2007

2007 Supplement Vol. 2

American Dental Association

ADA American Dental Association®

America's leading advocate for oral health

2007

Supplement to
Annual Reports and Resolutions
Volume 2

148th Annual Session

San Francisco, California

September 28 – October 2, 2007

ADA American Dental Association®

America's leading advocate for oral health

2007

Supplement to
Annual Reports and Resolutions
Volume 2

148th Annual Session

San Francisco, California

September 28 – October 2, 2007

Table of Contents Volume 2

Legal and Legislative Matters (continued)

New Business

Dental Education and Related Matters

Resolution No. 1 New ■ Substitute □ Amendment □

Report: NA Date Submitted: July 2007

Submitted By: Council on Dental Education and Licensure

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

DEFINITION OF CURRICULUM INTEGRATED FORMAT

Background: (*Reports*:41)

Curriculum Integrated Format: Resolutions 34-2006 and 34S-1-2006 (*Trans.*2006:334) were referred to the Council with a mandate to "develop a definition of curriculum integrated format and the necessary steps from the communities of interest to implement such an evaluation and report to the 2007 House of Delegates."

The North East Regional Board, Inc. (NERB) initially developed the curriculum integrated format (CIF) in response to ADA Resolution 89H-2001 (*Trans.*2001:411), which encouraged the dental testing agencies to collaborate with dental educators to investigate offering clinical licensing examinations to dental students on patients within dental schools, and that these examinations be given early enough in the year to allow those who do not pass the board examination to remediate prior to graduation. The CIF has been a permanent part of the NERB examination process since 2003. The CIF is now a part of the examination developed by the American Board of Dental Examiners and administered since 2005 by NERB and the Central Regional Dental Testing Service (CRDTS). The Council of Interstate Testing Agencies also uses a CIF.

The Council requested input on a definition from the clinical dental testing agencies, the American Association of Dental Examiners, the American Dental Education Association and the American Student Dental Association. Based on the information collected, the Council drafted a definition. The Council recognizes that implementation of the CIF will vary somewhat among testing agencies and plans to monitor the agencies' progress. Accordingly, the Council presents the following proposed CIF definition for consideration. This resolution supports the ADA Strategic Plan Goal: Achieve Effective Advocacy.

Resolution

1. Resolved, that the American Dental Association adopt the following definition:

> **Curriculum Integrated Format:** An initial clinical licensure process that provides candidates an opportunity to successfully complete an independent "third party" clinical assessment prior to graduation from a dental education program accredited by the ADA Commission on Dental Accreditation.

If such a process includes patient care as part of the assessment, it should be performed by candidates on patients of record, whenever possible, within an appropriately sequenced treatment plan. The competencies assessed by the clinical examining agency should be selected components of current dental education program curricula.

All portions of this assessment are available at multiple times during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake any portions of the assessment which they have not successfully completed.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 2 New ■ Substitute □ Amendment □

Report: NA Date Submitted: July 2007

Submitted By: Council on Dental Education and Licensure

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy, Create and Transfer Knowledge (Required)

GUIDELINES FOR THE USE OF SEDATION AND GENERAL ANESTHESIA BY DENTISTS AND GUIDELINES FOR TEACHING PAIN CONTROL AND SEDATION TO DENTISTS AND DENTAL STUDENTS

Background: (*Reports*:42)

Proposed Guidelines and Policy on Sedation and General Anesthesia: The 2005 ADA House of Delegates adopted Resolution 42H-2005 (*Trans.*2005:333) supporting the CDEL Committee on Anesthesiology's comprehensive review of the ADA's anesthesia guidelines documents and policies. Other dental and medical organizations (American Society of Anesthesiologists, American Academy of Pediatric Dentistry, American Academy of Pediatrics, American Academy of Periodontology, and American Association of Oral and Maxillofacial Surgeons) with policies and guidelines on sedation and anesthesia had recently made significant changes to their documents. The Council believed it was imperative for the ADA documents to be updated to reflect contemporary terminology and to be reorganized by levels of sedation versus routes of administration, making the ADA's documents current and consistent with other leading organizations' policies and guidelines. The documents and policies under review included:

- Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists (Guidelines for Dentists) (*Trans.*2005:334)
- Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry (Guidelines for Teaching) (*Trans.*2005:334)
- ADA Policy Statement: The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry (Policy Statement) (*Trans.*2005:334)
- Dentist's Right to Administer Conscious Sedation, Deep Sedation and General Anesthesia (*Trans*.2000:470)

The Committee began by hosting an Invitational Anesthesia Conference at the ADA Headquarters in May 2006 to gather information from nationally-recognized experts in the science and clinical practice of sedation and general anesthesia in dentistry. The following organizations had representatives at the conference: American Society of Anesthesiologists, American Society of Dentist Anesthesiologists, American Academy of Periodontology, American Association of Oral and Maxillofacial Surgeons, American Dental Society of Anesthesiology, American Academy of Pediatric Dentistry, Academy of General Dentistry (AGD), AADE, American Association of Endodontists, American Association of Hospital Dentists, American College of Prosthodontics, ADEA, Dental Organization for Conscious Sedation and the National Institutes of Health.

Throughout the summer and fall, the Committee developed draft documents, focused on being consistent with other leading organizations and reorganizing the content from a "route of administration" approach

to a "level of sedation" approach. In November 2006, CDEL carefully reviewed and forwarded the proposed documents to the Board of Trustees with a request to circulate the documents to the communities of interest for comment. The Board approved the request at its December 2006 meeting.

A call for comments was issued to the communities of interest on December 15, 2006, with a February 23, 2007, deadline date for submission of written comments. The communities of interest included the ADA Councils on Dental Practice, Scientific Affairs, Access Prevention and Interpersonal Relations, Government Affairs, the ADA Committee on the New Dentist, constituent and component dental societies, state boards of dentistry, dental school deans and advanced education program directors, ADA-recognized dental specialty organizations and certifying boards, ADEA, AADE, AGD, American Student Dental Association, American Society of Dentist Anesthesiologists, American Dental Society of Anesthesiology and the American Society of Anesthesiology. A general call for comments appeared in the January 8, 2007, issue of *ADA News* and was posted on ADA.org.

More than 1,400 letters were received by the February 23 deadline: 18 state and national dental–related organizations, one constituent dental society, three state dental boards, one ADA Council, one dental sedation continuing education organization, 313 individual dentists and 33 dental patients. Letters contained both support for and concern about the proposed guidelines. Additionally, a nonprofit organization, Trust for Equal Access Medicine (TEAM) 1500 submitted over 1,000 letters from dentists and dental patients. TEAM 1500 describes itself as "a non-profit coalition of more than 1,500 independent healthcare providers who are dedicated to making quality medical and dental care available to all Americans," advocating against burdensome regulation of healthcare professionals.

Those expressing support for the proposed guidelines noted that they provide appropriate guidance to dental practitioners, educators and regulators for the safe and effective administration of sedation and general anesthesia in the dental office. Many commenters also expressed support for the development of an alternative course to the current Advanced Cardiac Life Support (ACLS) requirement in Section III of the Use Guidelines, Educational Requirements for Moderate Sedation, and Deep Sedation or General Anesthesia that would have a strong focus on sedation emergencies and airway management.

In general, concerns focused on 1) very similar definitions for minimal and moderate sedation; 2) an unclear provision for state dental boards to grandfather those already administering sedation and anesthesia services; 3) the requirement that dentists must remain in the room to monitor sedated patients until they meet the criteria for discharge; and 4) the educational requirement for moderate enteral sedation to be 60 hours of instruction and 10 patient experiences per participant, including experience in establishing intravenous access.

Some who opposed the draft documents, particularly those from TEAM 1500, expressed the belief that dentists would not be able to continue to use sedation in the dental office under the proposed new guidelines. Many of the letters received expressed concern that some of the requirements would result in higher fees overall and reduce access to care for dental phobic patients, who would not seek needed dental treatment without sedation services.

The Committee on Anesthesia met on March 10, 2007, to carefully consider all comments and additional changes to the proposed documents. At its April 2007 meeting, the Council considered the revised documents as proposed by the Committee. The following is a summary of those deliberations, including rationale for the original proposed changes and those now suggested based on the comments from the communities of interest.

Proposed Revisions to Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists (Guidelines for Dentists): The initial changes to the Guidelines for Dentists focused on:

- A new title for the document—ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists (Use Guidelines)
- The use of the American Society of Anesthesiologists (ASA) definitions, either all or in part, from the ASA document—Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2004—to reflect level of sedation rather than routes of administration;
- Amendments to the "Education Guidelines" and the "Clinical Guidelines" sections to reflect the new definitions (level of sedation versus route of administration)
- A new "Additional Resources" section at the end of the document to provide the reader with additional information.

The Council also recommended that a course be developed with a curriculum specifically designed for dentists, which concentrates on the emergency management situations faced by dentists administering sedation or general anesthesia in the dental office. Council and Committee members believed this course could serve as an alternative to the ACLS training currently recommended in the Guidelines. Current ACLS courses involve interventions concentrating on cardiac arrhythmias, which are not the early presentation of the emergencies most commonly faced by dentists administering sedation. Rather, dentists may experience the eventual result of an unrecognized, untreated or improperly treated emergency. CDEL is working with the ADA Foundation to develop the criteria for a Request for Proposals (RFP) for a project that could be funded via the Foundation's 2008 funding cycle. The project would be for development of an emergency management course focusing on airway management for dentists administering sedation or general anesthesia.

Additional Proposed Revisions Based on Comments from the Communities of Interest. The Council agreed with many commenters who noted that the definitions of minimal and moderate sedation were too similar and made clarifying edits to both definitions. Additionally, the definition of "titration" was moved from under the minimal sedation definition to the moderate sedation definition. A definition of "supplemental dosing" was placed in the minimal sedation definition, which the Council felt more accurately reflects what occurs when dentists administer oral sedative drugs to achieve minimal sedation (Appendix 1, Worksheets:5007-5008).

The requirement that the dentist remain in the room with a minimally sedated patient until that patient meets the criteria for recovery was carefully reconsidered by the Committee and Council. Those commenting believed that the dentist should be able to leave the patient, for example, to see an emergency patient or check a patient who is seeing the dental hygienist. The Committee and Council agreed, noting that once treatment stops, patients who are minimally sedated meet the criteria for post-sedation care and/or discharge and no longer require monitoring by the dentist. Accordingly, the Council made additional clarifications regarding the monitoring requirements for minimally sedated patients, revising the proposed monitoring requirement to state that "a dentist, or at the dentist's direction, an appropriately trained individual must remain in the operatory during active dental treatment to monitor the patient continuously until the patient meets the criteria for discharge. The appropriately trained individual must be familiar with monitoring techniques and equipment." Provisions in states where dental assistants or hygienists are currently authorized to monitor sedated patients would not be affected by the guidelines.

The proposed monitoring requirements for *moderate* sedation were not changed because the standard of care requires the dentist to monitor the patient until that patient meets the criteria for recovery. To clarify, the Council has proposed additional language that the dentist must not leave the facility until the patient meets the criteria for discharge, and is discharged from the facility.

Commenters also expressed concern that dentists who have been safely practicing sedation and anesthesia under current state rules and regulations would not be able to continue practicing without further

education. Although Section IV. Educational Requirements of the current document states that the guidelines should not exclude individuals who would be grandfathered by individual state laws, the Council believed it could further strengthen the intent of this language. The proposed language states, "For all levels of sedation and anesthesia, dentists who are currently providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document, are not subject to these educational requirements" (Appendix 1, Worksheet:5011, lines 28-30).

Proposed Revisions to Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry (Guidelines for Teaching): The initial proposed changes to the Guidelines for Teaching focused on:

- A new title for the document—Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (Teaching Guidelines).
- Use of the American Society of Anesthesiologists (ASA) definitions, either all or in part, from the ASA document Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2004. [The ASA uses the terms minimal sedation (anxiolysis) and moderate sedation, where as the ADA 2005 Guidelines use the terms conscious sedation and combination inhalation-enteral conscious sedation (combined conscious sedation)].
- Elimination of educational requirements pertaining to deep sedation and general anesthesia from the Teaching Guidelines because the Committee believed this instruction must take place at the advanced education level in a program with Standards set by the Commission on Dental Accreditation.
- Elimination of Parts I, II and III and reorganization of the educational requirements by level of sedation, whether the dentist is at the predoctoral, advanced education or continuing education level.
- A requirement that education courses for enteral moderate sedation contain 60 hours of didactic training and 10 patient experiences per participant, including experience in establishing intravenous access.
- A new "Additional Resources" section at the end of the document to provide the reader with additional information.

Additional Proposed Revisions Based on Comments from the Communities of Interest. To complement the Use Guidelines, the Council made clarifying edits to the definitions of minimal and moderate sedation, moved the definition of "titration" from the minimal sedation definition and relocated it under moderate sedation definition, and added a definition for "supplemental dosing" under the definition for minimal sedation.

Comments on the Teaching Guidelines also addressed the educational requirements for minimal and moderate sedation courses. Commenters expressed concern that the initially proposed training requirements would be difficult to provide and could be cost prohibitive for both course providers and participants. Limited availability of proper facilities also would limit a dentist's ability to find the training required. As a result, access to care could be affected because dental phobic patients would not be able to readily find a dentist who could provide sedation services.

The Council carefully reconsidered the minimum number of instructional didactic hours and clinical cases that would be required to teach moderate enteral sedation exclusively and proposed a new educational framework separating the didactic instruction from the clinical experiences. In doing so, the Council believes that the moderate enteral sedation training requirements should reflect 24 hours of didactic instruction and the management of at least 10 adult case experiences, which includes at least three live clinical dental experiences managed by participants in groups no larger than five (the remaining cases may include simulations and/or video presentation, but must include one experience in returning (rescuing) a patient from deep to moderate sedation), and a participant/faculty ratio of 5:1. Further, the Council agreed that clinical experience in establishing intravenous access for moderate enteral sedation should not be required.

In summary, the Council made the following changes to the proposed Teaching Guidelines:

- Inhalation Sedation—Course Duration **(**Appendix 2, page 5029, lines 8-9) add language to clarify that the inhalation sedation course most often is completed as part of the predoctoral program, but could also be completed in a postdoctoral continuing education competency course. This clarification addresses concerns that a dentist would need additional training outside dental school education to qualify to administer inhalation sedation.
- Enteral and/or Combination Inhalation-Enteral Minimal Sedation—Course Duration (Appendix 2, page 5031, lines 4-5): add a similar statement under the inhalation course duration that indicates the training may be obtained in the predoctoral curriculum or postdoctoral continuing education competency course.
- Moderate Enteral Sedation Course Duration (Appendix 2, pages 5032-5033, lines 37-48 and 1-2) and Faculty; page 5033, lines 28-32):

    - Revise the requirement of 60 hours of instruction, management of l0 patients that includes experience in establishing intravenous access and the participant/faculty ratio of 3:1 to 24 hours of didactic instruction, management of at least 10 adult case experiences, which includes at least three live clinical dental experiences managed by participants in groups no larger than five (the remaining cases may include simulations and/or video presentation, but must include one experience in returning (rescuing) a patient from deep to moderate sedation), and a participant/faculty ratio of 5:1.
    - Eliminate the requirement to receive clinical experience in establishing intravenous access.

After thorough review of the Association's anesthesia guidelines documents and policies, the Council presents the following resolution. This resolution supports the ADA Strategic Plan Goals: Achieve Effective Advocacy, Create and Transfer Knowledge.

Resolution

2. Resolved, that the Guidelines for the Use of Sedation and General Anesthesia by Dentists (Appendix 1, Worksheet:5007) and Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (Appendix 2, Worksheet:5020) be adopted, and be it further

Resolved, that the previous Guidelines for Dentists (*Trans.*2000:490, 511; 2002: 400; 2003:368; 2005:334) and the previous Guidelines for Teaching (*Trans.*2000:490, 518; 2002:400; 2003:368; 2005:334) be rescinded.

BOARD COMMENT: The Board fully supports Resolution 2 as submitted by the Council on Dental Education and Licensure and commends the Council on its thorough review of these important ADA documents. The Board believes that the proposed ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists and the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students clearly reflect contemporary terminology and are consistent with other leading dental and medical organizations' guidelines. The Board agrees with the new approach which focuses on levels of sedation and includes the definitions used by the American Society of Anesthesiology. The Board recognizes that the Council received more than 1,300 comments (both pro and con) during the open comment period and appreciates the Council's reconsideration of some sections as recommended by the communities of interest. These Guidelines will provide clear guidance to the profession on the safe and effective use of sedation and general anesthesia in the dental office.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 2S-1 New ☐ Substitute ☐ Amendment ■

Report: NA Date Submitted: September 17, 2007

Submitted By: Eleventh Trustee District

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

AMENDMENT TO RESOLUTION 2:
GUIDELINES FOR THE USE OF SEDATION AND GENERAL ANESTHESIA BY DENTISTS AND GUIDELINES FOR TEACHING PAIN CONTROL AND SEDATION TO DENTISTS AND DENTAL STUDENTS

The following resolution was submitted by the Eleventh Trustee District and transmitted on September 17, 2007, by Linda Edgar, delegate, Washington State Dental Association.

Background: The Eleventh Trustee District wishes to thank this committee for their hard work in producing these guidelines. We respectfully request the following amendments be accepted for consideration by the delegates:

1. Page 5008, line 19, amend by addition of the words "on the day of treatment" to the last sentence to read:

   The total aggregate dose must not exceed 1.5x the MRD on the day of treatment.

   Reason for the addition:

   *This clarification is needed because several practitioners find that giving a small amount of the same drug (that will be used for minimal sedation) the night before the appointment is helpful to the patient. It is desired that this small amount NOT be included in the MAXIMUM total amount allowed to be given (1.5xmrd) under the defined criteria to stay within the requirements described for minimal sedation.

2. Page 5014, lines 29-31, amend by addition to read:

   Monitoring: A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. When the patient recovers to a minimally sedated level a qualified auxiliary may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

3. Page 5032, lines 37-42, amend by addition to read:

C. Moderate Enteral Sedation Course Duration: A minimum of *24 hours* of instruction, plus management of *at least 10 adult case experiences* by the enteral and/or enteral-nitrous oxide/oxygen route are required to achieve competency. These ten cases must include at least three live clinical dental experiences managed by participants in groups no larger than five. The remaining cases may include simulations and/or video presentations, but must include one (simulation or video presentation) experience in returning (rescuing) a patient from deep to moderate sedation.

Resolution

2S-1. Resolved, that the proposed ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists (Worksheet:5007) and the proposed ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (Worksheet:5020) be amended as follows (additions are underlined):

1. Page 5008, line 19, amend by addition of the words "on the day treatment" to the last sentence to read:

The total aggregate dose must not exceed 1.5x the MRD on the day of treatment.

2. Page 5014, lines 29-31, amend by addition to read:

Monitoring: A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. When the patient recovers to a minimally sedated level a qualified auxiliary may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

3. Page 5032, lines 37-42, amend by addition to read:

C. Moderate Enteral Sedation Course Duration: A minimum of *24 hours* of instruction, plus management of *at least 10 adult case experiences* by the enteral and/or enteral-nitrous oxide/oxygen route are required to achieve competency. These ten cases must include at least three live clinical dental experiences managed by participants in groups no larger than five. The remaining cases may include simulations and/or video presentations, but must include one (simulation or video presentation) experience in returning (rescuing) a patient from deep to moderate sedation.

and be it further

Resolved, that the previous Guidelines for Dentists (*Trans*.2000:490,511; 2002:400; 2003:368; 2005:334) and the previous Guidelines for Teaching (*Trans*.2000:490,518; 2002:400; 2003:368; 2005:334) be rescinded.

BOARD COMMENT: The Board believes that the addition proposed in Amendment 1 does not change the intent of the guideline and that the proposed amendment provides acceptable clarification.

The Board supports the intent of Amendment 2, but believes that additional clarification is required to indicate that monitoring by a qualified auxiliary should take place only when active treatment has concluded.

Regarding the addition of "(simulation or video)," the Board understands that the Committee intentionally wrote the guideline the way it appears to allow the course provider to select the method for instruction and may be limiting if the amended language is added. The intent was not to intentionally, deeply sedate a patient for the purpose of rescue, but if it occurred, should be used as the learning experience. By adding the language in the amendment, it appears that that is the only option. The Board does not support this amendment.

The Board therefore recommends the following substitute resolution:

2S-1B. Resolved, that the proposed ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists (Worksheet:5007) and the proposed ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (Worksheet:5020) be amended as follows (<u>additions</u> are underlined):

1. Page 5008, line 19, amend by <u>addition</u> of the words “on the day of treatment” to the last sentence to read:

> The total aggregate dose must not exceed 1.5x the MRD <u>on the day of treatment</u>.

2. Page 5014, lines 29-31, amend by <u>addition</u> to read:

> **Monitoring:** A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. <u>When active treatment concludes and the patient recovers to a minimally sedated level a qualified auxiliary may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility.</u> The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

and be it further

Resolved, that the previous Guidelines for Dentists (*Trans*.2000:490,511; 2002:400; 2003:368; 2005:334) and the previous Guidelines for Teaching (*Trans*.2000:490,518; 2002:400; 2003:368; 2005:334) be rescinded.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

BOARD VOTE: UNANIMOUS.

APPENDIX 1
AMERICAN DENTAL ASSOCIATION
GUIDELINES FOR THE USE OF SEDATION AND GENERAL ANESTHESIA BY DENTISTS

(2000:490, 511; 2002:400; 2003:368; 2005:334)

I. Introduction

The administration of local anesthesia, sedation and general anesthesia is an integral part of dental practice. The American Dental Association is committed to the safe and effective use of these modalities by appropriately educated and trained dentists. The purpose of these guidelines is to assist dentists in the delivery of safe and effective sedation and anesthesia.

Dentists providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document are not subject to *Section III. Educational Requirements.*

II. Definitions

Methods of Anxiety and Pain Control

analgesia - the diminution or elimination of pain.

local anesthesia - the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

Note: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression, especially in combination with sedative agents.

minimal sedation - a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond *normally* to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.[1]

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.

When the intent is minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use.

The use of preoperative sedatives for children (aged 12 and under) except in extraordinary situations must be avoided due to the risk of unobserved respiratory obstruction during transport by untrained individuals.

[1] Portions excerpted from *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia*, 2004, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

Children (aged 12 and under) can become moderately sedated despite the intended level of minimal sedation; should this occur, the guidelines for moderate sedation apply.

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*.

Nitrous oxide/oxygen may be used in combination with a single enteral drug in minimal sedation.

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

The following definitions apply to administration of minimal sedation:

maximum recommended dose (MRD) - maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use.

incremental dosing - administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).

supplemental dosing - during minimal sedation, supplemental dosing is a single additional dose of the initial dose of the initial drug that may be necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD.

moderate sedation - a drug-induced depression of consciousness during which patients respond *purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. [2]

Note: In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to the administration of moderate or greater sedation:

titration-administration of incremental doses of a drug until a desired effect is reached. Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

deep sedation - a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to

[2] Excerpted from *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia,* 2004, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.[2]

general anesthesia - a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.[2]

For all levels of sedation, the practitioner must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.

Routes of Administration

enteral - any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

parenteral - a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].

transdermal - a technique of administration in which the drug is administered by patch or iontophoresis through skin.

transmucosal - a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

inhalation - a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

Terms

qualified dentist - meets the educational requirements for the appropriate level of sedation in accordance with Section III of these *Guidelines*, or a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document.

must/shall - indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

should - indicates the recommended manner to obtain the standard; highly desirable.

may - indicates freedom or liberty to follow a reasonable alternative.

continual - repeated regularly and frequently in a steady succession.

continuous - prolonged without any interruption at any time.

time-oriented anesthesia record - documentation at appropriate time intervals of drugs, doses and physiologic data obtained during patient monitoring.

immediately available – on site in the facility and available for immediate use.

American Society of Anesthesiologists (ASA) Patient Physical Status Classification System[3]

ASA I - A normal healthy patient.

ASA II - A patient with mild systemic disease.

ASA III - A patient with severe systemic disease.

ASA IV - A patient with severe systemic disease that is a constant threat to life.

ASA V - A moribund patient who is not expected to survive without the operation.

ASA VI - A declared brain-dead patient whose organs are being removed for donor purposes.

E - Emergency operation of any variety (used to modify one of the above classifications, i.e., ASA III-E).

III. Educational Requirements

A. Minimal Sedation

1. To administer minimal sedation the dentist must have successfully completed:

a. training to the level of competency in minimal sedation consistent with that prescribed in the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*, or a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the *ADA Guidelines* at the time training was commenced,

or

b. an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage minimal sedation commensurate with these *Guidelines*;

and

c. a current certification in Basic Life Support for Healthcare Providers.

2. Administration of minimal sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

B. Moderate Sedation

1. To administer moderate sedation, the dentist must have successfully completed:

a. a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced,

[3] ASA Physical Status Classification System is reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

or

b. an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage moderate sedation commensurate with these *Guidelines*;

and

c. a current certification in 1) Basic Life Support for Healthcare Providers and 2) Advanced Cardiac Life Support (ACLS) or an appropriate dental sedation/anesthesia emergency management course.

2. Administration of moderate sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

C. Deep Sedation or General Anesthesia

1. To administer deep sedation or general anesthesia, the dentist must have completed:

a. an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage deep sedation or general anesthesia, commensurate with Part IV.C of these *Guidelines*;

and

b. a current certification in 1) Basic Life Support for Healthcare Providers and 2) Advanced Cardiac Life Support (ACLS) or an appropriate dental sedation/anesthesia emergency management course.

2. Administration of deep sedation or general anesthesia by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

For all levels of sedation and anesthesia, dentists who are currently providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document are not subject to these educational requirements.

IV. Clinical Guidelines

A. Minimal sedation

1. Patient Evaluation

Patients considered for minimal sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this may consist of a review of their current medical history and medication use. However, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Preoperative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.

- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.

- Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.

- A focused physical evaluation must be performed as deemed appropriate.

- Preoperative dietary restrictions must be considered based on the sedative technique prescribed.

- Preoperative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

3. Personnel and Equipment Requirements

Personnel:

- At least one additional person trained in Basic Life Support for Healthcare Providers must be present in addition to the dentist.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.

- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.

- An appropriate scavenging system must be available if gases other than oxygen or air are used.

4. Monitoring and Documentation

Monitoring: A dentist or, at the dentist's direction, an appropriately trained individual must remain in the operatory during active dental treatment to monitor the patient continuously until the patient meets the criteria for discharge to the recovery area. The appropriately trained individual must be familiar with monitoring techniques and equipment. Monitoring must include

- Oxygenation:
  - Color of mucosa, skin or blood must be evaluated continually.
  - Oxygen saturation by pulse oximetry may be clinically useful and should be considered.
- Ventilation:
  - The dentist and/or appropriately trained individual must observe chest excursions continually.

- The dentist and/or appropriately trained individual must verify respirations continually.

- Circulation:

  - Blood pressure and heart rate should be evaluated preoperatively, postoperatively and intraoperatively as necessary (unless the patient is unable to tolerate such monitoring).

  Documentation: An appropriate sedative record must be maintained, including the names of all drugs administered, including local anesthetics, dosages and monitored physiological parameters.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.

- The qualified dentist or appropriately trained clinical staff must monitor the patient during recovery until the patient is ready for discharge by the dentist.

- The qualified dentist must determine and document that the level of consciousness, oxygenation, ventilation and circulation are satisfactory prior to discharge.

- Postoperative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

6. Emergency Management

If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation.

The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of minimal sedation and providing the equipment and protocols for patient rescue.

7. Management of Children

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.*

B. Moderate Sedation

1. Patient Evaluation

Patients considered for moderate sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this should consist of at least a review of their current medical history and medication use. However, patients with significant medical considerations (e.g., ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Preoperative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.
- A focused physical evaluation must be performed as deemed appropriate.
- Preoperative dietary restrictions must be considered based on the sedative technique prescribed.
- Preoperative verbal or written instructions must be given to the patient, parent, escort, guardian or care giver.

3. Personnel and Equipment Requirements

Personnel:

- At least one additional person trained in Basic Life Support for Healthcare Providers must be present in addition to the dentist.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

- Consciousness:
  - Level of consciousness (e.g., responsiveness to verbal command) must be continually assessed.

- Oxygenation:
  - Color of mucosa, skin or blood must be evaluated continually.
  - Oxygen saturation must be evaluated by pulse oximetry continuously.
- Ventilation:
  - The dentist must observe chest excursions continually.
  - The dentist must monitor ventilation. This can be accomplished by auscultation of breath sounds, monitoring end-tidal CO_2 or by verbal communication with the patient.
- Circulation:
  - The dentist must continually evaluate blood pressure and heart rate (unless the patient is unable to tolerate and this is noted in the time-oriented anesthesia record).
  - Continuous ECG monitoring of patients with significant cardiovascular disease should be considered.

<u>Documentation:</u>

- An appropriate time-oriented anesthetic record must be maintained, including the names of all drugs administered, including local anesthetics, dosages and monitored physiological parameters.
- Pulse oximetry, heart rate, respiratory rate and blood pressure must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The qualified dentist or appropriately trained clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The qualified dentist must determine and document that the level of consciousness, oxygenation, ventilation and circulation are satisfactory for discharge.
- Postoperative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.
- If a reversal agent is administered before discharge criteria have been met, the patient must be monitored until recovery is assured.

6. Emergency Management

If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation.

The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue.

7. Management of Children

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.*

C. Deep Sedation or General Anesthesia

1. Patient Evaluation

Patients considered for deep sedation or general anesthesia must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this must consist of at least a review of their current medical history and medication use and NPO status. However, patients with significant medical considerations (e.g., ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Preoperative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative or anesthetic agents and informed consent for the proposed sedation/anesthesia must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.
- A focused physical evaluation must be performed as deemed appropriate.
- Preoperative dietary restrictions must be considered based on the sedative/anesthetic technique prescribed.
- Preoperative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.
- An intravenous line, which is secured throughout the procedure, must be established except as provided in part IV. C.6. Pediatric and Special Needs Patients.

3. Personnel and Equipment Requirements

Personnel: A minimum of three (3) individuals must be present.

- A dentist qualified in accordance with part III. C. of these *Guidelines* to administer the deep sedation or general anesthesia.
- Two additional individuals who have current certification in Basic Life Support for Healthcare Providers.

- When the same individual administering the deep sedation or general anesthesia is performing the dental procedure, one of the additional appropriately trained team members must be designated for patient monitoring.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.
- Equipment and drugs necessary to provide advanced airway management and advanced cardiac life support must be immediately available.
- If volatile anesthetic agents are utilized, an inspired agent analysis monitor and capnograph should be considered.
- Resuscitation medications and an appropriate defibrillator must be immediately available.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

- Oxygenation:
  - Color of mucosa, skin or blood must be continually evaluated.
  - Oxygenation saturation must be evaluated continuously by pulse oximetry.
- Ventilation:
  - Intubated patient: End-tidal CO_2 must be continuously monitored and evaluated.
  - Non-intubated patient: Breath sounds via auscultation and/or end-tidal CO_2 must be continually monitored and evaluated.
  - Respiration rate must be continually monitored and evaluated.
- Circulation:
  - The dentist must continuously evaluate heart rate and rhythm via ECG throughout the procedure, as well as pulse rate via pulse oximetry.

- The dentist must continually evaluate blood pressure.

- Temperature:

  - A device capable of measuring body temperature must be readily available during the administration of deep sedation or general anesthesia.

  - The equipment to continuously monitor body temperature should be available and must be performed whenever triggering agents associated with malignant hyperthermia are administered.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs administered, including local anesthetics, doses and monitored physiological parameters.

- Pulse oximetry and end-tidal CO_2 measurements (if taken), heart rate, respiratory rate and blood pressure must be recorded at appropriate intervals.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.

- The dentist or clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.

- The dentist must determine and document that the level of consciousness, oxygenation, ventilation and circulation are satisfactory for discharge.

- Postoperative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

6. Pediatric and Special Needs Patients

Because many dental patients undergoing deep sedation or general anesthesia are mentally and/or physically challenged, it is not always possible to have a comprehensive physical examination or appropriate laboratory tests prior to administering care. When these situations occur, the dentist responsible for administering the deep sedation or general anesthesia should document the reasons preventing the recommended preoperative management.

In selected circumstances, deep sedation or general anesthesia may be utilized without establishing an indwelling intravenous line. These selected circumstances may include very brief procedures or periods of time, which, for example, may occur in some pediatric patients; or the establishment of intravenous access after deep sedation or general anesthesia has been induced because of poor patient cooperation.

7. Emergency Management

The qualified dentist is responsible for sedative/anesthetic management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of deep sedation or general anesthesia and providing the equipment, drugs and protocols for patient rescue.

*****

V. Additional Sources of Information

American Academy of Pediatric Dentistry (AAPD). *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update*. Developed through a collaborative effort between the American Academy of Pediatrics and the AAPD. Available at http://www.aapd.org/media/policies.asp.

American Academy of Periodontology (AAP). *Guidelines: In-Office Use of Conscious Sedation in Periodontics.* Available at http://www.perio.org/resources-products/posppr3-1.html.

American Dental Association Council on Scientific Affairs. Acceptance Program Guidelines: *Nitrous Oxide-Oxygen Conscious Sedation Systems, 2000*. Available at http://www.ada.org/prof/resources/positions/standards/denmat.asp#ada.

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Parameters and Pathways: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParPath o1) Anesthesia in Outpatient Facilities*. Contact AAOMS at 1-847-678-6200 or visit http://www.aaoms.org/index.php.

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Office Anesthesia Evaluation Manual 7th Edition*. Contact AAOMS at 1-847-678-6200 or visit http://www.aaoms.org/index.php.

American Society of Anesthesiologist (ASA). *Practice Guidelines for Preoperative Fasting and the Use of Pharmacological Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures.* Available at http://www2.asahq.org/publications/p-178-practice-guidelines-for-preoperative-fasting.aspx.

American Society of Anesthesiologists (ASA). *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists.* Available at http://www.asahq.org/publicationsAndServices/practiceparam.htm#sedation. The ASA has other anesthesia resources that might be of interest to dentists. For more information, go to http://www.asahq.org/publicationsAndServices/sgstoc.htm.

Commission on Dental Accreditation (CODA). *Accreditation Standards* for Predoctoral and Advanced Dental Education Programs. Available at http://www.ada.org/prof/ed/accred/standards/index.asp.

National Institute for Occupational Safety and Health (NIOSH). *Controlling Exposures to Nitrous Oxide During Anesthetic Administration* (NIOSH Alert: 1994 Publication No. 94-100). Available at http://www.cdc.gov/niosh/noxidalr.html.

Dionne, Raymond A.; Yagiela, John A., et al. Balancing efficacy and safety in the use of oral sedation in dental outpatients. JADA 2006;137(4):502-13. ADA members can access this article online at http://jada.ada.org/cgi/content/full/137/4/502.

APPENDIX 2
AMERICAN DENTAL ASSOCIATION
GUIDELINES FOR TEACHING PAIN CONTROL AND SEDATION TO DENTISTS AND DENTAL STUDENTS
(2000:490, 518; 2002:400; 2003:368, 2005:334)

I. Introduction

The administration of local anesthesia, sedation and general anesthesia is an integral part of the practice of dentistry. The American Dental Association is committed to the safe and effective use of these modalities by appropriately educated and trained dentists.

Anxiety and pain control can be defined as the application of various physical, chemical and psychological modalities to the prevention and treatment of preoperative, operative and postoperative patient anxiety and pain to allow dental treatment to occur in a safe and effective manner. It involves all disciplines of dentistry and, as such, is one of the most important aspects of dental education. The intent of these *Guidelines* is to provide direction for the teaching of pain control and sedation to dentists and can be applied at all levels of dental education from predoctoral through continuing education. They are designed to teach initial competency in pain
control and minimal and moderate sedation techniques.

These *Guidelines* recognize that many dentists have acquired a high degree of competency in the use of anxiety and pain control techniques through a combination of instruction and experience. It is assumed that this has enabled these teachers and practitioners to meet the educational criteria described in this document.

It is not the intent of the *Guidelines* to fit every program into the same rigid educational mold. This is neither possible nor desirable. There must always be room for innovation and improvement. They do, however, provide a reasonable measure of program acceptability, applicable to all institutions and agencies engaged in predoctoral and continuing education.

The curriculum in anxiety and pain control is a continuum of educational experiences that will extend over several years of the predoctoral program. It should provide the dental student with the knowledge and skills necessary to provide minimal sedation to alleviate anxiety and control pain without inducing detrimental physiological or psychological side effects. Dental schools whose goal is to have predoctoral students achieve competency in techniques such as local anesthesia and nitrous oxide inhalation and minimal sedation must meet all of the goals, prerequisites, didactic content, clinical experiences, faculty and facilities, as described in these *Guidelines.*

Techniques for the control of anxiety and pain in dentistry should include both psychological and pharmacological modalities. Psychological strategies should include simple relaxation techniques for the anxious patient and more comprehensive behavioral techniques to control pain. Pharmacological strategies should include not only local anesthetics but also sedatives, analgesics and other useful agents. Dentists should learn indications and techniques for administering these drugs enterally, parenterally and by inhalation as supplements to local anesthesia.

The predoctoral curriculum should provide instruction, exposure and/or experience in anxiety and pain control, including minimal and moderate sedation. The predoctoral program must also provide the knowledge and skill to enable students to recognize and manage any emergencies that might arise as a consequence of treatment. Predoctoral dental students must complete a course in Basic Life Support for the Healthcare Provider (BLS). Though BLS courses are available online, any course taken online should

be followed up with a hands-on component and be approved by the American Heart Association or the American Red Cross.

Local anesthesia is the foundation of pain control in dentistry. Although the use of local anesthetics in dentistry has a long record of safety, dentists must be aware of the maximum safe dosage limit for each patient, since large doses of local anesthetics may increase the level of central nervous system depression with sedation. The use of minimal and moderate sedation requires an understanding of local anesthesia and the physiologic and pharmacologic implications of the local anesthetic agents when combined with the sedative agents.

The knowledge, skill and clinical experience required for the safe administration of deep sedation and/or general anesthesia are beyond the scope of predoctoral and continuing education programs. Advanced education programs that teach deep sedation and/or general anesthesia to competency have specific teaching requirements described in the Commission on Dental Accreditation requirements for those advanced programs and represent the educational and clinical requirements for teaching deep sedation and/or general anesthesia in dentistry.

The objective of educating dentists to utilize pain control, sedation and general anesthesia is to enhance their ability to provide oral health care. The American Dental Association urges dentists to participate regularly in continuing education update courses in these modalities in order to remain current.

All areas in which local anesthesia and sedation are being used must be properly equipped with suction, physiologic monitoring equipment, a positive pressure oxygen delivery system suitable for the patient being treated and emergency drugs. Protocols for the management of emergencies must be developed and training programs held at frequent intervals.

II. Definitions

Methods of Anxiety and Pain Control

analgesia - the diminution or elimination of pain.

local anesthesia - the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

> *Note*: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must always be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression especially in combination with sedative agents.

minimal sedation - a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond *normally* to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.[4]

> *Note:* In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients

[4] Portions excerpted from *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia,* 2004, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.

When the intent is minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use.

Nitrous oxide/oxygen may be used in combination with a single enteral drug in minimal sedation.

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

The following definitions apply to administration of minimal sedation:

maximum recommended dose (MRD) - maximum FDA-recommended dose of a drug as printed in FDA-approved labeling for unmonitored home use.

incremental dosing - administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).

supplemental dosing - during minimal sedation, supplemental dosing is a single additional dose of the initial dose of the initial drug that may be necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial total dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD.

moderate sedation - a drug-induced depression of consciousness during which patients respond *purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.[5]

Note: In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to administration of moderate and deeper levels of sedation:

titration - administration of incremental doses of a drug until a desired effect is reached. Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

deep sedation - a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in

[5] Excerpted from *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia*, 2004, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.[2]

general anesthesia – a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.[2]

For all levels of sedation, the practitioner must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.

Routes of Administration

enteral - any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

parenteral - a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].

transdermal - a technique of administration in which the drug is administered by patch or iontophoresis through skin.

transmucosal – a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

inhalation - a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

Terms

qualified dentist – meets the educational requirements for the appropriate level of sedation in accordance with Section III of these *Guidelines*, or a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document.

must/shall - indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

should -indicates the recommended manner to obtain the standard; highly desirable.

may - indicates freedom or liberty to follow a reasonable alternative.

continual - repeated regularly and frequently in a steady succession.

continuous - prolonged without any interruption at any time.

time-oriented anesthesia record - documentation at appropriate time intervals of drugs, doses and physiologic data obtained during patient monitoring.

immediately available – on site in the facility and available for immediate use.

Levels of Knowledge

familiarity - a simplified knowledge for the purpose of orientation and recognition of general principles.

in-depth - a thorough knowledge of concepts and theories for the purpose of critical analysis and the synthesis of more complete understanding (highest level of knowledge).

Levels of Skill

exposed - the level of skill attained by observation of or participation in a particular activity.

competent - displaying special skill or knowledge derived from training and experience.

proficient - the level of skill attained when a particular activity is accomplished with repeated quality and a more efficient utilization of time (highest level of skill).

American Society of Anesthesiologists (ASA) Patient Physical Status Classification System[6]

ASA I - A normal healthy patient.

ASA II - A patient with mild systemic disease.

ASA III - A patient with severe systemic disease.

ASA IV - A patient with severe systemic disease that is a constant threat to life.

ASA V - A moribund patient who is not expected to survive without the operation.

ASA VI - A declared brain-dead patient whose organs are being removed for donor purposes.

E - Emergency operation of any variety (used to modify one of the above classifications, i.e., ASA III-E).

Education Courses

Education may be offered at different levels (competency, update, survey and advanced education courses). A description of these different levels follows:

1. **Competency Courses** are designed to meet the needs of dentists who wish to become knowledgeable and proficient in the safe and effective administration of local anesthesia, minimal and moderate sedation. They consist of lectures, demonstrations and sufficient clinical participation to assure the faculty that the dentist understands the procedures taught and can safely and effectively apply them so that mastery of the subject is achieved. Faculty must assess

[6] ASA Physical Status Classification System is reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

and document the dentist's competency upon successful completion of such training. To maintain competency, periodic update courses must be completed.

2. **Update Courses** are designed for persons with previous training. They are intended to provide a review of the subject and an introduction to recent advances in the field. They should be designed didactically and clinically to meet the specific needs of the participants. Participants must have completed previous competency training (equivalent, at a minimum, to the competency course described in this document) and have current experience to be eligible for enrollment in an update course.

3. **Survey Courses** are designed to provide general information about subjects related to pain control and sedation. Such courses should be didactic and not clinical in nature, since they are not intended to develop clinical competency.

4. **Advanced Education Courses** are a component of an advanced dental education program, accredited by the ADA Commission on Dental Accreditation in accord with the *Accreditation Standards* for advanced dental education programs. These courses are designed to prepare the graduate dentist or postdoctoral student in the most comprehensive manner to be knowledgeable and proficient in the safe and effective administration of minimal, moderate and deep sedation and general anesthesia.

III. Teaching Pain Control

These *Guidelines* present a basic overview of the recommendations for teaching pain control.

A. General Objectives: Upon completion of a predoctoral curriculum in pain control the dentist must:

1. have an in-depth knowledge of those aspects of anatomy, physiology, pharmacology and psychology involved in the use of various anxiety and pain control methods;
2. be competent in evaluating the psychological and physical status of the patient, as well as the magnitude of the operative procedure, in order to select the proper regimen;
3. be competent in monitoring vital functions;
4. be competent in prevention, recognition and management of related complications;
5. be familiar with the appropriateness of and the indications for medical consultation or referral;
6. be competent in the maintenance of proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs administered and patient response.

B. Pain Control Curriculum Content:

1. Philosophy of anxiety and pain control and patient management, including the nature and purpose of pain
2. Review of physiologic and psychologic aspects of anxiety and pain
3. Review of airway anatomy and physiology
4. Physiologic monitoring
    a. Observation

(1) Central nervous system
(2) Respiratory system
a. Oxygenation
b. Ventilation
(3) Cardiovascular system
b. Monitoring equipment

5. Pharmacologic aspects of anxiety and pain control
a. Routes of drug administration
b. Sedatives and anxiolytics
c. Local anesthetics
d. Analgesics and antagonists
e. Adverse side effects
f Drug interactions
g. Drug abuse

6. Control of preoperative and operative anxiety and pain
a. Patient evaluation
(1) Psychological status
(2) ASA physical status
(3) Type and extent of operative procedure
b. Nonpharmacologic methods
(1) Psychological and behavioral methods
(a) Anxiety management
(b) Relaxation techniques
(c) Systematic desensitization
(2) Interpersonal strategies of patient management
(3) Hypnosis
(4) Electronic dental anesthesia
(5) Acupuncture/Acupressure
(6) Other
c. Local anesthesia
(1) Review of related anatomy, and physiology
(2) Pharmacology
(i) Dosing
(ii) Toxicity
(iii) Selection of agents
(3) Techniques of administration
(i) Topical
(ii) Infiltration (supraperiosteal)
(iii) Nerve block – maxilla-to include:
(aa) Posterior superior alveolar
(bb) Infraorbital
(cc) Nasopalatine
(dd) Greater palatine
(ee) Maxillary (2nd division)
(ff) Other blocks
(iv) Nerve block – mandible-to include:
(aa) Inferior alveolar-lingual
(bb) Mental-incisive
(cc) Buccal
(dd) Gow-Gates

(ee) Closed mouth

(v) Alternative injections-to include:

(aa) Periodontal ligament

(bb) Intraosseous

d. Prevention, recognition and management of complications and emergencies

C. Sequence of Pain Control Didactic and Clinical Instruction: Beyond the basic didactic instruction in local anesthesia, additional time should be provided for demonstrations and clinical practice of the injection techniques. The teaching of other methods of anxiety and pain control, such as the use of analgesics and enteral, inhalation and parenteral sedation, should be coordinated with a course in pharmacology. By this time the student also will have developed a better understanding of patient evaluation and the problems related to prior patient care. As part of this instruction, the student should be taught the techniques of venipuncture and physiologic monitoring. Time should be included for demonstration of minimal and moderate sedation techniques.

Following didactic instruction in minimal and moderate sedation, the student must receive sufficient clinical experience to demonstrate competency in those techniques in which the student is to be certified. It is understood that not all institutions may be able to provide instruction to the level of clinical competence in pharmacologic sedation modalities to all students. The amount of clinical experience required to achieve competency will vary according to student ability, teaching methods and the anxiety and pain control modality taught.

Clinical experience in minimal and moderate sedation techniques should be related to various disciplines of dentistry and not solely limited to surgical cases. Typically, such experience will be provided in managing healthy adult patients. The sedative care of pediatric and special needs patients requires advanced didactic and clinical training.

Throughout both didactic and clinical instruction in anxiety and pain control, psychological management of the patient should also be stressed. Instruction should emphasize that the need for sedative techniques is directly related to the patient's level of anxiety, cooperation, medical condition and the planned procedures.

D. Faculty: Instruction must be provided by qualified faculty for whom anxiety and pain control are areas of major proficiency, interest and concern.

E. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

IV. Teaching Administration of Minimal Sedation

The faculty responsible for curriculum in minimal sedation techniques must be familiar with the ADA Policy Statement: *Guidelines for the Use of Sedation and General Anesthesia by Dentists*, and the Commission on Dental Accreditation's *Accreditation Standards* for dental education programs.

These *Guidelines* present a basic overview of the recommendations for teaching minimal sedation. These include courses in nitrous oxide/oxygen sedation, enteral sedation, and combined inhalation/enteral techniques.

General Objectives: Upon completion of a competency course in minimal sedation, the dentist must be able to:

1. Describe the adult and pediatric anatomy and physiology of the respiratory, cardiovascular and central nervous systems, as they relate to the above techniques.
2. Describe the pharmacological effects of drugs.
3. Describe the methods of obtaining a medical history and conduct an appropriate physical examination.
4. Apply these methods clinically in order to obtain an accurate evaluation.
5. Use this information clinically for ASA classification and risk assessment.
6. Choose the most appropriate technique for the individual patient.
7. Use appropriate physiologic monitoring equipment.
8. Describe the physiologic responses that are consistent with minimal sedation.
9. Understand the sedation/general anesthesia continuum.

Inhalation Sedation (Nitrous Oxide/Oxygen)

A. Inhalation Sedation Course Objectives: Upon completion of a competency course in inhalation sedation techniques, the dentist must be able to:

1. Describe the basic components of inhalation sedation equipment.
2. Discuss the function of each of these components.
3. List and discuss the advantages and disadvantages of inhalation sedation.
4. List and discuss the indications and contraindications of inhalation sedation.
5. List the complications associated with inhalation sedation.
6. Discuss the prevention, recognition and management of these complications.
7. Administer inhalation sedation to patients in a clinical setting in a safe and effective manner.
8. Discuss the abuse potential, occupational hazards and other untoward effects of inhalation agents.

B. Inhalation Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations.
3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
4. Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and the unconscious state.
5. Review of pediatric and adult respiratory and circulatory physiology and related anatomy.
6. Pharmacology of agents used in inhalation sedation, including drug interactions and incompatibilities.
7. Indications and contraindications for use of inhalation sedation.
8. Review of dental procedures possible under inhalation sedation.
9. Patient monitoring using observation and monitoring equipment, with particular attention to vital signs and reflexes related to pharmacology of nitrous oxide.
10. Importance of maintaining proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs and doses administered and patient response.
11. Prevention, recognition and management of complications and life-threatening situations.
12. Administration of local anesthesia in conjunction with inhalation sedation techniques.
13. Description and use of inhalation sedation equipment.

14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting occupational exposure.
15. Discussion of abuse potential.

C. Inhalation Sedation Course Duration: While length of a course is only one of the many factors to be considered in determining the quality of an educational program, the course should be a minimum of *14 hours*, including a clinical component during which competency in inhalation sedation technique is achieved. The inhalation sedation course most often is completed as a part of the predoctoral dental education program. However, the course may be completed in a postdoctoral continuing education competency course.

D. Participant Evaluation and Documentation of Inhalation Sedation Instruction: Competency courses in inhalation sedation techniques must afford participants with sufficient clinical experience to enable them to achieve competency. This experience must be provided under the supervision of qualified faculty and must be evaluated. The course director must certify the competency of participants upon satisfactory completion of training. Records of the didactic instruction and clinical experience, including the number of patients treated by each participant must be maintained and available.

E. Faculty: The course should be directed by a dentist or physician qualified by experience and training. This individual should have had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain control. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, cardiologists and psychologists, should be encouraged.

A participant-faculty ratio of not more than ten-to-one when inhalation sedation is being used allows for adequate supervision during the clinical phase of instruction; a one-to-one ratio is recommended during the early state of participation.

The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

<u>Enteral and/or Combination Inhalation-Enteral Minimal Sedation</u>

A. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Objectives: Upon completion of a competency course in enteral and/or combination inhalation-enteral minimal sedation techniques, the dentist must be able to:

1. Describe the basic components of inhalation sedation equipment.
2. Discuss the function of each of these components.
3. List and discuss the advantages and disadvantages of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
4. List and discuss the indications and contraindications for the use of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
5. List the complications associated with enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
6. Discuss the prevention, recognition and management of these complications.
7. Administer enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation) to patients in a clinical setting in a safe and effective manner.

8. Discuss the abuse potential, occupational hazards and other effects of enteral and inhalation agents.
9. Discuss the pharmacology of the enteral and inhalation drugs selected for administration.
10. Discuss the precautions, contraindications and adverse reactions associated with the enteral and inhalation drugs selected.
11. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for management of life-threatening situations.
12. Demonstrate the ability to manage life-threatening emergency situations, including current certification in Basic Life Support for Healthcare Providers.
13. Discuss the pharmacological effects of combined drug therapy, their implications and their management. Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

B. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological profiling.
3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
4. Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and the unconscious state.
5. Review of pediatric and adult respiratory and circulatory physiology and related anatomy.
6. Pharmacology of agents used in enteral and/or combination inhalation-enteral minimal sedation, including drug interactions and incompatibilities.
7. Indications and contraindications for use of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
8. Review of dental procedures possible under enteral and/or combination inhalation-enteral minimal sedation).
9. Patient monitoring using observation, monitoring equipment, with particular attention to vital signs and reflexes related to consciousness.
10. Maintaining proper records with accurate chart entries recording medical history, physical examination, informed consent, time-oriented anesthesia record, including the names of all drugs administered including local anesthetics, doses, and monitored physiological parameters.
11. Prevention, recognition and management of complications and life-threatening situations.
12. Administration of local anesthesia in conjunction with enteral and/or combination inhalation-enteral minimal sedation techniques.
13. Description and use of inhalation sedation equipment.
14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting occupational exposure.
15. Discussion of abuse potential.

C. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Duration:
Participants must be able to document current certification in Basic Life Support for Healthcare Providers and have completed a nitrous oxide competency course to be eligible for enrollment in this course. While length of a course is only one of the many factors to be considered in determining the quality of an educational program, the course should include a minimum of *16 hours*, plus clinically-oriented experiences during which competency in enteral and/or combined inhalation-enteral minimal sedation techniques is demonstrated. Clinically-oriented experiences may include group observations on patients undergoing enteral and/or combination inhalation-

enteral minimal sedation. Clinical experience in managing a compromised airway is critical to the prevention of life-threatening emergencies. The faculty should schedule participants to return for additional clinical experience if competency has not been achieved in the time allotted. The educational course may be completed in a predoctoral dental education curriculum or a postdoctoral continuing education competency course.

These *Guidelines* are not intended for the management of enteral and/or combination inhalation-enteral minimal sedation in children, which requires additional course content and clinical learning experience.

D. Participant Evaluation and Documentation of Instruction: Competency courses in combination inhalation-enteral minimal sedation techniques must afford participants with sufficient clinical understanding to enable them to achieve competency. The course director must certify the competency of participants upon satisfactory completion of the course. Records of the course instruction must be maintained and available.

E. Faculty: The course should be directed by a dentist or physician qualified by experience and training. This individual should have had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain control. Dental faculty with broad clinical experience in the particular aspect of the subject under consideration should participate. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, cardiologists and psychologists, should be encouraged. The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

V. Teaching Administration of Moderate Sedation

These *Guidelines* present a basic overview of the requirements for a competency course in moderate sedation. These include courses in enteral moderate sedation and parenteral moderate sedation. The teaching guidelines contained in this section on moderate sedation differ slightly from documents in medicine to reflect the differences in delivery methodologies and practice environment in dentistry. For this reason, separate teaching guidelines have been developed for moderate enteral and moderate parenteral sedation.

A. Course Objectives: Upon completion of a course in moderate sedation, the dentist must be able to:

1. List and discuss the advantages and disadvantages of moderate sedation.
2. Discuss the prevention, recognition and management of complications associated with moderate sedation.
3. Administer moderate sedation to patients in a clinical setting in a safe and effective manner.
4. Discuss the abuse potential, occupational hazards and other untoward effects of the agents utilized to achieve moderate sedation.
5. Describe and demonstrate the technique of intravenous access, intramuscular injection and other parenteral techniques.
6. Discuss the pharmacology of the drug(s) selected for administration.
7. Discuss the precautions, indications, contraindications and adverse reactions associated with the drug(s) selected.
8. Administer the selected drug(s) to dental patients in a clinical setting in a safe and effective manner.

9. List the complications associated with techniques of moderate sedation.
10. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for the prevention and management of emergency situations.
11. Discuss principles of advanced cardiac life support or an appropriate dental sedation/anesthesia emergency course equivalent.
12. Demonstrate the ability to manage emergency situations.

B. Moderate Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations.
3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
4. Description of the sedation anesthesia continuum, with special emphasis on the distinction between the conscious and the unconscious state.
5. Review of pediatric and adult respiratory and circulatory physiology and related anatomy.
6. Pharmacology of local anesthetics and agents used in moderate sedation, including drug interactions and contraindications.
7. Indications and contraindications for use of moderate sedation.
8. Review of dental procedures possible under moderate sedation.
9. Patient monitoring using observation and monitoring equipment, with particular attention to vital signs and reflexes related to consciousness.
10. Maintaining proper records with accurate chart entries recording medical history, physical examination, informed consent, time-oriented anesthesia record, including the names of all drugs administered including local anesthetics, doses, and monitored physiological parameters.
11. Prevention, recognition and management of complications and emergencies.
12. Description and use of moderate sedation monitors and equipment.
13. Discussion of abuse potential.
14. Intravenous access: anatomy, equipment and technique.
15. Prevention, recognition and management of complications of venipuncture and other parenteral techniques.
16. Description and rationale for the technique to be employed.
17. Prevention, recognition and management of systemic complications of moderate sedation, with particular attention to airway maintenance and support of the respiratory and cardiovascular systems.

C. <u>Moderate Enteral Sedation Course Duration</u>: A minimum of *24 hours* of instruction, plus management of *at least 10 adult case experiences* by the enteral and/or enteral-nitrous oxide/oxygen route are required to achieve competency. These ten cases must include at least three live clinical dental experiences managed by participants in groups no larger than five. The remaining cases may include simulations and/or video presentations, but must include one experience in returning (rescuing) a patient from deep to moderate sedation.

Participants should be provided supervised opportunities for clinical experience to demonstrate competence in airway management. Clinical experience will be provided in managing healthy adult patients; **this course in moderate enteral sedation is not designed for the management of children (aged 12 and under)**. Additional supervised clinical experience is necessary to prepare participants to manage medically compromised adults and special needs patients. This course in moderate enteral sedation does not result in competency in moderate parenteral

sedation. The faculty should schedule participants to return for additional didactic or clinical exposure if competency has not been achieved in the time allotted.

Moderate Parenteral Sedation Course Duration: A minimum of *60 hours* of instruction, plus management of *at least 20 patients* by the intravenous route per participant, is required to achieve competency in moderate sedation techniques. Clinical experience in managing a compromised airway is critical to the prevention of emergencies. Participants should be provided supervised opportunities for clinical experience to demonstrate competence in management of the airway. Typically, clinical

experience will be provided in managing healthy adult patients. **Additional supervised clinical experience is necessary to prepare participants to manage children (aged 12 and under) and medically compromised adults.** Successful completion of this course does result in clinical competency in moderate parenteral sedation. The faculty should schedule participants to return for additional clinical experience if competency has not been achieved in the time allotted.

D. Participant Evaluation and Documentation of Instruction: Competency courses in moderate sedation techniques must afford participants with sufficient clinical experience to enable them to achieve competency. This experience must be provided under the supervision of qualified faculty and must be evaluated. The course director must certify the competency of participants upon satisfactory completion of training in each moderate sedation technique, including instruction, clinical experience and airway management. Records of the didactic instruction and clinical experience, including the number of patients managed by each participant in each anxiety and pain control modality must be maintained and available for review.

E. Faculty: The course should be directed by a dentist or physician qualified by experience and training. This individual should have had at least three years of experience, including formal postdoctoral training in anxiety and pain control. Dental faculty with broad clinical experience in the particular aspect of the subject under consideration should participate. In addition, the participation of highly qualified individuals in related fields, such as anesthesiologists, pharmacologists, internists, cardiologists and psychologists, should be encouraged.

A participant-faculty ratio of not more than five-to-one when moderate enteral sedation is being taught allows for adequate supervision during the clinical phase of instruction. A participant-faculty ratio of not more than three-to-one when moderate parenteral sedation is being taught allows for adequate supervision during the clinical phase of instruction; a one-to-one ratio is recommended during the early stage of participation.

The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses in moderate sedation must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies. These facilities may include dental and medical schools/offices, hospitals and surgical centers.

*****

Additional Sources of Information

American Academy of Pediatric Dentistry (AAPD). *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update*. Developed through a collaborative effort between the American Academy of Pediatrics and the AAPD. Available at http://www.aapd.org/media/policies.asp.

American Academy of Periodontology (AAP). *Guidelines: In-Office Use of Conscious Sedation in Periodontics.* Available at http://www.perio.org/resources-products/posppr3-1.html.

American Dental Association Council on Scientific Affairs. Acceptance Program Guidelines: *Nitrous Oxide-Oxygen Conscious Sedation Systems, 2000*. Available at http://www.ada.org/prof/resources/positions/standards/denmat.asp#ada.

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Parameters and Pathways: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParPath o1) Anesthesia in Outpatient Facilities*. Contact AAOMS at 1-847-678-6200 or visit http://www.aaoms.org/index.php.

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Office Anesthesia Evaluation Manual 7th Edition*. Contact AAOMS at 1-847-678-6200 or visit http://www.aaoms.org/index.php.

American Society of Anesthesiologists (ASA). *Practice Guidelines for Preoperative Fasting and the Use of Pharmacological Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures.* Available at http://www2.asahq.org/publications/p-178-practice-guidelines-for-preoperative-fasting.aspx.

American Society of Anesthesiologists (ASA). *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists.* Available at http://www.asahq.org/publicationsAndServices/practiceparam.htm#sedation. The ASA has other anesthesia resources that might be of interest to dentists. For more information, go to http://www.asahq.org/publicationsAndServices/sgstoc.htm.

Commission on Dental Accreditation (CODA). *Accreditation Standards* for Predoctoral and Advanced Dental Education Programs. Available at http://www.ada.org/prof/ed/accred/standards/index.asp.

National Institute for Occupational Safety and Health (NIOSH). *Controlling Exposures to Nitrous Oxide During Anesthetic Administration* (NIOSH Alert: 1994 Publication No. 94-100). Available at http://www.cdc.gov/niosh/noxidalr.html.

Dionne, Raymond A.; Yagiela, John A., et al. Balancing efficacy and safety in the use of oral sedation in dental outpatients. JADA 2006;137(4):502-13. ADA members can access this article online at http://jada.ada.org/cgi/content/full/137/4/502.

***

Resolution No. 3 New ■ Substitute □ Amendment □

Report: NA Date Submitted: July 2007

Submitted By: Council on Dental Education and Licensure

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy, Create and Transfer Knowledge (Required)

POLICY STATEMENT: THE USE OF SEDATION AND GENERAL ANESTHESIA BY DENTISTS

Background: (*Reports*:46)

Proposed Revisions to the ADA Policy Statement: The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry: The initial proposed changes to the ADA Policy Statement focused on:

- A complementary new title for the document—ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists (Policy Statement).
- Expansion of the "Introduction" section to include information on dentistry's contributions to sedation and anesthesia in dentistry and medicine.
- Revisions to reflect the restructure of the Guidelines documents from route of administration to level of sedation.

Additional Proposed Revisions Based on Comments from the Communities of Interest. In addition to the proposed revisions listed above, the Council suggests new language under the section State Regulation (Appendix, page 5037, lines 28-32) to address the use of permits and to emphasize that dentists who were providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of the revised documents are not subject to the requirements as outlined in the Policy Statement or Use Guidelines.

Resolution

3. Resolved, that the Policy Statement: The Use of Sedation and General Anesthesia by Dentists (Appendix, Worksheet:5036) be adopted, and be it further

Resolved, that the previous Policy Statement (*Trans.*1999:326, 935; 2005:334) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

APPENDIX
AMERICAN DENTAL ASSOCIATION POLICY STATEMENT: THE USE OF SEDATION AND GENERAL ANESTHESIA BY DENTISTS

(1985:577; 1994:74; 1996:327; 1998:436; 1999:326, 935; 2005:334)

Introduction

The administration of sedation and general anesthesia has been an integral part of dental practice since the 1840s. Dentists have a legacy and a continuing interest and expertise in providing anesthetic and sedative care to their patients. It was the introduction of nitrous oxide by Horace Wells, a Hartford, Connecticut dentist, and the demonstration of anesthetic properties of ether by William Morton, Wells' student, that gave the gift of anesthesia to medicine and dentistry. Dentistry has continued to build upon this foundation and has been instrumental in developing safe and effective sedative and anesthetic techniques that have enabled millions of people to access dental care. Without these modalities, many patient populations such as young children, physically and mentally challenged individuals and many other dental patients could not access the comprehensive care that relieves pain and restores form and function. The use of sedation and anesthesia by appropriately trained dentists in the dental office continues to have a remarkable record of safety. It is very important to understand that anxiety, cooperation and pain can be addressed by both psychological and pharmacological techniques and local anesthetics, which are the foundation of pain control in dentistry. Sedation may diminish fear and anxiety, but do not obliterate the pain response and therefore, expertise and in-depth knowledge of local anesthetic techniques and pharmacology is necessary. General anesthesia, by definition, produces an unconscious state totally obtunding the pain response.

Anxiety and pain can be modified by both psychological and pharmacological techniques. In some instances, psychological approaches are sufficient. However, in many instances, pharmacological approaches are required.

Local anesthetics are used to control regional pain. Sedative drugs and techniques may control fear and anxiety, but do not by themselves fully control pain and, thus, are commonly used in conjunction with local anesthetics. General anesthesia provides complete relief from both anxiety and pain.

This policy statement addresses the use of minimal, moderate and deep sedation and general anesthesia, as defined in the American Dental Association (ADA) *Guidelines for the Use of Sedation and General Anesthesia by Dentists.* These terms refer to the effects upon the central nervous system and are not dependent upon the route of administration.

The use of sedation and general anesthesia in dentistry is safe and effective when properly administered by trained individuals. The American Dental Association strongly supports the right of appropriately trained dentists to use these modalities in the treatment of dental patients and is committed to their safe and effective use.

Education

Training to competency in minimal and moderate sedation techniques may be acquired at the predoctoral, postgraduate, graduate, or continuing education level. Dentists who wish to utilize minimal or moderate sedation are expected to successfully complete formal training which is structured in accordance with the ADA's *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students.* The knowledge and skills required for the administration of deep sedation and general anesthesia are beyond the scope of predoctoral and continuing education. Only dentists who have completed an advanced education program accredited by the Commission on Dental Accreditation (CODA) that provides training in deep sedation and

general anesthesia are considered educationally qualified to use these modalities in practice.[1] The dental profession's continued ability to control anxiety and pain effectively is dependent on a strong educational foundation in the discipline. The ADA supports efforts to expand the availability of courses and programs at the predoctoral, advanced and continuing educational levels that are structured in accordance with its *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students.* The ADA urges dental practitioners to regularly participate in continuing education in the areas of sedation and anesthesia.

Safe Practice

Dentists administering sedation and anesthesia should be familiar with the ADA *Guidelines for the Use of Sedation and General Anesthesia by Dentists.* Dentists who are qualified to utilize sedation and general anesthesia have a responsibility to minimize risk to patients undergoing dental treatment by:

- Using only those drugs and techniques in which they have been appropriately trained;
- Limiting use of these modalities to patients who require them;
- Conducting a preoperative evaluation of each patient consisting of at least a thorough review of medical and dental history, a focused clinical examination and consultation, when indicated, with appropriate medical and dental personnel;
- Conducting physiologic and visual monitoring of the patient;
- Having available appropriate emergency drugs, equipment and facilities and maintaining competency in their use;
- Maintaining fully documented records of drugs used, dosage, vital signs monitored, adverse reactions, recovery from the anesthetic, and, if applicable, emergency procedures employed;
- Utilizing sufficient support personnel who are properly trained for the functions they are assigned to perform;
- Treating high-risk patients in a setting equipped to provide for their care.

The ADA expects that patient safety will be the foremost consideration of dentists who use sedation and general anesthesia.

State Regulation

Appropriate permitting of dentists utilizing moderate sedation, deep sedation and general anesthesia is highly recommended. State dental boards have the responsibility to ensure that only qualified dentists use sedation and general anesthesia. State boards set acceptable standards for safe and appropriate delivery of sedation and anesthesia care, as outlined in this policy and in the ADA *Guidelines for the Use of Sedation and General Anesthesia by Dentists.*

[1] Until the CODA accreditation cycles for those advanced education programs in deep sedation and general anesthesia are completed, the 2005 ADA *Guidelines for Teaching* remain in effect.

The ADA recognizes that office-based, ambulatory sedation and anesthesia play an integral role in the management of anxiety and pain control for dental patients. It is in the best interest of the public and the profession that access to these cost-effective services be widely available.

Research

The use of minimal, moderate and deep sedation and general anesthesia in dentistry will be significantly affected by research findings and advances in these areas. The ADA strongly supports the expansion of both basic and clinical research in anxiety and pain control. It urges institutions and agencies that fund and sponsor research to place a high priority on this type of research, which should include: 1) epidemiological studies that provide data on the number of these procedures performed and on morbidity and mortality rates, 2) clinical studies of drug safety and efficacy, 3) basic research on the development of safer and more effective drugs and techniques, 4) studies on improving patient monitoring, and 5) research on behavioral and other non-pharmacological approaches to anxiety and pain control.

***

Resolution No. 4 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: July 2007

Submitted By: Council on Dental Education and Licensure

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy, Create and Transfer Knowledge (Required)

RESCISSION OF POLICY, "DENTIST'S RIGHT TO ADMINISTER CONSCIOUS SEDATION, DEEP SEDATION AND GENERAL ANESTHESIA"

Background: (*Reports*:46)

Dentist's Right to Administer Conscious Sedation, Deep Sedation and General Anesthesia: The Council considered the 2000 ADA policy, Dentist's Right to Administer Conscious Sedation, Deep Sedation and General Anesthesia, for the purpose of revising this policy to be consistent with the proposed revised documents.

> **Dentist's Right to Administer Conscious Sedation, Deep Sedation and General Anesthesia**
> (*Trans.*2000:470)
>
> **Resolved,** that the American Dental Association supports the right of appropriately trained dentists to administer conscious sedation, deep sedation and general anesthesia for the management of dental patients and is committed to ensuring and supporting the safe and effective use of these modalities by dentists.

The same or similar language appears in the Introduction sections of all three ADA anesthesia documents. In accordance with Resolution 15H-1995, which directs that policies be reviewed for currency and usefulness on a periodic basis, the Council believes that duplicate policies are not necessary and recommends that this policy be rescinded. The Council emphasizes that this is to relocate, not eliminate the concepts in the policy.

Resolution

> **4. Resolved,** that the policy "Dentist's Right to Administer Conscious Sedation, Deep Sedation and General Anesthesia" (*Trans.*2000:470) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 5 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: July 2007

Submitted By: Council on Dental Education and Licensure

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

COMPOSITION OF THE ADA CERP COMMITTEE

Background: (*Reports*:50)

Composition of the ADA CERP Committee: Resolution 49H-2006 (*Trans.*2006:334) directed CDEL to review Resolution 82H-1996 (*Trans.*1996:706) that established the composition of the ADA CERP Committee. The Resolution also directed that the Council seek input from a focus group of dental meeting planners. In response to Resolution 49H-2006, the Council appointed an ad hoc committee to review the history of the ADA CERP program and conducted a focus group with meeting planners during the February 2007 Chicago Mid-Winter Meeting. The Council chair also charged the ad hoc committee to consider ADEA's request to allow for dentists and non-dentists to serve as the ADEA representative on the ADA CERP Committee.

History of ADA CERP. In 1992, the ADA House of Delegates adopted Resolution 25H-1992 establishing the ADA CERP (*Trans.*1992:613), including an 18-member Steering Committee (Policy Board), which set the standards and policies related to program governance, and an eight member Review Committee, which conducted the provider reviews and managed program operations. In 1995, the House of Delegates adopted Resolution 133H-1995 (*Trans*.1995:646) directing a review of ADA CERP, including the structure and function of its supporting committees. A Special Committee on ADA CERP was assigned this responsibility. The Special Committee's 1996 Report 13, Proposed Organizational Restructure of the ADA CERP Committees, proposed that the Policy Board's responsibilities be transferred to the Council on Dental Education (CDE) and the Review Committee to become a subcommittee of the CDE. The intent was for the Council to be responsible for the appointment of the ADA CERP Committee members, based on nominations made by the representing organizations. The House supported the proposal. The size of the Subcommittee was revised from 8 to 15 members representing the following communities:

- 1 American Association of Dental Schools
- 1 American Association of Dental Examiners
- 4 American Dental Association (general dentists)
- 8 ADA recognized dental specialty organizations
- 1 Canadian Dental Association

In 2002, the ADA CERP added a representative from the American Society of Constituent Dental Executives (ASCDE) to the Committee composition as a result of concerns raised by the ASCDE about ADA CERP. To date, both individuals who have served as ASCDE representatives have been non-dentists.

Focus Group Input. The Council reviewed input received from the Conference of Dental Meetings during the February 2007 Chicago Mid-Winter Meeting. In general, the meeting planners in attendance believed that it is important for a representative from their community to participate in ADA CERP because meeting planners are responsible for ensuring that their organizations and speakers comply with ADA CERP standards.

ADA CERP Committee Input. The ADA CERP Committee did not support the proposal to add a meeting planner to the Committee noting that almost all of the ADA CERP-approved providers and organizations represented on the ADA CERP Committee have meeting planners within their organizational structures. The Council agreed, also noting that dental meeting planners' concerns typically focus on procedural matters, rather than CE content or speaker qualifications, and unlike all other organizations represented on the ADA CERP, the Conference of Dental Meetings is not a formalized organization/agency. The Council also agreed with the Committee to support ADEA's request that it be permitted to nominate a dentist or a non-dentist to serve on the ADA CERP Committee, noting that former and current ASCDE representatives on the ADA CERP Committee are not dentists.

The Council concluded that the current composition of ADA CERP is appropriate and that the House's intentions for the four ADA appointees to be general dentists should be maintained. Further, all dentist representatives serving on the Committee must be ADA members. The Council believed that the ADA CERP Committee should not be expanded to include dental meeting planners at this time, but that the composition of the Committee should be revisited periodically to ensure that it accurately reflects the continuing dental education communities of interest. Accordingly, the CDEL presents the following resolution for consideration. This resolution supports the ADA Strategic Plan Goal: Create and Transfer Knowledge.

Resolution

5. Resolved, that the ADA policy on the Organizational Restructure of the ADA CERP Committees (*Trans*.1996:705) be amended as follows [deleted language struck through; additions are underscored]:

> **Resolved,** that responsibility for the conduct of the American Dental Association's Continuing Education Recognition Program (ADA CERP) be transferred from the existing ADA CERP Policy Board to the Council on Dental Education, and be it further
>
> **Resolved,** that a continuing education subcommittee of the Council be created to facilitate the conduct of the ADA CERP by developing expertise and making recommendations regarding continuing education provider recognition for consideration by the Council, and be it further
>
> **Resolved,** that the continuing education subcommittee shall have the following composition: one representative each representing the ~~dental education community~~ American Dental Education Association, the ~~dental licensure community~~ American Association of Dental Examiners, the parent organizations of the ADA-recognized dental specialties, the ~~dental profession in Canada~~ Canadian Dental Association, the American Society of Constituent Dental Executives and four American Dental Association general dentists, and be it further

Resolved, that all representatives who are dentists be members of the American Dental Association or the Canadian Dental Association. , and be it further

Resolved, that the CERP Standards and Criteria for Recognition and related program documents be revised to reflect this change in program governance.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: CDEL/CEBJA Joint Report Date Submitted: July 2007

Submitted By: Council on Dental Education and Licensure/Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy; Create and Transfer Knowledge (Required)

COUNCIL ON DENTAL EDUCATION AND LICENSURE AND COUNCIL ON ETHICS, BYLAWS AND JUDICIAL AFFAIRS JOINT REPORT TO THE HOUSE OF DELEGATES: INTEGRITY AND ETHICS IN DENTAL EDUCATION

Background: As a result of allegations of cheating in 2006 and 2007 by dental students and graduates on graduation requirements, national board examinations and clinical licensure exams, the Council on Dental Education and Licensure (CDEL) proposed to the Board of Trustees that stakeholders be convened to address an apparent increase in unethical and unprofessional behaviors. Believing that the ADA should do more to ensure that all students and graduates of dental schools appreciate the special position of trust they will have within society, Board members supported the proposal and approved supplemental funding for a June 7-8, 2007 Symposium. The American Dental Education Association (ADEA) and the American College of Dentists (ACD) were invited to join in this effort and welcomed the opportunity to participate. The CDEL and the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) sponsored the event in collaboration with and with financial support from ADEA and ACD.

A total of 78 participants, including key stakeholders and national experts on ethics, convened to understand the context of ethical misconduct in dental schools and explore innovative approaches to furthering ethics and integrity in education. Participants represented the ADA, ADEA, ACD, the American Society for Dental Ethics (ASDE), the American Association of Dental Examiners (AADE), the American Student Dental Association (ASDA), the Commission on Dental Accreditation, and the Joint Commission on National Dental Examinations. The overall goals of the Symposium were to (1) engage organizations and thought leaders in a discussion on ethical behavior and professionalism and what that means in today's educational and practice environment; (2) foster an increased awareness of ethical issues and an urgency to address any gaps throughout the profession on this issue; and (3) identify and demonstrate educational programs that may stimulate students' interest and commitment to professional integrity within the dental profession.

Stakeholders heard opening remarks from the presidents of ADA, ADEA and ACD followed by brief presentations from deans of several dental schools where incidents of cheating occurred. Dr. Mark G. Brennan, University of Kent, Canterbury, UK, presented a keynote address on a broad look at professional codes and ethics in education followed by questions and answers. On the second day, participants listened to wide-ranging diverse perspectives on ethical issues among other professions and within dentistry. For example, an ethics professor at the Air Force Academy noted that institutional expectations about ethical behavior increase as cadets move from the first year to graduation with steeper

punishment inflicted on violators as they get closer to graduating. The professor observed in comparison that the reverse seems to be true in dental education. Participants got a glimpse of how medicine views the importance of ethics and professionalism when hearing how the Accreditation Council for Graduate Medical Education (ACGME) developed an outcomes project to assess the professional competencies among medical residents. Mega issue questions followed by interactive discussions took place during the breakout sessions. Participants agreed that the profession needs to take a closer look at itself to continue to ensure that dentistry remains a profession the public can trust.

By the end of the Symposium, participants concluded that there were no simple or quick answers to the complex ethical issues facing students, dental schools and the entire profession. ADEA, ASDA, ACD and AADE representatives felt that the communities of interest must continue to work together on the issues. The role of the Symposium attendees was to discuss the issues and present suggestions for action and long-term strategies for consideration by CDEL and CEBJA at their meetings in November 2007 and for other stakeholders as appropriate. Both of these Councils have representatives from ADEA, ASDA, ACD and AADE to provide input from the key stakeholders. Some of the suggestions follow:

- Create a dental school environment that fosters pride and honor to be members of the dental profession— including faculty role modeling
- Encourage integrity to be the normative behavior – this is what is expected at all levels (students, faculty, practitioners)
- Emphasize positive messages in honor codes along with appropriate consequences for unethical behavior and positive reinforcement for ethical behavior
- Create harmony with dental school codes and ASDA's code and consider amending the ADA *Code* to add an aspirational statement on the ADA's expectations regarding student integrity with the caveat that students are under the disciplinary jurisdiction of the dental schools
- Reexamine the admissions process; consider development and use of tools that can assess an applicant's professionalism
- Encourage development and use of more online courses in ethics and offerings for members of ADA, ADEA, ASDA and ACD at annual sessions
- Encourage dental schools to require faculty/staff to understand and stay current with technology
- Urge the Commission on Dental Accreditation to develop a consistent ethics standard for predoctoral and advanced dental education programs
- Consider establishment of an ADA task force to look into this issue further and support the development of best practices for addressing unethical behavior in dental education
- Develop case studies to be used throughout the dental school curriculum
- Coordinate efforts with the broader academic community to address cheating occurring in early years, such as middle schools

The theme of the Symposium continues at ADEA's Deans Conference in November and into 2008 when the ADA and ADEA co-host the March 9-10, 2008, AADE Mid-Year meeting. The focus at this meeting will be integrity and ethics in dental practice and the implications for regulatory agencies. In addition, the Commission on Dental Accreditation will conduct a mega issue discussion in July 2007 on the role of accreditation in advancing ethical behavior within the profession.

Resolutions

This report is informational in nature and no resolutions are presented.

BOARD COMMENT: The Board of Trustees reviewed the report on the Symposium and noted that CDEL and CEBJA intend to discuss the issues at their November 2007 meetings. The Board accepted the report of the Symposium for transmission to the House of Delegates. However, the Board believed that these issues are of critical importance to the profession and that it is important for the ADA to act immediately and to take a leadership role in developing actions to address the challenges related to ethics and professionalism in students and the dental education environment. To expedite the process, the Board adopted the following resolution.

B-68-2007. Resolved, that the Council on Dental Education and Licensure and the Council on Ethics, Bylaws and Judicial Affairs develop recommendations for advancing ethics and professionalism in dental schools that begin with the evaluation of candidates for admission to dental schools and follow through the dental education process, and be it further

Resolved, that the councils utilize consultants as needed from the American Dental Education Association, the American Association of Dental Examiners, the American Student Dental Association, the American College of Dentists and any others it deems appropriate, and be it further

Resolved, that the councils study and include in their evaluation what other professional disciplines are doing to accomplish common core requirements that might aid dental schools in developing common discipline modalities, and be it further

Resolved, that the councils submit a proposal to the Board seeking funding, if necessary, and give progress reports to the Board of Trustees with a final report for the 2008 House of Delegates.

Resolution No. 38 New ■ Substitute □ Amendment □

Report: NA Date Submitted: September 11, 2007

Submitted By: Second Trustee District

Reference Committee: Dental Education and Related Matters

Total Financial Implication: $23,300

Amount One-time $ $23,300 Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

ADA POLICY ON REQUIREMENT OF A YEAR OF POST-GRADUATE CLINICAL TRAINING FOR ALL DENTAL SCHOOL GRADUATES

The following resolution was submitted by the Second Trustee District and transmitted on September 11, 2007, by Mr. Roy E. Lasky, secretary, Second Trustee District Caucus.

Background: In 1926, the Gies report, "Dental Education in the United States and Canada," recommended that dentists receive two years of academic college followed by three years of dental school for general practitioners. The report also recommended an optional one or more years of graduate training, stating that "students cannot be made a finished product in a real sense" following dental school alone. That the time has come to examine how to best train and prepare doctors – physicians and dentists – for practice in the 21st century is indisputable.

New York State is the first state to require a year of post-doctoral training for all new dental school graduates as a condition for licensure. New York passed the law establishing this requirement based on the New York State Dental Association's (NYSDA) recommendations. NYSDA's recommendations resulted from deliberation by its Council on Dental Health Planning and Hospital Dentistry. The council began by analyzing dental education. The council was concerned about the ability of existing dental schools and curricula to incorporate the scope of necessary scientific, pre-clinical and clinical information and experience within the confines of the four-year training period. In this endeavor, the council consulted with dental educators from New York's dental schools and hospital training programs. The Council then considered the potential benefits that could be achieved by an additional year of clinical experience following graduation from dental school. These benefits include:

- a sound transition between the dental school to the real world of dental practice
- continuation of the maturation or socialization process through which the individual becomes a "full-fledged" dentist
- expands and enhances competencies by filling in potential gaps in experience that were not available due to limited opportunities in dental curriculum.
- the opportunity to and coordinate with dental hygienists and assistants and work with dental office staff
- additional clinical experience in more of a more "real world" setting
- experience in a patient-centered system of care, rather than student-centered system of education
- experience with modern management systems and opportunity to develop efficiency in provision of care
- experience in a system with continuity of patient care and an opportunity to use quality assurance measures in patient care

- the opportunity for experience working in groups of general dentists and specialists as well as other health care professionals
- exposure to greater variety of patients including experience treating those with complex medical problems that are becoming more common due to population demographics
- if serving in underserved areas, the potential to increase cultural competency and comfort in working with diverse populations
- potential for rural and underserved areas to attract and retain graduates who might not otherwise consider such geographic areas for practice opportunities
- provides grounded, clinical experience for those who may want to seek career in academia, industry or non-clinical occupation.
- provides opportunities for research and publication experiences.

The post-doctoral year provides two significant additional benefits to the new dentist and the public. First, it increases access to care for underserved populations. Second, it provides potential economic benefits for the graduate dentist both through the potential for educational loan repayment programs associated with services provided in underserved areas and the compensation that these dentists would receive for their clinical services.

NYSDA's conclusions are consistent with those reached by other dental educators and scholars who agree that a year of post-graduate clinical training better prepares graduates with the skills required for practice today and in the future. As noted above, it has additional benefits for the public and the profession as well. Among those supporting the need for a year of post-graduate clinical training, the 1995 Institute of Medicine (IOM) report "issued a clarion call for general practice residency (GPR) and advanced education in general dentistry (AEGD) programs to provide a continuum of education for general practitioners".

In 2004, the Journal of Dental Education published Dr. Howard L. Bailit's report entitled, "The Origins and Design of the Dental Pipeline Program." Dr. Bailit describes the efficacy of a program designed to reduce disparities in access to dental care in part by exposing dental students and residents to "patient-centered community clinics and practices serving underserved populations". Post-graduate training settings usually provide access to underserved patient populations. Not only is the post-graduate experience beneficial to the new dentist, it can significantly improve patient access to oral health care."

The dean of the Harvard School of Dental Medicine, Dr. R. Bruce Donoff's article, "It is Time for a New Gies Report," was published in the ADA's Journal of Dental Education in 2006. Dr. Donoff's principal recommendation includes support for a post-doctoral year of clinical experience. Further, in 2006, the American Dental Education Association (ADEA) held a summit on dental education. One outcome of the summit also is the recommendation that all dental school graduates be required to complete a year of post-graduate clinical training.

Last but not least, the ADA's own "Future of Dentistry Report" includes two related recommendations supporting the requirement of a year of post-graduate clinical training for all dental school graduates. It is time for the ADA to embrace these recommendations and adopt policy supportive of a required year of post-graduate training for all dental school graduates.

Resolution

38. Resolved, that the American Dental Association adopt policy supporting the requirement of a year of post-graduate clinical training for all dental school graduates, and be it further

Resolved, that the ADA develop lobbying efforts in support of increased funding for programs sufficient to offer all future dental graduates the opportunity for further clinical training following dental school graduation.

BOARD COMMENT: The Board agrees with the Second District that there are many potential benefits that could be achieved by an additional year of clinical experience. Currently, approximately 48% of students apply to a postdoctoral education program and approximately 35-40% are accepted and enroll. A recent American Dental Education Association (ADEA) survey indicates that only 27.8% of senior dental students believe a year of postdoctoral education should be required. Over 90% of students have educational debt. ADA surveys show that there are approximately 4,500 dental graduates annually but only 2,900 first-year positions in postdoctoral education programs. Lack of funding and faculty shortages appear to be obstacles to expanding the number of programs. Currently, there are no estimates of other potential opportunities that might qualify as "postgraduate clinical training." Further, the nature of this clinical experience should be more clearly defined. While the emphasis should be on enhancing the clinical education and experience of new dental graduates, expanded access to care should be an important goal and outcome. The Board believes that it is also important to emphasize that this is not a "PGY1 licensure" issue.

The Board believes that there are a number of issues that must be resolved before such a policy could be implemented. Therefore, the Board recommends that a workgroup be convened to explore the challenges and opportunities for implementing this requirement, to define the types of experiences that would qualify and to outline a plan for implementation. The financial implication includes funding for two, two-day meetings for a workgroup of seven people, miscellaneous expenses and support for attendance of up to three external consultants at one meeting. The workgroup should submit its recommendations to the 2008 House of Delegates. Although the Board supports lobbying efforts for funding for such programs, the Board believes that the program and requirements should be more clearly defined before this resolution is considered. The Board therefore recommends adoption of the following substitute resolution.

38B. Resolved, that the American Dental Association convene a workgroup appointed by the president to develop a proposed policy regarding a required year of post-graduate clinical education, experience and/or clinical service for all new dental school graduates and a plan for transition and implementation of the requirement, and be it further

Resolved, that the workgroup present its recommendations to the 2008 House of Delegates.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

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. 38B

Resolution No. 39 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 12, 2007

Submitted By: Ninth Trustee District

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

ACCREDITATION STANDARDS FOR DENTAL HYGIENE EDUCATION PROGRAMS

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: In July 2007, the ADA Commission on Dental Accreditation (CODA) considered comments from the communities of interest on proposed revisions to the Accreditation Standards for Dental Hygiene Education Programs.

Seventeen constituent dental societies and four ADA Councils (Dental Education and Licensure; Dental Practice; Access, Prevention and Interprofessional Relations; and Government Affairs) submitted comments concerned about the use of the term "dental hygiene diagnosis." The Council on Dental Education and Licensure believed that the term diagnosis is inappropriate in Standard 2-17 because only a dentist may assume this responsibility (*Reports* 2007:40). The Commission was requested to consider changing the language in the proposed document (page 23, Standard 2-17, under the title Planning) by substituting the term "dental hygiene diagnosis" with the term "dental hygiene assessment."

Rather than changing the term, CODA adopted the following definition for inclusion in the Accreditation Standards document: *"Dental Hygiene Diagnosis: Identification of an Existing or Potential Oral Health Problem that a Dental Hygienist is Qualified and Licensed to Treat*." The definition suggests that there are dental hygiene diseases or conditions, which are distinctive from dental disorders and conditions, which is a fallacy. Nowhere else in the CODA document is dental hygiene examination and diagnosis addressed. The accreditation standard describes the gathering of clinical observations and data, which more correctly should lead to an assessment rather than the more comprehensive and definitive analytical result of a diagnosis, which requires a much broader background of education and experience than the current dental hygiene education provides. Moreover, it ignores the fact that, under state law, making a diagnosis is generally treated as the practice of dentistry.

The adoption of this definition by CODA ignores the fact that there are many technical procedures that dental hygienists are legally licensed to perform but for which they do not have the training to make and determine a treatment plan for a specific patient. For example, the simple fact that in most states dental hygienists are legally licensed to perform dental scaling and root planing does not mean they have the extensive education and training that is necessary in order for them to diagnose the need for scaling and

root planing. Using the CODA response, dental hygienists may be even more assertive in approaching policymakers and arguing that it is the expectation of the accreditation process that dental hygienists have the ability to diagnose the need for any procedure they are clinically capable and licensed to perform under state statutes. Hygienists may seek to argue that state legislatures need not require dentist supervision, examination or diagnosis for any procedures a dental hygienist performs. With the diagnosis definition, CODA is essentially relinquishing the curriculum scope to the state legislatures.

Resolution

39. Resolved, that the ADA Commission on Dental Accreditation be urged to reconsider and revise the Accreditation Standards for Dental Hygiene Education Programs by substituting the term "dental hygiene diagnosis" with "dental hygiene assessment" to more accurately reflect the scope of the training and licensure of the dental hygienist in the process of providing dental care to patients, and be it further

Resolved, that CODA be urged to remove the definition of dental hygiene diagnosis from the standard.

BOARD RECOMMENDATION: Vote Yes.

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. 39

Resolution No. 40 New ■ Substitute □ Amendment □

Report: NA Date Submitted: September 13, 2007

Submitted By: Alaska Dental Society

Reference Committee: Dental Education and Related Matters

Total Financial Implication: $308,000 (for one program-DHAT)

Amount One-time $ 156,000 Amount On-going $ 152,800

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

INDEPENDENT VERIFICATION OF GRADUATES OF DENTAL EDUCATION PROGRAMS

The following resolution was submitted by the Alaska Dental Society and transmitted on September 13, 2007, by Mr. Jim Towle, executive director.

Background: The concessions made by the ADA when it entered into the settlement agreement following the Alaskan trial judge's summary judgment allow persons with a minimal of didactic and clinical training to perform irreversible procedures as a routine part of their daily "professional" employment. Therefore, it is appropriate that the ADA House of Delegates recognize the potential risk to the patients under the care of these non-licensed persons. To that end, it is appropriate that the ADA authorize the establishment of a process whereby "dental education programs" that graduate students who will be entitled to treat patients in settings where they are not under the direct supervision of a licensed dentist, or where a licensed dentist is not required to be available to assist in the delivery of therapeutic procedures, to ensure that these "therapists" are competent to perform the procedures they're authorized to do. This verification of their knowledge and skills should be, at a minimum, provided by licensed dentists, who are independent of the educational institution and of the corporations or organizations that employ these dental therapists.

The current standards that dentists are expected to meet in order to be licensed to practice exist, in large part, because the existing licensure process includes independent testing by examinations developed and conducted by dentists who are independent of the nation's dental schools and the employers of dentists. As a result, Americans have, until now, enjoyed dental care that is arguable the finest and safest in the world.

The ADA owes it to the public it serves to ensure that this basic safeguard of verification of skills and education by dentists independent of the schools that train and the employers who pay should continue in the new paradigm whereby the ADA accepts dental health aide therapists performing those irreversible procedures that have heretofore been limited to licensed dentists.

Resolution

40. Resolved, that the ADA will work vigorously to establish a process whereby graduates of non-accredited programs of dental education, whose graduates are employed to treat patients in settings or circumstances where a dentist is not present, or can not be promptly summoned and

are not required to be licensed or certified by the state in which they are providing treatment, shall be evaluated, including an examination of their clinical skills, by an independent committee, comprised of licensed dentists, to determine that they have achieved a level of knowledge and skills adequate to perform at a level skill equal to dentists or other state licensed practitioners who provide the same services.

BOARD COMMENT: The Board disagrees with the implications of the last paragraph of the background statement and believes that ADA participation in the quality evaluation of these graduates could give the impression that the ADA recognizes and supports the use of these dental health aide therapists as mid-level providers.

The Board does not believe the ADA should be delivering clinical examinations to graduates of non-accredited dental education programs. To do so, would be very costly and would be duplicative of processes that might already available in the dental examining community from groups that have existing resources and processes in place as well as the expertise to conduct such evaluations.

BOARD RECOMMENDATION: Vote No.

BOARD VOTE: UNANIMOUS.

Resolution No. 54 New ■ Substitute ☐ Amendment ☐

Report: Board Report 14 Date Submitted: September 2007

Submitted By: Board of Trustees

Reference Committee: Dental Education and Related Matters

Total Financial Implication: $2,000,000

Amount One-time $ 2,000,000 Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

REPORT 14 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: UPDATE ON ALLIED DENTAL PERSONNEL WORKFORCE MODELS

Background: The 2006 ADA House of Delegates approved two resolutions related to new allied dental personnel workforce models:

Resolution 3H-2006: Expanded Duties for Allied Dental Personnel

3H-2006. Resolved, that the American Dental Association supports the model for expanded duties for allied dental personnel as presented in the Report of the Workforce Task Force with the exception that references to "formal education" and "Certification Required" be changed to "additional education and a certificate of completion as determined by each state board of dentistry" wherever this reference occurs, if and when the model is put into practice, and be it further

Resolved, that the constituent dental societies in consultation with state boards of dentistry be urged to review the model and determine its possible applicability in their states, and be it further

Resolved, that the President, in consultation with the chair of the 2005-2006 Task Force, appoint a work group of five individuals from the Task Force to design and develop pilot projects that can be carried out to test the "oral preventive assistant" (OPA) model in selected states or locales, and be it further

Resolved, that the relevant constituent dental societies and licensing boards be urged to collaborate on these pilot projects, and be it further

Resolved, that a form of short and long term data collection and evaluation be developed to support documentation of the progress that the pilot projects and other models outlined by the Task Force have made in private practice, community clinics, underserved areas, and other innovative dental care delivery systems, and be it further

Resolved, that the Board of Trustees provide a progress report to the 2007 House of Delegates on the status of the pilot projects and other aspects of the Workforce Task Force Report, and be it further

Resolved, that the Report of the Workforce Task Force 2006 is a guide for states to develop programs.

Resolution 25H-2006: The Community Dental Health Coordinator Proposal

25H-2006. Resolved, that the ADA establish a National Coordinating and Development Committee (members appointed by the President in consultation with the Resolution 96H-2005 Committee) to create a Community Dental Health Coordinator (CDHC) model training program including a complete curriculum with implementation and evaluation guidelines consistent with the Report of the Dental Workforce Task Force 2006, and be it further

Resolved, that the Coordinating and Development Committee issue the RFP by November 2006, and be it further

Resolved, that the Coordinating and Development Committee oversee the implementation of at least three pilot CDHC training programs in 2007-2008, and be it further

Resolved, that the Coordinating and Development Committee evaluate the overall success and impact of the pilot programs in training individuals to function in the role of a CDHC and establish an ongoing process for assessment of the impact of this provider on improving access to dental care and reducing disparities of dental care in their communities, and be it further

Resolved, that the Coordinating and Development Committee report progress on this activity to the 2007 House of Delegates.

Workforce Models National Coordinating and Development Committee: In accord with the resolutions, the Workforce Models National Coordinating and Development Committee (NCDC) was established to create a Community Dental Health Coordinator (CDHC) model training program, including a complete model curriculum and evaluation guidelines consistent with the Report of the Dental Workforce Task Force 2006. Because the skill set of the Oral Preventive Assistant (OPA) is a subset of the CDHC skill set, the Committee was assigned the development of the OPA curriculum as well.

The NCDC has been charged to identify funding to pilot the training program in at least three sites selected via the RFP process and to monitor the pilot programs and report progress to the ADA Board of Trustees and the ADA Foundation.

Individuals appointed to the NCDC have expertise in dental and allied dental education, dental industry, dental public health, government affairs, foundations, and community health clinics. Dr. Robert Brandjord chairs the NCDC. Committee members include Dr. Amid Ismail, Dr. John W. McFarland, Dr. Kathy O'Loughlin, Dr. Vincent Filanova and Dr. Ken Rich. Ex-officio members include Dr. Kathleen Roth, Dr. Mark Feldman and Dr. James Bramson.

NCDC Curriculum Committee: The NCDC Curriculum Committee was established to assist the NCDC in fulfilling its assignments. The Curriculum Committee is composed of individuals with expertise in dental education, dental practice, dental public health, community health clinics, health promotion, instructional design, certification, licensure and accreditation: Dr. Amid Ismail, chair, Dr. Paul Glassman, Dr. Marshall W. Kreuter, Ms. JoAnn Nyquist, Dr. Judith Skelton, Adm. Carol Turner, and Dr. Robert J. Weyant, members.

Progress to Date: The NCDC and the Curriculum Committee met numerous times in person and via teleconferencing during this past year. Their progress has been reported to the Board of Trustees.

Phase 1 of the project called for the development of a model CDHC training program. The 18-month training program will prepare individuals to work under a dentist's supervision in health and community

settings such as schools, churches, senior citizen centers, Head Start Programs, and other public health settings with people similar to their own ethnic and cultural background. Particularly in low income communities and rural areas, they will promote oral health and provide preventive services, including screenings, simple teeth cleanings, fluoride treatments, placements of sealants and placement of temporary fillings. This new team member will increase access to dental care and has the potential to increase the number of Medicaid recipients or residents in an area who see a dentist.

With a $334,000 grant from the ADA Foundation, the Curriculum Committee began Phase 1 in November 2006, drafting the full CDHC and OPA curriculum plans and education outcome assessment models. The model program includes a comprehensive curriculum with objectives, outlines, teaching resources, learning activities and evaluation mechanisms. The draft, "Community Dental Health Coordinator Curriculum: Community Health Worker and Health Promotion Skills and Dental Skills" (Appendix 1), briefly outlines the 15 training modules and includes the foundation knowledge and clinical/practical skills for each module. The modules were prepared by a cadre of curriculum writers with expertise in their assigned subjects with oversight by the Curriculum Committee. All curriculum documents will be completed by December 2007.

Phase 2 calls for the CDHC model training program to be piloted in at least three sites, i.e., urban, rural and Native American reservations. Pending funding, each institution selected to participate in Phase 2 will recruit and train approximately 18 CDHCs in the 3-year period starting in 2008. Each pilot site will work with a coordinating committee that includes representatives of agencies such as the state board(s) of dentistry, dental association(s), Indian Health Service, tribal councils, and dental academic institution(s) where the pilot projects are conducted, as well as the NCDC.

Phase 2 also encompasses a follow-up study to evaluate the overall success of the pilot programs in training individuals as well as in improving access to dental care and reducing disparities of care in the selected communities. This evaluation will be conducted by a national evaluation team and coordinated by the NCDC.

In February 2007, the ADA circulated a call for letters of interest to institutions interested in participating as a pilot training site. Eight letters were received, each addressing the following requirements:

1. Affiliation with a dental, advanced dental, dental hygiene or dental assisting program accredited by the ADA Commission on Dental Accreditation.

2. Commitment from a state coordinating committee (e.g., state board of dentistry, state or local dental society, academic institution) to collaborate on the development of the proposed program.

3. Commitment from a leading community organization representing the targeted community that can play a key role in planning and implementation of the pilot program (e.g., local departments of health, tribal councils, community health organizations; local public health associations; and faith-based organizations).

4. Commitment from community health centers, preferably Federally Qualified Health Centers, or private practices devoted to serving individuals residing in areas with no or limited access to care to collaborate on the development of the proposed program. [The number of clinical sites to be determined based on the number of proposed trainees.]

5. Agreement to establish admissions criteria for the pilot program that includes a high school diploma or its equivalent. [Bilingual candidates should be encouraged to apply. Applicants to the

program may be, but need not be limited to: high school graduates, college students/graduates, social workers, dental assistants, dental hygienists, dentists, and other healthcare providers.]

6. Agreement to establish a certificate of completion that is awarded by the institution, attesting to the graduate's completion of all program training requirements and competencies. [Achievement of each core competency to be clearly specified on the certificate.]

7. Agreement to work with the NCDC in implementation and coordination of all activities of the pilot program.

8. Agreement to work with the national evaluation team by collecting and sharing of outcome measures.

Throughout this year, Association leaders made dozens of presentations on the CDHC model to local, state and national dental and public health organizations and foundations. Some of the larger external presentations were or are planned for the National Oral Health Conference, the Academy of General Dentistry's Council on Governmental Affairs, and the American Dental Assistants Association. On April 13, 2007, the CDHC program was the focus of an ADA-sponsored Webinar with 87 constituent Presidents and Executive Directors.

Several presentations and mega issues discussions on workforce models were conducted by Association agencies, including the Board, CODA, CDEL, and CAPIR. Panelists included experts on the CDHC model, the American Dental Hygienists' Association's Advanced Dental Hygiene Practitioner (ADHP) model, and the DHAT model. Representatives of regulatory agencies also participated to share their perspectives on creating and regulating new allied dental personnel categories.

Association representatives have networked with potential funding sources and the NCDC has researched more than 100 foundations and federal grant-making agencies for possible funding. Local funding support for the CDHC pilot programs has also been encouraged.

During the summer, the NCDC carefully reviewed the letters of interest and selected the Michigan Coalition for Development and Implementation of the Community Dental Health Coordinators, in collaboration with the Wayne County Community College as a pilot training site. The Committee identified several other candidates in Arizona, California, Montana, Oklahoma and South Dakota, but believed that site visits to some of the potential sites would be necessary before final selections could be made in the late fall of 2007. Final selections will be based on:

- Potential impact on the target community;
- Potential to produce graduates for target community;
- Demonstrated commitment to the program by the grant applicant;
- Potential for continuous program operation;
- Demonstrated collaboration among the communities of interest; and
- Originality, creativity and innovation.

Next Steps: Simultaneously with final site selections, the NCDC must continue to look for funding for the pilot programs, estimated to be approximately $300,000 per site, per year, for three years. However, specific funding requirements of a site will vary depending on the facilities, equipment, faculty, and staffing costs for that particular sponsoring institution. Potential financial support for each site will also vary based on specific local, state, federal and or private agencies and foundations that are identified by the site in collaboration with the NCDC and the ADA.

In addition to the costs of operating the pilot programs, there are administrative costs related to the NCDC's oversight of the project in 2008. Specifically, the NCDC and its Evaluation Committee will need to meet at least twice during the year, conduct site visits to the pilot programs and oversee consultant services that will analyze the effectiveness of the curriculum and make the necessary modifications.

On September 18, 2007, Dr. Robert Brandjord provided the Board with an update on the NCDC's activities and shared examples of the curriculum modules drafted to date. The Board was impressed with the scope and depth of the draft documents, noting that the 15 modules include individual lessons with syllabi, faculty guides, student handouts, student activities, PowerPoint presentations with scripts, performance evaluations and examinations. Board members were pleased to learn that the modules have been designed for online delivery.

Dr. Brandjord also reported on the recent site visits. Decisions regarding the pilot site locations should be made no later that December 2007.

In regarding to funding, the Board discussed a number of federal, national and state funding agencies/sources that are very interested in the CDHC pilot program. The Board recognized that many of these groups look more favorably upon pilot programs that have private and local funding support as well and concluded that funding from the ADA must be made available to demonstrate the Association's commitment to this new model.

In summary, the Board vigorously endorsed the CDHC model and concluded that the Association must take the necessary steps to ensure that the pilot training programs can begin in 2008. The Board recommends that a maximum of $2,000,000 from reserves be allocated to fund the selected pilot programs over the three year period and that the NCDC work closely with each selected pilot to identify complementary funding from other sources. Accordingly, the following resolution is submitted by the Board of Trustees.

Resolution

54. Resolved, that the Board of Trustees encourages the Workforce Models National Coordinating and Development Committee (NCDC) to complete Phase 1 of the CDHC workforce model initiative, i.e., the comprehensive CDHC curriculum, by December 2007, and be it further

Resolved, that the Board strongly supports Phase 2, i.e., piloting and evaluating the model training program in at least three sites, with at least 6 students per year per site, over a 3-year period, and be it further

Resolved, that the Workforce Models National Coordinating and Development Committee select the pilot sites on or before December 2007, and be it further

Resolved, that up to $2,000,000 from reserves be allocated to fund selected pilot programs over a 3 year period, and be it further

Resolved, that the ADA Executive Director, in cooperation with the NCDC, oversee the allocations of these funds and work with each pilot site to seek additional local funding to complement the ADA funding where feasible, and be it further

Resolved, that the Board of Trustees provide a progress report to the 2008 House of Delegates on the status of the CDHC pilot project.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Appendix 1

COMMUNITY DENTAL HEALTH COORDINATOR CURRICULUM

Community Health Worker and Health Promotion Skills

&

Dental Skills

Revised September 11, 2007

It is the vision of the American Dental Association that the Community Dental Health Coordinators will assist in the reduction of disparities in oral health and improving access to dental care through organized community development in an integrated dental care system provided in community-based clinics. The Community Dental Health Coordinator will provide oral health promotion, prevention, palliative care and patient navigation.

TABLE OF CONTENTS

Modules 1 through 14 will be completed in a maximum of 12 months. Module 15 requires 3-6 months of on-site practice depending on prior experience of the student. This document is based on the American Dental Association Workforce Models Task Force Report June 2006

Competencies of the Community Dental Health Coordinators*

1. The CDHC must be competent in the development and implementation of community-based oral health prevention and promotion programs.
    a. Support water fluoridation programs
    b. Collaborate and develop community oral health initiatives
    c. Collaborate and develop oral health programs with other health and social services organizations and providers to promote oral health (e.g., Women, Infants and Children Programs, Head Start, mental health organizations, healthy baby initiatives, long-term care providers, hospices, senior citizen centers, substance abuse clinics, cancer societies, chambers of commerce, local businesses, school boards)

2. The CDHC must be competent in the knowledge and skill required to collect diagnostic data.
    a. Medical and dental histories
    b. Dental health screening/assessment (data collection) via:
        1. Visual inspection of the oral cavity for carious lesions and other hard tissue anomalies
        2. Visual soft tissue inspection
        3. Take radiographs, when appropriate
    c. Vital Signs
    d. Dental Charting

3. The CDHC must be competent in the knowledge and skill required to perform a variety of clinical supportive treatments:
    a. Practice infection and hazard control protocol consistent with published professional guidelines
    b. Prepare tray set-ups
    c. Prepare and dismiss patients
    d. Apply topical anesthetics (not realistic for CDHC per Curriculum Committee)
    e. Assist with or apply fluoride agents
    f. Process and store digital radiographs
    g. Provide oral health instruction
    h. Maintain accurate patient treatment records
    i. Maintain operatory area and dental equipment in a community setting.
    j. Assist in the management of medical and dental emergencies
    k. Administer basic life support
    l. Clean removable oral appliances and prostheses in community settings

4. The CDHC must be competent in the knowledge and skill required for administrative procedures:
    a. Collaborate with community partners including telephone management and communication skills
    b. Maintain supply inventory
    c. Control appointments and manage recall systems
    d. Operate business equipment, including computers
    e. Complete and process appropriate reimbursement papers and online forms.
    f. Facilitate basic legal and regulatory compliance, (e.g., HIPAA, Informed Consent)

5. The CDHC must be competent in the knowledge and skill required to prioritize population/patient groups:
    a. Identify potential emergent dental care needs
    b. Communicate findings to the supervising dentist using electronic or paper transmissions
    c. Revise the screening/assessment based upon dentist directive
    d. Develop a referral recommendation and submit it to the dentist for approval
    e. Develop an oral preventive recommendation and submit it to the dentist for approval

6. The CDHC must be competent in the knowledge and skill required to provide individual preventive services based upon plans, including:
    a. Oral hygiene education
    b. Tobacco cessation
    c. Dietary counseling
    d. Fluoride applications
    e. Sealant applications
    f. Coronal polishing
    g. Scaling for periodontal Type I (gingivitis) patients in community settings

7. The CDHC has the knowledge and skill required to temporize dental cavities in preparation for restorative care by a dentist:
    a. Hand instrumentation only
    b. Only open cavities that are accessible to hand instruments
    c. Manual removal of debris from cavities
    d. Placement of temporary materials such glass ionomer materials

*Based upon the American Dental Association Workforce Models Task Force Report, June 2006

Community Health Worker and Health Promotion Skills

Module 1: Advocacy and Outreach

Foundation Knowledge

1. Community health workers: historical perspective and future development in the field
2. Definition of health from a community perspective
3. Social, behavioral, cultural, community, and environmental determinants of health
4. Public health practice
5. ABC of advocacy in local communities
6. How to build and maintain social networks

Community organizational skills

1. Foster local partnerships that will improve service delivery
2. Assist individuals and groups in identifying and pursuing personal and community goals
3. Develop leadership skills in community members to improve oral health
4. Assess and assist in prioritizing the oral health and general health care needs and assets of the community
5. Map out the social and health support networks within a community; access the resources; and inform community members of the available resources.

Advocacy Skills

1. Demonstrate the role of advocacy within the scope of practice of the CDHC
2. Inform community members of their rights and responsibilities in obtaining needed services*
3. Represent and provide a voice for members of the community, their individual needs and the needs of the community as a whole
4. Promote organized action related to identified community needs, and mobilize community members, existing resources and data to support the action
5. Identify and work with advocacy groups, local community leaders, and with local dental societies.

*Ethics

Module 2: Communication and cultural competency

Foundation knowledge

1. Communication strategies with individuals and groups
2. Culturally-, gender-, and age-appropriate verbal and non-verbal communications
3. Literacy and its impact on health
4. Oral health literacy

Communication skills

1. Speak and write with individuals and community groups in their preferred and plain language
2. Recognize and adapt to verbal and non-verbal communication
3. Assist community members in understanding technical/dental/legal processes, documents and information
4. Present information in a clear and concise way
5. Listen actively and non-judgmentally
6. Organize, work, and communicate with groups
7. Provide clear and constructive feedback to the dental team and to other groups

Interpersonal Skills

1. Show sensitivity, respect and empathy*
2. Gain and maintain trust, integrity, and reliability*
3. Initiate and maintain respectful and mutually supportive relationships with community members, organizations, and service providers
4. Assist individuals and groups in resolving conflicts
5. Recognize and appropriately respond to the beliefs, values, cultures, languages and points of view of the individuals and communities served [cultural competence]
6. Maintain confidentiality of client information*

*Ethics

Module 3: Interviewing skills

Foundation knowledge

1. Human behaviors and health
2. When and how behaviors change: life stories
3. The difference between reported and actual behaviors
4. The difference between different types of questions (biased, double barreled, confusing questions, assumptive questions)
5. Types of interviews (face-to-face, telephone, email, chats)
6. Interviews do's and don'ts

General interviewing skills

1. Prepare for an interview with community members and potential patients
2. Introduce and explain the purpose of the interview
3. Read or ask open and closed questions without directing the respondents
4. Listen to respondents' questions
5. Probe for answers
6. Provide appropriate feedback or clarifications
7. Appropriately manage rejections and unpleasant behaviors

Motivational interviewing skills

Foundation knowledge

1. Behavioral change theories and why we need them
2. History and background on motivational interviewing

Skills

1. Develop a collaborative environment with the interviewee
2. Practice the principle of autonomy
3. Probe with evocative questions
    a. Ask open-ended questions
    b. Affirm the responses
    c. Reflect on the responses
    d. Summarize responses of interviewees
4. Express empathy
5. Develop discrepancy
6. Roll with the resistance
7. Support self-efficacy
8. Start and maintain a change talk
9. Assess the intention to change
10. Assist in developing personal goals
11. Assist in defining the next steps and milestones for behavioral change

Module 4: Coordination, documentation, and reporting

Foundation knowledge

1. Health care system serving the community
2. Insurance program for community members
3. Medicaid, SCHIP, and other special programs
4. Social, mental, and family support systems
5. Local health and human services organizations and programs
6. Laws and regulation affecting community health

Interpersonal skills

1. Work effectively by balancing the demands and needs as a member of the clinical and community teams
2. Demonstrate the capability to resolve conflicts between different stakeholders

Service Coordination Skills

1. Recognize situations appropriate for referrals to various agencies and programs
2. Refer community members to appropriate service providers and assure completion of the referral by supporting/coaching and follow-up
3. Develop and maintain active referral networks and coalitions with other healthcare professionals and agencies
4. Serve as a liaison between organizations, community and clinical groups
5. Coordinate the dental care with the clinical team and communicate to the community members the progress in their care

Organizational Skills

1. Record and maintain information on individuals, referrals, appointments, activities and outcomes* using the continuity of care record,
2. Plan, organize and set up events as needed to achieve work objectives
3. Effectively manage time
4. Prioritize activities while remaining flexible
5. Create a community-specific resource directory

*Ethics

Module 5: Teaching and learning skills

Foundation knowledge

1. Definition of teaching and learning
2. Definition and resources for life-long learning
3. The Web as a source for information

Individual and group teaching skills

1. Identify and explain the goals and objectives of a training program
2. Use culturally-appropriate methods for individual and group teaching sessions
3. Employ instructional and coaching techniques that address various learning styles
4. Organize culturally-appropriate presentation materials using various media
5. Evaluate the success of a training program and measure the progress of individual learners*

Life-long learning skills

1. Achieve competency in computer skills (install, troubleshoot, and use programs necessary for the CDHC work)
2. Identify and access resources for life-long learning and to answer questions on oral and health issues facing the community
3. Search and identify reliable access to information on the WW Web

*Ethics

Module 6: Legal and ethical issues

Foundation knowledge

1. Laws, policies and regulations, especially concerning consumer rights
2. Legally mandated reporting requirements
3. Work contract for CDHC

Ethical analysis skills

1. Apply an ethical decision model to community and individual dilemma and decide what is the most appropriate action
2. Advocate for human rights and welfare in the community

Dental Skills

Module 7: Introduction to Dentistry

Foundation knowledge

1. Dental anatomy
2. General microbiology
3. Infection control
4. Oral Pathology
5. History of dentistry
6. Dental organizations

Clinical skills:

1. Positioning and Basic Instrumentation

This module provides foundation knowledge, as necessary, to the dental modules (8-14)

Module 8: Screening and classification

Foundation knowledge: General

1. Definition of an emergency
2. Definition of urgent dental care
3. Definition of dental and oral conditions and their signs and symptoms
4. Accuracy of dental screening criteria

Foundation knowledge: Dental

1. Gross anatomy of head and neck
2. Introduction to microbiology, oral pathology (general principles, the disease specific pathologies will be discussed in the disease-focused modules) and radiation safety

(Note: other background knowledge for dental practice is covered by Module 13)

Clinical skills

1. Collect the following information to assist the dentist to prepare a preliminary (interim) management plan for patients who do not have an emergency or are in need for urgent care :
    a. History of the chief complaint of the potential patient
    b. Medical and dental history including collection of information on reported chronic and infectious conditions
    c. Signs and symptoms of cavitated carious lesions
    d. Signs of questionable carious lesions (in children <6 years old, signs of early carious lesions on the facial and lingual surfaces of anterior teeth)
    e. Presence of root recession
    f. Visual signs of gingival bleeding
    g. Signs and symptoms of swellings indicative of infection
    h. Presence of any other swelling (hard or soft) of the mouth, throat, face and neck
    i. Presence of white, red, or mixed mucosal lesions
    j. Presence of ulcers
    k. Presence and status of dentures
    l. Presence of loose (mobile) teeth
    m. Presence of moderate or severe fluorosis
    n. Presence of any limitation of jaw movement
    o. Presence of pain on palpation of jaw muscles
    p. Other signs and symptoms reported by the potential patient

2. Understand the importance of keeping the Continuity of Care Record (CCR) to document the following:
    a. Clinical records of all information collected following the protocol described in Modules 9-12.
    b. Medical records including all relevant information on medical history and presence of chronic or acute conditions that may impact the oral health or care of a patient
    c. Updates of clinical records (after delivery of preventive care as well as once a year)
    d. Services rendered and dates
    e. Quality of preventive services rendered (using criteria defined by the State Executive Committee)

f. Scheduling information (CDHC has direct access to the schedule of the clinic and can enter information at any time)
g. Follow-up of dental visits
h. Recall preventive visits when directed by the supervising dentist
i. Referral status and follow-up
j. Communication with the supervising dentist
k. Payment method and eligibility/registration for government programs as described in Module 14

3. Follow the instructions of the supervising dentist regarding the immediate scheduling of patients with emergencies or urgent care
4. Collect information on risk factors using ADA-approved risk assessment protocols.
5. Describe how to adhere to applicable HIPAA regulations in community-based settings.
6. Take digital bitewing or periapical radiographs utilizing appropriate radiation safety techniques
7. Take digital photographs for areas which the dentist may need to see the physical appearance of the intra-oral tissues.
8. Take alginate impressions and pour models as directed

Module 9: Prevention of dental caries

Foundation knowledge

1. The caries process
2. The determinants (biological, behavioral, social, community) of dental caries
3. The difference between primary and secondary prevention
4. The rationale and efficacy of different preventive approaches of dental caries
5. The American Dental Association Clinical Recommendations for application of topical fluorides and sealants

Clinical/practical skills

Following the supervising dentist preventive plan, the CDHC will perform the following:

1. Apply fluoride varnish and other topical fluorides following the ADA Clinical Recommendations and manufacturers' instructions.
2. Apply sealants following manufactures' recommendations
3. Identify stagnation areas where the biofilm is retained and using the motivational interviewing skills learned in Module 3 to encourage the patient to remove the biofilm
4. Advice individuals on best dietary practices to prevent dental caries
5. Follow-up on the preventive care (recall care) provided by CDHC or dentist
6. Develop community networks to support water fluoridation campaigns

Module 10: Prevention of periodontal diseases

Foundation knowledge

1. The classification and definition of periodontal diseases
2. The association between systemic conditions and periodontal diseases
3. The determinants (biological, behavioral, social, community) of periodontal diseases
4. The rationale and efficacy of different preventive approaches of periodontal diseases
5. The American Dental Association and American Academy of Periodontology Clinical Recommendations relevant to the prevention of periodontal diseases.

Clinical skills:

Following the supervising dentist preventive plan, the CDHC will perform the following:

1. Perform gross debridement in community settings which may include scaling using anterior and/or posterior sickle hand scalers for patients with Perio type I (gingivitis) and have calculus that impedes maintaining good oral hygiene.
2. Perform rubber cup (coronal) polishing using a fluoridated paste and a handpiece.
3. Identify stagnation areas where the biofilm is retained and using the motivational interviewing skills learned in Module 3 to encourage that the biofilm is effectively and consistently removed using a toothbrush and a floss (when indicated)
4. Follow-up on the preventive care provided

Module 11: Prevention of oral cancer

Foundation knowledge

1. The classification and definition of oral cancer
2. The association between use of tobacco, alcohol, and infection with human papilloma virus (HPV) and oral cancer
3. The importance of early detection on survival rates
4. The different treatments of oral cancer.

Clinical/practical skills

Following the supervising dentist preventive plan, the CDHC will perform the following:

1. Apply the National Cancer Institute 5A program using a motivational interviewing approach to develop personal goals for change in the use of tobacco products and heavy use of alcohol
2. Identify community support resources for cancer patients.
3. Track patients with suspicious oral mucosal lesions and assist them to see the supervising dentist
4. Educate and promote early screening for oral cancer
5. Organize community screening programs in collaboration with local dentists and clinics

Module 12: Palliative care

Foundation knowledge

1. The definition and classification of different restorative materials
2. The benefits and risks associated with each restorative material
3. The properties of the temporary and interim restorative materials

Clinical skills

Following the supervising dentist preventive plan, the CDHC will perform the following:

1. Using only an air syringe and a large spoon excavator, clean a cavity from loose debris
2. Apply a temporary or interim restorative material (glass ionomer cements) following the manufacturers' instructions
3. Check for presence of high spots and remove excess material using hand instruments or a slow-speed handpiece.
4. The slow speed handpiece will ONLY be used to polish teeth (Perio I care) and remove high spots from the temporary glass ionomer restorations (GIC). The CDHC will only be provided with a prophylaxis head and a large finishing bur for use with the handpiece.

Module 13: Clinical support system

Foundation knowledge

1. Infection control principles
2. Infectious disease in the US and potential epidemics
3. Ergonomics

Clinical skills

1. Manage a triage, referral and tracking system
2. Maintain all portable dental equipment
3. Operate dental equipment safely and ergonomically
4. Communicate with and manage patients of different age groups in the portable dental chair
5. Obtain and maintain current certification in CPR (Level II)
6. Interpret and read prescriptions written by the supervising dentist
7. Apply infection control practices in every location where the portable clinic will be set-up

Module 14: Financing and Payment for dental care

Foundation knowledge

1. Financing of dental care
2. Who pays for dental care for the poor and those with special needs
3. Type of services covered
4. Eligibility
5. Registration
6. Navigation of the system

Skills

1. Screen subjects for their eligibility
2. Assist individuals in registering for programs to pay for dental care
3. Conduct a financial needs assessment and incorporate in the continuity of care record (CCR)

Module 15: Internship at a Community-based Dental Clinic

Duration: 3-6 months depending or prior experience

Under the supervision of a dentist and the administrators of a community dental clinic perform the duties of the Community Dental Health Coordinators.

A structured program and evaluation system will be developed by the National Coordinating and Development Committee and the State Executive Committees.

Resolution No. 55 New ■ Substitute □ Amendment □

Report: NA Date Submitted: September 17, 2007

Submitted By: Sixteenth Trustee District

Reference Committee: Dental Education and Related Matters

Total Financial Implication: $28,500

Amount One-time $ 28,500 Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

ETHICS

The following resolution was submitted by the 16th Trustee District and transmitted on September 17, 2007, by Mr. Phil Latham, executive director, South Carolina Dental Association.

Background: The ADA June Symposium on Integrity and Ethics in Dental Education, co-sponsored by the American Dental Association, the American Dental Education Association, and the American College of Dentists, created extensive dialogue regarding the recent cheating scandals in several of our dental schools. The symposium posed many unanswered questions on how to specifically develop and implement solutions for the prevention of ethical misconduct in dental schools and questions on how to construct innovative approaches to furthering ethics and integrity in education.

The CDEL/CEBJA Joint Report to the House of Delegates (Worksheet:5044-5045, Dental Education and Related Matters) offered several excellent suggestions that should be explored and the ADA Board of Trustees agreed that these issues are of "critical importance to the profession and that it is important for the ADA to act immediately and to take a leadership role in developing actions to address the challenges related to ethics and professionalism in students and the dental education environment". The ADA Board of Trustees is to be applauded in constructing a resolution to this effect. However, if a study is to be done at this time it should also address strategies for advancing integrity and ethics in today's dental practice as well. Practitioners today are equally challenged to understand and maintain ethics in their practices as peer review cases and state board complaints are on the rise. Ethical questions face all of us in dentistry throughout our practicing years, not just as students.

The 16th District agrees with the intent of B-68-2007 (CEDEL/CEBJA Joint Report), but feel that the scope of the study and recommendations should be expanded to include dental practice in addition to dental education and that the Council on Dental Practice should be one of the communities of interest. We therefore respectfully submit the resolution to the ADA House of Delegates:

Resolution

55. Resolved, that the Council on Dental Education and Licensure and the Council on Ethics, Bylaws and Judicial Affairs develop recommendations for advancing ethics and professionalism in dental education that begin with the evaluation of candidates for admission to dental schools and follow through the dental education process, and be it further

Resolved, that the councils also develop recommendations on strategies for advancing integrity and ethical conduct in the profession of dentistry, and be it further

Resolved, that the councils utilize consultants as needed from the Council on Dental Practice, the American Dental Education Association, the American Association of Dental Examiners, the American Student Dental Association, the American College of Dentists and any others it deems appropriate, and be it further

Resolved, that the councils study and include in their evaluation what other professional disciplines are doing to accomplish common core requirements that might aid dental schools, associations and boards in developing common discipline modalities, and be it further

Resolved, that the councils submit a proposal to the Board seeking funding, if necessary, and give progress reports to the Board of Trustees with a final report for the 2008 House of Delegates.

BOARD COMMENT: The Board agrees that ethical issues are equally challenging in dental practice, but does not support expansion of the scope of the resolution for a number of reasons. First, the context and nature of ethical challenges in dental education and practice differ significantly and these differences could impede the councils' ability to develop specific, focused, actionable recommendations. Broadening the task will increase the complexity of the task and the amount of time and resources needed. Further, the additional charge is so broadly stated that it duplicates basic *Bylaws* responsibilities of CEBJA and CDP, as well as the mission of another major dental organization, the American College of Dentists. The Board also notes that this added dimension will be the topic of the AADE's mid-year meeting.

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.	55

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Board Report 13 Date Submitted: September 2007

Submitted By: Board of Trustees

Reference Committee: Dental Education and Related Matters

Total Financial Implication: Already Funded – See below for details

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

REPORT 13 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: UPDATE ON ACTIVITIES OF THE TASK FORCE TO STUDY THE COMMISSION ON DENTAL ACCREDITATION

The Board of Trustees is transmitting the following report which summarizes the work accomplished to date by the Task Force to Study the Commission on Dental Accreditation.

Background: At its April 2007 meeting, the Board of Trustees adopted Resolution B-21-2007 to examine the structure, governance, policies, operating procedures and functionality of the Commission on Dental Accreditation (CODA).

B-21-2007. Resolved, that the president appoint a task force, including the chair, to examine the structure, governance, policies, operating procedures and functionality of the Commission on Dental Accreditation, and be it further

Resolved, that the objectives of the task force 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, and be it further

Resolved, that the task force has as a goal to complete its charge in one year and that if more time is needed that the task force present to the BOT with reasons to extend, and be it further

Resolved, that the task force consist of up to 12 members comprised of representatives from CODA, CDEL, ADEA, AADE, and a current or past public member of CODA that has accreditation expertise, as well as members of the ADA BOT and HOD which have no affiliation with ADEA or AADE, and be it further

Resolved, that the task force be authorized and requested to retain a consulting firm with specific expertise in the professional education arena to staff and support the task force's work, and be it further

Resolved, that the task force convene an informal group of advisors, made up of at least one person from each of the disciplines represented on CODA, for purposes of consulting with and providing input into the work of the task force, and be it further

Resolved, that funding for the task force for 2007 expenses be presented to the Board in June in a supplemental appropriation request and that future funding be added to appropriate budget(s), and be it further

Resolved, that the Board be provided with regular progress reports on the work of the task force, and that similar updates be provided regularly to all communities of interest, including an immediate announcement about the formation of the task force and its objectives, and be it further

Resolved, that the Board provide a progress report to the 2007 House of Delegates and a comprehensive report to the 2008 House.

Since its creation in 1975, CODA has been the focus of special studies on various aspects of its operations. There is a natural tension that exists between CODA and its various and different communities of interest, because of the important role that CODA plays in accrediting a diverse portfolio of dental education programs. These stakeholders do not often share the same perspective about CODA's independence and the questions regarding influence by any stakeholder, including the ADA. If any one of the stakeholders perceived that another stakeholder had undue influence over CODA, then its credibility would be at issue. It is therefore natural and to be expected that tensions would arise when one stakeholder group believes it does not have enough influence and another stakeholder group believes some other stakeholder group has too much influence. These tensions have ebbed and flowed over the years.

For example, in 1991, the Commission was asked to study the costs associated with its accreditation programs. An extensive informational report was prepared and considered by the ADA Board of Trustees at its April 1992 meeting. There was a perception at that time by the educational community that the ADA had too much control over CODA, and the ADA providing the majority of CODA's funding at that time enhanced that perception. The study addressed changing that balance of funding.

In October 2003, the Board of Trustees adopted Resolution B-92-2003 (*Trans.*2003:283) to study the ADA's relationship with CODA. Specifically, a special committee of the Board was appointed by the president to study the ADA's arm's-length relationship with CODA, and CODA's relationship with the U.S. Department of Education. The Special Committee reported its findings and recommendations to the Board of Trustees at its June 2004 meeting and to the 2004 House of Delegates (*Supplement* 2004:5016; Resolution 40H-2004—*Trans.*2004:317).

More recently, tensions have been high again in light of the changes that CODA has adopted in response to concerns expressed by the U.S. Department of Education around stakeholders having too much control over the accreditation process. The Board has been concerned because these tensions have not dissipated, so it called for a broad review of CODA and its processes.

Members of the Task Force: The task force members are: Dr. David Whiston, past president, ADA, (chair); Dr. Patricia Blanton, member, House of Delegates; Dr. Donald Cadle, trustee, Seventeenth District; Dr. William Calnon, trustee, Second District; Dr. Mark Christensen, dental examiner; Dr. Henry Fields, former dean and former member of the Council on Dental Education; Dr. Linda Himmelberger, dental examiner and member of the Council on Dental Education; Dr. Jeffrey Hutter, member, Commission on Dental Accreditation; Dr. Kenneth Kalkwarf, dean, University of Texas, San Antonio; Karen Kershenstein, Ph.D., public member; Dr. Roger Kiesling, member of the Council on Dental Education; Dr. Larry Nissen, member, Commission on Dental Accreditation; Dr. Mark Feldman, ADA president-elect (ex-officio).

Budget: A supplemental budget was submitted and approved at the June 2007 Board meeting for $53,700 in travel and miscellaneous expenses, and up to $60,000 for consulting fees. This same amount of funding has been included in the 2008 budget. Thus, the total budget for the task force is $227,400 for the two-year assignment.

First Meeting: The task force held its first meeting on June 16, 2007, at the ADA's Washington office. The task force discussed organizational and communication issues, its focus and objectives, and the relative priorities of various tasks. The task force also received an update from the ADA's Washington office staff on pending regulatory action of the U.S. Department of Education regarding accreditation.

In addition, the task force held a preliminary discussion of how to form and coordinate an informal group of advisors (as called for in the Board resolution), "made up of at least one person from each of the disciplines represented on CODA, for purposes of consulting with and providing input into the work of the task force."

The task force decided to invite each of the disciplines represented on CODA (and selected others) to provide written comments, which would be considered by the task force at a meeting on October 31-November 1, 2007 at ADA Headquarters. In addition, each discipline would be invited to send a representative of its choice (at its expense) to this meeting.

The task force agreed to plan three meetings in 2008 and also hold periodic conference calls. The task force set a target date of May 2008 for submitting its report to the Board, with a final report (as specified in the resolution) to be provided to the 2008 House.

Selection of the Consultant: Shortly after the formation of the task force, names were gathered of consultants and a Request for Proposals (RFP) was created for services, which was sent to 15 potential candidates. Seven formal proposals were received. After significant review and discussion, and follow up after the meeting, the task force retained the Plexus Consulting Group, LLC, of Washington, DC.

Second Meeting: The second meeting of the task force was held August 14, 2007, at ADA Headquarters, Chicago. The task force discussed the research to be conducted by the consultant firm of key stakeholder groups regarding perceptions of the current structure, governance, policies, operating procedures and functionality of CODA and its accreditation practices and recommended changes. Key stakeholders include: internal (such as members of ADA governance, current and past CODA members); direct users of the accreditation process (including program directors of accredited programs and deans, key faculty members, and students), and external (such as thought leaders and decision makers).

The consultant presented an overview of trends in accreditation and best practices. The task force responded by enumerating comparative elements of performance it would like to have included in a report on the best practices used by accreditation agencies that operate in health-care and related professions.

The task force outlined major section headings for its final report, agreed upon a communications plan to keep the communities of interest regularly informed and updated, and confirmed that the research methods used will be electronic surveys, telephone interviews and focus groups. The task force received a second update from ADA staff regarding developments concerning the federal regulation of accreditors and the accrediting process. Finally, with the consultant, the task force drafted a work plan with milestones leading up to a final report to be presented to the 2008 House of Delegates.

Next Steps: As noted above, the task force's next meeting is later this fall, and three meetings are expected in 2008 in order to complete the work plan and have the final report prepared by May 2008. The task force is humbled by the assignment and notes that a tremendous amount of work is ahead in

order to fulfill every aspect of the Board's significant request. Perhaps most importantly, however, the task force realizes the importance of thoroughly exploring all the concerns that led to this assignment, and to maintaining complete objectivity and neutrality along the way. How the task force goes about its work, what data it gathers, how that data is analyzed, etc., (the process) must be so thorough, thoughtful and fair that it will be trusted in the end.

Resolutions

This report is informational in nature and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS.

Resolution No. 60 New ■ Substitute □ Amendment □

Report: NA Date Submitted: September 28, 2007

Submitted By: Sixteenth Trustee District

Reference Committee: Dental Education and Related Matters

Total Financial Implication: $110,000

Amount One-time $110,000 Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy; Create and Transfer Knowledge (Required)

ADA TASK FORCE FOR ETHICS AND PROFESSIONALISM

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 Association.

Background: The ADA June Symposium on Integrity and Ethics in Dental Education, co-sponsored by the American Dental Association, the American Dental Education Association and the American College of Dentists, created extensive dialogue regarding the recent cheating scandals in several dental schools. The symposium posed many unanswered questions as to how to specifically develop and implement solutions for the prevention of ethical misconduct in dental schools and questions on how to construct innovative approaches to furthering ethics and integrity in dental education.

The CDEL/CEBJA Joint Report to the House of Delegates (Worksheet:5044) offered several excellent suggestions that should be explored and the ADA Board of Trustees agreed that these issues are of "critical importance to the profession and that it is important for the ADA to act immediately and to take a leadership role in developing actions to address the challenges related to ethics and professionalism in students and the dental education environment." The ADA Board of Trustees is to be applauded for recognizing the need for a thorough and timely study.

The obligations and agenda items currently assigned to CDEL and CEBJA may preclude their ability to devote adequate time to the study and these councils could be overburdened with the enormity and scope of this matter. Therefore, a Task Force with a single focus and charge should be formed to address this most important issue. The Task Force would gather adequate testimony from all the stakeholders from the various communities of interest and deliver a comprehensive report to the House of Delegates. Therefore, be it

Resolution

60. Resolved, that a "Task Force on Ethics and Professionalism" be appointed and charged with completing an in-depth analysis regarding the causes, implications and possible strategies for solutions to improve the integrity and ethical conduct within dental education, and be it further

Resolved, that the American Student Dental Association (ASDA), American Dental Education Association (ADEA), American Association of Dental Examiners (AADE) and American College of Dentists (ACD) each be requested to designate a representative to the task force, and be it further

Resolved, that the communities of interest represented on the Task Force shall have representatives appointed by the President from the Board of Trustees, Council on Dental Education and Licensure, Council on Ethics, Bylaws and Judicial Affairs, Committee on the New Dentist, Commission on Dental Accreditation, and two at-large members of the House of Delegates, and the representatives designated by ASDA, ADEA, AADE and ACD, and be it further

Resolved, that the Task Force provide progress reports to the Board of Trustees with a final report submitted to the 2008 House of Delegates.

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

Legal and Legislative Matters

Resolution No. 7 New ■ Substitute □ Amendment □

Report: NA Date Submitted: July 2007

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: Legal and Legislative Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

AMENDMENT OF THE ADA *CONSTITUTION*—EDITORIAL LANGUAGE REGARDING REFERENCES TO "TWO-THIRDS VOTE"

Background: (*Reports*:98)

Editorial Review of the ADA *Bylaws*—Request of the Speaker of the House of Delegates on Review of "Two-Thirds Majority Vote" References: In response to a request from Dr. J. Thomas Soliday, ADA Speaker of the House of Delegates, the Council conducted an editorial review of references to the term "two-thirds majority vote" in the ADA *Constitution and Bylaws*. The Council examined all *Bylaws* references to "two-thirds majority" vote. Five different styles were employed to describe eight *Bylaws* references to "two-thirds" or "two-thirds majority" vote.

Two-Thirds Reference	*Bylaws*
1. Two-thirds (2/3) affirmative vote of the members of the House	Amendments to the *Constitution*
2. Two-thirds (2/3) vote of the House	HOD Introduction of new business
3. Two-thirds (2/3) majority	HOD Power to suspend constituent society
4. Two-thirds (2/3) majority vote of the members (or delegates) present and voting	HOD Approval of dues Special assessments *Bylaws* amendments
5. Affirmative vote of two-thirds of the delegates present and voting	Removal of Board of Trustees and Elective Officers

The Council then carefully reviewed the historical records of the House of the Delegates to ascertain the intent of drafters as to use of the term in question. After further consultation with the Speaker, the Council recommends the following proposals. In brief, the proposals substitute the words "a two-thirds (2/3) affirmative vote of the delegates present and voting" for all other references to "two-thirds majority" or "supermajority" votes to ensure consistency and clarity throughout the ADA *Constitution and Bylaws*. The proposals are presented as two separate resolutions, since one involves a constitutional amendment which would require a lay over to the 2008 House of Delegates.

Resolution

7. Resolved, that ARTICLE VIII. AMENDMENTS, of the ADA *Constitution* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

ARTICLE VIII • AMENDMENTS

This *Constitution* may be amended by a two-thirds (2/3) affirmative vote of the ~~members of the House of D~~delegates present and voting, provided that the proposed amendments have been presented in writing at any previous session of the House of Delegates.

This *Constitution* may also be amended at any session of the House of Delegates by a unanimous vote, provided the proposed amendments have been presented in writing at a previous meeting of such session.

BOARD COMMENT: The Board notes that the Speaker has advised that Resolution 7 would be referred to the 2008 House of Delegates as it proposes amendments to the ADA *Constitution.* The Speaker further advised that he would entertain a motion from the House of Delegates to consider this resolution by unanimous vote provided that the resolution has been presented in writing at a previous meeting of the same session of the 2007 House of Delegates.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 8 New ■ Substitute □ Amendment □

Report: NA Date Submitted: July 2007

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: Legal and Legislative Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

AMENDMENT OF THE ADA *BYLAWS*—EDITORIAL LANGUAGE REGARDING REFERENCES TO "TWO-THIRDS VOTE"

Background: (*Reports*:98)

Editorial Review of the ADA *Bylaws*—Request of the Speaker of the House of Delegates on Review of "Two-Thirds Majority Vote" References: In response to a request from Dr. J. Thomas Soliday, ADA Speaker of the House of Delegates, the Council conducted an editorial review of references to the term "two-thirds majority vote" in the ADA *Constitution and Bylaws*. The Council examined all *Bylaws* references to "two-thirds majority" vote. Five different styles were employed to describe eight *Bylaws* references to "two-thirds" or "two-thirds majority" vote.

Two-Thirds Reference	*Bylaws*
1. Two-thirds (2/3) affirmative vote of the members of the House	Amendments to the *Constitution*
2. Two-thirds (2/3) vote of the House	HOD Introduction of new business
3. Two-thirds (2/3) majority	HOD Power to suspend constituent society
4. Two-thirds (2/3) majority vote of the members (or delegates) present and voting	HOD Approval of dues Special assessments *Bylaws* amendments
5. Affirmative vote of two-thirds of the delegates present and voting	Removal of Board of Trustees and Elective Officers

The Council then carefully reviewed the historical records of the House of the Delegates to ascertain the intent of drafters as to use of the term in question. After further consultation with the Speaker, the Council recommends the following proposals. In brief, the proposals substitute the words "a two-thirds (2/3) affirmative vote of the delegates present and voting" for all other references to "two-thirds majority" or "supermajority" votes to ensure consistency and clarity throughout the ADA *Constitution and Bylaws*. The proposals are presented as two separate resolutions, since one involves a constitutional amendment which would require a lay over to the 2008 House of Delegates.

Resolution

8. Resolved, that CHAPTER V. HOUSE OF DELEGATES, Section 40. POWERS, Subsection F., of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

> F. It shall have the power to grant, amend, suspend or revoke charters of constituent societies. It shall also have the power by a two-thirds (2/3) ~~majority~~ affirmative vote of the delegates present and voting to suspend the representation of a constituent society in the House of Delegates upon a determination by the House that the bylaws of the constituent society violate the *Constitution* or *Bylaws* of this Association providing, however, such suspension shall not be in effect until the House of Delegates has voted that the constituent society is in violation and has one year after notification of the specific violation in which to correct its constitution or bylaws.

and be it further

Resolved, that CHAPTER V. HOUSE OF DELEGATES, Section 130. RULES OF ORDER, Subsection A. STANDING RULES AND REPORTS, subsection d. APPROVAL OF THE DUES OF ACTIVE MEMBERS, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

> d. APPROVAL OF THE DUES OF ACTIVE MEMBERS. The dues of active members of this Association shall be established by the House of Delegates as the last item of business at each annual session. The resolution to establish the dues of active members for the following year shall be proposed at each annual session by the Board of Trustees in conformity with Chapter VII, Section 100F of these *Bylaws*, may be amended to any amount and/or reconsidered by the House of Delegates until a resolution establishing the dues of active members is adopted by a two-thirds (2/3) ~~majority~~ affirmative vote of the ~~members~~ delegates present and voting.

and be it further

Resolved, that CHAPTER V. HOUSE OF DELEGATES, Section 130. RULES OF ORDER, Subsection A. STANDING RULES AND REPORTS, subsection e. INTRODUCTION OF NEW BUSINESS, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

> e. INTRODUCTION OF NEW BUSINESS. 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) affirmative vote of the ~~House of D~~delegates present and voting. 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 require a bylaw amendment cannot be adopted at such last meeting. Reference committee recommendations shall not be deemed new business.

and be it further

Resolved, that CHAPTER VII. BOARD OF TRUSTEES, Section 70. REMOVAL FOR CAUSE, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

> *Section 70.* REMOVAL FOR CAUSE: The House of Delegates may remove a trustee for cause in accordance with procedures established by the House of Delegates, which procedures shall provide for

notice of the charges and an opportunity for the accused to be heard in his or her defense. ~~The~~ A two-thirds (2/3) affirmative vote ~~of two-thirds (2/3)~~ of the delegates present and voting is required to remove a trustee from office. If the House of Delegates elects to remove the trustee, that action shall create a vacancy on the Board of Trustees which shall be filled in accordance with Chapter VII, Section 80.

and be it further

Resolved, that CHAPTER VIII. ELECTIVE OFFICERS, Section 70. REMOVAL FOR CAUSE, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

Section 70. REMOVAL FOR CAUSE: The House of Delegates may remove an elective officer for cause in accordance with procedures established by the House of Delegates, which shall include notice of the charges and an opportunity for the accused to be heard in his or her defense. ~~The~~ A two-thirds (2/3) affirmative vote ~~of two-thirds~~ of the delegates present and voting is required to remove an elective officer from office. If the House of Delegates elects to remove the elective officer, that action shall create a vacancy which shall be filled in accordance with Chapter VIII, Section 80.

and be it further

Resolved, that CHAPTER XVII. FINANCES, Section 40. SPECIAL ASSESSMENTS, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

Section 40. SPECIAL ASSESSMENTS: In addition to the payment of dues required in Chapter I, Section 20 of these *Bylaws*, a special assessment may be levied by the House of Delegates upon active, active life, retired and associate members of this Association as provided in Chapter I, Section 20 of these *Bylaws*, for the purpose of funding a specific project of limited duration. Such an assessment may be levied at any annual or special session of the House of Delegates by a two-thirds (2/3) ~~majority~~ affirmative vote of the delegates present and voting, provided notice of the proposed assessment has been presented in writing at least ninety (90) days prior to the first day of the session of the House of Delegates at which it is to be considered. Notice of such a resolution shall be sent by a certifiable method of delivery to each constituent society not less than ninety (90) days before such session to permit prompt, adequate notice by each constituent society to its delegates and alternate delegates to the House of Delegates of this Association, and shall be announced to the general membership in an official publication of this Association at least sixty (60) days in advance of the session. The specific project to be funded by the proposed assessment, the time frame of the project, and the amount and duration of the proposed assessment shall be clearly presented in giving notice to the members of this Association. Revenue from a special assessment and any earnings thereon shall be deposited in a separate fund as provided in Chapter XVII, Section 30 of these *Bylaws*. The House of Delegates may amend the main motion to levy a special assessment only if the amendment is germane and adopted by a two-thirds (2/3) ~~majority~~ affirmative vote of the delegates present and voting. The House of Delegates may consider only one (1) specific project to be funded by a proposed assessment at a time. However, if properly adopted by the House of Delegates, two (2) or more special assessments may be in force at the same time. Any resolution to levy a special assessment that does not meet the notice requirements set forth in the previous paragraph also may be adopted by a unanimous vote of the House of Delegates, provided the resolution has been presented in writing at a previous meeting of the same session.

and be it further

Resolved, that CHAPTER XXI. AMENDMENTS, Section 10. PROCEDURE, of the ADA *Bylaws* be amended by incorporating the changes indicated below (new language underscored; deletions stricken through):

Section 10. PROCEDURE: These *Bylaws* may be amended at any session of the House of Delegates by a two-thirds (2/3) ~~majority~~ affirmative vote of the ~~members~~ delegates present and voting, provided the proposed amendments shall have been presented in writing at a previous session or a previous meeting of the same session.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 20 New ■ Substitute □ Amendment □

Report: NA Date Submitted: July 17, 2007

Submitted By: District of Columbia Dental Society Delegation

Reference Committee: Legal and Legislative Matters

Total Financial Implication:

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

DENTISTS AS CANDIDATES FOR ELECTIVE OFFICE

The following resolution was submitted by the District of Columbia Dental Society Delegation and transmitted on July 17, 2007, by Dr. Alan Singer, chair.

Background: Many challenges face the ADA and its members which have the potential to shape the future of our organization and the profession. Changing membership demographics, the evolving healthcare marketplace and access to care will continue to be issues which will demand our attention and resources in the future. One of the five major goals of the ADA's Strategic Plan is to "Achieve effective advocacy for both oral health and the dental profession, within the healthcare, public and policy communities."

To preserve the dentist as the leader of the team which provides oral healthcare services in any healthcare system and to advocate for innovations that increase access to care for all segments of the population, we must have representation in local, state and national policy arenas. Involvement of dentists as elected officials provides a voice for the profession, as well as offering a unique oral health expertise and perspective when public policy decisions are made. Other issues which have been and will continue to be affected by legislation include universal health insurance coverage, pay for performance, scope of practice issues, regulatory issues such as amalgam waste and fluoridation of community water, business practice issues, tort reform and support for dental education and research.

We have been fortunate in the past to have one of our ADA members, Dr. Charles Norwood, as a representative to the U.S. Congress. Dr. Norwood was a stellar example of a dentist who was an effective public servant and champion of oral healthcare issues. Dr. Norwood was a valuable asset to our profession when legislative issues involving OSHA, scope of practice and amalgam regulation came before the House of Representatives. We currently have two dentists who serve in Congress and numerous other members who are active in their state legislatures, county commissions and city councils. An objective of the ADA's strategic goal, achieving effective advocacy, should be to increase the number of dentists involved in local, state and national elective offices. These dentists could advocate for the oral health of the public and would also preserve the interests of the profession.

Resolution

20. Resolved, that the ADA charge the appropriate ADA agencies to develop an activity that assists members in becoming candidates for elective public office at all levels of government.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 20S-1 New ☐ Substitute ■ Amendment ☐

Report: NA Date Submitted: Sept. 17, 2007

Submitted By: Sixteenth Trustee District

Reference Committee: Legal and Legislative Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

SUBSTITUTE TO RESOLUTION 20:
DENTISTS AS CANDIDATES FOR ELECTIVE OFFICE

The following substitute resolution was submitted by the Sixteenth Trustee District and transmitted on September 17, 2007, by Mr. Phil Latham, Executive Director, South Carolina Dental Association.

Resolution

20S-1. Resolved, that the ADA charge the appropriate ADA agencies to develop ~~an activity that assists~~ activities to assist, educate and recruit members in becoming candidates for elective public office at all levels of government and to educate our members to the importance of this and how to support candidates with their campaigns financially and otherwise.

BOARD COMMENT: The Board agrees with the Sixteenth Trustee District and with the District of Columbia Dental Society, which submitted Resolution 20 (Worksheet:6006), that the ADA can and should do more to help dentists seek elective office.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

BOARD VOTE: UNANIMOUS.

Resolution No. 21 New ■ Substitute □ Amendment □

Report: NA Date Submitted: July 13, 2007

Submitted By: Georgia Dental Association

Reference Committee: Legal and Legislative Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

REAUTHORIZATION OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

The following resolution was submitted by the Georgia Dental Association and transmitted on July 13, 2007, by Dr. Michael B. Rogers, president.

Background: In 1997 Congress created the State Children's Health Insurance Program (SCHIP) to provide insurance coverage for the growing number of uninsured children. The program was designed for those families who earned too much for Medicaid yet could not afford to purchase health coverage for their children (1997 authorization called for families with income less than or equal to 200% of federal poverty level).

Families are faced with many options for allocating their monthly paychecks. Budgeting for the necessities of life, including healthcare, can place financial demands that force tough decisions to be made. However, these are decisions that everyone is required to make. SCHIP enables those who are barely meeting these financial demands (those who are sometimes called "the working poor") to provide health insurance for their children. However, SCHIP was not envisioned to be a "universal provider" for all children's health insurance, regardless of income level.

State and federal governments have finite financial resources. Expanding SCHIP to include those persons with incomes up to 400% of federal poverty level ($82,600 per year for a family of four) will strain these financial resources. The United States has championed the underdog but has also been proud of promoting personal responsibility. Increasing coverage for those families with an income of 400% of the federal poverty level does not encourage personal financial responsibility or manage the limited financial resources of our state and federal governments. A move toward this income level could conceivably move individuals whose families are currently insured through employer-sponsored plans to the SCHIP program, further straining this program financially and administratively.

We strongly encourage the ADA to use its lobbying efforts to maintain the SCHIP program to cover the population it was intended to cover with a 200% FPL maximum that can be waived upon request and with appropriate documentation on a state-by-state basis.

Resolution

21. Resolved, that the ADA support the reauthorization of the State Children's Health Insurance Program (SCHIP) to maintain eligibility of those children with family income less than or equal to 200% of the federal poverty level.

BOARD COMMENT: The Board recognizes the many ramifications associated with any SCHIP program expansion, and takes very seriously the issues raised in support of the resolution. As has been indicated, a number of states have already expanded SCHIP coverage to individuals above 200% of the federal poverty level (FPL) pursuant to waivers granted by the Centers for Medicare and Medicaid Services. While no federal legislation currently before Congress requires states to expand coverage above the 200% of the FPL threshold, some would provide states the statutory authority to do so, including the "Children's Health First Act" (S. 895 and H.R. 1585), which allow states to expand coverage up to 400% of the FPL. It is the Board's understanding that the Congress is unlikely to adopt such an expensive proposal this year, and that a more modest reauthorization is expected to be enacted.

Further, the ADA has a long-held respect for the ability of the states to craft policy best suited to the needs of each jurisdiction. We believe it is important that each state maintain a large degree of flexibility within the parameters of the program to permit unique solutions and encourage innovation as appropriate for local conditions and concerns. An example of these concerns is varying potency of spending power afforded to a family at any given level of poverty based on geography (i.e., 200% of FPL will have more purchasing power in city A than in city B due to the cost of living relative to each location).

The Board is pleased to note that a joint session of the Council on Access, Prevention and Interprofessional Relations and the Council on Government Affairs is scheduled to address this issue on September 7. That being said, there is an obvious need to ensure that SCHIP first assures that children with the least resources receive medical and dental care before any expansion to children in families with higher income levels. Words matter, however, and the ADA cannot afford to be perceived as to being opposed to enhanced access in instances where children do not have care available to them. For all of these reasons, the Board recommends that the following substitute resolution be adopted.

21B. Resolved, that the ADA support the reauthorization of the State Children's Health Insurance Program (SCHIP) but make every effort to emphasize that funds dedicated to the program be used to provide medical and dental care to children with family income less than or equal to 200% of the federal poverty level before any expansion to children in families above that level, and that decisions to cover children beyond 200% of the federal poverty level continue to be made on a state-by-state basis.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

BOARD VOTE: UNANIMOUS.

Resolution No. 27 New ■ Substitute □ Amendment □

Report: NA Date Submitted: August 14, 2007

Submitted By: Eighth Trustee District

Reference Committee: Legal and Legislative Matters

Total Financial Implication:

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

ANNOUNCEMENT FOR ELECTED OFFICE

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 past years, many ADA trustees announced their candidacy for an ADA elective office at the House of Delegates held at the beginning of their last year as trustee. During the course of their last year, therefore, these candidates spend a substantial part of that year embroiled in their election campaigns. For this reason, it is difficult for these trustees, or any Board member candidate, to devote all of his/her volunteer time to their ongoing duties as a Board member.

Many discussions have been held about this current situation, and members of the Eighth District believe it is time to separate the last year as trustee, vice president or Treasurer, from the campaign year. While the Eighth District understands that this will not correct all problems in the current election system, we believe that it will help the process by allowing candidates to campaign without compromising their duties as a member of the Board of Trustees.

Current bylaws language specifies the makeup of the Board of Trustees, as follows: "Such seventeen (17) trustees, the President-elect and the two Vice Presidents shall constitute the voting membership of the Board of Trustees. In addition, the President, the Treasurer and the Executive Director of the Association, except as otherwise provided in the *Bylaws* shall be *ex officio* members of the Board without the right to vote." This resolution addresses all members of the Board of Trustees, whether voting members or *ex officio* members to make it clear that the Eighth District wishes to apply this announcement requirement to every board member.

Resolution

27. Resolved, that Chapter VIII. ELECTIVE OFFICERS, SECTION 20. ELIGIBILITY, of the ADA *Bylaws* be amended in the second sentence as follows (new language underscored; deletions stricken through):

> Section 20. ELIGIBILITY: Only an active, life or retired member, in good standing, of this Association shall be eligible to serve as an elective officer. <u>No member of the Board, including *ex officio* members, shall be eligible for nomination to an elective office while currently serving on the Board of Trustees</u>, except that the Treasurer may apply for a second term pursuant to

Chapter VIII, Section 50 of these *Bylaws* and that vacancies shall be filled in accordance with Chapter VIII, Section 80.

and be it further

Resolved, that the forgoing amendment to Chapter VIII take effect at the close *sine die* of the 2010 House of Delegates.

BOARD COMMENT: While the Board appreciates the intent of the Eighth District to strive to create optimal conditions for volunteer service at the trustee and elective officer levels as noted, the Board is concerned that barring these individuals from running for elective offices while simultaneously serving is not in the best interest of the Association. The Board believes that the continuity in the knowledge base of a candidate is most important to the service provided to the membership and thinks this resolution would compromise the talent pool available to the Association for officer positions. Therefore, the Board does not support the adoption of this resolution.

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. 27

Resolution No. 28 New ■ Substitute □ Amendment □

Report: NA Date Submitted: August 14, 2007

Submitted By: Eighth Trustee District

Reference Committee: Legal and Legislative Matters

Total Financial Implication: $7,850.

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

INTRODUCTION OF NEW BUSINESS TO THE HOUSE OF DELEGATES

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: For many years in the House of Delegates, there is an enormous amount of reports and resolutions distributed to the delegates upon registration at the annual session. Often, there may be as many as 200-300 pages of material delivered on Thursday, one day prior to the first House meeting. Delegates are expected to read all of this material overnight, at a time when there are other social events and meetings occurring. Such a rush to consume business for the House does not do justice to the matters being addressed.

The purpose of this resolution is to begin the process to reduce the volume of materials distributed on-site immediately preceding the House of Delegates. The Eighth District understands that this is a complex issue and, there are many factors involved that are not simply addressed. These include deadlines for introduction of business by trustee districts, review by the ADA Board of Trustees, administrative processing and turnaround, and circulation to the delegates in a timely manner to allow for sufficient study.

The Eighth District also understands there are some districts that do not caucus until they arrive at the annual session site, but we believe that contributes to the problem. While the Eighth District realizes full well that this goal relies heavily on the cooperation of constituent societies and trustee district delegations, we hope to urge delegations to begin their resolution preparations much earlier in future years and to caucus prior to arrival at the annual session.

For the above reasons, the following resolution is presented so that a thoughtful study and recommendations to address this issue may take place.

Resolution

28. Resolved, that the President appoint a committee to study the matter of introduction of new business in the House of Delegates with the goal of reducing the amount of business distributed to the House on-site the day before the opening meeting of the House, and be it further

Resolved, that in its deliberations the committee include, but not be limited to, deadlines for introduction of new business, deadlines for ADA councils' and agencies' reports, resolution review timetable of the Board of Trustees, expeditious transmittal of new business to the delegates, the process for last minute resolutions, and related topics, and be it further

Resolved, that this committee seek the advice and counsel of the Speaker of the House, and be it further

Resolved, that the committee report its findings and recommendations to the 2008 House of Delegates.

BOARD COMMENT: The Board of Trustees compliments the Eighth Trustee District for its effort to address, in a positive fashion, concerns about the volume of reports and resolutions distributed to the delegates upon registration at annual session. While there is logic to the resolution, the Board of Trustees believes recent changes undertaken by the ADA already address many of the concerns. One such change is making greater use of ADA.org to disseminate resolutions and reports to the delegates as soon as they become available, rather than waiting for on site distribution. See, for example, http://www.ada.org/ada/about/governance/hod_2007_resolutions.asp. In addition, the Board has been working internally with the councils and other ADA agencies and departments to expedite the transmission of their reports. As a result, some councils have changed their meetings to dates earlier in the year to help accomplish the more timely dissemination of reports. The Speaker of the House of Delegates has a work group comprised of delegates which offers a vehicle to discuss efficiencies to help expedite the work of the House. While it might be possible to consider other approaches, such as amending the deadline for new business, the Board believes that the burdens on the districts and constituents of meeting earlier deadlines would significantly outweigh the benefits and would restrict the House's ability to address important and timely issues. Therefore the Board recommends against adoption.

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. 28	

Resolution No. 29 New ■ Substitute □ Amendment □

Report: NA Date Submitted: September 2007

Submitted By: Board of Trustees

Reference Committee: Legal and Legislative Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

AMENDMENT OF THE MANUAL OF THE HOUSE OF DELEGATES—CLOSED AND ATTORNEY-CLIENT SESSION

Background: Currently, the "Rules of the House of Delegates" define an Attorney-Client Session as follows: "An attorney-client session is a form of a closed session during which legal advice of any kind is sought from an attorney acting in a professional capacity" (*2007 Manual of the House of Delegates and Supplemental Information*, page 14). While technically correct, this definition does not sufficiently convey the scope or importance of an Attorney-Client Session. Indeed, over the past year some tripartite leaders from around the country have expressed confusion, and a number of questions have been raised, about the scope and application of the important attorney-client privilege doctrine. In order to clear up any confusion and answer the questions that have been posed, the ADA Legal Division prepared a new brochure, "Litigation Overview for ADA Staff & Volunteers: Attorney-Client Privilege and Discovery," which is available upon request. The brochure was distributed at this year's Management Conference and Constituent Society Workshop in conjunction with presentations on the privilege. The brochure explains the nature of the attorney-client privilege in general, and then gives numerous practical examples, with comment, of where the privilege would and would not apply, mistakes that can lead to its waiver, and the consequences that can result from waiver. The Board also believes that the explanation of the attorney-client privilege in the HOD Manual would benefit from additional clarification and expansion. Therefore, the Board of Trustees presents the following resolution for the House's consideration.

Resolution

29. Resolved, that the "Rules of the House of Delegates," section entitled "Attorney-Client Session" of the *Manual of the House of Delegates and Supplemental Information, 2007*, be amended to read as follows (additions are underlined; deletions stricken):

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

Client Session are revealed to third parties. Once the privilege has been waived, there is a danger that all privileged communications on the issues covered in the Attorney-Client Session, regardless of when or where they took place, may become subject to disclosure. 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.

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

The entire new section will read as follows:

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 alternate delegates, and the elective and appointive officers, trustees and general counsel of the Association. 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 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.

Immediately after a closed session, the Speaker will inform the 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 those members present at the session. This provision is not applicable to an attorney-client session.

Attorney-Client Session. An attorney-client session is a form of closed session during which an attorney acting in a professional capacity provides legal advice, or a request is made of the attorney for legal advice. During these sessions, the legal advice given by the attorney may be discussed at length, and such discussion is "privileged." The requests, advice, and any discussion of them are protected, which means that opponents in litigation, media representatives, or others cannot legally compel their disclosure. The purpose of the privilege is to encourage free and frank discussions between an attorney and those seeking or receiving legal advice. The privilege can be lost (waived) if details about the Attorney-Client Session are revealed to third parties. Once the privilege has been waived, there is a danger that all privileged communications on the issues covered in the Attorney-Client Session, regardless of when or where they took place, may become subject to disclosure. 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.

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

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Board Report 15 Date Submitted: September 2007

Submitted By: Board of Trustees

Reference Committee: Legal and Legislative Matters

Total Financial Implication:

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

REPORT 15 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ALASKA

Background: "The situation in Alaska has been the most difficult, complex and divisive issue for the profession that the ADA Board of Trustees has had to address in its recent memory." This was the opening statement in the Board's formal comment to the House of Delegates in 2006. A year later, it is an equally poignant comment. Much has changed in this year, but the complexities and difficulties of the underlying issues around scope of practice and access to care will continue to challenge this organization, state dental societies, the entire profession, and our nation's policy makers for years to come.

The ADA and the Alaska Dental Society have expended extraordinary amounts of volunteer and staff time, political capital and money over the past four years, always with the goal of ensuring the safety of dental patients in Alaskan villages. This battle has been waged on legal, legislative and public relations fronts. Throughout, those who are on the front lines of scope of practice and access battles (in Alaska and elsewhere) have, of course, been extremely concerned about the potential ramifications that the DHAT issue in Alaska could have on access to care issues in other states. Be assured that the Board has always had these ramifications in mind while deliberating on this issue. The Board has not lost sight of these complexities, ADA polices and its duties to the Association and the membership.

The ADA has been at the eye of a small but mighty storm this year, for three primary reasons: (1) some delegates wrongly believe that the Board abandoned ADA policy and the Alaska Dental Society in settling the lawsuit; (2) the profession is divided on how to address the underlying complex and multi-faceted issues of access to dental care and scope of practice; and (3) misinformation about the lawsuit and settlement process, combined with a basic disagreement about what decisions would be in the best interests of the entire dental profession, made the interactions between the ADA and the Alaska Dental Society awkward at best and, at times, quite difficult. In short, the ADA has been through tremendous turmoil this year, and the Board cannot recall any other issue on which it has been so passionately thanked and praised by many members and yet also so stridently criticized by others. The Board also is aware of no other issue in its recent history in which it has had to contend with such a steady flow of misinformation that required correction again and again. The Board has worked hard to explain the actions taken on this issue, described in lengthy detail its reasons for taking those actions, and is thankful for the support that most colleagues have shown in response.

The purpose of this report from the Board of Trustees is to provide an overview of the history of the Alaska situation, a synopsis of the settlement that occurred this summer, a discussion of ADA policy, and insights from the Board's experience about what is needed moving forward. The Board believes it is important to

provide these remarks to the House of Delegates to bring closure on this difficult chapter in the ADA's recent past.

Timeline: The Board acknowledges that the underlying issues that led to the creation of a DHAT program in Alaska must be addressed by the profession if we are to ensure that the every patient receives appropriate dental care. It is critically important, therefore, that we learn lessons from the experiences of the past few years. To that end, following is a timeline of the events and activities that, from the Board's perspective, are significant.

2003

- Alaska Dental Society (ADS) leaders brought to the ADA's attention concerns about the potential (and then later the actuality of the) expansion of the existing Dental Health Aide Program in Alaska to include dental health aide therapists (DHATs).
- The House of Delegates established a task force to explore options available for delivering high quality oral health care services to Alaska Natives.

2004

- The ADA Task Force traveled to Alaska in March and met with Indian Health Service (IHS) and tribal representatives, ADS leadership and Alaska dentists. The trip included a site visit. In addition, some members of the Council on Government Affairs spent a week in various Alaska villages providing pro bono dental services. In all, three trips to Alaska were made in this year by various ADA leaders.
- The House of Delegates adopted a resolution to establish a number of strategies to help assure access to quality oral health for Alaska Natives in rural villages. The Alaska Task Force was continued. ADA policy was established to support all aspects of the dental health aide program except the portion that permits DHATs to perform irreversible surgical dental procedures. The Board also was directed to use all appropriate federal legislative and judicial means to resist any effort that would allow non-dentists to diagnose or perform irreversible dental procedures.
- ADA lobbying on Capitol Hill honed in on the Indian Health Care Improvement Act (IHCIA), legislation that authorizes a number of federal Indian health programs, including the Community Health Aide Program (CHAP) in Alaska that spawned the DHAT program. The primary effort was to seek an amendment to the IHCIA that would explicitly prohibit DHATs from performing irreversible dental procedures. Significantly, the IHCIA had a new provision in it that, if enacted into law, would allow for the expansion of the currently Alaska-only CHAP to other states, creating the potential for federally-authorized DHAT programs in the lower 48 (tribes would still have needed to secure federal funding). For a number of reasons, however, the legislation did not pass during that Session.
- More than 200 dentists expressed a willingness to volunteer to go to Alaska to serve remote Native communities.

2005

- Preparations were made in the Congress to reintroduce the IHCIA, with the starting point being the version introduced in the previous Session. Efforts to convince the three-member Alaska congressional delegation to support our DHAT prohibition amendment met with mixed success, with both Senators opposing us but with Rep. Don Young (AK) agreeing to support the prohibition. Importantly, Rep. Young was the House sponsor of the IHCIA in the previous Congress and was expected to sponsor it again in the current Session. However, Rep. Young did inform representatives from the ADS that he had come under heavy criticism in his state as a result of supporting the ADA's position. Nonetheless, he vowed to keep his commitment.

- This was the top lobbying issue for the ADA during the year. There were a number of efforts made to use the grassroots network to develop legislative support for our amendment (an effort that met with mixed success, with a disappointing number of our members responding to the alerts); testimony by the then-CGA chair before a House Interior subcommittee on appropriations; testimony by ADA's president before a joint hearing of the Senate Indian Affairs and Senate Health, Education, Labor & Pensions committees; a meeting with Sen. John McCain (R-Ariz.), chair of the Indian Affairs Committee; a meeting with Health & Human Services Secretary Michael Leavitt; and regulatory lobbying on related Medicaid reimbursement issues. During this entire year, the ADA was repeatedly assured by Rep. Young that the amendment to prohibit DHATs from performing irreversible procedures would be inserted in the House version of the IHCIA.
- In February, the Alaska Board of Dental Examiners sent a letter to the Alaska Attorney General declaring that DHATs were performing dentistry illegally and stating that this illegal activity was putting Alaska citizens at risk. The ADA and ADS sent letters supporting the Board's actions.
- In April, the ADA Board authorized extensive funding for a public affairs campaign and related activities (television and print ads, etc.). A media consultant who had been recommended to the ADA and ADS by Rep. Young was hired. The ads began running in May (print) and July (television), just prior to a Senate Indian Affairs mark-up of the IHCIA. The ANTHC responded with its own broadcast and print ad campaign.
- The Senate Indian Affairs Committee voted out the IHCIA. Sen. Tom Coburn (R-Okla.) offered the ADA's amendment, which was rejected. Importantly, however, Sen. McCain offered an amendment to limit DHAT services to Alaska only in a section that otherwise would have expanded the availability of the Community Health Aide Program nationally. The amendment was approved.
- Spokesperson training was provided by the ADA for Alaska leaders and a public opinion survey was conducted in Alaska to measure support for our position on DHATs.
- Extensive news and editorial coverage in Alaska began to appear. The news was initially fairly balanced; the editorials were not. Dentists were characterized as fighting a turf war, not caring about Alaska Natives, etc. As time went on, the news and editorial coverage and public opinion continued on a downward spiral against dentists, the ADS and the ADA.
- The Board adopted a resolution in June to provide financial support to the ADS in the planned lawsuit. That resolution included the following, "Resolved, that this authorization is contingent on the Alaska Dental Society's recognition of the Association's right to 'participate in and direct the project for which the funds are requested, to the extent it considers appropriate and necessary' pursuant to the Guidelines for Providing Financial Assistance for Proactive Legal Actions Having National Significance. . . . " The Board's action was communicated to the ADS.
- In July, an inflammatory editorial was published in an ADS publication that further eroded the reputation of the profession in the eyes of the ANTHC and others.
- During this same time period, an ADS officer posted an inflammatory message on the ADA president/president-elects listserve, which was then picked up, posted and discussed on a public health listserve. Some of the inflammatory information published by ADS during this time frame were used by the defendants against the ADA and ADS in written materials presented to the court.
- In September, the Alaska Attorney General issued an opinion declaring that, as long as DHATs were employed by Native Health Clinics and treating patients authorized to receive care in those clinics, the aides did not have to comply with the state dental licensing laws (and as long as the procedures fell within the scope of Congress' seven listed dental health objectives).
- Following the Attorney General's opinion the ADA and ADS spent considerable time and effort preparing for the possible filing of a lawsuit.

- The ADA House continued the Task Force for an additional year and called for the ADA to oppose pilot programs that were in violation of the specific ADA policy in opposition to non-dentists making diagnoses, developing treatment plans and performing irreversible procedures.
- The ADA hired a manager for ADA's Native American/Alaska Native Dental Placement Program. One of his first assignments was to travel to Alaska in December for a 10 day trip to learn firsthand about local dental needs and the logistical challenges related to placing dentists in rural villages, as well as general terms of contracting, credentialing, professional liability insurance and assignment limitations. He identified two Alaska Native health corporations that expressed a general willingness to accept volunteers.

2006

- The ADA, ADS and individual dentists filed a lawsuit on January 31, 2006, in the state court in Alaska, seeking to stop the practice of allowing unlicensed, non-dentists to perform surgery on Alaskan citizens. The complaint asked the court to declare the ANTHC and DHATs in violation of state law by engaging in the practice of dentistry without a license.
- Prior to the filing of the lawsuit, the ADA had negotiated placements for eight volunteers with two tribal health corporations in Alaska. After the filing, both corporations suspended their offer to host ADA-sponsored volunteer dentists.
- In June, the IHCIA continued to await consideration by the full Senate, and efforts to introduce and move a version in the House began. A turning point in the ADA's legislative advocacy strategy occurred on June 21, when Rep. Don Young suddenly abandoned his previous support for our amendment to prohibit dental aides from performing irreversible dental procedures in favor of what his staff considered to be compromise language that would place limits on certain irreversible dental procedures performed by DHATs. This new position was presented to the ADA as a final offer and only hours before the House Resources Committee marked up the IHCIA. While making it clear that the ADA did not endorse the new IHCIA language, the ADA acted immediately to improve it. In exchange for some significant revisions, including retention of the McCain provision limiting the DHAT program to Alaska insofar as the IHCIA was concerned, the ADA agreed not to fight the IHCIA. The ADA also worked to ameliorate the IHCIA language through report language that accompanied the legislation. In short, the ADA agreed not to scuttle the new language, made no commitment to actively support it, and looked for ways to amend the bill to add provisions that would meet the overarching goal: get more dentists into underserved tribal areas so that, in the long run, DHATs performing any irreversible dental procedures would become a moot point. At the same time, the ADA tried to make the most of the potential opportunity to develop a working relationship with tribal leaders, which previously had been impossible because of ill will generated by some of the early ad campaigns and the filing of the lawsuit.
- The Board of Trustees and the Alaska Task Force provided a lengthy and detailed report to the 2006 House of Delegates, outlining this legislative activity, (and included extensive supplemental notes and emails describing the last-minute nature of Rep. Young's change of heart) (*Supplement* 2006:6003). This report to the House made it clear that the ADA could not legislatively stop DHATs from doing irreversible procedures in Alaska and how the ADA would continue to work towards limiting DHATs to the best of our ability while working to provide a better model of care that would eventually make DHATs unnecessary. ANTHC's Paul Sherry addressed the House of Delegates.
- The ADA hired a new public relations firm (Chlopak, Leonard, Schecter & Associates - CLS) in an effort to develop a national advocacy campaign that would help with the ongoing public relations and opinion challenge as an outgrowth of Resolution 41 (*Supplement* 2006:3052; *Trans.*2006:305) – State-based Public Affairs programming. This is the same firm that is now advising the ADA and

state dental societies on the state public affairs initiative. Based upon a review of both survey data and media coverage of the issue, CLS strongly recommended that all future communications emphasize only positive messages about alternatives to the DHAT program (e.g., placement of volunteers; support for new ways to attract dentists to funded programs; new collaborative solutions with Native American leaders; etc.).

- ADA House of Delegates approved a Workforce Model (Report of the Dental Workforce Task Force 2006, Resolution 3 (*Supplement* 2006:5000; *Trans*.2006:306) as a more effective strategy to affect lack of access to care in underserved areas and directed several activities for 2006-7. A progress report on that initiative can be found elsewhere in the House of Delegates materials (Board Report 14).
- Key learnings in 2005 and 2006 from our public relations efforts: Without positive solutions to offer, speaking out against DHATs was viewed as anti-access to care and positioned dentists as uncaring about the plight of Native Alaskans. This presented a dilemma for the ADA: how to communicate with two dramatically different audiences (members and the outside world) with dramatically different views of what constitutes "good news" on this issue. Communicating to the members that the ADA was holding the line steadfastly on its commitment to having only dentists perform the irreversible dental procedures signaled to the media, public officials, the public health community and the general public that dentists care only about their turf, not about delivering care to people in great need. Communicating to the outside world that dentists want a solution that all stakeholders can support, or at least live with, signaled to some members that the ADA Board was "giving up."
- Two primary events of significance in the lawsuit were the August filing of an amended complaint to add the State of Alaska as a defendant (on the grounds that the State failed to enforce the Alaska Dental Practice Act against DHATs) and, in December, the ANTHC and the State filing of separate motions for summary judgment, in which they argued that federal law preempted state law on the scope of practice for DHATs. ADA, ADS and its individual defendants filed cross motions for summary judgment on the same issue, arguing that federal law did not preempt state law, and that the federal and state laws could co-exist.
- The Congress ended without any further legislative action on the IHCIA.

2007

- In January, President Kathy Roth and Bill Prentice met with ANTHC representatives, including ANTHC chair Don Kashevaroff, executive director Paul Sherry, attorney Valerie Davidson and dental directors Ron Nagel and Ed Allgair, in Anchorage to find out more about the DHAT program (this meeting was preceded earlier in the month by a similar meeting between ADS and ANTHC). Dr. Roth and Mr. Prentice then met with ADS president Mike Boothe, executive director Jim Towle and former ADA president Geraldine Morrow to share information.
- A very significant event occurred in our lawsuit in March when the United States Attorney filed a "Statement of Interest" with the court on behalf of the Department of Health and Human Services, the cabinet level agency in charge of administering the IHCIA. The Statement of Interest amounted to an exhaustive argument that the IHCIA preempted Alaska's licensing law and permitted the DHAT program in the form adopted by the ANTHC. The fact that an administration known for favoring state authority came out in favor of federal preemption in this particular instance was deemed a very unfavorable development in the lawsuit.
- The IHCIA was reintroduced in both the House and Senate and hearings were held. Also in March, Kathy Roth, Mark Feldman, Mary Smith, Jim Bramson and Bill Prentice went to Anchorage to meet with ADS representatives Drs. Michael Boothe, Pete Higgins, David Logan, Robert Robinson and ADS Executive Director, Jim Towle and attorneys (Doug Serdahely and Thomas Van Flein,

representing ADA and ADS, respectively) to ensure that all had a shared understanding of the state of the lawsuit, our legislative options and our continued public relations challenges. During the discussion, which centered on a shared prognosis by both the ADA and ADS outside attorneys that the likelihood of a victory in the litigation was quite poor, a decision was made by both ADA and ADS attendees to explore mediation with ANTHC. It was agreed by all that it would be in everyone's best interests to attempt a settlement through mediation. It was also agreed that a proffer to mediate would only be made by the ADA outside attorney to the ANTHC counsel, so as to preserve attorney client privilege. Unfortunately, ADA later learned that at least one ADS leader chose to ignore the agreed-upon strategy, put the attorney-client privilege at risk, and contacted the ANTHC to discuss mediation.

After the ADA attorney properly conveyed the offer to mediate, it was learned that ANTHC would prefer a settlement offer rather than mediation. A major stumbling block was the ADS' insistence that any settlement contain a statement that nothing in the IHCIA would be considered to impact a State's authority to regulate the health care of its citizens. Since this was the entire issue in the lawsuit, the State of Alaska and the ANTHC could not accept that provision, as it would amount to a concession that was completely contrary to their position in court.

- On May 21, 2007, the ADA sent a draft Settlement Proposal letter to ADS for their review and comment. During the evening of May 21st, the ADA and ADS leadership (and their attorneys) had a confidential, attorney/client conference call to discuss various settlement related issues.
- Thereafter, on May 22, 2007, ADS sent a revised draft of the settlement proposal letter which ADS advised that they would like to have co-signed by their attorney.
- On May 23, 2007, the ADA sent ADS a further revised draft settlement proposal letter incorporating some, but not all of the ADS' proposed changes.
- In an e-mail dated May 24, 2007, Jim Towle conveyed the ADS' further proposed changes to the draft settlement proposal letter and stipulated that they would only agree to sign this letter if it was revised as indicated, and that the "ADS had the right to refuse any settlement and that the ADA would continue to fund the lawsuit and any appeals that ADS believed to be appropriate."
- It was the Board's unanimous view that further delay in reaching a settlement was increasing the likelihood that the defendants would walk away from the bargaining table—a state of affairs that would have left the ADA with little opportunity to improve increasingly bad legal, political and public relations situations. The Board of Trustees could not accept the conditions the ADS wished to impose and of course could not give the ADS the complete control it sought. Therefore, in a letter dated May 30, 2007, to ADS' President, Dr. Roth commented on ADS' most recent changes to the draft settlement proposal letter, and advised that, "[a]fter careful thought, the ADA's Board unanimously concluded that litigation funding for the ADS in this litigation would cease if the ADS declined to join the ADA in [its] settlement offer…" Dr. Roth again asked the ADS to join the ADA in the version of the draft settlement proposal that was attached to her letter. If the ADS declined to do so then, as the ADA made clear, the ADS was choosing to work independently of the ADA.
- In a letter to the ADA dated May 31, 2007, ADS President, Dr. Michale L. Boothe, advised the ADA that ADS would not participate in the proposed settlement and that the ADS intended to continue with its lawsuit even if the ADA withdrew funding for it. The letter indicated that "the ADS chooses not to agree to the terms the ADA has set forth, but to continue to have the suit disposed of by the courts, even if it means the ADA chooses to withdraw financial support for the ADS." Further, the letter ended with, "we wish the ADA luck in its efforts to settle its portion of the lawsuit and hope the same will be returned. We take no offense if the ADA wants to work out a unilateral dismissal of itself and Dr. Jones, provided that the ADA does nothing to prejudice our ongoing issues." Settlement

discussions between the ADA and ANTHC continued after ADS declined to join ADA in the terms of the proposed settlement.

- The ADA, in a June 12, 2007, letter, responded to Dr. Boothe's May 31, 2007, letter correcting certain ADS comments and allegations about the ADA and its position which, in the ADA's view, were inaccurate and unwarranted. The ADA also agreed with ADS' observation that the ADA and ADS are "partners" in promoting the interests of dentistry in numerous ways.

As the above chronology indicates, in its communications between ADA and ADS, ADA affirmatively involved ADS in settlement discussions until such time as (1) ADS declined to join ADA in the proposed settlement letter that was sent to the defendants and (2) ADA rejected ADS' demand that ADA provide ADS with a complete control of the Alaska litigation.

- On June 15, the ADS' attorney presented the ADA, ADS and individual plaintiffs' position on the preemption issue to the court in oral argument on the summary judgment motions. Questioning by the judge left little doubt that the odds were heavily against us.
- On June 27, the trial court judge entered his ruling in favor of ANTHC and the State of Alaska, stating that federal law preempted the licensing requirements in the Alaska Dental Practice Act as applied to DHATs. Following the court's ruling, the ANTHC indicated that it was still willing to continue the ongoing settlement discussions. ADA released a statement expressing disappointment with the ruling. "Our only objective in this litigation has been to improve access to high-quality oral health care in remote areas of Alaska, to ensure that dental personnel providing this care are properly trained, and to maximize patient safety," Kathy Roth said. She pointed out that ADA's goal was to ensure that Alaska Natives had access to the same oral health care as all other Americans and reiterated our commitment to "get sufficient dentists into remote Alaska to meet the complex dental needs of Alaska Natives."
- On June 28, the ADA informed the membership of the court's ruling and that settlement discussions were continuing.
- On June 30, when it appeared that the ADA and the defendants had reached an acceptable settlement, the ADA asked ANTHC to give ADS one last chance to sign onto the settlement agreement, which would allow ADS and the individual plaintiffs to be protected under the negotiated terms of the settlement from the financial jeopardy of having to pay some portion of ANTHC and the State's large legal fees. At the same time, Dr. Roth sent an e-mail to the ADS once again inviting it to join the settlement, and explaining the potential liability situation faced by it (and the individual plaintiffs aligned with it). Dr. Roth further explained that the settlement would require no payment by them. Dr. Roth conveyed ANTHC's deadline of July 3, (since the holiday was imminent). ADS indicated that they needed more time. ADA approached ANTHC who then agreed to give ADS until noon on July 5. ADS agreed to participate in the settlement, but indicated it needed more time to get all its signatures. ANTHC agreed to give ADS until July 9 to get the signatures, since this date was the court's deadline for ANTHC and the State to file post-ruling motions. The ADA Board had no control over these final deadlines. The ANTHC also made it clear that they would not settle with the ADA and allow the ADA to continue to fund an appeal by the ADS. In addition the ANTHC also advised that any settlement that included the individual ADS dentists would also have to include the ADS. No partial releases with ADS aligned individuals would be considered.
- On July 5, the ADA and Dr. Jones executed a settlement agreement.
- On July 6, an officer of the ADS once again put the attorney-client privilege at risk and inappropriately posted the settlement agreement on the ADA's president and president-elect's listserve, resulting in much misinformation being bandied about concerning the terms of the agreement.

- On July 8, the ADA was advised by ADS' attorney that the ADS was going to participate in the settlement agreement, but no one from the ADS signed it at that point.
- On July 9, the ADA sent an extensive electronic memo to all dentists for whom the ADA had an e-mail address, advising of the settlement, which had been signed by the ADA but still not signed by the ADS. The ADA had been waiting to inform the membership of the settlement until ADS signed the papers, but was compelled to send the memo early to dispel the misinformation resulting from the unfortunate and premature posting by an ADS leader on the listserve over the weekend.
- On July 10, that agreement was executed by the ADS and the ADS individual plaintiffs.
- The IHCIA, having been approved in committee with no significant changes, continues to await consideration by both the House and Senate.

The Legal Issues in the Lawsuit: The ADA/ADS raised a number of legal issues in the lawsuit to challenge that portion of the DHAT program that permits the performance of permanent, irreversible dental procedures, i.e., dental surgery, by unlicensed, under-trained individuals. The ADA and ADS sought several remedies, all aimed exclusively at stopping the complained of practices. The ADA and ADS did not seek a money judgment.

For example, the ADA and ADS sought a declaration by the court that the DHATs were practicing dentistry without a license in violation of the Alaska Dental Practices Act and also asked the court to enjoin the DHATs from doing so. The ADA and ADS further asked the court to order the Alaska Attorney General to enforce Alaska's dental licensure law, which the Attorney General had refused to do. Finally, the ADA and ADS sought a declaratory judgment that the private plaintiffs could seek enforcement of the Alaska Dental Practices Act in the face of the Attorney General's refusal to do so.

The Defendants denied or challenged each of the Complaint's allegations. Soon after filing their Answer, they filed a motion for summary judgment that Alaska's licensure law was preempted, or displaced, by the Federal Indian Health Care Improvement Act (IHCIA) as it applied to the DHAT program. The ADA and ADS also filed a summary judgment motion on the preemption issue, arguing that the objectionable DHAT practices were not permitted by the IHCIA in the first place. The ADA and ADS maintained that the state law was not preempted by the federal statute, and in fact that the issue of preemption in this context was merely a red herring. It was the position of the ADA and ADS that the Alaska licensure law and the IHCIA could coexist without conflict. During oral argument on the summary judgment motions in June of 2007 the judge asked questions such as, "[i]f I don't find preemption, won't this wonderful DHAT program go away?"

As mentioned above, the Defendants' argument that Alaska's dental licensure law did not apply to DHATs was based on the doctrine of federal preemption as established by the Supremacy Clause of the United States Constitution. The Supremacy Clause provides that the laws of the United States are supreme and binding regardless of any conflicting state law. The Defendants did not try to argue that Alaska law was simply inapplicable against the sovereign tribe. They did not argue that the DHATs' practices were authorized because Alaska could not legislate the affairs of the tribe. The Defendants rightly agreed that Alaska could legislate those affairs. They argued, instead, that the United States could also legislate those affairs, and that the federal legislation preempted Alaska's law.

The sovereignty of the Alaska tribes was sharply curtailed by the Supreme Court's *Venetie* decision, which ruled that Congress's abolition of reservations in Alaska virtually eliminated such sovereignty (in *Venetie* the Court held that an Alaska tribe was not able to tax the state of Alaska in connection with a school built on land owned by a tribal corporation). But whether or not the tribes were sovereign, there can be no question that the United States is sovereign, and that its laws are the supreme law of the land. Thus, the only issue in

the lawsuit filed by the ADA and ADS was whether the United States' law preempted Alaska's law. The ADA and ADS, like the Defendants, chose not to touch on tribal sovereignty because it would have distracted from the only important issues.

In early September, a new unfounded assertion was circulated by an ADS official, specifically, that the ADA's outside attorneys in the litigation had a "conflict of interest" with respect to the case. This groundless allegation was apparently based on no more than the mere fact that two or three attorneys who are members of the same firm as ADA's lawyers have represented some Native Alaskan entities in business and real estate matters. That does not create a "conflict of interest." ADA's law firm, Patton Boggs, LLP, employs over 500 lawyers nationwide, and some of its major work in Alaska is representing oil and gas companies in lawsuits **against** the state. The State of Alaska, of course, was one of the defendants in the recent litigation. Interestingly, the law firm that represented the ADS has also represented the State of Alaska in at least a couple of lawsuits. Yet no irresponsible "conflict of interest" accusation has been directed against that law firm. Based on the excellent representation the ADA has received from Patton Boggs, there was absolutely no justification for making it the target of such a charge.

Terms of the Settlement: The ADA was able to negotiate some key commitments from ANTHC in the settlement negotiations that will prove very helpful to the dental profession as we move forward to develop and implement positive solutions to access to care problems in underserved tribal areas that concur with ADA's standards:

1) ANTHC will ask the Indian Health Service to add a second seat to the Community Health Aide Program (CHAPS) Certification Board and to that Board's Dental Academic Review Committee, for a licensed dentist nominated by the ADA. This is the Board that certifies, regulates, and disciplines the DHATs in Alaska.

2) ANTHC will support a pilot program for the ADA's community dental health coordinator model.

3) ANTHC will support a longitudinal study of the delivery of health care in remote areas of Alaska that reviews the use of dental health aides, dental health aide therapists, public health dentists, private sector dentists, community dental health coordinators and any other model that provides direct care to patients.

4) For three years, ANTHC will work with the ADA to preserve the language in the Indian Health Care Improvement Act (IHCIA) limiting the scope of dental health therapist practice and the language confining such practice to Alaska. Without this concession on their part the IHCIA CHAP program could expand both in scope and territory as we lost the lawsuit.

5) 5) ANTHC will not seek attorneys' fees (to which our legal counsel advises they would have been entitled) in this litigation.

As a part of this settlement, ADA paid ANTHC's foundation $537,500 (to support ANTHC's efforts to promote preventative oral health in remote Alaska) and the State of Alaska $75,000.

Some members have asked why the ADA agreed to settle the lawsuit. When the ADA Board began to enter into serious mediation/settlement discussions with ANTHC and the Alaska Dental Society in March 2007, it was hoped at that time that ADS and ADA would be involved together in submitting a proposal to ANTHC, but ADS elected not to participate, for reasons of its own. It was the ADA's hope that a settlement would be reached before the court ruled in the case, for the following primary and related reasons:

First, a negative ruling would have left us with very little leverage to obtain any improvements or input on the DHAT program (fortunately, as events have shown, we were still able to leverage the possibility of appeal to effect a settlement after the trial court ruling). Second, whether we won or lost, any court decision would put the public spotlight back on the program and potentially tarnish the profession's image. Third, a victory in the lawsuit at any level would have spurred the ANTHC, in conjunction with the broader tribal community, to specifically amend existing law to legislatively fix this in their favor (of course, with media and public support). Fourth, as long as this litigation was pending, our hands were tied in trying to do anything to help improve the oral health of Alaska Natives because the tribes would not work with us, having this cloud hanging over everyone's head.

In short, the alternative to the path we chose stood in stark contrast: waste hundreds of thousands of dollars on a lawsuit appeal with little chance of victory (and with the knowledge that even a victory would be short-lived as the tribal community would have broad support for a legislative change to "correct" a judicial decision against them); a growing animosity with the broader tribal community that we need to work with so as to prevent other DHAT programs; further tarnishing of the reputation of the profession in both the public health community and the media; and increased suspicion from policymakers that our motives were based upon a desire to protect our turf rather than to protect our patients.

Some have also asked how it is that a settlement is a better option than appeal or just taking our lumps with the court's decision.

Taking an appeal would have exacerbated the situation rather than make it better, for all of the reasons noted above. Some individuals have stated that they believe an appeal would be inexpensive and easy to win. The ADA Board respectfully and strongly disagrees. The ADA has extensive experience in appeals and litigation to much higher courts and the Board knows ADA would have paid hundreds of thousands of dollars in legal fees if the case went all the way to the U.S. Supreme Court. For the same reasons, the ADA and ADS were advised that we could expect a negative ruling at the trial court level, and that there was little likelihood that an appellate court or the U.S. Supreme Court would overturn a carefully rendered and articulated trial court ruling. In addition, while that trial court ruling is not binding precedent on any other court, there was a huge risk that an appellate or U.S. Supreme Court decision would be have been viewed differently and might have some value as a national precedent. Finally, as noted above, a victory in the lawsuit at any level might have led ANTHC, in conjunction with the broader tribal community, to specifically amend existing law to legislatively fix this in their favor (and, in all likelihood, removed the limitation in the bill that currently restricts the program to Alaska).

ADA Policy: Some delegates have contended that the settlement of the lawsuit was either a violation of existing House policy that opposes DHATs performing irreversible dental procedures or that the Board adopted interim policy that in effect rescinded that policy.

The Board strenuously disagrees with both contentions; it was neither a violation of existing policy nor an adoption of interim policy. The Board still believes that surgical treatments by non-dentists is inappropriate but must contend with reality. Achieving full implementation of this policy statement was not achievable through continued litigation. The Board believes that the settlement was more likely to achieve the objectives of ADA policy than a strategy of pursuing to the end a litigation that was unsuccessful for the profession both legally and in the court of public opinion. The ADA has not changed its position, and our ultimate goal remains to prevent non-dentists from performing irreversible procedures. Getting there means that we have to show that other alternatives to a DHAT are better, safer and more efficient and reduce access to dental care problems more effectively.

The ADA Board believes that to try to achieve full implementation of House policy through conventional means would have resulted in a far worse outcome than what was accomplished. The joint efforts over the past four years have shown clearly that neither the ADA nor ADS could achieve the goal through legislative means, either in Alaska or in Congress. It also became very clear that litigation was a dead-end as well. The only hope for any success was through a negotiated agreement that preserved as much as we could preserve, while at the same time ramping up standards and education. Certainly, the settlement reflects this.

The Board believes that mitigating our concerns was better than leaving them unabated and brings the Association in closer concert with stated ADA policy. We all want to achieve our policy, but we could no longer believe that this litigation, lobbying or public relations could accomplish it, and our settlement strategy was the best option and showed beyond words that the profession cares about improving the oral health of Alaska Natives.

The Board continues to believe that we owe it to the members and the public to pursue a reasoned approach that will improve oversight of the DHATs to the greatest extent reasonably possible, while at the same time working to eliminate the conditions that led to the perceived need for DHATs in the first place. Otherwise, we risk ending up with nothing.

Of particular relevance here is a paragraph that the Board included last year in its comment on the Alaska report to the 2006 House of Delegates:

> The Board of Trustees believes that the only hope for moving forward in a positive way that does not completely destroy any opportunity for the ADA to have a meaningful role in Alaska efforts to improve access for Alaska Natives (and other dentally disenfranchised people throughout this nation) is to shift our collective focus toward furthering these discussions and to develop constructive solutions and programs that ensure that Alaska Natives have access to the same oral health care as all other citizens. We believe that as our CDHC proposal develops and is hopefully piloted in Alaska, it will prove to be a safe and effective way to provide increased access to care and prevention to the Alaskan villages and ultimately should replace the DHAT model. (page 6007, lines 33-40)

Thus, the Board took this action with the goal of ensuring that DHATs are not authorized under the existing federal law beyond Alaska, and in the hopes that a resolution of a contentious legal action will open up discussions with the ANTHC that will allow us to get more dentist-provided care in tribal areas and make DHATs performing irreversible procedures unnecessary. We are also hopeful of achieving some oversight of the DHAT program with the placement of an ADA nominated dentist on the CHAP Board.

Conclusion: Lessons Learned and Insights Gained: The dental profession cannot allow itself to be defined in the media, Congress, in State Houses or in the eyes of the public solely by what it is opposed to. It must be defined by a positive agenda that credibly responds to public concerns. If we are viewed as being opposed to change, rather than as open to working with others on positive things that truly make a difference in improving access, it is very unlikely that ADA will be part of any solution that others develop. That is precisely what happened in Alaska, and it is poised to happen again and again throughout the United States if the dental profession continues to be known only for its propensity to say “no” to other perspectives. Outside groups, especially community based groups, believe they know better than the ADA or state dental societies how their community needs can best be met and they are seen by the media, regulators and legislators as a more neutral voice in this debate. If the ADA and state dental societies insist on the “ADA” or “state dental society” way, we will probably not even be invited to sit at the table to provide input when new solutions are conceived.

The ADA's CDHC model is one solution, but it cannot be the only one. It is the best answer right now but undoubtedly, others are needed and will be identified

Increasingly, the public, the media, and even, at times, policymakers, give less credence to traditional authority. Where once the word of the ADA and state dental societies on dental matters, or the AMA and traditional medical associations on medical matters, was sufficient to forestall bad policy, increasingly that no longer holds true. The growth of other "experts," the ability to use the Internet to get alternative opinions and views, the increased desire of the mainstream media to look for conflict rather than answers, all make it harder for groups like the ADA to advocate its views. It is critically important that the ADA ensure that our advocacy efforts enhance, rather than diminish, the reputation of the profession. We have all worked hard over the years to develop the high regard that both the public and policymakers have of dentistry and cannot let that lapse. Once tarnished, a reputation is hard to repair.

The ADA Board knows that it faced a tough issue this past year with less than perfect choices to work with. Further, it did not enjoy or revel in the discomfort of being at odds with one of its state societies. But the Board went about its business with clarity of mind and purpose for the good of the entire Association and the profession based on the facts and circumstances as it found them.

The Board is comfortable with its actions; it acted unanimously and only after careful and painstaking discussion. And, it remains resolute that we have to find a better way to resolve access to dental care problems. We think we did the best we could for the Association and ask for your continued trust and confidence in our abilities to manage the Association in times of complex and constant change. It is time for us to move on and work together to construct solutions to help America's underserved get the dental care that we know they need in a manner we can all support.

As challenging as it was for all involved, many good lessons have been learned from the Alaska experience. Most importantly, finding positive solutions to access to care for the underserved is at front and center of the entire profession's attention like it never has been before. The substantial progress that has been made on developing the new CDHC model is a good example of a positive solution that has come about in large part because of the need for a viable alternative to the DHAT. A significant piece of federal legislation addressing access to care has been introduced by the ADA. The ADA's volunteer placement program, and the planned Native American Summit, all arose in response to the Alaska situation and offer opportunities to work with Native American communities to help them solve their access issues. The ADA's advocacy initiative was started, and numerous outstanding recommendations have been implemented, in large part to ensure that we are positioned in Washington, DC to do everything possible to achieve successful advocacy for this profession. The advocacy summit never would have happened had the ADA not been dealing with Alaska-related issues. The state public affairs initiative was developed in large part out of the need for the development of positive, proactive ways to address public image issues at the state level. More recently, the many questions and confusion about the attorney/client privilege led to our legal department creating a very helpful brochure that explains the attorney/client privilege, and they led a discussion at this summer's constituent society workshop on the same subject. The ADA's new chief legal counsel also has reviewed and made adjustments to the scope of matters that the legal department historically had covered in attorney/client sessions, in order to address the Board's desire that those sessions be as minimal as possible while not exposing the Association's legal interests. The Board also has learned from this experience how critical it is for any state dental society, no matter how large or small, to have some financial stake in any litigation they initiate with ADA support, because one's perspective is very different when it includes a financial commitment. The Board also has spent more time than ever before reflecting on its own responsibilities and leadership role Fundamentally, however, it is the need for solid access to care solutions (not limited to the

CDHC model) that this organization can support that must be the Association's guiding light as we remember the lessons of the recent past**.**

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: CGA Supplemental Report 1 Date Submitted: September 2007

Submitted By: Council on Government Affairs

Reference Committee: Legal and Legislative Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

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

Background: This report provides responses to 2006 House of Delegates resolutions not already addressed in the Council's annual report.

Chair and Vice-Chair: The Council forwarded the name of Dr. Keith W. Suchy to the Board of Trustees for approval as the Council's next chair. Dr. Timothy R. Kinzel was elected vice-chair.

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

Response to Assignments from the 2006 House of Delegates

This section contains responses to the 2006 House of Delegates not otherwise addressed in the Council's annual report.

Incentives for Dental School Graduates to Work in Tribal Areas: Resolution 39H-2006 (*Trans.* 2006:338), requires the ADA to develop and support new or enhanced post-dental school programs and clinical experiences for recent dental school graduates to work in remote American Indian/Alaska Native communities, and develop and support opportunities for retired dentists to work in AI/AN communities, and to work with various agencies and others to establish an Internet process whereby individuals could obtain information concerning job vacancies and loan repayment programs. In 2007, the ADA spearheaded a lobbying effort that resulted in an additional $5 million funding for Indian Health Service loan repayments, which is the first step in a four-year appropriations plan to fully fund loan repayments for all health positions within the agency. The ADA is also very actively lobbying for additional dental residency program funding and has developed a legislative proposal that will waive the tax liability associated with Indian Health Service loan repayments, which otherwise is paid by the Service, significantly reducing the amount of loan repayment funds available to distribute. In response to the third resolving clause, the ADA continues to provide the link to the IHS Internet recruitment pages in *ADA News* and in other articles related to the Dental Placement Program, as well as information concerning other features about American Indian/Alaska Native oral health. The IHS is also described in the "Careers in Dentistry InfoPak," published by Office of Student Affairs and available on ADA.org.

Freedom of Choice in Publicly Funded Aid Programs: Resolution 42H-2006 (*Trans.*2006:344) states that the ADA should pursue regulatory or legislative action to ensure that any licensed dentist may participate in a publicly funded program without joining a third-party network that requires the dentist to see privately funded commercial patients under a managed care contract. The ADA explicitly addressed this issue in federal legislation. The "Essential Oral Health Care Act of 2007," H.R. 2472, offers states enhanced federal matching funds if they fix their Medicaid and State Children's Health Insurance Program (SCHIP) plans in a variety of ways, including ensuring that any licensed dentist may participate in the publicly funded plan without having to participate in any other plan. H.R. 2472 is at the heart of the ADA's lobbying effort to improve access to oral health care services for underserved populations and will remain a very high priority of the ADA in 2007 and 2008 and beyond, if necessary.

Insurance Benefits for Necessary Dental Treatment of Certain Medical Conditions: Resolution 58RC-2006 (*Trans.*2006:324) was referred to the Council on Government Affairs (CGA) for further study. It states that the ADA should seek changes in federal law concerning ERISA (and urge constituent societies to seek changes in state law) to mandate that dental treatment that is considered an integral part of the treatment of a diagnosed medical disease be afforded coverage under the third-party medical payer's contract. The CGA discussed this resolution at its September meeting in great detail and determined that the ADA needed additional information and time to determine how best to proceed on this matter to assure that third party coverage is expanded in a manner that ensures patients are offered necessary coverage that properly targets "medically necessary" treatment while remaining mindful of the ramifications of any changes. A particularly thorny element is how such efforts would impact policymakers as they look at universal health care coverage. Accordingly, the Council believes it needs the input of many additional stakeholders, both in and out of the profession, before taking action.

In addition, the CGA was mindful that the House will have a mega topic discussion on universal health coverage at the annual session and believes this discussion will help inform the Association on matters that might influence how the ADA should address the medically necessary coverage issues. At its own mega discussion on universal health care during its January and April meetings, the CGA discussed the following:

- As Congress considers proposals for universal medical coverage it should keep universal dental care coverage separate from universal medical care coverage. The current separation between dental and medical coverage works well; however, perhaps coverage for some dental services could be added to medical plans to cover dental services that are necessary before a medical condition is addressed.
- Regarding universal dental coverage – there should be a distinction between essential and elective services, with services addressing deformities and related complications, and Head Start type programs given priority as being essential and potentially covered. Essential oral health care is not comprehensive oral health care.
- Model programs should be researched, keeping in mind that the dentists' role must be clearly defined.
- The Council was uncertain whether the changes will be driven by changes at the federal or state levels, as well as how the cost of the increased coverage will be paid. Regardless, dentistry must be at the table to ensure our voice is heard.

Some of the findings the CGA considered were that while it is clearly in the patients' interests to cover medically necessary procedures and it makes sense from a practice standpoint, it may be difficult to determine where the line should be drawn regarding what is medically necessary and what is not. On the other hand, the ADA has long standing policy that requires the Association to make every effort to see to it that health insurance plans be "clarified" so that medically necessary care is available (*Trans.*1988:474; 1996:686), and

that part B of Medicare provides coverage for dental services that are necessary and directly associated with a medical procedure or diagnosis (*Trans.*1993:705).

Medicaid and Indigent Care Funding: Resolution 79-2005H (*Trans.*2006:338) calls for the ADA to make lobbying for indigent populations the highest priorities. During the 110th Congress the ADA has been working hard to advance a number of initiatives to address access to dental services for underserved populations. The populations include uninsured low-income adults, low-income children that received benefits from Medicaid or the SCHIP and individuals living in Alaska or on tribal lands. The ADA Washington office currently participates in coalitions with organizations such as the American Academy of Pediatrics, the National Association of Community Health Centers, the March of Dimes, the Children's Dental Health Project, the Children's Defense Fund, the National Rural Health Association and the National Association of Children's Hospitals to name a few. Working with Representatives Wynn (D-MD) and Simpson (R-ID), the Association played a key role in the introduction of the "Essential Oral Health Care Act of 2007" (H.R. 2472), which provides enhanced federal funds to states that choose to fix their Medicaid and SCHIP programs (including paying dentists at market rates, addressing administrative barriers, and educating caregivers), provides grants to expand free dental care programs, and establishes a tax credit for donated dental services. The ADA also supports "Deamonte's Law" (H.R. 2371) by Representative Cummings (D-MD), which provides grants to improve access to pediatric dental services. In an ongoing battle, the ADA has also effectively joined forces with other oral health care advocates to ensure that federal legislation reauthorizing the SCHIP law contains significant oral health care coverage improvements.

Resolutions

This report is informational in nature and no Resolutions are presented.

Resolution No. 41 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 12, 2007

Submitted By: Arizona Dental Association

Reference Committee: Legal and Legislative Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

BYLAWS REVIEW AND CLARIFICATION: TRANSFER OF DUTIES AND POWERS FROM THE ADA HOUSE OF DELEGATES TO THE BOARD OF TRUSTEES

The following resolution was submitted by the Arizona Dental Association and transmitted on September 12, 2007, by Mr. Rick Murray, executive director.

Background: All organizations require a mechanism for developing and enacting policy when unique situations arise and the usual governing processes cannot be utilized. The House of Delegates (HOD) is the legislative and governing body of the ADA. The Board of Trustees (BOT) is the administrative body of the ADA. Since the HOD is in session only one time per year, occasions will arise when the BOT will be required to make necessary policy decisions when the HOD is not present nor readily available for consultation. Current ADA *Bylaws* (Chapter V. House of Delegates, Section 60) and (Chapter VII. Board of Trustees, Section 90. Powers: E.) address the transfer of powers to the BOT and requirements for reporting back to the HOD. The settlement of the ADA lawsuit against the State of Alaska and the ANTHC is an example of the BOT acting on behalf of the ADA without direct HOD consultation or consent.

Differences in opinion regarding the interpretation of existing *bylaws* relative to the nature of "ad interim" policies and reporting requirements for actions taken by the BOT when the HOD was not in session became apparent following analysis of the official reports to the HOD, current ADA *Bylaws* and current ADA policy. Should permanent or unalterable decisions made by the BOT on behalf of the HOD be processed in the same fashion as temporary or interim policies? What process should be used to determine if policies created are consistent with existing ADA policy or are in fact new policy? What type of policy change should trigger consultation or presentation to the HOD via special session or mail/electronic voting? Current ADA *Bylaws* are not sufficiently comprehensive, concise or clear in regards to these issues. Clarity is essential to maintain the intended governance structure of the ADA.

Resolution

41. Resolved, that the ADA Council on Ethics, Bylaws and Judicial Affairs review and clarify ADA *Bylaws* pertaining to:

- Indications for transfer of HOD policy making duties and power to the ADA BOT to include: the nature of the policies the BOT is allowed to enact when duties and powers are transferred (*ad interim* or temporary, or permanent); clarification regarding what constitutes policy change and who makes that determination; requirements for the BOT to report their actions to the HOD the nature of that

report (informational or ratification); and definitions of terminology used in these sections (e.g. *ad interim*, extraordinary emergencies, etc.).

- Indications and mechanisms for calling special sessions of the HOD and/or mail/electronic voting by the HOD when not in session, be it further

Resolved, that the Council on Ethics, Bylaws and Judicial Affairs bring their recommendations and/or revisions of the *Bylaws* to the 2008 House of Delegates.

BOARD COMMENT: While the Board of Trustees respects the interests and concerns reflected in this resolution, the Board does not believe the directive proposed for the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) will adequately address them. From a purely technical standpoint, it would very difficult for CEBJA to clearly define all of the circumstances in which the Board of Trustees has the power to make a decision and then further delineate the needs and circumstances that require involvement by the House of Delegates. Management duties differ from ministerial duties and cannot be stated in the same detailed way as defining the responsibilities of an employee or support staff. Moreover, this sort of approach seems contrary to the spirit of *Sturgis* (p. 204) which says on drafting: "Bylaws should be concise and are best arranged in outline form. Many organizations keep their bylaws simple and brief by including only essential provisions…"

The Board believes the current ADA *Bylaws* adequately set forth the responsibilities of the House and the Board in a clear manner. Several relevant sections are cited below. For example, Chapter V. HOUSE OF DELEGATES, *Section 40.* POWERS, states in relevant part:

> A. The House of Delegates shall be the supreme authoritative body of this Association.
>
> B. It shall possess the legislative powers.
>
> C. It shall determine the policies which shall govern this Association in all of its activities.

Chapter VII. BOARD OF TRUSTEES, Section 90. POWERS, Subsections "A," "C" and "E" of the ADA *Bylaws*, provides in relevant part:

> A. The Board of Trustees shall be the managing body of the Association, vested with full power to conduct all business of the Association, subject to the laws of the State of Illinois, the *Articles of Incorporation*, the *Constitution and Bylaws* and the mandates of the House of Delegates. The power of the Board of Trustees to act as the managing body of the Association shall not be construed as limiting the power of the House of Delegates to establish policy with respect to the governance of this Association in all its activities, except for areas expressly reserved in these *Bylaws* as powers and/or duties of the Board of Trustees, as the same may be amended by the House of Delegates from time to time in accordance with these *Bylaws.*
>
> C. It shall have the power to direct the President to call a special session of the House of Delegates as provided in Chapter V, Section 80, of the *Bylaws.*
>
> E. It shall have the power to establish *ad interim* policies when the House of Delegates is not in session and when such policies are essential to the management of the Association provided, however, that all such policies must be presented for review and consideration by the House of Delegates at its next session.

As to calling special and emergency sessions, Chapter V. HOUSE OF DELEGATES of the ADA *Bylaws* states:

Section 80. SPECIAL SESSIONS: A special session of the House of Delegates shall be called by the President on a three-fourths (3/4) affirmative vote of the members of the Board of Trustees or on written request of delegates representing at least one-third (1/3) of the constituent societies and not less than one-fifth (1/5) of the number of officially certified delegates of the last House of Delegates. The time and place of a special session shall be determined by the President, provided the time selected shall be not more than forty-five (45) days after the request was received. The business of a special session shall be limited to that stated in the official call except by unanimous consent.

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

For the reasons stated, the Board recommends against adoption of Resolution 41.

BOARD RECOMMENDATION: Vote No.

BOARD VOTE: UNANIMOUS.

Resolution No. 42 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 13, 2007

Submitted By: Fifth Trustee District

Reference Committee: Legal and Legislative Matters

Total Financial Implication: $2,000,000

Amount One-time _____ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

LEGAL ASSISTANCE TO STATES

The following resolution was submitted by the Fifth Trustee District and transmitted on September 13, 2007, by Ms. Connie Lane, executive director, Mississippi Dental Association.

Background: Organized dentistry has a responsibility to help protect the public from groups of dental providers that are inappropriately trained and unqualified to provide oral health care but do so under the guise of providing access to care. State dental associations are often faced with entities who seek to change the law for the purpose of allowing non-qualified entities to legislate education, training and, in some cases, licensure of these individuals without the appropriate educational requirements or necessary safeguards for the public.

Dentistry has witnessed the advancement of this type of entity through the Alaska Native Tribal Health Consortium (ANTHC) training of Dental Health Aide Therapists (DHATs) to perform irreversible procedures. DHATs are trained in programs both inside and outside the country that do not meet the established standards of the United States. The DHAT program represents a real and present danger to the Alaska natives who will have irreversible procedures provided in questionable conditions.

In July 2007, the ADA Board of Trustees entered into an agreement with ANTHC to settle a lawsuit between the ADA and the Alaska Dental Society (ADS) against ANTHC regarding the use of DHATs in delivering dental care to the Native Tribes of Alaska. A part of that settlement was the stipulation that the DHAT would be "walled off" in Alaska. However, based on the outcome of the negotiations with ANTHC, there is concern that the DHAT issue will migrate to the other 49 states.

The ADA and ADS recognize the need to provide for additional ways to provide care to the Alaska Native Tribes because of their unique geography and transportation problems as well as the overall health challenges of this population. Through a Work Force Task Force report, the ADA promoted the Community Dental Health Coordinator (CDHC) as a model that could be used to meet the dental care needs of the Native Alaska Tribes and be used in other unique situations such as the Reservations of the Native Americans in the other 49 states. The ADA House accepted this task force report in 2005 and a curriculum and pilot projects are being developed.

Despite efforts to solve access issues through the use of appropriately trained personnel, there is reason to be concerned that other states will be faced with efforts to establish DHATs in their communities. The ADA Board of Trustees has already received correspondence from the Intertribal Council of Arizona indicating an interest in DHATs.

The ADA has a standing policy of assisting any state with issues of critical concern when asked. We are aware that the ADA Board of Trustees already has the ability to designate appropriate funds from the reserve account to assist states. However, we believe that putting this information in a resolution sends a positive message to the members and others that the ADA is diligent about protecting and defending the public's oral health. Therefore be it:

Resolution

42. Resolved, that the ADA designate up to $2 million of reserve funds to provide legal assistance and public relations support, exclusive of other ADA public relations campaigns, if requested by any states faced with DHATs, Advanced Dental Hygiene Practitioners (ADHPs) or any like unaccredited provider entity seeking to provide irreversible procedures in their state jurisdiction, and be it further

Resolved, that the ADA develop a legal and public relations contingency plan specifically to assist those states that are faced with problems mentioned in the above resolving clause.

BOARD COMMENT: The Board appreciates and shares the concerns of ADA members in the Fifth District and throughout the nation about the spread of well-intentioned but misguided efforts to improve access to underserved communities. The Board further recognizes the need for the ADA to assist states facing such challenges, by providing public affairs and, when necessary, legal resources to help ensure that such efforts do not risk undermining the quality and safety of care that patients receive.

These were among the principal reasons that the Board proposed and the 2006 House funded the ongoing nationally-coordinated, state-based public affairs (SPA) program. Indeed, several of the states participating in the program this year are doing so expressly because of concerns that patient safety might be jeopardized by increasing the scope of practice of non-dentists. The SPA program is designed and funded to help states meet these challenges, ideally by positioning themselves as leaders in improving access to care for the underserved before others propose solutions that risk doing more harm than good. Examples of these initiatives include Maine and Minnesota, where we are working with the constituents to deal with potential mid-level challenges, and Pennsylvania, where the SPA program has worked with the state to better position the PDA in relation to access to care issues, resulting in new momentum for community water fluoridation efforts and expanded functions for dental assistants by moving beyond other scope challenges. Further, within the purview of the SPA, the ADA has conducted significant research on public attitudes and perceptions relating to scope of practice issues. With this new information, the ADA is better prepared to meet these challenges than ever before.

The Board does not want to create a separate fund that could detract from that program and would prefer to continue to enhance the SPA program as needed to address future needs. The Board also believes using the SPA program approach is potentially a more cost effective means of advocating, because it seeks to help states preempt problems, rather than react to them. (Of course, the SPA program also helps states address situations that already have developed.)

Regarding legal support, the Board recommends that the existing system, whereby the Board considers requests from state dental societies for assistance on a case-by-case basis using its Criteria For Providing Financial Assistance on Matters of National Significance, has served the ADA well and should continue, unless and until there is a reason to reconsider it.

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. 42	

Resolution No. 45 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 13, 2007

Submitted By: Alaska Dental Society

Reference Committee: Legal and Legislative Matters

Total Financial Implication: None

Amount One-time _____ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

REQUIREMENT OF LICENSURE FOR FEDERAL SERVICE DENTISTS

The following resolution was submitted by the Alaska Dental Society and transmitted on September 13, 2007, by Mr. Jim Towle, executive director.

Background: It is our understanding that there is no specific law, nor rule or regulation that has been submitted for public comment and been subjected to the rigors of the federal rule and regulation making process that mandates that dentists in the employment of the United States government must hold a valid active dental license in at least one state, commonwealth or territory. Rather this is a policy that can be dismissed or changed based with minimal scrutiny by the Congress or the established regulatory process. We believe that it is in the best interest of those who receive their dental treatment as beneficiaries of the federal largess that the dentists and dental hygienists, employed by the United States in any capacity whereby they are expected, or may be called upon to provide care and treatment, or to review, authorize or otherwise evaluate the professional services provided by a dentist to patients, must hold a valid, active license from at least one state, commonwealth or territory of the United States of America.

Resolution

45. Resolved, that the ADA pursue federal legislation that will require that any dentist, dental hygienist, or other practitioner employed by the federal government or by a contractor of dental services for the federal government, hold an active license in at least one state or territory of the United States.

BOARD COMMENT: This resolution asks the ADA to expend Association resources lobbying for a law to require federal agencies to do that which they already do. The federal services already require dentists to, at a minimum, be licensed to practice in a state, the District of Columbia or Puerto Rico before they can practice in a federal facility. To cite just one example -- regarding the hiring of dentists to provide care through funding provided to the Indian Health Service (IHS), licensure requirements vary by the personnel system under which a dentist is hired. Commissioned Corps and civil service dentists can practice if they are licensed in any state, territory, or the District of Columbia. Requirements affecting dentists hired directly by the tribes are more site-specific, with some tribes requiring a license in the state in which the tribe is located while others are satisfied that the dentist has a license in any state (or territory or DC). The legal instrument used by the agencies to establish a requirement for a state license varies. The Department of Defense has a federal statute that speaks directly to the requirement of needing a state license (10 USC § 1094), while other agencies use federal regulations or agency circulars, but the requirement to obtain a valid license before practicing dentistry in a federal facility is universally accepted. In fact, federal facilities go beyond merely

assuring proper licensing. For example, the IHS requires their dentists to undergo a credentialing and privileging process in order that the agency's facilities can meet national accrediting or certifying body standards. For these reasons, the Board believes it would be a waste of lobbying resources and could actually harm the ADA's credibility if the ADA were to lobby for a federal requirement that already exists.

BOARD RECOMMENDATION: Vote No.

BOARD VOTE: UNANIMOUS.

Resolution No. 46 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 17, 2007

Submitted By: Sixth Trustee District

Reference Committee: Legal and Legislative Matters

Total Financial Implication: Minimal

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

FEDERAL MATCHING MEDICAID FUNDS TO COMPENSATE STATES FOR DENTIST TAX CREDITS

The following resolution was submitted by the Sixth Trustee District and transmitted on September 17, 2007, by Mr. David Horvat, Executive Director, Tennessee Dental Association.

Background: The ADA House of Delegates voted in 2003 to support the use of tax credits to compensate dentists who provide Medicaid dental care, but the efforts to obtain legislation to establish tax credits for dental Medicaid have not been possible due to lack of federal matching funds to states.

Therefore, the loss of federal money flowing into dental Medicaid and the loss of tax revenue from tax credits have been negative factors preventing the legislation of tax credits to reimburse Medicaid dental care.

Resolution

46. Resolved, that the ADA Council on Governmental Affairs report to the ADA 2008 House of Delegates an implementation plan to seek legislation on the federal level that would allow for federal matching funds to compensate each state for tax credits given to dentists providing Medicaid dental care.

BOARD COMMENT: The Board appreciates the intent of the Sixth Trustee District's resolution that would provide federal funds to offset the costs states incur in providing tax credits to dentists who provide care to Medicaid patients. In fact, current ADA policy calls for the ADA to seek federal tax credit legislation (*Federal Tax Credit/Voucher for Medicaid Dentist Providers* 2003:383) for dental Medicaid services. The ADA is aggressively supporting the "Essential Oral Health Care Act of 2007", H.R. 2472, which provides a tax credit to dentists donating dental services to low income individuals (not to exceed 200% of the FPL). This legislation takes a comprehensive approach to reforming Medicaid and the State Insurance Health Insurance Program (SCHIP), as a State is offered a 25 percentage points increase (not to exceed 90 percent) of the Federal Medical Assistance Percentage (FMAP) with respect to expenditures for dental and oral health services for children if the State provides the Secretary of the Department of Health and Human Services with assurances regarding the following:

1. Children enrolled in the State plan have access to oral health care services to the same extent as such services are available to the pediatric population of the State.

2. Payment for dental services for children under the State plan is made at levels consistent with the market-based rates.

3. No fewer than 35 percent of the practicing dentists (including a reasonable mix of general and pediatric dentists and oral and maxillofacial surgeons) in the State participate in the State plan and there is a reasonable distribution of dentists serving the covered population.

4. Administrative barriers are addressed, including improving eligibility verification, ensuring that any licensed dentist may participate in the publicly funded plan without having to participate in other plans, simplifying claims processing, assigning a single plan administrator for the dental program, and employing case managers to reduce the number of missed appointments.

5. Educating caregivers regarding the need to seek dental services and addressing oral health literacy issues.

H.R. 2472 also provides grants to pilot test Community Dental Health Coordinators and to expand free dental services through volunteer dental projects provided by community based organizations, including dental schools, dental associations, and others.

The resolution suggests an additional approach to incentivize dentists to treat the underserved and merits consideration by the Council on Government Affairs. Accordingly, the Board recommends adoption of Resolution 46.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 48 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 17, 2007

Submitted By: Eleventh Trustee District

Reference Committee: Legal and Legislative Matters

Total Financial Implication: $2,000,000

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

ADDITIONAL RESOURCES FOR ADA WASHINGTON OFFICE

The following resolution was submitted by the Eleventh Trustee District and transmitted on September 17, 2007, by Ms. Amanda Tran, director, Membership & Component Services, Washington State Dental Association.

Background: Without question, one of the most important, if not the most important, functions of the American Dental Association is representing the profession in our nation's capitol. In virtually every membership survey completed on both the state and national level, advocacy is viewed as critical to the future of the profession. The question of whether the profession remains relatively-lightly regulated by the federal government, unlike the medical profession, depends largely on the success of the ADA with members of Congress, regulators, and the executive branch.

In recent years, the ADA has taken significant steps to strengthen the Washington, D.C. office. Recent personnel changes have been well received and without doubt have improved communications within the ADA family. There has been significant improvement in reaching out to members both individually and through constituent and component societies. The ADA has implemented an improved grassroots lobbying effort. The recently developed public affairs program assisting component and constituent societies in addressing pressing regulatory issues of interest not only to legislatures but also to the public at large, has begun to show results. While these efforts have paid dividends, greater challenges to dentistry are on the horizon. It is time for the membership to "step up" in a big way to prepare for the highly-volatile situation the profession most probably will be facing in the next five years. We are proposing an additional $2 million annually to radically improve the ability of the ADA Washington office to participate effectively in national issues affecting the profession.

Why do we need to budget this additional amount at this time? It is probable that at the conclusion of the 2008 elections, the House, Senate and White House will be Democratic. There is not a Democratic candidate for the Presidency that does not have universal health coverage at the top of the agenda. For that matter, most Republican candidates are committed in varying degrees to this goal. It is imperative that the ADA begin an educational campaign focused on the fact that the dental delivery system is far different from the medical one, and that drastic changes to the system will not improve care and may, in fact, have an adverse affect on the delivery of quality dental care. "Dentistry is Health Care That Works." Regardless of the outcome of the 2008 election, the ADA will need to increase its presence on behalf of dentistry with a new Administration.

The ADA also needs additional resources to address ongoing issues. Congress is committed to raising the eligibility level for SCHIP to as high as 300 percent of poverty, but has not addressed inadequate funding for even current reimbursements. Congress should fully fund these programs before the cap is increased any more. At 300 percent of poverty, up to 90 percent of the residents in some rural counties become eligible further diluting income to rural dentists. This hurts dentists practicing in these areas and discourages new dentists from locating to small towns.

Because these issues are far broader in nature than just dentistry, the dental profession must be on par in its lobbying activities with the AARP, the union lobby, the medical profession, the insurance industry and all others with a stake in the future of health care. The Washington office must be given the ability to hire additional staff to research issues and educate Congress, to obtain outside lobbying support for specific issues and for key Congressional contacts, to enhance ADPAC, and to continue to improve grassroots communication within the profession. Therefore be it,

Resolution

48. Resolved, that $2 million in addition to current funding be allocated to the Washington D.C. office to increase staffing and retain out of house lobbying/public affairs firms as needed to:

- Educate decision makers on the difference between medicine and dentistry in the universal health coverage debate.
- Strive for full funding of SCHIP before addressing any increase in the eligibility cap.
- Support efforts by ADPAC to increase its visibility with elected officials and the profession.
- Begin to influence in a more dynamic way the discussion on health care.
- And, if necessary, retain proper expertise to develop an issue management strategy to maximize these resources.

and be if further

Resolved, that the funding for this initiative shall come from an increase in member dues sufficient to cover the costs.

BOARD COMMENT: The Board appreciates and agrees with the Eleventh Trustee District that the Association's advocacy efforts in Washington, D.C. are very important for assuring the continued well being of the profession and for making strides to improve the nation's oral health. The Eleventh District correctly noted in its background statement that the ADA has taken a number of significant steps to improve our presence in our nation's capitol in the last couple of years (e.g., the Advocacy Initiative) and we are doing a better job of helping the constituent societies address their challenges, as well (e.g., state public affairs initiative). The Advocacy Initiative led to numerous recommendations to improve our advocacy effectiveness, and those recommendations are in the process of being implemented, with an infusion of $800,000 in additional budget dollars to support that effort. Examples include the hiring of an additional congressional lobbyist and a new advocacy communications staff person and the contracting of additional outside lobbyists. The Board also agrees that universal health care coverage and other health care access-related issues will be at the top of the agenda of any new administration and the new Congress. At the same time, Association reserves are strong, and the Board is already requesting a $9 dues increase for the 2008 budget, which the Board and senior staff believe will be adequate to meet the ADA's financial needs for 2008. If additional funding is needed in 2008 for advocacy efforts around the election debates on healthcare reform, the Board can work within the existing budget and handle unanticipated needs through the

contingency fund and/or reserves. In addition, it is more likely that, if significant funding is needed on healthcare reform and other issues with a new presidential administration, that will become more clear in the coming months as the candidates unveil their platforms with greater specificity, and likely would not be needed until after the election, in 2009. In short, at this time, the Board is confident that if the House approves the $9 dues increase that the Board requested, it will be sufficient to meet the demands on resources we anticipate for the next year. The potential need for additional significant resources in a new presidential administration will become clearer in 2008, which then can be considered at the 2008 House of Delegates, either through the budget or an anticipated extensive report to the House from the Board on health care reform issues. In short, the Board expects that the 2008 House will see a significant funding request, either as a part of the 2009 budget process or as a part of a comprehensive report on health care reform, or both. The Board believes it is more appropriate to let this standard ADA process develop and unfold, especially since there is no current urgency that needs to be addressed at this time.

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. 48	

Resolution No. 49 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 13, 2007

Submitted By: Alaska Dental Society

Reference Committee: Legal and Legislative Matters

Total Financial Implication: $5 Million ($500,000 annually for 10 years)

Amount One-time _____ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

FUNDING FOR A COMMUNITY DENTAL HEALTH COORDINATOR PILOT PROGRAM

The following resolution was submitted by the Alaska Dental Society and transmitted on September 13, 2007, by Mr. Jim Towle, executive director.

Background: The settlement negotiated by the American Dental Association following the summary judgment entered by the Alaska Superior Court in the lawsuit against the Alaska Native Tribal Health Consortium states that the "ADA has indicated intent to 'work towards the establishment of community dental health coordinator pilot program to determine the efficacy of this model as a means of improving the delivery of dental care in rural Alaska.' ANTHC supports the expansion of alternative provider types, including ADA's proposed community dental health coordinator, to increase access to effective, culturally appropriate dental services."

To ensure that the ADA makes good on its stated "intent" and that the ANTHC also makes good on its claim of support for alternative provider types it is appropriate that sufficient funds be made available as soon as possible. To ensure that these funds are directed to the development of a program which is acceptable to the dentists whose patients will be most directly affected by the program, it is appropriate that the leadership of the constituent society where the pilot program is established should be a full and equal partner in determining how the funds are disbursed and overseeing development and administration of the funds and program.

Resolution

49. Resolved, that to demonstrate its willingness to fulfill its commitments stated in Paragraph 7 of the settlement with the Alaska Native Tribal Health Consortium, the ADA shall appropriate $500,000 per year for the next 10 years either to the University of Alaska, the University of Washington, the Oregon Health Sciences University or other accredited college or university in the US or Canada that is willing to develop a community dental health coordinator program and to coordinate with the ADA and the ANTHC a pilot program that will determine the efficacy of this model as opposed to the Dental Health Aide Therapist as a means of improving the delivery of dental care in rural Alaska, and be it further

Resolved, that the awarding of these funds shall be made by a joint committee, appointed by the ADA Board of Trustees and the Alaska Dental Society's Executive Council with equal representation and voting rights between the American Dental Association and the Alaska Dental Society.

BOARD COMMENT: The ADA's commitment to the programs and initiatives provided for pursuant to the Settlement Agreement with ANTHC are reflected in, and ensured by, the terms of the Settlement Agreement itself, to which the ADS is a party. That particular term in the settlement agreement provides simply that ANTHC will support a pilot program for the CDHC model.

The Community Dental Health Coordinator program is intended to be national in scope and pilot programs will be launched in a number of regions based on a range of criteria. In order to most effectively use members' dollars with respect to the CDHC program, the ADA requires funding flexibility and the ability to evaluate each program's needs in the context of the overall effort. Neither of these elements, which are essential for the program's success, would be served by committing a specific dollar amount to the program in Alaska for a ten-year plan, when the scope and needs of the program in Alaska have not been determined as yet. In addition, the resolution calls for the joint administration of ADA funds by the ADA and the ADS, which is inappropriate and would be administratively unworkable. Instead, the Board recommends that the House adopt proposed Resolution 54 (Worksheet:5053), which allocates up to $2,000,000 to fund selected CDHC pilot programs over a three year period, and describes a detailed framework for the development and implementation of the CDHC work model on a nation-wide basis. Educational institutions have already been asked to submit letters of intent to conduct pilot programs. Such letters are being evaluated for resources, understanding of the CDHC, and the ability to facilitate and conduct the pilot at a specified location. The ADA's Workforce Models National Coordinating and Development Committee will select the pilot sites no later than December 2007.

BOARD RECOMMENDATION: Vote No.

BOARD VOTE: UNANIMOUS.

Resolution No. 50 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 13, 2007

Submitted By: Alaska Dental Society

Reference Committee: Legal and Legislative Matters

Total Financial Implication: None

Amount One-time _____ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

OPPOSITION TO FEDERAL INTRUSION INTO THE REGULATION OF DENTISTRY

The following resolution was submitted by the Alaska Dental Society and transmitted on September 13, 2007, by Mr. Jim Towle, executive director.

Background: In 2004 the House of Delegates adopted the following resolution:

> "**Resolved,** that the American Dental Association by all appropriate federal legislative and judicial means resist any effort compromising the quality of dental health care services by allowing any nondentist to diagnose or perform irreversible dental procedures except as otherwise authorized by state law with reference to physicians."

The settlement that was negotiated after the trial judge had issued a summary judgment, puts the ADA in the position of supporting federal legislation that is specifically intended to allow non-dentists to perform irreversible procedures. "ADA and ANTHC **agree to use their best efforts to preserve the language concerning the scope of dental health aide therapists practice."** That legislation which the ADA is committed to using its "best efforts to preserve" includes ensuring "that pulpal therapy (not including pulpotomies on deciduous teeth) or extraction of adult teeth can be performed by dental health aide therapist."

While the authors of the settlement have argued vociferously that they included a number of qualifications and limitations, the fact remains that non-dentists are and will continue, with the support of the ADA to protect their right to continue to provide irreversible procedures. The rationale that the ADA's efforts to pursue the policy set forth by the House of Delegates in 2004 was damaging the association's public image. In order to protect public image, the ADA has now implicitly endorsed the practice of non-dentists performing irreversible procedures. Members who take the time to acquaint themselves with what is being touted by the US Public Health Service dentists and dental hygienists and dentists who work within the larger public health structure recognize that the use of non-dentists to provide surgical procedures that are fundamental to the practice of general dentistry is a goal to be achieved in every state, commonwealth and territory of the United States of America.

Claims and assertions that what has been deemed to be acceptable in Alaska, can not and will not be acceptable anywhere else are simply that, claims and assertions made in an effort to divert close scrutiny as to the long term ramifications of the concessions that were incorporated in the settlement to the lawsuit against the Alaska Native Tribal Health Consortium.

Resolution

50. Resolved, that this House of Delegates directs the Board of Trustees to aggressively oppose any federal legislation, or regulatory action that undermines, diminishes, curtails or preempts, either explicitly or implicitly, the right, the ability or the authority of any state to regulate dentistry or any form of health care delivery, or any territory with a territorial government that is capable of the regulations of health care, and be it further

Resolved, that the Board of Trustees with actively pursue this opposition until such time as a future House of Delegates explicitly amends or repeals this position.

BOARD COMMENT: The first resolving clause directs the ADA to actively oppose any federal legislation or regulation that undermines the rights of states to regulate dentistry or "any form of health care delivery." Regarding the regulation of the dental profession, current ADA policy states, in part, "that the board of dentistry in each state should be the sole licensing and regulating authority for all dental personnel, including dental specialists;" (See Policy on Dental Licensure [1998:720; 2003:341]. This policy provides the ADA with all the authority it needs to address federal legislation or regulations that would undermine the ability of states to regulate dentistry. On the other hand, the ADA has no policy regarding the regulation of other health professions and should not have policy that requires the Association to act unilaterally on their behalf. Current policy is sufficient to protect ADA members' interests by, for example, allowing the ADA to participate in a coalition with organizations representing physicians or other health care professionals in response to a common threat. The Board recommends a vote of "no" because this resolution calls for the ADA to take an action that is already covered by current policy and opens the door to the possibility of the ADA taking a unilateral advocacy position that affects other health professions in a manner that could be outside the expertise of the ADA.

BOARD RECOMMENDATION: Vote No.

BOARD VOTE: UNANIMOUS.

Resolution No. 51 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 13, 2007

Submitted By: Alaska Dental Society

Reference Committee: Legal and Legislative Matters

Total Financial Implication:

Amount One-time $100. Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

NON-COMPLIANCE WITH EXISTING POLICY

The following resolution was submitted by the Alaska Dental Society and transmitted on September 13, 2007, by Mr. Jim Towle, executive director.

Background: Current Policies of the American Dental Association, adopted 1954 to 2006 states that the following is the position of the American Dental Association as adopted by the House of Delegates:

> "The American Dental Association has repeatedly recorded its support for the principle of dental licensure at the individual state level and its opposition for placing this important function under federal control. A basic premise of the American Dental Association's position is that American dentistry has reached a level of quality and availability not matched elsewhere in the world. The system of state licensure has been an important factor in dentistry's development. Therefore, the Association would oppose replacement of the state licensure system. In the opinion of the Association, federal control of dental licensure would not only fail to solve existing problems involving delivery of dental care to the public, but also could be expected to create new problems. Licensure involves more than issuing licenses to candidates who qualify. Regulatory agencies also must ensure that licensed dentists maintain competence and practice in accordance with the law. It is in this policing function that federal licensure seems most inadequate. To be most effective, regulatory responsibility should be placed at the lowest level of government capable of performing the functions – in this instance, the state, through its board of dentistry. For the reasons cited, the American Dental Association strongly opposes federal licensure and federal intervention in the state licensing system."

It is also current ADA policy that state licensure is a crucial element in preserving the "standards of dental practice" in this country. The House recognized that protection of the public was a vital role of state licensure. The House recognized that while "licensing provisions vary among U.S. licensing jurisdictions, all jurisdictions have the same three types of requirements: an educational requirement, a written examination and a clinical examination requirement. The traditional educational requirement is graduation from an accredited dental school. Only dental schools in the United States and Canada are recognized as accredited."

Resolution

51. Resolved, that this House of Delegates, in accordance with the *Bylaws* of the association, Chapter VII Board of Trustees, Section 90 Powers, Sub-section E, determines that the "*ad interim* policies" established by the Board of Trustees by virtue of the approval of the settlement agreement regarding the

lawsuit against the Alaska Native Tribal Health Consortium is rejected because the settlement does not reflect the will of the House of Delegates as expressly stated in multiple policy statements and in resolutions which expressly state the ADA's opposition to non-dentists performing irreversible procedures and may be used to establish social, political and possibly legal precedents which are contrary to the association's long standing belief that the citizens of the United States are best served when the practice of dentistry is defined and regulated under the laws of the individual states and the regulatory agencies established by the states for the governance of dentistry, and be it further

Resolved, that the this House of Delegates believes that the role of the federal government in the regulation of the practice of dentistry is, and should continue to be strictly limited to dentists practicing as employees of the federal government, or who practice in territories of the United States that do not have a territorial government capable of the self regulation of health care, including dentistry, and be it further

Resolved, that this House of Delegates instructs the President of the American Dental Association to notify the Speaker of the US House of Representatives, the Majority and Minority Leaders of the US Senate, and the US Surgeon General of the American Dental Association's objection to any federal intrusion into the licensure and regulation of the practice of dentistry, except for residents living on land under the jurisdiction of the federal government and explicitly exempted by Congress from control by the states and territories.

BOARD COMMENT: The Board disagrees with the assertions made by the Alaska Dental Society in the first resolving clause. As we said in our report to the House of Delegates and in a number of other communications with ADA members, we believe the strategy begun with the settlement is more likely to achieve the objectives of ADA policy than any other course of action open to us at this time. Nowhere in the settlement agreement does it state (expressly or implicitly) that the Association supports non-dentists performing irreversible dental procedures. On the contrary, the agreement attempts to start the ADA on a road of working with tribal leaders that should, over time, eliminate the conditions that led to the perceived need for DHATs. Concerning the second and third resolving clauses, the Board does not agree with the Alaska Dental Society. The Board believes the federal government should not be in the business of regulating dentistry at all. The licensing of dentists should be a state activity, regardless of where the dentists are employed or who they serve, so the Board rejects the premise presumed in resolving clauses two and three that the federal government would control licensing of federal service dentists and dentists providing care to "residents under the jurisdiction of the federal government."

BOARD RECOMMENDATION: Vote No.

BOARD VOTE: UNANIMOUS.

Resolution No. 52 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 13, 2007

Submitted By: Alaska Dental Society

Reference Committee: Legal and Legislative Matters

Total Financial Implication: None

Amount One-time _____ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

BYLAWS CHANGE REGARDING BOARD OF TRUSTEES' AUTHORITY TO HIRE AND TERMINATE CERTAIN ASSOCIATION EMPLOYEES

The following resolution was submitted by the Alaska Dental Society and transmitted on September 13, 2007, by Mr. Jim Towle, executive director.

Background: The American Dental Association Board of Trustees hires the Executive Director. The remainder of the senior management positions within the association are hired and terminated at the sole discretion of the executive director. To ensure that the Board of Trustees can be confident that it is receiving the candid communications from key members of the senior management team, particularly regarding issues where there may be a diversity of opinion, it is crucial that these other senior managers be accountable to the Board of Trustees as well as to the Executive Director. In addition, the vast resources and scope of knowledge which the Board of Trustees would bring to the hiring process, it is prudent to involve them in the hiring of a limited number of key senior management positions. This same experience will better serve the association with the involvement of the trustees in the termination of these same key employees. The trustees come from different areas of the country and have a wide range of backgrounds and experiences. Utilizing their expertise would enhance selection process of the Chief Legal Counsel and Senior Vice President of Government and Public Affairs.

Having the American Dental Association Board of Trustees responsible for the hiring of these key individuals would enable the Board of Trustees to solicit potentially different opinions from these individuals, who may be reluctant to voice their opinion under the current system. Having the Chief Legal Counsel and Senior Vice President of Government and Public Affairs directly responsible to the American Dental Association Board of Trustees would broaden information and widen vision, accountability and transparency. With the responsibility of the American Dental Association Board of Trustees to make interim policy between annual American Dental Association House of Delegates meetings, it is important to have the full spectrum of opinions necessary in their decision making process. This wider vision, accountability and transparency are crucial to our organization especially in light that the supreme authority in our organization, our House of Delegates, meets once a year. The accountability of these individuals ultimately to the American Dental Association Board of Trustees assures checks and balances in our organization.

Resolution

52. Resolved, that Chapter VII. BOARD OF TRUSTEES, SECTION 100. DUTIES, SUB-SECTION B of the ADA *Bylaws* be amended as follows (new language underscored; deletions stricken through):

B. To appoint and terminate the Executive Director, the Chief Legal Counsel and the Senior Vice-President of Government and Public Affairs,

and be it further

Resolved, that Chapter IX APPOINTIVE OFFICER, SECTION 40, DUTIES, SUB-SECTION (C) of the ADA *Bylaws* be amended as follows (new language underscored; deletions stricken through):

(c) engage the staff of this Association except as provided for in Chapter VII, Section 100, sub-section (b),

and be it further

Resolved, that while performing this duty, the Board of Trustees is encouraged to utilize a Standing Committee of the Board that is similar to the existing Board Compensation Committee for the purposes of efficiency, confidentiality and privacy issues, and be it further

Resolved, that the forgoing amendments to Chapters VII and IX shall take effect at the close *sine die* of the 2008 House of Delegates.

BOARD COMMENT: While the Board of Trustees understands that the proponents' intent appears to be to aid the Board of Trustees in its work by having access to candid communications with the individuals named, the Board believes this action is not needed and in fact would be ill-advised for several reasons. Perhaps most importantly, the Board already has regular and direct access with all of the senior staff (and others) at Board meetings and at all other times. Further, the Compensation Committee of the Board annually discusses senior staff performance with the Executive Director and uses this mechanism to provide him with feedback on the staff. The Executive Director in fact is accountable for the performance of his staff and his own performance review with the Compensation Committee takes this into consideration each year.

One of the most basic responsibilities of an Association executive director is the hiring and supervision of staff. The Board believes it would be unwise to eliminate that basic responsibility in a $110 million business that must operate efficiently and effectively 365 days of the year, not only for the Board and the House.

The Board also is concerned that this change would blur reporting lines of senior staff. Those who were hired (and presumably could be fired) by the Board would have different and confusing reporting lines than other staff, which would cascade down through the entire line of staff reporting up to them.

Moreover, all senior staff at the ADA have equally significant responsibilities. While the two senior staff positions that are the focus of this resolution were highly visible this year in the Alaska situation, the other senior staff at the ADA have equally weighty, and at times, equally visible assignments that subject them to the politics of this Association. It is unclear to the Board why or how the management of the ADA would be better served by having two in this highly accomplished group hired, supervised and open to termination by the Board.

Finally, by codifying this responsibility in the Board's *Bylaws* responsibilities, it may also have the unintended effect of imposing significant employment liabilities upon the Board members individually (which would probably be covered by the ADA's D&O insurance coverage, but which would unnecessarily complicate these situations for the ADA and for the Board).

In summary, the Board is comfortable with and believes that this duty should remain vested with the executive director. This practice is entirely consistent with contemporary association management practices – the Board hires the Executive director and the Executive Director is charged with hiring the staff. For these reasons, the Board recommends against adoption.

BOARD RECOMMENDATION: Vote No.

BOARD VOTE: UNANIMOUS.

Resolution No. 57 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 28, 2007

Submitted By: Fifth Trustee District

Reference Committee: Legal and Legislative Matters

Total Financial Implication: $200,000

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

DEVELOPMENT OF MEDICAID AND SCHIP DATA FROM ALL STATES

The following resolution was submitted by the Fifth Trustee District and transmitted on September 28, 2007, by Ms. Martha Phillips, executive director, Georgia Dental Association.

Background: Medicaid and SCHIP issues are consuming an enormous amount of time and resources at the state level. States constantly face the problem of inadequate funding of Medicaid and SCHIP programs which provide access to care for this segment of the population. The ability to search and review data relating to these programs is essential.

State legislators through national organizations have access to other states' information on Medicaid and SCHIP and often use that knowledge to make decisions within their state. State dental associations are left scrambling to collect data to respond to the proposals. Collection of that data is time consuming, often incomplete, and uses an enormous amount of resources in an inefficient manner. States can seek help from the ADA State Government Affairs Department and SGA is willing to help; however, this is not a substitute for having the data collected and made available on an ongoing basis. The gathering and compilation of this data would be beneficial for all states and would help identify trends early on in the process. Therefore, be it

Resolution

57. Resolved, that the ADA collect and compile Medicaid and SCHIP data from all of the states on an annual basis, and be it further

Resolved, that this data be accessible, i.e., downloadable and searchable in the aggregate, or by desired subset via the Internet, and be it further

Resolved, that the ADA create a standard set of reports that can be downloaded from the ADA's Web site by constituent societies which show trends among jurisdictions relating to funding levels (as, for example, a percentage of UCR), utilization levels, and other facets of the delivery of dental and dental hygiene services and that, in addition to enabling constituent societies to access this data "on the fly," this information be reported in written form to the ADA Board of Trustees and state executive directors on an annual basis.

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

Resolution No. 58 New ■ Substitute □ Amendment □

Report: NA Date Submitted: Sept. 28, 2007

Submitted By: Fourteenth Trustee District

Reference Committee: Legal and Legislative Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

UNIVERSAL HEALTHCARE REFORM

The following resolution was submitted by the Fourteenth Trustee District and transmitted on September 28, 2007, by Dr. A.J. Smith, delegate.

Background: In the interest of providing direction to our ADA Washington Office, it appears timely that the ADA House of Delegates address this issue of universal healthcare and lobbying efforts. Therefore, be it

Resolution

58. Resolved, that future ADA lobbying efforts emphasize the promotion of those government programs designed and implemented for those in need, and be it further

Resolved, that the ADA oppose those programs which by design or implementation could be expanded to include all segments of the population.

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

Notes

New Business

Resolution No. 68 New ■ Substitute □ Amendment □

Report: NA Date Submitted: September 30, 2007

Submitted By: Fifth Trustee District

Reference Committee: NA

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

DIAGNOSIS OR PERFORMANCE OF IRREVERSIBLE DENTAL PROCEDURES BY NON-DENTISTS

The following resolution was submitted by the Fifth Trustee District and transmitted on September 30, 2007, by Dr. Howard Gamble, delegate. (Deletions are shown by ~~strikethroughs~~; additions are underscored.)

Resolution

68. Resolved, that Resolution 67H-2004 (*Trans*. 2004:328) be amended as follows:

That the American Dental Association ~~by all appropriate federal legislative and judicial means resist any effort compromising the quality of dental health care services by allowing~~ shall not give approval to any program which allows any nondentist to diagnose or perform irreversible dental procedures except as otherwise authorized by state law with reference to physicians, and be it further

Resolved, that nothing in this policy shall be construed in such a manner as to conflict with the ADA & ADS/ANTHC Settlement Agreement.

Notes

Index of Resolutions

* Resolutions 63-67 will be indexed in Transactions 2007.

Index of Reports

Supplemental Agency Reports

Committee/Task Force Reports