs. Direct mail postage is expected to increase by 12% starting in May 2007 based on feedback from the ADA's printer and the post office. Sales commissions are projected to increase due to the ADA hiring a new company to sell advertising for *JADA, ADA News*, and the *ADA Annual Session Official Guide*. Partially offsetting these increases is an employee position being transferred from the Division of ADA Publishing to Accounting.

Capital Budget

House of Delegates Resolution 132H-1992 (*Trans.*1992:588) directs that a description of all proposed capital expenditures exceeding $25,000 be incorporated into the report of the Board on financial matters. The schedule and explanatory narrative that follows are intended to comply with this requirement.

Individual expenditures below this $25,000 threshold, when possible, have been aggregated into broad categories for presentation.

2008 CAPITAL BUDGET

Description	COST
Building	
Generator Replacement	296,400
23rd Floor Cooling Tower Panel Replacement	87,550
Refurbish 23rd Floor Chillers	46,800
3rd & 23rd Floor Flooring System	72,800
S-1 FSC Controller Upgrade Phase 1	94,200
Replace Multi-Tenant Stats Project	27,250
Interior Elevator Cab Metal Refinish	32,450
Building Monument/Kiosk Sign Installation	49,400
Miscellaneous Building Repairs	87,000
Tenant Improvement Allowances	488,050
Elevators – DC Building	180,000
Total Building	**1,461,900**
Technology	
Computer Hardware and Software	903,250
PeopleSoft Financials Upgrade	40,000
COBOL Compiler Software	35,500
Total Technology	**978,750**
Central Services Equipment	110,000
Office Equipment	165,100
Contingency Fund	250,000
Grand Total	**2,965,750**

Generator Replacement: Phases I-V of the new 600 KW generator installation project will occur in 2007. Phases VI and VII will occur in 2008. This work includes shut downs of the EM temp service to rework Fire Pump cables to new EMDP; rework Lighting Panel feeders to EMDP; cable tie-ins from Transfer Switch to New Elevator Distribution panel; Start Up & Commissioning of Generator; Training and Project Close Out. By increasing the 350 KW sized generator to 600 KW, the building will meet the City Code to operate more than one elevator in an emergency and at the same time run the power to operate the fire pumps.

23rd Floor Cooling Tower Panel Replacement: The existing panels that cover the cooling tower are fabricated from aluminum in addition to the threaded studs and nuts. The existing studs and nuts are stripped beyond repair. This is creating a safety hazard as numerous times the panels come unattached (flapping in the wind). The new panels budgeted will be stainless steel along with the nuts and studs. Stainless steel nuts and studs will resist stripping or breaking off.

Refurbish 23rd Floor Chillers: The main chillers were installed in 1988. Typical refurbishment of chillers can occur ten years after commissioned to enhance the longevity of their life span. Since these chillers have not been refurbished they are well overdue. Refurbishment includes refrigerant pumped out, compressors overhauled, worn seals, rings and gaskets replaced, as well as associated fittings and hoses.

3rd & 23rd Floor Flooring System: With the concrete replacement project coming to an end in 2007, it is prudent to protect and seal the mechanical floor. The work includes stripping of the mechanical floors to the bare concrete, followed by an epoxy paint system application which will resist acids, chemicals and oils from damaging the floors.

S-1 FSC Controller Upgrade: The existing controllers or D/X boxes for the fans are obsolete. The company that installed them is no longer in business. The new Metasys panels will give us greater control of the fans.

Replace Multi-tenant Stats: The object with this project is to standardize the t-stats on the tenant and multi-tenant floors. Currently, these floors have two various styles of Honeywell stats. Replacement with Johnson Controls T-4002 stats will reduce the need to stock multiple stats.

Interior Elevator Cab Metal Refinishing: The objective of this project is to create an updated metal finish appearance by stripping the antiqued bronze oxidize to a satin finish. This is purely aesthetic but appropriate with the new stone, glass, and metal materials used in the lobby renovation.

Building Monument/Kiosk Sign Installation: This project is a carry over from the lobby project should it not be completed or approved in 2007 as a part of the renovation.

Miscellaneous Building Repairs: Miscellaneous repairs include: installing D/X control boxes in the west stairwell, replacing the basin covers due to ongoing wear, rebuilding S-10 and S-11 fans that supply heat to janitorial rooms, replacing the four main fan chilled water valves, and performing caulking on the exterior and windows of the Washington D.C. building.

Tenant/Building Improvements – Washington Building: Tenant improvement estimate is based on the number of tenants who are in the process of negotiating a renewal of their lease. If they renew, they are allocated an allowance for improvements to their leased space.

Tenant Improvements – Chicago Building: When tenants sign new leases or renew current leases they are allocated an allowance for improvements to their leased space. The 2008 budget includes tenant improvements for the American Association of Endodontists and the Alliance of the American Dental Association.

Elevators Washington D.C. Building: The elevators are 26 years old and are in need of modernization. This project would completely replace the existing cabs and mechanical areas.

Computer Hardware and Software: It has been the Association's practice to replace and upgrade a portion of existing computer equipment on an annual basis in recognition of technical obsolescence and excessive repair. The rapid pace of technological improvements has caused the Association to cycle replacements every three years.

PeopleSoft Financials Upgrade: This upgrade allows for system fixes, patches, and upgrading of scripts to move to the next version and support third-party applications used to develop interfaces to existing applications, such as Siebel, TS, Accreditation, ExpoCad and for future interfaces with AdManager Pro and Raiser's Edge.

COBOL Compiler: This project funds the purchasing of COBOL compiler software licenses required for the continued maintenance of the PeopleSoft Financial and Human Resources System.

Central Services Equipment: The 2008 budget provides for replacement of one digital photocopy machine, one stahl folder machine, one dual-line fax machine, and one Bourg perfect binder machine.

Office Equipment: This category includes refurbishing 130 House of Delegates tables, purchasing four TV/DVD combination units, one MediaSite recorder, a new salad bar buffet for the 2nd floor café, and refurbishing executive dinning room chairs. This also provides for standard Association-wide furniture replacement

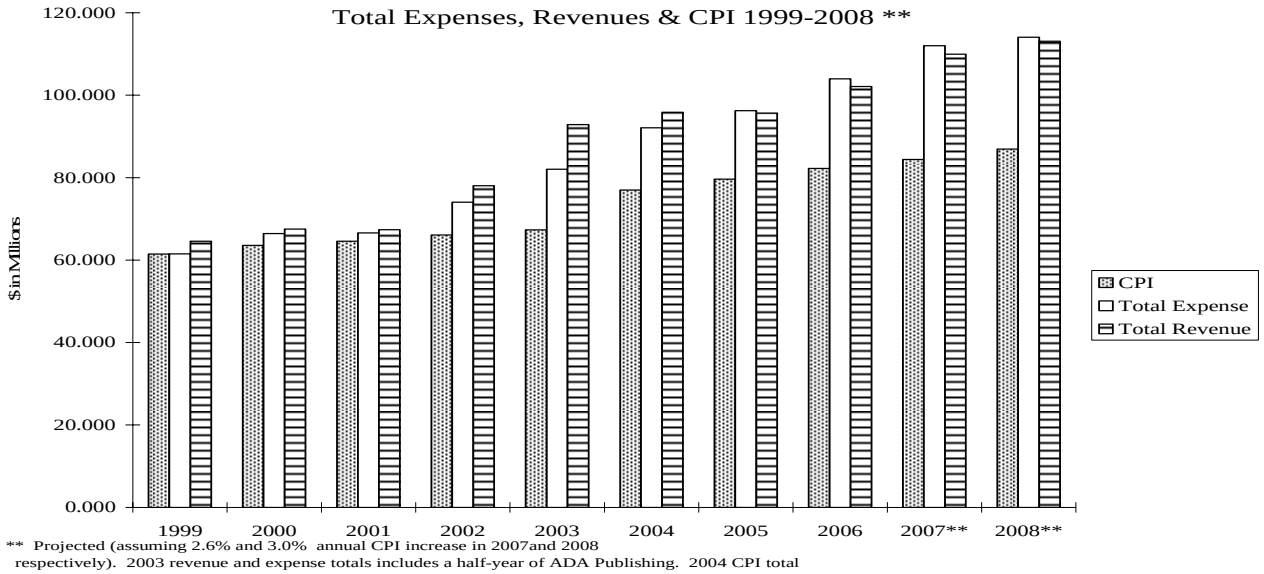
Contingency Fund: The capital budget includes a contingency fund for unanticipated but necessary expenditures, just as the operating budget does. The Board will approve all expenditures from the capital contingency fund.

Budgeted depreciation exceeds requested capital expenditures as computed below:

	Capital Budget
Total Capital Budget	$ 2,965,750
Depreciation in Operating Budget	(6,751,900)
Net Capital Expenditures	($ 3,786,150)

Consumer Price Index

The preparation of the following chart was directed by the House of Delegates Resolution 87H-1983 (*Trans.* 1983:573). Its original purpose was to provide a comparison of Association expenses and revenues to the Consumer Price Index (CPI) as compiled by the Bureau of Labor Statistics.



** Projected (assuming 2.6% and 3.0% annual CPI increase in 2007and 2008 respectively). 2003 revenue and expense totals includes a half-year of ADA Publishing. 2004 CPI total adjusted to include ADA Publishing

Association Reserves

The Association's Reserve Division consists of a Capital Formation Account and an Investment Account. The former includes long-term capital investments, such as the investment in ADA subsidiaries, which are not easily liquidated and therefore not available for immediate situations.

On the other hand, the Investment Account represents liquid reserves that are more readily convertible to cash. The objectives of the liquid reserve fund are to sustain basic operations and core member services during a short- or long-term economic downturn, as well as to cover unbudgeted expenditures brought about by events or opportunities requiring immediate funding. Association leadership attempts to balance the need for liquid reserve funds against maintaining an affordable membership dues structure, recognizing that a strong reserve position is a key component of the long-term financial strategy of dues stabilization.

At the end of 2006, net assets of the reserve division totaled $62,831,279. It should be noted that $4,448,648 of this amount represents the Capital Formation Account that is not liquid.

A two-year comparison of monies held in ADA reserves follows:

	December 31	
	2006	2005
Reserve Division Investment Account	$ 58,382,631	51,077,406
Capital Formation Account	4,448,648	13,557,175
Total Reserves	$ 62,831,279	64,634,581

The following observations are offered about the changes in these accounts.

Capital Formation Account. The Capital Formation Account experienced an investment gain of $4,867 in 2006 resulting from the net income of ADABEI. The decline in net assets is due to the American Dental Real Estate Corporation (ADREC) subsidiary being merged into the ADA effective January 1, 2006. The book value of the Washington D.C. building and land are included in property and equipment on the ADA's balance sheet.

Investments held by the Capital Formation Account are reflected at original cost adjusted by additional investments, accumulated earnings or losses, and dividends paid to the ADA. A two-year comparison of ending balances for the account is shown below:

	December 31	
	2006	2005
Land in Washington, D.C.	$ 0	3,030,000
Investment in ADREC	0	6,083,394
Investment in ADABEI	4,448,648	4,443,781
	$4,448,648	13,557,175

Reserve Division Investment Account. Investments in this account are currently allocated among mutual funds and managers with differing investment strategies. This approach diversifies the overall portfolio and distributes the risk.

Several transactions affected the Reserve Division Investment Account during 2006:

Balance, December 31, 2005	$ 51,077,406
Investment results net of management fees	7,956,731
Transfer of dividends to operations	(1,021,258)
Transfer of 2005 net surplus from General Fund	1,267,965
Executive Parity Plan Activity:	
Funding	351,526
Distributions	(213,487)
Net increase in liability	(138,039)
Retiree Medical Plan:	
Funding	1,069,660
Reduction of receivable for funding	(1,069,660)
Reserve Commitments Activity:	
Constituent & component grants for Hurricane dues waivers	(99,550)
Contributions to ADA Foundation Disaster Response Fund	(75,000)
Funding of Amalgam Initiatives	(322,903)
Funding of Alaska Oral Health Initiatives	(400,759)
Balance, December 31, 2006 before commitments	$ 58,382,632
Pending Transfers:	
Transfer of 2006 deficit from reserves	(664,902)
Alaska Oral Health Initiatives spending	(76,666)
Amalgam position issues spending	(31,396)
Constituent & Component grants for hurricane dues waivers	(1,695)
Authorized Commitments	
Funding 2007 budget deficit from reserves	(2,044,850)
Alaska Oral Health initiatives	(198,201)
Amalgam position issues	(39,451)
Funding ADA Headquarters lobby renovation	(1,700,779)
Balance, December 31,2006 after commitments	$ 53,624,692

Resolution 26H-2005 (*Trans*.2005:294) urged the Board to have as its target the total uncommitted balance of the Reserve Investment Account at 40% of the Association's annual budgeted operating expenses. Outlined below are the transactions affecting the Reserve Division account in the first five months of 2007, as well as the balance (unaudited) at May 31, 2007.

Balance, May 31, 2007 before commitments	$ 62,943,565
Pending Transfers:	
Funding of Alaska Oral Health initiatives - litigation	(23,809)
Remaining Authorized Commitments:	
2007 budget deficit	(2,044,850)
Alaska Oral Health initiatives - litigation	(149,747)
Amalgam Position - Communication plan	(39,451)
ADA Headquarters Building - Lobby Renovation funding	(1,700,779)
Balance, May 31, 2007 adjusted for commitments	$ 58,984,929
Percent of 2007 budgeted expenses of $112,000,500	52.7%

An update of the Reserve Division Investment Account will be provided to the delegates during the 2007 Annual Session. Final reserve position at the end of 2007 will be dependent upon audited operating results for the year and investment performance for the balance of the year.

2006 Financial Results

ADA Operating Results: The 2006 budget approved by the House of Delegates projected a net deficit of ($1,867,018). Actual results yielded a net deficit of ($664,902). This represents a favorable variance of approximately $1.2 million to budget.

The improvement in the actual operating surplus was primarily attributable to the following:

	Variance Favorable (Unfavorable)
Membership Dues Revenue	$ (906,452)
Testing Fees and Accreditation Revenue	779,817
Investment Earnings	641,184
Direct Reimbursement Program Expenses	423,688
Science Division, net margin	361,409
Travel	341,077
Indirect Cost Recovery on Government Grants	283,156
Information Technology Consulting Fees	256,270
Information Technology Telephone Usage & WATS line	218,214
Publishing Division, net margin	(999,405)
Salable Materials Division, net margin including CDT Royalties	(1,057,424)
Income Taxes	568,945
All other variances, net	291,637
Total improvement in net operating results	$1,202,116

*These amounts are net of compensation and travel variances.

The surplus transfer was determined by adjusting net income reported on the audited financial statements to a budgetary basis. These adjustments represent specific items that are treated differently by prescribed accounting rules than by the ADA's budget funding guidelines as follows:

Net income per 2006 financial statements	$ 560,931
Additions to net income:	
Net capital expenditures	700,621
Reserve Funding	942,165
Deductions from net income:	
Renovation Program funding	(1,000,000)
Pension adjust. to restate expense per accounting rules to contrib. amount	(1,868,619)
Net Deficit	$ (664,902)

Headquarters Building Renovation and Valuation

At the request of the Board of Trustees, the activities and financial details for the Capital Improvement Program for renovation of tenant space in the Headquarters Building, as well as the renovation project to remodel Association-occupied space, have been summarized in Report 9 of the Board of Trustees to the House of Delegates: Renovation of Tenant and Association Occupied Space.

The House adopted Resolution 69H-2002 (*Trans.*2002:372), directing that the estimated market value of the ADA headquarters building be included in Board Report 2. The two most likely uses of the ADA building by a purchaser would be as an office building or a conversion to a residential property. These are two very different uses and very different markets which yield different estimated valuations. Per discussion with real estate transaction professionals in Chicago, the value of the ADA building as an office building has appreciated in the last year due to the completion of the renovation project, full occupancy, and continued general appreciation in the Chicago office market. The residential market has essentially remained flat over the last year. Thus, the estimated market values are approximately $48 million for sale to a residential developer and $37 million to $43 million for office use. The value for office use assumes that the building would be occupied, meaning the ADA would commit to a long-term lease as a tenant (an expense not now incurred) or find a replacement tenant and rent space in a different building.

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

One-Time Activities

The following chart is in response to Resolution 86H-1999 (*Trans.*1999:894). The resolutions listed below were approved at the 2006 House for spending in 2007 for one-time activities. These items are not included in the 2008 budget.

2006 House Resolution	Description	Expenses
	Dental Practice	
30H	CDBP – Status of the Direct Reimbursement Program	$ 350,000
	Education	
3H	Report of the Dental Workforce Taskforce 2006	25,000
5H	Report of the Task Force on Elder Care Vision for the Future	15,000
	Total one-time activities in the 2007 budget	390,000

Revisions During Budget Process

The following chart is in response to Resolution 101H (*Trans.*1999:894). The chart details 2008 budget actions from submission to presentation in this report.

	Net Rev (Exp)	Capital Budget
2008 Budget (Deficit) Prior to Administrative Review	**($416,100)**	
Description of Action		
Administrative Services		
Office of the Executive Director – Fund Sesquicentennial Celebration Decision Package	($18,300)	
Office of the President – Fund CODA Task Force Decision Package	(113,700)	
Human Resources – Fund E-Recruit Implementation Decision Package	(60,000)	
	(192,000)	
Membership and Dental Society Services		
Dental School Programs – Fund DSP Enhancements Decision Package	(100,750)	
	(153,250)	
Information Technology, Standards and Salable Materials		
Dept of Application Development – Fund COBOL Complier Decision Package	(6,400)	(35,500)
Dept of Application Development – Fund PS Financials Upgrade to 9.v Dec Package	0	(40,000)
	6,400	(75,500)
Dental Practice		
Dept Dental Informatics – Fund SNODENT Editorial Panel Decision Package	(61,550)	
	(61,550)	
Science		
CSA – Fund Evidence-Based Dentistry Decision Package	(73,050)	
CSA – Fund 2008 International Conference on Caries Lesion Decision Package	(67,450)	
	(140,500)	
Total ADA Budget Actions	**(501,200)**	**(75,500)**
Net (Deficit), Including Capital Items	**($992,800)**	

RESOLUTIONS

SEE RESOLUTION 12; WORKSHEET:2040
SEE RESOLUTION 13; WORKSHEET:2041

Resolution No. 12 New ■ Substitute ☐ Amendment ☐

Report: Board Report 2 Date Submitted: July 2007

Submitted By: Board of Trustees

Reference Committee: Budget, Business and Administrative Matters

Total Financial Implication: $113,089,500 Revenue
$114,082,300 Ongoing Expense

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Supports achievement of all five-strategic goals (Required)

APPROVAL OF 2008 BUDGET

Background: (See Report 2 of the Board of Trustees to the House of Delegates: ADA Operating Account Financial Affairs and Recommended Budget, Fiscal Year 2008, Worksheet:2000).

Resolution

12. Resolved, that the 2008 Annual Budget of revenues and expenses, including net capital requirements be approved.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 13 New ■ Substitute □ Amendment □

Report: Board Report 2 Date Submitted: July 2007

Submitted By: Board of Trustees

Reference Committee: Budget, Business and Administrative Matters

Total Financial Implication: $993,650 Revenue

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Supports achievement of all five-strategic goals (Required)

RECOMMENDED DUES CHANGE

Background: The Board of Trustees at its June 2007 session approved a preliminary budget with a deficit of $992,800 and a recommended dues increase of $9.00, which would produce a budgeted surplus of $850.00 Notification of this dues increase was circulated to all constituent dental societies and announced in an official Association publication. The following resolution, submitted by the Board of Trustees, reflects a proposed dues increase of $9.00.

Resolution

13. Resolved, that the dues of ADA active members shall be four hundred ninety-eight dollars ($498.00), effective January 1, 2008.

BOARD COMMENT: After carefully evaluating all strategic considerations, the Board voted to propose a dues level of $498 for 2008. The recommended $9.00 dues increase is 40% less than a 3% inflationary increase. The Board believes that the proposed budget and dues increase are consistent with the Association's long-term financial strategy of dues stabilization.

This dues increase amount does not reflect any House actions that may be adopted with financial implications and funded through membership dues.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 9 New ■ Substitute □ Amendment □

Report: NA Date Submitted: July 2007

Submitted By: Council on Members Insurance and Retirement Programs

Reference Committee: Budget, Business and Administrative Matters

Total Financial Implication: *$ 200,000 (Net Revenue) - 2008

Amount One-time Amount On-going $ 300,000 (Net Revenue) – 2009 and beyond

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

AMENDMENT OF THE ADA *BYLAWS* REGARDING THE DUTIES OF THE COUNCIL ON MEMBERS INSURANCE AND RETIREMENT PROGRAMS

Background: (*Reports:* Page 117)

Proposal to Endorse AXA Equitable Members Retirement Program and to Terminate ADA Members Retirement Trusts: After a study of the market for administrative and investment services for group retirement plans, the Council has concluded that the participants in the ADA-sponsored Program would benefit significantly if their assets were to be transferred to the AXA Equitable Members Retirement Program. It offers administrative services that are as comprehensive as those of the ADA-sponsored Program and is used by all other association group clients of the Company. The J.P. Morgan Chase Bank serves as Trustees of the AXA Equitable Members Retirement Program and AXA Equitable provides administrative and marketing services.

The Council's study focused on the costs of maintaining a stand-alone program as compared to one in which fixed costs are spread among a greater number of clients. It was concluded that a stand-alone program presented additional costs that were passed to participants in the form of higher expense ratios on their investment accounts as well as higher administrative fees. As part of its study, the Council also evaluated other financial services companies that offered management services for tax-qualified retirement plans. It concluded that AXA Equitable was best positioned to provide the administrative services required by the ADA Members Program and could do so at reasonable costs.

Following its August 25-26, 2006, meeting, the Council submitted a report to the Board of Trustees calling for the assets of the ADA Members Retirement Program to be transferred to the AXA Equitable Members Retirement Program effective April 30, 2008. Coincident with this change, the Council's duty to serve as Trustees would cease and be assumed by the J.P. Morgan Chase Bank. The Association would then give its exclusive endorsement to the AXA Equitable Members Retirement Program. The assets of each participating dentist or dental office employee would be reinvested, in accordance with their directions, in equity funds

*This net revenue was included in the ADA's 2008 budget.

offered through two investment trusts managed by AXA Equitable, a money market fund and/or three- or five-year Guaranteed Rate Accounts underwritten by the Company.[2]

The Council's report was considered by the Board at its December 10, 2006, meeting. After considering the Council's recommendations, the Board adopted the following resolution.

> **B-96-2006. Resolved,** that the Board of Trustees supports the recommendation of the Council on Members Insurance and Retirement Programs that the ADA Members Retirement Program in its present form be terminated effective April 30, 2008, and its assets transferred to the AXA Equitable Members Retirement Trust, and be it further
>
> **Resolved,** that the Association endorse the AXA Equitable Members Retirement Program effective April 30, 2008, and be it further
>
> **Resolved,** that the Board of Trustees recommends that the House of Delegates amend the *Bylaws* to eliminate the Council on Members Insurance and Retirement Programs duty to serve as Trustees of the ADA Members Retirement Program and to replace it with a duty to advise and recommend courses of action on retirement programs effective April 30, 2008, and be it further
>
> **Resolved,** that the Board of Trustees authorizes the Council on Members Insurance and Retirement Programs to oversee the ongoing management of Association-endorsed member retirement programs and to recommend changes in those programs when appropriate.

Increased Number of Investment Options. Although final decisions have not as yet been made regarding the specific funds and accounts to be made available to the participants, at present it is envisioned they will have 28 equity options in addition to a money market fund as well as guaranteed rate accounts with three- and five-year maturities. The equity funds will be selected from the AXA Premier VIP Trust, which has 16 funds, and the EQ Advisors Trust, which has 36 funds. AXA Equitable serves as investment manager for the funds in these Trusts but may hire sub-advisors to manage the individual portfolios. Thus, these Trusts have funds that are similar to publicly available mutual funds managed by firms such as Van Kampen, Wells Fargo, Janus, PIMCO, Ariel, Templeton, et. al. A comparison of expense ratios of the funds offered through the AXA investment trusts and the current Program indicates that, for some asset classes, fund expense ratios are higher in one trust than in the other. However, the expectation is that when all assets are viewed in the aggregate, the fund expense ratios will be lower in the AXA investment trusts than in the Members Retirement Program.

Elimination of Separate Account Charge on Equity Investment Options. Most of the assets of the Members Retirement Program are currently subject to a .15% (15 basis point) Separate Account Accounting Charge. When held in the separate account established for the AXA Equitable Members Retirement Program, these ADA Program assets will no longer need their own separate accounts; and the .15% accounting charge will be eliminated. Based upon the amount of money held in the ADA Program separate accounts on January 31, 2006, the elimination of this charge will save participants investing in the equity options approximately $1.5 million in fees annually.

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[2] Like the ADA Members Retirement Program, all assets invested in the AXA Equitable Members Retirement Program, except those held in the three- or five-year Guaranteed Rate Accounts, would be held in "separate accounts" of the Company. Under New York State law, all assets held in such separate accounts are immune from the claims of the insuring company's other policyholders and credits. Thus, there would be no reduction in the guarantees of the safety of assets that presently exist with the ADA Members Retirement Program.

Reduction in Program Expense Charge. The most significant fee paid by each participant in the Members Retirement Program is the expense charge.[3] This charge is the primary source of revenue to AXA Equitable for its administrative services and overall management of the Program. When the Program is merged, it is anticipated that there will be economies of administration. Based upon these expected savings, AXA Equitable will accept a lower expense charge. Assuming January 31, 2006, asset and participation levels, the expense charge would fall from .62% to .5455%. This fee reduction represents annual savings to participants of $1.5 million.

In compensation for the expenses it incurs on behalf of the Council in fulfilling its duties as Trustees of the Members Retirement Program, the Association is currently reimbursed in accordance with the provisions of the Employee Retirement Income Security Act of 1974. For the one-year period beginning May 1, 2006, the participants' are being assessed an annualized charge of .0125% (one and one-quarter basis points.) Under the proposed arrangement, the Association would be paid an annual royalty from the revenues AXA Equitable derives from other Program fees. The royalty will not be directly obtained from participants. The royalty would be determined by a formula that is based upon the amount of assets held in the Program.

Total Participant Savings. Based upon January 31, 2006, asset and participation levels, the expense charges paid by all the participants would decline as shown in the table below.

Program Expense Charge Comparison		
	Current	Proposed
AXA Equitable Component	.6200%	.5455%
ADA Component	.0125%	N/A
Expense Charge	.6325%	.5455%

In addition to the above savings, participants who invest in the equity funds would benefit from the elimination of the .l5% Separate Account Charge. As an example of these savings, if a participant has $500,000 invested, of which $400,000 is held in equity options, his/her annual fees would decline from $3,763 to $2,728, a reduction of nearly 28%.

Council Oversight Duties. Although the Council would not be Trustees of the AXA Equitable Members Retirement Program, the Board has agreed that the Council should oversee the Association's endorsement of the AXA Equitable Members Retirement Program. This oversight authority would be similar to that exercised by the Council with respect to the ADA member insurance programs. The Council would continue to review the reports of the administrator and the Program's investment performance and provide its recommendations to AXA Equitable and/or the Board of Trustees as appropriate. However, the Council would not have the authority to select or remove the Program's investment options. That authority would rest with the new Trustees, the J.P. Morgan Chase Bank.

Conversion Royalty. In addition to the annual royalty, the Association would be paid a conversion royalty. This is in recognition of the substantial contributions the Association has made to the Program's design and growth since 1968. This royalty would be derived from revenues received by AXA Equitable from distributors of some

[3] There are also nominal fixed dollar fees. They include a $12/participant annual record keeping fee plus a one-time $25/participant enrollment fee.

of the mutual funds offered as investment options under the Program. These payments are the result of 12b-1 fees included in some of the investment options' expense ratios as well as sub-transfer agency fees.[4]

At this time, the amount of the conversion royalty has not yet been determined. However, AXA Equitable indicated that it would range between 25% and 50% of the 12b-1 revenues that remain on the date the endorsed arrangement takes effect. AXA Equitable would then use the balance of the 12b-1 account assets solely for advertising and other product promotions in ADA venues (e.g., the annual session, ADA membership card, *Connections* booklet, etc.)

AXA Equitable estimates that by May 1, 2008, there may be approximately $500,000 of revenues from which it could pay the conversion royalty. Therefore, the value of the conversion royalty payment to the Association would be about $125,000 to $250,000.

Endorsement Agreement. The Association's relationship with AXA Equitable will be set forth in an endorsement agreement that is proposed to have an initial term of five years beginning May 1, 2008. The agreement will be developed in the coming months by legal counsel for the Association and AXA Equitable. The Association's legal counsel has reviewed a preliminary draft of the contract and, while the Association will request changes to the legal terms, it is expected that the parties will be able to reach final agreement without delay.

House of Delegates Approval. In order to proceed with the implementation of the termination of the ADA Members Retirement Trusts, the transfer of its assets and the endorsement of the AXA Equitable Members Retirement Program, it is necessary that the House of Delegates amend the *Bylaws* to eliminate the Council's duty to serve as Trustees of the ADA Members Retirement Program. To that end, the Council has submitted a resolution calling for the amendment of the *Bylaws* to take effect on April 30, 2008.

Resolution

9. Resolved, that Chapter X. COUNCILS, Section 120. DUTIES, Subsection I. COUNCIL ON MEMBERS INSURANCE AND RETIREMENT PROGRAMS, of the ADA *Bylaws* be amended by addition of an asterisk and footnote to duty "e" to read as follows (new language underscored):

e. To serve as the Trustees for the American Dental Association Members Retirement Program.*

*This duty shall expire April 30, 2008.

and be it further

Resolved, that Chapter X. COUNCILS, Section 120. DUTIES, Subsection I. COUNCIL ON MEMBERS INSURANCE AND RETIREMENT PROGRAMS, of the ADA *Bylaws* be further amended by adding a new duty "f" and footnote to read as follows:

f. To advise and recommend courses of action on retirement programs.**

** This duty shall commence April 30, 2008.

[4] 12b-1 fees are used by distributors of mutual funds to cover the marketing costs, including commissions paid to brokers. Sub-transfer agency fees are paid by distributors to "omnibus" clients, which are groups of clients which, for record keeping purposes act as a single client as is the case with group pension and 401k plans.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 14 New ■ Substitute □ Amendment □

Report: Board Report 3 Date Submitted: July 2007

Submitted By: Board of Trustees

Reference Committee: Budget, Business and Administrative Matters

Total Financial Implication:

Amount One-time $ 1,850,799 Amount On-going $

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

REPORT 3 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:
RENOVATION OF THE ADA WASHINGTON, D.C. OFFICE

Background: The ADA's Washington office has not been significantly renovated since the building's construction in 1984. Office space, technology and meeting facilities are outdated and no longer support optimal office productivity. The Washington offices are composed of the 11th and 12th floors in the building, covering an area of approximately 12,000 square feet (sf) in total with significant space on each floor dedicated to the mechanicals, storage, unusable space and restrooms. As a result, the configuration is very inefficient.

The conference room facilities need to be expanded and updated in order to support current and future activities. Council meetings (three per year) and ADPAC meetings (two per year) must be held off-site due to current limited conference room space and technology. Most meetings could be held in the Washington office following renovation, with off-site rental expense reductions ranging from $5,000 to $10,000 per meeting. Other dental related meetings are currently held in surrounding hotel facilities, which could be held in the Washington building with modest revenue generating potential. Tenants of the building have also expressed interest in availability of conference space, offering additional potential for modest revenue.

Key objectives in modernizing the overall office space include: improved space efficiencies (which also allows room for future growth); reconfigured offices; increased conference room capacity to support larger meetings; enhanced conference room audio-visual technology, including video and teleconferencing, LCD projection equipment, internet/laptop connectivity, and communication technology; reallocating file space to reflect current needs and electronic storage capability; addition of computer room storage space; increased office security; updated power supplies and fire protection; improved office lighting and acoustics; updated washroom and pantry facilities; improved ventilation and airflow; and better continuity between floors 11 and 12. Overall, modernized offices will enhance ADA's image with frequent visits from various important legislative coalitions, other dental groups, consensus building groups, volunteers, policymakers, candidates and visits from out of town members requesting a tour.

Office reconfigurations to standard sizes include: (1) executive office (405 sf), (7) director offices (225 sf each), (15) manager offices (150 sf each), suspended lighting and replaced carpeting throughout. The large conference room would be re-configured and expanded to seat 30, and two smaller conference rooms would be added to seat eight each. Furniture would be of the same quality and look as in the ADA Headquarters office.

Financial projections for 2008 expenditures have been prepared, with a total budget of approximately $1,850,799. The proposed schedule would call for schematic design and permitting to begin in the 4th quarter, 2007, with construction beginning and completed in the third and fourth quarters of 2008.

Schematic design (interior architecture, engineering)	$ 117,669
Permits	11,944
Construction (including contingencies)	1,111,408
Furniture	354,780
AV System for (3) conference rooms	143,213
Signage and project contingencies	111,785
Total Approximate Expense	$1,850,799

Resolution

14. Resolved, that the American Dental Association's Washington, D.C. office renovation proposal be approved, and be it further

Resolved, that the funding for this project come from Reserves.

BOARD COMMENT: At this time, the Board is recommending that funding for this needed renovation come from reserves. Reserves are strong, and the solid investment returns this year so far make the Board comfortable that paying for this project from reserves is appropriate. The Board would need to re-assess this recommendation at the House of Delegates if there are serious declines in the market or significant funding implications through 2007 House actions.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Board Report 4 Date Submitted: July 2007

Submitted By: Board of Trustees

Reference Committee: Budget, Business and Administrative Matters

Total Financial Implication: See below for details

Amount One-time $ Amount On-going $

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

REPORT 4 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: COMPENSATION AND CONTRACT OF EXECUTIVE DIRECTOR

Background: This report is in response to Resolution 34H-1993 (*Trans.*1993:682) which was adopted by the House of Delegates and directs an annual informational report from the ADA Board of Trustees to the House of Delegates regarding compensation and employment contract issues of the Executive Director.

Contract of Executive Director: The Board of Trustees executed a three-year employment agreement with the current Executive Director on June 13, 2006. The current agreement is effective for a period commencing January 1, 2007 for a three-year term ending on December 31, 2009. The term of the agreement will automatically be extended for successive one year periods unless either party gives notice of termination at least one year in advance. Two such automatic renewals are available under this Agreement. Either party may terminate the agreement without cause by giving the other party written notice of termination at least 60 days prior to the termination date.

It should be noted that the Executive Director is the only member of the ADA staff with a written employment contract.

The contract provides that the Executive Director's performance is to be reviewed by the Board on an approximate annual basis or more frequently, if deemed appropriate by the Board.

Compensation and Benefits: The Executive Director's annual base salary is currently $425,000 and is paid in accordance with the Association's standard payroll schedule and policies. This current compensation shall be effective through the remainder of 2007. A bonus of $15,000 was awarded by the Board to the Executive Director in April 2007. Effective January 1, 2008, the Executive Director's annual salary increases to $450,500, to be paid and reviewed in accordance to the terms of the existing agreement. The Executive Director is entitled to all of the fringe benefits offered during the term of this Agreement to all similarly situated Association employees having his length of service in the employ of the Association.

The Executive Director participates in the Executive Parity Plan, a non-qualified retirement plan that restores the value of lost benefits to senior ADA executives who otherwise would suffer significant benefit reductions (20% to 60% reduction) because of the tax laws. This non-qualified plan is funded via a specified cash amount the Board sets aside annually to be paid upon vesting. The set asides are strictly restorative and are funded from the savings in the qualified pension plan contributions which result because of the reduction in executive covered benefits under the qualified plan. This plan came about after the Omnibus Budget

Reconciliation Act of 1993 reduced future covered pension benefits for any employee whose earnings exceeded an annual threshold. Like virtually all for profit corporations, and other Chicago based professional associations, the Board recompenses the Executive Director and other affected senior executives for this reduction in pension plan benefits.

The Executive Director also receives a $5,000 annual contribution to the Great-West Variable Annuity Plan; a parking space in the Association Headquarters building; the reimbursement of reasonable, substantiated expenses incurred to purchase and maintain a membership in one city or athletic club in the Chicago area; one cellular telephone, spousal travel for selected meetings; membership dues in professional associations, (except the dues of the American Dental Association and its constituent and component dental societies) not to exceed the total sum of $2,000 per year; and annual dues of a membership in one country club in the Chicago area, up to $10,000 per year. The Board collects data from outside consultants and various published reports in order to compare the compensation and benefits package of the Executive Director to other similarly sized non-profit organizations.

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 2007

Submitted By: Board of Trustees

Reference Committee: Budget, Business and Administrative Matters

Total Financial Implication: See below for details

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: INFORMATION TECHNOLOGY INITIATIVES, EXPENDITURES AND ESTIMATED COSTS, AND ANTICIPATED FUTURE PROJECTS

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

The Division of Technology, Standards and Sales (TSS) uses an established plan to provide technology staff with the goals and objectives necessary to support the ADA Strategic Plan. This plan allows the TSS division to address immediate issues and the opportunity to provide quality information technology operations to service ADA members and the tripartite.

Year 2007 Projects and Expenditures: In 2007, the TSS division continues to move forward with projects in its core areas. As of this report, the following projects are completed and others are currently in the working stages with a completion goal by the end of the year.

- *Document Management (FileWeb)*. ADA FileWeb, the Association's document management system was implemented during the first half of 2002. This system allows the Association to analyze, interpret, synthesize and disseminate information to ADA members, to be regarded as the most credible, timely and referenced information source by ADA members and the public, and to facilitate the ability to transfer relevant information to members in a timely manner. Since its implementation, approximately 777,802 documents have been added to this system. An upgrade is scheduled for later in 2007, which will provide new functionality making the system more user-friendly and increasing the capabilities for sharing information throughout the Association. In 2008, a software upgrade is planned to improve the document management process.

- *Data Warehouse*. A new data mart was developed for the Member Service Center (MSC) to provide better management, scheduling, and planning for growth as more areas centralize their customer support functions to the MSC. Several functional and reporting capabilities have been added to the Dental Accreditation application for the Division of Education. This application allows CDA staff to schedule, track and follow up on dental school accreditation site visits. A project was completed to evaluate potential replacement tools used to build and maintain the data warehouse, since it was

anticipated that the vendor of the current tool will discontinue upgrades and support. Business Objects was selected and purchased in December 2006. The software has been installed for software development and testing. This project is scheduled for completion by December 2007.

- *Internet*. Online meeting registrations were deployed for Membership and Dental Practice, as well as the annual Give Kids a Smile Program. Online updates were deployed for the Dental Admission Test and National Boards to include the new pricing structure. New online applications were implemented for Conference and Meeting Services including Annual Session Speaker Registration and Program Submissions, onsite Exhibitor Registration, which allows exhibitors to register for exhibit space at the following year's meeting, and an online Chicago Hotel Registration application for ADA members and staff, which interfaces directly to hotels, providing a streamlined reservation confirmation process. A major update to the eCatalog was completed to accommodate the new personalized products offered by SMP. This initiative added over 300 new products into the eCatalog. Maintenance and support continues for the eCatalog, which includes product and pricing updates, fulfillment functionality and offers.

- *PeopleSoft*. The Budget module was redesigned to closer align the budgeting program with the ADA's strategic plan. These changes were completed in February in preparation for the 2008 budget cycle. A major enhancement was implemented in February with the creation of the online Accounts Payable Check Request. This upgrade replaces two paper forms, the Check Request and Employee Travel Advance Request. The program includes online approvals similar to the requisition/purchase order process to keep in compliance with the ADA's Purchasing Policy and replaces the current process of signing paper forms. Express Billing was implemented in March, which allows staff to easily create invoices following a standardized format. This functionality was implemented as part of the Association's initiative to standardize and centralize business functions. The ePay module was implemented in May. This module provides a secure mechanism for staff to review their paychecks online via the PeopleSoft system. It also eliminates the need for Payroll staff to stuff paychecks and hand deliver pay stubs to staff. Research is being done in preparation for a system upgrade, which is scheduled to begin in late 2008 and continue into 2009. This new version contains enhancements, improvements and new features that allow more compliance and efficiency in supporting centralizing and standardizing business transactions. It also provides enhanced functionality to meet security and confidentiality requirements identified in recent audits. The vendor who provides the COBOL Compiler, a software component that maintains a number of PeopleSoft programs, has recently changed its licensing agreement. This change will require that this software be re-licensed. This purchase is scheduled in 2008.

- *Tripartite System*. The version 8.0 upgrade, which began in July 2006, was rolled out to the ADA and participating tripartite sites in March 2007. This version offers a Legislative module and other small enhancements. Version 8.1, which began in April, will fix bugs and add minor enhancements mainly to the Referrals module. These updates will benefit the component societies that give referrals and is based on their input. This version is scheduled to be deployed in September 2007. As of this report, 36 states, 39 components and the ADA are actively using TS. While funding is not specifically earmarked for TS in 2008, the system will be reviewed for enhancements, fixes and updates using existing staff.

- *MRM and E-Commerce*. The Member Relationship Management (MRM) initiative, which began in 2004, includes a Member Service Center (MSC) designed to provide members with the information they need with one phone call; an e-Commerce solution to provide online purchasing of ADA products; and a Technical Help Desk solution to manage technical support calls from ADA members and staff. In January 2006, the ADA embarked on a project to assess its business processes. This assessment involved reviewing how departments completed their work and identifying where

processes could be centralized and/or standardized. In June, ADA-staff work groups were established for the areas of Sales and Service, Marketing, Finance, and Fulfillment. These groups were charged with developing standardized business processes that would be followed throughout the organization. In addition, they identified key services that could be centralized into the MSC that Member Service Agents could service immediately. The groups completed their work in November. In February 2007, pilots of the Sales and Service, and Fulfillment processes were developed and the Survey Center and the Dental Benefit Programs were selected to implement the transfer of work into the Member Service Center. The pilots went live in June. Departmental processes will continue to be reviewed and centralized into the MSC as appropriate. The MRM Finance Team established and has been successfully implementing a detailed project plan for the standardization and centralization of all invoicing, cash receipts, and accounts receivable transactions. Request for Proposals (RFPs) were sent out to various vendors for pricing quotes to complete the Siebel software upgrade assessment, which reviews Siebel System's new version of its MRM software to determine if this version's functionality delivers the enhancements being requested in Phase VII by the Member Service Center, Department of Salable Materials and Technical Support Center. The assessment was completed in April and new Request for Proposals were sent out to eight vendors to bid on the software upgrade. Four vendors responded and a vendor was selected in June. The upgrade is scheduled to begin in mid-July 2007 and be completed by March 2008.

The table below outlines expenditures in the core areas in 2006, projected spending in 2007, and budgeted spending for 2008. Also disclosed is spending related to infrastructure hardware and major projects.

IT Core Area	2006 Actual Spending	2007 Projected Spending	2008 Budgeted Spending
FileWeb	$ 40,510	53,000	40,000
Data Warehouse	201,300	150,000	122,000
Internet	4,860	166,920	50,000
PeopleSoft	0	0	75,500
Tripartite System	82,211	0	0
Infrastructure Hardware/Licenses	964,079	1,157,450	944,250
MRM/E-Commerce	681,792	1,227,300	796,300
Total Project Spending	1,974,752	2,754,670	2,028,050
Balance of IT Operating Budget	4,619,268	5,507,330	5,532,800
Total IT Spending	$ 6,594,020	8,262,000	7,560,850

The table below summarizes the previous information based on the source of funding. The TSS division continues to maintain and upgrade its current core areas, while also providing ongoing support and completing various IT-related projects for ADA divisions.

IT Core Area

2006 Spending	Operating Budget	Capital Budget	Total
FileWeb	$ 15,677	24,833	40,510
Data Warehouse	32,000	169,300	201,300
Internet	4,860	0	4,860
PeopleSoft	0	0	0
Tripartite System	11,003	71,208	82,211
Infrastructure Hardware/ Licenses	20,454	943,625	964,079
MRM/E-Commerce	556,340	125,452	681,792
Total Project Spending	640,334	1,334,418	1,974,752
Balance of IT Operating Budget	4,619,268	-	4,619,268
Total IT Spending	$ 5,259,602	1,334,418	6,594,020
2007 Projected Spending			
FileWeb	$ 10,000	43,000	53,000
Data Warehouse	105,000	45,000	150,000
Internet	75,420	91,500	166,920
PeopleSoft	0	0	0
Tripartite System	0	0	0
Infrastructure Hardware/Licenses	50,650	1,106,800	1,157,450
MRM/E-Commerce	819,300	408,000	1,227,300
Total Project Spending	1,060,370	1,694,300	2,754,670
Balance of IT Operating Budget	5,507,330	-	5,507,330
Total IT Spending	$ 6,567,700	1,694,300	8,262,000
2008 Planned Spending			
FileWeb	$ 40,000	0	40,000
Data Warehouse	122,000	0	122,000
Internet	50,000	0	50,000
PeopleSoft	0	75,500	75,500
Tripartite System	0	0	0
Infrastructure Hardware/Licenses	41,000	903,250	944,250
MRM/E-Commerce	796,300	0	796,300
Total Project Spending	1,049,300	978,750	2,028,050
Balance of IT Operating Budget	5,532,800	0	5,532,800
Total IT Spending	$ 6,582,100	978,750	7,560,850

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 6 Date Submitted: July 2007

Submitted By: Board of Trustees

Reference Committee: Budget, Business and Administrative Matters

Total Financial Implication: (See report for details of previously approved project expenses)

Amount One-time $ Amount On-going $

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

REPORT 6 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: RENOVATION OF TENANT AND ASSOCIATION OCCUPIED SPACE

Background: The Board of Trustees is again submitting a comprehensive report on the renovation of the Headquarters Building, which includes asbestos remediation and renovation.

Initially the scope of work included tenant space and selected mechanical and common areas within the facility. Since 1993, the Board has reported annually on the status of that portion of the project. The 2000 House of Delegates approved renovation of Association occupied floors. Information on that project is also included herein.

1992 Capital Improvement Program

The Association continues to work through the final stages of a major renovation of the tenant and common areas of the Headquarters Building. This phased project plan for asbestos abatement and renovation began in 1992, and includes the tenant floors and common and mechanical areas within the Headquarters Building. The Headquarters Building management firm of Jones Lang LaSalle estimates that the total cost of the tenant redevelopment project, exclusive of the lobby discussed later, will be approximately $23 million.

Project Funding: When this project was first conceived, the Board considered several alternatives for financing these activities including debt. The 1992 House of Delegates wished to lessen the Association's reliance on outside financing and structured the terms of a dues increase accordingly. The resulting Resolution 35H-1992 (*Trans.*1992:583) increased membership dues by $55 for a four-year period, 1993 to 1996. Use of these monies was restricted by Resolution 110H-1992 (*Trans.*1992:587) to the Capital Improvement Program (CIP) and a separate investment account was established to generate interest earnings. The 1992 House of Delegates further proposed that the Board of Trustees liquidate $3.5 million in the Reserve Division Restricted Investment Account and temporarily transfer the funds to the Capital Improvement Program to minimize borrowings from outside financial institutions. These monies were repaid with interest in May 1995.

Project Status: Since the last reporting period, the half of the 17th floor not occupied by the ADA has been renovated and leased. The 12th floor, which served as swing space for the ADA through the renovation and which had already been abated, has also been recently leased. The initial Capital Improvement Project provided funding for the buildout of the 17th floor tenant space and the recently leased tenant space on the 12th

floor. The balance of that fund has been directed to the lobby abatement and renovation which is in progress, and is addressed in the section of the report on renovation of ADA occupied space.

Below is a summary of project transactions through 2006.

ADA Capital Improvement Account
Cumulative Cash Activities
As of December 31, 2006

Cash inflows:	
Dues receipts	$ 23,647,863
Loan proceeds from reserve account	3,500,000
Repayment of advance to ADA Renovation Program	1,000,000
Net investment income	3,931,687
Subtotal	32,079,550
Cash outflows:	
Renovation expenditures	(22,620,367)
Loan payoff to reserve account	(3,500,000)
Transfer to ADA Renovation Program	(2,500,000)
Temporary advance to ADA Renovation Program	(1,000,000)
Interest expense on loan	(337,554)
Miscellaneous expense	(2,276)
Subtotal	(29,960,197)
Adjustments to reconcile to investment balance:	
Due to ADA Operating Account	42,248
Net accounts payable	1,979
Subtotal	44,227
Balance at December 31, 2006,	
Short-term invested funds	$ 2,163,580

As the summary above explains, cumulative collections of the dues increase restricted to this program total $23,647,863 and project expenditures total $22,620,368 through December 31, 2006.

The initial $3.5 million advance from reserves was repaid in May 1995 with accrued interest once accumulated funds became sufficient to sustain the project. In December 2000, $2.5 million was transferred to the ADA Renovation Program as directed by the 2000 House of Delegates. During 2005, $1 million was temporarily advanced to the Renovation Account for cash flow purposes and was repaid in May 2006.

ADA Renovation Program (ADARP)

The House of Delegates approved extending the renovation project to the remainder of the building in October 2000.

Existing ADA Office Space: When this project was approved in 2000, Association staff occupied nine full floors, in addition to designated administrative space on the 2nd floor for the Division of Conference and Meeting Services, and support agency operations for Duplicating, Shipping/Receiving and the Mailroom

located in the lower level. Each full floor represents approximately 13,263 square feet and at that time accommodated an estimated 50 staff members.

The configuration of work space was largely predicated on the office needs of the 1960s when the ADA Building was originally designed. The layout was outdated with oversized, hard construction private offices, and administrative support personnel in work environments that were difficult to conform to new ergonomic standards. Asbestos conditions above the ceiling and in wall partition systems severely limited the ability to modify existing office space to accommodate changes in staffing, technology or new program activities. ADA space alterations were inevitably more complicated in design and costly due to the asbestos hazard.

Project Management Services: In early 2001, the Association contracted with its real estate agent, Jones Lang LaSalle (JLL), to provide project consulting services and with architects from the firm of Griswold, Heckel and Kelley, (GHK) who have extensive experience in occupancy planning and interior design. JLL's Project Management Division provides access to a full range of integrated real estate services, including facility project management and strategic occupancy planning. GHK's architects have considerable experience in designing and implementing space plan strategies to achieve organizational efficiencies. Both companies are well respected in the industry and have successfully completed facility alteration projects of this magnitude for a diverse group of clients.

While the proposed new design standards accommodate more staff per floor, the project architects emphasized the need to integrate records management systems, electronic document retention protocols, and universal filing systems to facilitate this goal.

Budget Considerations: The project budget was developed with JLL and GHK and assumed a six year (2001 through 2006) phased schedule for completion. Budget assumptions recognized potential changes in future headcount, interior design selections, swing space requirements, transitional and relocation related expenses, consulting and project management fees, inflation and other cost contingencies.

The expense projections included base building system reconstruction of elevator corridors, restrooms, heating, ventilating and air conditioning systems, fire protection and sprinkler system connections, new ceiling and lighting fixtures as well as other interior finishes. Additionally, the cost projections anticipated the purchase of modular partition furniture systems.

At the time this budget was compiled in 2000, there was recognition that the lobby would require abatement and renovation as well. Since it was difficult to anticipate what funding would be available in the remaining CIP budget and the extent of the subsequent lobby renovation, a placeholder of $1 million was included in this budget.

The effect of inflation on labor and material costs over the six-year project span added another dimension of complexity to managing a project of this scope and its attendant expenses. Competitive bidding of project specifications and coordination by an independent project management firm has helped ensure the general contractor pricing is reasonable and the schedule is not compromised.

It was originally estimated that the total costs for demolition, abatement and renovation of the Association space were $28.7 million. This figure included $500,000 for a telephone switch and $1.4 million for document management software and system implementation.

Funding: The 2000 House of Delegates approved financing for this project through a special dues assessment. In order to limit the amount of the assessment to reduce adverse impact on membership, the

House also selected supplemental options for funding. The following additional monies were earmarked to underwrite the project, coupled with the assessment:

1. Using $2.5 million from the current tenant renovation project;

2. Using $1.5 million from the accumulated balance of the Building Fund Account (Funded Depreciation); and

3. Taking $1 million each year from the annual funded depreciation allocation for the six year life of the project.

This funding arrangement is summarized below:

Special Assessment	$18,900,000
Utilization of Capital Improvement Funds	2,500,000
Portion of the annual Funded Depreciation provision	6,000,000
Portion of Building Fund Balance	1,500,000
Total	$28,900,000

During 2005, $1 million was temporarily advanced from the CIP account for cash flow purposes and was repaid in May 2006.

Project Status: Since the last reporting period, all ADA occupied office space has been fully renovated.

The lobby, which is currently being renovated, is the last phase of the renovation program. Late in 2005, JLL project management, building management and staff interviewed three architectural firms with strong backgrounds in lobby renovation. The chosen firm, Goettsch Partners, presented three different design concepts after learning about the Association and its vision, and the membership's professional image, all of which ultimately would be reflected in the renovated space.

Additionally, a preliminary analysis of the remaining funds in both the CIP and ADARP Funds was done. This analysis included estimates for all future obligations of both funding sources. At that time, the remaining balances less those obligations yielded $3.875 million of funds available for the lobby renovation, while very preliminary pricing indicated a total project cost of approximately $7 million.

The architects, contractor and project management team went back and performed extensive value engineering which included use of alternate, less expensive materials and elimination of some design elements. Ultimately, the lobby renovation proposed cost came in within the $3.875 million budget, but did not produce a design thought to be appropriate for the ADA's professional image or supportive of its efforts to remain competitive in the Chicago office rental market.

The team identified design features and materials thought to be key to the overall project and worthy of added consideration, and other items that were desirable but "postponeable." In June of 2006, the Board reviewed the proposed design in light of the budget implications and approved up to an additional $1 million in funding from reserves to allow for inclusion of key design elements and materials for a total budget of up to $4.875 million. The strength of the Association reserves at that time allowed the Board to supplement the final design from reserves rather than seek additional member dues support.

One of the items on the desirable, but "postponeable" list was an exterior canopy with prominent ADA signage. The Board reviewed a report in December 2006 which highlighted the desirability of adding the canopy:

1. It would provide shelter from the elements now that the curtain wall will extend to the pillars.

2. It would allow for prominent signage and increase the ADA's presence on the street. (The building façade does not lend itself to exterior signage. This option was explored with the architects.)

3. And, while not a thoroughly persuasive reason without the desire to accomplish 1 and 2, in all likelihood the pricing would continue to increase.

Also reviewed by the Board was pricing detail. The total for the canopy and signage was $700,779. Again, the Board approved funding of this element from Association reserves.

The demolition and abatement of the lobby began in the fall of 2006. The project, like most major construction projects, has been faced with its fair share of challenges, the most significant being highly unusual city permitting requirements which have delayed completion by several months. Completion is anticipated for fall 2007. A final report on the project will be provided to the 2008 House of Delegates.

Below is a summary of project transactions through December 31, 2006:

ADA Renovation Project Account
Cumulative Cash Activities
As of December 31, 2006

Cash inflows:	
Dues assessment receipts	$19,228,243
Transfer from Capital Improvement Program	2,500,000
Transfer from Building Fund	1,500,000
Temporary advance from CIP	1,000,000
Budgeted funding transfer	6,000,000
Net investment income	723,991
Subtotal	30,952,234
Cash outflows:	
Renovation expenditures	(26,636,417)
Repayment of Temporary Advance from CIP	(1,000,000)
Document management system	(1,254,132)
Telephone switch	(618,876)
Subtotal	(29,509,425)
Adjustments to reconcile to investment balance:	
Due to ADA Operating Account	43,039
Accounts payable	32,464
Subtotal	75,503
Balance at December 31, 2006,	
Short-term invested funds	$ 1,518,312

Summary: The Board is pleased to be approaching the end of this 13 year abatement and renovation project and in retrospect appreciates that the planning for and funding of both projects was done with great thought and foresight. The subsequent management of the renovation accommodated unanticipated renovations responsive to an evolving organization.

While both the CIP and ADARP budgets recognized the ultimate need to renovate the lobby, both budgets were only able to reasonably anticipate what the extent and cost would ultimately be. Both budgets contained modest funding for lobby abatement and renovation. In light of this, the $5.575 million budget now being estimated for completion of the lobby is funded in large part from balances of both these budgets totaling $3.875 million. The $l.7 million recently appropriated from reserves by the Board will constitute the additional funding necessary to complete the lobby renovation.

Over the last decade, the ADA's Headquarters Building has been transformed from its original 1960's design and functionality to a modern, flexible and technology friendly work environment. The lobby will complete this total renovation project, which will hopefully serve as a source of pride for the membership and tenants, allow the ADA to remain competitive in the Chicago real estate market and sustain high occupancy rates, and contribute to attracting and retaining quality employees.

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. 30 New ■ Substitute □ Amendment □

Report: NA Date Submitted: August 14, 2007

Submitted By: Eighth Trustee District

Reference Committee: Budget, Business and Administrative Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Build Dynamic Communities (Required)

ADA SUPPORT FOR CHICAGO OLYMPICS, 2016

The following resolution was submitted by the Eighth Trustee District and transmitted on August 14, 2007, by Mr. Robert Rechner, executive director, Illinois State Dental Society.

Background: In April 2007 the United States Olympic Committee announced that Chicago, Illinois, had won the right to represent the United States in the effort to host the 2016 Olympic Games. As the City of Chicago begins the international phase of the competition, there is a great deal of work to be done and a great deal of support needed. According to Chicago officials "To bring the Games to Chicago, we need everyone in the community to show their support. Let's ignite the torch and 'Stir the Soul' of Chicago and the world." Chicago is pulling out the stops to bring the Games back to the U.S.

As the Headquarters of the American Dental Association, Chicago also holds a special place in the hearts of organized dentistry. To add its valuable support to this effort, and to show that volunteer dentists will enthusiastically share their skills and talents to the Olympic effort, the Eighth District proposes the following resolution.

Resolution

30. Resolved, that the ADA send a letter to the Chicago Olympic Committee expressing its enthusiastic support for bringing the Games to Chicago in 2016, and be it further

Resolved, that the ADA urge its members to be volunteer dentists during the Chicago Olympic Games if the City of Chicago is awarded the 2016 Games.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 31 New ■ Substitute □ Amendment □

Report: NA Date Submitted: August 29, 2007

Submitted By: Fifteenth Trustee District

Reference Committee: Budget, Business and Administrative Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Create and Transfer Knowledge (Required)

SUPPORT OF DENTAL EDUCATION: OUR LEGACY – OUR FUTURE

The following resolution was submitted by the Fifteenth Trustee District and transmitted on August 29, 2007, by Ms. Mary K. Linn, executive director, Texas Dental Association.

Background: The American Dental Association and other dental education stakeholders identified several critical challenges facing dental education several years ago. Since that time, the Association, through its ADA Foundation, has committed to help secure the future of dental education. One of the most important areas is raising the awareness among dentists of the importance of financially supporting dental education through personal contributions to dental schools, specialty groups and other dental organizations raising funds for dental education. To that end, the ADA Foundation has created Dental Education: Our Legacy - Our Future, whose sole purpose is to raise the awareness of the needs of dental education, develop a culture of philanthropy within the dental profession and deliver a call to action to support dental education. All ADA constituent and component societies can participant in this collaborative, national effort by becoming a partner in Our Legacy - Our Future. It is as important for the constituent and component societies to make this commitment as it is for the ADA, because the future of the profession depends on the overall strength of dental education.

As of August 24, 2007, sixteen constituent and component societies (and/or foundations) are partners: Alabama Dental Association; California Dental Association Foundation; Colorado Dental Association; Florida Dental Association; Florida Dental Health Foundation; Illinois State Dental Society; Illinois State Dental Society Foundation; Missouri Dental Association; Missouri Dental Foundation; New York State Dental Foundation; Ohio Dental Association Foundation: Oklahoma Dental Association; San Diego Dental Health Foundation; Seattle-King Dental Foundation, Texas Dental Association; and Washington State Dental Association.

To become a partner, simply submit a non-binding letter of intent to Our Legacy - Our Future (in care of the ADA Foundation) which simply states that your organization will keep organizers informed of the amount of funds it has raised or anticipates raising for dental education between July 1, 2004 and December 31, 2014. Twice a year, all partners will be asked to report the funds raised for dental education. It is estimated that the total amount of funds raised by the partners at the conclusion of this effort in 2014 will surpass $500 million.

It is important to note that Our Legacy - Our Future will not collect a single dollar of its own. Instead, it is a value-added support tool for partners to raise awareness while helping them raise additional funds more efficiently and effectively. It is also designed to provide additional publicity for their fundraising efforts

in regional and national publications; additional recognition for donors; and valuable fundraising and marketing resources for staff and volunteers.

It is clear that the challenges facing dental education in America cannot and will not be adequately addressed with anything less than a national response. Our Legacy - Our Future is creating greater visibility about the challenges facing dental education while showcasing the opportunities and various fundraising campaigns of its partner organizations.

Resolution

31. Resolved, that the ADA House of Delegates encourages all constituent and component societies to become an official partner in Dental Education: Our Legacy - Our Future.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 32 New ■ Substitute □ Amendment □

Report: NA Date Submitted: August 30, 2007

Submitted By: Fourteenth Trustee District

Reference Committee: Budget, Business and Administrative Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Create and Transfer Knowledge (Required)

ADA PRESENTATION SHARING INFRASTRUCTURE

The following resolution was submitted by the Fourteenth Trustee District and transmitted on August 30, 2007, by Mr. Monte Thompson, secretary.

Background: Every day ADA staff and volunteers present information at meetings, conferences and other occasions. The material presented represents the work of many talented individuals and valuable ADA resources, however in many cases only a small fraction of the number of people that would benefit by the information actually get to see it. Since many of these presentations are prepared in a digital format like PowerPoint, there are many circumstances in which they could be readily shared with select expanded audiences via the Internet. Simple audio and video data are also readily distributed digitally. While creating protocols and infrastructure for presentation sharing will require effort and some investment, the value to the Association, constituents and members should offset the effort and cost-sharing arrangements should also be considered. The Association already shares some presentation materials on a limited basis, but it is inconsistent, at best. Developing an infrastructure to facilitate sharing and manage the costs, will encourage the various agencies of the Association to anticipate the expanded audiences in their planning and format presentations for subsequent distribution.

Resolution

32. Resolved, that the appropriate ADA agencies prepare a plan to facilitate routine sharing of presentations via the Internet to appropriate selected audiences; this plan should include guidelines for the content, type of audience, protocols for preparation and distribution, and technical considerations including cost recovery.

BOARD COMMENT: The Board appreciates the value of information sharing consistent with building tripartite knowledge-based decision-making capacity. The Board supports the intent of the resolution to prepare a plan that would identify appropriate guidelines to enhance ADA information-sharing. In order to ensure the feasibility of the plan, the Board recommends clarifying language to assist ADA agencies in developing a feasible, useful plan.

Therefore, the Board recommends the following substitute resolution.

32B. Resolved, that to increase tripartite knowledge-based decision-making, the appropriate ADA agencies, with input from tripartite dental organizations, prepare a plan to facilitate sharing of, as feasible, ADA-developed presentations via the Internet to appropriate selected audiences; this plan should include guidelines for the content, type of audience, protocols for preparation and distribution, and technical considerations including cost recovery.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

File 4: Res. 32-Pgs. 2064-2065

Board Vote:

Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CADLE	■	☐	☐	☐	GRAMMER	■	☐	☐	☐	SCHWEINEBRATEN
■	☐	☐	☐	CALNON	■	☐	☐	☐	GROVER	■	☐	☐	☐	SMITH C.
■	☐	☐	☐	FELDMAN	■	☐	☐	☐	KELL	■	☐	☐	☐	STRATHEARN
■	☐	☐	☐	FINDLEY	■	☐	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SYKES
■	☐	☐	☐	GIST	■	☐	☐	☐	MANNING	■	☐	☐	☐	TANKERSLEY
■	☐	☐	☐	GLECOS	■	☐	☐	☐	NICOLETTE	■	☐	☐	☐	WEBB
■	☐	☐	☐	GLOVER	■	☐	☐	☐	SCHWARTZ					Res. 32B

Resolution No. 56 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 27, 2007

Submitted By: Third Trustee District

Reference Committee: Budget, Business and Administrative Matters

Total Financial Implication: $200,000

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

INCREASE IN VOLUNTEER PER DIEM

The following resolution was submitted by the Third Trustee District and transmitted on September 27, 2007, by Dr. Gary Davis, caucus secretary.

Background: The ADA is fortunate to have a dedicated group of volunteers that spend hours at preparation, travel, and meetings taking time away from family and practice to do the work of our Association, our profession, and the patients we serve.

In 1998, nine years ago, the per diem was increased from $60 to $75. At that time the Association's budget was $64,512,300. The percentage of the annual budget related to volunteer per diem was .008%. The annual budget for 2008 is approximately $114,000,000. The percent of this budget related to volunteer per diem is .005%.

It should be noted, for comparison sake, that in 1998 gasoline prices were $1.19 per gallon, and a postage stamp cost $.32. During that time the ADA budget has almost doubled.

The federal government's per diem is $140 per day.

Since our Association respects the volunteers and the work they do, both at home and at meetings, the Third Trustee District offers the following resolution:

Resolution

56. Resolved, that starting with the 2008 budget the Board of Trustees be urged to increase the ADA volunteers' per diem to $100.

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

Resolution No. 59 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 28, 2007

Submitted By: 16th Trustee District

Reference Committee: Budget, Business and Administrative Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

ADA RESERVES

The following resolution was submitted by the Sixteenth Trustee District and transmitted on September 28, 2007, by Mr. Phil Latham, executive director, South Carolina Dental Society.

Background: In 2005 the House adopted Resolution 26H-2005, setting the uncommitted Reserves level target at 40% of the annual operating budget. In addition, the excess over the target should be considered in developing the following year's operating budget consistent with the long-term financial strategy of "dues stabilization" (which means maintaining, dues increases at roughly inflation levels-not using all monies over 40% towards abating dues increases).

Consider the following facts:

- Reserves are strong at this time – more than 50% of the 2007 budget and potentially almost 49% of the 2008 budget even with the D.C. building renovation project funded by reserves.
- More than 50% of the 2008 budget is being funded by non dues revenue.
- The returns on ADA invested monies are returning near 14% - every $2 million left to earn at this rate saves EVERY ADA Member $2.50 in dues increases EVERY YEAR.
- According to American Society of Association Executives (ASAE), most large nation wide associations maintain reserves at 50-75%.

Now that ADA reserves are strong, this is a great opportunity to become even stronger, therefore, be it

Resolution

59. Resolved, that the Board be urged to maintain the ADA's liquid reserves at a targeted level of 50% of the Association's annual budgeted operating expenses, and to consider any excess in developing the following year's annual operating budget consistent with a long-term strategy of dues stabilization taking into consideration any known contingent use of reserves. Liquid reserves are defined as the total uncommitted balance of the Reserve Division Investment Account, and be it further

Resolved, that Resolution 26H-2005, Association Reserve Policy (*Trans.* 2005:294), be rescinded.

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

Resolution No. 59S-1 Citation for Original Resolution: Blue: 2067

Submitted By: Eighth Trustee District Date Submitted: Sept. 30, 2007

Substitute ■ Amendment □

Reference Committee Report On: Budget, Business and Administrative Matters

Financial Implications (if different from original resolution): $

SUBSTITUTE FOR RESOLUTION 59: ADA RESERVES

The following substitute for Resolution 59 (Worksheet:2072) was adopted by the Eighth Trustee District and submitted on September 30, 2007, by Dr. H. Todd Cubbon, delegate.

Resolution

59S-1. Resolved, that the Board be urged to maintain the ADA's ~~liquid~~ reserves at a targeted level of 50% of the Association's annual budgeted operating expenses, and to consider any excess in developing the following year's annual operating budget consistent with a long-term strategy of dues stabilization taking into consideration any known contingent use of reserves, ~~Liquid reserves are defined as the total uncommitted balance of the Reserve Division Investment Account,~~ and be it further

Resolved, that the Board perform a study of the reserve policy that would include, but not be limited to, the following considerations: the appropriate target level or range, the definition of what should be included in the calculation, a risk assessment of the types of contingencies and future financial needs that could be funded from reserves. ~~and be it further~~

~~**Resolved,** that Resolution 26H-2005, Association Reserve Policy (*Trans.* 2005:294), be rescinded.~~

Communications and Membership Services

Resolution No. 10 New ■ Substitute □ Amendment □

Report: Joint Report of the Council on Membership and Council on Ethics, Bylaws and Judicial Affairs Date Submitted: June 2007

Submitted By: Council on Membership and Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: Communications and Membership Services

Total Financial Implication: $35,624 annually

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Build Dynamic Communities (Required)

JOINT REPORT OF THE COUNCIL ON MEMBERSHIP AND COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS: RESPONSE TO RESOLUTION 32H-2006 ON THE MEMBERSHIP STUDY PROPOSALS APPROVED FOR DEVELOPMENT AS ADA BYLAWS CHANGES

Background: This being transmitted for consideration at the 2007 House of Delegates and is being shared with the Board of Trustees for review and comment.

Response to Resolution 32H-2006 on the Membership Study Proposals Approved for Development as ADA *Bylaws* Changes: By adoption of Resolution 32H-2006 (*Trans*.2006:310), the House of Delegates approved the development of proposed ADA *Bylaws* amendments to implement the approaches presented by the Council on Membership pursuant to its comprehensive, multi-year Membership Study Proposal and Report (*Supplement*.2006:3015).

32H-2006. Resolved, that the Membership Study Proposal containing the following comprehensive approach to ensure that the ADA anticipates current issues facing the dental profession and future trends be approved as a proposal for further development:

- Dentist Member as proposed by the membership study proposal
- Graduate Student as proposed by the membership study proposal
- Supporting Professional Member, as proposed by the membership study proposal
- Pre-doctoral Student, as proposed by the membership study proposal
- Other Elements, as proposed by the membership study proposal

and be it further

Resolved, that the Council on Ethics, Bylaws and Judicial Affairs, in consultation with the Council on Membership, as needed, develop *Bylaws* changes that will be consistent with the Membership Study Proposal for consideration by the 2007 House of Delegates, and be it further

Resolved, that the constituent and component societies be urged to create parallel membership categories to mirror those available at the ADA level, and be it further

Resolved, that the concept of a Dental Team (non-dentist Member) category of the membership be referred to the appropriate ADA agency for further study and report its recommendations to the 2007 ADA House of Delegates.

Through this report, the 2007 House of Delegates is asked to consider and approve the proposed changes to Chapters I, X and XII of ADA *Bylaws*, which are attached to this report as Appendix 1. The Dental Team membership concept, which was referred for further study in the fourth resolving clause of Resolution 32H-2006, is not addressed herein. That concept will be addressed by the Council on Membership in its supplemental report to the House of Delegates.

For context, it may be useful to briefly summarize the purpose and approach provided in the 2006 Membership Study Proposal. The study was initially prompted by growing numbers of requests from member dentists who expressed interest in including prominent dental researchers and other professional colleagues as part of ADA membership to encourage meaningful input into the profession's future. Further, the Council on Membership sought to position the ADA as a membership organization that welcomes a broad spectrum from the dental community to ensure that these wider communities lend their perspectives, voices and support to ADA initiatives related to community, advocacy, knowledge and standards. In the Membership Study Proposal, the Council proposed flexible yet lasting changes for the ADA *Bylaws* to take into account current and future membership issues and to ensure that the ADA *Bylaws* supported the strategic direction of the ADA. The Council also determined, as part of the Membership Study process, to review Chapter I. Membership, of the ADA *Bylaws,* as a whole with an aim to streamlining the *Bylaws* to facilitate tripartite administration of the ADA *Bylaws*.

Key changes approved for development by the 2006 House of Delegates involve: creation of a new membership category for nonpracticing dentists, expansion of the reduced dues program for graduates, a new approach to waivers based on financial need only (this eliminates disability waivers with an exemption provision for those members currently granted such waivers), and a strategic promotional incentive (perhaps for a time-limited dues reduction for a specific membership category such as faculty) pending Board approval. The proposal also includes waiving the dues for dentists working for charitable organizations (dues are currently $5.00 for such members).

The Council on Ethics, Bylaws and Judicial Affairs developed draft ADA *Bylaws* changes that were shared with the Council on Membership for review and comment. Each Council reviewed and approved the changes proposed in Appendix 1.

The following is an explanation of the changes reflected in Appendix 1, organized by chapter, sections and subsections of the ADA *Bylaws*.

Chapter I. MEMBERSHIP

Section 10. CLASSIFICATION.

- A new category of "nonpracticing dentists" is added.
- The Councils considered but rejected changing the title "associate" to "supporting member" due to concern the change would be confusing since there already is an associate membership category.

Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS,

Subsection A. ACTIVE MEMBER, subsection a. QUALIFICATIONS.

- This subsection sets out three categories of "direct" membership: dentists in the federal dental services, dentists practicing outside the United States, and nonpracticing dentists with U.S. licenses. Paragraph breaks and parenthetical numbering were added for clarity. The sentences pertaining to the federal dentist were repositioned, but no changes were made in the text. To avoid confusion with the new category of nonpracticing dentists, the term and applicable text regarding nonpracticing dentists is stricken.
- A new explanatory note explains the term direct member, which appears in several places in the *Bylaws*.

Subsection A. ACTIVE MEMBER, subsection c. DUES AND SPECIAL ASSESSMENTS.

- (1) Changes expand the reduced dues program to permit graduate students to place on hold their reduced dues schedule until they complete the graduate program.

- (3) The provision providing a dues reduction for dentists working for charitable organizations is deleted because such members will pay $0 dues (100% dues waiver). This provision was repositioned under Section 50 as a dues waiver. Sections that follow are renumbered accordingly.

- (5) This is a new condition which addresses strategic promotional incentives authorized by the Board of Trustees.

[New] Subsection D. NONPRACTICING DENTIST MEMBER.

- This new provision provides for direct membership and would move to tripartite membership, if and when available.
- Eligibility is conditioned on the following: the dentist must have a dental degree from any country; must reside in the U.S. or territories, but not be licensed in the U.S.; cannot be delivering patient care as a dentist for remuneration; or have a U.S. license that is revoked. (Examples include researchers, administrators, faculty, consultants and corporate employees and graduates of non-U.S. dental schools who may be going through the licensure process in the U.S as a dental team member)
- Dues: 50% of full active member dues
- Benefits: all benefits afforded active members
- Representation: Shall be eligible for election by the House of Delegates as a member of any council. Also eligible for appointment by the Board of Trustees as an additional member to any council, if the council requests such a representative and the Board of Trustees approves it. A cross reference to this section regarding additional council membership was added to Chapter X, Section 20A.
- In addition, nonpracticing dentist membership is added to the requirements set forth in Chapter X, Section 30E for the recipient of the Gold Medal Award for Excellence in Dental Research as to eligibility for service on the Council on Scientific Affairs. An exemption is provided for the incumbent 2006 recipient
- Re-lettered Subsections D through H as E through I, respectively.

Subsection E. STUDENT MEMBER, subsection a. QUALIFICATIONS.

- Added new text to reflect inclusion of international dental students.

Section 30. DEFINITION OF "IN GOOD STANDING" (Second Paragraph).

- Added clarifying language regarding dues waivers as applied to the definition of in good standing.
- The language regarding disability waivers is deleted. An exemption provision for those members currently granted such waivers are added to Section 50.

Section 40. LAPSE OF MEMBERSHIP AND REINSTATEMENT.

Subsection B. REINSTATEMENT.

- This line is expanded to include non-practicing dentists.

Section 50. DUES OR SPECIAL ASSESSMENT RELATED ISSUES.

[New] Subsection D. WAIVERS FOR ACTIVE MEMBERS WORKING FOR A CHARITABLE ORGANIZATION.

- This is a new waiver for charitable dentists.

Chapter X. COUNCILS
Chapter XII. PRINCIPLES OF ETHICS, BYLAWS AND JUDICIAL AFFAIRS

- Removal of the parenthetical language defining the term direct member.

- The words "a member in good standing who pursuant to Chapter I of these *Bylaws* does not hold membership in any constituent society of this Association" are stricken from the provisions cited below. This term is defined in the section titled explanatory notes under Section 20 of this Chapter.
    - Chapter X. COUNCILS, *Section 120*. DUTIES, Subsection G. COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS, subsection e.
    - Chapter XII. PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT AND JUDICIAL PROCEDURE, *Section 20*. DISCIPLINE OF MEMBERS, Subsection A. CONDUCT SUBJECT TO DISCIPLINE and Subsection D. APPEALS.

Based on the foregoing, the Councils are pleased to forward the following resolution to the House of Delegates:

Resolution

10. Resolved, that Chapter I, Chapter X and Chapter XII of the ADA *Bylaws* be amended in accordance with Appendix 1 of the Joint Report of the Council on Membership and the Council on Ethics, Bylaws and Judicial Affairs, and be it further

Resolved, that the foregoing changes in the ADA Bylaws take effect January 1, 2008.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

APPENDIX 1: PROPOSED AMENDMENTS FOR CHAPTERS I, X AND XII OF THE ADA *BYLAWS*

Note: New language is underscored, deletions are ~~stricken through.~~

CHAPTER I. MEMBERSHIP

Section 10. CLASSIFICATION: The members of this Association shall be classified as follows:

Active Members
Life Members
Retired Members
Nonpracticing Dentist Members
Student Members
Honorary Members
Provisional Members
Associate Members
Affiliate Members

Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS:

A. ACTIVE MEMBER.

a. QUALIFICATIONS. An active member shall be a dentist who is licensed to practice dentistry (or medicine provided the physician has a D.D.S. or D.M.D. or equivalent dental degree) in a state or other jurisdiction of the United States and shall be a member in good standing of this Association as that is defined in these *Bylaws*. In addition, a dentist shall be a member in good standing of this Association's constituent and component societies, unless:

(1) the dentist is in the exclusive employ of, or is serving on active duty in, one of the federal dental services~~,~~. A dentist is considered to be in the exclusive employ of one of the federal dental services when the dentist is under contract to provide dental services to the beneficiaries of the federal agency on a full-time basis and does not engage in private practice within the jurisdiction of a constituent or component society;

(2) the dentist is practicing in a country other than the United States and consequently is ineligible for membership in a constituent or component society; or

(3) the dentist is ~~a nonpracticing dentist. A dentist is considered to be in the exclusive employ of one of the federal dental services when the dentist is under contract to provide dental services to the beneficiaries of the federal agency on a full-time basis and does not engage in private practice within the jurisdiction of a constituent or component society. A dentist is considered to be a nonpracticing dentist when the dentist works~~ working as a dental school faculty member, dental administrator or consultant within the territorial jurisdiction of a constituent society and is ineligible for active membership in the constituent or component society because the dentist is not licensed in the territorial jurisdiction of that constituent.

Explanatory Notes: The term "other jurisdiction of the United States" as used in this *Constitution and Bylaws* shall mean the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the

Northern Mariana Islands and the territories of the United States Virgin Islands, Guam and American Samoa.

The term "federal dental services" as used in this C*onstitution and Bylaws* shall mean the dental departments of the Air Force, the Army, the Navy, the Public Health Service, the department of Veterans Affairs and other federal agencies.

The term "direct member" as used in this *Constitution and Bylaws* shall mean a member in good standing who pursuant to Chapter I of these *Bylaws* does not hold membership in any constituent society of this Association.

b. PRIVILEGES.

(1) An active member in good standing shall receive annually a membership card and *The Journal of the American Dental Association*, the subscription price of which shall be included in the annual dues. An active member shall be entitled to attend any scientific session of this Association and receive such other services as are provided by the Association.

(2) An active member in good standing shall be eligible for election as a delegate or alternate delegate to the House of Delegates and for election or appointment to any office or agency of this Association, except as otherwise provided in these *Bylaws.*

(3) An active member under a disciplinary sentence of suspension shall not be privileged to hold office, either elective or appointive, including delegate and alternate delegate, in such member's component and constituent societies and this Association, or to vote or otherwise participate in the selection of officials of such member's component and constituent societies and this Association.

c. DUES AND SPECIAL ASSESSMENTS.

Beginning January 1, 2006, and each year thereafter, the dues of active members shall be the amount established annually by the House of Delegates in accordance with the procedure set forth in Chapter V, Section 130Ad of these *Bylaws*. In addition to their annual dues, active members shall pay any special assessments levied by the House of Delegates, due January 1 of each year. However, any dentist, who satisfies the eligibility requirements for active membership and any of the following conditions shall be entitled to pay the reduced active member dues and any special assessment stated under such satisfied condition so long as that dentist maintains continuous membership, subject to the further reductions permitted under the provisions of Chapter I, Section 20Ad of these *Bylaws*:

(1) Dentists, when awarded a D.D.S. or D.M.D. degree, shall be exempt from the payment of active member dues and any special assessment for the remaining period of that year and the following first full calendar year. Dentists shall pay twenty-five percent (25%) of active member dues and special assessment for the second full calendar year following the year in which the degree was awarded, fifty percent (50%) of active member dues and special assessment in the third year, seventy-five percent (75%) of active member dues and special assessment in the fourth year and one hundred percent (100%) in the fifth year and thereafter. Eligibility for this benefit shall be conditioned on maintenance of continuous membership or payment of reduced dues and special assessment(s) for the years not previously paid, at the rates current during the missing year(s).*

(2) The dentist who is engaged full-time in (a) an advanced training course of not less than one (1) academic year's duration in an accredited school or a residency program in areas neither recognized by

this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall pay thirty dollars ($30.00) due on January 1 of each year until December 31 following completion of such program. For the dentist who enters such a course or program ~~within one (1) year of the award of D.D.S. or D.M.D. degree~~ while eligible for the ~~applicable~~ dues reduction program set forth in the foregoing condition (1), the applicable reduced dues rate shall be tolled until completion of that program. Upon completing the program, the dentist shall pay dues and any special assessments for active members at the reduced dues rate where the dentist left off in the progression ~~next period in time level that is applicable~~ under condition (1). Eligibility for this benefit shall be conditioned on maintenance of continuous membership or payment of post-graduate student dues and active member dues and special assessment(s) for years not previously paid, at the rates current during the missing years. The dentist who is engaged full-time in (a) an advanced training course of not less than one (1) academic year's duration in an accredited school or residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall be exempt from the payment of any active member special assessment then in effect through December 31 following completion of such course or program.

~~(3) An active member who is serving the profession by working full-time for a charitable organization and is receiving neither income nor a salary for such charitable service other than a subsistence amount which approximates a cost of living allowance shall pay dues of five dollars ($5.00) due January 1 of each year, and shall be exempt from the payment of any special assessment then in effect through December 31 following completion of such service; provided that such charitable service is being performed continuously for not less than one year and provided further that such member does not supplement such subsistence income by the performance of services as a member of the faculty of a dental or dental auxiliary school, as a dental administrator or consultant, or as a practitioner of any activity for which a license to practice dentistry or dental hygiene is required.~~

(3) A graduate of a non-accredited dental school who has recently been licensed to practice dentistry in a jurisdiction in which there is a constituent dental society of the American Dental Association shall be exempt from payment of active member dues and any special assessment for the remaining period of the year in which the license was issued and the following first full calendar year. The newly licensed graduate of a non-accredited school shall pay twenty-five percent (25%) of active member dues and any special assessment the second calendar year following the year in which the license was obtained, fifty percent (50%) of active member dues and any special assessment in the third year, seventy-five percent (75%) of active member dues and any special assessment in the fourth year and one hundred (100%) in the fifth year and thereafter.*

* This footnote clarifies the expansion of the reduced dues program approved by the 2003 House of Delegates. Only new dental school graduates and newly licensed dentists of non-accredited dental schools entering the reduced dues program in 2004 or thereafter are eligible for the expanded reduced dues program at the progression set forth in these *Bylaws* under conditions 1 and 4. Dentists who entered the reduced dues program prior to 2004 continue their progression to next applicable rate. That progression is as follows: twenty-five percent (25%) of active member dues and special assessment for the first full calendar year following graduation from an accredited dental school or the year in which the license was obtained for graduates of non-accredited dental schools, fifty percent (50%) of active member dues and special assessment in the second year, seventy-five (75%) of active member dues and special assessment in the third year and one

(~~5~~4) A licensed dentist who has never been an active member of this Association and is ineligible for dues reduction as a new graduate under this Section of the *Bylaws*, shall pay fifty percent (50%) of active member dues and any special assessment in the first year of membership, and shall pay one hundred percent (100%) of active member dues and any special assessment in the second year and each year thereafter.

(5) The Board of Trustees may authorize limited dues reduction, up to fifty percent (50%) of active member dues and special assessment(s), for the purposes of promoting membership in target markets through marketing campaigns recommended by the Council on Membership.

d. ACTIVE MEMBERS SELECTED AFTER JULY 1 AND OCTOBER 1. Those members selected to active membership in this Association after July 1, except for those whose membership has lapsed for failure to pay the current year's dues and/or special assessments, shall pay one half (1/2) of the current year's dues and one half (1/2) of any active member special assessment then in effect, and those selected after October 1, shall be exempt from the payment of the current year's dues and any active member special assessment then in effect on a one-time only basis.

B. LIFE MEMBER.

a. QUALIFICATIONS. A life member shall be a member in good standing of this Association who (1) has been an active and/or retired member in good standing of this Association for thirty (30) consecutive years or a total of forty (40) years of active and/or retired membership or has been a member of the National Dental Association for twenty-five (25) years and subsequently held at least ten (10) years of membership in the American Dental Association; (2) has attained the age of sixty-five (65) years in the previous calendar year; and (3) has submitted an affidavit attesting to the qualifications for this category through said component and constituent societies, if such exist.

A dentist who immigrated to the United States may receive credit for up to twenty-five (25) consecutive or total years of membership in a foreign dental association in order to qualify for the respective requirements for life membership.

Years of student membership shall not be counted as active membership for purposes of establishing eligibility for life membership unless the dentist was an active member in good standing prior to becoming a student member.

The Association will give notification to members who are eligible for life membership. Life membership shall be effective the calendar year following the year in which the requirements are fulfilled. Maintenance of membership in good standing in the member's constituent and component societies, if such exist, shall be a requisite for continuance of life membership in this Association.

b. PRIVILEGES. A life member in good standing of this Association shall receive annually a membership card. A life member shall be entitled to all the privileges of an active member, except that a retired life member shall not receive *The Journal of the American Dental Association* except by subscription.

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hundred percent (100%) in the fourth year and thereafter. Such reductions are conditioned on maintenance of continuous membership or payment of dues and special assessment(s) for the years not previously paid at the rates current during the missing years. This footnote shall expire at adjournment *sine die* of the 2007 House of Delegates.

A life member under a disciplinary sentence of suspension shall not be privileged to hold office, either elective or appointive, including delegate and alternate delegate, in such member's component and constituent societies and this Association, or to vote or otherwise participate in the selection of officials of such member's component and constituent societies and this Association.

c. DUES AND SPECIAL ASSESSMENTS.

(1) ACTIVE LIFE MEMBERS. Regardless of a member's previous classification of membership, the dues of life members who have not fulfilled the qualifications of retired membership pursuant to Chapter I, 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 1 of each year. In addition to their annual dues, active life members shall pay fifty percent (50%) of any active member special assessment levied by the House of Delegates, due January 1 of each year.

(2) RETIRED LIFE MEMBERS. Life members who have fulfilled the qualifications of Chapter I, Section 20C of these *Bylaws* with regard to income related to dentistry shall be exempt from payment of dues and any special assessment levied by the House of Delegates.

(3) ACCEPTANCE OF BACK DUES AND SPECIAL ASSESSMENTS. For the purpose of establishing continuity of active membership to qualify for life membership, back dues and special assessments, except as otherwise provided in these *Bylaws*, shall be accepted for not more than the three (3) years of delinquency prior to the date of application for such payment. The rate of such dues and/or special assessments, except as otherwise provided in these *Bylaws*, shall be in accordance with Chapter I, Section 40 of these *Bylaws*.

For the purpose of establishing continuity of active membership in order to qualify for life membership, an active member, who had been such when entering upon active duty in one of the federal dental services but who, during such federal dental service, interrupted the continuity of active membership because of failure to pay dues and/or special assessments and who, within one year after separation from such military or equivalent duty, resumed active membership, may pay back dues and special assessments for any missing period of active membership at the rate of dues and/or special assessments current during the missing years of membership.

C. RETIRED MEMBER.

a. QUALIFICATIONS. A retired member shall be an active member in good standing of this Association who is now a retired member of a constituent society, if such exists, and is no longer earning income from the performance of any dentally related activity, and has submitted an affidavit attesting to qualifications for this category through said component and constituent society, if such exist. Maintenance of active or retired membership in good standing in the member's component society and retired membership in good standing in the member's constituent, if such exist, entitling such member to all the privileges of an active member, shall be requisite for entitlement to and continuance of retired membership in this Association.

b. PRIVILEGES. A retired member in good standing shall receive annually a membership card. A retired member shall be entitled to all the privileges of an active member.

A retired member under a disciplinary sentence of suspension shall not be privileged to hold office, either elective or appointive, including delegate and alternate delegate, in such member's component and

constituent societies and this Association, or to vote or otherwise participate in the selection of officials of such member's component and constituent societies and this Association.

c. DUES AND SPECIAL ASSESSMENTS. The dues of retired members shall be twenty-five percent (25%) of the dues of active members, due January 1 of each year. In addition to their annual dues, retired members shall pay twenty-five percent (25%) of any active member special assessment levied by the House of Delegates, due January 1 of each year.

~~E~~D. NONPRACTICING DENTIST MEMBER.

a. QUALIFICATIONS. A nonpracticing dentist member shall be a dentist who is ineligible for any other classification of membership and:

(1) has a dental degree from any country;

(2) resides in the United States or its territories;

(3) does not hold a dental license in the United States nor has a revoked U.S. dental license;

(4) is not delivering patient care as a dentist for remuneration; and

(5) is a member in good standing of this Association, and the Association's constituent and component societies, if such exists.

b. PRIVILEGES.

(1) A nonpracticing dentist member in good standing shall receive annually a membership card and *The Journal Of The American Dental Association*, the subscription price of which shall be included in the annual dues. A nonpracticing dentist member shall be entitled to attend any scientific session of this Association and receive such other services as are authorized by the Association.

(2) A nonpracticing dentist member in good standing shall be eligible for election to any council.

(3) A nonpracticing dentist member shall also be eligible for appointment as an additional member to any council, provided the council requests such additional nonpracticing membership representation and the Board of Trustees approves the council's request. Such members shall be appointed by the Board of Trustees. The tenure of an additional council member shall be one (1) term of four (4) years.

(4) A nonpracticing dentist member under a disciplinary sentence of suspension shall not be privileged to serve as a member of any council.

c. DUES AND SPECIAL ASSESSMENTS. The dues of nonpracticing dentists shall be fifty percent (50%) of the dues of active members, due January 1 of each year. In addition to their annual dues, nonpracticing dentists shall pay fifty percent (50%) of any active member special assessment levied by the House of Delegates, due January 1 of each year.

~~D~~E. STUDENT MEMBER.

a. QUALIFICATIONS. A student member shall be ~~either~~ a predoctoral student of a dental school accredited by the Commission on Dental Accreditation of this Association, a predoctoral student of a dental school listed in the World Directory of Dental Schools compiled by the FDI World Federation or a dentist

eligible for membership in this Association who is engaged full time in an advanced training course of not less than one academic year's duration in an accredited school or residency program.

b. PRIVILEGES. A student member in good standing of this Association shall receive annually a membership card and *The Journal of the American Dental Association,* the subscription price of which shall be included in the annual dues. A student member shall be entitled to attend any scientific session of this Association.

A student member under a disciplinary sentence of suspension shall not be privileged to serve as the American Student Dental Association's delegate or alternate delegate in this Association's House of Delegates.

c. DUES AND SPECIAL ASSESSMENTS.

(1) PREDOCTORAL STUDENT MEMBERS: The dues of predoctoral student members shall be five dollars ($5.00) due January 1 of each year. Such student members shall be exempt from the payment of any special assessment levied by the House of Delegates.

(2) POSTDOCTORAL STUDENTS AND RESIDENTS: The dues of dentists who are student members pursuant to Chapter I, Section 20E shall be thirty dollars ($30.00) due January 1 of each year. Such student members shall be exempt from the payment of any special assessment levied by the House of Delegates.

(3) Student membership terminates on December 31 after graduation or after completion of a residency or graduate work.

~~E~~F. HONORARY MEMBER.

a. QUALIFICATIONS. An individual who has made outstanding contributions to the advancement of the art and science of dentistry, upon election by the Board of Trustees, shall be classified as an honorary member of this Association.

b. PRIVILEGES. An honorary member shall receive a membership card and *The Journal of the American Dental Association.* An honorary member shall be entitled to attend any scientific session of this Association and receive such other services as are authorized by the Board of Trustees.

c. DUES AND SPECIAL ASSESSMENTS. Honorary members shall be exempt from payment of dues and any special assessment levied by the House of Delegates.

~~F~~G. PROVISIONAL MEMBER.

a. QUALIFICATIONS. A provisional member shall be a dentist who:

(1) has received a D.D.S. or D.M.D. degree from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or shall be a graduate of an unaccredited dental school who has recently been licensed to practice dentistry in a jurisdiction in which there is a constituent dental society;

(2) has not established a place of practice; and

(3) shall have applied for provisional membership within 12 months of graduation or licensure.

Provisional membership shall terminate December 31 of the second full calendar year following the year in which the degree was awarded.

b. PRIVILEGES. A provisional member in good standing shall be entitled to all the privileges of an active member except that, notwithstanding anything in these *Bylaws* to the contrary, a provisional member shall have no right to appeal from a denial of active membership in the Association.

A provisional member under a disciplinary sentence of suspension shall not be privileged to hold office, either elective or appointive, including delegate and alternate delegate, in such member's component and constituent societies and this Association, or to vote or otherwise participate in the selection of officials of such member's component and constituent societies and this Association.

c. DUES AND SPECIAL ASSESSMENTS. The dues and/or special assessments of provisional members shall be the same as the dues and/or special assessments of active members.

~~G~~H. ASSOCIATE MEMBER.

a. QUALIFICATIONS. An associate member shall be a person ineligible for any other type of membership in this Association, who contributes to the advancement of the objectives of this Association, is employed in dental-related education or research, does not hold a dental license in the United States, and has applied to and been approved by the Board of Trustees.*

b. PRIVILEGES. An associate member in good standing shall receive annually a membership card and *The Journal of the American Dental Association*, the subscription price of which shall be included in the annual dues. An associate member shall be entitled to attend any scientific session of this Association and receive such other services as are authorized by the Board of Trustees.

c. DUES AND SPECIAL ASSESSMENTS. The dues of associate members shall be twenty-five percent (25%) of the dues of active members, due January 1 of each year. In addition to their annual dues, associate members shall pay twenty-five percent (25%) of any active member special assessment levied by the House of Delegates, due January 1 of each year.

~~H~~I. AFFILIATE MEMBER.

a. QUALIFICATIONS. An affiliate member shall be a dentist who is ineligible for any other classification of membership and:

(1) is practicing in a country other than the United States;

(2) has been classified as an affiliate member upon application to and approval by the Board of Trustees; and

(3) is a member in good standing of this Association.

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* Individuals who are classified as associate members of this Association prior to the 1996 annual session of the House of Delegates but who are not employed full-time in dentally-related education or research by an accredited institution of higher education, may maintain their associate membership so long as other eligibility requirements are met and current dues and special assessments are paid.

b. PRIVILEGES. An affiliate member in good standing shall receive annually a membership card, have access to the members-only content areas of ADA.org, be entitled to attend any scientific session of this Association, purchase items through the ADA Catalog at the member rate and receive such other services as are authorized by the Board of Trustees.

c. DUES AND SPECIAL ASSESSMENTS. The dues of affiliate members shall be twelve dollars ($12.00) for those members practicing in least developed and low income countries eligible for special fee criteria as established by the Fédération Dentaire Internationale and seventy-five dollars ($75.00) for other such members, due January 1 of each year. Affiliate members shall be exempt from the payment of any special assessment levied by the House of Delegates.

Section 30. DEFINITION OF "IN GOOD STANDING". A member of this Association whose dues and special assessments for the current year have been paid shall be in good standing; provided, however, that a member, to remain in good standing may be required under the bylaws of the member's constituent or component society, to meet standards of continuing education, pay special assessments, cooperate with peer review bodies or committees on ethics, or attend, if a newly admitted active member, a stated number of membership meetings between the date of admission and the completion of the first calendar year of active membership. If under a disciplinary sentence of suspension, such member shall be designated as a "member in good standing temporarily under suspension" until the member's disciplinary sentence has terminated.

The requirement of paying current dues does not apply to retired life, ~~and~~ honorary and those members of this Association who pursuant to Section 50 of this Chapter have been granted dues waivers for the purpose of determining their good standing. The requirement of paying special assessments does not apply to retired life, honorary, affiliate, ~~and~~ student and those members of this Association who pursuant to Section 50 of this Chapter have been granted special assessment waivers for purposes of determining their good standing. ~~A member of this Association who is disabled for a period of one year, is no longer earning income from the performance of dentally-related activity because of the disability, and who was a member in good standing at the time such disability was incurred, shall be exempt from the payment of dues and special assessments and shall be in good standing during the period of disability. A disabled member, in order to receive entitlement to dues and special assessments exemption, shall submit through the member's component and constituent societies, if such exist, to this Association a medical certificate attesting to disability and a certificate from said component and constituent societies, if such exist, attesting to this disability. During the period of exemption from dues and special assessments, further such certificates shall be presented on request to this Association.~~[*]

Section 40. LAPSE OF MEMBERSHIP AND REINSTATEMENT.

A. LAPSE OF MEMBERSHIP. Any member whose dues and special assessments have not been paid by March 31 of the current year shall cease to be a member of this Association. Further, an associate member who terminates employment in dental-related education or research shall cease to be an associate member of this Association December 31 of that calendar year.

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[*] ~~Members with disabilities incurred during active military duty who were granted dues and special assessment disability waivers prior to the 2002 annual session of the House of Delegates may continue to receive such waivers so long as they are unable to practice dentistry within the definition of these *Bylaws*. Members with disabilities other than those disabled during active military duty who were granted dues and special assessment disability waivers prior to the 2002 annual session of the House of Delegates may continue to receive such waivers, provided such members can submit further certification attesting to the disability, upon request of the Association, during the exemption period.~~

B. REINSTATEMENT. Reinstatement of active, life, ~~student,~~ retired, nonpracticing dentist, student or affiliate membership may be secured on payment of appropriate dues and special assessments of this Association by any former member and on compliance by any former member with the pertinent bylaws and regulations of the constituent and component societies involved and this Association.

Section 50. DUES OR SPECIAL ASSESSMENT RELATED ISSUES.

A. PAYMENT DATE AND INSTALLMENT PAYMENTS. Dues and special assessments 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 special assessment amount fully paid by June 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 special assessments to this Association and the applicable constituent or component dental society, if such exists, as soon as commercially feasible.

B. FINANCIAL HARDSHIP WAIVERS. Those members who have suffered a significant financial hardship that prohibits them from payment of their full dues and/or special assessments may be excused from the payment of fifty percent (50%), seventy-five percent (75%) or all of the current year's dues and/or special assessment(s) as determined by their constituent and component dental societies. The constituent and component society secretaries shall certify the reason for the waiver, and the constituent and component societies shall provide the same proportionate waiver of their dues as that provided by this Association.[*]

C. WAIVERS FOR ACTIVE MEMBERS TEMPORARILY ACTIVATED TO FEDERAL SERVICE. An active member in good standing who pursuant to Chapter I of these *Bylaws* holds membership in a constituent and component society and is temporarily called to active duty with a federal dental service on a non-career basis shall be exempt from the payment of dues to this Association during such military duty, but not to exceed a period of three years.

D. WAIVERS FOR ACTIVE MEMBERS WORKING FOR A CHARITABLE ORGANIZATION. An active member who is serving the profession by working full-time for a charitable organization and is receiving neither income nor a salary for such charitable service other than a subsistence amount which approximates a cost of living allowance shall be exempt from the payment of dues and any special assessment then in effect through December 31 following completion of such service provided that such charitable service is being performed continuously for not less than one (1) year and provided further that such member does not supplement such subsistence income by the performance of services as a member of the faculty of a dental or dental auxiliary school, as a dental administrator or consultant, or as a practitioner of any activity for which a license to practice dentistry or dental hygiene is required.

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[*] Members with disabilities who were granted dues and special assessment disability waivers prior to the 2007 House of Delegates may continue to receive such waivers provided they are unable to practice dentistry within the definition of these *Bylaws* and they submit through the member's component and constituent societies, if such exist, to this Association, a medical certificate attesting to the disability and a certificate from said component and constituent societies, if such exist, attesting to the disability, upon request of the Association, during the exemption period.

~~D~~E. CALCULATING PERCENTAGE DUES OR SPECIAL ASSESSMENTS. In establishing the dollar rate of dues or special assessments in this chapter expressed as a percentage of active member dues or special assessments, computations resulting in fractions of a dollar shall be rounded up to the next whole dollar.

Section 60. INTERIM SERVICES FOR APPLICANTS. A dentist who has submitted a complete application for active membership in this Association and the appropriate constituent and component societies, if such exist, may on a one-time, interim basis: receive complimentary copies of *The Journal of the American Dental Association* and the *ADA News*, have access to the ADA.org member-only content areas and purchase items at a member rate through the ADA Catalog. Such interim services shall terminate when the membership application has been processed or within six (6) months of the application submission, whichever is sooner. Applicants shall have no right of appeal from a denial of membership in the Association.

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CHAPTER X • COUNCILS

Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS

A. The composition of the councils of this Association shall be as follows: In addition, a council may request an additional member who shall be a nonpracticing dentist member appointed in accordance with Chapter I, Section 20Db of these *Bylaws*.

Section 30. ELIGIBILITY.

Subsection A

A. All members of councils must be active, life, ~~or~~ retired or nonpracticing dentist members in good standing of this Association except as otherwise provided in these *Bylaws*.

Subsection E.

E. To be eligible to serve on the Council on Scientific Affairs, the current recipient of the Gold Medal Award for Excellence in Dental Research shall be an active, life, ~~or~~ retired or nonpracticing dentist* member in good standing of this Association if the current recipient qualifies for such membership.

* The eligibility requirement for non-practicing dentist membership shall take effect upon completion of the 2006 Gold Medal Award for Excellence in Dental Research recipient's term on the Council on Scientific Affairs.

***Section 120*. DUTIES, Subsection G. COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS, subsection e.**

e. To discipline any of the direct members of this Association ~~(members in good standing who pursuant to Chapter I of these *Bylaws* do not hold membership in any constituent society of this Association)~~ in accordance with the requirements and procedures of Chapter XII of these *Bylaws*, using hearing panels composed of not less than three (3) of its elected members selected by the Council chair. The Council may adopt procedures governing the discipline of direct members of this Association ~~(members in good standing who pursuant to Chapter I of these *Bylaws* do not hold membership in any constituent society of this Association)~~ consistent with Chapter XII of these *Bylaws*, which may include the use of an investigating committee or individual to investigate any complaint

made against such member and report findings to the hearing panel concerning whether charges should issue.

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CHAPTER XII • PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT AND JUDICIAL PROCEDURE

***Section 20*. DISCIPLINE OF MEMBERS: Subsections A and D.**

A. CONDUCT SUBJECT TO DISCIPLINE. A member may be disciplined for (1) having been found guilty of a felony, (2) having been found guilty of violating the dental practice act of a state or other jurisdiction of the United States, (3) having been discharged or dismissed from practicing dentistry with one of the federal dental services under dishonorable circumstances, or (4) violating the *Bylaws*, the *Principles of Ethics and Code of Professional Conduct*, or the bylaws or code of ethics of the constituent or component society of which the accused is a member. For a member of a constituent society, disciplinary proceedings may be instituted by either the member's component or constituent society. Disciplinary proceedings against a direct member of this Association ~~(a member in good standing who pursuant to Chapter I of these *Bylaws* does not hold membership in any constituent society of this Association)~~ may be instituted by the Council on Ethics, Bylaws and Judicial Affairs of this Association…..

D. APPEALS. The accused member under sentence of censure, suspension or expulsion shall have the right to appeal from a decision of the accused's component society to the accused's constituent society by filing an appeal in affidavit form with the secretary of the constituent society. Such an accused member, or the component society concerned, shall have the right to appeal from a decision of the constituent society to the Council on Ethics, Bylaws and Judicial Affairs of this Association by filing an appeal in affidavit form with the Chair of the Council on Ethics, Bylaws and Judicial Affairs. Where the accused is a direct member of this Association, ~~(a member in good standing who pursuant to Chapter I of these *Bylaws* does not hold membership in any constituent society of this Association),~~ the accused member shall have the right of appeal from a disciplinary decision of a hearing panel of the Council on Ethics, Bylaws and Judicial Affairs to the Council by filing an appeal in affidavit form with the Chair of the Council on Ethics, Bylaws and Judicial Affairs. Members of the hearing panel shall not have the right to vote on the Council's decision on such an appeal

Resolution No. 10S-1 New ☐ Substitute ■ Amendment ☐

Report: Joint Report of the Council on Membership and Council on Ethics, Bylaws and Judicial Affairs Date Submitted: Sept. 17, 2007

Submitted By: Sixteenth Trustee District

Reference Committee: Communications and Membership Services

Total Financial Implication: $35,624

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Build Dynamic Communities (Required)

SUBSTITUTE FOR RESOLUTION 10: RESPONSE TO RESOLUTION 32H-2006 ON THE MEMBERSHIP STUDY PROPOSALS APPROVED FOR DEVELOPMENT AS ADA BYLAWS CHANGES

The following substitute resolution for Resolution 10 (Worksheet:3003) was submitted by the Sixteenth Trustee District and transmitted on September 17, 2007, by Mr. Phil Latham, executive director, South Carolina Dental Association

Background: The Sixteenth Trustee District requests that the following amendments to Appendix 1 as shown in the substitute resolution attached be accepted for consideration by the delegates (amendments shaded):

1. Page 3015c, amend by striking line 11

This and the following amendments eliminate the proposed Nonpracticing Dentist category.

2. Page 3015h, amend by striking lines 7-31

3. Page 3015l, lines 1-4, amend by striking "nonpracticing dentist" to read as follows:

B. REINSTATEMENT. Reinstatement of active, life, ~~student,~~ retired, ~~nonpracticing dentist~~, student or affiliate membership may be secured on payment of appropriate dues and special assessments of this Association by any former member and on compliance by any former member with the pertinent bylaws and regulations of the constituent and component societies involved and this Association.

4. Page 3015m, amend by striking lines 16-18

5. Page 3015m, lines 24-26, amend by striking "or nonpracticing dentist*" as follows:

E. To be eligible to serve on the Council on Scientific Affairs, the current recipient of the Gold Medal Award for Excellence in Dental Research shall be an active, life, ~~or~~ retired ~~or nonpracticing dentist*~~ member in good standing of this Association if the current recipient qualifies for such membership.

6. page 3015m, amend by striking lines 27-29

7. Page 3015f, amend by striking lines 5-7

This eliminates limited dues reductions recommended by the Council on Membership.

Resolution

10S-1. Resolved, that Chapter I, Chapter X and Chapter XII of the ADA *Bylaws* be amended in accordance with the Revised Appendix 1: Proposed Amendments for Chapters I, X and XII of the ADA *Bylaws*, and be it further

Resolved, that the foregoing changes in the ADA *Bylaws* take effect January 1, 2008.

BOARD COMMENT: The Board appreciates the consideration the Sixteenth District has given Resolution 10. After two years of study, the Council on Membership submitted a new approach to membership that makes changes to Chapter I of the ADA *Bylaws* enabling the ADA to be more inclusive. The 2006 House of Delegates adopted the membership concepts proposed by the Council on Membership, with the exception of membership for dental team members, which the House sent back to the Council for further study. Among the approved member concept changes, Resolution 10 allows for a group of dentists who, for various reasons, are not licensed, to belong to the ADA. These dentists might include for example: a small number of educators (likely deans); dentists who serve in corporate, executive, managerial or sales role; or researchers. Further, this group includes prominent dentists who are not licensed in the U.S. who may influence the overall dental profession and who have been recipients of prestigious honors for the contributions they have made to dentistry in some capacity. Currently, these dentists are ineligible for active membership or only eligible for an associate membership if they are in dental education or research. Approximately 8,619 dentists may be in this group.

The Board concurs with the Council that it is important to provide these opportunities to build inclusion and acknowledge fellow professionals as "dentist" members of the ADA.

Further, the concept proposed by the Council on Membership also includes a mechanism to offer a strategic promotional incentive that would enable the ADA to reach out to target groups—limiting receipt of the incentive to one-time per individual. For example, this might include a discount for all nonmember faculty who join the ADA during a limited time (e.g., one week, two weeks, one month, etc.) The incentive would mitigate the ADA's financial risk but still allow for limited discounts to target groups on a one-time basis. This could provide opportunities to test selected membership outreach strategies for positive tripartite membership goals.

BOARD RECOMMENDATION: Vote No.

Board Vote: Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
☐	■	☐	☐	CADLE	☐	■	☐	☐	GRAMMER	☐	■	☐	☐	SCHWEINEBRATEN
☐	■	☐	☐	CALNON	☐	■	☐	☐	GROVER	☐	■	☐	☐	SMITH C.
☐	■	☐	☐	FELDMAN	☐	■	☐	☐	KELL	☐	■	☐	☐	STRATHEARN
☐	■	☐	☐	FINDLEY	☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SYKES
☐	■	☐	☐	GIST	☐	■	☐	☐	MANNING	■	☐	☐	☐	TANKERSLEY
☐	■	☐	☐	GLECOS	☐	■	☐	☐	NICOLETTE	☐	■	☐	☐	WEBB
☐	■	☐	☐	GLOVER	☐	■	☐	☐	SCHWARTZ					Res. 10S-1

REVISED APPENDIX 1: PROPOSED AMENDMENTS FOR CHAPTERS I, X AND XII OF THE ADA *BYLAWS*

Note: New language is underscored, deletions are ~~stricken through.~~
Sixteenth District proposed amendments are identified by shading.

CHAPTER I. MEMBERSHIP

Section 10. CLASSIFICATION: The members of this Association shall be classified as follows:

Active Members
Life Members
Retired Members
~~Nonpracticing Dentist Members~~
Student Members
Honorary Members
Provisional Members
Associate Members
Affiliate Members

Section 20. QUALIFICATIONS, PRIVILEGES, DUES AND SPECIAL ASSESSMENTS:

A. ACTIVE MEMBER.

a. QUALIFICATIONS. An active member shall be a dentist who is licensed to practice dentistry (or medicine provided the physician has a D.D.S. or D.M.D. or equivalent dental degree) in a state or other jurisdiction of the United States and shall be a member in good standing of this Association as that is defined in these *Bylaws*. In addition, a dentist shall be a member in good standing of this Association's constituent and component societies, unless:

(1) the dentist is in the exclusive employ of, or is serving on active duty in, one of the federal dental services~~.~~; A dentist is considered to be in the exclusive employ of one of the federal dental services when the dentist is under contract to provide dental services to the beneficiaries of the federal agency on a full-time basis and does not engage in private practice within the jurisdiction of a constituent or component society;

(2) the dentist is practicing in a country other than the United States and consequently is ineligible for membership in a constituent or component society; or

(3) the dentist is ~~a nonpracticing dentist. A dentist is considered to be in the exclusive employ of one of the federal dental services when the dentist is under contract to provide dental services to the beneficiaries of the federal agency on a full-time basis and does not engage in private practice within the jurisdiction of a constituent or component society. A dentist is considered to be a nonpracticing dentist when the dentist works~~ working as a dental school faculty member, dental administrator or consultant within the territorial jurisdiction of a constituent society and is ineligible for active membership in the constituent or component society because the dentist is not licensed in the territorial jurisdiction of that constituent.

Explanatory Notes: The term "other jurisdiction of the United States" as used in this *Constitution and Bylaws* shall mean the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the

Northern Mariana Islands and the territories of the United States Virgin Islands, Guam and American Samoa.

The term "federal dental services" as used in this C*onstitution and Bylaws* shall mean the dental departments of the Air Force, the Army, the Navy, the Public Health Service, the department of Veterans Affairs and other federal agencies.

The term "direct member" as used in this *Constitution and Bylaws* shall mean a member in good standing who pursuant to Chapter I of these *Bylaws* does not hold membership in any constituent society of this Association.

b. PRIVILEGES.

(1) An active member in good standing shall receive annually a membership card and *The Journal of the American Dental Association*, the subscription price of which shall be included in the annual dues. An active member shall be entitled to attend any scientific session of this Association and receive such other services as are provided by the Association.

(2) An active member in good standing shall be eligible for election as a delegate or alternate delegate to the House of Delegates and for election or appointment to any office or agency of this Association, except as otherwise provided in these *Bylaws.*

(3) An active member under a disciplinary sentence of suspension shall not be privileged to hold office, either elective or appointive, including delegate and alternate delegate, in such member's component and constituent societies and this Association, or to vote or otherwise participate in the selection of officials of such member's component and constituent societies and this Association.

c. DUES AND SPECIAL ASSESSMENTS.

Beginning January 1, 2006, and each year thereafter, the dues of active members shall be the amount established annually by the House of Delegates in accordance with the procedure set forth in Chapter V, Section 130Ad of these *Bylaws*. In addition to their annual dues, active members shall pay any special assessments levied by the House of Delegates, due January 1 of each year. However, any dentist, who satisfies the eligibility requirements for active membership and any of the following conditions shall be entitled to pay the reduced active member dues and any special assessment stated under such satisfied condition so long as that dentist maintains continuous membership, subject to the further reductions permitted under the provisions of Chapter I, Section 20Ad of these *Bylaws*:

(1) Dentists, when awarded a D.D.S. or D.M.D. degree, shall be exempt from the payment of active member dues and any special assessment for the remaining period of that year and the following first full calendar year. Dentists shall pay twenty-five percent (25%) of active member dues and special assessment for the second full calendar year following the year in which the degree was awarded, fifty percent (50%) of active member dues and special assessment in the third year, seventy-five percent (75%) of active member dues and special assessment in the fourth year and one hundred percent (100%) in the fifth year and thereafter. Eligibility for this benefit shall be conditioned on maintenance of continuous membership or payment of reduced dues and special assessment(s) for the years not previously paid, at the rates current during the missing year(s).*

(2) The dentist who is engaged full-time in (a) an advanced training course of not less than one (1) academic year's duration in an accredited school or a residency program in areas neither recognized by

this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall pay thirty dollars ($30.00) due on January 1 of each year until December 31 following completion of such program. For the dentist who enters such a course or program ~~within one (1) year of the award of D.D.S. or D.M.D. degree~~ while eligible for the ~~applicable~~ dues reduction program set forth in the foregoing condition (1), the applicable reduced dues rate shall be tolled until completion of that program. Upon completing the program, the dentist shall pay dues and any special assessments for active members at the reduced dues rate where the dentist left off in the progression ~~next period in time level that is applicable~~ under condition (1). Eligibility for this benefit shall be conditioned on maintenance of continuous membership or payment of post-graduate student dues and active member dues and special assessment(s) for years not previously paid, at the rates current during the missing years. The dentist who is engaged full-time in (a) an advanced training course of not less than one (1) academic year's duration in an accredited school or residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall be exempt from the payment of any active member special assessment then in effect through December 31 following completion of such course or program.

~~(3) An active member who is serving the profession by working full-time for a charitable organization and is receiving neither income nor a salary for such charitable service other than a subsistence amount which approximates a cost of living allowance shall pay dues of five dollars ($5.00) due January 1 of each year, and shall be exempt from the payment of any special assessment then in effect through December 31 following completion of such service; provided that such charitable service is being performed continuously for not less than one year and provided further that such member does not supplement such subsistence income by the performance of services as a member of the faculty of a dental or dental auxiliary school, as a dental administrator or consultant, or as a practitioner of any activity for which a license to practice dentistry or dental hygiene is required.~~

(3) A graduate of a non-accredited dental school who has recently been licensed to practice dentistry in a jurisdiction in which there is a constituent dental society of the American Dental Association shall be exempt from payment of active member dues and any special assessment for the remaining period of the year in which the license was issued and the following first full calendar year. The newly licensed graduate of a non-accredited school shall pay twenty-five percent (25%) of active member dues and any special assessment the second calendar year following the year in which the license was obtained, fifty percent (50%) of active member dues and any special assessment in the third year, seventy-five percent (75%) of active member dues and any special assessment in the fourth year and one hundred (100%) in the fifth year and thereafter.*

* This footnote clarifies the expansion of the reduced dues program approved by the 2003 House of Delegates. Only new dental school graduates and newly licensed dentists of non-accredited dental schools entering the reduced dues program in 2004 or thereafter are eligible for the expanded reduced dues program at the progression set forth in these *Bylaws* under conditions 1 and 4. Dentists who entered the reduced dues program prior to 2004 continue their progression to next applicable rate. That progression is as follows: twenty-five percent (25%) of active member dues and special assessment for the first full calendar year following graduation from an accredited dental school or the year in which the license was obtained for graduates of non-accredited dental schools, fifty percent (50%) of active member dues and special assessment in the second year, seventy-five (75%) of active member dues and special assessment in the third year and one

(~~5~~4) A licensed dentist who has never been an active member of this Association and is ineligible for dues reduction as a new graduate under this Section of the *Bylaws*, shall pay fifty percent (50%) of active member dues and any special assessment in the first year of membership, and shall pay one hundred percent (100%) of active member dues and any special assessment in the second year and each year thereafter.

~~(5) The Board of Trustees may authorize limited dues reduction, up to fifty percent (50%) of active member dues and special assessment(s), for the purposes of promoting membership in target markets through marketing campaigns recommended by the Council on Membership.~~

d. ACTIVE MEMBERS SELECTED AFTER JULY 1 AND OCTOBER 1. Those members selected to active membership in this Association after July 1, except for those whose membership has lapsed for failure to pay the current year's dues and/or special assessments, shall pay one half (1/2) of the current year's dues and one half (1/2) of any active member special assessment then in effect, and those selected after October 1, shall be exempt from the payment of the current year's dues and any active member special assessment then in effect on a one-time only basis.

B. LIFE MEMBER.

a. QUALIFICATIONS. A life member shall be a member in good standing of this Association who (1) has been an active and/or retired member in good standing of this Association for thirty (30) consecutive years or a total of forty (40) years of active and/or retired membership or has been a member of the National Dental Association for twenty-five (25) years and subsequently held at least ten (10) years of membership in the American Dental Association; (2) has attained the age of sixty-five (65) years in the previous calendar year; and (3) has submitted an affidavit attesting to the qualifications for this category through said component and constituent societies, if such exist.

A dentist who immigrated to the United States may receive credit for up to twenty-five (25) consecutive or total years of membership in a foreign dental association in order to qualify for the respective requirements for life membership.

Years of student membership shall not be counted as active membership for purposes of establishing eligibility for life membership unless the dentist was an active member in good standing prior to becoming a student member.

The Association will give notification to members who are eligible for life membership. Life membership shall be effective the calendar year following the year in which the requirements are fulfilled. Maintenance of membership in good standing in the member's constituent and component societies, if such exist, shall be a requisite for continuance of life membership in this Association.

b. PRIVILEGES. A life member in good standing of this Association shall receive annually a membership card. A life member shall be entitled to all the privileges of an active member, except that a retired life member shall not receive *The Journal of the American Dental Association* except by subscription.

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hundred percent (100%) in the fourth year and thereafter. Such reductions are conditioned on maintenance of continuous membership or payment of dues and special assessment(s) for the years not previously paid at the rates current during the missing years. This footnote shall expire at adjournment *sine die* of the 2007 House of Delegates.

A life member under a disciplinary sentence of suspension shall not be privileged to hold office, either elective or appointive, including delegate and alternate delegate, in such member's component and constituent societies and this Association, or to vote or otherwise participate in the selection of officials of such member's component and constituent societies and this Association.

c. DUES AND SPECIAL ASSESSMENTS.

(1) ACTIVE LIFE MEMBERS. Regardless of a member's previous classification of membership, the dues of life members who have not fulfilled the qualifications of retired membership pursuant to Chapter I, 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 1 of each year. In addition to their annual dues, active life members shall pay fifty percent (50%) of any active member special assessment levied by the House of Delegates, due January 1 of each year.

(2) RETIRED LIFE MEMBERS. Life members who have fulfilled the qualifications of Chapter I, Section 20C of these *Bylaws* with regard to income related to dentistry shall be exempt from payment of dues and any special assessment levied by the House of Delegates.

(3) ACCEPTANCE OF BACK DUES AND SPECIAL ASSESSMENTS. For the purpose of establishing continuity of active membership to qualify for life membership, back dues and special assessments, except as otherwise provided in these *Bylaws*, shall be accepted for not more than the three (3) years of delinquency prior to the date of application for such payment. The rate of such dues and/or special assessments, except as otherwise provided in these *Bylaws*, shall be in accordance with Chapter I, Section 40 of these *Bylaws*.

For the purpose of establishing continuity of active membership in order to qualify for life membership, an active member, who had been such when entering upon active duty in one of the federal dental services but who, during such federal dental service, interrupted the continuity of active membership because of failure to pay dues and/or special assessments and who, within one year after separation from such military or equivalent duty, resumed active membership, may pay back dues and special assessments for any missing period of active membership at the rate of dues and/or special assessments current during the missing years of membership.

C. RETIRED MEMBER.

a. QUALIFICATIONS. A retired member shall be an active member in good standing of this Association who is now a retired member of a constituent society, if such exists, and is no longer earning income from the performance of any dentally related activity, and has submitted an affidavit attesting to qualifications for this category through said component and constituent society, if such exist. Maintenance of active or retired membership in good standing in the member's component society and retired membership in good standing in the member's constituent, if such exist, entitling such member to all the privileges of an active member, shall be requisite for entitlement to and continuance of retired membership in this Association.

b. PRIVILEGES. A retired member in good standing shall receive annually a membership card. A retired member shall be entitled to all the privileges of an active member.

A retired member under a disciplinary sentence of suspension shall not be privileged to hold office, either elective or appointive, including delegate and alternate delegate, in such member's component and

constituent societies and this Association, or to vote or otherwise participate in the selection of officials of such member's component and constituent societies and this Association.

c. DUES AND SPECIAL ASSESSMENTS. The dues of retired members shall be twenty-five percent (25%) of the dues of active members, due January 1 of each year. In addition to their annual dues, retired members shall pay twenty-five percent (25%) of any active member special assessment levied by the House of Delegates, due January 1 of each year.

~~ED. NONPRACTICING DENTIST MEMBER.~~

~~a. QUALIFICATIONS. A nonpracticing dentist member shall be a dentist who is ineligible for any other classification of membership and:~~

~~(1) has a dental degree from any country;~~

~~(2) resides in the United States or its territories;~~

~~(3) does not hold a dental license in the United States nor has a revoked U.S. dental license;~~

~~(4) is not delivering patient care as a dentist for remuneration; and~~

~~(5) is a member in good standing of this Association, and the Association's constituent and component societies, if such exists.~~

~~b. PRIVILEGES.~~

~~(1) A nonpracticing dentist member in good standing shall receive annually a membership card and *The Journal Of The American Dental Association*, the subscription price of which shall be included in the annual dues. A nonpracticing dentist member shall be entitled to attend any scientific session of this Association and receive such other services as are authorized by the Association.~~

~~(2) A nonpracticing dentist member in good standing shall be eligible for election to any council.~~

~~(3) A nonpracticing dentist member shall also be eligible for appointment as an additional member to any council, provided the council requests such additional nonpracticing membership representation and the Board of Trustees approves the council's request. Such members shall be appointed by the Board of Trustees. The tenure of an additional council member shall be one (1) term of four (4) years.~~

~~(4) A nonpracticing dentist member under a disciplinary sentence of suspension shall not be privileged to serve as a member of any council.~~

~~c. DUES AND SPECIAL ASSESSMENTS. The dues of nonpracticing dentists shall be fifty percent (50%) of the dues of active members, due January 1 of each year. In addition to their annual dues, nonpracticing dentists shall pay fifty percent (50%) of any active member special assessment levied by the House of Delegates, due January 1 of each year.~~

~~D~~E. STUDENT MEMBER.

a. QUALIFICATIONS. A student member shall be ~~either~~ a predoctoral student of a dental school accredited by the Commission on Dental Accreditation of this Association, a predoctoral student of a dental school listed in the World Directory of Dental Schools compiled by the FDI World Federation or a dentist

eligible for membership in this Association who is engaged full time in an advanced training course of not less than one academic year's duration in an accredited school or residency program.

b. PRIVILEGES. A student member in good standing of this Association shall receive annually a membership card and *The Journal of the American Dental Association,* the subscription price of which shall be included in the annual dues. A student member shall be entitled to attend any scientific session of this Association.

A student member under a disciplinary sentence of suspension shall not be privileged to serve as the American Student Dental Association's delegate or alternate delegate in this Association's House of Delegates.

c. DUES AND SPECIAL ASSESSMENTS.

(1) PREDOCTORAL STUDENT MEMBERS: The dues of predoctoral student members shall be five dollars ($5.00) due January 1 of each year. Such student members shall be exempt from the payment of any special assessment levied by the House of Delegates.

(2) POSTDOCTORAL STUDENTS AND RESIDENTS: The dues of dentists who are student members pursuant to Chapter I, Section 20E shall be thirty dollars ($30.00) due January 1 of each year. Such student members shall be exempt from the payment of any special assessment levied by the House of Delegates.

(3) Student membership terminates on December 31 after graduation or after completion of a residency or graduate work.

~~E~~F. HONORARY MEMBER.

a. QUALIFICATIONS. An individual who has made outstanding contributions to the advancement of the art and science of dentistry, upon election by the Board of Trustees, shall be classified as an honorary member of this Association.

b. PRIVILEGES. An honorary member shall receive a membership card and *The Journal of the American Dental Association.* An honorary member shall be entitled to attend any scientific session of this Association and receive such other services as are authorized by the Board of Trustees.

c. DUES AND SPECIAL ASSESSMENTS. Honorary members shall be exempt from payment of dues and any special assessment levied by the House of Delegates.

~~F~~G. PROVISIONAL MEMBER.

a. QUALIFICATIONS. A provisional member shall be a dentist who:

(1) has received a D.D.S. or D.M.D. degree from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or shall be a graduate of an unaccredited dental school who has recently been licensed to practice dentistry in a jurisdiction in which there is a constituent dental society;

(2) has not established a place of practice; and

(3) shall have applied for provisional membership within 12 months of graduation or licensure.

Provisional membership shall terminate December 31 of the second full calendar year following the year in which the degree was awarded.

b. PRIVILEGES. A provisional member in good standing shall be entitled to all the privileges of an active member except that, notwithstanding anything in these *Bylaws* to the contrary, a provisional member shall have no right to appeal from a denial of active membership in the Association.

A provisional member under a disciplinary sentence of suspension shall not be privileged to hold office, either elective or appointive, including delegate and alternate delegate, in such member's component and constituent societies and this Association, or to vote or otherwise participate in the selection of officials of such member's component and constituent societies and this Association.

c. DUES AND SPECIAL ASSESSMENTS. The dues and/or special assessments of provisional members shall be the same as the dues and/or special assessments of active members.

~~G~~H. ASSOCIATE MEMBER.

a. QUALIFICATIONS. An associate member shall be a person ineligible for any other type of membership in this Association, who contributes to the advancement of the objectives of this Association, is employed in dental-related education or research, does not hold a dental license in the United States, and has applied to and been approved by the Board of Trustees.*

b. PRIVILEGES. An associate member in good standing shall receive annually a membership card and *The Journal of the American Dental Association*, the subscription price of which shall be included in the annual dues. An associate member shall be entitled to attend any scientific session of this Association and receive such other services as are authorized by the Board of Trustees.

c. DUES AND SPECIAL ASSESSMENTS. The dues of associate members shall be twenty-five percent (25%) of the dues of active members, due January 1 of each year. In addition to their annual dues, associate members shall pay twenty-five percent (25%) of any active member special assessment levied by the House of Delegates, due January 1 of each year.

~~H~~I. AFFILIATE MEMBER.

a. QUALIFICATIONS. An affiliate member shall be a dentist who is ineligible for any other classification of membership and:

(1) is practicing in a country other than the United States;

(2) has been classified as an affiliate member upon application to and approval by the Board of Trustees; and

(3) is a member in good standing of this Association.

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* Individuals who are classified as associate members of this Association prior to the 1996 annual session of the House of Delegates but who are not employed full-time in dentally-related education or research by an accredited institution of higher education, may maintain their associate membership so long as other eligibility requirements are met and current dues and special assessments are paid.

b. PRIVILEGES. An affiliate member in good standing shall receive annually a membership card, have access to the members-only content areas of ADA.org, be entitled to attend any scientific session of this Association, purchase items through the ADA Catalog at the member rate and receive such other services as are authorized by the Board of Trustees.

c. DUES AND SPECIAL ASSESSMENTS. The dues of affiliate members shall be twelve dollars ($12.00) for those members practicing in least developed and low income countries eligible for special fee criteria as established by the Fédération Dentaire Internationale and seventy-five dollars ($75.00) for other such members, due January 1 of each year. Affiliate members shall be exempt from the payment of any special assessment levied by the House of Delegates.

Section 30. DEFINITION OF "IN GOOD STANDING". A member of this Association whose dues and special assessments for the current year have been paid shall be in good standing; provided, however, that a member, to remain in good standing may be required under the bylaws of the member's constituent or component society, to meet standards of continuing education, pay special assessments, cooperate with peer review bodies or committees on ethics, or attend, if a newly admitted active member, a stated number of membership meetings between the date of admission and the completion of the first calendar year of active membership. If under a disciplinary sentence of suspension, such member shall be designated as a "member in good standing temporarily under suspension" until the member's disciplinary sentence has terminated. The requirement of paying current dues does not apply to retired life, ~~and~~ honorary and those members of this Association who pursuant to Section 50 of this Chapter have been granted dues waivers for the purpose of determining their good standing. The requirement of paying special assessments does not apply to retired life, honorary, affiliate, ~~and~~ student and those members of this Association who pursuant to Section 50 of this Chapter have been granted special assessment waivers for purposes of determining their good standing. ~~A member of this Association who is disabled for a period of one year, is no longer earning income from the performance of dentally-related activity because of the disability, and who was a member in good standing at the time such disability was incurred, shall be exempt from the payment of dues and special assessments and shall be in good standing during the period of disability. A disabled member, in order to receive entitlement to dues and special assessments exemption, shall submit through the member's component and constituent societies, if such exist, to this Association a medical certificate attesting to disability and a certificate from said component and constituent societies, if such exist, attesting to this disability. During the period of exemption from dues and special assessments, further such certificates shall be presented on request to this Association.~~[*]

Section 40. LAPSE OF MEMBERSHIP AND REINSTATEMENT.

A. LAPSE OF MEMBERSHIP. Any member whose dues and special assessments have not been paid by March 31 of the current year shall cease to be a member of this Association. Further, an associate member who terminates employment in dental-related education or research shall cease to be an associate member of this Association December 31 of that calendar year.

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[*] ~~Members with disabilities incurred during active military duty who were granted dues and special assessment disability waivers prior to the 2002 annual session of the House of Delegates may continue to receive such waivers so long as they are unable to practice dentistry within the definition of these *Bylaws*. Members with disabilities other than those disabled during active military duty who were granted dues and special assessment disability waivers prior to the 2002 annual session of the House of Delegates may continue to receive such waivers, provided such members can submit further certification attesting to the disability, upon request of the Association, during the exemption period.~~

B. REINSTATEMENT. Reinstatement of active, life, ~~student,~~ retired, ~~nonpracticing dentist~~, student or affiliate membership may be secured on payment of appropriate dues and special assessments of this Association by any former member and on compliance by any former member with the pertinent bylaws and regulations of the constituent and component societies involved and this Association.

Section 50. DUES OR SPECIAL ASSESSMENT RELATED ISSUES.

A. PAYMENT DATE AND INSTALLMENT PAYMENTS. Dues and special assessments 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 special assessment amount fully paid by June 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 special assessments to this Association and the applicable constituent or component dental society, if such exists, as soon as commercially feasible.

B. FINANCIAL HARDSHIP WAIVERS. Those members who have suffered a significant financial hardship that prohibits them from payment of their full dues and/or special assessments may be excused from the payment of fifty percent (50%), seventy-five percent (75%) or all of the current year's dues and/or special assessment(s) as determined by their constituent and component dental societies. The constituent and component society secretaries shall certify the reason for the waiver, and the constituent and component societies shall provide the same proportionate waiver of their dues as that provided by this Association.[*]

C. WAIVERS FOR ACTIVE MEMBERS TEMPORARILY ACTIVATED TO FEDERAL SERVICE. An active member in good standing who pursuant to Chapter I of these *Bylaws* holds membership in a constituent and component society and is temporarily called to active duty with a federal dental service on a non-career basis shall be exempt from the payment of dues to this Association during such military duty, but not to exceed a period of three years.

D. WAIVERS FOR ACTIVE MEMBERS WORKING FOR A CHARITABLE ORGANIZATION. An active member who is serving the profession by working full-time for a charitable organization and is receiving neither income nor a salary for such charitable service other than a subsistence amount which approximates a cost of living allowance shall be exempt from the payment of dues and any special assessment then in effect through December 31 following completion of such service provided that such charitable service is being performed continuously for not less than one (1) year and provided further that such member does not supplement such subsistence income by the performance of services as a member of the faculty of a

[*] Members with disabilities who were granted dues and special assessment disability waivers prior to the 2007 House of Delegates may continue to receive such waivers provided they are unable to practice dentistry within the definition of these *Bylaws* and they submit through the member's component and constituent societies, if such exist, to this Association, a medical certificate attesting to the disability and a certificate from said component and constituent societies, if such exist, attesting to the disability, upon request of the Association, during the exemption period.

dental or dental auxiliary school, as a dental administrator or consultant, or as a practitioner of any activity for which a license to practice dentistry or dental hygiene is required.

~~D~~E. CALCULATING PERCENTAGE DUES OR SPECIAL ASSESSMENTS. In establishing the dollar rate of dues or special assessments in this chapter expressed as a percentage of active member dues or special assessments, computations resulting in fractions of a dollar shall be rounded up to the next whole dollar.

Section 60. INTERIM SERVICES FOR APPLICANTS. A dentist who has submitted a complete application for active membership in this Association and the appropriate constituent and component societies, if such exist, may on a one-time, interim basis: receive complimentary copies of *The Journal of the American Dental Association* and the *ADA News*, have access to the ADA.org member-only content areas and purchase items at a member rate through the ADA Catalog. Such interim services shall terminate when the membership application has been processed or within six (6) months of the application submission, whichever is sooner. Applicants shall have no right of appeal from a denial of membership in the Association.

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CHAPTER X • COUNCILS

Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS

~~A. The composition of the councils of this Association shall be as follows:~~ In addition, a council may request an additional member who shall be a nonpracticing dentist member appointed in accordance with Chapter I, Section 20Db of these *Bylaws*~~.~~

Section 30. ELIGIBILITY.

Subsection A

A. All members of councils must be active, life, ~~or~~ retired or nonpracticing dentist members in good standing of this Association except as otherwise provided in these *Bylaws*.

Subsection E.

E. To be eligible to serve on the Council on Scientific Affairs, the current recipient of the Gold Medal Award for Excellence in Dental Research shall be an active, life, ~~or~~ retired ~~or nonpracticing dentist*~~ member in good standing of this Association if the current recipient qualifies for such membership.

~~* The eligibility requirement for non-practicing dentist membership shall take effect upon completion of the 2006 Gold Medal Award for Excellence in Dental Research recipient's term on the Council on Scientific Affairs.~~

***Section 120*. DUTIES, Subsection G. COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS, subsection e.**

e. To discipline any of the direct members of this Association ~~(members in good standing who pursuant to Chapter I of these *Bylaws* do not hold membership in any constituent society of this Association)~~ in accordance with the requirements and procedures of Chapter XII of these *Bylaws*, using hearing panels composed of not less than three (3) of its elected members selected by the Council chair. The Council may adopt procedures governing the discipline of direct members of this

Association ~~(members in good standing who pursuant to Chapter I of these *Bylaws* do not hold membership in any constituent society of this Association)~~ consistent with Chapter XII of these *Bylaws*, which may include the use of an investigating committee or individual to investigate any complaint made against such member and report findings to the hearing panel concerning whether charges should issue.

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CHAPTER XII • PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT AND JUDICIAL PROCEDURE

***Section 20*. DISCIPLINE OF MEMBERS: Subsections A and D.**

A. CONDUCT SUBJECT TO DISCIPLINE. A member may be disciplined for (1) having been found guilty of a felony, (2) having been found guilty of violating the dental practice act of a state or other jurisdiction of the United States, (3) having been discharged or dismissed from practicing dentistry with one of the federal dental services under dishonorable circumstances, or (4) violating the *Bylaws*, the *Principles of Ethics and Code of Professional Conduct*, or the bylaws or code of ethics of the constituent or component society of which the accused is a member. For a member of a constituent society, disciplinary proceedings may be instituted by either the member's component or constituent society. Disciplinary proceedings against a direct member of this Association ~~(a member in good standing who pursuant to Chapter I of these *Bylaws* does not hold membership in any constituent society of this Association)~~ may be instituted by the Council on Ethics, Bylaws and Judicial Affairs of this Association…..

D. APPEALS. The accused member under sentence of censure, suspension or expulsion shall have the right to appeal from a decision of the accused's component society to the accused's constituent society by filing an appeal in affidavit form with the secretary of the constituent society. Such an accused member, or the component society concerned, shall have the right to appeal from a decision of the constituent society to the Council on Ethics, Bylaws and Judicial Affairs of this Association by filing an appeal in affidavit form with the Chair of the Council on Ethics, Bylaws and Judicial Affairs. Where the accused is a direct member of this Association, ~~(a member in good standing who pursuant to Chapter I of these *Bylaws* does not hold membership in any constituent society of this Association),~~ the accused member shall have the right of appeal from a disciplinary decision of a hearing panel of the Council on Ethics, Bylaws and Judicial Affairs to the Council by filing an appeal in affidavit form with the Chair of the Council on Ethics, Bylaws and Judicial Affairs. Members of the hearing panel shall not have the right to vote on the Council's decision on such an appeal.

Resolution No. 15 New ■ Substitute □ Amendment □

Report: CM Supplemental Report 1 Date Submitted: July 2007

Submitted By: Council on Membership

Reference Committee: Communications and Membership Services

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Build Dynamic Communities (Required)

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

Overview: This report updates the House of Delegates on the Council on Membership's activities since its annual report. Also included in the report is the Council's response to Resolution 32H-2006 (*Trans.*2006:310) and a resolution related to the dental team membership category.

Background: Since its annual report was submitted, the Council on Membership addressed several important issues at its June 2007 meeting and via its listserv. The Council continued work to focus on strengthening membership recruitment and retention outreach, including enhancing and energizing the Tripartite Grassroots Membership Initiative beyond 2007; developing additional strategies to reach out to target markets; seeking opportunities to enhance member value for targeted groups; and nonmember outreach for the 2007 annual session. Further, the Council also discussed the strategic membership study and related referrals from the House of Delegates regarding an approach to dental team membership.

Tripartite Grassroots Membership Initiative: The Council discussed the current status of the Membership Initiative and its future beyond 2007. It is working with an outside agency to assess its current Membership Initiative tools, processes and procedures and to recommend new strategies to continue the Membership Initiative success and take it to the next level. The results of their findings will be used to enhance volunteer engagement and build membership in urban areas, among other goals. The Membership Initiative will be revamped to promote and expand opportunities for member outreach incentives, motivate volunteers, reenergize state staff and promote new ADA support services within respective districts. State and local dental society staff and volunteers will be encouraged to participate in updated training, perhaps via audio Webcasts, Webinars and other formats. The Council recommended that the ADA continue to seek opportunities for an ADA presence at ethnic dental society meetings.

The Council reviewed the activities and recommendations from the 2007 Membership Recruitment and Retention Conference and made several suggestions regarding formats and speakers for the conference with a goal to enhance subsequent conferences for participants. Best practices from constituent and component dental societies, a goal-setting session and expansion of breakout sessions to include separate tracks for volunteers and staff will be explored for the 2008 conference.

Office of Student Affairs. The Council reviewed the current ADA student initiatives for the 2007 Student Block Grant Program. The Council set a new metric of personal outreach for evaluating the effectiveness

of Block Grant-funded initiatives. After receiving responses to the "Where Are You Going" postcard from seniors, appropriate brochures are being sent including membership information and an application.

Dental Recap, an e-publication, expanded this year from four issues to seven, engages students on a regular basis. *OSA Update*, an e-newsletter sent to faculty, demonstrates to school administrators the messages and resources that are distributed to students from the ADA.

Target Market Recruitment and Retention. The ADA conducts recruitment campaigns targeted to under-represented segments, including new dentists and minority/ethnic dentists. This year, in continuing support of the Membership Initiative goals, direct marketing contact has been expanded to lapsed dentists who were members in 2005 but had not paid their 2006 dues.

The 2005 House of Delegates restructured dues rates for affiliate members, resulting in a significant increase in the number of affiliate members. In March 2007, multilingual ADA staff hosted a booth at the International Dental Show in Cologne, Germany, to raise awareness of affiliate membership, resources available through the ADA Catalog and Survey Center and other ADA initiatives. The Council considered the pros and cons of providing the Board with administrative flexibility for affiliate membership, which would allow the ADA to respond on a case-by-case basis to opportunities that may arise from other national dental organizations headquartered outside of the United States. The Council recommended it appoint a workgroup to continue consideration of the issue with the Committee on International Programs and Development.

A recruitment mailing, including a free *Dental Pharmacopoeia* pocket dosing guide, was sent to dentists eligible for graduate student membership. An outbound telephone program was conducted that focused on tripartite members. Mailings to promote half-year dues and the $0 national quarter-year dues rate are planned.

Annual Session Nonmember and First-time Attendee Activities. The Council reviewed a report on the 2006 outreach activities to nonmembers and first-time attendees, noting that 995 nonmembers attended the Las Vegas meeting. Of those nonmember dentists who attended last year, 82 joined the ADA and an additional 16 who joined last year are currently nonrenews. The Council discussed promotion of the 2007 meeting to nonmembers and agreed that the first-time attendee Orientation Center should be continued.

Council members and Membership Initiative volunteers will participate in outreach activities in San Francisco. The Council on Membership will work with the Council on ADA Sessions to develop additional nonmember promotions for subsequent meetings based on results and feedback from the 2007 annual session. As in previous years, names of nonmembers attending will be sent to the respective dental societies for follow-up.

The Council discussed various ways to educate both members and nonmembers about ADA products and services, including alternate methods of sharing member benefit information with members. The 2007 *Member Handbook* utilization survey contained a question regarding the preferred method of delivery for the member value messages found in the handbook.

The Council reviewed a report about retired membership, as well as a proposed pre-retirement survey. Pending final survey results, the Council may consider changes to eligibility requirements for retired and life membership. It will also consider responses from dentists who are in "limited practice" related to ADA membership.

Interim Services for Applicants. The Council reviewed usage statistics for dentists taking advantage of Interim Services to Applicants and found that more than 1,160 applicants have been able to begin enjoying identified ADA benefits, reinforcing ADA member value early in their relationship with the ADA.

Strategic Membership Study: The Council on Membership has been conducting a multi-year study that aims to position the ADA as a membership organization that welcomes a broad spectrum from the dental community, ensuring that these wider communities lend their perspectives, voices and support to ADA initiatives related to community, advocacy, knowledge and standards. Input from a vibrant, strong membership will build capacity to anticipate future trends in the profession, enabling the organization to stay relevant and proactive, creating ongoing value for its members. This study resulted in an approach to membership that was reported to the 2006 House of Delegates in the Council on Membership's Supplemental Report 2 to the House of Delegates: Membership Study Proposal.

At its recent meeting, the Council approved the ADA *Bylaws* language for the portions of the membership study proposal that were approved in concept by the 2006 House of Delegates through adoption of Resolution 32H-2006. The Council on Ethics, Bylaws and Judicial Affairs developed the enabling language, with input from the Council, for Resolution 10 (Worksheet:3003) found in the joint report submitted to the 2007 House of Delegates.

Dental Team Membership. As requested by the 2006 House of Delegates, the Council continued its discussion of dental team membership. It considered ongoing feedback from communities of interest along with quantitative results of the 2007 Dental Team Membership Survey.

There is a long-standing policy urging constituent societies to expand membership to allied team membership (*Trans.*1987:498).

> **Resolved,** that constituent societies be encouraged to offer a new category of membership for dental office auxiliaries utilizing the ADA Guidelines for Constituent Society Auxiliary Membership, and be it further
>
> **Resolved,** that the ADA monitor constituent activities regarding this membership category and report periodically to the House of Delegates.

Additionally, Resolution 84-2005 (*Trans.*2005:317), Assistant and Hygiene Membership Categories, was referred to the Council on Membership to explore the creation of new membership categories for assistants and hygienists. According to the 2005 Constituent Feedback Survey, there were 19 dental societies that offered membership for dental team members. Since that time several others have added or are preparing to add a category.

The 2007 Dental Team Membership Survey was sent to a nation-wide sample of dental team members (hygienists, dental assistants, dental laboratory technicians and dental business office managers) with a response rate of 34.9%. The survey provided valuable data on interest level, possible benefits and dues levels. Data showed strong interest in belonging to the ADA among all respondents from all groups and a willingness to personally pay for membership. The survey also demonstrated strong interest from all groups surveyed for membership opportunities at the state and local levels. Based on the data and

feedback from the communities of interest, the Council finalized an approach for consideration at the 2007 House of Delegates.

There are a few basic changes in the 2007 proposed approach to dental team membership that differ from the concept outlined in the 2006 supplemental report to the House.

1. Single category of membership for the dental team versus separate categories—based on the feedback from the communities of interest about Dental Team membership following last year's House, the Council is proposing a simpler approach than was offered in 2006—a single category for dental team membership, with all team members eligible on an undifferentiated basis.

2. $35 proposed dues rate.

3. Modified approach to representation—only one representative/alternate to the House of Delegates, with a requirement that the category build over time in order to earn representation.

Eligibility. The 2007 Dental Team Membership Survey data did show an interest in separate categories of membership for each category of dental team member (hygienists, dental assistants, dental laboratory technicians and dental business office administrators). The Council felt that one category of membership was a simple, easy-to-administer approach that would allow the ADA to gain experience and insight on dental team membership in a straightforward manner. The Council also considered the ADA expanded workforce model and agreed that the Community Dental Health Coordinator and Oral Preventive Assistant would be considered either a dental hygienist or dental assistant and thus would be eligible for membership in this category.

Dues. According to the results from the 2007 Dental Team Membership Survey, dental team members felt that dues should cost $50 or less. At its June meeting, the Council reviewed revised financial models based on the quantitative feedback from the survey. The new models included various dues rates and participation levels. Based on tripartite considerations and a review of the financial models, the Council dropped the recommended dues from $44 to $35, which is projected to result in a positive net revenue to the ADA in year one of implementation.

Representation. The Council considered the concerns raised at the 2006 House of Delegates regarding dental team member representation at the House and on ADA councils. In order for the dental team membership to be meaningful, the Council agreed that some type of representation should be included to enable members of the dental team membership category to have value and pride, as well as input into, the organization.

Further, the Council felt that some councils would benefit from the input of one *ex officio* member from the dental team membership category. All non-dentist team members are proposed to be part of a single membership category with total representation at the ADA House of Delegates not to exceed one delegate and one alternate, no sooner than three years following the adoption of the category by the ADA House of Delegates, provided that membership in this category exceeds 25,000 members. This would give this group a "voice at the table" consistent with the privileges and benefits of this non-dentist category.

Any changes in representation for the dental team category, if adopted, regardless of the number of members in this category, would occur at the House of Delegates. Representatives for this category to the House and councils will be selected by the Board, based on submissions from trustees and

constituent/component societies and recommendations made through the Council on Dental Practice. As such, these members have a fiduciary duty on behalf of the ADA, not a particular discipline or professional organization's point of view.

The inclusion of a dental team membership category anticipates future trends (e.g., career options for dental professionals, importance of dental team members, cooperative solutions to access issues, etc.) and reinforces the collaborative nature of the dental team, with the dentist as the head of the dental. Inclusion of dental team members has the possibility to create a cohesive environment for dentists, dental team members, and the patients they serve.

By adopting this membership category, the ADA's position as the umbrella organization for the profession would be reinforced. The ADA would be seen as more inclusive and diverse, spanning the various contributors to the dental profession including dental team members, researchers, etc. Through inclusion, the ADA could offer a strong portfolio of benefits, have the capacity to "give a voice" to its members and support the model of dental team delivery. Expanded membership could create a more unified profession, legislative collaboration, synergy with other organizations and tripartite opportunities. This also advances the ADA's Strategic Plan and public affairs orientation and looks toward the future.

The dental team membership category is proposed as a direct membership at the outset. Constituent and component societies will be urged to create these categories to mirror those at the national level. For those constituents that already have allied membership categories in place, those allied members would be urged to join the ADA as well, but would not be required to do so at this time.

The Council believes a strong dental team with the dentist as the head of the team will continue to be critical in delivering patient care in the future. In keeping with the concept of embracing the profession as a whole, the Council felt it was important to welcome the dental team into ADA membership. Further, the Council believed that this was best accomplished through an approach that gives dental team members a voice at the table.

Throughout the Membership Study process, the Council gathered and considered feedback from communities of interest, including the ADA House of Delegates, Board of Trustees, various ADA Council and Committees, Council on Dental Practice's Dental Team Advisory Panel, constituent and component dental societies via a series of conference calls as well as feedback through the district representatives and the membership initiative e-mail box. The Council synthesized the feedback along with the quantitative results at its meetings this year.

The concept advanced in this report differs from what the Council offered in its 2006 supplemental report; as a direct result of the thoughtful feedback it received throughout the process. Responding to feedback from the 2006 House of Delegates, the Council reviewed possible dental team membership structures and representation. The Council modified its approach to representation based on concerns that emerged from various communities of interest. Based on the feedback from constituent and component dental societies as well as the quantitative research, the Council considered several financial models reflecting various dues levels.

The Council carefully considered all the feedback it received along with the quantitative results to finalize the approach offered here.

Resolution

15. Resolved, that the Membership Study Proposal related to the dental team membership category containing the following comprehensive approach to ensure that ADA anticipates current issues facing the dental profession and future trends be approved, and be it further

Resolved, that the Council on Ethics, Bylaws and Judicial Affairs, in consultation with the Council on Membership, as needed, develop *Bylaws* changes to implement the dental team membership category for consideration by the 2008 House of Delegates, and be it further

Resolved, that constituent and component societies be urged to provide membership opportunities for dental team members in this ADA category.

Dental Team Membership Proposal

The ADA *Bylaws* would be amended to create a single category for dental team members, and all team members would be eligible on an undifferentiated basis, and

- **Eligibility**: Eligibility for this category would be open to:
  - Dental hygienists, dental assistants, dental laboratory technicians, dental office administrative staff, based on application. Eligibility for this category is contingent on being ineligible for any other classification of membership.
  - Eligibility for membership in the proposed new ADA dental team member category is contingent on membership in any available category for dental team members at the constituent or component levels for which the applicant is also eligible.
  - Does not have a license which is revoked or suspended, if applicable, is not practicing in their stated profession illegally.
  - U.S.-based: intent is that dental team member earns all "dentally related" income within the US and/or its territories.
- **Dues:** the Council recommended that dues for members of the dental team category be set at a flat rate of $35.
- **Benefits:** will include electronic publications, member rate for ADA Scientific Session and other services as authorized by the Board of Trustees.
- **Representation:** Selection process for representation for the dental team membership category is the following: candidates will apply though a component and/or constituent society, this application may be forwarded to the trustee. The trustee of the district may nominate the candidate for review by the Council on Dental Practice and be forwarded to the Board of Trustees for appointment to the appropriate positions listed below.
  - ***Ex Officio*** member of the following agencies: Council on Access, Prevention and Interprofessional Relations, Council on ADA Sessions, Council on Ethics, Bylaws and Judicial Affairs, Council on Dental Practice, Council on Goverment Affairs and Council on Membership.

- ***Three years following the adoption of this category, provided there is a membership of 25,000:*** Representation in the House of Delegates consisting of one delegate and one alternate delegate with a term at each position, being a maximum of two years.
- The delegate from the dental team category be seated and caucus with the delegation from the district in which the delegate practices.

Other Items:

- Membership would be a direct membership and would move to tripartite membership, if and when eligible.
- Discipline:
  - *Bylaws* provisions related to privileges to members under a disciplinary sentence or suspension shall be broadened to include the dental team category.
  - Members in the dental team category may be subject to discipline for conviction of a felony or violation of the dental practice act (see Chapter XII of the ADA *Bylaws*).
- Miscellaneous:
  - The *Bylaws* provision relating to reinstatement of membership shall be broadened to include the new category.

BOARD COMMENT: The Board appreciates the significant efforts of the Council to be responsive to its charge to develop a comprehensive approach to ADA membership. The Board acknowledges the Council's diligence in conducting both qualitative and quantitative research, and ensuring ongoing dialogue with communities of interest. The Board believes it is important to be proactive in addressing the needs of an evolving dental workforce, to be able to represent all oral health care providers, in order to address critical issues such as access to care. The Dental Team Membership category provides an opportunity to bring all parties together for the benefit of the public and the profession. The Board realized that the proposal contains some elements that may be controversial, such as, representation, timing and the menu of benefits, but believed that the Council's proposal should be supported and forwarded in its current form for House discussion.

BOARD RECOMMENDATION: Vote Yes.

Board Vote:

Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CADLE	■	☐	☐	☐	GRAMMER	☐	■	☐	☐	SCHWEINEBRATEN
☐	■	☐	☐	CALNON	☐	■	☐	☐	GROVER	■	☐	☐	☐	SMITHC
■	☐	☐	☐	FELDMAN	■	☐	☐	☐	KELL	■	☐	☐	☐	STRATHEARN
■	☐	☐	☐	FINDLEY	☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SYKES
■	☐	☐	☐	GIST	■	☐	☐	☐	MANNING	■	☐	☐	☐	TANKERSLEY
■	☐	☐	☐	GLECOS	■	☐	☐	☐	NICOLETTE	■	☐	☐	☐	WEBB
☐	■	☐	☐	GLOVER	■	☐	☐	☐	SCHWARTZ					Res. 15

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: CC Supplemental Report 1 Date Submitted: July 2007

Submitted By: Council on Communications

Reference Committee: Communications and Membership Services

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

COUNCIL ON COMMUNICATIONS SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES: STRATEGIC COMMUNICATIONS PLAN OF THE AMERICAN DENTAL ASSOCIATION

Background: As a part of the Council on Communications redefined *Bylaws* duties approved by the House of Delegates in Resolution 26H-2006 (*Trans*.2006:309), the Council was charged "to identify, recommend and maintain an external communications plan for the Association to facilitate other work throughout and on behalf of the Association." In response to that charge, the Council appointed a subgroup in January 2007 to develop the external communications plan.

To guide the work of the subgroup, ADA councils were invited to provide their input regarding assumptions about the relevant future environment within which the strategic communications plan will operate. The Council on Access, Prevention and Interprofessional Relations, Council on Dental Practice and Council on Scientific Affairs provided input, and the subgroup also considered information from the ADA environmental scan as well as the ADA Strategic Plan in order to develop the strategic communications plan.

The subgroup met at ADA Headquarters on May 15 to develop the strategic communications plan outlined in this report. Participants at the session, facilitated by Ms. Cate Bower, Tecker Consultants, LLC, included: Dr. Sally J. Cram, Council chair; Dr. Larry D. Herwig, Council vice chair; Dr. Peter Carroll, Dr. Dennis W. Engel, Dr. Edward J. Green, Council members; Mr. Richard Green, managing director, Department of Public Affairs; Ms. Lydia Hall, communications manager; Ms. Leslee Williams, Council director; and consultant Charles Leonard, a partner at Chlopak, Leonard, Schechter and Associates, the national public affairs firm engaged in the state-based public affairs program. Ms. Beril Basman, managing vice president, Strategy Management, also participated in a portion of the meeting.

It was agreed that the strategic communications plan should be externally focused, intended to position ADA in the broader world and not an internally focused plan directed to members. That said, the group also agreed that it needed an internal component designed to keep ADA members aware of the external efforts and what they are intended to accomplish.

Among the objectives subgroup members had for the initiative were to:

- create a road map with a central focus for external communications efforts;
- start creating awareness of the importance and impact of considering communications implications of actions in advance of those actions;

- create a silo busting approach to communications and a communications template for use by the Council's liaisons to other councils prior to the 2007 House of Delegates meeting;
- recognize that the position of the profession is partly dependent on effective communications;
- support the ADA's strategic plan by guiding external communications strategy to enhance/improve the image of the ADA and the profession;
- create a framework to make strategic communications an integral part of ADA activities;
- include a way to educate the members-at-large about the impact of ADA decisions which could affect "image;" and
- set strategic goals and objectives that can be used as a lens for any issue that is not message specific.

The group agreed that they viewed the outcome of their work as a high-level effort with a series of broad goals and objectives and that, upon approval of that strategically-focused plan, specific implementation plans would need to be developed by staff and/or specifically assigned work groups.

The communications plan is based upon ADA's Mission, Vision and the organizationally focused goals of the current ADA Strategic Plan (2007-10), specifically:

- Mission—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.
- Vision—The American Dental Association: The oral health authority committed to the public and the profession.
- Achieve Effective Advocacy for oral health and the dental profession, within the health care, public and policy communities—Objective: Maintain the trusted professional image of the dentist
- Build Dynamic Communities to collaborate through new, cost effective ways on strategic initiatives and policies.
- Create and Transfer Knowledge to improve oral health, being the most trusted source for information.
- Attain Excellence in Operations through progressive and efficient business management practices.

As the plan was developed, several key points were taken into consideration:

- Communications is not an end in itself—it is a tool to accomplish other outcomes.
- A successful external communications program must be implemented organization-wide. It cannot succeed if it is delegated only to the Council on Communications.
- An effective plan requires time and consistency to achieve impact.
- ADA has access to a major communications network through the Tripartite which should be factored into our thinking.
- All external communications need to be coordinated throughout the ADA to maintain consistency of key messages.

Board of Trustees Review: At its July session, the Board of Trustees reviewed a report from the Council on Communications outlining the development of the Strategic Communications Plan for the American Dental Association. At that time, the Board also adopted the following resolution:

B-66-2007. Resolved, that the Board of Trustees approves the Strategic Communications Plan for the American Dental Association, and be it further

Resolved, that this plan be established Association-wide beginning in 2007 to help ensure successful positioning of the ADA's core beliefs, while safeguarding the highly-valued image and reputation of the ADA, and be it further

Resolved, that the Council on Communications and appropriate ADA agencies be charged with maintaining this Strategic Communications Plan for the American Dental Association with the dedication of appropriate resources for the same.

For the House of Delegates information, the Council presents the following Strategic Communications Plan for the American Dental Association.

STRATEGIC COMMUNICATIONS PLAN OF THE AMERICAN DENTAL ASSOCIATION

Every organization has at its heart a system of values and beliefs contained in its mission and vision statement. These values should be reflected in all that the organization plans and does, including communications. The American Dental Association's mission statement is the cornerstone of this strategic communications plan and supports several goals of the current Strategic Plan. Implementation of this strategic communications plan throughout the organization, concurrent with the overall Strategic Plan, will help ensure successful positioning of the ADA's core beliefs, while safeguarding the highly valued image and reputation of the ADA.

This plan has four outcome-focused communications goals and a series of objectives under each goal. These communications goals and objectives serve as the basis for implementation plans that will be developed once the overarching plan is approved. The implementation plans will be developed based on a prioritization, for which the criteria has yet to be developed.

Communications is far reaching and these communications goals are intended to support the overall thrust of ADA's strategic plan, linking to many of the plan's goals and objectives. The collective impact of these communications goals and objectives were considered to create greater support for the ADA's strategic direction and to move the collective forward.

Key Findings. The four most important aspects of an externally-focused strategic communications plan for the American Dental Association are:

1. A successful external communications program must be implemented organization wide. It cannot succeed if it is delegated to the Council on Communications only.

2. There is a great need to create awareness of the importance and impact of considering communications implications of actions in advance of those actions.

3. External communications need to be coordinated throughout the ADA to maintain consistency of key messages.

4. In order to maintain and enhance its status as the leader of the nation's oral health, dentistry must be perceived as being on the side of the public.

Communications Goals and Objectives. The communications objectives are linked to the ADA Strategic Plan Goals/Objectives. The key below is a cross reference to the ADA Strategic Communications Plan goals with the ADA Strategic Plan goals:

Reference Key for the ADA Strategic Communications Plan Goals and Objectives:

- A = Advocacy
- B = Build Dynamic Communities
- C = Create and Transfer Knowledge
- AE = Attain Excellence in Operations

Appendix 1 outlines in detail the above goals and objectives of the ADA Strategic Plan to provide additional explanation and to cross reference the ADA Strategic Communications Plan goals and objectives with the ADA Strategic Plan goals and objectives. For example, ADA Strategic Plan "A2" is the goal A: Achieve Effective Advocacy, and objective 2: Advocate for innovations that measurably increase access to care for all segments of the population.

- Communications Goal: Advocacy.
  The ADA will be viewed by key publics as the premier advocate for the public's oral health

  Objectives:
  1. Increase public awareness of the ADA's commitment to being a solutions-based organization, focused on serving the entire community
     - *ADA Strategic Plan Goal/Objectives: C1, C2, C3, C4*
  2. Communicate our willingness to collaborate and cooperate in addressing access issues
     - *ADA Strategic Plan Goal/Objective: A2*
  3. Encourage ADA to be "first to market" in addressing issues and leverage communications opportunities that result, particularly at the state level
     - *ADA Strategic Plan Goal/Objective: C1*
  4. Increase policy makers' understanding that the baseline solution to oral health disparities is prevention
     - *ADA Strategic Plan Goal/Objective: C2*
  5. Reinforce the role of the dentist as the leader of the oral health care team
     - *ADA Strategic Plan Goal/Objectives: A1, A2, A3*

- Communications Goal: Importance of Oral Health
  The public will recognize the value of good oral health and its impact on general health

  Objectives:
  1. Communicate to the public the lifetime benefits of preventive dental care
     - *ADA Strategic Plan Goals/Objectives: B3, C3*
  2. Position the ADA as the interpreter of information about oral health and its relationship to general health
     - *ADA Strategic Plan Goals/Objectives: A3, C1, C2*
  3. Reinforce the value to the public of the dentist's education and clinical experience
     - *ADA Strategic Plan Goals/Objectives: A1, A3, A5, C3*

- Communications Goal: Trusted Resource

The ADA will be viewed as the trusted resource for science-based oral health information

Objectives:

1. Increase our ability to balance strategic communications and scientific evidence on issues in real time
   - *ADA Strategic Plan Goal/Objectives: C1, C3*
2. Increase our ability to be proactive in addressing emerging issues
   - *ADA Strategic Plan Goal/Objective: A2*
3. Expand our use of non traditional communications technologies to deliver our messages
   - *ADA Strategic Plan Goals/Objectives: B3, C3*
4. Continue to position recognized experts at the local level to address national and state issues
   - *ADA Strategic Plan Goal/Objective: C1*
5. Position ADA as the interpreter of information about oral health and its relationship to general health
   - *ADA Strategic Plan Goals/Objectives: A1, C1*

- Communications Goal: Consistency

The ADA's external communications will be research-based, consistent, coordinated throughout the various ADA agencies, and focused on key messages. All external communications need to be coordinated throughout the ADA to maintain consistency of key messages.

Objectives

1. Improve the collaboration and cooperation among various agencies of the organization
   - *ADA Strategic Plan Goal/Objective: AE4*
2. Increase availability and use of real time data to make informed decisions especially for message development and message delivery
   - *ADA Strategic Plan Goal/Objective: C3*
3. Increase the consistency of messages delivered by the ADA and dental societies at the national, state and local level
   - *ADA Strategic Plan Goal/Objective: C3*
4. Increase member understanding of the importance and value of ADA's external communications efforts.
   - *ADA Strategic Plan Goals/Objectives: AE4*

Resolutions

This report is informational in nature and no resolutions are presented.

Appendix 1

GOAL: ACHIEVE EFFECTIVE ADVOCACY (Key: Goal A, Objectives 1-5)
for both oral health and the dental profession, within the health care, public and policy communities.

Objectives

1. Preserve the dentist as the leader of a team which provides comprehensive oral health care services in any health care system.
2. Advocate for innovations that measurably increase access to care for all segments of the population.
3. Maintain the trusted professional image of the dentist among the top three professions.
4. Achieve full geographic practice mobility for licensed dental professionals nationally by 2008 and explore international mobility issues by 2010.
5. Advocate for the small business interests of the dental office.

GOAL: BUILD DYNAMIC COMMUNITIES (Key: Goal B, Objectives 1-3)
to collaborate through new, cost effective ways on strategic initiatives and policies.

Objectives

1. Achieve a net growth in membership market share of at least 0.5% annually with an ultimate goal of 75% by 2010.
2. Explore new categories of ADA membership addressing oral health care team members, other related populations and the international community.
3. Establish at least three innovative mechanisms that enhance collaboration across all communities of interest within dentistry, the global health care community and the public.

GOAL: CREATE AND TRANSFER KNOWLEDGE (Key: Goal C, Objectives 1-5)
to improve oral health, being the most trusted source for information.

Objectives

1. Increase the Association's value to the public through the transfer of timely, relevant and emerging oral health information, annually.
2. Increase the understanding of oral health by the public, other health professions and legislators by developing at least one initiative specifically tailored to each group every year.
3. Increase the Association's value to the profession annually, through the transfer of timely science and practice information based on data, new knowledge and emerging theory.
4. Participate in at least three initiatives that develop and advance clinical dental practice research.

5. Advance the culture of lifelong learning in the dental profession by developing at least four new mechanisms that address the unique learning needs of the various demographics of the profession

GOAL: ATTAIN EXCELLENCE IN OPERATIONS (Key: Goal AE, Objectives 1-4) through progressive and efficient business management practices.

Objectives

1. Achieve a 2% real growth annually in non-dues revenues in order to minimize dues increases.
2. Explore and implement at least three new and innovative means to achieve direct member and/or potential member input and leadership development that is representative of the demographics of the profession.
3. Gather and utilize appropriate information and market research for major ADA initiatives and target all new ADA products, services and activities with greater acknowledgment of the diversity of the membership across generational, cultural and professional perspectives.
4. Examine and optimize the ADA processes, management and governance structures annually to focus all resources to achieve the Association's strategic goals.

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Board Report 7 Date Submitted: July 2007

Submitted By: Board of Trustees

Reference Committee: Communications and Membership Services

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Build Dynamic Communities (Required)

REPORT 7 OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES: ANNUAL REPORT OF THE STANDING COMMITTEE ON THE NEW DENTIST

Overview: This annual report will summarize the programs and activities of the Board of Trustees 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.

Committee Composition: The following individuals served as members of the Standing Committee on the New Dentist in 2006-07: Dr. Matthew Krische, Kansas, chair; Dr. Jennifer Barrington, Texas, vice chair; Dr. Benjamin Adams, South Carolina; Dr. Jennifer Davis, Pennsylvania; Dr. John Dale Dumas, Mississippi; Dr. Kate Gilson, Wisconsin; Dr. Benjamin Jensen, South Dakota; Dr. Christopher Liang, Maryland; Dr. Garrick Lo, Washington; Dr. Brandon Maddox, Illinois; Dr. Jennifer McConathy, New Hampshire; Dr. Ioanna Mentzelopoulou, New York; Dr. Deepinder Nijjar, California; Dr. Gino Pagano, Pennsylvania; Dr. Ian Paisley, Colorado; Dr. Shiva Shanker, Ohio; Dr. J. Christopher Smith, West Virginia; and Dr. Steven Zuknick, Florida. Dr. Pagano resigned from the Committee in May 2007; his replacement is Dr. Jennifer Davis.

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. At its January and June 2007 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. The Committee has also begun the internal environmental scanning process, focusing on trends in demographics and generational preferences, use of technology and similar topics.

Leadership Development: The Committee is keenly interested in the development of ADA's future leaders. It supports the development of new dentist committees throughout the tripartite. There are currently 42

constituent new dentist committees and 160 component committees in the New Dentist Committee Network. To aid in the development of new committees and enhance effectiveness of established committees, the Committee offers the Basic and Advanced New Dentist Committee Workshops. In 2007, a workshop was conducted for the Ohio Dental Association New Dentist Committee. The Committee is also exploring the use of the online "webinar" format for enhancing outreach and strategic planning for small new dentist committees and those where distance makes it difficult for in-person meetings. The Committee encourages the Board of Trustees to consider involvement in new dentist activities at the local and state level when selecting nominees for the ADA Committee on the New Dentist.

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 five times each year by mail. Electronic copies are posted for download on Dental Society Resources (DSR), a special Web site for tripartite staff and volunteers. Topics range from ADA awards programs and the ADA New Dentist Conference to resource availability and initiatives of interest to new dentists, such as the ADA-Pankey Education Connection, ADA online continuing education opportunities, legislative updates and ADA Catalog products.

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 2007 conference offered extensive leadership programming as pre-conference workshops. The Committee monitors the number of leaders attending as well as the feedback they provide; at the 2007 New Dentist Conference in Portland, Oregon, a total of 61 New Dentist Committee Network volunteers attended from 23 states. Also in attendance were 16 officers and members of the Board of Trustees as well as 15 members of the Committee. The 2007 conference offered leadership development programming for new and experienced volunteers, as well as a session to facilitate networking and peer sharing for all Network leaders.

In an effort to offer leadership development opportunities outside of the New Dentist Conference, the Committee evaluated conference call/web seminar opportunities for leadership development outreach. "Leadership Development Seminar" and "Fostering a Strong Team Ethic" will be offered in 2007. The Committee will evaluate these programs at its next meeting.

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. Individual awards include the Golden Apple Awards for New Dentist Leadership and Outstanding Leadership in Mentoring. Society awards include the Golden Apple for Achievement in Dental School/Dental Student Involvement in Organized Dentistry and the New Dentist Committee Outstanding Program Award of Excellence (recognizing a single program of a state or local new dentist committee). The Committee monitors the number and quality of nominees. In 2007, Dr. Robert Leland of Massachusetts and Dr. Douglas Walsh of Washington State were honored with the New Dentist Leadership award and the Outstanding Leadership in Mentoring award respectively. The Committee selected the Minnesota Dental Association as the 2007 award recipient of the New Dentist Committee Outstanding Program Award of Excellence for its "Ideas Exchange Seminar," which offered recent dental school graduates the opportunity to interact in a series of round table discussions on practice topics following the state's Star of the North meeting. The Texas Dental Association was the 2007 award recipient of the Golden Apple for Achievement in Dental School/Dental Student Involvement for its emphasis on including dental schools and dental students in the Mission of Mercy project.

In order to make resources more conveniently available to the Network and dental society staff, many Committee resources are posted on the DSR Web page. Publicizing this site, and gaining feedback to

enhance it, is an ongoing opportunity for the Committee. A DSR demonstration was held at the 2007 New Dentist Conference and is frequently highlighted in New Dentist Committee Network Updates and is included in the Basic and Advanced New Dentist Committee Workshops curriculum.

Additionally, in response to Resolution 78H-2005, Online Basic Leadership Education (*Trans.*2005:316), the Committee is developing a Web-based leadership training program targeted to meet new dentist needs. The self-guided, modular program with a self-testing feature will cover topics such as the basics of associations, tripartite structure and function, effective leadership, strategic planning, committee organization, policy development, volunteer recruitment and retention, finances, communications and diversity. The program is scheduled to launch in 2007.

All Committee resources and outreach to the New Dentist Committee Network are being evaluated through a Web survey of Network volunteers and staff contacts, to be completed in the fall of 2007.

New Dentist Membership: One key role for the Committee is the facilitation of new dentist involvement in organized dentistry. To encourage tripartite membership for dental school graduates, the ADA implemented an expanded reduced dues program in 2003 and offers a graduate student membership rate. Membership among active licensed new dentists increased one percentage point in 2006 (69.7%) from 2005 (68.7%). This figure represents an additional 418 new dentist members. The Committee supports the availability of these membership options and encourages state and local dental societies through new dentist committee networks to match the ADA Reduced Dues Program for recent dental school graduates and establish reduced dues for graduate students. Promotional materials about the reduced dues program were provided to the senior class as part of the Transition Program and by mail.

The Committee supports the goal of achieving a 75% membership market share for all dentists, including recent graduates, through outreach to dental students and new dentists. The Committee worked with state and local dental societies and new dentist volunteers to provide the Smart Start Program for freshmen and the Transition Program for seniors. The Smart Start Program focuses on financial planning issues and the Transition Program focuses on the transition from dental school to practice. There were 23 Smart Start programs and 12 Transition programs conducted at dental schools across the country in the 2006-07 academic year.

In 2007, an interagency advisory group recommended that ADA's dental school programs be consolidated under the SUCCESS umbrella, and that revisions be made to current programming and new programs developed in order to provide valuable content to students in every year of dental school, each year and at each school. The Board of Trustees approved an implementation plan and the Smart Start Program was incorporated into the SUCCESS: Dental School Programs continuum and the Transition Program was discontinued by the Committee as a stand-alone, ADA-sponsored program. Resources offered to the constituent dental societies will encourage the societies to utilize the Transition Program at the state level. In the 2007-08 academic year, programs offered to each dental school will include the SUCCESS: Smart Start for Freshmen and the SUCCESS: Practice Management for Seniors programs. Committee members continue as presenters for both programs.

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 showcases member resources of particular interest to new dentists and includes a "Network News" section twice a year written by Committee district representatives to highlight activities in

the New Dentist Committee Network. The publication is sponsored by Matsco, an ADA Member Advantage endorsed provider offering practice acquisition, start-up and expansion loans; its focus is a particularly good fit with *ADA New Dentist News* readers. A Reader Survey, conducted every other year to gather data on newsletter design, content and topic relevance, and suggestions for future issues, was distributed in 2007. Reflecting the expressed preferences of new dentists, the 2008 editorial calendar includes the following topics: financing a dental office, researching practice loan options, patient compliance, managing a dental office team, ADPAC, OSHA compliance and dental practice marketing, among others.

Another resource to meet new dentist needs is the ADA New Dentist Conference, which has been offered every summer for the last 21 years. The 2007 conference provided up to 11 hours of high quality continuing education at a low registration fee and was designed to facilitate peer sharing and social opportunities. Ratings for the conference have been consistently high and the Committee continues to consider opportunities to improve the conference experience. At the 2007 conference, the Committee piloted a live webcast of educational programming and expanded opportunities for post-conference purchase of audiorecording (MP3 downloads and CDs) and videorecording (also as downloads or on DVD). Success of these new initiatives will be evaluated by the end of 2007.

In support of new dentist membership, the Committee has also been very active with the Tripartite Grassroots Membership Initiative. Information about the Membership Initiative has been included in mailings to the New Dentist Committee Network, as well as *ADA New Dentist News*. The Committee monitors the percentage of Membership Initiative volunteers who are new dentists; as of July 2007, 21.7% of Membership Initiative volunteers are new dentists, up from 19.5% in 2006.

The Voice of the New Dentist: The Committee provides the voice of the new dentist to nine ADA agencies, through its *ex officio* assignments. 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 Practice, Council on Government Affairs, Council on Membership, Council on Scientific Affairs and ADPAC Board. As a result of the *ex officio* appointment to the Council on Scientific Affairs, the Committee on the New Dentist and the Council on Scientific Affairs will provide, for the fourth year, *The Little Dental Drug Booklet* free of charge to the senior class. Additionally, the Committee and the Council on ADA Sessions will be co-sponsoring 14 workshops at the 2007 ADA annual session.

On other councils, Committee members have provided insight on diverse topics: access to care; course offerings at the ADA annual session; wellness resources for new dentists; 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; 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, ADPAC Board, Symposium on Integrity and Ethics in Dental Education, Center for Education and Lifelong Learning (CELL) CE Online Advisory Group and CELL CE Online Editorial Board.

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. Joseph DeLuca (ASDA); Major Kathleen Morganti, D.D.S. (U.S. Air Force Dental Corps); Captain Kathleen

Seiler, D.D.S. (U.S. Army Dental Corps), Lieutenant Commander Orville J. Stein, D.M.D. (U.S. Navy Dental Corps) and Lieutenant Commander Shani Lewins, D.D.S. (U.S. Public Health Service). The Department of Veterans Affairs consultant position was vacant for 2006-07. Dr. DeLuca provided information to the Committee regarding dental student issues related to membership, dental careers and transition to dental practice as well as conversion of dental students to active membership. 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 income, membership dues, special pays, licensure issues and advocacy initiatives.

Mega Issue Discussions: At its January and June 2007 meetings, the Committee participated in mega issue discussions. The January discussion focused on knowledge-based decision making and discussed the topic "How to Help New Dentists Become Better Dentists." The Committee examined the Intelligent Association model and increased their familiarity with the knowledge-based decision making process to address issues facing the Committee. The Committee answered numerous questions which examined ways to overcome barriers to delivering value to members in the context of helping new dentists become better dentists.

The June discussion, "New Dentist and ADA Membership" further examined outcomes of the January 2007 discussion with an emphasis on "Helping New Dentists Be Better Dentists" and "How Can the ADA Add Value to Membership for New Dentists?" ADA loyalty research results were considered in the context of new dentist loyalty and participation in the ADA. The Committee generated ideas on how the ADA and the Committee can continue to provide resources and programs for new dentist members and made specific recommendations related to communications and member service.

In June, the Committee also held a "mini" mega issue discussion on the topic of teledentistry, following up on a similar discussion held by the Council on Access, Prevention and Interprofessional Relations. Dr. Michael Helgeson of Appletree Dental in Minnesota participated remotely via the Web. The Committee was keenly interested in the topic and took action to request participation in any future work group or task force on teledentistry.

Response to 2006 House of Delegates Assignments: There were no resolutions from the 2006 House of Delegates assigned to the Committee on the New Dentist. The Committee continues to implement activities in response to Resolution 107H-1996 (*Trans*.1996:710) which directed the ADA to formulate a comprehensive plan to assist and educate dental students and recent graduates on issues such as debt management and financing their dental education responsibly and Resolution 52H-1997 (*Trans*.1997:669) which directed the ADA to implement the plan. These activities include offering the Smart Start Program for first-year dental students in the 2006-07 academic year, and the SUCCESS: Smart Start for Freshman in the 2007-08 academic year. In addition, the Committee collects and provides financial information and data through various publications, including *ADA New Dentist News*, *Financial Planning Issues for Dental Students* and results from the *2002 Survey of New Dentist Financial Issues* and the *2005 Committee on the New Dentist Constituent and Component Dental Society Survey* and the *2006 Survey of New Dentist Occupations*, a quantitative survey to provide insight into new dentists' career choices and related income.

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 escalating level of student debt and serves as a resource to dental students through its dental school outreach, while also continuing to develop financial resources for new dentists and dental students. The Committee examined the 2006 American Dental Education Association Survey of Dental School Seniors and determined that the graduating debt from public schools among the

Class of 2006 was $124,700 (up $20,217) and from private and private-state related schools was $174,241, (up $12,741). The Committee will continue to provide information to dental students to assist them in making wise financial decisions that will help them anticipate financial issues related to the transition to dental practice. Through the SUCCESS programs and other financial resources provided, the Committee will continue to address the issues of educational debt and provide new information to students as it relates to managing adequate finances.

The Committee also reviewed the report of the 2006 *Survey of New Dentist Occupations*, a quantitative survey to provide insight into new dentists' career choices and related income. The report reveals average annual income for new dentists of $179,333 for full-time private practitioners, $113,718 for part-time private practice, $38,819 for graduate students and $84,000-$108,000 for other occupations. The report also outlined occupation transitions for new dentists. For example, 54.8% of dentists who are one year out of dental school are in full-time private practice, 8.5% are part-timers, 23.4% are graduate students and 13.4% are in other occupations. By the time new dentists are ten years out of dental school, 77.3% are in full-time private practice, 18.4% are in part-time private practice and a small number are in other occupations. The survey also addressed practice ownership, benefits received by employed new dentists, specialty status, marital status, number of children under 18 in the household, racial/ethnic background and differences between male and female new dentists. For example, while similar numbers of male and female new dentists are single (18.2% for men and 21.7% for women), male dentists are much more likely to have a spouse who does not work outside the home (36.1% for men and 4.4% for women). Overall, the average number of children in a new dentist household was 1.22, but male dentists had more children than female dentists overall.

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.

Through the New Dentist Committee Network, the Committee supports the establishment of mentor programs, peer-sharing opportunities and practice management and clinical continuing education to meet new dentist needs. In 2007, the Committee updated and distributed to dental societies the *Mentor Program Manual* and the *Career Network Manual.* At the national level, the Committee continuously provides resources to new dentists via its New Dentist conference, *ADA New Dentist News*, the new dentist section of ADA.org, Dental Society Resources and the New Dentist Resource Kit (provided free to new dentists on request). The Committee believes that all ADA resources related to associateships and the purchase of a dental practice reflect both the perspectives and needs of the new dentist as well as the more established dentist.

Dental Education. The Committee follows dental education issues, particularly as they impact dental students and new dentists. A member of the Committee participated in the Symposium for Ethics and Integrity in Dental Education, and the Committee supports and encourages participation in the ADA Foundation's Our Legacy—Our Future campaign.

Dental Licensure. The Committee strongly supports the development of a single national clinical examination for initial licensure. The Committee is pleased that the lines of communication between communities of interest are still open and that the ADA plays a role in the examination development process. The Committee has long supported mutual recognition of clinical examinations and receives a report at every meeting reflecting the growth in licensure by credentials and the increase in state dental boards' acceptance of more than one clinical regional examination.

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*. The Committee also provided copies of the most up-to-date licensure information at the New Dentist Conference membership booth in Portland, Oregon.

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 9 Date Submitted: July 2007

Submitted By: Board of Trustees

Reference Committee: Communications and Membership Services

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Create and Transfer Knowledge; Attain Excellence in Operations (Required)

REPORT 9 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 ADA's annual strategic planning activities is submitted as required by Resolution 104H-1990 (*Trans.*1990:570) which directs the Board and staff to establish and implement the ADA strategic planning process and to provide annual reports on its progress.

In addition, information in response to Resolution 59H-2006 (Issues Management) reads as follows:

> **59H-2006. Resolved,** that the Board of Trustees provide to the ADA House of Delegates in 2007, a plan for the implementation of its issues management process incorporating input from the consultant report in 2006 and subsequent feedback from the councils and the tripartite during the limited pilot of the program.

New Scanning Process: The Strategic Planning Committee (SPC), under the direction of the Board, is overseeing the implementation of the new ongoing scanning process, which was approved by the Board early in 2006. In addition, last year the House of Delegates directed that information from this process be utilized in issues identification and management.

Environmental scanning is an analytical process through which organizations identify the forces that will affect their future. For the ADA these are forces of significance to associations, dentistry, and healthcare generally.

In past years, the ADA worked with external consultants to develop periodic (every four years or so) environmental scan reports. In 2005, ADA Board of Trustees directed that an "in-house" process be implemented to conduct scanning and issues identification. It is anticipated that internalizing the process will strengthen the Association's knowledge-base, enhance its ability to track key emerging issues, and help it to monitor socio-demographic, technological, economic, environmental (natural environment), and political trends of significance to the Association, dentists, dentistry and the public.

By routinely "scanning" the published literature, technical journals, popular press, professional meeting findings and other resources, the ADA can anticipate and address upcoming challenges and opportunities of potential importance to the public and to ADA members. Environmental scanning will help the ADA recognize shifts in key trends and to "connect-the-dots" among developments that might otherwise appear unrelated. Guided by such knowledge, the ADA will be better-prepared to act strategically and consider emerging issues.

Under the leadership of the Strategic Planning Committee of the ADA Board of Trustees (SPC), the Office of Strategic Management (OSM) has defined a collaborative process for ongoing environmental scanning based on the recommendations of expert consultants[1]. The process is being implemented in 2007, evaluated and revised as necessary.

The collaborative scanning process involves all the ADA councils, key ADA staff and an initial group of tripartite states. (The process will be opened to all interested states once the initial process kinks are worked out, hopefully by mid-2008.) Participants will contribute information for consideration and review periodic reports by providing feedback on potential implications of the scan information. The councils are being asked especially to focus on their various areas of expertise when scanning for potential emerging trends and issues. The initial five of six states participating have identified their individual members for the process: Alabama—Zack Studstill, Wayne McMahan; California—no individuals identified at report time; Colorado—Gary Cummins, Rhett Murray; Georgia—Mark Ritz, Martha Phillips; Maine—Mark Zajkowski, Jonathan Shenkin, Frances Miliano; and Ohio—Henry Fields, David Owsiany. These state sentinels will provide local trends that may have implications nationwide as well as reviewing and commenting on the quarterly reports which will provide summary lists of trends identified. Council sentinels and all other participants will also provide information to the Scan and review the resultant reports. A final annual report is anticipated although this may not occur until 2008. Periodic 'issues agendas' will result from the process as more immediate concerns are identified. These will be managed through the regular ADA governance processes via the Council on Government Affairs, the Council on Communications and other ADA agencies as appropriate.

To manage the collaborative scanning process and the potentially vast amount of information in the most efficient way, the first two quarters of 2007 have focused on establishing the infrastructure for information processing and storage, and establishing the procedures for use by all the participants. Information will be collected and shared electronically through the SiteScape tool at the ADA. An operational handbook with various forms has been created and is being shared with all the participants in the process.

Issues Identification/Management/Rapid Response Continuum. As a means of ensuring that the ADA has the ability to rapidly respond to emerging or quick-moving issues, the Division on Government and Public Affairs has created three advocacy teams, each comprised of staff from congressional affairs, federal affairs and state government affairs who work together on a specific range of issues. Each team also has Council on Government Affairs (CGA) members assigned it, and these staff/volunteer teams communicate frequently between CGA meetings as issues emerge or bills/regulations are identified that potentially require a response. The advocacy teams use the new position review forms to ensure that a paper trail is established to ensure that both a thorough review is conducted and that all appropriate stakeholders are included in the review.

Pilot Project Approach. 2007-08 will be years during which the ongoing scanning/issues identification process as currently designed will be constantly evaluated to determine whether it is productive, cost-efficient and meets ADA's needs as envisioned. Revisions will be made along the way as necessary and the whole approach will be reevaluated with further recommendations to the Board at the end of that period.

The Strategic Planning Committee (SPC) of the Board held two meetings during 2007. The 2007 SPC members are: Dr. Teri Barichello, chair, Oregon; Dr. James B. Bramson, ADA executive director; Dr. William Calnon, trustee, Second District; Dr. Mark Feldman, ADA president-elect; Dr. John S. Findley, trustee, Fifteenth District; Dr. William G. Glecos, trustee, Third District; Dr. Kim U. Jernigan, Florida; Dr. Matthew Krische, Kansas; Ms. Mary Logan, ADA chief operating officer; Dr. Jeanne M. Nicolette,

[1] The Forbes Group, Alexandria, VA and Suzanne Resnick, SMR Project Management.

trustee, Seventh District; Dr. Carol Summerhays, California; Dr. M. Lynn Wallace, South Carolina and Ms. Beril L. Basman, SPC facilitator, managing vice president, ADA Office of Strategic Management. Mr. Mark Rubin, Esq., and Mr. Thomas Elliot, Esq., ADA Division of Legal Affairs, and Ms. Diane Ward, manager, ADA Office of Strategic Management, provided staff support to the Committee.

Resolutions

This report is informational in nature and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS.

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Board Report 12 Date Submitted: July 2007

Submitted By: Board of Trustees

Reference Committee: Communications and Membership Services

Total Financial Implication: See below for details

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

REPORT 12 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: UPDATE ON STATE PUBLIC AFFAIRS PROGRAM

Introduction: This report constitutes an overview of the progress of the nationally coordinated state public affairs program approved by the 2006 ADA House of Delegates. It focuses broadly on:

1. Success metrics;
2. Significant outcomes;
3. Lessons learned;
4. Program calibration for 2007 and planning for 2008; and
5. Budget Update.

The House should be aware that timing limits the scope of this report. In some cases, operations in the participating states did not begin for several months into the year. Indeed, some states are just coming on board at this writing (July 20). Work in other states is ongoing, and in the case of some Tier 1 states, activities such as media education, materials development, opinion research or coalition building are just being initiated. The House, Board of Trustees and other tripartite leaders will continue to receive monthly reports that provide greater detail of specific activities.

Throughout this and other reports on this initiative, the term, "state public affairs (SPA) team" refers to the combined ADA leaders, staff and Chlopak, Leonard, Schechter Associates (CLS) staff working on the project at the national level. "Local team" refers to the combined ADA and state dental society leaders and staff, CLS and local consultants.

Overview: Every state was interviewed and invited to participate in the program depending on state-specific needs. The Board of Trustees has been able to grant every request (in a few instances modified) from states wishing to participate in the program, with nine states each in Tiers 1 and 2 and one state benefiting from customization of a national research project. Local operations include (but are not limited to):

- Narrowly targeted pushes for legislation to increase water fluoridation or reimbursement for dentists who treat patients under Medicaid;
- Broader efforts to prevent or defeat proposals that would inappropriately limit or restrict the choice among safe and effective treatment options;
- Creating incentives to locate more dentists in designated underserved areas; and
- Pursuing new allied dental worker models, such as the community dental health coordinator, intended to increase access for underserved populations without compromising the safety or quality of care.

In addition to conducting these state-specific operations, the SPA team is:

- Consolidating some of the research projects planned for individual states into a national program investigating public knowledge of and attitudes toward issues involving perceived risks and benefits of water fluoridation and restorative materials, and various aspects of access to care issues, including the degree to which access is lacking, financing Medicaid, supervision and scope of practice of allied personnel, and adequacy of the dentist workforce. This will provide greater benefits to all states from research;
- Conducting region-wide research and spokesperson training on restoratives in the First District, where legislative and regulatory activity remains particularly intense;
- Coordinating national and state activities in support of federal bills to address meth mouth and reauthorize SCHIP; and
- Compiling a library of case histories, talking points, editorial essays and other resources to help both participating and non-participating dental societies keep current on common issues and avoid wheel-reinvention when working on those issues (referred to as Tier 3 of the program).

The combination of a dramatic increase in ADA staff support, backed by CLS and local consultants, has significantly increased state societies' capacity to communicate with the media, legislators, other stakeholders and the public. Operating on so many issues in so many locations is new to everyone involved. Evaluation and calibration must occur continually. But, by and large, the SPA program is dramatically improving state dental societies' public affairs capabilities.

Success Metrics (Updates are in *Italics*):

1. Participation by approximately 20 states. Involvement of significantly fewer would signal a failure to engage states. Involvement of more than 20 would indicate a failure to manage program scope.

This metric is being met. As of July 1, nine states each are enrolled in Tier 1 or Tier 2. Wyoming (denturism) and Washington (meth mouth, ADHP) recently have requested assistance. Maryland (Medicaid and other issues) and Georgia (access issues) are likely to do so formally in the next few weeks.

2. Focus efforts in states with greatest need, whether by importance of issue or resource need.

This metric is being met. The majority of participating states are small and fit the "greatest need" criterion, including Arizona, Connecticut, Iowa, Maine, New Mexico, South Carolina and Vermont in Tier 1 (year-round, multi-issue support), and Alaska, Louisiana, Montana and North Dakota in Tier 2 (time-limited, single-issue support). Among the better-resourced participating states, Pennsylvania has benefited from an external perspective provided by outside consultants, to which the state would not have been exposed without this program. Minnesota is facing an advanced dental hygiene practitioner educational program that will admit its first class in 2008. And Texas is undertaking a unique, major research/publication project on access to care that could substantially benefit all of organized dentistry.

3. Budget covers planned activities in selected states without significant over- or under-spending.

This metric is being met. As the budget update below shows, the SPA program is running under budget at mid-year, owing primarily to 2007 being the first year of the program. The SPA team has recommended additional opinion research into issues critical to all states, additional regional activities, such as the restoratives training seminar in the First District, a seminar for state lobbyists at that

group's annual meeting, and ramp-up operations during Q4 of 2007 in states that expect early legislative activity in 2008. It is expected that approximately $550,000 will remain unspent at year end. ***The House should note that savings of this magnitude are unlikely in 2008 after more states are engaged. The program is fully funded at 2007 levels in the 2008 budget.***

4. Improve state outcomes compared to prior years; manage brand/reputation by taking the offensive.

This metric is being met. At this writing, the SPA program has helped two states, Missouri and Connecticut, win fights to increase Medicaid funding. Oregon, North Dakota and Montana did not achieve their legislative goals this year, but all report great satisfaction with the SPA program, stating that their outreach efforts enhanced their positions with the media and other key audiences in ways that make success in the future more likely. Details on these and other states follow in the "Significant Operations and Outcomes" section of this report.

5. Public affairs efforts in individual states strengthen the reputation of dentistry nationally.

There is no mechanism built into the initial design of this program to measure progress in this metric. The SPA team is including in plans for the remainder of 2007 and for future years a research instrument to answer this. Details on this appear in the sections on calibration for the remainder of 2007 and planning for 2008 that follow. Both research and anecdotal reports from state societies in those states that are engaged or have engaged in purely defensive issues, such as proposed amalgam bans, suggest that even wins can cost a state in both reputation and expenditure of political capital. This contrasts with states such as Connecticut (successful Medicaid increase) and California (oral health assessment requirement for public-school children), in which dentists and dentistry received extensive, positive media coverage.

6. Surveys of state societies and/or public demonstrate that program has influenced opinion.

The SPA team will conduct a more formal survey of participating states over the summer. Pending that outcome, here are some comments from participating states:

- *Vicki Wilbers, executive director,* ***Missouri Dental Association****: "Through the ADA state public affairs initiative, we were provided with an arsenal of resources regarding Medicaid history in other states, information about negative impacts of removing oral healthcare benefits to those less needy and links on the importance of oral healthcare to overall health care. It was then through CLS we received assistance in delivery of the message to the public, our members and the legislators. Our efforts were successful with full reinstatement of adult dental Medicaid beginning in 2008."*

- *Liz Snow, chief strategy officer,* ***California Dental Association****: "Both CDA volunteer members and staff are excited about the attention our public awareness partnership has generated. ADA's assistance has allowed California to embark on an innovative program targeting ethnic communities with a positive message about oral health and organized dentistry. Together we have helped strengthen dentistry's image with policy makers and opinion leaders. Additionally, we created an opportunity to further our contacts and relationship with the media."*

- *Mary McCue, executive director,* ***Montana Dental Association****: "In Montana funding from the ADA through the state public affairs program allowed us to carry our message to all corners of the state of the maldistribution of dentists, particularly in our rural areas. . . . The most*

successful aspect of the program in Montana involved our hiring of an experienced lobbyist to assist me in lobbyist the RIDE (Regional Initiatives in Dental Education) legislation. Although we were not successful in getting funding for RIDE this session we are very well positioned for our next legislative session to request and receive additional funding for dental education of Montana students."

- *Rick Murray, executive director,* ***Arizona Dental Association****: "Our staff and volunteers have found our progress to be substantial. We feel that the state public affairs program is doing exactly what is was intended to do and that is to help individual states with their priority list of action items."*

- *Larry Carl, executive director,* ***Iowa Dental Association****: "An exceptional partnership between the Iowa Dental Association and the American Dental Association! Because of the partnership, there are significantly more high quality resources available to address the needs of Iowa dentists."*

- *Frances Miliano, executive director,* ***Maine Dental Association****: "The MDA Executive Board is extremely pleased with our participation. We think we have a great team hired . . . they work well together and each has unique strengths that complement each other. . . collecting 'good news' stories about Maine dentists . . . developed a full MDA media kit . . . has traveled around the state with a local area dentist to meet with editorial boards of several newspapers. . . interviewing key 'stakeholders' to determine their perception of the MDA and how they see MDA as a player (or not) in the public policy arena, and helping the MDA Executive Board develop a game plan to build political capital and become more effective in solving the access to care problem in Maine (determined to be the key issue). If it weren't for our position as a Tier 1 state, we would never be able to be this engaged on our own….limited staff, time, and resources.*

- *Bill Zepp, executive director,* ***Oregon Dental Association****: "When an amalgam separator bill, scope of practice and denturist questions were added to the mix, Oregon moved from Tier 2 to Tier 1. I cite that promotion because one of the advantages I see to this program is that as soon as the ADA folks and CLS recognized the fact that our situation was changing, this program was flexible enough to change with it and they were able to move in and give Oregon some additional resources in the fight."*

7. Volunteer and state society buy-in results in support for ongoing program in 2007 HOD.

Feedback from participating states and others indicates strong support. The Board welcomes additional feedback from the House.

Significant Operations and Outcomes:

- **Alaska** completed the signature-gathering phase for a ballot initiative to *re*fluoridate the city of Juneau (the state capital), which elected last year to stop fluoridation. With the petition certified, this means that there will be a question on the next ballot. The combined team has launched the campaign which will include opinion research and advertising. The public affairs team also is encouraging the ADS to explore other ways to raise its profile as a leader in improving oral health among the state's underserved populations.

- **Arizona** is reaching out to Native American and other underserved populations to provide basic oral health education, preventive services and triage patients for referral to dentists. The local team has focused initially on outreach to potential allies and other third parties, resulting in heightened awareness of the AzDA as a leader in improving oral health throughout the state. The **New Mexico** Dental Association is considering collaborating with Arizona on the portion of the community program that addresses Indian reservations, because Navajo Nation straddles the two states.

- **California** is conducting a major paid and earned media campaign to educate dentists and families about the new requirement that children entering public schools receive an oral health assessment. The campaign has generated significant, positive media coverage for the CDA and has sweetened the dental society's relationships with both the executive and legislative branches of government.

- **Connecticut** succeeded, in collaboration with a coalition of groups, in getting $20 million for additional funding for dental Medicaid in the state budget. The team now is focused on working to influence the Department of Social Services, which administers the Medicaid program, to limit the dental funding to children's care, which was the intent of the legislature. There is concern that the department may try to use the funds for both adults' and children's care. If adult care is included, the funds would not be adequate to increase reimbursement appreciably and, therefore, dentist participation also would not increase. The national team oversaw local consultants, who guided the CSDA's leading role in a coalition of groups supporting the measure. Activities included media outreach and advertising. As is so often the case, the story isn't over. CSDA still must labor to ensure that the state's Department of Social Services implements the program in such a way that dentists are sufficiently reimbursed to secure their participation in Medicaid.

- **Maine** defeated a proposed amalgam ban and an effort to defluoridate Bangor through a ballot initiative. The local team now is working to influence a "sunrise review" committee that is considering creating separate boards for hygienists and denturists, create a mid-level provider and license foreign trained dentists.

- **Missouri** successfully advocated for reinstatement of adult Medicaid dental coverage. Here again, vigilance is needed to guard against the possibility that the state health agency does not administer the program in ways that discourage dentists from participating.

- **Vermont** fended off bills in both the House and Senate that sought to ban the use of amalgam. However, Vermont in particular, and New England generally, remain hotbeds of anti-amalgam activity, and adversaries are all but sure to renew their efforts every year.

- **Montana, North Dakota and Oregon all engaged in ambitious single-issue public affairs campaigns that fell short of their ultimate legislative goals but achieved significant progress nonetheless.**

    - The local team ran a well-organized and vigorous campaign in **Montana** to fund slots for students from the state to attend the University of Washington dental school. Although lobbying and media operations succeeded in garnering support for the proposal, it died for the year. The state dental society remains extremely pleased with the public affairs support it received from the SPA program, which resulted in multiple, positive media placements and other reputation-building outcomes. The MDA is enthusiastic about renewing this push in the next legislative session.

- The local team in **North Dakota** also did everything right on the media, third-party and lobbying fronts in its effort to increase funding for dental care in Medicaid. After securing passage of similar bills in both the House and Senate, the effort stalled when a back-room deal stripped nearly all funding from a conference measure. Here again, the state dental society is extremely pleased with the progress made, both in pushing the issue and in enhancing the image of the state's dentists. The NDDA is enthusiastic about another attempt during the next legislative session in 2009.

- An **Oregon** bill that would have mandated community water fluoridation appeared headed for passage until some of the state's environmental groups succeeded in scaring key senators away from supporting it. The local team executed a comprehensive strategy, including media, lobbying, coalition-building and grassroots. This was a case of being outgunned at the grassroots level. Here again, the dental society remains enthusiastic about the SPA program. The local team will focus on building infrastructure, with an emphasis on beefing up the Healthy Smiles Coalition's grassroots capability with the aim of reintroducing fluoridation legislation next year and broadening the coalition's focus to include other issues that affect Oregonians' oral health.

Lessons Learned: This section of the report is perhaps the most important because it will help all of us improve the program moving forward, and it also helps show the program's limitations if we fail to take the lessons seriously. Some readers might find a few of the lessons difficult to swallow, especially what we have learned about how the public reacts quite differently to certain issues than we react to them within the profession. By pointing out what we have learned from the public, this report does not intend to suggest that the profession's perspective is wrong or misguided. Rather, these lessons help inform the work of the states and the ADA and what we can expect to achieve—or not—if we overlook or ignore how the profession or our organizations will be perceived.

Program in General

- **The advantages of a proactive agenda cannot be overemphasized.** Every state society, whether a direct SPA participant or not, would be well-served by identifying and pursuing initiatives that position dentistry squarely on the side of the public by, for instance, crafting and advocating solutions to access problems that help more people get needed care from dentists. This might consist of narrowly targeted proposals, such as a plan to bring more dentists into underserved areas, an increase in Medicaid reimbursement or a requirement that public school children receive oral health assessments, with referrals to dentists as appropriate, and adequate funding to provide needed care. Or it could be as ambitious as a long-term, comprehensive plan for the state's oral health.

- Dental societies should make every effort to initiate these efforts *before* competing proposals emerge from other interest groups. If competing proposals have already emerged, the society must work all the harder to position itself as a source of better ideas, rather than simply as a "spoiler."

- As noted earlier, 2007 resources precluded the ADA's having to turn down a single state's request for assistance. Should resources be more squeezed in future years, the Board may consider a state's willingness to lay out and pursue an active, rather than reactive agenda as a criteria for selection.
Coalition building can be critical to both short- and long-term success. Historically, this has not been dentistry's strong suit, and this must be reinforced on an ongoing basis. On issues like water fluoridation and, especially, larger access-to-care issues like scope of practice, dentistry cannot count on

winning if it is out there on its own. Accordingly, the program is increasing its efforts to help states build new coalitions and lead existing ones.

- **Societies should work to build and enhance their reputations *before* they are challenged.** Many smaller dental societies don't have the staff or other resources to fix the roof while the sun shines. In other cases, the society historically has seen no need for active public affairs absent a threat or challenge. States participating in tier 1 of the SPA program are recognizing great value from outreach to other stakeholders and the media as building-block activities.

- **The program must focus more on developments at the national level that provide opportunities to state societies.** This is occurring already on such issues as meth mouth, on which the public affairs team is preparing a comprehensive toolkit to help states conduct local activities to position themselves as leaders in preventing meth addiction and treating the raving oral affects of meth use. It also is evident in the team's decision to redirect to the national level a significant amount of opinion research on issues that are common to many states. But greater infrastructure is needed to increase the effectiveness of both state societies *and* the ADA to take coordinated, comprehensive actions on both breaking events and longer-term, strategic issue management. This infrastructure likely will include recommendations for increased staff and other resources in the future.

- **More research is needed at both the national and state levels.** In addition to focusing on specific issues, the research projects conducted so far at both the state and national levels underscore the need to learn more about public perception of dentistry and oral health.

    - None of the participants in four focus groups on scope of practice and supervision had first-hand experience or even knowledge of access to oral health care as a significant issue. Participants in those groups struggled to compare dental surgical procedures to medical procedures in terms of complexity or seriousness.

    - Research also is needed to gauge the standing of the state dental societies and the ADA among targeted audiences. This cannot be accomplished solely through polling voters or consumers. Some of dentistry's most important issues—particularly those relating to access to care—can be decided without ever registering with the public.

    - Tracking opinion regularly is important not only to the success of individual state operations, but also in measuring progress to the ADA Strategic Plan goal of maintaining "the trusted professional image of the dentist among the top three professions."

- **State societies vary dramatically in their capabilities to take action, interact with consultants and, in some cases, make decisions.** Some states are very advanced, and are essentially ready to move when the SPA program's resources become available. Others don't have capacity to send out press releases, or craft and pursue a proactive public affairs agenda. Depending on internal society dynamics, some can move quickly to a consensus position on their public affairs—others taking much longer. The national team has found that in-person strategic planning meetings with state society staff and leaders and local consultants often are needed to help states focus on their goals and strategies to pursue those goals.

- **State societies find it easier to oppose opponents' legislative proposals than to advance their own solutions.** It is easier to build consensus internally to oppose something imminent, whereas divisions within state society membership can make it difficult for states to take on an issue affirmatively. This is especially significant on issues such as scope of practice, in which experience and research show that

simply fighting someone else's bad proposal isn't enough, absent a competing solution that addresses access problems in ways that the state society and its members can support. Unless and until state societies build consensus around their own initiatives they remain in a defensive posture which, even if they succeed in defeating threats, can cause significant reputational damage.

- **Early starts can be critical—especially in states with short legislative sessions.** The Montana and North Dakota initiative in particular would have been better served by ramping up in the Q4 of 2006. This was, of course, not possible because the program was not yet operational. But it should guide future efforts.

- **Local consultants who provide turnkey service—media, lobbying, coalition-building—and who have experience in developing strategies for public affairs campaigns offer distinct advantages over teams assembled from multiple vendors.** The latter has worked well in some states, less so in others. The fact that many states have existing relationships with contract lobbyists can limit choices. But in any case, consultants from different firms must be encouraged—in some cases pressured—to work in close collaboration and to participate meaningfully in strategic planning, in addition to providing tactical support.

- **Maintaining trust and buy-in of states' existing outside consultants—such as contract lobbyists—is a critical success factor.** The SPA team has had to deal with local lobbying firms suspicious of its motives. These firms sometimes react with concern that their services are not up-to-par and that the SPA team is intended to supplant them. It is important to assuage this concern early on in dealing with outside firms.

- **The amount of ADA and CLS staff time required to manage this program exponentially exceeded expectations.** SPA program management originally fell to a single staffer in the Department of Public Affairs (formerly Strategic Communications), with unofficial but substantial assists from State Government Affairs and Legal Affairs. At the midyear point, staff from Public Affairs and State Government Affairs work on the program essentially full-time, and a dozen staff from the Division of Government and Public Affairs put in substantial time. Staff conducts as many as five, one-hour conference calls with state dental societies and local and national consultants and vendors daily. Staff travel also has greatly exceeded what was anticipated, with key staff traveling at least weekly, and sometimes more frequently. The amount of work involved will warrant permanent staff restructuring as the program evolves.

- **National dental leaders must help their constituents understand the SPA program.** Managing expectations on an investment of this scope is critical to helping members understand the long-term goals and successes of the program. Early on, some state society leaders expressed confusion and frustration, based in many cases on the misperception that the ADA was going to conduct a major advertising or PR campaign to enhance the profession's image. Although $3.8 million is a substantial investment, it would require funding of another magnitude to conduct such a campaign. More pointedly, that is not what the House of Delegates authorized in approving funds for the SPA. Rather, it is to help the state dental societies and the ADA identify and achieve policy goals in critical issue areas. For the most part, the campaign does not target the general public, except through earned media and extremely limited advertising, both of which target specific issues and initiatives in individual states.

- **Members need to understand that the success of the program cannot be judged solely on individual, short-term outcomes, particularly when it comes to passing legislation, which is subject to so many variables.** Certainly, the program is racking up victories on state-specific issues. But even

in cases in which a legislative or ballot effort fails, participating states are building long-term equity with public officials, the media and other key audiences. This is arguably much more significant to the ADA's and state societies' long-term abilities to "achieve effective advocacy" on behalf of their members. The larger goal is to develop ways for state societies to obtain objectives without resorting to the use of political "chits;" instead, the societies will work with other stakeholders to develop meritorious proposals that legislators will want to support.

Comments on Specific Issues

Amalgam

- States with strong inside lobbying capabilities still are preventing passage of bans but polling suggests these will become increasingly very tough battles, as environmental concerns, which are less clear cut than health claims, continue to dominate policy discussions.

- When voters are first exposed to the issue, a substantial majority favor a ban. Exposure to effective messages brings the pro amalgam side to an effective draw which, while an improvement, is no guarantee of success.

- The increasing public awareness of the danger of mercury exposure in general will make this issue increasingly difficult.

Fluoride

- The recent defeat of a "soft" mandate bill in Oregon demonstrates the difficulty of fighting this on a statewide basis. Despite professed support, key lawmakers bolted at the last minute rather than risk angering powerful environmental groups.

- Maine's successfully defeating a defluoridation ballot initiative demonstrates the importance of forging alliances with public health groups.

- The ongoing ballot initiative to *re*fluoridate Juneau, Alaska will be another test case.

- The ADA should consider reaching out to national environmental organizations in an effort to mitigate local chapter opposition to fluoridation.

Access – Financing

- Dentists are not perceived negatively for advocating for more Medicaid funding. This should help address state societies concern about being perceived as self-serving if they advocate for Medicaid increases, as long as this is not the only strategy for improving access to care..

- Medicaid increases, even when passed, present new risks and challenges. Legislators easily can water down a proposed funding increase during negotiations. If the reductions are significant, the funds may not be adequate to induce more dentists to participate, which creates the awkward situation in which dentistry must explain why, having secured additional funding, participation and utilization don't improve. For this and other reasons, lobbying for increased funding of government dental programs must be viewed as an ongoing process, rather than a one-time event.

- As in North Dakota, even the best efforts can still fall short in the face of legislative budget wrangling. This reinforces need for societies to provide long-term leadership on oral healthcare issues to ensure a seat at the table in budget negotiations affecting their issues.

- Initial qualitative research shows that while there is very low awareness of the dental funding crisis in Medicaid, respondents tend to support increasing funding when it is framed as a reallocation of existing Medicaid funds toward dental care, rather than a tax increase to provide more services to low-income people.

- The most effective messages focus on investing in preventative dental care to save money in the long run and the connection between oral health and overall good health.

Access – Scope of Practice and Supervision

- Initial qualitative research shows that people appear comfortable allowing hygienists to perform the same basic services as they do now without a dentist's supervision.

- People are not comfortable with the idea of hygienists performing surgical procedures like root canals.

- Proponents of expanding the scope of non-dentists to include surgery likely will emphasize the argument that additional training makes it possible for them to do so safely and skillfully.

- The strongest message emphasizes that dentists' training, continuing education and certification make them singularly qualified and experienced to perform surgical procedures.

Program Planning for the Remainder of 2007 and 2008:

- **Greater focus on national and issues activities that can benefit the states.** As noted above, the original program design did not take into account the degree to which states need assistance capitalizing on and responding to events at the national level. Examples include the death of Deamonte Driver, release of oral disease statistics by the CDC that showed increased dental disease among young children, and grassroots support and state-federal articulation around federal legislation such as SCHIP, other access bills and the meth mouth bills.

- **A more formal process for states to apply for participation.** ADA and CLS staff conducted conference calls with almost every state society during November, December and January to explain the program and gauge which states needed and wanted to participate. (Some states decided that the call was not needed.) This was a necessary, if time-consuming part of the ramp-up process. However, state societies now should be sufficiently familiar with the program that much of the initial discussion can be obviated by having interested states fill out an application form. A more formal application process might also induce interested states to consider the need for a proactive agenda and a strategic approach to pursue that agenda.

- **Identifying states to participate in 2008 has already begun**. In many cases, ramp-up for 2008 activities will begin in Q3 2007, to better prepare for legislative activity as soon as the new year begins.

- **Research will be ramped up in Qs 3 and 4 2007**. Projects under consideration include:
    - Further exploration of scope-of-practice issues;

- Benchmarking in individual states, focused primarily on those states in which operations are just beginning; and
- Exploration of how the renewed push for universal health coverage might affect dentistry.

- **Additional states will be added to the program in Qs 3 and 4 2007.** Most state operations did not begin until well into Q1 of 2007. This, along with scrupulous budget management, will afford additional states the opportunity to participate in the program before year's end. Discussions are under way with several states, with recommendations likely to be made to this Board at its July and September meetings.

- **Ramp-up operations for states participating in 2008 will begin in Q4 of 2007.** To the extent possible, state selection, hiring of local consultants, strategic planning and design of research projects will be timed so that operations can begin immediately in the new year.

Budget Update: For this first year of the program, this report provides more detail than needed on the budget, to help delegates understand how funding is needed/used for these types of activities. In future years, it is expected that the budget will be summarized with less detail, which, of course, will always be available upon request.

State or Program-Consulting Fees	Jan-June	Expenses	July-Dec	Expenses	Total
AK Media Services	$24,000	$500	$66,000	$2,000	$92,500
AK Ivan Moore Research	$0	$0	$6,625	$0	$6,625
AZ Moses Anshell	$30,000	$200	$45,000	$0	$75,200
CT Duby McDowell	$25,440	$200	$25,440	$0	$51,080
IA PolicyWorks	$6,000	$200	$36,000	$0	$42,200
PA Triad	$22,500	$200	$30,000	$0	$52,700
ME Public Affairs Grp & JD'A	$37,500	$200	$45,000	$0	$82,700
MT 3 consultants	$14,700	$400	$0	$0	$15,100
NM DW Turner	$14,500	$200	$17,500	$0	$32,200
ND Kranzler Kingsley	$6,000	$200	$0	$0	$6,200
OR Conkling Fiskum McCormick	$32,000	$200	$48,000	$0	$80,200
VT Kimbell Sherman Ellis	$30,000	$200	$30,000	$0	$60,200
CLS	$360,000	$43,000	$360,000	$43,000	$806,000
ADA Travel (staff and volunteers)	$0	$40,748	$0	$40,000	$80,748
Subtotals	**$602,640**	**$86,448**	**$709,565**	**$85,000**	**$1,483,653**
Research and Other Projects					
New England Amalgam Research	$64,119	$0	$30,000	$1,000	$95,119
South Carolina Research	$28,000	$0	$0	$0	$28,000
National Messaging Focus Groups	$0	$0	$105,297	$6,000	$111,297
Juneau Fluoridation Campaign	$0		$115,640	$0	$115,640
Northeast Communications Seminar	$0	$0	$20,000	$0	$20,000
Missouri Print Ad	$2,406	$0	$0	$0	$2,406
Connecticut Print Ad	$7,048	$0	$0	$0	$7,048
Connecticut Radio Ad	$17,486	$0	$0	$0	$17,486
California Matching Funds	$0	$0	$250,000	$0	$250,000
Contingency Fund	$250,000	$0	$0	$0	$250,000

Subtotals	**$369,059**	**$0**	**$520,937**	**$7,000**	**$896,996**
Total Consulting, Research & Projects	**$971,699**	**$86,448**	**$1,230,502**	**$92,000**	**$2,380,649**
Original Budget					**$3,780,000**
Unobligated Balance					**$1,399,351**
Projected Expenditures					
LA Consultant	$0	$0	$30,000	$200	$30,200
MN Consultant	$0	$0	$30,000	$200	$30,200
WA Consultant	$0	$0	$30,000	$200	$30,200
WY Consultant	$0	$0	$30,000	$200	$30,200
Addn'l '08 Ramp-up Consultants (6 states)	$0	$0	$90,000	$1,200	$91,200
MN Research (survey and two focus groups)	$0	$0	$43,000	$0	$43,000
NM Research (statewide survey)	$0	$0	$29,000	$0	$29,000
IA Research (survey of IDA members)	$0	$0	$45,000	$0	$45,000
PA Research (survey of PDA members)	$0	$0	$45,000	$0	$45,000
Amalgam Partial Ban survey	$0	$0	$23,000	$0	$23,000
ADHP/CDHC focus groups (two)	$0	$0	$16,470	$1,500	$17,970
ADHP/CDHC in-depth interviews (15-20)	$0	$0	$28,000	$0	$28,000
Native American focus groups (6)	$0	$0	$70,000	$3,000	$73,000
Universal Care focus groups (four)	$0	$0	$32,942	$3,000	$35,942
Universal Care national survey	$0	$0	$47,060	$0	$47,060
Access National survey	$0	$0	$100,591	$0	$100,591
Dental Tourism focus groups (4)	$0	$0	$41,000	$0	$41,000
Dental tourism survey (soCA, AZ, NM, TX)	$0	$0	$56,000	$0	$56,000
Dental Hygienist survey	$0	$0	$53,000	$0	$53,000
TX Study	$0	$0	TBD	TBD	$0
Subtotals	**$0**	**$0**	**$840,063**	**$9,500**	**$849,563**
Remaining uncommitted funds					**$549,788**

Notes to the Budget Update. The obligations to date, commitments through year end, and the additional states and projects that are currently anticipated will leave approximately a balance of $550,000 in uncommitted funds at year end. The major components of this are:

1. The plan as presented to the Board and House last year includes a reserve of $250,000 to address problems that develop late in the year in one or more states.

2. Another $250,000 of the remaining funds results from a ramp-up process that occurred in Qs 1 and 2 of 2007. This amount would have been spent had the program been operating at full capacity, with the ability to make commitments to all states that needed help on January 1, 2007.

The pace of the 2007 program ramp-up also affected the establishment of a financial reporting system. It took some months to get a clear picture of the program's "burn rate," during which the team was necessarily

conservative in committing funds beyond what was deemed essential, in order to ensure that the program did not overspend. With a firm hold on financial reporting in place, the team has identified the priority projects listed in the table above and will be better positioned to commit funds to individual states for such projects white papers, advertising and media events, all of which the team limited in Qs 1 and 2 of 2007.

Thus, as noted above, it is expected that approximately $550,000 will remain unspent at year end.

Resolutions

This report is informational in nature and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS.

Resolution No. 53 New ■ Substitute □ Amendment □

Report: NA Date Submitted: September 17, 2007

Submitted By: Seventeenth Trustee District

Reference Committee: Communications and Membership Services

Total Financial Implication:

Amount One-time $ 2,655 Amount On-going $

ADA Strategic Plan Goal: (Required)

STUDY OF EFFECT OF GROUP ACCEPTANCE OF INTERNATIONAL DENTISTS AND ADA BRANDING

The following resolution was submitted by the Seventeenth Trustee District and transmitted on September 17, 2007, by Mr. Dan Buker, executive director, Florida Dental Association.

Background: The ADA is among the most respected organizations representing dentistry and is made up of approximately 130,000 members. Its brand is widely recognized throughout the world. The ADA has many policies and gives direction to its individual members regarding such things as ethics, appropriate levels of care, and professionalism. Traditional methods of accepting members provides for adequate screening of applications on an individual basis. Accepting individual members as part of a large group does not afford the ability to adequately screen applications on an individual basis. Because most of the world opinion of the ADA is based on the behavior of the membership both in groups and individuals, the potential effects of accepting groups should be studied.

Resolution

53. Resolved, that the appropriate bodies of the ADA including the Council on Membership and Council on Communications study the potential effects of accepting members in groups rather than on an individual basis with regards to the value of the ADA brand and how it would be affected by potential misuse of ADA membership representation and report to the ADA House of Delegates in 2008 as a report with enabling resolutions, if necessary, and be it further

Resolved, that the ADA does not engage in group acceptance of members until ADA policy has been resolved by the ADA House of Delegates.

BOARD COMMENT: The Board agrees that the value of the ADA brand is very important; it both affects, and is affected by, every ADA initiative from the various agencies and divisions of the Association. The Board concurs that any consideration of group membership would require substantial study and input from ADA leaders and members, and involves many issues, including perception of the ADA nationally and internationally, financial implications, collaborative opportunities and many other factors. The Committee on International Programs and Development, a Standing Committee of the Board, and the Council on Membership have discussed this issue in the context of questions from a few international dental associations interested in offering affiliate membership to their members. At its August 2007 meeting, the Committee on

International Programs and Development recommended that it appoint two members to participate on a workgroup with the Council on Membership to explore issues relating to affiliate membership, in order to make recommendations to both agencies. The Board believes that the topic of group affiliate membership relative to the ADA brand amongst other issues should be considered as part of this discussion.

BOARD RECOMMENDATION: Vote Yes on Referral.

BOARD VOTE: UNANIMOUS.

REPORT OF THE PRESIDENT

As I stand here today, it is hard to believe a year has passed and I have seen my role as ADA president unfold to this moment. The time has gone so quickly, it seems only a short time ago that I stood before you, telling you that the ADA has a platter of activities we're engaged in and that platter is overflowing. Today that statement is as true as it was last October. And our Association should have a full menu of important, critical programs and projects continuously—working our volunteers, staff and the Board of Trustees to the fullest potential!

I can report to all of you today: we are functioning in overdrive; and though it is stressful and exhausting at times, it is also energizing and fulfilling!

I want to begin my report by turning for a moment to a subject that has consumed so much of our time and attention these past few years: the continued practice of surgery by non-dentists on Native Alaskans living in some of Alaska's rural communities and, specifically, the settlement that the ADA reached this summer in our lawsuit seeking to halt that practice.

Nothing about this issue has been easy; but for me, the most difficult part has been the degree of confusion and, unfortunately, mistrust that it has engendered within our organization.

So I want to take this opportunity to set the record straight, in the hope that beginning now this House of Delegates can turn its eyes forward and concentrate on the challenges ahead.

First, there is the matter of the Board's confidentiality on this issue prior to the settlement agreement. Confidentiality is fundamental to negotiating in good faith. If you can't guarantee that to the other side, they aren't going to negotiate with you. More pointedly, confidentiality is critical to maintaining whatever leverage you have in a settlement discussion.

These fundamental principles precluded the ADA Board from being able to provide to the House and all of the other groups and individuals with a stake in this issue a constant stream of updates and rationales for every move. When we could share updates, we did. And after the settlement, we prepared a lengthy Q&A outlining the Board's reasons for its actions.

Of course, nature abhors a vacuum, and this holds just as true when it comes to information as it does in physics. In the absence of comprehensive, accurate information, it's perfectly natural for people to form their own ideas about what's happening. In the Internet age, someone who's upset, struggling to understand, and has a finger poised over the "send" button can easily create controversy where none should exist.

The ADA Board and Officers pursued, and will continue to pursue, the goals that we all share and the policies that support those goals: protecting patients from possible harm at the hands of well-intentioned but under-trained providers and helping bring the best quality dental care to people who badly need it.

Last year, the Democratic take-over of Congress extinguished any last vestige of hope we may have had that Congress would amend the Indian Health Care Improvement Act to prohibit DHATs from performing surgical procedures. This year, unfortunately, our attempt to use the courts to reach that same goal led to another dead end.

Obviously, it is also true that the settlement with the ANTHC the Board approved does not achieve our goal. But the lawsuit had become a major roadblock in and of itself. By removing it, we have at least cleared the

way to continue pursuing our aims, by working with the ANTHC and others in crafting programs that will lead to more dentist-provided care in remote rural Alaska.

The more dentists there are providing care in these areas, the less need for other solutions. The only way we can ensure that dental patients get the level of care we believe is appropriate is if we are at the table where decisions are made. When you consider the merits of settling the suit, you also have to consider the alternative. That alternative was to spend hundreds of thousands of additional dollars on an appeal in spite of sound legal advice that we would have no reasonable chance of prevailing, as well as good political advice that even a miracle win would in short order be overturned by Congress.

Then there's the matter of how continuing a court battle would affect the larger issue of preventing the spread of non-dentists doing surgery. Our lawsuit against the ANTHC has had the unfortunate side effect of tarnishing our reputation among the public health community, the media and some policymakers. This is not a popularity contest; but, when you're in a hole, the first thing you need to do is stop digging.

If we really want to end the practice of non-dentists performing surgery, we need to turn our attention and energy away from blaming one another for what has already occurred and toward becoming the undisputed leaders in creating solutions that will bring professional dental care—that is, care led by fully qualified and licensed dentists—to the millions of Americans who don't currently receive it.

We're making great strides in that direction by helping individual states take the lead in access solutions through our state public affairs initiative, and by national initiatives such as the community dental health coordinator, the oral health literacy effort and many other promising programs.

The decisions made by the Board give us a foundation upon which we can build long-term solutions to access problems in tribal areas and thousands of other communities across the nation where problems continue to exist.

The work involved in coming to the next phase of activity in Alaska was by no means the only work we accomplished over the course of my year as president.

As March arrived and a young man in Maryland died tragically, apparently from an untreated dental disease that led to severe infection, the spotlight focused on the system of dental care for the underserved in America. The public and the policymakers reacted with justifiable outrage. It is unacceptable that in 2007 a child in this country could die from a dental infection.

It will take all of us and the broad range of coalitions engaged in this issue to bring about significant change. Working together, we can press those policy makers for action. The time is now.

You've heard it said that all politics is local. It is also true that all need is local, and it follows that the answer to need must ultimately be local. That's what makes our community dental health coordinator such an effective solution—a preventive resource in the public health setting, reaching out to people in need where they live, in exactly the areas where our delivery system has fallen short. This new provider is focused on prevention and health promotion in community settings, with someone from the community working there, providing both clinical services and education to the families. We must stay on track with the pilot testing of the education and then the implementation and replication that will place these new care providers where they are needed throughout the country.

We have also made strong progress in responding to this House's call to strengthen elder care and promote greater oral health literacy. Our work in these two critical areas will continue to evolve and the public will be grateful for the efforts we expend.

In the first year of the public affairs initiative the House approved last year, we have racked up important victories in participating states and created materials that can be used when needed in other states throughout the country.

We have another important opportunity for success in the Our Legacy: Our Future initiative. It must succeed—because what is at stake is the future of the foundation of our profession: dental education. I challenge all of you to be as generous as you can in your support of this initiative.

It has been an exceptional year for me. The people I have worked with this year and throughout my time with the ADA have been the best part of the experience.

My close working relationship with Mark Feldman has meant so much to me. He served you well as your treasurer, and I know the ADA will be in great hands with Mark as your president this coming year.

To so many of you right here in the House: thank you so much for your warm hospitality and interaction as I traveled and met with you in your districts. Your generosity, support and sharing of ideas have meant so much to me.

There are some among our colleagues in dentistry who stand out for their exceptional commitment and talents. I would like to recognize the leaders of our federal dental services here today in our House. Would the federal dental chiefs stand to be recognized?

On a personal note, I had the pleasure of meeting with the then Brigadier General Gar Graham of the Air Force in March when he hosted me to welcome a C-17 military plane of wounded U.S. soldiers returning home from Iraq. That day at Andrew's Air Force base is etched in my mind forever as one of the moments I was proudest to be an American and on that day the welcoming voice for the ADA.

Last month General Graham became a two-star Major General. The ADA lobbied hard and successfully in 2005 to ensure that a two-star general would lead the Air Force dental corps. Another proud moment in my presidency came on August 24 when I had the honor of attending the ceremony in which he was promoted.

Congratulations again General Graham and my most sincere thanks to you and to all of our federal dentists.

I also continue to be impressed and honored to work with some of the most dedicated and impressive supporters of our profession within the ADA: our staff, both in Chicago and in Washington. To all of you who work so hard to support our profession and keep its voice strong—Jim, Mary and all of you on the ADA staff—thank you so much for all you do. If you are here with us today, please stand and be thanked by this House!

And as I thank those who have made this year so special, my Board comes first and foremost. It has been an honor to work with such a conscientious, dedicated group of leaders. We tackled the most difficult of issues, always professional in our debates, exploring every option for solutions, and when the tough decisions had to be made, we stepped up to the job. Thank you for such outstanding leadership through trying times.

I also want to recognize my colleagues in District Nine who supported me over these last years and made this opportunity of leadership possible. Thank you all!

And certainly my biggest gratitude is to the dentist I happen to know best—Dan. Thank you for supporting me through all these intense, blackberry-filled days. I don't see how anyone could do this job without the love and limitless understanding of family. Mine is the greatest—Dan, Sara and Jeff, Andy and Julie, and most of all my grandkids Kate and Joe!

I would like to close with a few comments for the House as you continue your deliberations into this coming week.

First, be good listeners. Knowing all the facts is important to formulating good decisions.

Second, keep the well-being of our patients and all that this encompasses as the basis of all of your plans.

Lastly, use science as your pillar of strength, because it always gives credence and authority to any of our endeavors as a profession.

I wish you well in your deliberations and thank you for the honor and privilege of serving as your ADA president. God bless!

Dental Benefits, Practice, Science and Health

Resolution No. 6 New ■ Substitute □ Amendment □

Report: NA Date Submitted: July 2007

Submitted By: Council on Dental Practice and Council on Government Affairs

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)

NOTIFICATION OF PROSTHETIC CASES SENT TO FOREIGN OR ANCILLARY DOMESTIC LABS FOR CUSTOM MANUFACTURE

Background: (*Reports*:92)

Notification of Prosthetic Cases Sent to Foreign or Ancillary Domestic Labs for Custom Manufacture: Resolution 69H-2006 (*Trans.*2006:326) directed that that the appropriate agencies of the ADA investigate the feasibility of requesting federal or state agencies to require that a subcontracting dental laboratory notify the dentist in advance when prostheses, components or materials indicated in the dentist's prescription are to be manufactured or provided, either partially or entirely, by a foreign dental laboratory or any ancillary domestic dental laboratory, and that the appropriate agencies of the ADA report their findings to the 2007 House of Delegates.

Both the CDP and the Council on Government Affairs (CGA) discussed Resolution 69H-2006 at their respective spring 2007 Council meetings. An understanding of existing regulations is essential in determining the best approach to fulfill the intent of the resolution. The Food and Drug Administration (FDA) has the legislative authority to regulate medical (including dental) devices through the Food, Drug and Cosmetic Act. The FDA does not require the registration of dentists or dental laboratories with respect to a dental prosthesis. Only the materials used are regulated and it is assumed by the FDA that only FDA materials will be used in the manufacture of prostheses. The FDA does regulate dental prostheses, by function:

- *Registration.* If a device is imported from overseas, the FDA requires the foreign exporter to register. The U.S. agent accepting the prosthesis is also required to register.

- *Labeling.* Current FDA regulations require that if a *foreign* dental laboratory fabricates a case, the laboratory must either label the case as "Manufactured for (name of lab contracting with dentist)" or "Distributed by (name of lab contracting with dentist)." This means that dentists do not know prior to delivery where a case will be fabricated or the origin of the materials. Upon delivery of the case, the dentist would need to note the "manufactured by" or "distributed by" label on the case and understand its significance. Some dentists may wish to have this information prior to selecting a dental laboratory.

- *Materials.* As part of importation, the manufacturer must certify that only FDA-approved materials are used. Actual enforcement of this requirement is done by the U.S. Customs and Border Protection in coordination with the FDA.

Both the federal and states approaches were considered as means to address the advanced disclosure of subcontracting of dental prosthesis to a foreign laboratory.

The FDA does not believe it has the authority to regulate dental labs as suggested by Resolution 69H-2006; therefore, pursuing a legislative change to the Food, Drug and Cosmetic Act would be required. The federal approach would require the support of the U.S. Congress to change federal law to give the FDA regulatory authority over dental laboratories that it does not currently have (nor want or support); would be a very long-term process (require years to accomplish both the legislative and then regulatory process); would require a compelling reason to change the law; and ultimately, any subsequent regulation could impact both dentists and dental laboratories in unanticipated ways. Additionally, the federal approach could be considered in conflict with ADA policy that states: "The Association opposes the creation of additional regulatory boards to oversee dental care and therefore, opposes any form of governmental regulation or licensure of dental laboratories not promulgated under the auspices of the state board of dentistry."[1]

The states approach is consistent with current ADA policy on laboratory regulation and offers many advantages such as, expediency and ability to create state-specific policy based on impact on members, including determining if the regulation should be voluntary or mandatory. One state, Missouri, offers its members a downloadable advance disclosure form on its Web site.

The NADL feels that voluntary regulation will not be effective because there will be no means of enforcement. Rather, the NADL advocates that each state regulate dental labs through registration and/or certification of either laboratories, laboratory technicians or both. Therefore, the Councils recommend adoption of the following resolution.

Resolution

6. Resolved, that the Statement on Prosthetic Care and Dental Laboratories (*Trans.*1990:543; 1995:623; 1999:933; 2000:454; 2003:365; 2005:327) be amended in the section The Laboratory/Technician by the addition of the following new language before Glossary of Terms Related to Dental Laboratories:

> **Notification of Prosthetic Cases Sent to Foreign or Ancillary Domestic Labs for Custom Manufacture:** Constituent dental societies are urged to pursue legislation or voluntary agreements to require that a subcontracting dental laboratory notify the dentist in advance when prostheses, components or materials indicated in the dentist's prescription are to be manufactured or provided, either partially or entirely, by a foreign dental laboratory or any domestic ancillary dental laboratory.

BOARD RECOMMENDATION: Vote Yes.

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

[1] Statement on Prosthetic Care and Dental Laboratories (*Trans.*1990:543; 1995:623; 1999:933; 2000:454; 2003:365; 2005:327)

Resolution No. 11 New ■ Substitute □ Amendment □

Report: CDBP Supplemental Report 1 Date Submitted: June 2007

Submitted By: Council on Dental Benefit Programs

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Create and Transfer Knowledge (Required)

COUNCIL ON DENTAL BENEFIT PROGRAMS SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES: UPDATE ON DENTAL TOURISM

Background: This report is a follow-up to the Board of Trustees' mega issue discussion on dental tourism at its February 2007 meeting. The mega issue discussion was a continuation of the dialogue on dental tourism that began at the 2006 House of Delegates and Resolution 44H (*Trans*.2006:323) which reads as follows.

> **44H-2006. Resolved,** that the appropriate ADA agency research the issues surrounding the practice of dental tourism including service levels, quality, reimbursement, ethics and other related concerns especially those associated with problems related to the payment of dental claims to non U.S. practitioners, and be it further
>
> **Resolved,** that the appropriate ADA agency initiate dialog with benefits administrators and representatives of the dental insurance industry, including payers and purchasers and regulators, to address treatment, payment and claim-related issues related to dental tourism, and be it further
>
> **Resolved,** that the appropriate ADA agency report its findings to the 2007 House of Delegates, including any recommendations for new or revised policies addressing the concerns related to dental tourism.

Simply put, dental tourism is obtaining dental services while traveling or vacationing in another country. For many years, patients have been seeking lower cost health care in countries other than the U.S. What is often referred to as medical or dental "tourism"—patients going to a different country for either urgent or elective procedures—is fast becoming a world-wide, multi-billion dollar industry.

Dental tourists from the U.S. are seeking treatment in other countries that is either not covered by their insurance, or can be obtained at a fraction of the cost. Implants, crowns and dentures are among the dental services for which patients seek treatment elsewhere. For many of these individuals, becoming a dental tourist is a chance to combine their vacation with elective dental care.

The Board invited guest speakers to provide various industry perspectives on dental and medical tourism including a physician who is the medical director of the nation's largest employer health care purchasing coalition, a dentist representing the dental insurance industry, and an ADA economist. The speakers helped to frame the discussion by providing a broad understanding of the issue. The Board sought information to help answer the question, "*What will be the impact of dental tourism on the ADA and the practice of dentistry and how can the ADA ensure success for itself and its members in this arena?*"

Expert Testimony on the Current State of Dental Tourism: The Board heard three speakers who gave a detailed overview of the current state of dental tourism. While all the speakers agreed that dental tourism is not currently at the level of magnitude of medical tourism for the general U.S. population, they believe that the ADA's strategic planning for dental tourism will prepare them well for the future. They also recognize that member dentists in border states are very concerned about the care their patients are receiving outside of the U.S.

Arnold Milstein, M.D., M.P.H is the medical director of the Pacific Business Group on Health, the largest employer health care purchasing coalition in the U.S. He has authored recently published articles on the subject in *Health Affairs* and the *New England Journal of Medicine*. Dr. Milstein reported:

- Offshore providers are being added to U.S. insurer networks.

- Economic pressures of global competition are forcing employers to shift health care costs to their employees, and as these insurance costs rise, the number of individuals with health insurance drops. CEOs of large companies are seeking ways to alleviate the rising cost of healthcare for their employees including using a network of providers that meet lower-cost and high-quality measures.

- Overseas pricing of dental and medical procedures is 50-80% less that in the U.S.

- Americans will travel for care in instances of a life-preserving intervention.

  --Based on a random study, Dr. Milstein reported that individuals less well off would be willing to travel for care outside the U.S. if their savings were between $500 and $1,000. The amount rises to $5000 for those who can better afford it.

- Dentistry probably has five years before the prevalence of dental tourism increases to a noticeable level.

Dr. Milstein closed by suggesting that the profession work closely with dental schools and continuing dental education to address future needs.

- Thomas Fleszar, D.D.S., M.S., president and chief executive officer of Delta Dental of Michigan, Ohio, Indiana and Tennessee also addressed the Board. He indicated that from a payer perspective: Less than $1/100^{th}$ of their business is for foreign claims.

- While they are seeing an increase in foreign claims, currently 2% per year, the balance of trade for dental care will not shift negatively for the U.S. for a decade or more.

- Additional cost and time goes into processing foreign claims. Every foreign claim is reviewed by hand.

- Delta requires original documentation of all treatment including a dated, paid receipt confirming payment method and currency, the treating dentist's full name, license number, address and phone; fee(s) for services. Reimbursement is only made to the patient when all criteria are met.

- Delta generally only pays 60% of the foreign claims that come in.

- While they have some concerns about the claims for care across U.S. borders, they realize that patients have freedom of choice.

Dr. Fleszar also indicated that Delta conducts extensive claims review for foreign claims. They utilize International SOS (ISOS) service for overseas reviews (www.internationalsos.com). They go out to each practitioner and check:

- language proficiency (presumably, ability to communicate with patients in their native language)
- that environmental cleanliness meets "standards"
- that educational degrees are legitimate

If there are any complaints or issues, that dental office's claims will not be paid until there is a resolution to the problem(s). In a nutshell, ISOS proclaims to be the world's leading provider of medical assistance, international healthcare, security services and outsourced customer care. With over 4,400 professionals operating in 65 countries, they help organizations manage the health and safety risks facing their travelers, global workforce and customers.
Dr. Fleszar closed by recommending that for patients who seek care outside the U.S., the ADA should work toward providing them with a system for selecting the best care. World markets are changing, but resistance to the change is not the answer.

Dr. Jack Brown, managing vice president of the ADA's Health Policy Resources Center, also provided an economist's perspective of dental tourism.

Board Discussion: Following the testimony, the Board discussed several issues related to dental tourism. Resolution 44H-2006 charges the ADA with developing and understanding the complex issues by opening dialogue with other stakeholders and reporting to the 2007 House of Delegates. The Board felt that while the testimony indicated that dentistry may have several years to address this issue, they wanted to immediately begin to address the impact of dental tourism on the profession—not only those who practice in U.S. border states, but on the profession as a whole. The Board approached the topic by looking at not only minimizing the risks, but also maximizing opportunities for the Association and the profession. The ADA is working to position the profession for the future through:

- increasing quality of workforce through ADA Foundation work in education
- increasing efficiency by maximizing use of technology through the work of the Council on Dental Practice (CDP) (to improve the functionality of the electronic claim); the Department of Dental Informatics (DDI) (to improve dental practice through the application of computer and information science); and the ADA's National Healthcare Information Infrastructure (NHII) Task Force (to proactively advocate for the needs of dental patients and the goals of the dental profession in the electronic health record).
- improving access through the development of new practice models, such as the Community Dental Health Coordinator (CDHC)

The Board also followed up on some of the points addressed by the speakers including the statement that, with the exception of the U.S. border states, dental tourism is not as large an issue as the media might suggest. The Board believes that dental tourism is a symptom of decreased access, cost shifting to patients and the "flattening" of the world. Also, because dentistry has not defined quality in terms that some patients/consumers can understand, these same patients may focus primarily on cost. Some patients that are initially satisfied with their care may not know whether it meets any level of quality until problems arise at a later date.

The Board believes that:

- higher cost elective procedures are most vulnerable to dental tourism
- lack of follow-up care and the inability to file a complaint in the case of bad treatment may limit a patient's desire to receive care abroad
- bundling of dental and medical procedures can be self-limiting (i.e., a patient can only have so many procedures done while on "vacation"
- recovery times and locale may inhibit a patient's desire to travel for care
- language and cultural barriers may exist for some patients

Based on the testimony received, and discussions held during its February meeting and a follow-up report presented to the Board's April meeting by the Associate Executive Director, Dental Practice, the Board requested that the Council on Dental Benefit Programs develop ways to help patients and plan purchasers better understand the value of quality dentistry as well as the value of having a dental home.

Recommendations: The Council, at its April 2007 meeting, reviewed the materials and testimony presented to the Board. The Council, like the Board, believes dental tourism is a symptom of decreased access, cost-shifting to patients and the "flattening" of the world. While the amount of dental tourism may not currently be at the level of medical tourism for the general U.S. population, the Council recognizes that member dentists in border states are very concerned about the care their patients are receiving outside of the U.S.

Individuals may choose to travel to another country to obtain dental care for many reasons. Generally, patients perceive the value of dental services either in the U.S. or abroad based on their perception of quality of service and cost. When they feel that they can obtain care that is personally acceptable in terms of quality, and total cost of treatment abroad is attractive, they may elect to receive treatment abroad. Total cost includes travel expenses, time commitment, potential cost of re-treatment and liability exposure.

The Council further believes that the appropriate ADA agencies should continue to keep abreast of developments impacting dental tourism, use the information to actively position our membership as the "world leader" in the profession and continue to provide all relevant information to the membership on this issue. Therefore, the Council recommends adoption of the following resolution.

Resolution

11. Resolved, that the following strategies to address dental tourism by appropriate ADA agencies be adopted:

- continue to support ADA members in general and those who practice in border states specifically, by promoting the value of dentistry in the U.S. and the importance of a dental "home" through patient, payer and plan purchaser education

- recommend that the Council on Dental Benefit Programs contact, and when appropriate, work with representatives of the dental insurance industry, including payers and purchasers, to address treatment, payment and claim-related issues related to dental tourism including "standard of care," liability, disclosure and performance guarantees

- recommend that the Health Policy Resources Center and appropriate ADA agencies further research the practice of dental tourism including: service levels (both U.S. patients abroad and foreign patients receiving treatment in the U.S.); quality; reimbursement and other related concerns

- recommend that the appropriate ADA agencies examine and monitor regulations and legislation at the state and federal level related to dental tourism

- work to increase access to care for the uninsured while monitoring the affects that a movement to a single-payer system might have on dental/medical tourism

- recommend that the appropriate ADA agencies review existing credentialing procedures for foreign dentists who treat U.S. patients abroad in comparison to existing procedures

- increasing technological efficiencies for the profession by working to improve functionality of electronic claims processing and proactively advocate for the needs of dental patients and the goals of the dental profession in the electronic health record

- recommend that appropriate ADA agencies monitor the ethical ramifications of dental tourism

- monitoring the migration and economics of dental office technology, including laboratory services, out of the country

and be it further

Resolved, that in order to continue to address the issue of dental tourism, the ADA adopt the following definition of dental tourism, including categories based on cost and urgency of treatment, in order to address concerns of the membership while at the same time, prepare the profession for the future.

Dental Tourism is the act of traveling to another country by patients for the purpose of obtaining non-emergency dental treatment, and can be grouped in one of the following categories:

- Category I: High-cost, non-urgent major procedures suitable for air travel anywhere in the world by any (U.S.) patient.

- Category II: Many non-urgent services suitable for longer-distance driving/bus travel to Canada or Mexico by U.S. patients within a reasonable drive from the respective border.

- Category III: Most non-emergent services suitable for shorter-distance driving/bus travel to Canada or Mexico by U.S. patients living immediately adjacent to the respective border.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 16 New ■ Substitute □ Amendment □

Report: CAPIR Supplemental Report 1 Date Submitted: July 2007

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: $60,000

Amount One-time $60,000 Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy; Create and Transfer Knowledge (Required)

COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS
SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES:
ACTIVITIES TO IMPROVE ORAL HEALTH LITERACY

Background: This report provides an update about activities related to oral health literacy (OHL) and a summary of proposed activities for 2008. The 2006 House of Delegates adopted Resolution 14H (*Trans*.2006:317) which affirmed that "limited oral health literacy is a potential barrier to effective prevention, diagnosis and treatment of oral disease" and authorized the formation of the National Oral Health Literacy Advisory Committee in its adoption of Resolution 17H (*Trans*.2006:317), an ad hoc advisory committee of the Council on Access, Prevention and Interprofessional Relations (CAPIR). Resolution 17H reads as follows:

> **17H-2006. Resolved,** that the ADA President appoint, with the recommendation of the Council on Access, Prevention and Interprofessional Relations, a three-year oral health literacy ad hoc advisory committee, not to exceed 12 national health literacy experts from dentistry, public health, literacy and other advocacy organizations, and be it further
>
> **Resolved,** that this advisory committee assist the Council in developing policy recommendations, targeted educational strategies and other health promotion programs to address oral health literacy issues.

In July 2007, the Council adopted the following purpose for the National Oral Health Literacy Advisory Committee (Committee or NOHLAC). The charge of the Committee includes, but is not necessarily limited to:

- assisting the Council on Access, Prevention and Interprofessional Relations (CAPIR) to develop recommendations about policies, programs, interventions and research related to improving oral health literacy
- discussing challenges facing oral health literacy practice and research and making recommendations to minimize these barriers
- reviewing select ADA policies, at the Council's request, and making recommendations to CAPIR for amending or developing oral health literacy related policies

- serving as an informal conduit of information between the ADA and external organizations and institutions on activities related to oral health literacy

- identifying and making recommendations to CAPIR about approaches to promote oral health literacy through mechanisms and partnerships in both the public and private sectors

- aiding CAPIR to identify public and private resources to support proposed oral health literacy programs and other activities.

National Oral Health Literacy Advisory Committee: The National Oral Health Literacy Advisory Committee was appointed by the ADA President and includes the following 12 representatives: Dr. Lawrence H. Meskin[1] (chair), director of Continuing Dental Education, University of Colorado School of Dentistry; Dr. Philip Barbell, director of Dental Risk Management & Consulting, The Redwoods Group; Cynthia Baur, Ph.D., director of Health Communication and Marketing, National Center for Health Marketing, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; Ms. Jill Griffiths**,** vice president of Business Communications, Aetna, Inc.; Alice Horowitz, Ph.D., advisor to the Dean on Health Literacy, College of Health & Human Performance, University of Maryland at College Park; James Hyde, M.A., associate professor of Family Medicine & Community Health, Tufts University School of Medicine; Debra Roter, Dr.P.H., professor, Johns Hopkins Bloomberg School of Public Health; Rima Rudd, Sc.D., senior lecturer, Department of Society, Human Development and Health, Harvard School of Public Health; Dean Schillinger, M.D., assistant professor of Clinical Medicine, University of California at San Francisco; Joanne Schwartzberg, M.D., director of Aging and Community Health, American Medical Association; William A. Smith, Ed.D., executive vice president/senior scientist and director of Social Change Group, Academy for Educational Development; Michael S. Wolf, Ph.D., Assistant Professor of General Internal Medicine and Director, Health Literacy and Learning Program (HeLP), Institute for Health Care Studies, Feinberg School of Medicine, Northwestern University.

The CAPIR chair appointed one Council member, Dr. Scott Lingle, to serve as a liaison to the Committee. At CAPIR's request, the Council on Communications (CC) chair appointed one CC member, Dr. Teri-Ross Icyda, as a liaison to the Committee.

The Committee held its first meeting April 11-12, 2007, at the ADA Headquarters Building in Chicago. Committee members discussed their vision of the Committee (in light of Resolutions 14H-2006 and 17H-2006 and the ADA 2007-2010 Strategic Plan), identified possible challenges and barriers to the ADA's efforts to improve oral health literacy, developed focus areas to address these obstacles and created a set of strategic goals to guide the Committee's future work (see Appendix). These activities were reported to CAPIR for its consideration following the NOHLAC April meeting. These focus areas and strategic goals, approved by the Council, will also form the foundation for CAPIR's comprehensive plan to address oral health literacy. These focus areas and goals encompass oral health literacy in relation to dental education and practice, public awareness, research, policy development and coalition building.

During the April meeting, the Committee met with Dr. Kathleen Roth, ADA president, and Dr. Jack Brown, managing vice president of the Health Policy Resources Center, who invited the Committee to submit several

[1] In the interval between the April Committee meeting and the preparation of this report, Dr. Larry Meskin died unexpectedly on June 26. The Council gratefully acknowledges his enthusiastic leadership and service to CAPIR and the Committee. A new member will be appointed by the ADA President, and a chair will be selected by the Committee at its next meeting.

oral health literacy questions for inclusion in the upcoming ADA survey in rural and low socioeconomic urban areas. The same questions may also be included in the periodic "Survey of Current Issues in Dentistry" (SCID) which is also scheduled to be administered in 2007.

American Public Health Association Invitation (APHA): CAPIR has been invited by the organizing Committee of the Oral Health Section of APHA to lead a presentation, "Oral health literacy: The dental profession's response," at APHA's annual meeting in November 2007. This interactive session will focus on what the oral health care team can do to reduce the information burden and more effectively communicate with dental patients and the general public. Approaches to promote oral health literacy through systems and partnerships in both the public and private sectors will be discussed. The APHA session may further inform future recommendations by the Council. The APHA's invitation is a milestone in the relationship between the ADA and APHA which, at times, been tumultuous. Collaborating within the framework of improving the nation's oral health literacy provides the opportunity to continue to bridge the gap between the ADA and its public health colleagues.

Oral Health Literacy Surveys: In 2008, CAPIR proposes to develop two questionnaires to better understand health literacy in the context of oral health care. The first will be a survey of dental team members to ascertain knowledge, attitudes and behaviors related to health literacy and communication. The second will be a survey of dental schools to determine the extent to which oral health literacy and communication skills are addressed in current curricula. The findings from these surveys will assist CAPIR in its planning of future continuing education for member dentists and other intervention strategies with the profession and the public. The costs for these surveys are $60,000 to develop, pre-test and administer the surveys, $50,000 for the professional questionnaire and $10,000 for the educational survey. This amount also includes basic statistical analysis and reporting of the results.

Oral Health Literacy Symposium: CAPIR also proposes to conduct a one and one-half day oral health literacy symposium as a pre-conference meeting to the 2008 American Dental Association Annual Session. This interactive session would focus on oral health literacy and its implications for the dental practice, including effective communication by the dental team, ethical responsibilities and risk management. The keynote address would set the tone for the session by describing limited oral health literacy in the context of the Surgeon General's "National Call to Action to Promote Oral Health." The former Surgeon General, Dr. Richard Carmona, is being considered as the keynote speaker because of his leadership and commitment to health literacy during and after his term of service. Other speakers would guide discussions related to oral health literacy and its potential impact on the dental team and their patients. The learning objectives include 1) recognizing the problem of limited oral health literacy and its impact on health outcomes, 2) discussing the ethical responsibilities related to oral health literacy, 3) describing the potential liability risks associated with patient-provider communication and limited oral health literacy and identify ways to mitigate these dangers and 4) exploring practical solutions for dental team members and organizations to improve their responses to patients with limited oral health literacy.

The ADA received funding in the amount of $20,000 from Great-West Life & Annuity Insurance Company to partially support a 2008 symposium. A fund has been established within the ADA Foundation for donations targeted toward oral health literacy initiatives. The Great-West contribution has been deposited into this account. The Council will continue to seek additional external support for CAPIR's future oral health literacy activities.

In conclusion, the Council recommends adoption of the following resolution.

Resolution

16. Resolved, that the Council on Access, Prevention and Interprofessional Relations, in consultation with appropriate ADA agencies, develop, pilot test, administer and analyze a survey of dental team members about their knowledge, attitudes and behaviors regarding oral health literacy, and be it further

Resolved, that the Council, in consultation with appropriate ADA agencies, conduct a survey of dental schools to determine the extent to which curricula and continuing education courses address oral health literacy and associated professional communication skills.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 16S-1 New ☐ Substitute ☐ Amendment ■

Report: NA Date Submitted: Sept. 20, 2007

Submitted By: First Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: $60,000

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Advocacy (Required)

AMENDMENT TO RESOLUTION 16:
ACTIVITIES TO IMPROVE ORAL HEALTH LITERACY

The following amendment to Resolution 16 (Worksheet:4011) was submitted by the First Trustee District Caucus and transmitted on September 20, 2007, by Dr. Joseph R. Kenneally, caucus coordinator.

Background: The First Trustee District would like to propose a friendly amendment to Resolution 16. On page 4011, line 4, after the word "members," please add the phrase "and other health care professionals"; and on line 7, after "dental schools," add the phrase "medical schools, and allied health training programs." (Additions are shown by underscoring.)

Resolution

16S-1. Resolved, that the Council on Access, Prevention and Interprofessional Relations, in consultation with appropriate ADA agencies, develop, pilot test, administer and analyze a survey of dental team members and other health care professionals about their knowledge, attitudes and behaviors regarding oral health literacy, and be it further

Resolved, that the Council, in consultation with appropriate ADA agencies, conduct a survey of dental schools, medical schools, and allied health training programs, to determine the extent to which curricula and continuing education courses address oral health literacy and associated professional communication skills.

BOARD COMMENT: The Board gratefully acknowledges the work of the First Trustee District and its desire to broaden the scope of the proposed studies. However, the Council's purpose for these surveys is to specifically target dentists, dental team members and dental schools. Many studies have been conducted in the fields of medicine, medical schools and residency programs, allied health professional training and physician-patient communication. The proposed studies will provide the first-ever reliable, generalizeable data on the dental profession and health literacy. The National Oral Health Literacy Advisory Committee, an ad hoc committee of the Council, has identified these areas as critical factors in the ADA's efforts to improve oral health literacy. The Committee has examined existing data sources and has not found information on the oral health profession's understanding of the health literacy problem. These surveys will contribute to the limited information about health literacy and the response of the dental team.

The Board believes that increasing the scope of the study to include other health care professionals will dilute the impact of the research and would be redundant, as much of the data already exists regarding the knowledge, attitudes and beliefs of other health care professionals and their training programs specific to health literacy. Therefore, the Board recommends that Resolution 16S-1 not be adopted.

BOARD RECOMMENDATION: Vote No.

Board Vote:													
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
☐	■	☐	☐	CADLE	☐	■	☐	☐	GRAMMER	☐	■	☐	☐	SCHWEINEBRATEN
☐	■	☐	☐	CALNON	☐	☐	☐	■	GROVER	☐	■	☐	☐	SMITH C.
☐	■	☐	☐	FELDMAN	☐	■	☐	☐	KELL	☐	■	☐	☐	STRATHEARN
☐	■	☐	☐	FINDLEY	☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SYKES
☐	■	☐	☐	GIST	☐	■	☐	☐	MANNING	☐	■	☐	☐	TANKERSLEY
☐	■	☐	☐	GLECOS	☐	■	☐	☐	NICOLETTE	☐	■	☐	☐	WEBB
☐	■	☐	☐	GLOVER	☐	■	☐	☐	SCHWARTZ					Res. 16S-1

Appendix

National Oral Health Literacy Advisory Committee

Vision, Focus Areas and Strategic Goals

Vision: Providers, organizations and their publics have the capacity to make appropriate oral health decisions.

Focus Area 1: Competing issues and scarce resources of potential partners

Goal 1.1. Establish oral health literacy as a priority issue for dental-related organizations.

Goal 1.2. Obtain adequate funding for CAPIR, other ADA agencies and/or external organizations to implement significant oral health literacy improvement projects.

Focus Area 2: Insufficient evidence of effective health literacy interventions

Goal 2.1. Summarize, communicate and replicate known best practices or "near-best" practices in responding to limited health literacy.

Goal 2.2. Develop, refine, test and translate oral health literacy-specific interventions with the public and dental team members.

Focus Area 3: Scope of oral health literacy is broad and complex

Goal 3.1. Establish mutually agreed upon (by all affected constituencies) priorities and targeted actions and audiences to address limited oral health literacy (i.e., limit the things to be accomplished to a realistic set of actions).

Goal 3.2. Set priorities and make decisions based on the best science available.

Focus Area 4: Limited recognition of the importance of oral health literacy by the dental team (cultural and linguistic differences, jargon, gender, age, disabilities, etc.)

Goal 4.1. Educate and convince dental team members that limited oral health literacy is an issue for their practice settings.

Goal 4.2. Develop and evaluate training programs for dental team members to address limited oral health literacy in private and public practices.

Goal 4.3. Create, adopt, implement and evaluate model oral health literacy curriculum module(s) for use in dental schools and training programs for allied dental team members.

Focus Area 5: Unclear who should take what actions to address oral health literacy

Goal 5.1. Define key activities, stakeholder responsibilities, allocation of resources and timelines through action planning processes.

Goal 5.2. Encourage coalition development and shared responsibility among key oral health and related organizations.

Goal 5.3. Coordinate, monitor and evaluate Implementation strategies and task assignments.

Focus Area 6: Difficult to achieve sustained funding without demonstrating relevancy and viability

Goal 6.1. Build relationships with funders for oral health literacy intervention and research programs.

Goal 6.2. Forge alliances with key stakeholders to promote, advocate and support oral health literacy initiatives.

Focus Area 7: Limited public demand for good oral health

Goal 7.1. Increase public awareness of importance of oral health to overall health.

Goal 7.2. Improve public perception of the importance of self care in maintaining oral health.

Goal 7.3. Establish partnerships to develop and disseminate simple, standardized messages on proper use of dental services and self care.

Focus Area 8: Problems will likely get worse while solutions are being developed

Goal 8.1. Create and use “fast track” mechanisms to identify solutions.

Goal 8.2. Identify and use “fast track” mechanisms to fund solutions.

Goal 8.3. Identify and use “fast track” mechanisms to implement and evaluate solutions.

Goal 8.4. Identify and use “fast track” mechanisms to disseminate solutions are identified and used.

Focus Area 9: Absence of valid, reliable and accepted oral health literacy research instruments

Goal 9.1. Advocate for sufficient funding to develop and test research instruments.

Goal 9.2. Encourage the use of valid, reliable and accepted oral health literacy research instruments.

Resolution No. 17 New ■ Substitute □ Amendment □

Report: CAPIR Supplemental Report 2 Date Submitted: July 2007

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: $ 32,000

Amount One-time $32,000 Amount On-going

ADA Strategic Plan Goal: Build Dynamic Communities (Required)

COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES: PLAN FOR A 2009 ACCESS TO DENTAL CARE SUMMIT

Introduction: Time and again, history has demonstrated that tragedies can be transformative and serve as tipping points for policy change. In response to the tragic death of a 12 year old Maryland boy, Deamonte Driver, from a brain abscess that has been attributed to untreated dental disease, and the ensuing national attention focused on access to care for underserved children, the Council on Access, Prevention and Interprofessional Relations (CAPIR) recommends that the ADA host a national access to dental care summit. The Council believes that the summit will provide the ADA with an opportunity to serve as the convener of representatives from the various stakeholder groups that have a commitment and role in improving access to oral health care for the underserved and to create a common vision for action.

Background: The issue of access to dental care continues to challenge the profession with a litany of proposed solutions to address this dilemma. To list these is redundant and unnecessary, since the profession is well aware of the ones the profession has proposed and supported, and the profession is equally aware of remedies suggested and supported by others. Due to increased attention to access to oral health care, created by the tragic death of the young Mr. Driver, the ADA has the unique opportunity to seize the attention of legislators, children's health advocates and the media to inspire, motivate and mobilize forces to establish programs focused on improving the oral health of our most vulnerable citizens. The ADA recently joined Rep. Elijah Cummings (D-MD) to support "Deamonte's Law" (H.R. 2371), legislation that will help reduce these disparities. The Council feels that this is simply the first of many steps needed to address the access dilemma.

Access Summit: In partnership with other organizations, the Council feels that the time is ripe for moving forward and developing new initiatives that all communities of interest can support. In order for the profession to make significant progress toward improving access to care for the underserved, it will take the commitment of a broad group of external stakeholders, working together, to move new initiatives forward. CAPIR plans to convene a three-day access summit to occur in early 2009, shortly after the inauguration of the new U.S. President. At the summit, participants, including members of the new federal administration, will come together to develop new strategies and initiatives that all can support. The summit will serve as another outstanding example of the ADA's commitment to serve as a convener and a collaborator committed to finding common ground and shared solutions to problems facing the nation.

Goals for the summit include:

- creating a common vision for long-term improvement to access to oral health care
- engaging in participatory problem solving, where the knowledge and perspectives of different sources of expertise and interests work together, so that all aspects of the challenges to improve oral health are addressed collaboratively
- identifying and discussing new approaches and initiatives that all stakeholders can support to address oral health disparities and improve access to care for the underserved
- developing a draft implementation plan for improving access to care

CAPIR, the Council on Government Affairs (CGA), the Council on Dental Education and Licensure, the Council on Dental Benefit Programs, the Council on Communications (CC), the Health Policy and Resources Center, the Chief Policy Advisor, and outcomes from the Public Affairs Initiative, all play a role in the development of policies and programs related to access to oral health care. Planning for the summit will provide an opportunity for multiple ADA agencies to work with external stakeholders to collaborate and initiate a process for identifying cooperative solutions to the complex issues surrounding access to care for the underserved.

The Council will engage a summit study design team, composed of volunteers and staff from CAPIR, CGA, and CC, along with external stakeholders in early 2008 to begin planning for the summit. The Council also proposes that an external consultant, experienced in the "Future Search" meeting model, be contracted to assist the design team in planning and conducting the summit. The design team will develop a list of stakeholders and an agenda for the summit. Input from the Board of Trustees and appropriate ADA agencies will be solicited regarding stakeholders to invite to the summit. A partial list of participating organizations is appended.

2008 expenses associated with design and planning facilitation will be $32,000 for volunteer travel, meeting facilitation and other related meeting expenses. 2009 summit expenses for approximately 75 individuals (including travel stipends, scholarships, hosting and facilitation costs) will be $80,000. External funding will be sought to support the summit, but it is impossible to predict whether such funding will be received. CAPIR will submit a 2009 budget decision package to the 2008 House of Delegates to support the summit.

The Council, therefore, recommends adoption of the following resolution.

Resolution

17. Resolved, that the Council on Access, Prevention and Interprofessional Relations, in cooperation with other appropriate ADA agencies, convene a national access to dental care summit, with planning in 2008 and implementation in early 2009, and be it further

Resolved, that the summit will include a broad spectrum of stakeholders in order to:

- consolidate information about current efforts focused on improving access to care activities
- develop a coordinated strategy for addressing access to oral health care challenges
- establish metrics for activities related to the defined strategies

BOARD RECOMMENDATION: Vote Yes.

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

Appendix

Access to Dental Care Summit

Proposed Participating Organizations

(Partial List)

Agency for Families and Children (Head Start)
American Academy of Pediatric Dentistry
American Academy of Pediatrics
American Association of Public Health Dentistry
American Dental Association
American Dental Education Association
American Dental Hygienists' Association
American Public Health Association
Association of State and Territorial Dental Directors
Centers for Medicare and Medicaid
Children's Defense Fund
Children's Dental Health Project
Council of Foundations
Grantmakers In Health
Health Resources and Services Administration
Hispanic Dental Associations
Indian Health Service
March of Dimes
National Academy for State Health Policy
National Association of County and City Health Officials
National Conference of State Legislatures
National Dental Association
National Primary Care Association
National Rural Health Association
The Tripartite
U.S. Public Health Service
UCLA Oral Health Policy Centers

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: CDBP Supplemental Report 2 Date Submitted: July 2007

Submitted By: Council on Dental Benefit Programs

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)

COUNCIL ON DENTAL BENEFIT PROGRAMS SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES: DIRECT REIMBURSEMENT NATIONAL ADVERTISING CAMPAIGN RESEARCH AND PLAN OF ACTION

CDBP activities regarding the promotion of direct reimbursement (DR) during 2007 are focused on two areas; **maintenance** of current sales channels and promotional infrastructure and **research** on the dental benefits market and current perceptions of DR. In the following plan, the Council has proposed a significant redirection of the DR campaign and most of these activities have an exploratory character, consistent with the available funding, and research is continuing. The Council believes these activities will continue to maintain the current sales and constituent infrastructure by generating leads through direct mail and supporting local lead generation through the Co-op program.

- **Target larger companies with strong ties to organized dentistry—**making a concerted effort to market to larger national companies can most naturally begin with companies that already have regular dialog with the ADA

- **Target marketing toward third-party administrators (TPAs)—**TPAs are the revenue-generating link in the DR chain and there has been a shift from self-administered to TPA-administered plans

- **Shift general marketing orientation from "simplicity" to "features" and specifically target "C" level officers (CEOs, CFOs, COOs)** because HR directors are suspicious of hidden "catches" in the simplicity message and upper management should have more appreciation for the economic advantages of DR

- **Link DR to "consumer-directed" plans (HSAs, HRAs & FSAs) by appropriate rebranding and building partnerships with Consumer Directed Health Administrators**

- **Continuation of the Co-op program** to encourage and increase local DR promotional efforts by constituent dental societies.

Background: The American Dental Association is now in the eleventh full year of its national Direct Reimbursement Marketing Campaign mandated by Resolutions 129H-1995 (*Trans.*1995:621), 47H-1996 (*Trans.*1996:690), 35H-1999 (*Trans.*1999:925), 25H-2002 (*Trans.*2002:396) and 30H-2006 (*Trans.*2006:322). Resolution 30H-2006 reads as follows:

> **30H-2006. Resolved,** that an additional $350,000 be allocated to the proposed 2007 national DR marketing campaign $500,000 budget request for the purposes of marketing research activities and innovative support of constituent dental society DR programs.

The Council on Dental Benefit Programs is responsible for guiding and overseeing the campaign.

Direct Reimbursement Market Assessment—Forrester Research: The Council recommended that extensive market research be conducted to determine what employers are looking for in dental benefit plans and how purchasing decisions are made. It was suggested that funding up to $150,000 should be allocated to conduct this important research. The Council contracted Forrester Research for this project.

A kickoff meeting was held in January 2007 prior to the commencement of the research and Forrester conducted a one-hour teleconference call with members of the Council and staff to confirm project objectives and timelines. The Council identified target employer groups, geographies and state dental societies for interviews. This included dental societies that have had success marketing and promoting DR as well as societies that have not been successful promoting the concept.

Forrester's research objective was to identify the challenges facing the DR product, marketing or sales channel and recommend changes in marketing strategy consistent with these challenges. Forrester conducted 30 qualitative interviews with employers, brokers and state dental society staff.

On June 20, 2007, Forrester representatives met with the Council's Dental Benefit Information Service (DBIS) and Third-Party Issues Subcommittee members and staff to present Forrester's findings and recommendations for the future marketing and promotion of the direct reimbursement national advertising campaign. Their presentation, including research results and recommendations, is included as an Appendix to this report and is the basis for the Council's plan of action.

Electronic Transaction Payment Card—AspireUp Research Update: The Council recommended investigation of the possible benefits of an electronic transaction card for administration of dollar-based employee benefits, including direct reimbursement dental benefit plans. AspireUp was contracted as a consultant. The objectives for the project are to develop the product concept for the electronic transaction card, evaluate the market demand for the concept, define the business model and conduct a high-level feasibility assessment. Given the complexity and importance of this project, AspireUp recommended using the "stage gate" approach, an accepted best practice in product development. At each stage a decision (based on the research and recommendations from the consultant) will need to be made on whether or not to continue with the study.

Stage 1, which has been completed, defined the product concept and took approximately six weeks to complete. Major deliverables included a high-level situation assessment, product concept statement and a market research plan. The study concluded that conceptually a card could be developed that would serve the proposed uses and that there are indications that such a product might be viable in the market. The Council determined that there was adequate evidence to continue the investigation and recommended proceeding with Stage 2.

Stage 2 is underway and a report is expected to be prepared by AspireUp for delivery in August 2007. Major deliverables include qualitative research analysis and market needs assessment, high-level feasibility assessment, refined product concept statement, executive summary presentation and detailed plan for product testing and business case development.

Decisions regarding Stage 3 will be made after review of the Stage 2 results. No budget request has been made for Stage 3, so if the decision is to move forward, a supplemental appropriation request will be presented to the Board of Trustees (or a decision package will be submitted to the 2008 House of Delegates, as appropriate).

2007 DR Campaign: Objectives of the DR campaign in 2007 are focused on two areas; maintenance of current sales channels and promotional infrastructure and research on the dental benefits market and current perceptions of DR. Financial industries and school districts have been targeted in 2007 via a new creative direct mail piece that appeals to these groups. These groups have been the most productive leads for DR implementations. The campaign is evaluated annually and adjusted to improve the receptivity of target audiences and improve the quality of leads.

Highlights of the 2007 advertising campaign include:

- The 2007 DR advertising campaign budget includes $250,000 for innovative support of constituent dental society local DR promotional programs; $288,200 for new direct mail; and $311,800 for marketing research activities including electronic transaction payment card and DR research.
- Direct mail was targeted to financial institutions, school districts, benefits brokers and an “all other” employers category. The direct mail function was handled internally by ADA staff in 2007 and substantial cost savings were realized as a result.
- The contract with GreenHouse Communications, the advertising agency that conducted the national DR campaign for the past several years, was terminated at the end of 2006, and all advertising and marketing functions are now handled in-house by ADA staff.

The 2007 campaign consists of two direct mail drops, one in the spring and one in the fall. Also, an increased emphasis on assisting constituent dental societies in their local promotional efforts through the Promotional Co-op program will continue.

2007 Direct Mail: Testing of new lists, formats and market segments will occur in 2007 to determine if targeting specific industries through customized copy and new mailing lists will affect the response rate. Plans are to continue with the execution of bi-annual spring and fall direct mail campaigns.

New creative for the spring campaign was designed in-house at a lower cost than if the advertising agency had been retained to do the work. Response channels and tracking will continue through business reply cards, the DR Web site, source codes and 800 telephone numbers.

Promotional Co-op Program: The DR Promotional Co-op Program is designed to augment the reach and impact of the ADA’s national DR marketing campaign by making additional funds available to each participating constituent dental society for the purpose of promoting DR locally. In 2006, any participating dental society could utilize up to $5,000 in co-op funds. Based on discussions between members of the Board of Trustees, the Council and senior management, it was recommended that a matching grant and mentoring type of program be incorporated into the Program for 2007 with an idea that successful programs might be utilized to mentor those interested states that do not currently have successful programs. The new Program was structured as follows:

For states that already had an established DR program:

Up to $30,000 matching grant; and must be willing to participate as a mentor for other states.

For states that did not have an established DR program:

Up to $5,000 non-matching grant, and up to an additional $10,000 matching grant, if working with a mentor state on developing a DR program.

There was a maximum cap of $250,000 on the Program, which was an increase from the $100,000 cap in 2006. All payments were to be made on a first-come, first-served basis. Past co-op projects have included: customization of national print advertisements; placement of print advertisements in local publications; mailing lists and postage for direct mail promotions; trade show exhibit fees and the purchase of cost-estimation software.

In 2006, eight states participated in the program and $35,674 was spent by these dental societies to support local DR promotional efforts. In 2005, ten states participated in the program and $41,952 was utilized. This compares with approximately 12 states in 2001; 20 states in 2000; and 19 states in 1999. (The Promotional Co-op Program was not utilized 2002-04.) The table below reflects the constituent dental societies that participated in the promotional co-op program the last two years.

DR Promotional Co-op Participants	**2005** **Amount Spent and DR Activities**	**2006** **Amount Spent and DR Activities**
California	***Did not participate***	• $4,845 • Trade show exhibiting fee • Printing New DR Brochures
Colorado	• $5,000 • Consultant to develop DR marketing plan	• $829 • DR Brochures
Florida	• $5,000 • Trade show exhibiting fee	• $5,000 • Trade show exhibiting fee • Sponsorship of HR Florida membership party to promote Pelican Dental Concepts
Georgia	• $2,280 • DR ads in GDA publications	• $5,000 • Exhibiting fee at Georgia Dental Association annual conference • DR ad in local HR publication (Georgia Trend Magazine)

Massachusetts	• $5,000 • Cost-estimation software • Postage/postcards for DR direct mail	• $5,000 • DR Exhibiting fee at Yankee Dental Conference
New York	• $290 • DR ad in local HR publication	***Did not participate***
North Carolina	• $5,000 • DR direct mail to local businesses	***Did not participate***
Ohio	• $4,382 • Local trade show • DR ads in local publications • DR direct mail	• $5,000 • Print Advertisements
Oklahoma	• $5,000 • Cost-estimation software • Postage/postcards for DR direct mail	***Did not participate***
Texas	• $5,000 • Badge holder for trade show	• $5,000 • Cost-estimation software • DR lanyards
Virginia	• $5,000 • Cost-estimation software • DR ads in local HR publications	• $5,000 • Direct Mail
TOTALS	**$41,952**	**$35,674**

At the time of this report, state dental societies had just recently received the mailing announcing the new and improved Co-op program. It is anticipated that more states will utilize the funds and at higher levels than in 2006 as evidenced by the number of calls requesting additional information on the Program. The reaction so far has been positive and several states, including Florida, Iowa, Minnesota, Montana, New Mexico and North Carolina, have inquired about the Program or begun cooperative programs.

Broker Recognition Program: For the eighth consecutive year, the ADA sponsored a Direct Reimbursement Broker Recognition Program as a way to recognize brokers who sell DR plans. The Program consists of two categories: 1) greatest number of employees covered, and 2) greatest number of DR plans sold. In 2006-2007, the total prize money remained the same at $10,000 with first place prize money at $3,500. The total number of award categories remained at six. The winners are traditionally announced at the National Dental Benefits Conference, with each winner receiving a commemorative plaque and a cash award. The contest ran from July 1, 2006 to June 30, 2007 and results were not available as of the writing of this report.

DR Campaign Results: In 2006, the DR campaign generated over 2,200 combined HR leads, broker responses and cost estimate requests that resulted from ADA marketing efforts. Between January 1, 2007 to June 29, 2007, 119 leads made up of 97 employer leads and 22 broker leads have been generated by the ADA's combined marketing efforts. Historically, the vast majority of leads have been generated in the second half of each year due to the timing of marketing efforts. This year should be no different. Of the 2007 leads generated to date, the majority are a result of direct mail. Other lead sources include the ADA Web site, prior print advertising and other sources including tradeshows, dentist referrals and unspecified sources.

The Council conservatively estimates the accumulated dental expenditures of DR plan participants for 2006 to be just over $400 million, based on the Centers for Medicare and Medicaid Services and Bureau of Labor Statistics calculations of annual expenditures per capita and the estimated number of lives covered by DR plans in that year. As of June 22, 2007, the ADA's DR Information Repository contains 4,162 plans, representing approximately 1.43 million individuals covered by DR, although these figures are likely low due to under reporting by brokers, TPAs, etc. In 2006, the ADA learned of a total of 58 new DR plans, representing over 4,400 employees (an estimated 10,300 covered lives). Between January 1, 1997 to June 22, 2007, there have been 3,511 new plans reported to the ADA representing 303,659 additional employees covered by DR—an estimated 711,776 lives. An average of 351 new plans have been added annually since 1997, with a renewal rate of over 90%.

Conclusions: Industry reports indicate that the number of new dental plans sold is at a low point, with benefits managers focusing more on the ever-increasing premiums of medical plans and a largely stagnant economy. The Forrester research indicates that there is a sufficient level of satisfaction among employers with their current plans that most are not actively looking for new plans. The relatively few accounts that are considering a change are targets for more aggressive anti-DR marketing by dental benefits competitors. With fewer companies making changes, there is good reason to devote more marketing resources toward larger employers because successful implementations have a greater impact on covered lives and positive marketing opportunities. The Council suspects that the current capacity of TPAs administrating DR plans is insufficient to service these larger accounts, but its recommendations will include items to address both marketing to larger accounts and TPA capacity.

Plan of Action for 2008: The Council plans for the national marketing campaign to continue the existing programs for the remainder of 2007 and include the following for 2008:

1) *Target Larger Companies with Strong Ties to Organized Dentistry.* The Council plans to develop a presentation strategy and materials to allow ADA staff and brokers or TPAs to effectively target large dental manufacturers for presentations on direct reimbursement. The Council believes that leveraging current relationships may help to overcome some natural barriers in presenting to larger companies. If any of these companies implement DR, it may facilitate co-marketing opportunities and remove barriers to other large companies. The Council plans to target presentations to several large dental manufacturers in 2008.

   Metrics. This activity would be considered accomplished if:

   a. Professional presentation materials are developed for presentation to large companies
   b. The presentation is delivered to at least 10 dental manufacturers/distributors with 5,000 or more employees
   c. One large employer implements or agrees to implement when feasible, a DR plan

2) *Target marketing toward Third-Party Administrators (TPAs) in unserved and underserved markets.* Because the earliest concepts of DR were all self-administered, DR marketing has focused on employers and brokers in the past, but targeting administrators has several benefits in the current marketplace. Most new DR plans are being administered by third parties and, according to reports from the National Association of Dental Plans and Delta Dental Plans Association the number of dental plans that utilize only administrative services has exceeded the number that are underwritten with insurance. It is also recognized that in those areas where DR has been most successful, local and regional TPAs are generating revenue from DR and commissioning sales. In targeting TPAs the Council has three goals:

- Identify partner TPAs in currently underserved areas to support constituent marketing of DR
- Sponsor TPAs with the capacity to service larger national employers
- Sponsor TPAs that are successfully implementing consumer directed health plans

Marketing to TPAs is efficient because there are fewer to contact; they may already have an affiliated sales force; and may already be a recognizable brand in their regions. TPAs are also likely to understand the inherent advantages in administrating dollar-based plans. Since TPAs generate revenue from administration, they are less dependent upon ADA marketing to perpetuate DR sales. In order for DR to be successful in the current market, it is imperative to have administrators capable of administering large DR plans and to have TPAs in many regions across the country to provide adequate access for employers that wish to outsource the administration of their DR plans. Once a large prominent employer implements a DR plan through a TPA, this could create a "domino" effect on other interested employers.

Metrics. This activity would be considered accomplished if:

a. Develop a direct mail piece and/or marketing presentation to improve TPA understanding of DR concepts

b. Three percent of any mailings results in inquiries or follow-up presentations

c. Ten regional TPAs implement a DR plan, partner with a constituent dental society, or agree to follow-up a lead generated by ADA marketing

d. One TPA implements or plans to implement a DR plan for an employer with 5,000 or more employees

3) *Shift general marketing orientation from "simplicity" to "features" and add direct marketing to Target "C" level officers (CEOs, CFOs and COOs).* Since the cost has been significantly lowered by bringing the service "in-house," the Council plans to continue to send direct mail advertising to employers and brokers/consultants, but modify the emphasis of the message from "simplicity" to a more direct comparison with the kind of features advertised in other kinds of dental plans. Based on the Forrester research, the Council is planning to also target CEOs, CFOs and COOs. C-level executives may have a better understanding of the favorable economics involved in these types of dental benefit plans and may be more likely to consider the potential long-term cost savings.

New creative would be designed to target this preferred audience and a smaller number of employers would receive the mailings. This could potentially improve the quality of the leads in response to concerns expressed by brokers and constituent dental societies. It was suggested that the prior message of "simplicity" should be changed to include a list of covered services in order to better compete with perceptions about dental insurance plans and suspicions by HR managers. The Council

plans to carry out two direct mail campaigns in 2008 targeting approximately 200,000 employers in each mailing (one in the spring and one in the fall).

Metrics. This activity would be considered accomplished if:

a. Direct mail is sent to 400,000 C-level executives with a response rate of 1% (which is considered good by industry standards) and to see 1% of those leads implement a DR plan (40 closes)

~~4)~~ *Link DR to Consumer Directed Healthcare (CDH)—Rebrand Direct Reimbursement.* The Council has recognized the compatibility of DR and consumer-directed dollar based benefits, like HSAs, HRAs and FSAs. Forrester's recommendations include linking the DR concept to the CDH trend and suggested that ADA consider rebranding the DR concept to better include the variety of consumer-directed dollar-based dental plans that may now fall under a broader DR concept. The Council plans to send a request for proposal (RFP) to consulting firms for purposes of recommending a new brand for direct reimbursement to overcome current misperceptions associated with DR and to find ways to effectively link DR to consumer-directed health plans. The consultant will be asked to review the feasibility of making the brand change, recommend appropriate changes based on market research, and suggest market implementation practices.

Metrics. This activity would be considered accomplished if:

a. Consultant recommendations are received on whether new DR brand indicates improved interest in DR concepts without negative perceptions and ways to link DR to CDH

b. Market research determines feasibility of new DR brand recommends market implementation practices

5) *Promotional Co-op Program.* This Program will be continued in order to entice and encourage participating state dental societies (states that are participating in the national direct mail campaign) to actively market and promote DR. The Council plans to continue the Co-op program with the 2008 annual co-op allowance remaining at a matching grant of up to $30,000 for mentoring states; up to $15,000 for states willing to be mentored; and $5,000 non-matching grants to other states. The Council expects that this Program will be utilized to a greater degree in 2007 based on early interest, and that the program will continue to grow as states are able to integrate successful ideas through the mentor program.

Metrics: This activity would be considered accomplished if the following are demonstrated:

a. Increase of five new states without established programs participating in grant and mentoring programs

b. Increase of two new states participating as mentors

c. Use of total amount allocated to program

Resolutions

This report is informational in nature and no resolutions are presented.

BOARD COMMENT: The Board appreciates the Council's work in developing metrics tied to actual implementation of DR programs and covered lives. The Board will continue to assess the success of the DR Marketing Campaign based on additional factors, including but not limited to, cost to the Association per covered lives gained.

Appendix

Forrester Consulting

Helping Business Thrive on Technology Change

Prepared for the American Dental Association
June, 2007

Direct Reimbursement Market Assessment

Liz Boehm – Principal Analyst
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Table Of Contents

BACKGROUND

- Since piloting and promoting this program in 1996, the ADA has sold more than 4,100 plans, and covered lives have grown to approximately 1.4 million members representing a 1% market penetration.

- ADA's primary role is awareness, marketing, and lead generation. Brokers and state dental societies directly sell the plans to employers that are then administered by third parties.

- The growth path of the ADA's direct reimbursement product has steadily slowed during the past few years. In 2006, the ADA has only sold 55 new dental plans More Normal text:

METHODOLOGY

- **Research goals:**
    - Identify the challenges the ADA faces with its DR product, marketing, or sales channel.
    - Address the marketing and advertising challenges the ADA faces by recommending changes to its marketing and advertising mix and messages.
    - Improve ADA's current relationships with brokers and state dental societies by aligning more directly with their needs and enriching the current business development process.
- **Conducted 30 qualitative interviews:**
    - 6 Brokers
    - 6 State Dental Associations
    - 15 employers
    - 3 ADA Executives
- **Brokers:** to better understand how leads are coming to brokers and where Direct Reimbursement fits within their overall product portfolio. To better understand what the ADA needs to do in order to get more mindshare with brokers and more effectively sell DR alongside traditional plans.
    - Majority working in small (less than 10) sized brokerage firms
    - Sell dental as well as other products including medical
- **State dental societies:** to better understand their ability to distribute and effectively follow up on leads, as well as to better understand any obstacles that prevent state societies from effectively promoting Direct Reimbursement within their states.
    - Florida

- Iowa
- Massachusetts
- New York
- Texas
- Virginia

- **Employers:** to better understand their dental plan, marketing and service preferences and how Direct Reimbursement is perceived in the marketplace. Also to obtain insights that reveal how to position DR plans vis-à-vis traditional dental insurance options.
  - Employers representing 12 states including Nebraska, Georgia, North Carolina, Alabama, Connecticut, Pennsylvania, Oklahoma, Colorado, Ohio, Montana, Washington and Utah.
  - Industries focused on include government, financial services and healthcare.
  - Company sizes span from less than 50 to 25,000+

WHAT WE HEARD

Employers

EMPLOYERS: OFFERING DR

- No DR employers work with brokers for dental
  - "We use brokers more for their intellectual property and strategic partnerships. We don't work with them for dental."
  - "We have a broker. But we recently have done it ourselves. It's less expensive that way."
  - "We do not work with brokers at all. We don't feel like it's necessary."
- All DR employers use a TPA
  - "The cost of the TPA is so small, it is worth it to not have to deal with the administration ourselves."
  - "Without our TPA I would have to add staff to manage this."
  - "We have a TPA. We did it on our own at first, but it just doesn't make sense."
- Two of four DR employers have elected for direct assignment

- "If you are a regular patient, the dentist just bills me and I reimburse them. If you are using a new dentist you'll likely have to pay up front."

- "All dentists file first, so the employees don't have to upfront the funds."

- DR Employers report predominantly positive experiences

  - "Our employees like it because they don't have to have anything pre-approved. Whatever they want to use their money for they can. We have not had a problem with inappropriate use of the benefit."

  - "DR was very well received because there was no restriction on which dentist you could use. We did not want to limit our employees to a network. At the time we switched, the general manager was ready to be converted because of the increasing prices of dental insurance."

  - "I find that people tend to really are tied to their dentists more than they are their doctor and DR offered people the choice. The employees who don't understand DR had a few problems initially. But once they get used to, they seem to like it a lot."

  - "It's very important for employees not to have a network to deal with. In Delta, they did not like dealing with the pre-approvals. It took so long, and dentists needed to explain what they wanted to do. I have no dentists that calls and complains about anything. They have no complaints about plan at all – turnaround is very good."

- DR Employers report cost savings with the plan

  - "We probably will use the DR plan in the future – we may look at increasing the benefits. I can't see us going back because this plan is costing us less than when we were with Delta Dental."

  - "Our experiences have been mixed. The first three or four years were great. We had predictable costs so it was easy to budget. We decided to share the wealth – we increased the maximum benefit amount. Since then our cost rose dramatically. So we've had to increase the premiums to employees. Then it stabilized again. We have very few people reach their maximum."

  - "The admin cost for DR was a lot lower. Prior to this we had an indemnity plan with a carrier. Once we got settled, we were given an estimate, and we found that we came in close to that and below it."

  - "This strategy works for us. I don't believe having a network would save us anything. I think a lot of dentists raise their prices in order to give a discount. All a network does is restrict access."

EMPLOYERS: NOT OFFERING DR

TWO EMPLOYERS HAD FORMERLY OFFERED DR:

- One planned to propose it at his new company once he had been there a little longer:

- "We had DR at my last company, but we did it ourselves. And I think we had greater satisfaction because of the breadth of the network. Also, employees could negotiate their fees, which made them better consumers. I'm waiting to figure out the state of the state here. I doubt if there will be much push back because dental is already self-funded. I'm going to have someone else administer it."

- The other had just stopped offering it at her company:

  - "We no longer have our DR plan. It ended a year ago. Employees wanted enhanced benefits. We were looking to taking advantage of discounts from carriers. And employees did not want to pay up front. The design of our new plan is first dollar coverage, there is so little out-of-pocket."

- **Most non-DR employers purchase directly from a carrier**

  - Purchase directly from a carrier: 6

    --1 bundles dental and healthcare

  - Purchase from a carrier through a broker 3

    -- 3 bundle dental and healthcare

  - Purchase from a carrier through a consultant 2

- **Most are self-insured for dental**

  - Self insured: 8

  - Fully insured: 2

- **Most offer open-network dental options**

  - PPO: 6

  - HMO: 3

  - Indemnity: 1

EMPLOYERS EXPRESSED SOME FAMILIARITY AND LOTS OF CONCERNS:

- Cost:

  - "I'm somewhat familiar with DR. I have a little apprehension about this product. From my understanding dentists can charge whatever they want – there's no control over costs like traditional dental plans. Cost is pretty important."

- "I have heard of DR. I know just a little bit about it from some articles I've seen. From what I know, I'm not interested. I think we would lose some of the control over valid claims submitted to the dental plan by using DR."

- Upfront cost outlay:

  - "I've heard a little bit about DR, but I still have some questions about it. I haven't talked to carriers that administer it. My understanding is that it's like an FSA account. I think it would be a tough sell, asking people to pay first. I don't like that idea. It makes people less likely to use the service."

- Information:

  - "DR is not compelling for this employee group. They are looking for a lot more guidance. We have more guidance in our current plan design. They want to have the employer figure out what's an important service."

  - "I'd be interested in DR if there was enough data around to provide information for employees about pricing and quality. Until there is more data gathered don't think this would be good. I think a lot of employers get sold on DR but still there is not enough data – at least in this area – to help employees make good choices."

- Overhead:

  - "I doubt there would be interest here, not at this time. We are self-insured. We have a TPA that we work with and even if there was a dollar savings by not having middle man, I don't know that we are set up for the administrative part."

- Employers are pretty content with their current arrangements:

  - "We talked about that DR the other day. Delta Dental has a DR product. What we have is easier, because it is tied in with our health benefit. At this point we would probably not change because we are happy with what we have. We do look at things that come through just to see what's out there. What we have found is that HMO isn't cheap, but it's about as cheap with low overhead. It's just easier.

  - "I don't believe DR would be something we would be interested in. Get the same thing with a [PPO] plan right now with small admin fee. DR would shift more administration to us."

  - "People are happy they way things are. Our employees are in a metro area. All the nearby providers are in the network. There is no problem with the network scope."

  - "Once in a great while have a problem with the network. But the plan has been in place so long, most providers are in it."

EMPLOYERS: ALL

- Employers use all sources for learning about dental

- Internet: 7
- Direct mail: 6
- Email: 3
- Print: 3
- In person: 3

- Most employers believe that dental is an important benefit
  - Employers are roughly split between believing dental is very valuable and believing they'll continue it, but it's not a top priority
- Employers are satisfied with current coverage and not planning to change
  - "We're very satisfied; we're not likely to change unless there is a huge cost savings."
  - "I have no desire to make any changes to the type of plan we have."
  - "No one has complained, especially with the company paying the bulk. They would like the employer to pay more and less out of pocket expense, and they want more coverage like braces. But we are not likely to change because it comes in a package."
  - "In general, dental coverage is always second to health. I would like to see our maximums increase, but don't see it happening because of cost."
  - "My union contracts which prohibit change unless negotiated."
- What matters most about dental plans: Cost, service, network
  - "Cost is important, the more we can save, the better."
  - "Three things: Network discounts, size of network and their customer service. Cost is huge, but network discounts are tied in to the overall costs. We want customer satisfaction along with an affordable plan."
  - "The number one thing we look for is whether they can handle a group our size administratively. Beyond that, we look for ability for them to do the billing and correctly and in a timely manner."
  - "I want good customer service to me and my employees. I also want some expertise in guiding us as to what is accepted dental care. Then helping keep costs down through network discounts. It's important to get new advancements as well."
  - "Cost is very important. Plus the brand name."
  - "We look for reputation and ease of use."

EMPLOYERS SUMMARY

- Employers who have DR are very happy with it
- Those that don't, lack awareness and understanding
    - They harbor negative misperceptions
- Dental is an important benefit, but not one that causes much anxiety
- Employers are happy with the dental coverage they have, and not planning to change

<u>Brokers</u>

- Dental is important – can act as an entrée to bigger sales
    - "The alert broker can show the benefit of offering dental to employers who are being beat-up on the health benefit side. For a little money, they can make someone happy."
    - " Many times dental can get us in the door."
    - "Our skills are best suited for advising clients on health insurance costs. And we make the lion share of money on health insurance. Dental is not a driver of money – it's important, but it takes a considerable back seat. It isn't that we wouldn't sell it standalone, but we would have to know that we could pick up other lines of business."
- Employers are more ignorant about dental than health
    - "Most employers you deal with are not familiar with the different types of dental benefits/products available."
    - "There's a lot more awareness around medical carriers. The increase in health insurance premiums has been such a problem, most of the creative energy of brokers has been spent trying to lower healthcare costs."
- The brokers we spoke with love DR
    - "We see consumer issues for the first few months – they need training. But after than, they seem happy."
    - "We love DR – employer groups love it. We started to sell them six year ago, then started administering them."
    - "We have never had a problem selling DR. When we get a decent lead, we can sell, but often the leads are not decent. We typically sell one or two out of 100 leads."

- "We believe that traditional dental is overly managed. The benefit designs are restrictive with little need. DR consumers don't over utilize dental. There's a lack of this in dental overall, and no risk of catastrophic costs. Ease of understanding DR makes it superior to any other dental."

- "Employers large and small are stressed by the cost of employee benefits, what with heath insurance going up. What we like about DR, is that whatever you would be willing to spend on dental – even $15 per employee per month – we can build a DR benefit."

- And they also love direct assignment

- "As soon as we started offering DA and DR more went to DA. We especially see this with companies that already had an insured dental plan. Direct assignment is an easier sell."

- Brokers say that traditional carriers denigrate DR

  - "The traditional dental insurance industry belittles direct reimbursement, in an overt or a covert manner."

  - "At Mercer, they advise clients to go away from DR and to go to Delta. Large consulting firms have need to validate their existence. DR is too simple. Don't see large firms ever embracing DR, and we don't have the same clout as the consulting firm."

  - "Here in Virginia, Delta published a brochure that said bad things about DR. It took the claims from DR and debunked them. This brochure was presented to me by a client. I asked Delta to cease and desist and they did. They are very sensitive to it. Guardian and others have come up with dollar based plans. They treat this as extreme competition."

- Brokers we spoke with believe that others don't know how to sell it – it's a more involved sale

  - "The hardest one to sell is the first one because it is so unfamiliar to the person making buying decision but so simple in concept. People think, it must not be that easy. Most brokers need a trust relationship with the buyer to get them to take a chance. Once the first one has been successful, then the broker can speak with much more confidence and the rest will come pretty quick."

  - "The large employers get advice from large broker firms. Most of those firms have not been receptive to DR. This has been a real liability."

  - "Self-funding eliminates large margins and many broker agencies or consultants are unwilling to do this, because it reduces income. DR represents a threat for positive cash flow and reduced margin for the insurance company."

  - "There are no commissions or broker bonuses. In DR you have to negotiate price with the client and a lot of brokers are uncomfortable with that. Fully insured products are easy to present and brokers are more comfortable with that."

- Broker commissions can be an issue – unless they're offset

- "I find that brokers are least likely to sell DR are the one's who ask about our commission scale. We just ask what the broker wants on commission per employer, and we build it in to the admin fees. The amount of commission has not been an obstacle for us."

- "There is no incentive for us. You are compensated more off of fully insured products, but if you are a broker looking for the best product for the client, this is what you give."

- "Brokers have to be schmoozed. Delta has awards that they give for top sales and they give trips. The ADA has a contest, but the top prize is $3k and it's just not enough. There's not much incentive there compared to what insurers do."

- Employers don't understand DR – they look for the catch

  - "They're very familiar with the insured plans, but they are not familiar with DR and they're not believers in it – it's more that they're not interested or they've never heard of it. We need to educate them. But once they get it and try it, then typically we see more proposal requests."

  - "Most employers have never heard of DR. It doesn't have a big name attached to it. They are always skeptical about how a plan this simple can be effective. Everyone is convinced that you have to manage dental, but dental is so small you don't need to. Still, current plans work ok for most people so why should they change?"

  - "It's the employer that makes it complicated. I can make the presentation but the employer thinks it's too easy, where is the catch? Once they offer a DR program they stick with it. In the regular dental market, groups change every two years."

  - "Self-funding scares them. They're afraid dentists might take advantage."

- Brokers distinguish HR from C-level executives

  - "Human resource people are rarely entrepreneurial. They are administrative in nature. They are looking for something which will be the least problematic, and they're not creative about looking for new products. To overcome this, the CFO or CEO will sometimes hear about this, and they direct their HR person to look into it. This happens about 1/3 of the time."

  - "Dental is predictable and there is a stop loss. If you speak with CFOs they understand DR. But our target market is human resources and they don't understand."

  - "If I'm with a CFO and CIO, I would sell it all day. They understand the economics of running company. HR is more administrative and they make the decision."

- Most brokers think CDH and debit cards will help

  - "CDH has an impact on DR. DR is a CDH type of plan. On our proposals we talk about it as a consumer directed dental plan. There was some discussion with ADA about changing the name, but met with huge resistance. CDH is known by HR and brokers and they are the one's who are buying this. By calling it this, you put it in a place in their mind that they can understand."

- "We are developing debit card for DR. I have advised the ADA of this. It will eliminate paper claims. This simplifies and eliminates the claim system."

- "Tie it to an HRA? No, I don't think so. That is another sale as well and anytime you have to sell two things at the same time it's a harder sell."

- Current ADA support is not viewed as strong enough to drive sales

  - "The ADA spent a lot of money advertising on awareness but it doesn't get core issues. It creates awareness but doesn't overcome the concern that people have about the products – it doesn't talk about the catch."

  - "My strong advice, do a better job of educating the brokers. The employers will do what the brokers tell them to. I think it's an exceptional product. And if it got into the right hands it would be huge, but I don't think the ADA is the one to do this."

  - "Client interest is relatively rare. If ADA does marketing campaign then I get some leads, but the lead generation has not been successful."

  - "People at ADA are not professional marketers. We should bring in people that are, and listen to them. We should bring in someone from large marketing firm and some marketing research."

  - "The consumer directed dental association put together a 3-4 minute video using case testimonials of actually clients using the plan. We presented it to ADA and they said they liked it, but they did not produce it or support us."

BROKERS: SUMMARY

- Brokers we spoke with are mostly DR evangelists

  - But they still defer to client demands

- Brokers acknowledge that DR is a more complicated sale because employers don't understand it

  - C-level execs understand better than HR managers

- Incentives to sell DR are lacking – brokers sell it because it's better for the client

- Brokers liken DR to CDH

- ADA support is viewed as lacking

<u>State Dental Societies</u>

- Societies are mixed on the importance of DR

- "On a one through five scale, it's about a 3."
- "It's not something that we focus on."
- "We try to educate consumers about all types of plans, including DR. We just feel that money would be better spent on educating consumers about dental plans than on a specific plan."
- "I believe it's the right product. It's time to get out there and gain confidence. We're dealing with change which a lot of companies are resistant to. But as CDH market continues to develop more entities will look into it."
- "We try to encourage business, we will support it from the standpoint of the association – show up at meetings talk to employers. That way they can make money and we can follow our philosophical dream."

- Most dental societies leave lead management to others
  - "We use our consultants, TPAs and brokers. They go out and meet with leads. Our office is responsible for marketing only."
  - "We outsource the handling of inquiries about DR to a third party. We found that brokers are really the only people inquiring anyway, not employers."
  - "We don't follow up on leads, we are a a big state with too many other things to do. We leave this up to brokers."
  - "We have agreement with TPA (TASC) and they have three field reps in Texas, we send our leads to them and they do the follow up. They have adopted DR and they sell it under their own brand which they call Pay Dental."
  - "All leads come to me first. I follow up immediately with sending them more information by mail and then I forward the lead to the TPA. In about three days I calls on every lead. And then we go from there."

- Societies complain about poor lead quality
  - "Most of the leads that we do get from the ADA are of poor quality. They're small groups, not what we are looking for. Or the people are really not serious. They're not the decision makers."
  - "Most of the ADA leads are garbage. I have to research a lead because a lot of the information is incorrect. We find they are not qualified leads. I don't have this kind of time to waste."
  - "We've gotten about 400 leads from just DR marketing campaigns nationally over two year period. Most of them have been through magazines, Inc and Entrepreneur and Forbes. But here you get small companies. One person shops. But our target is groups. Get those by direct mail and one-on-one meetings."
  - "A lot are not leads – they are more inquiries."

- "With the ADA when were getting a lot of leads (now we get none). But of those 30 were not quality leads. From our campaigns we get less response but more quality."

- "We are struggling with the fact that we are getting no leads from the ADA. We have limited resources to do our own internal campaigns."

- Societies are frustrated by lack of awareness

  - "In 5 years with the Iowa Dental Association, only one dentist has ever asked about supporting DR."

  - "State leaders and dentists do not understand this product. I had lunch with a board member two years ago we were talking about DR, and he asked, what is DR?"

  - "Name recognition can scare people and the lack of commission. Broker will say I get 4% from Delta and your product is not paying as well. But tell them they are offering a better product to their client."

  - "It's easier for insurance sales to say here is Aetna, Delta, here is the policy, give me a check, broker gets commission, employer gets something familiar and easy. The fact that DR can be easier and save the money falls by the wayside."

- The ADA's efforts are viewed as off-target

  - "Resources have been dwindling every six months, so out in the field we are wondering if the ADA wants to go forward with this. It sends a message that worries us."

  - "The brochures spend so much time on disclaimers, but they don't get at what the issues are. They were too detailed. They need to be simple and straight to the point."

  - "It seems like their mailings go to the same companies and markets over and over again."

  - "The ADA spent money on individual ads. They should be spending money on brokers – training brokers with videos. Brokers are very important. Less than 20% know what DR is. The only people that know work with our TPAs."

  - "I think the ADA has to look at more guerilla marketing. They need new avenues and they need to be more flexible . . . . Maybe some new marketing materials, a new tagline. Think out of the box."

  - "We used to use the ADA logo on some of pieces but when we went through a look at all our pieces we did new colors, new branding, the ADA did not permit us to use any of the colors that we wanted. So we dropped it."

- Several societies have chosen to go it alone

  - "We decided to re-brand it (DR). We call is Pelican Dental. We have a Pelican on billboards. People understand it. We have our own resources because of Pelican. We don't even use the ADA."

  - "Besides promoting DR we do have our own branded plan which is like the DR. It actually creates income for us so this is important."

- "We promote it as dental direct. We also promote direct assignment as well. We see that as plan that has become more popular in Virginia."

- "We decided to promote a plan people were more familiar with. We started with both a DR type and a regular plan, and the classic plan was the one that got sold. The ADA plan is offered first and then the pay dental plan is offered if they don't get the DR concept."

- Societies lament a lack of resources . . .

  - "Iowa has tons of small employers with fewer than 25 employees. It would take a lot of resources to educate lots of small employers about the benefits of DR and the Iowa Dental Society just doesn't have the resources to do so."

  - "We support the concept of DR, but we are not taking an active role in promoting it. We don't do any marketing, we run ads in dental society newsletters (informational articles). Our state society feels like we are not in the insurance business."

  - "We could do anything if we had the wherewithal."

- . . . But are still mixed about revenue opportunities from DR

  - "If this was a revenue source, I do think we'd have more resources to support it. We have even talked about this."

  - If DR implementations were to become a potential revenue source for state societies, would they dedicate or add staff resources to more active DR promotion? "I don't know. Not sure if the association would do that. Our TPA would use more resources on it and add more staff."

DENTAL SOCIETIES: SUMMARY

- Societies are mixed on how much they should push DR

- Societies feel that leads are not strong enough to warrant a lot of attention

- Lack of awareness among dentists dampens their interest in supporting DR

- Several societies have launched their own DR initiatives

  - They felt cramped by ADA branding

- Societies feel that the ADA's efforts to promote DR have missed the mark

- Society resources are stretched thin

ADA Executives

- General thoughts on the DR product
    - "Philosophically DR is good, but it's been a tough sell and I'm not sure why."
    - "What we were selling was the idea, with no real incentive to buy the idea, for that alone, it has been an uphill battle."
    - "Was a great idea, but selling dental benefits is not a core business of the ADA, it is not a core strength."
    - It's motherhood for dentists, you can't argue again that. But we don't have the finances that make it work. Most members don't even know what DR is.
- Specific challenges with DR product
    - "The marketing the ADA is doing is OK, but it is not generating leads. Unless you have a network or brokers or states or others taking on the concept of DR, then no one else is pushing. Need more than just the ADA marketing this."
    - "As benefits start to dry up, dentistry is taking back seat. Dentist like DR philosophically, but practically they don't see how it can function in an environment that is so cut throat."
    - "The challenge, to get brokers who work on commission model. For us, how do we set up a sales structure when we are not a sales organization?"
    - "We need to know that there is a way of marketing DR that will penetrate the market and not drain our treasury and will be something that will sustain itself."
- Moving forward with DR
    - "Give this (DR) a new look and present it in a way that is acceptable to ADA members that right now don't think the way it's going is really relevant in this market."
    - "DR would have to be a modified version if was going to succeed, would have to deliver it in a package that would make it more attractive to the buyer."
    - "We are much better at collaborating these days . . . I would not be adverse to some kind of national partner that has expertise." "Over the last five or six years we have been partnering with more dental industry people, like Colgate, Glaxo, In the past we were afraid of aligning ourselves with the dental trade industry."
    - "We are better at facilitating because we are not business people."

What We Heard—Summary

- Though it's a simple product, DR requires up-front education of both employers and members to sell
    - Employers have some prejudices and misconceptions

- Those that have or sell DR report largely positive experiences
    - There's often an initial adjustment period
- Most employers value dental and are happy with their current arrangements
    - Most are not looking to make any changes
    - Dental considerations take a backseat to healthcare
- Stakeholders are not happy with the ADA's efforts to promote DR
- Most believe that a lack of marketing and awareness is DR's biggest challenge
- There are some channel conflicts: consultancies, large brokerages

MARKETING RECOMMENDATIONS

OVERVIEW:

- Use dentists and orthodontists to promote the plan
- Co-market with preferred TPAs
- Partner with a consumer dental brand
- Tie in to CDH – rebrand
- Market to CIOs, CFOs, CEOs

Use dentists and orthodontists to promote the plan

- Create low/no admin fee services for dental and orthodontist office staff
    - Staff gets "at-cost" dental fees offset by DR coverage
    - Cross coverage? (dental for orthodontist offices, orthodontia for dental offices)
- Create collateral to display in dental offices
    - "It's not just any dental plan, it's our dental plan."
- Build a Web site to route leads to preferred TPAs by geography

Co-market with preferred TPAs

- TPAs have little brand recognition, but are crucial to DR
- Create co-marketing campaigns with preferred TPAs
    - Exclusivity in geographies
    - Gives TPA an “edge” to promote to employers and brokers
- Leads automatically go to TPAs (based on branding)
- Promote success stories with local TPA + local business
    - Potentially tie in with local dental society (adds logistical complexity)
- Allow local customization
    - Minimize ADA requirements
- Build and distribute software to facilitate DR and DA administration
    - One interviewee was creating his own system
        - Test and license?

Partner with a consumer dental brand

- Approach Crest, Colgate, Oral B, etc.
    - Bargain for the best opportunity
- Education-oriented consumer mass marketing
    - Dental is important (health, aesthetics, etc.)
    - We’re committed to your dental health so we’ve teamed up with the ADA
- TV, print, packaging, etc.
- Would require flexibility in marketing approach

SUMMARY

- DR is well-liked by brokers and employers who sell/have it, but it’s looked down on by those who don’t
- Most companies are pretty happy with their current dental coverage

- To make DR more successful, the ADA needs to conduct marketing that:
    - Magnifies the problems with current dental coverage
    - Fixes the perceptions of DR
        --Possibly rebrands DR all-together
- This kind of marketing will take deep pockets
    - The ADA should explore marketing partnerships
    - Look for win-win opportunities that trade the ADA brand for access to budgets and markets

Resolution No. 18 New ■ Substitute □ Amendment □

Report: CDP Supplemental Report 1 Date Submitted: July 2007

Submitted By: Council on Dental Practice

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)

COUNCIL ON DENTAL PRACTICE SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES: REAL-TIME CLAIMS ADJUDICATION

Background: This report will provide information regarding real-time claims adjudication (RTCA). Claims adjudication, in the insurance industry, refers to the determination of a member's payment or financial responsibility after a health or dental claim is applied to the patient's insurance benefits. RTCA is a process that will adjudicate a claim before the patient leaves the office.

Dentists and other health care providers have to manage direct consumer payments and insurance claims. The systems and technology to bill a dental plan directly at the point of care are not universally implemented. Many providers use third-party billing companies who execute claims to insurance companies in batches, not in real time. Because each provider usually deals with multiple insurance companies, the challenge of determining what each plan pays is daunting. There is no universal way to exchange electronic financial data in health care in a manner similar to that found in retail.

Real-time claims are the rule today, rather than the exception, for pharmacy claims transactions. Retail pharmacy has not only embraced electronic data interchange (EDI) like the rest of the health care industry, it has gone the extra step to real-time claims adjudication. For example, a pharmacist can submit an individual's information to a health plan; the pharmacy system verifies recipient eligibility and monitors the health plan pharmacy policy. Within seconds of submitting a real-time claim, these processes are completed and the pharmacist receives an electronic response indicating the amount of payment or denial.

In dentistry, RTCA would enable a dentist to bill for services before the patient leaves the office and to receive a fully adjudicated response back at the time of service. With this technology, a dentist could print out the response, displaying total and allowable charges, as well as the patient's responsibility (co-insurance, deductible and co-payment). Providers and patients would be certain of the amount the patient should pay at the time of service.

The notion of real-time adjudication has been around for some time. The consumer-driven health plan business model has now made it a priority. When a dentist or other health care provider bills a patient's health or dental plan, and gets paid eventually, there's no real impetus for the payers to move into real-time transactions. But providers have to worry about consumers with bad debt—or possibly not being paid at all. So real-time claims strategies are directly related to the execution of consumer-driven, direct business models.

Additionally, in today's world of electronic payments, consumers want and expect to know the exact cost of a product, including dental treatment, prior to agreeing to pay. They have a difficult time understanding why

the dental insurance adjudication system can take days, weeks or months to determine their coverage and co-payment amount.

Not only are there real-time claims adjudication obstacles on the provider side, there are major barriers with the health and dental plan technologies. Many payers use multiple legacy applications not suited for handling real-time processing. This presents difficulties when multiple systems need to communicate with each other to get a real-time response. Although auto-adjudication rates (adjudication without human intervention) have been increasing within the past few years, it doesn't mean the claims are processed in real time. Most health care adjudication systems, besides those in the pharmacy world, execute claims in batches, not in real time.

Future Model: The health care industry is meeting the challenges of claims adjudication in different ways. One of the largest programs for integrating real-time transactions is being conducted by a few large health plans in Florida. The plans teamed with a company that serves as a real-time transactions gateway for electronic data interchange. The pilot was launched as integrated real-time claims adjudication earlier this year with the goal of making it easier for provider offices to get real-time information, simplifying the collection process, and allowing providers to more accurately collect patient-owed portions of claims at the time of the office visit.

The model being used in the Florida pilot program is a likely scenario for implementing real-time transactions throughout the health care industry. It's a model similar to the ones used by the retail and financial industries where data from the point of sale is directed through banks via credit card companies to debit a consumer's account in real time. However, health care is a little different than financial transactions.

In health care, not only is it necessary to make a connection between disparate systems and share a translated message, it needs to be encrypted according to specific standards for personal health information. This is a real challenge. The security portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance means not divulging information to the wrong people. Security is a necessary element to real-time transactions, but it adds a layer of complexity.

In addition to security issues there are other barriers that must be considered with the implementation of real-time claims adjudication including the following:

- Many dentists and other health care providers are not able to have bills ready for submission at the time the patient leaves the office.
- Many practice management systems are unable to submit claims in real-time.
- Most clearinghouses are unable to transmit dental claims in real-time.
- Current payer adjudication systems may need major modifications in order to deliver a real-time adjudication response.
- The electronic standards do not meet the needs of real-time transactions at this time.

Although there are several barriers to overcome, real-time adjudication lowers costs for consumers and dentists while reducing one of the most significant hassles of health care: the billing, collection and settlement of a health care transaction. After the patient receives the service, the practice staff can either swipe the patient’s dental plan card that utilizes a real-time gateway transaction service, or use a plan’s web-based service to determine the dentist’s payment and the patient’s cost-sharing responsibilities. Many observers believe that real-time claims adjudication is the key to the ultimate success of consumer-directed plans.

The Council, therefore, recommends adoption of the following resolution.

Resolution

18. Resolved, the appropriate ADA agencies monitor any new real-time claims adjudication initiatives to determine the impact on dentists, and be it further

Resolved, that the appropriate ADA agencies communicate to dental plans, employers and patients the concerns about current payment issues, while encouraging the dental benefits industry to move towards real-time claims adjudication, and be it further

Resolved, that the appropriate ADA agencies educate dentists about the complexities of claims adjudication and third-party payment processes to enable them to more efficiently manage their practices, and be it further

Resolved, that the appropriate ADA agencies work with the national organizations responsible for developing electronic standards for electronic data interchange (EDI) to encourage the development of real-time claims adjudication standards.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 19 New ■ Substitute □ Amendment □

Report: CDP Supplemental Report 2 Date Submitted: July 2007

Submitted By: Council on Dental Practice

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Create and Transfer Knowledge (Required)

COUNCIL ON DENTAL PRACTICE SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES: DENTISTRY'S ROLE IN EMERGENCY PREPAREDNESS AND DISASTER RESPONSE

Background: In June 2002, the ADA convened a workshop on the role of dentistry in bioterrorism. The workshop produced several key findings regarding dentistry's role in the event of a bioterrorism attack and included:

- diagnosis and monitoring—observation of physical and behavioral signs of disease; procurement of salivary or nasal samples from patients for laboratory testing
- surveillance and notification – detection of intraoral or cutaneous lesions, detection of patterns of cancellations or missed appointments that are unexplainable; notification of local public health authorities
- treatment—augment and assist medical and surgical personnel for victims of bioterrorist attacks by treating cranial and facial injuries, providing or assisting in administration of anesthetics, starting intravenous lines, performing appropriate surgery and suturing, assisting in shock management, assisting in stabilizing patients, collecting pre-antibiotic blood specimens, taking medical histories, performing CPR
- distribution of medications – prescribe and dispense chemotherapeutic or chemoprophylactic medications; inform patients concerning appropriate use of medications; monitor patients for adverse reactions and side effects
- decontamination and infection control
- forensic dentistry

Since this time, the focus of emergency preparedness has shifted from bioterrorism to an all hazards approach. The term "all hazards" refers to nuclear, biological, chemical, explosive and natural disasters. The federal government has developed a National Response Plan to enhance the ability of the United States to prepare for and to manage domestic incidents by establishing a single, comprehensive national approach. This plan forms the basis of how federal departments and agencies will work together and how the federal government will coordinate with state, local, and tribal governments and the private sector during incidents. A key element in this planning is that regional or federal help may not be available for 24-72 hours following the incident.

The possibility of a global pandemic adds another layer of complexity to emergency preparedness planning. It is estimated that if a moderate to severe pandemic were to occur in the United States without any control mechanisms, over 30% of the population would be affected. Ninety million people could become ill, 45 million might seek medical help through outpatient visits, 10 million could be hospitalized, and up to 2 million might die. Some of those who become ill would likely be health care workers which would dramatically decrease the number available to treat the ill. Hospital beds, equipment and supplies would probably be inadequate. In this scenario, the surge of patients would overburden the existing health care delivery system. It is unlikely that any regional or federal assistance would be available.

Various resources have been developed to assist members with disaster planning for the dental office. These are available on the Web site (www.ada.org/goto/disasters). Also available online are resources for an individual dentist's personal or business needs following a disaster.

The ADA has continued to advance the role of dentistry in disaster planning and emergency preparedness. To date, the potential role of dentistry in mass disasters has been established; dental school curricula includes disaster preparedness and emergency care competences; support for legislation addressing liability and licensure issues for dentists as emergency responders is provided; a template for disaster planning has been given to state societies, to be developed in conjunction with local emergency response agencies; and a partnership with the American Medical Association, Centers for Disease Control and Prevention and the American Public Health Association has been established to work toward common goals regarding emergency preparedness issues.

In view of the ongoing commitment to increase the awareness of the emergency response sector as to the education, training and abilities of dentists during emergency response situations, the Council recommends adoption of the following resolution.

Resolution

19. Resolved, that dentists have the clinical skills and medical knowledge that are invaluable assets in a mass casualty event, and that with additional targeted training, dentists are appropriate responders to natural disasters and other catastrophic events, and be it further

Resolved, that the American Dental Association provide leadership in national, state and community disaster planning and response efforts by increasing participation in coalitions and programs that put "disaster preparedness into practice," and be it further

Resolved, that the ADA promote multidisciplinary disaster education and training programs such as core, basic and advanced disaster life support courses, or other courses that train dentists and dental staff in the handling of declared emergencies, and be it further

Resolved, that the ADA advocate for national emergency preparedness solutions through research, public policy, and legislation.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 22 New ■ Substitute □ Amendment □

Report: CSA Supplemental Report 1 Date Submitted: July 2007

Submitted By: Council on Scientific Affairs

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Create and Transfer Knowledge (Required)

COUNCIL ON SCIENTIFIC AFFAIRS SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES: EBD CENTER AND UPDATE ON CSA ACTIVITIES

Background: CSA Supplemental Report 1 proposes changes in the Guidelines for Participation in the ADA's Seal of Acceptance Program to reflect phase-out of the professional Seal of Acceptance Program which the House approved in 2004. It also informs the House about Board-approved planning for ADA activities in evidence-based dentistry, and provides the House with the most up-to-date version of the ADA Statement on Dental Amalgam, incorporating the latest research.

Board-Approved Planning for ADA Activities in Evidence-Based Dentistry--Proposed ADA Center for the Advancement of Science in Oral Health: Over the past two decades, dentistry and other health care professions have moved toward an evidence-based model of clinical decision-making. The evidence-based approach relies on systematic methods to evaluate and summarize the vast body of literature available to practitioners, in tandem with clinical experience and patient preferences, to determine the best care for an individual patient. Today, evidence-based dentistry (EBD) is commonly accepted in the healthcare community as a high-quality, integrative approach to support clinical decision-making, based upon sound scientific principles and research in the context of patient care.

The Council on Scientific Affairs (CSA) has served as lead agency for the ADA Advisory Committee on Evidence-Based Dentistry, a cross-divisional committee that provides guidance on the Association's EBD activities and presents periodic recommendations and status reports to the Board. The Advisory Committee's charge is to ensure that the entire spectrum of research, dental practice and education is taken into account as the ADA moves forward with EBD-related activities.

In spring 2006, the EBD Advisory Committee reviewed the progress of its EBD-related programs and commissioned a workgroup of Council directors to develop a plan to enhance the implementation and impact of the ADA's EBD activities. With input from other staff and Advisory Committee volunteers, the workgroup took a business plan approach that resulted in a proposal to establish the Center for the Advancement of Science in Oral Health (Center). The Board reviewed the Advisory Committee's proposal earlier in 2007 and approved the proposed business plan to establish the Center for the Advancement of Science in Oral Health.

The phased implementation plan for this new interdisciplinary Center will help to position the ADA as the EBD leader in the United States and to influence this area on an international level. The Chicago-based Center will develop and deliver valuable member-focused tools and resources to enhance the integration of

evidence-based dental practice. The rationale for the Center is to address the following needs of the profession:

- provide the most current scientific evidence in clinical decision-making
- provide a centralized resource for the latest scientific information on oral health topics
- deliver scientifically valid information in a concise, user-friendly format

The ADA acknowledges that EBD is critical to giving practitioners up-to-date information in order to help them provide the most appropriate oral health care to patients, and has developed significant programs to address this need. However, implementation and developmental efforts have not been sufficient to achieve the needs of the profession. The Center will allow ADA to accelerate and expand plans to provide tools and information for both practitioners and patients to advance and improve oral health.

The Center's vision and mission provide the context for its future activities:

Vision:

To Lead in the Promotion of Oral Health by Disseminating the Best Available Scientific Information and Helping Practitioners Implement it into Clinical Practice.

Mission:

The Center for the Advancement of Science in Oral Health assists practitioners and improves the oral health of the public by:

- Collaborating with other interested parties to enhance the evidence base and its integration in clinical practice;
- Appraising and disseminating the best available scientific evidence on oral health care; and
- Helping practitioners understand and apply the best available evidence in their clinical decision-making.

The Center will help members to further refine their scientific acumen by re-invigorating the ADA's EBD efforts, including development of a strong and successful collaboration program, an essential component for success. The Center will collaborate with stakeholder groups (including non-dental groups) and other EBD centers at the national and international levels; internal ADA divisions; and volunteers—through an expanded EBD consultant pool, which includes clinical specialty representatives, scientists, and a range of methodological experts. In order to fulfill its Vision and achieve its Mission, the Center will also establish mechanisms to better understand the needs of the profession-at-large and implement programs that promote more direct involvement of "grassroots" clinicians in the development and dissemination of evidence-based practice tools and methods. Two examples are the EBD Web Site described below and the EBD Champions Conference described in the 2006 CSA Annual Report to the House of Delegates.

The Center will benefit the ADA members, the profession and the general public primarily by:

1) *Providing tools to help dentists apply evidence-based principles and improve patient care.* By providing resources, tools, and educational opportunities needed to implement evidence-based dental practice, such as evidence-based clinical recommendations, new systematic reviews in

collaboration with other organizations, the EBD web site with critical summaries of systematic reviews, and more.

2) *Orchestrating EBD efforts among stakeholders and representing the interest of ADA members to the research community.* In August 2004, the ADA hosted an EBD symposium with attendees from academia, the research community, industry and third-party payers. Collectively, these stakeholders indicated that they are looking toward the ADA for leadership in EBD. Through a periodic survey and registry of clinical questions of interest to dentists and via collaboration with stakeholders to encourage research, study identified topics, and disseminating information, the Center will take this leadership role.

3) *Supporting the interests of dentists and the public.* Through application of and disseminating information about EBD principles. The ADA's definition of EBD includes not only the "judicious integration of systematic assessments of clinically relevant scientific evidence" but also "the dentist's clinical expertise and the patient's treatment needs and preferences." Communication and support of these principles to the stakeholder community will benefit dentists and the patients they serve.

The Center for the Advancement of Science in Oral Health will focus on ensuring that the ADA's EBD activities remain fully aligned with the ADA Strategic Plan and form core components of clinical practice, dental education and science. It is envisioned that acceptance and application of evidence-based practice methods will increase trust in dentistry as a learned profession; elevate the scientific knowledge base and competency of dental practitioners; and, most importantly, improve patient care.

EBD Web Site Introduction and Future Plans. In summer 2007, staff from the Council and the Division of Science developed brand-new resources for ADA.org (www.ada.org/goto/ebd) to support evidence-based clinical decision-making. The primary feature of the EBD Web page is a new searchable list of over 400 published systematic reviews on dental and oral health topics, grouped in an A-Z topic list from "adhesives" to "wisdom tooth." The new EBD resources also offer: full-text copies of systematic reviews published in *JADA*; links to summaries of systematic reviews developed by other organizations; lists of EBD journals, databases and tutorials; Google search boxes to identify systematic reviews of interest; and a glossary of EBD terms.

These resources are simply the first step as the ADA works to develop a central online location to help dentists and patients access the best clinical evidence. In spring 2007, the ADA Foundation received a three-year grant totaling $450,000 from the National Library of Medicine and the National Institute of Dental and Craniofacial Research (NIDCR, grant #1G08LM008956-01A2) to develop an EBD Web site. The new content on ADA.org is an interim step in that process, which will be enhanced substantially with the establishment of the new Center for Advancement of Science in Oral Health.

Updated ADA Statement on Dental Amalgam: In April 2007, the Council on Scientific Affairs reviewed and approved an updated version of the ADA Statement on Dental Amalgam. The revised statement continues to support dental amalgam as a safe, affordable and durable restorative material. The update incorporates information from recent clinical trials and scientific reviews that have been published since January 2002. The updated statement has been posted on the "Amalgam" A-Z topic page at ADA.org.

Proposed Revision to ADA Policy on Guidelines for Participation in ADA Seal of Acceptance Program: At its July 2007 meeting, the Council approved changes to the Guidelines for Participation in the ADA's Seal of Acceptance Program (*Trans.*2003:388; 2004:300) to incorporate revisions coinciding

with the three-year phase-out of the professional component of the Seal Program, which will terminate on December 31, 2007. The Council's suggested revisions to the Guidelines for Participation in the ADA's Seal of Acceptance Program include:

- removal of references to the professional Seal of Acceptance
- revisions that reflect changes in advertising review for Accepted Products
- additional information about mandatory Seal statements

The proposed revisions and other minor editorial changes to the Guidelines are incorporated in the Appendix to this report.

In keeping with the CSA's responsibility for the ADA Seal of Acceptance Program, the Council also presents a resolution that would empower CSA to propose and approve future revisions to the Guidelines for Participation in the ADA's Seal of Acceptance Program. This resolution would enable the Council to update the Guidelines document without House approval, significantly facilitating future administrative revisions as appropriate. This proposed resolution is provided in accordance with the Council's *Bylaws*-mandated duty "to award the American Dental Association Seal to dental products that meet the Association's requirements for acceptance." (Additions are shown by underlines; deletions are shown by strikethroughs.)

Resolution

22. Resolved, that the revised Guidelines for Participation in the ADA's Seal of Acceptance Program effective January 1, 2008, as set forth in the Council on Scientific Affairs Supplemental Report 1 to the 2007 House of Delegates be adopted, and be it further

Resolved, that the House empowers the Council on Scientific Affairs to make and approve future changes to the Guidelines for Participation in the ADA's Seal of Acceptance Program as necessary, consistent with the Council's *Bylaws* responsibility for the ADA Seal of Acceptance Program.

BOARD RECOMMENDATION: Vote Yes.

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

Appendix

American Dental Association

GUIDELINES FOR PARTICIPATION IN THE ADA'S SEAL OF ACCEPTANCE PROGRAM

INTRODUCTION

The *Guidelines ~~F~~for Participation ~~I~~in ~~T~~the ADA's Seal ~~O~~of Acceptance Program ("Guidelines")* are provided for informational purposes only and may be modified at any time. These *Guidelines* provide a general overview of the ADA Seal of Acceptance Program; they do not govern a company's rights to use the ADA Seal. The ADA Seal of Acceptance is a registered certification mark of the American Dental Association. All rights to use the ADA Seal are governed solely by a separate license agreement between the ADA and the manufacturer or distributor of an Accepted product. The ADA Seal of Acceptance may not be used on or in connection with a product until after it has been granted the Seal of Acceptance by the Council on Scientific Affairs and only after a license agreement has been signed. Upon termination or expiration of the ADA license agreement, regardless of cause, all rights of a company to use the ADA Seal immediately cease.

PURPOSE OF THE COUNCIL

Under the *Bylaws* of the American Dental Association, the Council on Scientific Affairs studies, evaluates and disseminates information with regard to: the safety, efficacy, promotional claims, and proper use of dental therapeutic agents, their adjuncts and dental cosmetic agents used by the public or profession. The Council also determines the safety and effectiveness of and disseminates information on, materials, instruments and equipment that ~~is~~ are offered to the public or the profession and further critically evaluates statements of efficacy and advertising claims.

Additionally, the Council maintains liaison with related regulatory, research and professional organizations, and encourages, establishes and supports research in the field of dental therapeutics and dental materials, instruments and equipment. Furthermore, the Council encourages development and improvement in materials, instruments and equipment by coordination of national and international standardization programs.

TYPES OF PRODUCTS CONSIDERED FOR ACCEPTANCE

Products eligible to apply for the ADA Seal are those that have been cleared by the U.S. Food and Drug Administration for market directly to consumers, regardless of whether the company elects to market the products over-the-counter or exclusively through oral health care professionals. The Council on Scientific Affairs evaluates consumer dental products such as therapeutic agents, drugs, chemicals, materials, instruments, and equipment that are employed in the ~~diagnosis,~~ treatment or prevention of dental disease. In addition, cosmetic agents may also be eligible for the Seal. ~~Drugs are considered useful in the treatment of oral disease if they are effective in the treatment of disease of similar causation in other regions of the body. Fixed combination drugs are considered eligible for Acceptance if each of the components makes a contribution to the claimed effect, and the dosage of each component is safe and effective for a significant patient population. Combinations having components added to enhance the safety or efficacy of the principal active component, or to minimize the potential for abuse are also eligible. Also considered are chemicals that may affect the health of dentists, dental auxiliaries and the public.~~ When evaluating these products the Council utilizes published technical standards, including official ADA guidelines, as well as

ANSI/ADA and ISO specifications. Products for which ADA Guidelines or technical standards do not exist may also be evaluated if sufficient acceptable data demonstrating safety and efficacy are submitted. ADA Guidelines and ~~T~~technical standards may be modified at any time. ADA will notify companies of any changes applicable to their products. ~~Mouthwashes or dentifrices that do not claim therapeutic value are not eligible for Acceptance.~~

PRODUCT SUBMISSION AND ACCEPTANCE

Commercial products are evaluated upon the request of a distributor or manufacturer, or upon the initiative of the Council. Any company may submit appropriate products to the Council for consideration for Acceptance. Products which meet the ADA Seal Program's Acceptance criteria with respect to safety, efficacy, composition, labeling, package inserts, advertising and other promotional material will be granted the ADA Seal of Acceptance. Notification of a product's Acceptance into the ADA's Seal Program will be made in writing by the Council. A company may not begin use of the ADA Seal of Acceptance unless and until it has executed the ADA's standard ADA Seal license agreement and complied with the ADA's advertising requirements. The Council may require a company to use an authorized statement in conjunction with its use of the ADA Seal. Acceptance is renewable and may be reconsidered at any time. If there is a change in the manufacturer or distributor of a product, the Seal of Acceptance is withdrawn automatically and the license agreement expires simultaneously.

~~Provisionally Accepted products consist of those products that lack sufficient evidence to justify classification as Accepted, but for which there is reasonable evidence of safety and usefulness including clinical feasibility. These products meet the other qualifications established by the Council. The Council may authorize the use of a suitable statement to define specifically the area of usefulness of products classified as Provisionally Accepted. Classification in this category is reviewed periodically and is not ordinarily continued for more than three years.~~

Products that are obsolete, substantially inferior, ineffective or dangerous to the health of the user will be declared unaccepted. When it is in the best interest of the public or the profession, the Council may submit reports on unaccepted products to the Editor for publication in *The Journal of the American Dental Association* or in another Association medium.

GENERAL CRITERIA FOR ACCEPTANCE

I. Name

A. *Established or Generic Names:* The selection and use of established or generic names must conform to the requirements of the Federal Food, Drug and Cosmetic Act.

B. *Trade Names:* Proprietary names will be acceptable to the Council provided the names meet certain professional standards:

a. *Misleading Names:* Names which are misleading or which suggest diseases or symptoms will not be acceptable. This provision may not apply to certain biological products such as serums or vaccines.

b. *Titles in Names:* Products that include titles such as Doctor or Dentist or the designation D.D.S. or D.M.D. in the name of a product will not be acceptable.

Unacceptable product names (as determined by, but not limited to, the above criteria) must be revised before Acceptance.

II. Composition, Nature and Function

A. *Product Information*: A company is required to provide a quantitative statement of composition, including excipients, to the Council. For therapeutic agents, adequate information on the properties of all ingredients must also be provided. For materials, instruments and equipment, a description of the materials used in the construction and the method of operation must be provided. Any change in the composition, nature or function of an Accepted product must be submitted to the Council for review and approval before a modified product is marketed. A modified product is prohibited from using the ADA Seal unless and until it is approved by the Council.

B. *Manufacturing Standards*: The company must provide evidence that manufacturing and laboratory control facilities are under the supervision of qualified personnel, are adequate to assure purity and uniformity of products, and are in compliance with Good Manufacturing Practices. The company must agree to permit representatives of the Council to visit laboratories and factories upon request. For products whose guidelines include an official American National Standard Institute/American Dental Association Specification (ANSI/ADA Specification), the manufacturer is required to conduct testing on a regular basis to determine continued compliance with the specification. Upon request of Council, the company must make these test records available to the Council. In addition the manufacturer must make available to the Council on request test records and data for any batch of an Accepted product.

C. *Complying with Guidelines and/or Specifications:*

i. The company must provide evidence that a product demonstrates compliance with its relevant guideline and/or specification.

ii. The Council at any time and without notice to the ~~manufacturer~~ company, may authorize the testing of such products.

iii. For Products which fall under the scope of official ANSI/ADA Specifications the following information must be submitted: (1) the serial or lot number; (2) the physical properties as obtained by standard test methods; and (3) data covering every provision of the official specification. Responsibility for guaranteeing that product complies with an official specification lies solely with the manufacturer and not with the American Dental Association.

iv. Test samples will be procured at the expense of the manufacturer as indicated in Section III. In the event that an Accepted product fails to comply with the appropriate specification, the ADA Seal of Acceptance will be withdrawn from the product, the license agreement will terminate immediately, and all rights of the company to use the ADA Seal will cease. All products that do not comply with the specification must be removed from the market. If the ADA Seal of Acceptance is withdrawn from a product, the product may be resubmitted at any time, provided adequate evidence of safety and effectiveness is submitted for Council review.

III. Evidence of Safety and Efficacy

A. *Submission of Evidence:* Evidence must be submitted pertaining to: actions, safety and efficacy; and where applicable, mechanical and physical properties. Information on acceptable standard test methods for physical properties may be obtained from the Council on Scientific Affairs. In general, the data required on physical tests will include: methods, results, names of the observers, and dates of testing.

B. *Nature of Evidence:* The company must provide objective data from clinical and laboratory studies demonstrating safety and effectiveness. Evaluation of a product may also be based on similarity to a

previously Accepted product. Products that fall under the scope of an official ANSI/ADA~~/ANSI~~ Specification will be tested for compliance with the specification by the ADA laboratory. Test samples, unless otherwise indicated in the appropriate specification, will be procured on the open market at the expense of the manufacturer.

C. *Supplemental Evidence:* All proprietary studies for the product as well as a list of all other studies conducted using the final product must be submitted. Additionally, the ADA may, through use of its own laboratory facilities or use of other facilities, conduct any additional evaluation deemed necessary by the Council.

D. *Post Marketing Surveillance*: Any new information regarding safety and efficacy must be submitted as it becomes available. This evidence may be in the form of new clinical studies, reports of adverse reactions or follow-up investigations of previously submitted clinical studies.

E. *Renewal of Acceptance*: The company may be required to submit evidence demonstrating continued acceptable clinical performance of the product. This evidence may be in the form of new clinical and/or laboratory studies, reports of adverse reactions or follow-up investigations of previously submitted clinical studies.

F. *Disclosure:* The company must disclose any past, present or anticipated financial arrangements between the investigators and the company, its affiliates or subsidiaries, including, but not limited to, consulting agreements, speakers' fees, grants or contracts to conduct research, or membership on the company's advisory committees including remuneration policies, or in the product that is the subject of the investigation. If the Council determines that the financial interests raise a question about the integrity of the data, the Council may take any action it deems necessary to ensure the reliability of the data, including but not limited to:

- requesting that the company submit further analyses of the data;
- requesting that the company conduct additional independent studies; and
- rejecting the data as a basis for council action.

IV. Governmental Regulations

A product must conform to all applicable laws and governmental regulations.

V. USE OF BIODEGRADABLE AND RECYCLABLE MATERIALS

The American Dental Association is concerned about the environment and about the negative impact that the widespread use of non-biodegradable materials for the manufacture and packaging of disposable products can have on the environment. Therefore, the ADA encourages all dental manufacturers, especially those with Accepted products, to use, whenever possible, materials that are biodegradable and/or recyclable.

VI. Labeling, Package Inserts, Advertising and Other Promotional Material

A. *Name:* The established or generic name of a product must be displayed in a prominent manner in all material directed to the dental profession.

B. *Claims:* Claims of significance to dentistry for a product must be clear and accurate.

C. *Packaging/Labeling~~Review/Approval Before Use~~:* All packaging/labeling ~~dentally related product material~~ must be submitted to the Council for review and approval prior to use. ~~in the public and dental media~~.

~~D~~. E.*~~Unwarranted~~ Disparagement of Other Products:* Advertising of an ~~Accepted~~ Accepted product must not result in the disparagement of other products.

D. ~~E.~~ *Advertising*: Advertising must conform to the ADA's advertising standards and certification mark usage guidelines. The ADA's name and the ADA Seal and~~/or~~ Seal Statement ~~of Acceptance~~ may appear in advertising and promotional materials, to include point-of-purchase advertising if it is presented in good taste and professional dignity and is only part of the commercial message. The Seal statement sets forth the basis for acceptance by the Council and must be used whenever the Seal is used, unless otherwise authorized by the Council.

F. *Implied Acceptance:* An ~~Accepted~~ Accepted product must not be advertised or displayed with unaccepted products in a manner that implies Acceptance of the unaccepted product. This provision does not apply to conventional price lists or catalogs.

G. *Responsibility:* The responsibility of providing substantiation of claims for safety and efficacy or claims of compliance with an official standard must reside with the manufacturer and not with the American Dental Association.

VII. Reference to Council Acceptance ~~or Provisional Acceptance~~

A. Any reference to the Council in labeling, package inserts, advertising and other promotional material for an Accepted ~~Accepted or provisionally Accepted~~ product is permitted solely to indicate to the profession or public that the claims for product effectiveness in treating or preventing oral disease are valid.

B. The Seal of Acceptance may only be used after notification of Acceptance in writing by the Council and execution of the ADA's standard ADA Seal license agreement. The ADA Seal must not appear in conjunction with the seal or certification mark of any other investigative group unless approval for such display has been obtained from the Council. The ADA Seal is to be used without comment on its significance unless the Council has previously approved such comment. The Seal must be legible and must not be used in any manner that detracts from its dignity.

C. ~~When a statement is authorized by the Council to specifically define the effectiveness of a product, or to indicate its Acceptance status, t~~The same principles established for the use of the ADA Seal ~~of Acceptance~~ must apply to the Seal Statement.

VIII. Changes to the ADA Seal of Acceptance Program

The ADA reserves the right to make changes to the ADA Seal of Acceptance Program at any time at its sole discretion. Such changes may include, by way of example only and without limitation, changes to the guidelines or specifications, testing criteria, license agreement or advertising standards. Note that in some instances, changes to the Program may result in the permanent withdrawal of the ADA Seal from a product or product category. If the foregoing circumstance occurs, ADA will determine the date by which the license agreement will terminate and will notify affected companies accordingly. All rights of a company to use the ADA Seal will cease upon termination of the license agreement.

IX. Withdrawal of Acceptance

The Council may on occasion find it necessary to permanently withdraw the ADA Seal of Acceptance from a product or product category. Such decisions may be made at any time at the sole discretion of the Council.

Any violation of the ADA Seal license agreement is grounds for Council's withdrawal of the ADA Seal of Acceptance from the Product.

X. Confidentiality of Submission Material

It is the policy of the American Dental Association to treat the material submitted for Council review as confidential. Any confidential information submitted by a company should be marked as "confidential," "proprietary" or with a similar legend indicating its confidential nature.

Although ADA utilizes outside consultants in its review of products, ADA Seal Program consultants are required to sign the ADA's Code of Conduct. The Code of Conduct requires the consultants to refrain from disclosing confidential product submission materials to anyone outside the ADA. Except as required to evaluate a product submission or otherwise implement the ADA's Seal of Acceptance Program or as may be required by law, ADA refrains from voluntarily disclosing properly marked product submission materials to any third party without the prior consent of the manufacturer. ADA also takes commercially reasonable steps to ensure that such materials are not disclosed or distributed by its employees, consultants or other agents. However, ADA will not be liable for any damages resulting from the acts or omissions of ADA consultants, including but not limited to their failure to abide by the Code of Conduct.

ADA does not treat as confidential any information that (i) is or becomes a part of the public domain through no act or omission of ADA; (ii) was in ADA's lawful possession prior to the disclosure; (iii) is lawfully disclosed to ADA by a third party without restriction on disclosure; or (iv) is independently developed by ADA without use of or reference to the company's Confidential Information.

XI. TERMINATION OF PROFESSIONAL PRODUCT COMPONENT OF ADA ACCEPTANCE PROGRAM

Notwithstanding any other provision of these Guidelines, the ADA will stop accepting professional products for evaluation and inclusion in the Acceptance Program on December 31, 2004. No ADA Seal license agreement shall have a term that extends beyond December 31, 2007.

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Board Report 8 Date Submitted: July 2007

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: Create and Transfer Knowledge (Required)

REPORT 8 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: DENTAL WORKFORCE MODEL: 2005-2025

Background: The 1981 House of Delegates adopted Resolution 124H (*Trans*.1981:571) directing that the Board of Trustees examine and report, on a continuous basis, the rate of growth in the number of licensed dentists. The primary source of data for the Dentist Workforce Model (DWM) is the House-mandated census survey, *Distribution of Dentists in the United States by Region and State*. A second source of statistics on the profession's demographics is the *Survey of Predoctoral Dental Education*. The appended full report has been prepared in response to the 1981 House mandate. For the Board's convenience, a few highlights from the report follow.

Projected Number of Professionally Active Dentists and Active Private Practitioners: The number of both professionally active dentists and active private practitioners is expected to increase over the projection period. The number of professionally active dentists increased 13.9% between 1993 and 2005. Between 2005 and 2025, the number of professionally active dentists is projected to increase 8.3%, reaching 191,246. The number of active private practitioners increased 13.7% between 1993 and 2005. Between 2005 and 2025, the number of active private practitioners is projected to increase 8.2%, reaching 175,469. The number of professionally active dentists and active private practitioners per 1,000 U.S. population have been fairly stable—although both are projected to decline slightly in the coming years. Increases in productivity of dental practices in the future should permit the capacity of the delivery system to be maintained or to expand.

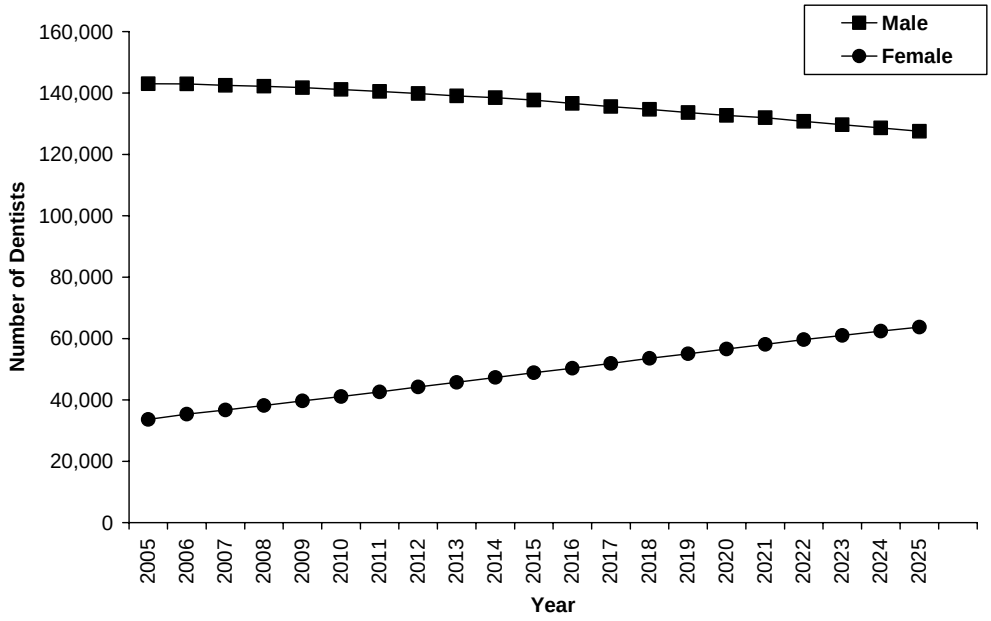
Table 1: Census Counts and Projections, 1993-2025

Year	Professionally Active Dentists	Active Private Practitioners	Applicants to Dental School	Applicants per Admission	U.S. Resident Population (in thousands)	Professionally Active Dentists per 1,000 U.S. Resident Population	Active Private Practitioners per 1,000 U.S. Resident Population
1993	155,087	142,603	6,761	1.6	260,255	0.60	0.55
1994	157,228	144,581	7,713	1.9	263,436	0.60	0.55
1995	158,641	146,089	7,996	1.9	266,557	0.60	0.55
1996	160,388	147,247	8,598	2.0	269,667	0.59	0.55
1997	160,781	147,778	9,829	2.3	272,912	0.59	0.54
1998	163,291	151,309	9,447	2.2	276,115	0.59	0.55
1999	164,664	152,151	9,010	2.1	279,295	0.59	0.54
2000	166,383	152,798	7,772	1.8	282,339	0.59	0.54
2001	168,556	155,716	7,412	1.7	285,024	0.59	0.55
2002	169,894	156,921	7,538	1.7	287,676	0.59	0.55
2003	173,574	160,177	7,987	1.7	290,343	0.60	0.55
2004	175,705	162,181	9,433	2.0	293,028	0.59	0.55
2005	176,634	162,180	10,731	2.3	295,734	0.60	0.55
2010	182,255	167,540	11,739	2.2	309,163	0.59	0.54
2015	186,557	171,453	12,476	2.1	322,593	0.58	0.53
2020	189,295	174,073	11,918	2.0	336,032	0.56	0.52
2025	191,246	175,469	12,343	2.0	349,666	0.55	0.50

Source: American Dental Association, Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025.*

Female Dentists: Female dentists are joining the profession in steadily increasing numbers. Judging by the recent increasing percentages of females in dental school enrollments, it is fair to say that the ratio of male to female dentists has yet to stabilize, unlike that of the medical profession. Based on ADA's *Distribution of Dentists in the United States by Region and State*, the percentage of professionally active female dentists has increased from 18.3% in 2004 to 19% in 2005. The number of female dental graduates in 2005 was 1,962, representing 43.8% of the graduating class. As graduating classes continue to move into the profession, women should continue to form an ever-increasing portion of practicing dentists through the foreseeable future.

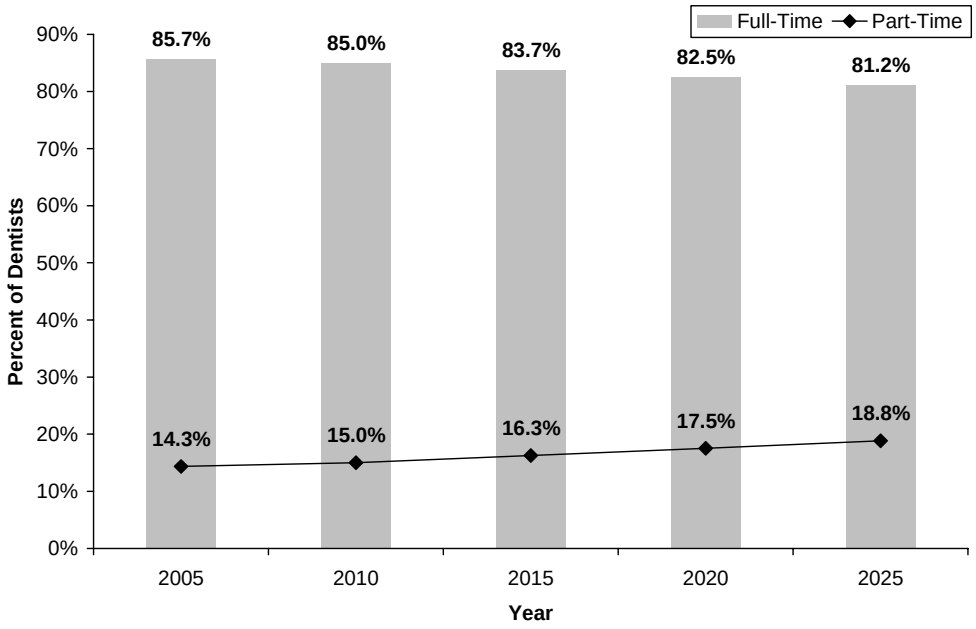
Figure 1: Projected Number of Active Private Practitioners, by Gender, 2005-2025



Source: American Dental Association, Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025.*

Part-Time Active Private Practitioners: In 2005, 14.3 % of active private practitioners were part-time. As shown in Figure 2, the percent of part-time active private practitioners is expected to follow a general trend of increase over the course of the projection period. This increase is mainly driven by the increase of female dentists since in general, female dentists are more likely to be part-time than their male counterparts.

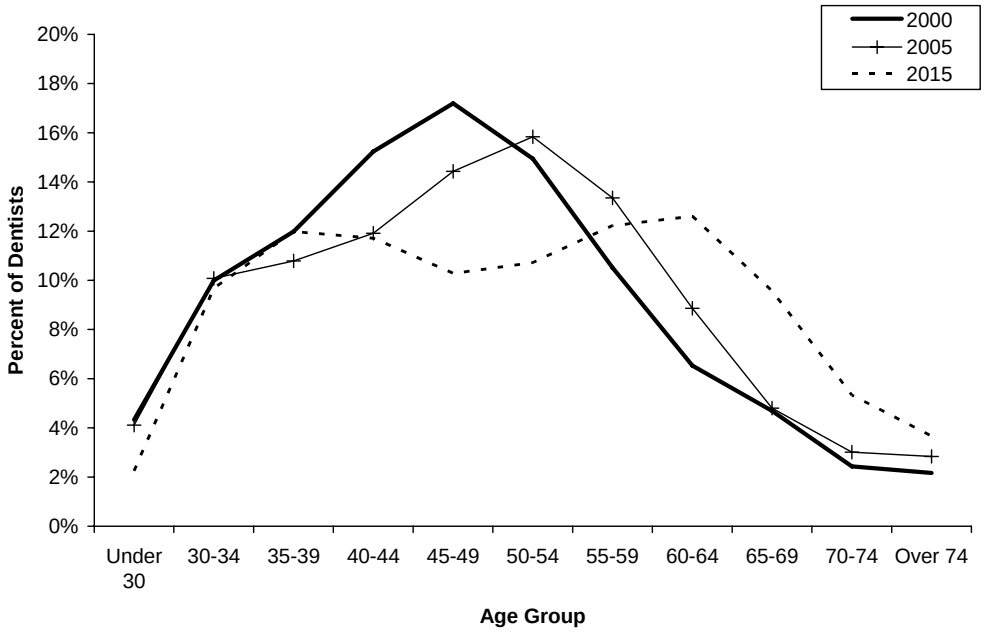
Figure 2: Percentage Distribution of Active Private Practitioners, by Full-Time and Part-Time Status, 2005-2025



Source: American Dental Association, Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025.*

Age Distribution of Professionally Active Dentists: As shown in Figure 3, the upward age shift that had been predicted over the last few years has begun. In 2000, for example, there was a significant peak in the age distribution among the 45-49 age group (17.20% of professionally active dentists); by 2005, the peak (15.83%) in age distribution occurs among the 50-54 age group. By 2015, the age distribution will be flatter and more diffuse with significantly more dentists in higher age groups—the largest distribution of 12.80% occurring among the 60-64 age group.

Figure 3: Percentage Age Distribution of Professionally Active Dentists in 2000, 2005 and the Projected Distribution in 2015

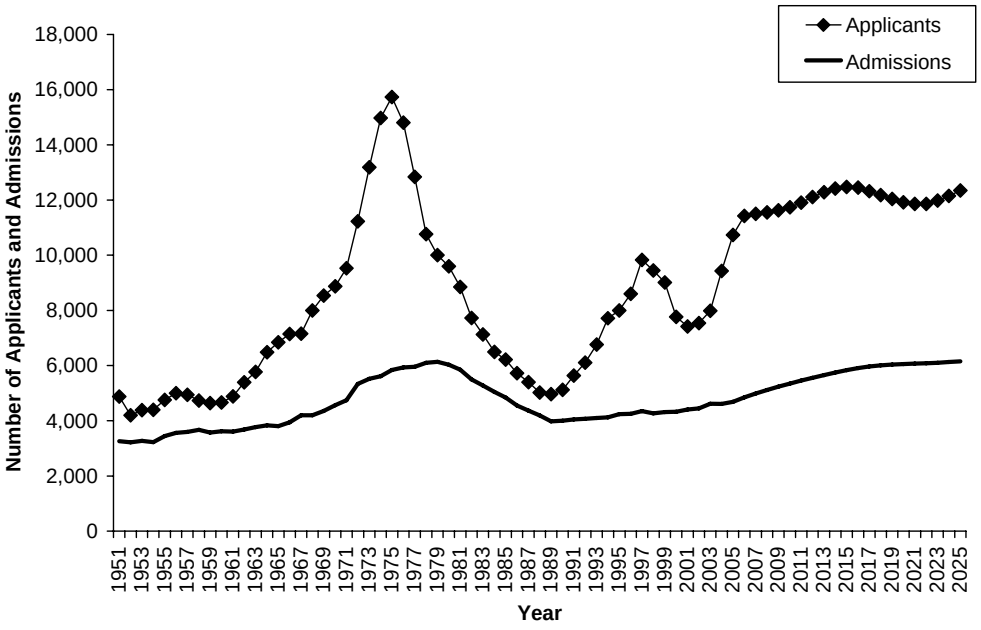


Source: American Dental Association, Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025.*

Dental School Applicants: There were 10,731 applicants in 2005, up from 9,433 in 2004—an increase of 13.8%. The number of applicants dropped each year between 1997 and 2001. Since 2001, however, the number of applicants has increased each year and is projected to continue to increase. This upward trend is heavily influenced by two major factors: the projected increase in the U.S. population 22-26 years of age until the year 2015, and the continued increase in dental income relative to the income of other professionals with a bachelors degree or higher. After the year 2015, the number of applicants is projected to decline. This decline corresponds to the Census Bureau's projected decline for the U.S. population aged 22-26 during this same period.

Dental School Admissions: The number of first-year enrollments increased 1.6% from 4,612 in 2004 to 4,688 in 2005. Enrollments in U.S. dental schools have responded to the trends in applicants with some delays as institutions adjust to large shifts in demand for dental education. Hence, it follows that the enrollments are not very responsive in the short-run, as one would expect. The long-run trend in enrollment shows a moderate, but direct response to the size of the applicant pool.

Figure 4: Actual and Projected Dental School Applicants and Admissions, 1951-2025



Source: American Dental Association, Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025.*

Sensitivity Analysis: The projection of professionally active dentists depends, among other factors, on the assumed rate of return to dental education. The sensitivity analysis suggests that an increase in the rate of return positively affects the size of the dental workforce within approximately six years. When examining the impact of a reduction in the rate of return, the results are found to have similar downward effects. (The Appendix of the attached full report contains a complete analysis that explores the impact of changes in the rate of return on future applicants, graduates, professionally active dentists and active private practitioners.)

Resolution

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)

Appendix

2007 American Dental Association Dental Workforce Model: 2005-2025

Overview: The Dental Workforce Model (DWM) performs long-term projection of the U.S. dental workforce using statistical transition models for retirements, occupation change, location choice, specialty education and death. Additional allocation models distribute new dental school graduates into dental occupations, locations and specialty programs. The DWM was developed for the ADA's Health Policy Resources Center[1] with significant extensions to the original work.

The DWM was extended in 1993 by using more sophisticated statistical methods to handle the new rotating panel method used for the ADA census of dentists, the *Distribution of Dentists in the United States by Region and State* (DOD). An improved accounting of net foreign dentist immigration was also implemented. The DWM also projects the number and gender of dental school graduates based on: relative lifetime earnings of dentists (vis-à-vis that of other college graduates), dental education costs, and financial support available in dental schools. The theory is that the number of dental graduates is very well explained by the rate of return to dentistry, which is the relative expected financial reward from dental education (net of the cost of schooling) and availability of financial support while in school.

It should be noted that the dental workforce projections apply only to dentists within the United States, not U.S. territories. Also, the projections assume that there will be no major structural change in the economy, technology, politics, or the delivery mechanisms and organization of the dental care industry. In particular, no major component of the dental care sector is expected to be nationalized over the horizon of the projections. However, while some technological change can be expected, if it is of a similar impact to the changes over the past 20-30 years it will not substantially affect the projections.

The growth of managed care may have some effects on the dental care marketplace. However, these effects are not expected to create major changes in the delivery of dentistry over the next decade. Despite the large number of participating dentists, managed care patients currently make up a relatively small portion of the patient base. Further, there is no compelling economic argument for dentistry to move significantly toward managed care at the levels found in general medicine. Dentistry as a whole currently practices preventive care to a larger extent than any other segment of the health care industry, and dental costs are much more predictable and limited than major medical costs. Unless these market structure changes are much more rapid and dramatic than they have been in the past ten years, the overall pattern of the projections will not be affected.

Using the current estimates from the models for dental workforce projections, selected results and remarks about future trends in applicants, admissions, dental school graduates, as well as the number of professionally active dentists[2] and active private practitioners[3] are provided below.

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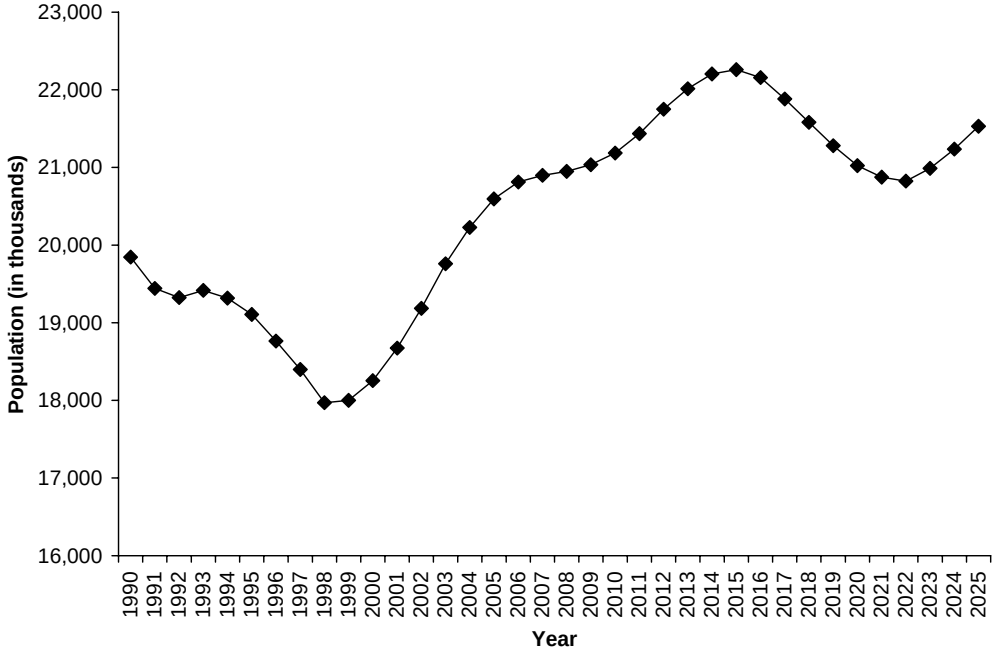
[1] An important part of this work is documented in: Nash KD, House DR. The dental school applicant pool and the rate of return to dentistry. *J Am Dent Assoc 1982;105(2):271-5.*

[2] Professionally active dentists are those whose primary and/or secondary occupation is private practice (full- or part-time), dental school faculty/staff member, armed forces, other federal services, state or local government employee, hospital staff dentist, graduate student/intern/resident, other health/dental organization staff member.

[3] Active private practitioners are a subset of professionally active dentist category and are defined as dentists whose primary and/or secondary occupation is private practice (full- or part-time).

Applicants, Admissions, and Graduates: The 2005 projections of applications, admissions and dental school graduates are in line with the 2004 projections. Note that the projections published in this report are influenced by changes in population projections of the U.S. Census Bureau. A graph of the current Census projections of the U.S. population aged 22-26 years is presented in Figure 1.

Figure 1: Current Census Projections of the Population Aged 22-26 Years (Time-Adjusted from 20-24 Age Group Projections)



Source: U.S. Census Bureau, International Data Base, Table 094: Midyear Population, by Age and Sex, available at: http//www.census.gov/icp/www/idbprint.html. Last Revised: 24 August 2006, accessed 08 March 2007. (Since the Census Bureau provides projections for the age cohort 20-24, the time-adjustment was done by RRC, Inc.)

Applicants. Dental schools in the U.S. generally experienced substantial declines in the number of applicants during the late 1970s and 1980s, but these numbers rebounded strongly in the early 1990s. The number of applicants fell from a high of 15,734 in 1975 to 4,964 in 1989. This decline can largely be attributed to the relative decrease in dentists' net incomes as compared with net incomes of other professionals and college graduates. During the early to mid-1990s, this trend in net incomes reversed itself, and the number of applicants to dental schools increased by 91.9% between 1990 and 1997. These increases occurred during a period (1990-97) in which the U.S. population aged 22 to 26 years declined by 7.3%. This can be explained by the fact that the increase in the applicant rate (fraction of people aged 22-26 years applying to dental schools) caused the number of applicants to increase such that it more than offset the decline in the population in this age group.

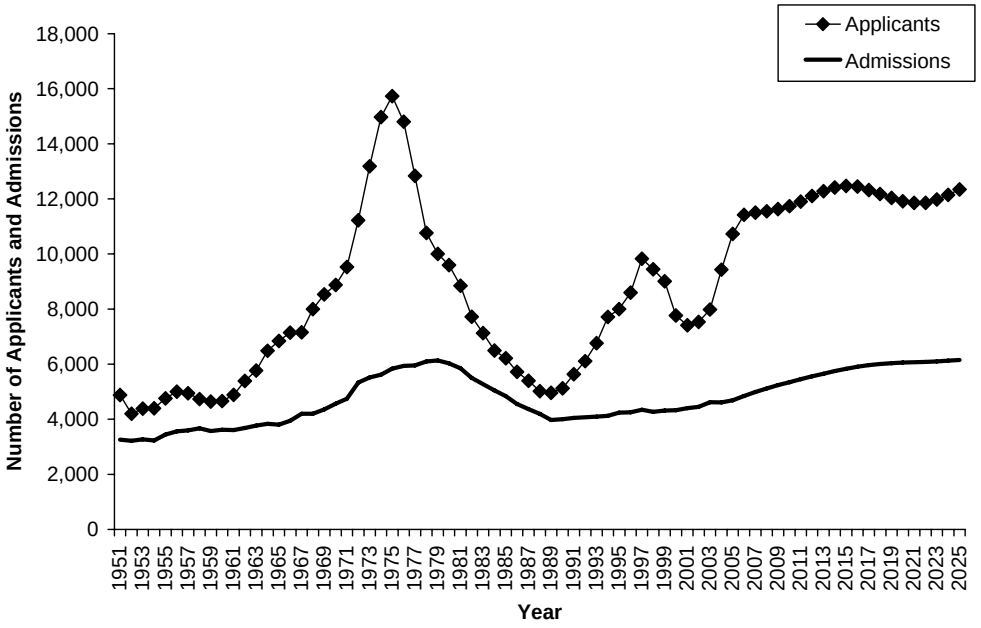
From 1997-2001, the number of applicants has dropped each year, falling from 9,829 in 1997 to 7,412 in 2001. This decline can be partly attributed to the decrease in the actual U.S. population aged 22-26 years. Another explanation can be found in the decline in dental income relative to income of other professionals with a bachelor's or higher degree between 1995 and 1997. Particularly, between 1996 and 1997, the ratio of dental income to the income of college graduates fell by approximately 2.5%. In 1998, this ratio increased by

5.3%. Recent results from the ADA's *Survey of Dental Practice* suggest that continued increases in dental incomes are to be expected. The number of applicants has increased every year since 2001. In 2005, the number of applicants increased to 10,731—a 13.8% increase from 9,433 in 2004.

The number of applicants is projected to continue this upward trend over the next 11 years. This upward trend is heavily influenced by two major factors: the projected increase in the U.S. population 22-26 years of age until the year 2015; and, the continued increase in dental income relative to the income of other professionals with a bachelor's or higher degree.

After the year 2015, the number of applicants is projected to decline (s Figure 2 and Table 1a). This decline corresponds to the Census Bureau's projected decline for the U.S. population aged 22-26 years during this same period.

Figure 2: Actual and Projected Dental School Applicants and Admissions, 1951-2025



Source: American Dental Association, Survey Center, *Survey of Predoctoral Dental Education* (various years), and Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025*.

Admissions. In 2005, the number of first-year enrollments increased by 1.6%, reaching 4,688. For the first time since 1988, the number of admissions or first-year enrollments had not increase in 2004—rather they decreased slightly from 4,618 in 2003 to 4,612 in 2004.

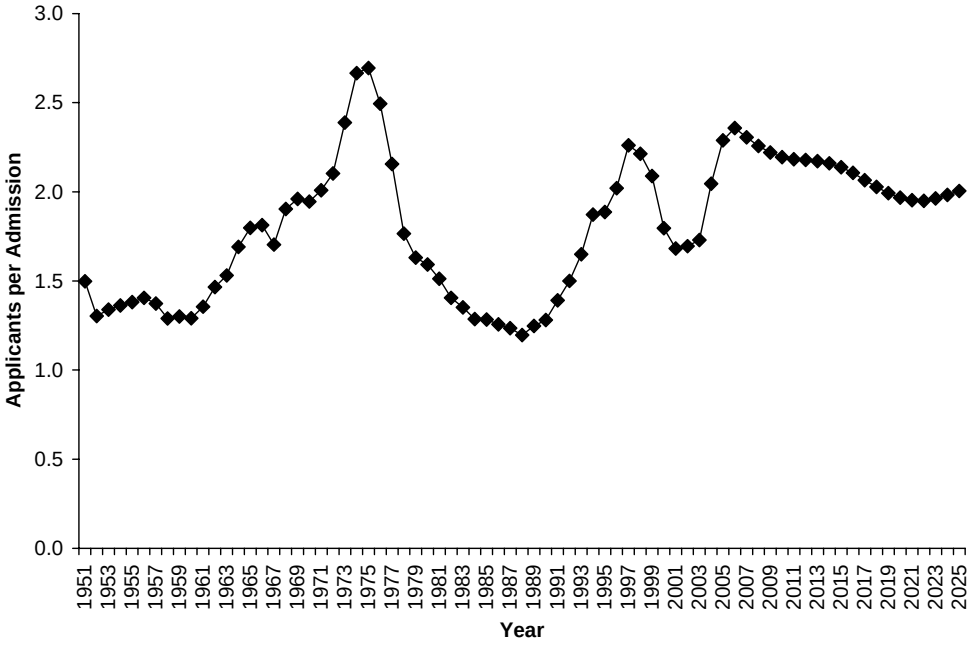
Enrollments in U.S. dental schools have responded to the trends in the number of applicants, with some delays as institutions adjust to large shifts in demand for dental education. Hence, it follows that the enrollments are not very responsive in the short-run, as one would expect. The long-run trend in enrollment shows a moderate but direct response to the size of the applicant pool.

When examining the historical trends in dental school admissions, it is evident that the last three decades can be divided into three major phases. The first period occurred from 1970-78. During this period, the number

of first-year enrolled dental students increased by 33.6%, or about 4.2% simple average rate per year. The second period of 1978-89 witnessed a decline in first-year enrollments by almost the same percentage, 4.4% per year. In the final period, since 1990, the number of first-year enrollments has followed a general trend of increase, increasing an average of 1% per year to 4,688 in 2005. The number of first-year enrollments is expected to increase through the end of the projection period.

Applicants Per Admission. The number of dental school applicants exhibited periods of relatively sharp increases and decreases in the past decades. Following the declining trend in applications during the 1980s, the number of applicants per admission to dental school reached an all-time low of 1.2 applicants per admission in 1988. This apparent instability in the number of applicants per admission stems from the fluctuation in the number of applicants. The delayed adjustment process of admissions also magnifies this fluctuation. The applicant-per-admission ratio increased each year between 1990 and 1997, reaching a high of 2.3 in 1997. However, since 1997, this ratio decreased each year, reaching a low of 1.7 in 2001—and it remained at 1.7 in 2002 and 2003 before increasing to 2.0 in 2004. In 2005, the applicant-per-admission ratio reached 2.5.

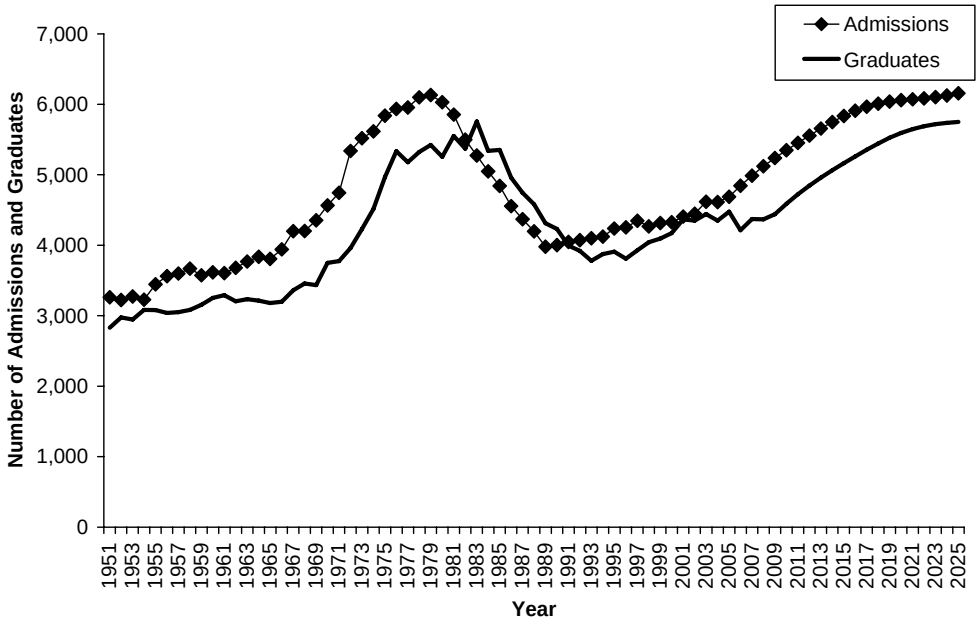
Figure 3: Actual and Projected Applicants per Dental School Admission 1951-2025



Source: American Dental Association, Survey Center, *Survey of Predoctoral Dental Education* (various years), and Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025*.

Graduates. Trends in the number of dental graduates lag those of applicants and admissions by approximately four years, although the changes are somewhat restricted by the relatively stable number of seats available in dental schools in the short-run. Not surprisingly, there was a general trend of growth in the number of graduates since 1994, approximately four or five years after a growth trend in applicants emerged. In 2005, the number of graduates increased to 4,478—a 2.9% increase from 4,350 in 2004. A general trend of growth is expected to continue. Figure 4 depicts both the actual and projected numbers of admissions and graduates.

Figure 4: Actual and Projected Number of Admissions and Graduates, 1951-2025



Source: American Dental Association, Survey Center, *Survey of Predoctoral Dental Education* (various years), and Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025*.

Forecasts of the Dentist Workforce: When estimating the future size of the active dentist workforce, several factors must be taken into consideration. A starting base, which is derived from the current year's "soft-counts,"[4] is projected into the future as the base, onto which additions and losses are applied. Additions to this base can occur in the form of new dental school graduates or in the form of foreign dentists entering the United States. Losses can occur in the form of death or retirement. In light of these factors, it is helpful to review their historical trends in order to better understand the effect they have on each other and the overall size of the active dentist workforce.

Throughout the 1980s, dentistry witnessed a general decline in the number of applicants to dental schools. This decline in applicants began in 1975 and was soon followed by a decline in first-year enrollments in dental schools (which began in 1978), a decline in the number of graduates from dental schools (which began in 1983), and five dental school closings. However, these trends reversed during the period of 1989-97, which experienced increases in applicants and first-year enrollments in dental schools. Graduation, which lags these trends by about four years, also increased with the first increase since 1985 occurring in 1994 (a 2.6% increase to 3,875).

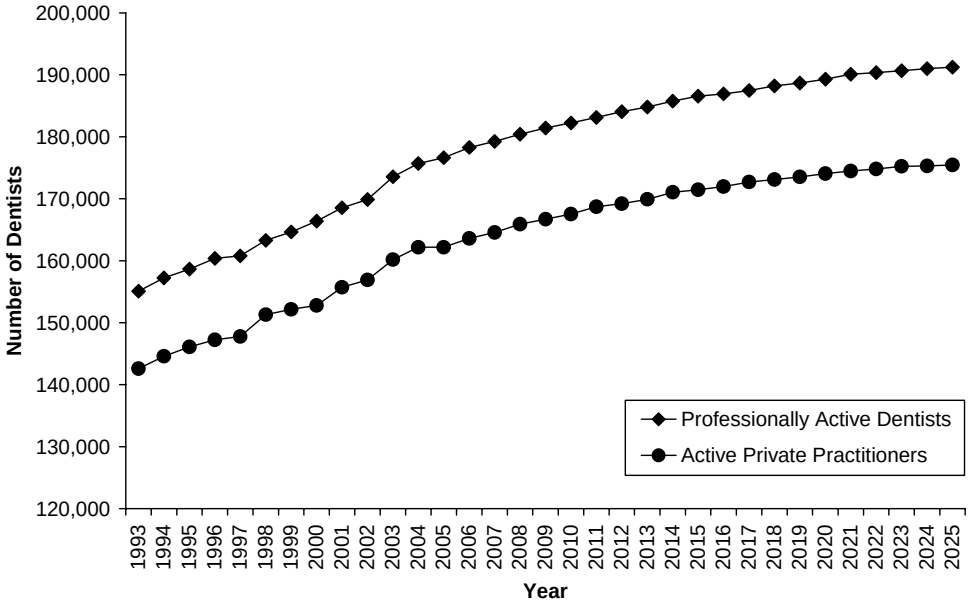
[4] Each year, the Survey Center of the American Dental Association surveys one-third of the dentist population to determine the number and occupational status of all dentists in the U.S. The responses to these one-third samples represent the "hard-counts" from which "soft-count" estimations are made based on the history of responses for each individual dentist. For two-thirds of the dentist population not included in an annual survey, estimates of occupational status are constructed based upon previous survey responses and the dentist's age and gender. "Soft-counts" serve as the complete dentist population count.

The reversal in the number of applicants between 1990 and 1997 coincided with a stabilization of relative net lifetime earnings between dentists and other college graduates (a relationship that declined between 1972 and the early 1990s). Since 1990, dental lifetime earnings generally increased faster than those of college graduates, making dentistry a more financially appealing profession. The rate of return to dentistry also continued to improve, and is expected to continue to increase into the future. The rapid rise of managed care programs in general medicine also makes dentistry a more attractive alternative to some individuals wishing to work in the health care field.

Considering these trends, it is projected that the total number of active dentists and the number of private practitioners will continue with a general trend of increase over the span of the projection period. However, beyond 2020, the growth in the number of professionally active dentists and active private practitioners is expected to level off (see Figure 5).

Professionally Active Dentists and Active Private Practitioners. Between the period of 1993 and 2005, the number of professionally active dentists and active private practitioners increased 13.9% and 13.7%, respectively. As shown in Figure 5 and Table 1a, the number of both professionally active dentists and active private practitioners is expected to increase over the projection period. Between 2005 and 2025, the number of professionally active dentists is expected to increase 8.3%, reaching 191,246, and the number of active private practitioners is expected to increase 8.2%, reaching 175,469.

Figure 5: Actual and Projected Number of Professionally Active Dentists and Active Private Practitioners, 1993-2025



Source: American Dental Association, Survey Center, *Distribution of Dentists in the United States by Region and State* (various years), and Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025.*

Table 1a: Census Counts and Projections, 1993-2025

Year	Professionally Active Dentists	Active Private Practitioners	Applicants To Dental School	Applicant Rate	1st Year Enrollment	Graduates	Applicants per Admission
1993	155,087	142,603	6,761	0.350	4,100	3,778	1.649
1994	157,228	144,581	7,713	0.402	4,121	3,875	1.872
1995	158,641	146,089	7,996	0.424	4,237	3,908	1.887
1996	160,388	147,247	8,598	0.463	4,255	3,810	2.021
1997	160,781	147,778	9,829	0.541	4,347	3,930	2.261
1998	163,291	151,309	9,447	0.534	4,268	4,041	2.213
1999	164,664	152,151	9,010	0.515	4,314	4,095	2.089
2000	166,383	152,798	7,772	0.440	4,327	4,171	1.796
2001	168,556	155,716	7,412	0.411	4,407	4,367	1.682
2002	169,894	156,921	7,538	0.407	4,448	4,349	1.695
2003	173,574	160,177	7,987	0.420	4,618	4,443	1.730
2004	175,705	162,181	9,433	0.466	4,612	4,350	2.045
2005	176,634	162,180	10,731	0.521	4,688	4,478	2.289
2010	182,255	167,540	11,739	0.554	5,349	4,588	2.195
2015	186,557	171,453	12,476	0.560	5,834	5,165	2.138
2020	189,295	174,073	11,918	0.567	6,058	5,594	1.967
2025	191,246	175,469	12,343	0.573	6,156	5,750	2.005

Source: American Dental Association, Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025.*

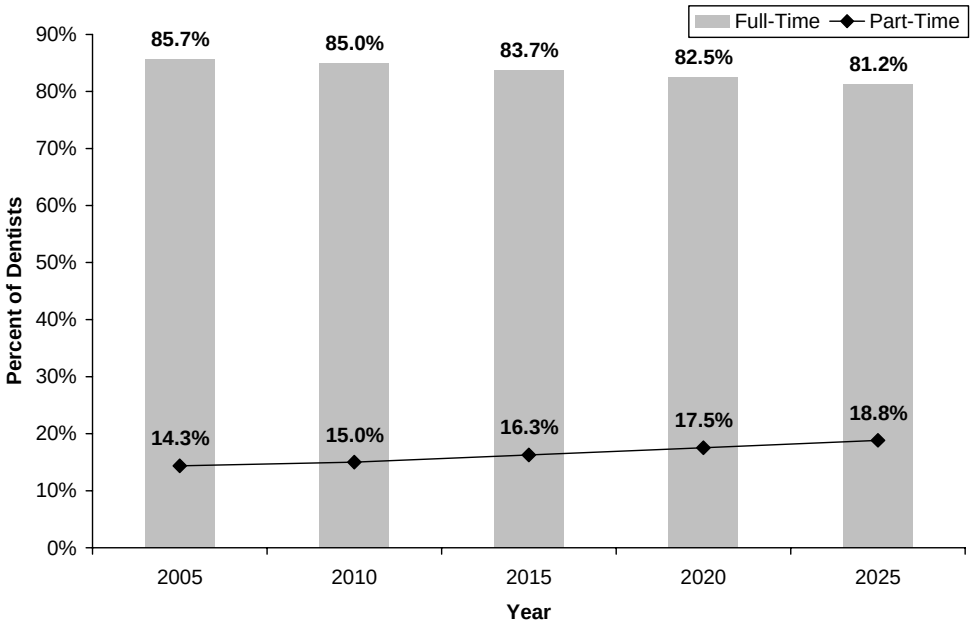
Table 1b: Census Counts and Projections, Including U.S. Resident Population, 1993-2025

Year	Population (in thousands)	Professionally Active Dentists	Active Private Practitioners	Professionally Active Dentist per 1,000 U.S. Resident Population	Active Private Practitioners per 1,000 U.S. Resident Population
1993	260,255	155,087	142,603	0.60	0.55
1994	263,436	157,228	144,581	0.60	0.55
1995	266,557	158,641	146,089	0.60	0.55
1996	269,667	160,388	147,247	0.59	0.55
1997	272,912	160,781	147,778	0.59	0.54
1998	276,115	163,291	151,309	0.59	0.55
1999	279,295	164,664	152,151	0.59	0.54
2000	282,339	166,383	152,798	0.59	0.54
2001	285,024	168,556	155,716	0.59	0.55
2002	287,676	169,894	156,921	0.59	0.55
2003	290,343	173,574	160,177	0.60	0.55
2004	293,028	175,705	162,181	0.59	0.55
2005	295,734	176,634	162,180	0.60	0.55
2010	309,163	182,255	167,540	0.59	0.54
2015	322,593	186,557	171,453	0.58	0.53
2020	336,032	189,295	174,073	0.56	0.52
2025	349,666	191,246	175,469	0.55	0.50

Source: American Dental Association, Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025*; and United States Census Bureau, International Data Base, Table 001: Total Midyear Population, available at: "http://www.census.gov/ipc/www/idbprint.html." (Last Revised: *24 Aug 2006.)* Accessed 12 March 2007.

Full-Time and Part-Time Status. The DWM allows for the distinction of full-time active private practitioners (32 or more hours per week) from part-time active private practitioners (less than 32 hours per week). In 2005, 14.3% of active private practitioners were part-time. That is, there were 138,930 full-time active private practitioners and 23,250 part-time active private practitioners. The percent of part-time active private practitioners is expected to follow a general trend of increase over the course of the projection. This increase is mainly driven by the increase of female dentists. In general, female dentists are more likely to be part-time than their male counterparts. By the year 2025, it is projected that 18.8% of active private practitioners will be part-time (see Figure 6).

Figure 6: Projected Percentage Distribution of Active Private Practitioners, by Full-Time and Part-Time Status, 2005-2025

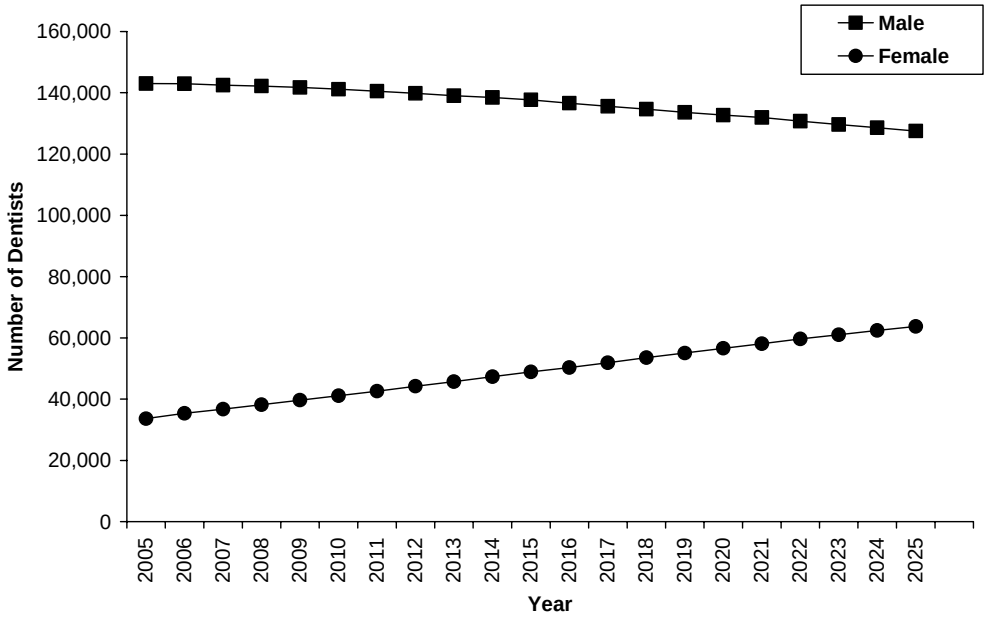


Source: American Dental Association, Survey Center, *2005 Distribution of Dentists in the United States by Region and State*, and Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025*.

Female Dentists. Female dentists are joining the profession in steadily increasing numbers. Judging by the recent increasing percentages of females in dental school enrollments, it is fair to say that the ratio of male to female dentists has yet to stabilize, unlike that of the medical profession. Based on ADA's *Distribution of Dentists in the United States by Region and State*, the percentage of professionally active female dentists has increased from 18.3% in 2004 to 19.04% in 2005. The number of female dental graduates in 2005 reached 1,962 representing 43.8% of the graduating class. As graduating classes continue to move into the profession, women will continue to form an ever-increasing portion of practicing dentists through the foreseeable future (see Figure 7).

Originally, the DWM used only the gender composition of graduating classes to project the future gender composition of the dental workforce. In the 2003 Model, the DWM was updated to also incorporate the gender composition of incoming classes to dental schools. This update has resulted in a slightly higher percentage distribution of female dentists over the course of the projection.

Figure 7: Projected Number of Professionally Active Dentists, by Gender, 2005-2025



Source: American Dental Association, Survey Center, *2005 Distribution of Dentists in the United States by Region and State*, and Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025*.

Age Distribution. The projection of the age distribution of professionally active dentists is presented in Table 2 as derived from the DWM for several periods from 2000 through 2025. As can be seen in Table 2 and Figure 8, the upward age shift that had been predicted over the last few years has begun. In 2000, for example, there was a significant peak in the age distribution among the 45-49 age group (17.20% of professionally active dentists); by 2005, the peak (15.83%) in age distribution occurs among the 50-54 age group. By 2015, the age distribution will be flatter and more diffuse with significantly more dentists in higher age groups—the largest distribution of 12.80% occurring among the 60-64 age group.

Table 2: Percentage Age Distribution of Professionally Active Dentists, 2000-2025

Age Group	2000	2005	2010	2015	2020	2025
Under 30	4.33%	4.11%	1.95%	2.19%	2.37%	2.47%
30-34	9.99%	10.08%	10.84%	9.42%	10.35%	11.02%
35-39	11.98%	10.78%	11.28%	12.14%	11.02%	12.02%
40-44	15.24%	11.91%	10.66%	11.11%	12.02%	11.07%
45-49	17.20%	14.43%	11.31%	10.20%	10.73%	11.67%
50-54	14.94%	15.83%	13.48%	10.64%	9.64%	10.20%
55-59	10.51%	13.35%	14.48%	12.37%	9.81%	8.96%
60-64	6.53%	8.86%	11.74%	12.80%	10.92%	8.69%
65-69	4.69%	4.80%	7.41%	9.74%	10.67%	9.04%
70-74	2.43%	3.01%	3.56%	5.53%	7.19%	7.91%
Over 74	2.16%	2.84%	3.29%	3.86%	5.28%	6.94%

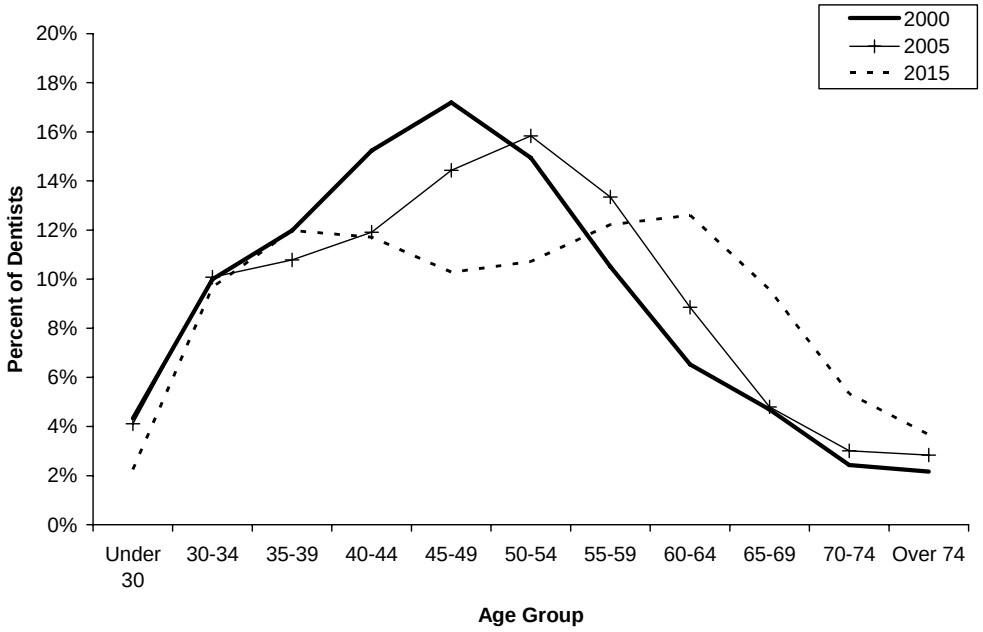
Source: American Dental Association, Survey Center, *2000* and *2005 Distribution of Dentists in the United States by Region and State,* and Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025*.

One can observe from Table 2 that as early as 2010, a sizable proportion of professionally active dentists will have moved past the most productive period for dentists—35-54 years of age. In 1991, 23.4% of professionally active dentists were past this age group (over 54 years old); by 2010 this percentage is expected to reach 40.48%. In fact, the single largest five-year age bracket in 2010 will be just past the highest productivity period (i.e., dentists 55-59 years old will account for 14.48% of professionally active dentists)

Overall, the percentage of dentists in the most productive age bracket (35-54 years old) was at a peak of 61.6% in 1996, from which it slid to 52.95% in 2005 and is projected to continue falling to 43.41% in 2020. That is, over the next 15 years, it is expected that a gradual "graying" of the U.S. dentist population will occur. Beyond 2020, the aging of the large number of 1980s dental graduates will be complete, and the age composition of dentists is expected to become much more stable.

The large "bubble" of the dentists educated in the 1970s—when federal capitation payments were in place and the relative financial returns to dentistry was simultaneously at an all time high—will help stabilize the age composition of dentists. As this group of dentists retires, the profession will encounter smoother workforce transitions. In the absence of future government intervention, the ensuing workforce is expected to be much more stable, both in terms of numbers and age distribution.

Figure 8: Percentage Age Distribution of Professionally Active Dentists in 2000, 2005 and the Projected Distribution in 2015



Source: American Dental Association, Survey Center, *2000 and 2005 Distribution of Dentists in the United States by Region and State*, and Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025*.

Sensitivity Analysis of the 2007 ADA Dental Workforce Model: 2005-2025: The Dental Workforce Model (DWM) sensitivity analysis explores the sensitivity of various indicators of the dental workforce to the changes in rate of return to dental education (ROR). These indicators include the number of applicants to and graduates of dental schools, the number of professionally active dentists and the number of active private practitioners.

The ROR is a term used to express the return that dental students receive from their education investment over the course of their dental careers. Its calculation is supported with data on dentists' net incomes across all ages, the cost of dental education (net of scholarships), and data on incomes of competing careers, across all ages. Intuitively, one can expect the number of applicants, graduates, professionally active dentists and active private practitioners to rise if the ROR increases, and to fall if the ROR decreases.

This section on sensitivity analysis explores the impact of changes in the ROR on future applicants, graduates, professionally active dentists and active private practitioners. The sensitivity analysis examines both a 2.5% increase and a 2.5% decrease in the ROR. In this analysis, a one-time change is applied to the 2005 ROR and, using the DWM, future RORs are projected to 2025. The change is applied to the base RORs, which as shown in Table A-1 ranged from 20.5% in 2005 to 20.7% in 2025.

After a one-time increase in ROR between 2005 and 2006 occurs, there is an increase in applicants almost immediately (see Figure A-1). This increase in applicants leads to an increase in graduates within five years, or by 2010 (see Figure A-2). The effect of the increase in the ROR on graduates continues through the remainder of the projection. An increase in the number of professionally active dentists begins to emerge by

2011 (see Figure A-3), as does an increase in the number of active private practitioners (see Figure A-4). This reflects the increase of graduates into the dental workforce from the previous three years. The impact of an increase in the ROR will continue as more graduates are added into the workforce.

A one-time decrease in the ROR has similar downward effects on applicants, graduates, professionally active dentists and active private practitioners. However, the magnitude of the effect of a downward adjustment of 2.5% in the ROR seems to be slightly stronger compared to a 2.5% upward adjustment. The primary reason for this is that in the base-case scenario, the ROR is increased by 0.05% annually, including the 2005-06 period when the two ROR adjustments take place. This results in the upward ROR adjustment being closer to the base-case ROR than the downward ROR adjustment (see Table A-1).

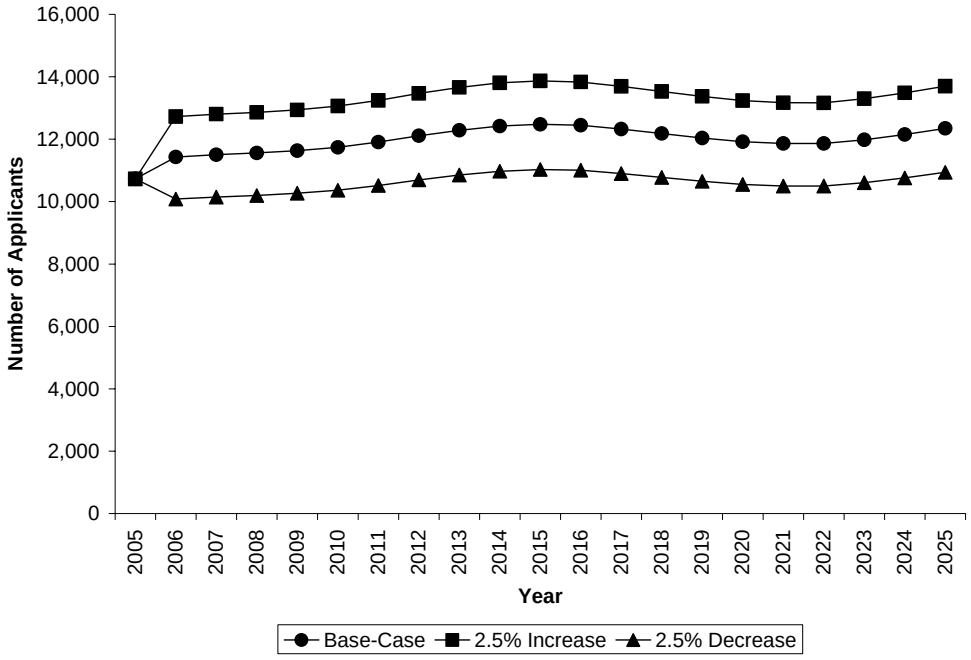
In conclusion, an adjustment in the ROR will begin to impact the size of the dental workforce within approximately six years. This impact will continue as more graduates are added to or as existing dentists are lost from the dental workforce.

Table A-1: Three Scenarios of Rate of Return Used for the Projections in Figures A-1 through A-4

Year	Rate of Return		
	Base-Case	2.5% ROR Increase	2.5% ROR Decrease
2005	20.45%	20.95%	19.93%
2006	20.46%	20.96%	19.94%
2007	20.47%	20.97%	19.95%
2008	20.48%	20.98%	19.96%
2009	20.49%	20.99%	19.97%
2010	20.50%	21.00%	19.98%
2011	20.51%	21.01%	19.99%
2012	20.52%	21.02%	20.00%
2013	20.53%	21.03%	20.01%
2014	20.54%	21.05%	20.02%
2015	20.55%	21.06%	20.03%
2016	20.56%	21.07%	20.04%
2017	20.57%	21.08%	20.05%
2018	20.58%	21.09%	20.06%
2019	20.59%	21.10%	20.07%
2020	20.60%	21.11%	20.08%
2021	20.61%	21.12%	20.09%
2022	20.62%	21.13%	20.10%
2023	20.63%	21.14%	20.11%
2024	20.64%	21.15%	20.12%
2025	20.66%	21.16%	20.13%

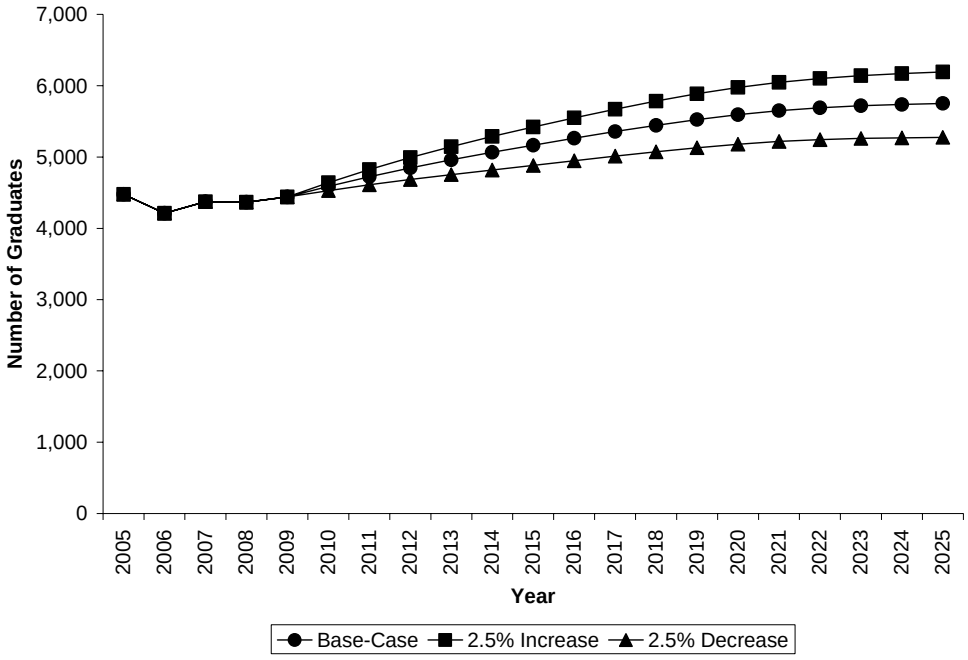
Source: American Dental Association, Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025.*

Figure A-1: Projected Number of Dental School Applicants Under Base-Case, Increasing and Decreasing Rate of Return Scenarios, 2005-2025



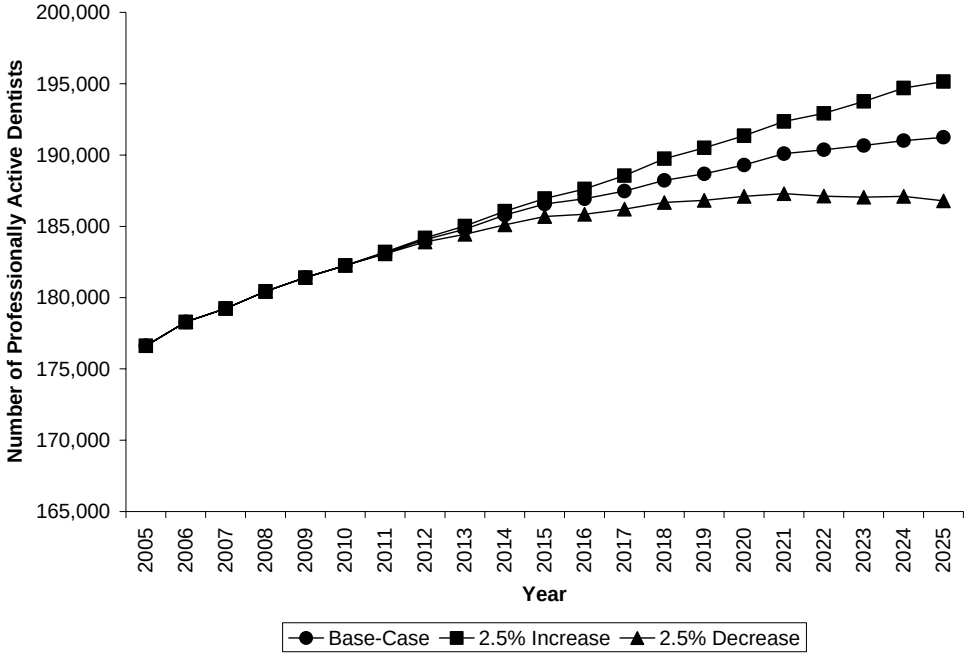
Source: American Dental Association, Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025.*

Figure A-2: Projected Number of Dental School Graduates Under Base-Case, Increasing and Decreasing Rate of Return Scenarios, 2005-2025



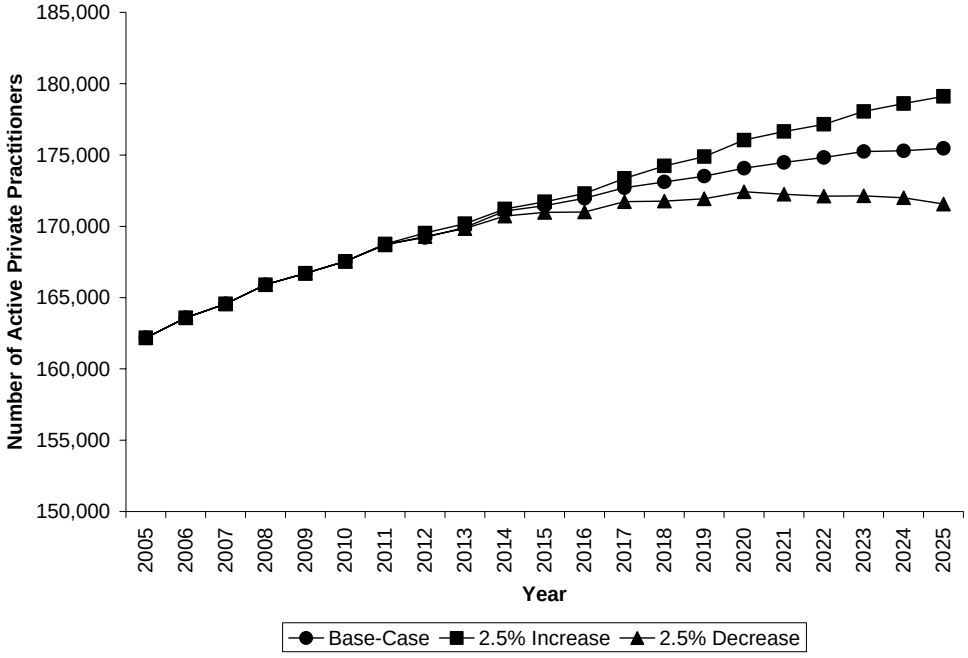
Source: American Dental Association, Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025*.

Figure A-3: Projected Number of Professionally Active Dentists Under Base-Case, Increasing and Decreasing Rate of Return Scenarios, 2005-2025



Source: American Dental Association, Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025.*

Figure A-4: Projected Number of Active Private Practitioners Under Base-Case, Increasing and Decreasing Rate of Return Scenarios, 2005-2025



Source: American Dental Association, Health Policy Resources Center, *2007 ADA Dental Workforce Model: 2005-2025*

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Board Report 10 Date Submitted: July 2007

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)

REPORT 10 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: STRATEGIES TO ADDRESS ORAL HEALTH ISSUES OF VULNERABLE ELDERS

Background: The 2004 ADA House of Delegates adopted Resolution 73H (*Trans*.2004:300) requesting appointment of a two-year task force to "explore the challenges in rendering comprehensive dental care to our aging population; and that special attention be given to identifying varying needs based on the variety of resident situations…" An interim report was provided to the 2005 ADA House of Delegates (*Supplement* 2005:474) and a final white paper encompassing the findings of the Task Force on Elder Care and recommendations for the future to the 2006 ADA House of Delegates. The 2006 House of Delegates adopted Resolution 5H *(Trans.*2006:317) which reads as follows:

5H-2006. Resolved, that the following strategies to address oral health issues of vulnerable elders be adopted:

Advocacy to Address Elders' Health Care. The ADA, with input from key stakeholders will develop strategies that will persuade legislators and regulators at all levels to make vulnerable elders' oral health a priority, and that these strategies may include but not be limited to the following:

- At least three new supportive programs to be implemented in 2008 (e.g., loan forgiveness, loan repayment, tax treatments, scholarships, grants, service opportunities) for dentists who provide care to vulnerable elders
- At least two new advocacy strategies that will result in 2010 compliance by all institutional settings with the minimum federal standards for daily mouth care for vulnerable elders
- At least two new strategies to educate and seek the support of key senators, representatives and agency officials within a year on key legislation, and the critical need for advanced general dentistry programs in geriatric dentistry and those programs with an emphasis in geriatrics
- At least three legislative, regulatory and market-based initiatives to improve the oral health of vulnerable elders developed in collaboration with stakeholders in the aging network and health communities
- A plan developed with key stakeholders by 2007 to influence and persuade those who fund and approve clinical trials in dental research to include people over 65 in study populations

- the ADA to encourage constituent and component dental societies to join in these advocacy efforts

Education of Health Care Workers to Support Elders' Oral Health Care. The following strategies will facilitate education of health care workers on issues related to oral health of the vulnerable elderly population:

- ADA collaborating with key stakeholders to develop a plan with strategies designed to expand opportunities for advanced general dentistry programs in geriatric dentistry and those programs with an emphasis in geriatrics that will commence within three years

- Appropriate ADA agencies developing and implementing by 2008 approved continuing education programs for certified nursing assistants in oral health and daily mouth care for vulnerable elderly

- ADA collaborating with stakeholders to create for implementation in 2008 a Web-based clearinghouse of community-based outreach programs, practice resources, continuing education opportunities and consensus reports related to providing oral health care to vulnerable elders

Additional strategies will include:

- The ADA redoubling efforts to provide enhanced educational content on the oral health needs of vulnerable elders at national, regional, state and local dental meetings, as well as online and for study groups

- The ADA encouraging constituent and component dental societies to join in efforts to provide enhanced educational content on the oral health needs of vulnerable elders

- The ADA working collaboratively with key stakeholders to enhance undergraduate dental education to better prepare dental and allied dental students for caring for the growing elderly population, and to find additional ways to include dentistry in interdisciplinary and other special geriatric training programs

- Appropriate ADA agencies collaborating with key stakeholders and investigating the need for a non-specialty interest area in general dentistry for geriatric dentistry

- Appropriate ADA agencies developing elder care programming and obtaining staff support to carry out the vision set forth in the white paper of the Task Force on Elder Care.

Education of the Public and Policymakers to Enhance Elders' Oral Health.

- The ADA will collaborate with appropriate stakeholders to develop a proposal for the 2007 ADA House of Delegates to build the public's awareness on how good oral health enhances overall health and quality of life in vulnerable elders

- The ADA in 2007, in collaboration with stakeholders, will develop educational material (e.g., FAQ and three articles) for elders and their families for the public side of ADA.org to increase awareness about how oral health impacts overall health and quality of life within a year

- The ADA will develop position papers and supporting materials in 2007 (including talking points) to educate policymakers on oral health issues relating to vulnerable elders

- The ADA will seek opportunities to educate policymakers and others that funding advanced general dentistry programs in geriatric dentistry and those programs with an emphasis in geriatrics is critical to improving the health of vulnerable elders

- The ADA will initiate or support key pieces of legislation that would improve the health of vulnerable elders

- The ADA will develop educational tools on oral health issues of residents in long term care facilities and assisted living facilities

Exploring New Types of Dental Insurance for Elders. The appropriate agencies of the ADA will develop a plan for convening a 2008 meeting of key stakeholders to discuss new insurance plan models for people over age 65, with an interim report to the 2007 House of Delegates and a final report, with recommendations, to the 2008 House.

Exploring Dental Workforce Needs to Support Elders' Oral Health Care. Appropriate agencies of the ADA will investigate new dental workforce roles specifically for the geriatric population including appropriate functions for dental assistants and dental hygienists to support care for the vulnerable elderly population.

Research to Support Oral Health for Elders. The ADA in 2007 will develop with key stakeholders a plan to aggregate, identify, collect and synthesize existing research on the oral health of the vulnerable elderly in order to identify knowledge gaps, including:

- Mechanisms designed to ensure consistent and comprehensive data generation on the oral health of vulnerable elderly populations through regular gap analyses of existing research

- Mechanisms to identify and secure funding for at least three oral health care research projects within three years that have the potential to prevent oral disease and improve the oral health status of vulnerable elders

- Mechanisms for urging and finding funding for 2008-10 research for therapeutic trials designed to prevent, reduce and/or eliminate oral diseases affecting vulnerable elders; and research that investigates the relationship between oral health and general health in vulnerable elders

- Mechanisms for disseminating research findings that impact vulnerable elders' oral health to health care workers, the public and policymakers

Furthermore, the ADA will

- Conduct in 2007 a 'Survey of Current Issues in Dentistry' devoted to vulnerable elders to collect current data from general dentists and specialists on the care they are providing for vulnerable elders in a variety of practice settings

- Develop in 2007 an ADA Health Policy Resources Center analysis of vulnerable elders' oral health issues to increase the understanding of age-associated and disease-associated oral disorders and their impact on clinical care.

and be it further

Resolved, that the Board of Trustees report to the 2007 House of Delegates on the status of these elder care initiatives.

The resolution and accompanying strategies presented in the report were broken out into logical and connected components focused on education, advocacy, and research in relation to the oral health care needs of the elderly. This report describes progress made in addressing the goals, objectives and initiatives implemented in 2007.

Education Results: The Oral Longevity™ program will launch at this year's annual session. In 2007, thanks to a generous grant from GlaxoSmithKline Consumer Healthcare (GSKCH), a wealth of education and awareness resources geared toward oral health issues facing older adults has been developed and will be the first-to-market national initiative of its kind. The Council on Access, Prevention and Interprofessional Relations (CAPIR) is coordinating this joint initiative between the ADA, ADA Foundation and GSKCH. The 2007 launch of OralLongevity™ kicks off with a Special Supplement to the September issue of *JADA*, with articles on oral health issues specific to the geriatric population. Annual session events include distribution of an educational brochure, DVD and the *JADA* Supplement at a special OralLongevity™ exhibit in the World Marketplace Exhibition. Additionally, every member dentist and *JADA* subscriber will receive a copy of the DVD and brochure along with the *JADA* supplement. The DVD will be designed to assist dentists and their patients to navigate and learn about specific interest areas such as xerostomia, nutrition, oral health maintenance, the oral systemic connection, reducing risk for oral cancer and other issues of significant to older Americans. OralLongevity™ will be a featured initiative in the ADA Pavilion as well. A four-day CE track titled OralLongevity and Healthy Aging will be available for attendees. ADA.org content focused on OralLongevity™ will be launched in 2007 as well, and *ADA News* will include articles with more information about OralLongevity™. A public relations plan is being developed to spotlight the OralLongevity™ launch in San Francisco to interest the popular press and drive consumers to the ADA's Web site to access the DVD and other complementary consumer educational materials.

This Oral Longevity™ program allows the ADA to undertake activities in 2007 that address specific objectives adopted in Resolution 5H-2006, including:

- redoubling ADA efforts to provide enhanced educational content on the oral health needs of vulnerable elders at national, regional, state and local dental meetings, as well as online and study groups

- collaborating with appropriate stakeholders to build the public's awareness on how good oral health enhances overall health and quality of life in vulnerable elders

- developing educational materials for elders and their families for the public side of ADA.org to increase awareness about how oral health impacts overall health and quality of life

- developing supporting materials to educate policymakers on oral health issues relating to vulnerable elders

- developing educational tools on oral health issues of residents in assisted living facilities

Dental Benefit Program Results: The Task Force on Elder Care reported to the 2006 House that 19 individual, third-party benefit and dental discount plans were available to senior citizens as of December 2005. Some of these plans are targeted to seniors; however, most of them are available to any adult. The Task Force discussed limited options available to senior citizens in the dental benefits marketplace because most seniors no longer belong to employer-sponsored group dental plans and most employers do not offer coverage to retirees. The Council on Dental Benefit Programs and CAPIR are working toward structuring a concurrent program for the 2008 National Dental Benefits Conference to focus upon insurance plan models for people over age 65. This addresses both the concerns of the Task Force and the call in Resolution 5H for appropriate ADA agencies to plan in 2007, and to convene a 2008 meeting of key stakeholders to discuss new insurance plan models for people over age 65.

Success measures for the 2008 conference will include:

- Heightening participants' awareness of the importance of oral health for seniors
- Participants gaining a deeper understanding of current mechanisms in place to pay for oral health care services for seniors—what is the current system like?
- Recommendations to be offered for the development of new viable economic products for this age group
- ADA conveying to the public its concerns about the oral health of the elderly and working to identify solutions on the issue

Dental Workforce Issues: Another key strategy of Resolution 5H is to initiate a process for exploring dental workforce needs to support elders' oral health care. Initiatives to address this objective in 2007 are encompassed through the ADA's effort to support the development of a new member of the oral health team, the Community Dental Health Coordinator (CDHC), who will be responsible for promoting oral health through organized and dentally coordinated community-based promotion and prevention programs. The CDHC is envisioned to be a new mid-level allied dental staffer who will work in underserved communities where residents have limited or no access to dental care. It is anticipated that the CDHC would be employed by federally qualified health clinics, the Indian Health Service, state or county public health clinics, or private practitioners serving the dentally underserved areas.

Under the supervision of a dentist, CDHCs would implement integrated oral health care programs with community or private dental clinics. The CDHC would work in collaboration with health and community organizations to promote good oral health and to provide community-focused oral health promotion, prevention, and coordination of dental care. It is believed that this new team member may help increase access to dental care and has the potential to increase the number of elders who get navigated into dental care. As the ADA's geriatric oral health program continues to develop and mature, efforts to address the specific workforce need to serve seniors will advance.

Research Results: Specific to research needed to support oral health care for elders, the ADA has initiated dialogue with Special Care Dentistry (SCD) to begin collecting baseline information to address the research needs of elders. A panel of geriatric dentists recommended by SCD is providing technical assistance to the Health Policy Resources Center (HPRC) and CAPIR to assist in the development of a survey instrument designed to collect current data from general dentists and specialists on the care they are providing for vulnerable elders in a variety of practice settings. The survey will provide baseline data on care being provided to vulnerable elders, barriers/challenges in providing care, management issues, referrals to community resources and ways dentists have accommodated this population. The SCD panel has provided

technical assistance to the HPRC with its analysis of vulnerable elder' oral health issues in order to increase the understanding of age-associated and disease associated oral disorders and their impact on clinical care.

Advocacy Opportunities: In 2007, CAPIR provided financial support to the Oral Health for the Elderly: Challenges and Opportunities Conference sponsored by the Santa Fe Group in late June.[1] The forum involved stakeholders and leaders from a variety of disciplines and focused on identifying and remedying barriers to oral health care that face America's growing elderly population. The Conference featured an interactive format with a broad based information exchange between experts in various health care fields, examined common issues and stimulated discussion in caring for and addressing the oral health needs of America's older adults.

The forum insights into the use of dental services and quality of life, care delivery systems for aging adults, the challenges for geriatric dental education, and financing mechanisms for the senior dental market, dovetailed with the strategies outlined in Resolution 5H-2006. The ADA's current major activities in the arena of geriatric oral health, i.e., OralLongevity™ and the 2006 report and recommendations of the Task Force on Elder Care were showcased. At the end of the meeting participants were provided with time to synthesize findings and make recommendations for future action. The group agreed to carefully review the strategies outlined in the ADA report and to utilize it as a springboard for future action.

In addition, in July 2007, the ADA sent Congress a letter of support for the Special Care Dentistry Act, which includes an expansion of Medicaid coverage for the aged, blind and disabled, many of whom are in nursing homes or assisted living facilities and have difficulty obtaining access to oral health care services as a result of limited mobility.

Summary: In conclusion, CAPIR and its partners fulfilled or began work on all 2007 recommendations from Resolution 5H-2006. This represented significant effort on the parts of a number of volunteers and staff and is shining a positive light on the Association and the ADA Foundation as the year comes to a close. The new CAPIR staff position funded via Resolution 5H-2006 has been filled. The Board of Trustees is pleased to present to the House of Delegates this progress report and looks forward to continuing this meaningful work to assist members, the patients they serve and the public at large.

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS.

[1] Two days before the conference Dr. Larry Meskin the founder of the Santa Fe Group and mentor and friend to many of those present passed away unexpectedly. The decision was made to continue with the conference as a tribute to his memory.

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Board Report 11 Date Submitted: July 2007

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)

REPORT 11 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:
GIVE KIDS A SMILE ANNUAL REPORT

Background: Since its approval by the Board in 2002 and its inception in 2003, Give Kids A Smile (GKAS) has emerged as the ADA's signature access to care program, exemplifying dentists' patient focus and charitable orientation and keeping the public health promise of the ADA's mission statement. By voting in 2002 to approve a program to provide free dental care, screening and education to underserved children, the Board and House signaled a commitment to addressing the access-to-care issue. During the ensuing five years, access has emerged as a key issue, both with policymakers and dentistry. The remarkable success of Give Kids A Smile has provided a moral platform from which dentistry can engage in debate on the access issue.

From the beginning, the program was envisioned as having two components: first, dental team members would donate large amounts of care on a single day; they would be encouraged to brand those access activities as GKAS events; and the ADA would be able to aggregate those charitable endeavors more effectively than in the past; second, the results of the campaign, combined with the message that charitable activities, no matter how widespread, do not constitute an oral health care system sufficient to address the unmet needs of low-income children, would be communicated to policymakers.

The 2002 House of Delegates adopted the following resolution (*Trans*.2002:384):

> **29H-2002. Resolved,** that the ADA conduct and fund an annual "Give Kids A Smile!" campaign and annually report to the Board of Trustees at its June meeting and to the House of Delegates on the results of that campaign.

The campaign was initially funded at $261,500, an amount that had been reduced to $151,600 in 2007.

The fifth annual program took place February 2, 2007.

Results: Program participation trends have been impressive. In 2007, more than 52,000 dental team members registered to participate on ADA.org. That total included 14,312 dentists, up from 12,246 in 2006 and 10,700 in 2005. Some 2,225 programs signed up, compared to 2,017 in 2006 and almost 1,800 in 2005. It is likely that the online medium deters some from registering so the above numbers may understate program participation. Registered participants estimated that they treated more than 757,000 children in 2007, up from 512,649 in 2006 and 485,700 in 2005. Care was valued at $72 million, nearly

double the 2006 total. By any measure, these are impressive results and indicate strong support by dental team members.

The national GKAS press event was held in New York City on February 2, 2007, at the NYU School of Dental Medicine. Drs. Roth and Bramson welcomed sponsor representatives and praised NYU representatives for their hard work in planning a first-class event. ADA's mascot, Dudley the Dinosaur, made a very successful guest appearance.

GKAS media coverage continued to grow over previous years at local and national levels and was highlighted by a Good Morning America segment on ABC. Nationally, a satellite media tour broadcast from a New Orleans GKAS event was the most successful ever. It was viewed by 4.1 million people and aired by 161 TV stations, including all top ten markets: New York; Los Angeles; Chicago; Philadelphia; San Francisco; Dallas; Boston; Atlanta; Washington, D.C. and Houston. At least 225 GKAS news stories appeared in local outlets. Other national coverage included the *Washington Post, Forbes, I Village, Discovery Health, Yahoo, MSN, Dr. Koop* and many other outlets. The electronic press kit designed for use by journalists and producers was accessed over 550 times, with nearly 430 informational downloads. On the constituent level, both Arizona and New Mexico held clinical events within their state capitol buildings, setting up operatories there to attract the attention of legislators. Involvement in local programs by elected officials, first ladies and policymakers continues to increase.

Corporate Sponsorship: Corporate support in 2007 again was a key element in the program's success. Generous sponsors even supported a GKAS program in Baghdad, Iraq, which was organized by an American military dentist.

Sullivan-Schein donated 2,500 professional product kits containing products for screening and prevention. Each kit treated 50 children.

DEXIS Digital X-Ray Systems provided x-ray units and expert staff to U.S. dental schools participating in GKAS.

Colgate donated 275,000 each of children's toothbrushes, toothpaste and educational brochures and ran a free-standing insert in Sunday newspapers nationwide tied to GKAS.

Program Expansion: Given the program's increasingly impressive results and the heightened awareness of access to care as a public policy issue, the Board adopted a resolution in December 2006 intended to raise the program's profile and make it "more than just a day," a year-round event. As part of that initiative, a National Advisory Board accountable to the ADA Foundation was formed, with goals of: stimulating collaboration and coalition building to address children's unmet oral health care needs; implementing an expanded fundraising program to financially and otherwise assist new and existing community-based local and regional GKAS programs; and enabling the ADA and others to effectively advocate for better access to oral health care for all children, but in particular children from low income families.

The National Advisory Board members are: Mr. Steve Kess, chair, vice president, Professional Relations, Henry-Schein, Inc.; Dr. William R. Calnon, trustee, Second District, ADA; Dr. Peter J. Carroll, member; Council on Communications,, ADA; Ms. Liz Cermak, vice president, Professional Sales and Marketing, Johnson & Johnson; Dr. Burt Edelstein, Children's Dental Health Project; Dr. Raul Garcia, member, Board of Directors, ADA Foundation; Ms. Cindy Hearn, vice president, Marketing, CareCredit; Dr. Robert C. Henderson, member, Board of Directors, ADA Foundation; Dr. Joy Ann Jordan; Mr. Robert

Joyce, president, Americas, Danaher Dental Equipment Platform; Dr. Kathleen Roth, president, ADA; and Dr. Jeanne Strathearn, trustee, First District, ADA.

As part of the fundraising efforts, foundations have been approached and asked to earmark funds for GKAS grants, and it is hoped that corporate members and others on the program's Advisory Board will participate in fundraising efforts. Other corporations with which the ADA has relationships also will be approached and encouraged to support the program. The long-term goal is to move beyond grants into construction of clinics. With that would come increased visibility, which should translate to more effective advocacy for access to care. One of the ADA's affinity partners, CareCredit, has become the founding donor of the new GKAS fund with a $100,000 contribution.

Another program expansion activity is the GKAS Promising Practices Symposium that the Dental Trade Alliance Foundation is co-sponsoring with the ADA for the next three years. The Symposium will bring together representatives from leading, innovative GKAS programs around the country to share their successes and experiences with other program participants. Proceedings will be published and made available to other GKAS programs. The first Symposium will be August 27.

Summary: In summary, Give Kids A Smile continues to be a signature program for dentistry. The good works, charitable care and impressive results that characterize the program should continue to boost dentistry's image and provide a strong advocacy platform. Just as important, the program continues to energize members and staff. Anecdotal accounts from dentists reflect a high degree of personal reward as a result of participation, which translates into good will for organized dentistry. The program also continues to improve the ADA's relations with the dental industry, serving as a model that attracts dental and other companies to ADA sponsorship opportunities.

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. 33 New ■ Substitute □ Amendment □

Report: NA Date Submitted: August 30, 2007

Submitted By: Fourteenth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Advocacy (Required)

MONITORING AND RESOLUTION OF CODE MISUSE

The following resolution was submitted by the Fourteenth Trustee District and transmitted on August 30, 2007, by Mr. Monte Thompson, caucus secretary.

Background: The *Code on Dental Procedures and Nomenclature (Code)* is the HIPAA standard code set for covered reporting and third-party payers must use it for adjudication of dental claims. Because the ADA owns the copyright on the *Code*, third-party payers must purchase a license to use it. The *Code* describes dental procedures with great specificity and all users of the *Code* are expected to follow the provisions carefully. Dentists should be aware that when they encounter instances of potential misuse by third-party payers, they should report these events to the Council on Dental Benefits Programs.

Resolution

33. Resolved, that the ADA educate members on the appropriate use of the *Code on Dental Procedures and Nomenclature* and encourage them to report misuse by third-party payers, and be it further

Resolved, that the ADA actively pursue violations of the third-party licensing agreement for use of the *Code on Dental Procedures and Nomenclature*.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 34 New ■ Substitute □ Amendment □

Report: Board Report 16 Date Submitted: September 2007

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: Create and Transfer Knowledge (Required)

REPORT 16 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: UPDATE ON DENTAL TOURISM

Background: This report was initially submitted and published as Council on Dental Benefit Programs Supplemental Report 1 to the House of Delegates. Following publication, the Council asked the Board of Trustees to resubmit the report as a report from the Board to the House based on the fact that the Board had more lengthy discussion and analysis than the Council throughout the year. This report is a compilation of the February 2007 Board of Trustees' mega issue discussion on dental tourism, additional feedback from the April 2007 Board meeting, and discussions of the Council on Dental Benefit Programs. The mega issue discussion was a continuation of the dialogue on dental tourism that began at the 2006 House of Delegates and Resolution 44H (*Trans*.2006:323) which reads as follows.

> **44H-2006. Resolved,** that the appropriate ADA agency research the issues surrounding the practice of dental tourism including service levels, quality, reimbursement, ethics and other related concerns especially those associated with problems related to the payment of dental claims to non U.S. practitioners, and be it further
>
> **Resolved,** that the appropriate ADA agency initiate dialog with benefits administrators and representatives of the dental insurance industry, including payers and purchasers and regulators, to address treatment, payment and claim-related issues related to dental tourism, and be it further
>
> **Resolved,** that the appropriate ADA agency report its findings to the 2007 House of Delegates, including any recommendations for new or revised policies addressing the concerns related to dental tourism.

Simply put, dental tourism is obtaining dental services while traveling or vacationing in another country. For many years, patients have been seeking lower cost health care in countries other than the U.S. What is often referred to as medical or dental "tourism"—patients going to a different country for either urgent or elective procedures—is fast becoming a world-wide, multi-billion dollar industry.

Dental tourists from the U.S. are seeking treatment in other countries that is either not covered by their insurance, or can be obtained at a fraction of the cost. Implants, crowns and dentures are among the dental services for which patients seek treatment elsewhere. For many of these individuals, becoming a dental tourist is a chance to combine their vacation with elective dental care.

The Board invited guest speakers to provide various industry perspectives on dental and medical tourism including a physician who is the medical director of the nation's largest employer health care purchasing coalition, a dentist representing the dental insurance industry, and an ADA economist. The speakers helped to frame the discussion by providing a broad understanding of the issue. The Board sought information to help answer the question, "*What will be the impact of dental tourism on the ADA and the practice of dentistry and how can the ADA ensure success for itself and its members in this arena?*"

Expert Testimony on the Current State of Dental Tourism: The Board heard three speakers who gave a detailed overview of the current state of dental tourism. While all the speakers agreed that dental tourism is not currently at the level of magnitude of medical tourism for the general U.S. population, they believe that the ADA's strategic planning for dental tourism will prepare them well for the future. They also recognize that member dentists in border states are very concerned about the care their patients are receiving outside of the U.S.

Arnold Milstein, M.D., M.P.H., is the medical director of the Pacific Business Group on Health, the largest employer health care purchasing coalition in the U.S. He has authored recently published articles on the subject in *Health Affairs* and the *New England Journal of Medicine*. Dr. Milstein reported:

- Offshore providers are being added to U.S. insurer networks.

- Economic pressures of global competition are forcing employers to shift health care costs to their employees, and as these insurance costs rise, the number of individuals with health insurance drops. CEOs of large companies are seeking ways to alleviate the rising cost of healthcare for their employees including using a network of providers that meet lower-cost and high-quality measures.

- Overseas pricing of dental and medical procedures is 50-80% less that in the U.S.

- Americans will travel for care in instances of a life-preserving intervention.

  --Based on a random study, Dr. Milstein reported that individuals less well off would be willing to travel for care outside the U.S. if their savings were between $500 and $1,000. The amount rises to $5,000 for those who can better afford it.

- Dentistry probably has five years before the prevalence of dental tourism increases to a noticeable level.

Dr. Milstein closed by suggesting that the profession work closely with dental schools and continuing dental education to address future needs.

- Thomas Fleszar, D.D.S., M.S., president and chief executive officer of Delta Dental of Michigan, Ohio, Indiana and Tennessee also addressed the Board. He indicated that from a payer perspective: Less than $1/100^{th}$ of their business is for foreign claims.

- While they are seeing an increase in foreign claims, currently 2% per year, the balance of trade for dental care will not shift negatively for the U.S. for a decade or more.

- Additional cost and time goes into processing foreign claims. Every foreign claim is reviewed by hand.

- Delta requires original documentation of all treatment including a dated, paid receipt confirming payment method and currency, the treating dentist's full name, license number, address and phone; fee(s) for services. Reimbursement is only made to the patient when all criteria are met.

- Delta generally only pays 60% of the foreign claims that come in.
- While they have some concerns about the claims for care across U.S. borders, they realize that patients have freedom of choice.

Dr. Fleszar also indicated that Delta conducts extensive claims review for foreign claims. They utilize International SOS (ISOS) service for overseas reviews (www.internationalsos.com). They go out to each practitioner and check:

- language proficiency (presumably, ability to communicate with patients in their native language)
- that environmental cleanliness meets "standards"
- that educational degrees are legitimate

If there are any complaints or issues, that dental office's claims will not be paid until there is a resolution to the problem(s). In a nutshell, ISOS proclaims to be the world's leading provider of medical assistance, international healthcare, security services and outsourced customer care. With over 4,400 professionals operating in 65 countries, they help organizations manage the health and safety risks facing their travelers, global workforce and customers.

Dr. Fleszar closed by recommending that for patients who seek care outside the U.S., the ADA should work toward providing them with a system for selecting the best care. World markets are changing, but resistance to the change is not the answer.

Dr. Jack Brown, managing vice president of the ADA's Health Policy Resources Center, also provided an economist's perspective of dental tourism.

Board Discussion: Following the testimony, the Board discussed several issues related to dental tourism. Resolution 44H-2006 charges the ADA with developing and understanding the complex issues by opening dialogue with other stakeholders and reporting to the 2007 House of Delegates. The Board felt that while the testimony indicated that dentistry may have several years to address this issue, they wanted to immediately begin to address the impact of dental tourism on the profession—not only those who practice in U.S. border states, but on the profession as a whole. The Board approached the topic by looking at not only minimizing the risks, but also maximizing opportunities for the Association and the profession. The ADA is working to position the profession for the future through:

- increasing quality of workforce through ADA Foundation work in education
- increasing efficiency by maximizing use of technology through the work of the Council on Dental Practice (CDP) (to improve the functionality of the electronic claim); the Department of Dental Informatics (DDI) (to improve dental practice through the application of computer and information science); and the ADA's National Healthcare Information Infrastructure (NHII) Task Force (to proactively advocate for the needs of dental patients and the goals of the dental profession in the electronic health record)
- improving access through the development of new practice models, such as the Community Dental Health Coordinator (CDHC)

The Board also followed up on some of the points addressed by the speakers including the statement that, with the exception of the U.S. border states, dental tourism is not as large an issue as the media might suggest.

The Board believes that dental tourism is a symptom of decreased access, cost shifting to patients and the "flattening" of the world. Also, because dentistry has not defined quality in terms that some patients/consumers can understand, these same patients may focus primarily on cost. Some patients that are initially satisfied with their care may not know whether it meets any level of quality until problems arise at a later date.

The Board believes that:

- higher cost elective procedures are most vulnerable to dental tourism
- lack of follow-up care and the inability to file a complaint in the case of bad treatment may limit a patient's desire to receive care abroad
- bundling of dental and medical procedures can be self-limiting (i.e., a patient can only have so many procedures done while on "vacation"
- recovery times and locale may inhibit a patient's desire to travel for care
- language and cultural barriers may exist for some patients

Based on the testimony received, and discussions held during its February meeting and a follow-up report presented to the Board's April meeting by the Associate Executive Director, Dental Practice, the Board requested that the Council on Dental Benefit Programs develop ways to help patients and plan purchasers better understand the value of quality dentistry as well as the value of having a dental home.

Recommendations: The Board believes dental tourism is a symptom of decreased access, cost-shifting to patients and the "flattening" of the world. While the amount of dental tourism may not currently be at the level of medical tourism for the general U.S. population, the Board recognizes that member dentists in border states are very concerned about the care their patients are receiving outside of the U.S.

Individuals may choose to travel to another country to obtain dental care for many reasons. Generally, patients perceive the value of dental services either in the U.S. or abroad based on their perception of quality of service and cost. When they feel that they can obtain care that is personally acceptable in terms of quality, and total cost of treatment abroad is attractive, they may elect to receive treatment abroad. Total cost includes travel expenses, time commitment, potential cost of re-treatment and liability exposure.

The Board further believes that the appropriate ADA agencies should continue to keep abreast of developments impacting dental tourism, use the information to actively position our membership as the "world leader" in the profession and continue to provide all relevant information to the membership on this issue. Therefore, the Board recommends adoption of the following resolution.

Resolution

34. Resolved, that the following strategies to address dental tourism by appropriate ADA agencies be adopted:

- continue to support ADA members in general and those who practice in border states specifically, by promoting the value of dentistry in the U.S. and the importance of a dental "home" through patient, payer and plan purchaser education
- recommend that the Council on Dental Benefit Programs contact, and when appropriate, work with representatives of the dental insurance industry, including payers and purchasers, to address

treatment, payment and claim-related issues related to dental tourism including "standard of care," liability, disclosure and performance guarantees

- recommend that the Health Policy Resources Center and appropriate ADA agencies further research the practice of dental tourism including: service levels (both U.S. patients abroad and foreign patients receiving treatment in the U.S.); quality; reimbursement and other related concerns

- recommend that the appropriate ADA agencies examine and monitor regulations and legislation at the state and federal level related to dental tourism

- work to increase access to care for the uninsured while monitoring the affects that a movement to a single-payer system might have on dental/medical tourism

- recommend that the appropriate ADA agencies review existing credentialing procedures for foreign dentists who treat U.S. patients abroad in comparison to existing procedures

- increasing technological efficiencies for the profession by working to improve functionality of electronic claims processing and proactively advocate for the needs of dental patients and the goals of the dental profession in the electronic health record

- recommend that appropriate ADA agencies monitor the ethical ramifications of dental tourism

- monitoring the migration and economics of dental office technology, including laboratory services, out of the country

and be it further

Resolved, that in order to continue to address the issue of dental tourism, the ADA adopt the following definition of dental tourism, including categories based on cost and urgency of treatment, in order to address concerns of the membership while at the same time, prepare the profession for the future.

Dental Tourism is the act of traveling to another country by patients for the purpose of obtaining non-emergency dental treatment, and can be grouped in one of the following categories:

- Category I: High-cost, non-urgent major procedures suitable for air travel anywhere in the world by any (U.S.) patient.

- Category II: Many non-urgent services suitable for longer-distance driving/bus travel to Canada or Mexico by U.S. patients within a reasonable drive from the respective border.

- Category III: Most non-emergent services suitable for shorter-distance driving/bus travel to Canada or Mexico by U.S. patients living immediately adjacent to the respective border.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 35 New ■ Substitute □ Amendment □

Report: CDBP Supplemental Report 3 Date Submitted: September 2007

Submitted By: Council on Dental Benefit Programs

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Lead in the Advancement of Standards (Required)

COUNCIL ON DENTAL BENEFIT PROGRAMS SUPPLEMENTAL REPORT 3 TO THE HOUSE OF DELEGATES: AMENDMENT TO THE POLICY ON GUIDELINES ON THE USE OF IMAGES IN DENTAL BENEFIT PROGRAMS

Background: At its November 2006 and April 2007 meetings, the Council discussed the ADA policy on Guidelines on the Use of Images in Dental Benefit Programs (*Trans*.1995:617) and is recommending that a change in policy be approved by the House of Delegates.

Recently a major dental insurance carrier announced that as of October 1, 2007, it will no longer return radiographs or photos unless a stamped, self-addressed envelope is provided. Another major carrier announced that as of September 1, 2007, it will no longer return radiographs at all. Other carriers have implemented similar policies over the years which have the potential to create problems for dental offices.

A joint workgroup between members of the Council and the National Association of Dental Plans (NADP) was formed to address the issues of unsolicited radiographs and the return policies of some of NADP's member companies. It was recommended that NADP develop a set of common criteria used by NADP members in determining when radiographs are, in fact, required for claims adjudication, with a view toward industry standardization. The goals were to reduce the number of unsolicited submissions, which create administrative burdens on payers, and give providers direction as to when image submission is necessary.

At the November 3, 2005, meeting of the workgroup, NADP proposed that the following be submitted to NADP members for standards or guidelines:

- X-rays that have been requested or required by a dental plan will be returned by the plan to the dentist, and x-rays not requested by a dental plan for adjudication of a claim will be returned only when requested by the dentist.

This policy was adopted by NADP as a voluntary policy for its member companies, but the Council was not in a position to endorse this policy because the policy is voluntary, allowing continued variance in submission policies from plan to plan and it does not address what should be initially submitted, providing insufficient direction to dentists. That message was conveyed to NADP from the Council in a letter dated May 18, 2006. NADP has since proposed an interim solution to the problem of radiograph return policies of its member companies. NADP has entered into a joint agreement with an organization that provides an on-line portal to

access dental payer claim attachment requirements by payer name and *CDT* code. This subscription service has an associated cost to the members and does not address the issue of lack of standardization.

Recommended Revisions to the Guidelines: The Council is recommending addition of a sentence to the opening paragraph, revisions in Items 1, 2, 3, 4 and 7 (renumbered to 8), adding a new Item 5 and renumbering the current Items 5-12 to 6-13 (additions are shown be underscoring; deletions are shown by strikethroughs).

Revision to the opening paragraph. The Council recommends addition of a standard acknowledgment that federal and state laws may supersede these guidelines. The revised paragraph would read:

> The American Dental Association's recommendations on selection criteria for images states that diagnostic imaging should be used only after clinical evaluation, review of the patient's history, and consideration of the dental and general health needs of the patient. The type, frequency and extent of diagnostic images necessary for each individual patient will be provided in accordance with the dentist's professional judgment. Federal and state laws regarding patient privacy are subject to change and may supersede these guidelines.

Revision to Item 1. The Council understands that payers may need to request images as part of a system for determining benefits to which the patient is entitled under the terms of a contract; however, the Council recommends clarification that the images should be generated as part of the clinical treatment and not solely for administrative purposes. The revised Item 1 would then read:

> 1. Images should be generated only for clinical reasons as determined by the patient's dentist. Clinical images may be used as part of a system for determining those benefits to which the patient is entitled under the terms of a contract. ~~However,~~ T~~t~~hird-party payers should not request that images be generated solely for administrative purposes. ~~and dentists should not comply with such requests.~~ If a third party requests an image which was not generated as part of the dentist's clinical treatment, dentists should consider the clinical necessity of the image in connection with the request.

Revision to Item 2. The Council understands that since there is no industry standardization on the submission and return policies of carriers, it can be very difficult and time consuming for dental offices to be completely familiar with the various payers' requirements for image submissions. Additionally, there are third-party payers that have developed policies indicating they will not return images. Therefore, the Council feels that all images, except those in electronic format, should be returned. Images are the property of dentists/patients. The revised Item 2 would read:

> 2. When a dentist determines that it is appropriate to comply with a third-party payer's request for images, it is recommended that a duplicate set ~~should~~ be submitted and the originals retained by the dentist. All images, including duplicates, except those submitted in digital or other electronic form, and whether or not it has been requested, should be returned to the dentist.

Revision to Item 3. The Council recommends clarification of Item 3 to indicate that since treatment decision cannot be made solely on the basis of images, neither can benefits determination. The revised Item 3 would read:

> 3. There are many instances in which a determination of care cannot be made solely on the basis of images and it is improper for third-party payers to deny ~~care~~ authorization for payment or make

determinations about treatment ~~that could not ordinarily be made without proper evaluation of the patient~~ based solely on images.

Revision to Item 4. The Council recommends a single word change more appropriate for guidelines. The revised Item 4 would read:

4. Third-party payers ~~shall~~ should not use images to infringe upon the professional judgment of the treating dentist or to interfere in any way with the dentist-patient relationship. All questions of interpretation of images must be reviewed by a dentist consultant.

Addition of new Item 5. The Council recommends that the policy reflect that all images requested should be for actual review and that dentists licensed in the United States, preferably within the jurisdiction of the dentist providing the images, should review the images. The new Item 5 would read:

5. Clinical images should only be requested when they will be reviewed by a dentist to make a determination regarding the patient's entitlement to benefits. Dentists reviewing images for this purpose should be licensed in the United States, preferably within the jurisdiction of the dentist providing the images in accordance with applicable state law.

Renumbering due to addition of new Item 5. The Council recommends renumbering the current items 5-12 to 6-13.

Revision to Item 7 renumbered as Item 8. The Council recommends revising the second sentence in Item 7 since using a scanner to send electronic or digital images to third-party payers may pose a less expensive alternative than submitting duplicate x-rays and digital or electronic copies of these images would not need to be returned to dental offices. The Council also recommends adding a new sentence regarding the deletion of images contained in electronic files. The revised Item 7 (renumbered to 8) would read:

8. Third-party payers should protect the confidentiality of all records, including images, which are submitted to them by dental offices. All images submitted to third-party payers, except those in digital or other electronic form, should be returned to the treating dentist within fifteen (15) working days. Images received in an electronic form should be permanently deleted within 30 days of the completion of claims adjudication.

For the reasons noted above, the Council recommends adoption of the following resolution.

Resolution

35. Resolved, that the Guidelines on the Use of Images in Dental Benefit Programs (*Trans*.1995:617) be amended as follows (additions are shown by underscoring; deletions are shown by strikethroughs):

Guidelines on the Use of Images in Dental Benefit Programs

The American Dental Association's recommendations on selection criteria for images states that diagnostic imaging should be used only after clinical evaluation, review of the patient's history, and consideration of the dental and general health needs of the patient. The type, frequency and extent of diagnostic images necessary for each individual patient will be provided in accordance with the dentist's professional judgment. Federal and state laws regarding patient privacy are subject to change and may supersede these guidelines.

The Association believes that the following guidelines should be applied in the use of images in dental care plans:

1. Images should be generated only for clinical reasons as determined by the patient's dentist. Clinical images may be used as part of a system for determining those benefits to which the patient is entitled under the terms of a contract. ~~However,~~ T~~t~~hird-party payers should not request that images be generated solely for administrative purposes. ~~and dentists should not comply with such requests.~~ If a third party requests an image which was not generated as part of the dentist's clinical treatment, dentists should consider the clinical necessity of the image in connection with the request.

2. When a dentist determines that it is appropriate to comply with a third-party payer's request for images, it is recommended that a duplicate set ~~should~~ be submitted and the originals retained by the dentist. All images, including duplicates, except those submitted in digital or other electronic form, and whether or not it has been requested, should be returned to the dentist.

3. There are many instances in which a determination of care cannot be made solely on the basis of images and it is improper for third-party payers to deny ~~care~~ authorization for payment or make determinations about treatment ~~that could not ordinarily be made without proper evaluation of the patient~~ based solely on images.

4. Third-party payers ~~shall~~ should not use images to infringe upon the professional judgment of the treating dentist or to interfere in any way with the dentist-patient relationship. All questions of interpretation of images must be reviewed by a dentist consultant.

5. Clinical images should only be requested when they will be reviewed by a dentist to make a determination regarding the patient's entitlement to benefits. Dentists reviewing images for this purpose should be licensed in the U.S., preferably within the jurisdiction of the dentist providing the images in accordance with applicable state law.

~~5.~~ 6. Patients should be exposed to radiation only when clinically necessary, as determined by the treating dentist. Postoperative images should be required only as part of dental treatment.

~~6.~~ 7. It is important that images be correctly identified and be of diagnostic quality.

~~7.~~ 8. Third-party payers should protect the confidentiality of all records, including images, which are submitted to them by dental offices. All images submitted to third-party payers, except those in digital or other electronic form, should be returned to the treating dentist within fifteen (15) working days. Images received in an electronic form should be permanently deleted within 30 days of the completion of claims adjudication.

~~8.~~ 9. Images held by parties other than the treating dentist should not be transmitted to any agency or entity without written consent of the dentist or patient.

~~9.~~ 10. Where a claim or predetermination request indicates that images are provided, the third-party payer should immediately notify the submitting dentist's office if the images are missing.

~~10.~~ 11. A patient's predetermination request or claim should not be prejudiced by the third-party payer's loss or misplacement of images.

~~11.~~ 12. Images are an integral part of the dentist's clinical records and, as such, should be considered the property of the dentist where consistent with state law. Because it is necessary for a dentist to maintain accurate and complete records, third-party payers should accept copies of images in lieu of originals.

~~12.~~ 13. Any additional costs incurred by the dentist in copying images and clinical records for claims determination should be reimbursed by the third-party payer or the patient.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 36 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 11, 2007

Submitted By: Second Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

ESTABLISHMENT OF ADA POLICY RELATING TO STATE NO FAULT AND WORKERS' COMPENSATION PROGRAMS

The following resolution was submitted by the Second Trustee District and transmitted on September 11, 2007, by Mr. Roy Lasky, secretary, Second Trustee District Caucus.

Background: The current expansion of publicly regulated and funded benefit programs makes it desirable for the professional associations to recommend policies to legislators and regulators responsible for establishing and administering such programs. Such policies ultimately would benefit the programs, the profession and the public.

Most public policy relating to health care is driven by medical benefits. Medical benefits differ from dental benefit plans, as the typical relationships between physicians and payers differ from those between most dentists and payers.

The ADA currently has no policies regarding the development of policies and dental fee schedules for state no fault and workers' compensation programs. Because the characteristics and payment for accident-related dental injuries and treatment differ from those in medicine, the ADA should develop guidelines to aid constituent dental associations in this area.

States establish no fault and workers' compensation programs to ensure that the victims of motor vehicle and workplace accidents, respectively, receive prompt medical and dental intervention and remediation. Associated laws and regulations principally define the automobile and workers' compensation insurers' financial liability and limit such liability. These laws and regulations also should protect covered patients, as well as the doctors who treat them. Patients and doctors should not have to bear financial loss as a result of receiving or providing treatment for injuries resulting from motor vehicle or workplace accidents. However, when payment procedures are too cumbersome or payment is too low, patients have difficulty accessing necessary care.

Dental benefit plans differ from medical reimbursement. Dental benefit plans typically reimburse only a portion of prevailing dental fees leaving the balance to be borne by patients. Unlike medicine, fees for dental treatment by and large have not been set by government and other third-party programs. Therefore, public programs should not adopt a third-party or government reimbursement schedule as a dental fee schedule if such schedules would not result in full reimbursement. Further, payment is expedited when such programs utilize the standard claim form and code sets.

The objective of such programs should be to restore patients requiring treatment as the result of a workplace or motor vehicle injury to health at no cost to the patient. Lastly, the policy developed should include recommendations for time-frames for reimbursement, standardization of claim forms and code sets, appeal procedures and assurance that patients can choose their treating dentist.

Resolution

36. Resolved, that the appropriate ADA agencies develop a proposal for policy on public workers' compensation and no fault insurance programs for consideration by the 2008 House of Delegates, and be it further

Resolved, that such proposal include recommendations for time-frames for reimbursement, standardization of claim forms and code sets, appeals procedures, as well as recommendations relating to the following concepts:

- that the doctor-patient relationship remain sacrosanct in such programs
- that programs should not require patients to be treated by dentists other than their own dentists of record for injuries sustained that fall within the purview of such programs
- that the objective of such programs should be to restore to health patients requiring treatment as the result of a workplace or motor vehicle injury to health at no cost to the patient

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 37 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 12, 2007

Submitted By: Ninth Trustee District

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)

INTERIM GUIDANCE ON FLUORIDE INTAKE FOR INFANTS AND YOUNG CHILDREN

The following resolution was submitted by the Ninth Trustee District and transmitted on September 12, 2007, by Dr. Joanne Dawley, Michigan Dental Association delegation chair, and Dr. Monica Hebl, Wisconsin Dental Association delegation chair.

Background: The Ninth District has long been an advocate of local community water fluoridation initiatives as one of the most cost effective methods of reducing tooth decay. In fact, the first fluoridated community was in Grand Rapids, Michigan. Periodically, local communities have referendum ballots to begin or to continue adding fluoride supplements to their water supply. The dental community has had to combat anti-fluoridation groups who are very active in vocalizing the purported dangers of fluoride in the communities when a referendum on fluoridation is being held.

The Ninth District is appreciative of ADA's interim guidance on fluoride intake for infants and young children as it provides dental associations with the necessary background data and gives the members detailed information to educate the parents of young children on achieving the optimal level of fluoride. However, this guidance is too lengthy and detailed to use with outside entities. When working with the media and responding to anti-fluoridation groups, dental associations need a concise, targeted message. The anti-fluoridation groups are using the ADA statement as a weapon by picking out only the negative language to use in communities who are trying to maintain fluoride in their water supply. We believe this is an unintentional consequence of the ADA interim guidance.

Interim Guidance on Fluoride Intake for Infants and Young Children

Recent studies cited in the report of the National Research Council (NRC), "Fluoride in Drinking Water: A Scientific Review of EPA's Standards," have raised the possibility that infants could receive a greater than optimal amount of fluoride through liquid concentrate or powdered baby formula that has been mixed with water containing fluoride during a time that their developing teeth may be susceptible to enamel fluorosis.

The appropriate amount of fluoride is essential to prevent tooth decay. But fluoride intake above optimal amounts can create a risk for enamel fluorosis in teeth during their development before eruption through the gums.

Enamel fluorosis is not a disease but rather affects the way that teeth look. Most cases of fluorosis result in faint white lines or streaks on tooth enamel that are not readily apparent to the affected individual or the casual observer.

While more research is needed before definitive recommendations can be made on fluoride intake by bottle-fed infants, the American Dental Association (ADA) issues this interim guidance because we know that parents and other caregivers are understandably cautious about what is best for their children.

ADA Interim Guidance: Infant Formula

The ADA offers these recommendations so parents, caregivers and health care professionals who are concerned have some simple and effective ways to reduce fluoride intake from reconstituted infant formula.

- Breast milk is widely acknowledged as the most complete form of nutrition for infants. The American Academy of Pediatrics recommends human milk for all infants (except for the few for whom breastfeeding is determined to be harmful).
- For infants who get most of their nutrition from formula during the first 12 months, ready-to-feed formula is preferred to help ensure that infants do not exceed the optimal amount of fluoride intake.
- If liquid concentrate or powdered infant formula is the primary source of nutrition, it can be mixed with water that is fluoride free or contains low levels of fluoride to reduce the risk of fluorosis. Examples are water that is labeled purified, demineralized, deionized, distilled or reverse osmosis filtered water. Many grocery stores sell these types of drinking water for less than $1 per gallon.
- The occasional use of water containing optimal levels of fluoride should not appreciably increase a child's risk for fluorosis.

Parents and caregivers should consult with their pediatrician, family physician or dentist on the most appropriate water to use in their area to reconstitute infant formula. Ask your pediatrician or family physician whether water used in infant formula should be sterilized first (sterilization, however, will not remove fluoride).

The Ninth District is recommending adoption of a short, concise positive statement using laymen's terms to be used when communicating to outside groups.

Resolution

37. Resolved, that in order to address concerns about fluoride intake by bottle-fed infants, the ADA adopt the following external statement to use with media and other groups outside of the dental community, and be it further

Resolved, that this statement be posted on the public section of the ADA Web site.

The American Dental Association (ADA) continues to endorse fluoridating community water supplies to the level necessary for optimum public health as a safe, beneficial and cost-effective measure for preventing tooth decay. Reports link regular use of fluoridated water mixed with infant formula to a slight, increased risk for faint white lines or streaks on tooth enamel (enamel fluorosis).

In light of these reports, the ADA still believes the health benefits of fluoride outweigh the slight risk. Parents concerned that their child could experience this cosmetic impact may consider breast milk, liquid formula or reconstituting powdered formula with non-fluoridated water.

BOARD COMMENT: The Board applauds the dedication of local and state societies as well as individual member dentists, our partners in the public health community and oral health coalitions in the continued effort to secure, and in some instances, to retain community water fluoridation programs. The Board understands and empathizes with members' frustration in communicating with the media and public on complex scientific issues, especially those that involve a risk/benefit communication. While the Board appreciates the Ninth District's efforts at developing a new statement, the Board believes that this can best be done using the resources of the ADA state-based Public Affairs Initiative, which is equipped to assess the needs of the constituent and components, command the services of communications experts and test the messages for effectiveness with their intended audience. This process will also ensure that the messages are scientifically accurate and defensible. The Board believes existing ADA resources can accomplish the stated purpose of this resolution, which is to develop short, concise, targeted messages on this topic for use with media and other groups outside of the dental community. Therefore, the Board recommends adoption of the following substitute resolution.

37B. Resolved, that as part of the ADA's Public Affairs Initiative, the ADA consult with health communication experts to develop short, concise, targeted messages related to the ADA's Interim Guidance on Fluoride Intake for Infants and Young Children for use with media and other groups outside of the dental community, and be it further

Resolved, that messages related to the ADA's Interim Guidance on Fluoride Intake for Infants and Young Children be based on the best scientific evidence available and be tested with members, consumers and others outside the dental community to help ensure their effectiveness prior to their release.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

BOARD VOTE: UNANIMOUS.

Resolution No. 43 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 13, 2007

Submitted By: Alaska Dental Society

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

RANKING OF *JADA* ARTICLES RELATED TO EVIDENCE-BASED DENTISTRY

The following resolution was submitted by the Alaska Dental Society and transmitted on September 13, 2007, by Mr. Jim Towle, executive director.

Background: Given the growing emphasis placed upon "evidence-based" practice, it is altogether fitting and proper that the American Dental Association should take the initiative to ensure that articles that purport to deal with current or developing trends or techniques in delivering care and treatment to patients are rated in a way that will clearly and concisely indicate to the reader how rigorously the "scientific evidence" relied upon by the authors has been scrutinized to ensure that what is being described actually reflects current and authenticated "evidence-based" materials.

Both professional and commercial publications, starting with the ADA's *Journal of the American Dental Association* should incorporate this use of this rating scale to assist the reader in determining if the material presented in each article conveys solid, verifiable "evidence-based" facts and conclusions.

Resolution

43. Resolved, that the ADA establish a system for ranking articles regarding the clinical practice of dentistry that reflects the level or degree of "evidence-based dentistry" upon which each article is based, and be it further

Resolved, that the ADA implement this ranking in *The Journal of the American Dental Association*, and be it further

Resolved, that the ADA use appropriate means of persuasion to encourage all other publications, commercial, not-for-profit and educational, that publish articles on/or regarding clinical practice to implement this practice.

BOARD COMMENT: Although the Board appreciates the intent of Resolution 43 that highlights the importance of evidence-based dentistry (EBD), the Board believes a ranking of each article published in *JADA* is not feasible or appropriate.

The field of EBD is evolving and there are multiple systems available to evaluate the level of evidence. However, currently available systems do not accommodate the wide variety of articles published in *The Journal of the American Dental Association*.

Currently plans are in progress to implement level-of-evidence systems for evidence-based dentistry articles published in *JADA* and ADA.org. These include systems to evaluate the quality of systematic reviews addressed through Critical Summaries, a new *JADA* feature that will begin in 2008; evidence-based Clinical Recommendations published in *JADA* that use a level of evidence ranking system developed by Shekelle, 1999;[1] and the planned EBD Web site that will include a database of all systematic reviews on oral health topics and Critical Summaries of systematic reviews. Thus, for EBD, where level-of-evidence systems are most appropriate, plans for implementation are already in place. Once developed, other publications will be encouraged to adopt the evaluation systems. The Board, therefore, recommends that Resolution 43 not be adopted.

1. Shekelle PG, Woolf SH, Eccles M, Grimshaw J. Clinical guidelines: developing guidelines. BMJ 1999;318(7183):593-6.

BOARD RECOMMENDATION: Vote No.

BOARD VOTE: UNANIMOUS.

Resolution No. 44 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 17, 2007

Submitted By: Seventeenth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: $16,450

Amount One-time $ 16,450 Amount On-going $

ADA Strategic Plan Goal: (Required)

MEDICAID PROVIDER SYMPOSIUM

The following resolution was submitted by the Seventeenth Trustee District on September 17, 2007, by Mr. Dan Buker, executive director, Florida Dental Association.

Background: Since the inception of the ADA's being involved in the discussion and prioritization of access to care for the underserved, there has been a glaring absence of input from those dentists who routinely treat significant numbers of these patients on a day-to-day basis. Considering the "uniqueness" this population brings in terms of their prioritization of care ("emergency only" attitude), making and keeping dental appointments, treating the doctor and their staff with courtesy and respect, as well as waiting room etiquette, it would appear that current discussions surrounding low reimbursement rates are just the tip of the iceberg. It seems only feasible that if the ADA is to truly serve as the professional experts in terms of treatment of this population, then all parameters affecting delivery of dental care to this group must be thoroughly investigated and discussed. This being the case, it would seem natural to seek out the advice and discussion this group of providers may have in treatment of this population of patients. Therefore, be it

Resolution

44. Resolved, that if the Council on Access, Prevention and Interprofessional Relations convenes a meeting of related groups to discuss the access to care issue, then prior to such meeting, the ADA hold a one day symposium at the ADA office in Chicago, of at least one Medicaid provider per district who has had at least 1,000 Medicaid patient visits in the last calendar year, with the symposium's purpose being to elicit problems in delivering dental care to the Medicaid population other than reimbursement levels, and be it further

Resolved, that the Medicaid providers should be an ADA member in good standing and in private practice (i.e., not practicing in a free clinic, community health center, a county or state public health unit, nor practicing in a dental school setting), and be it further

Resolved, that a synopsis of this symposium will be provided as a part of the background resources for the 2009 Access to Dental Care Summit, and be it further

Resolved, that the ADA incur the expense of transportation and lodging for one individual per ADA district. Each state or district may send an additional individual, if they so choose, at their own expense.

BOARD COMMENT: The concerns expressed by the Seventeenth Trustee District regarding access to dental services by underserved populations are fully understood by the Board. Social determinants such as culture, language spoken at home, preventive health behaviors, economic status, oral health literacy and ethnicity all play significant roles in patients' attitude, beliefs and knowledge in accessing dental services.

Should the 2007 House of Delegates adopt and fund Resolution 17 (Worksheet:4015) as proposed by the Council on Access, Prevention, and Interprofessional Relations, a planning committee composed of various stakeholders, including private practice dentists who serve Medicaid clients as well as those who do not serve such individuals, should inform the process.

Since less than 2% of dentists provide care in community settings, such as public health clinics and other safety net settings and the vast majority of care provided to Medicaid recipients is delivered by private practice dentists, it will be incumbent upon the Summit planners to assure that private practice dentists who treat large numbers of Medicaid patients actively participate in both the planning of the Summit and have a strong voice at the Summit itself. A key dimension of the "future search" process that will be utilized at the Summit requires that those individuals who have a major stake in the issue at hand, in this case private practice dentists who serve large numbers of Medicaid clients, are included in the process for developing solutions.

The Board believes that the planning committee will avail itself of a variety of tools and techniques to inform its deliberation, such as surveys and key informant interviews. The Board does not believe it is necessary to be prescriptive as to the process the planning committee utilizes to inform its deliberations and is confident that the voices of private practice dentists who serve large numbers of Medicaid recipients will be represented in the process.

Therefore, the Board recommends that Resolution 44 not be adopted.

BOARD RECOMMENDATION: Vote No.

Board Vote:															
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		
■	☐	☐	☐	CADLE	☐	■	☐	☐	GRAMMER	■	☐	☐	☐	SCHWEINEBRATEN	
☐	■	☐	☐	CALNON	☐	■	☐	☐	GROVER	■	☐	☐	☐	SMITH C.	
☐	■	☐	☐	FELDMAN	☐	■	☐	☐	KELL	☐	■	☐	☐	STRATHEARN	
■	☐	☐	☐	FINDLEY	☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SYKES	
☐	■	☐	☐	GIST	☐	■	☐	☐	MANNING	☐	■	☐	☐	TANKERSLEY	
☐	■	☐	☐	GLECOS	☐	■	☐	☐	NICOLETTE	☐	■	☐	☐	WEBB	
☐	■	☐	☐	GLOVER	☐	■	☐	☐	SCHWARTZ					Res. 44	

Resolution No. 44S-1 New ☐ Substitute ■ Amendment ☐

Report: NA Date Submitted: Sept. 28, 2007

Submitted By: Seventeenth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: $16,450

Amount One-time $ 16,450 Amount On-going $

ADA Strategic Plan Goal: (Required)

SUBSTITUE FOR RESOLUTION 44:
MEDICAID PROVIDERS SYMPOSIUM

The following substitute for Resolution 44 (Worksheet:4112) was submitted by the Seventeenth Trustee District on September 28, 2007, and transmitted by Dr. Thomas P. Floyd, delegate.

Background: Additions are shown by underscoring; deletions are shown by strikethroughs.

Resolution

44S-1. Resolved, that if the Council on Access, Prevention and Interprofessional Relations convenes a meeting of related groups to discuss the access to care issue, then prior to such meeting, the ADA hold a one day symposium at the ADA office in Chicago, of at least one Medicaid or SCHIP provider per district, ~~who has had at least 1,000 Medicaid patient visits in the last calendar year,~~ with the symposium's purpose being to ~~elicit problems~~ examine the challenges in delivering dental care to the Medicaid population other than reimbursement levels, and be it further

Resolved, that the Medicaid providers should be an ADA member in good standing and in private practice (i.e., not practicing in a free clinic, community health center, a county or state public health unit, nor practicing in a dental school setting), and who have had at least 1,000 Medicaid or SCHIP patient visits in the last calendar year, and be it further

Resolved, that a synopsis of this symposium will be provided as a part of the background resources for the 2009 Access to Dental Care Summit, and be it further

Resolved, that the ADA incur the expense of transportation and lodging for one individual per ADA district. Each state or district may send an additional individual, if they so choose, at their own expense.

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

Resolution No. 47 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 17, 2007

Submitted By: Sixteenth Trustee District

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)

CDT LICENSING FEES

The following resolution was submitted by the Sixteenth Trustee District and transmitted on September 17, 2007, by Mr. Phil Latham, executive director, South Carolina Dental Association.

Background: The ADA has instituted a revised licensing policy related to the use of *Current Dental Terminology* (*CDT*) by ADA constituent and component societies, recognized dental specialty organizations and the Academy of General Dentistry in their seminars and publications. This new policy will substantially increase the licensing fees that these related organizations will have to pay for use of *CDT* in an educational environment intended to encourage accurate and proper coding of dental procedures. The unfortunate result of this proposed policy is that dental societies may be forced to remove *CDT* codes from their workshops and publications, as some have already done, and thus cease to encourage their membership to purchase *CDT* manuals prior to attending coding workshops and seminars.

It is worth noting that the AMA which holds the copyright to *CPT*® (*Current Procedural Terminology*) has a page on its Web site that explains the rights of the public to reproduce published materials from *CPT*® under the doctrine of "fair use." The U.S. Copyright Office currently explains the doctrine of fair use as follows:

> One of the rights accorded to the owner of copyright is the right to reproduce or to authorize others to reproduce the work in copies or phonorecords. This right is subject to certain limitations found in section 107 through 118 of the Copyright Act (title 17, U.S. Code). One of the more important limitations is the doctrine of "fair use." Although fair use was not mentioned in the previous copyright law, the doctrine has developed through a substantial number of court decisions over the years. This doctrine has been codified in section 107 of the copyright law.
>
> Section 107 contains a list of the various purposes for which the reproduction of a particular work may be considered "fair," such as criticism, comment, news reporting, teaching scholarship, and research. Section 107 also sets out four factors to be considered in determining whether or not a particular use is fair:
>
> 1. the purpose and character of the use, including whether such use is of commercial nature or is for nonprofit educational purposes;
> 2. the nature of the copyrighted work;
> 3. amount and substantiality of the portion used in relation to the copyrighted work as a whole; and
> 4. the effect of the use upon the potential market for or value of the copyrighted work.

Clearly, the entire profession and the patients we serve benefit from the educational programs and publications calling attention to *CDT* and encouraging accurate and proper coding of dental procedures. By postponing the effective date for increasing the license fees, the ADA in effect has acknowledged the administrative burden and negative financial impact that these new fees will have on its constituents and components and the recognized specialty organizations—all of whom live with the same budget realities as ADA does. When the profession supported the ADA's efforts to secure its copyright of *CDT*, surely it was not with the intent that ADA would use that copyright to inflate revenues to its coffers at the expense of its related organizations.

As explained in the Board Report 2—Royalties (Worksheet:2005, line 1) "the increase in royalties received are projected to come from the *ADA Member Advantage* program, *CDT* licenses, and the selling of mailing lists. Royalty revenue is projected to increase by $433,000. The increase is largely related to the *ADA Member Advantage* and anticipated royalties from *CDT* licensing." Even without an estimated amount of revenue from *CDT* licensing fees, it would appear that the amount of anticipated gain in relation to the total budget would be very small, but the impact on the education of the member dentists of these organizations would be very great.

Resolution

47. Resolved, that the American Dental Association be urged to charge no more than a $1,000 annual licensing fee to its constituent and component societies, the ADA-recognized dental specialty organizations and the Academy of General Dentistry for use of *Current Dental Terminology* (*CDT*) and its various components in their continuing education workshops, publications and newsletters.

BOARD COMMENT: In today's health information technology (Health IT) the government is keeping a watchful eye on those entities responsible for developing and maintaining code sets used in healthcare for both reimbursement and clinical applications. This was evidenced by the government agencies' discussion of our licensing pricing models during meetings held on our concerns for updated HIPAA transactions. It was noted that the ADA as the owner of the intellectual property needs to be fair and equitable to all the customers they serve. Given the ADA's role as steward for dental code sets, of which *CDT* is only one, the ADA developed its licensing fees based on the business model appropriate to the licensee such as publisher, government and reseller.

The ADA strives to make the *CDT* widely available, at a reasonable cost, to the entire dental community. To facilitate appropriate use of the *CDT* code set, the ADA offers a variety of licensing programs to meet business needs.

Commercial users include software vendors, print and/or electronic publishers, academic institutions and educators, government agencies, consultants, actuaries and other professionals, dental insurers, third-party claims processors, and anyone providing or administering dental benefits. The ADA has seven licensing categories.

Except as permitted by law, (e.g., fair use doctrine) all use, copying or distribution of the *CDT*, or any portion thereof (including the *Code on Dental Procedures and Nomenclature*) in any product, publication report, document, presentation, fee schedule, user manual, advertising, marketing or promotional materials or derivative work relating to products or services (including works prepared for clients by consultants and other professionals), whether in printed, electronic or other format, requires a valid user license from the ADA.

The Software License grants a license to software developers to incorporate and distribute the *CDT* content solely as part of Licensee's application software product (the bundled product). A software licensee is

permitted to incorporate the *CDT* content into the bundled product in a ***non-static text*** format. "Non-static" text means that the *CDT* data **can** be removed and used separately from the other non-*CDT* content contained in Licensee's bundled product. Thus, bundled product has functionality that enables end user to: sort, filter, rearrange, copy, print and/or electronically transmit the *CDT* data (or portions thereof); copy *CDT* data into new documents; and combine *CDT* data with non-*CDT* data, such as reports and patient billing statements. A practice management software vendor's license is granted solely to vendors who develop/distribute practice management software designed for use in a private dental office or other care facility where patients are receiving direct treatment. This *CDT* license grants that licensee a right to sublicense use of *CDT* to ultimate end user. The license for software developers who develop/distribute application software for other uses in the dental industry (other than dental office management and direct patient treatment), such as for claims processing, are also included in this category.

The Publisher License grants a license to republish the *CDT* content in print and/or electronic books, such as textbooks, reference manuals and practice management guides. For electronic books, this license allows use of the *CDT* content ***only in static text format***. "Static" text means that *CDT* data ***cannot*** be removed or used separately from its non-*CDT* editorial content. Thus, ultimate end user is ***not*** permitted to: sort, filter, rearrange, copy, print and/or electronically transmit the *CDT* data (or portions thereof); copy *CDT* data into new documents; or combine *CDT* data with non-*CDT* data, such as reports or patient billing statements.

The Associations and Educational Organizations license grants a license to educators to use the *CDT* content in course presentations and student handout materials for dental coding educational seminars and workshops.

The Government User License grants a license to departments and agencies of a federal, state or local government.

The Dental Benefit Plans license grants a license to dental benefits companies and third-party administrators of dental benefits programs.

The Consultant/Professional license grants a license to consultants and other professionals who distribute copies of the *CDT* to third parties in the course of providing consulting or other professional services, such as fee schedule reviews or actuarial services.

To date, no constituent or component society has sought a license or has incorporated *CDT* in any specific seminar or publication developed by the society for the means of gaining financial success. Tripartite societies are offered a 10% discount for all ADA catalog products which includes *CDT* publications. Since constituent and component societies do not currently develop revenue generating products requiring a *CDT* license, it would appear that this resolution is really directed toward the above licensing structure as it is applied to specialty organizations.

Prior to now, the ADA has charged a fee of $1,000 annually to the specialty organizations. That fee has been in existence for several years without any price increase. This flat fee method created an inconsistency with ADA's other licensees and is viewed to be unfair to others in the same license category. ADA's new license fees provide specialty organizations that require a license to enjoy the same level of discount that the constituent and component societies receive of 10%. This is 10% below what the ADA charges other licensees in the dental community in their same license category. To provide specialty organizations an opportunity to make the transition to the new fee schedule into their budgeting process, for 2008, the ADA extended the flat fee of $1,000, for one more year, 2007.

The Board believes that sharing in the profits that the specialty organizations make by incorporating ADA intellectual property in both dues and non-dues revenue generating products is appropriate. The fees beginning January 1, 2008, are 6.75% of their net sale revenues or $2.70 per unit whichever is greater, for all publications developed and distributed by them to their end users. Although the rate may be increased annually by the ADA, the dental family organizations will be kept 10% below peer licensees. This requires societies that incorporate the *CDT* code set publications into their benefits for membership dues or provide them in revenue generating publications and seminars, to ensure the revenues they collect are sufficient to maintain their ADA *CDT* code set license.

It is important to note that revenue received from these societies represent less than 5% of the total received for licensing and is anticipated to remain this low even after the new fee schedule goes into effect in 2008. The two largest revenue sources for licensees are practice management software vendors and the payer/benefits organizations.

As the cost to maintain existing code sets such as *CDT* continues to increase, and to ensure fair and equitable practices for the *CDT* code set, the Board believes that licensing models being offered to societies are appropriate and enable the ADA to maintain its leadership position in the broader healthcare community. Therefore, the Board recommends that Resolution 47 not be adopted.

BOARD RECOMMENDATION: Vote No.

Board Vote:															
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		
☐	■	☐	☐	CADLE	☐	■	☐	☐	GRAMMER	■	☐	☐	☐	SCHWEINEBRATEN	
☐	■	☐	☐	CALNON	☐	■	☐	☐	GROVER	☐	■	☐	☐	SMITH C.	
☐	■	☐	☐	FELDMAN	☐	■	☐	☐	KELL	☐	■	☐	☐	STRATHEARN	
☐	■	☐	☐	FINDLEY	☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	SYKES	
☐	■	☐	☐	GIST	☐	■	☐	☐	MANNING	■	☐	☐	☐	TANKERSLEY	
☐	■	☐	☐	GLECOS	☐	■	☐	☐	NICOLETTE	☐	■	☐	☐	WEBB	
☐	■	☐	☐	GLOVER	☐	■	☐	☐	SCHWARTZ					Res. 47	

Resolution No. 61 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 28, 2007

Submitted By: Third Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: $20,000

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

NEW BROCHURE ON DENTAL RESTORATIVE MATERIALS

The following resolution was submitted by the Third Trustee District and transmitted on September 28, 2007.

Resolution

61. Resolved, that the ADA develop and make available a new brochure on the safety and effectiveness of dental restorative materials, approved and subject to future modification by the ADA Board of Trustees.

E:\New Brochure Resolution 61.doc

Resolution No. 62 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 28, 2007

Submitted By: Third Trustee District

Reference Committee: Reference Committee on Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Optional)

AMENDMENT TO THE POLICY "ADA ACTION PLAN ON AMALGAM IN DENTAL OFFICE WASTEWATER"

The following resolution was submitted by the Third Trustee District and transmitted on September 28, 2007.

Background: The following resolution proposes an amendment to the policy "ADA Action Plan on Amalgam in Dental Office Wastewater" (addition is shown by underscoring).

Resolution

62. Resolved, that the ADA defines "dental best management practices" to mean a series of amalgam waste handling and disposal practices that include but are not limited to initiating bulk mercury collection programs, using chair side traps, amalgam separators and vacuum collection, inspecting and cleaning traps, and recycling or using a commercial waste disposal service to dispose of the amalgam collected, and be it further

Resolved, that the ADA take and constituent and component dental societies be urged to take immediate steps to increase universal awareness and use of best management practices by dentists to reduce amalgam waste, and be it further

Resolved, that the ADA acknowledges the need for flexibility for each constituent and component society to make appropriate policy choices on behalf of their members based on local conditions.

Notes