2009

2009 Supplement Vol. 2

American Dental Association

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America's leading advocate for oral health

2009

Supplement to
Annual Reports and Resolutions
Volume 2

150th Annual Session

Honolulu, Hawaii

October 2-6, 2009

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Dental Benefits, Practice, Science and Health

** Report of the Reference Committee on Dental Benefits, Practice, Science and Health, pages 3173-3198; Committee reports are reflected in the Minutes of the House of Delegates

Dental Benefits, Practice, Science and Health

Resolution No. 1 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: August 2009

Submitted By: Council on Dental Benefit Programs

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

AMENDMENT OF THE "GUIDELINES ON COORDINATION OF BENEFITS FOR GROUP DENTAL PLANS"

Background: (*Reports*:56)

ADA Coordination of Benefits Policy: The Council reviewed the ADA coordination of benefits policy with a goal of revising the policy to make it clearer and easier to understand, consistent with Resolution 61H-2008 (*Trans*.2008:496), Coordination of Benefits Reform. The resolution called for the ADA to work with government agencies and dental carriers to enact coordination of benefit laws requiring that when a premium is paid and a claim submitted, that each benefit plan will pay the same amount the carrier would allow if no other coverage was applicable up to 100% of the total claim; and that the ADA encourage states to enact similar laws; and that the ADA use its staff and resources to assist states in this process. In response to Resolution 61H-2008, the Council adopted a resolution to submit revisions to the coordination of benefits policy for action by the 2009 House of Delegates. The Council also worked with the Council on Government Affairs and DSGA to facilitate legislative advocacy that incorporates the principles of 61H-2008. The Council, therefore, recommends adoption of the following resolution. This resolution supports the ADA Strategic Plan Goal of Achieve Effective Advocacy.

Resolution

1. Resolved, that the policy "Guidelines on Coordination of Benefits for Group Dental Plans" (*Trans.*1996:685) be amended by substitution of the following:

Guidelines on Coordination of Benefits for Group Dental Plans

When a patient has coverage under two or more group dental plans the following rules should apply:

a. The coverage from those plans should be coordinated so that the patient receives the maximum allowable benefit from each plan.
b. The aggregate benefit should be more than that offered by any of the plans individually, allowing duplication of benefits up to the full fee for the dental services received.

and be it further

Resolved, that third-party payers, representing self-funded as well as insured plans, should be urged to adopt these guidelines as an industry-wide standard for coordination of benefits, and be it further

Resolved, that constituent societies are encouraged to seek enactment of legislation that would require all policies and contracts that provide benefits for dental care to use these guidelines to determine coordination of benefits.

BOARD RECOMMENDATION: Vote Yes.

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

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

Report: NA Date Submitted: August 2009

Submitted By: Fourteenth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

SUBSTITUTE FOR RESOLUTION 1:
AMENDMENT OF THE "GUIDELINES ON COORDINATION OF BENEFITS FOR GROUP DENTAL PLANS"

The following substitute for Resolution 1 (Worksheet:3000) was submitted by the Fourteenth Trustee District and transmitted on August 28, 2009, by Dr. Kenneth Versman, trustee, Fourteenth District.

Background: An additional problem related to coordination of benefits is that payers may adopt any rules or policies for determination of primary coverage they wish. The policy they use may or may not be compatible with the plan they must coordinate with. This substitute adds two resolving clauses which call on payers to adopt a unified standard method for determination of primary and secondary coverage and specifies that it be a method which is readily determined by the offices in which a patient is being seen. It further calls on the ADA to seek federal legislation or regulation to mandate benefits providers and administrators to utilize the same policy.

Resolution

1. Resolved, that the policy "Guidelines on Coordination of Benefits for Group Dental Plans" (*Trans.*1996:685) be amended by substitution of the following:

Guidelines on Coordination of Benefits for Group Dental Plans

When a patient has coverage under two or more group dental plans the following rules should apply:

a. The coverage from those plans should be coordinated so that the patient receives the maximum allowable benefit from each plan.
b. The aggregate benefit should be more than that offered by any of the plans individually, allowing duplication of benefits up to the full fee for the dental services received.

and be it further

Resolved, that third-party payers, representing self-funded as well as insured plans, should be urged to adopt these guidelines as an industry-wide standard for coordination of benefits, and be it further;

Resolved, that constituent societies are encouraged to seek enactment of legislation that would require all policies and contracts that provide benefits for dental care to use these guidelines to determine coordination of benefits, and be it further

Resolved, that all third parties providing or administering dental benefits should adopt a unified standardized formula for determining primary or secondary coverage and that the formula should be readily applied by dental providers based on information easily obtained from the patient, and be it further

Resolved, that the ADA seek federal legislation requiring that third parties comply with a standardized formula for determining primary and secondary coverage.

WORKSHEET ADDENDUM

COUNCIL ON DENTAL BENEFIT PROGRAMS

POLICY TO BE AMENDED

Guidelines on Coordination of Benefits for Group Dental Plans (*Trans*.1996:695) (additions are shown by underscoring; deletions are shown by strikethroughs)

Resolved, that the following Guidelines on Coordination of Benefits for Group Dental Plans be adopted.

Guidelines on Coordination of Benefits for Group Dental Plans

~~1.~~ When a patient has coverage under two or more group dental plans the following rules should apply:

a. The coverage from those plans should be coordinated so that the patient receives the maximum allowable benefit from each plan.

b. The aggregate benefit should be more than that offered by any of the plans individually, ~~but not such that the patient receives more than~~ allowing duplication of benefits up to the full fee ~~total charges~~ for the dental services received.

~~c. The difference between the benefits payments that the secondary plan would have paid had it been the primary plan and the benefits that it actually paid or provided shall be recorded as a benefit reserve for the patient.~~

~~d. The secondary plan will use the benefit reserve to pay up to 100% of the patient's covered expenses incurred during the claim determination period.~~

~~e. At the end of each claim determination the secondary plan will provide the patient and plan purchaser with a status report of claims paid and the benefit reserve.~~

~~2. In determining order of payment for care, the following rules should apply to group dental plans:~~

~~a. The plan covering the patient other than as a dependent is the primary plan.~~

~~b. When both plans cover the patient as a dependent child, the plan of the parent whose birthday occurs first in a calendar year should be considered as primary.~~

~~c. When a determination cannot be made in accordance with the above, the plan that has covered the patient for the longer time should be considered as primary.~~

~~d. When one of the plans is a medical plan and the other is a dental plan, and a determination cannot be made in accordance with the above, the medical plan should be considered as primary.~~

~~3. In coordinating care with a group dental plan which contractually reduces the fees for services which participating dentists accept as payment in full, the following rules should apply:~~

~~a. When the reduced-fee plan is primary and treatment is provided by a participating dentist, the reduced fee is that dentist's full fee unless the dentist has contractually arranged that the reduced-fee plan should provide its allowed amount for participating dentists and the secondary plan should pay the lesser of: its allowed benefit for the service or the difference between the primary plan care and the dentist's full fee. The secondary plan should pay the lesser of: its allowed benefit or the difference between the primary plan's benefit and the reduced fee.~~

~~b. When the reduced-fee plan is primary and treatment is provided by a nonparticipating dentist, the reduced-fee plan should provide its allowed amount for nonparticipating dentists and the secondary plan should pay the lesser of: its allowed benefit for the service or the difference between the primary plan care and the dentist's full fee.~~

~~c. When a full-fee plan is primary and a reduced-fee plan is secondary, the full-fee plan should provide its allowed amount for the service and the secondary plan should pay the lesser of: its allowed benefit for the service or the difference between the primary plan care and the dentist's full fee.~~

~~4. In coordinating care between a group indemnity plan and a capitation dental plan, the following rules should apply:~~

~~a. When the capitation plan is primary, the capitation payments to the treating dentist remain the capitation plan's usual care. The indemnity plan should pay benefits for the patient's surcharges or copayments up to the indemnity plan's allowable benefit.~~
~~b. When the indemnity plan is primary, and treatment is received from a capitation-participating dentist, the indemnity plan should pay its allowable benefit. The capitation payments to the dentist are the secondary coverage since they constitute care up to the capitation plan's allowable amount.~~
~~c. When the indemnity plan is primary, and treatment is received from a non-capitation-participating dentist, the indemnity plan should pay its allowable benefit. The capitation plan will pay care, in keeping with the capitation plan's allowed amount for treatment by nonparticipating dentists.~~
~~d. No dental plan should contractually direct a dentist to charge a secondary carrier for more than the amount which would be charged to the patient absent secondary coverage.~~

and be it further

Resolved, that third-party payers, representing self-funded as well as insured plans, should be urged to adopt these guidelines as an industry-wide standard for coordination of benefits, and be it further

Resolved, that constituent societies are encouraged to seek enactment of legislation that would require all policies and contracts that provide benefits for dental care to use these guidelines ~~rules~~ to determine coordination of benefits~~, and be it further~~.

~~**Resolved,** that Resolution 10H-1991 (*Trans.*1991:635), Guidelines on Coordination of Benefits, be rescinded.~~

Resolution No. 2 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: August 2009

Submitted By: Council on Dental Benefit Programs

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Lead in the Advancement of Standards (Required)

AMENDMENT OF THE POLICY, "REPORTING OF DENTAL PROCEDURES TO THIRD PARTIES"

Background: (*Reports*:60)

Reporting of Dental Procedures to Third Parties: Resolution 4-2008 (*Trans.*2008:451) from the Council on Dental Benefit Programs was referred back to the Council to further develop the third resolving clause of the policy Reporting of Dental Procedures to Third Parties (*Trans.*1991:637). In addition, the Council believes that the second resolving clause of the policy should also be clarified. The Council, therefore, recommends adoption of the following resolution. This resolution supports ADA Strategic Plan Goal, Lead in the Advancement of Standards.

Resolution

2. Resolved, that the ADA's policy on Reporting of Dental Procedures to Third Parties (*Trans.*1991:637) be amended in the second and third resolving clauses as follows (deleted language stricken through and new language underscored):

Resolved, that third-party payers should not require the reporting of dental treatment or filing fees by any other coding ~~system~~ taxonomies, and be it further

Resolved, that since third-party payers are voting participants in the Association's code revision process, the Association formally contact commercial carriers, service corporations, any and all other third-party payers and their agents who process dental claims, and vendors of electronic claims processing, to request that the ADA's *Code on Dental Procedures and Nomenclature* be used as the code taxonomy for their claims ~~processing systems~~ adjudication process, and be it further

BOARD RECOMMENDATION: Vote Yes.

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

WORKSHEET ADDENDUM

COUNCIL ON DENTAL BENEFIT PROGRAMS

POLICY TO BE AMENDED

Reporting of Dental Procedures to Third Parties (1991:637) (additions are shown by underscoring; deletions are shown by strikethroughs)

Resolved, that when reporting dental treatment under dental plans, the method used by dentists for submitting claims to third-party payers and for filing fees should be the American Dental Association's *Code on Dental Procedures and Nomenclature*, as contained in the ADA's publication, *Current Dental Terminology* (*CDT*), and be it further

Resolved, that third-party payers should not require the reporting of dental treatment or filing fees by any other coding ~~system~~ taxonomies, and be it further

Resolved, that since third-party payers are voting participants in the Association's code revision process, the Association formally contact commercial carriers, service corporations, any and all other third-party payers and their agents who process dental claims, and vendors of electronic claims processing, to request that the ADA's *Code on Dental Procedures and Nomenclature* be used as the code taxonomy for their claims ~~processing systems~~ adjudication process, and be it further

Resolved, that when an unusual procedure, or a procedure that is accompanied by unusual circumstances, is reported by a narrative description, that may or may not include a reference to an appropriate unspecified (-999) code, it should be accepted by the third-party payer to assist in benefit determination, and be it further

Resolved, that Resolution 59H-1986 (*Trans.*1986:515), entitled "Reporting of Dental Procedures to Carriers," be rescinded.

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

Report: NA Date Submitted: August 2009

Submitted By: Council on Dental Benefit Programs

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

SUBSTITUTE FOR RESOLUTION 2:
AMENDMENT OF THE POLICY "REPORTING OF DENTAL PROCEDURES TO THIRD PARTIES"

The following substitute for Resolution 2 (Worksheet:3004) was submitted by the Council on Dental Benefit Programs and transmitted on August 20, 2009, by Dr. Joseph F. Hagenbruch, chair.

Background: The Council believes the original wording of Resolution 2 omits another appropriate change to the third resolving clause of the policy, Reporting of Dental Procedures to Third Parties (*Trans*.1991:637), deletion of the text "…since the third-party payers are participants in the Association's code revision process…" The Council believes that this is an unnecessary reference to the code revision process because the Association would request that the ADA's *Code on Dental Procedures and Nomenclature* be used as the code taxonomy for claims adjudication regardless of any third-party payer involvement in the code revision process. The Council, therefore, recommends adoption of the following substitute resolution.

Resolution

2S-1. Resolved, that the ADA's policy on Reporting of Dental Procedures to Third Parties (*Trans.*1991:637) be amended in the second and third resolving clauses as follows (deleted language stricken through and new language underscored):

Resolved, that third-party payers should not require the reporting of dental treatment or filing fees by any other coding ~~system~~ taxonomies, and be it further

Resolved, that ~~since third-party payers are voting participants in the Association's code revision process,~~ the Association formally contact commercial carriers, service corporations, any and all other third-party payers and their agents who process dental claims, and vendors of electronic claims processing, to request that the ADA's *Code on Dental Procedures and Nomenclature* be used as the code taxonomy for their claims ~~processing systems~~ adjudication process, and be it further

BOARD RECOMMENDATION: Vote Yes on the Substitute.

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

WORKSHEET ADDENDUM

COUNCIL ON DENTAL BENEFIT PROGRAMS

POLICY TO BE AMENDED

Reporting of Dental Procedures to Third Parties (1991:637) (additions are shown by underscoring; deletions are shown by strikethroughs)

Resolved, that when reporting dental treatment under dental plans, the method used by dentists for submitting claims to third-party payers and for filing fees should be the American Dental Association's *Code on Dental Procedures and Nomenclature*, as contained in the ADA's publication, Current Dental Terminology (CDT), and be it further

Resolved, that third-party payers should not require the reporting of dental treatment or filing fees by any other coding ~~system~~ taxonomies, and be it further

Resolved, that ~~since the third-party payers are participants in the Association's code revision process~~ the Association formally contact commercial carriers, service corporations, any and all other third-party payers and their agents who process dental claims, and vendors of electronic claims processing, to request that the ADA's *Code on Dental Procedures and Nomenclature* be used as the code taxonomies for their claims ~~processing systems~~ adjudication process, and be it further

Resolved, that when an unusual procedure, or a procedure that is accompanied by unusual circumstances, is reported by a narrative description, that may or may not include a reference to an appropriate unspecified (-999) code, it should be accepted by the third-party payer to assist in benefit determination, and be it further

Resolved, that Resolution 59H-1986 (*Trans.*1986:515), entitled "Reporting of Dental Procedures to Carriers," be rescinded.

Resolution No. 3 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: August 2009

Submitted By: Council on Dental Benefit Programs

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Lead in the Advancement of Standards (Required)

AMENDMENT OF THE *BYLAWS* DUTIES OF THE COUNCIL ON DENTAL BENEFIT PROGRAMS

Background: (*Reports*:63)

Council on Dental Benefit Programs *Bylaws* Duties: The Council's ADA *Bylaws* duties include responsibility for formulation of procedural and diagnostic codes used by dentists. Council review of duty "g" led to concerns with its wording: 1) why the scope limited to formulation of procedural and diagnostic codes; 2) code taxonomy maintenance is not addressed; and 3) there is specific reference to formulation in conjunction with the "dental benefits industry." Council consensus is that code taxonomies support myriad functions and are not limited to reporting on claim forms. In addition, the *Bylaws* should describe the Council's responsibilities and how the work is done (e.g., in consultation with dental organizations and payers).

The Council, therefore, recommends adoption of the following resolution. This resolution supports ADA Strategic Plan Goal, Lead in the Advancement of Standards.

3. Resolved, that the ADA *Bylaws*, Chapter X. COUNCILS, Section 120. Duties, Subsection D. COUNCIL ON DENTAL BENEFIT PROGRAMS, duty "g" be amended as follows (deleted language stricken through and new language underscored):

g. To formulate and maintain dental coding taxonomies ~~procedural and diagnostic codes in conjunction with national dental organizations and the dental benefits industry~~ that dentists can use to document ~~report~~ patient care and to explore applications and opportunities for new coding taxonomies. ~~on dental benefit claim forms~~

BOARD COMMENT: See Council Substitute Resolution 3S-1 (Worksheet:3006a).

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

WORKSHEET ADDENDUM

COUNCIL ON DENTAL BENEFIT PROGRAMS

POLICY TO BE AMENDED

Chapter X. COUNCILS, Section 120. DUTIES, Subsection D. COUNCIL ON DENTAL BENEFIT PROGRAMS of the ADA *Bylaws* (a. through g.) (additions are shown by underscoring; deletions are shown by strikethroughs)

a. To formulate and recommend policies relating to the planning, administration and financing of dental benefit programs.

b. To study, evaluate and disseminate information on the planning, administration and financing of dental benefit programs.

c. To assist the constituent societies and other agencies in developing programs for the planning, administration and financing of dental benefit programs.

d. To provide assistance, guidance and support to constituent and component societies in the development and management of professional review systems.

e. To encourage the inclusion of dental benefits in health benefit plans and to promote dental benefit plans in accordance with Association policy.

f. To conduct activities and formulate and recommend policies concerning the assessment and improvement of the quality of dental care relating to dental benefit plans.

g. To formulate and maintain dental coding taxonomies ~~procedural and diagnostic codes in conjunction with national dental organizations and the dental benefits industry~~ that dentists can use to document ~~report~~ patient care and to explore applications and opportunities for new coding taxonomies. ~~on dental benefit claim forms~~

Resolution No. 3S-1 New ☐ Substitute ■ Amendment ☐

Report: NA Date Submitted: August 2009

Submitted By: Council on Dental Benefit Programs

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

SUBSTITUTE FOR RESOLUTION 3:
AMENDMENT OF THE *BYLAWS* DUTIES OF THE
COUNCIL ON DENTAL BENEFIT PROGRAMS

The following substitute for Resolution 3 (Worksheet:3006) was submitted by the Council on Dental Benefit Programs and transmitted on August 20, 2009, by Dr. Joseph F. Hagenbruch, chair.

Background: The Council's 2009 annual report to the House of Delegates includes a recommendation for change to the Council's ADA *Bylaws* duties in duty "g" that concern formulation and maintenance of code taxonomies used by dentists.

During its August 2009 meeting, the Board of Trustees reviewed Resolution 3 and referred it back to the Council for further clarification.

The Council believes that inclusion of the word "dental" needlessly restricts the scope of coding taxonomies of interest to the Council, and that there is cumulative beneficial effect of adding the words "including but not limited to" while retaining the words "… procedural and diagnostic codes…"The Council, therefore, recommends adoption of the following resolution.

Resolution

3S-1. Resolved, that the ADA *Bylaws*, Chapter X. COUNCILS, Section 120. Duties, Subsection D. COUNCIL ON DENTAL BENEFIT PROGRAMS, duty "g" be amended as follows (deleted language stricken through and new language underscored):

g. To formulate and maintain coding taxonomies, including but not limited to procedural and diagnostic codes ~~in conjunction with national dental organizations and the dental benefits industry~~ that dentists can use to document ~~report~~ patient care and to explore applications and opportunities for new coding taxonomies. ~~on dental benefit claim forms~~

BOARD COMMENT: The Board is in agreement with the rationale behind the Council's clarification of the proposed amended language in duty "g" and, therefore, recommends the adoption of Resolution 3S-1.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

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

WORKSHEET ADDENDUM

COUNCIL ON DENTAL BENEFIT PROGRAMS

POLICY TO BE AMENDED

Chapter X. COUNCILS, Section 120. DUTIES, Subsection D. COUNCIL ON DENTAL BENEFIT PROGRAMS of the ADA *Bylaws* (a. through g.) (additions are shown by underscoring; deletions are shown by strikethroughs)

a. To formulate and recommend policies relating to the planning, administration and financing of dental benefit programs.

b. To study, evaluate and disseminate information on the planning, administration and financing of dental benefit programs.

c. To assist the constituent societies and other agencies in developing programs for the planning, administration and financing of dental benefit programs.

d. To provide assistance, guidance and support to constituent and component societies in the development and management of professional review systems.

e. To encourage the inclusion of dental benefits in health benefit plans and to promote dental benefit plans in accordance with Association policy.

f. To conduct activities and formulate and recommend policies concerning the assessment and improvement of the quality of dental care relating to dental benefit plans.

g. To formulate and maintain coding taxonomies, including but not limited to procedural and diagnostic codes ~~in conjunction with national dental organizations and the dental benefits industry~~ that dentists can use to document ~~report~~ patient care and to explore applications and opportunities for new coding taxonomies. ~~on dental benefit claim forms~~

Resolution No. 13 New ■ Substitute ☐ Amendment ☐

Report: CAPIR Supplemental Report 1 Date Submitted: August 2009

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS
SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES:
TOBACCO FREE SCHOOLS

Background: This report is in response to action taken by the Council at its June 22-23, 2009, meeting to support proposed policy on tobacco free schools. Each year, an estimated 438,000 people in the United States die prematurely from smoking or exposure to secondhand smoke and another 8.6 million have a serious illness caused by smoking. For every person who dies from smoking, 20 more people suffer from at least one serious tobacco-related illness. Despite these risks, approximately 45.3 million U.S. adults smoke cigarettes.[1]

Since 1964, 29 Surgeons General's reports on smoking and health have concluded that tobacco use is the single most avoidable cause of disease, disability and death in the United States. Over the past four decades, cigarette smoking has caused an estimated 12 million deaths, including 4.1 million deaths from cancer, 5.5 million deaths from cardiovascular diseases, 2.1 million deaths from respiratory diseases and 94,000 infant deaths related to mothers smoking during pregnancy. Smokeless tobacco, cigars, and pipes also have deadly consequences, including lung, larynx, esophageal and oral cancers. [1]

According to recent statistics for youth and adolescents:

- If current smoking patterns in the United States persist, approximately 5 million people younger than 18 years of age today will die prematurely of tobacco-related diseases.[2]
- Approximately 80% of adult smokers started smoking before the age of 18.[2]
- Fourteen percent of high school students have smoked a whole cigarette before age 13.[3]
- Each day in the United States, approximately 4,000 young people aged 12–17 years initiate cigarette smoking and an estimated 1,140 young people become daily cigarette smokers.[2]
- Children and teenagers constitute the majority of all new smokers, and the industry's advertising and promotion campaigns often have special appeal to these young people.[4]
- A third of high school students who try smoking eventually become daily smokers. Young smokers appear to be more vulnerable to nicotine addiction than are older smokers; teen users report symptoms of dependence after smoking fewer cigarettes than adults, and they have more difficulty quitting and experience more severe withdrawal than adults who smoke similar amounts.[5]

- Secondhand smoke exposure during childhood and adolescence may contribute to new cases of asthma or worsen existing asthma, which is the leading health-related cause of school absences. There is no risk-free level of secondhand smoke exposure. Even brief exposure can be dangerous.[6]

Healthy People 2010 Objective 27-2 covers reducing tobacco use by adolescents and calls for reducing rates of cigarette use by students in grades nine through 12 to 16%[7] (currently 20% according to 2007 data[3]), cigar use to 8%[7] (currently 14%[3]) and smokeless tobacco use to 1%[7] (currently 8%[3]). Smoking rates among youth fell during 2000-03, but remained unchanged during 2003-06. Recent surveys indicate that rates may again be on the decline among both youth and adults. However, if the nation is to achieve the objectives in Healthy People 2010, comprehensive, evidence-based approaches for preventing smoking initiation and increasing cessation need to be fully implemented.[1]

A tobacco-free school environment is the cornerstone of a comprehensive policy intended to prevent and reduce tobacco addiction in young people. Studies have found that schools with consistently enforced tobacco free policies are more likely to have lower rates of student tobacco use than comparable schools without such policies.[8,9] Healthy People Objective 27-11 calls for 100% smoke-free and tobacco-free environments in schools, including all school facilities, property, vehicles and school events. Children and youth spend most of their days at school. Tobacco free schools support the message that students receive in the classrooms, creating no conflict between what is taught in class and what is experienced in the rest of the school environment. Prohibiting tobacco use at all times on school grounds and at all school events reinforces the norm that most people do not use tobacco products and do not want to breathe secondhand smoke. Tobacco-free school policies prepare young people to experience—and in fact demand—tobacco-free workplaces and communities.

For schools to effectively prevent and reduce youth tobacco use, they must create an environment that encourages anti-tobacco beliefs and behaviors. The following is a brief listing of the Guidelines for School Health Programs to Prevent Tobacco Use and Addiction developed by the CDC in collaboration with tobacco-use prevention experts across the country. The Guidelines identify the most effective policies and practices for schools and are based on an extensive review of research, theory and current practice in tobacco-use prevention, cessation and health education.[10] They are:

- Develop and enforce a school policy on tobacco use that establishes environments that are tobacco-free at all times, including off-site school events for students, staff and visitors.

- Provide instruction regarding the short- and long-term physiologic and social consequences of tobacco use, social influences on tobacco use, peer norms regarding tobacco use and skills that promote a tobacco-free lifestyle.

- Provide tobacco-use prevention education in Kindergarten through 12th grade.

- Provide program-specific training for teachers.

- Involve parents, families, and the community in support of school-based programs to prevent tobacco use.

- Provide support for tobacco-use cessation efforts among students and all school staff who use tobacco.

- Assess the tobacco-use prevention program at regular intervals.

In addition to the CDC, the value and effectiveness of tobacco free school environments are noted in policies and statements from such organizations as the American Public Health Association, Campaign for Tobacco Free Kids, National Association of State Boards of Education and National School Boards Association.

Additionally, many of these organizations have developed resources to assist those interested in pursuing tobacco free school environments at the state and local levels.

Therefore, the Council recommends adoption of the following resolution.

Resolution

13. Resolved, that the American Dental Association recognizes that a tobacco-free school environment is the cornerstone of a comprehensive policy intended to prevent and reduce tobacco addiction in young people, and be it further

Resolved, that the ADA support the adoption of tobacco-free school laws or policies that incorporate the guidelines developed by the Centers for Disease Control and Prevention for school-based health programs to prevent tobacco use and addiction, and be it further

Resolved, that the ADA urge its members and dental societies to collaborate with students, parents, school officials and members of the community to establish tobacco free schools.

BOARD RECOMMENDATION: Vote Yes.

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

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Resolution No. 13S-1 New ☐ Substitute ☐ Amendment ■

Report: NA Date Submitted: September 2009

Submitted By: Third Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

AMENDMENT TO RESOLUTION 13:
TOBACCO FREE SCHOOLS

The following amendment to Resolution 13 (Worksheet:3010) was submitted by the Third Trustee District and transmitted on September 16, 2009, by Dr. Gary S. Davis, secretary, Pennsylvania Dental Association.

Background: Amend Resolution 13 between lines 11 and 12 by inserting the following new third resolving clause:

> **Resolved,** that the ADA provide a link on its website of existing resources to assist those at the state and local levels who are interested in pursuing tobacco free school environments.

so the amended resolution reads:

Resolution

13S-1. Resolved, that the American Dental Association recognizes that a tobacco-free school environment is the cornerstone of a comprehensive policy intended to prevent and reduce tobacco addiction in young people, and be it further

Resolved, that the ADA support the adoption of tobacco-free school laws or policies that incorporate the guidelines developed by the Centers for Disease Control and Prevention for school-based health programs to prevent tobacco use and addiction, and be it further

Resolved, that the ADA provide a link on its website of existing resources to assist those at the state and local levels who are interested in pursuing tobacco free school environments, and be it further

Resolved, that the ADA urge its members and dental societies to collaborate with students, parents, school officials and members of the community to establish tobacco free schools.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

BOARD VOTE: UNANIMOUS.

Resolution No. 14 New ■ Substitute ☐ Amendment ☐

Report: Board Report 3 Date Submitted: August 2009

Submitted By: Board of Trustees

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Lead in the Advancement of Standards (Required)

REPORT 3 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:
PRINCIPLES FOR THE APPLICATION OF RISK ASSESSMENT
IN DENTAL BENEFIT PLANS

Background: The Board of Trustees received a report, "Report of the Chief Policy Advisor and the Senior Vice-President Dental Practice/Professional Affairs: Risk Management and the Clinical Assessment of Risk for Oral Disease" at its June 2008 meeting. Among the four resolutions adopted by the Board from that report, Resolution B-20-2008 (*Trans*.2008:321) directed that the Chief Policy Advisor, in consultation with the Councils on Scientific Affairs, Dental Practice and Dental Benefit Programs, draft policy recommendations related to oral disease risk assessment that will protect dentists and patients.

Recently, there has been considerable discussion concerning treatment based upon assessed risk for oral disease, both caries—especially in children and young adults—and periodontal disease. Risk assessment is basically a triage system whereby time and resources can be allocated most efficiently, with the goal of early intervention in high risk individuals to move them as quickly as possible into a lower risk category.

The application of risk assessment in dental benefit plans has the potential for making them operate more efficiently and benefiting patient care. It also has the potential for interfering with treatment decisions by attending dentists. ADA policies guiding the application of risk assessment in dental benefit plans can help assure that patients' well being remains paramount and the patient-doctor relationship is respected.

The draft Principles for the Application of Risk Assessment in Dental Benefit Plans, included below, have been presented to the three Councils listed above and discussed by the Chief Policy Advisor with the request that modifications the Councils may suggest would be welcome. Each of the Councils has submitted recommendations for modifications, which have been incorporated into the draft Principles. The Board, therefore, recommends adoption of the following resolution.

Resolution

14. Resolved, that the Principles for Application of Risk Assessment in Dental Benefit Plans be adopted.

Principles for the Application of Risk Assessments in Dental Benefit Plans

1. The assessment of the risk for the development of oral diseases, the progress of existing disease or the adverse outcomes of treatment of oral disease for an individual patient is a professional matter that is the sole responsibility of the attending dentist.
2. Individual risk assessment is an important consideration in developing a complete diagnosis and treatment recommendations for each patient, the complexity of which is determined by the oral

health status, goals and desires of the individual patient. The assessment should be as scientifically based as possible and should be continually refined through outcomes studies.

3. There should be no interference by outside parties in the patient-doctor relationship by injecting factors unrelated to the patient's needs in any aspect of the diagnosis of the patient's oral health status or the attending dentist's treatment recommendations
4. Risk assessments should not limit access to care for patients, including individuals who require extraordinary levels or type of care, nor provide a disincentive for practitioners to treat complex or difficult cases because of concern about performance ratings. There should be a system of risk adjustments for difficult or complex cases.
5. Risk assessments should be conducted periodically on a schedule determined by the attending dentist based upon the needs and medical status of the individual patient, since risk can change over time due to application of preventive measures, changes in science, the effects of therapy and changes in patient behaviors.
6. Self-administered patient questionnaires provided by third-party payers used for risk assessment purposes have limited value and should contain the admonition that they are not to be considered as a substitute for a clinical evaluation performed by a dentist.
7. When predictive modeling is used by payers for identifying individuals or groups for underwriting purposes that have the potential for incurring high health care costs, the payers should alert dentists to future risks among their patients when they have been identified, particularly when actionable opportunities for timely interventions present themselves.|
8. Risk assessment for communities or groups within a community is a science separate from individual patient risk assessment, one that requires different skills and techniques than those used in the assessment of individual patients.
9. When risk considerations are used in profiling practitioners, establishing tiers of practitioners within plans or monitoring compliance of practitioners to guidelines for care, the algorithms used in making those determinations should include adjustments for the risk characteristics of the practitioner's patient population.
10. When a disease is present in a community and its prevalence is low because of the effectiveness of preventive efforts, third-party payers should continue those preventive services as benefits of a dental plan.

BOARD RECOMMENDTION: Vote Yes.

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

Resolution No. 14S-1 New ☐ Substitute ☐ Amendment ■

Report: NA Date Submitted: September 2009

Submitted By: Sixteenth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Lead in the Advancement of Standards (Required)

AMENDMENT TO RESOLUTION 14:
PRINCIPLES FOR THE APPLICATION OF RISK ASSESSMENT
IN DENTAL BENEFIT PLANS

The following amendment to Resolution 14 (Worksheet:3012) was submitted by the Sixteenth Trustee District and transmitted on September 21, 2009, by Mr. Phil Latham, executive director, South Carolina Dental Association.

Background: See Board Report 3 (Worksheet:3012). Amend Resolution 14 by deleting the words "have limited value and" in principle no. 6.

Resolution

14S-1. Resolved, that the Principles for Application of Risk Assessment in Dental Benefit Plans be adopted.

Principles for the Application of Risk Assessments in Dental Benefit Plans

1. The assessment of the risk for the development of oral diseases, the progress of existing disease or the adverse outcomes of treatment of oral disease for an individual patient is a professional matter that is the sole responsibility of the attending dentist.
2. Individual risk assessment is an important consideration in developing a complete diagnosis and treatment recommendations for each patient, the complexity of which is determined by the oral health status, goals and desires of the individual patient. The assessment should be as scientifically based as possible and should be continually refined through outcomes studies.
3. There should be no interference by outside parties in the patient-doctor relationship by injecting factors unrelated to the patient's needs in any aspect of the diagnosis of the patient's oral health status or the attending dentist's treatment recommendations
4. Risk assessments should not limit access to care for patients, including individuals who require extraordinary levels or type of care, nor provide a disincentive for practitioners to treat complex or difficult cases because of concern about performance ratings. There should be a system of risk adjustments for difficult or complex cases.
5. Risk assessments should be conducted periodically on a schedule determined by the attending dentist based upon the needs and medical status of the individual patient, since risk can change over time due to application of preventive measures, changes in science, the effects of therapy and changes in patient behaviors.
6. Self-administered patient questionnaires provided by third-party payers used for risk assessment purposes ~~have limited value and~~ should contain the admonition that they are not to be considered as a substitute for a clinical evaluation performed by a dentist.

7. When predictive modeling is used by payers for identifying individuals or groups for underwriting purposes that have the potential for incurring high health care costs, the payers should alert dentists to future risks among their patients when they have been identified, particularly when actionable opportunities for timely interventions present themselves.|
8. Risk assessment for communities or groups within a community is a science separate from individual patient risk assessment, one that requires different skills and techniques than those used in the assessment of individual patients.
9. When risk considerations are used in profiling practitioners, establishing tiers of practitioners within plans or monitoring compliance of practitioners to guidelines for care, the algorithms used in making those determinations should include adjustments for the risk characteristics of the practitioner's patient population.
10. When a disease is present in a community and its prevalence is low because of the effectiveness of preventive efforts, third-party payers should continue those preventive services as benefits of a dental plan.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LONG	■	☐	☐	☐	SYKES
■	☐	☐	☐	ELLIOTT	■	☐	☐	☐	MANNING	■	☐	☐	☐	TANKERSLEY
■	☐	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	■	☐	☐	☐	THOMPSON
■	☐	☐	☐	GIST	■	☐	☐	☐	RICH	■	☐	☐	☐	VERSMAN
■	☐	☐	☐	GLECOS	■	☐	☐	☐	SCHWEINEBRATEN	■	☐	☐	☐	VIGNA
☐	☐	☐	■	KREMPASKY SMITH	■	☐	☐	☐	STEFFEL	■	☐	☐	☐	WEBB
■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN				Res.	14S-1

Resolution No. 27-31 New ■ Substitute ☐ Amendment ☐

Report: Board Report 8 Date Submitted: August 2009

Submitted By: Board of Trustee

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

REPORT 8 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: WORKFORCE POLICIES

Background: At its June 2009 meeting, the Board of Trustees created the Workforce Policy Workgroup to review and discuss recommended policies put forth in the June 2009 report of its former Task Force on the Dental Team. The Workgroup members were: Dr. O. Andy Elliott, first vice-president; Dr. S. Jerry Long, trustee, Fifteenth District; Dr. Samuel B. Low, trustee, Seventeenth District; Dr. Marie C. Schweinebraten, trustee, Fifth District; and Dr. Russell I. Webb, trustee, Thirteenth District. The Workgroup also reviewed Resolution 74H-2008 (*Trans*.2008:435), ADA's Position on Dental Mid-Level Provider, which reads as follows.

> **74H-2008. Resolved,** that the ADA's position on any proposed new member of the dental team shall be an individual supervised by a dentist and be based upon a determination of need, sufficient education and training, and a scope of practice that ensures the protection of the public's oral health.

Review of Existing ADA Policies and Potential Policy Gaps and Summary: The Board agrees with the Workgroup that it is evident that several inconsistencies exist in the following ADA policies: Comprehensive Policy Statement on Allied Dental Personnel (*Trans*.1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307); Dentist Administered Dental Assisting and Dental Hygiene Education Programs (*Trans*.1992:616); Opposition to Pilot Programs which Allow Nondentists to Diagnose Dental Needs or Perform Irreversible Procedures (*Trans*.2005:343); Diagnosis or Performance of Irreversible Dental Procedures by Nondentists (*Trans*.2004:328); and ADA's Position on Dental Mid-Level Provider (*Trans*.2008:435). The Board believes that many statements are written negatively or are not scientifically supported. The Board also believes that ADA policies should be defined in a manner to respect and recognize individual states' rights, and that this may best be accomplished by broad or general policy statements.

The Board believes the American Dental Association has the responsibility to define policies affecting the provision of care to patients and to serve as a resource to the states as they individually determine the role and duties of dental team members according to their respective state dental practice acts. The Board also agrees with the former Task Force on the Dental Team that the dentist must remain the head of the team and that the highest level of patient safety and quality care is to be the goal in all provisions that address new members of the dental team. The Board believes that dentists must identify those procedures or functions that must be performed only by a licensed dentist. This includes but is not limited to examination, evaluation, diagnosis and treatment planning of the patient. Dentists should determine, through their individual state dental practice acts, what duties are delegatable to the appropriate team member and the level of supervision (as defined by the ADA; direct, indirect, personal, general, public health).

The Board also agrees with the Task Force that surgical procedures (defined as the cutting of hard or soft tissues) when delegated to nondentists should have appropriate supervision (this may be direct, indirect, or

personal supervision) as determined by the individual state dental practice act. The Board recognizes that states or other government agencies may determine some form of general supervision that will be accepted; whether it is through technology like teledentistry, prescriptive care, or some other method designed to reach remote or underserved populations. It is critical that the ADA be able to serve as a resource and remain relevant to educate the public and the legislatures on the benefits of dentist-provided surgical/irreversible procedures and the appropriate level of supervision. The Association must also educate these groups on the rigors and level of education required of a dentist.

The Board supports the recommendation of the Task Force on the Dental Team and the Workforce Policy Workgroup to develop a plan of educating the public and policy-makers on the extent and rigors of dental school education. The Board, therefore, recommends adoption of the following resolutions.

Resolutions

See Resolution 27, Worksheet: 3016
See Resolution 28, Worksheet: 3023
See Resolution 29, Worksheet: 3024
See Resolution 30, Worksheet: 3025
See Resolution 31, Worksheet: 3026

Resolution No. 27 New ■ Substitute ☐ Amendment ☐

Report: Board Report 8 Date Submitted: August 2009

Submitted By: Board of Trustees

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

AMENDMENT TO THE "COMPREHENSIVE POLICY STATEMENT ON ALLIED DENTAL PERSONNEL"

Background: (See Board Report 8, Workforce Policies, Worksheet:3014)

Resolution

27. Resolved, that the ADA policy on the Comprehensive Policy Statement on Allied Dental Personnel (*Trans*.1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307) be amended to read as follows (additions are shown by underscoring; deletions are shown by strikethroughs):

Comprehensive Policy Statement on Allied Dental Personnel

General Principles

Dentistry is committed to improving the health of the American public by providing the highest quality comprehensive dental care, which includes the inseparable components of medical and dental history, examination, diagnosis, treatment planning, treatment services and health maintenance. Preventive care services are an integral part of the comprehensive practice of dentistry and should be rendered in accordance with the needs of the patient as determined by a diagnosis and treatment plan developed and executed by the dentist.

The dentist is ultimately responsible, ethically and legally, for patient care. In carrying out that responsibility and to increase the capacity of the profession to provide patient care in the most cost-effective manner, the dentist may delegate to allied dental personnel certain patient care functions for which the allied dental personnel has been trained.

~~The three recognized categories of allied dental personnel are dental hygienists, dental assistants and dental laboratory technicians. (See the glossary for definitions of each category.) A dental laboratory technician who is employed in the dental office is considered to allied dental personnel. A dental technician who performs a supportive function in an environment outside the dental office may be properly termed a supportive or allied member of the dental health team.~~

Delegation of Functions

The primary purpose of dentists delegating functions to allied dental personnel is to increase the capacity of the profession to provide patient care while retaining full responsibility for the quality of care. This responsibility includes identification of the need for specific types of allied dental personnel

and establishment of appropriate controls on the patient care services provided by allied dental personnel.

The dental profession has the responsibility to provide guidance to all agencies, organizations and governmental bodies, such as state dental boards and legislatures, that have an interest in, or responsibility and authority for, decisions on utilization, education, and supervision of allied dental personnel. In this context, the primary responsibility is to assure that decisions on allied dental personnel utilization will not adversely affect the health and well-being of the public or cause an increased risk to the patient. In meeting these responsibilities, dentists must also identify those functions or procedures that require the knowledge and skill of the dentist and therefore must be performed only by a licensed dentist. ~~These functions and procedures include, but are not limited to: examination, diagnosis and treatment planning; prescribing work authorizations; surgical or cutting procedures on hard or soft tissue; prescribing drugs and other medications; and administering local, parenteral, inhalational, or general anesthesia.~~

Nothing in this statement should be interpreted to limit a dentist from delegating to a properly trained allied dental personnel responsibility for assisting the dentist in the performance of these functions under the dentist's supervision and in accordance with state law, if, in the dentist's professional judgment, this is in the patient's best interest. The transfer of permissible functions from the dentist to the allied dental personnel must not result in a reduced quality of patient care. In all cases, the authority and responsibility of the dentist for the overall oral health of the patient must be maintained to assure cost-effective delivery of services to the patient and avoid fragmentation of the dental team. Any surgical/irreversible procedures that are delegated should have appropriate supervision (personal, indirect, or direct) as determined by the individual state dental practice act.

Constituent dental societies should advocate the functions which may be appropriately delegated to allied dental personnel based on (1) the best interests of the patient; (2) the education, training and credentialing of the allied dental personnel; (3) considerations of cost-effectiveness and efficiency in delivery patterns; and (4) valid research demonstrating the feasibility and practicality of utilizing allied dental personnel in such roles in actual practice settings.

Delegation of Expanded Functions

Provision for the delegation of intraoral expanded functions to allied dental personnel which are included in state dental practice acts and regulations should specify (1) education and training requirements; (2) level of supervision by the dentist; (3) assurance of quality; and (4) regulatory controls to assure protection of the public. Final decisions on delegation of expanded functions should be made by the dentist, based on the best interests of the patient and in compliance with legal requirements in the jurisdiction. Because of the complexity of the procedures involved and the need to assure protection of the public, intraoral expanded functions as defined in state dental practice acts and regulations shall be performed by allied dental personnel only under the ~~direct~~ appropriate supervision of the dentist.

Supervision of Allied Dental Personnel

In all instances, a dentist assumes responsibility for determining, on the basis of diagnosis, the specific treatment patients will receive and which aspects of treatment may be delegated to qualified personnel. As the dentist is best educated and trained to provide the care and has the responsibility for patient care, supervision by the dentist is paramount in assuring the highest quality of care and the safety of the patient. The degree of supervision required to assure that treatment is appropriate and does not jeopardize the systemic or oral health of the patient varies with the nature of the procedure and the medical and dental history of the patient, as determined with evaluation and examination by the dentist.

~~Supervision and coordination of treatment by a dentist are essential to comprehensive oral health care. Unsupervised practice by allied dental personnel reduces the quality of oral health care, fails to protect the dental health of the public and is opposed by the American Dental Association.~~ The types of supervision are:

Personal supervision. A dentist is personally operating on a patient and authorizes the allied dental personnel to aid treatment by concurrently performing a supportive procedure.

Direct supervision. A dentist is in the dental office or treatment facility, personally diagnoses the condition to be treated, personally authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the allied dental personnel and, before dismissal of the patient, evaluates the performance of the allied dental personnel.

Indirect supervision. A dentist is in the dental office or treatment facility, has personally diagnosed the condition to be treated, authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the allied dental personnel and will evaluate the performance of the allied dental personnel.

General supervision. A dentist is not required to be in the dental office or treatment facility when procedures are being performed by the allied dental personnel, but has personally diagnosed the condition to be treated, has personally authorized the procedures and will evaluate the performance of the allied dental personnel.

~~General supervision is not acceptable to the American Dental Association because it fails to protect the health of the public. Personal, direct, and indirect supervision are appropriate for delegation of duties to allied dental personnel providing direct patient care. However, in some state licensed dental hygienists are permitted to perform duties, except for intraoral expanded functions, under general supervision, as delegated by the supervising dentist. In order to assure the safety of the patient, the following criteria must be followed whenever functions are performed under general supervision:~~

~~1. Any patient to be treated by a dental hygienist must first become a patient of record of a dentist. A patient of record is defined as one who:~~
~~a. has been examined by the dentist;~~
~~b. has had a medical and dental history completed and evaluated by the dentist; and~~
~~c. has had his/her oral condition diagnosed and a treatment plan developed by the dentist.~~

~~2. The dentist must provide to the dental hygienist prior written authorization to perform clinical dental hygiene services for that patient of record. Such authorization should remain in effect for a limited time period as specified by state law.~~

~~3. The dentist shall examine the patient following performance of clinical services by the dental hygienist. Such examination shall be performed within a reasonable time as determined by the nature of the services provided, the needs of the patient and the professional judgment of the dentist.~~

Public Health Supervision. That oversight where a licensed dental hygienist may provide dental hygiene services, as specified by state law or regulations, when such services are provided as part of an organized community program in various public health settings, as designated by state law~~, and with general oversight of such programs by a licensed dentist designated by the state~~.

Appropriate Settings for Dental Hygiene Services

The settings in which a dental hygienist may perform legally delegated functions shall be limited to treatment facilities under the jurisdiction and supervision of a dentist. ~~When the employer of the dental hygienist is not a licensed dentist, the~~The method of compensation and other working conditions for the dental hygienist must not interfere with the quality of dental care provided or the relationship between the responsible supervising dentist and the dental hygienist.

~~The federal dental services are urged to assure that their utilization of allied dental personnel is in compliance with policies of the American Dental Association.~~

Public oral health programs should utilize all appropriate dental team members in implementation of programs which have been endorsed by constituent dental societies. The dental hygienist, in this setting, may provide screening and preventive care services under an appropriate supervisory arrangement, as specified in state practice acts and regulations, as well as oral health education programs for groups within the community served.

Allied Dental Personnel Education

All personnel who participate in the provision of oral health care must have appropriate education and training and meet any additional criteria needed to assure competence. The type and length of education needed to prepare allied dental personnel to perform specific delegated patient care procedures should be specified in state dental practice acts and regulations.

~~Dental assisting and dental hygiene educational programs should be administered or directed by a dentist.~~ Further, licensed or legally permitted dentists must be involved in the clinical supervision of dental assisting and dental hygiene education programs, in accordance with state law.

Dental hygiene education programs are designed to prepare a dental hygienist to provide preventive dental services under the direction and supervision of a dentist. Two academic years of study or its equivalent in an education program accredited by the Commission on Dental Accreditation (CODA) typically prepares the dental hygienist to perform clinical hygiene services. However, other programs, CODA accredited or approved by the respective state's board of dental examiners, which utilize such methods as institutionally-based didactic course work, in-office clinical training, or electronic distance education can be an acceptable means to train dental hygienists. Boards of dentistry are urged to review such innovative programs for acceptance.

The dental hygiene education curriculum does not provide adequate preparation to enable graduates to provide comprehensive oral health care or to practice without the supervision of a dentist.

Formal education and training are essential for preparing allied dental personnel to perform intraoral expanded functions which are permitted by state law. Such expanded functions training should be provided only in educational settings with the resources needed to provide appropriate preparation for clinical practice under the supervision of a dentist.

Licensure of Dental Hygienists

There should be a single state board of dentistry in each state which serves as the sole licensing and regulatory authority for all dental personnel. Graduation from a dental hygiene education program accredited by the Commission on Dental Accreditation, or the successful completion by dental students of an equivalent component of a predoctoral dental curriculum accredited by the Commission on Dental Accreditation, is the essential educational eligibility requirement for dental hygiene licensure and practice. The clinical portion of the dental hygiene licensure examination, during which patient care is provided, must be conducted under the supervision of a licensed dentist.

Constituent Legislative Activities

Constituent dental societies should work with the state dental boards to assure that delegation of functions, educational requirements, supervisory and setting provisions for allied dental personnel in state dental practice acts and regulations are structured according to the basic principles contained in this policy statement.

In order to maintain the highest standard of patient care, assure continuity of care and achieve cost-effective delivery of services to the patient, constituent dental societies should seek to maintain, in statute and regulation, the authority and responsibility of the dentist for the overall oral health of the patient.

Glossary of Terminology Related to Allied Dental Personnel Utilization and Supervision

This Glossary is designed to assist in developing a common language for discussion of allied dental personnel issues by dental professionals and public policy makers. The terms included were selected from the American Dental Association's policies on allied dental personnel education, utilization and supervision and are defined consistently with the intent of those policies. It should be noted that some of the terms included do not lend themselves to rigid definition and can only be described as to use and meaning. Also, certain terms are defined in dental practice acts and regulations, which vary from state to state.

Authorization: The act by a dentist of giving permission or approval to the allied dental personnel to perform legally allowable functions, in accordance with the dentist's diagnosis and treatment plan.

Community Dental Health: (1) The overall oral health status of a geographically based population group, (2) the branch of dentistry concerned with the distribution and causes of oral diseases in the population and the management of resources for their prevention and treatment and (3) commonly used to refer to programs which are designed to improve the oral health status of the population as a whole and conducted under the direction of a dentist (such as access programs, education programs, fluoridation and school-based mouthrinse programs).

Comprehensive Dental Care: A coordinated approach, by a dentist, to the restoration or maintenance of the oral health and function of the patient, utilizing the full range of clinically proven dental care procedures, which includes examination and diagnostic, preventive and therapeutic services.

Delegation: The act by a dentist of directing allied dental personnel to perform specified legally allowable functions.

Allied Dental Personnel: Individuals who assist the dentist in the provision of oral health care services to patients, including, but not limited to, dental assistants, dental hygienists and dental laboratory technicians who are employed in dental offices or other patient care facilities.

Dental Assistant. An individual who may or may not have completed an accredited dental assisting education program and who aids the dentist in providing patient care services and performs other nonclinical duties in the dental office or other patient care facility. The scope of the patient care functions that may be legally delegated to the dental assistant varies based on the needs of the dentist, the educational preparation of the dental assistant and state dental practice acts and regulations. Patient care services are provided under the supervision of a dentist. To avoid misleading the public, no occupational title other than dental assistant should be used to describe allied dental personnel.

Dental Hygienist. An individual who has completed an accredited dental hygiene education program, and an individual who has been licensed by a state board of dental examiners to provide preventive care services under the supervision of a dentist. Functions that may be legally delegated to the dental hygienist vary based on the needs of the dentist, the educational preparation of the dental hygienist and state dental practice acts and regulations, but always include, at a minimum, scaling and polishing the teeth. To avoid misleading the public, no occupational title other than dental hygienist should be used to describe allied dental personnel.

Dental Laboratory Technician/Certified Dental Technician. An individual who has the skill and knowledge in the fabrication of dental appliances, prostheses and devices in accordance with a dentist's laboratory work authorization. To avoid misleading the public, no occupational title other than dental laboratory technician or certified dental technician (when appropriate) should be used to describe this allied dental personnel.

Examination, Complete: A dentist thoroughly evaluates the state of health of the patient including a thorough examination of the hard and soft tissues of the oral cavity and contiguous structures. This includes but is not limited to the use of diagnostic information acquired through interpretation of appropriate dental radiographs and may also include pulp vitality tests, transillumination, study models and laboratory tests, when indicated.

Examination, Limited: A dentist thoroughly evaluates the state of health of the patient and includes an evaluation of the hard and soft tissues of a portion of the oral cavity. Includes but is not limited to the use of diagnostic information acquired through interpretation of selected dental radiographs; may also include diagnostic information acquired through interpretation of other diagnostic tests, as indicated.

Expanded Functions: Additional tasks, services or capacities, often including direct patient care services, which may be legally delegated by a dentist to allied dental personnel. The scope of expanded functions varies based on state dental practice acts and regulations but is generally limited to reversible procedures which are performed under the supervision of a dentist. Authorization to perform expanded functions generally requires specific training in the function (also expanded duties or extended functions).

Functions: An action or activity proper to an individual; a task, service or capacity which has been legally delegated by a dentist to allied dental personnel (also duties or services).

Oral Diagnosis: The determination by a dentist of the oral health condition of an individual patient, achieved through the evaluation of data gathered by means of history taking, direct examination, patient conference, and such clinical aids and tests as may be necessary in the judgment of the dentist (*Trans.*1978:499).

Preventive Care Services: The procedures used to prevent the initiation of oral diseases, which may include screening, fluoride therapy, nutritional counseling, plaque control, and sealants.

Screening: Identifying the presence of gross lesions of the hard or soft tissues of the oral cavity.

Supervision: The authorization, direction, oversight and evaluation by a dentist of the activities performed by allied dental personnel.

Personal supervision. A type of supervision in which the dentist is personally operating on a patient and authorizes the allied dental personnel to aid treatment by concurrently performing a supportive procedure.

Direct supervision. A type of supervision in which a dentist is in the dental office or treatment facility, personally diagnoses the condition to be treated, personally authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the allied dental

personnel, and, before dismissal of the patient, evaluates the performance of the allied dental personnel.

Indirect supervision. A type of supervision in which a dentist is in the dental office or treatment facility, has personally diagnosed the condition to be treated, authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the allied dental personnel, and will evaluate the performance of the allied dental personnel.

General supervision. A type of supervision in which a dentist is not required to be in the dental office or treatment facility when procedures are provided, but has personally diagnosed the condition to be treated, has personally authorized the procedures, and will evaluate the performance of the allied dental personnel.

Public Health Supervision. That oversight where a licensed dental hygienist may provide dental hygiene services, as specified by state law or regulations, when such services are provided as part of an organized community program in various public health settings, as designated by state law, and with general oversight of such programs by a licensed dentist designated by the state.

Treatment Plan: The sequential guide for the patient's care as determined by the dentist's diagnosis and used by the dentist for the restoration to and/or maintenance of optimal oral health (*Trans*.1978:499).

BOARD RECOMMENDATION: Vote Yes.

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LONG	■	☐	☐	☐	SYKES
☐	■	☐	☐	ELLIOTT	■	☐	☐	☐	MANNING	■	☐	☐	☐	TANKERSLEY
■	☐	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	■	☐	☐	☐	THOMPSON
■	☐	☐	☐	GIST	■	☐	☐	☐	RICH	■	☐	☐	☐	VERSMAN
■	☐	☐	☐	GLECOS	■	☐	☐	☐	SCHWEINEBRATEN	■	☐	☐	☐	VIGNA
■	☐	☐	☐	KREMPASKY SMITH	■	☐	☐	☐	STEFFEL	■	☐	☐	☐	WEBB
■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN					Res. 27

Resolution No. 28 New ■ Substitute ☐ Amendment ☐

Report: Board Report 8 Date Submitted: August 2009

Submitted By: Board of Trustees

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

AMENDMENT TO THE POLICY, "DENTIST ADMINISTERED DENTAL ASSISTING AND DENTAL HYGIENE EDUCATION PROGRAMS"

Background: (See Board Report 8, Workforce Policies, Worksheet:3014)

Resolution

28. Resolved, that the ADA policy on Dentist Administered Dental Assisting and Dental Hygiene Education Programs (*Trans*.1992:616) be amended by deletion of the first resolving clause, so that the amended policy reads as follows:

~~**Resolved,** that dental assisting and dental hygiene educational programs should be administered or directed by a dentist, and be it further~~

Resolved, that licensed or legally permitted dentists must be actively involved in the clinical supervision of dental assisting and dental hygiene educational programs.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 29 New ■ Substitute ☐ Amendment ☐

Report: Board Report 8 Date Submitted: August 2009

Submitted By: Board of Trustees

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

AMENDMENT TO THE POLICY, "OPPOSITION TO PILOT PROGRAMS WHICH ALLOW NONDENTISTS TO DIAGNOSE DENTAL NEEDS OR PERFORM IRREVERSIBLE PROCEDURES"

Background: (See Board Report 8, Workforce Policies, Worksheet:3014)

Resolution

29. Resolved, that the ADA policy on Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform Irreversible Procedures (*Trans*.2005:343) be amended to read as follows (additions are shown by underscoring; deletions are shown by strikethroughs).

~~Resolved, that the American Dental Association opposes pilot programs that are in violation of the ADA policy stated in Resolution 24H-2004 (*Trans.*2004:291), no. 13 (stating that, "The ADA is opposed to non-dentists making diagnoses, or developing treatment plans or performing irreversible procedures.")~~

Resolved, that the American Dental Association asserts that the dentist is the head of the dental team and is solely responsible for examination, evaluation, diagnosis, and development of the patient's treatment plan, and be it further

Resolved, that the ADA encourages any new member of the dental team proposed in a pilot program be supervised by a dentist (as determined by the individual state dental practice act) and that new member be based upon determination of need, sufficient education and training, and a scope of practice that ensures the protection of the public's oral health.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 30 New ■ Substitute ☐ Amendment ☐

Report: Board Report 8 Date Submitted: August 2009

Submitted By: Board of Trustees

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

AMENDMENT TO THE POLICY, "DIAGNOSIS OR PERFORMANCE OF IRREVERSIBLE DENTAL PROCEDURES BY NONDENTISTS"

Background: (See Board Report 8, Worksheet:3014)

Resolution

30. Resolved, that the ADA policy on Diagnosis or Performance of Irreversible Dental Procedures by Nondentists (*Trans*.2004:328) be amended as follows (additions are shown by underscoring; deletions are shown by strikethroughs):

Resolved, that the American Dental Association by ~~all appropriate~~ federal legislative and ~~judicial~~ any other appropriate means support ~~resist any~~ efforts to deliver ~~compromising the~~ quality ~~of~~ dental health care services provided by the dental team with the dentist as the head of the team, delegating duties to team members under appropriate supervision as determined by the individual states. ~~allowing any nondentist to diagnose or perform irreversible dental procedures oral diseases except as otherwise authorized by state law with reference to physicians.~~

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 31 New ■ Substitute ☐ Amendment ☐

Report: Board Report 8 Date Submitted: August 2009

Submitted By: Board of Trustees

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

AMENDMENT TO THE POLICY, "ADA'S POSITION ON DENTAL MID-LEVEL PROVIDER"

Background: (See Board Report 8, Worksheet:3014)

Resolution

31. Resolved, that the policy, ADA's Position on Dental Mid-Level Provider (*Trans.* 2008:435), be amended to read as follows (additions are shown by underscoring; deletions are shown by strikethroughs):

Resolved, that the determination of workforce needs are under the jurisdiction of the state and are determined at the state level, ~~the ADA's position on~~ and any proposed new member of the dental team should be established at the state level with the advice and counsel of the relevant state dental association, and be it further

Resolved, that the ADA shall serve as a resource to the state dental associations as they respond to workforce needs and advocate for the best workforce solution, and be it further

Resolved, that the ADA recommends that any new member of the dental team ~~shall~~ be ~~an individual~~ supervised by a dentist and be based upon a determination of need, sufficient education and training, and a scope of practice that ensures the protection of the public's oral health.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 31S-1 New ☐ Substitute ■ Amendment ☐

Report: NA Date Submitted: August 2009

Submitted By: Fourteenth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

SUBSTITUTE FOR RESOLUTION 31:
AMENDMENT TO THE POLICY, "ADA'S POSITION ON DENTAL MID-LEVEL PROVIDER"

The following substitute for Resolution 31 (Worksheet:3026) was submitted by the Fourteenth Trustee District and transmitted on August 28, 2009, by Dr. Kenneth Versman, trustee, Fourteenth District.

Background: It is probably inevitable that more constituent societies will be faced with legislative initiatives relating to mid-level providers that will conflict with current ADA policies. Rather than amending our policy to resolve conflicts, it is preferable to enable the ADA to assist societies to the best solution acceptable to that society, even if that solution may at times conflict with the ADA's policy. Assisting constituent societies to the best outcome possible should not require us to change a policy that continues to reflect our fundamental principles. Allowing the Association enough latitude to deal with situations in individual jurisdictions that may conflict with existing policies, serves the broadest interest of the rest of the Association by permitting us to continue to uphold our principles regarding mid-level providers, while acting on another important principle: supporting each other in adverse political circumstances.

Resolution

31S-1. Resolved, that the policy, ADA's Position on Dental Mid-Level Provider (*Trans.* 2008:435), be amended to read as follows (revisions proposed for Resolution 31S-1 are underscored, stricken through and shaded):

POSITION ON NEW DENTAL ~~MID-LEVEL PROVIDER~~ TEAM MEMBERS

Resolved, that the determination of workforce needs are under the jurisdiction of the state and are determined at the state level, ~~the ADA's position on~~ and any proposed new member of the dental team should be established at the state level with the advice and counsel of the relevant ADA constituent ~~state~~ dental society ~~association~~, and be it further

Resolved, that when state governments consider development of a new dental team member inconsistent with current ADA policy, the ADA may assist and serve as a resource at the request of a constituent dental society as they respond to workforce needs and advocate for the best workforce solution, and be it further

~~**Resolved,** that the ADA shall serve as a resource to the state dental associations as they respond to workforce needs and advocate for the best workforce solution, and be it further~~

Resolved, that the ADA recommends that any new member of the dental team ~~shall~~ be ~~an individual~~ supervised by a dentist and be based upon a determination of need, sufficient education and training, and a scope of practice that ensures the protection of the public's oral health.

BOARD COMMENT: The Board of Trustees agrees with the intent of the proposed amendments in Resolution 31S-1 and believes the revised recommendations reinforce the flexibility needed for the American Dental Association to serve as a resource for constituent dental societies as they individually determine the role and duties of dental team members according to their respective state dental practice acts.

However, the Board believes that the role of state governments should be more clearly defined and, therefore, recommends adoption of the following substitute resolution.

POSITION ON NEW DENTAL TEAM MEMBERS

31S-1B. Resolved, that the determination of workforce needs are under the jurisdiction of the state and are determined at the state level, and any proposed new member of the dental team should be established at the state level with the advice and counsel of the relevant ADA constituent dental society, and be it further

Resolved, that this does not include any ongoing pilot initiatives that the ADA presently is involved in, and be it further

Resolved, that when state governments consider regulatory or legislative authorization of a new dental team member, the ADA may assist and serve as a resource at the request of a constituent dental society as they respond to workforce needs and advocate for the best workforce solution, and be it further

Resolved, that the ADA recommends that any new member of the dental team be supervised by a dentist and be based upon a determination of need, sufficient education and training, and a scope of practice that ensures the protection of the public's oral health.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

BOARD VOTE: UNANIMOUS.

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: CDBP Supplemental Report 1 Date Submitted: August 2009

Submitted By: Council on Dental Benefit Programs

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

COUNCIL ON DENTAL BENEFIT PROGRAMS SUPPLEMENAL REPORT 1
TO THE HOUSE OF DELEGATES: UPDATE ON DENTAL TOURISM

Background: This report is in response to Resolution 28H-2008 (*Trans*.2008:450), Update on Dental Tourism. The Council on Dental Benefit Programs (CDBP) was assigned as the lead agency with additional research and support by the Health Policy Resources Center (HPRC) to respond to Resolution 28H, which reads as follows.

28H-2008. Resolved, that the following definition of dental tourism be adopted:

Dental tourism is the act of traveling to another country for the purpose of obtaining dental treatment.

and be it further

Resolved, that the appropriate agencies of the ADA continue to promote the importance of a dental home while working for increased affordable access to dental care and freedom of choice so that every American who needs dental care can receive it, and be it further

Resolved, that the appropriate agencies of the ADA establish a repository of information relevant to dental tourism, that the information be collected in a manner that protects patient confidentiality and that the information is used in a lawful manner, and be it further

Resolved, that the appropriate agencies of the ADA increase efforts to provide patients, insurance companies and plan purchasers with credible information and resources about quality dental care, including follow-up, delivered by professionals with accredited education, and be it further

Resolved, that in keeping with the ADA position on freedom of choice, patients seeking dental care outside of the U.S. should do so voluntarily, and that prior to travel, be urged to arrange for local follow-up care to ensure continuity of care upon return to the U.S., and be it further

Resolved, that patients who have insurance coverage for dental care performed outside the U.S. should confirm with their insurer and/or employer that follow-up treatment is covered upon return to the U.S., and be it further

Resolved, that patients choosing to travel outside the U.S. for dental care should seek information about the potential risks of combining certain procedures with long flights and vacation activities, and be it further

Resolved, that the transfer of patient records to-and-from facilities outside the U.S. should be consistent with current U.S. privacy and security guidelines.

Specifically, the CDBP was assigned lead responsibility for reporting on activities related to this update and the HPRC is charged with establishing the repository of information related to dental tourism. Additionally, the Council on Communications has been charged with responding to Resolution 78H-2008 (*Trans*.2008:490), Development of Print and Electronic Media for "Dental Care While Traveling."

Current ADA Activities: The CDBP provided direction to staff on the development of a survey distributed to internal ADA agencies to determine what credible information is readily available to consumers and members on the ADA Web site and elsewhere. Below are relevant activities currently being addressed by the Association through the various agencies:

ADA News

- *Patient Safety crux of House actions on dental tourism*, January 5, 2009

Council on Access Prevention and Interprofessional Relations (CAPIR)

- The Concept of a Dental Home meeting was held in Washington D.C. in September 2008. Organizational representatives included the American Dental Association (CAPIR), American Academy of Pediatric Dentistry (AAPD), American Academy of Pediatrics (AAP), Association of State and Territorial Dental Directors (ASTDD), American Association of Public Health Dentistry (AAPHD), American Dental Hygienists' Association (ADHA), American Association of Community Dental Programs (AACDP), Children's Dental Health Project, Family Voices, Medicaid SCHIP Dental Association, National Academy for State Health Policy, the Catalyst Institutes and schools of public health.

- In collaboration with AAPD the ADA has developed a one page flyer that was mailed to all general dentists in February 2007 on the importance of the age one dental visit and the dental home. CAPIR is also providing input to the AAPD in its Head Start initiative focused on establishing a dental home for children that participate in Head Start/Early Head Start.

- CAPIR is also leading related projects such as Give Kids A Smile, Oral Longevity, Medicaid Provider Symposium, the Access to Dental Care Summit, Access Strategic Work Plan, Implementation of the recommendations of the Task Force on Elder Care, American Indian/Native Alaska (AI/AN) Summit follow-up activities, AI/AN Volunteer Placement Program, Oral Health Literacy Initiative, American Academy of Pediatrics' collaborative activities, dissemination of the Evidence Based Clinical Recommendations on the Use of Pit-and-Fissure Sealants to the public health community.

Council on Communications (CC)

- CC is working on updating the information for print and electronic media to help educate patients regarding "Dental Care While Traveling to Other Countries." The information includes a general overview, a description of education and clinical training of U.S. dentists, safety procedures, travel advisories and information about insurance and continuity of care. As stated above, the Council will be reporting further on this information in more detail in response to Resolution 78H-2008.

Council on Dental Benefit Programs (CDBP)

- CDBP continues to monitor the Medical Tourism Association (MTA) and has presented dental tourism-related information at the MTA Annual Meeting. The MTA is the first international non-profit association made up of the top international hospitals, healthcare providers, medical travel facilitators, insurance companies, and other affiliated companies and members with the stated goal of promoting the highest level of quality of healthcare to patients in a global environment. The MTA promotes the interests of its healthcare provider and medical travel facilitator members and MTA has three tenets: transparency, communication and education.

Council on Dental Education and Licensure (CDEL)

- CDEL is encouraging dental schools to increase community based/service clinical experiences and supporting the development of the ADA workforce models (Community Dental Health Coordinator and Oral Preventive Assistant).

Council on Dental Practice (CDP)

- CDP has produced the publication titled *Dental Letters Made Easy* sold through the *ADA Catalog*. The book contains a sample patient letter titled "Preparing to travel abroad" in the Patient Education section on pages 149-150.

- CDP developed a "tip sheet" for dentists concerned about knowing where their dental prostheses are manufactured which can be accessed at http://www.ada.org/prof/resources/pubs/adanews/adanewsarticle.asp?articleid=2915

- The ADA also provides information for the public concerned about dental prostheses made overseas which can be accessed at https://www.ada.org/prof/resources/pubs/adanews/adanewsarticle.asp?articleid=2914**.**

Council on Members Insurance and Retirement Programs (CMIRP)

- CMIRP has been monitoring trends in dental professional liability insurance claims. To date, there have been no indications that any claims have resulted from dental tourism or the outsourcing of laboratory services. The Council will continue to monitor these issues; and will advise the Board of Trustees and other ADA agencies should any significant developments emerge.

Department of State Government Affairs (DSGA)

- The primary place DSGA works in this area is promotion of the dental home concept as a recommendation to constituent dental societies as a way to promote access to care through continuity of care. For states that decide to pursue this approach DSGA provides support through:

    - talking points
    - comparative data
    - testimony
    - the State Public Affairs program

Based on this information, the CDBP believes that credible information is readily available to consumers and members on the ADA web site and that new information will continue to be posted as it becomes available.

Information Repository: The third resolving clause of Resolution 28H focuses specifically on the establishment of a repository of information, as follows:

> **Resolved,** that the appropriate agencies of the ADA establish a repository of information relevant to dental tourism, that the information be collected in a manner that protects patient confidentiality and that the information is used in a lawful manner.

Implementation of this directive was referred to the HPRC, based on discussions with the CDBP. The CDBP agrees with the HPRC that the repository consist of the following:

- Copies of articles written on the topic of dental tourism (and perhaps medical tourism) that have been published in peer reviewed journals (subject to copyright restrictions). It is anticipated that the HPRC will identify articles meeting these criteria, and evaluate them with the CDBP, the Division of Legal

Affairs and other appropriate agencies in regards to technical quality, copyright, legal and other possible restrictions.

- Published data on dental tourism from sources such as the U.S. government, state governments, academic institutions, the American Dental Association, the American Medical Association and similar professional associations and credible sources. It is anticipated that the HPRC will identify data sources meeting these criteria, and evaluate them with the CDBP, the Division of Legal Affairs and other appropriate agencies in regards to technical quality, copyright, legal and other possible restrictions.

The repository will be housed on an ADA server and will be accessed through the ADA web site. It is expected that the repository will use existing ADA resources and personnel.

While Resolution 28H does not specify explicitly whether the repository should be a members-only benefit or available to the public, given the other resolving clauses of Resolution 28H, the Council believes that the intent of this resolution leans to both member and public availability.

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Resolution No. 38 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: August 2009

Submitted By: Sixth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

CDT CODE FOR AMALGAM REMOVAL

The following resolution was submitted by the Sixth Trustee District and transmitted on August 25, 2009, by Ms. Vickie Wilbers, executive director, Missouri Dental Association.

Background: In 2007, the ADA updated Best Management Practices to include the use of amalgam separators in dental offices. A number of states mandate their use and several states are considering regulations requiring their installation. The expense of installing, maintaining and using an amalgam separator, as well as recycling amalgam, has made the removal of amalgam and teeth with amalgam much more costly than the original placement. At present, the ADA *CDT* codes do not have a separate code for amalgam removal, processing or recycling. This is a legitimate cost of doing business and is similar to other services such as recycling of computers, batteries, tires, oil, etc. The ADA has the opportunity to allow for this option in dental offices to code for and bill a separate amount for this service at a time of increasing cost of care and limited reimbursements.

Resolution

38. Resolved, that the Council on Dental Benefit Programs study the addition of a separate *CDT* code for amalgam removal, processing and recycling, and be it further

Resolved, that the Council report its recommendations to the House of Delegates and the ADA membership by the 2010 House of Delegates.

BOARD COMMENT: The Board thanks the Sixth Trustee District for the thoughtful presentation of this issue. The Board notes that the correct protocol for addition of potential procedure codes is through a code change request to the Code Revision Committee. Therefore, the Board recommends that Resolution 38 not be adopted.

BOARD RECOMMENDATION: Vote No.

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Board Vote: Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
☐	■	☐	☐	CALNON	☐	■	☐	☐	LONG	☐	■	☐	☐	SYKES
■	☐	☐	☐	ELLIOTT	☐	■	☐	☐	MANNING	☐	■	☐	☐	TANKERSLEY
☐	■	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	☐	■	☐	☐	THOMPSON
☐	■	☐	☐	GIST	■	☐	☐	☐	RICH	☐	■	☐	☐	VERSMAN
☐	■	☐	☐	GLECOS	☐	■	☐	☐	SCHWEINEBRATEN	☐	■	☐	☐	VIGNA
☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	STEFFEL	☐	■	☐	☐	WEBB
☐	■	☐	☐	LOW	☐	■	☐	☐	SULLIVAN				Res.	38

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Resolution No. 41 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: August 2009

Submitted By: Fourteenth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

PROMOTING WELLNESS FOR THE PROFESSION

The following resolution was submitted by the Fourteenth Trustee District and transmitted on August 28, 2009, by Dr. Kenneth Versman, trustee, Fourteenth District.

Background: Health and wellness are the benchmarks of a care profession like dentistry. Doing what's best for our patients becomes second nature, but nurturing our own health and wellness is far less natural. Developing and promoting a plan to encourage and develop wellness in our offices is good medicine for our teams. Making this a public campaign that is lead by dentists and their staffs will not only benefit our dental teams, but patients and the general public, as well.

Resolution

41. Resolved, that the ADA identify and promote a wellness program to promote healthy diet, exercise and lifestyle for the dental team.

BOARD COMMENT: The Board agrees with the intent Resolution 41, but believes that the term "wellness program" is not sufficiently defined.

The Board notes that existing ADA policy, Statement on Dentist Health and Wellness (*Trans*.2005:321) includes the following language.

> The ADA and/or its constituent and component societies, as appropriate, are encouraged to assist members in being able to provide safe and effective care by:
>
> - Promoting health and wellness among dentists

Furthermore, issues related to both dentist health and wellness and liaison relationships with members of the dental team fall under the *Bylaws* authority of the Council on Dental Practice (CDP). A Dentist Wellness Advisory Committee (DWAC) consisting of select Council members and non-dentist wellness experts meets and makes health and wellness recommendations to the CDP on an annual basis. Dental team representatives of the American Dental Assistants Association and the American Dental Hygienists' Association also make collaborative presentations at CDP meetings each year.

The CDP sponsored 11 biannual "National Institute on Dentist Well-being" programs, which were held until 2005, and which featured courses in addiction and recovery issues for dentists. Policy changes adopted in 2005 gave direction to CDP to broaden the institute and emphasize other aspects of wellness. Beginning in 2007, the program was re-named the Dentist Health and Wellness Conference. Two Health and Wellness

Conferences have been held, each providing three learning tracts: addiction, ergonomics and wellness. The theme for the 2009 Conference, held on September 10-11, was "Body, Mind and Soul: Thriving in a Chaotic World." Speakers at this year's event focused on personal improvement, dental ergonomics and impairment issues.

The change in emphasis in this program is relatively new. While CDP has moved the direction of its programs into a well rounded wellness model, this information is not translating to members who may only associate addiction with the CDP program. To address this inconsistency, a section on wellness is being developed for CDP's new economic micro-site, www.dentalpracticehub.ada.org. More information on dental wellness issues will be featured in upcoming editions of *ADA News*.

For these reasons, the Board recommends that Resolution 41 be referred to the Council on Dental Practice for study and report to the 2010 House of Delegates.

BOARD RECOMMENDATION: Vote Yes on Referral.

BOARD VOTE: UNANIMOUS.

Resolution No. 42 New ■ Substitute ☐ Amendment ☐

Report: CAPIR Supplemental Report 2 Date Submitted: September 2009

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: $24,450

Amount One-time $24,450 Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS
SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES:
UPDATE ON ACCESS TO CARE ACTIVITIES

The following information is provided to update the House of Delegates on activities related to access to dental care, which have occurred since the preparation of the Council's 2009 annual report.

Access to Dental Care Summit

Background: As described in CAPIR's annual report and in response to Resolution 17H (*Trans.*2007:421), approving the convening of an access to dental care summit in 2009, the Access to Dental Care Summit focused on creating a common vision among diverse stakeholders to begin to improve access to oral health care for underserved people. The Summit represented an important moment in ADA history laying the foundation of collaboration upon which to build initiatives that will help meet the needs of the underserved, but it was only a beginning. The Summit's long-term success depends upon the continued commitment and vision of its participants and their constituencies. The proceedings of the Summit were widely distributed and can be found in Appendix 1.

With support from an oral health foundation and expressed interest from dental industry, an effort to establish a sustainable infrastructure for coordination and communication among the eight topical workgroups established at the Summit has begun. A case statement to invite funding for facilitation and ongoing support of these workgroups has been drafted, which can be found in Appendix 2.

Access Advocacy Networks

Background: Strengthening the public health infrastructure was a foundational premise within the ADA's Universal Healthcare Reform document, *Improving Oral Health in America* (*Trans*.2008:429). CAPIR and the Council on Government Affairs (CGA), along with other ADA agencies, continue to advocate for greater collaboration between dentists working in private practice and those working within community-based and/or public health settings, such as federally qualified health centers (FQHCs). This is an update on activities, which address Board of Trustees Resolution B-91-2008, which reads as follows.

B-91-2008. Resolved, that in an effort to enhance its advocacy networks and the advocacy networks of constituent societies, the ADA shall:

1. Reach out to ADA member dentists working in health centers and/or those working as private practitioners who are Medicaid providers for participation in the ADA grassroots program.
2. Develop coalitions with national organizations that have mutually shared oral health access goals and objectives with the ADA.

3. Encourage constituent societies to reach out to ADA member dentists working in health centers and/or those working as private practitioners who are Medicaid providers for participation in the ADA grassroots program.
4. Encourage constituent societies to develop coalitions with state organizations that have mutually shared oral health access goals and objectives with the ADA and the constituent society.

Enhancing the State Public Health Infrastructure:

- In consultation with CGA and the Department of State Government Affairs (DSGA), CAPIR surveyed the constituent dental society executive directors to better understand the relationship between constituent dental societies and state oral health programs, identify opportunities to strengthen those relationships in order to improve the health of the public, identify the best elements of state oral health plans, and gauge constituent society involvement in developing this plan and its participation in an associated state oral health coalition.

  More than three-quarters of responding constituent dental societies in states with an oral health director agreed or strongly agreed that the state oral health program provides value toward the improvement of oral health. Greater than 87% of constituent dental societies agreed or strongly agreed that their presence enhanced the advocacy efforts of the state oral health plan. The results of the survey can be found in Appendix 3.

- Constituent and component societies were encouraged to provide greater leadership within their state oral health coalitions at the 2008 President-Elect's and Lobbyist Conferences. The survey was shared with the constituent and component dental societies, the Council on Government Affairs and ADA staff within CGA, DSGA, and the Department of Dental Society Services. The survey will be repeated in 2010 to gauge further collaboration of constituent dental societies with state oral health coalitions.

Enhancing the National Public Health Infrastructure:

- The ADA convened the 2009 Access to Dental Care Summit.

- CAPIR and DSGA staff served on the 2009 National Oral Health Conference (NOHC) planning committee. The ADA sponsored this Conference with budgeted funds from CAPIR and CGA. The ADA had a prominent display in the exhibit area to encourage greater familiarity with organized dentistry and to promote the 50% ADA dues discount for dentists working in community-based and/or public health settings.

- The ADA and American Association of Public Health Dentistry will hold their third consecutive joint leadership meeting at the 2009 ADA Annual Session in Hawaii with the goal of continuing to find common ground and potential synergies between the public health community and organized dentistry.

- CAPIR and the Council on ADA Sessions have begun discussions with the National Network for Oral Health Access about co-locating their 2010 National Primary Oral Health Conference with the 2010 ADA Annual Session.

Enhancing the Local Public Health Infrastructure:

- At its June 2009 meeting, the Board of Trustees visited the Erie Family Health Center in Chicago in order to increase its familiarity with FQHCs.

- CAPIR is sponsoring a free continuing education session at the 2009 ADA annual session entitled *The ABCs of FQHCs.* An abbreviated version will be shared with constituent and component

societies to further educate their members on the critical role that FQHCs play in increasing access to dental care within the dental safety net.

- At its April 2009 meeting, the Board approved a one-time 50% reduction in ADA dues for dentists working in community-based and/or public health settings through 2010.

- The 2009 Give Kids A Smile® (GKAS) Promising Practices Symposium emphasized continuity of care and best practices of coordinating private and public resources within local communities as foundational building blocks for moving the underserved towards a permanent dental home.

Access to Care Inventory and Access Work Plan Framework

Background: The ADA has a clear mission and vision for improving the oral health of the underserved as outlined in its *Constitution and Bylaws* and *Strategic Plan:* 2007-2010. In July 2007, the ADA Board of Trustees conducted a mega-discussion on the issue of access to dental care for the underserved. While the session provoked as many questions as answers, a theme that emerged was the clear need for the profession to be a leader in generating and advocating for solutions. While the ADA can play a significant role in searching for answers, the Board concluded that other stakeholders must be involved in order for any serious solution to be implemented on a national and global scale. Subsequently, the 2007 ADA House of Delegates authorized an Access to Dental Care Summit in 2009 by adopting Resolution 17H (*Trans.*2007:421).

The Access to Dental Care Summit laid the foundation for a common vision to begin to improve access to oral health care for underserved people. Through participatory problem solving and sharing common and unique perspectives, collaboration among 12 diverse oral health stakeholder groups was embraced as the best means to address challenges to improving oral health access. Working within eight topical workgroups, participants identified new approaches and initiatives that could be collectively supported to reduce oral health disparities and enhance access to oral health care.

Assessment: In response to Resolution 69H-2008 (*Trans.*2008:457), on the development of a draft access to care strategic work plan for presentation to the 2009 House of Delegates, current ADA programs, projects and activities specific to access to care were assessed with outcomes and gaps identified whenever possible. Their responses were collated into an inventory, which can be found in Appendix 4. As a means of approximating access to care focus efforts external to the ADA, the proceedings of the 2009 Access to Dental Care Summit were utilized as a proxy reflecting targets, goals and activities prioritized by finding common ground among a broad community of oral health stakeholders.

Next Steps: Increasing familiarity and seeking common ground between the public and private sectors of dentistry, as well as increasing collaboration among a diverse group of internal and external oral health stakeholders, is the foundation for developing an access work plan. CAPIR has begun to educate itself and other agencies about federally qualified health centers (FQHCs), state oral health plans and coalitions, and advocacy. Increasing public health outreach and enhancing the presence of organized dentistry in community-based and public health settings have become major efforts. To inform and support its advocacy position between the ADA and the public health community, a CAPIR Public Health Advisory Committee has been formed, composed of individuals from the public health community, to advise CAPIR and the ADA about issues related to public health outreach and building collaborative relationships.

Activities that once appeared disparate are aligning and yielding promising next steps. These include ongoing ADA participation in a post-Summit coordination and communication workgroup, developing best practices to enhance fiscal viability when introducing Medicaid/SCHIP patients into private dental practices, constituent dental societies providing greater leadership within their state oral health coalitions, and enhancing local access advocacy networks by increasing familiarity between dentists working in private practice and those working within safety net settings. The emphasis upon continuity of care and case

management within the GKAS expansion efforts will continue to move individuals towards dental homes and decrease reliance upon volunteer events, such as GKAS, Missions of Mercy and Remote Area Medical programs, as a sole means of accessing primary oral health care.

Due to the timing of the completion of the proceedings of the Access to Dental Care Summit and the ADA Access Inventory, this work plan is a draft document, which can be found at the end of Appendix D. As part of its future work, the Council on Access, Prevention and Interprofessional Relations will build upon this framework and offer evaluation components and monitoring plans, while contemplating any recommendations for changes in current ADA policy. Once finalized, this access work plan will serve as a vehicle to enlist collaborative action to improve access to care by a broad stakeholder community.

Medicaid Provider Symposium Follow-up

Background: The 2007 House of Delegates authorized a Medicaid Provider Symposium for 2008 by adopting Resolution 44H (*Trans*.2007:421). The primary goal of the Symposium was to gain an understanding of the challenges to providing care to Medicaid recipients and discuss successful strategies to integrate Medicaid patients into private practice settings. Numerous challenges to serving a large number of Medicaid patients within private dental practices were described. Many went beyond the confines of individual practices to focus on systematic concerns, such as a lack of awareness of the oral health needs of this population and the educational preparedness of dental providers to meet those demands. Most of the group's recommendations for action were directed to systemic concerns, rather than changes that could be implemented immediately within an individual practice.

The report of the 2008 Medicaid Symposium was widely distributed and has been utilized to call attention to needed changes within the Medicaid program. The report can be found in Appendix 5.

Next Step: The 2008 Symposium participants and CAPIR expressed a strong desire to reconvene a similar group to explore various business models and lessons learned for successfully incorporating Medicaid and State Children's Health Insurance Program (SCHIP) into a private practice. Case studies can be developed to address topics that include working with systems for identifying patient eligibility and assessing how private practices successfully overcome the barriers of current state Medicaid systems to provide care in a financially viable manner. Lessons learned can be showcased and replicated to expand the capacity of private dental practices to better address the needs of this underserved population. Prior to the Symposium, structured phone interviews will be conducted by the ADA's Health Policy Resources Center, following an in-person pre-test of two participants to verify the interview tool. The total financial implication is a one-time amount of $24,450. The Council, therefore, recommends adoption of the following resolution.

Resolution

42. Resolved, that the Council on Access, Prevention and Interprofessional Relations, in conjunction with the Council on Dental Practice and the Health Policy Resources Center, convene a symposium in 2010 to explore various business models and existing best practices for successfully incorporating Medicaid and SCHIP patients into a private practice, and be it further

Resolved, that the invited participants include one dental representative from each trustee district, who had at least 1,000 Medicaid or SCHIP patient visits in the last calendar year, and that participants should be ADA members in good standing and in private practice (i.e., not practicing in a free clinic, community health center, a county or state public health unit, nor practicing in a dental school setting), and be it further

Resolved, that the ADA incur the expense of lodging and transportation for one individual per ADA district, and that each state or district may send an additional individual at their own expense, if they so choose.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Index of Appendix Material*

Appendix 1	Proceedings of the March 23-25, 2009 Access to Dental Care Summit
Appendix 2	Case Statement for Resource Development
Appendix 3	2009 *Survey of Constituent Dental Societies on State Oral Health Directors and* Plans—Final Results
Appendix 4	ADA 2009 Inventory of Access Programs/Activities/Projects and Draft Access Work Plan Framework
Appendix 5	Report on the June 23, 2008 Medicaid Provider Symposium

To review the referenced appendices, please contact the Office of the Executive Director at (312) 440-2700.

Resolution No. 43 New ■ Substitute ☐ Amendment ☐

Report: CAPIR Supplemental Report 3 Date Submitted: September 2009

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: $36,000

Amount One-time $ Amount On-going $36,000

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

COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS
SUPPLEMENTAL REPORT 3 TO THE HOUSE OF DELEGATES:
ACTIVITIES TO IMPROVE HEALTH LITERACY

Background: This report provides an update of the Council's 2009 activities related to health literacy in dentistry and a summary of proposed endeavors for the future. The Council also requests reauthorization of its ad hoc advisory committee on health literacy in dentistry as CAPIR continues to rely on the expertise of these consultants. This will be increasingly true as CAPIR attempts to implement its plan for health literacy improvement.

The 2006 House of Delegates defined health literacy in dentistry as "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate oral health decisions" (*Trans*.2006:315). The 2006 House of Delegates also adopted Resolution 14H (*Trans*.2006:317) which affirmed that limited health literacy "is a potential barrier to effective prevention, diagnosis and treatment of oral disease" and authorized the formation of a national advisory committee on health literacy in dentistry, an ad hoc advisory committee of CAPIR, in its adoption of Resolution 17H (*Trans*.2006:317).

The 2007 House of Delegates adopted Resolution 16H (*Trans*.2007:418), permitting the Council to oversee two surveys to improve the ADA's understanding of health literacy in the dental profession and dental education. The ADA House of Delegates has affirmed that "clear, accurate and effective communication is an essential skill for effective dental practice" (*Trans*.2008:454) and emphasized the need for "undergraduate, graduate and continuing education programs to train dentists and allied dental team members to effectively communicate with patients with limited literacy skills" (*Trans*.2006:316).

Survey of Dental Team Members: The Council, in cooperation with the ADA Survey Center, conducted a survey of dental team members in order to:

1. Evaluate the knowledge base of the dental community about health literacy.
2. Verify the beliefs of dental team members related to health literacy.
3. Evaluate attitudes and motivation of the dental community to learn about, measure and address health literacy.
4. Identify practical methods employed by the dental team to minimize barriers related to limited health literacy.
5. Gather data and information that can be used by the ADA to recommend and develop policies, programs and research to address health literacy.

A summary of results of the dental team survey is found in Appendix 1. At its June 2009 meeting, CAPIR recommended that members of its Ad Hoc Advisory Committee on Health Literacy in Dentistry prepare and submit an article, describing the health literacy study of dental team members, to a peer-reviewed journal. The Council noted that among dentists surveyed:

- 26% have taken a health communication course
- 68% would be interested in attending a continuing education course to improve communication and increase patient satisfaction with their dental office
- 62% indicated that they would prefer to receive information and skills about provider-patient communication through a local dental society meeting
- 48% review patient education materials for readability and suitability
- 35% follow up with patients by telephone to check understanding and adherence to recommendations

Survey of Dental Schools: CAPIR conducted this study, in consultation with the ADA Survey Center, in order to:

1. Verify what is currently being done by predoctoral, postdoctoral and continuing dental education programs to address health literacy and communication skills of students.
2. Determine what plans (if any) each educational program has to increase course content in the areas of health literacy and communication skills.
3. Clarify barriers to incorporating health literacy and communication skills into course content.
4. Identify faculty members who have particular interests in health literacy and/or communication skills instruction or research or both.
5. Identify meritorious course syllabi and/or related course content to collect and share with other predoctoral, postdoctoral and continuing dental education programs.
6. Discuss potential impacts on students and the profession of inadequately addressing health literacy and communication skills in dental education programs.

A summary of results of the dental school survey is found in Appendix 2. The Council noted that among dental schools surveyed:

- Most schools (79%) indicated that oral health literacy is explicitly covered in the curriculum as part of “professional communication.”
- One-third (33%) of responding dental schools reported that there are faculty members conducting oral health literacy research.
- Three-quarters of responding dental schools reported that there are specific communication skill competencies on which students are evaluated.
- Over one-third of responding dental schools (38%) use standardized patients to evaluate students’ communication skills.

At its June 2009 meeting, CAPIR recommended that one advisory committee member and one CAPIR staff person attend the American Dental Education Association (ADEA) Fall 2009 Meeting, October 21-24, 2009, in Dallas to conduct focus groups with academic deans and/or other dental educators as a way to further analyze and validate the findings of “Communicating with Patients: Survey of Dental Schools.”

National Institutes of Health: In response to Resolution 25H-2008 (*Trans*.2008:450) on health literacy research, Dr. John S. Findley, ADA president, sent a letter to the acting director of the National Institutes of Health (NIH), Raynard S. Kington, M.D., Ph.D., encouraging continuation and increased funding for health literacy research through the NIH’s multi-institute health literacy program announcement (see Appendix 3).

A response was received from Dr. Lawrence Tabak, director, National Institute of Dental and Craniofacial Research (see Appendix 4). The final sentence of the letter is quite promising: "Given the advancements in the science of health literacy and its promise of improving health, there is every reason to anticipate that funding opportunity announcements focused on health literacy will be reissued."

National Plan to Improve Health Literacy: The Council co-sponsored, with the U.S. Department of Health and Human Services (HHS) Office of Disease Prevention and Health Promotion, a roundtable meeting to review and discuss a national action plan to improve health literacy. The meeting was held June 29, 2009, at the ADA Headquarters in Chicago, and participants included recognized experts in their fields and whose organizations have an interest in improving health literacy. Guests were asked for their comments on the draft national action plan, ideas about other organizations and stakeholders to involve in the process and the interest of their organizations in supporting the plan. The HHS noted that the ADA "is a leading organization in supporting health literacy improvement, and it has worked with the HHS Office of the Surgeon General on several documents supporting oral health literacy, including a Surgeon General's Call to Action."

American Public Health Association: CAPIR was invited by the Program Planning Committee for the Oral Health Section of the American Public Health Association (APHA) to organize an invited session on health literacy in dentistry for the APHA annual meeting and exhibition, November 7-11, 2009, in Philadelphia. This meeting is the oldest and largest gathering of public health professionals in the world, attracting more than 13,000 national and international physicians, administrators, nurses, educators, researchers, epidemiologists, and related health specialists. The Council's session, moderated by Dr. Scott Lingle, CAPIR member, will include presentations on the ADA's health literacy efforts, as well as CAPIR's surveys of dental schools and dental team members.

The Joint Commission: A CAPIR representative participated in a meeting of the Expert Advisory Panel for Developing Proposed Requirements to Advance Effective Communication, Cultural Competence and Patient-centered Care for The Joint Commission Hospital Accreditation Program. The meeting included developing a list of priority issues to cover in an implementation guide for the 22 proposed standards. The meeting participants also began developing a list of practices and resources related to the identified priorities.

ADA Annual Session: At its January 2009 meeting, the Council approved a motion, urging the Council on ADA Sessions (CAS) to consider a CAPIR sponsored one-day oral health literacy workshop as a preconference course at the 2009 ADA annual session. In response, the CAS allotted a 2.5 hour space for CAPIR's health literacy course, "Communicating with Patients: Oral Health Literacy and Implications for Dental Practice." This workshop will provide general information about health literacy in dentistry and specific content about related legal and ethical issues.

Advisory Committee on Health Literacy in Dentistry: The Council's ad hoc advisory committee on health literacy in dentistry met twice in 2009. At these meetings, the committee discussed the five-year strategic action plan authorized by Resolution 26H-2008 (*Trans.*2008:456) to address health literacy (Appendix 5), including five focus areas directly related to the "actions" articulated in the 2003 *National Call to Action to Promote Oral Health* developed under the leadership of The Office of the Surgeon General. Findings from the two surveys described above informed the plan.

The advisory committee's vision is that "dentists and dental team members, and the ADA and related organizations, will use and promote clear and accurate, interactive communication to achieve optimal oral health for all." The committee emphasized the following "promising/best practices" in health care to help achieve this vision.

- Create a respectful environment and use a universal precautions approach, where <u>all</u> patients are offered assistance with understanding printed and written communications.
- Use clear and plain language in talking and in writing.
- Encourage question-asking and dialogue.

- Use “teach-back” or “teach-to-goal” method to check on successful communication by asking patients to repeat their interpretation of instructions and other information that has been provided.
- Offer take-home tools designed for easy use with clear directions.

The purpose of the advisory committee is to:

- assist the Council on Access, Prevention and Interprofessional Relations (CAPIR) to develop recommendations about policies, programs, interventions and research related to improving health literacy;
- discuss challenges facing health literacy practice and research and make recommendations to minimize these barriers;
- review current ADA policies and make recommendations to CAPIR for amending and developing health literacy related policies;
- serve as an informal conduit of information between the ADA and external organizations and institutions on activities related to health literacy;
- identify and make recommendations to CAPIR about approaches to promote health literacy through mechanisms and partnerships in both the public and private sectors;
- aid CAPIR to identify public and private resources to support proposed health literacy programs and other activities; and
- foster the development of health literacy expertise within the dental profession.

Recent Council Actions: At the June 2009 CAPIR meeting, the Council recommended the reauthorization of its ad hoc advisory committee on health literacy in dentistry. The Council approved a recommendation to identify and pursue funding sources to support the development, pilot-testing, production and dissemination of the “health literacy in dentistry toolkit.” The Council approved a resolution to approach Aetna to explore opportunities to collaborate to more broadly disseminate Aetna’s “Oral health literacy: A dental practice priority” course content, developed by Columbia University, and available CE units to other oral health professionals and all ADA members. The Council will continue to identify other external opportunities for collaboration.

The Council requests reauthorization of its 12-member ad hoc advisory committee on health literacy in dentistry comprised of experts in the fields of health literacy; public health policy, research and interventions; behavioral research; and community development and social change. Therefore, the Council recommends adoption of the following resolution.

Resolution

43. Resolved, that the ad hoc advisory committee on health literacy in dentistry be reauthorized to assist the Council on Access, Prevention and Interprofessional Relations in the implementation of its five-year strategic action plan, development of policy recommendations, targeted educational strategies and other health promotion programs and activities to improve health literacy.

BOARD RECOMMENDATION: Vote Yes.

Board Vote:															
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		
■	☐	☐	☐	CALNON	☐	■	☐	☐	LONG	■	☐	☐	☐	SYKES	
■	☐	☐	☐	ELLIOTT	■	☐	☐	☐	MANNING	■	☐	☐	☐	TANKERSLEY	
■	☐	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	☐	■	☐	☐	THOMPSON	
■	☐	☐	☐	GIST	■	☐	☐	☐	RICH	■	☐	☐	☐	VERSMAN	
■	☐	☐	☐	GLECOS	■	☐	☐	☐	SCHWEINEBRATEN	■	☐	☐	☐	VIGNA	
■	☐	☐	☐	KREMPASKY SMITH	■	☐	☐	☐	STEFFEL	■	☐	☐	☐	WEBB	
■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN					Res.	43

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To review the referenced appendices, please contact the Office of the Executive Director at (312) 440-2700.

Resolution No. 44 New ■ Substitute ☐ Amendment ☐

Report: CDBP Supplemental Report 2 Date Submitted: September 2009

Submitted By: Council on Dental Benefit Programs

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

COUNCIL ON DENTAL BENEFIT PROGRAMS SUPPLEMENTAL REPORT 2
TO THE HOUSE OF DELEGATES: ADA POLICY RECOMMENDATION

Background: The Council on Dental Benefit Programs, after the 2008 annual session, began a review and discussion of existing ADA policies that address definitions of a dentist's fees and their reporting on claims. This work led the Council to conclude that existing policy is dated and incomplete. ADA policy, where it exists, does not reflect current business practices and the variations that can occur based on an individual dentist's business decisions. Gaps in ADA policy present the opportunity for other entities to promote practices that can be misleading or detrimental to an individual dentist and the profession at large.

The Council notes that the ADA policy that defines the terms usual fee, customary fee and reasonable fee was adopted by the House of Delegates in 1987 (*Trans*.1987:501), and the policy that defines fee-for-service was adopted in 1994 (*Trans*.1994:666). The Council also determined that there is no ADA policy concerning reporting of fees on paper or electronic claims, other than what is included in ADA policy relating to coordination of benefits, which dates from 1996 (*Trans*.1996:684).

Although there is no ADA policy concerning reporting fees on original claim submissions, there is guidance in the ADA Dental Claim Form completion instructions first printed on the reverse side of the 2002 version of the form and continues to be in the completion instructions in the *CDT Manual* ("Report the dentist's full fee for the procedure."). However, "full fee" is not defined.

During its November 2008 meeting, the Council discussed the Second Trustee District member's oral report on claim fee reporting guidance published by the New York State Dental Association and the absence of any definitive ADA policy on the matter. The Council approved a motion directing its Subcommittee on the Code to review available ADA documents that concern fees reported on dental claims and to prepare recommendations for consideration by the Council at its April 2009 meeting.

The Subcommittee discussed this matter during its December 2008 meeting and determined that there is no ADA policy adopted by the House of Delegates concerning reporting of fees on claims other than what is included in the policy relating to coordination of benefits cited above. There was consensus on the need for ADA policy on reporting of fees on original claim submissions and recommendations were presented for consideration during the April 2009 Council meeting.

During its April 2009 meeting, the Council discussed the Subcommittee on the Code's recommendations. The Subcommittee prepared a definition for a new term—"baseline fee"—and a proposed new ADA policy to address reporting fees on paper and electronic claims. The Council discussed the Subcommittee's draft definition and questioned whether inclusion of the word "baseline" in the draft was appropriate as it may limit change over time or for exceptional circumstances. The Council's consensus was that this matter, and the

draft ADA policy concerning reporting fees on claims, be referred back to the Subcommittee for additional work and preparation of an amended recommendation.

The Subcommittee prepared an amended recommendation that incorporated the term "full fee" in lieu of "baseline fee" as the former is the term used in the ADA Dental Claim Form completion instructions. Extensive Council deliberation led to consensus that recommending a new policy that defined the term "full fee" and incorporating that term into a new policy concerning reporting fees on dental claims would address the gap in ADA policy. The Council recommends these changes so that ADA policy accurately reflects the way dentists report fees, not as a change in the norm.

During its discussion the Council also noted that the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) was considering an amendment to the *Principles of Ethics* Advisory Opinion 5.B.3. Fee Differential, and that CEBJA may include the fee definition recommended by CDBP, if adopted by the House of Delegates. CEBJA is expected to conclude its work when it meets in November 2009.

Recommendation: The Council on Dental Benefit Programs believes that adoption of new ADA policy will fill a void by providing guidance on fee reporting on claim submissions, both paper and electronic, that is in the interest of all members of the profession. Such ADA guidance, available to member dentists, constituent and component societies, and all other sectors of the dental community, is consistent with the ADA's national leadership role. Therefore, the Council recommends adoption of the following resolution.

Resolution

44. Resolved, that the following Statement on Reporting Fees on Dental Claims be adopted.

Statement on Reporting Fees on Dental Claims

1. A full fee is the fee for a service that is set by the dentist, which reflects the costs of providing the procedure and the value of the dentist's professional judgment.

2. A contractual relationship does not change the dentist's full fee.

3. It is always appropriate to report the full fee for each service reported to a third-party payer.

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 45 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: August 2009

Submitted By: Sixth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

WARNINGS ON MEDICATIONS THAT CAUSE DRY MOUTH

The following resolution was submitted by the Sixth Trustee District and transmitted on August 25, 2009, by Ms. Vickie Wilbers, executive director, Missouri Dental Association.

Background: As more medications become available to the public, and the incidence of patients on multiple medications increases, the chance of a patient taking a medication that causes dry mouth is ever increasing. Especially at risk is the geriatric population, but patients of all ages are affected. While these patients are aware that dry mouth is a side effect of their medications, they are not told, nor do they have the knowledge of physiology to know that decreased saliva flow significantly increases the risk for dental caries, and also increases the rate of decay. As practitioners, we do our best to educate and warn patients of these side effects. The problem arises when patients start these medications in the middle of their hygiene cycle. Patients can be taking these medications for six months before they see a dental provider for their routine care. During this time, they may have experienced significant and widespread breakdown. When questioned, patients will often report using mints or other hard candies to help hydrate their mouths. They report being told their medications caused dry mouth, but not told of the associated dental risks, nor given any instruction on how to properly care for their teeth while taking these medications. Many medications already come with warning stickers (Avoid direct sunlight, etc.). The ADA should encourage the FDA to have a warning sticker put on the bottles of medications that cause dry mouth warning people of the increased risk of dental decay. Patients should be advised to talk to their dentist about strategies to safely reduce symptoms, while modifying their home care to protect against decay.

Resolution

45. Resolved, that the ADA encourage the Food and Drug Administration to require warning labels for medications that cause dry mouth and a resultant increased risk of tooth decay.

BOARD COMMENT: The Board agrees with the spirit of Resolution 45 and supports ongoing efforts by ADA agencies to increase awareness of the potential dangers to oral health that may result from chronic xerostomia.

Based on communications with the Food and Drug Administration (FDA) about drug labeling (prescribing information or “package insert”), including the use of warnings, precautions, etc., as defined by federal regulations, the Board believes the approach suggested to “encourage the Food and Drug Administration to require warning labels for medications that cause dry mouth” will not yield the desired results.

Prescribing information, including warnings, are authored by drug manufacturers. Final versions of prescribing information are agreed to through negotiations with FDA. The information included in the

prescribing information is generally “drug specific” and is based on studies submitted to FDA to support market approval. Warnings and precautions describe clinically significant adverse reactions that are specific to the drug or in some cases, general drug class adverse reactions. Drug/drug interactions may also be included in this section of the prescribing information. Warning labels applied to prescription containers when medications are dispensed to patients are based on these warnings and precautions.

The potential increase in dental caries as described in the background and resolution is not an adverse drug reaction. In other words, caries is not a direct result of drug actions on the body or interactions with other drugs. Consequently, encouraging FDA to require a warning label regarding the potential for increased risk of dental caries from drug-induced xerostomia would not lead to the desired results.

The Board does understand the concern expressed in this proposal and recommends referral to appropriate ADA agencies to consider ways to enhance the delivery of this message to the public through existing ADA programs and/or through collaboration with appropriate external organizations. Therefore, the Board recommends that Resolution 45 be referred to the Council on Scientific Affairs for study and report to the 2010 House of Delegates.

BOARD RECOMMENDATION: Vote Yes on Referral.

BOARD VOTE: UNANIMOUS.

Resolution No. 46 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: August 2990

Submitted By: Fourteenth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Build Dynamic Communities (Required)

COLLABORATION WITH SPECIALTY ORGANIZATIONS ON WORKFORCE

The following resolution was submitted by the Fourteenth Trustee District and transmitted on August 28, 2009, by Dr. Kenneth Versman, trustee, Fourteenth District.

Background: As constituent dental societies are confronted with possible models for a mid-level provider and expansion of duties for existing classes of allied dental personnel it may become difficult to keep up with the variations and nuances of each proposal. Enlistment of specialists in associated areas as consultants and allies in development of strategy and advocacy will assist societies in finding acceptable solutions to difficult and controversial situations.

Resolution

46. Resolved, that the American Dental Association and its constituent societies be urged to notify appropriate dental specialty organizations for advice and assistance when strategizing advocacy efforts relating to mid-level providers and expanded duty allied personnel, and be it further

Resolved, that when specialist members are available within the ADA or constituent dental societies to act as liaisons to specialty organizations, that they be extensively utilized to coordinate efforts and ensure that complete information is communicated between groups.

BOARD COMMENT: The Board agrees with the intent of Resolution 46. In fact, many current ADA policies advocate collaboration among the ADA, constituent societies and dental specialty organizations on a variety of projects including Communication Strategies for Increasing ADA Assistance in Legislative Initiatives (*Trans*.1982:513); Awareness of Issues in Dental Education (*Trans*.2002:404); Federal Lobbying Efforts that Support Dental Education (*Trans*.2001:470); Professional Liability Insurance Legislation (*Trans*.1984:548); Need for HIPAA Standards Reform (*Trans*.2003:384); Legislative Assistance by the Association (*Trans*.1977:948; 1986:530); and Statement of Statutory Regulation of Dental Specialty Practice and Dental Specialists (*Trans*.1959:192, 205; 1994:615). However, there are no existing policies specifically related to the workforce issues mentioned in the Resolution 46.

The Board does, however, believe there are existing channels of communication between the ADA and other organizations and agencies. These roles are clearly spelled out in both the American Dental Association *Constitution and Bylaws* and the American Dental Association *Standing Rules for Councils and Commissions*.

The Board, therefore, recommends adoption of the following substitute:

46B. Resolved, that the American Dental Association and its constituent societies be urged to collaborate with appropriate dental organizations for comment and assistance when strategizing advocacy efforts relating to legislative and regulatory proposals regarding dental team members.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

BOARD VOTE: UNANIMOUS.

Resolution No. 47 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: August 2009

Submitted By: Fourteenth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

POLICY ON OBESITY

The following resolution was submitted by the Fourteenth Trustee District and transmitted on August 28, 2009, by Dr. Kenneth Versman, trustee, Fourteenth District.

Background: Adult obesity rates have gone up from 15% to 33% in the United States between 1976 and 2003. The Centers for Disease Control and Prevention states that 72 million people were considered obese in the US in 2003.

Linked to this is the upswing in Type II diabetes, which closely parallels obesity. In 2008, there were 24 million people diagnosed with diabetes, with another 57 million considered pre-diabetic. Those that did not know that they were diabetic were over 25% overweight at the time that they were diagnosed.

More obesity statistics to consider:

- More than 85% of all diabetes cases are due to obesity and being overweight.
- More than 70% of all heart-related disease is heavily correlated with being overweight and/or obese.
- Almost 45% of all breast and colon cancer cases are heavily related to obesity and/or being overweight.
- More than 30% of all gall bladder operations are caused by obesity and/or being overweight.
- More than one quarter of all obese people have hypertension (high blood pressure).

Diabetes increases the risks of heart disease, blindness, kidney failure and lower extremity amputation. A child born in the year 2000 has a 30% chance of being diabetic if male, 40% if female, and closely linked to obesity.

Obesity, its direct and indirect costs in the U.S. are approximately $250-300 billion per year. What has become known as “poor diet and lack of physical activity” in 2000 claimed the lives of over 365,000 people in the United States, second only to smoking.

Obesity itself is linked to hypertension, heart disease, diabetes, osteoarthritis, stroke and several types of cancer.

Statistics bear out that approximately one-third of our population is overweight, and another third obese. Obese individuals are 7.5-9.0 times as likely to be diabetic as someone who is not overweight.

It is recognized that being overweight or obese affects two-thirds of the U.S. population and the high cost of dealing with the immediate and secondary effects of these conditions. Education for people of all ages to prevent this condition is fundamental to the public's oral and general health. Therefore, be it

Resolution

47. Resolved, that the ADA initiate and support collaborative efforts with other health agencies (AMA, nursing, nutritionists, etc.) to combat the growing problems of overweight and obesity, and be it further

Resolved, that the ADA develop educational tools that address obesity and overweight issues, outlining the immediate and secondary health issues associated with them, that can help channel those patients into programs or practitioners who can help them better understand and control these issues.

BOARD COMMENT: The Board agrees that obesity in the United States continues to be a significant public health concern.

The Council on Access, Prevention and Interprofessional Relation (CAPIR) has noted that current research indicates certain racial/ethnic populations have been disproportionally affected by obesity. Data from the Behavioral Risk Factor Surveillance System (BRFSS) surveys conducted during 2006-08 indicated that more than a quarter of non-Hispanic blacks, non-Hispanic whites and Hispanics were obese. Non-Hispanic blacks had 51% greater prevalence of obesity and Hispanics had 21% greater prevalence, when compared with non-Hispanic whites. (Reference: *CDC Morbidity and Mortality Weekly Report*, July 17, 2009, Vol. 58, No. 27.)

CAPIR is involved in educating people of all ages regarding nutrition as it applies to oral and overall health. The ADA maintains a Web page on Diet and Dental Health that includes links to the U.S. Department of Agriculture's Web site. The USDA's dietary recommendations are designed to promote optimal health and to prevent obesity-related diseases including cardiovascular disease, Type 2 diabetes and cancers. The ADA also provides several patient brochures regarding diet and dental health through the *ADA Catalog*.

In October 2008, the ADA formally appointed a representative to the Pharmacy, Podiatry, Optometry and Dental professional workgroup of the National Diabetes Education Program (NDEP). The NDEP partners with over 200 public and private organizations that work together to develop awareness campaigns, educational materials for people with diabetes, tools for health care professionals and support community interventions.

In light of the current budget restraints, the existing resources and activities noted above should be promoted to ADA members.

Therefore, the following substitute resolution is suggested.

47B. Resolved, that the ADA support collaborative efforts with other health professionals (physicians, pediatricians, nurses, dieticians, nutritionists, etc.) to combat the growing problems of overweight and obesity, and be it further

Resolved, that the ADA work in collaboration with appropriate stakeholder organizations/agencies to assure that issues specific to nutrition and oral health, as well as the systemic/oral health relationship, are incorporated into documents and educational materials, and be it further

Resolved, that the ADA investigate opportunities to offer continuing education courses related to nutrition and obesity.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LONG	■	☐	☐	☐	SYKES
■	☐	☐	☐	ELLIOTT	■	☐	☐	☐	MANNING	■	☐	☐	☐	TANKERSLEY
■	☐	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	■	☐	☐	☐	THOMPSON
■	☐	☐	☐	GIST	■	☐	☐	☐	RICH	■	☐	☐	☐	VERSMAN
■	☐	☐	☐	GLECOS	■	☐	☐	☐	SCHWEINEBRATEN	■	☐	☐	☐	VIGNA
■	☐	☐	☐	KREMPASKY SMITH	■	☐	☐	☐	STEFFEL	■	☐	☐	☐	WEBB
☐	■	☐	☐	LOW	■	☐	☐	☐	SULLIVAN				Res.	47B

Resolution No. 48 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2009

Submitted By: Fifteenth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

ENSURING THE PUBLIC'S PROTECTION UNDER LAWS GOVERNING THE DELIVERY OF ORAL HEALTH CARE

The following resolution was submitted by the Fifteenth Trustee District and transmitted on September 3, 2009, by Ms. Mary Kay Linn, executive director, Texas Dental Association.

Background: Policies supporting and opposing certain types of practice models have been established by, and are contained in the manuals of the American Dental Association. Over time, many individual state legislatures have enacted dental practice laws in conflict with these policies.

The ADA State Public Affairs Initiative is partnering with constituent societies, helping to fund advocacy for certain issues within those states. There have been occasions when funds from this program were denied to constituent societies because actions of their respective state legislatures put those state associations in political situations where all "acceptable" initiatives or compromises were in conflict with ADA policy.

The ADA has existing policies that state its support for, and the recognition of, the authority of each state government to adopt and enforce laws and rules that regulate the practice of dentistry and enhance the oral health of the public within its jurisdiction; that the responsibility for such health, safety, and welfare of its citizens rests with each state individually, and should not be abrogated.

Practice models are continuing to evolve that are allowing more duties to be performed by auxiliary personnel that were traditionally performed by only a dentist. Some of these practice models are a natural progression of evolving safety measures and technology, while others are initiatives attained through negotiation with governmental authorities, or mandates.

Board Report 8 (Worksheet:3014) provides additional background material for supporting individual constituent societies with Association resources, including funding, in their efforts to promote various practice models, many of which are in violation of ADA policy. Therefore be it

Resolution

48. Resolved, that the American Dental Association will assist within existing ADA resources whenever practical as determined by the Board of Trustees or the House of Delegates, the constituent societies in their advocacy and public relations efforts to ensure that the laws governing the delivery of oral health care and regulating oral health care providers in their respective states, protect and support the welfare of the public.

BOARD COMMENT: The Board agrees with the intent of Resolution 48, but believes that the specific relationship to workforce-related issues is addressed in its substitute Resolution 31S-1B (Worksheet:3026b). Therefore, to avoid duplicate policies, the Board recommends that Resolution 48 not be adopted.

BOARD RECOMMENDATION: Vote No.

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
☐	■	☐	☐	CALNON	■	☐	☐	☐	LONG	☐	■	☐	☐	SYKES
☐	■	☐	☐	ELLIOTT	☐	■	☐	☐	MANNING	☐	■	☐	☐	TANKERSLEY
☐	■	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	☐	■	☐	☐	THOMPSON
☐	■	☐	☐	GIST	☐	■	☐	☐	RICH	■	☐	☐	☐	VERSMAN
☐	■	☐	☐	GLECOS	☐	■	☐	☐	SCHWEINEBRATEN	☐	■	☐	☐	VIGNA
☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	STEFFEL	☐	■	☐	☐	WEBB
☐	■	☐	☐	LOW	☐	■	☐	☐	SULLIVAN				Res.	48

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: CSA Supplemental Report 1 Date Submitted: September 2009

Submitted By: Council on Scientific Affairs

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

COUNCIL ON SCIENTIFIC AFFAIRS SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES: RESPONSE TO ASSIGNMENTS FROM THE 2008 HOUSE OF DELEGATES

Background: This reports to the House of Delegates on actions taken by various ADA agencies involved with implementation of Resolution 73H-2008 (*Trans.*2008:476), ADA Policy on Tooth Whitening Administered by Non-Dentists, and includes a CSA report on treatment considerations for dentists and patients prior to the initiation of tooth whitening/bleaching procedures; and an update on an ADA petition to the U.S. Food and Drug Administration to classify whitening/bleaching agents. Resolution 73H reads as follows.

> **73H-2008. Resolved,** that the American Dental Association supports educating the public on the need to consult with a licensed dentist to determine if whitening/bleaching is an appropriate course of treatment, and be it further
>
> **Resolved,** that the Council on Scientific Affairs compile scientific research to describe treatment considerations for dentists prior to the tooth whitening/bleaching procedure in order to reduce the incidence of adverse outcomes and report these findings to all state dental associations, and be it further
>
> **Resolved,** that the American Dental Association petition the Food and Drug Administration to properly classify tooth whitening/bleaching agents in light of the report from the Council on Scientific Affairs, and be it further
>
> **Resolved,** that the American Dental Association urges constituent societies, through legislative or regulatory efforts, to support the proposition that the administering or application of any intra-oral chemical for the sole purpose of whitening/bleaching of the teeth by whatever technique, save for the lawfully permitted self application and application by a parent and/or guardian, constitutes the practice of dentistry and any non-dentist engaging in such activity is committing the unlicensed practice of dentistry.

Report on Treatment Considerations for Dentists Prior to Tooth Whitening/Bleaching Procedures: Resolution 73H-2008 was adopted in response to the growing proliferation of whitening/bleaching procedures offered to the public in non-dental venues, such as day spas, salons, home and garden shows, bridal conventions, retail outlets and cruise ships. The resolution directed the Council on Scientific Affairs (CSA) to "compile scientific research to describe treatment considerations for dentists prior to the tooth whitening/bleaching procedure in order to reduce the incidence of adverse outcomes." To address this House directive, the Council developed the attached Appendix and will distribute it to the state dental associations in response to Resolution 73H.

The Council's report outlines a range of information on whitening/bleaching that can be considered by dentists and their patients, including:

- safety of tooth whitening/bleaching materials in dental and non-dental settings
- general whitening/bleaching treatment considerations, including examination and diagnosis by a licensed dentist, evaluation of patient habits, lifestyle, and health history
- whitening/bleaching method-specific considerations
- role and rationale for dental professional involvement in extracoronal whitening/bleaching treatmentd
- an overview of regulatory and scope of practice aspects

The Council concluded that "bleaching is best performed under professional supervision and always with a dental examination and diagnosis prior to any type of treatment." This recommendation is consistent with the dentist's role in providing ethical and optimal oral health care to patients. Essential to this role are the accurate diagnosis of diseases or conditions, and treatment planning with the patient to maximize oral health benefits and minimize potential adverse events.

The Council finalized the draft report in the summer of 2009. After informing the Board of Trustees of the report, the Council will distribute the document to state dental associations in September.

Petition for FDA Classification of Tooth Whitening/Bleaching Agents: Resolution 73H-2008 also directed appropriate agencies of the ADA to "petition the U.S. Food and Drug Administration to properly classify tooth whitening/bleaching agents in light of the report from the Council on Scientific Affairs."

To date, the U.S. Food and Drug Administration (FDA) has approved hydrogen peroxide and carbamide peroxide as oral antiseptic agents. Extracoronal whitening/bleaching products have not yet been classified.

To address the direction provided by the House in Resolution 73H-2008, the Council on Government Affairs (CGA) requested that staff prepare a formal petition to the FDA. Both CSA and CGA staffs agreed to delay the petition until the CSA report was complete so that it could be included with the petition. The petition is being prepared and, along with the report prepared by CSA, will be sent to the FDA before the 2009 House of Delegates meeting in Hawaii.

Additional Activities: The ADA Division of Government and Public Affairs, in collaboration with the Divisions of Science, Dental Practice/Professional Affairs and Legal Affairs, prepared an advocacy document on whitening by retail staff for use by state dental societies. The document includes an overview of possible legislative, administrative and legal actions that might be considered when confronting this issue at the state level. The advocacy document was distributed to state dental societies in advance of a national issues conference call hosted by Drs. Mark Feldman and John Findley. The document was also provided to attendees of the general assembly session at the 2008 ADA Lobbyist Conference. The advocacy document is currently available to state dental associations upon request.

The Council on Scientific Affairs has previously developed information for patients on the importance of consulting a dentist to determine if whitening/bleaching is an appropriate course of treatment. Most recently, this information was publicized in the feature "For the Dental Patient" in the March 2009 issue of *JADA* (http://www.ada.org/prof/resources/pubs/jada/patient/patient_83.pdf). The same information is available in the Council's statement on the safety and effectiveness of tooth whitening products available on ADA.org (http://www.ada.org/prof/resources/positions/statements/whiten2.asp).

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Appendix

Tooth Whitening/Bleaching: Treatment Considerations for Dentists and Their Patients

ADA Council on Scientific Affairs

Introduction

Over the past two decades, tooth whitening or bleaching has become one of the most popular esthetic dental treatments. Since the 1800s, the initial focus of dentists in this area was on in-office bleaching of non-vital teeth that had discolored as a result of trauma to the tooth or from endodontic treatment. By the late 1980s, the field of tooth whitening dramatically changed with the development of dentist-prescribed, home-applied bleaching (tray bleaching) and other products and techniques for vital tooth bleaching that could be applied both in the dental office and at home.

The tooth whitening market has developed into four categories: professionally applied (in the dental office); dentist-prescribed/dispensed (patient home-use); consumer-purchased/over-the-counter (OTC) (applied by patients); and other non-dental options (e.g., mall kiosks, spa settings, cruise ships). Additionally, dentist-dispensed bleaching materials are sometimes used at home after dental office bleaching to maintain or improve whitening results.

Consumer whitening products available today for home use include gels, rinses, chewing gums, toothpastes, paint-on films and strips. The latest tooth whitening trend is the availability of whitening treatments or kits in non-dental retail settings, such as mall kiosks, salons, spas and, more recently, aboard passenger cruise ships. Non-dental whitening venues have come under scrutiny in several states and jurisdictions, resulting in actions to reserve the delivery of this service to dentists or appropriately supervised allied dental personnel.

Current tooth bleaching materials are based primarily on either hydrogen peroxide (H_2O_2) or carbamide peroxide. Both may change the inherent color of the teeth, but have different considerations for safety and efficacy. In general, most in-office and dentist-prescribed, at-home bleaching techniques have been shown to be effective, although results may vary depending on such factors as type of stain, age of patient, concentration of the active agent, and treatment time and frequency. However, concerns have remained about the long-term safety of unsupervised bleaching procedures.

Although published studies tend to suggest that bleaching is a relatively safe procedure, investigators continue to report adverse effects on hard tissue, soft tissue, and restorative materials.[1-3] The rate of adverse events from use or abuse of home-use OTC products is also unclear because consumers rarely report problems through the FDA Medwatch system. Based on these factors, the ADA has advised patients to consult with their dentists to determine the most appropriate whitening treatment, particularly for those with tooth sensitivity, dental restorations, extremely dark stains, and single dark teeth.[4] Additionally, a patient's tooth discoloration may be caused by a specific problem that either will not be affected by whitening agents and/or may be a sign of disease or pathology that requires dental therapy.

The purpose of this report is to outline treatment considerations for dentists and their patients prior to tooth whitening/bleaching procedures so that the potential for adverse effects can be minimized. This report does not address agents used for non-vital intracoronal bleaching procedures.

Safety Concerns with Tooth Bleaching Materials

Concerns regarding the safety of all bleaching treatments and products have long existed, but were heightened since the introduction of at-home bleaching.[5-8] Discussions in this section focus on peroxides and their use as active ingredients in tooth bleaching materials. Important concerns related to patient examination and diagnoses are addressed elsewhere in this report.

A variety of peroxide compounds, including carbamide peroxide, H_2O_2, sodium perborate and calcium peroxide, have been used as active ingredients for bleaching materials; however, essentially all extracoronal bleaching materials currently available for whitening of vital teeth in the United States contain carbamide peroxide and/or H_2O_2. Recently, products containing chlorine dioxide were introduced in the United Kingdom, but there is no evidence that tooth bleaching products using chlorine dioxide as the active ingredient are safer than peroxide-based materials. In fact, safety concerns have been documented with chlorine dioxide and its use for tooth bleaching treatment due to the low pH of the material and resultant tooth etching.[9]

Most OTC bleaching products are H_2O_2-based, although some contain carbamide peroxide. Carbamide peroxide decomposes to release H_2O_2 in an aqueous medium: 10% carbamide peroxide yields roughly 3.5% H_2O_2. In-office bleaching materials contain high H_2O_2 concentrations (typically 25-38%), while the H_2O_2 content in at-home bleaching products usually ranges from 3% to 7.5%; however, there have been home-use products containing up to 15% H_2O_2.

Safety issues have been raised regarding the effects of bleaching on the tooth structure, pulp tissues, and the mucosal tissues of the mouth, as well as systemic ingestion. Regarding mucosal tissues, safety concerns relate to the potential toxicological effects of free radicals produced by the peroxides used in bleaching products. Free radicals are known to be capable of reacting with proteins, lipids and nucleic acids, causing cellular damage. Because of the potential of H_2O_2 to interact with DNA, concerns with carcinogenicity and co-carcinogenicity of H_2O_2 have been raised, although these concerns so far have not been substantiated through research.[5] However, studies have shown that H_2O_2 is an irritant and also cytotoxic. It is known that at concentrations of 10% H_2O_2 or higher, the chemical is potentially corrosive to mucous membranes or skin, causing a burning sensation and tissue damage.[5,10,11] During office bleaching treatment, which routinely uses materials of ≥25% H_2O_2, severe mucosal damage can occur if gingival protection is inadequate. Clinical studies have also observed a higher prevalence of gingival irritation in patients using bleaching materials with higher peroxide concentrations.[12,13]

Data accumulated over the last 20 years indicate no significant, long-term oral or systemic health risks associated with professional at-home tooth bleaching materials containing 10% carbamide peroxide (3.5% H_2O_2). However, these data were collected from studies conducted by dental professionals, and there is no safety evidence on bleaching materials that do not involve dental professionals, regardless of H_2O_2 concentration or application venue. Additionally, consumers are not generally aware of how to report adverse events through FDA's Medwatch system. If a licensed dental professional is not consulted when patients use OTC bleaching products, many adverse effects may go unreported.

Regarding hard tissues, transient mild to moderate tooth sensitivity can occur in up to two-thirds of users during early stages of bleaching treatment.[14] Sensitivity is generally related to the peroxide concentration of the material and the contact time; it is most likely the result of the easy passage of the peroxide through intact enamel and dentin to the pulp during a five- to 15-minute exposure interval. However, there have been no reported long-term adverse pulpal sequellae when proper techniques are employed. The incidence and severity of tooth sensitivity may depend on the quality of the bleaching material, the techniques used, and an individual's response to the bleaching treatment methods and materials. To date, there is little published evidence documenting adverse effects of dentist-monitored, at-home whiteners on enamel, but two clinical cases of significant enamel damage have been reported, apparently associated with the use of OTC whitening products.[15,16] This damage may be related to the low pH of the products and/or overuse.

In vitro studies suggest that dental restorative materials may be affected by tooth bleaching agents.[1,17] These findings relate to possible physical and/or chemical changes in the materials, such as increased surface roughness, crack development, marginal breakdown, release of metallic ions, and decreases in tooth-to-restoration bond strength. Such findings have not appeared in clinical reports or studies.

To address the safety of bleaching materials, the American Dental Association (ADA) convened a panel of experts in 1993. The ADA subsequently published its first set of guidelines for evaluating peroxide-containing tooth whiteners.[18] These guidelines have been revised periodically.

In March 2005, the European Scientific Committee on Consumer Products (SCCP) concluded the following: "The proper use of tooth whitening products containing >0.1 to 6.0% hydrogen peroxide (or equivalent for hydrogen peroxide-releasing substances) is considered safe after consultation with and approval of the consumer's dentist."[11] The SCCP, in January 2008, again recommended that up to 6% H_2O_2 is a safe limit to use for at-home tooth bleaching; however, it did not recommend use of such products without dental consultation.[19]

In summary, available data indicate that extracoronal bleaching treatment in the dental office or at home may cause short-term tooth sensitivity and/or gingival irritation. More severe mucosal damage is possible with high H_2O_2 concentrations. While available evidence supports the safety of using bleaching materials of 10% carbamide peroxide (3.5% H_2O_2) by dental professionals, there are concerns with the use of at-home bleaching materials with high H_2O_2 concentrations. Studies designed specifically to assess the long-term safety of high H_2O_2 concentration in at-home bleaching materials are needed, especially for repeated use of these products. There appears to be insufficient evidence to support unsupervised use of peroxide-based bleaching materials.

Similar to other dental and medical interventions, questions have been raised about the safety of tooth whitening treatments during pregnancy. In the absence of such evidence, clinicians may consider recommending that tooth whitening be deferred during pregnancy.

The safety of tooth bleaching for children and adolescents is also a consideration. More research is needed to establish appropriate use and limitations for these patients. However, bleaching is a conservative approach compared with restorative options when tooth discoloration causes significant concern. If possible, delaying treatment until after permanent teeth have erupted is recommended, as is use of a custom-fabricated bleaching tray to limit the amount of bleaching gel.[20] Close professional and parental/guardian supervision are needed to maximize benefits and minimize adverse effects and overuse.

Bleaching Treatment Considerations

General Considerations

A typical dental examination begins with a health and dental history. Intra-oral and extra-oral examinations of the hard and soft tissues of the mouth and head are also conducted to exclude or diagnose cancer, abscesses, periodontal disease and other pathology. Seminal to decisions regarding tooth bleaching, the patient history would include the patient's opinions regarding the cause of tooth discoloration, a history of allergies (which may include ingredients in bleaching materials), and information regarding any past problems with tooth sensitivity. Some tooth discolorations may be the result of pathology or conditions that require endodontic therapy, restorations or dental surgery. Such diagnoses can only be made by a dentist or another licensed health care professional, depending on local licensing regulations. In light of these and additional factors noted below, a dental examination with appropriate radiographs or other screening or diagnostic tests is recommended prior to considering tooth bleaching.

Bleaching discolored teeth in which the color change is the only visible indication of underlying pathology may change tooth color, but will not remove any underlying pathology. This masking effect, which can occur in abscessed teeth and teeth with external or internal resorption, can result in tooth loss or other complications.

Dental caries or leaking restorations may also cause teeth to appear dark. Patients should be advised that bleaching treatments will not remove tooth decay that may subsequently progress and result in the need for more extensive and expensive treatments. Examination of tooth function and para-function may reveal conditions that could affect bleaching procedures. For example, bruxism, temporomandibular dysfunction, or other conditions may be aggravated by use of bleaching trays.[21] Radiographs may be necessary to aid in screening and diagnosis of pathologies that may manifest as tooth discoloration, such as periradicular abscess, anomalous pulp chamber size and anatomy, calcific metamorphosis, root resorption or other pathoses. A history of tooth sensitivity should be investigated carefully to determine the cause(s) and whether treatment before tooth bleaching will benefit the patient.

A dental examination will identify and record the presence and locations of existing tooth restorations. This step may be quite important to an acceptable tooth bleaching outcome, since restorations do not change color. Dental restorations can also be a cause of tooth discoloration: metallic and other restorative materials may influence tooth color significantly depending on the translucency and thickness of the remaining tooth structure.

Patient expectations may be unrealistic unless cosmetic issues with existing restorations are addressed initially. Additional examination considerations include: tooth/enamel cracks and related sensitivity; exposed root surfaces (that resist bleaching); and other smile considerations such as translucency or defects in tooth form or anatomy.

Patient habits and lifestyle, as well as the presence of removable or fixed appliances or prostheses, should also be considered during an examination. Pre-treatment photographs are often helpful to record a baseline to better assess treatment success.

Upon completion of the dental examination and diagnosis, treatment may be recommended and prioritized. Although the patient's primary concern may be tooth discoloration, bleaching procedures may not be recommended (or effective) until other problems are addressed. If dental restorations are present, often the expense and/or the risks related to the replacement fillings or crowns to match post-bleaching tooth color may contraindicate bleaching.

When bleaching is pursued, the dental team will consider and recommend the appropriate materials, techniques, and delivery systems to best serve the patient's needs and desires (see next section for further discussion of method-specific considerations). These factors affect the costs and may influence treatment decisions.

The length of treatment and expected outcome will depend on the discoloration etiology and diagnosis, as well as the chosen product and technique. Dentists can discuss these concerns with their patients in the treatment plan development process. Success will vary when tooth discoloration is related to inherited/developmental aspects, age-related tooth changes, extrinsic staining (e.g., from diet or smoking), or intrinsic staining such as tetracycline-associated stain or color change secondary to tooth trauma.

If a patient has a history of sensitive teeth, or experiences sensitivity during tooth bleaching, appropriate measures can be initiated to minimize and manage further discomfort before, during and after tooth bleaching. Pre-treatment options may include use of non-steroidal anti-inflammatory drugs (NSAIDs), fluoride, amorphous calcium phosphate, or potassium nitrate. During treatment, it may be necessary to select an alternate bleaching product, or change the delivery system, treatment duration or treatment interval. Depending on the patient's response, side effects or other issues, it may be in the patient's best interest to discontinue treatment.

Method-Specific Considerations

Dentist-managed bleaching treatments may include in-office bleaching, at-home use of bleaching trays at night or during the day, or a combination of these treatment methods. Additionally, the need for and

effectiveness of maintenance or periodic re-treatment can be addressed depending on the patient's individual response to tooth whitening. A dental examination, including any necessary radiographs, should precede re-treatment.

Other considerations consistent with those covered previously, such as the presence or history of sensitivity, presence of dental restorations, and occlusal/temporomandibular dysfunction may raise method-specific concerns that merit attention as well. Allergies to bleaching tray materials, isolation barriers, or bleaching materials may also limit treatment options.

With the tray bleach method, if tooth sensitivity is problematic, the tray may be used in advance for the application of potassium nitrate for ten to 30 minutes.[22,23] Use of potassium nitrate-containing toothpaste before bleaching and throughout the bleaching therapy can also help minimize side effects.[24] Higher peroxide concentrations result in more sensitivity without significantly shortening the treatment time, since the tooth can only change color at a certain rate, regardless of the peroxide concentration of the materials.

Although brown discolorations respond well to bleaching, white discolorations remain unchanged, though the background may be lightened to make the white areas less noticeable. Occasionally, bleaching may need to be combined with abrasion techniques or bonded restorations to address non-esthetic white areas. With tray bleaching, teeth normally lighten in three days to six weeks. However, nicotine-stained teeth may take one to three months, and tetracycline-stained teeth may require two to six months (or more) of nightly treatment.

Bleaching products should ideally be formulated at neutral pH. Carbamide peroxide seems to be more effective overnight as a result of its urea content elevating the pH to desirable levels. Hydrogen peroxide formulations are short-acting and have a lower pH. Bleaching with H_2O_2 takes more days but less time per day, while carbamide peroxide takes fewer days but more contact time. The choice between the two types of products relate to the patient's lifestyle, caries history, tooth sensitivity, and discoloration type. The need for re-treatment also varies widely, from as soon as one to three years after initial treatment to more than ten years.[25,26]

With in-office bleaching, both proper isolation and protection of mucosal tissues are essential. Dentists may also wish to consider prescribing non-steroidal anti-inflammatory medications prior to treatment,[27] since post-treatment sensitivity is unpredictable. The treatment schedule may also be a useful method to help minimize tooth sensitivity. Multiple appointments are typically scheduled one week apart to allow sensitivity to abate. A "bleaching light" is sometimes used with in-office bleaching procedures as well. Some reports suggest that pulpal temperature can increase with bleaching light use, depending on the light source and exposure time. Pulpal irritation and tooth sensitivity may be higher with use of bleaching lights or heat application, and caution has been advised with their use.[28,29]

There is conflicting evidence on the effects of bleaching lights on tooth color change. Most studies comparing effectiveness of in-office bleaching with or without light application were conducted *in vitro.*[28] The effects on tooth color change were variable, and some differences detected electronically were not detectable visually. This observation was reported in a recent clinical study report as well.[30] Of studies conducted *in vivo*, most found no added benefit for light-activated systems.[28,31] Heat and light application may initially increase whitening due to greater dehydration, which reverses with time. Actual color change will not be evident until two to six weeks after bleaching treatment.

The average number of in-office visits for maximum whitening is three,[32] with a range of one to six visits, so the patient should be prepared for additional in-office treatments or for a combination of office visits and tray delivery to complete the process.[33]

As noted previously, the unsupervised use of OTC whitening products raises concerns about possible masking of undiagnosed pathology (whether related to tooth discoloration or not), cosmetic or functional aspects of existing dental restorations, and unknown allergies or other untoward responses. In addition to these safety concerns, absent a dental examination and consultation, user expectations may not be realistic.

Finally, bleaching offered in a mall kiosk or other non-dental venue may present the image of a dental practice and professional supervision without providing the benefits of care from fully trained and licensed oral health care providers.

Regulatory and Scope of Practice Aspects of Bleaching Treatment

Presently, all extracoronal tooth bleaching products remain unclassified by the U.S. Food and Drug Administration (FDA). This includes all peroxide-based products used in the in-office, dentist-dispensed products for at-home use, OTC (patient-purchased) products, as well as products used in non-dental settings.

In the early 1990s, the FDA proposed regulating the peroxide-based bleaching materials as drugs and sent warning letters to manufacturers.[34] The FDA's position was challenged legally, and in alignment with court decisions, the FDA suspended attempts to classify the bleaching materials. To date, the FDA has taken no further action to classify tooth bleaching products.

Products from reputable manufacturers are developed and marketed according to U.S. "cosmetic" regulations. This may lead to the perception that the products are innocuous, though they have the potential to cause harm and may result in undesirable effects to the teeth or oral mucosa.[3] Such adverse effects are generally related to low pH and poor product quality.

The recent appearance of tooth-bleaching businesses in non-dental settings has led to state dental board decisions, attorney general opinions, and legislation in some states. Some jurisdictions have taken recent action to better limit patient risks associated with tooth bleaching. These include: Florida, Iowa, Massachusetts, Nevada, New Jersey, Tennessee and the District of Columbia.

Concerns regarding tooth bleaching in non-dental settings have been raised. Non-dental personnel lack the knowledge, resources (such as radiographs), education and license needed to provide dental examinations. The facilities generally lack effective infection control capabilities and protocols, personnel are not trained in standard infection control precautions and may not be prepared to provide emergency care for allergic reactions.

Tooth bleaching in the United Kingdom (U.K.) emerged in conflict with existing regulations that applied to hairdressers and the use of hydrogen peroxide. Steps toward resolution of this conflict are underway, including an extensive review of tooth bleaching safety data. As noted previously, the Scientific Committee for Consumer Products (SCCP) in Europe supported the safety of tooth bleaching materials containing up to 6.0% H_2O_2 for use by dental professionals.[11,19] It is expected that this SCCP recommendation will eventually be ratified by the European Council and by the U.K. government. The timeline for these actions is unclear at present.

<u>Rationale for Dental Professional Involvement in Extracoronal Bleaching Treatment</u>

Dental professionals are responsible for managing patient care, and are a key resource on oral health to the public at large. Consumers may pursue tooth bleaching without understanding the risks of treatment or the factors that may affect treatment success or failure. For optimal safety and to ensure proper diagnosis and treatment, examination by a dentist is necessary. To aid in patient communication on whitening/bleaching, a helpful summary of considerations is available that can also be used as a resource for the public at large.[35]

As discussed previously, tooth discoloration, particularly intrinsic discolorations, may not be amenable to bleaching. Bleaching materials can affect filling materials, and may also result in color mismatch of teeth with existing fillings or crowns. Therefore, pre-treatment examination and routine monitoring of bleaching by dentists allow for professional assessment of each patient's situation, recommendations for methods and/or materials to help minimize problems, as well as earlier detection and better management of any adverse effects. Professionally performed or supervised bleaching reduces the risk of patients selecting and using inferior products, inappropriate application procedures and/or product abuse.

Summary

Tooth bleaching is one of the most conservative and cost-effective dental treatments to improve or enhance a person's smile. However, tooth bleaching is not risk-free and only limited long-term clinical data are available on the side effects of tooth bleaching. Accordingly, tooth bleaching is best performed under professional supervision and following a pre-treatment dental examination and diagnosis.

In consultation with the patient, the most appropriate bleaching treatment option(s) may be selected and recommended based on the patient's lifestyle, financial considerations, and oral health. Patients considering OTC products should have a dental examination, and should be reminded that they may unknowingly purchase products that may have little or no beneficial effect on the color of their teeth and may also have the potential to cause harm.

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Resolution No. 49 New ■ Substitute ☐ Amendment ☐

Report: CSA Supplemental Report 2 Date Submitted: September 2009

Submitted By: Council on Scientific Affairs

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

COUNCIL ON SCIENTIFIC AFFAIRS SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES: PROPOSED REVISION TO ADA POLICY ON PROMOTION OF DENTAL MATERIALS TO PUBLIC

Background: As the primary agency for evaluating ADA policies related to dental science, the Council on Scientific Affairs (CSA) periodically reviews existing policies on relevant scientific issues and proposes revisions to the House of Delegates as appropriate.

At its July 2009 meeting, the Council reviewed the ADA policy on Promotion of Dental Materials to Public (*Trans*.1997:716), which reads as follows:

> **88H-1997. Resolved,** that the American Dental Association strongly encourages the direct promotion to the public of any dental equipment, materials, pharmaceuticals or other products, the selection of which is exclusively the dentist's responsibility, be submitted to the Council on Scientific Affairs for review and comment prior to use in the public and dental media, and be it further
>
> **Resolved,** that the American Dental Association strongly encourages manufacturers to submit for acceptance into the ADA Seal Program any dental equipment, materials, pharmaceuticals or other products so that any public promotion be truthful in fact and implication, and be it further
>
> **Resolved,** that the policy entitled Promotion of Dental Materials to Public (*Trans.*1957:371) be rescinded.

The above policy replaced a predecessor policy that disapproved of direct-to-consumer (DTC) advertising for professional dental products. After the Food and Drug Administration (FDA) changed its position in 1997 by issuing draft guidance that permitted DTC advertising, the ADA adopted the 1997 policy to reflect the change in FDA guidance.

Proposed Policy Revision: The Council determined that the second resolving clause of the 1997 ADA policy should be rescinded in its entirety because it refers to "dental equipment, materials, pharmaceuticals," all of which are professional product categories. As of January 2008, professional dental products are no longer included or evaluated as part of the ADA Seal of Acceptance Program, and are now evaluated through the *ADA Professional Product Review* program. Because those professional product categories are not eligible for the Seal of Acceptance, the second resolving clause is no longer necessary.

Several dental product manufacturers provide direct-to-consumer advertising for their products and procedures. Consequently, the Council recommends retaining the first policy resolving clause to continue encouraging the submission of direct promotional materials for professional dental products, "the selection of which is exclusively the dentist's responsibility," to the Council "for review and comment prior to use in the public and dental media." Retaining this resolving clause supports the ADA's vision of serving as America's

"oral health authority committed to the public and the profession," and would allow the ADA to continue its advocacy of scientifically accurate DTC dental product advertisements that are neither misleading nor deceptive.

The Council, therefore, recommends adoption of the following resolution.

Resolution

49. Resolved, that the policy on Promotion of Dental Materials to Public (*Trans.*1997:716) be amended to read as follows (deletions shown by strikethroughs):

Resolved, that the American Dental Association strongly encourages that the direct promotion to the public of any dental equipment, materials, pharmaceuticals or other products, the selection of which is exclusively the dentist's responsibility, be submitted to the Council on Scientific Affairs for review and comment prior to use in the public and dental media.~~, and be it further~~

~~**Resolved,** that the American Dental Association strongly encourages manufacturers to submit for acceptance into the ADA Seal Program any dental equipment, materials, pharmaceuticals or other products so that any public promotion be truthful in fact and implication, and be it further~~

~~**Resolved,** that the policy entitled Promotion of Dental Materials to Public (*Trans.*1957:371) be rescinded.~~

BOARD RECOMMENDATION: Vote Yes.

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

Resolution No. 61 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2009

Submitted By: Fourth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: Undetermined

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

OPPOSITION TO CORPORATE MANDATED VOLUME REQUIREMENTS FOR PATIENT TREATMENT

The following resolution was submitted by the Fourth Trustee District and transmitted on September 15, 2009, by Mr. Frank McLaughlin, executive director, Maryland State Dental Association.

Background: Some companies provide products or services that require dentists to take initial courses or training to gain the specific knowledge necessary to provide their product or service to patients. Some companies also require additional periodic continuing education requirements to keep dentists informed and up-to-date on the latest advancements of their product or service.

Recently, some companies have imposed certain patient volume mandates in order for the participating dentists to continue use of their product. In some cases, these dentists have expended considerable funds to acquire the knowledge required to become proficient in the use of these products and services.

It has always been the position of the ADA that the dentist is directly responsible for appropriate diagnosis and patient treatment. This treatment should be predicated on patient need and dentist competence—not on meeting an arbitrary quota from a third party.

While the dentist has an ethical responsibility to provide appropriate care, these company-imposed volume mandates could, in some instances, encourage dentists to make treatment decisions based upon their ability to continue to use the product or service or based upon recouping their initial investment required to become proficient in using the product.

Resolution

61. Resolved, that the ADA is opposed to any corporate mandated volume requirements which inappropriately interfere with the dentist's judgment regarding treatment of a patient or which adversely affect the quality of patient care, and be it further

Resolved, that the ADA shall not accept sponsorship from, accept advertising for, or permit exhibition at ADA meetings of any products or services with respect to which the promoter of the product or service has imposed a volume requirement—unless the promoter has justified the specific volume requirement to the satisfaction of ADA with scientifically sound data.

BOARD RECOMMENDATION: Vote Yes.

NOTE: Implementing this policy could result in a potential loss of advertising revenue and/or sponsors.

1

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LONG	■	☐	☐	☐	SYKES
☐	■	☐	☐	ELLIOTT	☐	■	☐	☐	MANNING	■	☐	☐	☐	TANKERSLEY
■	☐	☐	☐	FAIELLA	☐	☐	☐	■	NORMAN	☐	■	☐	☐	THOMPSON
■	☐	☐	☐	GIST	☐	■	☐	☐	RICH	■	☐	☐	☐	VERSMAN
■	☐	☐	☐	GLECOS	■	☐	☐	☐	SCHWEINEBRATEN	■	☐	☐	☐	VIGNA
■	☐	☐	☐	KREMPASKY SMITH	■	☐	☐	☐	STEFFEL	■	☐	☐	☐	WEBB
■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN				Res.	61

Resolution No. 62 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2009

Submitted By: Ninth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: Undetermined

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

CREATING NATIONAL ELECTRONIC DATABASE ON PATIENT DENTAL IMPLANTS

The following resolution was submitted by the Ninth Trustee District and transmitted on September 15, 2009, by Ms. Michelle M. Nichols-Cruz, Board and House administrator, Michigan Dental Association.

Background: Implants are becoming a more common restoration for the American public. At the same time, mobility of the people with implant restorations is increasing. Often patients do not know what type of implant was placed in their mouths nor do they always remember who placed the implant. Baby boomer dentists are aging and (even in the current economy) are going to be retiring at an increased rate making it difficult to find out what type of implant was used in the case of a failure. In addition, implant companies have gone out of business making it impossible to get the necessary instruments to repair failed implants. Therefore, the Ninth District would like to encourage the American Dental Association (ADA) to try to mitigate some of these challenges for patients and dentists when restoring implants.

The Ninth District encourages the ADA to facilitate the creation and maintenance of an electronic database to track the manufacturers' implant type and size for each patient who receives an implant. This database could serve as an interim solution until the electronic health record negates the need for this database in the future. With this database in place, a dentist could go to the database to determine the type and size of implant without having to track down the actual dental records to make any repairs.

Resolution

62. Resolved, that the appropriate agency of the ADA work with the dental community to develop and maintain an electronic database which would track the placement of each implant by patient, the manufacturers' type and size of implant until national electronic health records are established.

BOARD COMMENT: The Board understands and appreciates the intent of the Ninth District in submitting Resolution 62. The Board notes, however, that although this may seem like a simple project on its face, it is fraught with difficulty. Data warehousing of this nature can be prohibitively expensive and there are HIPAA compliance implications that complicate the collection and use of this information. Therefore, the Board recommends that Resolution 62 not be adopted.

BOARD RECOMMENDATION: Vote No.

1

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
☐	■	☐	☐	CALNON	☐	■	☐	☐	LONG	☐	■	☐	☐	SYKES
☐	■	☐	☐	ELLIOTT	☐	■	☐	☐	MANNING	☐	■	☐	☐	TANKERSLEY
☐	■	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	☐	■	☐	☐	THOMPSON
■	☐	☐	☐	GIST	☐	■	☐	☐	RICH	☐	■	☐	☐	VERSMAN
☐	■	☐	☐	GLECOS	☐	■	☐	☐	SCHWEINEBRATEN	☐	■	☐	☐	VIGNA
☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	STEFFEL	☐	■	☐	☐	WEBB
☐	■	☐	☐	LOW	☐	■	☐	☐	SULLIVAN				Res.	62

2

Resolution No. 63 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2009

Submitted By: Ninth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication:

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

PREVENTION OF BISPHOSPHONATE-ASSOCIATED OSTEONECROSIS OF THE JAW

The following resolution was submitted by the Ninth Trustee District and transmitted on September 15, 2009, by Dr. Gary Jeffers and Dr. Kent Vandehaar, Delegation chairs.

Background: For patients prescribed bisphosphonates to treat osteopenia or osteoporosis, the physician should refer the patient to their dentist for evaluation prior to beginning or during the early stages of bisphosphonate treatment. A dental treatment plan could then be developed, aimed at preventing the need for future invasive procedures. For example, conditions such as severe periodontal disease or those that may require tooth extraction or bone recontouring could be addressed. Although the risk of developing bisphosphonate-associated osteonecrosis of the jaw in patients taking oral bisphosphonates appears to be very low compared to the risk following intravenous therapy for cancer treatment, it has been documented in a small percentage of patients. Patients taking oral bisphosphonates should be advised to maintain optimal dental health. Physicians and dentists should reinforce the need for routine dental examinations.

Resolution

63. Resolved, that for physicians prescribing intravenous bisphosphonates, it is recommended that the physician refer the patient to their dentist for evaluation prior to beginning or during the very early stages of bisphosphonate treatment, and be it further

Resolved, that the American Dental Association communicate the preceding information to its members, the American Medical Association and other relevant groups, with a request for assistance in communicating this information to the medical community.

BOARD COMMENT: The Board fully supports the intent of Resolution 63: to communicate important information about dental treatment of patients on bisphosphonate therapy to dentists, physicians and other health care professionals. The ADA has already accomplished much in this area, working in collaboration with the FDA, medical associations and the pharmaceutical industry. The Board believes it would be desirable to build on these efforts under the guidance of the Council on Scientific Affairs (CSA). The Board recommends referral to CSA to develop an action plan that would continue these efforts (with any associated financial implications).

In doing so, the Board notes there is a discrepancy between the resolution (which focuses on intravenous bisphosphonates) and the background statement (which focuses on bisphosphonates used to treat osteopenia/osteoporosis). Osteopenia/osteoporosis are more commonly treated with oral bisphosponates (e.g., Fosamax, Boniva, Actonel). Even when treated intravenously, the regimen for osteopenia/osteoporosis

usually calls for annual or at most quarterly infusion. Currently, there are no reports of osteonecrosis of the jaw (ONJ) associated with this dosage form. ONJ is primarily associated with intravenous bisphosphonate therapy used in patients undergoing cancer treatment. In these patients, a drug like Zometa may be administered intravenously as often as every three to four weeks.

This illustrates the value of CSA involvement. The Council took the lead in ADA's previous communications campaign as part of a joint effort with the FDA and a manufacturer of intravenous bisphosphonates (Novartis) in 2005. (JADA, August 2006, http://www.ada.org/prof/resources/pubs/jada/reports/report_bisphosphonate.pdf); updated 2008 (http://jada.ada.org/cgi/content/abstract/139/12/1674. Referral will allow the CSA to pursue ongoing activities immediately, recommend ways to supplement them as needed during the coming year and report the results to the 2010 House of Delegates.

BOARD RECOMMENDATION: Vote Yes on Referral.

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LONG	■	☐	☐	☐	SYKES
■	☐	☐	☐	ELLIOTT	■	☐	☐	☐	MANNING	■	☐	☐	☐	TANKERSLEY
■	☐	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	☐	■	☐	☐	THOMPSON
■	☐	☐	☐	GIST	■	☐	☐	☐	RICH	■	☐	☐	☐	VERSMAN
■	☐	☐	☐	GLECOS	■	☐	☐	☐	SCHWEINEBRATEN	■	☐	☐	☐	VIGNA
■	☐	☐	☐	KREMPASKY SMITH	■	☐	☐	☐	STEFFEL	■	☐	☐	☐	WEBB
■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN				Res.	63

Resolution No. 78 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2009

Submitted By: Third Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

EDUCATION OF HUMAN RESOURCES PROFESSIONALS ON THE VALUE OF DENTAL BENEFITS

The following resolution was submitted by the Third Trustee District and transmitted on September 16, 2009, by Dr. Gary S. Davis, secretary, Pennsylvania Dental Association.

Background: Dental patients are not receiving full insurance benefits to which they are entitled. Some insurance companies are profit driven and looking for ways to contain their costs. Most employers and their human resource professionals are not adept at evaluating the quality of dental benefits in their insurance review process. Employers and their human resource professionals are not aware of specific contract language that would ensure comprehensive, quality dental insurance coverage. Dental insurance companies also often work within regional boundaries and thereby have an impact on large geographic areas. Educating employers about dental insurance would facilitate optimal patient access to appropriate insurance benefits while making prudent care by the membership more feasible. Therefore, be it

Resolution

78. Resolved, that the Council on Dental Benefit Programs study the development of an aggressive national public relations program to educate human resource professionals on the value of dental coverage and the process of evaluating comprehensive dental insurance benefits, with a report to the 2010 House of Delegates.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

Resolution No. 79 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2009

Submitted By: New Mexico Dental Association

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

USE OF THE TERMS "USUAL," "REASONABLE" AND "CUSTOMARY"

The following resolution was submitted by the New Mexico Dental Association and transmitted on September 16, 2009, by Mr. Mark Moores, executive director, New Mexico Dental Association.

Background: The terms "UCR" or "usual," "customary" and "reasonable" are something of a "black box" in dentistry. It sounds legitimate to patients but it's seems impossible to determine how the values are arrived upon by those using the terms. The current definitions of these terms only validate the inscrutability of their use by allowing them to be the domain of third parties. They also fail to distinguish the casual use of these terms from the formally derived values which they were meant to represent.

This resolution clarifies that the values of these terms are mathematically derived from statistical data. It also points out that the relevance of these terms is dependent on the completeness of the data, and in some cases the intentions of the parties designating them. The arbitrariness of their designation is further cited as a reason for limiting their use.

When these terms are used inappropriately it leads to patient misunderstanding and dentists' frustration. Demystifying the methods of calculating these values may not bring satisfaction, but it is a step toward improved communication and understanding. It is high time that our policy technically defines these terms and suggests a more appropriate usage for the sake of consistency and accuracy in communications.

Resolution

79. Resolved, that the values of "usual," "reasonable" and "customary" fees are statistically derived from the historical data of fees actually charged by an individual dentist or collectively charged by the dentists of a particular designated community, and be it further

Resolved, that the following definitions of usual, reasonable and customary fees be adopted:

Usual fee is the fee which an individual dentist most frequently charges for a specific dental procedure.

Reasonable fee is a value that falls within the range of fees charged by an individual dentist for a specific dental procedure which have been adjusted higher or lower than the dentist's usual fee to reasonably reflect unusual difficulty or circumstances in delivering a particular service.

Customary fee is an amount that has been designated by a single party from a range of values that reflect both the predominately reported charges of the dentists in a particular community for a specific dental procedure and the purposes of the party making the designation. The designated value of the

customary fee for a particular community will vary greatly depending on the computational parameters selected and the intent of its use.

and be it further

Resolved, that it is inappropriate to assign or communicate values for "usual" and "reasonable" fees based on a sample of a dentist's charging history that is less than complete for a given period, and be it further

Resolved, that the use of the term "customary" or "UCR" to justify denial of a claim or communicate with patients or dental benefit plan purchasers is inappropriate due to the arbitrary and prejudicial manner in which it can be designated, and be it further

Resolved, that the ADA should communicate these definitions to insurance regulators, consumer advocacy groups, and dental benefits administrators to encourage the proper use of these terms, and be it further

Resolved, that the current policy on definitions of usual, customary and reasonable fees (*Trans.*1973:668; 1981:574; 1987:501) be rescinded.

BOARD COMMENT: The Board appreciates the New Mexico Dental Association's desire to clarify the fee definitions used in reporting to dental benefit carriers. The Board is aware that the Council on Dental Benefit Programs (CDBP) is scheduled to review this policy at its November 2009 meeting and, therefore, recommends that Resolution 79 be referred to CDBP for study and report to the 2010 House of Delegates.

BOARD RECOMMENDATION: Vote Yes on Referral.

BOARD VOTE: UNANIMOUS.

WORKSHEET ADDENDUM

POLICY TO BE RESCINDED

Usual, Customary and Reasonable Fees (1987:501)

Resolved, that the following definitions of usual, customary and reasonable fees be adopted:

Usual fee is the fee which an individual dentist most frequently charges for a specific dental procedure.

Reasonable fee is the fee charged by a dentist for a specific dental procedure which has been modified by the nature and severity of the condition being treated and by any medical or dental complications or unusual circumstances, and therefore may differ from the dentist's "usual" fee or the benefit administrator's "customary" fee.

Customary fee is the fee level determined by the administrator of a dental benefit plan from actual submitted fees for a specific dental procedure to establish the maximum benefit payable under a given plan for that specific procedure.

and be it further

Resolved, that the current definitions of usual, customary and reasonable fees (*Trans*.1973:668; 1981:574, 575) be rescinded.

Resolution No. 80 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2009

Submitted By: Eighth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: Substantial

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

GUIDELINES FOR SELF-APPLIED TOOTH WHITENING PRODUCTS

The following resolution was submitted by the Eighth Trustee District and transmitted on September 17, 2009, by Mr. Robert A. Rechner, executive director, Illinois State Dental Society.

Background: An increasing number of states are attempting to protect the public from a growing non-dental tooth whitening industry by legislating that non-dentists cannot apply or assist a person in applying tooth whitening material being sold as a safe alternative to dental office whitening procedures. Illinois and other states have been successful in limiting non-dentists from putting their hands in the mouth or applying tooth whitening materials but have faced resistance from legislators for an outright ban on selling tooth whitening products since they are available over-the-counter. The strength of the products varies greatly, but it appears that they range from 3% to 14% peroxide. While a ban on selling products containing peroxide is unrealistic given the commercial market, an argument could reasonably be made that only a dentist should be selling or applying a chemical agent for tooth whitening over a certain percentage of peroxide in order to protect the public. Anecdotal evidence suggests that kits containing up to 35% peroxide are commonly sold to customers in shopping malls and spas.

As reported in a joint paper prepared by the ADA Divisions of Government and Public Affairs, Dental Practice/Professional Affairs, Science, and Legal Affairs titled *Tooth Whitening Service by Non-Dentists*, "Major safety problems associated with tooth sensitivity, soft tissue irritation and two cases of reported enamel damage (in 1991 and 1998), as well as indirect safety problems related to peroxide diffusing to the pulp have been reported in the literature. A recent systematic review of home-based chemically-induced whitening of teeth in adults found tooth sensitivity and gingival irritation were the most common side effects reported by 18 out of 28 studies. Gingival (gum) irritation was more frequently reported after use of whitening gels delivered in trays. Studies show that the risk for developing these side effects increases with higher bleach concentrations and more frequent bleach applications… Bleaching agents that are used inappropriately have the potential to cause injury to oral health. For example, studies show that bleaching can damage tooth structure and that this risk increases with longer bleach application times and higher bleach concentrations. Bleaching agents have also been shown to penetrate into dentin with unknown effects on the dental pulp particularly for patients with cervical abrasion or leaking restorations. For these reasons, it is important to carefully monitor patients during the bleaching process and the interval between applications."

A scientific analysis of the safe levels of bleaching agents in materials used by the public needs to be conducted so that legislative bodies feel confident that dentistry has the best interests of the patient as its ultimate concern.

Resolution

80. Resolved, that the ADA's Council on Scientific Affairs direct that research be conducted by the appropriate ADA agency on the safe levels of bleaching agents used for tooth whitening, and be it further

Resolved, that the Council on Scientific Affairs develop guidelines regarding the maximum level of bleaching agent in tooth whitening products that could safely be self-applied by the public, and be it further

Resolved, that these guidelines be published and distributed to constituent societies in order to assist states in their efforts to effectively advocate for the protection of the public.

BOARD COMMENT: The intent of this resolution is laudable, but the complexity involved in doing the desired research explains why the research conducted to date has not completely addressed all aspects of safety. Comments obtained from experts in the field through the Division of Science highlight some of the obstacles:

- The bleaching agent concentration in tooth whitening products is *not the sole risk factor*, and may not be the most important risk factor. Known risks with tooth bleaching are numerous, including pH and formulation/delivery methods among others. Additionally contraindications, frequency and duration applications, total application time and compliance with instructions for use are important variables. Adequate control of these factors is an implausible task for OTC bleaching products.
- Designing and conducting research on OTC bleaching products that adequately represents the intended scenario described in Resolution 80 may not be possible. The "Hawthorne Effect" is an important phenomenon in clinical research, where subjects tend to improve an aspect of their behavior being experimentally measured. OTC products are generally used without the direction of a health care professional, while any clinical research on the products must involve professionals. Therefore, the Hawthorne Effect may influence outcomes of OTC bleaching research significantly.
- The objective of the proposed research should be considered in light of the Council on Scientific Affairs Supplemental Report 1 to the House of Delegates—Response to Assignments from the 2008 House of Delegates (Worksheet:3056) on Treatment Considerations for Dentists Prior to Tooth Whitening Procedures developed in response to Resolution 73H-2008 (*Trans*.2008:476). This comprehensive review of available credible research on tooth bleaching clearly shows that the involvement of dental professionals is imperative in order to maximize benefits while minimizing the risks of tooth bleaching treatment. This report updates and significantly expands the scientific information included in the advocacy document *Tooth Whitening Service by Non-dentists*. The Council report will be distributed to the constituent societies in September.
- The potential financial impact of Resolution 80 would be substantial. Laboratory studies would not effectively address the safety issue and therefore are not mentioned further. If appropriate studies could be designed and conducted, the rough estimated cost of one product/concentration of one active ingredient in 100 patients for six months could be as much as $500,000 or more. If studies can be designed and approved by patient safety review boards, the research program would be measured in tens of millions of dollars in addition to personnel costs.

The report is intended to assist the constituent societies in the advocacy efforts and will provide the basis for the ADA to petition the U.S. Food and Drug Administration (as called for in Resolution 73H-2008) to properly classify tooth whitening/bleaching agents. FDA classification of these products would appropriately place the burden on the manufacturers to demonstrate their safety.

In light of the issues involved in ADA undertaking the research called for in this resolution, the Board recommends referral to the appropriate ADA agencies to assess what further scientific support might be feasible in connection with the FDA petition and to advocate on behalf of the appropriate FDA regulation of these products in collaboration with consumer groups and other interested parties as feasible.

BOARD RECOMMENDATION: Vote Yes on Referral.

Board Vote:

Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LONG	■	☐	☐	☐	SYKES
■	☐	☐	☐	ELLIOTT	■	☐	☐	☐	MANNING	■	☐	☐	☐	TANKERSLEY
■	☐	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	■	☐	☐	☐	THOMPSON
■	☐	☐	☐	GIST	■	☐	☐	☐	RICH	■	☐	☐	☐	VERSMAN
■	☐	☐	☐	GLECOS	■	☐	☐	☐	SCHWEINEBRATEN	■	☐	☐	☐	VIGNA
☐	☐	☐	■	KREMPASKY SMITH	■	☐	☐	☐	STEFFEL	■	☐	☐	☐	WEBB
■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN					Res. 80

Resolution No. 80S-1 New ☐ Substitute ■ Amendment ☐

Report: NA Date Submitted: October 2009

Submitted By: Eighth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

SUBSTITUTE FOR RESOLUTION 80:
GUIDELINES FOR SELF-APPLIED TOOTH WHITENING PRODUCTS

The following substitute for Resolution 80 (Worksheet:3078) was submitted by the Eighth Trustee District and transmitted on October 2, 2009, by Mr. Robert A. Rechner, executive director, Illinois State Dental Society.

Resolution

80.S-1. Resolved, that the ADA Council on Scientific Affairs, in conjunction with the Council on Government Affairs, actively pursue that research be conducted by the appropriate federal agency on the safe levels of agents used for tooth whitening, and be it further

Resolved, that the Council on Scientific Affairs develop guidelines regarding the agents used in tooth whitening products that could safely be self-applied by the public, and be it further

Resolved, that these guidelines be published and distributed to constituent societies in order to assist states in their efforts to effectively advocate for the protection of the public.

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

Resolution No. 81 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2009

Submitted By: Sixteenth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

RESOLUTION OPPOSING EXTERNAL DETERMINATION OF FEES FOR NON-COVERED DENTAL SERVICES

The following resolution was submitted by the Sixteenth Trustee District and transmitted on September 21, 2009, by Mr. Phil Latham, executive director, South Carolina Dental Association.

Background: Third-party dental coverage has allowed more patients to afford dental care. Third-party payers have the contractual ability to set maximum fees for covered services, and now they seek to **establish maximum fees for services they do not cover**. These restrictive policies are being advanced under the guise of "added value," "consistency" or "market and subscriber pressures." In reality, these policies represent competitive marketing tools designed to sell more policies and attract more subscribers.

These maximum fee policies for non-covered dental services will confuse patients and add another barrier to successful delivery of dental care by (1) compelling the dentist to obtain a waiver from the patient before providing or billing for non-covered services and (2) potentially requiring the dentist to submit a claim for non-payment and for no constructive purpose.

Rhode Island already has enacted legislation to prohibit this practice, and several other states are developing similar legislation. Although the Association is working to prohibit these policies on a national level through enactment of the "Health Care Value and Transparency Act of 2009," there currently is no ADA policy on this issue. Therefore, be it

Resolution

81. Resolved, that, as a matter of policy, the American Dental Association opposes any contract provision that establishes fee schedules for non-covered dental services, and be it further

Resolved, that the Association encourages and supports efforts by its constituent societies to seek legislative remedies prohibiting these contract provisions.

BOARD RECOMMENDATION: Vote Yes.

1

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LONG	■	☐	☐	☐	SYKES
■	☐	☐	☐	ELLIOTT	■	☐	☐	☐	MANNING	■	☐	☐	☐	TANKERSLEY
■	☐	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	■	☐	☐	☐	THOMPSON
■	☐	☐	☐	GIST	■	☐	☐	☐	RICH	■	☐	☐	☐	VERSMAN
■	☐	☐	☐	GLECOS	■	☐	☐	☐	SCHWEINEBRATEN	■	☐	☐	☐	VIGNA
☐	☐	☐	■	KREMPASKY SMITH	■	☐	☐	☐	STEFFEL	■	☐	☐	☐	WEBB
■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN				Res.	81

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: ADAF, CAPIR, CGA and CC Joint Report Date Submitted: September 2009

Submitted By: ADA Foundation, Council on Access, Prevention and Interprofessional Relations, Council on Government Affairs and Council on Communications

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

JOINT REPORT OF THE ADA FOUNDATION, COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS, COUNCIL ON GOVERNMENT AFFAIRS AND COUNCIL ON COMMUNICATIONS TO THE HOUSE OF DELEGATES: GIVE KIDS A SMILE DAY AND EXPANSION ACTIVITIES

Background: This is a joint informational report to the ADA House of Delegates providing an overview of Give Kids A Smile (GKAS) Day and the related expansion activities of the program.

Give Kids A Smile Day

Council on Access, Prevention and Interprofessional Relations

Give Kids A Smile Day Background: Since its approval by the Board in 2002, and its inception in 2003, GKAS has emerged as the ADA's signature access to care program, exemplifying dentists' patient focus and charitable orientation and keeping the public health promise of the ADA's Mission Statement. By voting in 2002 to approve a program promoting the provision of free dental care, screening and education to underserved children, the Board and House signaled an even stronger commitment to addressing the access-to-care issue. During the ensuing seven years, access to oral health care has emerged as a key issue, both with policy-makers and dentistry. The remarkable success of Give Kids A Smile has provided a platform from which dentistry can engage in discussions with policymakers. As evidence by GKAS programs across the country, dentists care about providing dental services to the underserved; however, volunteerism is not a health care system. Adequate funding needs to be provided for dental services provided under public health programs.

From the beginning, the program was envisioned as having two components: first, dental team members would donate large amounts of care on a single day; they would be encouraged to brand those access activities as GKAS events; and the ADA would be able to aggregate those charitable endeavors more effectively than in the past; second, the results of the campaign, combined with the message that charitable activities, no matter how widespread, do not constitute an oral health care system sufficient to address the unmet needs of children from low-income families, would be communicated to policy-makers.

The 2002 House of Delegates adopted the following resolution (*Trans*.2002:384):

> **29H-2002. Resolved,** that the ADA conduct and fund an annual "Give Kids A Smile!" campaign and annually report to the Board of Trustees at its June meeting and to the House of Delegates on the results of that campaign.

The campaign was initially funded at $261,500, an amount that had been reduced to $148,200 in 2009.

The seventh annual program took place February 6, 2009.

Results: Program participation trends continue to be impressive. In 2009, more than 46,000 dental team members registered on ADA.org to participate. That total included more than 12,000 dentists and 33,000 other volunteers: hygienists, dental assistants, office managers, spouses, school health nurses, dental students, etc. Some 1,700 programs signed up to participate in the program. It is likely that some multi-year participants no longer are registering and accessing planning toolkits because they are familiar with the program, so the above numbers may understate program participation. The number of programs is slightly fewer than the previous year, most likely because smaller, individual programs are combining with larger, more established programs throughout the year. Registered participants estimated that they treated more than 450,000 children. Care was valued at approximately $30 million. The GKAS team is working with staff from the Survey Center and Information Technology to improve data collection and analysis. As the data is studied, the results will enable the ADA to make data driven decisions, which in turn will improve the quality of the program delivery. By any measure, 2009 program results are impressive and indicate strong support by dental team members.

The 2009 national GKAS press event was held in St. Louis at the St. Louis University Center for Advanced Dental Education. Dr. John Findley welcomed sponsor representatives and praised the St. Louis GKAS team for its hard work in planning a first-class event. Approximately 550 children received dental care valued at $431,000. In Miami, Dr. Ronald Tankersley participated in a national satellite media event with Dr. Maria Lopez Howell, ADA media spokesperson. Broadcast news outlets in 22 markets, including Los Angeles, Detroit, Cincinnati and Charlotte, NC, interviewed the ADA spokespersons. Dr. Howell also conducted several interviews for Spanish-speaking television and radio stations. As a result of the satellite media tour, GKAS segments aired in 112 markets to an estimated four million viewers. Additionally, several hundred GKAS news and feature items appeared in local print and broadcast media outlets. National outlets, including Reuters*, Associated Press, McClatchy-Chicago Tribune News Service* and *CNN Money* carried GKAS items.

Corporate Sponsorship: Corporate support in 2009 again was a key element in the program's success.

- Henry Schein Dental donated 3,000 professional product kits containing products for screening and prevention. Each kit provided enough supplies to treat 50 children.

- DEXIS Digital X-Ray provided one DEXIS Digital X-ray System to each of the 56 U.S. dental schools requesting help for GKAS, as well as support staff to assist in taking X-rays.

- Colgate-Palmolive Co. supplied 300,000 toothbrushes and 300,000 tubes of toothpaste for children at GKAS events.

In summary, Give Kids A Smile Day continues to be a signature program for dentistry. The good works, charitable care and impressive results that characterize the program should continue to boost dentistry's image and provide a strong advocacy platform. Just as important, the program continues to energize members and staff. Anecdotal accounts from dentists reflect a high degree of personal reward as a result of participation, which translates into good will for organized dentistry. The program also continues to improve the ADA's relations with the public health community and the dental industry.

Give Kids A Smile Program Expansion

ADA Foundation

Background: Given the program's increasingly impressive results and the heightened awareness of access to care as a public policy issue, in December 2006, the Board of Trustees adopted Resolution B-110-2006, intended to raise the program's profile and expand it from "more than just a day," to a year-round event. As part of that initiative, a National Advisory Board was formed, with goals of: stimulating collaboration and coalition building to address children's unmet oral health care needs; implementing an expanded fundraising program to financially and otherwise assist new and existing community-based local and regional access to care programs; and enabling the ADA and others to effectively advocate for better access to oral health care for all children, but in particular children from low income families.

The Give Kids A Smile National Advisory Board is accountable to the ADA Foundation Board for adherence to the ADA Foundation mission and goals; appropriate use of the GKAS fund; successful management of the promising practices symposium and overall growth of the program.

The National Advisory Board members are: Mr. Steve Kess, chair, vice president, Global Professional Relations, Henry Schein, Inc.; Dr. C. Moody Alexander, private practice; Ms. Cheryl Burke, director, CHC, Professional Sales & Marketing, Johnson & Johnson; Dr. William R. Calnon, trustee, Second District, ADA; Dr. Peter J. Carroll, member; Council on Communications, ADA; Dr. Burt Edelstein, chair, Children's Dental Health Project; Dr. Ernest Garcia, member, Board of Directors, ADA Foundation; Ms. Cynthia Hearn, senior vice president, Marketing, CareCredit; Dr. Robert C. Henderson, member, Board of Directors, ADA Foundation; Mr. Robert Joyce, president, Americas, Danaher Dental Equipment; Mr. Gary W. Price, chief executive officer, Dental Trade Alliance; Dr. Kathleen Roth, past president, ADA; Dr. Jeffrey Stasch, member, Council on Access, Prevention and Interprofessional Relations; and Dr. Wayne Thompson, trustee, Twelfth District, ADA.

The expansion of GKAS requires collaboration with organizations that provide oral health services to children through community health centers, voluntary clinics, private programs and public-private partnerships. The expansion aims to help community-based programs be more effective so they can reach more children in need. With that in mind, the GKAS National Advisory Board and the ADA Foundation Board approved the following mission statement:

> We are the professional and industry alliance dedicated to the elimination of cavities in U.S. five year olds by 2020 through our ability to nurture, empower and showcase community based prevention and care programs.

In an effort to nurture, empower and showcase community based prevention and care programs, the GKAS National Advisory Board established four Committees: 1) Promising Practices Symposium Committee; 2) Fundraising Committee; 3) Program Enhancement Committee and 4) Marketing Communications Committee. A brief description of each committee's accomplishments throughout 2009 is listed below:

Promising Practices Symposium Committee. On June 25-26, 2009, the ADA and its generous co-sponsor, the Dental Trade Alliance Foundation (DTAF), hosted the third GKAS symposium, "Maintaining Momentum through Continuity of Care: Finding Dental Homes for America's Children." A very participatory audience of 130 people, from as far away as Alaska and Hawaii, came together to hear 18 dynamic speakers. Of these attendees, 80% had not attended a GKAS symposium before. As in previous years, the written proceedings will be compiled and posted on ADA.org. This helps attendees share the information they gathered at the Symposium and helps non-attendees benefit from the materials they were not able to hear first-hand. This year's Symposium focused on finding dental homes for underserved children who receive preventive care via GKAS, so those children can receive regular rather than episodic care. The DTAF is in the process of considering a similar commitment to a GKAS symposium for 2010.

Fundraising Committee. As part of the fundraising efforts, foundations have been approached and asked to earmark funds for GKAS grants, and it is hoped that corporate members and others on the program's Advisory Board will participate in fundraising efforts. Other corporations with which the ADA and ADA Foundation have relationships also will be approached and encouraged to support the program. One of the ADA Business Enterprises, Inc. (ADABEI) endorsed partners, CareCredit, is the founding donor of the GKAS Fund and has made three $100,000 contributions. Colgate has made two annual $100,000 contributions. The current GKAS Expansion fund balance as of June 30, 2009, is $535,404.

The second *Give Kids A Smile Program Growth Grant Program* offered opportunities for national health and human service organizations to enhance their participation in Give Kids A Smile. The objective of the 2009 grant program was for national organizations to fund their state/local affiliates' GKAS activities in order to grow their capacity to serve children and inspire GKAS participation. Three national organizations each received $20,000 GKAS grants:

- Hispanic Dental Association
- National Dental Association
- Oral Health America

Awards Gala. The 2009 Gala, held at the Library of Congress, was a success despite fewer attendees and less corporate sponsorship than in 2008. Factors driving these results probably included the state of the U.S. economy and the proximity of the ADA's 150th Anniversary event just four and one-half weeks later. A total of $199,900 was raised through sponsorships and individual seats for a net of $45,700 after expenses. Expenses were considerably higher in 2009, largely as a result of having to hold the reception and dinner in a relatively expensive venue. This was necessitated because the Gala timing was under review and that delay resulted in fewer venue selections. Attendance at the dinner was 230, with 400 attending the reception.

It is hoped that the reception, which for the first time was open to all Washington Leadership Conference (WLC) attendees, will in the future grow in size and give GKAS a higher profile with WLC attendees. As a means of comparison, the 2008 Gala netted $231,350 after expenses because of larger and more numerous sponsorships, a larger number of individual seat sales and lower expenses. Aside from financial results, the Gala continues to be an excellent opportunity for the GKAS community to come together and celebrate the program. The number of members of Congress attending increased markedly over 2008, especially at the reception, where two high-visibility Senators, Susan Collins (R-ME) and Russ Feingold (D-WI), were recognized by the ADA. Representative Mike Ross (D-AR) also was recognized at the dinner, which additionally serves as a forum for awarding grants from the ADA Foundation's GKAS Fund. The GKAS National Advisory Board's Gala Subcommittee will continue to work closely with the WLC Planning Committee regarding future GKAS gala plans.

Program Enhancement Committee. GKAS Program Champions are established national oral health programs which collaborate with GKAS to enhance children's oral health. In 2009, two additional programs were approved as GKAS Program Champions: American Academy of Pediatric Dentistry's (AAPD) Head Start Dental Home Initiative and The National Museum of Dentistry. America's Dentists Care Foundation/Missions of Mercy, a GKAS Program Champion, and TeamSmile, which are non-profit organizations, both received $20,000 grants this year. The Committee continues to nurture existing Program Champions and research potential new champions.

Marketing Communications Committee. A Marketing Communications Committee was formed by the National Advisory Board at its meeting in January 2009. The communications plan for moving forward is broken out into three sections: 1) resource development, 2) constituent development (target markets) and 3) brand awareness and recognition (social networking). Ten public relations goals were set for 2009 including outreach to print and electronic media. The first-ever GKAS Public Service Announcement (PSA), which was filmed with St. Louis Cardinal first baseman, Albert Pujols (who generously donated his time) in October 2008

and launched in January 2009, has had a total of 20,632 television airings nationwide. When compared to rates charged for advertising, the many free of charge broadcasts of the GKAS PSA featuring Albert Pujols garnered an estimated $1 million in free publicity. The National Advisory Board continues to explore opportunities for Albert's continued involvement with the program. A new Give Kids A Smile microsite was also launched in 2009 in collaboration with the launch of the PSA. The new site address, GiveKidsASmile.ada.org, is in an introductory stage and will be enhanced as the program expands. The microsite includes the PSA by Albert Pujols, an educational component and resource information on how to find care for a child.

On July 30-31, 2009, representatives of the GKAS National Advisory Board, its committees and program champions, attended a special Momentum Building Meeting. This time was set aside for the group to set a strategic focus for the GKAS Expansion. The next National Advisory Board meeting is scheduled for Monday November 2, 2009.

In summary, the Give Kids A Smile National Advisory Board and champions in industry and the dental community are committed to expanding the program's scope to affect lasting change which will enable year-round care for America's children who may otherwise receive little or no service.

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: CAPIR Supplemental Report 4 Date Submitted: September 2009

Submitted By: Council on Access, Prevention and Interprofessional Relations

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy; Lead in the Advancement of Standards (Required)

COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS SUPPLEMENTAL REPORT 4 TO THE HOUSE OF DELEGATES: UPDATE ON THE COMMUNITY DENTAL HEALTH COORDINATOR PILOT PROGRAM

Brief Summary: This informational report provides an update on the Community Dental Health Coordinator (CDHC) Pilot Program, including a chronology of the development of the CDHC, progress made before and after the transfer of the management of the project to the Council on Access, Prevention and Interprofessional Relations (CAPIR), a description of the process and approach CAPIR has taken in managing the program, a description of current field activities and operations of pilot training sites, efforts to identify outside funding to support the project, an update on the evaluation and a financial report.

Chronology of the Development of the CDHC Project:

- 2004: In June 2004, the ADA Board of Trustees approved funding for a task force to develop strategies for the ADA to address proposals for new workforce models and to build on the Association's efforts on access and workforce (*Trans.*2004:216). The Workforce Models Task Force was charged to analyze all of the available data and information regarding the adequacy of the current workforce to meet the access needs of the underserved in both rural and urban settings and develop a position paper with recommendations and solutions to address the concerns. The Board's action was reported to the 2004 ADA House of Delegates in Board Report 18 (*Supplement 1* 2004:4088).

- 2005: Report 15 of the Board of Trustees to the House of Delegates: Dental Workforce Models (*Supplement 2* 2005:6002) was considered by the House. In the report, the Workforce Models Task Force proposed five classifications of dental assistants and two classifications of dental hygienists. Included was the "community dental health aide," a proposed allied dental team member with preventive skills and who could provide basic restorative procedures under a dentist's supervision in community-based settings. The Task Force's report was discussed and debated at both the Reference Committee on Dental Workforce and the House of Delegates. The House adopted Resolution 85H-2005 (*Trans.*2005:300), calling for a new 19-member task force to collect and review existing data, develop additional information and report to the 2006 House of Delegates.

  In a separate but related resolution, the House also adopted Resolution 96H-2005 (*Trans.*2005:343), which called for the President to appoint a committee to define, develop and evaluate a training and certification process for community-based oral health aides who would function under the supervision of a dentist.

- 2006: In April 2006, the Chair of the Resolution 96H-2005 Committee, Dr. Perry Tuneberg, reported to the Board the Committee's progress developing core competencies for the new position. He noted that the Committee had determined that the term "Community Dental Health Coordinator" would better describe this new auxiliary role.

- In June 2006, the Board considered a report of the ADA Dental Workforce Task Force 2006 (*Supplement 2* 2006:5000) which was subsequently forwarded to the 2006 House of Delegates. The report recommended four categories of allied dental workforce personnel: dental assistants, oral preventive assistants, dental hygienists and community dental health coordinators. The House of Delegates adopted Resolution 3H-2006 (*Trans*.2006:306), supporting the models as presented in the report, with the exception that references to "formal education" and "Certification Required" throughout the report be changed to "additional education and a certificate of completion as determined by each state board of dentistry." The resolution also called for the appointment of a task force to develop and test the Oral Preventive Assistant model and to report progress to the 2007 House of Delegates.

  In a separate report, the Resolution 96H-2005 Committee outlined its progress and recommended the establishment of the National Coordinating and Development Committee (NCDC) to create the Community Dental Health Coordinator model training program, including a complete curriculum with implementation and evaluation guidelines. The House was supportive and adopted Resolution 25H-2006 (*Trans*.2006:308), directing the appointment of the NCDC to oversee the project, including implementation of at least three pilot programs, with a progress report to the 2007 House of Delegates. The estimated cost for development of the model training program was $334,000. The ADA Foundation Board of Directors committed the funding to support the development of the model.

- The Board of Trustees considered a Progress Report on Workforce Initiatives at its December 2006 meeting. The report included information on members appointed by ADA President, Dr. Kathleen Roth, to the NCDC (Dr. Robert, Brandjord, chair, Dr. Amid Ismail, Dr. Vincent Filanova, Dr. Kathleen O'Loughlin and Dr. John McFarland) and the Curriculum Committee (Dr. Amid Ismail, chair, Dr. Carol Turner, Dr. Paul Glassman, Ms. Joanne Nyquist, Dr. Robert Weyant and Dr. Judith Skelton).

- 2007: ADA President, Dr. Mark Feldman, appointed members to two CDHC-related committees in late 2007 to support the work of the NCDC. The CDHC Implementation and Evaluation Committee, chaired by Dr. Carol Turner, was charged with oversight of the Pilot Project. The CDHC Philanthropic Committee, chaired by Dr. Vince Filanova, was charged to explore and indentify potential funding sources to support the pilots. Drs. Mark Feldman, John Findley and Robert Brandjord served as *ex officio* members of both committees.

- The House received Report 14 of the Board of Trustees: Update on the Allied Dental Personnel Workforce Models (*Supplement 2* 2007:5053). At that time, the House adopted Resolution 54H-2007 (*Trans*.2007:383), encouraging the NCDC to complete the development of the curriculum and pilot and evaluate the model in at least three sites, allocating up to $2,000,000 from reserves to fund the pilots and encouraging the Committee to seek additional funding to complement the ADA funding where feasible, and directing that the Board of Trustees provide a progress report to the 2008 House of Delegates.

- 2008: The Board considered a progress report, Update on Workforce Models: Community Dental Health Coordinator and Oral Preventive Assistant Projects, in April 2008. The report described the selected pilot sites for the CDHC program (University of Oklahoma for rural, UCLA for Native American and University of Michigan for urban) and the progress related to the creation of the OPA curriculum. A draft communications plan for the CDHC Program was also included.

- In June 2008, members of the CDHC Implementation and Evaluation Committee (Dr. Carol Turner, chair, Dr. Amid Ismail, Dr. Dunn Cumby, Dr. John McFarland and Dr. Robert Brandjord, *ex officio),* reviewed two independent research agencies' proposal to conduct the evaluation component of the CDHC pilot project.

- The 2008 ADA House of Delegates received Report 10 of the Board of Trustees: Update on the Community Dental Health Coordinator Pilot Program (*Supplement 2 2008:4037*). The report outlined the current funding status as well as anticipated additional financial implications for ongoing operations and evaluation. The report described the activities and conclusions of the CDHC Implementation and Evaluation Committee. It also included a recommendation that the ADA commit to long term financial support of the program. Dr. Robert Brandjord also made a presentation to all interested delegates. The House adopted Resolution 39H-2008 (*Trans.2008:424*) which reads as follows.

  39H-2008. **Resolved**, that the ADA commit up to $5 million to support the continuation of the CDHC pilot programs in order to evaluate the effectiveness of the CDHC model, and be it further

  Resolved, that the ADA identify outside funding for the three pilot sites, project support, equipment and supplies, and be it further

  Resolved, that as soon as possible the CDHC curriculum modules be made available for possible integration into expanded function dental assistant programs, and be it further

  Resolved, that the ADA assist states as they develop workforce models, and be it further

  Resolved, that the CDHC Philanthropic Committee and the CDHC Implementation and Evaluation Committee report with a financial update annually and outcomes assessment when available to the House of Delegates for the duration of the pilot program.

- The Board received another update report at its December 2008 meeting. The report noted the potential transfer of the urban pilot training site from Detroit to Philadelphia, under the leadership of Dr. Amid Ismail and included a letter of support regarding this transfer from the Michigan Dental Association. The ADA Foundation's additional support of $250,000 over five years was also described.

Licensing Agreements Requests to Date: Pursuant to the directive of the House of Delegates in Resolution 39H-2008 that the CDHC curriculum modules be made available as soon as possible, the development of a template CDHC preliminary curriculum license was completed in early 2009 before the transfer of program management to the Council on Access, Prevention and Interprofessional Relations (see below). Under the license, constituent societies will receive a limited non-exclusive three-year license to use the preliminary CDHC curriculum to develop, implement and conduct training programs within the jurisdictional limits of the licensed constituent, with the right to sublicense third parties for the purposes of training individuals within jurisdictional limits of the constituent. The template license specifies that material changes to the preliminary CDHC curriculum can be implemented only with prior approval of the ADA. In addition, under the license all use of the licensed preliminary curriculum must be for non-profit purposes. To date, inquiries on the licensing of the preliminary CDHC curriculum have been received only from the Arizona Dental Association (the AzDA) and New Mexico Dental Association (NMDA). No final action has been taken with respect to either inquiry.

Transfer of the Management of the CDHC Pilot Program to the Council on Access, Prevention and Interprofessional Relations: In February, the ADA Board of Trustees adopted Resolution B-14-2009 which reads as follows.

B-14-2009. Resolved, that the CDHC be placed under the primary purview of the Council on Access, Prevention and Interprofessional Relations (CAPIR), and that CAPIR shall work with the Council on Dental Education and Licensure and the Council on Dental Practice.

CAPIR's *Bylaws* duties state that a key role for the Council is to evaluate for the ADA trends in dental public health and access to care that enhance community oral health. They also charge the Council to provide advice and technical assistance to constituencies and communities in the core public health competencies of assessing community oral health need; in the design, implementation and evaluation of programs to meet identified need; and in building community oral health infrastructure and capacity to address access to care needs and prevention needs at the community level.

After the Board of Trustees adopted Resolution B-14:2009, CAPIR staff met with CDEL staff to begin transition planning. A transitional management plan was developed with input from the CAPIR Chair and Vice Chair and position description questionnaires were developed to add additional staff. The Chair has designated Dr. David Holwager, CAPIR member from the Seventh Trustee District, to assume a lead role in working with Council staff on the project. More details are provided below.

Official Launch: The pilot CDHC workforce initiative officially launched March 6-7, 2009, with a kickoff meeting at the University of Oklahoma College of Dentistry (OU). Twelve CDHC students participated. Dr. John Findley and Dr. Wayne Thompson provided opening remarks and reiterated the Association's support for the CDHC project as one of the ADA's proactive initiatives for improving access to oral health. The meeting was an opportunity for students, clinic supervisors, site directors and instructors to meet each other and be oriented about the program.

On March 16, 2009, the first 12 CDHC students in pilot training programs at OU and the University of California-Los Angeles (UCLA) School of Dentistry began their 12 months of online coursework through Rio Salado College in Tempe, AZ. Following the successful completion of this coursework, the students will then begin a six-month supervised internship in a federally qualified health center or Indian Health Service dental clinic.

Challenge by Oklahoma Dental Hygienists Association (ODHA): On April 18, 2009, the ODHA wrote to the State of Oklahoma Board of Dentistry regarding the CDHC program underway at the OU. Specifically, the ODHA requested that "a declaratory ruling be issued from the Oklahoma Board of Dentistry regarding the application and enforcement of the State Dental Act of Oklahoma and Rules and Regulations of the Board as set forth pursuant to Title 59 O.S. 328.1 ET SEQ, Section 1905:3-1-10."

The letter asked the Board of Dentistry to respond to a number of inquiries, such as:

- What statutory provision allows the University of Oklahoma to allow pilot or research programs to teach dentistry to persons who are not dental or dental hygiene students?
- What statutory authority allows the CDHC students to treat Type I gingivitis and scale teeth, apply fluoride and sealants and take radiographs?
- When dentists or dental hygienists participate in the training of the CDHC students, have they violated provisions of the state's dental practice act?

The Board of Dentistry has invited a submission from the University of Oklahoma College of Dentistry, which has formulated a response. It is anticipated that the Oklahoma Board of Dentistry may begin to deliberate on questions raised by the ODHA in November 2009. On August 26, 2009, the Oklahoma Attorney General's office contacted the attorneys at the University for Information about the CDHC program.

CAPIR Deliberations Regarding the CDHC Program: At its June meeting CAPIR spent the majority of its time learning about the CDHC project and developing plans for forward movement. The meeting began with Dr. Wayne Wendling, managing vice president, ADA Health Policy Resources Center and Dr.

John Luther, senior vice president, ADA Division of Dental Practice/Professional Affairs, providing an overview of workforce issues. This was followed by two Council members, Drs. Scott Lingle (MN) and Gary Davis (PA), who served on the Board of Trustees Task Force on the Dental Team discussing the deliberations of that group. Dr. Mary Smith, trustee, Eleventh District, and Dr. Ken Rich, trustee, Sixth District, were also present and fielded questions regarding the Task Force report to the Board of Trustees and the deliberations of the Board.

These discussions were foundational and contextualized the two presentations that followed.

Dr. Dunn-Cumby, from OU, site-director for the OU project and a member of the 2009 CDHC Implementation and Evaluation Committee, provided a history of the project. He described the structure that had been in place to manage the project, the work done by the various committees, and described activities that are currently underway in the field. He identified three key issues which he considered to be immediate and urgent needs of the project in order to assure its success:

- purchasing equipment for the current cohort of 12 students currently enrolled in the program, and clarification of post-pilot ownership of that equipment
- the urgent need for the finalization of an evaluation framework and process for the project
- resolution regarding an urban site

Ms. Nicole Albo-Lopez, Rio Salado College in Arizona, then joined the Council via the phone. She described the online curriculum and the Council was given a tour of the website and the actual mechanics used for teaching the students in the field.

Under the direction of Dr. Lindsey Robinson, chair, CAPIR, the Council initiated a SWOT analysis specific to the CDHC Pilot program. Although not comprehensive, as this was the first time the Council as a whole had an opportunity to discuss the program, it identified the following strengths, weakness, opportunities and threats to the pilot:

- *Strengths.* The curriculum has been developed; there is a broad applicant pool available; the ADA is engaged in program development; CDHCs are prevention focused; the House of Delegates supports and has committed funding; patient safety issues are addressed; and the model is community-based.

- *Weaknesses.* The model was developed without collaboration with other groups; the urban pilot is delayed; no management structure is in place and no active subcommittees are functioning; students are in place without the necessary resources; equipment-related decisions for the students' clinical internships are not final; it's unclear whether adequate referral sources exist to respond to increased demand (FQHCs have unfilled provider vacancies); and although an evaluation was outlined, the contracts for the conduct of the evaluation have not been negotiated.

- *Opportunities.* Collaboration with other ADA councils; potential for rapid expansion of the program; collaboration with public health and FQHCs not previously available; cited in health care reform legislation and the Pew Charitable Trust report; potential funding from outside sources; ADA membership will be seen as publicly active rather than reactive; and it gives the ADA an opportunity for leadership in workforce models.

- *Threats.* Further Medicaid reductions may make alternative workforce models less viable; state licensure issues; although a project management position has been posted it currently is unfilled; an unbiased evaluation process is not in place making outcomes suspect; and the ADA's credibility is at stake.

The Council concluded that there were critical issues that need to be addressed including immediate financial needs and took the following action by approving the following resolutions.

Resolved, that a workgroup be appointed by the Chair comprised of three CAPIR Council members and one representative from the Board of Trustees to establish a management structure for the CDHC program.

Resolved, that CAPIR request the Board of Trustees direct that $2.5 million be immediately transferred from the ADA reserves into the CDHC cost center.

Dr. David Holwager (IN) was appointed by Dr. Robinson to chair the Workgroup. Drs. Eleanor Gil (MS) and Gary Davis (PA) are the two other council members appointed by Dr. Robinson to serve on the Workgroup. Dr. Ken Rich, who had been appointed by President John Findley to serve as the Board of Trustees liaison to CAPIR specific to the CDHC project, is also part of the Workgroup. The Workgroup has met five times by conference calls on June 30, July 7, July 23, August 10 and September 3. Priorities areas were identified. In this very short period of time, a great deal of progress has been made in addressing these needs. Progress made by the CAPIR Workgroup in the following areas is addressed below:

- establishing a management structure for the project
- finalizing plans for an urban site
- addressing issues surrounding the equipment needs and curriculum improvement
- addressing issues surrounding program evaluation and program financing

Establishing a management structure for the project: Shortly after the Council meeting, Dr. Kathleen O'Loughlin informed the Workgroup that ADA human resources would be aligned and directed, as needed, to support the project. With her assistance, the approval of the Workgroup and the CAPIR Chair, a structure that is volunteer driven has been developed. This will allow the project to function within the context of the directives established by the House of Delegates (Appendix 1). Staff from various ADA agencies have been tasked to support the CDHC program. A monthly log of hours spent by each staff member to assess ADA human resource investment in the CDHC program has been created.

At its September 3, 2009, meeting, the CAPIR Workgroup approved specific individuals or types of individuals who should serve on the National Advisory Committee (NAC), the Evaluation Committee, the Education Committee, and the Development/Sustainability Committee (Appendix 2). Invitation letters to appropriate Council Chairs and other individuals to serve on the NAC are being drafted and distributed as this report is being written.

Plans for the Urban CDHC Pilot Site: Addressing access to dental care issues for underserved urban communities has been identified as a critical national priority and one that the CDHC model has been developed to address. In February 2009, the Michigan Dental Association (MDA), while supportive of the CDHC model, determined that MDA did not have the resources to serve as the urban pilot for the CDHC program. The MDA had planned to work with the state legislature to amend the dental practice act to allow for a CDHC to work in Michigan in response to a ruling by the Michigan Board of Dentistry indicating that the practice act would not allow for such. It was anticipated that three dental clinics in Detroit and Jackson would participate in the pilot study. However, following the closure of one of the clinics in Detroit, the MDA concluded that the urban pilot project would best be implemented in another state where facilities and resources are more available to provide the care.

The ADA received a Letter of Intent (LOI) on April 3, 2009, from the Temple University Maurice H. Kornberg School of Dentistry, to implement the urban training program. Due to negotiations on related issues now concluded, consideration of the LOI by the CAPIR CDHC Workgroup was deferred until June 2009. On its first call, the Workgroup was provided an update on the status of the contract with Temple University and informed that all confidentiality agreements had been executed. After a lengthy discussion

regarding the status of the Temple agreement, the Workgroup suggested that a conference call with Rio Salado College and Temple University would be an appropriate next step. On July 14, the conference call was held. Temple University agreed to resubmit a proposal to the ADA to serve as the urban site. Agreement was reached that the first Temple student cohort would commence studies in March 2010.

On July 30, 2009, a second LOI was received from Temple University. Temple's LOI and its accompanying materials have been reviewed by the Workgroup. Many of the proposals made therein were generally acceptable to the Workgroup. There were, however, a few areas where the Workgroup felt modifications were in order. On the September 3, 2009, conference call the Workgroup approved a draft agreement which has been forwarded to Temple for its review. It is anticipated that a final agreement will be in place before the end of the calendar year.

Equipment Needs and Curriculum Improvement: Each student currently enrolled in the project requires the following equipment: a portable delivery system, patient chair, stool with case, portable light, a portable x-ray system, a digital X-Ray system, intraoral camera, sterilizer, ultrasonic unit, instrument supply case and portable folding equipment cart. Students also will need a practice management software system and a Web-based data collection tool that is integrated within the context of an evaluation plan (see below). The pilot commenced without guidance to the Council regarding the purchase of equipment for the first cohort as the ADA leadership had not concluded any agreement regarding corporate donation of equipment to the project.

On its first call on June 30, 2009, the CAPIR CDHC Workgroup discussed the programmatic needs of the first cohort of students. In order for the first student cohort to successfully meet curriculum and training requirements, the Workgroup agreed that it was critical for the appropriate equipment be on site no later than August 1, 2009. The Workgroup directed that equipment orders be placed for the students currently enrolled in the program. There was consensus among Workgroup members that all efforts should be made to donate the equipment to the affiliated clinics upon completion of the pilot. It should also be noted that in the original estimates for the project the laptop computers currently utilized by the first cohort of students were to have been donated. Before the transfer of the program to CAPIR, and to assure that the students were provided with computers in order to begin their online studies, 12 laptop computers were purchased by the ADA directly from Dell for the OU and UCLA students at a total cost of $17,087.

Equipment costs per student were estimated to be $32,836. Additional anticipated costs included practice management software, estimated to be approximately $10,000 for every ten users. These costs were not planned for in the 2009 budget. It was anticipated that the practice management program to be utilized by the CDHC program would integrate with that utilized by both Indian Health Service (IHS) and Federally Qualified Health Centers (FQHC) facilities without incurring significant additional cost.

The Education Committee has been meeting regularly via conference call since the June 2009 Council meeting. Guidelines for suggestions to improving the curriculum revisions have been created; templates for documenting revisions/solutions have been distributed to the Education Committee members so that modifications and enhancements to the curriculum can be vetted and agreed upon before changes are implemented.

Program Evaluation: A proposed comprehensive evaluation plan was developed by the former Implementation and Evaluation Committee (Appendix 3). The purpose of the evaluation is to assess the following four areas: (a) Does the CDHC program contribute to improvement in access to oral health care? (b) Has the CDHC program positively impacted oral health outcomes? (c) Has the CDHC program impacted the financial sustainability of the dental health clinic sites? (d) How can the CDHC initiative be improved post pilot?

In light of the transfer of the program to CAPIR, the Workgroup and the Evaluation Committee will be reconsidering the evaluation component of the project. There must be a very realistic assessment of whether all processes can be in place to conduct the evaluation of the first cohort of students. Based on

the prior experience of one site director and information from an ADA volunteer familiar with processes in the IHS and Tribal Councils, it could take at least one year to receive approval from IHS clinics and Tribal Councils for both data collection instrument and methods, and approval from Institutional Review Boards (IRBs). In addition, CAPIR should consider alternative plans to the original evaluation strategy to help manage the cost of the evaluation.

A preliminary assessment of the evaluation suggests that the budget estimates for the evaluation may have been understated and do not reflect the current reality of the programs. Alternative evaluation strategies are being examined including a scaled back evaluation (Plan B) focused only on evaluation of access and oral health outcomes, and an open evaluation (Plan C). Of particular interest to the Workgroup is the *Plan C* evaluation strategy because*:*

- It appears that the full economic cost of the evaluation would be borne by the ADA under options A (the original plan) and/or B.
- The CDHC program appears to be consistent with other developments in research based on informal conversations at the Health Resources and Services Administration meeting and with the public health dental community.
- The Plan C strategy would entail the ADA approaching various external funding organizations, such as Josiah Macy Foundation, HRSA, Kellogg or others, to provide funding to independent organizations- academic institutions to conduct independent evaluation of the CDHC program focusing on access and oral health outcomes.

If such an approach were taken, the ADA would have no role in selecting the organizations to conduct the evaluations; but the ADA would support the data collection and methods efforts.

Pursuit of industry support for the evaluation of the program was delayed due to unforeseen circumstances and no progress have been made with any of the key entities involved with the original evaluation design since February of 2009. However, the Workgroup and the evaluation committee is in the process of determining if the original entities considered to conduct and fund the evaluation still have an interest in the effort.

Next steps for consideration by the Council and Workgroup regarding the evaluation include, but are not limited to: (1) convening the Evaluation Committee which will be comprised of ADA members and the representatives of the institutions involved in the pilot training programs; (2) meeting with previous entities involved with the evaluation plan to address interest, timing and budget issues; (3) reaching consensus on the appropriate evaluation plan to use; and (4) using Plan C, if there is agreement, to develop the strategy to approach to the foundations, as described above.

Financial Update: The ADAF Board of Directors approved a grant of $50,000 in support of the Community Dental Health Coordinator (CDHC) program for 2009 during its June 12, 2009, meeting. This grant reflects the Foundation's continued support for the CDHC program since its inception in 2006 and moves forward in fulfilling its 2008 pledge of programmatic support as outlined below in Resolution ADAF-B-32-2008.

Resolved, that the ADA Foundation Board of Directors approves a $250,000 pledge, with minimum annual payments of $50,000 each year over a five year period beginning in 2009, in support of the on-going development of the ADA Community Dental Health Coordinator (CDHC) program, and be it further

Resolved, that the ADA Foundation's Finance Committee, beginning in 2009, conduct yearly assessments of the Foundation's financial ability to meet, or exceed, its $50,000 annual pledge payment for the program as well as its aggregate pledge amount. The ADA Foundation restored its CDHC program support of $250,000 over five years.

It should be noted that even though many issues remain to be addressed regarding external financing to support the program ADA Foundation staff has been working with the CDHC staff and volunteers to identify additional sources for funding for the programs. The Foundation began by identifying 18 potential foundation and corporate donors to the program, with a special emphasis on non-dental related foundations. The Foundation has met regularly with CDHC staff, and volunteers where appropriate, to identify potential connections with these prospective donors and to develop next steps for each prospect.

Federal and state support is a possibility. When the ADA worked on developing the CDHC model a career ladder was also developed. In light of current interest at the federal level, this will be promoted, as the CDHC program expands the dental team into the communities. Community health workers are known to increase access to care and by doing so market health care; the current administration is also placing significant emphasis on the community as being part of the health care solution. CAPIR will give serious consideration and devote the necessary time to look at federal grant opportunities that HRSA has in the area of "workforce innovation." The CDHC has a number of characteristics that have been extolled at various meetings sponsored by federal agencies as potential answers to the access dilemma. At a recent meeting with the ADA staff in Washington D.C., the new HRSA Administrator, Dr. Mary Wakefield, made it clear to ADA staff that HRSA is looking to work in new and innovative ways and is looking for opportunities to collaborate with organizations such as the ADA. She expressed interest in hearing more about the CDHC program and the Council will pursue this opportunity.

CDHC students are expected to be working in 2010 in WI, MN, OK, and AZ, with future cohorts in PA. At present, it is not clear whether CDHCs in all of these states will be able to bill Medicaid for their services. In some states, legislation may be necessary to assure recognition of the new provider under state law. In others, the state Medicaid plan may need to be amended.

Based on the general budget developed and presented to the House of Delegates in 2008, anticipated annual expenses for the conduct of the pilot programs through 2012 were reported as follows:

Summary of Funding Required as Reported to the 2008 House of Delegates

	2008	2009	2010	2011	2012	2013	**Total**
3 pilot sites		$636,000	$1,206,000	$1,326,000	$696,000	$126,000	**$3,990,000**
Management of online curriculum	$155,500	$122,000	$183,000	$183,000	$21,000		**$664,500**
Evaluation of Program	0	250,000	250,000	250,000	250,000		**$1,000,000**
Project Support	250,000	200,000	200,000	100,000	100,000		**$850,000**
Equipment and Supplies		$324,000	$486,000	$486,000	$162,000		**$1,458,000**
Total	**$405,500**	**$1,532,000**	**$2,325,000**	**$2,345,000**	**$1,229,000**	**$126,000**	**$7,962,500**

Resolution 54H-2007 (*Trans.2007:383*) committed $2 million from reserves to initiate the pilots. Resolution 39H-2008 then committed up to $5 million to support the continuation of the pilots and to evaluate the model.

A line item budget was not developed before the transfer of the program to CAPIR as decisions needed to be made regarding the location of the urban pilot program, equipment, and evaluation mechanisms. A specific line item budget has now been developed for 2009 and a similar budget has been developed for 2010. It should be noted that the line item budget has been developed in light of past experience and is a best estimate based on current programmatic needs and plans. As described above there remain a great number of unknown variables, at the same time a number of opportunities to garner external funding and/or in-kind contributions to support the program also exist. Line item expenditures and estimates for 2008/2009 equal $2,341,192, which includes an estimated expenditure of $500,000 for web-based data collection. Line item estimates for 2010 equal $2,365,100.

Summary: This informational report provides an update of the CDHC Pilot Program activities. The rural and Native American CDHC pilot training programs at the University of Oklahoma College of Dentistry and the University of California Los Angeles, launched in March 2009 with 12 trainees beginning their online training. The CDHC Pilot Project has been placed under the primary purview of the Council on Access, Prevention and Interprofessional Relations, in collaboration with the Council on Dental Education and Licensure and Council on Dental Practice. Temple University has submitted a request to offer the urban CDHC pilot training program in Philadelphia. Work continues on the design of the pilot program's evaluation component. Efforts to identify companies and foundations that potentially could provide support for the CDHC project also continue.

Resolutions

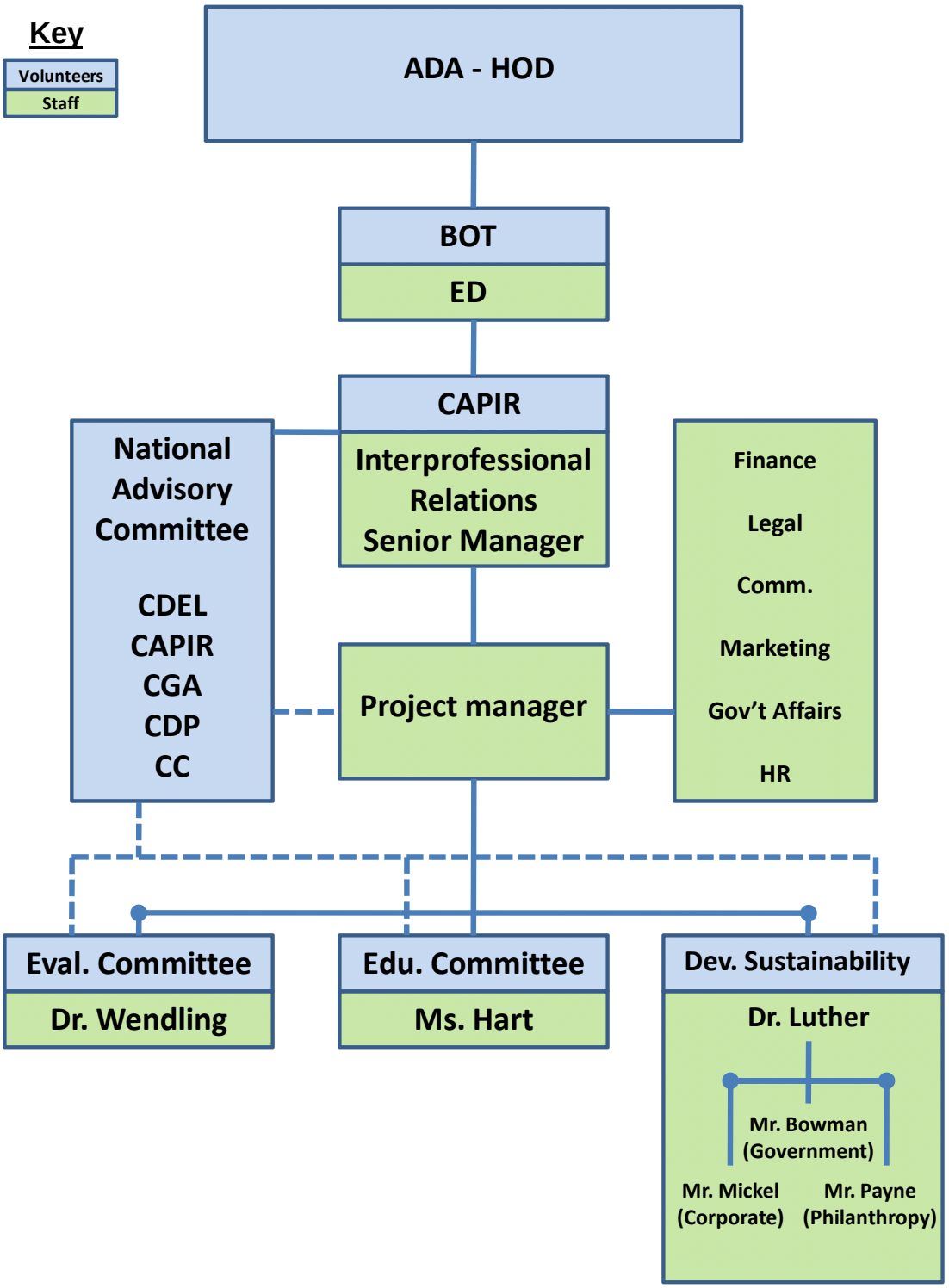
This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS.

1

Appendix 1



2

Appendix 2

CDHC National Advisory Committee Members

- Dr. David Holwager, chair
- Dr. Ken Rich, Board of Trustees liaison
- Representative from each of the following Councils: Council on Dental Education and Licensure, Council on Dental Practice, Council on Government Affairs, and the Council on Communications.
- RADM Carol Turner, DC, USN, RET
- Dr. Jane Grover, representing Federally Qualified Health Center dental directors
- Dr. Jay Anderson, chief dental officer, HRSA
- Dr. Gary L. Pannabecker, Capt., U.S. Public Health Service, chief, Blackfeet IHS Dental Program
- Dr. Chris Halliday,chief dental officer, Indian Health Service
- A Dean of a U.S. Dental School not affiliated with the program
- An individual with community health worker expertise
- A representative of the Centers for Medicare and Medicaid Services and/or a representative of the Medicaid SCHIP Dental Association
- A State Executive Director
- Dr. Kathleen O'Loughlin, ADA executive director (ex-officio)
- ADA President (ex-officio)
- ADA President-elect (ex-officio)
- Staff Support: CAPIR Direct, Senior Manager Interprofessional Relations; and the CDHC Project Manager

Evaluation Committee members:

- Dr. Eleanor Gill, chair
- One site director from each of the pilot sites
- An independent expert in public health program evaluation
- Staff: Dr. Wayne Wendling, managing vice-president, Health Policy Resources Center

Education Committee members:

- Dr. Gary Davis, Chair
- Ms. Nicole Albo-Lopez
- Dr. Angela Ambrosia
- Dr. Nancy Reifel
- Ms. Donna Kotyk
- Dr. Dunn Cumby
- Dr. Rosita Long
- Dr. Amid Ismail
- Dr. Sally Gray
- Dr. Carol Turner
- Staff: Ms. Karen Hart, director, Council on Dental Education and Licensure

Sustainability Committee members:

- Dr. David Holwager, chair
- One representative each from industry, government, philanthropy
- Staff: Dr. John Luther, senior vice-president, Dental Practice/Professional Affairs; Mr. Clay Mickel, managing vice-president, Corporate Relations and Strategic Alliances; Mr. Barkley Payne, executive director, ADAF; Mr. Jerome Bowman, Esq. public affairs counsel, Government and Public Affairs

Appendix 3

Rio Salado College will oversee the evaluation of the educational outcomes, e.g., achievement of competencies, student graduation rates and job placement rates. In June 2008, an independent research agency, the National Opinion Research Center (NORC) at the University of Chicago, was selected by the CDHC Implementation and Evaluation Committee to assess the following:

- number of people who are receiving care at the clinic that is attributed directly or indirectly to the CDHC
- types and mix of services provided to patients recruited by the CDHC
- number of Medicaid recipients who are new patients recruited to the clinic by the CDHCs
- satisfaction of the CDHCs with their tasks
- satisfaction of patients cared for by the CDHC
- quality of life improvement by community members seen by the CDHC
- reduction in untreated disease in patients recruited by the CDHC (interviews, and audit of patient records)
- financial outcomes: cost of the CDHC to the clinic; increased revenues generated by the CDHC
- number of home visits or community activities generated by the CDHCs
- perception of community organizations who have been contacted by the CDHC

NORC is a not-for-profit organization pursuing objective research in the public interest since 1941. The Center has pioneered studies in health, education, economics and demography, substance abuse, criminal justice and other areas of public policy.

The Committee also considered a proposal from another agency, Outcome Sciences, Inc., to create a web-based tool that could provide data collection and reporting to support the community-based care management program and the data necessary for NORC to conduct its evaluation. This agency is a provider of outcomes studies and patient registries with more than 100 programs initiated and more than four million patients enrolled. The company has experience with long-term programs focused on outcomes, quality improvement and departments of public health, healthcare organizations and manufacturers. Clients include the American Heart Association, American Association of Oral and Maxillofacial Surgeons, American Orthopedic Association and the American Society of Plastic Surgeons. Outcomes representatives conducted a webinar presentation for the Committee.

The Committee concluded that NORC and Outcome Sciences, Inc. together would meet the needs of the CDHC Evaluation Project and recommended that the ADA pursue arrangements with NORC to conduct the overall evaluation ($477,000) and a contract with Outcome Sciences, Inc. to develop the clinical care data management system ($550,000) to support the CDHC program and evaluation.

In early 2009, Committee members met with NORC and Outcome representatives separately to further discuss the development of a comprehensive program evaluation, using quantitative and qualitative methods that will address the following four general areas:

Does the program contribute to improvements in access to oral health care?
Has the program positively impacted oral health outcomes?
Has the program impacted the financial sustainability of the dental health clinic sites?
How can the CDHC initiative be improved post pilot?

An initial consulting agreement between the ADA and NORC for $25,000 was executed in February 2009 for the development of outlines for questionnaires to be used in the formal evaluation. To date, there are no agreements between NORC, Outcome Sciences and the ADA to conduct the evaluation. The universities, ADA, and the evaluation agencies will all be required to meet the requirements of their

Institutional Review Boards (IRBs). IRBs are independent bodies who review research design and protocols to assure that research subjects are protected, not put at risk, have a full understanding of the nature of the search and provide informed consent.

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: CDBP Supplemental Report 3 Date Submitted: September 2009

Submitted By: Council on Dental Benefit Programs

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Lead in the Advancement of Standards (Required)

COUNCIL ON DENTAL BENEFIT PROGRAMS SUPPLEMENTAL REPORT 3 TO THE HOUSE OF DELEGATES: SNODENT TERMINOLOGY PROJECT

Background: SNODENT is the Systematized Nomenclature of Dentistry. It is a vocabulary that was designed for use in the electronic health and dental records environment. It was initially developed by the ADA in the mid-1990s. In April 2007, the Board appointed the SNODENT Editorial Panel which began review and update of the clinical descriptors of SNODENT.

SNODENT Update: In 2008, the Board of Trustees dissolved the Editorial Panel and, based on the Council on Dental Benefits Programs' (CDBP) *Bylaws* authority, assigned responsibility for SNODENT to it. Individuals from the former panel were appointed as consultants, all of whom are being utilized by CDBP. The Council believes that the continued participation and expertise of the original panel participants will contribute to the successful development and implementation of the next version of SNODENT.

The CDBP takes its charge very seriously and has been working diligently to ensure that the next version of SNODENT is a complete vocabulary of clinical concepts for ultimate use by the profession. There are many facets to this project that still need to be completed, including preparing/finalizing SNODENT for use by information technology programmers, coordination of activities with the ADA Electronic Health Record Workgroup, selection of potential beta test partners, testing and maintenance.

The Council appreciates the authority it has been given on this important project and will be submitting a detailed report of all related activities to the 2010 House of Delegates.

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: CDP Supplemental Report 1 Date Submitted: September 2009

Submitted By: Council on Dental Practice

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

COUNCIL ON DENTAL PRACTICE
SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES:
RESPONSE TO RESOLUTION 58H-2008—GOING GREEN

Background: This report provides an update about the Council's activities related to "Going Green" and a summary of proposed activities for 2010.

The 2008 House of Delegates adopted Resolution 58H-2008 (*Trans*.2008:474) which directed the Council on Dental Practice (CDP) to "undertake a one-year project to develop a 'Going Green' initiative for the dental office with recommendations that are simple and practical to implement, in order to minimize adverse environmental impacts and promote responsible resource use by the profession." Further, Resolution 58H-2008 stated that "a report on the 'Going Green' initiative be presented to the 2009 House of Delegates." This report reviews progress made in developing a "Going Green" initiative for the dental profession.

Strategy: In response to Resolution 58H-2008, the CDP formed a "Going Green" subcommittee. The subcommittee was appointed in November 2008, met in 2009 and addressed the strategic direction and educational materials to be considered for development by the Council. The work of the subcommittee was organized logically and focused on literature review, consultation with experts in environmental sustainability in the dental office and the development of educational materials related to "Going Green" in the dental office.

Literature Review: The literature examined focused on the soaring consumption of diminishing natural resources, air and water pollution, dentistry's growing impact on burgeoning landfills and the effects of global warming. The "Going Green" movement, which is rapidly becoming a worldwide priority, seeks to address these and other critical environmental issues. Dentistry can lessen its combined environmental impact by utilizing the "Four R's of Going Green," namely "Reduce, Reuse, Recycle, and Rethink."

The "Four R's of Going Green" can be applied to the dental office:

Reduce: The easiest way to have more of a resource is to use less of it; for example, reducing the consumption of disposable items used in dental practice would aid the environment. A simple tip like making two sided printing and copying a standard practice in the dental office can have a significant positive effect.

Re-use: By re-using things instead of throwing them away, resources and energy necessary to manufacture new things are saved. For example, incorporating sterilizable stainless steel suction tips and saliva ejectors can reduce the use of disposables in the dental office.

Recycle: According to the U.S. Environmental Protection Agency, more than 75% of material destined for a landfill could be recycled. Currently recycled materials divert 68 million tons of material from landfills

and incinerators. Many dentists actively recycle dental office paper products; however opportunities exist to recycle aluminum, cardboard, glass and plastics as well.

Rethink: Stopping to think about changes that could be implemented in a more environmentally friendly way is an effective method of incorporating "Going Green" in every day dental practice. In its discussions, the CDP was particularly interested in new "Green" ideas and materials that could be incorporated dental office design, construction and maintenance.

Surveying "Going Green" Options: In March 2009, the CDP staff surveyed members of two of the CDP's standing committees, the Dentist Well Being Advisory Committee (DWAC) and the Ergonomic and Disability Support Advisory Committee (EDSAC). DWAC and EDSAC members were provided with copies of the *San Francisco Green Business Program Standards for Dental Practices*. This comprehensive and exhaustive list of standards for "Going Green" was developed by industry experts, utility companies, pollution prevention professionals, city inspectors and trade associations and is used by dental practitioners in the San Francisco area who seek official recognition as a "Green Dental Practice." Committee members were asked to identify the simplest and most practical ways of "Going Green" taken off the list. The DWAC and EDSAC members recommended a list of 20 "Going Green" options to forward for further consideration by the CDP at its May 2009 meeting. The DWAC/ EDSAC combined survey list of 20 simple and practical ways of "Going Green" is attached as Appendix 1.

"Going Green" Expert Advice: The CDP consulted with additional "Going Green" experts to evaluate ways dentists can "Go Green" in the dental office. The Council was particularly interested in identifying ways to "Go Green" and save money at the same time. The managing editor of *Dental Economics* and the Eco Dentistry Association (EDA) provided background materials and content expertise to the CDP. CDP staff attended a "Going Green" course at the Oregon Dental Conference in April 2009. The EDA presented a "Going Green" PowerPoint at the CDP meeting in May 2009. Based upon consideration of the information presented, the CDP recommended that a list of the "Top Ten" simple and practical ways to "Go Green" in the dental office be developed and forwarded to the 2009 House of Delegates as part of CDP's response to Resolution 58H-2008.

CDP's Top Ten Ways to "Go Green": Following its May 2009 meeting, the CDP members were surveyed to determine the top ten simple and practical ways to "Go Green" in the dental office. All respondents received the DWAC/EDSAC list of 20 "Going Green" options and were asked to identify their favorites. The CDP's Top Ten Ways to "Go Green" are as follows:

1. Install an amalgam separator.
2. Turn off equipment when not in use.
3. Reuse paper scraps.
4. Utilize recycle bins and create a "Green Team" to bring them to recycle centers.
5. Recycle shredded confidential patient information.
6. Convert to digital technology; for example, digital radiography.
7. Install solar or tinted shades.
8. Install locked or programmable thermostats.
9. Install high efficiency light bulbs.
10. Don't over disinfect and use non-toxic cleaners.

CDP's *150 Ways to Go Green*: In the spirit of the American Dental Association's (ADA) sesquicentennial celebration, the CDP developed an additional list of *150 Ways to Go Green* in the dental office. The CDP developed this list to stress the importance of environmental sustainability through waste reduction, energy conservation, water conservation and pollution prevention. The point of the comprehensive list is not to encourage dentists to attempt to accomplish every item on the on the list. Rather, the point is to provide dentists with a resource that allows them to pick and choose those items on the list that would work the best in their office. The CDP list of *150 Ways to Go Green* in the dental office is attached as Appendix 2.

"Going Green" Workshop at the 2009 Management Conference: On July 23, 2009, the CDP staff participated in a "Going Green" panel discussion at the 2009 Management Conference. This Conference is promoted annually by the Department of Dental Society Services (DDSS). The goal of the panel was to provide an overview of the "Going Green" movement, identify some of the myths affecting "Going Green," including the sacrifice, costs and politics involved and offer ideas and resources for constituent dental societies, their meeting planners and members. The DDSS received positive feedback from the "Going Green" panel discussion and is interested in developing a subsequent session for the 2010 Conference. The 2009 Management Conference "Going Green" panel discussion PowerPoint presentation is attached as Appendix 3 and a handout from the event *The ADA Makes Going Green Easy* is attached as Appendix 4.

Golden Apple "Going Green" Award: In May 2009, Dr. Edward Vigna, trustee, Tenth District, approached CDP and DDSS staff about creating a "Going Green" category for the ADA's Golden Apple Awards Program. Gathering constituent and component feedback from the 2009 Management Conference "Going Green" panel discussion, CDP and DDSS staff developed draft entry guidelines, which will be evaluated by the CDP at its next meeting. The "Going Green" Golden Apple Award is intended to recognize the efforts of dental society volunteers and staff and is not intended to recognize an individual dentist who has developed an environmentally sustainable office. It is hoped that the Golden Apple Award: Excellence in Environmental Programs and "Going Green" Education Category will be in place by 2010. The CDP has volunteered to judge this award.

"Going Green" and Information Overload: Throughout the past year, the CDP has been astonished with the volume of information available on the topic of "Going Green." Information overload has the potential to create a "paralysis by analysis" affecting even the most sincere dentist seeking to "Go Green" in the dental office. The CDP sees an opportunity for the ADA to act as a "curator" of "Going Green" information in the future, cutting through the "fog" of information overload to provide members with future "Going Green" advice based on solid science and a positive financial return on investment.

Future Activities: The CDP has reviewed the topic of "Going Green" in the dental office for the past year and intends to continue to work on this topic in the future on behalf of the membership. An additional opportunity exists to provide members with future "Going Green" advice through the development of a new ADA.org "Going Green" Web page in 2010.

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Appendix 1

DWAC/EDSAC List of the 20 "Going Green" Options

The Committees reviewed the "Resource Conservation and Pollution Prevention Checklist for Dental Office" from the San Francisco Green Business Program and provided their feedback on which recommendations from the checklist are simple and practical for dentists to implement in their offices.

DWAC/EDSAC Recommendation: The Committees suggested submitting the following practical tips for implementation in dental practices to the CDP's Going Green Initiative Subcommittee:

- Reuse paper scraps.
- Utilize recycle bins and create a "Green Team" to bring them to recycle centers.
- Use glass and silverware instead of paper plates and cups and plastic bottles.
- Install ENERGY Star appliances.
- Recycle shredded confidential patient information.
- Use CDC compliant biodegradable plastic products.
- Use separators for amalgam waste.
- Convert to digital technology; for example, digital radiography.
- Utilize soy based instead of oil based products.
- Install solar or tinted shades.
- Install locked or programmable thermostats.
- Install high efficiency light bulbs.
- Turn off equipment when not in use.
- Install dry vacuum systems.
- Install water conservation sensors on faucets.
- Water during non daylight hours.
- Don't over disinfect and use non-toxic cleaners.
- If possible, dental offices should have a Northern exposure
- Install solar panels and solar energy storage cells
- Install wind turbines.

Appendix 2

- Convert high-energy consuming office lights to energy-efficient fluorescent lighting
- Install programmable thermostats
- Add reflective glass (low E) windows
- Install mini-fluorescent fixtures
- Install a central vacuum that uses no water and has an amalgam trap
- Convert heating and cooling return-air vents from the ceiling return vents in the summer to the floor return vents during the winter
- Install three high-efficiency heating and ventilating units on the roof
- Replace the old 30-gallon hot water heater with an efficient ten-gallon one
- Recycle the big five: aluminum, glass, plastic, paper and steel
- Install water-saving toilets
- Walk to work or drive a hybrid
- Sign up for your energy company's summer energy savings program
- Use paint that does not include Volatile Organic Compounds (VOCs)
- Use office furniture made from recycled or reclaimed wood
- Consider using windmill generated electricity for power consumption
- Install energy-efficient appliances (washer, dryer, dishwasher)
- Go paperless! Utilize a virtual office for patient charting, billing and radiography
- Use LCD computer screens instead of CRT screens
- Use your local recycling program
- If traditional x-rays are taken, recycle fixer and developer solutions
- Recycle lead foil from x-rays
- Use less harmful surface disinfectants to clean and sterilize
- Consider installation of linoleum for flooring
- Use stainless steel prophy cups instead of disposable prophy-containing cups
- Implement an environmentally-friendly sterilization program
- Use reusable stainless steel high- and low-volume, surgical/endodontic suction tips as an alternative to disposable plastic
- Use reusable glass irrigation syringe as a substitute for disposable plastic
- Use biodegradable disposable cups instead of regular paper cups
- Use chlorine-free, high post-consumer recycled paper products instead of traditional paper products
- Use disposable, plastic or paper barriers only when necessary
- Use sensor-operated faucets
- Use low flow faucets and fixtures
- Turn off your computer when you leave the office for the day
- Turn off your lights when you leave the room.
- Teach your patients to turn off the faucet when they brush
- Use a water-free hand disinfectant to clean hands
- Carpool to work with colleagues
- Bike to work!
- Install a dimmer lighting system, which saves electricity and only uses as much light as needed depending on the office's natural light
- Distribute organic toothbrushes made from recycled yogurt cups to your patients after their visit
- Install water-free urinals
- Install low-flush or dual-flush toilets
- Provide brochures to patients that contain green tips in the waiting room
- Take public transportation
- Install an amalgam separator
- Partner with businesses that have sustainable principals. For example, use a green bank, recycling service or green architect/engineer to help with office design
- Send appointment reminders on recycled paper, or through email or text message
- Print double-sided
- Talk to dental students about green dental practices, where to buy supplies, and recycling
- For those serious about their practices going completely green, find an office that is Leadership in Energy and Environmental Design (LEED) certified by the U.S. Green Building Council
- Keep in mind that simple energy efficiency modifications - like lighting and water changes will pay for themselves in two to three years
- Buy recycled file folders
- Use Forest Stewardship Council (FSC)-certified wood flooring
- Think about your day-to-day work habits and how you can lighten your environmental impact on the most basic levels
- Purchase organic or eco-friendly scrubs
- Recycle computer parts and electronics
- Install solar electric panels
- Install solar water heaters
- Consider developing an office policy on "green purchasing" - while price should play a major role in purchasing decisions, environmentally-friendliness is an equally important factor to consider
- Consider switching to products that use minimal packaging to reduce waste
- Install motion detectors and timers for lights
- Install skylights to enhance lighting and keep it energy free
- Educate your patients not only about oral health but protecting the health of the environment
- Use digital thermometers instead of mercury thermometers
- Reuse rechargeable batteries
- "Tune up" your heating/cooling systems
- Cut back on the number of printers in the practice

- Use your copier's reduction feature
- Edit letters, budgets, paperwork on screen instead of hardcopy
- Request to be removed from receiving dental junk mail
- Use hot air dryers in washrooms instead of paper towels
- When looking to buy a new practice check to see if it is close to public transportation
- Reuse old envelopes for scratch paper
- Receive and store financial statements electronically
- Buy indoor plants
- Bring your own mug and dishware for meals at the office
- If possible, reduce your driving each month by a small percent
- Water your lawn at the appropriate/designated time of day
- When feasible, buy local
- Have staff members plant and adopt a tree
- When you wash your hands, turn the water off while you lather
- Drink tap water, not bottled water
- Plant rain gardens
- Run the dishwasher when it is full
- If possible, start an office garden
- Use shredded paper for packaging material
- Keep office toilets in good working order, check for leaks
- Insulate your hot water pipes
- Fix a leaky faucet
- Weather-strip and caulk your office windows
- Use cloth napkins and dish towels in practice break areas
- Pay practice bills online
- Fix broken items instead of throwing them away
- Purchase smart power strips for electronics
- Clean or replace heater/air conditioner filters
- Run a practice energy audit
- Turn off the water when brushing your teeth
- Get rid of aerosol products
- Recycle or refill toner cartridges
- Learn how much energy and water you are using in your practice
- Eliminate electronics that sleep on a standby setting; they continue to pull a current even when "turned off"
- Be aware that AC adapters on some power cables pull current so pull the plug when not in use
- Consider solar chargers for charging cell phones, PDA, laptops, etc
- Utilize soy based instead of oil based products
- Install solar or tinted window shades
- Install solar panels that are connected to your power company to receive credit for the power you generate
- Install wind turbines
- Eliminate fax cover sheets by using fax directory stickers or use software that allows you to send and receive faxes directly from your computer
- Purchase recyclable letterhead, envelopes, fax paper, and business cards
- Purchase LED or electroluminescent (LEC) exit signs to improve energy efficiency
- Use ceiling fans to promote air circulation and reduce the need for air conditioning
- Install occupancy sensors to adjust set points for air conditioning and heating equipment
- Plant native shrubs or trees near windows for shade
- Replace windows with double pane energy-efficient windows
- Post signs in practice restrooms and break areas encouraging water conservation
- Reduce the use of toxic pesticides
- Changes and recycle vacuum pump filter screens at least once per month or as directed by the manufacturer
- Have a licensed recycling contractor or hazardous waste hauler remove your amalgam wastes
- Do business with other "green" vendors
- Inform your patients about public transportation options and post transit schedules and routes
- Purchase sealants, adhesives and other restorative materials in package sizes, which will allow all the contents to be used during the procedure
- Post steps you are taking to a be a "green" dental office in your waiting or patient rooms
- Know your recycling rules and what you can and cannot recycle!
- Bring your meals to work in reusable containers
- Use digital versions of journals and publications
- Purchase recycled trash bags
- Use HEPA filters
- Remove TVs from the waiting room!
- Install environmentally friendly cabinetry (no added urea-formaldehyde)
- Consider using recycled sheetrock and denim for acoustical insulation
- Install chair covers made of organic bamboo and organic cotton
- Clearly label recycling containers in accessible areas for patients and staff to encourage recycling and reuse
- Consider stocking all-natural oral care products, from toothpaste to mouthwash
- Perform regular maintenance and check-ups on mechanical equipment
- Consider using stainless steel suction tips and saliva ejectors
- Clean accumulated dust and dirt off fans to ensure quality performance
- Market your practice as a socially-responsible practice
- Enclose patient giveaways in degradable plastic bags
- Implement an instrument recycling program
- Implement strict operating procedures for staff to ensure toxic chemicals don't pollute the environment
- Stock recycled toilet paper, paper towels and tissue
- Review your waste volumes and costs and implement opportunities to reduce both
- Install biodegradable ceiling and/or wall panels
- Educate your patients about your "green" dental office
- If building a practice, recycle unused building materials
- Reuse shipping boxes
- Seek out a recycling center that recycles light bulbs
- Install a trash compactor
- Research local, state and federal tax incentives for earning Leadership in Energy & Environmental Design (LEED) certification
- Plan the office layout to maximize natural light and ventilation

Just do something! Start with small steps that work on any budget and don't require a lot of effort!

Appendix 3

8/28/09

Going Green

ADA Management Conference
July 2009
Council on Dental Practice

150 years 1859 2009 American Dental Association®

Resolution 58H-2008

- Directed the Council on Dental Practice to undertake a one-year project to develop a "Going Green" initiative for the dental office with recommendations that are simple and practical to implement.

150 American Dental Association®

8/26/09

San Francisco Green Business Program

Green Business Standards for Dental Practices

- Waste Reduction
- Energy Conservation
- Water Conservation
- Pollution Prevention
- General/Staff Education

150 American Dental Association®

Waste Reduction for Dental Practices

- Recycle all aluminum, glass and plastic
- Recycle or reuse paper, including cardboard
- Use marketing materials that require no envelope
- Substitute permanent ware in the break room
- Use recycled toner and inkjet cartridges

150 American Dental Association®

8/26/09

Waste Reduction for Dental Practices

- Print and copy on two sides of paper
- Eliminate the use of plastic bags
- Purchase copy paper with minimum 50% PCWC
- Purchase janitorial paper with minimum 35% PCWC
- Opt out of junk mail

150 American Dental Association®

Energy Conservation for Dental Practices

- Install a programmable thermostat and use it
- Apply window film to reduce solar heat gain
- Maintain your HVAC system for efficiency
- Purchase only ENERGY STAR® appliances
- Purchase only EPEAT computers and LED monitors

150 American Dental Association®

8/26/09

Energy Conservation for Dental Practices

- Replace incandescent bulbs with CFLs
- Use LED bulbs in exit signs
- Install high-efficiency T-8 or T-5 fluorescents
- Install motion sensors and turn off power at night
- Install ceiling fans where appropriate

150 American Dental Association®

Water Conservation for Dental Practices

- Install low flow aerators on sinks
- Review your water bill monthly for spikes
- Check office for leaks every 6 months
- Install toilets with maximum of 1.28 gpf
- Replace urinals with HE models at .5 gpf

150 American Dental Association®

8/26/09

Water Conservation for Dental Practices

- Incorporate waterless hand sanitizer
- Invest in a dry vacuum system
- Adjust sprinklers for proper coverage
- Water lawns during non-daylight hours
- Plant drought tolerant plants and shrubs

150 American Dental Association®

Pollution Prevention for Dental Practices

- Install an amalgam separator if necessary
- Use only low toxic cleaning products
- Don't use bleach to disinfect vacuum lines
- Invest in a digital radiographic system
- Use steam sterilization

150 American Dental Association®

8/26/09

Pollution Prevention for Dental Practices

- Encourage staff to bike, walk or carpool
- Keep dumpsters covered and watertight
- Replace all aerosols with pump dispensers
- Use low- or no-VOC paint products
- Keep spill kits handy

150 American Dental Association®

Six Simple Things Anyone Can Do…

- Don't idle your automobile
- Drink tap water
- Turn off computers
- Use online banking
- Adjust your thermostat
- Wash laundry in cold water

150 American Dental Association®

Appendix 4

150 years 1859 2009 American Dental Association®

The ADA Makes Going Green Easy

The future is green, and you just found it. These days you probably feel flooded by dire-sounding environmental news and endless suggestions for greener living. We're here to help sort things out and get your eco practice on the road. Here, we bring it back to basics and break it down into simple and practical ways to "Go Green" in the dental office.

How to Go Green: Top Back to Basics Tips

Waste Reduction Tips

- Recycle the big five: aluminum, glass, plastic and steel
- Recycle or reuse paper, including cardboard
- Send appointment reminders on recycled paper, or through email or text message
- Print double-sided
- Recycle computer parts and electronics
- Pay practice bills online

Energy Conservation Tips

- Install programmable thermostats
- Install motion sensors and turn off power at night
- Replace incandescent bulbs with CFLs
- "Tune up" your heating/cooling systems
- Purchase LED bulbs for exit signs
- Purchase smart power strips for electronics

Water Conservation Tips

- Check your practice for leaks every 6 months
- Install low flow aerators on sinks
- Incorporate waterless hand sanitizer
- Teach your patients to turn off the water when brushing
- Review your water bill for spikes each month
- When you wash your hands, turn the water off while you lather

Pollution Prevention Tips

- Bike, walk or carpool to work
- Use only low toxic cleaning products
- Install an amalgam separator, if necessary
- Use low- or no-VOC paint products
- Encourage the use public transportation
- Replace all aerosols with pump dispensers

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: CDP Supplemental Report 2 Date Submitted: September 2009

Submitted By: Council on Dental Practice

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

COUNCIL ON DENTAL PRACTICE
SUPPLEMENTAL REPORT 2 TO THE HOUSE OF DELEGATES:
RESPONSE TO RESOLUTION 62H-2008—FUTURE OF DENTAL LABORATORY TECHNOLOGY CONFERENCE

This report provides a brief summary of the Future of Dental Laboratory Technology Conference held August 7, 2009, at the ADA Headquarters Building in Chicago.

Background: The 2008 House of Delegates adopted Resolution 62H (*Trans.*2008:475), which directed the ADA to convene a conference of interested stakeholders to discuss the current state of dental laboratory services, training in the U.S. and to consider actions each organization could take to insure that the quality of prosthetic services delivered in the U.S. remains high in the future.

Meeting Report

A wide range of interested parties attended the Conference. The Conference agenda is attached as Appendix 1.

The following subjects were discussed at the Conference:

- adequacy of undergraduate dental school training and examination in prosthetic dental laboratory techniques
- workforce concerns, the state of education and alternative training models for dental laboratory technicians
- the changing marketplace for dental prosthetic solutions
- the impact of off-shore dental laboratory outsourcing
- safety and regulatory concerns related to dental laboratories future needs

The six Conference speakers provided statistics and in-depth background material on these subjects. Though the laboratory industry is largely unregulated, there are standards that apply to both labs and those who work in them. The National Board for Certification in Dental Laboratory Technology (NBC) is an independent board founded by the National Association of Dental Laboratories (NADL) to certify dental laboratories and technicians (certification is voluntary). NBC is the certifying body for dental laboratory technicians (DLT). The American National Standards Institute (ANSI) also sets standards for Certified Dental Technician (CDT) programs. NBC administers the voluntary Certified Dental Laboratory (CDL) certification, which means the lab (the facility, not the staff) has met specific standards relating to quality, safety and good manufacturing practices.

The other accredited program for dental laboratories is the Dental Appliance Manufacturers Audit System (DAMAS), which requires an annual third party inspection of processes; including review of managerial and quality assurance systems.

Many lab owners do not have a technical background in dentistry; they come from other industries and apply skills learned to the dental lab. Of small lab owners, 34% are CDTs. There are not enough new DLTs entering the field to replace lab owners as they retire.

Demographic information was provided on the dental lab industry. Because the industry is largely unregulated, these statistics are estimates.

- 13,000 U.S. dental laboratories
- 6,000 labs are one person labs
- 7,000 labs have more than one employee
- 4,500 labs have less than ten employees
- 53,000 DLTs
- 7,000 CDTs
- $10.5 billion estimated dental lab industry yearly sales
- $632,000 average gross sales per dental lab

Small labs have the highest profit margins, while medium sized labs have been most affected by the recession. Despite the economy, projections for future growth in the laboratory business for 2010 are as follows: Computer Aided Design/Computer Aided Manufacturing (CAD/CAM) restorations: +14-20%, pressables: +10-15%, implant restorations: +12-16%. Porcelain fused to metal restorations and removable prostheses are projected to remain about the same.

Regulation of Dental Labs: Most non third-world countries require a minimum of a three year degree to become a certified DLT. The United Kingdom, Canada and Australia provide examples of how to transition from no regulation to certification. According to the NADL, the cost of lab regulation and/or registration is very low and should not increase costs to dentists or cause marketplace restrictions. Statutes in five states (FL, KY, OK, SC and TX) currently require certification or registration of dental technicians and/or dental laboratories under the dental board or its umbrella licensing agency. Summaries of these statutes are shown in Appendix 2.

Concern about use of off-shore dental laboratories has led to a number of new regulations in various states. An update in the August 2009 Department of State Government Affairs' *State Legislative Report* stated that several states have passed new regulations. A bill in New Jersey would require dentists to notify and obtain a patient's consent before providing a dental prosthesis manufactured outside the United States. A New York bill requires the establishment of quality standards for dental prostheses and that dental laboratories make full disclosure to dentists and patients of where the dental prosthetic devices were manufactured. A new Oregon law requires dental technicians to provide the dentist or patient, at their request, with the location of where an oral prosthetic device was manufactured.

Texas adopted a rule requiring its registered dental laboratories to certify to the prescribing dentist that a prosthesis or appliance was: (1) manufactured entirely by a dental laboratory registered with the Texas State Board of Dental Examiners; (2) manufactured in part or whole by a domestic laboratory inside of the United States; or, (3) manufactured in part or whole by a laboratory outside of the U.S. Current ADA policies related to dental laboratories are attached as Appendix 3.

Off-shore Laboratories: In 2005, five million dental crowns were manufactured by foreign dental laboratories for patients in the U.S. (10% of the market at the time). In 2007, it was estimated that 7.1 million dental crowns were manufactured by foreign labs. By 2010, it is predicted that 14 million dental crowns will be manufactured by foreign dental laboratories for U.S. dental patients (sources: U.S. Department of

Commerce and U.S. International Trade Commission). Thirty-two countries import dental products into the U.S. Fifty-three percent of Chinese manufactured dental products go to the U.S.

Mr. David Owsiany, executive director, Ohio Dental Association (ODA), gave a presentation on the 2008 media story on lead found in a dental crown made in China. The story focused on lack of standards for an acceptable level of lead in a dental prosthesis and the patient's right to know the content of the prosthetic placed in their mouth. As a result of the media attention on this story, the ODA developed a voluntary disclosure form for dentists to send to their lab asking for disclosure on outsourcing and material content.

Laboratory Summit: Three speakers focused on the history and findings of the Laboratory Summit, held for the past five years immediately prior to the Chicago Dental Society's Midwinter Meeting. The idea for a Lab Summit originated with Drs. Gordon Christensen and William Yancey's discussions on concerns about the U.S. laboratory industry and desire to identify the problems and propose solutions. Four topic areas were identified as critical issues at the Lab Summits: DLT training and recruitment, off-shore dental labs, dentist/lab relationship and certification.

Conference speakers presented several findings from the Laboratory Summit. There has been a drastic reduction in DLT programs with only 20 programs left that are currently operational. Dental schools do not encourage communication between the dentist and the DLT. Dentists are not routinely exposed to new dental materials, which is compounded by the fact that there are many new materials and it is difficult for a dentist to stay up-to-date. As a result, there is more reliance on the DLT to select materials used in prosthetic devices. Dentists are also less experienced in evaluating prosthetics when they come back from the lab.

DLTs need to receive continuing education (CE) to stay updated. It is not known how DLTs will be educated to understand what is necessary to manufacture restorations for complex cases. The level of education required to teach DLTs has recently been changed, eliminating the requirement for an instructor to have one degree higher than the level being taught. There are not enough four-year programs to educate DLTs. Dentists do not understand the need for DLTs to have education or be certified. Eleven thousand DLTs are projected to leave the industry in the next seven years. Current DLT programs only have the capacity to train 2,800 within that time frame.

All programs, accredited and non-accredited, struggle to keep up with equipment and material technology advances. Some common issues facing recently graduated DLTs include:

- Many labs utilize an assembly line process.
- Commercial labs complain that new hires are overqualified for the assembly line.
- Labs also complain that accredited program graduates are not prepared to be productive upon graduation.
- Recent graduates are not paid commensurate with their educational investment and potential value.

Although Dr. Gordon Christensen was unable to attend the Conference due to a scheduling conflict, he did transmit a written a list of suggestions for Conference attendees to consider:

- More accredited DLT schools should be developed.
- The ADA should assist in the development and funding of these schools and with student recruitment.
- DLTs should be encouraged to attain CDT certification.
- States should be encouraged to develop laboratory certification programs, with mandatory CDT supervision in the labs.
- Dental school administrators and CE directors should be encouraged to combine dental and DLT students together in common educational programs.
- The ADA should include more dental laboratory technology programs in its sponsored programs.

- The ADA should be encouraged to work with the FDA to provide adequate observation of offshore lab products coming into the U.S.
- The ADA should be encouraged to work with the FDA to monitor offshore lab products for content, including metals and other materials used in the products.
- The ADA should be encouraged to make a statement supporting the disclosure of offshore lab use; both labs disclosing to dentists and dentists disclosing to patients.

The Summit found that dentistry is leaving out an important member of the dental team by not including contributions from DLTs in CE courses and in dental journal articles. A poll of dental laboratory owners indicated that their perception of the biggest gaps in dental education is in impression taking, communications, and adequacy of crown preparations. Seventy-seven percent of the time, the lab or technician must select materials to fulfill a licensed dentist's prescription. Dentists and DLTs should both understand why each does different procedures. Some critical points that encourage good dentist/DLT relationships are listed below:

- Dentists should develop a face-to-face relationship with their DLT.
- The DLT should be able to communicate with the dentist without fear of losing business.
- Technicians need and want better impressions from their dentists.
- Dental labs should be more involved with dentists.
- Dental societies should encourage DLTs to present CE course with dentists.

Dental School Involvement: There is a need for data on DLT involvement in dental schools. Dental educators cited lack of time in the curriculum and the cost involved as factors contributing to the lack of dentist/DLT interaction in dental school. Few dental schools have labs with technicians. It was noted that many dental schools are sending their lab work to China, and by doing so, the dental schools are sending a message to dental students.

The last Conference speaker was a laboratory owner from Oldsmar, Florida. He stated that contemporary dental labs are facing complex challenges, especially those that are investing in new equipment. The publication *Laboratory Management Today* surveyed dentists on why they switch labs. The survey indicated the number one reason was inconsistent quality; second was poor communication between dentists and laboratory; third was delayed cases; and fourth was not reading the dentist's prescription. There are a number of steps that a lab can take to overcome some of these challenges. These include standardization and concentration on reducing non-standard processes. In 2009, the presenter's laboratory began to require dentists to fill out an online prescription form that does not allow submission of a case until all fields are filled in.

The dental lab owner also presented information on his laboratory's standard operating procedures. He noted that non-standard processes required the DLT to interpret a dentist's prescription; it is difficult for a lab to tell a dentist that the impression does not meet conformance; 68% of prescriptions did not have materials specified in 2008; fifteen out of 100 cases come in with the notation "please call me" which is interpreted as meaning the dentist needs additional guidance to write the prescription; 58% of impressions that require a re-impression occur on triple trays; and 9% of lab payroll is devoted to staff dealing with communications about non-standard processes.

Four breakouts sessions were held on the topics of dentist/lab communication, regulatory/off-shore, education and technology. Each group presented a summary of its discussion and recommendations, as shown below.

The Dentist/Laboratory Relationship Breakout:

1. Dental and DLT schools should be surveyed to determine:

- What is being taught?
- What relationship/interaction exists between the dentist and the DLT students?
- How are students being exposed to the dentist/DLT relationship?
- Beyond dental school, what CE planning is being done?
- How many CE courses use team approach with dentists and DLTs working together?
- How many dental schools have a CDT on staff?

2. Workforce concerns included the following:

- Relationships with high schools should be developed to promote dental laboratory technology as a career choice.
- Local dental societies should be encouraged to create a partnership with DLT schools to introduce dental technology education/training to high school students.
- ADA policy should be created to support DLT standards and certification.
- The relationship between dentists and DLTs should be promoted.
- CE courses at meetings that feature both dentist and DLT speakers should be promoted.

Education Breakout Session:

- The value of DLTs to the profession of dentistry should be promoted through interdisciplinary education.
- Dental schools should be encouraged to use local dental labs so that dental students can interface with DLTs.
- Each annual meeting of ADA's Committee on the New Dentist should include sessions that provide interactions with DLTs.
- The ADA should strongly support increasing the number of DLTs in the workforce.
- The ADA should recommend that dental schools use CDLs to support their programs.
- Dental laboratory technology programs should be located in dental schools.
- DLT students should take relevant courses along with dental students, such as dental morphology and dental materials.

Regulatory/Offshore Breakout Session:

- Dentists should document materials used in fabrication of prosthetics.
- Uniform state regulations are needed.
- A national curriculum for DLTs is needed.
- Market based, rather than government based, solutions should be encouraged.
- Full disclosure on point of origin should be made to both the dentist and patient.

Technology Breakout Session:

Digital Impressions

- This new technology will impact the profession significantly in the future.
- Digital impressions have a steep learning curve.
- Manufacturers appear to use dentists as beta testers and encourage them to invest in new technology that may not have a positive return on investment.
- Digital impressions can eliminate steps, improve accuracy and result in fewer remakes.
- Technology alone cannot change behavior; a dentist can still take a bad digital impression.

CAD/CAM Technology

- There are currently 20 manufacturers in the CAD/CAM marketplace, but over 60 companies are considering this new technology.
- CAD/CAM technology is complex and costly, especially as companies compete to survive in the marketplace.
- It is not likely this technology will eliminate the dental laboratory, as there is still a need for treatment planning, case design and material selection.
- Digital communication tools, such as shade matching, may increase and improve the dentist/lab relationship and reduce remakes.
- The trend towards offshore outsourcing and in-office CAD/CAM puts pressure on labs to stay competitive.
- CAD/CAM may make dental labs attractive to investors.

Follow-up to the Future of Dental Laboratory Technology Conference: The Council on Dental Practice will review a comprehensive report of the Conference at its October 29-31, 2009, meeting and make recommendations to the Board.

An additional summary meeting report will be compiled and sent to all Conference participants shortly after the conclusion of the 2009 ADA annual session.

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Appendix 1

2009 Future of Dental Laboratory Technology Conference
August 7, 2009
Executive Board Room – 22nd Floor

When	What/Where				Who
8:00-8:30 am	Registration & breakfast – Executive dining room				All
8:30-8:40 am	Welcome, introductions and goals of the Conference - Board room				Dr. Jake DeSnyder
8:40-8:50 am	Greeting from ADA Executive Director				Dr. Kathleen O'Loughlin
8:50-9:30 am	Laboratory statistics, regulations, offshore stats				Mr. Bennett Napier, NADL
9:30-9:50 am	Offshore and regulatory concerns – Ohio's respond to a media firestorm regarding "lead in dental crowns"				Mr. David Owsiany, ODA
9:50-10:05 am	Break				All
10:05-11:30 am	Recommendations from Lab Summits (held annually for past 5 years in conjunction with Chicago Dental Society Midwinter meeting) Adequacy of undergraduate dental school training and examination in prosthetic dental laboratory techniques, Workforce concerns, the state of education and alternative training models for dental laboratory technicians Doctor-Technician Relationships: Techno-Clinical Success into the Future				Dr. William Yancey, UCLA Dr. Burney Croll Dr. Damon Adams
11:30-12 noon	The Complex Challenges within Contemporary Dental Laboratories				Mr. Warren Rogers
Noon-1 pm	Lunch – Executive Dining Room				All
1:00-2:30 pm	**Breakouts**				All
	Dentist/Lab Relationship (Back of Board Room) Dr. Diane Hoelscher	Regulation (Video Conference Room) Dr. Linda Niessan	Technology (Executive Conference Room) Dr. Charles D'Auito	Education (Front of Board Room) Dr. Gary Goldstein	
2:30-2:45 pm	Break				All
2:45-3:45 pm	Brief presentation from each group – Board room				All
3:45-5:00 pm	Discussion, development of recommendations for report to HOD – Board room				All

Appendix 2

STATE REGULATION OF DENTAL LABORATORIES AND TECHNICIANS, details

Statutes in five states currently require certification or registration of dental technicians and/or dental laboratories under the dental board or its umbrella licensing agency. Summaries of these statutes follow.[1]

FLORIDA (1957, amended 1979, 1986, 1989). Florida law requires dental laboratory operators to register every 2 years with the Department of Professional Regulation (DPR) and pay a registration fee not to exceed $300.00. DPR is empowered to promulgate rules governing dental laboratories, in consultation with the dental board and industry representatives. Periodic inspection of all dental labs operating in the state is required. DPR may bring an action to enjoin those who fail to register from continuing to operate. FL Stat. Ann. sections 466.031, et seq.

In 2008 Florida's new law, S 2760, requires that a dental lab located in Florida and registered as required with the board of dentistry disclose where a dental prosthesis is manufacture and the materials used. Florida is the first state to require both of these provisions. The owner of a dental lab or at least one employee must complete 18 hours of continuing education every two years.

In 2009, the **Florida** Board of Dentistry adopted a rule that changes the title of the rule to "Prescription Forms" from Prescription Work Order Forms; adds new language to clarify the original prescription must be retained in a file by the dental laboratory for a period of four (4) years; provides language detailing requirements for a registered dental laboratory to perform work for another registered dental laboratory.

KENTUCKY (1974). Every dental laboratory and dental technician must register annually and pay a registration fee established by the Board of Dentistry. Dental laboratories must give the Board a list of their employees who are not dental technicians. An advisory commission composed of dental laboratory owners/managers and technicians advises the Board on all matters relating to their regulation. Dentist may use only the services of a commercial dental laboratory duly registered with the Board. The Board is empowered to bring an action to enjoin violations of the act. Ky. Rev. Stat. section 313.510, et seq.

OKLAHOMA (1959, amend 1981). Oklahoma requires all persons, firms, corporations or partnerships that engage in the dental laboratory business to obtain an operating permit from the board of Governors of Registered Dentists. The application for a permit must include the name and address of every owner and operator of the laboratory. The permit is renewable annually. Dentists may, however, own and operate a private, non-commercial dental lab in their own office for their own use. Okla. Stat. Ann. sections 328.36 and .37.

SOUTH CAROLINA (1946, amended 1986). South Carolina prohibits anyone but a registered dental technician or a person working under the supervision of a registered technician or a licensed dentist from performing dental technological work. The Board of Dentistry is responsible for regulation of dental technicians. Requirements for registration are:

1) Evidence of a good moral character;

2) A high school diploma or its equivalent;

3) Successful completion of a two-year course of study in dental technology at a Board-approved school or three years experience performing dental technological work under the direct supervision of a registered technician or a licensed dentist;

4) Successful completion of an examination administered by the Board; and

[1] In Pennsylvania, standards for operation of dental laboratories are set by regulation of the state's Drug, Device and Cosmetic Board.

5) Evidence that the applicant has not violated the practice laws of any other jurisdiction where he or she is licensed or certified. S.C. Code Ann. section 40-15-120, et seq.

In 2008 the South Carolina Dental Association was successful in convincing the legislature to overwhelmingly override the governor's veto of the SCDA's dental lab bill, H 3906. The new law requires that dental labs inform the prescribing dentist the name of the country of origin in which any part of the dental prosthesis was manufactured and a list of the materials used, by percentage of ingredients. The new law also requires that the employee of the dental lab authorizing the work be registered with the SC state board of dentistry.

TEXAS (1973, amended 1981, 1987, 2004). Owners or managers of dental laboratories must register their laboratories and each dental technician they employ with the Board of Dental Examiners on an annual basis. The dental board is assisted by a Dental Laboratory Certification Council in evaluating the eligibly of applicants for registration.

Applications for a certificate of registration must include proof that at least one technician working on the premises is certified by a nationally-recognized board. Applications for renewal of registration must provide evidence that at least one employee has completed a minimum of twelve hours of continuing education during the preceding 12 months, but the dental board will accept evidence that one employee is currently certified as a dental technician in lieu of continuing education.

Fees are set by the Board. Lapsed certificates may be renewed anytime within two years upon payment of all fees and penalties. After two years, a lapsed certificate can only be reinstated by complying with the requirements for obtaining the original certificate.

Only registered dental laboratories and technicians may fill prescriptions for the preparation or repair of dental prosthetic appliances. Dentists who perform laboratory services are exempt from the requirements of the act. Dentists who knowingly deal with an unregistered laboratory are subject to sanctions. Tex. Stat. Ann. Title 3, subtitle D, chapter 266, section 266.001; Title 22, Part 5, Chapter 116 of the Texas Administrative Code.

In 2009, the Texas State Board of Dental Examiners adopted a rule that requires a Texas registered dental laboratory to certify in writing to the prescribing dentist that the prosthesis was either:

(1) Manufactured entirely by a dental laboratory registered with the Texas State Board of Dental Examiners;
(2) Manufactured in part or whole by a domestic laboratory inside of the United States; or,
(3) Manufactured in part or whole by a foreign laboratory outside of the United States.

Please note that this summary of state regulations pertaining to dental laboratories and technicians is offered as information only and not as practice, financial, accounting, legal or other professional advice. Readers need to consult their own professional advisors for such advice.

Department of State Government Affairs
June 12, 2009
#42 Regulation of Dental Labs provisions

Appendix 3

Policies on Laboratories and Technicians

National Board for Certification of Dental Laboratory Technicians' Continued Recognition (2002:400)

Resolved, that the National Board for Certification of Dental Laboratory Technicians' request for continued recognition as the certification board for dental laboratory technicians be approved.

Criteria for Approval of a Certification Board for Dental Laboratory Technicians (1998:92, 713)

One of the duties of the Council on Dental Education and Licensure indicated in the *Bylaws* of the American Dental Association is 'to study and make recommendations including the formulation and recommendation of policy on: (4) The approval or disapproval of national certifying boards for special areas of dental practice and for dental auxiliaries. (5) The educational and administrative standards of the certifying boards for special areas of dental practice and for dental auxiliaries.' The Council on Dental Education and Licensure believes that the examination and certification of dental laboratory technicians is necessary to provide the dental profession with an indication of those persons who have demonstrated their ability to fulfill the dental laboratory work authorization. Such a certification program should be based on the educational requirements for dental laboratory technicians approved by the Commission on Dental Accreditation.

The following basic requirements are prescribed by the Council on Dental Education and Licensure for the evaluation of an agency which seeks approval of the American Dental Association for a program to certify dental laboratory technicians on the basis of educational standards approved by the dental profession.

I. Organization: An agency that seeks approval as a Certification Board for Dental Laboratory Technicians should be representative of or affiliated with a national organization of the dental laboratory industry and have authority to speak officially for that organization. It is required that each dental laboratory technician member of the Certification Board hold a certificate in one of the areas of the dental laboratory technology.

II. Authority and Purpose: The rules and regulations established by the Certification Board of Dental Laboratory Technicians will be considered for approval by the Council on Dental Education and Licensure on the basis of these requirements. Changes that are planned in the rules and regulations of the Certification Board should be reported to the Council before they are put into effect. The Board shall submit data annually to the Council on Dental Education and Licensure relative to its financial operations, applicant admission and examination procedures, and results thereof.

The principal functions of the Certification Board shall be:

a. to determine the levels of education and experience of candidates applying for certification examination within the requirements for education established by the Commission on Dental Accreditation;
b. to prepare and administer comprehensive examinations to determine the qualifications of those persons who apply for certification; and
c. to issue certificates to those persons who qualify for certification and to prepare and maintain a roster of certifees.

III. Qualifications of Candidates: It will be expected that the minimum requirements established by the Certification Board for the issuance of a certificate will include the following:

a. satisfactory legal and ethical standing in the dental laboratory industry;

b. graduation from high school or an equivalent acceptable to the Certification Board;
c. a period of study and training as outlined in the Accreditation Standards for Dental Laboratory Technology Education Programs, plus an additional period of at least two years of working experience as a dental laboratory technician; or, five years of education and/or experience in dental technology; and
d. satisfactory performance on examination(s) prescribed by the Certification Board.

Support of the Dental Laboratory Technician Certification Program and Continuing Education Activities (1997:682)

Resolved, that the American Dental Association encourage dental laboratory technicians to achieve certification status and pursue the continuing education that is required to provide dentists with technical support that will contribute to high standards of restorative dental care, and be it further
Resolved, that the American Dental Association encourage efforts by those engaged in dental laboratory technology and dental laboratory technology education to ensure that the future workforce in dental laboratory technology is adequately educated and skilled in the art and science of dental laboratory technology by promoting pursuit of certification, and be it further
Resolved, that the American Dental Association encourage constituent and component dental societies to recognize the continuing education needs of certified dental technicians by inviting their attendance at appropriate continuing education seminars and meetings that can enhance mutual understanding.

Statement on Prosthetic Care and Dental Laboratories (Trans.1990:543; 1995:623; 1999:933; 2000:454; 2003:365; 2005:327; 2007:XXX)

Introduction: Patient care in dentistry often involves the restoration or reconstruction of oral and peri-oral tissues. The dentist may elect to use various types of prostheses to treat the patient and may utilize the supportive services of a dental laboratory and its technical staff to custom manufacture the prostheses according to specifications determined by the dentist.

Since the dentist-provider is ultimately responsible for the patient's care, the Association believes that he or she is the only individual qualified to accept responsibility for prosthetic care. At the same time, the dental profession recognizes and acknowledges with gratitude and respect the significant contributions of dental laboratory technicians to the health, function and aesthetics of dental patients.

This statement outlines the Association's policy on the optimal working relationship between dentist and dental laboratory, the regulation of dental laboratories and issues regarding the provision of prosthetic care. A glossary of terms is a part of this statement.

Because of the dentist's primary role in providing prosthetic dental care, the Association, through its Department of State Government Affairs and the Council on Dental Practice, provides upon request assistance to state dental societies in dealing with issues addressed in this statement.

Diagnosis and Prosthetic Dental Treatment: It is the position of the American Dental Association that diagnosis and treatment of complete and partial denture patients must be provided only by licensed dentists and only within the greater context of evaluating, treating and monitoring the patient's overall oral health. The Association believes that the dentist, by virtue of education, experience and licensure, is best qualified to provide denture treatment to the public with the highest degree of quality. As a result of its belief that dental care is the responsibility of a licensed dentist, the Association opposes prosthetic dental treatment by any other individuals. Further, the Association will actively work to prevent the enactment of any legislation or regulation allowing such activity or programs, on the grounds that it would be dangerous and detrimental to the public's health.

Working Relationships Between Dentists and Dental Laboratories: The current high standard of prosthetic dental care is directly related to, and remains dependent upon, mutual respect within the dental

team for the abilities and contributions of each member. The following guidelines are designed to foster good relations between dental laboratories, dental laboratory technicians and the dental profession.

Applicable laws shall take precedence if they are inconsistent with any of the following guidelines.

The Dentist:

1. The dentist should provide written instructions to the laboratory or dental technician. The written instructions should detail the work which is to be performed, describe the materials which are to be used and be written in a clear and understandable fashion. A duplicate copy of the written instructions should be retained for a period of time as may be required by law.
2. The dentist should provide the laboratory/technician with accurate impressions, casts, occlusal registrations and/or mounted casts. Materials submitted should be identified.
3. The dentist should identify, as appropriate, the crown margins, post palatal seal, denture borders, any areas to be relieved and design of the removable partial dentures on all cases.
4. The dentist should furnish instruction regarding preferred materials, coloration, description of prosthetic tooth/teeth to be utilized for fixed or removable prostheses which may include, but not be limited to a written description, photograph, drawing or shade button.
5. The dentist should provide verbal or written approval to proceed with a laboratory procedure, or make any appropriate change(s) to the written instructions as the dentist deems necessary, when notified by a laboratory/dental technician that a case may have a questionable area with respect to paragraphs 2-4.
6. The dentist should clean and disinfect all items according to current infection control standards prior to sending them to the laboratory/technician. All prostheses and other materials that are forwarded to the laboratory/technician should be prepared for transport utilizing an appropriate container and packaged adequately to prevent damage and maintain accuracy.
7. The dentist should return all casts, registration and prostheses/appliances to the laboratory/technician if a prosthesis/appliance does not fit properly, or if shade selection is incorrect.

The Laboratory/Technician:

1. The laboratory/technician should custom manufacture dental prostheses/appliances which follow the guidelines set forth in the written instructions provided by the dentist, and should fit properly on the casts and mounting provided by the dentist. Original written instructions should be retained for a period of time as may be required by law.

   When a laboratory provides custom-printed written instructions forms to a dentist, the laboratory document should include the name of the laboratory and its address, provide ample space for the doctor's written instruction, areas to indicate the desired delivery date, the patient's name, a location for the doctor to provide his/her name and address, as well as to designate a site for the doctor to provide a signature. The form should also allow for other information which the laboratory may deem pertinent or which may be mandated by law.
2. The laboratory/technician should return the case to the dentist to check the mounting if there is any question of its accuracy or of the bite registration furnished by the dentist.
3. The laboratory/technician should match the shade which was described in the original written instructions.
4. The laboratory/technician should notify the dentist within two (2) working days after receipt of the case, if there is a reason for not proceeding with the work. Any changes or additions to the written instructions must be agreed to by the dentist and must be initialed by authorized laboratory personnel. A record of any changes shall be sent to the dentist upon completion of the case.
5. After acceptance of the written instructions, the laboratory/technician should custom manufacture and return the prostheses/appliances in a timely manner in accordance with the customary manner and with consideration of the doctor's request. If written instructions are not accepted, the laboratory/technician should return the work in a timely manner and include a reason for denial.
6. The laboratory should follow current infection control standards with respect to the personal protective equipment and disinfection of prostheses/appliances and materials. All materials should be checked for breakage and immediately reported if found.

7. The laboratory/technician should inform the dentist of the materials present in the case and may suggest methods on how to properly handle and adjust these materials.
8. The laboratory/technician should clean and disinfect all incoming items from the dentist's office; e.g., impressions, occlusal registrations, prostheses, etc., according to current infection control standards. All prostheses and related items which are returned to the dentist should be cleaned and disinfected, according to current infection control standards, placed in an appropriate container, packed properly to prevent damage, and transported.
9. The laboratory/technician should inform the dentist of any subcontracting laboratory/technician employed for preparation of the case. The laboratory/technician should furnish a written order to the dental laboratory which has been engaged to perform some or all of the services on the original written instructions.
10. The laboratory/technician should not bill the patient directly unless permitted by the applicable law. The laboratory should not discuss or divulge any business arrangements between the dentist and the laboratory with the patient.

Instructions to Dental Laboratories: Complete and clearly written instructions foster improved communication and working relationships between dentists and dental laboratories and can prevent misunderstanding. State dental practice acts may specify the extent and scope of written instructions that are provided to dental laboratories for the custom manufacture of dental prostheses. These acts may describe the written instructions from the dentists to the dental laboratory as a "prescription" while other states refer to the instructions as a "work authorization" or "laboratory work order." Realizing that terminology in state dental practice acts differ, constituent dental societies are urged to investigate appropriate terminology for their dental practice acts regarding the term(s) used to describe the written instructions between a dentist and a dental laboratory and between dental laboratories for subcontract work, since the term selected may have tax implications depending on state tax revenue codes.

Identification of Dental Prostheses: The Association urges members of the dental profession to mark, or request the dental laboratory to mark, all removable dental prostheses for patient identification. Properly marked dental prostheses assist in identifying victims in mass disaster, may be useful in police investigations and help prevent loss of the prostheses in institutional settings.

Shade Selection by Laboratory Personnel: Selection of the appropriate shade is a critical step in the custom manufacture of an aesthetically pleasing prosthesis. The Association believes that when a dentist requests the assistance of the dental laboratory technician in the shade selection process, that assistance on the part of the dental laboratory technician does not constitute the practice of dentistry, providing the activity is undertaken in consultation with the dentist and that it complies with the express written instructions of the dentist. The shade selection site, whether dental office or laboratory (where lawful), should be determined by the professional judgment of the dentist in the best interest of the patient and where communication between dentist, patient and technician is enhanced. When taking the shade in the laboratory, the dental technician should follow the appropriate clinical infection control protocol as outlined in the ADA's infection control guidelines when dealing with the patient.

Regulation of Laboratories: The relationship between a dentist and a dental laboratory requires professional communication and business interaction. The dental laboratory staff may serve as a useful resource, providing product and technical information that will help the dentist in the overall planning of treatment to meet each patient's needs. The dental laboratory staff may also consult with the dentist about new materials and their suggested uses. The Association applauds such cooperative efforts so long as the roles of the parties remain clear; the dentist must be responsible for the overall treatment of the patient and the dental laboratory is responsible for constructing high quality prosthetic appliances to meet the specifications determined by the dentist.

Some dentists may choose to own or operate a dental laboratory for the custom manufacture of dental prostheses for their patients or those patients of other dentists. The Association opposes any policy that prevents, restricts, or precludes dentists from acquiring ownership in dental laboratories.

In some states the issue of dental laboratory regulation has been addressed through requirements for registration, certification, licensure bills and some hybrids thereof. The Association believes the basic tenet of regulation by any governmental agency is the protection of the public's health and welfare. In the delivery of dental care, that collective welfare is monitored and protected by state dental boards that have the jurisdictional power, as legislated under the state dental practice act, to issue licenses to dentists. These boards also have the power to suspend or revoke such licenses if such action is deemed warranted.

For decades, the public health and welfare has proven to be adequately protected under the current system of dental licensure. The dentist carries the ultimate responsibility for all aspects of the patient's dental care, including prosthetic treatment. In a free market society, dentists select dental laboratories that provide the best quality services and prostheses.

The Association opposes the creation of additional regulatory boards to oversee dental care and therefore, opposes any form of governmental regulation or licensure of dental laboratories not promulgated under the auspices of the state board of dentistry. The Association believes that a single state board of dentistry in each state is the most effective and cost-efficient means to protect the public's dental welfare.

Notification of Prosthetic Cases Sent to Foreign or Ancillary Domestic Labs for Custom Manufacture: Constituent dental societies are urged to pursue legislation or voluntary agreements to require that a domestic dental laboratory which subcontracts the manufacture of dental prostheses notify the dentist in advance when such prostheses, components or materials indicated in the dentist's prescription are to be manufactured or provided, either partially or entirely, by a foreign dental laboratory or any domestic ancillary dental laboratory.

Glossary of Terms Relating to Dental Laboratories

Introduction: This glossary is designed to assist in developing a common language for discussion of laboratory issues by dental professionals and public policy makers. Certain terms may also be defined in state dental practice acts, which may vary from state to state.

Must: Indicates an imperative need or duty; an essential or indispensable item, mandatory.

Should: Indicates a suggested way to meet the standard; highly desirable.

May or Could: Indicates a freedom or liberty to follow suggested alternatives.

Dental Appliance: A device that is custom manufactured to provide a functional, protective, esthetic and/or therapeutic effect, usually as a part of oro-facial treatment.

Dental Laboratory: An entity that engages in the custom manufacture or repair of dental prostheses/appliances prostheses as directed by the written prescription or work authorization form from a licensed dentist.

Dental Prosthesis: An artificial appliance custom manufactured to replace one or more teeth or other oral or peri-oral structures in order to restore or alter function and aesthetics.

Laboratory Certification: A form of voluntary self-advancement in which a recognized, nongovernmental agency verifies that a dental laboratory technician or a dental laboratory has met certain predetermined qualifications and is granted recognition.

Laboratory Registration: A form of regulation in which a governmental agency requires a dental laboratory or dental laboratory technician to meet certain predetermined requirements and also requires registration with the agency and payment of a fee to conduct business within that jurisdiction.

Laboratory Licensure: A form of regulation in which a governmental agency, empowered by legislative fiat, grants permission to a dental laboratory technician or dental laboratory to provide services to dentists following verification of certain educational requirements and a testing or on-site review procedure to ensure

that a minimal degree of competency is attained. This form of regulation requires payment of a licensing fee to conduct business within a jurisdiction and may mandate continuing education requirements.

Work Authorization/Laboratory Work Order: Written directions or instructions from a licensed dentist to a dental laboratory authorizing the construction of a prosthesis. The directions or instructions included often vary from state to state but typically include: (1) the name and address of the dental laboratory, (2) the name and identification number, if needed, of the patient, (3) date, (4) a description of the work necessary and a diagram of the design, if appropriate for the appliance, (5) the specific type of the materials to be used in the construction of the appliance, (6) identification of materials used and submitted to the laboratory, and (7) the signature and license number of the requesting dentist. In those states where the term "prescription" is used in place of the term "work authorization" or "laboratory work order," prescription is defined as written instructions from a licensed dentist to a dental laboratory authorizing the construction of a prosthesis to be completed and returned to the dentist.

Recognition Program for Meritorious Service by Certified Dental Technologists (1987:496; 1999:922)

Resolved, that the American Dental Association endorse and support a program, conducted by the state and local dental societies, recognizing the meritorious service performed by individual Certified Dental Technologists on appropriate anniversaries of service to the dental profession, as determined by the Council on Dental Practice.

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Board Report 10 Date Submitted: September 2009

Submitted By: Board of Trustees

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

REPORT 10 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:
DENTAL WORKFORCE MODEL: 2007-2030

Background: The 1981 House of Delegates adopted Resolution 124H (*Trans*.1981:571) directing that the Board of Trustees examine and report, on a continuous basis, the rate of growth in the number of licensed dentists. The primary source of data for the Dentist Workforce Model (DWM) is the House-mandated census survey, *Distribution of Dentists in the United States by Region and State*. A second source of statistics on the profession's demographics is the *Survey of Predoctoral Dental Education*. The appended full report has been prepared in response to the 1981 House mandate. A few highlights from the report follow.

Projected Number of Professionally Active Dentists and Active Private Practitioners: The number of both professionally active dentists and active private practitioners is expected to increase over the projection period. The number of professionally active dentists increased 17.2% between 1993 and 2007. Between 2007 and 2030, the number of professionally active dentists is projected to increase 10.9%, reaching 201,453. The number of active private practitioners increased 17% between 1993 and 2007. Between 2007 and 2030, the number of active private practitioners is projected to increase 10.4%, reaching 184,122. The number of professionally active dentists and active private practitioners per 1,000 U.S. population have been fairly stable—although both are projected to decline in the coming years. Increases in productivity of dental practices in the future should permit the capacity of the delivery system to be maintained or to expand.

Table 1: Census Counts and Projections, 1993-2030

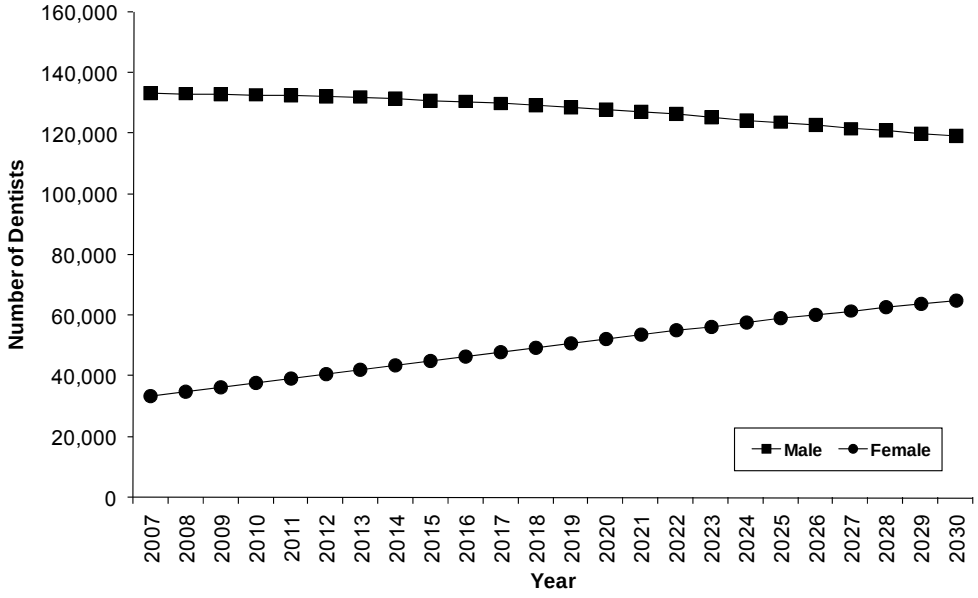
Year	Professionally Active Dentists	Active Private Practitioners	Applicants to Dental School	Applicants per Admission	U.S. Resident Population (in thousands)	Professionally Active Dentists per 1,000 U.S. Resident Population	Active Private Practitioners per 1,000 U.S. Resident Population
1993	155,087	142,603	6,761	1.649	260,255	0.60	0.55
1994	157,228	144,581	7,713	1.872	263,436	0.60	0.55
1995	158,641	146,089	7,996	1.887	266,557	0.60	0.55
1996	160,388	147,247	8,598	2.021	269,667	0.59	0.55
1997	160,781	147,778	9,829	2.261	272,912	0.59	0.54
1998	163,291	151,309	9,447	2.213	276,115	0.59	0.55
1999	164,664	152,151	9,010	2.089	279,295	0.59	0.54
2000	166,383	152,798	7,770	1.796	282,158	0.59	0.54
2001	168,556	155,716	7,412	1.682	284,915	0.59	0.55
2002	169,894	156,921	7,538	1.695	287,501	0.59	0.55
2003	173,574	160,184	8,176	1.770	289,986	0.60	0.55
2004	175,709	162,184	9,433	2.045	292,806	0.60	0.55
2005	176,634	162,180	10,731	2.289	295,583	0.60	0.55
2006	179,594	164,864	12,463	2.633	298,442	0.60	0.55
2007	181,725[1]	166,837[1]	13,742	2.881	304,280	0.60	0.55
2010	186,098	170,719	11,411	2.215	310,233	0.60	0.55
2015	191,620	175,970	12,343	2.169	325,540	0.59	0.54
2020	196,137	180,084	12,087	2.015	341,387	0.57	0.53
2025	199,230	182,789	12,655	2.046	357,452	0.56	0.51
2030	201,453	184,122	13,473	2.089	373,504	0.54	0.49

Source: American Dental Association, Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*.

[1] At the time of this report, the *2007 Distribution of Dentists in the United States by Region and State* was not published; therefore, the 2007 numbers are preliminary.

Female Dentists: Female dentists are joining the profession in steadily increasing numbers. Judging by the recent increasing percentages of females in dental school enrollments, it is fair to say that the ratio of male to female dentists has yet to stabilize, unlike that of the medical[2] profession. Based on ADA's *Distribution of Dentists in the United States by Region and State*, the percentage of professionally active female dentists has increased from 19.7% in 2006 to 20.6% in 2007[1]. The number of female dental graduates in 2007 reached 2,099, representing 44.5% of the graduating class. As graduating classes continue to move into the profession, women will continue to form an ever-increasing portion of practicing dentists through the foreseeable future.

Figure 1: Projected Number of Active Private Practitioners, by Gender, 2007-2030

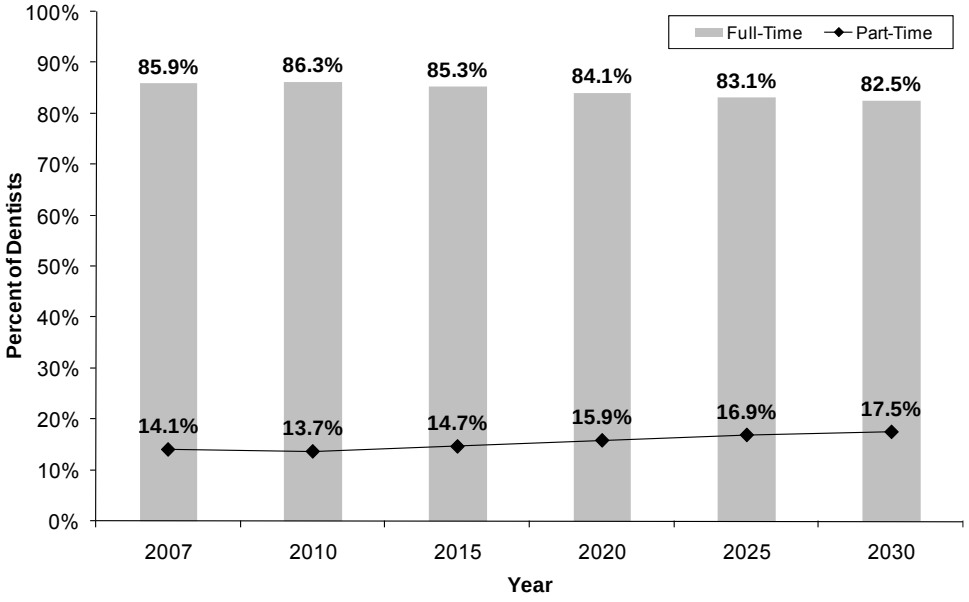


Source: American Dental Association, Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*.

Part-Time Active Private Practitioners: In 2007[1], 14.1 % of active private practitioners were part-time. As shown in Figure 2, the percent of part-time active private practitioners is expected to follow a general trend of increase over the course of the projection period. This increase is mainly driven by the increase of female dentists since in general, female dentists are more likely to be part-time than their male counterparts.

[2] For a data on medical school enrollments go to: http://www.aamc.org/data/facts/2008/2008school.htm.

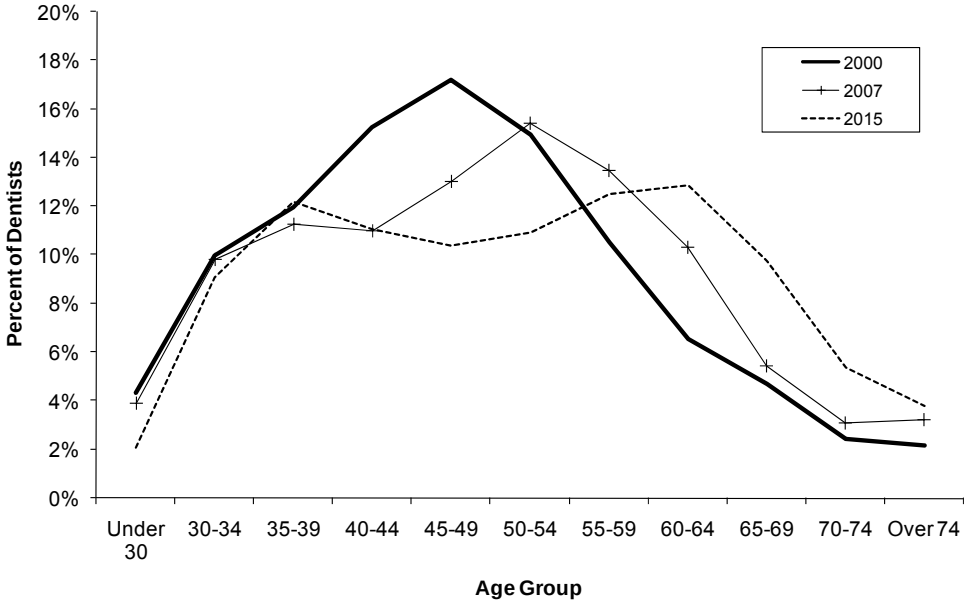
Figure 2: Percentage Distribution of Active Private Practitioners, by Full-Time and Part-Time Status, 2007-2030



Source: American Dental Association, Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030.*

Age Distribution of Professionally Active Dentists: As shown in Figure 3, the upward age shift that had been predicted over the last few years has begun. In 2000, for example, there was a significant peak in the age distribution among the 45-49 age group (17.2% of professionally active dentists); by 2007, the peak (15.4%) in age distribution occurs among the 50-54 age group. By 2015, the age distribution will be flatter and more diffuse with significantly more dentists in higher age groups—the largest distribution of 12.9% occurring among the 60-64 age group.

Figure 3: Percentage Age Distribution of Professionally Active Dentists in 2000, 2007 and the Projected Distribution in 2015

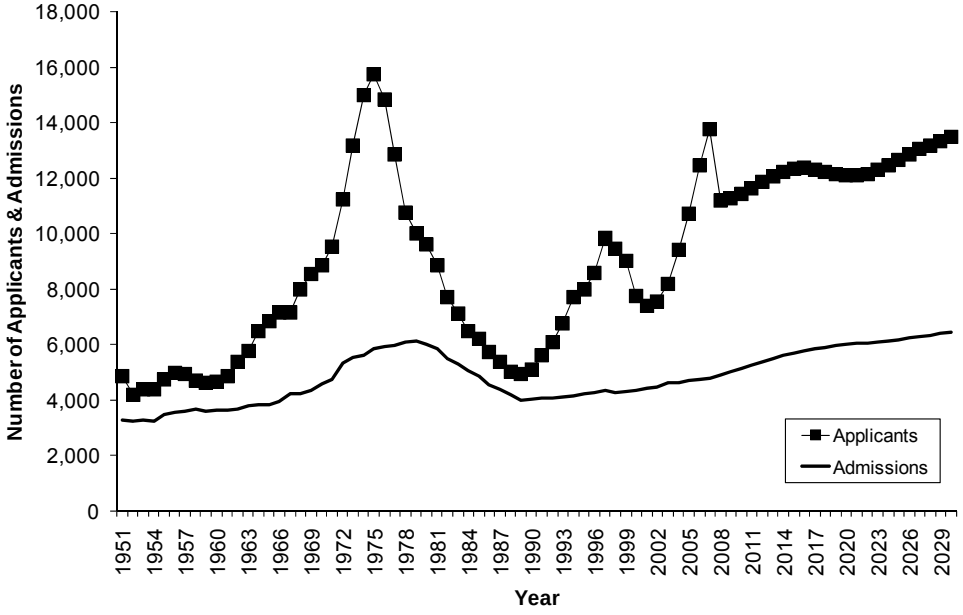


Source: American Dental Association, Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*.

Dental School Applicants: There were 13,742 applicants in 2007, up from 12,463 in 2006—an increase of 10.3%. The number of applicants dropped each year between 1997 and 2001. Since 2001, however, the number of applicants has increased each year and is projected to continue to increase. This upward trend is heavily influenced by two major factors: the projected increase in the U.S. population 22-26 years of age until the year 2015, and the continued increase in dental income relative to the income of other professionals with a bachelor's degree or higher. After the year 2016, the number of applicants is projected to decline. This decline corresponds to the Census Bureau's projected decline for the U.S. population aged 22-26 during this same period.

Dental School Admissions: The number of first-year enrollments increased 0.78% from 4,733 in 2006 to 4,770 in 2007. Enrollments in U.S. dental schools have responded to the trends in applicants with some delays as institutions adjust to large shifts in demand for dental education. Hence, it follows that the enrollments are not very responsive in the short-run, as one would expect. The long-run trend in enrollment shows a moderate, but direct response to the size of the applicant pool.

Figure 4: Actual and Projected Dental School Applicants and Admissions, 1951-2030



Source: American Dental Association, Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*.

Sensitivity Analysis: The projection of professionally active dentists depends, among other factors, on the assumed rate of return to dental education. The sensitivity analysis suggests that an increase in the rate of return positively affects the size of the dental workforce within approximately six years. When examining the impact of a reduction in the rate of return, the results are found to have similar downward effects. (The Appendix of the attached full report contains a complete analysis that explores the impact of changes in the rate of return on future applicants, graduates, professionally active dentists and active private practitioners.)

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Appendix

2009 American Dental Association Dental Workforce Model: 2007-2030

Overview: The Dental Workforce Model (DWM) performs long-term projection of the U.S. dental workforce using statistical transition models for retirements, occupation change, location choice, specialty education and death. Additional allocation models distribute new dental school graduates into dental occupations, locations and specialty programs. The DWM was developed for the ADA's Health Policy Resources Center[3] with significant extensions to the original work.

The DWM was extended in 1993 by using more sophisticated statistical methods to handle the new rotating panel method used for the ADA census of dentists, the *Distribution of Dentists in the United States by Region and State* (DOD). An improved accounting of net foreign dentist immigration was also implemented. The DWM also projects the number and gender of dental school graduates based on: relative lifetime earnings of dentists (vis-à-vis that of other college graduates), dental education costs and financial support available in dental schools. The theory is that the number of dental graduates is very well explained by the rate of return to dentistry, which is the relative expected financial reward from dental education (net of the cost of schooling) and availability of financial support while in school.

It should be noted that the dental workforce projections apply only to dentists within the United States, not U.S. territories. Also, the projections assume that there will be no major structural change in the economy, technology, politics, or the delivery mechanisms and organization of the dental care industry. In particular, no major component of the dental care sector is expected to be nationalized over the horizon of the projections. However, while some technological change can be expected, if it is of a similar impact to the changes over the past 20-30 years it will not substantially affect the projections.

The growth of managed care may have some effects on the dental care marketplace. However, these effects are not expected to create major changes in the delivery of dentistry over the next decade. Despite the large number of participating dentists, managed care patients currently make up a relatively small portion of the patient base. Further, there is no compelling economic argument for dentistry to move significantly toward managed care at the levels found in general medicine. Dentistry as a whole currently practices preventive care to a larger extent than any other segment of the health care industry, and dental costs are much more predictable and limited than major medical costs. Unless these market structure changes are much more rapid and dramatic than they have been in the past ten years, the overall pattern of the projections will not be affected.

Using the current estimates from the models for dental workforce projections, selected results and remarks about future trends in applicants, admissions, dental school graduates, as well as the number of professionally active dentists[4] and active private practitioners[5] are provided below.

Applicants, Admissions and Graduates: The 2007 projections of applications, admissions and dental school graduates are in line with the 2006 projections. Note that the projections published in this report are influenced by changes in population projections of the U.S. Census Bureau. A graph of the current Census projections of the U.S. population aged 22-26 years is presented in Figure 1.

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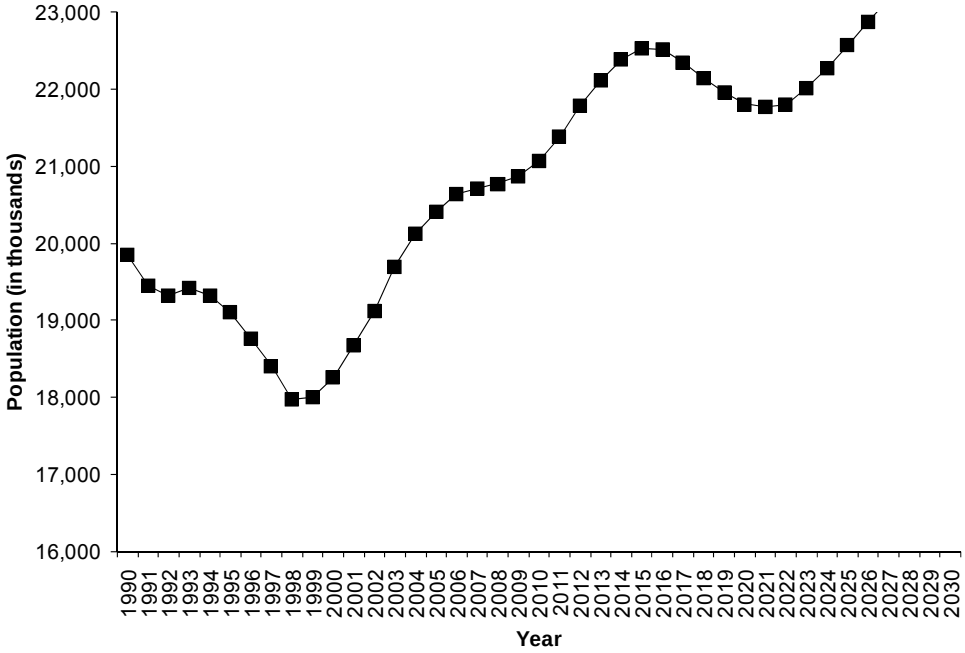
[3] An important part of this work is documented in: Nash KD, House DR. The dental school applicant pool and the rate of return to dentistry. *J Am Dent Assoc 1982;105(2):271-5.*

[4] Professionally active dentists are those whose primary and/or secondary occupation is private practice (full- or part-time), dental school faculty/staff member, armed forces, other federal services, state or local government employee, hospital staff dentist, graduate student/intern/resident, other health/dental organization staff member.

[5] Active private practitioners are a subset of professionally active dentist category and are defined as dentists whose primary and/or secondary occupation is private practice (full- or part-time).

Figure 1: Current Census Projections of the Population Aged 22-26 Years (Time-Adjusted from 20-24 Age Group Projections)



Source: U.S. Census Bureau, International Data Base, Table 094: Midyear Population, by Age and Sex, available at: http//www.census.gov/cgi-bin/ipc/idbsprd. Last Revised: 14 August 2008, accessed 11 June 2009. (Since the Census Bureau provides projections for the age cohort 20-24, the time-adjustment was done by RRC, Inc.)

Before delving into a description of applicants, it is important to consider the number of dental schools. The projections in this report do not include the impact of new dental schools coming on board. However, the number of universities offering dental school programs has remained relatively stable over time. The history of dental schools has been marked by a period of slow, consistent growth from 1950-1978; a plateau period from 1978-1985, which represented both its most stable period and the period in which the number of dental schools open was at its peak; a period of general decline from 1986-2001; and, the more modern period, 2002 to the present, which is experiencing a period of growth. Currently there are a number of new dental school programs under development. Midwestern University opened its first dental school in Glendale, AZ in the fall of 2008 with an enrollment of 110 students in its first predoctoral class. Western University of Health Sciences in California plans to enroll its first class of 64 students in fall of 2009 and Eastern Carolina University in North Carolina is scheduled to begin classes in fall of 2011 with an initial class size of 50. Additionally, Midwestern University has plans to open a second dental school in Illinois in the fall of 2011. Proposals are currently under consideration for Texas Tech University to sponsor a dental school in El Paso as well as the University of Arkansas in Little Rock and the University of New England in Portland, ME. The University of Southern Nevada is considering expanding both its predoctoral and postdoctoral dental education programs as well.

Although the Dental Workforce Model does not consider the number of dental schools that are in the planning stage, it does utilize three more granular aggregated measures collected from all open universities; the number of net applicants, the number of admissions and the number of graduates. Changes in the rate of return to dentistry, the relative expected financial reward from dental education, is a significant underlying factor that triggers change in the applicant pool. And, depending on the direction of the change, dental schools respond by opening or closing and/or expanding or contracting ongoing programs.

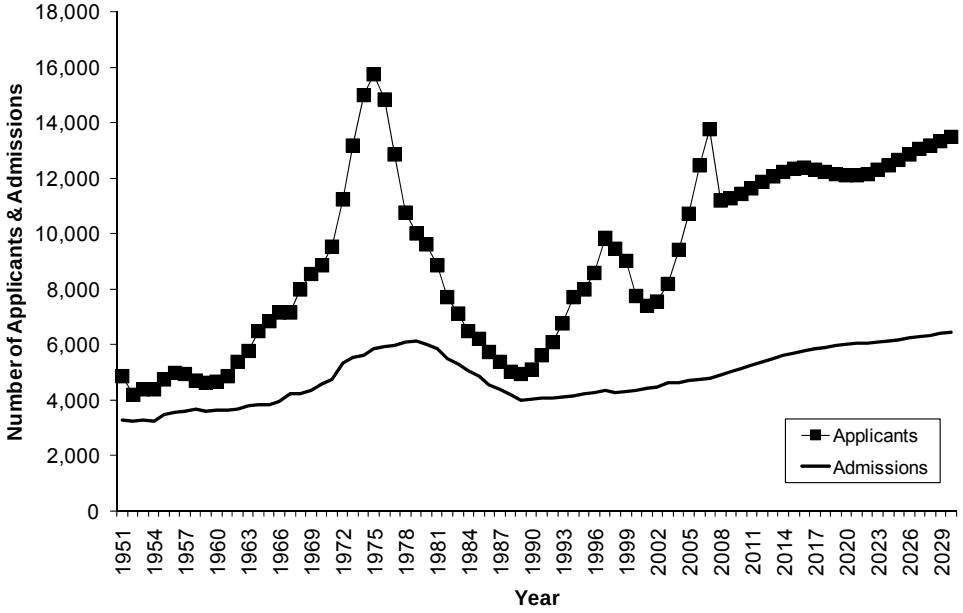
Applicants. Dental schools in the U.S. generally experienced substantial declines in the number of applicants during the late 1970s and 1980s, but these numbers rebounded strongly in the early 1990s. The number of applicants fell from a high of 15,734 in 1975 to 4,964 in 1989. This decline can largely be attributed to the relative decrease in dentists' net incomes as compared with net incomes of other professionals and college graduates. During the early to mid-1990s, this trend in net incomes reversed itself and the number of applicants to dental schools increased by 91.9% between 1990 and 1997. These increases occurred during a period (1990-97) in which the U.S. population aged 22 to 26 years declined by 7.3%. This can be explained by the fact that the increase in the applicant rate (fraction of people aged 22-26 years applying to dental schools) caused the number of applicants to increase such that it more than offset the decline in the population in this age group.

From 1997-2001, the number of applicants has dropped each year, falling from 9,829 in 1997 to 7,412 in 2001. This decline can be partly attributed to the decrease in the actual U.S. population aged 22-26 years. Another explanation can be found in the decline in dental income relative to income of other professionals with a bachelor's or higher degree between 1995 and 1997. Particularly, between 1996 and 1997, the ratio of dental income to the income of college graduates fell by approximately 1.5%. In 1998, this ratio increased by 5.4%. The number of applicants has increased every year since 2001. In 2007, the number of applicants increased to 13,742—a 10.3% increase from 12,463 in 2006.

The number of applicants is projected to continue this upward trend over the next ten years. This upward trend is heavily influenced by two major factors: the projected increase in the U.S. population 22-26 years of age until the year 2015; and the continued increase in dental income relative to the income of other professionals with a bachelor's or higher degree.

After the year 2016, the number of applicants is projected to decline (see Figure 2 and Table 1a). This decline corresponds to the Census Bureau's projected decline for the U.S. population aged 22-26 years during this same period.

Figure 2: Actual and Projected Dental School Applicants and Admissions, 1951-2030



Source: American Dental Association, Survey Center, *Survey of Predoctoral Dental Education* (various years) and Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*.

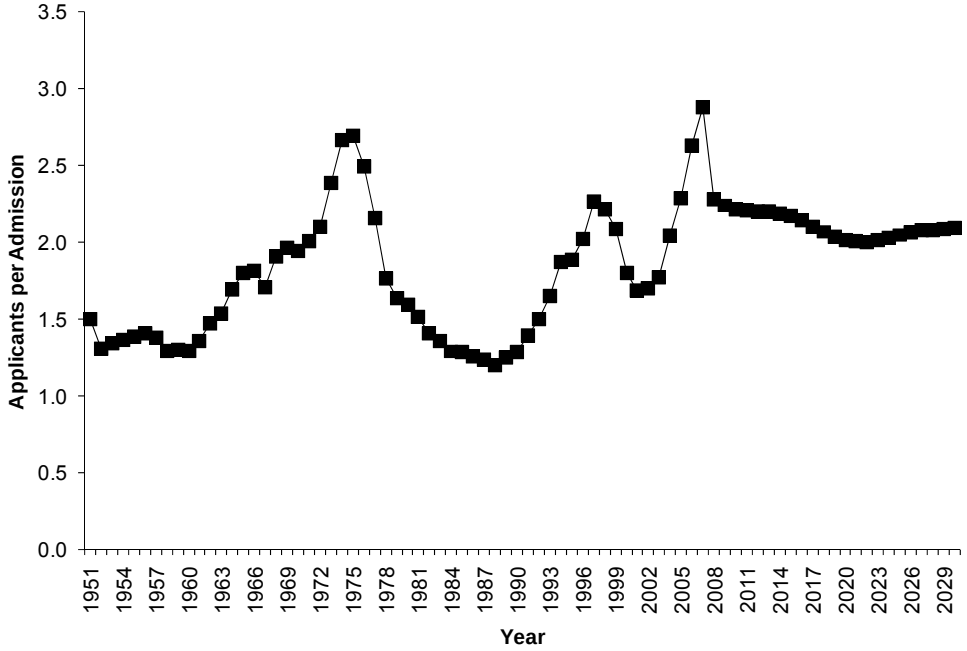
Admissions. In 2007, the number of admissions or first-year enrollments increased again after briefly stalling in 2004. In 2005 and 2006, there were 4,688 and 4,733 first-year enrollments, respectively. In 2007, the number of first-year enrollments increased 0.78% to 4,770.

Enrollments in U.S. dental schools have responded to the trends in the number of applicants, with some delays as institutions adjust to large shifts in demand for dental education. Hence, it follows that the enrollments are not very responsive in the short-run, as one would expect. The long-run trend in enrollment shows a moderate but direct response to the size of the applicant pool.

When examining the historical trends in dental school admissions, it is evident that the last three decades can be divided into three major phases. The first period occurred from 1970-78. During this period, the number of first-year enrolled dental students increased by 33.6%, or about 4.2% simple average rate per year. The second period of 1978-89 witnessed a decline in first-year enrollments by about 3.2% per year. In the final period, since 1990, the number of first-year enrollments has followed a general trend of increase, increasing an average of 1.1% per year to 4,770 in 2007. The number of first-year enrollments is expected to increase through the end of the projection period.

Applicants Per Admission. The number of dental school applicants exhibited periods of relatively sharp increases and decreases in the past decades. Following the declining trend in applications during the 1980s, the number of applicants per admission to dental school reached an all-time low of 1.2 applicants per admission in 1988. This apparent instability in the number of applicants per admission stems from the fluctuation in the number of applicants. The delayed adjustment process of admissions also magnifies this fluctuation. The applicant-per-admission ratio increased each year between 1989 and 1997, reaching a high of 2.3 in 1997. However, since 1997, this ratio decreased each year, reaching a low of 1.7 in 2001—and it remained at 1.7 in 2002 and 2003 before increasing to 2.0 in 2004. The ratio has continued to increase since 2004 reaching 2.9 in 2007.

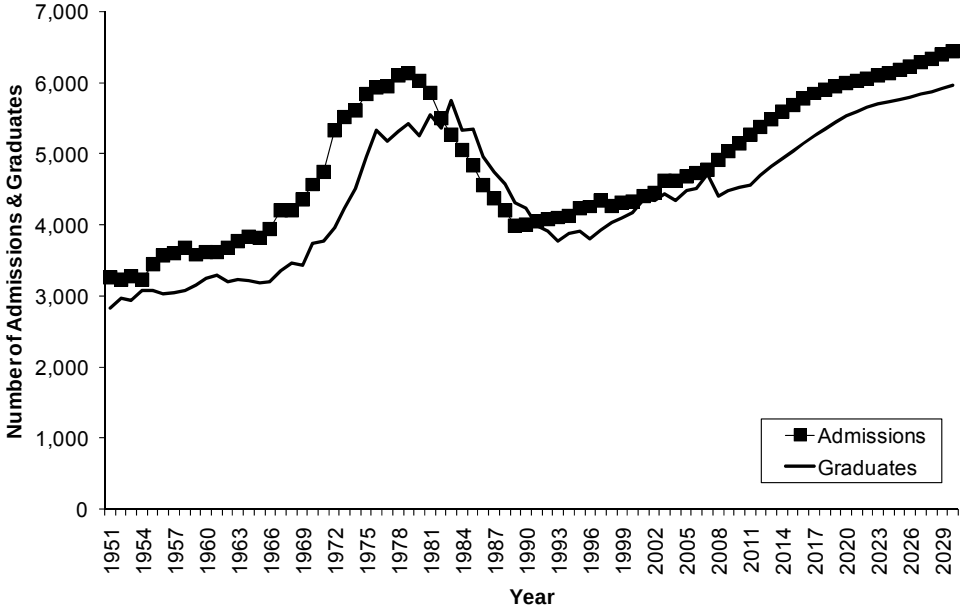
Figure 3: Actual and Projected Applicants per Dental School Admission 1951-2030



Source: American Dental Association, Survey Center, *Survey of Predoctoral Dental Education* (various years) and Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*.

Graduates. Trends in the number of dental graduates lag those of applicants and admissions by approximately four years, although the changes are somewhat restricted by the relatively stable number of seats available in dental schools in the short-run. Not surprisingly, there was a general trend of growth in the number of graduates since 1994, approximately four or five years after a growth trend in applicants emerged. In 2007, the number of graduates increased to 4,714—a 4.4% increase from 4,515 in 2006. A general trend of growth is expected to continue. Figure 4 depicts both the actual and projected numbers of admissions and graduates.

Figure 4: Actual and Projected Number of Admissions and Graduates, 1951-2030



Source: American Dental Association, Survey Center, *Survey of Predoctoral Dental Education* (various years) and Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*.

Forecasts of the Dentist Workforce: When estimating the future size of the active dentist workforce, several factors must be taken into consideration. A starting base, which is derived from the current year's "soft-counts,"[6] is projected into the future as the base, onto which additions and losses are applied. Additions to this base can occur in the form of new dental school graduates or in the form of foreign dentists entering the United States. Losses can occur in the form of death, retirement or transitions to occupations unrelated to dentistry. In light of these factors, it is helpful to review their historical trends in order to better understand the effect they have on each other and the overall size of the active dentist workforce.

Throughout the 1980s, dentistry witnessed a general decline in the number of applicants to dental schools. This decline in applicants began in 1976 and was soon followed by a decline in first-year enrollments in dental schools (which began in 1980), a decline in the number of graduates from dental schools (which began in 1984) and five dental school closings. However, these trends reversed during the period of 1989-97, which experienced increases in applicants and first-year enrollments in dental schools. Graduation, which lags these trends by about four years, also increased with the first increase since 1985 occurring in 1994 (a 2.6% increase to 3,875).

The reversal in the number of applicants between 1990 and 1997 coincided with a stabilization of relative net lifetime earnings between dentists and other college graduates (a relationship that declined between 1972 and the early 1990s). Since 1990, dental lifetime earnings generally increased faster than those of college graduates, making dentistry a more financially appealing profession. The rate of return to dentistry also continued to improve, and is expected to continue to increase into the future. The rapid rise of managed care

[6] Each year, the Survey Center of the American Dental Association surveys one-third of the dentist population to determine the number and occupational status of all dentists in the U.S. The responses to these one-third samples represent the "hard-counts" from which "soft-count" estimations are made based on the history of responses for each individual dentist. For two-thirds of the dentist population not included in an annual survey, estimates of occupational status are constructed based upon previous survey responses and the dentist's age and gender. "Soft-counts" serve as the complete dentist population count.

programs in general medicine also makes dentistry a more attractive alternative to some individuals wishing to work in the health care field.

Considering these trends, it is projected that the total number of active dentists and the number of private practitioners will continue with a general trend of increase over the span of the projection period. However, beyond 2020, the growth in the number of professionally active dentists and active private practitioners is expected to level off (see Figure 5).

Professionally Active Dentists and Active Private Practitioners. Between the period of 1993 and 2007, the number of professionally active dentists and active private practitioners increased 17.2% and 16.9%, respectively. As shown in Figure 5 and Table 1a, the number of both professionally active dentists and active private practitioners is expected to increase over the projection period. Between 2007[7], and 2030, the number of professionally active dentists is expected to increase 10.9%, reaching 201,453 and the number of active private practitioners is expected to increase 10.4%, reaching 184,122.

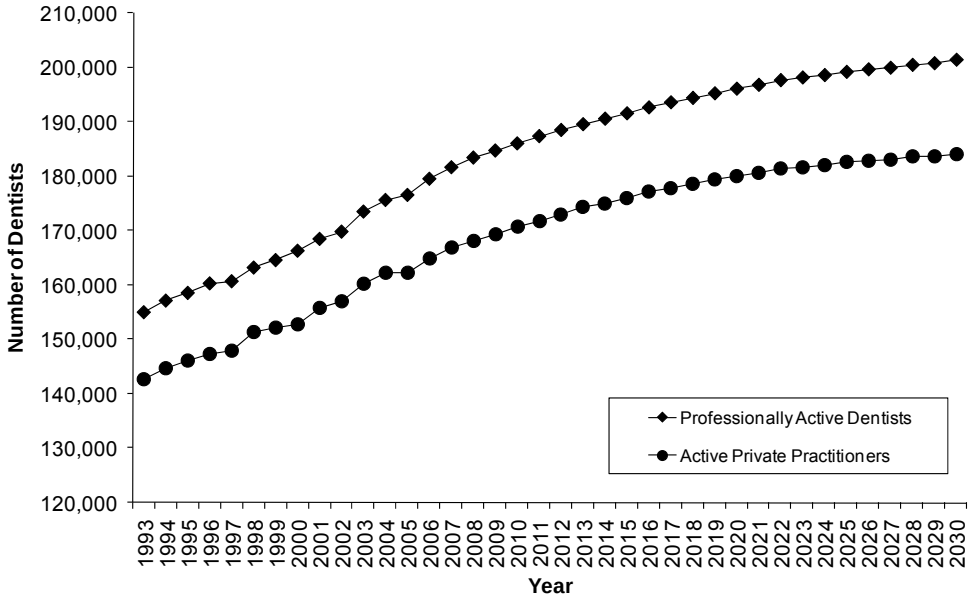
The numbers of both professionally active dentists and active private practitioners per 1,000 U.S. resident population are listed in Table 1b. For both groups of dentists this ratio has been fairly stable, but it is projected to decline in the coming years. The reader should note, however, that this ratio implicitly holds constant many relevant factors—such as dentists' productivity—that affect both the population's need and desire for dental care as well as dentists' ability to produce those services. For example, improved productivity[8] in the provision of dental services in the future would mean that in the future, fewer dentists will be able to produce the same amount of dental services as compared to dentists in previous years. Thus, relying solely on dentist-to-population ratios as a measure of workforce adequacy[9] is misleading.

[7] At the time of this report, the *2007 Distribution of Dentists in the United States by Region and State* was not published; therefore, the 2007 numbers are preliminary.

[8] For a detailed discussion of productivity of dentists and the pitfalls of simple dentist-to-population ratios refer to *Future of Dentistry* (American Dental Association. Future of Dentistry. Chicago: American Dental Association, Health Policy Resources Center; 2001). This publication is available online at: http://www.ada.org/prof/resources/topics/futuredent/, paper copies can be purchased by calling 800-947-4746.

[9] For a detailed discussion of workforce adequacy refer to the following ADA reports: *Adequacy of Current and Future Dental Workforce* and/or a more detailed version *Adequacy of Current and Future Dental Workforce: Theory and Analysis*. Both reports can be purchased by calling 800-947-4746.

Figure 5: Actual and Projected Number of Professionally Active Dentists and Active Private Practitioners, 1993-2030



Source: American Dental Association, Survey Center, *Distribution of Dentists in the United States by Region and State* (various years) and Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*.

Table 1a: Census Counts and Projections, 1993-2030

Year	Professionally Active Dentists	Active Private Practitioners	Applicants to Dental School	Applicant Rate	1st-Year Enrollment	Graduates	Applicants per Admission
1993	155,087	142,603	6,761	0.348	4,100	3,778	1.649
1994	157,228	144,581	7,713	0.399	4,121	3,875	1.872
1995	158,641	146,089	7,996	0.418	4,237	3,908	1.887
1996	160,388	147,247	8,598	0.458	4,255	3,810	2.021
1997	160,781	147,778	9,829	0.534	4,347	3,930	2.261
1998	163,291	151,309	9,447	0.526	4,268	4,041	2.213
1999	164,664	152,151	9,010	0.501	4,314	4,095	2.089
2000	166,383	152,798	7,770	0.426	4,327	4,171	1.796
2001	168,556	155,716	7,412	0.397	4,407	4,367	1.682
2002	169,894	156,921	7,538	0.394	4,448	4,349	1.695
2003	173,574	160,184	8,176	0.415	4,618	4,443	1.770
2004	175,709	162,184	9,433	0.469	4,612	4,350	2.045
2005	176,634	162,180	10,731	0.526	4,688	4,478	2.289
2006	179,594	164,864	12,463	0.604	4,733	4,515	2.633
2007	181,725[7]	166,837[7]	13,742	0.663	4,770	4,714	2.881
2010	186,098	170,719	11,411	0.542	5,153	4,530	2.215
2015	191,620	175,970	12,343	0.548	5,691	5,041	2.169
2020	196,137	180,084	12,087	0.554	5,998	5,530	2.015
2025	199,230	182,789	12,655	0.561	6,186	5,774	2.046
2030	201,453	184,122	13,473	0.562	6,448	5,968	2.089

Source: American Dental Association, Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*.

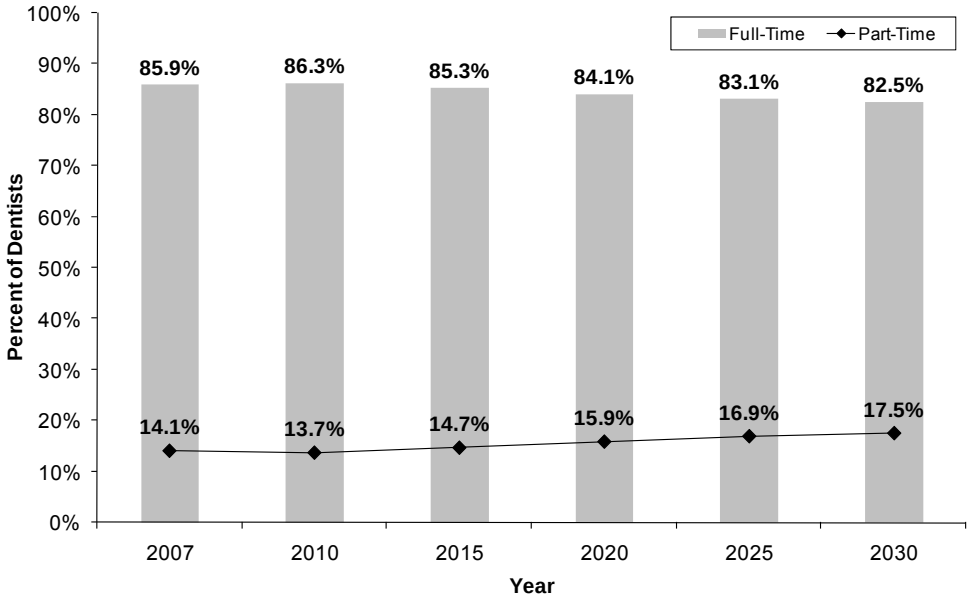
Table 1b: Census Counts and Projections, Including U.S. Resident Population, 1993-2025

Year	Population (in thousands)	Professionally Active Dentists	Active Private Practitioners	Professionally Active Dentist per 1,000 U.S. Resident Population	Active Private Practitioners per 1,000 U.S. Resident Population
1993	260,255	155,087	142,603	0.60	0.55
1994	263,436	157,228	144,581	0.60	0.55
1995	266,557	158,641	146,089	0.60	0.55
1996	269,667	160,388	147,247	0.59	0.55
1997	272,912	160,781	147,778	0.59	0.54
1998	276,115	163,291	151,309	0.59	0.55
1999	279,295	164,664	152,151	0.59	0.54
2000	282,158	166,383	152,798	0.59	0.54
2001	284,915	168,556	155,716	0.59	0.55
2002	287,501	169,894	156,921	0.59	0.55
2003	289,986	173,574	160,184	0.60	0.55
2004	292,806	175,709	162,184	0.60	0.55
2005	295,583	176,634	162,180	0.60	0.55
2006	298,442	179,594	164,864	0.60	0.55
2007	304,280	181,725[7]	166,837[7]	0.60	0.55
2010	310,233	186,098	170,719	0.60	0.55
2015	325,540	191,620	175,970	0.59	0.54
2020	341,387	196,137	180,084	0.57	0.53
2025	357,452	199,230	182,789	0.56	0.51
2030	373,504	201,453	184,122	0.54	0.49

Source: American Dental Association, Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030* and United States Census Bureau, International Data Base, Table 094: Total Midyear Population, available at: "http://www.census.gov/cgi-bin/ipc/idbsprd."
(Last Revised: *14 Aug 2008.)* Accessed 11 June 2009.

Full-Time and Part-Time Status. The DWM allows for the distinction of full-time active private practitioners (32 or more hours per week) from part-time active private practitioners (less than 32 hours per week). In 2007[7], 14.1% of active private practitioners were part-time. That is, there were 143,310 full-time active private practitioners and 23,527 part-time active private practitioners. The percent of part-time active private practitioners is expected to follow a general trend of increase over the course of the projection. This increase is mainly driven by the increase of female dentists. In general, female dentists are more likely to be part-time than their male counterparts. By the year 2030, it is projected that 17.5% of active private practitioners will be part-time (see Figure 6).

Figure 6: Projected Percentage Distribution of Active Private Practitioners, by Full-Time and Part-Time Status, 2007-2030



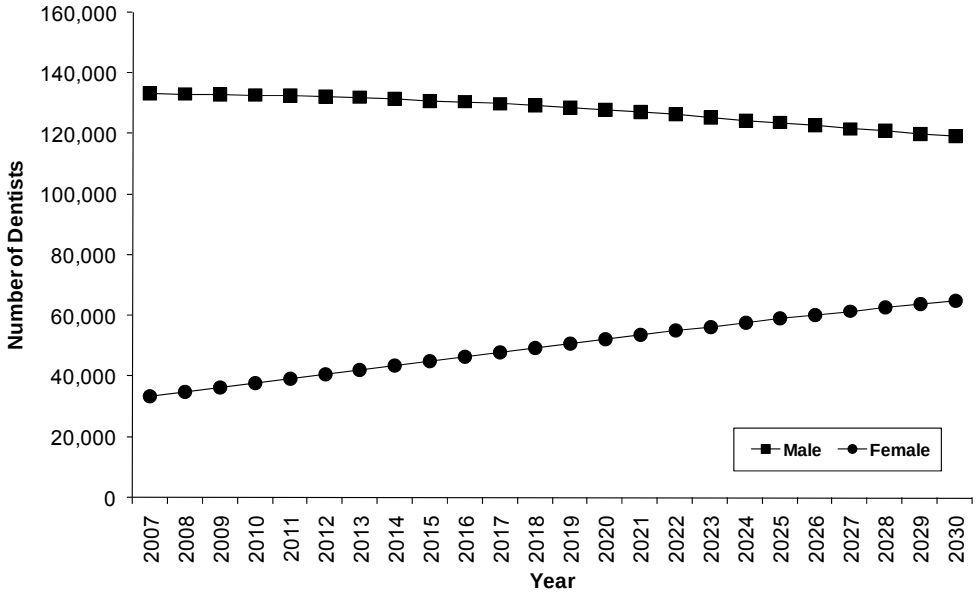
Source: American Dental Association, Survey Center, *2007 Distribution of Dentists in the United States by Region and State*[7] and Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*.

Female Dentists. Female dentists are joining the profession in steadily increasing numbers. Judging by the recent increasing percentages of females in dental school enrollments, it is fair to say that the ratio of male to female dentists has yet to stabilize, unlike that of the medical[10] profession. Based on ADA's *Distribution of Dentists in the United States by Region and State*, the percentage of professionally active female dentists has increased from 19.7% in 2006 to 20.6% in 2007[7]. The number of female dental graduates in 2007 reached 2,099 representing 44.5% of the graduating class. As graduating classes continue to move into the profession, women will continue to form an ever-increasing portion of practicing dentists through the foreseeable future (see Figure 7).

Originally, the DWM used only the gender composition of graduating classes to project the future gender composition of the dental workforce. In the 2003 Model, the DWM was updated to also incorporate the gender composition of incoming classes to dental schools. This update has resulted in a slightly higher percentage distribution of female dentists over the course of the projection.

[10] For a data on medical school enrollments go to: http://www.aamc.org/data/facts/2008/2008school.htm.

Figure 7: Projected Number of Professionally Active Dentists, by Gender, 2007-2030



Source: American Dental Association, Survey Center, *2007 Distribution of Dentists in the United States by Region and State*[7] and Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*.

Age Distribution. The projection of the age distribution of professionally active dentists is presented in Table 2 as derived from the DWM for several periods from 2000-30. As can be seen in Table 2 and Figure 8, the upward age shift that had been predicted over the last few years has begun. In 2000, for example, there was a significant peak in the age distribution among the 45-49 age group (17.2% of professionally active dentists); by 2007[7], the peak (15.4%) in age distribution occurs among the 50-54 age group. By 2015, the age distribution will be flatter and more diffuse with significantly more dentists in higher age groups—the largest distribution of 12.9% occurring among the 60-64 age group.

Table 2: Percentage Age Distribution of Professionally Active Dentists, 2000-2030

Age Group	2000	2007[7]	2010	2015	2020	2025	2030
Under 30	4.33%	3.90%	2.09%	2.05%	2.29%	2.40%	2.39%
30-34	9.99%	9.81%	10.96%	9.09%	9.68%	10.35%	10.77%
35-39	11.98%	11.26%	11.13%	12.21%	10.62%	11.40%	12.11%
40-44	15.24%	10.99%	10.73%	11.05%	12.19%	10.76%	11.60%
45-49	17.20%	13.04%	11.55%	10.37%	10.71%	11.87%	10.56%
50-54	14.94%	15.44%	13.50%	10.91%	9.85%	10.26%	11.41%
55-59	10.51%	13.51%	14.46%	12.53%	10.12%	9.24%	9.65%
60-64	6.53%	10.31%	11.71%	12.88%	11.18%	9.06%	8.32%
65-69	4.69%	5.42%	7.20%	9.77%	10.76%	9.48%	7.65%
70-74	2.43%	3.09%	3.38%	5.38%	7.33%	8.06%	7.07%
Over 74	2.16%	3.24%	3.29%	3.77%	5.28%	7.12%	8.48%

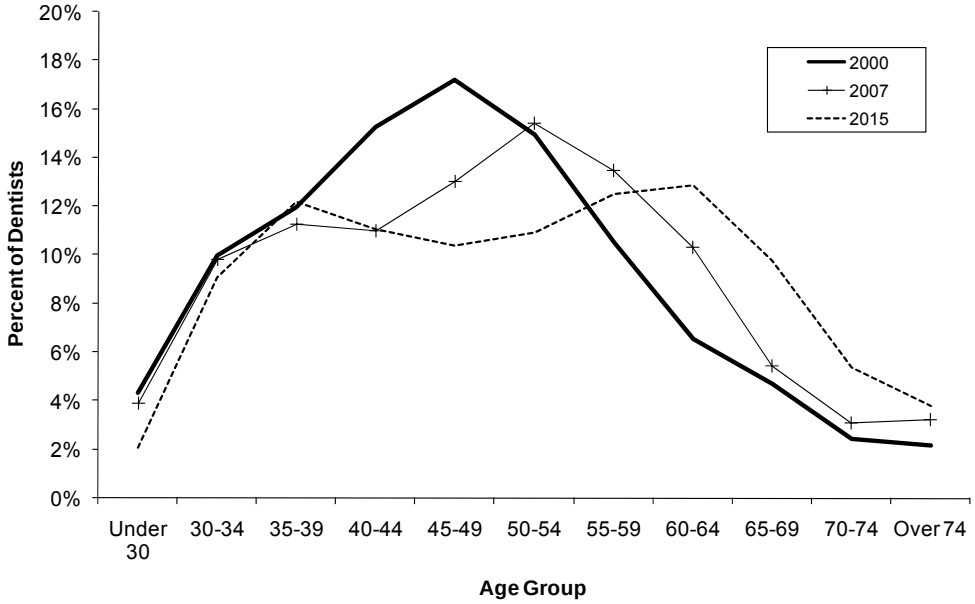
Source: American Dental Association, Survey Center, *2000* and *2007 Distribution of Dentists in the United States by Region and State*[7] and Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*.

One can observe from Table 2 that by 2010, a sizable proportion of professionally active dentists will have moved past the most productive period for dentists—35-54 years of age. In 1991, 23.4% of professionally active dentists were past this age group (over 54 years old); by 2010 this percentage is expected to reach 40.1%. In fact, the single largest five-year age bracket in 2010 will be just past the highest productivity period (i.e., dentists 55-59 years old will account for 14.5% of professionally active dentists).

Overall, the percentage of dentists in the most productive age bracket (35-54 years old) was at a peak of 61.6% in 1996, from which it slid to 50.7% in 2007[7] and is projected to continue falling to 43.4% in 2020. That is, over the next 13 years, it is expected that a gradual "graying" of the U.S. dentist population will occur. Beyond 2020, the aging of the large number of 1980s dental graduates will be complete, and the age composition of dentists is expected to become much more stable.

The large "bubble" of the dentists educated in the 1970s—when federal capitation payments were in place and the relative financial returns to dentistry were simultaneously at an all time high—will help stabilize the age composition of dentists. As this group of dentists retires, the profession will encounter smoother workforce transitions. In the absence of future government intervention, the ensuing workforce is expected to be much more stable, both in terms of numbers and age distribution.

Figure 8: Percentage Age Distribution of Professionally Active Dentists in 2000, 2007 and the Projected Distribution in 2015



Source: American Dental Association, Survey Center, *2000 and 2007 Distribution of Dentists in the United States by Region and State*[7]
and
Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*.

Sensitivity Analysis of the 2009 ADA Dental Workforce Model: 2007-2030: The Dental Workforce Model (DWM) sensitivity analysis explores the sensitivity of various indicators of the dental workforce to the changes in rate of return to dental education (ROR). These indicators include the number of applicants to and graduates of dental schools, the number of professionally active dentists and the number of active private practitioners.

The ROR is a term used to express the return that dental students receive from their education investment over the course of their dental careers. Its calculation is supported with data on dentists' net incomes across all ages, the cost of dental education (net of scholarships), and data on incomes of competing careers, across all ages. Intuitively, one can expect the number of applicants, graduates, professionally active dentists and active private practitioners to rise if the ROR increases and to fall if the ROR decreases.

This section on sensitivity analysis explores the impact of changes in the ROR on future applicants, graduates, professionally active dentists and active private practitioners. The sensitivity analysis examines both a 2.5% increase and a 2.5% decrease in the ROR. In this analysis, a one-time change is applied to the 2007 ROR and, using the DWM, future RORs are projected to 2030. The change is applied to the base RORs, which as shown in Table A-1 ranged from 20.37% in 2007 to 20.61% in 2030.

After a one-time increase in ROR between 2007 and 2008 occurs, there is an increase in applicants almost immediately (see Figure A-1). This increase in applicants leads to an increase in graduates within five years, or by 2012 (see Figure A-2). The effect of the increase in the ROR on graduates continues through the remainder of the projection. An increase in the number of professionally active dentists begins to emerge by 2013 (see Figure A-3), as does an increase in the number of active private practitioners (see Figure A-4). This reflects the increase of graduates into the dental workforce from the previous three years. The impact of an increase in the ROR will continue as more graduates are added into the workforce.

A one-time decrease in the ROR has similar downward effects on applicants, graduates, professionally active dentists and active private practitioners. However, the magnitude of the effect of a downward adjustment of 2.5% in the ROR seems to be slightly stronger compared to a 2.5% upward adjustment. The primary reason for this is that in the base-case scenario, the ROR is increased by 0.05% annually, including the 2007-08 period when the two ROR adjustments take place. This results in the upward ROR adjustment being closer to the base-case ROR than the downward ROR adjustment (see Table A-1).

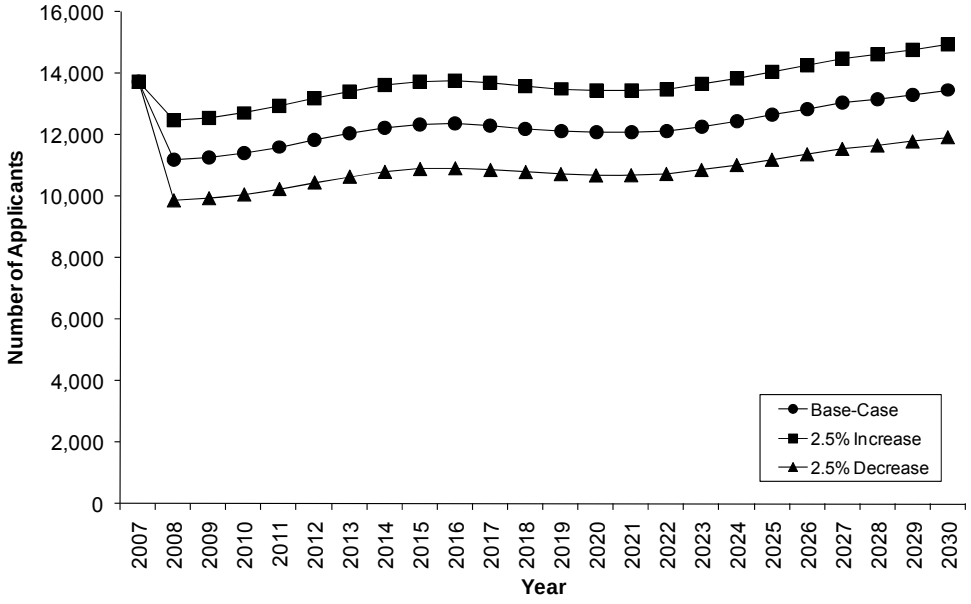
In conclusion, an adjustment in the ROR will begin to impact the size of the dental workforce within approximately six years. This impact will continue as more graduates are added to or as existing dentists are lost from the dental workforce.

Table A-1: Three Scenarios of Rate of Return Used for the Projections in Figures A-1 through A-4

Year	Rate of Return		
	Base-Case	2.5% ROR Increase	2.5% ROR Decrease
2007	20.37%	20.87%	19.85%
2008	20.38%	20.88%	19.86%
2009	20.39%	20.89%	19.87%
2010	20.40%	20.90%	19.88%
2011	20.41%	20.91%	19.89%
2012	20.42%	20.92%	19.90%
2013	20.43%	20.93%	19.91%
2014	20.44%	20.94%	19.92%
2015	20.45%	20.95%	19.93%
2016	20.46%	20.96%	19.94%
2017	20.47%	20.97%	19.95%
2018	20.48%	20.98%	19.96%
2019	20.49%	20.99%	19.97%
2020	20.50%	21.01%	19.98%
2021	20.51%	21.02%	19.99%
2022	20.52%	21.03%	20.00%
2023	20.53%	21.04%	20.01%
2024	20.54%	21.05%	20.02%
2025	20.55%	21.06%	20.03%
2026	20.56%	21.07%	20.04%
2027	20.57%	21.09%	20.05%
2028	20.59%	21.09%	20.06%
2029	20.60%	21.10%	20.07%
2030	20.61%	21.11%	20.08%

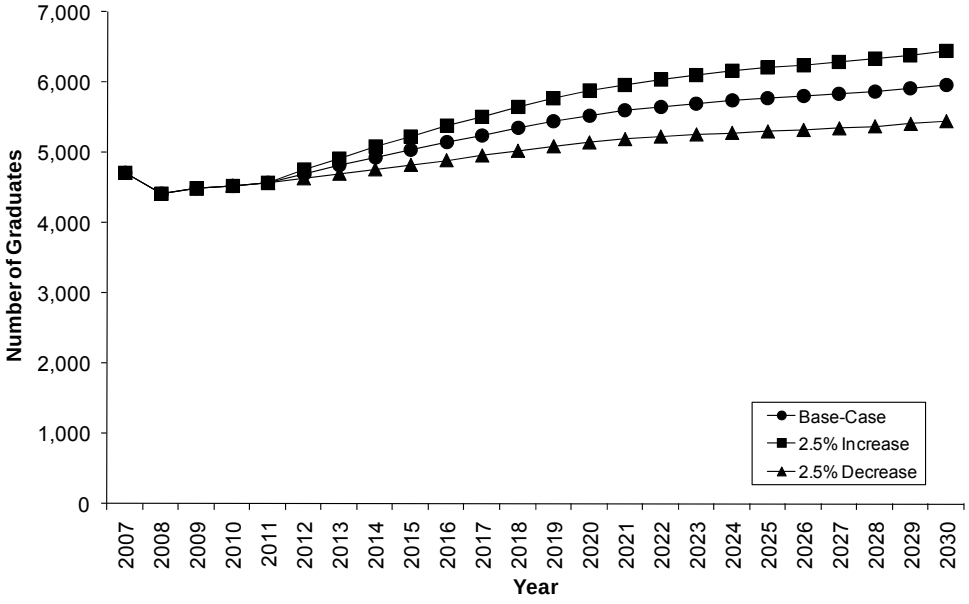
Source: American Dental Association, Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*.

Figure A-1: Projected Number of Dental School Applicants Under Base-Case, Increasing and Decreasing Rate of Return Scenarios, 2007-2030



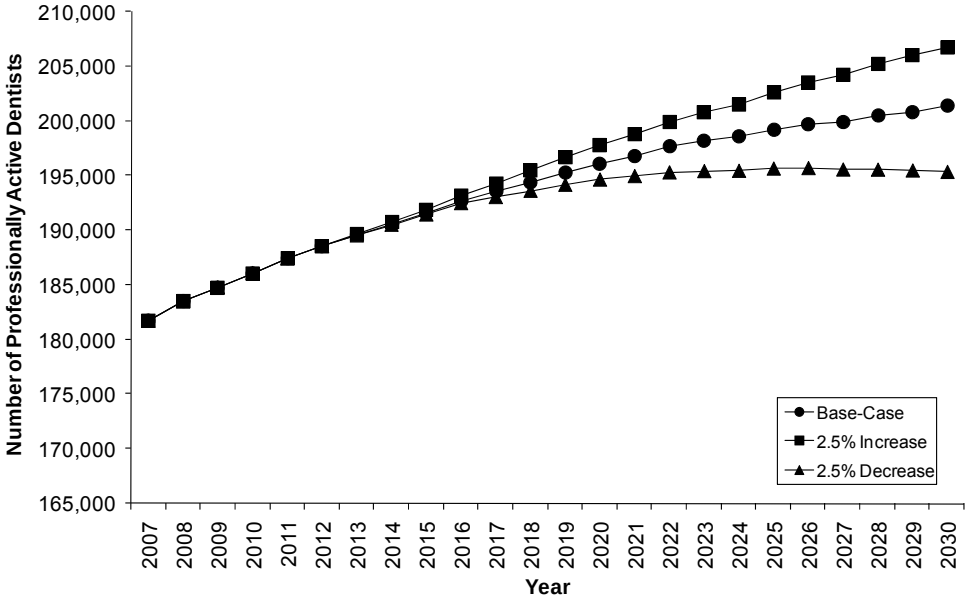
Source: American Dental Association, Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*.

Figure A-2: Projected Number of Dental School Graduates Under Base-Case, Increasing and Decreasing Rate of Return Scenarios, 2007-2030



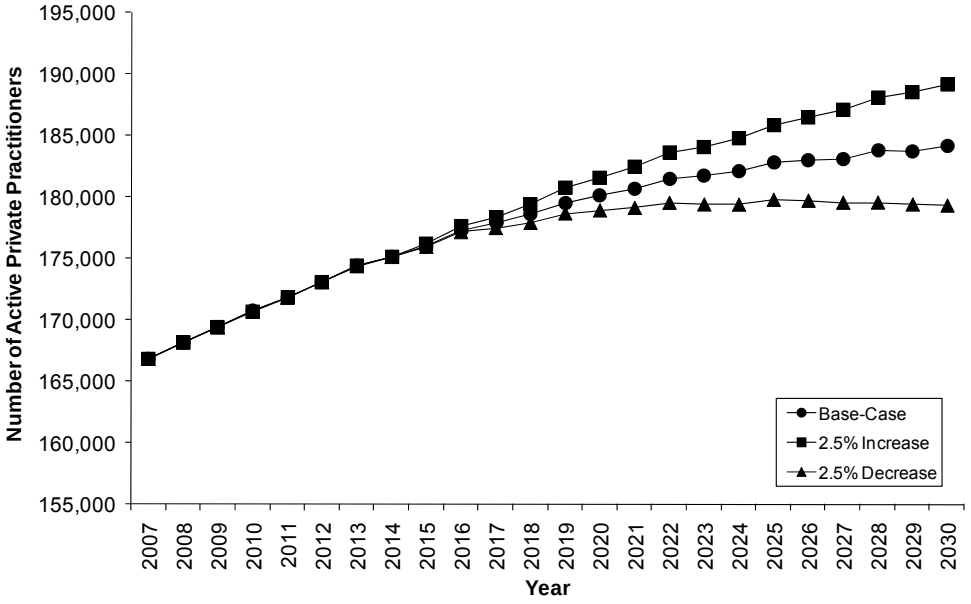
Source: American Dental Association, Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*.

Figure A-3: Projected Number of Professionally Active Dentists Under Base-Case, Increasing and Decreasing Rate of Return Scenarios, 2007-2030



Source: American Dental Association, Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*.

Figure A-4: Projected Number of Active Private Practitioners Under Base-Case, Increasing and Decreasing Rate of Return Scenarios, 2007-2030



Source: American Dental Association, Health Policy Resources Center, *2009 ADA Dental Workforce Model: 2007-2030*

Resolution No. None New ☐ Substitute ☐ Amendment ☐

Report: Board Report 11 Date Submitted: September 2009

Submitted By: Board of Trustees

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

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

REPORT 11 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:
FUTURE OF PAFFENBARGER RESEARCH CENTER

Executive Summary: Concern about the future of the Paffenbarger Research Center (PRC) led the Board of Trustees to appoint a panel of external experts to study the challenges facing PRC and recommend ways to meet them.[1] Subsequently, the Board asked the Council on Scientific Affairs to use the report of the external experts and other resources to develop mission and vision statements for PRC, aggressively identify candidates for the open position of PRC senior director, and develop a plan of action, milestones and a budget for review and consideration by the Board of Trustees.

The Council submitted its report with recommendations to the April 2009 meeting of the Board. The Board approved the Council recommendations and authorized a Work Group to begin implementing them. The Work Group is chaired by ADA trustee, Dr. Russell Webb. Other members are Dr. Robert Faiella (ADA Board of Trustees, liaison to Council on Scientific Affairs), Dr. Raul Garcia (ADAF Board of Directors) and Drs. Michael Rethman and Mark Lingen (Council on Scientific Affairs). This report informs the House of the Council's findings and recommended plan for revitalizing PRC and outlines the future, multi-year budget implications of the plan.

The Council identified PRC's key strengths, among them PRC's:

- association with the ADA
- international reputation for research excellence
- track record in securing grants and obtaining patents
- unique relationship to NIST (National Institute of Standards and Technology)
- proven ability to develop groundbreaking technology and promote rapid translation to market. More than 200 products on the market today are based on PRC patents.

PRC's breadth and depth of scientific expertise are not duplicated anywhere else at ADA. Only PRC has a large staff of scientists doing basic and applied research on a full-time basis and the capability to lead in emerging issues research of critical importance to the profession. PRC generates substantial revenue for the ADA/ADA Foundation. In 2008, PRC generated close to $1.5 million in royalties and more than $500,000 in indirect costs from grants.

[1] The PRC external review panel consisted of Dr. David Sarrett (chair, Virginia Commonwealth University) and Drs. Christopher Fox (IADR), Jeremy Mao (Columbia University. College of Dental Medicine), Richard Valachovic (ADEA) and James Wefel (University. of Iowa College of Dentistry).

However, PRC's successes mask challenges that threaten the institution's future. These challenges are interdependent and must be addressed comprehensively. They include:

- difficulty filling the key leadership position at PRC
- a changing environment for private and public research funding
- missing generations of scientists ready to obtain independent grant support for their own research projects
- lack of resources to move PRC in new research directions

Unless these challenges are met, PRC is unlikely to be able to sustain its current research program beyond the next two to three years. If this happens, the dental profession will lose future technological breakthroughs and an independent source of sound, unbiased science on increasingly complex oral health issues tied to general health. Further, the ADA's ability to participate meaningfully in standards activities and engage in critical issues research will be considerably diminished.

The Council identified and the Board approved 14 key recommendations to assure PRC's future and an action plan and budget to support them. The budget calls for a significant investment of resources over an extended period of time in order to revitalize PRC's research programs and make them self-sufficient. Although various factors will influence the final amount, preliminary estimates call for $12.5M over six years (the budget can be found in the Appendix). The ADAF Board of Directors has already approved tapping ADAF royalty funds (which derive from PRC patents) to meet PRC's immediate (2009) needs and is prepared to consider a proposal to fund the first year of the multi-year transition budget (2010) from the same source. The ADA Board of Trustees has not sought additional funds for PRC in the proposed 2010 ADA budget. However, the Board intends to propose additional funding for PRC, beginning with the 2011 ADA budget that takes account of funding available to PRC from the ADAF.

Assignment from the Board of Trustees: In 2007, concern about the future of the Paffenbarger Research Center (PRC) led the ADA Board of Trustees to appoint a review panel of external experts to study the challenges facing PRC and recommend ways to meet them. The immediate cause for concern was the difficulty ADA experienced in filling the position of senior director, PRC. The previous incumbent left PRC in 2006, and the position remains open despite active efforts to recruit a successor. The Board perceived this as an opportunity to re-examine PRC's mission and vision in order to attract a candidate who can lead PRC into the future. The PRC external review panel submitted its report to the Board in June 2008.

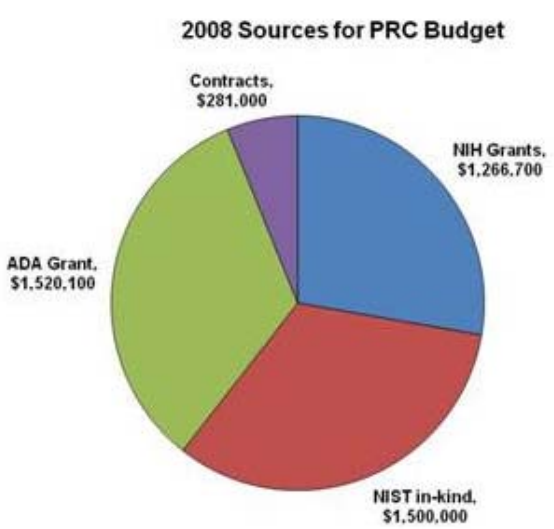
The Board voted to task the Council on Scientific Affairs with utilizing the report and other resources to develop a future mission and vision statement for PRC; aggressively identify candidates for the position of PRC senior director; and develop a plan of action, milestones and a budget for review and consideration by the Board of Trustees. The Council delivered its report with recommendations to the Board in April 2009. In its report, the Council cautioned that its recommendations on the future of PRC should be read with the understanding that the type of individual the ADA is looking for to lead PRC will contribute his or her own ideas about the research direction PRC should pursue. It will be necessary to refine the recommendations presented in this report accordingly. The budget, in particular, can only be estimated at this time.

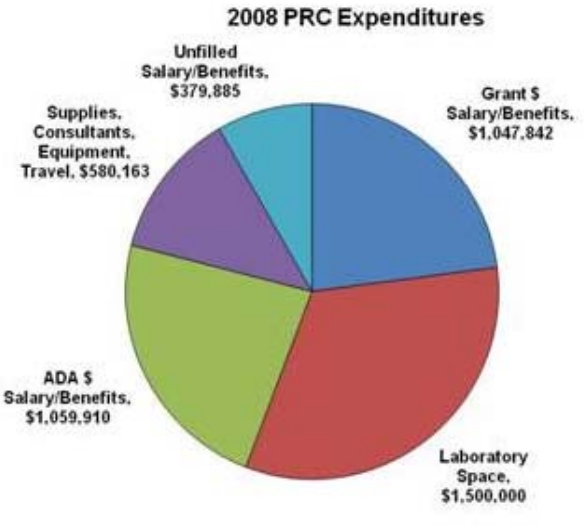
Strengths of PRC: The Council identified the following as strengths that PRC should build on for future success:

1. *PRC's Association with American Dental Association*. PRC's association with the ADA enhances the center's prestige and influence; ADA funding provides PRC with a source of financial stability. Conversely, the ADA's association with PRC increases the Association's credibility and influence in matters related to science and research.

2. *PRC's Reputation for Research Excellence*. Over the years, PRC has evolved from its early role as a collaborator with the National Bureau of Standards (now NIST) to develop a purchasing specification for dental amalgam, into a leading center for dental research with a strong national and international reputation.[2] PRC's reputation is particularly strong in the areas of polymer chemistry for restorative dentistry and calcium, phosphate, and fluoride chemistry for caries prevention, tooth remineralization and tissue scaffolds. ADA support of PRC reflects positively on the Association's dedication to science and on the image of dentistry as a science-based profession.[3]

3. *PRC's Proven Success in Obtaining Grants.* Every dollar the ADA invests in PRC is matched by one dollar of NIH grant support for specific research projects and one dollar of in-kind support from the National Institute of Standards and Technology (NIST). The charts below provide a snapshot of the sources of PRC funding support and PRC expenditures. PRC has 26 employees (23 in research positions) and an annual budget of approximately $4.6M.





4. *Record of Productivity*. PRC excels in the three measures generally used to assess the productivity of research institutions: patents, publications and grants. Table 1 shows PRC productivity measures for the years 2004-08.

[2] PRC extends its reach internationally by collaborating with scientists in industry and academia throughout the world. Currently, Dr. Go Inoue from the Tokyo Medical and Dental University is working with our Dr. Chow developing improved formulations for fluoride releasing varnishes, and improved prophy pastes. Other collaborations involve scientists from the University of Maryland, Howard University, Armed Forces Institute of Pathology (AFIP), University of Alabama, Johns Hopkins University, University of Colorado, Nihon University and the University of Campinas, Brazil. Over the past five years, PRC scientists have mentored more than 12 graduate dental students in their Masters of Science degrees at the U.S. Naval Dental Graduate School. Forty abstracts and presentations, and ten publications have resulted from these collaborations.

[3] Recent *ADA News* articles contributing to that image include June 9, 2008 "Paffenbarger Research Center Marks 80 Years of Leadership" and August 20, 2007 "Inventing the Future."

Table 1. PRC Research Productivity, 2004-08

Year	Papers/Abstracts	U.S. Patents	New Grants
2008	41/17	1	1
2007	37/20	1	2
2006	53/25	1	1
2005	59/31	2	3
2004	42/26	1	4

- **Patents.** PRC scientists have generated 88 U.S. patents since 1977, many of which are licensed by industry. In 2008 alone, the ADA Foundation filed three U.S. patent applications based on PRC inventions and was awarded one new U.S. patent and several foreign patents based on U.S. patents. Royalties from patents on PRC inventions are a significant source of revenue to the ADA Foundation, amounting to $5.5M over the past six years and $1.4M in 2008 alone.

- **Publications.** In 2008, scientists at PRC published 41 peer-reviewed papers and presented 28 lectures and invited talks to ADA constituents and components, related dental organizations, universities, academies, study clubs and other organizations. Eight PRC researchers presented their data at the 2008 American Association for Dental Research (AADR) meeting.

- **Grants.** PRC receives substantial support from its very successful grant program. Table 1 above shows the number of new grants received by PRC scientists over the past five years. However, this number alone is not an adequate measure of research productivity. Research facilities commonly use a formula to calculate grant support per square footage of research space. In 2008, PRC generated a total of $1,839,284 from NIH grants (direct and indirect costs). Grant support per square foot averaged between $309/sq.feet and $195/sq.feet, depending on how much office and administrative space is included in the calculation of "research space." In general, productivity that exceeds $250/sq.feet is considered optimal.

  The ADA/ADAF also benefit from PRC grants in the form of the indirect costs paid to the ADA from PRC grants (indirect costs amount to 50% of direct costs, or $25K on a $75K grant where $50K are the direct costs). Indirect costs are the institution's costs of doing business (in this case, ADA's) that are not readily identified with a specific research project, but are necessary to PRC's operation. In 2008, the ADA received payment of $507,957 in indirect costs from PRC research grants. The ADA subsequently passed this revenue on to the ADA Foundation.

  Table 2 compares revenue generated by PRC for the ADA and ADA Foundation with ADA dollar support for PRC to help visualize the revenue that the ADA and ADA Foundation receive for their investment in PRC. Table 2 shows that indirect cost recovery income to ADA and royalty income to the ADAF have increased every year since 2004. During the same period ADA support of PRC has remained essentially flat or even decreased somewhat. Beginning in 2005, PRC generated more income for the ADA and ADAF than it has received in support from the ADA.

Table 2. Comparison of Royalty and Indirect Cost Recovery to ADA and ADAF with ADA Support of PRC, 2004-08

Year	Indirect Cost Recovery Income to ADA	Royalty Income to ADA Foundation	ADA Funding of PRC	Difference
2008	$ 507,957	$1,381,216	$1,109,346	$ 779,827
2007	$ 679,250	$1,065,000	$1,199,400	$ 544,850
2006	$ 691,709	$1,085,464	$1,231,338	$ 545,835
2005	$ 520,918	$1,022,794	$1,251,205	$ 292,507
2004	$ 551,840	$ 618,925	$1,194,379	$ -23,615

5. *Unique Relationship with NIST*. PRC is located on the campus of the National Institute of Standards and Technology (NIST) in Gaithersburg, MD and operates under a Cooperative Research and Development Agreement (CRADA) between NIST and the ADA Foundation. This CRADA provides PRC with free space and other services to engage in research, and to improve the quality of health care through the development of improved materials, techniques, instruments and measurement methods. The PRC external review panel estimated the value of in-kind NIST support of PRC to be approximately $1.5 million a year.

   PRC's relationship with NIST produces other, equally important benefits. NIST provides a robust research environment where basic research is eagerly pursued and highly valued. The unique collaboration between PRC and NIST has afforded the dental profession the ability to participate in the development of science-based standards and new technologies that are relevant to the needs of the profession. PRC has been engaged in research to devise standards and develop materials for the dental profession since its inception in 1928. Research at PRC continues to support this effort.[4] NIST has repeatedly stated that it relies on PRC to provide dental standards so NIST can focus on medical and other standards.[5]

   NIST shares significant resources with PRC. Specifically:

   - **Shared Scientific Instrumentation.** Over the past ten years, the Polymers Division at NIST has invested $10M in state-of-the-art instrumentation. This instrumentation is made available at no charge to PRC scientists.[6] Without access to this instrumentation, much of the research conducted at PRC on adhesives, composites and remineralization would be impossible.

   - **Shared Staff.** Currently, PRC and NIST scientists are collaborating on three significant projects: 1) a real-time determination of polymerization shrinkage as a function of degree of conversion of monomer to polymer; 2) measurement standards and techniques for the determination and modeling of secondary caries; and 3) improving the design of the tensometer instrumentation

[4] The first standard was ADA Specification No.1: Amalgam Alloys (JADA Vol. 17 pp 112-124, 1930). The most recent NIST standard is Standard Reference Material No.2910a: Calcium Hydroxyapatite, adopted August 2008.

[5] See http://www.nist.gov/public_affairs/factsheet/100396.htm for a fact sheet on why NIST supports dental research.

[6] A few examples of state-of-the-art instrumentation that NIST makes available to PRC scientists are: Scanco x-ray microcomputed tomography, Thermo Electron Ultra Centrifuge, Bruker Matrix-assisted laser desorption/ionization – Time of Flight Mass Spectrometer, Eppendorf High-speed Centrifuge, and TA Instruments Dynamic Mechanical Rheometer.

invented at PRC.[7] This instrumentation is used to measure composite shrinkage in three dimensions under stress. Past collaborations have led to numerous PRC-NIST co-inventions that are jointly licensed to the dental industry (e.g., adhesives, amorphous calcium phosphate (ACP) resins, ACP cements, glassy metals and amalgam alternatives).[8]

- **Shared Laboratory Space.** PRC and NIST share several special purpose laboratories (e.g., microbiology, instrumentation, organic synthesis) and the expense of their equipment and maintenance. These labs support PRC's research on cariology, biological reactor models for caries and secondary caries; toxicology for new dental materials; and synthesis and bonding properties of dental adhesives.

- **Standard Reference Materials (SRMs).** NIST funds PRC to develop standard reference materials (SRMs) relevant to dentistry. One current project involves the preparation and production of a SRM for abrasive standards for dentifrice. NIST funding of this project has totaled approximately $100K over the past five years. Recently, NIST awarded PRC $25K to develop a SRM for hydroxyapatite. PRC anticipates NIST funding in the future of SRMs for synthetic enamel and dentin, gradient scaffolds for determining cellular response to nanomaterials, secondary caries substrate for new anticaries therapies and test procedures to determine erosive capacity of fluids (e.g., beverages, oral rinses and liquid medications).

6. *Proven Capability to Develop Groundbreaking Technology and Promote Rapid Translation to Market*. PRC plays a key role in helping industry understand the needs of the dental practitioner and how to translate those needs into improved products. Historically, PRC has made such improvements possible with the following technological breakthroughs:

- Contra-angle high-speed handpiece (1953)[9]

- Panographic x-rays (1957)[10]

- Composites (1965)[11]

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[7] U.S. Patent No. 6,871,550 issued March 29, 2005 patent license pending with Sabri Enterprises.

[8] NIST-ADA co-invented patents: Adhesive patent U.S. 6,458,869 and U.S. 5,756,560; ACP resins and cements U.S. 5,508,342; glassy metals U.S. 4,627,482 and U.S. 4,538,671; and amalgam alternatives U.S. 6,375,894 and U.S. 6,001,289.

[9] Introduced by Robert J. Nelsen, DDS (ADA) and his associates Carl E. Perlander (NBS) and John W. Kumpula (NBS) all three of whom were then at the National Bureau of Standards. This handpiece drastically revolutionized restorative dentistry, serving as the basis for the present-day high-speed turbine dental drills used all over the world. It practically eliminated vibration, lessened patient discomfort and recovery time and permitted the dentist to prepare the tooth more efficiently from a seated position. *JADA* Sept 1953. The prototype handpiece is now part of the Smithsonian Museum's permanent collection. Invention of the high-speed handpiece also led to development of tungsten-carbide tipped burs to maintain cutting efficiency at ultra-high speeds.

[10] The panographic x-ray machine was introduced by John W. Kumpula (NBS), Robert J. Nelsen, DDS (ADA), Donald Hudson (USAF), and George Dickson (NBS). The unique machine produces an x-ray picture of the entire dental arch with the supporting bone structure. It does this with one large 5" x 7" film replacing the former complete mouth examination of 18 pictures. This saved time as well as reducing the radiation exposure to the patient by as much as 90%. U.S. Armed Forc Med J Vol 8#1, 1957.

[11] Composites for dental use were invented by Dr. Rafael Bowen of PRC prior to the 1960s, but the first resin-based composite was patented by Dr. Bowen and commercialized in 1965 with improvements in adhesives, fillers and photoinitiators. U.S.Patent Nos. 3,066,112 and U.S. 3,194,783.

- Adhesives (1966)[12]
- Calcium phosphate remineralization (1993)[13]
- The first calcium-phosphate bone cements accepted by the FDA for use in humans (1996)[14]
- Amalgam alternatives (2002)[15]

More recently, PRC has led with development of:

- ACP remineralization and desensitizing technology [NIH Grant R01DE13169 Dr. D. Skrtic, PI and Dr. M. Tung's collaborative projects with industry],
- Calcium phosphate bone cements [NIH Grant R01DE16416 Dr. L. Chow, PI],
- Improved adhesives for dentin bonding [NIH Grant R01DE05129 Dr. R. Bowen, PI], and
- Atraumatic restorative materials and remineralizing pulp-capping therapies [NIH Grant R01DE13298 Dr. S. Dickens, PI].

PRC plays an important role in the rapid translation of science from the laboratory to market through its commitment to aggressive licensing of PRC patents. More than 200 products on the market today are based on PRC patents.[16]

7. *Value of PRC Research in the Pipeline*. Today, PRC scientists are conducting basic and applied research on a wide range of dental materials and therapies that have the potential to pay important dividends in the future.[17] These include:

- improvements in dental adhesives and composites
- caries treatment and prevention
- early childhood caries therapies and caries models for use by regulatory agencies
- dental chemistry for remineralization strategies
- further development of fluoride therapies to prevent caries and reverse active caries and to evaluate current strategies for fluoride delivery. Examples are: glass ionomer cements, fluoride

[12] Dental Adhesives were improved and reported in a series of ten articles published by Dr. Bowen beginning in J Dent Res Vol 44, pp 690-695, 1966 and patented U.S. 3,200,142.

[13] Amorphous calcium phosphate (ACP) has been found to be very effective for the treatment of sensitive teeth. Laboratory tests and small clinical trials are showing that ACP is effective for remineralizing teeth, possibly reversing early caries. Patented by Dr. Ming Tung of the PRC, U.S. 5,037,639 and marketed in 1993 by Jeneric Pentron.

[14] The calcium-phosphate bone cement technology is licensed to Stryker Howmedica Osteonics, Ltd.; the Foundation received more than $900K in license fees in 2008 under this agreement.

[15] Amalgam alternative research was the subject of a 10-year NIH project grant to the ADA Foundation in collaboration with NIST scientists. U.S. Patents for amalgam alternatives are U.S. 6,001,289 and 6,375,895.

[16] To cite only a few examples of products containing ACP: Arm & Hammer Age Defying Toothpaste; Discus Dental Nite White ACP; Premier Dental Enamel Pro Varnish and Enamel Pro Prophy Paste; Jeneric Pentron Quell Desensitizer; Bosworth Aegis Orthodontic Cement and Aegis Flowable Sealant.

[17] See http://www.ada.org/ada/adaf/researchcenters/paffenbarger.asp for a comprehensive list of research projects underway at PRC.

varnishes and nano-calcium fluoride to promote remineralization for populations at increased caries risk, especially children and the elderly

8. *Pillar of ADA Standards Activities*. Scientists at PRC and in the ADA laboratories in Chicago work in concert to support the ADA's goal to lead in the advancement of standards that are essential for the safe, appropriate and effective delivery of oral health care. PRC scientists hold leadership positions at the American Association of Dental Research (AADR) and with the International Standards Organization (ISO). PRC scientists serve on working groups as U.S. Experts involved in standards development and are currently leading four international multi-laboratory studies that will lead to improved U.S. and international standards for dental products. These standards are for erosive capacity of oral rinses, bioavailability of fluoride in dentifrices, fluoride release from dental varnishes and the release of lead from porcelain crowns.

9. *Leader in Research of Critical Importance to the Profession*. PRC leads the way with the ADA laboratories to conduct research on emerging issues of critical importance to the dental profession. A recent example is their joint investigation of potentially available lead content in dental ceramic crowns. The ADA Laboratories provided the budget and materials. PRC developed and validated the analytical methods and conducted the testing, using its extensive laboratory facilities, instrumentation (the inductively coupled plasma-atomic emission spectrometer, or ICP-AES) and scientific expertise. NIST loaned the x-ray fluorescence (XRF) equipment that was used to validate the initial test results.

   Scientists at PRC are collaborating with scientists in the ADA laboratories in Chicago on a bioaerosol project to determine the quantity of bioaerosol produced and how long the aerosol lingers in the operatory air after a typical restorative procedure or prophylaxis with an ultrasonic scaler. The study is also measuring and evaluating the production of ultrafine particles during resin composite finishing and polishing. This work, which is being conducted in PRC's clinical research dental operatory, could lead to a safer environment for dentists to work and treat patients.

   Scientists at PRC freely share their expertise on research questions with their colleagues in Chicago. Recent examples include consulting on the development of standardized testing to use in the ADA Seal of Acceptance Program; advice on obtaining patents for instrumentation developed to evaluate products for the Professional Product Review; management of the NIH grant from the National Library of Medicine to create a Web site on evidence-based dentistry;[18] and collaboration on the recently completed grant from the National Cancer Institute to fund oral cancer awareness.

   The potential exists to expand PRC's human capital through cross-appointments with academic institutions in a distributed PRC Chair program. Under this program, academic chair positions would be established at several leading research universities, permitting the exchange of top scientists between academia and PRC to conduct research in each others' facilities. This would make available to PRC scientists the expertise, resources and clinical populations that are not presently available at PRC.

10. *Education of Dentists, Dental Students and Researchers*. PRC is currently engaged in educational activities that expand the knowledge of dentists, dental students and researchers around the world. For example:

[18] G08 LM008956, Dr. J. Frantsve-Hawley, PI provides $450K over three years to create an ADA EBD Web site. Scheduled for launch in March 2009, the Web site will provide improved access by the profession and the public to the best current clinical evidence relevant to oral health care.

- PRC researchers provided 20 continuing education programs to practicing dentists at state, local and regional dental meetings in 2008.[19]

- Under a research agreement with the National Naval Medical Center (NNMC), Naval Postgraduate Dental School, PRC scientists mentor residents in their scientific research while they complete a Master of Science degree through the school. In the past five years, PRC has mentored 12 students and collaborated with them on ten peer-reviewed publications.

- PRC assisted residents from the University of Maryland Baltimore College of Dental Surgery, Howard University College of Dentistry, NNMC, and University of Maryland, Baltimore County and supported sabbaticals of professors from the University of Seoul, Tokyo Medical and Dental University and Nihon University.

- PRC researchers lectured students at the University of Maryland, Howard University, NNMC, Tokyo Medical and Dental University, and Nihon University.

- PRC supports three to four undergraduate internships every summer.[20]

- PRC and NIST co-sponsor and present a hands-on course on fractography. This course teaches researchers, dentists and educators the best methods to determine the causes of dental restoration fracture and failure. The course is taught annually and is funded in part through a grant from the NIH.

PRC's Strengths Mask Critical Challenges: However, PRC's undoubted strengths mask critical challenges that threaten the institution's future. These challenges are interdependent and must be addressed comprehensively. They are discussed below.

1. *Difficulty Filling Key Leadership Position at PR*C. Despite active recruitment and the fact that the position was upgraded to an executive level, the ADA has not been able to fill the open senior director position at PRC since the previous incumbent left in mid-2006. In the Council's opinion, the key impediment is the need to offer reasonable assurances of stable employment and sufficient funding during the time it will take for the senior director to revitalize PRC's research programs and make them self-sustaining.

2. *Changing Economy for Dental Research*. The current, world-wide recession is having a significant impact on industry-sponsored research. Research projects are being postponed indefinitely, and a number of companies have announced staff layoffs. PRC receives only a relatively small portion of its budget from industry-sponsored research ($281K in 2008). More significant is the likely impact of the slowing economy on new product development. PRC could adapt by emphasizing technology that is quick and easy to bring to market.

   The single largest public agency for funding extramural dental research is the National Institutes of Health (NIH), National Institute of Dental and Craniofacial Research (NIDCR). Since 2000, the budget and research priorities of the NIDCR have changed substantially. In recent years, a larger proportion of investigator-initiated funding from NIH/NIDCR (R01 grants) is going to medical schools

[19] The senior scientists have made themselves available to local dental study groups, universities, and other interested groups at no charge. Typical presentations include what's new in dental research, the history of the PRC and its role in changing dentistry, and research updates on specific topics such as fluoridation, ACP, standards, and caries.

[20] The PRC summer research internship program has been funded through corporate donations. The intern, mentored by a senior PRC scientist, conducts a significant research project that can be completed in the 8 to 10 weeks of the program. It is the goal of the program that each intern is coauthor on the research when it is presented at the AADR meeting and on publications that arise from the work. The experience has inspired many of these interns to attend dental school and to be involved in dental research. In the last 15 years, there have been 42 interns, and more than half went on to dental school.

for research that has applications for both medicine and dentistry, such as pain and neuroscience, head and neck cancer, HIV/AIDS, gene and environmental interactions and pharmacogenetics.

Over the years, NIST has also changed its research focus to encourage growth in biosystems and health research and is building an important program in tissue engineering. To maintain its grant success, PRC must adapt its research programs to focus on areas of greater interest to NIST, such as tissue engineering.

3. *Missing Generation of Principal Investigators.* PRC will need to engage a new generation of principal investigators over the next four to six years to maintain its robust grant-funded research programs. Some of PRC's principal investigators may choose to retire, rather than apply for new grants when existing ones expire. As shown in the table below, three grants already expired in 2008, and seven more are set to expire between 2009 and 2012. This represents an average loss of $390K in direct grant funding to PRC each year between 2009 and 2012, or a total loss of almost $1.6M. It also represents a $0.8M loss to ADA of revenue from indirect cost recovery. The future loss of patents, licenses and royalties to the ADA Foundation associated with these research projects cannot be estimated.

Ending Dates and Annual Funding from Current Grants		
Year	**Annual Funding Amount Each Grant**	**Total Funding for All Grants Ending in Year**
2008	94,853	**380,949**
2008	126,096	
2008	160,000	
2009	165,530	**265,530**
2009	100,000	
2010	142,500	**512,500**
2010	185,000	
2010	185,000	
2012	250,000	**400,000**
2012	150,000	
Average for All Years		**389,745**

PRC must begin to create a balanced spectrum of scientists at various stages in their careers to replace the current principal investigators should they elect to retire. PRC has not previously had a formal pipeline program to recruit and develop entry and mid-level scientists.

4. *Lack of Resources to Take PRC in New Research Directions*. PRC currently lacks the resources to recruit and train researchers who are capable of taking PRC in new research directions. PRC needs to hire entry and mid-level scientists and establish a pipeline and career path for these scientists to become independent researchers.

5. *Dated Vision and Mission Statements*. PRC's ability to move in new research directions and to recruit and retain the scientists it needs to succeed will require clear and current vision and mission statements. The Council included working vision and mission statements in its report to the Board.

Consequences for ADA, ADAF and the Profession if Challenges Are Not Met: Unless the challenges facing PRC are successfully addressed, PRC will not be able to sustain its status as a leading research institution or its vital research programs beyond the next two to three years. This will have negative consequences for the ADA, the ADA Foundation and the entire dental profession. Some of these consequences are listed below.

- Dentistry's reputation as a science-based profession will be diminished.[21]
- ADA's ability to influence the nation's research agenda on behalf of the dental profession will be reduced.[22]
- ADA programs will lose a significant source of scientific expertise that cannot be duplicated in the ADA laboratories in Chicago.
- ADA's ability to undertake research on urgent, emerging issues of critical importance to the dental profession will be significantly reduced.
- Delay or loss of ongoing PRC research that will improve the oral health of the public through significant advances in dentistry, such as research in calcium phosphate chemistry as it relates to the dentition. This research is developing cutting edge methods to rebuild a carious tooth with hydroxyapatite, resulting in a tooth that is restored to its prediseased state. Other current projects include calcium phosphate cement for periodontal bone restoration to augment bone grafting procedures, caries reversal through calcium phosphate and fluoride therapies, a dentin adhesive for composites, and therapies that reduce moderate fluorosis and reverse mild fluorosis. Industry monitors PRC's progress toward these new technologies and has expressed interest in licensing them even before patents have been issued.
- Inventions that directly benefit dentists and patients will take longer to reach the market without PRC's influence.
- Current royalty income of more than $1.4M from PRC patents will end without scientific support and renewal.
- The ADA Foundation will lose a substantial portion of its research program. Research is one of the three pillars of ADAF's mission (the others are education and access to care).
- The dental profession could become dependent on others for development of standards for dental products.[23]

The following section of this report lists each of PRC's key challenges, followed by actions recommended by the Council on Scientific Affairs and endorsed by the Board to address them.

Challenge 1: Recruit Senior Director. The most urgent need facing PRC is filling the key leadership position that has been open for over two and one-half years at this critical time in PRC's history. This individual needs to be someone who: 1) shares the ADA's vision for PRC; 2) has an established track record in a field of research that is critical to PRC's future; 3) has demonstrated leadership skills and the ability to build a

[21] PRC scientists represent the ADA in a number of different ways including interviews with the national news media (most recently as scientific experts about lead in porcelain fused to metal crowns) and through scientific testimony before the U.S. Congress and other governmental agencies, e.g., FDA.

[22] PRC scientists regularly participate in meetings of the National Advisory Dental and Craniofacial Research Council (NIH-NIDCR) and serve as councilor for the American Association of Dental Research.

[23] Currently standards are being developed through the ISO for CAD/CAM, dental instrumentation, and biocompatibility where the U.S. experts are not from the ADA or the PRC.

research program; and 4) is able to attract new researchers and funding opportunities to PRC. The ADA must be prepared to compete aggressively with academia and industry to recruit this individual. The Council identified the following steps that need to be taken if the ADA is to succeed in recruiting a highly qualified individual for the senior PRC position:

1. **Revise the position description to focus on key leadership qualities and open the position to an expanded field of candidates whose education and experience qualify them to lead a major research institution. A dental degree is desirable but not essential for this position.**

2. **Use volunteers with relevant experience and standing in the community from which the ADA expects to draw applicants to help identify and screen potential applicants.**

3. **Put together a recruitment package that includes competitive salary and benefits, initial funding of the senior director's own research project (up to three years) and reasonable assurances of ongoing funding support of PRC during the projected period needed to revitalize its research programs. The Council on Scientific Affairs recommended that the ADA investigate offering an employment contract covering an initial period of three years with performance measures and conditions that would facilitate termination of the contract without liability if these measures are not met. The Council also recommended that the ADA relax its general bias against outside employment for PRC employees, subject to conflict of interest and conflict of commitment rules, in keeping with practices that prevail in other research settings.**

4. **Create a new position: Senior Manager, Operations, PRC. Both the Council on Scientific Affairs and the external review panel agreed that PRC is inadequately staffed to address its operating needs, including the area of grants administration. Currently, these responsibilities are handled by scientists whose time would be more effectively spent on scientific activities.**

Challenge 2: Clear and Current Vision and Mission Statements. The PRC senior director will be expected to help shape PRC's vision and mission statements, but the Council on Scientific Affairs offered the following working language:

- **Vision: PRC creates new generations of breakthrough discoveries that can be rapidly translated into advanced treatments of oral diseases and improvements in oral health.**

- **Mission: PRC conducts basic, applied and clinical research to develop new test methods, standards and technologies. Through technology transfer and education these advances are used to improve oral health and advance the dental profession.**

Challenge 3: Recruit and Retain Mid- and Entry-level Scientists. PRC lacks a robust pipeline to recruit and retain entry and mid-level scientists on a career track leading to independent, grant-funded research. To address this challenge, PRC should:

5. **Institute a formal program to attract and retain entry and mid-level scientists, including a robust post-doctoral recruitment and retention program modeled on the program in place at NIST. Under this program, PRC would offer a three-year appointment to one postdoctoral scientist per year. Those individuals who were able to establish independent research programs with outside grant funding would be considered for continued employment.**

6. **Follow the standard practice of including salary support in its grant budgets. An account should be created to "capture" ADA hard money saved as a result of this practice that would be available for the senior director to use on discretionary projects, such as research on critical, emerging issues. Some percentage of the indirect funds obtained from grants should be placed in the same fund.**

7. **Create an emeritus program at PRC that would allow senior scientists who voluntarily retire to return with some benefits to mentor entry and mid-level employees and continue their research. This could be modeled on similar programs in place at other research institutions like NIST or The Forsyth Institute.**

Challenge 4: Transition Funding. Non-grant funding will be needed to carry PRC over during the period when its research programs are being reinvigorated until they become self-sufficient (approximately six years). The Council on Scientific Affairs provided the Board with an estimated budget covering 2009 through 2014. Subsequently, the Board-appointed Work Group on the Future of PRC modified the budget slightly to continue through 2015. The modified budget is found in the Appendix to this report. Further analysis will be needed to develop a detailed budget projection covering this period, but the Council's initial estimate calls for an investment of approximately $12.5M over six years. The budget also projects revenue from PRC royalties amounting to $10.8 million during the same period.

Other Actions. In addition, the Council on Scientific Affairs recommended, and the Board supports the following actions:

8. **PRC should enter into additional collaborations with other research facilities to achieve strategic purposes, including collaborations with leading research institutions for faculty exchanges and staff development. It would be desirable for PRC scientists to obtain adjunct faculty positions with collaborating universities to give PRC scientists access to resources not available at the PRC such as patient populations, research clinicians, clinical research managers, clinical research assistants, and dental office technologies. This would also impart greater recognition to PRC scientists in the academic world, recognizing their contributions to clinical and outcomes research.**

9. **Establish a Paffenbarger Chair Program that would establish faculty positions at several leading research dental schools. The individual faculty member who held the chair would rotate to conduct research at PRC in collaboration with PRC scientists.**

10. **Design and implement a marketing plan to align PRC with the ADA's new brand initiative. The Council recommends that the ADA/ADAF consider changing the name of PRC as one aspect of the rebranding effort.**

Next Steps: The Board-appointed Work Group on the Future of PRC has already presented a budget to meet PRC's immediate (2009) needs to the ADA Foundation Board of Directors, which approved payment from the ADAF's royalty accounts. The ADAF Board is prepared to consider a proposal to fund the first year of the multi-year transition budget (2010) from the same source.

The Work Group will continue work on implementation of the plan laid out in this report to assure PRC's future. The Work Group has identified several action items to address on a priority basis and is working with the appropriate ADA agencies to implement them. First and foremost is recruitment of the PRC senior director. The Work Group will continue to keep the Boards of the ADA and ADAF apprised of its activities, seeking their guidance as needed.

The ADA Board has not sought additional funds for PRC in the proposed 2010 ADA budget. However, the Board intends to propose additional funding for PRC, beginning with the 2011 ADA budget that takes account of funding available to PRC from the ADAF. At that time, the Board will update the House of the implementation of the PRC action plan.

Resolutions

This report is informational and no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

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

Appendix Material*

Appendix Budget and Timeline for PRC Transition (revised)

Budget and Timeline for PRC Transition (revised)

Action Item	Report Reference	Preliminary (2009)	Year 1 (2010)	Year 2 (2011)	Year 3 (2012)	Year 4 (2013)	Year 5 (2014	Year 6 (2015)
Hire Senior Director p. 18 line 11								
Search Costs		$10,000	$10,000					
Executive Level Salary			$250,000	$260,000	$270,400	$281,216	$292,455	$304,163
Taxes & Fringe (43 %)			$107,500	$111,800	$116,272	$120,923	$125,750	$130,790
Lab Renovation[1]	p. 21 line 21		$500,000					
Project Funding[2]	p. 18 line 22		$200,000	$200,000	$200,000			
Relocation			$20,000					
Hire Senior Administrator								
E11 Salary[3]	p. 19 line 5		$113,640	$118,186	$122,913	$127,830	$132,943	$138,260
Taxes & Fringe (43 %)			$48,865	$50,820	$52,853	$54,967	$57,155	$59,452
Recruit mid career Scientist #1 p.19 line 16								
E12 Salary[4]			$125,250	$130,260	$135,470	$28,178	$29,305	$30,477
Taxes & Fringe (43 %)			$53,858	$56,012	$58,252	$12,116	$12,601	$13,105
Lab Renovation[1]	p. 21 line 21		$500,000					
Project Funding[2]	p. 19 line 16		$300,000	$200,000	$100,000			
Relocation			$20,000					
Recruit mid career Scientist #2								
E12 Salary				$130,260	$135,470	$140,889	$29,305	$30,477
Taxes & Fringe (43 %)				$56,012	$58,252	$60,582	$12,601	$13,105
Lab Renovation[1]	p. 21 line 21			$500,000				
Project Funding[2]	p. 19 line 16			$300,000	$200,000	$100,000		
Relocation				$20,000				
Recruit mid career Scientist #3								
E12 Salary					$135,470	$140,889	$146,524	$30,477
Taxes & Fringe (43 %)					$58,252	$60,582	$63,005	$13,105
Lab Renovation[1]	p. 21 line 21				$500,000			
Project Funding[2]	p. 19 line 16				$300,000	$200,000	$100,000	
Relocation					$20,000			
Recruit mid career Scientist #4								
E12 Salary						$140,889	$146,525	$152,386
Taxes & Fringe (43 %)						$60,582	$63,006	$65,526
Lab Renovation[1]	p. 21 line 21					$500,000		
Project Funding[2]	p. 19 line 16					$300,000	$200,000	$100,000
Relocation						$20,000		
Pipeline for entry level scientist #1[5] (p. 21 line 6)								
Salary E8				$85,690	$89,118	$92,682	$19,278	$20,049
Taxes & Fringe (43 %)				$36,847	$38,321	$39,853	$8,290	$8,621
Project Funding[2]	p.21 line 8			$125,000	$125,000	$125,000		
Pipeline for entry level scientist #2[5]								
Salary E8					$89,118	$92,683	$96,390	$20,049
Taxes & Fringe (43 %)					$38,321	$39,854	$41,448	$8,621
Project Funding[2]	p.21 line 8				$125,000	$125,000	$125,000	
Pipeline for entry level scientist #3[5]								
Salary E8						$92,683	$96,390	$100,246
Taxes & Fringe (43 %)						$39,854	$41,448	$43,106
Project Funding[2]	p.21 line 8					$125,000	$125,000	$125,000
Pipeline for entry level scientist #4[5]								
Salary E8							$96,390	$100,246

Budget and Timeline for PRC Transition (revised)

Action Item	Report Reference	Preliminary (2009)	Year 1 (2010)	Year 2 (2011)	Year 3 (2012)	Year 4 (2013)	Year 5 (2014	Year 6 (2015)
Taxes & Fringe (43 %)							$41,448	$43,106
Project Funding[2]	p.21 line 8						$125,000	$125,000
Establish Emeritus Program p.21 line 12								
Lab Supplies		$5,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000
Travel		$5,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000
Enhanced collaborations with Academia								
Establish Adjunct Faculty appointments[6]	p. 8 line 4; p.12 line 13	$10,000	$20,000	$20,000	$20,000	$20,000	$20,000	$20,000
PRC Distributed Chair positions at Universities (costs are per Chair position)								
Chair Salary & Project Costs[7]	p. 11 line 20		$400,000	$400,000	$400,000	$425,000	$425,000	$425,000
Other Immediate Needs								
Project Funding for Existing Entry-Level Scientist	n/a	$30,000	$30,000	$30,000				
Support Patent Licenses	n/a	$20,000						
Support Staff Funding	n/a	$125,000						
Move Support Staff on 100% Soft Money to 100% Hard Money	n/a		$247,000	$247,000	$247,000	$247,000	$247,000	$247,000
Revenue								
Royalties[8]			$1,400,000	$1,540,000	$1,694,000	$1,863,400	$2,049,740	$2,254,714
Indirect cost recovery[9]	p. 15		$425,000	$425,000	$175,000	$175,000	$0	$0
TOTALS								
Grand Total		$205,000	$2,966,113	$3,097,886	$3,655,482	$3,834,252	$2,939,286	$2,387,367
								$18,880,385
Anticipated Revenue			$1,825,000	$1,965,000	$1,869,000	$2,038,400	$2,049,740	$2,254,714
								$12,001,854
New Funds Needed			$1,931,613	$2,049,086	$2,621,810	$2,760,113	$1,849,061	$1,280,414
								$12,492,097

[1] Cost will vary depending on the amount of new equipment needed. The amount included ($500,000) is probably the maximum that would be needed. These funds could come from

[2] Program funding is used by an investigator to carry out their project including salary support for assistants. It is proposed that an investigator be allowed to carry over unspent program funds from one year to the next to give the scientist the flexibility to use these funds as needed. The new investigators recruited to the PRC through this transition program are required to generate new funding such that their programs will become financially independent.

[3] This and the other positions included in the budget are budgeted at the mid-point currently established by the ADA for positions of the same grade, e.g., E12, E11, etc. A current salary review will help determine whether these salaries are competitive within the research community. The subcommittee believes that the senior director position, in particular, will require a higher salary ($250,000) to recruit a highly qualified individual. The senior director is an existing, unfilled position. The other proposed positions are new.

[4] Salary for the midcareer and entry level scientists is at 100 % support for the first three years and at 20 % support subsequently. The continuing 20 % support makes available time for the scientists to be available to respond to critical Association needs and to prepare grant proposals which under current regulations is required to be paid for by the Association.

[5] Entry level scientists would generally be allowed three years to achieve independent researcher status. Following standard practice in the research community, only entry level scientists who achieve independent status are retained beyond three years.

[6] These funds will be used for travel and minor laboratory costs.

[7] The costs for this program are proposed to come from ADA Foundation "Our Legacy – Our Future" program.

[8] Royalty income to the ADA Foundation was $1.4M in 2008 and we expect this to increase over the next 6 years by 10% each year.

[9] Indirect costs are recovered from NIH grants at the rate of 50 % of the direct costs incurred. These funds are currently transferred to the ADA Foundation at the end of each year.

Budget and Timeline for PRC Transition (revised)

Action Item	Report Reference	Preliminary (2009)	Year 1 (2010)	Year 2 (2011)	Year 3 (2012)	Year 4 (2013)	Year 5 (2014	Year 6 (2015)
[6] These funds will be used for travel and minor laboratory costs.								
[7] The costs for this program are proposed to come from ADA Foundation "Our Legacy – Our Future" program.								
[8] Royalty income to the ADA Foundation was $1.4M in 2008 and we expect this to increase over the next 6 years by 10% each year.								
[9] Indirect costs are recovered from NIH grants at the rate of 50 % of the direct costs incurred. These funds are currently transferred to the ADA Foundation at the end of each year.								

Resolution No. 83 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2009

Submitted By: Tenth Trustee District

Reference Committee: Dental Benefits, Practice, Science and Health

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

DEVELOPMENT OF A STANDARD FOR SECURE ELECTRONIC TRANSMISSION OF DIGITAL RADIOGRAPHS

The following resolution was submitted by the Tenth Trustee District and transmitted on September 30, 2009, by Mr. Paul Knecht, executive director, South Dakota Dental Association.

Background: Dental offices regularly transmit digital radiographs with other dental offices as third-party payers but often the quality of the transmitted image is such that it is unusable by the recipient. As a result of resolutions adopted by the 2000 ADA House of Delegates, the ADA has been working diligently, over many years, on a standard for the transfer of dental diagnostic images, yet most digital radiographs and photographs transmitted electronically are unusable by the intended recipients.

Resolution

83. Resolved, that the 2009 House of Delegates urge the ADA Standards Committee on Dental Informatics to develop a standard for the secure electronic transmission of digital radiographs and photographs and promote this standard for use by practitioners as well as third-party payers, and be it further

Resolved, that such a standard be provided to the ADA Board of Trustees by June 2010.

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

Resolution No. 80S-2 Citation for Original Resolution: Orchid:3197

Submitted By: Eighth Trustee District Date Submitted: October 2009

Substitute ☐ Amendment ■

Reference Committee Report On: Dental Benefits, Practice, Science and Health

Financial Implications (if different from original resolution): $

AMENDMENT TO RESOLUTION 80S-1:
GUIDELINES FOR SELF-APPLIED TOOTH WHITENING PRODUCTS

The following amendment to Resolution 80S-1 (Worksheet:3197) was adopted by the Eighth Trustee District and submitted on October 4, 2009, by Dr. Barbara Mousel, Eighth Trustee District Caucus.

Resolution

80S-2. Resolved, that the ADA Council on Scientific Affairs, in conjunction with the Council on Government Affairs, actively advocate to federal agencies that fund, promote or perform research that they pursue research on the safe levels of agents used for tooth whitening as a priority matter, and be it further

Resolved, that the Council on Scientific Affairs develop guidance based on the scientific evidence on the safety of agents used in tooth whitening products, and be it further

Resolved, that this guidance be published and distributed to constituent societies in order to assist states in their efforts to effectively advocate for the protection of the public.

Dental Education and Related Matters

Resolution No. 4 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: August 2009

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)

RESCISSION OF ENDORSEMENT OF RECOMMENDATIONS OF THE JOINT ADA/AADE GUIDELINES FOR VALID AND RELIABLE DENTAL LICENSURE CLINICAL EXAMINATIONS AND UTILZATION OF THE ADA GUIDELINES FOR LICENSURE BY CREDENTIALS

Background: (*Reports:82*)

In accord with Resolution 15H-1995 (*Trans.*1995:660), the Council reviewed current ADA policies to determine whether any policies were redundant, irrelevant, or needing revision. Based on this review, the Council recommends the following actions.

Endorsement of Recommendations of the Joint ADA/AADE Guidelines for Valid and Reliable Dental Licensure Clinical Examinations and Utilization of the ADA Guidelines for Licensure by Credentials: The Council determined that this policy is outdated and should be rescinded. The document, Joint ADA/AADE Guidelines for Valid and Reliable Dental Licensure Clinical Examinations, has been replaced with AADE's new document, Guidance for Clinical Licensure Examinations in Dentistry. The new document meets the intent of the document named in this policy and includes updated information. The second resolve is also outdated since almost all licensing jurisdictions (except Delaware, Florida, Hawaii, Nevada and the Virgin Islands) now have authority to grant licensure by credentials. The 1992 policy reads as follows:

> **93H-1992. Resolved,** that the ADA, in cooperation with other involved agencies, actively endorse and urge all dental licensing jurisdictions to follow the recommendations of the Joint ADA/AADE Guidelines for Valid and Reliable Dental Licensure Clinical Examinations, and be it further
>
> **Resolved,** that the ADA actively endorse and urge all dental licensing jurisdictions to utilize the ADA Guidelines for Licensure by Credentials, and be it further
>
> **Resolved,** that the ADA Council on Dental Education and Licensure monitor the endorsement of these recommendations by the dental licensing jurisdictions and report annually to the House of Delegates.

The Council recommends adoption of the following resolution:

Resolution

> **4. Resolved,** that Resolution 93H-1992 (*Trans*.1992:628), Endorsement of Recommendations of the Joint ADA/AADE Guidelines for Valid and Reliable Dental Licensure Clinical Examinations and Utilization of the ADA Guidelines for Licensure by Credentials, be rescinded.

BOARD RECOMMENDATION: Vote Yes.

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

***

Resolution No. 5 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: August 2009

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)

AMENDMENT OF THE "REQUIREMENTS FOR RECOGNITION OF DENTAL SPECIALTIES AND NATIONAL CERTIFYING BOARDS FOR DENTAL SPECIALISTS"

Background: (*Reports:83*)

In accord with Resolution 15H-1995 (*Trans.*1995:660), the Council reviewed current ADA policies to determine whether any policies were redundant, irrelevant, or needing revision. Based on this review, the Council recommends the following actions.

Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists: In November 2008, the Council and its Committee on Specialty Recognition agreed that modifications to the policy, *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists,* should be considered. In February 2009, the Council sent correspondence to the presidents and executive directors of the ADA recognized dental specialty organizations and ADA recognized dental specialty certifying boards, as well as the presidents and executive directors of constituent dental societies asking for written comments regarding the proposed modifications to the policy.

In April 2009, the Council considered the comments received from one constituent dental society, four dental specialty certifying boards and five recognized dental specialty organizations. All respondents agreed with the proposed editorial changes to the policy's section on the Requirements for Recognition of Dental Specialties; the majority was supportive of the changes in the section on Requirements for Recognition of National Certifying Boards. In addition, the American Academy of Pediatric Dentistry and the American Board of Pediatric Dentistry proposed changes to this section in an effort to reflect language currently used by the dental specialty organizations and boards.

After further review of the proposed amendments and consideration of the responses from interested parties, the Council concluded that the changes should be pursued and directed that the proposed amendments to the policy be forwarded to the 2009 House of Delegates for consideration:

Resolution

5. Resolved, that the ADA's policy on "Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists" (*Trans.*1959:204; 1968:251; 1973:705; 1975:690; 1976:879; 1983:527; 1995:634; 2001:470; 2004:313) be amended in the Requirements for Recognition of Dental Specialties section by the addition of the term "proposed" in item 2; addition of the term "applicant" in item 4; addition of the term "proposed" in item 5; and the deletion of the "'s" and "Standards for Advanced Specialty Education Programs" and the addition of the term "proposed" to item 6, such that the amended section reads as follows (deleted language ~~stricken~~ new language <u>underscored</u>):

(1) In order for an area to be recognized as a specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.

(2) A proposed specialty must be a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards. [1]

(3) The scope of the proposed specialty requires advanced knowledge and skills that: (a) are separate and distinct from any recognized dental specialty or combination of recognized dental specialties; and (b) cannot be accommodated through minimal modification of a recognized dental specialty or combination of recognized dental specialties.

(4) The specialty applicant must document scientifically, by valid and reliable statistical evidence/studies, that it: (a) actively contributes to new knowledge in the field; (b) actively contributes to professional education; (c) actively contributes to research needs of the profession; and (d) provides oral health services for the public; all of which are currently not being met by general practitioners or dental specialists.

(5) A proposed specialty must directly benefit some aspect of clinical patient care.

(6) Formal advanced education programs of at least two years beyond the predoctoral dental curriculum as defined by the Commission on Dental Accreditation ~~'s Standards for Advanced Specialty Education Programs~~ must exist to provide the special knowledge and skills required for practice of the proposed specialty.

and be it further

Resolved, that item 5, Operation of Boards, Requirements for Recognition of National Certifying Boards for Dental Specialists section be amended by deletion of the words “continue in advanced education,” and addition of the words “engage in lifelong learning and continuous quality improvement,” such that the amended item 5 reads as follows (deleted language ~~stricken~~; new language underscored):

(5) Each board shall encourage its diplomates to ~~continue in advanced education~~ engage in lifelong learning and continuous quality improvement.

and be it further

Resolved, that the footnote to item 2, Certification Requirements, Requirements for Recognition for National Certifying Boards for Dental Specialists section be amended in the second paragraph by deleting the word “eligible” and adding the word “qualified,” such that the amended item 2 reads as follows (deleted language ~~stricken~~; new language underscored):

Candidates for board certification who completed the prescribed length of education for board certification in a program of an institution then listed by the Council on Dental Education and Licensure prior to 1967, and who have announced ethically limitation of practice in one of the recognized dental specialties, are considered educationally ~~eligible~~ qualified.

and be it further

[1] Predoctoral accreditation standards are contained in the Commission on Dental Accreditation’s document *Accreditation Standards for Dental Education Programs.*

Resolved, that item 2, Certification Requirements, Requirements for Recognition of National Certifying Boards for Dental Specialists section be amended by the addition of a new paragraph to read as follows (new language underscored) :

Each board may establish an exception to the qualification requirement of completion of an advanced specialty education program accredited by the Commission on Dental Accreditation for the unique candidate who has not met this requirement *per se*, but can demonstrate to the satisfaction of the certifying board, equivalent advanced specialty education. A certifying board must petition the Council on Dental Education and Licensure for permission to establish such a policy. If granted, the provisions of the certifying board's policy shall be reported to the House of Delegates in the Annual Report of the Council on Dental Education and Licensure.

BOARD RECOMMENDATION: Vote Yes.

Board Vote:

Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LONG	■	☐	☐	☐	SYKES
☐	■	☐	☐	ELLIOTT	■	☐	☐	☐	MANNING	■	☐	☐	☐	TANKERSLEY
■	☐	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	■	☐	☐	☐	THOMPSON
■	☐	☐	☐	GIST	■	☐	☐	☐	RICH	■	☐	☐	☐	VERSMAN
■	☐	☐	☐	GLECOS	■	☐	☐	☐	SCHWEINEBRATEN	■	☐	☐	☐	VIGNA
■	☐	☐	☐	KREMPASKY SMITH	■	☐	☐	☐	STEFFEL	■	☐	☐	☐	WEBB
■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN					Res. 5

WORKSHEET ADDENDUM

PROPOSED CHANGES

ADDITIONS ARE UNDERLINED AND HIGHLIGHTED;

DELETIONS ARE ~~STRICKEN~~

Updated: April 9, 2009

Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists

Approved by the 2001 ADA House of Delegates

October 2001

Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists

Introduction

A specialty is an area of dentistry that has been formally recognized by the American Dental Association as meeting the "Requirements for Recognition of Dental Specialists" specified in this document. Dental specialties are recognized by the Association to protect the public, nurture the art and science of dentistry, and improve the quality of care. It is the Association's belief that the needs of the public are best served if the profession is oriented primarily to general practice. Specialties are recognized in those areas where advanced knowledge and skills are essential to maintain or restore oral health. *

Not all areas in dentistry will satisfy the requirements for specialty recognition. However, the public and profession benefit substantially when non-specialty groups develop and advance areas of interest through education, practice and research. The contributions of such groups are acknowledged by the profession and their endeavors are encouraged.

The sponsoring organization must submit to the Council on Dental Education and Licensure a formal application which demonstrates compliance with all the requirements for specialty recognition. The Council will submit its recommendation for approval or denial of the proposed specialty to the Association's House of Delegates.

Following approval by the House of Delegates, the sponsoring organization must establish a national board for certifying diplomates in accordance with the "Requirements for National Certifying Boards for Dental Specialists" as specified in this document. Additionally, the Commission on Dental Accreditation develops educational requirements and establishes an accreditation program for advanced educational programs in the specialty. The Council on Dental Education and Licensure and the sponsoring organization monitors the administrative standards and operation of the certifying board.

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* Association policies regarding ethical announcement of specialization and limitation of practice are contained in the *ADA Principles of Ethics and Code of Professional Conduct*.

Requirements for Recognition of Dental Specialties

A sponsoring organization seeking specialty recognition for an area must document that the discipline satisfies all the requirements specified in this section.

(1) In order for an area to be recognized as a specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.

(2) A proposed specialty must be a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards. *

(3) The scope of the proposed specialty requires advanced knowledge and skills that: (a) are separate and distinct from any recognized dental specialty or combination of recognized dental specialties; and (b) cannot be accommodated through minimal modification of a recognized dental specialty or combination of recognized dental specialties.

(4) The specialty applicant must document scientifically, by valid and reliable statistical evidence/studies, that it: (a) actively contributes to new knowledge in the field; (b) actively contributes to professional education; (c) actively contributes to research needs of the profession; and (d) provides oral health services for the public; all of which are currently not being met by general practitioners or dental specialists.

(5) A proposed specialty must directly benefit some aspect of clinical patient care.

(6) Formal advanced education programs of at least two years beyond the predoctoral dental curriculum as defined by the Commission on Dental Accreditation's ~~Standards for Advanced Specialty Education Programs~~ must exist to provide the special knowledge and skills required for practice of the proposed specialty.

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* Predoctoral accreditation standards are contained in the Commission on Dental Accreditation's document Accreditation Standards for Dental Education Programs.

Requirements for Recognition of National Certifying Boards for Dental Specialists*

In order to become, and remain, eligible for recognition by the American Dental Association as a national certifying board for a special area of practice, the area shall have a sponsoring or parent organization whose membership is reflective of the recognized special area of dental practice. A close working relationship shall be maintained between the parent organization and the board. Additionally, the following requirements must be fulfilled.

Organization of Boards:

(1) Each Board shall have no less than five or more than 12 voting directors designated on a rotation basis in accordance with a method approved by the Council on Dental Education and Licensure. Although the Council does not prescribe a single method for selecting directors of boards, members may not serve for more than a total of nine years. Membership on the board shall be in accordance with a prescribed method endorsed by the sponsoring organization. All board directors shall be diplomates of that board and only the parent organizations of boards may establish additional qualifications if they so desire.

(2) Each board shall submit in writing to the Council on Dental Education and Licensure a program sufficiently comprehensive in scope to meet the requirements established by the American Dental Association for the operation of a certifying board. This statement should include evidence of sponsorship of the board by a national organization representing dental practitioners interested in that special area of practice.

(3) Each board shall submit to the Council on Dental Education and Licensure evidence of adequate financial support to conduct its program of certification.

(4) Each board may select suitable consultants or agencies to assist in its operations, such as the preparation and administration of examinations and the evaluation of records and examinations of candidates. Consultants who participate in clinical examinations should be diplomates.

*Amended by the 2004 ADA House of Delegates

Operation of Boards:

(1) Each board shall certify qualified dentists as diplomates only in the special area of dental practice approved by the American Dental Association for such certification. No more than one board shall be recognized by the Association for the certification of diplomates in a single area of practice.

(2) Each board, except by waiver of the Council on Dental Education and Licensure, shall give at least one examination in each calendar year and shall announce such examination at least six months in advance.

(3) Each board shall maintain a current list of its diplomates.

(4) Each board shall submit annually to the Council on Dental Education and Licensure data relative to its financial operations, applicant admission and examination procedures, and results thereof. A diplomate may, upon request, obtain a copy of the annual financial report of the board.

(5) Each board shall encourage its diplomates to ~~continue in advanced education~~ engage in lifelong learning and continuous quality improvement.

(6) Each board shall provide periodically to the Council on Dental Education and Licensure evidence of its examination and certification of a significant number of additional dentists in order to warrant its continuing approval by the American Dental Association.

(7) Each board shall bear full responsibility for the conduct of its program, the evaluation of the qualifications and competence of those it certifies as diplomates, and the issuance of certificates.

(8) Each board shall require an annual registration fee from each of its diplomates intended to assist in supporting financially the continued program of the board.

Certification Requirements:

(1) Each board shall use, in the evaluation of its candidates, standards of education and experience approved by the Commission on Dental Accreditation.

(2) Each board shall require, for eligibility for certification as a diplomate, the successful completion of an educational program accredited by the Commission on Dental Accreditation of two or more academic years in length, as specified by the Commission.*

*The following interpretation for educational eligibility was provided by the 1975 House of Delegates of the American Dental Association (*Trans*.1975: 690).

Candidates for board certification who graduated after January 1, 1967, must have successfully completed an accredited advanced specialty program. Candidates for board certification who completed the prescribed length of education for board certification in a program of an institution then listed by the Council on Dental Education and Licensure prior to 1967, and who have announced ethically limitation of practice in one of the recognized dental specialties, are considered educationally ~~eligible~~ qualified.

Although desirable, the period of advanced study need not be continuous, nor completed within successive calendar years. An advanced educational program equivalent to two academic years in length, successfully completed on a part-time basis over an extended period of time as a graduated sequence of educational experience not exceeding four calendar years, may be considered acceptable in satisfying this requirement. Short continuation and refresher courses and teaching experience in specialty departments in dental schools will not be accepted in meeting any portion of this requirement.

Each board may establish an exception to the ~~eligibility~~ qualification requirement of completion of an advanced specialty education program accredited by the Commission on Dental Accreditation for the unique candidate who has not met this requirement per se, but can demonstrate to the satisfaction of the certifying board, equivalent advanced specialty education. A certifying board must petition the Council on Dental Education and Licensure for permission to establish such a policy. If granted, the provisions of the certifying board's policy shall be reported to the House of Delegates in the Annual Report of the Council on Dental Education and Licensure.

(3) Each board shall establish its minimum requirements for years of practice in the area for which it grants certificates. The years of advanced education in this area may be accepted toward fulfillment of this requirement.

(4) Each board, in cooperation with its parent organization, shall prepare and publicize its recommendations on the educational program and experience requirements which candidates will be expected to meet.

Founding Boards and Waivers: Members of a founding board in an area of practice not recognized previously by the American Dental Association shall be exempt from certifying examination. Newly recognized boards may petition the Council on Dental Education and Licensure for permission to waive the formal education requirements for candidates who apply for examination. If granted, the provisions of the waiver shall be reported to the House of Delegates in the Annual Report of the Council on Dental Education and Licensure.

***

Resolution No. 26 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: July 2009

Submitted By: Second 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)

DEVELOPING A NEW PART THREE OF THE NATIONAL BOARDS, ELIMINATING LIVE PATIENTS

The following resolution was submitted by the Second Trustee District and transmitted on July 29, 2009, by Dr. Mark J. Feldman, executive director, New York State Dental Association.

Background: In 2005, the American Dental Association (ADA) House of Delegates adopted Resolution 20H-2005 (*Trans.*2005:336), which modified existing policy regarding the elimination of human subjects in the clinical licensure process:

> **20H-2005. Resolved,** that the Association supports the elimination of human subjects/patients in the clinical licensure examination process with the exception of the curriculum integrated format within dental schools, and be it further
>
> **Resolved,** that the Association encourages all states to adopt methodologies for licensure that are consistent with this policy.

Two years later, in adopting Resolution 1H-2007 (*Trans.*2007:389), the ADA House clarified what a clinical licensure process involving the curriculum integrated format should entail:

> **1H-2007. Resolved,** that the American Dental Association adopts the following definition:
>
> > 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 within each institution 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.

These two policies provide a valuable and necessary vehicle by which we, as a profession, can undertake a necessary change in how we determine competency to practice.

The existence of a true curriculum-integrated format (CIF) as defined in Resolution 1H-2007 has been hard to achieve, resulting in exams that still close dental school clinics and require obtaining patients

expressly for the examination. It is time to consider a better alternative. One need only look to the success of the Canadian Dental Examining Board's use of the Objective Structured Clinical Examination (OSCE), which tests clinical skill performance and competence without the use of live patients, to see how this could be achieved. The state of Minnesota decided recently to use a similar test. This is in keeping with the intent behind 20H-2005 and 1H-2007, not to mention recommendations made by the Institute of Medicine.

The development of a nationally recognized Part III examination of the National Boards, excluding any use of live patient subjects, provides all those entering the profession with a safe, reliable and statistically valid test of their competency. As is the case with the OSCE, such an examination would provide examiners with a highly useful tool in gauging that competency. Another advantage is that, while the test would be nationally standard, it could be administered via regional examining boards. Passage of the exam would allow for acceptance by all state dental boards and provide freedom of movement, while preserving each state's right to protect its citizens.

The profession has been promised a national license exam for some time now, but this has not materialized. While we support calls for all states to accept the results of the regional boards, this does not solve the ethical problem of live patient testing. Therefore, the Second Trustee District respectfully submits the following recommendation to the ADA House of Delegates:

Resolution

26. Resolved, that the American Dental Association urge the Joint Commission on National Dental Examinations to develop a new written Part Three of the National Boards that will evaluate clinical competency, ethics and professionalism, and will enable successful candidates to become licensed upon graduation.

BOARD COMMENT: The Board believes there is a difference between written exams and practical, clinical exams, and that an Objective Structured Clinical Examination (OSCE) would test only clinical judgment, not psychomotor skills and other aspects of patient care.

BOARD RECOMMENDATION: Vote No.

Board Vote:

Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	☐	■	☐	☐	LONG	☐	■	☐	☐	SYKES
☐	■	☐	☐	ELLIOTT	☐	■	☐	☐	MANNING	☐	■	☐	☐	TANKERSLEY
☐	■	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	■	☐	☐	☐	THOMPSON
☐	■	☐	☐	GIST	☐	■	☐	☐	RICH	☐	■	☐	☐	VERSMAN
☐	■	☐	☐	GLECOS	☐	■	☐	☐	SCHWEINEBRATEN	☐	■	☐	☐	VIGNA
☐	■	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	STEFFEL	☐	■	☐	☐	WEBB
☐	■	☐	☐	LOW	☐	■	☐	☐	SULLIVAN				Res.	26

***

Resolution No. 26S-1 New ☐ Substitute ■ Amendment ☐

Report: NA Date Submitted: September 2009

Submitted By: First 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)

SUBSTITUTE FOR RESOLUTION 26:
DEVELOPING A NEW PART THREE OF THE NATIONAL BOARDS, ELIMINATING LIVE PATIENTS

The following resolution was submitted by the First Trustee District and transmitted on September 23, 2009, by Dr. Robert A. Faiella, trustee.

Background: The First Trustee District agrees with the intent of Resolution 26 to develop a standardized national examination to evaluate clinical judgment, ethics, and professionalism. Some regional examinations are attempting to do this.

The American Dental Association has no control over the Joint Commission on National Dental Examinations and the intent of this resolution is to have an agency of the ADA (CDEL) study the development of an exam which, if successful, could replace the regional exams.

Resolution

26S-1. Resolved, that the American Dental Association House of Delegates direct the Council on Dental Education and Licensure to study the development of a Part Three examination of the National Boards that will evaluate clinical competency, ethics and professionalism.

BOARD COMMENT: The Board questioned the appropriateness of the resolution and possible conflicts regarding the *Bylaws* responsibilities of CDEL and JCNDE with respect to the National Board examinations. There was also confusion about the intent of the resolution and terminology such as “clinical competency”, “clinical demonstration”, “clinical dexterity” and the implications of both the resolution and background statement. Consideration should also be given to ADA policy on elimination of use of human patients in clinical licensure exams. The Board therefore recommends that the resolution be referred to a Board of Trustees work group.

BOARD RECOMMENDATION: Vote Yes on Referral.

BOARD VOTE: UNANIMOUS.

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Resolution No. 50 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: August 2009

Submitted By: Second 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)

CONTINUING EDUCATION APPROVAL

The following resolution was submitted by the Second Trustee District and transmitted on August 25, 2009, by Dr. Mark J. Feldman, executive director, New York State Dental Association.

Background: Many states have regulations calling for dentists to complete continuing education in order to be eligible for license renewal. These hours must be in courses that meet certain criteria such as acceptance by the Continuing Education Recognition Program (CERP) of the American Dental Association. It is well established that good oral health is part of overall health and many times dentists will benefit from medical CE courses that have been approved by the Accreditation Council for Continuing Medical Education (ACCME). The ACCME is a well-established and internationally recognized agency with standards that appear to meet or exceed those of CERP. Joint approval of courses that meet either CERP or ACCME standards would open up a vast array of education opportunities for both dentists and physicians and would appear to be worth considering. The Second Trustee District would ask the ADA Council on Dental Education and Licensure to study this possibility and report back to the Board of Trustees on its findings, and submits the following resolution to the 2009 ADA House of Delegates.

Resolution

50. Resolved, that the American Dental Association Council on Dental Education and Licensure study the possibility of joint approval by the ADA Continuing Education Recognition Program (CERP) and the Accreditation Council for Continuing Medical Education (ACCME) of continuing education courses that have met their individual certification requirements and report to the ADA Board of Trustees with its recommendations.

BOARD RECOMMENDATION: Vote Yes.

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

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Resolution No. 51 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: August 2009

Submitted By: Fourteenth Trustee District

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)

ADA LIBRARY ON THE WEB

The following resolution was submitted by the Fourteenth Trustee District and transmitted on August 28, 2009, by Dr. Kenneth Versman, trustee, Fourteenth District.

Background: While "Access to Care" is the buzz in the dental profession these days, it is access to information that is having the most profound effect on dental practice. In the past, literature research required access to printed journals and a library of subscription volumes. Computers and the Internet have put information on almost any subject just a "click" away. The vast array of digital resources available globally has made even the most esoteric research in any language, accessible to the dental practitioner in the United States. Unfortunately, dental practitioners are still limited if they don't have access to a library resource and most of these are medically oriented.

As the leader of the profession and advocate for evidence-based practice, the American Dental Association could become the go-to resource for access to dental research on the Internet. Private practitioners outside academia are already relying on the ADA's library as the most comprehensive resource available to them, but it is rapidly becoming antiquated to a membership that increasingly needs access to research in real time. Developing the library as the access point to digitized global dental resources would ensure that our members have access to the widest variety and best research available, and preserve the value of our library's relevance to changing member needs.

Licensing access to many journals and developing the infrastructure to access it, will require some investment, but it is a service that provides a tangible value to members and might be offset through a subscription service or other arrangement. Copying or partnering with existing services will expedite implementation. Like iTunes, it might work to provide a number of subscription plans ranging from unlimited access to pay-as-you-go depending upon a member's needs. Ideally, a basic plan could even be available as a member benefit and perceived as a membership enticement.

Recognizing that a similar plan was not deemed feasible a decade ago, this resolution would allow the Association to reevaluate the current situation and technology, particularly in light of how Evidence-based Dentistry is changing practice. Positioning the Association and our library as the preeminent resource and portal for literature research will benefit our organization in many ways. Mindful of the likely need for initial investment, a well-developed automated web-based service has high potential for revenue generation for many years into the future.

Resolution

51. Resolved, that the Board of Trustees and appropriate agencies investigate the development of a web-based literature search and access service through the ADA library, and be it further

Resolved, that the revenue generating potential of such a service be evaluated along with its value as a member benefit, and be it further

Resolved, that the Board report to the 2010 House of Delegates on the demand, feasibility, costs and related issues of implementing such a service.

BOARD COMMENT: The Board believes that providing access to electronic journals may be a tremendous value-added member benefit. Many ADA members expect or want immediate access to electronic resources, especially younger dentists and recent graduates. There is no financial implication for 2010 as the ADA has staff resources in place to investigate the development of web-based access to dental literature and scientific information and to provide the information regarding technical requirements, potential costs, member demand and potential revenue that could be realized from offering this service.

BOARD RECOMMENDATION: Vote Yes.

Board Vote:

Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LONG	☐	■	☐	☐	SYKES
■	☐	☐	☐	ELLIOTT	■	☐	☐	☐	MANNING	■	☐	☐	☐	TANKERSLEY
☐	■	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	☐	■	☐	☐	THOMPSON
☐	■	☐	☐	GIST	■	☐	☐	☐	RICH	■	☐	☐	☐	VERSMAN
■	☐	☐	☐	GLECOS	■	☐	☐	☐	SCHWEINEBRATEN	■	☐	☐	☐	VIGNA
■	☐	☐	☐	KREMPASKY SMITH	■	☐	☐	☐	STEFFEL	☐	■	☐	☐	WEBB
☐	■	☐	☐	LOW	☐	■	☐	☐	SULLIVAN				Res.	51

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Resolution No. 52-53 New ■ Substitute ☐ Amendment ☐

Report: Board Report 13 Date Submitted: September 2009

Submitted By: Board of Trustees

Reference Committee: Dental Education and Related Matters

Total Financial Implication: $20,400

Amount One-time $ 20,400 Amount On-going $

ADA Strategic Plan Goal: Lead in the Advancement of Standards (Required)

REPORT 13 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:
UPDATE ON IMPLEMENTATION OF RECOMMENDATIONS IN THE CODA TASK FORCE REPORT

Executive Summary: As directed by Resolution 37H-2008 (*Trans*.2008:442), this report provides a progress report on the activities of the committee to monitor and assist the Commission on Dental Accreditation in implementing recommendations from the 2008 Report of the Task Force on the Commission on Dental Accreditation. Two resolutions are submitted for the Board's consideration and recommendation to the House of Delegates.

The following are the highlights of the ADA Monitoring Committee's observations regarding CODA progress on implementation of ADA Task Force recommendations during the past year.

- The Monitoring Committee met three times during the year and participated in several meetings of the Commission and various CODA committees. The Monitoring Committee prioritized Task Force recommendations and communicated perceptions and concerns of the House of Delegates and various segments of the profession to CODA and offered suggestions for addressing the relevant issues.
- The process for analysis and implementation of Task Force recommendations by CODA and the Committee has been open and collaborative.
- Both groups found reason for concern over the historical use of the term "arms-length" in describing the relationship between ADA and CODA, and concluded that CODA is an arm of the ADA. There was consensus that ADA input on policy matters is appropriate, while influence on accreditation decisions is inappropriate.
- ADA and all communities of interest should understand and respect CODA's conflict of interest policy and the need for objectivity in CODA's decision-making process. The Committee achieved clarity on CODA's obligations in relation to its recognition by USDE and implications for the ADA and all stakeholders.
- The ADA values CODA's role and responsibility for quality assurance in dental education and provides significant financial support for the process. While ADA and CODA should maintain a close relationship, alternative structure and funding models will be considered.
- CODA has demonstrated initial efforts to enhance communication with its communities of interest and will continue to expand these initiatives.
- CODA and the Monitoring Committee recommend that the CDEL recognize non-specialty interest areas of general dentistry so that CODA does not assume this perceived responsibility by default through its accreditation of educational programs.
- CODA has addressed a number of Task Force recommendations but will require additional time and resources to complete the process.

Background: During 2007-2008, an ADA task force conducted an in depth study of the ADA Commission on Dental Accreditation (CODA). The task force provided a comprehensive report of its findings and recommendations to the ADA Board of Trustees and 2008 House of Delegates.

The House subsequently adopted Resolution 37H-2008:

> **37H-2008. Resolved,** that the American Dental Association out of its deep concern about aspects of the accreditation process strongly urges the ADA Commission on Dental Accreditation to accept and implement the Report of the Task Force on CODA, and be it further
>
> **Resolved,** that the American Dental Association urges CODA to work with all interested parties to implement the recommendations as they are reflected in the body of the Report, and be it further
>
> **Resolved,** that the President of the ADA appoint a committee for the express purpose of monitoring and assisting CODA in implementing the recommendations of the Task Force Report, and be it further
>
> **Resolved,** that this committee consist of a chair, three members of the Board of Trustees and three members of the House of Delegates, and be it further
>
> **Resolved,** that this committee provide updates to the Board of Trustees at each of its 2008-2009 meetings prior to the 2009 House, and be it further
>
> **Resolved,** that the ADA urges CODA to provide a comprehensive report to the 2009 House detailing progress on the implementation of the recommendations of the Task Force Report.

ADA Monitoring Committee: The ADA President appointed the following members for the purpose of monitoring and assisting CODA in implementing the recommendations of the Task Force Report. Committee members are: Dr. Kathryn Kell (chair), Tenth District; Dr. Rick Crinzi, Eleventh District; Dr. O. Andy Elliott, first vice president; Dr. Robert Faiella, First District; Dr. Charles Norman, Sixteenth District; Dr. Matthew Roberts, Fifteenth District; and Dr. Perry Tuneberg, Eighth District. Dr. Marie Schweinebraten, Fifth District, serves as CODA Liaison.

Committee Activities: The narrative below summarizes the activities of the Committee and progress observed and/or reported to the Committee by CODA during the past year.

November 2008-March 2009: Although scheduling conflicts prevented the Monitoring Committee from meeting earlier than April 2009, members of the Committee were informed of the schedule for the January 2009 CODA meetings and encouraged to attend if feasible. Dr. Perry Tuneberg attended the Commission's mega issue discussion prior to the January 2009 CODA meeting and participated in the discussion that focused on the ADA Task Force Report. ADA Board Liaison Marie Schweinebraten also attended.

Current CODA chair, Dr. James Koelbl communicated directly with the chair and members of the Monitoring Committee regarding CODA's plans for consideration of the recommendations in the Task Force Report. Dr. Koelbl indicated that he was committed to conducting a complete and objective review of all ADA Task Force recommendations in an open and collaborative manner, and that he intended to communicate the results of CODA's review process as effectively as possible to both ensure openness and to help inform the communities of interest about the accreditation process.

At the January 29, 2009 Commission mega issue discussion, the Commission reviewed and discussed at great length each of the 34 recommendations. The Commission considered the report in the spirit of improving the structure, governance, policies, operating procedures, functionality and use of best practices. In addition, the Commission noted that progress was already being made in implementing some of the recommendations, especially in the area of communication. For example, CODA instituted an electronic newsletter to be disseminated after each meeting. CODA also held an all-day information session for

representatives of organizations in its communities of interest in August 2008; the session covered most of the topics that are included in training sessions for Commissioners and review committee members. Other recommendations that were already under consideration and/or implemented included exploring alternative methods, including the use of advanced technology, for monitoring programs' compliance, and evaluating and adopting new technological advances in reporting and management of information.

During its regular January 2009 session, the Commission determined that further detailed study and possible implementation plans should be considered for each of the 34 recommendations. The consensus was that this could best be accomplished through the appointment of an *ad hoc* subcommittee by the Commission chair. In addition, the Subcommittee would interact directly with the ADA Committee established by Resolution 37H-2008 by the House of Delegates at the 2008 ADA Annual Session. It was noted that a number of the recommendations could be more efficiently reviewed by existing standing committees of the Commission, and a table with proposed assignments was reviewed and approved during the CODA meeting. Members of the CODA Subcommittee include: Dr. James Koelbl, Chair (ADEA); Dr. E. Les Tarver, vice chair (ADA); Dr. Sharon Turner (ADEA); Dr. Larry Nissen (ADA); Dr. Karen Kershenstein (public); Dr. Patrick Louis (AAOMS); Dr. Vince Iacono (AAP); Dr. Bryan Edgar (AADE); Dr. Heidi Crow (ADEA/AAHD); and Mr. Gary Gann (NADL).

April 2009-June 2009:

April, 27, 2009 Monitoring Committee Meeting. The CODA Monitoring Committee held its first face-to-face meeting on April 27, 2009, at ADA Headquarters. Dr. Kell provided opening remarks about the committee's task and discussed goals for the meeting. Dr. Perry Tuneberg and Dr. Marie Schweinebraten, trustee liaison to CODA, reported on the January 2009 CODA meeting and mega issue discussion which focused on the Task Force Report and recommendations. The Committee discussed recent communications between the CODA chair, Committee chair and trustee liaison, and reviewed actions taken by CODA at its January 2009 meeting.

The CODA Monitoring Committee devoted most of its April 2009 meeting to discussion of the 34 Task Force recommendations, focusing on the intent of the recommendations and their relative priorities. The Committee reviewed the table of recommendations and assignments adopted by CODA and developed a scheme for grouping and prioritizing the recommendations. The Committee considered all recommendations to be important and sorted the recommendations into the following categories: 1) those that would require significant time and effort, and/or were likely to have a high level of controversy or sensitivity (red); 2) those that were considered relatively straightforward and easy to implement (green); and 3) those of intermediate difficulty and those associated with financial implications (yellow). The Committee identified the recommendations relating to the structure (#2) and governance (#5 and #6) of CODA as being most critical. The Committee believed that addressing the structure recommendations would be an essential prerequisite to implementation of other recommendations. Likewise, responses to the recommendations on governance would establish over-riding principles to provide clarity of purpose and goals for all. Although Resolution 37H-2008 is directed toward CODA, the Committee noted that both CODA and the House of Delegates share responsibility for communicating, educating/learning and understanding.

The Committee used its analysis of the recommendations to develop a color-coded table of the 34 recommendations grouped by the categories described above. Appendix 1 (Worksheet:4025, Summary of Prioritized CODA Task Force Recommendations) provides an abbreviated summary of the Task Force recommendations organized according to the Monitoring Committee's prioritization scheme with CODA's initial assignment of responsibility for the recommendation. The Committee also prepared a more detailed version of the table with the complete recommendations and the Committee's comments where appropriate to clarify intent or explain prioritizations. The Committee planned to use the analysis to communicate its priorities and expectations to CODA.

The Committee reviewed a proposed 2010 Decision Package submitted by CODA as part of the ADA budgeting process. Certain recommendations with specific financial implications were addressed within the

decision package. The Committee understood that the funding request identified potential activities that CODA anticipated would comply with the intent of various recommendations. With consideration to the difficult economic environment, the Committee discussed potential alternatives that might be less costly to implement. For example, several recommendations specified that outside experts should be consulted to assist CODA, and the Committee suggested use of internal ADA resources as potential alternatives.

May 29, 2009 CODA Subcommittee Meeting. On May 29, 2009, the CODA Subcommittee on the ADA Task Force Recommendations met at ADA Headquarters. Dr. Kathy Kell, chair of the ADA Monitoring Committee and Dr. Marie Schweinebraten, ADA Trustee liaison to CODA also attended.

Dr. Kell reported on the ADA Monitoring Committee meeting of April 27, 2009 and discussed the Monitoring Committee's goals and prioritization of the 34 recommendations. Dr. Kell explained that the Monitoring Committee understood that initial CODA activities would focus on planning and emphasized the importance of communication and keeping stakeholders informed about CODA's plans and activities. The group engaged in a general discussion of perceptions about CODA and the concerns of the ADA House of Delegates. Most of the meeting was devoted to a review of the list of Task Force recommendations as categorized and prioritized by the Monitoring Committee. Participants exchanged questions for clarification and shared information about activities that had already been assigned and/or initiated. The CODA Subcommittee continued its deliberation of remaining recommendations for which it retained responsibility. Drs. Kell and Schweinebraten were invited to participate in the discussion and share perceptions on each of the recommendations. The group also discussed the budget process and potential ways of dealing with recommendations that had financial implications, especially those involving the addition of staff positions and the engagement of external consultants. Minutes of the CODA Subcommittee meeting were prepared and distributed to the CODA Monitoring Committee.

July 2009-August 2009:

Committee Conference Call. On July 15, 2009, the Committee met by conference call to review CODA activities to date and to plan for its joint meetings with CODA later in the month. Drs. Kell and Schweinebraten reported on the May 29, 2009 meeting of CODA's Subcommittee. The Committee also reviewed minutes of the meeting and discussed CODA's assignments, actions and comments on the prioritized list of recommendations. The Committee identified some recommendations that may need clarification of intent and further discussion of what might constitute a "completed" recommendation. The Committee developed a list of eight recommendations to be placed on the agenda for the joint meeting. These represented either high priority items or items that required discussion to ensure understanding. The Committee also determined that it would like to follow up on CODA's process for handling recommendations referred to either standing or ad hoc committees to ensure that the recommendations are addressed and that they do not disappear.

Participation in CODA July 2009 Subcommittee Meeting. On Wednesday, July 29, 2009, CODA's Subcommittee met at ADA Headquarters to continue its work on the recommendations. Drs. Kathy Kell and Marie Schweinebraten attended, and the CDEL chair, Dr. Denis "Chip" Simon participated as a guest. The Subcommittee agenda included recommendations 5, 6, 26, 27, 28, 33, and 34. Several items of New Business were added: Discussion of recommendations 3, a report from CODA's Communications Task Force, discussion of the term of service of CODA commission members, discussion of the joint meeting with the ADA Monitoring Committee for July 31, 2009, and discussion of the format of the report to the ADA House of Delegates.

The Subcommittee first considered a report from CODA's Communications Task Force and discussed the challenges in implementing recommendations with financial implications now that CODA has learned that its requests for funding in the 2010 budget were not included in the budget that will be submitted to the House of Delegates for approval. Specifically, the Task Force report recommended that CODA add a staff position devoted to communications and that an outside consultant be engaged to advise CODA on communications

strategies. The Subcommittee noted that a similar problem exists with regard to a recommendation on strategic planning.

The Subcommittee engaged Dr. Simon in an extensive discussion regarding recommendation 6, including the CDEL role in recognition of dental specialties and the concerns about the relative roles of CDEL and CODA in dealing with non-specialty interest areas in general dentistry. Dr. Simon offered several suggestions for clarifying roles and responsibilities of CDEL and CODA, and these suggestions were discussed at length. The Subcommittee adopted recommendations to be forwarded to the full Commission relating to the definition of terms and CODAs process for handling requests for establishing accreditation programs in new disciplines.

The Subcommittee also engaged in extensive discussion about recommendations 5 regarding the roles and responsibilities of ADA and CODA and the meaning of the term "arms-length." With respect to recommendations relating to strategic planning, the Subcommittee agreed to recommend that CODA restructure its standing committees. Finally the Subcommittee directed staff to gather additional information for consideration at future meetings.

July 31, 2009, CODA Meeting. Members of the Monitoring Committee attended the open session of the July 2009 CODA meeting as observers. Approximately 60 individuals from various communities of interest attended the open session as observers, including representatives and staff of many national dental organizations.

- The Committee noted a cultural change from the opening of the Commission meeting with the roll call and introduction of Commissioners by name and home location rather than by the organization they represented. The chair provided a statement about this new approach, indicating that the Commission was making this change to show its desire to meet the intent of ADA Task Force recommendation #15*: CODA commissioners, review committee members, site visitors and volunteers should serve the interest of CODA without personal or member organization profiles or agendas. This policy should be clearly articulated internally, and strongly articulated externally to all relevant organizations that supply persons for position on CODA or any of its working committees,* and recommendation #25: *CODA should view this effort toward cultural change not just as increasing communication but as a change in its culture regarding transparency, accountability, and responsiveness. This cultural change should be emphasized at the beginning of each CODA meeting.*
- The Committee noted that the Hillenbrand auditorium appeared to allow more seating and appropriate space for observers. Meeting materials had been made available to registered observers in advance via the CODA shared electronic workspace on ada.org.
- The Committee also noted that CODA had revised its meeting sequence to allow more time for discussion of accreditation decisions by conducting that closed portion of the meeting on the afternoon preceding the open policy session. This schedule was adopted in January 2009 and is consistent with ADA Task Force recommendation #7: *CODA should extend its meeting format to allow more time for discussion regarding accreditation decisions.*
- With regard to CODA functionality, the Committee observed that CODA could benefit from the assistance of a parliamentarian and other procedures to achieve greater efficiency and less confusion in managing its discussions and decision-making process during the policy portion of the meeting.
- The Committee noted CODA's discussion of plans for open hearings at future dental meetings and commented that CODA has begun to allow more time for comments and communicated greater willingness to listen. Future open hearings will allow time for comment on any topic, not just standards proposed for revision or adoption.

July 31, 2009 Joint Meeting of CODA Subcommittee and ADA Monitoring Committee. Following the conclusion of the CODA open policy session, members of the ADA Monitoring Committee met with members of CODA's internal subcommittee that has taken the lead for CODA's analysis and implementation of ADA Task Force recommendations. Following brief opening remarks by the two chairs, the committees discussed a prioritized list of Task Force recommendations.

- Recommendation #5: *CODA and the ADA should clarify their respective roles, responsibilities and expectations and communicate these to their communities of interest*. This recommendation was identified as a high priority item—high in importance, effort and level of sensitivity with much of the discussion focusing on the term "arms-length" which has been used in the past to define the relationship between CODA and the ADA. Members of the committees affirmed that CODA is an agency or "arm" of the ADA and asserted that the term "arms-length" should not be used. Some members of the ADA and House of Delegates expressed frustration that they perceived that the term was used to deter ADA from pursuing concerns with CODA. Members of the Monitoring Committee acknowledged that it would not be appropriate for ADA to have influence on accreditation decisions regarding individual education programs, but asserted that the ADA's input on policy decisions should be considered due to its prominence in representing a significant proportion of the profession and employers of graduates of education programs. They also emphasized the importance of the flow of information between CODA and the profession.

  Members of the committees noted that the term "arms-length" is not included in any governance documents of the Association, nor is it specified by the U.S. Department of Education. In reviewing the Secretary of Education's criteria for recognition of accrediting agencies, four categories of agencies are described. CODA falls under the category in the Secretary's criteria (Appendix 2, Worksheet:4026, USDE Requirements, selected sections), Section 602.14 (a) "(2) An accrediting agency that (i) Has a voluntary membership; and (ii) Has as its principal purpose the accreditation of higher education programs, or higher education programs and institutions of higher education, and that accreditation is a required element in enabling those entities to participate in non-HEA Federal programs." Accordingly, CODA is not required to satisfy the requirement that it is "separate and independent" from ADA. However, CODA, and all accrediting agencies must comply with the requirement of Section 602.15 (a) (6): "The agency has clear and effective controls against conflicts of interest, or the appearance of conflicts of interest, by the agency's—(i) Board members; (ii) Commissioners; (iii) Evaluation team members; (iv) Consultants; (v) Administrative staff; and (vi) Other agency representatives." Members of both committees commented that if this requirement is observed, the appropriate relationship between CODA and the ADA and other communities of interest can be maintained. CODA has a written policy on conflict of interest that has recently been reviewed and updated; the policy is contained in its *Evaluation Policies and Procedures* document that is publicly available and this topic is covered in both CODA orientation sessions and information sessions for communities of interest.

  Members of the Monitoring Committee noted that a particular concern to some members of the ADA House of Delegates is the significant financial support that ADA provides to CODA. Although ADA's financial support reflects the profession's commitment to quality education, the finances should be reviewed and the full extent of ADA financial support should be clearly reported.

- Recommendation #6: *CODA should openly collaborate with its communities of interest to resolve the issue of perceptions versus realities of CODA accrediting educational programs in non-recognized specialty areas of general dentistry and publicize the results of this process.*

  Members of the committees noted that considerable confusion exists regarding roles and responsibilities and the meaning of terms, such as accreditation, certification and recognition. The groups agreed that the definition of terms must be addressed, and CODA agreed to convene a group to develop definitions for mutual adoption and dissemination. The committees noted that although the CDEL had previously considered its potential role in the review and recognition of non-specialty interest areas in dentistry, the ADA's House of Delegates did not support the recommendations in Board Report 12-2006, Resolution 9-2006, which would have revised CDEL's *Bylaws* responsibilities to include the recognition of non-specialty interest areas in general dentistry. (Although a majority supported the resolution, the 2/3 affirmative vote required for adoption was not achieved. A separate resolving clause clarifying CDEL's role in recognizing dental specialties was adopted and is reflected

in current *Bylaws*, paragraph 2.) Thus, by default, this "recognition" became attributable to CODA. CODA representatives noted that they had invited the CDEL chair to their Subcommittee meeting and planned to consider his suggestions for a CDEL/ADA role in the process. Members of both committees concurred that the House of Delegates should be asked to reconsider the recommendation that CDEL assume this responsibility.

- Recommendation #8 addressed the composition of specialty review committees. CODA members indicated that a process for expanding review committees was implemented and content experts have been added to a number of committees. Survey evaluations of the impact of changes have been positive, but CODA intends to continue the evaluation for three more years.

- Recommendation #15 (*CODA commissioners, review committee members, site visitors and volunteers should serve the interests of CODA without personal or member organization profiles or agendas. This policy should be clearly articulated internally, and strongly articulated externally to all relevant organizations that supply persons for positions on CODA or any of its working committees*.) was addressed by CODA's Task Force on Communications. CODA adopted recommendations for immediate implementation to enhance understanding, awareness and practices that promote the duty of loyalty to the Commission and the best interests of the public. This perspective will be emphasized internally and in information sessions for communities of interest.

- Recommendation #25 clarified the need for more effective communication by CODA as an effort toward cultural change regarding transparency, accountability and responsiveness. CODA participants acknowledged their understanding and effort in this direction, and asked for similar respect from the communities of interest.

- Recommendation #3 advised that *CODA should develop a detailed business plan, complete with timelines and fiscal implications for implementing any recommendations regarding structure*. The committees noted that splitting CODA could lead to unintended consequences; however, all agreed that they should explore potential structures using information in the Task Force report and develop potential options with financial implications. A workgroup consisting of Drs. Nissen and Kershenstein from CODA and Drs. Faiella and Roberts from the ADA committee was appointed to address this task.

- Recommendation #14 advised that *CODA should continue the nomination process it has initiated*. CODA concurred and has affirmed and communicated the process to communities of interest.

- Recommendation #31 stated that *CODA should maintain its recognition by USDE.* The committees discussed the requirements for maintaining and potential disadvantages of giving up USDE recognition, noting that many federal funding programs require that educational programs be accredited by an agency recognized by USDE. Nevertheless, CODA's strategic planning initiative will include an assessment of the benefits, risks, obligations and alternatives.

- Recommendations #23 and #24 advised that CODA should use outside expertise and create a dedicated staff position to assist in the development and implementation of a communications plan. CODA's Communications Task Force had contacted the chair of the ADA Council on Communication for assistance and learned that the Council would not be able to meet CODA's needs. The group discussed potential alternatives to an outside consultant in light of the challenging economic environment and budget constraints, and concluded that ADA staff should be consulted for assistance in developing a request for proposals for an assessment and planning for improved communications, and that funding should be sought to support this activity.

- Recommendations #26, 27 and 28 related to CODA's use of best practices for quality management and strategic planning and also recommended the use of outside assistance. ADA participants noted

that ADA no longer has internal resources for these types of activities. CODA has assigned these responsibilities to its internal subcommittee, but all agreed that these activities may need to be deferred, pending availability of resources and concentration of effort on other priority recommendations.

- Recommendations #7, 9, 16, and 18 were identified by CODA members as implemented; ADA committee members concurred.
  - #7: *CODA should extend its meeting format to allow more time for discussion regarding accreditation decisions*.
  - #9: CODA should continue to include a public member on each review committee.
  - #16: *CODA should continue to develop and improve an orientation and training process for volunteers after the volunteer is selected but before the volunteer assumes the responsibilities of the position*.
  - #18: *CODA should require that all specialty areas of practice continue to be responsible for funding the formal training of site visitors and should provided content expertise for the training curricula. CODA staff should continue to conduct the training and assure that the training is well organized and consistent across all specialty areas*.

- CODA representatives noted that Recommendations #8, 10, 13, 15, 21, 22, 23 and 24 had been referred to its Task Force on Communications and the group discussed the task force report that had been presented to CODA. Work on these recommendations is in progress.

- Recommendation #20 (*CODA should establish a system by which all members of site visit teams, including the chair, are evaluated*.) has been referred to CODA's Outcomes Assessment Committee.
- As part of their discussion of Recommendation #32 (*CODA should monitor how USDE recognition influences funding for education programs*), the committees reviewed a table summarizing the federal funding programs relevant to dental education programs and the eligibility requirements tied to accreditation and recommended that this information be provided to the House of Delegates (Appendix 3, Worksheet:4029, Federal Funding Links to Accredited Dental Education Programs). CODA's internal Subcommittee will analyze information relating to alternative recognition processes by the council for Higher Education Accreditation (CHEA) and the American National Standards Institute (ANSI/ISO) as advised by Recommendations #33 and 34.

Following their review of progress on recommendations, the group briefly discussed next steps, including the potential to use open hearings as opportunities to communicate how CODA is responding to the Task Force recommendations. Participants acknowledge that the process of responding to the recommendations will require continued time and effort.

August 1, 2009 Meeting of ADA Monitoring Committee. The Committee met to review the joint meeting from the previous day and CODA's progress in implementing Task Force recommendations.

The Committee observed a culture of cooperation and sharing in its interaction with CODA's Subcommittee and noted that CODA leadership has been open and willing to listen and share information. The Committee believes it is important for CODA to understand the need for a process to continue open, proactive communication. Although CODA has demonstrated that it is responding and taking action on the recommendations, the Committee would like to see operating procedures that support action on the recommendations and continued cooperation and communication.

The Committee summarized the key points from the discussion with CODA's Subcommittee about the ADA-CODA relationship as follows. CODA is the ADA's Commission. CODA has been an agency of the ADA since its inception and has been financially supported by ADA because the profession values a system of quality assurance for dental education. The Committee reviewed CODA finances in depth and noted that although education programs began paying fees for accreditation in the mid-1990s, the fees do not fully cover

the cost of accreditation. The ADA provides approximately half of the direct and all of the indirect expenses for CODA operation. Although a workgroup will review current CODA funding and potential alternatives, the Committee concluded that financial support for CODA was money well spent. The Committee believes that it is important to be able to communicate with CODA on mutual areas of interest or concern and observed that the ability to do so could be lost if CODA were to become an independent agency. The Committee also believed that it is advantageous for CODA to maintain its relationship with ADA and receive input from ADA on policy matters. The Committee noted that there will be instances where CODA may not be able to strictly adhere to ADA's wishes, and that it will be important for all to understand CODA's conflict of interest policy and the rationale.

With regard to communication, the Committee concluded that it is important for ADA and other communities of interest to engage in dialogue on accreditation standards and policy matters at an early stage instead of being reactive. The Committee noted that recent CODA open hearings have allowed more time and demonstrated greater willingness of CODA to listen to communities of interest. The Committee believed that the ADA needs to become more knowledgeable about CODA and be prepared to have members who will serve in CODA leadership positions.

In reviewing the discussion of the joint meeting, the Committee noted that both groups concurred that it would be appropriate for CDEL to assume the role of recognizing non-specialty interest areas of general dentistry and that this could guide CODA in determining whether to establish an accrediting program in a new discipline. The Committee determined that Resolution 9-2006 should be resubmitted to the ADA House of Delegates and agreed to submit the resolution with its report.

Next steps: The Committee observed that CODA's process of reviewing, analyzing and acting on the Task Force recommendations will take more time, probably another year. In addition, CODA will require adequate resources to implement recommendations. Funds will be needed for additional meetings of CODA committees and to obtain the expertise required for some of the recommendations that cannot be addressed through the use of internal ADA resources.

The Committee believes that it has developed a good working relationship with CODA and that the Committee should plan to continue its work in 2010. Additional funding will be needed to support the Committee's work for one two-day meeting and one one-day meeting in 2010. Funding in the amount of $20,400 is being requested to support the costs of volunteer travel, meals, lodging and miscellaneous expenses, such the cost of conference calls.

Summary: This report describes the activities of the Resolution 37H-2008 Committee to Monitor Implementation of Recommendations from the CODA 2008 Task Force Report. The Committee analyzed and prioritized Task Force recommendations and met with CODA to share ADA's perspective, provide guidance and obtain information and feedback from CODA. The process has been open and collaborative and will continue in 2010. Two resolutions are presented for consideration of the Board and House of Delegates.

Resolutions

See Resolution 52; Worksheet:4031
See Resolution 53; Worksheet:4032

Appendix 1 Summary of Prioritized CODA Task Force Recommendations			
Rec #	**Short Description**	**TF Recommendation**	**CODA Assignment**
Red			
2	Investigate appropriate new structures	Change/Implement	Review by Subcommittee
5	CODA/ADA roles/responsibilities	Modify/Improve/Clarify	Review by Subcommittee
6	Accreditation of non-specialty programs	Modify/Improve/Clarify	Review by Subcommittee
8	Composition of specialty RCs	Maintain	Review by Subcommittee
15	Independence from specialty orgs	Modify/Improve/Clarify	Refer to Communication TF
21	Communication quality/content/processes	Modify/Improve/Clarify	Refer to Communication TF
22	Communication- transparency/accountability value/outcomes	Modify/Improve/Clarify	Refer to Communication TF
25	Culture	Change/Implement	Review by Subcommittee
26	Quality management program tied to strategic planning	Change/Implement	Review by Subcommittee
29	Alternate methods/enhanced technology for monitoring	Monitor/Evaluate	Refer to ad hoc Committee Alt Site Visits
30	Use of technology/data reporting and management	Monitor/Evaluate	Refer to ad hoc Committee Alt Site Visits
Yellow			
1	Restructure	Change/Implement	Review by Subcommittee
3	Business plan for implementation fiscal implications and timelines	Change/Implement	Review by Subcommittee
10	RC volunteer staffing	Modify/Improve/Clarify	Refer to Outcomes Committee
12	Site visit flexibility	Modify/Improve/Clarify	Refer to Outcomes Committee
18	Site visitor training with specialties	Maintain	Review by Subcommittee
20	Site visitor/chair evaluation by programs	Change/Implement	Refer to Outcomes Committee
23	Communication public relations plan	Change/Implement	Review by Subcommittee
24	Communication hire staff person	Change/Implement	Review by Subcommittee
27	Quality management program hire an expert	Change/Implement	Review by Subcommittee
28	Strategic Planning hire a consultant	Change/Implement	Review by Subcommittee
32	USDE-dental education funding	Monitor/Evaluate	Refer to Outcomes Committee
33	Recognition by CHEA	Monitor/Evaluate	Review by Subcommittee
34	Recognition by ANSI/ISO	Monitor/Evaluate	Review by Subcommittee
Green			
4	Legal/fiscal relationship with ADA	Maintain	Review by Subcommittee
7	Time for accreditation decisions	Modify/Improve/Clarify	Review by Subcommittee
9	Public member of RCs	Maintain	Review by Subcommittee
11	Commissioner term of service	Change/Implement	Review by Subcommittee
13	Pre-nomination education process	Modify/Improve/Clarify	Refer to Communication TF
14	Current RC nominating process	Maintain	Refer to Nominations Cmte
16	Training for volunteers	Modify/Improve/Clarify	Refer to Outcomes Committee
17	RC members observe a site visit	Change/Implement	Refer to Outcomes Committee
19	Site visitor re-orientation	Change/Implement	Refer to Outcomes Committee
31	Recognition of USDE	Maintain	Review by Subcommittee

Appendix 2
USDE REQUIREMENTS

602.14 Purpose and organization.

(a) The Secretary recognizes only the following four categories of agencies:

The Secretary recognizes...	that...
(1) An accrediting agency	(i) Has a voluntary membership of institutions of higher education; (ii) Has as a principal purpose the accrediting of institutions of higher education and that accreditation is a required element in enabling those institutions to participate in HEA programs; and (iii) Satisfies the separate and independent requirements in paragraph (b) of this section.
(2) An accrediting agency	(i) Has a voluntary membership; and (ii) Has as its principal purpose the accrediting of higher education programs, or higher education programs and institutions of higher education, and that accreditation is a required element in enabling those entities to participate in non-HEA Federal programs.
(3) An accrediting agency	for purposes of determining eligibility for Title IV, HEA programs-- (i) Either has a voluntary membership of individuals participating in a profession or has as its principal purpose the accrediting of programs within institutions that are accredited by a nationally recognized accrediting agency; and (ii) Either satisfies the separate and independent requirements in paragraph (b) of this section or obtains a waiver of those requirements under paragraphs (d) and (e) of this section.
(4) A State agency	(i) Has as a principal purpose the accrediting of institutions of higher education, higher education programs, or both; and (ii) The Secretary listed as a nationally recognized accrediting agency on or before October 1, 1991 and has recognized continuously since that date.

(b) For purposes of this section, the term **separate and independent** means that--

(1) The members of the agency's decision-making body--who decide the accreditation or preaccreditation status of institutions or programs, establish the agency's accreditation policies, or both--are not elected or selected by the board or chief executive officer of any related, associated, or affiliated trade association or membership organization;

(2) At least one member of the agency's decision-making body is a representative of the public, and at least one-seventh of that body consists of representatives of the public;

(3) The agency has established and implemented guidelines for each member of the decision-making body to avoid conflicts of interest in making decisions;

(4) The agency's dues are paid separately from any dues paid to any related, associated, or affiliated trade association or membership organization; and

(5) The agency develops and determines its own budget, with no review by or consultation with any other entity or organization.

(c) The Secretary considers that any joint use of personnel, services, equipment, or facilities by an agency and a related, associated, or affiliated trade association or membership organization does not violate the separate and independent requirements in paragraph (b) of this section if--

(1) The agency pays the fair market value for its proportionate share of the joint use; and

(2) The joint use does not compromise the independence and confidentiality of the accreditation process.

(d) For purposes of paragraph (a)(3) of this section, the Secretary may waive the "separate and independent" requirements in paragraph (b) of this section if the agency demonstrates that--

(1) The Secretary listed the agency as a nationally recognized agency on or before October 1, 1991 and has recognized it continuously since that date;

(2) The related, associated, or affiliated trade association or membership organization plays no role in making or ratifying either the accrediting or policy decisions of the agency;

(3) The agency has sufficient budgetary and administrative autonomy to carry out its accrediting functions independently; and

(4) The agency provides to the related, associated, or affiliated trade association or membership organization only information it makes available to the public.

(e) An agency seeking a waiver of the "separate and independent" requirements under paragraph (d) of this section must apply for the waiver each time the agency seeks recognition or continued recognition.

(Authority: 20 U.S.C. 1099b)

602.15 Administrative and fiscal responsibilities.

The agency must have the administrative and fiscal capability to carry out its accreditation activities in light of its requested scope of recognition. The agency meets this requirement if the agency demonstrates that--

(a) The agency has--

(1) Adequate administrative staff and financial resources to carry out its accrediting responsibilities;

(2) Competent and knowledgeable individuals, qualified by education and experience in their own right and trained by the agency on its standards, policies, and procedures, to conduct its on-site evaluations, establish its policies, and make its accrediting and preaccrediting decisions;

(3) Academic and administrative personnel on its evaluation, policy, and decision-making bodies, if the agency accredits institutions;

(4) Educators and practitioners on its evaluation, policy, and decision-making bodies, if the agency accredits programs or single-purpose institutions that prepare students for a specific profession;

(5) Representatives of the public on all decision-making bodies; and

(6) Clear and effective controls against conflicts of interest, or the appearance of conflicts of interest, by the agency's-

(i) Board members;

(ii) Commissioners;

(iii) Evaluation team members;

(iv) Consultants;

(v) Administrative staff; and

(vi) Other agency representatives; and

(b) The agency maintains complete and accurate records of--

(1) Its last two full accreditation or preaccreditation reviews of each institution or program, including on-site evaluation team reports, the institution's or program's responses to on-site reports, periodic review reports, any reports of special reviews conducted by the agency between regular reviews, and a copy of the institution's most recent self-study; and

(2) All decisions regarding the accreditation and preaccreditation of any institution or program, including all correspondence that is significantly related to those decisions.

(Approved by the Office of Management and Budget under control number 1845-0003)

(Authority: 20 U.S.C. 1099b)

Appendix 3
Federal Funding Program Links to Accredited Dental Education Programs

Legislation	Section	Applicable/eligible Education Programs
Title 42 Public Health Service Act Vol. 2, Chapter IV, Centers for Medicare & Medicaid Services, DHHS	Subchapter B Medicare Program, Part 405-426 Direct and indirect GME funding/hospital insurance	Residency programs approved by the Commission on Dental Accreditation
Title 42 Public Health Service Act Title VII, Health Professions Education	Part B Centers of Excellence Sec. 736 Grants to health professions schools and educational entities to support programs of excellence in health professions education for underrepresented minorities	Schools of dentistry*
	Part B Centers of Excellence Sec. 737 Scholarships for disadvantaged students	Schools of dentistry* Schools of public health* Schools of allied health*
	Part B Centers of Excellence Sec. 738 Loan Repayments and Fellowships Regarding Faculty Positions	Individuals who have a degree in dentistry and are enrolled in an approved graduate training program in dentistry; are enrolled full-time in an accredited school Eligible schools* include dentistry, public health
	Part B Centers of Excellence Sec. 739 Educational Assistance in the health Professions regarding Individuals from Disadvantaged Backgrounds	Schools of public health* Schools of dentistry* Schools of allied health*
	Part C Training in Family Medicine, General Internal medicine, General Pediatrics, Physician Assistants, Genera Dentistry, and Pediatric Dentistry Sec. 747 To plan, develop, operate or participate in an approved professional training program; to provide traineeships and fellowships	Dental schools*, approved* residency programs in the general or pediatric practice of dentistry, approved advanced education programs in the general or pediatric practice of dentistry, or approved residency programs in pediatric dentistry.

Legislation	Section	Applicable/eligible Education Programs
	Part D Interdisciplinary, Community-Based Linkages Sec. 753 Education and Training Regarding Physicians and Dentists	Postdoctoral dental education program sponsored by a school of dentistry*
	Part E, Subpart 2 – Public Health Workforce Sec. 765 Grants or contracts for planning, developing or operating training programs; financial assistance to residency trainees Sec. 768 Preventive medicine; dental public health	Accredited school or program of public health, or dental public health*
	Part F General Provisions Sec. 799B, (1)(A), (E)	*School of dentistry means an "accredited public or nonprofit private school in a State that provides training leading, respectively to a degree of doctor of dentistry or an equivalent degree . . . and including advanced training related to such training provided by any such school" "The term 'accredited', when applied to a school of medicine, osteopathic medicine, dentistry, veterinary medicine, optometry podiatry, pharmacy, public health, or chiropractic, or a graduate program in health administration, clinical psychology, clinical social work, professional counseling, or marriage and family therapy, means a school or program that is accredited by a recognized body or bodies approved for such purposes by the Secretary of Education. . . ".
Public Health Service Act Title 26 HIV Health Care Service Program	Ryan White Care Act HIV/AIDS Dental Reimbursement Program	Dental schools, postdoctoral dental education programs such as hospital-based residencies, and dental hygiene education programs that are accredited by the Commission on Dental Accreditation
Public Health Service Act	Sec. 319 F(g) Bioterrorism Training and Curriculum Development	Accredited* and licensed health professions schools

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Resolution No. 52 New ■ Substitute ☐ Amendment ☐

Report: Board Report 13 Date Submitted: September 2009

Submitted By: Board of Trustees

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Lead in the Advancement of Standards (Required)

CDEL *BYLAWS* AMENDMENT REGARDING RECOGNITION OF NON-SPECIALTY INTEREST AREAS IN GENERAL DENTISTRY

Background: (See Board Report 13-2009 to the House of Delegates, Worksheet:4016)

Resolution

52. Resolved, that Chapter X. COUNCILS, Section 120. DUTIES, Subsection E. COUNCIL ON DENTAL EDUCATION AND LICENSURE, subsection b, of the ADA *Bylaws*, be amended by addition of the following new paragraph:

(3) The recognition of non-specialty interest areas in general dentistry.

and be it further

Resolved, that existing paragraphs "3" through "7" be renumbered as "4" through "8," respectively, and be it further

Resolved, that the Council on Dental Education and Licensure review the recommendations from Board Report 12-2006 and present criteria for recognition of non-specialty interest areas in general dentistry for consideration of the House of Delegates at its 2010 annual meeting.

BOARD COMMENT: The Board believes that the ADA should take ownership of this issue and that the CDEL should be involved in reconsideration of this issue. In addition, confusion with the terms "recognition," "certification" and "accreditation" continues to exist. The Board understands that the Council will be taking the lead in developing definitions for these terms in the coming year. For these reasons, the Board believes this resolution should be referred to the Council on Dental Education and Licensure.

BOARD RECOMMENDATION: Vote Yes on Referral.

BOARD VOTE: UNANIMOUS.

***

Resolution No. 53 New ■ Substitute ☐ Amendment ☐

Report: Board Report 13 Date Submitted: September 2009

Submitted By: Board of Trustees

Reference Committee: Dental Education and Related Matters

Total Financial Implication: $20,400

Amount One-time $20,400 Amount On-going $

ADA Strategic Plan Goal: Lead in the Advancement of Standards (Required)

FUNDING SUPPORT FOR CONTINUATION OF THE ADA COMMITTEE TO ASSIST CODA IMPLEMENTATION OF THE 2008 ADA TASK FORCE RECOMMENDATIONS

Background: (See Board Report 13-2009 to the House of Delegates, Worksheet:4016)

Resolution

53. Resolved, that funding in the amount of $20,400 be added to the ADA 2010 budget to support the continuation of the ADA Committee to Monitor and Assist CODA Implementation of the 2008 ADA Task Force recommendations.

BOARD COMMENT: The Monitoring Committee has provided valuable assistance to CODA in the implementation of the 2008 ADA Task Force's recommendations. The Committee's continued assistance will keep CODA on track with implementation of Task Force recommendations and provide opportunities for ongoing dialogue with all stakeholders. The ability to develop rapport and improved communication and mutual understanding of critical issues through face-to-face discussion has been critical to the success of the Committee's work to date. The Board supports continuing the process in this manner and the associated financial implication.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.

***

Resolution No. 54-55 New ■ Substitute ☐ Amendment ☐

Report: CODA Supplemental Report 1 Date Submitted: 9/4/2009

Submitted By: Commission on Dental Accreditation

Reference Committee: Dental Education and Related Matters

Total Financial Implication: $164,000

Amount One-time $61,000 Amount On-going $103,000 annually

ADA Strategic Plan Goal: Lead in the Advancement of Standards (Required)

COMMISSION ON DENTAL ACCREDITATION SUPPLEMENTAL REPORT 1 TO THE HOUSE OF DELEGATES: PROGRESS ON IMPLEMENTATION OF RECOMMENDATIONS IN THE REPORT OF THE TASK FORCE ON CODA

Executive Summary: As directed by Resolution 37H-2008, this report provides a progress report on the Commission on Dental Accreditation (CODA) in implementing recommendations from the 2008 Report of the Task Force on CODA. One resolution is submitted for the Board's consideration and recommendation to the House of Delegates.

The following are the highlights of the CODA progress on implementation of ADA Task Force recommendations during the past year.

- The Commission has appointed an *ad hoc* Subcommittee on the ADA Task Force on CODA Report and Recommendations to conduct a complete and objective review of all ADA Task Force recommendations in an open and collaborative manner. In addition, this Subcommittee has been interacting directly with the ADA Monitoring Committee.
- To date in 2009, the Subcommittee has met twice in face-to-face meetings at ADA Headquarters. At the first meeting on May 29, the prioritized table of recommendations developed by the ADA Monitoring Committee was used as a starting point for consideration of the recommendations. Some recommendations were referred to Standing Committees and Task Forces of the Commission for further evaluation and implementation strategies. Other recommendations were considered directly by the Subcommittee and were designated for further discussion with the ADA Monitoring Committee.
- At its second meeting, on July 29, the Subcommittee considered the implementation strategies for several of the recommendations developed by the Commission's Task Force on Communication.
- At its July 31st meeting, the Commission directed that the implementation strategies proposed by the Task Force on Communications and the Subcommittee be adopted.
- The Subcommittee met jointly with the ADA Monitoring Committee following the July 31st Commission meeting.
- To date, the Commission has implemented, or has begun implementation, for 18 of the 34 recommendations. The remaining 16 recommendations are all in various stages of study by the Subcommittee, Standing Committees of the Commission, and/or the ADA Monitoring Committee. A summary of the progress of the Commission in implementing each of the ADA Task Force recommendations is included at the end of this report.

Background: As directed by Resolution 37H-2008, this report details progress on implementation of recommendations in the 2008 Report of the Task Force on the Commission on Dental Accreditation (CODA).

37H-2008. Resolved, that the American Dental Association out of its deep concern about aspects of the accreditation process strongly urges the ADA Commission on Dental Accreditation to accept and implement the Report of the Task Force on CODA, and be it further

Resolved, that the American Dental Association urges CODA to work with all interested parties to implement the recommendations as they are reflected in the body of the Report, and be it further

Resolved, that the President of the ADA appoint a committee for the express purpose of monitoring and assisting CODA in implementing the recommendations of the Task Force Report, and be it further

Resolved, that this committee consist of a chair, three members of the Board of Trustees and three members of the House of Delegates, and be it further

Resolved, that this committee provide updates to the Board of Trustees at each of its 2008-2009 meetings prior to the 2009 House, and be it further

Resolved, that the ADA urges CODA to provide a comprehensive report to the 2009 House detailing progress on the implementation of the recommendations of the Task Force Report.

At the January 29, 2009 Commission mega issue discussion, the Commission received the ADA Task Force on the Commission on Dental Accreditation Report and Recommendations. Dr. Kathy Kell, Chair of the ADA Monitoring Committee, and Dr. Perry Tuneberg, one of the ADA Monitoring Committee members from the House of Delegates, were in attendance. The ADA report was discussed at great length and each of the 34 recommendations were reviewed. The Commission considered the report in the spirit of improving the structure, governance, policies, operating procedures, functionality and use of best practices. The Commission is committed to conducting a complete and objective review of all ADA Task Force recommendations in an open and collaborative manner. The Commission intends to communicate the results of CODA's review process as effectively as possible to both ensure openness and to help inform the communities of interest about the accreditation process.

Further detailed consideration, study, and possible implementation plans are necessary for each of the 34 recommendations. The consensus was that this could best be accomplished through the appointment of an *ad hoc* Subcommittee by the Commission chair, Dr. James Koelbl. In addition, the Subcommittee would interact directly with the ADA Monitoring Committee established by the House of Delegates at the 2008 ADA Annual session. The subcommittee members are: Dr. James Koelbl (ADEA), Chair; Dr. E. Les Tarver (ADA); Dr. Sharon Turner (ADEA); Dr. Larry Nissen (ADA); Dr. Karen Kershenstein (public); Dr. Patrick Louis (AAOMS); Dr. Vince Iacono (AAP); Dr. Bryan Edgar (AADE); Dr. Heidi Crow (AAHD); and Mr. Gary Gann (DLT). The charges of this subcommittee are as follows:

1. To review and prioritize each of the recommendations of the ADA Task Force on the Commission on Dental Accreditation in light of the mission of the Commission on Dental Accreditation.
2. To investigate possible implementation strategies for each of the recommendations.
3. To interact directly with the ADA Monitoring Committee, keeping the Monitoring Committee informed on the progress of the review process and possible implementation strategies.
4. To solicit input from and communicate with all Commission Communities of Interest regarding the ADA Task Force on CODA Recommendations.
5. To provide overall coordination with other Commission standing committees and ad hoc committees that are assigned to review ADA Task Force on CODA recommendations.
6. To make a report to the Commission with possible recommendations for actions at the regular Commission meetings.
7. To report to the ADA Board of Trustees and House of Delegates on a regular basis.

To date, the Subcommittee has met twice in 2009, both face-to-face meetings at ADA Headquarters on May 29 and July 29. In addition, the Subcommittee met with the ADA Monitoring Committee in a joint meeting on July 31.

May 29, 2009 Subcommittee Meeting: In attendance at the first meeting of the Subcommittee was the Chair of the ADA Monitoring Committee, Dr. Kathy Kell, and Board of Trustees Liaison to the Commission, Dr. Marie Schweinebraten.

- The Subcommittee received an update on the current status of the ADA budget, and how this might affect implementation of some of the recommendations. Funds for implementation of the recommendations were requested in a decision package and presented to the Board of Trustees at its April meeting. The financial implications associated with the recommendations included: two face-to-face meetings of the CODA subcommittee; five recommendations that deal with an increase in the amount of training given to Commission volunteers; the recommendation of the hiring of a Communications staff person; and three recommendations for the use of outside consultants. The total requested was $220,050. The Subcommittee was informed that there is no provision in this budget for hiring extra staff or outside consulting, although meeting requests for committees will probably be approved.

- The Subcommittee received a report from Dr. Kell on the April 27 ADA Monitoring Committee meeting. She presented the prioritized table of recommendations, along with the rationale for the ranking of importance/sensitivity of each of the ADA recommendations. The ADA Monitoring Committee came to the conclusion that the communication component of the report and recommendations are very important, and they discussed the types of communication that are important for the Commission to consider. It was acknowledged that there is a significant amount of communication from the Commission; however, the Commission needs to "communicate better on how it communicates." In light of budget considerations, the ADA Monitoring Committee recommended the use of "in-house" ADA resources to help the Commission address the communication and strategic planning recommendations.

- The prioritized table of recommendations developed by the ADA Monitoring Committee was used as a starting point for consideration of the recommendations (Appendix 1-See Worksheet:4025). Some recommendations were referred to standing committees and task forces of the Commission for further evaluation and implementation strategies, including the Standing Committee on Outcomes Assessment (recommendation #s 20, 32, 33 and 34); the Task Force on Communication (recommendation #s 8, 10, 13, 15, 21, 22, 23 and 24); the Standing Committee on Nominations (recommendation #14); and the Standing Committee on Finance (recommendation #3). Other recommendations were considered directly by the Subcommittee, for further discussion at the next meeting of the Subcommittee and with the ADA Monitoring Committee (recommendation #s 1, 5, 6, 11, 26, 27, 28, 29 and 30). Discussion of two recommendations (#s 2 and 12) was deferred, pending development of implementation strategies for other recommendations directly related to these two recommendations. Finally, the Subcommittee determined that several recommendations had already been implemented by the Commission, or the strategies were already in place for implementation (recommendation #s 4, 7, 9, 16, 17, 18, 19, 25 and 31).

July 29, 2009 Subcommittee Meeting: In attendance at the second meeting of the Subcommittee was the Chair of the ADA Monitoring Committee, Dr. Kathy Kell, and Board of Trustees Liaison to the Commission, Dr, Marie Schweinebraten. The CDEL chair, Dr. Denis "Chip" Simon participated as a guest.

- The implementation strategies developed by the Commission's Task Force on Communication for several of the communication recommendations were considered. As suggested by the ADA Monitoring Committee, Dr. Peter Carroll, chair of the ADA Council on Communication, participated as a guest at the Task Force on Communication conference call. Dr. Carroll explained the Council on Communication has recently been reconstituted with new *Bylaws*. It will focus on external ADA

images and branding. The Council will be able to help the Commission on a short-term basis; however, in the long-term, Dr. Carroll believes the Commission will need to hire a dedicated, communication staff person. He noted that the ADA Task Force Recommendations center around tactical, internal, and strategic processes, areas which are not the purview of the Council on Communication. In addition, he expressed some concern about the Commission's relationship with the ADA and the propriety of an ADA Council creating and disseminating messages to the communities of interest, including the public. Dr. Carroll suggested Mr. Dick Green and his staff may be able to provide some consultation services in this regard; however, it is not a long-term solution to the use of outside expertise to assess current communications efforts and assist in the development and implementation of a detailed communications and public relations plan (recommendation #s 21 and 23). It also would not be a long-term solution to the hiring of an additional Commission staff person with expertise in communication (recommendation #24). The Subcommittee discussed the implementation strategies for each of the other recommendations made by the Task Force on Communications (recommendation #s 8, 10, 13, 15 and 22) and recommended the Commission endorse and accept the Task Force on Communication implementation plans, with the Subcommittee additions, for recommendation #s 8, 10, 13 and 15. In addition, the Commission was urged to make a request to the House of Delegates for adequate funding in order to implement recommendation #s 21, 23 and 24.

- Dr. Simon addressed the role the CDEL might play in resolving the issue of perception versus realities of accreditation of non-recognized specialty areas of general dentistry (recommendation #6). He noted there is much confusion and misinterpretation surrounding the terms accreditation, certification, recognition, credential and licensure. There are no standard definitions used throughout the different ADA councils and commissions and the House of Delegates. He stressed that new definitions need to be formulated that are less confusing and these new definitions need to be disseminated to all communities of interest. Dr. Simon indicated that collaboration with communities of interest on this issue could be enhanced by the Commission making available, much earlier in the process, a general dentistry interest area groups' application for accreditation of their training programs. Current Commission policy and procedures do not solicit community of interest at the application stage, rather, an ad hoc committee of the Commission determines whether a general dentistry interest area groups application meets all the criteria. The Commission then acts on the recommendation of the ad hoc committee. Input is only solicited once the proposed standards are put out for comment. The Subcommittee noted that there was a previous Board of Trustees Report 12 to the House of Delegates, Resolution 9-2006 (*Trans.*2006:332) calling for a change in *Bylaws* relating to the CDEL. The change in ADA *Bylaws* would, in essence, require that non-recognized specialty interest areas first seek recognition by the House of Delegates, then, after receiving approval of the House, the non-recognized specialty interest area could then seek accreditation of training programs by CODA. This resolution failed to get the necessary two-thirds vote to change the duties of CDEL in the ADA *Bylaws*. Finally, Dr. Simon felt communication could be improved by the appointment of a CDEL Liaison to the ad hoc Commission committee that is formed to consider the accreditation application. After further discussion, the CODA Subcommittee recommended to the Commission that a joint group, made up of representatives of CODA, CDEL and CEBJA, formulate standardized definitions for the terms accreditation, certification, recognition, credential and licensure. The CODA Subcommittee also supported the appointment of a CDEL Liaison to *ad hoc* Commission committees formed to consider accreditation applications. The CODA Subcommittee deferred further discussion on early notification of accreditation applications in non-specialty areas of general dentistry until the next meeting.

- The Subcommittee considered a brief overview of the relationship between the ADA and the Commission as related to recommendation #5, the clarification of the respective roles, responsibilities and expectations of both the Commission and the ADA. The Commission is an agency of the ADA and the ADA provides organizational framework and structure. As there is no U.S. governmental agency that ensures the quality of education, the profession believes this quality assurance function

must be done with integrity and independently (i.e., with no bias) in order to serve both the profession and the public. In regards to the USDE recognition criteria, the Commission-ADA relationship falls under section 602.15 (a) (6) of the USDE criteria, as the Commission has clear and effective controls against conflict of interest. The Subcommittee came to the conclusion that recommendation #5 is closely associated with the three recommendations (#s 1, 2 and 3) which deal with the structure of the Commission. It was decided that further discussion of these recommendation should done in conjunction with the ADA Monitoring Committee.

- The Subcommittee learned that there are no longer in-house strategic planning services available, as suggested by the ADA Monitoring Committee for implementation of recommendations 26, 27 and 28. There were several suggestions made regarding strategic planning, including looking at increasing the terms of Commissioners; a 30-60 minute review of agenda items prior to the Commission meeting for first time Commissioners and any other Commissioners who would be interested; the possibility of more time between Review Committee meetings and the Commission meeting; and strategic planning as part of every Commission meeting agenda. The Subcommittee agreed that a restructuring of standing committees of the Commission would enhance the strategic planning process. Consideration of further implementation strategies for recommendation #s 26, 27 and 28 was deferred until the ADA Strategic Planning process has been re-established.

- The Subcommittee recommended immediate implementation of recommendation #s 17, 19 and 25 at the next Commission meeting.

July 31, 2009 Commission Meeting: The Commission reviewed the verbal report of the Subcommittee and noted that the following recommendations had already been implemented: #s 7, 9, 16 and 18.

- The Commission directed that the following recommendations be implemented immediately: #s 17, 19 and 25.

- The Commission adopted the implementations strategies to address the following recommendations which deal primarily with communication: #s 8, 13, 15 and 22.

- The Commission referred consideration of recommendation #10 to the Standing Committee on Outcomes Assessment.

- The Commission directed that a request be made to the House of Delegates for adequate funding in order to implement the following recommendations: #s 21, 23 and 24.

- The Commission directed that a joint group, made up of representatives of CODA, CDEL and CEBJA, formulate standardized definitions for the terms accreditation, certification, recognition, credential and licensure. This would be one component of the implementation of recommendation #6.

- The Commission deferred the consideration of the reorganization of the Commission's standing committees until the February 2010 Commission meeting. This was to give more time for the Commissioners to review the proposed changes.

July 31, 2009 Joint Meeting: Following the conclusion of the Commission open policy session, the Subcommittee met with the ADA Monitoring Committee. There was discussion about the following recommendations:

- Recommendation #5: *CODA and the ADA should clarify their respective roles, responsibilities and expectations and communicate these to their communities of interest*. Much of the discussion focused on the term "arms-length" which has been used in the past to define the relationship between CODA and the ADA. Members of the committees affirmed that CODA is an agency or "arm" of the ADA and

asserted that the term “arms-length” should not be used. Some members of the ADA and House of Delegates expressed frustration that they perceived that the term was used to deter ADA from pursuing concerns with CODA. Members of the Monitoring Committee acknowledged that it would not be appropriate for ADA to have influence on accreditation decisions regarding individual education programs, but asserted that the ADA’s input on policy decisions should be considered due to its prominence in representing a significant proportion of the profession and employers of graduates of education programs. They also emphasized the importance of the flow of information between CODA and the profession.

Members of the committees noted that the term ”arms-length” is not included in any governance documents of the Association, nor is it specified by the U.S. Department of Education. In reviewing the Secretary of Education’s criteria for recognition of accrediting agencies, four categories of agencies are described. CODA falls under the category in the Secretary’s criteria (Appendix 2-See Worksheet:4026, USDE Requirements, selected sections), Section 602.14 (a) “(2) An accrediting agency that (i) Has a voluntary membership; and (ii) Has as its principal purpose the accreditation of higher education programs, or higher education programs and institutions of higher education, and that accreditation is a required element in enabling those entities to participate in non-HEA Federal programs.” Accordingly, CODA is not required to satisfy the requirement that it is “separate and independent” from ADA. However, CODA and all accrediting agencies must comply with the requirement of Section 602.15 (a) (6): “The agency has clear and effective controls against conflicts of interest, or the appearance of conflicts of interest, by the agency’s—(i) Board members; (ii) Commissioners; (iii) Evaluation team members; (iv) Consultants; (v) Administrative staff; and (vi) Other agency representatives.” Members of both committees commented that if this requirement is observed, the appropriate relationship between CODA and the ADA and other communities of interest can be maintained. CODA has a written policy on conflict of interest that has recently been reviewed and updated; the policy is contained in its *Evaluation Policies and Procedures* document that is publicly available and this topic is covered in both CODA orientation sessions and information sessions for communities of interest.

Members of the Monitoring Committee noted that a particular concern to some members of the ADA House of Delegates is the significant financial support that ADA provides to CODA. Although ADA’s financial support reflects the profession’s commitment to quality education, the finances should be reviewed and the full extent of ADA financial support should be clearly reported.

- Recommendation #6: *CODA should openly collaborate with its communities of interest to resolve the issue of perceptions versus realities of CODA accrediting educational programs in non-recognized specialty areas of general dentistry and publicize the results of this process.*

- Members of the committees noted that considerable confusion exists regarding roles and responsibilities and the meaning of terms, such as accreditation, certification and recognition. The groups agreed that the definition of terms must be addressed, and CODA agreed to convene a group to develop definitions for mutual adoption and dissemination. The committees noted that although the CDEL had previously considered its potential role in the review and recognition of non-specialty interest areas in dentistry and at the time did not support such a concept. Nevertheless, the recommendations in Board Report 12, Resolution 9-2006, as forwarded to the House of Delegates by the Board of Trustees proposed revisions to CDEL’s *Bylaws* responsibilities to include the recognition of non-specialty interest areas in general dentistry. Although a majority of delegates supported the resolution, the two-thirds affirmative vote required for adoption was not achieved. With respect to CODA, the perception developed that by accrediting education programs in new areas, CODA was *de facto* recognizing specialty areas of practice. CODA representatives noted that they had invited the CDEL chair to their Subcommittee meeting and planned to consider his suggestions for a CDEL/ADA role in the process. Members of both committees concurred that the House of Delegates should be asked to reconsider the recommendation that CDEL assume this responsibility.

- Recommendation #3 advised that *CODA should develop a detailed business plan, complete with timelines and fiscal implications for implementing any recommendations regarding structure*. The committees noted that splitting CODA could lead to unintended consequences; however, all agreed that they should explore potential structures using information in the Task Force report and develop potential options with financial implications. The committees noted that this recommendation has a potential significant impact on recommendation #s 1 and 2, which also relate to the structure of the Commission. A workgroup consisting of Drs. Nissen and Kershenstein from CODA and Drs. Faiella and Roberts from the ADA committee was appointed to address this task.

- Recommendation #31 stated that *CODA should maintain its recognition by USDE.* The committees discussed the requirements for maintaining and potential disadvantages of giving up USDE recognition, noting that many federal funding programs require that educational programs be accredited by an agency recognized by USDE. The ADA Monitoring Committee suggested that assessment of the benefits, risks, obligations and alternatives of USDE is an ongoing process and should be referred to the Commission's Standing Committee on Outcomes Assessment for further study. It should also be part of the Commission's strategic planning process.

- As part of their discussion of Recommendation #32 (*CODA should monitor how USDE recognition influences funding for education programs*), the committees reviewed a table summarizing the federal funding programs relevant to dental education programs and the eligibility requirements tied to accreditation and recommended that this information be provided to the House of Delegates (Appendix 3-See Worksheet:4029, Federal Funding Links to Accredited Dental Education Programs). CODA's internal Subcommittee will analyze information relating to alternative recognition processes by the Council for Higher Education Accreditation (CHEA) and the American National Standards Institute (ANSI) as advised by Recommendations #33 and 34.

- The ADA Monitoring Committee was given an update on the implementation and/or progress on the following recommendations: #s 7, 8, 9, 10, 13, 14, 15, 16, 18, 20, 22, 23, 24, 25, 26, 27 and 28. The group briefly discussed next steps, including the potential to use open hearings as opportunities to communicate how CODA is responding to the Task Force recommendations. Participants acknowledge that the process of responding to the recommendations will require continued time and effort.

Summary of Progress Made in Implementing Recommendations:

1-CODA should restructure to better meet the current and future needs of the dental profession and the public. (Structure)

2-CODA should conduct a comprehensive investigation of appropriate structures. This investigation should build on and extend the work of the Task Force. (Structure)

3-CODA should develop a detailed business plan, complete with timelines and fiscal implications for implementing any recommendations regarding structure. (Structure)

- Recommendation #2 has been prioritized as highly important; recommendation #s 1 and 3 have been prioritized as moderately important. These three recommendations will be considered together by a workgroup consisting of Drs. Nissen and Kershenstein from the Commission and Drs. Faiella and Roberts from the ADA Monitoring Committee.

4-CODA and the ADA should maintain their current legal and fiscal relationship. (Governance)

- Recommendation #4 has been prioritized as easy to implement and non-controversial. The legal and fiscal relationship is currently defined in the *Bylaws* of the American Dental Association and the *Rules* of the Commission on Dental Accreditation. Neither the Commission, nor the ADA Task Force, has recommended any changes in the CODA-ADA legal and fiscal relationship. This relationship is described as, "…in the best interests of the dental community" in the ADA Task Force on CODA Report.

5-CODA and the ADA should clarify their respective roles, responsibilities and expectations and communicate these to their communities of interest. (Governance)

- Recommendation #5 has been prioritized as highly important. The ADA Task Force, "…investigated the advantages and disadvantages of creating a formal Memorandum of Understanding (MOU) that defines the respective roles and responsibilities of the ADA and CODA. While this option works for several other accreditation agency/professional association models, the Task Force believes that an MOU for the ADA and CODA may become too cumbersome, too inflexible, and too broad and that it may also result in unintended consequences." Members of the Subcommittee affirmed that CODA is an agency or "arm" of the ADA and agreed with the ADA Monitoring Committee that the term "arms-length" should not be used. While it would not be appropriate for ADA to have influence on accreditation decisions regarding individual education programs, the ADA's input on policy decisions should be considered due to its prominence in representing a significant proportion of the profession and employers of graduates of education programs. The Commission has a written policy on conflict of interest that has recently been reviewed and updated; the policy is contained in its *Evaluation Policies and Procedures* document that is publicly available and this topic is covered in both CODA orientation sessions and information sessions for communities of interest. Although ADA's financial support reflects the profession's commitment to quality education, the finances should be reviewed and the full extent of ADA financial support should be clearly reported.

6-CODA should openly collaborate with its communities of interest to resolve the issue of perceptions versus realities of CODA accrediting educational programs in non-recognized specialty areas of general dentistry and publicize the results of this process. (Governance)

- Recommendation #6 has been prioritized as highly important. The Commission agreed that there is much confusion and misinterpretation surrounding the terms accreditation, certification, recognition, credential and licensure. There are no standard definitions used throughout the different ADA councils and commissions and the House of Delegates. New definitions need to be formulated that are less confusing and these new definitions need to be disseminated to all communities of interest. The Commission directed that a joint group, made up of representatives of CODA, CDEL and CEBJA, formulate standardized definitions for the terms accreditation, certification, recognition, credential and licensure. This would be one component of the implementation of recommendation #6. The Subcommittee concurred that it would be appropriate for CDEL to assume the role of recognizing non-specialty interest areas of general dentistry and that this could guide the Commission in determining whether to establish an accrediting program in a new discipline. The Subcommittee supported the resubmission of Resolution 9b-2006 by the ADA Monitoring Committee to the ADA House of Delegates.

7-CODA should extend its meeting format to allow more time for discussion regarding accreditation decisions. (Policies)

- Recommendation #7 has been prioritized as easy to implement and non-controversial. At the January 2009 Commission meeting, the closed portion of the meeting was moved to the afternoon of the first day, which allowed significantly more time for accreditation discussions and decisions. In addition, detailed, written explanations of outstanding recommendations are provided for all programs that face adverse actions (i.e., intent to withdraw or withdrawal) or for programs reporting a major change. The written explanations have triggered additional questions and discussion of individual programs by the Commissioners.

8-CODA should define the composition of the specialty review committees regarding the number of content experts, and should develop procedures for determining that a critical threshold of generalist, specialist and public members is available for each decision at the review committee level. (Note: The ADA Task Force is not recommending any changes in review committee composition for predoctoral, dental hygiene, dental assisting, dental laboratory technicians and advanced educational general dentistry/graduate programs.) (Policies)

- Recommendation #8 has been prioritized as highly important. In January 2007, the Commission implemented the revised review committee (RC) structure. The new structures were phased in at that

time, through replacement of members with naturally expiring terms. The composition of each review committee is defined in Operational Policies and Procedures manual (OPP, pp. 36-37). In addition, the policy and procedures regarding the critical threshold of the various categories of RC members is also defined in OPP (p. 36). There is a process for adding additional content experts to advanced specialty review committees when the workload of the RC warrants the additional members. The following advanced specialty RCs have added content experts over the past two years: endodontics, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics. In addition, the Commission's Standing Committee on Outcomes Assessment developed a survey which was distributed to all those who were Commissioners and/or Review Committee members during 2007 and 2008. The ADA Survey Center conducted the survey in fall 2008. A summary of the results of that survey are attached (Appendix 4-See Worksheet:4048). Following a review of the survey results, the Committee determined that most respondents felt the revised RC structure was functioning well and meeting the needs of the review committees. The Commission intends to repeat and review the survey in 2010, 2011 and 2012 in order to more accurately assess the impact of a review committee structure. Finally, the lead topic in the next issue of the Commission's e-newsletter, the CODA Communicator will be the review committee structure; the process for adding additional content experts to the advanced specialty review committees; and the most recent survey results. This issue of the CODA Communicator will be sent via e-mail to all communities of interest in late September.

9-CODA should continue to include a public member on each review committee. (Policies)

- Recommendation #9 has been prioritized as easy to implement and non-controversial. Each review committee has a public member (see pp. 36-37 of OPP). There are no plans to change this policy.

10-CODA should establish a system to permit an academic program to postpone its review if a critical threshold of generalist, specialist and public members is not available at that review committee meeting. (Policies)

- Recommendation #10 has been prioritized as moderately important. The Standing Committee on Outcomes Assessment will consider policies and procedures for implementation of this recommendation and present the revisions for Commission consideration at the February 2010 meeting.

11-CODA should change the term of commissioners from the current policy of one four-year term to the possibility of two three-year terms if desired by the sponsoring agency and by CODA. (Policies)

- Recommendation #11 has been prioritized as easy to implement and non-controversial. The Standing Committee on Outcomes Assessment will consider advantages and disadvantages for a change of term of commissioners and present a recommendation for Commission consideration at the February 2010 meeting. The change of term of commissioners would require a change in the *Rules of the Commission* and subsequent approval by the House of Delegates.

12-CODA should consider site visit flexibility including the authority to conduct unannounced site visits when deemed necessary. However, the Task Force does not support the concept of routinely conducting unannounced site visits at this time. (Policies)

- Recommendation #12 has been prioritized as moderately important. The Standing Committee on Outcomes Assessment will consider policy and procedures for site visit flexibility and present a recommendation for Commission consideration at the February 2010 meeting.

13-CODA should enhance its pre-nomination education process that provides information regarding expectations and duties of commissioners, review committee members and site visitors. This information should be made available by CODA to all communities of interest and interested individuals. (Operating Procedures)

- Recommendation #13 has been prioritized as easy to implement and non-controversial. The Task Force on Communication will create a cover letter, detailing information regarding expectations and duties of commissioners, review committee members and site visitors for review and approval by the Commission at the February 2010 meeting. The cover letter will be disseminated in the following

ways: 1) Attached to all nomination forms. 2) Posted on the CODA portion of the ADA website. 3) Provided at the ADA and ADEA open hearings along with other written materials. 4) Verbally referenced at the beginning of open hearings at the ADA and ADEA meetings. 5) Hyperlink from the CODA Communicator.

14-CODA should continue the nomination process it has initiated. This process calls for multiple nominations from each group with nominations to be evaluated by CODA's Nominating Committee based on criteria developed by CODA. The nomination process should be strongly articulated to all nominating communities. (Operating Procedures)

- Recommendation #14 has been prioritized as easy to implement and non-controversial. The Commission adopted a revised policy on nominations to specialty or discipline specific positions on review committees at the July 2009 meeting. The revised policy states that nominating organizations must submit at least two (2) individuals for the Standing Committee on Nominations to consider. Organizations may rank their nominees in order of preference; however, the ranking is just one factor in considering the nominations. In addition, if fewer than two nominees are submitted, the appointment process will be delayed until such time as the minimum number of required nominations is received. The requirement of at least two nominations is clearly outlined in the letters sent by the Commission soliciting nominees (Appendix 5-See Worksheet:4050).

15-CODA commissioners, review committee members, site visitors and volunteers should serve the interest of CODA without personal or member organization profiles or agendas. This policy should be clearly articulated internally, and strongly articulated externally to all relevant organizations that supply persons for positions on CODA or any of its working committees. (Operating Procedures)

- Recommendation #15 has been prioritized as highly important. The Commission strengthened the existing portion of the "Conflict of Interest Policy" (EPP, pg 21) by implementing the following at the July 2009 Commission meeting: 1) At the beginning of the closed session of each Commission and Review Committee meeting, the Commission/Review Committee chair will reiterate that Commissioners are expected to evaluate each accreditation action, policy decision or standard adoption for the overall good of the public. Although Commissioners and most Review Committee members are appointed by designated communities of interest, their duty of loyalty is first and foremost to the Commission. 2) At the beginning of the open session of each Commission and Review Committee meeting, the Commission/Review Committee chair will read a statement emphasizing that members' duty of loyalty is first and foremost to the Commission. 3) Commissioners and Review Committee members will no longer refer to the sponsoring organizations that have appointed them when introducing themselves at meetings. The Commission meetings now open with the roll call and introduction of Commissioners by name and home location rather than by the organization they represented. The chair provided a statement about this new approach, indicating that the Commission was making this change to show its desire to meet the intent of ADA Task Force recommendation #15 and 25. 4) Case studies on conflict of interest presented at orientation sessions for new members will be expanded and emphasized. 5) Information and a case study for group discussion on this topic were provided at community of interest training session on August 21, 2009. It will continue to be an emphasized topic at future community of interest training sessions.

16-CODA should continue to develop and improve an orientation and training process for volunteers after the volunteer is selected but before the volunteer assumes the responsibilities of the position. (Operating Procedures)

- Recommendation #16 has been prioritized as easy to implement and non-controversial. New site visitor training, new Review Committee member training, and new Commissioner training have been expanded in a workshop format facilitated by Commission staff and experienced volunteers. Prior to the workshops, volunteers are required to complete six online training/assessment modules. Commission staff continues to refine and modify the training, based on input from the participants solicited after the training session is completed (Appendix 6-See Worksheet:4052). In addition, new site visitors who are unable to attend the in-house training session must observe an experienced consultant on a site visit prior to being assigned as a site visitor.

17-CODA should require all review committee members to observe at least one site visit. (Operating Procedures)

- Recommendation #17 has been prioritized as easy to implement and non-controversial. This recommendation was implemented immediately by the Commission at the July 2009 meeting through minor changes in existing policy. The requirement that all review committee members observe at least one site visit will be added to the "Summary of Review Committee Structure" (p. 34, OPP).

18-CODA should require that all specialty areas of practice continue to be responsible for funding the formal training of site visitors and should provide content expertise for the training curricula. CODA staff should continue to conduct the training and assure that the training is well organized and consistent across all specialty areas. (Operating Procedures)

- Recommendation #18 has been prioritized as moderately important. The Commission currently is responsible for the formal training of site visitors and provides content expertise for the training curricula. New site visitors from each discipline are required to attend an in-house training session at the ADA Headquarters, with the entire group attending lectures on general policies and procedures, and discipline-specific breakout groups doing exercises on report-writing and standards review. CODA staff conducts the training, and post-training surveys show a significant majority of participants regard the training as well-organized. Currently, only the AAOMS funds additional training for site visitors in their discipline. Commission staff is available to provide additional training for any discipline that requests it, and this is communicated to the organizations on a regular basis.

19-CODA should require that all site visitors not participating in site visits at least every two years should participate in a training exercise. (Operating Procedures)

- Recommendation #19 has been prioritized as easy to implement and non-controversial. This recommendation was implemented immediately by the Commission at the July 2009 meeting through minor changes in existing policy. The requirement that all site visitors not participating in site visits at least every two years should participate in a training exercise will be added to the "Policy Statement on Consultant Training" (p. 50, OPP).

20-CODA should establish a system by which all members of site visit teams, including the chair, are evaluated. (Operating Procedures)

- Recommendation # 20 has been prioritized as moderately important. Evaluation forms for all members of site visit teams, including the chair, have been revised, expanded, and made more comprehensive (Appendix 7-See Worksheet:4054). These forms will be implemented starting with the fall 2009 site visits. Evaluations will be done anonymously and electronically through the ADA survey center. In addition, the forms will be pre-populated with relevant information to reduce the time burden on the program and institutional personnel that are requested to complete the evaluations.

21-CODA should communicate more effectively with its communities of interest by improving the quality and content of its communications. The processes of communication should also be improved. (Functionality)

- Recommendation #21 has been prioritized as highly important; this recommendation is being considered together with recommendation #s 23 and 24, both of which have been prioritized as moderately important. The Commission came to the conclusion that the successful implementation of recommendation #21 is strongly dependent upon outside expertise to improve the quality and content of communication. The Commission also noted that the implementation of these three recommendations has significant financial implications. A request for funding for outside expertise for development and implementation of a communications plan (recommendation #23) and an additional staff person with expertise in communication (recommendation #24) were put into a decision package and presented to the Board of Trustees at its April meeting. The Subcommittee was informed that there is no provision in this budget for hiring extra staff or outside consulting. The use of "in-house" resources was suggested by the ADA Monitoring Committee, and the chair of the ADA Council on Communication participated as a guest at the Task Force on Communication conference call. The chair of the council explained that the Council on Communication has recently been reconstituted with

new bylaws and it will focus on external ADA images and branding. While the chair felt the Council will be able to help the Commission on a short-term basis, in the long-term, he believes the Commission will need to hire a dedicated, communication staff person. The ADA Task Force Report and Recommendations also strongly urged, "...that this individual should not be assigned to CODA from the ADA Communications area." He noted that the ADA Task Force Recommendations center around tactical, internal, and strategic processes, areas which are not the purview of the Council on Communication. Concern was expressed about the Commission's relationship with the ADA and the propriety of an ADA Council creating and disseminating messages to the communities of interest, including the public. In addition, while current ADA staff with communication expertise may be able to provide some consultation services, once again, it is not a long-term solution to the use of outside expertise to assess current communications efforts and assist in the development and implementation of a detailed communications and public relations plan (recommendation #s 21 and 23). As adequate funding is essential to successful implementation of these recommendations, the Commission will request funding from the House of Delegates at the 2009 ADA Annual Session.

22-CODA should focus its communications efforts on increasing transparency and accountability as well as communicating the value/outcomes of accreditation. (Functionality)

- Recommendation #22 has been prioritized as highly important, and was considered together with recommendation #25, also prioritized as highly important. These recommendations were implemented immediately by the Commission at the July 2009 meeting: 1) The Commission will utilize time at the beginning of open hearings at the ADA and ADEA meetings to communicate the value and outcomes of accreditation. 2) The Commission will continue to conduct two open hearings at the ADA Annual Session. The format of the open hearings will be expanded to allow for questions and comments on Commission policy and procedure. 3) The community of interest training session will continue to be conducted every year. The webinar format from the August 21, 2009 training session was recorded and will be available on-line. 4) All information sent to the communities of interest will be sent to individual educational program directors in order to increase transparency and accountability. The Commission requested that the same information be sent to the members of the House of Delegates; however, the Commission was informed that e-mail addresses of delegates and alternates cannot be provided, per ADA policy. 5) The Task Force on Communication, at its next meeting, will meet with a representative of the ACGME Communication Department to discuss possible strategies for improving transparency and accountability as well as communicating the value and outcomes of accreditation. 6) The Commission meetings now open with the roll call and introduction of Commissioners by name and home location rather than by the organization they represent, an example of the cultural change that will be emphasized at the beginning of each CODA meeting.

23-CODA should use outside expertise to assess its current communications efforts and assist in the development and implementation of a detailed communications and public relations plan. (Functionality)

- See response to recommendation #21 above.

24-CODA should create a dedicated staff position requiring specific expertise in communications to sustain the implementation of its communications plan and to assist in cultural change. (Functionality)

- See response to recommendation #21 above.

25-CODA should view this effort toward cultural change not just as increasing communication but as a change in its culture regarding transparency, accountability, and responsiveness. This cultural change should be emphasized at the beginning of each CODA meeting. (Functionality)

- See response to recommendation #22 above.

26-CODA should establish ongoing evaluation measures to systematically monitor the use of CODA accreditation and its perceived value. This implies the use of an ongoing quality management program tied to strategic planning. (Best Practices)

- Recommendation #26 has been prioritized as highly important; recommendation #s 27 and 28 have been prioritized as moderately important. These three recommendations are being considered

together, as the establishment of an ongoing quality management program tied to strategic planning (recommendation #26) is dependent on the recommendations to hire an outside consultant in both the design and facilitation of strategic planning efforts (recommendation #s 27 and 28). The Commission noted that the implementation of these three recommendations has significant financial implications; however, as with the recommendation to utilize an outside consultant to assess and implement communication strategies, there is no provision in this budget for hiring an outside consultant to facilitate strategic planning. The Commission also learned that in-house strategic planning services are no longer available. Consideration of further implementation strategies for recommendation #s 26, 27 and 28 was deferred until the ADA Strategic Planning process has been re-established. The Commission will consider a proposed restructuring of the Standing Committees of the Commission, including the formation of a Standing Committee on Strategic Planning, at the February 2010 Commission meeting.

27-CODA should design and implement a quality management system and seek outside assistance in the design as needed from a quality management system expert. (Best Practices)

- See response to #26 above.

28-CODA should use an outside facilitator to design and support its strategic planning efforts. CODA's strategic planning efforts should examine (but not be limited to) the following: development and implementation of an ongoing strategic planning process and the establishment of a committee to continue effective strategic planning; reassessment of its meeting format in light of its primary focus of accreditation decisions; consideration of the concept of flexible review cycles; consideration of other models for site visits, such as the use of professional site visitors or the use of fewer site visitors used more frequently to enhance consistency and reliability; consideration of important changes that may affect its operations including expansion of scope and international issues; consideration of its continuing effectiveness and the appropriateness of its structure. (Best Practices)

- See response to #26 above.

29-CODA should explore alternative methods, including the use of enhanced technology for monitoring programs' continuous compliance with the standards. (Best Practices)

- Recommendation #29 has been prioritized as highly important; as has recommendation #30. These two recommendations are being considered together, as they both concern the use of technology and its impact on Commission policies and procedures. The Commission's *ad hoc* Task Force on Alternate Site Visit Methods will consider these recommendations. This Task Force had its' scope expanded by the Commission at the July 2008 meeting to include the continual monitoring of technologic advances, the use of pilot projects to keep abreast of the latest technologies and techniques, and a broader analysis of the current site visit process.

30-CODA should evaluate and adopt new technological advances in accreditation for reporting and management of information. This could reduce the burden on CODA as well as the programs it accredits, and thus allow accreditation to move toward the concepts of continuous assessment, data collection, and readiness. (Best Practices)

- See response to #29 above.

31-CODA should maintain its recognition by USDE. (USDE Affiliation)

- Recommendation #31 has been prioritized as easy to implement and non-controversial; recommendation #s 32, 33 and 34 have been prioritized as moderately important. These four recommendations are being considered together. The Commission was re-recognized in 2006 as the national accrediting agency for accreditation of predoctoral dental education programs, advanced dental education programs, and allied dental education programs that are fully operational, or have attained "Initial Accreditation" status, and for its programs offered via distance education. The Commission's petition for continued recognition is due in 2011. The Commission will continue to monitor the relative requirements, benefits, risks, obligations, advantages and disadvantages of recognition by USDE. This monitoring, including government funding of educational programs under the Commission's purview, will be a regular item on the agenda of the Commission's Standing Committee on Outcomes Assessment and it will also be part of the Commission's strategic planning

process. CODA's internal Subcommittee will analyze information relating to alternative recognition processes by CHEA and ANSI as advised by recommendation #33 and #34.

32-CODA should monitor how USDE recognition influences funding for dental education programs. (USDE Affiliation)

- See response to #31 above.

33-CODA should explore advantages of recognition by additional agencies such as CHEA. CODA decision(s) regarding recognition by another agency should not be in lieu of USDE recognition. (USDE Affiliation)

- See response to #31 above.

34-CODA should monitor the progress of the proposed ANSI recognition system for accreditation agencies as it develops, and, if appropriate, investigate the advantages and disadvantages of also becoming recognized under this system. (USDE Affiliation)

- See response to #31 above.

Summary: This report details the progress of the Commission on Dental Accreditation (CODA) in implementing recommendations from the 2008 Report of the Task Force on the Commission on Dental Accreditation. The Commission has appointed a Subcommittee to develop implementation strategies for each of the 34 ADA Task Force recommendations and also is collaborating with the ADA Monitoring Committee in addressing the recommendations. Two resolutions are presented for consideration of the Board and House of Delegates. The first is to support the CODA's implementation of recommendation #23: the use of outside expertise to assess its current communications efforts and assist in the development and implementation of a detailed communications and public relations plan. This is considered a 10-12 month project, with a projected cost of $5,000 to $6,000 per month or approximately $61,000 total, and entails the following: an audit of the existing CODA communication strategies, target audiences, and current effectiveness; a comparison of CODA communication strategies with those of other comparable organizations; development of surveys of community of interest groups to determine their communication needs; development of a communication plan that is affordable and achievable; and establishment of benchmarks and assessment methods to determine the success of the communication efforts. The second resolution is to support CODA's implementation of recommendation #24: the hiring of a dedicated staff position requiring specific expertise in communications to sustain the implementation of its communications plan and to assist in cultural change for enhancing communications. Cost associated with this recommendation includes an annual staff salary of $72,000 per year, with $31,000 allocated for benefits per year, for a total cost of $103,000.

Resolutions

See Resolution 54; Worksheet:4060
See Resolution 55; Worksheet:4061

Appendices 1-3

Appendix 1: See Board Report 13; Worksheet:4025
Appendix 2: See Board Report 13; Worksheet:4026
Appendix 3: See Board Report 13; Worksheet:4029

Appendix 4

2008 *CODA Review Committee Survey*

Final results

Sample: The sample for this Web-based survey consisted of the members of Commission on Dental Accreditation (CODA) Review Committees in 2007 and 2008.

Methodology: A link to the survey was e-mailed to 122 individuals on September 18, 2008. A follow-up e-mail was sent to all non-respondents on October 3.

Response: Data collection ended on October 27, 2008. At that time, 100 individuals responded to the survey. The final response rate was 82.0%.

Purpose: The survey was conducted to assist CODA in assessing the impact of the new Review Committee composition. The survey results are presented in this report for all respondents, and are also broken down by number of meetings attended and level of agreement with the state that the new membership structure meets the needs of the review committee. The number of respondents in each category is presented in the tables. Please note that percentages may not be reliable for groups where the number of respondents is less than 30.

Executive Summary:

- Eighty-five percent of respondents have attended at least one review committee meeting with the revised membership structure. Over one quarter of respondents (27.0%) indicated that they have attended four or more of these meetings.

- Over three-quarters (78.6%) of respondents who have attended at least one review committee meeting agree or strongly agree that the new membership structure meets the needs of their review committee(s).

- Over half (63.1%) of respondents who have attended at least one review committee meeting disagree or strongly disagree that the new membership structure has had a negative impact on the workload of the members of their committee(s).

- Over eighty percent (85.7%) of respondents who have attended at least one review committee meeting agree or strongly agree that with recusals and/or absences of committee members, their review committee(s) still had enough members to vote on all recommendations regarding educational programs.

- Two-thirds (67.8%) of respondents who have attended at least one review committee meeting agree or strongly agree that non-subject matter experts on review committees are prepared to conduct the committee's business.

- Over three-quarters (79.8%) of respondents who have attended at least one review committee meeting agree or strongly agree that non-subject matter experts on review committees actively participate in committee discussions.

- With regard to Policy Issues, one-third (33.3%) of respondents who have attended at least one review committee meeting believe that the addition of new members who are not subject matter experts has had a positive impact on the work of their committee(s). More than half said there was no impact (28.6%) or it was too early to tell (23.8%).

- With regard to Accreditation Decisions, over one-quarter (27.4%) of respondents who have attended at least one review committee meeting believe that the addition of new members who are not subject matter experts has had a positive impact on the work of their committee(s); 62.0% said there was no impact or it was too soon to tell.

- A majority of respondents (63.9%) who have attended at least one review committee meeting do not believe there are additional steps that could be taken to improve the effectiveness of the new review committee structure.

- When results were analyzed by number of meetings attended, no clear patterns were evident except that respondents who attended only one meeting were more neutral in their level of agreement with statements on the new membership structure.

- Looking at results by level of agreement with the statement “The new committee meets the needs of my review committee,” those who selected “strongly agree” for that question showed much stronger levels of agreement with most other survey statements and were more likely to see the new members providing a positive impact.

Appendix 5

Date

Dr. Shepard S. Goldstein
American Association of Endodontists
211 E. Chicago Ave., Suite 1100
Chicago, IL 60611-2691

Dear Dr. Goldstein:

I am writing to you because the Commission on Dental Accreditation (CODA) needs nominations to fill upcoming vacancies on review committees. The recommendations from the American Association of Endodontists are valuable to CODA in their selection process.

Specialty or discipline specific positions on review committees will be filled by appointment by the Commission of an individual from a small group of nominees submitted by the relevant national organization, specialty organization or certifying board.

The American Association of Endodontists is requested to nominate **at least two candidates** for review committee members. This position will remain vacant until at least two nominations are submitted for review. Review committee members are responsible for the review of all policy matters, site visit reports, progress reports, applications for accreditation and special reports on accredited programs. Each review committee's comments and recommendations on policy matters and accreditation status are included in a report, which is submitted to the Commission for final action.

In making your selection, it should be made clear to the nominee that she/he will be required to make a significant time commitment. Review committee members serve as consultants to the Commission and are required to complete the *Web-based Site Visitor Training* prior to serving on the committee. The self-paced instructional manual on the Commission's policies, procedures and Standards takes approximately 6 to 8 hours to complete. Review committee members will also be required to become familiar with the *CODA Training Manual* and participate in a full day of training at ADA headquarters. Duties may include participation in site visits and ad hoc committees, in addition to review committee responsibilities.

Additionally, in order to facilitate committee activities, committee members are expected to be accessible and able to communicate by fax, electronic mail and be able to perform committee work and review committee materials via the Commission's web-based communication tools. This method of communication and distribution of materials can be frequent during periods of committee activity.

In selecting appointees to the review committee, the Commission requests that strong consideration be given to assisting this agency achieve diversity, including underrepresented groups, geographic diversity and varied clinical/educational philosophies.

Also enclosed is an *Informational Report on Review Committee and Commission Meeting Dates* through 2009. Review committee meetings are conducted approximately three weeks prior to the Commission meetings and the meeting duration can typically be up to two-days in length. The newly appointed representatives will attend his/her first Review Committee meeting in January 2009.

Please provide the Commission with nominations from your organization by April 4, 2008.

The Commission looks forward to working with the American Association of Endodontists during the coming year. If the Commission staff can be of assistance to you during this process, please don't hesitate to contact me.

Sincerely,

Anthony Ziebert, D.D.S., M.S.
Director
Commission on Dental Accreditation

AZ:s
Enclosures
cc: Mr. James Drinan, American Association of Endodontists
Dr. Jeffrey Hutter, chair, Commission on Dental Accreditation
Dr. Laura M. Neumann, senior vice president, Education/Professional Affairs
Managers, Commission on Dental Accreditation

Appendix 6

Review Committee Training Evaluation

November 21, 2008

Please take a few minutes to evaluate this workshop. Your opinion will be helpful in planning future events.

To what degree did the workshop meet the following Objectives for you?
Please circle the appropriate number from 1 to 5.

1. Improved understanding of and ability to discuss the Philosophy and Purpose of Accreditation and the Accreditation Process.

1 2 3 4 5
No improvement *Great improvement*

2. Improved understanding of the ability to explain the Roles and Responsibilities of the Review Committee Member.

1 2 3 4 5
No improvement *Great improvement*

3. Ability to identify prejudices and biases and ensure they are absent in the decision-making process.

1 2 3 4 5
No increase *Great increase*

4. Ability to discuss decision-making and consensus building processes.

1 2 3 4 5
No increase *Great increase*

5. Ability to describe the Commission's policies on confidentiality, conflict of interest and information usage and commit to adhering to them.

1 2 3 4 5
No improvement *Great improvement*

6. Improved understanding of the Commission's use of electronic communications.

1 2 3 4 5
No improvement *Great improvement*

For the Future:

7. How well do the Web-based Review Committee Member Training Materials complement the workshop?

8. What topics covered in the workshop need more in-depth discussion?

9. What other topics should be covered? (please specify)

10. What continuing training would you like to see offered?

11. Any other comments?

Thank you for your participation!

Appendix 7
Survey 1
Evaluation of process by program personnel

To be sent to program personnel following the site visit

Directions: Your comments are important to provide us with input on current processes and give feedback that can be used for improvement. Please take a few minutes to answer the following questions. Thank you for providing input to the Commission on Dental Accreditation

1. Please indicate your current position
   - Chief executive officer or Dean ___
   - Program director ___
   - Department chairperson or Chief of Dental Service ___
   - Site visit coordinator ___
   - Academic dean ___
   - Dean of clinical services ___

2. Please indicate your level of agreement with the following statements

	Strongly agree	Agree	Disagree	Strongly disagree	Not applicable
A. Communication with CODA staff while writing the self-study was helpful.	___	___	____	___	___

(If either 'disagree' or 'strongly disagree' is chosen, then ask, "Please provide specific feedback on how communication can be improved")

B. Communication with CODA staff while planning the site visit was helpful.	___	___	____	___	___

(If either 'disagree' or 'strongly disagree' is chosen, then ask, "Please provide specific feedback on how communication can be improved")

C. Communications, correspondence, and submission deadlines were clear and concise.	___	___	____	___	___

(If either 'disagree' or 'strongly disagree' is chosen, then ask, " Please provide specific feedback on how communication can be improved.")

D. The "Site Visit Orientation" website contained incomplete and/or incorrect information.	___	___	____	___	___

(If either 'agree' or 'strongly agree' is chosen, then ask, "What information was unclear or not useful? What information was missing or not correct?")

Appendix 7
Survey 1 (continued)
Evaluation of process by program personnel

	Strongly agree	Agree	Disagree	Strongly disagree	Not applicable
E. The "Self Study Guide" provided useful information on accessing the accreditation standards.	___	___	____	___	___

(If either 'disagree' or 'strongly disagree' is chosen, then ask, "Please provide a description of how the Self Study Guide can be improved.")

F. The "Self Study Guide" contained irrelevant information.	___	___	____	___	___

(If either 'agree' or 'strongly agree' is chosen, then ask, "Please provide a description of how the Self Study Guide can be improved.")

G. Completing the self-study helped identify the program's strengths and weaknesses prior to the site visit.	___	___	____	___	___

(If either 'disagree' or 'strongly disagree' is chosen, then ask, "Please provide a description of how the process can be improved to help you identify the program's strengths and weaknesses.")

	Strongly agree	Agree	Disagree	Strongly disagree
I. There was sufficient time in the site visit schedule to allow site visitors to get an accurate picture of the program.	___	____	___	___

(If 'disagree' or 'strongly disagree' is chosen, then ask, "Please provide specific feedback on how the site visit schedule can be improved.")

J. Overall, the process of completing the self-study and conducting the site visit enhanced program improvement.	___	___	___	___

(If 'disagree' or 'strongly disagree' is chosen, then ask, "Please provide specific feedback on how the process of writing the self study and/or conducting the site visit could be changed to allow for program improvement. ")

3. Please provide any additional comments on the process of writing the self–study, site visit logistics, and/or conducting the site visit.

Thank you for your input. Your comments will be beneficial in to the Commission in their efforts to improve the self study and site visit process.

Appendix 7
Survey 2 - Program personnel evaluation of site visitors

To be sent to program personnel following the site visit

Directions: The Commission on Dental Accreditation is committed to a fair and unbiased peer review process for program review. As part of our continuing effort to improve the accreditation process, the Commission appreciates feedback on the site visitors who have recently conducted the site visit to your program. Thank you for providing input to the Commission on Dental Accreditation.

1. During the site visit, did you have contact with the following site visitor ___?
(name will be prefilled according to site visit team list)
___ Yes ___ No
(If yes, the following questions will be presented. If no, the questions will be repeated for another site visitor)

Please indicate your level of agreement with the following statements.

	Strongly Agree	Agree	Disagree	Strongly Disagree
A. The above consultant was familiar with the Standards.	___	___	___	___
B. The above consultant was familiar with the information contained in the self study.	___	___	___	___
C. The above consultant conducted the site visit in an objective and unbiased manner.	___	___	___	___
D. During the site visit, the above consultant stayed on schedule.	___	___	___	___
E. During the site visit, the above consultant conducted him/herself in a professional manner.	___	___	___	___

2. Please explain any ratings of 'disagree' or 'strongly disagree' and/or provide any additional information on the above consultant.

3. Did the site visit team review the findings and recommendations (if any) with you prior to departure?
___ Yes ___No

(If answer is 'No', then ask, "What was the reason that the recommendations were not discussed with you?")

4. Did the site visit team inform you of the next steps in the accreditation process? ___ Yes ___No

(If answer is 'No', then add statement "CODA staff is available to answer any questions you may have. Please contact 1-312-440-4653 and you will be connected with the appropriate CODA staff.")

Appendix 7
Survey 3 - Consultants evaluation of the process

Directions: The feedback you provide on your recent site visit experience is an important part of the Commission's continuing efforts to assist consultants in fulfilling their responsibilities and improve the accreditation process. Please take a few minutes to answer the following questions. Thank you for providing input to the Commission on Dental Accreditation.

1. Please indicate your role in the recent site visit

Predoc team:
- Chairperson ___
- Curriculum ___
- Clinical sciences ___
- Basic sciences ___
- Finance ___
- National licensure ___

Post doctoral general dentistry ___
Specify discipline:

Advanced specialty education _____
Specify discipline:

Allied team:
- Allied staff representative ___
- Specify discipline:
- Allied curriculum ____
- Specify discipline:

Other:
- Silent observer ___
- Review committee observer ___
- State Board Representative ___
- Commissioner observer ____
- Site visitor trainee ___

2. Please indicate the type of visit you recently participated in:

Comprehensive dental school visit ___
Advanced specialty program visit ____
- If chosen, then ask: Single program ____
  - Indicate which
- Multiple programs ___
  - Indicate which

Post doctoral general dentistry program visit ___
- If chosen, then ask: Single program ____
  - Indicate which
- Multiple programs ___
  - Indicate which

Initial accreditation visit ___
- If chosen, then ask: "State program type"

Special focused visit ___
- If chosen, then ask: "State program type"

Appendix 7
Survey 3 - Consultants evaluation of the process (continued)

3. Please indicate your level of agreement with the following statements on the processes related to the site visit.

	Strongly agree	Agree	Disagree	Strongly disagree	Not applicable
A. Information received from the CODA office (logistics, accommodations, background materials etc) prior to the visit was useful.	___	___	___	___	___

(If answer is 'disagree' or 'strongly disagree', then ask, "Please provide feedback on how communication prior to the site visit can be improved.")

B. CODA staff provided prompt and useful answers to my questions about the site visit, self-study, &/or CODA policies and procedures.	___	___	___	___	___

(If answer is 'disagree' or 'strongly disagree', then ask, "Please provide feedback on how communication prior to the site visit can be improved.")

C. I understood my role as a Commission consultant.	___	___	___	___	___

(If answer is 'disagree' or 'strongly disagree', then ask, "Please describe the questions or concerns you have about your role as a Commission consultant."

D. I was able to answer questions about the accreditation process (Commission policies, procedures, the institution's rights under due process etc.) during the visit.	___	___	___	___	___

(If answer is 'disagree' or 'strongly disagree', then ask, "Please describe the questions you were unable to answer, and indicate how you answered the question or concern from the program.")

E. CODA staff were helpful during the site visit.	___	___	___	___	___

(If answer is 'disagree' or 'strongly disagree', then ask, "Please provide feedback on how staff support during the site visit can be improved.")

Appendix 7
Survey 3 - Consultants evaluation of the process (continued)

	Strongly agree	Agree	Disagree	Strongly disagree	Not applicable
F. The site visit schedule made it difficult for me to effectively and efficiently complete my responsibilities.	___	___	___	___	___

(If answer is 'agree' or 'strongly agree', then ask, "Please provide feedback on how the site visit schedule can be improved.")

G. Following the exit interview, it appeared that the program director and/or dean had a good understanding of the team's findings.	___	___	___	___	___

(If answer is 'disagree' or 'strongly disagree', then ask, "Please provide additional information on the program director and/or dean's lack of understanding.")

4. The self-study document and site visit materials were provided at least 60 days prior to the site visit.
__ Yes ___ No

5. Hotel accommodations were convenient and comfortable.
___ Yes ___ No
(If answer is 'no', then ask, "Please describe any problems with the hotel accommodations.")

6. Were there any unusual circumstances or occurrences during the site visit which you believe Commission staff should be aware of? ___ Yes ___ No
(If answer is 'yes', then ask, "Please explain these circumstances or occurrences.")

7. Please provide any additional comments on the process of serving as a Commission consultant.

Thank you for your input. Your comments will be beneficial to the Commission in their efforts to improve the self study and site visit process.

Appendix 7
Survey 4 - Consultants evaluation of other consultants

To be sent to consultants following the site visit

Directions: The Commission on Dental Accreditation is committed to a fair and unbiased peer review process for program review. Your feedback on the consultants who accompanied you on a recent site visit is one important part of the process to ensure that these goals are achieved. Please take a few minutes to answer the following questions. Thank you for providing input to the Commission on Dental Accreditation.

1. Do you believe you can provide an objective evaluation of _____(name will be prefilled according to site visit team list)

___ Yes ___ No (If yes, the following questions will be presented. If no, the questions will be repeated for another site visitor)

Please indicate your level of agreement with the following statements.

	Strongly Agree	Agree	Disagree	Strongly Disagree
A. The consultant was familiar with the Standards.	___	___	___	___
B. The consultant was familiar with the information contained in the self-study.	___	___	___	___
C. The consultant was open to discussion on interpreting the Standards.	___	___	___	___
D. The consultant conducted the site visit in an objective and unbiased manner.	___	___	___	___
E. During the site visit, the consultant used time wisely.	___	___	___	___
F. During the site visit, the consultant conducted him/herself in a professional manner.	___	___	___	___
G. The consultant was aware of his/her responsibilities during the site visit.	___	___	___	___

H. Please explain any ratings of ‘disagree’ or ‘strongly disagree’, and/or provide any additional information on the above consultant.

Resolution No. 54 New ■ Substitute ☐ Amendment ☐

Report: CODA Supplemental Report 1 Date Submitted: September 2009

Submitted By: Commission on Dental Accreditation

Reference Committee: Dental Education and Related Matters

Total Financial Implication: $61,000

Amount One-time $61,000 Amount On-going $

ADA Strategic Plan Goal: Lead in the Advancement of Standards (Required)

OUTSIDE EXPERTISE FOR DEVELOPMENT AND IMPLEMENTATION OF CODA COMMUNICATIONS AND PUBLIC RELATIONS PLAN

Background: (See CODA Supplemental Report 1 to the House of Delegates, Worksheet:4033)

Resolution

54. Resolved, that $61,000 be added to the ADA's 2010 budget to support the Commission on Dental Accreditation's implementation of 2008 ADA Task Force on CODA recommendation #23: the use of outside expertise to assess its current communications efforts and assist in the development and implementation of a detailed communications and public relations plan.

BOARD COMMENT: The use of outside expertise to assess current CODA communication efforts and assist in the development of and implementation of a detailed communications and public relations plan is considered a high priority recommendation from both the ADA Task Force on CODA and the ADA Monitoring Committee. CODA has consulted with the Council on Communications (CC) and has learned that internal ADA resources will not be adequate to provide tactical, internal, and strategic communication processes necessary to meet the intent of the recommendation. Since communication was the underlying element of many of the Task Force recommendations, the Board supports adoption of this resolution.

BOARD RECOMMENDATION: Vote Yes.

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	☐	■	☐	☐	LONG	■	☐	☐	☐	SYKES
■	☐	☐	☐	ELLIOTT	■	☐	☐	☐	MANNING	■	☐	☐	☐	TANKERSLEY
■	☐	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	☐	■	☐	☐	THOMPSON
■	☐	☐	☐	GIST	■	☐	☐	☐	RICH	■	☐	☐	☐	VERSMAN
■	☐	☐	☐	GLECOS	■	☐	☐	☐	SCHWEINEBRATEN	■	☐	☐	☐	VIGNA
■	☐	☐	☐	KREMPASKY SMITH	☐	■	☐	☐	STEFFEL	■	☐	☐	☐	WEBB
■	☐	☐	☐	LOW	☐	■	☐	☐	SULLIVAN				Res.	54

***

Resolution No. 55 New ■ Substitute ☐ Amendment ☐

Report: CODA Supplemental Report 1 Date Submitted: September 2009

Submitted By: Commission on Dental Accreditation

Reference Committee: Dental Education and Related Matters

Total Financial Implication: $103,000 annually

Amount One-time _____ Amount On-going $103,000 annually

ADA Strategic Plan Goal: Lead in the Advancement of Standards (Required)

DEDICATED STAFF TO SUSTAIN IMPLEMENTATION OF CODA COMMUNICATIONS PLAN

Background: (See CODA Supplemental Report 1 to the House of Delegates, Worksheet:4033)

Resolution

55. Resolved, that $103,000 be added to the ADA's 2010 budget to support the Commission on Dental Accreditation's implementation of 2008 ADA Task Force on CODA recommendation #24: the hiring of a dedicated staff position requiring specific expertise in communications to sustain the implementation of its communications plan and to assist in cultural change for enhancing communications.

BOARD COMMENT: The Board acknowledges that the communication recommendations from the ADA Task Force on CODA are a high priority; however, it is premature at this time to hire a dedicated staff person with expertise in communication prior to development of a communications plan. In addition, due to the economy and other pressing priorities, it is not feasible to provide the funding. CODA should continue efforts to enhance its communication using available resources. Therefore, the Board does not support adoption of this resolution.

BOARD RECOMMENDATION: Vote No.

BOARD VOTE: UNANIMOUS.

***

Resolution No. 56 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2009

Submitted By: AAOMP, AAP, AAPD, AAE, AAO, AAOMS, AAPHD and ACP

Reference Committee: Dental Education and Related Matters

Total Financial Implication:

		Resolution 56	Resolution 56B
	2010:	$287,500	$53,900
Amount One-time	2011:	$489,800	Amount On-going $

ADA Strategic Plan Goal: Lead in the Advancement of Standards (Required)

DEVELOPMENT OF AN EXAMINATION TO EVALUATE THE COMPETENCY OF DENTAL SCHOOL SENIORS AND GRADUATES USING QUANTITATIVE EXAMINATION SCORES

The following resolution was submitted by the American Association of Orthodontists on behalf of the following eight dental specialties, the American Academy of Oral and Maxillofacial Pathology (AAOMP), the American Academy of Periodontology (AAP), the American Academy of Pediatric Dentistry (AAPD), the American Association of Endodontists (AAE), the American Association of Orthodontists (AAO), the American Association of Oral and Maxillofacial Surgeons (AAOMS), the American Association of Public Health Dentistry (AAPHD) and the American College of Prosthodontists (ACP), and transmitted on September 2, 2009, by Ms. Carla Qualls, director of leadership entities, AAO.

Background: The 2008 ADA House of Delegates adopted the following resolution.

> **70H-2008. Resolved,** that the ADA House of Delegates urges the Joint Commission on National Dental Examinations (JCNDE) to modify or replace the current examination, to make it secure and to validate its use for quantitative scoring on or before November 1, 2011, and be it further
>
> **Resolved,** that the ADA House of Delegates urges the JCNDE to retain its current system of reporting standard scores from the National Board Dental Examinations until the new examination is available.

For various reasons the Joint Commission on National Dental Examinations (JCNDE) considered the ADA request and decided to continue with its plans to report scores in terms of “pass/fail” on the National Board Exams. The result is that the JCNDE has now eliminated a valuable evaluation tool for dental students, dental schools and the dental profession.

These scores were used by the General Dental Practice Residency and Dental Specialty Programs to evaluate applicants for advanced dental education opportunities. The scores also provided an opportunity for dental school faculty to evaluate the performance of their students in relationship to a standardized national test. Under the current system dental schools are able to identify their strengths and weaknesses, and evaluate areas in need of improvement.

The JCNDE denied implementation of the 2008 ADA House of Delegates suggested changes to the current national board and instead continue with plans to adopt a pass/fail score means that an alternate examination will be required to fill the void left by the JCDNE.

The ADA has the ability to develop an appropriate test and protocol that will serve the needs of students, graduates, dental schools and advanced dental education programs. There is a high degree of experience in test construction, with examination development for the Dental Aptitude Test.

Budgetary Implication: To be determined by the American Dental Association with testing revenue offsetting the cost.

Resolution

56. Resolved, that the ADA House of Delegates request that the American Dental Association, in conjunction with the recognized dental specialties and general practice residency programs, develop an examination to evaluate the competency of dental school seniors and graduates to successfully complete a post-graduate dental education program, and be it further

Resolved, that the examination be valid for quantitative scoring and provided in a secure format. Input from communities of interest such as dental specialty organizations, graduate school educators, ADEA and testing organizations should be sought to help develop, evaluate and maintain the examination, and be it further

Resolved, that the quantitative examination scores be reported to individual examinees, dental school deans and to the graduate dental education/residency programs upon examinee request.

BOARD COMMENT: The Board believes that development of the proposed examination is consistent with ADA's strategic goal of leading in the advancement of standards and that this is an important function that would meet the needs of the dental specialty groups and advanced general dentistry education programs. The ADA has the expertise and infrastructure to perform this function. Implementing this resolution would provide advanced education programs with significant support that will be needed due to the loss of the numerical scores from National Board examinations; however, at this time, there is no information to indicate that sufficient educational programs would use such a test to make it a worthwhile endeavor. If the resolution is implemented as submitted, there would be significant up-front implementation costs during 2010 and 2011 of approximately $287,500 and $489,800, respectively. Although a business plan can be developed to recover the start-up funds within three to five years and eventually provide a modest source of non-dues revenue without placing an inordinate financial burden to students/examinees, the potential for recovering the initial investment would depend on substantial participation of students/applicants and education programs. Accordingly, the Board believes a more prudent course of action would be to create a task force with the CDEL and the dental specialty groups to evaluate the potential commitment and cost of implementing an examination. The estimated financial implication for this activity is as follows:

Volunteer travel and meeting expenses	
for 13 volunteers, 2, 2-day meetings -	$32,100
Survey of educational programs (electronic) -	$20,000
Miscellaneous expenses -	$ 1,800
Total -	$53,900

56B. Resolved, that a task force be developed to include two members of CDEL, one representative from each ADA recognized specialty and a GPR program and one consultant to determine the feasibility of developing an examination to evaluate the competency of dental school seniors and graduates to successfully complete a post-graduate dental education program. Considerations for an examination would include 1) validity for quantitative scoring and providing in a secure format, 2) input from communities of interest such as dental specialty organizations, graduate school educators, ADEA and testing organizations should be sought to help develop, evaluate and maintain the examination, and 3) quantitative examination scores be reported to individual examinees, dental school deans and to the graduate dental education/residency programs upon examinee request, and be it further

Resolved, that the task force charge include 1) surveying the existing post graduate programs for potential commitment for an examination and 2) developing a detailed business plan with options for funding which may include initial subsidization/funding by the existing dental specialties, and be it further

Resolved, that a comprehensive plan be developed for consideration by the 2010 House of Delegates.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

BOARD VOTE: UNANIMOUS.

***

Resolution No. 57 New ■ Substitute ☐ Amendment ☐

Report: Board Report 12 Date Submitted: September 2009

Submitted By: Board of Trustees

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: Achieve Effective Advocacy
Lead in the Advancement of Standards (Required)

REPORT 12 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES:
INTERNATIONAL CONSULTATION AND ACCREDITATION

Executive Summary: The following is a status report of the activities of the Joint Advisory Committee on International Accreditation (JACIA). The JACIA has met four times in 2009 (January 29, March 9, and August 11 via conference call and at a face to face meeting at ADA Headquarters held on May 28). One resolution is submitted for the Board's consideration and recommendation to the House of Delegates. The following are the highlights of the JACIA meetings during the past year.

- The PACV survey from SDM College of Dental Sciences and Hospital, Bangalore, India was reviewed. The Committee determined that the dental school may have the potential to meet accreditation standards and is eligible to complete a Preliminary Accreditation Consultation Visit (PACV) self study in preparation for a consultation visit.

- The Committee received a PACV self study and all required fees from Universidad de San Martin de Porres, Lima, Peru. Following review of the self study document, the Committee determined that the dental school was not ready for a PACV visit.

- Revisions were made to the PACV survey to provide the Committee with additional information and insight on the potential of an international program to meet U.S. accreditation standards.

- The Committee determined that a requirement should be added that representatives from all international programs are required to attend a U.S. comprehensive site visit as an observer, and meet with staff to review the standards and reporting requirements. The Committee also determined a revised fee structure to cover additional costs associated with attendance at a comprehensive visit and additional staff consultation.

- The Committee determined that although several standards could be difficult for international dental education programs to meet, the requirement that the dental school be a component of a higher education institution that is accredited by a regional accrediting agency recognized by the United States Department of Education (Dental Education Standard 1-7) cannot be met by any international program. The Committee is proposing an alternate mechanism for determining compliance with Standard 1-7.

Background: In October 2005, the American Dental Association's House of Delegates adopted Resolution 39H-2005—Consultation and Evaluation of International Dental Schools:

Resolved, that the ADA and its Board of Trustees support the Commission on Dental Accreditation's initiative to offer consultation and accreditation services to international dental schools, and be it further

Resolved, that the ADA and Commission on Dental Accreditation establish a standing, joint advisory committee to provide guidance to the Commission in the selection, development and implementation of an international program of consultation and accreditation for dental education, and be it further

Resolved, that the advisory committee include two representatives from the Commission and three representatives from the ADA with one of these representatives from the ADA Board of Trustees as chair and two at-large members from the practicing community appointed by the President, and be it further

Resolved, that the terms of office of the ADA representatives be a staggered three-year term and be eligible for one additional term of appointment, and be it further

Resolved, that the advisory committee in conjunction with the Commission on Dental Accreditation provide a report annually on the progress of international activities to the House of Delegates.

In response to Resolution 39H-2005, the Joint Advisory Committee on International Accreditation was appointed. Dr. Donald I. Cadle, Jr. (chair), Dr. Steve Bruce and Dr. Roger Simonian were appointed from the ADA. Dr. James R. Cole, II and Dr. Cecile A. Feldman were appointed to represent the Commission on Dental Accreditation (CODA). Current members include: Dr. Kenneth Versman, chair, (ADA BOT), Dr. Steven Bruce (ADA), Dr. Richard Buchanan (CODA), Dr. Michael Reed (CODA), and Dr. Roger Simonian (ADA). Dr. James J. Koelbl, CODA chair, and Dr. Ronald L. Tankersley, ADA president-elect, participate as ex-officio members of the Committee. Additional historic background and rationale in regards to international accreditation is attached as Appendix 1 for readers who may not be familiar with the history and rationale for this activity. The following is a summary of the activities of the Committee over the past year.

Consideration of Preliminary Accreditation Consultation Visit (PACV) Surveys and PACV Self Studies: To date, there have been over twenty-five (25) inquiries from international programs regarding the process for obtaining accreditation from the CODA. In 2008, eight programs submitted PACV surveys. After review and discussion, the following international programs were approved for the next step in the international accreditation process, the submission of a preliminary accreditation consultation visit self-study and the scheduling of a site visit. These programs are:

1. Saraswati Medical and Dental College, Lucknow, India
2. King Abdulaziz University School of Dental Medicine, Jeddah, Saudi Arabia
3. Universidad de la Salle Bajio AC Dental Education Program, Leon, Mexico
4. Universidad de San Martin de Porres, Lima, Peru
5. Yonsei University College of Dentistry, Seoul, South Korea
6. Seoul National University, School of Dentistry, Seoul, South Korea
7. Yeditepe University Faculty of Dentistry, Istanbul, Turkey

In 2009, the Committee reviewed the PACV survey from SDM College of Dental Sciences and Hospital, Bangalore, India and determined that the dental school has the potential to meet accreditation standards and is eligible to complete a PACV self study in preparation for a consultation visit.

The Committee received a PACV self study and all required fees from Universidad de San Martin de Porres, Lima, Peru in January 2009. The dental school has said that it would be ready for a consultation visit in approximately one year. Following review of the self study document, the Committee determined that the dental school was not ready for a PACV visit. After lengthy discussion, the Committee determined that the majority of the consultation fee and site visit fee that the school had sent with the

PACV self study would be returned. The Committee also determined that a letter would be sent to the CEO and dean outlining the standards for which the school did not provide sufficient evidence of compliance and informing them that a portion of fees will be refunded.

PACV Survey Revision: Upon review of the responses to the PACV surveys to date, the Committee determined that several questions on the current PACV survey may be confusing to international programs, yielding incomplete and/or differing answers. A subcommittee of CODA representatives to JACIA evaluated and revised the PACV survey to add more specific examples of evidence and statements of intent to the survey. The Committee determined that the revised PACV survey as presented by the subcommittee would provide the necessary and accurate information on which to make decisions on the potential for the international program to attain U.S. accreditation (Appendix 2).

Discussion of the Potential for International Programs to Meet all U.S. Accreditation Standards: As the Committee began its review of policies and information submitted with PACV surveys, a concern was raised regarding the potential for any international dental education program to meet Standard 1-7 of the Accreditation Standards for Dental Education Programs. This is the requirement that the dental school be a component of a higher education institution that is accredited by a regional accrediting agency recognized by the United States Department of Education. Standard 1-7states:

> The dental school **must** be a component of a higher education institution that is accredited by a regional accrediting agency.

A review of existing institutional accreditation systems in countries with PACV programs revealed a mix of systems that are rapidly changing as more post secondary schools in the U.S. develop international programs, and more international schools seek U.S. accreditation. However, outside of the U.S., there are currently no comparable models that involve a regional, institutional accrediting agency. Several U.S. accreditors are in the process of developing policies and procedures related to international accreditation; however, few best practices have been developed or tested. During the discussion, the Committee affirmed that it is important to maintain the high level of educational quality that results from the application of CODA standards, including reliance on regional accrediting agencies for their roles in certain aspects of the educational quality assurance process.

Options for determining equivalency to Dental Education Standard 1-7 were discussed and the conclusion of the Committee was that there are essential components of regional accreditation in the U.S. that could be used in the evaluation of international dental education programs. The Committee determined that a policy on equivalency would allow the Committee and Commission to more broadly apply the predoctoral dental education Standard 1-7 within the specific environment of each international program. The Committee recommended to the Commission on Dental Accreditation that a policy on equivalency for Standard 1-7 for international predoctoral dental education programs be developed. CODA discussion of the issue of equivalency of pre-doctoral Standard 1-7 centered around the fact that the JACIA is a joint committee of both the Commission and the ADA; therefore, input on this issue should be solicited from the Board of Trustees before any proposed changes in Commission policy are considered.

At its January 2009 meeting, the Commission adopted the following resolution.

> **Commission Action:** The Commission directed that the issue of equivalency of predoctoral accreditation standards for international dental programs be brought to the attention of the ADA Board of Trustees for discussion and input.

At its February 2009 meeting, the Board of Trustees considered the action taken by the Commission and adopted the following resolution.

> **B-12-2009. Resolved,** that the Joint Advisory Committee on International Accreditation explore any proposed changes in the standards for international accreditation and bring a proposal back to the Board of Trustees to be presented to the House of Delegates.

In response to the Board of Trustees, the Committee drafted a policy on equivalency centering on the elements of regional accreditation that are not part of current standards for dental education programs, but are intended to be covered in Dental Education Standard 1-7. The Committee reviewed nine (9) additional questions designed to determine equivalency to U.S. regional accreditation. Resources used in determining the additional questions came from institutional accreditation standards of the Southern Association of Colleges and Schools (SACS) and the Higher Learning Commission (HLC). The JACIA determined that the questions would be part of a revision of the PACV survey and that those dental schools that have completed the PACV survey would be asked to respond to the questions (Appendix 2). Substantiation of information derived from these questions would be part of the PACV. In addition, the Committee noted that the Commission has the expertise to evaluate an international program's response to determine equivalency to Standard 1-7. The additional questions request the following information about the sponsoring institution:

- Degree granting authority
- Authority of the governing board
- Board oversight related to applicable governmental laws and regulations
- Institutional mission, goals, and/or values
- Board oversight and authority related to institutional planning and budgeting
- Financial stability of the sponsoring institution
- Adequacy of institutional administrative personnel
- Institutional policies and procedures regarding evaluation of administrators, faculty and staff; ownership and copyright; protection of academic freedom; protection of confidentiality and integrity of student records; ethical conduct in research and instructional activities; grievance procedures; nondiscrimination policy.

I**nternational Consultation Policy and Procedures Review:** Since 2006, JACIA has drafted policies specific to international consultation and accreditation fee-based services to be made available, upon request, to established international predoctoral dental education programs. Policies that have been discussed and/or developed include those related to the composition of the site visit team; the time interval between site visits for international programs; notification of relevant national dental associations, government agencies, and internal accrediting agencies and appeal and due process for international programs wishing to challenge Committee decisions. Following review of the PACV self-study from Universidad de San Martin de Porres, Lima, Peru, the Committee evaluated the current three step process for accreditation of international programs, and determined that additional steps with less cost to programs upfront is warranted. In addition, the Committee determined that a requirement should be added that representatives from all international programs are required to attend a U.S. comprehensive site visit as an observer, and meet with staff to review the standards and reporting requirements. A subcommittee of CODA representatives was formed to evaluate the three step process and provide input to the larger Committee. The Committee approved the subcommittee revision of the three (3) step process so that following review of the PACV survey, JACIA would take three (3) possible actions, 1) allow representative from the international dental education program to attend a comprehensive site visit and receive consultation from current site visitors and staff, 2) complete a focused self study and site visit on areas the Committee believes would limit the ability of the international program to attain accreditation, or 3) offer no additional consultation. The Committee determined that these revisions and clarifications would allow programs to receive additional consultation on U.S. accreditation and provide the Committee with additional feedback on the international program's potential to meet U.S. accreditation standards.

The Committee determined a revised fee structure to cover additional costs associated with attendance at a comprehensive visit and additional staff consultation. The Committee gave final approval to the subcommittee's revisions to the PACV survey including the additional nine (9) questions to determine equivalency to U.S. regional accreditation.

The Committee determined that training for site visitors should be done as a face-to-face session that includes information on educational and cultural issues in the host country. The international program will have the ability to screen off consultants in the same manner as U.S. programs. One consultant should be knowledgeable in the language and culture of the host country.

Summary: This report intended to keep the House of Delegates apprised of the activities of the Joint Advisory Committee on International Accreditation. In addition, this report outlines the rationale for establishment of policies and procedures to determine equivalency for Predoctoral Dental Education Accreditation Standard 1-7. No international programs would be able to meet Standard 1-7 without equivalency. The JACIA has developed nine (9) additional questions designed to determine equivalency to U.S. regional accreditation. The Commission would determine whether an international program meets Standard 1-7 through evaluation of the responses to these additional nine questions.

Resolution

57. Resolved, that the Joint Advisory Committee on International Accreditation and the Commission on Dental Accreditation implement policies and procedures to determine equivalency for Predoctoral Dental Education Standard 1-7 for International Predoctoral Dental Education Programs seeking accreditation.

BOARD COMMENT: The Board agrees that the proposed policy on equivalency for Dental Education Standard 1-7, centering on the elements of regional accreditation that are applicable to dental programs, will allow the process of international accreditation to move forward. The JACIA report makes it clear that the Committee worked very hard on this issue and is determined not to dilute the standards in using this approach. The Board believes that CODA and JACIA have the expertise to evaluate an international program's response to determine equivalency to Standard 1-7, and noted that the JACIA has expanded the requirements for international programs that wish to participate to provide greater clarity on the requirements, process and expectations. Therefore, the Board supports adoption of this resolution.

BOARD RECOMMENDATION: Vote Yes.

Board Vote:

Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LONG	☐	■	☐	☐	SYKES
■	☐	☐	☐	ELLIOTT	☐	■	☐	☐	MANNING	■	☐	☐	☐	TANKERSLEY
■	☐	☐	☐	FAIELLA	■	☐	☐	☐	NORMAN	☐	■	☐	☐	THOMPSON
■	☐	☐	☐	GIST	■	☐	☐	☐	RICH	■	☐	☐	☐	VERSMAN
■	☐	☐	☐	GLECOS	☐	■	☐	☐	SCHWEINEBRATEN	■	☐	☐	☐	VIGNA
■	☐	☐	☐	KREMPASKY SMITH	■	☐	☐	☐	STEFFEL	■	☐	☐	☐	WEBB
■	☐	☐	☐	LOW	■	☐	☐	☐	SULLIVAN					Res. 57

Appendix 1
INTERNATIONAL ACCREDITATION 2009: HISTORY, RATIONALE AND CURRENT STATUS
Joint Committee on International Accreditation & Commission on Dental Accreditation

History and Rationale: Several years ago, the ADA chose to take the proactive step of initiating an international accreditation and consultation program. This initiative responded to a number of compelling environmental conditions. First and foremost, the public, legislators, government officials and some members of the profession perceived a serious problem with access to care. Increasing the number and distribution of dentists by tapping the pool of international dentists was seen as a potential solution. For some states international accreditation appeared to offer a short cut to licensure and/or practice for internationally-trained dentists who would otherwise be required to repeat two or more years of dental school to obtain a dental degree from an accredited dental education program**.** California took the lead by adopting legislation requiring its dental board to approve international dental schools. California may be the lead state, but demographics are changing nation-wide and at least two other state boards have been considering evaluation of foreign schools themselves. Legislators want to appear responsive to their constituents and continue to push for such action. However, most state boards are not prepared to implement their own accreditation or credential evaluation systems; they simply lack the resources and expertise to perform this task. For the ADA, a single system of quality assurance for dental education and the ability to have a strong voice in the quality standard were critical to its decision to get involved.

In addition to the dominant access to care issue, significant trends in globalization have led to an increasingly diverse U.S. population. Underserved patients from diverse backgrounds are often more comfortable seeking care from dentists from similar backgrounds with the ability to communicate in their language. Today, individuals, spouses and entire families move and relocate as a matter of course. For dentists, this results in an ever-increasing demand for reasonable mechanisms for licensure that recognize their educational training and credentials. This is consistent with ADA's policy supporting freedom of movement for qualified individuals.

Marketing of international educational programs has expanded to promote opportunities for U.S. citizens to study dentistry abroad. This has prompted developing countries to seek advice and assistance from the U.S. in raising standards of dental education and oral health care. ADA's mission and goals support the improvement of oral health worldwide. Further, the U.S. dental school applicant pool has increased in number and quality so that even highly qualified students may not gain admission to U.S. dental schools. With strong interest in dental careers and concerns about the high cost of education in the U.S., some students are pursuing international dental education opportunities, with hopes of returning to the U.S. to practice.

Finally, many dental schools search worldwide for qualified faculty. Difficulties in obtaining licenses often interfere with this process since most states require graduation from a Commission-accredited dental school or completion of a supplemental education program for licensure. Although some states have provisions for special teaching licenses or permits, some believe that if internationally-trained dentists teach our students, we should be evaluating the quality of their education.

These conditions led to a growing concern that if the ADA did not address these needs and the Commission did not accredit international dental schools, other entities would fill these voids. Poorly understood international trade agreements and new, internationally-based efforts to standardize dental education added to the concerns. As state boards, state legislatures and private accrediting agencies assumed this task, the ability of the ADA, the Commission and the dental profession to influence and preserve the quality of education and practice would be lost.

In light of these developments, the ADA House of Delegates considered reports and resolutions on international accreditation in 2002, 2003 and 2004. In 2005, the House of Delegates adopted Resolution 39H-2005: Consultation and Evaluation of International Dental Schools, supporting an initiative to offer

consultation and accreditation services to international dental schools with oversight by a joint ADA-CODA committee, the Joint Advisory Committee on International Accreditation and Consultation (JACIA). It is composed of representatives of the ADA and CODA and current members include: Dr. Kenneth Versman, chair, (ADA BOT), Dr. Steven Bruce (ADA), Dr. Richard Buchanan (CODA), Dr. Michael Reed (CODA), and Dr. Roger Simonian (ADA). Dr. James Koelbl, chair, Commission on Dental Accreditation, and Dr. Ronald Tankersley, president-elect, American Dental Association, participate as *ex-officio* committee members.

Since 2006, JACIA has developed policies and procedures specific to international consultation and accreditation, including eligibility criteria for schools seeking accreditation from CODA. These activities are limited to predoctoral dental education at this time. The first step for an international dental education program seeking accreditation is to submit a written request for a Preliminary Accreditation Consultation Visit (PACV). This involves completion of a PACV Survey designed to provide specific programmatic information. The Advisory Committee then reviews the survey to determine whether the program's educational model has the potential to prepare graduates with competencies consistent with requirements for practice in the U.S. The Committee determines whether the program can proceed to the second step in the process and submit a self-study for an onsite consultation visit. Once an international program has successfully completed these first two steps, the program can pursue accreditation through the Commission. Both JACIA and CODA have adopted the policy that international programs will be evaluated and must comply with the same standards and policies as all U.S. programs. All communications and documentation from international programs must be in English. International programs seeking consultation and accreditation are required to pay fees for the preliminary screening and for consultation and accreditation, as well as all travel expenses for site visits. The fees are set at a level to recover both direct and indirect costs. JACIA policies also provide an opportunity for programs to request consultation services (for a fee) focused on a limited, specific aspect of their educational program.

Most members are probably not aware of the history and background relating to international accreditation and may not wish to support an activity they really don't understand. However, the reality of not taking a leadership role in this issue is that the average member will be impacted if current standards are not protected and the image of the profession is ultimately diminished. The profession continues to become more diverse. Internationally-trained dentists who have met the hurdles of licensure and are practicing in the U.S. will be less likely to join the ADA and sustain current standards of the profession if they perceive a lack of support from the ADA.

JACIA policy and Commission policy are very clear: the Commission will approve only programs that meet the same standards, policies and procedures that are applied to U.S. programs. While an international accreditation program is outside the scope of the United States Department of Education's recognition authority, the credibility of international accreditation would require adherence to standards, policies and principles that guide accreditation of U.S. programs. The Commission would not be well served by diminishing the value of its accreditation program by lowering its standards or approving unqualified programs.

Current Status: There is great variability in dental education worldwide. Some countries have systems of education and accreditation that closely parallel the U.S. systems. The number of international dental schools interested in accreditation by the Commission at this time is relatively small. Not every school that requests accreditation will qualify. Some schools want CODA accreditation simply because it offers a competitive advantage within their own country. Schools that request consultative services may take several years to prepare for accreditation. Many countries are also experiencing workforce shortages in the face of growing populations and cohorts of aging dentists; the number of dentists interested in relocating to the U.S. may be small. Accreditation of an international school would not retroactively qualify all the graduates of that school. Only future graduates would qualify as graduates of an accredited school. Immigration regulations place some constraints on the number of internationally-trained dentists

who may enter the U.S. Internationally-trained dentists must fulfill all other licensure requirements before they would be eligible to practice, including National Board certification, passing a clinical licensure examination and/or any state-specific requirements, such as a jurisprudence exam or required year of residency.

To date, eight international programs have submitted preliminary eligibility surveys and been approved for the second step in the process, the submission of a PACV visit self-study by the international program and the scheduling of a site visit. These programs are located in India, South Korea, Saudi Arabia, Mexico, Peru and Turkey. Only one of these programs (Universidad de San Martin de Porres, Lima, Peru) has submitted the self-study for a consultation visit. The Committee determined that the program was not ready for a consultation visit and has provided recommendations on how the program might appropriately prepare for the process. Another program (Seoul National University) requested onsite staff assistance and participation in a conference to inform Korean dental educators about the process and the standards.

Appendix 2

Joint Advisory Committee on International Accreditation

Guidelines for International Consultation and Preliminary Accreditation Consultation Visit (PACV) Survey

American Dental Association (ADA)
Commission on Dental Accreditation (CODA)

Revised: May, 2009

American Dental Association
Commission on Dental Accreditation

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COMMISSION ON DENTAL ACCREDITATION

The Commission on Dental Accreditation (CODA) has operated under the administrative aegis of the American Dental Association (ADA) since its establishment by the ADA House of Delegates in 1975. The Commission's independent and autonomous duties, which have been approved by the ADA House of Delegates, include formulation and adoption of accreditation standards for predoctoral, advanced dental and allied dental education programs, the accreditation of dental and dental-related educational programs and provision of a means for appeal from adverse decisions of the Commission to a separate and distinct body.

MISSION STATEMENT OF THE COMMISSION ON DENTAL ACCREDITATION

The Commission on Dental Accreditation serves the public by establishing, maintaining and applying standards that ensure the quality and continuous improvement of dental and dental-related education and reflect the evolving practice of dentistry. The scope of the Commission on Dental Accreditation encompasses dental, advanced dental and allied dental education programs.

CODA Adopted: 01/01

OVERVIEW OF INTERNATIONAL POLICIES AND PROCEDURES

Dental accreditation in the United States is a voluntary quality evaluation system that includes a standard setting and review process to promote the goal of continuous quality improvement in dental education. Additional goals are to provide public protection and accountability and to assure prospective students and state licensing agencies that educational programs provide appropriate education, training and experience to adequately prepare individuals for dental licensure and practice in the U.S. International dental education programs may seek consultation and/or accreditation services from the Commission on Dental Accreditation for the purpose of obtaining an independent, external review, for benchmarking or to serve the needs of graduates who may wish to demonstrate their preparedness for licensure in a state in the U.S.

International consultation and accreditation fee-based services are available to international predoctoral dental education programs, upon request. Once an international dental education program meets the established criteria, consultation and accreditation services will be provided in accord with Commission on Dental Accreditation (CODA) policies and procedures. Eligibility criteria and CODA policies, standards and procedures are subject to change and will be periodically reviewed and updated. It is the responsibility of programs to keep informed of changes in CODA accreditation policies and procedures, and abide by all current policies and procedures.

An international dental education program is defined as a program located and sponsored by an institution whose primary location is outside of the United States and Canada. CODA will only accept requests for consultation and accreditation fee-based services from established international dental education programs. The international dental education program must be: 1) accepted in its country of origin, 2) officially chartered/recognized in its country of origin, and 3) recognized or accredited by the country's relevant government or non-governmental agency.

International dental education programs seeking accreditation by the CODA must meet the same Accreditation Standards for Dental Education Programs as the United States-based programs and follow the same process and procedures.

Figure 1 (page 12) outlines a series of consultation steps that an international dental education program must go through to attain accreditation from CODA. All steps are required including attendance at a U. S. dental school site visit as a silent observer and a Preliminary Accreditation Consultation Visit (PACV). These steps are designed to provide consultation and evaluation of the international program's readiness for accreditation. Since the consultation and accreditation process is a voluntary one, programs can discontinue the process at any time. A Joint Advisory Committee decision to grant an international dental education program a PACV does not automatically mean that the program will achieve accreditation.

DEFINITIONS

The Joint Advisory Committee on International Accreditation has established definitions for consultation, accreditation and international dental education program. The remaining definitions are from, or adapted from; Harvey, L., 2004-9, *Analytic Quality Glossary*, Quality Research International, http://www.qualityresearchinternational.com/glossary/. Additional definitions can be found in the *Accreditation Standards for Dental Education Programs*.

Accountability: Accountability is the requirement, when undertaking an activity, to expressly address the concerns, requirements or perspectives of others.

Accreditation: A conformity assessment process where an agency, such as the Commission on Dental Accreditation, uses experts in a particular field of interest or discipline to define standards of acceptable operation/performance for a school or program. The agency grants public recognition to the school/program that has met predetermined standards.

Assessment of student learning: Assessment of student learning is the process of evaluating the extent to which participants in education have developed their knowledge, understanding and abilities.

Assessment of teaching and learning: Assessment of teaching and learning is the process of evaluating the quality and appropriateness of the learning process, including teacher performance and pedagogic approach.

Competence: Competence is the acquisition of knowledge skills and abilities at a level of expertise sufficient to be able to perform in an appropriate work setting (within or outside academia).

Consultation: discussion for advice; the process of discussing something either with experts or with participants and asking for their opinions or advice

Equivalency: Equivalency indicates that an international program is essentially the same as a program in the United States or Canada. For dental education programs outside the United States or Canada, equivalency is granted ONLY for dental education standards that require the sponsoring institution to be accredited by a regional accrediting agency. In countries where no system of national or regional accreditation of institutions exists, equivalency is determined by requiring additional evidence of institutional policies and procedures that are aligned with U. S. regional accreditation standards. The additional questions and documentation needed is on pages 16 to 18 of the PACV survey.

Governance: Governance in higher education refers to the way in which institutions are organized and operate internally. Governance also includes an institution's relationships with those outside of the organization, particularly with how the institution fulfills its mission in the areas of education, research, and service.

International Dental Education Program: A predoctoral dental education program located and sponsored by an institution whose primary location is outside of the United States and Canada.

Outcome: A measureable result. Often further divided into:

A. Learning outcome: A learning outcome is the specification of what a student should learn as the result of a period of specified and supported study.

B. Institutional Outcome: An institutional outcome is shorthand for the product or endeavors of a higher education institution, including student learning and skills development, research outputs and contributions to the wider society locally or internationally.

Self-assessment: Self-assessment is the process of critically reviewing the quality of one's own performance and provision.

INTERNATIONAL CONSULTATION PHILOSOPHY AND PROCESS

Philosophy of Consultation for International Programs[1]

In the United States accreditation is a non-governmental, voluntary peer review process by which educational institutions or programs may be granted public recognition for compliance with accepted standards of quality and performance. Specialized accrediting agencies exist to assess and verify educational quality in particular professions or occupations to ensure that individuals will be qualified to enter those disciplines. A specialized accrediting agency recognizes the course of instruction which comprises a unique set of skills and knowledge, develops the accreditation standards by which such educational programs are evaluated, conducts evaluation of programs, and publishes a list of accredited programs that meet the national accreditation standards.

The assessment of quality in educational programs is the foundation for accreditation, and quality improvement is reflected throughout the dental education standards. The standards are also established on a competency-based model of education through which students acquire the level of competence needed to begin the unsupervised practice of general dentistry. Accreditation standards are developed in consultation with those affected by the standards who represent the broad communities of interest.

Although globalization has prompted increasing interest in international collaboration and consensus on quality standards, most countries and regions of the world continue to use quality assessment programs that meet local needs. In that vein, accreditation of educational programs in the U.S. serves the purposes of public accountability and quality assurance within a context of local social, cultural, economic, regulatory and professional norms and assumptions. Accordingly consultation and accreditation reviews of the ADA Commission on Dental

Accreditation by CODA is intended to meet local needs and requirements. Reviews of international dental school programs that identify discrepancies or deficiencies in complying with CODA standards should not be construed as denigrating the relative quality and value of the educational program in its home country or region of the world. Comments and recommendations from the Joint Advisory Committee on International Accreditation (JACIA), CODA staff and on-site consultants are intended to identify differences in expectations and requirements appropriate to the U.S. regulatory system and should not be interpreted as arbitrary or intentionally critical. Upon receipt of feedback from the ADA's Joint Advisory Committee on International Accreditation, some educational programs may choose to make relevant changes in their programs and/or documentation to comply with CODA standards, while others may find the recommendations and evaluation criteria are not appropriate for their circumstances, and may choose not to continue the process.

The Consultation Process for International Programs

The Commission adopted its International Policies and Procedures in July 2006, and revised the process in 2009. The Joint Advisory Committee on International Accreditation has been established to receive requests for fee-based consultation services. The Joint Advisory Committee meets as needed to consider fee-based requests for consultation from international dental education programs.

Attainment of CODA accreditation is a multi-step process that involves self study, observation of CODA's accreditation process, and consultation with CODA staff, site reviewers, and the Joint Advisory

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[1] Taken in part from Commission on Dental Accreditation. .*Accreditation Standards for Dental Education Programs*, 2007.

Committee on International Accreditation. Figure 1 (page 12) outlines the steps in the process. International dental education programs can discontinue the process at any point, but must inform CODA staff if an on-site visit has been scheduled.

All of the documents described below must be submitted in English. All fees must be drawn on U.S. banks in U.S. dollars. The CODA staff selects consultants to all international site visits and forwards all self-study documents to the consultants. All interviews on each of the site visits described below must be conducted in English. If needed, CODA will employ a translator for on-site visits. Expenses for the translator are paid by the international program.

To begin the process, the Dean of the International Education Program or International University President/Provost requests, in writing, information regarding its fee-based consultation and accreditation services. CODA staff sends the following via e-mail:

1. Procedures and Policies for International Accreditation
2. PACV (Preliminary Accreditation Consultation Visit) Survey
3. PACV Self-study and Guide
4. Predoctoral Dental Education Standards

Step one. Completion of the PACV survey

The PACV survey and required fee (page 13) is submitted by the dean of the college and the president/provost of the university to formally begin the international consultation process. In addition, national dental associations, along with the appropriate government ministry and/or accrediting agency, must be informed that the program has begun the process of U.S. accreditation. The program will be required to request the appropriate government ministry and/or accrediting agency to submit a letter of acknowledgement directly to the committee.

The PACV survey is reviewed by the Joint Advisory Committee on International Accreditation, using the broad eligibility criteria (page 14). If the Committee consensus is that a PACV is warranted, the institution will be invited to attend a comprehensive site visit to a U.S. program to observe the accreditation process.

If the Committee consensus is that the international program is not yet ready to pursue CODA accreditation, the program will be advised that no further consultation will be offered, and will be provided with the specific areas that, in the opinion of the committee, limit the ability of the program to meet CODA accreditation standards.

If the Committee consensus is that the program has the potential to meet CODA accreditation standards, but selected accreditation standards may be difficult for the international program to meet, the program will be advised that a focused consultation visit is warranted. The program will be asked to submit additional information related to the selected standards and complete a focused consultation visit before the program will be invited to attend a U. S. comprehensive visit.

Focused consultation services are provided by content experts in the specific standards under review. In preparation for the consultation visit, the international dental schools will prepare a written document describing its policies and procedures related to the focused topics. The written material will be submitted 90 days prior to an on-site focused consultation visit. All documents and communications will be in English. Two consultants (staff and/or volunteers) selected for their expertise in the focused topic areas, will make up the visiting committee that provides the focused consultation services and carries out the visit. The trip may be seven days in length, allowing ample time for the committee to adjust to any time change. The program pays a focused consultation fee (page 13) and all expenses associated with the consultation visit, including travel, hotel, meals. The program will receive a written report summarizing the review and recommendations within 60 days. This report will be reviewed by the Joint Advisory Committee who will make a determination if the program 1) will be required to submit additional

information related to the consultants' findings, 2) can be invited to attend a U. S. comprehensive visit, or 3) will be offered no further consultation at this time.

If no further consultation services are offered, either following the focused consultation visit or the Joint Advisory Committee's review of the PACV survey, international programs may reapply one additional time by submitting a new PACV survey no sooner than one year from the date of the Joint Advisory Committee's decision.

Step two. Observation of a CODA dental school site visit and individual consultation

Observation of a CODA dental school site visit and consultation with staff and site visitors following the visit is a required step. All costs associated with the observation and consultation will be paid by the international program and include airfare, hotel and meals for the program's representatives. CODA dental school visits are three and a half (3 1/2) days in length and typically occur from February to May and from September to November each year. A maximum of two observers from the international program will be permitted.

All observers are required to sign the same confidentiality agreement as CODA site visitors and abide by the same policies and procedures. Observers must remain silent during sessions, but may ask questions during executive sessions and after the site visit is completed. Observers must be able to observe interviews and communicate with site visitors and CODA staff in English. No interpreters will be permitted during the site visit observation.

Following the site visit, CODA staff and selected site visitors will meet individually with international observers to answer questions and provide consultation on the accreditation process. Observers should therefore plan on a total of four (4) days for both the observation of the site visit and individual consultation with CODA staff and site visitors.

Following the observation and individual consultation, the international program may elect to complete the PACV self-study and submit the PACV consultation fees (page 13) within 6 mos. to 3 years The Joint Advisory Committee MUST have formal notification of the intent of the international program to continue to pursue CODA accreditation be provided to the Committee within thirty (30) days of the conclusion of the observation and individual consultation.

Step three. PACV self study and consultation visit

Once the international program has completed the PACV self-study, and submitted the appropriate fee, the self-study will be reviewed by the Joint Advisory Committee. If the Committee consensus is that the program has the potential to meet CODA accreditation standards, CODA staff and the institution will schedule the PACV at a time that is mutually convenient to the international dental education program representatives, the CODA representatives, and CODA staff. The program agrees to pay the expenses of the site visit including airfare, hotel, and meals (page 13).

The PACV is a comprehensive consultation service. This is a comprehensive, fee-based site visit with programmatic consultation by trained content experts regarding topics such as:

- Institutional effectiveness/outcomes assessment
- Curriculum content and scope
- Competency-based curriculum
- Faculty and staff qualifications and numbers
- Type and adequacy of facilities
- Patient care services and policies
- Student policies and services
- Research for both faculty and staff

- Readiness for accreditation by the CODA assessment
- Quality Assurance
- Comprehensive patient care
- Relationship of School to the University and government
- Standards of Care

The consulting committee that will conduct the PACV is made up of four consultants (curriculum specialist/committee chairperson, basic science specialist, clinician educator, and clinician practitioner representing the American Dental Association) and one CODA staff. One of the consultants will be a dental professional with experience and/or knowledge of the host country.

The visit will involve several interviews with the identified stakeholders of the international dental education program and the institution's administration. Interviews will be conducted with the appropriate administrators, faculty, staff and students. The consulting committee will also provide guidance regarding the facilities. A written report summarizing the evaluation will be provided to the program within 60 days of the visit.

The consultation report is submitted to the Joint Advisory Committee for its consideration. The Committee's report is communicated to the international dental education program and the CODA. If the consensus of the Joint Advisory Committee is that the international program will be able to most likely achieve U.S. accreditation, the program may elect to submit an application for accreditation to the CODA. **Please note, a positive determination from the Joint Advisory Committee does not guarantee that an application for accreditation will be successful.**

If the Joint Advisory Committee determines that an international program is not yet ready to pursue CODA accreditation, a PACV will not be scheduled. If the Committee consensus is that the program has the potential to meet CODA accreditation standards, but selected accreditation standards may be difficult for the international program to meet, the program will be advised that a focused consultation visit is warranted. If the Committee consensus is that an international program is not yet ready to pursue CODA accreditation, the program will be advised that no further consultation will be offered, and will receive a written report outlining the specific areas that, in the opinion of the committee, limit the ability of the program to meet CODA accreditation standards. International dental education programs may reapply one additional time by submitting a new PACV survey no sooner than three years from the date of the Joint Advisory Committee's decision.

Step four. Application for CODA accreditation.

Upon receipt of the application for accreditation, the CODA United States-based accreditation process and procedures are followed.

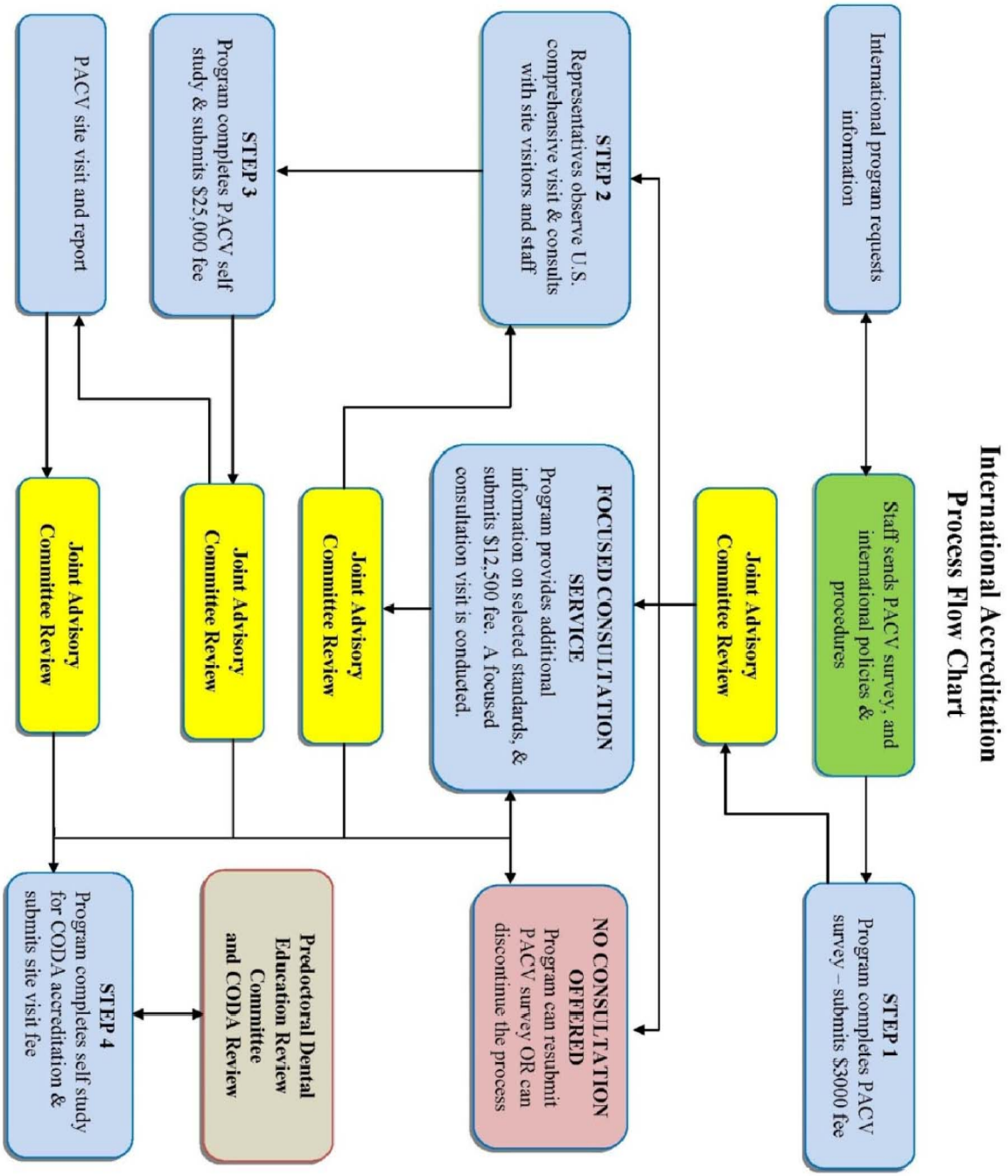
The CODA accreditation service is the same as the process and procedures of the accreditation program for U.S.-based dental education programs. Programs that are successful in the PACV may submit an application for accreditation and an application fee for accreditation. Commission consultants will then be selected to evaluate the written application and determine whether the application is complete. The program may elect to voluntarily withdraw its application or make the appropriate changes and resubmit with additional information. Once the Commission determines that the program has submitted sufficient information to determine the program's potential for complying with the Accreditation Standards, a site visit will be scheduled. This preliminary determination does not guarantee that an application for accreditation will be successful.

An accreditation site visit committee consists of six (6) Commission-trained volunteer site visitors and one CODA staff. The committee includes a chair, basic scientist, curriculum site visitor, clinical science site visitor, finance site visitor, and a national licensure site visitor. The trip may be seven days in length, allowing ample time for the committee to adjust to any time change.

The accreditation visit, following the process established by U.S. based programs, will involve several interviews with the identified stakeholders of the international dental program and the institution's administration. Interviews are conducted with the appropriate administrators, faculty, staff and students. The accreditation site visit committee also verifies that the written application accurately represents the program through multiple interviews, observations, on-site documentation review and facility inspection.

Following the site visit, the visiting committee writes a preliminary draft site visit report. The preliminary report is sent to the school within thirty (30) days of the site visit. The dental education program may respond to the preliminary report to correct factual inaccuracies and note differences in perception. Both the preliminary site visit report and the school's response are considered by the Review Committee on Predoctoral Dental Education and the CODA. The Board of Commissioners then determines whether to grant the program the appropriate accreditation status.

International Dental Education Programs who are successful in the PACV and wish to seek accreditation will be assessed an accreditation application fee. The program will also be responsible for all site visit expenses. Accredited programs also pay an annual fee (page 13).


International Accreditation Process Flow Chart
International program requests information
Staff sends PACV survey, and international policies & procedures
STEP 1
Program completes PACV survey – submits $3000 fee
Joint Advisory Committee Review
NO CONSULTATION OFFERED
Program can resubmit PACV survey OR can discontinue the process
FOCUSED CONSULTATION SERVICE
Program provides additional information on selected standards, & submits $12,500 fee. A focused consultation visit is conducted.
Joint Advisory Committee Review
STEP 2
Representatives observe U.S. comprehensive visit & consults with site visitors and staff
Joint Advisory Committee Review
STEP 3
Program completes PACV self study & submits $25,000 fee
Joint Advisory Committee Review
PACV site visit and report
Predoctoral Dental Education Review Committee and CODA Review
STEP 4
Program completes self study for CODA accreditation & submits site visit fee

INTERNATIONAL CONSULTATION AND ACCREDITATION FEES *

1. Payment/Check should be made out to the American Dental Association.

2. Drawn on a U.S. account in U.S. dollars.

3. Send to:

   The Commission on Dental Accreditation
   c/o Anthony J. Ziebert, DDS, MS
   211 E. Chicago Ave., Suite 1900
   Chicago, IL 60611

4. Fee Categories
   a. Application fee for PACV Survey - $3000.00

   b. Focused Consultation Service:
      a. $12,500.00 Focused Consultation Fee
      b. Actual costs for Focused Consultation Visit, including travel, hotel, meals for 2 volunteers/staff for 7 days; estimated $12,500.00 to 15,000.00

   c. Preliminary Accreditation Consultation Site Visit (PACV):
      a. $25,000.00 Consultation Fee for submission of PACV self study
      b. Actual costs for Preliminary Accreditation Consultation Site Visit, including travel, hotel, meals for 4 volunteers/staff for 7 days, estimated $25,000.00 to $30,000.00

5. Actual costs for Accreditation Site Visit, including travel, hotel, meals for 7 volunteers/staff for 7 days, estimated $44,300.00 to $47,000.00
   a. Annual Fees are $7,800.00 per year (once accredited, programs must pay this fee every year)

* Fees are subject to change each year.

BROAD ELIGIBILITY CRITERIA FOR PRELIMINARY ACCREDITATION CONSULTATION VISIT (PACV) SURVEY

The PACV survey will be evaluated by the Joint Advisory Committee on International Accreditation using the following broad criteria. These criteria are subject to change and will be periodically reviewed and updated.

1. Information from the U.S. State Department confirms that no conditions (war, threat of terrorism, etc.) exist that might put the safety of a visiting committee at risk.
2. There are no cultural restrictions or legal restrictions which would make site visits by U.S. citizens problematic.
3. The PACV survey responses in English are appropriate and understandable.
4. The dental school or program has a sponsoring university.
5. There is an accreditation and/or approval process within the country for higher education and the sponsoring university or dental school is accredited/approved within the country. A letter of support from the accreditation/approval agency has been submitted to CODA. The university or institution that sponsors the dental program has been determined to meet the requirements for equivalency to U.S. regional accreditation.
6. The school or program is degree-granting.
7. It appears the program has adequate financial support.
8. The dental school or program has been in existence long enough have several graduating classes.
9. The education model is essentially similar to that in the U.S. and Canada.
10. Pre-requisites for admission to the dental school are appropriate and adequate.
11. The number of full-time and part-time faculty appears to be adequate based on the number of students enrolled.
12. There appears to be a developed curriculum plan with adequate clock hours in:
    a. Basic Sciences
    b. Preclinical laboratory
    c. Clinical sciences
13. Clinical treatment of patients is an essential part of the educational program.
14. There appears to be developed facilities for dental education.
15. Health care standards and standards of care for dentistry support the practice of dentistry in essentially the same manner as in the U.S.

AMERICAN DENTAL ASSOCIATION
COMMISSION ON DENTAL ACCREDITATION
PRELIMINARY ACCREDITATON CONSULTATION VISIT SURVEY

SPONSORING UNIVERSITY
Name: Address: Country:
Chief Executive Officer (University President, Chancellor or Provost) Name: Title: Phone: Signature:
Chief Administrative Officer (Dean of the Dental School) Name: Title: Address: Phone: Fax: E-Mail: Signature:
Date - Month/Day/Year:

A. Information on the sponsoring institution:

The purpose of this section is to provide general information on the sponsoring institution, and the dental education program.

1. Please check the box that best describes the institution of higher education that sponsors the predoctoral dental education program.

a. A University _____
b. A Health Center _____
c. A Stand-alone institution that provides only dental education _____
d. Other _____

If you have checked other: please describe the sponsoring institution.

B. Information on accreditation/approval of higher education institutions[2]

Accreditation in the United States occurs at both the institutional as well as the programmatic level with institutional accreditation serving as an important component of programmatic or dental school accreditation. CODA standards for dental education programs rely on regional accrediting agencies to review institutional factors that impact the quality of education including the ways that institutions structure themselves to remain viable and to continuously improve. Outside the United States, countries may rely on a governmental agency or an independent, non-governmental agency or organization to regularly review higher education institutions against established standards.

2. Does your country have a system for accreditation or approval of higher education institutions? If yes, provide the following information: agency name, address, name of the chief executive officer or contact person, email of contact person, and the URL for the agency website

Please note- The agencies indicated in question number 2 must be informed by the program that it is applying for accreditation through the Commission on Dental Accreditation: government health agencies or ministries; institution or agencies of accreditation and/or higher education; and national/local dental societies. As applicable, each of these agencies must send a letter of acknowledgement directly to the Joint Advisory Committee on International Accreditation.

2.a. Is the dental school part of a larger institution and does that institution have degree-granting authority from the appropriate government agency or agencies?

To answer this question, please provide the following examples of evidence:

- Organizational chart showing the dental education program and its relationship to other institutional entities
- Statement of authority, charter, and/or official documentation that verifies degree granting authority of the institution and includes the dates of authority, and the name and address of the granting agency

2.b. Does the institution have a governing board that is a legal body with specific authority over the institution, that is an active policy making body for the institution, and that is ultimately responsible for ensuring that the financial resources of the institution are adequate to provide a sound educational program?

[2] Portions of information and questions in Section B from a) Southern Association of Colleges and Schools. The Principles of Accreditation: Foundations for Quality Enhancement, 2008; and b) The Higher Learning Commission. Handbook of Accreditation, 3rd Ed., 2003.

To answer this question, please provide the following examples of evidence:

- Narrative describing makeup and purpose of the governing board including the length of terms for board members, and a description of how the board is chosen
- Narrative describing the legal authority of the governing board to determine and enforce policy, hire and evaluate the chief executive officer, and ensure that the institution operates with adequate resources and is financially stable
- Examples of minutes of governing board meetings
- Position description of the chief executive officer whose primary responsibility is to the institution and who is not the presiding officer of the board

2.c. Does the institution uphold and protect its integrity by abiding by appropriate governmental laws and regulations, and does the board ensure that the institution operates legally, responsibly, and honestly?

To answer this question, please provide the following examples of evidence:

- Minutes of board meetings
- Narrative describing applicable laws and regulations and how these are upheld by the institution's board

2.d. Does the institution have a mission, set of goals and objectives, and/or statement of values that support education, are clearly stated, and are readily available to the public?

To answer this question, please provide the following examples of evidence:

- Institutional mission, goals, and/or statement of values
- Evidence that the above are available to the public and are known to institutional employees

2.e. Does the institution have a process of planning that is linked to the budgeting process, and based on the institutional mission, goals and objectives, and/or statement of values?

To answer this question, please provide the following examples of evidence:

- Narrative describing the planning process including the parties responsible, a copy of the current plan, and a description of how the planning process is implemented and integrated throughout the institution.
- Narrative describing how institutional budgeting and planning processes are linked

2.f. Does the institution have a sound financial base and demonstrated financial stability to support the stated purpose/mission and the scope of its programs and services?

To answer this question, please provide the following examples of evidence:

- Narrative and annual operating budget that addresses the ability of the institution to employ an adequate number of full-time faculty, purchase and maintain equipment; procure supplies, and provide for adequate reference material and teaching aids.
- Narrative that discusses the ability of the institution to recruit and retain qualified faculty and provide for innovations and changes necessary to reflect current concepts of education

2.g. Does the institution have sufficient and qualified administrative personnel to ensure the effective administration of admissions, student affairs, academic affairs, business and planning, and other administrative functions?

To answer this question, please provide the following examples of evidence:

- Position descriptions for administrative personnel who oversee the areas listed above
- Curriculum vitae of all current administrative officers who oversee the areas listed above

2.h. Does the institution have an ongoing, systematic quality review process that is integrated throughout the institution, is systematic, and continuous, and is designed to improve education?

To answer this question, please provide the following examples of evidence:

- Narrative that outlines how the institution engages in assessment, planning, implementation and evaluation of the educational quality of all of its education programs.
- Examples of changes in programs throughout the institution that were a result of the review process

2.i. Does the institution define, publish, and impartially enforce policies that include, but are not limited to, the following:

a. appointment and periodic evaluation of administrators, faculty, and staff

b. ownership of materials, copyright, and production of intellectual property

c. protection of academic freedom

d. protection of confidentiality and integrity of student records

e. grievance procedures for faculty, staff and students

f. ethical conduct in research and instructional activities

g. nondiscrimination policy

To answer this question, please provide the following examples of evidence:

- Copies of institutional policies that includes, but are not limited to, those listed above
- Records of complaints and/or grievances filed
- Narrative describing how appropriate parties are informed of the above policies

C. Information on the Predoctoral Dental Education Program

3. Enter the first year that students were admitted into the predoctoral program._____ year

4. Please fill out the following table to indicate the length of each academic year

Year of the program	Number of weeks
Year one	
Year two	
Year three	
Year four	
Year five	
Year six	

Directions: When calculating the length of an academic year, include summer sessions, exclude all vacation periods.

5. What are the educational prerequisites or general requirements for admission to the program?

6. What degree or credential is granted upon graduation or completion of the dental education program?

7. Is a period of government service or an internship required following dental school to practice in your country?

7.a. If you answered "yes" to the above question, please provide the following information about the voluntary service or internship.

- How long is the required period of service?
- Are graduates evaluated on clinical competencies during the period of voluntary service or internship? If yes, please provide a listing of those competencies, and describe who evaluates students and how they are evaluated.
- Does the program have affiliation agreements with the government or voluntary organization where the students complete their required service or internship? If yes, please provide an example of an affiliation agreement.
- Is the required period of service or internship considered to be part of the dental school curriculum as described in question number 4? If yes, which year in question number 4 does the period of service or the internship represent?

8. Check the box that best describes the type of financial support your program receives

a. Public – program is supported financially by the government _____

b. Private – the program is privately supported and receives no government funds _____

c. Private – Public related –a privately supported dental school receives a per capita enrollment subsidy from the government _____

d. Other _____

If you have checked other, please describe the type of financial support the program receives

9. Please describe the type of dental education model followed at your institution. In your description include the following:

a. prerequisites (for example, students complete three to four or more years of postsecondary instruction);
b. the typical amount of time it takes to finish the dental school curriculum (for example, four years of academic instruction in predoctoral dental education.);
c. the years that are considered to be a predental or general education program (for example, the first two years of the program are general education courses in philosophy, humanities, and general science); and
d. the year that students begin preclinical dental courses (for example, dental anatomy, oral pathology etc)

10. Complete the following chart on the current number of students enrolled by year:

Year of Program	Total number of male students	Total number of female students	Total number of all students
First year			
Second year			
Third year			
Fourth year			
Fifth year			
Sixth year			

11. List 2-3 most common reasons why students leave the dental education program.

12. Please provide the number of applicants for the current first year class.

13. How many applicants in question 12 above had credentials that were complete and examined by an admissions committee, and were considered for admission to the current first year class?

14. How many applicants in question 12 above were offered a position in your first year class?

15. What is the primary language spoken in your country?

16. What is the primary language used to teach within the dental education program.

D. Information on the Faculty

A faculty member is defined as one who is present for teaching, administrative and/or research responsibilities as determined by the dental school.

17. What is the definition of a full-time faculty member at your institution? Please indicate both the general responsibilities of the faculty member and the number of hours per week a full time faculty member is assigned to complete those responsibilities.

18. Indicate the total number of individuals in each faculty category below

Number of Full-Time Faculty	
Number of Part-Time Faculty	
Number of Volunteer Faculty	
Other:	

If you have placed faculty members in the last category, “other”, please describe their responsibilities and number of hours per week they are employed in the predoctoral program.

19. Using the formula below, what is the number of full time equivalent (FTE) faculty in the predoctoral program.

Directions: Use the following chart to calculate full-time equivalent (FTE) faculty:

½ day per week = .1 FTE
1 day per week = .2 FTE
1 ½ days per week = .3 FTE
2 days per week = .4 FTE
2 ½ days per week = .5 FTE
3 days per week = .6 FTE
3 ½ days per week = .7 FTE
4 days per week = .8 FTE
4 ½ days per week = .9 FTE
5 days per week =1.0 FTE

E. Information on the Core Curriculum

The core curriculum is the group of required courses in Biomedical Sciences, Behavioral/Social/Information/Research Sciences, and Dental/Clinical sciences that provide dental students with the essential foundational knowledge, behaviors and skills to become a competent practitioner.

20. Attach a copy of required courses by year. Underline those courses you consider to be part of the core curriculum as defined above.

21. Indicate the number of clock hours that are planned in the core curriculum for each type of instruction below.

Directions: Please be sure that your answers are the number of contact hours or clock hours for each type of instruction. A contact hour or clock hour is a unit of measure that represents an hour (greater than or equal to 50 minutes) of scheduled instruction given to students. Answers **should not** be in credit hours of instruction or numbers of courses. Instead, calculate the total number of hours a student would be engaged in each category of instruction for all required courses in the Biomedical Sciences, Behavioral/Social/Information/Research Sciences, and Dental/Clinical Sciences.

A. Instruction in the biomedical sciences For example: anatomy, physiology, neuroanatomy, biochemistry, craniofacial biology. microbiology, pathology, immunology, pharmacology	**Number of Clock Hours in the Core Curriculum**
Didactic: Scheduled time in which students are expected to complete instructional modules, computerized instruction, attend lectures/seminars/clinical conferences, or participate in small group learning.	
Laboratory: Instructional method in which a single instructor works closely with small groups of students who actively participate in learning exercises in a laboratory setting or practice behavior or psychomotor skills in a simulated environment.	
Patient Care: All clinic contact hours with patient, both block and comprehensive assignments, should be reported.	
Total Core Curriculum Clock Hours in biomedical sciences	

B. Instruction in the dental/clinical sciences For example: oral diagnosis and treatment planning, dental and medical emergencies, oral and maxillofacial radiology, oral and maxillofacial pathology, anesthesiology and pain control, periodontics, endodontics, orthodontics, oral and maxillofacial surgery, biomaterials, oral medicine, orofacial pain and dysfunction	**Number of Clock Hours in the Core Curriculum**
Didactic: Scheduled time in which students are expected to complete instructional modules, computerized instruction, attend lectures/seminars/clinical conferences, or participate in small group learning.	
Laboratory: Instructional method in which a single instructor works closely with small groups of students who actively participate in learning exercises in a laboratory setting or practice behavior or psychomotor skills in a simulated environment.	
Patient Care: All clinic contact hours with patient, both block and comprehensive assignments, should be reported.	
Total Core Curriculum Clock Hours in dental/clinical sciences	

C. Instruction in the behavioral, social, and research sciences For example: behavioral principles of dental practice, information management, practice management, research, ethics, and regulatory compliance	**Number of Clock Hours in the Core Curriculum**
Didactic: Scheduled time in which students are expected to complete instructional modules, computerized instruction, attend lectures/seminars/clinical conferences, or participate in small group learning.	
Laboratory: Instructional method in which a single instructor works closely with small groups of students who actively participate in learning exercises in a laboratory setting or practice behavior or psychomotor skills in a simulated environment.	
Patient Care: All clinic contact hours with patient, both block and comprehensive assignments, should be reported.	
Total Core Curriculum Clock Hours in behavioral/social sciences	

F. Information on Facilities

22. What is the total number of dental operatories/chairs within the dental school's clinical facilities that are available for the dental education students?

23. Please indicate the number of laboratory work stations in each laboratory in your dental school by completing the chart below

Type of laboratory	Number of stations
Anatomy	
Physiology	
Biochemistry	
Microbiology	
Pathology	
Preclinical	

Directions: If no lab is available, enter zero.

24. If any of the lab spaces listed above are used for more than one area (such as combined anatomy and physiology labs), please describe how they are shared. If any of the lab spaces listed above are used for more than one program (such as dental, medical and nursing students), please describe how the labs are shared or scheduled.

25. Please indicate the number of radiographic machines in each category.

Category	Number
Portable	
Wallmount	
Panoramic	
Other, please specify	

26. Complete the following chart indicating the number of classrooms available for instruction of dental students that are within as well as outside of the main dental school building.

Capacity of room:	**Within the Main Dental School Building**	**Outside the Main Dental School Building**
1-12 students		
13-30 students		
31-75 students		
More than 75 students		

***

Resolution No. 58 New ■ Substitute ☐ Amendment ☐

Report: NA Date Submitted: September 2009

Submitted By: Seventh Trustee District

Reference Committee: Dental Education and Related Matters

Total Financial Implication: $6,840

Amount One-time $ Amount On-going $6,840

ADA Strategic Plan Goal: Achieve Effective Advocacy (Required)

AMENDMENTS TO THE ADA *BYLAWS*: COMPOSITION OF THE COUNCIL ON DENTAL EDUCATION AND LICENSURE

The following resolution was submitted by the Seventh Trustee District and transmitted on September 15, 2009, by Dr. Charles L. Steffel, trustee.

Background: Currently the Council on Dental Education and Licensure has eight members representing the seventeen trustee districts, four members representing the American Association of Dental Examiners, and four members representing the American Dental Education Association. In contrast, the following councils have an ADA member representative from each ADA trustee district: Council on Access, Prevention and Interprofessional Relations, Council on ADA Sessions, Council on Communications, Council on Dental Benefit programs, Council on Dental Practice, Council on Ethics, Bylaws and Judicial Affairs, Council on Governmental Affairs, and Council on Membership.

The governance structure of the ADA recognizes the importance of member representation from each of the ADA's districts. This principle is demonstrated by the composition of the ADA Board of Trustees as well as the composition of the vast majority of ADA councils. Yet on the Council on Dental Education and Licensure, outside organizations have combined representation that equals ADA representation, while nine ADA trustee districts have no representation at all.

Recently, there have been issues in the area of dental education and licensure where the positions of the American Association of Dental Examiners and the American Dental Education Association have not been aligned with the American Dental Association. Why are these outside associations given so much control over ADA policy? The composition of the Council on Dental Education should be altered to assure that all ADA trustee districts are represented on the Council, and that the Council is primarily controlled by ADA member representatives. Consequently, it is proposed that the structure of the Council on Dental Education and Licensure be amended to allow for one (1) representative member from each of the Seventeen (17) American Dental Association trustee districts and one (1) member representing each of the American Association of Dental Examiners and the American Dental Education Association.

Resolution

58. Resolved, that Chapter X. COUNCILS, Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection A, the paragraphs on the Council on Dental Education and Licensure, of the ADA *Bylaws* be amended by incorporating the changes indicated below (deletions stricken through; new language underscored**):**

Council on Dental Education and Licensure shall be composed of ~~sixteen (16)~~ nineteen (19) members ~~selected~~ as follows:

a. Nominations ~~and Selection~~. ~~(1) Eight (8) members shall be nominated by the Board of Trustees on a~~

~~rotational system by~~ One (1) member from each trustee district whose term of office shall be staggered in such a manner that four (4) members will complete their terms each year except every fourth year when five (5) members shall complete their terms.[1] ~~from the active, life or retired members of this Association, no one~~ None of ~~whom~~ these members shall be a full-time member of a faculty of a school of dentistry or a member of a state board of dental examiners or jurisdictional dental licensing agency. A person shall be considered to be a full-time member of a faculty if he or she works for the school of dentistry more than two (2) days or sixteen (16) hours per week.

~~(2) Four (4)~~ One (1) member~~s~~ who ~~are~~ is an active, life or retired member~~s~~ of this Association shall be ~~selected~~ nominated by the American Association of Dental Examiners from the active membership of that body, ~~no one of whom~~ and who shall not be a member of a faculty of a school of dentistry.

~~(3) Four (4)~~ One (1) member~~s~~ who ~~are~~ is an active, life or retired member~~s~~ of this Association, shall be ~~selected~~ nominated by the American Dental Education Association from its active membership. ~~These~~ This member~~s~~ shall hold a position~~s~~ of professorial rank in a dental school~~s~~ accredited by the Commission on Dental Accreditation and shall not be a member~~s~~ of any state board of dental examiners or jurisdictional dental licensing agency.

~~b. Election. The eight (8) members of the Council on Dental Education and Licensure nominated by the Board of Trustees shall be elected by the House of Delegates from nominees selected in accordance with this section.~~

~~c.~~ Committees. The Council on Dental Education and Licensure shall establish a standing Committee on Dental Education and Educational Measurements and a standing Committee on Licensure, each consisting of eight (8) members selected by the Council. The Council may establish additional committees when they are deemed essential to carry out the duties of this Council.

and be it further

Resolved, that the foregoing amendment to Chapter X., Section 20.A. of the ADA *Bylaws* become effective at the adjournment *sine die* of the 2010 House of Delegates.

[1] This foot note shall govern the change in the composition of the Council commencing with the 2010 term and establish the required pattern Council member retirement. Council members elected by the House of Delegates who are in office shall finish their terms in accordance with their scheduled completion dates. Nine new Council members from the Trustee Districts not represented by a member on the Council whose terms shall be scheduled to begin at adjournment *sine die* of the 2010 House of Delegates shall be nominated for election by the 2010 House of Delegates. Two (2) new Council members each shall serve a one (1) year term and shall be eligible for reelection to a new four (4) year term on the Council commencing in 2011, two (2) new Council members shall each serve a two (2) year-term and shall be eligible for reelection to a new four (4) year term on the Council commencing in 2012. Two (2) new Council members shall each serve a three (3) year-term and three (3) new Council members shall each serve a four (4) year-term. A lottery shall determine which Trustee Districts from the 3rd, 6th, 7th, 9th 10th, 11th, 12th, 13th and 16th Trustee Districts shall serve two (2), three (3) and four (4) year terms. The American Association of Dental Examiners and the American Dental Education Association shall each select one Council member whose term shall be scheduled to begin at adjournment *sine die* of the 2010 House of Delegates. So that the terms of the Council members selected by the American Association of Dental Examiners and the American Dental Education Association do not expire simultaneously, the member selected by the American Dental Education Association shall serve a two (2) year-term and shall be eligible for reelection to a new four (4) year term on the Council commencing in 2012, while the member selected by the American Association of Dental Examiners shall serve a four (4) year-term. This footnote shall expire at the adjournment *sine die* of the 2014 House of Delegates.

BOARD COMMENT: The Board believes that the unique composition of the Council on Dental Education and Licensure serves the Association well and provides benefits from the expertise of members directly involved in education, practice and licensure. All members of the Council are members of the Association. Decreasing the number of ADEA and AADE representatives on the Council would eliminate valuable opportunities for collaboration on an informed level on issues of critical importance to the Association. Accordingly, the Board urges the House to defeat this resolution.

BOARD RECOMMENDATION: Vote No.

Board Vote:														
Yes	No	Abstain	Absent		Yes	No	Abstain	Absent		Yes	No	Abstain	Absent	
■	☐	☐	☐	CALNON	■	☐	☐	☐	LONG	☐	■	☐	☐	SYKES
☐	■	☐	☐	ELLIOTT	☐	■	☐	☐	MANNING	☐	■	☐	☐	TANKERSLEY
☐	■	☐	☐	FAIELLA	☐	■	☐	☐	NORMAN	☐	■	☐	☐	THOMPSON
☐	■	☐	☐	GIST	■	☐	☐	☐	RICH	■	☐	☐	☐	VERSMAN
☐	■	☐	☐	GLECOS	☐	■	☐	☐	SCHWEINEBRATEN	☐	■	☐	☐	VIGNA
☐	■	☐	☐	KREMPASKY SMITH	■	☐	☐	☐	STEFFEL	☐	■	☐	☐	WEBB
☐	■	☐	☐	LOW	■	☐	☐	☐	SULLIVAN				Res.	58

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Resolution No. 58S-1 New ☐ Substitute ■ Amendment ☐

Report: NA Date Submitted: October 2009

Submitted By: Second Trustee District

Reference Committee: Dental Education and Related Matters

Total Financial Implication: None

Amount One-time $ Amount On-going $

ADA Strategic Plan Goal: (Required)

SUBSTITUTE FOR RESOLUTION 58:
AMENDMENTS TO THE ADA *BYLAWS*:
COMPOSITION OF THE COUNCIL ON DENTAL EDUCATION AND LICENSURE

The following substitute for Resolution 58 (Worksheet:4097) was submitted by the Second Trustee District and transmitted on October 2, 2009, by Dr. Mark Feldman, executive director, New York State Dental Association.

Background: The Second Trustee District is sympathetic to many of the concerns expressed by the Seventh Trustee District in its background statement to Resolution 58. However, we can also fully appreciate the Board of Trustees' concerns in rejecting Resolution 58. Historically the Council on Dental Education and Licensure (CDEL) has been a forum where the American Dental Association, the American Dental Education Association (ADEA) and the American Association of Dental Examiners (AADE) have been able to interact. We agree that the current configuration of the Council encourages debate and discussion on issues of mutual interest to all three entities.

However, the Second Trustee District is concerned that in recent years a number of members serving as ADA appointees have previously served within the examination community, and maintain that perspective in dealing with issues currently being considered by the Council. This is an important distinction from their ADEA counterparts. Educators serving on the Council are invariably educators by vocation. However, many of those within the examination community are there by avocation. The language being proposed addresses this concern. Accordingly, the following substitute resolution is respectfully submitted for consideration by the House of Delegates.

Resolution

58S-1. Resolved, that Chapter X, Section 20 of the *Bylaws* be amended as follows (new language/~~deleted language~~):

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

a. Nominations and Selection.

(1) Eight (8) members shall be nominated by the Board of Trustees on a rotational system by trustee district from the active, life or retired members of this Association, no one of whom shall be a full-time member of a faculty of a school of dentistry or a current or former member of a state or regional board of dental examiners, state board of dentistry or jurisdictional dental licensing agency. A person shall be considered to be a full-time member of a faculty if he or she works for the school of dentistry more than two (2) days or sixteen (16) hours per week.

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

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

b. Election. The eight (8) members of the Council on Dental Education and Licensure nominated by the Board of Trustees shall be elected by the House of Delegates from nominees selected in accordance with this section.

c. Committees. The Council on Dental Education and Licensure shall establish a standing Committee on Dental Education and Educational Measurements and a standing Committee on Licensure, each consisting of eight (8) members selected by the Council. The Council may establish additional committees when they are deemed essential to carry out the duties of this Council.

and be it further

Resolved, that Chapter X, Section 40 of the *Bylaws* be amended as follows (new language/~~deleted language~~):

Section 40. CHAIRS: One member of each council shall be appointed annually by the Board of Trustees to serve as chair with exception of the Council on Dental Education and Licensure. The Chair of the Council on Dental Education and Licensure shall be appointed from nominations submitted by the Council provided that every other year, the nominee shall be a member of the Council elected by the House of Delegates in accordance with Section 20 of this Chapter of the *Bylaws*.

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