1994

1994 Supplement

American Dental Association

ADA®
American
Dental
Association

211 East Chicago Avenue
Chicago, Illinois 60611

Pages 241-480

1994

Supplement to Annual Reports and Resolutions

135th Annual Session

New Orleans, Louisiana

October 22-26, 1994

Table of Contents

House of Delegates 253 **Standing Committee on Credentials, Rules and Order** (Res. 80, 81 and 82)

Report of President 259 **Report of Dr. James H. Gaines**

Supplemental Reports and Resolutions

265 **Council on Communications**
Supplemental Report 1: Recent Council Activities (Res. 32)

266 **Commission on Dental Accreditation**
Supplemental Report 1: Revision of the *Rules of the Commission on Dental Accreditation* (Res. 76)

271 **Council on Dental Benefit Programs**
Supplemental Report 1: Submission of the Report and Recommendations of the Dental Practice Parameters Committee (Res. 35-47)

286 **Council on Dental Benefit Programs**
Supplemental Report 2: Update on Council Activities (Res. 48 and 49)

288 **Council on Dental Benefit Programs, Council on Dental Materials, Instruments and Equipment and Council on Dental Practice**
Joint Report: Electronic Data Interchange and Designation Systems for Teeth (Res. 50 and 51)

292 **Council on Dental Benefit Programs and Council on Dental Practice**
Joint Report: Summary of Survey of Infection Control and OSHA Compliance Costs

297 **Council on Dental Education**
Supplemental Report 1: Response to Resolution 147H-1993 Regarding Alternatives to Use of Human Subjects in Clinical Licensure Examinations

302 **Council on Dental Education**
Supplemental Report 2: Revised Definition of Pediatric Dentistry

303 **Council on Dental Education and Council on Ethics, Bylaws and Judicial Affairs**
Joint Report: Redesignation of the Specialty of "Orthodontics" to "Orthodontics and Dentofacial Orthopedics" (Res. 73)

304 **Council on Dental Practice**
Supplemental Report 1: Study of Dental Support Personnel

311 **Council on Dental Materials, Instruments and Equipment and Council on Community Health, Hospital, Institutional and Medical Affairs**
Joint Report: Precapsulated Amalgam Alloy (Res. 93)

312 **Council on Dental Materials, Instruments and Equipment and Council on Dental Therapeutics**
Joint Report: Revision of the Provisions for Acceptance of Products (Res. 94)

319 **Council on Ethics, Bylaws and Judicial Affairs**
Supplemental Report 1: Judicial Proceedings

321 **Council on Governmental Affairs and Federal Dental Services**
Supplemental Report 1: Recent Council Activities (Res. 55-66)

326 **Council on Governmental Affairs and Federal Dental Services**
Supplemental Report 2: Recent Council Activities (Res. 92)

327 **Council on Insurance**
Supplemental Report 1: Term of Office of Members of the Council on Insurance (Res. 85)

328 **Council on Membership**
Supplemental Report 1: Recent Council Activities (Res. 33 and 34)

332 **Board of Trustees**
Support Personnel Needs of Practicing Dentists (Res. 79)

332 **Board of Trustees**
Transferring Marketing and Seminar Services to the Council on Dental Practice (Res. 88)

332 **Arizona State Dental Association**
Audit of Arizona Health Care Cost Containment System (AHCCCS) (Res. 87)

333 **Louisiana Dental Association**
Policy on Stipends to Officers and Trustees (Res. 23)

333 **Louisiana Dental Association**
Discount Fee Charged by MBNA America for Credit Card Dues Payments (Res. 24)

333 **Missouri Dental Association**
Amendment of *ADA Principles of Ethics and Code of Professional Conduct* Regarding Behavior of Clinicians and Professional Speakers (Res. 77)

334 **New Mexico Dental Association**
Authorizing a Study of Public Policies on Infectious Diseases as They Pertain to Dental Practice (Res. 78)

334 **The Dental Society of the State of New York**
Protocol and Guidelines for Administration of Antibiotic Prophylaxis (Res. 74)

335 **The Dental Society of the State of New York**
Relief Fund Solicitation Disclosure (Res. 75)

335 **Pennsylvania Dental Association**
Discontinuation of the ADA's Continuing Education Recognition Program (Res. 83)

336 **South Dakota Dental Association**
Dental Vacuum System Standard (Res. 84)

336 **Texas Dental Association**
Evaluation of Need for Codes for the Complicated Extraction of Erupted Teeth (Res. 69)

336 **Texas Dental Association**
Definition of Freedom of Choice (Res. 72)

336 **Sacramento District Dental Society**
Electronic Billing Process Fees (Res. 109)

337 **Hawaii County Dental Society**
ADA *CDT-1* Copyright (Res. 124)

337 **First Trustee District**
Substitute for Resolution 74: Protocol and Guidelines for Administration of Antibiotic Prophylaxis (Res. 74S-1)

337 **First Trustee District**
Continuing Education for the Dental Assistant (Res. 95)

338 **First Trustee District**
ADA Publications Disclaimer (Res. 96)

338 **First Trustee District**
Substitute for Resolution 96: ADA Publications Disclaimer (Res. 96S-1)

338 **First Trustee District**
Amendment of ADA *Bylaws* Regarding the President as a Voting Member of the Board of Trustees (Res. 97)

339 **First Trustee District**
Expansion of Employee Retirement Income Security Act (ERISA) and Establishment of a Congressional Review Commission on ERISA (Res. 98 and 99)

340 **First Trustee District**
Review of the *ADA Principles of Ethics and Code of Professional Conduct* as It Relates to Dental Benefits Plans (Res. 100)

341 **First Trustee District**
Managed Care Programs' Administrative Costs, Profit and Treatment Expense (Res. 101)

341 **First Trustee District**
Automatic Review of Denied Claims by Independent Dental and/or Medical Experts (Res. 102)

341 **First Trustee District**
Standards for Managed Dental Care Programs (Res. 108)

342 **First Trustee District**
Guidelines on Coordination of Benefits for All Third-Party Payers (Res. 116)

343 **First Trustee District**
Member Advocacy (Res. 144)

343 **Second Trustee District**
First Meeting of ADA House of Delegates (Res. 110)

344 **Second Trustee District**
Distribution of *CDT-2* (Res. 129)

344 **Second Trustee District**
Mortgage Program (Res. 135)

344 **Third Trustee District**
Dental Identification Teams (Res. 133)

345 **Third Trustee District**
Definition of Pediatric Dentistry (Res. 134)

345 **Fourth Trustee District**
Dental Special Pay for Federal Service Dentists (Res. 127)

345 **Fourth Trustee District**
Federal Dental Service Representation in the House of Delegates (Res. 128)

347 **Fifth Trustee District**
Substitute for Resolution 4: Statement on Nonpayment for Incomplete Dental Treatment in Summary Plan Descriptions (Res. 4S-1)

347 **Fifth Trustee District**
Substitute for Resolution 21: Model Material Safety Data Sheet Form (Res. 21S-1)

347 **Fifth Trustee District**
Voting Record for ADA Council and Committees (Res. 103)

347 **Fifth Trustee District**
Volunteer Participation at the ADA Level (Res. 104)

348 **Fifth Trustee District**
Risk Assessment (Res. 105)

348 **Fifth Trustee District**
PAC Membership (Res. 106)

348 **Fifth Trustee District**
Dentists' Choice of Practice Settings (Res. 117)

349 **Fifth Trustee District**
Distribution of *CDT-2* and *JADA* (Res. 118)

350 **Fifth Trustee District**
Identification of Claims Reviewers on Explanation of Benefit Statements (Res. 119)

350 **Fifth Trustee District**
Expansion of "Dentistry—Health Care That Works" (Res. 122)

351 **Fifth Trustee District**
Adjustments in 1995 Budget (Res. 132)

351 **Sixth Trustee District**
Amendment to Resolution 26: Recommended Dues Increase (Res. 26S-1)

352 **Seventh Trustee District**
Survey of All Dental Assisting Programs (Res. 89)

352 **Seventh Trustee District**
Specialty Recognition (Res. 145)

352 **Seventh Trustee District**
Specialty Recognition (Res. 146)

353 **Eighth Trustee District**
Substitute for Resolution 74B: Protocol and Guidelines for Administration of Antibiotic Prophylaxis (Res. 74BS-1)

353 **Eighth Trustee District**
Standard for Acceptable Risk (Res. 111)

353 **Eighth Trustee District**
Dental Benefits for Military Reservists (Res. 112)

354 **Eighth Trustee District**
Face Shields on Batting Helmets (Res. 120)

354 **Ninth Trustee District**
Substitute for Resolution 23: Policy on Stipends to Officers and Trustees (Res. 23S-1)

354 **Ninth Trustee District**
Amendment of the Guidelines for Governing the Conduct of Campaigns for ADA Offices (Res. 90)

355 **Ninth Trustee District**
Antitrust Limitations (Res. 113)

355 **Ninth Trustee District**
Medical Savings Accounts (Res. 114)

355 **Ninth Trustee District**
Employer Mandates (Res. 115)

356 **Ninth Trustee District**
Washington, D.C. Property (Res. 123)

356 **Ninth Trustee District**
Study of the Impact of Managed Care on Dental Benefit Programs (Res. 125)

357 **Ninth Trustee District**
Fluoride Commemorative Project Support (Res. 126)

357 **Tenth Trustee District**
Substitute for Resolution 55: Definition of Fee-for-Service (Res. 55S-1)

358 **Twelfth Trustee District**
Preservation of the Dental Practice Parameters (Res. 107)

358 **Twelfth Trustee District**
Rescinding Resolution 62H-1993: Establishing Parameters (Res. 136)

358 **Thirteenth Trustee District**
Over-the-Counter Mouthwash Safety (Res. 70)

358 **Thirteenth Trustee District**
Dental Hygiene Education (Res. 71)

358 **Thirteenth Trustee District**
Expansion of an Electronic Dues Payment Program (Res. 86)

364 **Thirteenth Trustee District**
Management Responsibility of the Board of Trustees (Res. 130)

365 **Thirteenth Trustee District**
Annual Session Site Selection Criteria (Res. 131)

365 **Fifteenth Trustee District**
Amendment to Resolution 35: Preamble to the Dental Practice Parameters (Res. 35S-1)

366 **Fifteenth Trustee District**
Substitute for Resolution 55: Definition of Fee-for-Service (Res. 55S-2)

366 **Fifteenth Trustee District**
Addition to Strategic Plan (Res. 137)

	366	**Fifteenth Trustee District** Amendment to Strategic Plan (Res. 138)
	366	**Delegate James O. Henry, Jr., Texas** Substitute for Resolution 25: Approval of 1995 Budget (Res. 25S-1)
	367	**American Academy of Implant Dentistry** Ethical Announcement of Credentials Earned from Bona Fide Entities (Res. 121)
Reports of Board of Trustees to House of Delegates	368	**Report 1:** Association Affairs and Resolutions (Res. 53)
	382	**Report 2:** ADA Operating Account Financial Affairs and Recommended Budget, Fiscal Year 1995 (Res. 25 and 26)
	424	**Supplement to Report 2:** Financial Affairs and Recommended Budget for Fiscal Year 1995, Amendment of the Proposed 1995 Budget
	425	**Report 3:** Compensation and Contract of Executive Director
	426	**Report 4:** Amendment of the *ADA Bylaws* Dealing with Reappointment of Council, Commission and Committee Members (Res. 27, 28, 29 and 68)
	428	**Report 5:** Supplemental Activities of American Dental Association Health Foundation (Res. 30 and 31)
	429	**Report 6:** ADA's Vision of Future Dental Education
	433	**Report 7:** AIDS Update 1994
	435	**Report 8:** Annual Report of Strategic Planning Activities (Res. 54)
	441	**Report 9:** Response to Resolution 75H-1993 Regarding Duties of the Council on Community Health, Hospital, Institutional and Medical Affairs (Res. 67)
	450	**Report 10:** ADA Seal Program
	454	**Report 11:** The Grassroots Program
	456	**Report 12:** Dental Office Wastewater
	460	**Report 13:** Amendment of Section 4-A to the *Code of Professional Conduct* on Advertising of Exclusive Methods or Techniques (Res. 91)
	461	**Report 14:** Information Technology Project
	463	**Report 15:** Health System Reform and the Grassroots Program
Interim Response to Resolution 99H-1992	466	**Dental Manpower**
Appendix	469	**Index to Resolutions**
	inside back cover	**Map of Trustee Districts**

House of Delegates

Notes

Standing Committee on Credentials, Rules and Order

Minutes of 1993 Session of the House of Delegates: The minutes of the 1993 session of the House of Delegates have been published (*Trans.*1993:653-719) and circulated to the members of the House of Delegates and the officers of constituent and component dental societies. To date, no formal requests for corrections or amendments have been received.

80. Resolved, that the minutes of the 1993 session of the House of Delegates, as published in *Transactions, 1993*, pages 653-719 be approved.

The Chairman moves the adoption of this resolution.

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

Adoption of Agenda: The Committee has examined the agenda for the meetings of the House of Delegates. Accordingly, the Committee recommends approving the agenda as the official order of business for this session.

81. Resolved, that the agenda as printed in the *Manual of the House of Delegates and Supplemental Information, 1994*, be adopted as the official order of business for this session.

The Chairman moves the adoption of this resolution.

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

This preliminary list is called the Updated General Index to the resolution worksheets and it will be provided with the second distribution of resolution worksheets at the time of registration. The Speaker will make more referrals during the first meeting of the House of Delegates. A complete list of referrals, in the form of an agenda, will be available in the reference committee hearing rooms on Sunday morning.

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

The Chairman moves the adoption of this resolution.

***Annual Reports and Resolutions, Manual of the House of Delegates* and Resolution Worksheets:** Copies of *Annual Reports and Resolutions, 1994* were mailed to delegates and alternate delegates in mid-July. In addition, the first set of resolution worksheets was mailed to delegates and alternate delegates in early September.

Due to costs related to publication/duplication, paper stock, postage and labor, additional copies of *Annual Reports* and resolution worksheets will not be distributed at the annual session. Announcements were included in *Annual Reports and Resolutions, 1994*, in the cover letter transmitting the worksheets, as well as in the *ADA News*. A limited number of these items have been brought to the annual session and are available in the Information and Services Office upon request.

The publication, *Manual of the House of Delegates and Supplemental Information*, has been developed to complement the resolution worksheets. This booklet incorporates the *Manual of the House of Delegates* and all pertinent meeting information (i.e., House agendas, standing and reference committees, reference committee hearings and district caucuses). This booklet was mailed with the resolution worksheets in early September.

The publication, *Supplement to Annual Reports and Resolutions*, will include all reports and resolutions presented to the House of Delegates but not included in *Annual Reports*. This publication will be available in early February.

Hearings of Reference Committees: The reference committees will hold hearings Sunday, October 23, in various rooms of the Ernest N. Morial Convention Center. The list of reference committee hearing rooms appears in the *Manual of the House of Delegates and Supplemental Information.*

Sunday, October 23, 1994

8:00 a.m. to 11:00 a.m.	Budget and Business Matters
8:30 a.m. to 10:30 a.m.	Communications, Membership and Marketing Services
9:00 a.m. to 11:00 a.m.	Dental Benefits, Practice and Health
9:30 a.m. to 11:30 a.m.	President's Address and Administrative Matters
10:00 a.m. to 12:00 noon	Dental Education and Related Matters
10:30 a.m. to 12:30 p.m.	Legal and Legislative Matters
11:00 a.m. to 1:00 p.m.	Scientific Matters

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

Any member of the Association, whether or not a member of the House of Delegates, is privileged to attend and participate in the discussions during the reference committee hearings. Guests of the Association are also welcome to attend reference committee hearings. Nonmembers of the Association may participate at hearings only on the invitation of a majority of the reference committee. Association staff members are available at hearings to provide information requested by members of reference committees or through the Chairman by those participating in the discussion.

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

All delegates must bring their copies of reference committee reports to the meetings of the House of Delegates since additional copies will not be available.

Nominations of Officers: The nominations of officers will take place at the meeting on Saturday afternoon. Nominating speeches will not exceed four minutes in length. Seconding a nomination is not permitted.

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

Nominations of Trustees: Nominations of members of the Board of Trustees from Districts 2, 8, 11 and 13 will take place on Saturday. Prior to such nominations, the delegates from each of the districts concerned must caucus for the purpose of determining their nominee or nominees in accordance with provisions of Chapter VII, Section 40, of the *Bylaws*. A list of caucus meetings will be found in the *Manual of the House of Delegates and Supplemental Information*. This listing constitutes official notice of caucus.

The results of the caucus must be reported to the Secretary of the House of Delegates not later than the opening of the meeting on Saturday. In the event of a contested trustee election, a nominating speech of four minutes is allowed on behalf of each nominee. Seconding a nomination is not permitted.

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

Voting Procedures in House: The method of voting in the House of Delegates is usually determined by the Speaker of the House. The Speaker may call for a voice vote, show of hands (voting cards), standing vote, roll call of the delegations, electronic voting or such other means that the Speaker deems appropriate. The House may also, by majority vote, determine the method of voting that it prefers.

Election Procedures: Voting machines will be used in contested elections and in decisions on such other issues as the House may determine. Voting will be conducted in Room 96 of the Ernest N. Morial Convention Center on Tuesday, October 25, from 7:30 a.m. to 9:30 a.m. for the first balloting for the office of President-elect *and all other contested elections.* If necessary, a second balloting will be conducted on Tuesday, October 25, from 12:00 noon to 2:00 p.m. Members should bring their credentials and vote early in order to avoid delay at the voting machines.

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

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

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

Explanation of Resolution Numbering System for New Delegates and Alternate Delegates: Original resolutions are numbered consecutively regardless of whether the source is a council, other Association agency, constituent society, delegate, Board of Trustees or House reference committee.

Revisions made by the Board, reference committee or House are considered "amendments" to the original resolution. If amended by the Board, the suffix "B" follows the resolution number (Res. 24B); if amended by a reference committee, the suffix "RC" follows (Res. 24RC).

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

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

> Res. 78B is considered by the House and not adopted, the number remains the same: Res. 78B.
>
> Res. 7RC is considered by the House and referred for study, the number remains the same: Res. 7RC.

If a Board (B) or reference committee (RC) resolution is a substitute for several original resolutions, the Board's recommended substitute or the reference committee's recommended substitute uses the number of the first resolution submitted and adds the proper suffix (B or RC). The report will clearly state that the other resolution or resolutions have been considered and are included in the "B" or "RC" resolution.

A resolution submitted by an agency other than the Board or a reference committee as a substitute or amendment retains the original resolution number followed by the suffix "S-1" (Res. 24S-1). If two substitute resolutions are submitted for

the same original resolution the suffixes are "S-1" and "S-2" (Res. 24S-1, Res. 24S-2).

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

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

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

Admission to the floor will not be granted without the display of the appropriate annual session badge. Every delegate must also hand an attendance card to the attendant at the door for each meeting so that the official attendance record may be maintained.

The first row of the section reserved for alternate delegates has been reserved again for editors. Past vice-presidents and past trustees will also be admitted to the section reserved for alternate delegates. Past trustees, past vice-presidents and editors will receive all materials distributed to delegates and alternate delegates.

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

Substitution of Alternate Delegates for Delegates: If a delegate wishes to substitute an alternate delegate from his or her delegation for himself or herself during a meeting of the House of Delegates, the delegate must complete the appropriate delegate-alternate substitution form. The delegate is required to sign the form and surrender his or her admission card for the meeting or meetings not attended before admission cards will be issued to the alternate delegate by the Committee on Credentials, Rules and Order.

Substitution of alternate delegates may be made during all four meetings of the House of Delegates.

***Manual of the House of Delegates*:** Each member of the House of Delegates has received a copy of the *Manual of the House of Delegates, 1994*. The *Manual* contains the standing rules of the House of Delegates and the pertinent provisions of the *Bylaws*.

The Committee calls attention to the section of the *Manual* entitled "Guidelines on the Conduct of Campaigns." The 1990 House of Delegates directed that all campaign policies, guidelines and information be compiled into one document and that it be distributed annually to all members of the House.

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

Distribution of Materials in the House of Delegates: The Committee calls attention to the procedure to be followed for distributing materials in the House of Delegates: (1) no material may be distributed in the House without obtaining permission from the Secretary of the House; (2) material to be distributed must relate to subjects and activities that are proposed for House action or information; (3) materials to be distributed on behalf of any member's candidacy for office shall be limited to printed matter on paper only and nothing else (House *Manual*:6).

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

Information and Services Office: The Information and Services Office will be open October 21-24 and will be located in the Burgundy Room of the New Orleans Hilton Riverside. This office is maintained every year to provide assistance to delegates, alternates, constituent society officers and staff. The office will be equipped with typing, word processing and duplicating facilities as well as a wide variety of reference material. Association executive staff will be available for general assistance in researching issues, writing resolutions and providing general information about the meetings of the House of Delegates and related activities. Everyone is urged to use the Information and Services Office when drafting resolutions or testimony. Individuals having resolutions for submission to the House of Delegates will be directed by staff to the Headquarters Office where **final** resolution processing will occur.

Summary of Resolutions

80. Resolved, that the minutes of the 1993 session of the House of Delegates, as published in *Transactions, 1993*, pages 653-719 be approved.

81. Resolved, that the agenda as printed in the *Manual of the House of Delegates and Supplemental Information, 1994*, be adopted as the official order of business for this session.

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

Report of President

Notes

Report of the President

Dr. James H. Gaines

The report I'm submitting to you today is about an unbelievable year I can only describe as a nonstop challenge. It was a year in which major issues kept coming at us on what often seemed to be a weekly basis—old issues, new issues and the early signs of issues yet to come, and every one of them vital to the future of our profession.

Now I happen to be someone who does not even *own* a pair of rose colored glasses, but I can report to you that we have met these challenges very effectively.

I wish I had time to acknowledge all who have helped me so much. As briefly as possible, I would like to acknowledge some.

First, you, this entire House, for giving me the opportunity to serve.

And my District, the ADA's newest, the mighty sixteenth, my loyal friends. Will all of you please rise?

And the greatest state in the union—one that couldn't accept the conventional wisdom that such a small state couldn't have an ADA President. Will those from South Carolina please stand up again? Thanks so much to each of you.

Through it all—this year, last year as president-elect, during my six years on the Board and all through my career—one person has been a greater help to me than any other. She has gone along with everything these past several years, and on every occasion with poise, dignity and understanding. Nan, will you stand up with our family, please, and will the House please help me to show our appreciation!

Now, let me begin by saying what I do *not* intend to do in this report. As you know, I have been involved with you in the House of Delegates for a few years now; and I, like you, have heard my share of President's Reports that lay out a veritable laundry list of proposals. I've also seen what happens. Everybody listens, everybody applauds ever so politely—and then ignores every bit of it. I am not here this afternoon to bring new business before this already swamped House. Instead, I want this to be exactly what it's called, a *report* about the state of our organization: what we've dealt with and achieved this past year, what we all should have learned from it and the sense of direction we need as we move on.

Yes, it has been an action-packed year. We've been so busy, it wasn't really until recently, as annual session got closer, that the Board had a chance to take stock of just how much we've done. Beginning with the December Board meeting, we set an ambitious road map, and we haven't let up for one moment in following through. As a result, the ADA today is a stronger organization than it was a year ago and our members are better served and represented.

Health Care Reform

One of the things I'm proudest to stand here and report to you is this: We have made the most of the position on health care reform you gave us in San Francisco with Resolution 42H. We took it to Capitol Hill and hammered it home. The health care reform debate is not over, of course; but at the end of the first quarter, the halftime or wherever it is our country stands right now on this issue, I can tell you we're looking mighty good on the scoreboard.

Those who say the outcome would have been the same without our involvement are just plain wrong. They're as shortsighted as those who said we absolutely had to buy a ticket to get on the train, at any cost, even if it meant signing onto a basic package no matter what the end result might be for our patients and our profession.

Well, the train is still in the station and those who wanted on, come what may, are still holding their tickets and wondering what went wrong.

Not us. We knew very well that the ticket would be nonrefundable and carry severe restrictions and penalties; and, thanks to you, we had another route to take. Working with the resolution you gave us, we got our message across in Washington:

- American dentistry is health care that works.
- *We* have already realized health care reform goals such as cost effectiveness and emphasis on preventive treatment.
- Taxing dental benefits would undermine the goals of health care reform.
- Nothing should be done in the name of health care reform that would deprive millions of Americans of the access to quality oral health care they now enjoy.

What you gave us *worked*. Right down to the final proposal that had any hope of consideration before Congress finally gave up and went home, every proposal in either the House or the Senate followed our recommendation and either did not tax health benefits or specifically excluded dentistry. Proposals also included specific provisions that the ADA and American Association of Dental Schools (AADS) called for to fund graduate dental education and promote access to oral health care where it is lacking. These provisions included incentives for residency programs and individual practitioners and special allowances on student loan repayment for those who take their skills to underserved areas.

But what does it matter, some will say, if the train never got out of the station—if, in fact, none of these proposals went through?

It matters a *lot*. The health care reform debate is not going to go away and the points we got across will serve us well as the debate resumes. America is likely to be grappling with health care reform for years to come at both the state and national levels. We need to stay tuned and be ready to act. We need to repeat over and over that limited government resources should be concentrated where they will do the most good—for those who do not already have access to care: low and no-income groups, beginning with children. The victories I've described can be taken away from us if we take anything for granted or allow ourselves to let up in our efforts. That's why the strong and respected voice we have established for ourselves in the halls of power will continue to be one of the most important forces we have going for us.

Grassroots Network

A tremendous, permanent dividend from our health care reform activity, and certainly the centerpiece of this year's new activities, is our grassroots network. As recently as January of this year, it was nothing more than a concept. Today, our grassroots network is a living, breathing reality, with 14,000 members across the country actively involved. And as I pointed out in my letter to you last month, we haven't just signed these members up and let them dangle out there. Through regional workshops for action team leaders, a monthly newsletter and other means, we're seeing to it that they have the resources and information they need in order to be as effective as possible.

And it's *working*. Our consultants and lobbyists in Washington are now hearing legislators say things they didn't always say. Statements like "I can't believe it—I must have heard from every dentist in my district," and "Will somebody please call off the dentists?"

Well, "calling 'em off" isn't what we have in mind. And—count on it—there will be other issues coming down the pike that we can't even imagine right now. The contacts we've established through the grassroots program and the strategies we're mastering will be there for us *from now on out*.

Leadership Continuity

Another source of strength we have going for us right now is the improved continuity of our leadership from year to year.

In my year as president-elect, I was fortunate to have Jack Harris as an ally. Jack and I established a new standard as to the way the relationship between the two top officers can work—no ego problems, no turf battles, with the focus where it *belongs*: on the needs of our members and the well-being of our organization.

This same standard of cooperation has continued and grown even stronger this year with Dick D'Eustachio.

Jack and Dick, I have been very lucky to have had each of you to work with. Thank you. And, by the way, Dick, get some rest. There's plenty left on the table for you!

In this same context, sometimes we fall into a pattern of connecting issues with certain years or ADA presidents. You know the kind of thinking I'm talking about—last year and Jack Harris as OSHA, this year and yours truly as health care reform, and 1995 and Dick D'Eustachio as the wastewater issue.

Well, it just isn't like that and that kind of thinking can really hurt us. All the issues overlap. It was last year that the ground work was laid for our success this year on health care reform, and one of the first things I did this year was to sit down with the new director of OSHA. And far from being next year's issue, wastewater has already become so hot a topic, we convened a special Board meeting last month to come to terms with it.

All three of these issues are going to be around for some time to come, and other issues besides. The only way we're going to remain effective as an organization is by making each year the year of *every* issue—each and every issue in which there's something vital at stake for dentists and their patients.

Keep in mind, too—activity breeds activity. The level of new initiatives we've undertaken this year will help to keep our agenda full for the foreseeable future.

Reorganized Staff and Improved Communications

Before I highlight some of these initiatives, I want to call your attention to a couple of other new strengths we have going for us.

First we have our reorganized and reenergized ADA staff in Chicago and Washington under the capable direction of the hard-working John Zapp.

The other new strength I want to mention is this.

We have achieved better communications at all levels than we have ever had before—better communications with the dental specialties, the AGD, AADS, ASDA, and the dental industry; better communications between the ADA and state and local societies; and better communications within our own system of governance.

And I'm not just throwing a bunch of rhetoric at you. The improved communications I'm talking about are *measurable*. To give you just one example, I convened a meeting in January where all ADA council and commission chairs sat down together for the first time in ten years. They got to know each other better, shared their goals with each other and came away with a broader view of the ADA's programs and activities and the way each council fits into the big picture.

The issues today just don't fit into little cubicles anymore. Instead of being strictly a concern of, say, the scientific area, an issue today will also concern Communications and Dental Practice—and you'd better believe it will concern Legal. We must see to it that turf battles and narrow concerns are past history.

Now, let's briefly review some of the other new activities that have made this such a red-letter year for the ADA.

Parameters of Care

A monumental task we took on is the development of dental practice parameters of care for which you gave the go-ahead in San Francisco last fall.

Yes, a monumental task, but *we* must assume this responsibility because there are others who are only too willing to do it for us.

The committee and two review panels for this project have met your charge extremely well. Before you for your consideration are dental practice parameters for 12 separate categories of patient requirements or oral conditions.

Seals Programs

On another front, we're moving along with the restructuring of the ADA's Seals Programs, including a cost-sharing arrangement with the industry.

This summer, I called a special meeting in Chicago to get input and recommendations from industry representatives. As you might imagine, there are those who are not happy with the idea of cost sharing, but airing our differences and listening to industry has helped us make decisions that everyone concerned can live with. And the industry response to our plans to rev up promotion of the Seals Program has been enthusiastic all the way around. Just this week, a senior representative of a major consumer products corporation told

me our seal is a classic example of professional responsibility and self-regulation that works.

ADA Health Foundation

This is also the year the Board, at long last, said it's time for the ADA to have its own charitable fund-raising arm so that *we*—we, the ADA—can make the decisions about important grants for education and applied research.

Later this afternoon, you'll be seeing a videotape about it and there's an ADA Health Foundation booth here in the Convention Center. I hope each of you shares my excitement about this expanded role for the ADA Health Foundation. It puts *us* in the driver's seat in the funding process. We can emphasize projects and purposes that *we* know will have practical value and make a real difference to the practicing dentist.

Membership Benefits/ Scientific Division, Other Concerns

What else?

We're moving toward expanded benefits for members in the area of financial services and, at the same time, increased non-dues revenues for the Association. A greater variety of tangible, practical membership benefits will strengthen our ability to recruit and retain members. And I want to assure you, our revenue-sharing relationship with constituent societies will continue. With one important difference: There will be more revenue to share.

I am also able to report today that we are on the brink of a world-class scientific division through the combining of three councils. That's another decision that came directly from you last year. I thanked you then. I thank you again now for authorizing us to proceed with this important step forward.

All this we have done this year and more, far more than I have time to report this morning. As recently as two weeks ago, as we were working down toward the wire and this meeting, we triumphed at this year's FDI meeting in Vancouver. We accomplished everything the Board asked us to begin working toward three years ago. The FDI is going to be a more focused, goals-oriented organization, reflecting input from all its member nations, and the ADA now has a very strong voice in the process.

Proposed Dues Increase

Status quo is not the game plan of the American Dental Association. I am very proud that this is so, and I personally regard my ADA dues as the best single investment I make for my practice.

That brings me to one of the most important decisions you have before you—the Board's call for a $19 dues increase to balance the proposed 1995 budget.

I want you to know my strong personal feelings about this proposal.

A dues increase is not the sort of thing any president of this Association wants to find necessary on his or her watch. But the Board has worked hard to trim the budget, and many programs of unquestionable value to members have already been trimmed or eliminated. If the only alternative is to allow the momentum we have developed and the strong infrastructure we have built to deteriorate, then what we must do is clear. We must continue to keep the ADA's game plan strong, responsive to the needs of members and ready to take on any challenge. And meaningful programs cost money.

Think for a moment about the reduction in dental income if the government were to make a decision to tax dental benefits. The estimated loss per dental practice per year is anywhere from $30,000 to $65,000, depending upon whose statistics you're looking at.

And while you're thinking about that, don't forget the findings of a recent ADA survey, the one we conducted to determine what it's costing to comply with the OSHA standard and other infection control regulations.

Answer? Over $23,000 each year for the average American dental practice for OSHA alone, with the figure rising to over $45,000 when all infection control procedures are considered. And there's more to come, with OSHA currently formulating policy on ergonomics, air quality, TB and other issues.

This is survival time, ladies and gentlemen. The issues I've mentioned here this morning, and others I have not, are things none of us can successfully handle on our own. It takes our combined strength through the ADA; and this is no time for our organization to be cutting corners, standing still or moving backward.

To give you an idea of some of the logic out there we have to contend with:

Last month we held a special meeting in Chicago to share the results of our compliance cost survey with members of the dental benefits community. During the question and answer period, one person commented that the people she was there to represent don't care about OSHA compliance costs because "these costs have nothing to do with patient care." The people she was there to represent are in the capitation business. She informed us, in no uncertain terms, that they are not about to reimburse anyone for the cost of doing business.

Really makes you want to say "turnabout is fair play," doesn't it? If *that's* their logic, then when an employer purchases a capitation plan, the entire amount per capita should go to dental care. Right? I mean, why should the employer have to pay the plan for its administrative and other costs of business?

We have to be strong and financially solid as an organization in order to hold our own in a world where that kind of thinking tries to prevail. Think about that as you consider the dues increase proposal, and also ask yourself this:

Would we be listened to the way we are on Capitol Hill right now if we didn't have a long-standing reputation for serving the public's best interests? A Gallup Poll conducted just last month shows that dentistry is one of the three most respected professions in America. How did we build this reputation? In the dental office with our patients in the chair, of course, but also with the strong support of ADA activities—promoting water fluoridation, increasing public awareness of good oral health habits, accrediting dental school programs, the Seals Program, international activities and our Code of Ethics, to name a few.

The ADA is not just a political action committee. It's more than that—vastly more than that—and it's only because of everything else we are and do that our PAC is successful. We could have the biggest political action committee anybody ever heard of, but it wouldn't mean much without something to stand for. The programs that built what we stand for have a

price tag, and the programs that will preserve our reputation and build our future also have a price tag.

I couldn't help thinking this past year how surveys are always one of the first things to go when we start chopping away at the budget. Well, friends, one of the reasons we did so well in the health care reform debate is that we had reliable statistics. We had solid information to give Congress, and a lot of it came from surveys you funded years ago. Somewhere along the line, it all had to be paid for.

Unfinished Business/ Ideas for Consideration

As I said earlier, I don't intend to saddle you with any more work during this year's House. You don't need that. But I do want to bring some unfinished business to your attention, and there are some ideas I want to throw out there for your consideration as we go from here.

Conversion from Student to Active Membership: The conversion rate from student membership to active membership, as it stands now at 59%, is just plain unacceptable. We can be encouraged by the cooperation we have received from ASDA this past year, but we must watch this situation closely and evaluate the success of current initiatives very carefully. And we must be determined to do whatever is necessary to turn that 59% around, even if it means returning to the idea of direct student membership.

ADPAC/CGAFDS: The merging of ADPAC and the Council on Governmental Affairs and Federal Dental Services is an idea whose time has come. I know it's Washington style to have two or more different agencies for what really amounts to one purpose, but do we really have to imitate the federal bureaucracy? For maximum impact, we need our political and legislative initiatives working as one, and the sooner the better.

In that same regard, last year before the House, I asked the ADPAC Board to go to work and make ADPAC a million-dollar PAC. It's a realistic goal, but we haven't succeeded in doing it. It doesn't take a lot from anybody, just a little from everybody.

Organizational Structure: I also want to remind the House that responsible leadership, on your part and the Board's as well, demands that we reevaluate our organizational structure on a regular basis. That means asking whether the way a council is set up is still working for today's issues and needs and it means looking at the size of councils, responsibilities of councils, and terms of office.

Annual Session Registration Fee: Finally, there's a paradox all of us need to be aware of with regard to the growth and success of the ADA's annual session. We've made it the premiere dental meeting in the world, and all of us can join the Council and staff in being proud of that. But this very success has added to the demand on our financial resources. Our revenues from annual session remain more or less fixed, but our expenses go up as we accommodate more participants.

It's simple arithmetic. When someone watching the registration figures says, "Oh, oh, it looks like we're going to need more buses, more printed programs, larger halls," these activities automatically become line items. The solution may be a step other associations took years ago—a registration or user fee.

Conclusion

Those are some ideas for future thought. I throw them out there to you, our leadership, whose thinking has helped to make us the strong organization we are today.

I want to repeat how much I appreciate the opportunity you gave me to serve, and I want to close with something those of you who have heard me at meetings have heard me say before. I feel it more strongly with every passing day:

One basic realization has the power to keep us united, focus our efforts and make us of one strong will. It's the realization that *all the professional dedication and all the professional skill in the world will mean nothing to us if we lose the freedom to use it.*

Supplemental Reports and Resolutions

Notes

Council on Communications

Supplemental Report 1: Recent Council Activities

Background: At both its January and June meetings, the new Council considered its intentions and actions in light of the duties which were assigned to it with the 1993 House of Delegates' adoption of Resolution 69H-1993 (*Trans.*1993: 671).

The Council's duties are as follows:

a. To develop and recommend programs to educate the public about oral health, including national media relations programs, patient communications and materials for use in the dental office.
b. To identify public and media relations issues and to review existing programs and to utilize these programs, or, if appropriate, develop and recommend communications programs to address such issues.
c. To maintain liaison with national health organizations and the dental industry to promote cooperative oral health public education initiatives.
d. To assist dental editors and to support constituent and component dental societies with their media and community relations programs.
e. To review communication messages to the public and to the members concerning the public and private image of dentistry.

As the Council's interests and activities have evolved, the Council felt that clarification and elaboration of some of its duties was in order.

With regard to duty a., the Council felt that the word "review" rather than "develop" more appropriately described its role. With regard to duty d., the Council felt that adding the clause, "and communications with members," was important to capture all of the audiences for dental society communications. Finally, the Council felt that a new duty was needed to specify its role in dental society communications programs.

The Council felt that these changes in its duties would more appropriately define its role and describe its activity. At its June meeting, the Council approved motions to effect these changes and directed that the following resolution be transmitted to the 1994 House of Delegates.

Resolution

32. **Resolved,** that Chapter X. COUNCILS, Section 110. DUTIES, Subsection B. COUNCIL ON COMMUNICATIONS, of the *Bylaws* be amended by deleting in letter "a" the word "develop" and substituting in its place the word "review," and be it further
Resolved, that this section be further amended by adding at the end of letter "d" the phrase, "and communications with members," and be it further
Resolved, that this section be further amended by adding a new letter "f" to read:

f. To assist constituent and component dental society communications staff or other appropriate staff with their media and communications programs.

so that the amended Section 110B reads as follows:

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

a. To review and recommend programs to educate the public about oral health, including national media relations programs, patient communications and materials for use in the dental office.
b. To identify public and media relations issues and to review existing programs and to utilize these programs, or, if appropriate, develop and recommend communications programs to address such issues.
c. To maintain liaison with national health organizations and the dental industry to promote cooperative oral health public education initiatives.
d. To assist dental editors and to support constituent and component dental societies with their media and community relations programs and communications with members.
e. To review communication messages to the public and to the members concerning the public and private image of dentistry.
f. To assist constituent and component dental society communications staff or other appropriate staff with their media and communications programs.

Commission on Dental Accreditation

Supplemental Report 1: Revision of the *Rules of the Commission on Dental Accreditation*

Background: The 1973 ADA House of Delegates approved the establishment of the Commission on Dental Accreditation as the agency responsible for the profession's accreditation program (*Trans.*1973:695). In addition to recognition from the profession, the Commission is recognized by the Commission on Recognition of Postsecondary Accreditation (CORPA) and the United States Department of Education (USDOE). CORPA is a voluntary, nongovernmental agency. USDOE, a governmental agency, has statutory authority for determining federal funding eligibility, and only those educational programs accredited by USDOE-recognized accrediting agencies are eligible for such funding. Both of these agencies have established criteria for recognition of accrediting agencies.

The leadership of the American Dental Association and its House of Delegates in 1973 approved the development of the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs (later renamed the Commission on Dental Accreditation) with sufficient autonomy to develop and approve educational standards, policies and procedures affecting the accreditation program. The Commission was appropriately broadened and was granted operational independence as it relates strictly to accreditation affairs. Because of its structure and function, the Commission has been a precedent-setting organization used as a model by many related accrediting agencies. Its establishment kept pace with ever-changing concepts within the field, and the Commission continues to maintain an excellent reputation within the accreditation community.

The *Constitution and Bylaws* of the American Dental Association provides for the Commission to develop rules for the conduct of its business, contingent on approval by the House of Delegates. Specifically, the *Constitution and Bylaws* provides for the Commission to have the authority, through the *Rules of the Commission on Dental Accreditation* to determine the number of its members and to select its members.

USDOE Recognition Criteria: The recent publication of the final *Procedures and Criteria for the Recognition of Accrediting Agencies (Criteria)* of the USDOE notified accrediting agencies of the implementation of the provisions of the Higher Education Act (HEA), as amended in 1992. The *Criteria* contain strict requirements that relate to ensuring the autonomy of accrediting agencies.

In view of these requirements, contained in the HEA and implemented through the *Criteria*, the Association should consider taking steps to divest itself of current procedures that create the appearance of excessive Association influence on the membership and function of the Commission and the Appeal Board. For this reason, the Commission on Dental Accreditation is requesting the House of Delegates to grant it authority for the specific issues discussed below. The current procedures represent a potential influencing factor that could bring into question the operational independence of the Commission.

Although it is the recommendation of this report to revise the *Rules* in a number of specified areas, the Association *Bylaws*, as they relate to the Commission, would remain as previously established. In this context, the degree to which the Commission's autonomy could be challenged would be lessened if the Association were appointing only its designated members of the Commission and the Appeal Board.

It should also be noted that no changes in the duties and responsibilities of the Commission on Dental Accreditation are being suggested, and any revision of the *Rules of the Commission on Dental Accreditation* would continue to be subject to approval by the House of Delegates.

Representation of the Public: The revised *Criteria* require one public member for each six dental-related members of the Commission. Currently the Commission has 18 members who represent the dental communities of interest and two public members. In order to meet the required ratio of public members to professional members, the Commission proposes to add a third public member (Article II, Section 2).

Separate and Independent: The revised *Criteria* require accrediting agencies that act as HEA, Title IV gatekeepers, that is, whose accreditation qualifies educational institutions to participate in the Department of Education student financial aid programs, to be separate and independent of parent professional organizations in order that the accrediting agencies not represent the interests of the organization. The *Criteria* specifically mentions powers granted to the Board of Trustees or the officers of the parent professional organization.

Currently, although the Commission is a gatekeeper for other federal programs, it is not classified as an HEA, Title IV gatekeeper and is not strictly bound by the separate and independent requirements. However, several clauses in the current *Rules* grant the Association powers that unnecessarily bring into question, in the context of separate and independent, the autonomy of the Commission. These include:

- selection of the public members of the Commission by the Council on Dental Education of the American Dental Association (Article II, Section 2);
- selection of representatives for other organizations which fail to select a representative (Article II, Section 2);
- the power of a majority of the Commissioners who are members of the Council on Dental Education to call a special meeting (Article II, Section 6);
- appointment of the public member of the Appeal Board by the Council on Dental Education (Article III, Section 2);
- appointment of the general practice residency member of the Appeal Board by the Council on Dental Education (Article III, Section 2);

- appointment of the chairman of the Appeal Board by the Board of Trustees (Article III, Section 2); and
- appointment of temporary members to fill vacancies on the Commission or the Appeal Board by the President of the Association (Article VI, Section 2).

Limitation of Attendance During Meetings: Currently, the Commission conducts parts of its meetings in two formats: open sessions, in which the public is invited to observe the Commission's deliberations, and limited attendance sessions, in which only affiliated accreditors, selected staff and the Board liaison members are permitted to be in attendance. The *Standing Rules for Councils and Commissions* provides for the members of the Board of Trustees assigned as liaison to councils and commissions to attend regular and executive sessions of their assigned councils or commissions.

However, a portion of the meetings of the Commission and its standing and advisory committees involves consideration of the accreditation status of individual educational programs. These discussions and the information considered are held to be confidential. While the Board liaison members have not attempted to affect the accreditation decisions, the appearance that the Association might have an opportunity to influence the accreditation decisions of the Commission is created. In addition, this practice allows these liaison members access to confidential information. The *Criteria* mandate that accrediting agencies not provide to a parent professional organization any information that is not available to other audiences.

The revised Rules, appended, would divide meetings into three portions: 1) the open portion of the meetings for the discussion of policies and procedures during which members of the public may observe the process; 2) a limited attendance portion of the meetings during which only affiliated accreditors, selected staff and the Board liaison members are permitted to attend for the discussion of private issues, such as budget matters; and 3) a confidential, accreditation portion of the meetings, during which only affiliated accreditors and selected staff are permitted to be in attendance for discussion of accreditation matters related to individual programs. In order to establish this structure, the Commission proposes to designate a portion of its meetings as confidential (Article II, Section 6C).

Editorial Changes: Additional editorial revisions are recommended to reflect other changes made since 1987 by the Association or the Commission. They include:

- substituting the Commission's Mission Statement, adopted in May 1989, for the previous PURPOSE, (Article I);
- replacing "dental auxiliary" with "allied dental" as adopted by the Commission at its December 1990 meeting;
- replacing "secretary" with "director," to reflect changes in staff designation;
- replacing "requirements and guidelines" with "standards;"
- clarification of the provisions for a hearing provided for adverse actions (Article IV, Section 3);
- inclusion of advanced education programs in general dentistry on the Appeal Board (Article III, Section 2); and
- reflection of staff assignment changes, related to the Commission and the Council on Dental Education.

Resolution

76. Resolved, that the Rules of the Commission on Dental Accreditation be approved as revised.

APPENDIX

COMMISSION ON DENTAL ACCREDITATION

AMENDED

RULES OF THE COMMISSION ON DENTAL ACCREDITATION

Article I. ~~PURPOSE~~ MISSION

~~The purpose of the Commission on Dental Accreditation is (1) to formulate and adopt requirements and guidelines for the accreditation of predoctoral and advanced dental educational and dental auxiliary educational programs and (2) to accredit predoctoral and advanced dental educational and dental auxiliary educational programs.~~

The Commission on Dental Accreditation's mission is to ensure the quality of dental and dental-related education by conducting accreditation reviews to determine the degree to which individual programs meet the Commission's published accreditation standards and their own stated goals and objectives. The Commission recognizes only those programs meeting the accreditation standards that are developed and agreed upon by the various communities of interest, including the public. The Commission's second purpose is to enhance and encourage improvement in the quality of its accredited educational programs.

The Commission's accreditation program ensures that quality education is available for dentists, dental specialists and allied dental personnel. Quality education ultimately leads to quality dental care for the public.

Thus, the Commission's voluntary accreditation program serves to ensure educational quality and to improve the quality of the educational programs in 14 dental and dental-related disciplines. These disciplines include: dentistry, dental assisting, dental hygiene, dental laboratory technology, dental public health, endodontics, oral pathology, oral and maxillofacial surgery, orthodontics, pediatric dentistry,

~~Strikeout~~ indicates deletions
Shading indicates additions

periodontics, prosthodontics, general practice residency and advanced general dentistry.

Article II. BOARD OF COMMISSIONERS

Section 1. LEGISLATIVE AND MANAGEMENT BODY: The legislative and management body of the Commission shall be the Board of Commissioners.

Section 2. COMPOSITION: The Board of Commissioners shall consist of ~~twenty (20)~~ twenty-one (21) Commissioners. Twelve (12) of the ~~twenty (20)~~ twenty-one (21) Commissioners shall be the members of the Council on Dental Education of the American Dental Association and shall serve the same terms as Commissioners as they shall serve as members of the Council on Dental Education. The remaining ~~eight (8)~~ nine (9) Commissioners shall be selected as follows: one (1) certified dental assistant selected by the American Dental Assistants Association from its active or life membership, one (l) licensed dental hygienist selected by the American Dental Hygienists' Association, one (l) certified dental laboratory technician selected by the National Association of Dental Laboratories, one (l) student selected jointly by the American Student Dental Association and the Council of Students of the American Association of Dental Schools, two (2) dentists who are certified in special areas of practice and are selected on a rotating basis by two (2) of the specialty organizations of the eight (8) dental specialty certifying boards which are recognized by the American Dental Association, and ~~two (2)~~ three (3) consumers who are neither dentists nor ~~members of the dental auxiliary~~ allied dental personnel nor teaching in a dental or allied dental ~~auxiliary~~ education institution and who are selected by the ~~Council on Dental Education of the American Dental Association~~ Commission, based on established and publicized criteria. In the event a Commission member sponsoring organization fails to select a Commissioner, it shall be the responsibility of the ~~Council on Dental Education~~ Commission to select an appropriate representative~~, as specified in the Bylaws,~~ to serve as a Commissioner. The ~~Secretary~~ Director of the Commission~~, who shall be the Secretary of the Council on Dental Education,~~ shall be an *ex officio* member of the Board without the right to vote.

Section 3. TERM OF OFFICE: The term of office of the members of the Board of Commissioners shall be one four- (4) year term except that the members selected by the American Student Dental Association and the dental specialty organizations shall each serve only one two- (2) year term.

Section 4. POWERS:

A. The Board of Commissioners shall be vested with full power to conduct all business of the Commission subject to the laws of the State of Illinois, these *Rules* and the *Constitution and Bylaws* of the American Dental Association.

B. The Board of Commissioners shall have the power to establish rules and regulations not inconsistent with these *Rules* to govern its organization and procedures.

Section 5. DUTIES:

A. The Board of Commissioners shall prepare a budget at its ~~spring~~ midyear meeting each year for carrying on the activities of the Commission for the ensuing fiscal year and shall submit said budget to the Board of Trustees of the American Dental Association for funding in accordance with Chapter XIV of the *Bylaws* of the American Dental Association.

B. The Board of Commissioners shall submit an annual report of the Commission's activities to the House of Delegates of the American Dental Association and interim reports, on request, to the Board of Trustees of the American Dental Association, either through or in cooperation with the Council on Dental Education of said Association.

C. The Board of Commissioners shall appoint special committees of the Commission for the purpose of performing duties not otherwise assigned by these *Rules*.

D. The Board of Commissioners shall appoint consultants to assist in developing ~~requirements and guidelines~~ standards and conducting accreditation evaluations, including on-site ~~visitations~~ reviews, of predoctoral, advanced dental educational and allied dental ~~auxiliary~~ educational programs.

Section 6. MEETINGS:

A. REGULAR MEETINGS: There shall be two (2) regular meetings of the Board of Commissioners each year. Each of these two (2) meetings shall be held within the week immediately preceding two (2) of the meetings of the Council on Dental Education of the American Dental Association.

B. SPECIAL MEETINGS: Special meetings of the Board of Commissioners may be called at any time by the Chairman of the Commission. The Chairman shall call such meetings on request of at least ~~seven (7)~~ eleven (11) of the ~~twelve (12)~~ twenty-one (21) voting members of the Board ~~who also are serving as members of the Council on Dental Education of the American Dental Association~~, provided at least ten (10) days' notice is given to each member of the Board in advance of the meeting. No business shall be considered except that provided in the call unless by unanimous consent of the members of the Board present and voting.

C. LIMITATION OF ATTENDANCE DURING MEETINGS: In keeping with the confidential nature of the deliberations regarding the accreditation status of individual educational programs, a portion of the meetings of the Commission, its standing committees and advisory committees shall be designated as confidential, accreditation, with attendance limited to members, selected staff of the Commission and affiliated accreditors. During this part of the meeting, only confidential accreditation actions may be considered.

Section 7. QUORUM: A majority of the voting members of the Board of Commissioners shall constitute a quorum.

~~Strikeout~~ indicates deletions
Shading indicates additions

Article III. APPEAL BOARD

Section 1. APPEAL BOARD: The appellate body of the Commission shall be the Appeal Board which shall have the authority to hear and decide appeals filed by predoctoral and advanced dental educational and allied dental ~~auxiliary~~ educational programs from decisions rendered by the Board of Commissioners of the Commission denying or revoking accreditation.

Section 2. COMPOSITION: The Appeal Board shall consist of four (4) permanent members. The four (4) permanent members of the Appeal Board shall be selected as follows: one (1) selected by the Board of Trustees of the American Dental Association giving special consideration whenever possible to former members of the Council on Dental Education, one (l) member selected by the American Association of Dental Examiners from the active membership of that body, one (1) member selected by the American Association of Dental Schools from the active membership of that body and one (l) consumer member who is neither a dentist nor ~~member of~~ an allied dental ~~auxiliary~~ personnel nor teaching in a dental or ~~auxiliary~~ allied dental ~~institution~~ educational program and who is selected by the ~~Council on Dental Education of the American Dental Association~~ Commission, based on established and publicized criteria. In addition, a representative from either an ~~auxiliary~~ allied or advanced education discipline would be included on the Appeal Board depending upon the type and character of the appeal. Such special members shall be selected by the appropriate ~~auxiliary~~ allied or specialty organization. Since there is no national organization for general practice residencies and advanced education programs in general dentistry, a representatives of this~~e~~ area~~s~~ shall be selected by the ~~Council on Dental Education~~ Commission. One (l) member of the Appeal Board shall be appointed annually by the ~~Board of Trustees of the American Dental Association~~ Chairman of the Commission to serve as the Chairman and shall preside at all meetings of the Appeal Board. If the Chairman is unable to attend any given meeting of the Appeal Board, the other members of the Appeal Board present and voting shall elect by majority vote an acting Chairman for that meeting only. The ~~Secretary~~ Director of the Commission shall provide assistance to the Appeal Board.

Section 3. TERM OF OFFICE: The term of office of members on the Appeal Board shall be one four- (4) year term. The initial Board shall be elected on a staggered basis to provide annual rotation.

Section 4. MEETINGS: The Appeal Board shall meet at the call of the ~~Secretary~~ Director of the Commission, provided at least ten (10) days' notice is given to each member of the Appeal Board in advance of the meeting. Such meetings shall be called by the ~~Secretary~~ Director only when an appeal to the appellate body has been duly filed by a predoctoral or advanced dental educational or allied dental ~~auxiliary~~ educational program.

Section 5. QUORUM: A majority of the voting members of the Appeal Board shall constitute a quorum.

Article IV. ACCREDITATION PROGRAM

Section 1. REQUIREMENTS: The Commission, acting through the Board of Commissioners, shall establish and publish specific requirements and guidelines for the accreditation of predoctoral and advanced dental educational and allied dental ~~auxiliary~~ educational programs.

Section 2. EVALUATION: Predoctoral and advanced dental educational and allied dental ~~auxiliary~~ educational programs shall be evaluated for accreditation status by the Board of Commissioners on the basis of the information and data provided on survey forms and secured by the members of, and consultants to, the Board of Commissioners during site evaluations.

Section 3. HEARING: The Board of Commissioners shall notify the predoctoral or advanced dental educational or ~~auxiliary~~ allied dental educational program (hereinafter called "educational program") of its factual findings and proposed decision (intent to withdraw) to deny or revoke the ~~approval~~ accreditation status of the program. Such notice, together with announcement of the date of the next meeting of the Board of Commissioners, shall be sent to the educational program by registered or certified mail within thirty (30) days following the proposed intent to withdraw decision of the Board of Commissioners. Within thirty (30) days after receipt of such notice, the educational program may, in writing, request a hearing before the Board of Commissioners at its next meeting. Such request for a hearing shall automatically stay the Board of Commissioners' proposed decision and shall result in the Board of Commissioners scheduling such hearing and notifying the educational program within fifteen (15) days of the date, time and place of such hearing. At the hearing, the educational program may offer evidence and argument in writing or orally or both tending to refute or overcome the factual findings and proposed decision of the Board of Commissioners. However, any written evidence or argument must be received by the ~~Secretary~~ Director of the Board of Commissioners at least thirty (30) days prior to the hearing. The educational program may be represented by legal counsel at the hearing. The educational program need not appear in person or by its representative at the hearing, but may offer evidence and argument in writing tending to refute or overcome the factual findings and proposed decision of the Board of Commissioners. Upon conclusion of the hearing or review of written materials, the Board of Commissioners will render and notify the educational program of the Board of Commissioners' findings and decision by registered or certified mail. In the event the educational program does not make a timely request for a hearing, the Board of Commissioners' findings and proposed decision shall become final.

Section 4. APPEAL: In the event the final decision of the Board of Commissioners is a denial or withdrawal of

~~Strikeout~~ indicates deletions
Shading indicates additions

approval, the educational program shall be informed of this decision within fourteen (14) days following the Commission meeting. Within fourteen (14) days after receipt of the final decision of the Board of Commissioners, the educational program may appeal the decision of the Board of Commissioners by filing a written appeal with the ~~Secretary~~ Director of the Board of Commissioners. The filing of an appeal shall automatically stay the final decision of the Board of Commissioners. The Appellate Board of the Commission shall convene and hold its hearing within sixty (60) days after the appeal is filed. The educational program filing the appeal may be represented by legal counsel and shall be given the opportunity at such hearing to offer evidence and argument in writing or orally or both tending to refute or overcome the findings and decision of the Board of Commissioners. The educational program need not appear in person or by its representative at the appellate hearing. The Appellate Board shall advise the appellant educational program of the Appellate Board's decision in writing by registered or certified mail. The decision rendered by the Appeal Board shall be final and binding. In the event the educational program does not file a timely appeal of the Board of Commissioners' findings and decision, the Board of Commissioners' decision shall become final.

Section 5. HEARING AND APPEAL COSTS: If a hearing is held before the Board of Commissioners, the costs of the Commission respecting such hearing shall be borne by the Commission. If an appeal is heard by the Appeal Board, the costs of the Commission respecting such appeal shall be shared equally by the Commission and the appellant educational program filing the appeal except in those instances where equal sharing would cause a financial hardship to the appellant. However, each educational program shall bear the cost of its representatives for any such hearing or appeal.

Article V. OFFICERS

Section 1. OFFICERS: The officers of the Commission shall be a Chairman and a ~~Secretary~~ Director and such other officers as the Board of Commissioners may authorize. The Chairman ~~and the Secretary~~ of the Council on Dental Education of the American Dental Association shall be~~,~~ ~~respectively,~~ the Chairman ~~and Secretary~~ of the Commission.

Section 2. DUTIES: The duties of the officers are as follows:

A. CHAIRMAN: The Chairman shall preside at all meetings of the Board of Commissioners. If the Chairman is unable to attend any given meeting of the Board of Commissioners, the other members of the Board of Commissioners present and voting shall elect by majority vote an acting chairman for the purpose of presiding at that meeting only.

B. ~~SECRETARY~~ Director: The ~~Secretary~~ Director shall keep the minutes of the meetings of the Board of Commissioners, prepare an agenda for each meeting, see that all notices are duly given in accordance with the provisions of these *Rules* or as required by law, be the custodian of the Commission's records, and in general shall perform all duties incident to the office of ~~Secretary~~ Director.

Article VI. MISCELLANEOUS

Section 1. ADDITIONAL RULES: The rules contained in the current edition of *Sturgis Standard Code of Parliamentary Procedures* shall govern the deliberations of the Board of Commissioners and Appeal Board in all instances where they are applicable and not in conflict with the *Rules* or the previously established rules and regulations of the Board of Commissioners.

Section 2. VACANCIES: In the event of a vacancy in the membership of either the Board of Commissioners or the Appeal Board of the Commission, the ~~President of the American Dental Association~~ Chairman of the Commission shall appoint a member of the same organization, or in the case of a consumer of the general public, possessing the same qualifications as established by these *Rules*, to fill such vacancy until a successor is elected by the respective representative organization.

Article VII. AMENDMENTS

These *Rules* may be amended at any meeting of the Board of Commissioners by majority vote of the members of the Board present and voting subject to the subsequent approval of the House of Delegates of the American Dental Association.

As revised by the ADA House of Delegates
11/82; 10/87

~~Strikeout~~ indicates deletions
Shading indicates additions

Council on Dental Benefit Programs

Supplemental Report 1: Submission of the Report and Recommendations of the Dental Practice Parameters Committee

Background: Resolution 62H-1993 (*Trans.*1993:697), which was adopted by the 1993 House of Delegates directing the development of dental practice parameters, reads as follows:

> **Resolved,** that, with oversight by the Board of Trustees and through the appropriate agencies of the American Dental Association, dental practice parameters be developed in accordance with the format and mechanism outlined in Board Report 9 to the 1993 House of Delegates (*Supplement* 1993:392), as modified, to ensure scientific soundness and clinical credibility, and be it further
> **Resolved,** that dental practice parameters be developed and/or approved by the American Dental Association be made available in practical and useful formats, and be it further
> **Resolved,** that the Board of Trustees establish a protocol for the implementation and ongoing evaluation of the appropriateness, application and impact on professional performance on these parameters, and be it further
> **Resolved,** that initially, practice parameters for conditions likely to be included in health system reform be given the highest priority, and be it further
> **Resolved,** that dental practice parameters are not intended to establish standards of care, and be it further
> **Resolved,** that adherence to such parameters shall not serve as a condition of membership, and be it further
> **Resolved,** that the Council on Dental Care Programs' Office of Quality Assurance report to the 1994 House of Delegates, and be it further
> **Resolved,** that the House of Delegates' action on parameters be limited to voting any given parameter vote yes or no, or to referring the parameter back to the Dental Practice Parameters Committee.

Mechanism for Parameters Development: In accordance with Resolution 62H-1993, the Dental Practice Parameters Committee (DPPC) was appointed by the Chairmen of the Council on Dental Benefit Programs (CDBP), the Council on Dental Practice (CDP), and the Council on Dental Education (CDE) as follows: Drs. Kevin J. McNeil, CDBP (subsequently elected chairman of the DPPC), Massachusetts; Ron L. Tankersley, CDBP, Virginia; Myron L. Pudwill, CDBP, Nebraska; Frederick E. Aurbach, CDP, Texas; Roger L. Kiesling, CDP, Montana; Don N. Brotman, CDE, Maryland; and Richard D. Wilson, CDE, Virginia.

The Board of Trustees appointed 35 member dentists, selected by the DPPC, to serve on the Consensus Conference Committee. The Board also appointed an additional 44 member dentists to serve on the Mail Review Panel. (The membership lists for both the Consensus Conference and the Mail Review Panel are attached to this report as Appendix 1.)

The DPPC held its first meeting on January 21, 1994 and continued to meet in Chicago at ADA Headquarters on a monthly basis through June. In addition, to conserve travel time and costs, evening conference calls were held to prepare the parameters documents for submission to the Consensus Conference members and to the Mail Review Panelists.

The Consensus Conference met April 8-11, 1994 and June 24-26, 1994. Following the Consensus Conference meetings, the parameters were revised and submitted to the Mail Review Panel for comment.

The Format for Parameters Development: The format outlined in Board Report 9 stipulated that the Association should:

- seek a format that has professional judgment as the primary factor in determining appropriateness of care;
- keep the format simple and intelligible; and
- make sure the format is related to clinical practice.

The major responsibilities of the Mail Review Panel were to see that the above three key objectives had been attained and to review and make recommendations for any additional modifications to the parameters documents.

Condition-Based Parameters: The DPPC developed the following 12 parameters documents:

- Patient Requiring a Comprehensive Oral Evaluation;
- Patient of Record Requiring a Periodic Evaluation;
- Patient Requiring a Limited Evaluation of a Specific Problem;
- Patient Requiring a Detailed and Extensive Evaluation for a Specific Problem(s);
- Dental Caries;
- Periodontium Without Clinically Apparent Inflammation;
- Gingival Inflammation Without Loss of Periodontal Attachment (Gingivitis);
- Gingival Inflammation With Loss of Connective Tissue Attachment (Periodontitis);
- Partially Edentulous Arch(es);
- Edentulous Arch(es);
- Fractured/Cracked Tooth; and
- Patient Without Clinical Signs or Symptoms of Oral Disease Following Evaluation.

These documents are attached to this report as Appendices 3-14 (*Supplement*:276).

To assist the delegates in reading this report, the Preamble is presented, and will be voted upon, as a separate document (Appendix 2, *Supplement*:275). The Preamble will apply to each parameters document.

In reviewing each parameters document, delegates will recognize that there is considerable repetition. However, the parameters are intended to be "stand alone" documents and will be voted on separately by the House. Therefore, it is essential that the text of each set of parameters be complete.

Use of the parameters documents by dentists is completely voluntary. The documents describe clinical considerations in

the diagnosis and treatment of oral health conditions and, therefore, may assist in clinical decision making.

The Process: At its first meeting, the DPPC discussed the Board of Trustees' recommendation to use the term "parameters" rather than "standards" or "guidelines." These terms are defined as follows:

- *Standards* are rigid and represent what must be done.
- *Guidelines* are less rigid but represent what should be done.
- *Parameters* set the boundaries of what is acceptable.

Based on the objective that parameters have professional judgment of the practitioner as the primary factor in determining the appropriateness of care, the DPPC also gave considerable time and thought to its decision on the use of the verbs "may," "should" and "must." The verb "may" clearly allows the practitioner to decide whether to act. The verb "should" indicates a degree of preference and differs in meaning from "must" or "shall" (which require the practitioner to act).

During the first seven months of this project, the mechanism established for developing the parameters was thoroughly tested and proved. The DPPC fully supports the mechanism and recommends that it be continued.

Drafts of the parameters documents developed by the DPPC were submitted to the Consensus Conference members prior to their meetings with the DPPC. At each meeting, the conferees were divided into three groups and each group discussed all of the parameters documents. The discussions and recommendations served to improve and refine each document prior to submission to the Mail Review Panel.

The role of the Consensus Conference somewhat mirrored the role of the DPPC in the free exchange of ideas and full discussion of the parameters which were critical to the development process. The Mail Review Panel served an entirely different and extremely important function which, in essence, parallels the initial exposure of the delegates to the parameters documents. The panelists reviewed the parameters without the benefit of discussion with their colleagues.

The DPPC reviewed all comments from the Mail Review Panel and further refined the parameter documents. The parameter documents as presented to the Board of Trustees and the House of Delegates represent a consensus of the DPPC after considering the comments and recommendations of the Consensus Conference and the Mail Review Panel.

The issue of professional judgment of the attending dentist for a specific patient at a specific time is addressed as the key element in the design of each set of parameters.

The reader will also note that the issue of preventive care is reflected in each of the parameters documents presented for review.

Extent of the Review Process: It is important to emphasize that, during the development period, the parameters documents were thoroughly and continuously reviewed and revised. A summary of the review process is as follows:

- In January 1994, the DPPC established a list of the first 12 conditions for which parameters documents would be developed. The DPPC also established an outline of the information that should be included in the parameters.
- Preliminary drafts for eight of the parameters documents were then prepared by Association staff dentists, as directed by the House. The eight parameters were as follows:

  - Patient Requiring a Comprehensive Oral Evaluation;
  - Patient of Record Requiring a Periodic Evaluation;
  - Patient Requiring a Limited Evaluation of a Specific Problem;
  - Patient Requiring a Detailed and Extensive Evaluation for a Specific Problem(s);
  - Dental Caries;
  - Periodontium Without Clinically Apparent Inflammation;
  - Gingival Inflammation Without Loss of Periodontal Attachment (Gingivitis); and
  - Gingival Inflammation With Loss of Connective Tissue Attachment (Periodontitis).

- In February and March 1994, these eight documents were revised by the DPPC for submission to the Consensus Conference.
- In April, the Consensus Conference met to further discuss and revise the eight parameters documents.
- The revised documents were submitted to the Mail Review Panel for comment and additional recommendations.
- In early May, by conference call, the DPPC reviewed the Mail Review Panelists' recommendations and revised the eight parameters documents.
- The DPPC met in mid-May to review the four remaining parameters documents:

  - Partially Edentulous Arch(es);
  - Edentulous Arch(es);
  - Fractured/Cracked Tooth; and
  - Patient Without Clinical Signs or Symptoms of Oral Disease Following Evaluation.

- Conference calls were held in late May and in early and mid-June to discuss revisions of the first eight parameters, and to prepare the remaining four parameters documents for submission to the Consensus conferees, as well as to plan for the Consensus Conference.
- The Consensus Conference met June 24-26 to revise the remaining four parameters documents.
- The DPPC met on June 27 to prepare the four parameters documents, based on the input and recommendations of the Consensus conferees, for submission to the Mail Review Panel. The DPPC also developed the first draft of the Preamble to the parameters documents and the DPPC report to the House of Delegates.
- Conference calls were held in early and mid-July to revise the four parameters documents based on recommendations from the Mail Review Panel, and to perfect the Preamble to the parameters documents, the report to the House of Delegates and a final review of the 12 parameters documents.

Continuation of the Parameters Development Project: The Association has assumed responsibility for the development of dental practice parameters.

At the outset of this project, there was discussion by the DPPC and by the Consensus Conference members at their first meeting regarding the role of parameters documents already developed or in the process of being developed by some of the specialty organizations. It was agreed that these activities complement each other. During the development of the parameters, already existing documents were used as a reference. The Association's documents do not conflict with other dental parameters and guidelines. The DPPC believes that the Association's parameters development project will serve as a conduit for the work of the specialty organizations to become a part of overall dental practice parameters.

Because parameters will provide a reference for dentists in their clinical decision making, they are another way in which the profession can attend to its ongoing responsibility for up-to-date, high quality care.

Parameters will ultimately be integrated into many different services in which the Association is currently involved. They will be used as a reference from which quality assessment instruments will be derived. Parameters will also be coordinated with the Association's diagnostic coding project leading to outcomes research and with its project to develop components for computer-based patient dental records.

Special Acknowledgment: The Council on Dental Benefit Programs wishes to take this opportunity to pay a special tribute to the remarkable dedication and commitment to this project by the seven members of the Dental Practice Parameters Committee. The Council also acknowledges with great appreciation the efforts of the members of the Consensus Conference and the Mail Review Panel. Together, these 84 members of the Association have contributed a minimum of 4,200 hours (120 weeks) to produce the parameters documents presented with this report.

The Council on Dental Benefit Programs is pleased and proud to forward the following resolutions of the Dental Practice Parameters Committee to the House of Delegates and recommends their adoption.

Resolutions

35. Resolved, that the Preamble to the dental practice parameters documents be adopted.

36. Resolved, that the dental practice parameters document entitled Patient Requiring a Comprehensive Oral Evaluation be adopted.

37. Resolved, that the dental practice parameters document entitled Patient of Record Requiring a Periodic Evaluation be adopted.

38. Resolved, that the dental practice parameters document entitled Patient Requiring a Limited Evaluation of a Specific Problem be adopted.

39. Resolved, that the dental practice parameters document entitled Patient Requiring a Detailed and Extensive Evaluation for a Specific Problem(s) be adopted.

40. Resolved, that the dental practice parameters document entitled Dental Caries be adopted.

41. Resolved, that the dental practice parameters document entitled Periodontium Without Clinically Apparent Inflammation be adopted.

42. Resolved, that the dental practice parameters document entitled Gingival Inflammation Without Loss of Periodontal Attachment (Gingivitis) be adopted.

43. Resolved, that the dental practice parameters document entitled Gingival Inflammation With Loss of Connective Tissue Attachment (Periodontitis) be adopted.

44. Resolved, that the dental practice parameters document entitled Partially Edentulous Arch(es) be adopted.

45. Resolved, that the dental practice parameters document entitled Edentulous Arch(es) be adopted.

46. Resolved, that the dental practice parameters document entitled Fractured/Cracked Tooth be adopted.

47. Resolved, that the dental practice parameters document entitled Patient Without Clinical Signs or Symptoms of Oral Disease Following Evaluation be adopted.

APPENDIX 1

Consensus Conference Members

Dr. Richard A. Ansted, Toledo, OH
Dr. Wayne J. Barnes, Sioux City, IA
Dr. Erwin P. Barrington, Chicago, IL
Dr. George L. Bletsas, Lincoln Park, MI
Dr. Stanley E. Block, Annapolis, MD
Dr. Verdie Carsten, New York, NY
Dr. A. Riley Cutler, Boise, ID
Dr. Scott M. Dubowsky, Bayonne, NJ
Dr. Stuart B. Fountain, Chapel Hill, NC
Dr. Robert S. Gartrell, San Francisco, CA
Dr. Timothy F. Geraci, Oakland, CA
Dr. Raymond George, Sr., East Providence, RI
Dr. Howard Hill, Georgetown, MA
Dr. Kenneth L. Kalkwarf, San Antonio, TX
Dr. Fraya Karsch, New York, NY
Dr. James E. Kennedy, Farmington, CT
Dr. George A. Kirchner, Allentown, PA
Dr. Robert E. Lauer, Worthington, OH
Dr. Jacob J. Lippert, Union, MO
Dr. Rise L. Lyman McMichael, San Antonio, TX
Dr. Amp W. Miller, III, Dallas, TX
Dr. Jerome B. Miller, Oklahoma City, OK
Dr. Larry C. Miller, Savannah, GA
Dr. Sheldon H. Natkin, West Haven, CT
Dr. Linda C. Niessen, Dallas, TX
Dr. James H. Reisman, Dallas, TX
Dr. Mark Rogers, Salem, OR
Dr. Charles L. Ross, Miami, FL
Dr. Alan J. Smith, Murray, UT
Dr. Mary K. Smith, Spokane, WA
Dr. Richard A. Smith, Atlanta, GA
Dr. Anthony M. Storace, Nashua, NH
Dr. Steven Tonelli, North Redding, MA
Dr. George B. Valentine, Modesto, CA
Dr. Wallace C. Volz, Jr., Bremerton, WA

Review Panel Members

Dr. Stuart A. Bender, Vancouver, WA
Dr. Dave Borlas, Chesterfield, MI
Dr. Skip D. Buford, Shreveport, LA
Dr. W. Lynn Campbell, Columbia, SC
Dr. James Cerney, Fairbanks, AK
Dr. John D. Chandler, Huntsville, TX
Dr. Benjamin W. Curtis, Portland, OR
Dr. Frederick J. Diedrichson, Holdrege, NE
Dr. Gordon L. Douglass, Sacramento, CA
Dr. Lewis S. Earle, Winter Park, FL
Dr. Howard B. Fine, Rochester, NY
Dr. Robert J. Gheradi, Albuquerque, NM
Dr. Ronald B. Gross, Pottstown, PA
Dr. Frederick J. Halik, Honeoye Falls, NY
Dr. Charles Hall, Huntsville, AL
Dr. Paul W. Johnson, Lubbock, TX
Dr. Harmon R. Katz, New Brunswick, NJ
Dr. James B. Killinger, Oshkosh, WI
Dr. Lester L. Levin, Aston, PA
Dr. Carle Woodruff Mason, Jr., Wilson, NC
Dr. Bernard K. McDermott, Washington, DC
Dr. Charles E. McDermot, Pittsburgh, PA
Dr. Tom McDonald, Athens, GA
Dr. Thomas S. McLellan, Battle Creek, MI
Dr. Frank J. Metzmeir, Campellsville, KY
Dr. Frederick R. Michael, Poultney, VT
Dr. Emanuel W. Michaels, Norfolk, VA
Dr. Thomas S. Nordone, Philadelphia, PA
Dr. Paul Oberbreckling, Meqoun, WI
Dr. Charles H. Perle, Jersey City, NJ
Dr. Robert M. Perrin, South Burlington, VT
Dr. George B. Platt, Little Rock, AR
Dr. Bruce D. Raibley, Evansville, IN
Dr. Roger K. Rempfer, Modesta, CA
Dr. Neil B. Richter, Merrillville, IN
Dr. Edward P. Roy, Brunswick, ME
Dr. Jacqueline Roy, Utica, NY
Dr. Ansley W. Sawyer III, Agusta, ME
Dr. Eugene W. Seklecki, Tucson, AZ
Dr. Matthew Steinberg, Austin, TX
Dr. Lester H. Steinholtz, Syracuse, NY
Dr. Robert M. Stetzel, Fort Wayne, IN
Dr. Thomas E. Sullivan, Westchester, IL
Dr. Murray Sykes, Silver Spring, MD

APPENDIX 2

Preamble

The American Dental Association developed these dental practice parameters for voluntary use by practicing dentists. The parameters are intended, foremost, as an aid to clinical decision making and thus, they describe clinical considerations in the diagnosis and treatment of oral health conditions.

Additionally, parameters will assist the dental profession by providing the basis on which the profession's commitment to high quality care can be demonstrated and can continue to be improved.

The dental practice parameters are condition-based, presenting an array of possible diagnostic and treatment considerations for oral health conditions. Condition-based parameters, rather than procedure-based parameters, were determined to be the most useful because this approach recognizes the need for integrated treatments of oral conditions rather than emphasizing isolated treatment procedures. The parameters are also oriented toward the process of care and describe elements of diagnosis and treatment.

While the parameters describe the common elements of diagnosis and treatment, it is acknowledged that unique clinical circumstances, and individual patient preferences, must be factored into clinical decisions. This requires the dentist's careful professional judgment. Balancing individual patient needs with scientific soundness is a necessary step in providing care.

It is understood that dentists may deviate from the parameters, in individual cases, depending on the clinical circumstances presented by the patient. However, when the dentist provides treatment that deviates from the parameter, the rationale for the treatment should be documented and explained to the patient.

The elements of care that are described in the parameters were derived from a consensus of professional opinion. This consensus included expert opinion on the topic and the clinical experience of practicing dentists. In addition, the research literature, and parameters and guidelines of other dental organizations were reviewed.

The American Dental Association recognizes that other interested parties, such as payers, courts, legislators and regulators may also opt to use these parameters. The Association encourages users to become familiar with these parameters as the profession's statement on the scope of clinical oral health care. However, these parameters are not designed to address considerations outside of the clinical arena and, therefore, may not be directly applicable to all health policy issues.

Furthermore, these "parameters" are intended to describe the range of acceptable treatment modalities and are not intended to establish "standards" of dental care, which are rigid and inflexible.

Throughout the parameter document, "dentist" refers to the patient's attending dentist. Additionally, elements of the parameters concerned with patient consent refer to the patient's parent, guardian, or other responsible party, when the patient is a minor or is incompetent.

The Association intends to continually develop, revise and maintain parameters, substantiating them, whenever possible, with oral health outcomes data, and with advances in dental technology and science. The parameters will be coordinated with other Association projects such as development of a diagnostic coding system for dentistry, a computer-based patient dental record, and quality assessment instruments and indicators.

APPENDICES 3-14

Appendix 3

Patient Requiring a Comprehensive Oral Evaluation

The key element in the design of this set of parameters for comprehensive evaluation is the professional judgment of the attending dentist, for a specific patient, at a specific time.

The patient's chief complaint, concerns and expectations should be considered by the dentist.

The dentist should perform a comprehensive oral evaluation when indicated in his or her professional judgment.

The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the diagnosis and management of the oral health condition.

The patient should be provided with appropriate information by the dentist about the diagnostic procedure(s) to be performed prior to giving consent to a comprehensive evaluation.

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by diagnostic procedures provided without the medication or its modification.

Any evaluation performed should be with the concurrence of the patient and the dentist. If the patient refuses diagnostic procedures, the dentist may decline to evaluate the patient. If the patient insists upon diagnostic procedures not considered by the dentist to be necessary for evaluation, the dentist may decline to provide those procedures.

The attending dentist should review for accuracy the data collected as part of patient evaluation, in the process of diagnosis and treatment planning.

The behavioral, psychologic, developmental and physiologic limitations of the patient should be considered by the dentist in performing the comprehensive evaluation and in developing the treatment plan.

The dentist should attempt to manage the patient's pain, anxiety and behavior during evaluation to facilitate safety and efficiency.

An extra-oral examination of the head and neck should be performed by the dentist to determine the presence of disease, structural anomalies, functional anomalies, and signs of physical abuse.

An intraoral examination should be performed by the dentist to determine existing conditions. These may include the presence of disease, structural anomalies, functional anomalies, and signs of physical abuse. All restorations, including fixed and removable prostheses, should be examined.

Radiographs or images of diagnostic quality should be obtained. The number and type of radiographs or images required to provide the information needed for diagnostic purposes will vary according to the needs of the individual patient and should be determined by the attending dentist.

Additional diagnostic tests relevant to the evaluation of the patient may be performed and used by the dentist in diagnosis and treatment planning.

When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.

The dentist should refer the patient to (an)other health professional(s) when he or she deems it to be in the best interest of the patient.

Relevant and appropriate information about the patient should be communicated between the referring dentist and the health professional(s) accepting the referral.

The patient should be informed of the findings and observations of the comprehensive evaluation.

The dentist should emphasize the prevention and early detection of oral disease through patient education in preventive oral health practices, which may include oral hygiene instructions.

The dentist may recommend that the patient return for further evaluation. The frequency and type of evaluation(s) should be determined by the dentist, based on the patient's risk factors.

The health history, and the findings and observations of the comprehensive evaluation and general health assessment, including counseling and recommended preventive measures, as well as consultations with and referrals to other health professionals, should be included in the patient's dental record.

Appendix 4

Patient of Record Requiring a Periodic Evaluation

The key element in the design of this set of parameters for periodic evaluation is the professional judgment of the attending dentist, for a specific patient, at a specific time.

The patient's chief complaint, concerns and expectations should be considered by the dentist.

The dentist should perform a periodic evaluation when indicated in his or her professional judgment.

The dental and medical histories should be updated by the dentist to identify medications and predisposing conditions that may affect the diagnosis and management of the oral health condition.

The patient should be provided with appropriate information by the dentist about the diagnostic procedure(s) to be performed prior to giving consent to a periodic evaluation.

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by diagnostic procedures provided without the medication or its modification.

Any evaluation performed should be with the concurrence of the patient and the dentist. If the patient refuses diagnostic procedures, the dentist may decline to evaluate the patient. If the patient insists upon diagnostic procedures not considered by the dentist to be necessary for evaluation, the dentist may decline to provide those procedures.

The attending dentist should review for accuracy the data collected as part of patient evaluation, in the process of diagnosis and treatment planning.

The behavioral, psychologic, developmental and physiologic limitations of the patient should be considered by the dentist in performing the periodic evaluation and in developing the treatment plan.

The dentist should attempt to manage the patient's pain, anxiety and behavior during evaluation to facilitate safety and efficiency.

The dentist should perform an extraoral examination of the head and neck and an intraoral examination to determine if changes have occurred since previous evaluations.

Radiographs or images of diagnostic quality should be obtained. The number and type of radiographs or images required to provide the information needed for diagnostic purposes will vary according to the needs of the individual patient and should be determined by the attending dentist.

Additional diagnostic tests relevant to the evaluation of the patient may be performed and used by the dentist in diagnosis and treatment planning.

When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.

The dentist should refer the patient to (an)other health professional(s) when he or she deems it to be in the best interest of the patient.

Relevant and appropriate information about the patient should be communicated between the referring dentist and the health professional(s) accepting the referral.

The patient should be informed of the findings and observations of the periodic evaluation.

The dentist should emphasize the prevention and early detection of oral disease through patient education in preventive oral health practices, which may include oral hygiene instructions.

The dentist may recommend that the patient return for further evaluation. The frequency and type of evaluation(s) should be determined by the dentist, based on the patient's risk factors.

Changes in the patient's health history, and the findings and observations of the periodic evaluation and general health assessment, including counseling and recommended preventive measures, as well as consultations with and referrals to other health professionals, should be included in the patient's dental record.

Appendix 5

Patient Requiring a Limited Evaluation of a Specific Problem

The key element in the design of this set of parameters for limited evaluation of a specific problem is the professional judgment of the attending dentist, for a specific patient, at a specific time.

The patient's chief complaint, concerns and expectations should be considered by the dentist.

The dentist should perform a limited evaluation when indicated in his or her professional judgment.

The patient should be provided with appropriate information by the dentist about the diagnostic procedure(s) to be performed prior to giving consent to a limited evaluation.

Any evaluation performed should be with the concurrence of the patient and the dentist. If the patient refuses diagnostic procedures, the dentist may decline to evaluate the patient. If the patient insists upon diagnostic procedures not considered by the dentist to be necessary for evaluation, the dentist may decline to provide those procedures.

Medications should be prescribed, modified and/or administered by the dentist to dental patients whose known conditions would affect or be affected by diagnostic procedures provided without the medication or its modification.

The attending dentist should review for accuracy the data collected as part of patient evaluation, in the process of diagnosis and treatment planning.

The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the diagnosis and management of the oral health condition.

The behavioral, psychologic, developmental and physiologic limitations of the patient should be considered by the dentist in performing the limited evaluation and in developing the treatment plan.

The dentist should attempt to manage the patient's pain, anxiety and behavior during evaluation to facilitate safety and efficiency.

A limited examination should be performed by the dentist to diagnose and determine the treatment for a specific oral health problem.

Radiographs or images of diagnostic quality should be obtained. The number and type of radiographs or images required to provide the information needed for diagnostic purposes will vary according to the needs of the individual patient and should be determined by the attending dentist.

Additional diagnostic tests relevant to the evaluation of the patient's specific oral health problem may be performed and used by the dentist in diagnosis and treatment planning.

When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.

The dentist should refer the patient to (an)other health professional(s) when he or she deems it to be in the best interest of the patient.

Relevant and appropriate information about the patient should be communicated between the referring dentist and the health professional(s) accepting the referral.

The patient should be informed of the findings and observations of the limited evaluation.

The dentist may take this opportunity to emphasize the prevention and early detection of oral disease through patient education in preventive oral health practices, which may include oral hygiene instructions.

The dentist may recommend that the patient return for further evaluation. The frequency and type of evaluation(s) should be determined by the dentist, based on the patient's risk factors.

The health history, and the findings and observations of the limited evaluation and general health assessment, including counseling and recommended preventive measures, as well as consultations with, and referrals to other health professionals, should be included in the patient's dental record.

Appendix 6

Patient Requiring a Detailed and Extensive Evaluation for a Specific Problem(s)

The key element in the design of this set of parameters for a detailed and extensive evaluation for a specific problem(s) is the professional judgment of the attending dentist, for a specific patient, at a specific time.

The patient's chief complaint, concerns and expectations should be considered by the dentist.

The dentist should perform a detailed and extensive evaluation for a specific problem(s) when indicated in his or her professional judgment.

The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the diagnosis and management of the oral health condition.

The patient should be provided with appropriate information by the dentist about the diagnostic procedure(s) to be performed prior to giving consent to a detailed and specific evaluation.

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by diagnostic procedures provided without the medication or its modification.

Any evaluation performed should be with the concurrence of the patient and the dentist. If the patient refuses diagnostic procedures, the dentist may decline to evaluate the patient. If the patient insists upon diagnostic procedures not considered by the dentist to be necessary for evaluation, the dentist may decline to provide those procedures.

The attending dentist should review for accuracy the data collected as part of patient evaluation, in the process of diagnosis and treatment planning.

The behavioral, psychologic, developmental and physiologic limitations of the patient should be considered by the dentist in performing the detailed and extensive evaluation and in developing the treatment plan.

The dentist should attempt to manage the patient's pain, anxiety and behavior during evaluation to facilitate safety and efficiency.

A detailed and extensive evaluation should be performed by the dentist for a specific oral health problem(s) that may require a multidimensional approach.

Radiographs or images of diagnostic quality should be obtained. The number and type of radiographs or images required to provide the information needed for diagnostic purposes will vary according to the needs of the individual patient and should be determined by the attending dentist.

Additional diagnostic tests relevant to the evaluation of the patient's specific oral health problem may be performed and used by the attending dentist in diagnosis and treatment planning.

When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.

The dentist should refer the patient to (an)other health professional(s) when he or she deems it to be in the best interest of the patient.

Relevant and appropriate information about the patient should be communicated between the referring dentist and the health professional(s) accepting the referral.

The patient should be informed of the findings and observations of the detailed and extensive evaluation.

The dentist may take this opportunity to emphasize the prevention and early detection of oral disease through patient education in preventive oral health practices, which may include oral hygiene instructions.

The dentist may recommend that the patient return for further evaluation. The frequency and type of evaluation(s) should be determined by the dentist, based on the patient's risk factors.

The health history, and the findings and observations of the detailed and extensive evaluation and general health assessment, including counseling and recommended preventive measures, consultations with, and referrals made to other health professionals, should be included in the patient's dental record.

Appendix 7

Dental Caries

The key element in the design of this set of parameters of dental caries is the professional judgment of the attending dentist, for a specific patient, at a specific time.

The patient's chief complaint, concerns and expectations should be considered by the dentist.

The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the management of dental caries.

Following oral evaluation and consideration of the patient's needs, the dentist should provide the patient with information about the nature of his or her dental caries prior to obtaining consent for treatment.

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification.

The dentist may counsel the patient concerning the potential effects of the patient's health condition and behaviors on his or her oral health.

The dentist should recommend treatment, present alternative treatments, if any, and discuss the probable benefits, limitations and risks associated with treatment and the probable consequences of no treatment.

Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.

The behavioral, psychologic, developmental and physiologic limitations of the patient should be considered by the dentist in developing the treatment plan.

The dentist should attempt to manage the patient's pain, anxiety and behavior during treatment to facilitate safety and efficiency.

When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.

Additional diagnostic tests relevant to the patient's dental caries may be performed and used by the dentist in diagnosis and treatment planning.

The dentist should refer the patient to (an)other health professional(s) when he or she deems it to be in the best interest of the patient.

Relevant and appropriate information about the patient should be communicated between the referring dentist and the health professional(s) accepting the referral.

After consideration of the individual circumstances, the dentist should decide whether the tooth with a carious lesion(s) should be monitored, treated or removed.

Factors affecting the patient's speech, function, and aesthetics should be considered by the dentist in developing a treatment plan.

The dentist should emphasize the prevention and early detection of oral disease through patient education in preventive oral health practices, which may include oral hygiene instructions.

The dentist should consider the characteristics and requirements of each case in selecting the material(s) and technique(s) to be utilized.

The tooth preparation should be appropriate for the extent of the lesion and/or the choice of the restorative material.

All clinically apparent caries should be removed before the restoration is placed, except in those instances where indirect pulp-capping or pulpotomy techniques are used.

Pulpal tissue should be protected by the dentist when indicated.

The restorative material selected should restore form and function, and withstand the forces of occlusion.

The dentist may modify occluding, articulating, adjacent, or approximating teeth to enhance the final restoration's form and function as well as its ability to withstand the forces of occlusion.

Tissues and/or restorations adjacent to the restorative site may be altered by the dentist to facilitate treatment or sustain the tooth being restored.

Orthodontic repositioning may be performed by the dentist to facilitate treatment.

Transitional or provisional restorations may be utilized by the dentist to facilitate treatment or reduce pulpal symptoms.

Dental sealants may be applied as a preventive measure.

Chemotherapeutic agents may be used for caries prevention and the treatment of incipient caries.

Modification of the root surface followed by application of chemotherapeutic agents may be used to treat caries.

Depth and narrowness of pits and fissures may be modified by the dentist for caries prevention.

Dietary fluoride supplements may be prescribed by the dentist.

Topical fluoride may be applied or prescribed as a preventive measure.

Endodontic therapy and/or root resection may be performed by the dentist in the treatment of caries.

Teeth may be removed, as determined by the dentist. When appropriate, the patient should be informed of the necessity to replace any removed teeth.

The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and the condition of the oral cavity.

The dentist should determine the frequency and type of preventive treatment based on the patient's risk factors or presence of oral disease.

Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient's dental record.

Appendix 8

Periodontium Without Clinically Apparent Inflammation

The key element in the design of this set of parameters for periodontium without clinically apparent inflammation is the professional judgment of the attending dentist, for a specific patient, at a specific time.

The patient's chief complaint, concerns and expectations should be considered by the dentist.

The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the management of the patients with a periodontium without clinically apparent inflammation.

Following oral evaluation and consideration of the patient's needs, the dentist should provide the patient with information about the nature of his or her periodontium without clinically apparent inflammation prior to obtaining consent for treatment.

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification.

The dentist may counsel the patient concerning the potential effects of the patient's health condition and behaviors on his or her oral health.

The dentist should recommend treatment, present alternative treatments, if any, and discuss the probable benefits, limitations and risks associated with treatment and the probable consequences of no treatment.

Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

When the dentist considers it necessary, (an)other health professional(s) should be consulted to acquire additional information.

Following oral evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.

Additional diagnostic tests relevant to the patient's periodontium without clinically apparent inflammation may be performed and used by the dentist in diagnosis and treatment planning.

The behavioral, psychologic, developmental and physiologic limitations of the patient should be considered by the dentist in developing the treatment plan.

The dentist should attempt to manage the patient's pain, anxiety and behavior during treatment to facilitate safety and efficiency.

The dentist should refer the patient to (an)other health professional(s) when he or she deems it to be in the best interest of the patient.

Relevant and appropriate information about the patient should be communicated between the referring dentist and the health professional(s) accepting the referral.

The dentist should assess the potential for periodontal disease, even in the absence of clinically apparent inflammation.

The dentist should emphasize the prevention and early detection of oral disease through patient education in preventive oral health practices, which may include oral hygiene instructions.

The patient should be informed that the success of the treatment is often dependent upon patient compliance with home care instructions and recommendations for behavioral modifications. Lack of compliance should be recorded.

The patient should be encouraged to participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and the condition of the periodontium.

The dentist should determine the frequency and type of preventive measures based on the patient's risk factors or presence of oral disease.

Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient's dental record.

Appendix 9

Gingival Inflammation Without Loss of Periodontal Attachment (gingivitis)

The key element in the design of this set of parameters for gingival inflammation without the loss of periodontal attachment (gingivitis) is the professional judgment of the attending dentist, for a specific patient, at a specific time.

The patient's chief complaint, concerns and expectations should be considered by the dentist.

The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the management of gingivitis.

Following oral evaluation and consideration of the patient's needs, the dentist should provide the patient with information about the nature of his or her gingivitis prior to obtaining consent for treatment.

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification.

The dentist may counsel the patient concerning the potential effects of the patient's health condition and behaviors on his or her oral health.

The dentist should recommend treatment, present alternative treatments, if any, and discuss the probable benefits, limitations and risks associated with treatment and the probable consequences of no treatment.

Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

When the dentist considers it necessary, (an)other health professional(s) should be consulted to acquire additional information.

When recommending treatment, the dentist should recognize that periodontal disease can be episodic or linear, and generalized or site-specific.

Following oral evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.

The behavioral, psychologic, developmental and physiologic limitations of the patient should be considered by the dentist in developing the treatment plan.

The dentist should attempt to manage the patient's pain, anxiety and behavior during treatment to facilitate safety and efficiency.

The dentist should refer the patient to (an)other health professional(s) when he or she deems it to be in the best interest of the patient.

Relevant and appropriate information about the patient should be communicated between the referring dentist and the health professional(s) accepting the referral.

The dentist should emphasize the prevention and early detection of oral disease through patient education in preventive oral health practices.

The patient should be informed that the success of the treatment is often dependent upon patient compliance with home care instructions and recommendations for behavioral modifications. Lack of compliance should be recorded.

The presence of carious lesions should be considered in developing a treatment plan.

The relationship of the mucogingival junction to the loss of attachment should be noted and considered in developing a treatment plan.

Additional diagnostic tests relevant to the patient's gingivitis may be performed and used by the dentist in diagnosis and treatment planning.

Clinically apparent plaque, calculus and other local etiologic factors should be removed.

Chemotherapeutic agents may be used by the dentist to facilitate treatment.

Alteration of tooth morphology and/or position, placement of restorations, modification or replacement of restorations, and treatment of carious lesions may be performed by the dentist to facilitate treatment.

Gingival tissue may be altered by the dentist to produce a more acceptable gingival contour.

The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and the condition of the periodontium.

The dentist should determine the frequency and type of preventive treatment, based on the patient's risk factors or presence of oral disease.

Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient's dental record.

Appendix 10

Gingival Inflammation With Loss of Connective Tissue Attachment (periodontitis)

The key element in the design of this set of parameters for gingival inflammation with loss of connective tissue attachment (periodontitis) is the professional judgment of the attending dentist, for a specific patient, at a specific time.

The patient's chief complaint, concerns and expectations should be considered by the dentist.

The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the management of periodontitis.

Following oral evaluation and consideration of the patient's needs, the dentist should provide the patient with information about the nature of his or her periodontitis prior to obtaining consent for treatment.

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification.

The dentist may counsel the patient concerning the potential effects of the patient's health condition and behaviors on his or her oral health.

The dentist should recommend treatment, present alternative treatments, if any, and discuss the probable benefits, limitations and risks associated with treatment and the probable consequences of no treatment.

Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

When the dentist considers it necessary, (an)other health professional(s) should be consulted to acquire additional information.

When recommending treatment, the dentist should recognize that periodontal disease can be episodic or linear, and generalized or site-specific.

Following oral evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.

The behavioral, psychologic, developmental and physiologic limitations of the patient should be considered by the dentist in developing the treatment plan.

The dentist should attempt to manage the patient's pain, anxiety and behavior during treatment to facilitate safety and efficiency.

The dentist should refer the patient to (an)other health professional(s) when he or she deems it to be in the best interest of the patient.

Relevant and appropriate information about the patient should be communicated between the referring dentist and the health professional(s) accepting the referral.

The dentist should emphasize the prevention and early detection of oral disease through patient education in preventive oral health practices, which may include oral hygiene instructions.

The patient should be informed that the success of the treatment is often dependent upon patient compliance with home care instructions and recommendations for behavioral modifications. Lack of compliance should be recorded.

Additional diagnostic tests relevant to the periodontitis of the patient may be performed and used by the dentist in diagnosis and treatment planning.

The presence of carious lesions should be considered in developing a treatment plan.

The relationship of the mucogingival junction to the loss of attachment should be noted and considered in developing a treatment plan.

Clinically apparent plaque, calculus and other local etiologic factors should be removed.

Root planing should be performed.

Chemotherapeutic agents may be used by the dentist to facilitate treatment.

Alteration of tooth morphology and/or position, placement of restorations, modification or replacement of restorations, and treatment of carious lesions may be performed by the dentist to facilitate treatment.

The replacement of missing teeth and/or those indicated for extraction may be performed by the dentist to facilitate treatment.

Occlusal analysis and adjustments may be performed by the dentist to facilitate treatment.

Occlusal guards and/or splinting may be used by the dentist to stabilize mobile teeth.

Resective, regenerative, recontouring and/or augmentation procedures may be performed by the dentist.

Root resection may be performed by the dentist.

Endodontic therapy may be performed by the dentist.

Teeth may be removed as determined by the dentist.

The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and the condition of the periodontium.

The dentist should determine the frequency and type of preventive treatment, based on the patient's risk factors or presence of oral disease.

Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient's dental record.

Appendix 11

Partially Edentulous Arch(es)

The key element in the design of this set of parameters for partially edentulous arch(es) is the professional judgment of the attending dentist, for a specific patient, at a specific time.

The patient's chief complaint, concerns and expectations should be considered by the dentist.

The dental and medical histories should be considered by the dentist in identifying medications and predisposing conditions

that may affect the management of patients with partial edentulism.

Following oral evaluation and consideration of the patient's needs, the dentist should provide the patient with information about the nature of his or her partially edentulous arch(es) prior to obtaining consent for treatment.

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification.

When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.

Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.

The behavioral, psychologic, developmental and physiologic limitations of the patient should be considered by the dentist in the treatment plan.

The dentist should attempt to manage the patient's pain, anxiety and behavior during treatment to facilitate safety and efficiency.

The dentist may counsel the patient concerning the potential effects of the patient's health condition and behaviors on his or her oral health.

The dentist should refer the patient to (an)other health professional(s) when he or she deems it to be in the best interests of the patient.

Relevant and appropriate information about the patient should be communicated between the referring dentist and the health professional(s) accepting the referral.

The dentist should recommend treatment, present alternative treatments, if any, and discuss the probable benefits, limitations and risks associated with treatment and the probable consequences of no treatment.

The patient should be informed that the success of treatment is often dependent upon his or her adaptability to and acceptance and tolerance of the prosthesis.

Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

The dentist should emphasize the prevention and early detection of oral disease through patient education in preventive oral health practices, which may include oral hygiene instructions.

After consideration of the individual circumstances, the dentist should determine if the missing tooth (teeth) should be replaced.

Additional diagnostic procedures relevant to the patient's partially edentulous arch(es) may be performed and used by the dentist in developing a treatment plan.

The presence, prognosis, stability, positions, and treatment implications of any teeth, implants or prostheses in the opposing arch should be considered by the dentist in developing and implementing a treatment plan.

The dentist should consider the characteristics and requirements of each case in selecting the material(s) and technique(s) to be utilized.

Factors affecting the patient's speech, function, and aesthetics should be considered by the dentist in developing a treatment plan.

Tooth, implant, and/or tissue supported prosthetic options should be considered by the dentist in developing a treatment plan.

Fixed prosthesis(es), removable prosthesis(es) or a combination of these prosthetic options should be considered by the dentist in developing a treatment plan.

Soft and hard tissue characteristics and morphology, ridge relationships, occlusion and occlusal forces, aesthetics, and parafunctional habits should be considered by the dentist in the design of the prosthesis(es).

Restorative implications, endodontic status, tooth position, and periodontal prognosis should be considered by the dentist in developing a treatment plan.

Craniofacial, musculoskeletal relationships, including the clinically apparent status of the temporomandibular joints, should be considered by the dentist in developing a treatment plan.

The selected treatment should be compatible with the surrounding oral tissues and should be accessible for maintenance.

Alteration of tooth morphology and/or occlusal plane, orthodontic repositioning, and placement, replacement or modification of restorations may be performed by the dentist to facilitate treatment.

Teeth with carious lesions should be monitored or treated by the dentist.

Endodontic therapy may be performed by the dentist to facilitate treatment.

Teeth may be removed by the dentist to facilitate treatment.

Occlusal adjustments, guards and/or splinting may be used by the dentist to facilitate treatment.

Periodontal surgical procedures may be performed by the dentist to facilitate treatment.

Pre-prosthetic surgical procedures to alter hard and soft tissue morphology may be performed by the dentist to facilitate treatment.

Oral and maxillofacial surgical procedures may be performed by the dentist to facilitate treatment.

Tissue conditioners may be used by the dentist to facilitate treatment.

Transitional or provisional prostheses may be utilized by the dentist to facilitate treatment.

The dentist should communicate to the dental laboratory technician necessary information and authorization for fabrication of the prosthesis(es). Although the fabrication may be delegated, the dentist is responsible for the accuracy of the prosthesis(es).

Removable prostheses may be repaired, modified, relined, rebased or replaced, as determined by the dentist.

Fixed prostheses may be repaired, modified or replaced, as determined by the dentist.

The patient should be instructed by the dentist in the use and care of the prosthesis. The patient should be informed that the success of treatment is often dependent upon his or her compliance with the instructions. Lack of compliance should be recorded.

The patient should be informed by the dentist that the prosthesis(es) may need future replacement, rebasing and/or relining.

The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the prosthesis(es) and the condition of the oral cavity.

The dentist should determine the frequency and type of preventive treatment based on the patient's risk factors or presence of oral disease.

Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient's dental record.

Appendix 12

Edentulous Arch(es)

The key element in the design of this set of parameters for edentulous arch(es) is the professional judgment of the attending dentist, for a specific patient, at a specific time.

The patient's chief complaint, concerns and expectations should be considered by the dentist.

The dental and medical histories should be considered by the dentist in identifying medications and predisposing conditions that may affect the management of patients with edentulism.

Following oral evaluation and consideration of the patient's needs, the dentist should provide the patient with information about the nature of his or her edentulous arch(es) prior to obtaining consent for treatment.

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification.

When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.

Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.

The behavioral, psychologic, developmental and physiologic limitations of the patient should be considered by the dentist in the treatment plan.

The dentist should attempt to manage the patient's pain, anxiety and behavior during treatment to facilitate safety and efficiency.

The dentist may counsel the patient concerning the potential effects of the patient's health condition and behaviors on his or her oral health.

The dentist should refer the patient to (an)other health professional(s) when he or she deems it to be in the best interests of the patient.

Relevant and appropriate information about the patient should be communicated between the referring dentist and the health professional(s) accepting the referral.

The dentist should recommend treatment, present alternative treatments, if any, and discuss the probable benefits, limitations and risks associated with treatment and the probable consequences of no treatment.

The patient should be informed that the success of treatment is often dependent upon his or her adaptability to and acceptance and tolerance of the prosthesis.

Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

The dentist should emphasize the prevention and early detection of oral disease through patient education in preventive oral health practices, which may include oral health instructions.

After consideration of the individual circumstances, the dentist should determine if the missing teeth should be replaced.

Additional diagnostic procedures relevant to the patient's edentulous arch(es) may be performed and used by the dentist in developing a treatment plan.

The presence, prognosis, stability, position, and treatment implications of any teeth, implants or prostheses in the opposing arch should be considered by the dentist in developing and implementing a treatment plan.

The dentist should consider the characteristics and requirements of each case in selecting the material(s) and technique(s) to be utilized.

Factors affecting the patient's speech, function, and aesthetics should be considered by the dentist in developing a treatment plan.

Tissue and/or implant supported prosthetic options should be considered by the dentist in developing a treatment plan.

Fixed prosthesis(es), removable prosthesis(es) or a combination of these prosthetic options should be considered by the dentist in developing a treatment plan.

Soft and hard tissue characteristics and morphology, ridge relationships, occlusion and occlusal forces, aesthetics, and parafunctional habits should be considered by the dentist in the design of the prosthesis(es).

Craniofacial, musculoskeletal relationships, including the clinically apparent status of the temporomandibular joints, should be considered by the dentist in developing a treatment plan.

The selected treatment should be compatible with the surrounding oral tissues and should be accessible for maintenance.

Pre-prosthetic surgical procedures to alter hard and soft tissue morphology may be performed by the dentist to facilitate treatment.

Oral and maxillofacial surgical procedures may be performed by the dentist to facilitate treatment.

Tissue conditioners may be used by the dentist to facilitate treatment.

Transitional or provisional prostheses may be utilized by the dentist to facilitate treatment.

The dentist should communicate to the dental laboratory technician necessary information and authorization for fabrication of the prosthesis(es). Although the fabrication may be delegated, the dentist is responsible for the accuracy of the prosthesis(es).

Removable prostheses may be repaired, modified, relined, rebased or replaced, as determined by the dentist.

Fixed, implant supported prostheses may be repaired, modified or replaced, as determined by the dentist.

The patient should be instructed by the dentist in the use and care of the prosthesis(es). The patient should be informed that the success of treatment is often dependent upon his or her

compliance with the instructions. Lack of compliance should be recorded.

The patient should be informed by the dentist that the prosthesis(es) may need future replacement, rebasing and/or relining.

The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the prosthesis(es) and the condition of the oral cavity.

The dentist should determine the frequency and type of preventive treatment based on the patient's risk factors or presence of oral disease.

Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient's dental record.

Appendix 13

Fractured (Cracked) Tooth

The key element in the design of this set of parameters for a fractured tooth is the professional judgment of the attending dentist, for a specific patient, at a specific time.

The patient's chief complaint, concerns and expectations should be considered by the dentist.

The dental and medical histories should be considered by the dentist in identifying medications and predisposing conditions that may affect the management of patients with a fractured tooth.

Following oral evaluation and consideration of the patient's needs, the dentist should provide the patient with information about the nature of his or her fractured (cracked) tooth prior to obtaining consent for treatment.

The patient should be provided appropriate information by the dentist about fractured (cracked) tooth prior to giving consent for treatment.

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification.

The dentist may counsel the patient concerning the potential effects of the patient's health condition and behaviors on his or her oral health.

The dentist should recommend treatment, present alternative treatments, if any, and discuss the probable benefits, limitations and risks associated with treatment and the probable consequences of no treatment.

Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.

The behavioral, psychologic, developmental and physiologic limitations of the patient should be considered by the dentist in the treatment plan.

The dentist should attempt to manage the patient's pain, anxiety and behavior during treatment to facilitate safety and efficiency.

When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.

Additional diagnostic tests relevant to the patient's fractured (cracked) tooth may be performed and used by the dentist in diagnosis and treatment planning.

The dentist may take this opportunity to emphasize the prevention and early detection of oral disease through patient education in preventive oral health practices, which may include oral hygiene instructions.

The dentist should refer the patient to (an)other health professional(s) when he or she deems it to be in the best interests of the patient.

Relevant and appropriate information about the patient should be communicated between the referring dentist and the health professional(s) accepting the referral.

After consideration of the circumstances in each case, including the condition of the hard and soft tissues, and the extent and type of fracture, the dentist should determine whether the fractured tooth should be monitored, treated or removed.

The dentist should consider the characteristics and requirements of each case, in selecting the material(s) and technique(s) to be utilized.

The dentist may facilitate treatment by restorative and surgical extension of the clinical crown, orthodontic repositioning, or a combination of these.

Pulpal tissue should be protected by the dentist when indicated.

The dentist may modify occluding, articulating, adjacent, or approximating teeth to enhance the final restoration's form and function as well as its ability to withstand the normal forces of occlusion.

Tissues and/or restorations adjacent to the restorative site may be altered by the dentist to facilitate treatment.

Orthodontic repositioning and/or alteration of tooth morphology adjacent to the restorative site may be performed by the dentist to facilitate treatment.

Transitional or provisional restorations may be utilized by the dentist to facilitate treatment or reduce pulpal symptoms.

An interim treatment may be utilized by the dentist to attempt reduction of signs and symptoms.

Fractured tooth fragments may be removed.

Endodontic therapy and root resection may be used by the dentist in treating a fractured tooth.

Stabilization may be used by the dentist in the treatment of fractured teeth.

Occlusal guards may be used by the dentist for patients with fractured teeth.

Fractured teeth may be removed, as determined by the dentist.

The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and the status of the fractured tooth.

The dentist should determine the frequency and type of preventive treatment based on the patient's risk factors or presence of oral disease.

Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations

with and referrals to other health care professionals, should be included in the patient's dental record.

Appendix 14

Patient Without Clinical Signs or Symptoms of Oral Disease

The key element in the design of this set of parameters for patients without clinical signs or symptoms of oral disease is the professional judgment of the attending dentist, for a specific patient, at a specific time.

This parameter recognizes that the patient without clinical signs and symptoms may require counseling and preventive measures to assist in maintaining oral health.

The patient's chief complaint, concerns and expectations should be considered by the dentist.

The patient's aesthetic concerns and needs may be considered by the dentist.

The dental and medical histories should be considered by the dentist in identifying medications and predisposing conditions that may affect the management of patients.

Following oral evaluation and consideration of the patient's needs, the dentist should provide the patient with information about the status of his or her oral health prior to obtaining consent for treatment.

The patient should be provided with appropriate information by the dentist about the status of his or her oral health prior to giving consent for treatment.

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification.

The dentist may counsel the patient concerning the potential effects of the patient's health condition and behaviors on his or her oral health.

The dentist should recommend treatment, present alternative treatments, if any, and discuss the probable benefits, limitations and risks associated with treatment and the probable consequences of no treatment.

Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.

The behavioral, psychologic, developmental and physiologic limitations of the patient should be considered by the dentist.

The dentist should attempt to manage the patient's anxiety and behavior to facilitate counseling and potential treatment.

The dentist should emphasize the prevention and early detection of oral disease through patient education in preventive oral health practices, which may include oral hygiene instructions.

The dentist should refer the patient to (an)other health professional(s) when he or she deems it to be in the best interests of the patient.

Relevant and appropriate information about the patient should be communicated between the referring dentist and the health professional(s) accepting the referral.

The dentist is responsible for providing the patient with appropriate information about the maintenance of oral health, and the common risks and limitations associated with preventive measures. The patient should also be informed about the benefits of these measures and the potential consequences of no preventive treatment.

Nutrition counseling may be provided to assist in maintaining oral health.

Counseling may be provided regarding tobacco use or other behaviors that may compromise oral health.

Counseling may be provided regarding those general health conditions that may compromise oral health.

Dental sealants may be applied to pits and fissures as a preventive measure.

Counseling may be provided concerning the relationship of the fluoride levels in drinking water to dental caries and fluorosis.

Dietary fluoride supplements may be prescribed by the dentist.

Topical fluoride may be applied or prescribed as a preventive measure.

Nicotine cessation medications may be prescribed by the dentist.

Prophylaxis may be performed as determined by the dentist.

Oral protective appliances may be fabricated to reduce the risk of injuries.

The dentist should determine the frequency and type of preventive measures based on the patient's risk factors.

Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient's dental record.

Council on Dental Benefit Programs

Supplemental Report 2: Update on Council Activities

Background: At its April meeting, there were several issues that the Council on Dental Benefit Programs was unable to bring to closure. These issue are "Definitions," "Authorization of Benefits" and "Viewing of Radiographs."

Definitions: The 1993 House of Delegates adopted Resolution 150H-1993 (*Trans.*1993:691) which reads as follows:

> **Resolved,** that the appropriate agencies of the Association expeditiously develop definitions for the terms "primary care," "freedom of choice," "fee-for-service," "indigent," "balance billing" and any other appropriate term not clearly defined found in relevant health care reform proposals for submission to the Board of Trustees for approval, and be it further
> **Resolved,** that these terms, as defined, be used by the Association in its deliberations on health care reform.

The Council on Dental Benefit Programs (CDBP) developed definitions for these terms at its December 1993 meeting and submitted those definitions to the Board of Trustees and the Council on Governmental Affairs and Federal Dental Services (CGAFDS). CGAFDS made some changes and submitted the revised definitions to CDBP at its April 1994 meeting. These definitions are contained in Supplemental Report 1 of the Council on Governmental Affairs and Federal Dental Services to the House of Delegates (*Supplement*:321).

Both Councils agreed on definitions for "fee-for-service," "indigent" and "balance billing."

In its "freedom of choice" definition, CGAFDS added the phrase, "without economic discrimination." CDBP believes that the addition of these words makes the definition applicable to a third-party payment environment rather than a distinct definition of a patient's right as proposed by CDBP. Therefore, CDBP believes that the phrase should not be included in the definition and the definition should remain as originally submitted.

CGAFDS also amended CDBP's definitions of "primary dental care" and "primary dental care provider" by adding the word "examination." CDBP had originally changed these definitions to reflect an emphasis on the cognitive aspects of dentistry. Since "examination" is already contained in the term "evaluation," CDBP does not believe it is necessary to list "examination" separately. In fact, CDBP believes that adding the word "examination" may open the definition to a wide range of interpretation. Therefore, CDBP recommends that these definitions should remain as originally submitted.

Authorization of Benefits: At its April meeting, the Council reviewed the recommendation of the Standardized Dental Claim Form Advisory Group (comprised of representatives of the Council, the Health Insurance Association of America, Blue Cross and Blue Shield Association, Delta Dental Plans Association and members of the Electronic Claims Transmission Industry) to have legal counsel representing each of the members of the group review the signature block of the ADA Dental Claim Form for authorization to pay. After further review, the attorneys recommended to the Council that the block in question remain as follows:

> I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Current Association policy refers to *assignment*, not *authorization*, of benefits. The ADA Dental Claim Form does not include a true assignment of benefits. However, it includes an authorization of payment. Under a true assignment of benefits, a patient would "assign" the benefits he or she is eligible to receive to the dentist or another party. However, if the patient has either reached his or her maximum level of benefits for the year or is no longer eligible to receive benefits, the dentist could potentially receive no payment because the patient wasn't eligible for coverage. Generally, the right of the assignee (dentist) to the benefits is the same as the assignor (patient), subject to the same conditions and defenses.

The patient's signature on an authorization of payment, however, indicates that the patient authorizes the payer to reimburse the dentist directly. The dentist is not considered a part of the contract between the patient and the payer. Therefore, the dentist should still have some recourse with the patient if the patient is not eligible to receive benefits.

In order to gain consistency between Association policy and the ADA Dental Claim Form, the Council recommends adoption of the following resolution.

48. Resolved, that the American Dental Association supports the right of each dentist to accept or reject authorized benefits from any dental benefits plan, and be it further
Resolved, that the Association supports the right of every patient to authorize that his or her benefits be paid to the treating dentist and to have the authorization honored by the third-party payer, and be it further
Resolved, that when a third-party payer inadvertently submits payment directly to the patient, contrary to the patient's authorized preference, it is the responsibility of the third-party payer to submit the correct payment to the dentist and reclaim the erroneously submitted payment from the patient, and be it further
Resolved, that in those states where dentists are not notified of the rescission of a prior authorization of benefits, the Association encourage state dental societies to seek legislative relief, and be it further
Resolved, that Resolution 13H-1990 (*Trans.*1990:539), Assignment of Benefits, be rescinded.

Viewing of Radiographs: The Council on Dental Practice, the Council on Dental Benefit Programs, and the Council on Dental Materials, Instruments and Equipment have jointly recommended the rescission of the policies, ADA Tooth Numbering System and Nomenclature (*Trans.*1984:524) and System of Tooth Numbering and Radiograph Mounting (*Trans.*1968:25, 247) due to the necessity of a worldwide tooth numbering standard to be used in electronic data

interchange (*Supplement*:288). However, the second policy contains information regarding the viewing of radiographs that is not covered in any other policy.

The Council on Dental Benefit Programs proposes the addition of the following wording to guideline number six of the Guidelines on the Use of Radiographs in Dental Care Programs (*Trans.*1990:540): "Also, when looking at the teeth from outside the mouth, radiographs should be viewed in the same manner. For example, the raised dot in the film should face toward the person mounting the radiographs." Therefore, the Council recommends adoption of the following resolution.

49. Resolved, that the Association's Guidelines on the Use of Radiographs in Dental Care Programs (*Trans.*1990:540) be amended by the addition of the following sentences to guideline number six. "Also, when looking at the teeth from outside the mouth, radiographs should be viewed in the same manner. For example, the raised dot in the film should face toward the person mounting the radiograph." so that the guideline reads as follows:

6. It is important that radiographs be correctly mounted and are of diagnostic quality. Also, when looking at the teeth from outside the mouth, radiographs should be viewed in the same manner. For example, the raised dot in the film should face toward the person mounting the radiographs.

Summary of Resolutions

48. Resolved, that the American Dental Association supports the right of each dentist to accept or reject authorized benefits from any dental benefits plan, and be it further
Resolved, that the Association supports the right of every patient to authorize that his or her benefits be paid to the treating dentist and to have the authorization honored by the third-party payer, and be it further
Resolved, that when a third-party payer inadvertently submits payment directly to the patient, contrary to the patient's authorized preference, it is the responsibility of the third-party payer to submit the correct payment to the dentist and reclaim the erroneously submitted payment from the patient, and be it further
Resolved, that in those states where dentists are not notified of the rescission of a prior authorization of benefits, the Association encourage state dental societies to seek legislative relief, and be it further
Resolved, that Resolution 13H-1990 (*Trans.*1990:539), Assignment of Benefits, be rescinded.

49. Resolved, that the Association's Guidelines on the Use of Radiographs in Dental Care Programs (*Trans.*1990:540) be amended by the addition of the following sentences to guideline number six. "Also, when looking at the teeth from outside the mouth, radiographs should be viewed in the same manner. For example, the raised dot in the film should face toward the person mounting the radiograph." so that the guideline reads as follows:

6. It is important that radiographs be correctly mounted and are of diagnostic quality. Also, when looking at the teeth from outside the mouth, radiographs should be viewed in the same manner. For example, the raised dot in the film should face toward the person mounting the radiographs.

Joint Report of the Council on Dental Benefit Programs, the Council on Dental Materials, Instruments and Equipment and the Council on Dental Practice

Electronic Data Interchange and Designation Systems for Teeth

Background: The American Dental Association has been actively involved in issues of electronic data interchange through its Councils on Dental Practice (CDP), Dental Benefit Programs (CDBP), and Dental Materials, Instruments and Equipment (CDMIE), as well as the Department of Dental Informatics. Much of this activity stems from Resolutions 16H-1992 (*Trans.*1992:606); 17H-1992 (*Trans.*1992:597); 18H-1992 (*Trans.*1992:597) and 19H-1992 (*Trans.*1992:597) adopted by the 1992 House of Delegates, which read as follows:

> **16H-1992. Resolved,** that the American Dental Association represent the interests of the dental profession in all aspects of the development, growth and implementation of electronic technologies with administrative and clinical applications in dentistry, computer-based patient records, practice management systems, diagnostic and treatment applications of new technology, and the appropriate security systems to maintain confidentiality.
>
> **17H-1992. Resolved,** that the American Dental Association be actively involved at the policy-making levels of national organizations responsible for developing standards in electronic data interchange (EDI) that will affect the clinical, administrative, scientific and educational components of dentistry.
>
> **18H-1992. Resolved,** that the American Dental Association facilitate the development of electronic dental patient records through involvement with appropriate organizations and efforts to resolve legal, legislative and regulatory barriers to the evolution of this application of electronic technology.
>
> **19H-1992. Resolved,** that the American Dental Association, through appropriate means, seek to gain access to aggregate databases relating to dental treatment, patient care, epidemiology, scientific research, education, practice management, health services research and other areas.

The Association, through the CDMIE, has been sponsoring a standards program for dental materials, instruments and equipment since 1928. The Association is sponsor and secretariat of the Accredited Standards Committee (ASC) Medical Devices (MD) 156. Under a task group of the ASC MD 156, there are four separate standards-setting work groups coordinated entirely by the ADA. These groups are developing standards for 1) central processing units/office management systems; 2) diagnostic and clinical peripheral devices and software; 3) Electronic Data Interchange (EDI) communication protocols; and 4) computer-based patient oral health records software interfaces.

The Association is also a full voting member of the American Standards National Institute (ANSI) ASC X12 Committee dealing with claims reimbursement issues and the ANSI Healthcare Informatics Standards Planning Panel (HISPP). The Association also regularly attends the meetings of the Computer-Based Patient Records Institute (CPRI).

Within the Association, CDBP is developing a dental diagnostic coding system to be used in an electronic environment. CDP, through a working committee, is describing the basic content elements of the oral health record, and CDMIE, through its MD 156 standards groups, will be developing various technical papers, guidelines and standards to describe how this oral health information can be integrated into a clinical workstation and collected in a systematic and consistent manner.

Certainly, strategies proposed to improve the dental electronic infrastructure have been dramatic. For example, national groups have proposed the development of national standards for documenting and sharing patient information. This is suggested for patient data definition, codes, terminology, intersystem communication and uniform provider, patient and payer identifiers.[1] This Health and Human Services work group also recommended standards for the protection of the confidentiality of patient information and the development of interconnected communication networks to share patient data.

The rationale for any standardization lies in the harmony that can be provided for: 1) electronic communication between professionals, irrespective of practice locale; 2) monitoring of the patients' oral conditions or treatments; 3) practice management systems and business uses; and 4) data aggregation for professional research.

Current Environment: Today, patients' health information is contained in a myriad of forms, formats and locations. This fragmented approach can often lead to poor documentation as well as expensive and time-consuming duplicative efforts. Estimates indicate that over 60% of dental offices in the U.S. have computers. While studies show that more offices are installing computers, they are mainly used for administrative functions such as accounting, billing and word processing.

---

[1] "Toward a National Health Information Infrastructure," Work Group on Computerization of Patient Records to the Secretary of Health and Human Services, April 1993.

Computerizing the Patients' Oral Record: The Association's activities listed in this report are designed to bring greater comparability and standardization to the collection and transfer of data which must occur for information to be better used, analyzed and interpreted. For any computerized patient oral health record to meet the needs of practitioners, researchers and patients, the Association must continue to foster policies and programs that will facilitate this standardization process. A computer-based patient oral health record must be flexible enough to fully support patient care, improve quality, enhance productivity and enrich the research possibilities. Ultimately, practitioners must have this information in order to assist in practice decision-making and patient treatment.

EDI experts agree that digitalization of as many aspects of the record as possible is essential. The greatest argument for digitalizating record elements is that digits are not abstract; they are quantifiers of both rank and value. In that sense, they are conducive to scale systems and can therefore provide indices, aggregation and scanning.

Different Designation Systems for Teeth and Areas of the Oral Cavity for Use in Computers: The increasing use of computers to store information and to electronically transmit that information to others would be greatly facilitated if the systems were compatible with one another in common language, syntax or format. One such area of compatibility is the tooth designation system. A logical and useful designation system should be:

- simple and easy to understand;
- easy to pronounce in conversation;
- readily communicable by print and electronic media;
- easy to translate into computer input data; and
- easily adaptable to standardization.

Goaz[2] has identified 32 different tooth designation systems from several countries and cultures. Despite all these variations, there are two major tooth designation systems in use and another that is infrequently used. They are:

1. Universal or National System. This System is the most used method in the United States. Teeth are numbered 1-32, starting with the third molar (1) on the right side of the upper arch, following around the arch to the third molar (16) on the left side, and descending to the lower third molar (17) on the left side and following that arch to the lower right third molar (32). Consecutive upper case letters (A-T), in the same order as described in the numbering system, are used to identify the primary dentition. A schematic of this system is shown below:

FIG. 1 Universal/National System

Upper Right								Upper Left							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
			A	B	C	D	E	F	G	H	I	J			
			T	S	R	Q	P	O	N	M	L	K			
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Lower Right								Lower Left							

2. The International Standards Organization (ISO) 3950:1984. This System is based on the ISO Technical Committee (TC) 106 approval of the nomenclature agreed to by the Federal Dentaire International (FDI) and the World Health Organization (WHO). This method designates the oral cavity by a two-digit number with at least one of the two digits being zero, as follows:

00 designates the whole of the oral cavity
01 designates the maxillary area
02 designates the mandibular area
10 designates the upper right quadrant
20 designates the upper left quadrant
30 designates the lower left quadrant
40 designates the lower right quadrant
03 designates the upper right sextant
04 designates the upper anterior sextant
05 designates the upper left sextant
06 designates the lower left sextant
07 designates the lower anterior sextant
08 designates the lower right sextant

Teeth are designated by using a two-digit code. The first digit of the code indicates the quadrant and the second indicates the tooth in that quadrant.

a. First digit (quadrant)
   Digits 1-4 are used for quadrants in the permanent dentition; and similarly digits 5-8 for quadrants in the deciduous dentition, starting clockwise from the upper right quadrant.
b. Second digit (tooth)
   Teeth in the same quadrant are designated by the second digit 1-8 (1-5 in the deciduous dentition); this designation is from the median line in a distal direction.

A schematic diagram is shown for the ISO/FDI system:

FIG. 2 ISO/FDI Two-Digit System

Upper Right								Upper Left							
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
			55	54	53	52	51	61	62	63	64	65			
			85	84	83	82	81	71	72	73	74	75			
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
Lower Right								Lower Left							

[2] *Dental Charting Systems*, Goaz, Paul W., D.D.S., Dallas, 1981, ADA Library Manuscript.

3. The Zsigmondy/Palmer System. This method of tooth designation combines both numbers, letters and symbols to designate the tooth. Each quadrant is designated by a symbol as follows:

- ⌟ designates the upper right
- ⌞ designates the upper left
- ⌜ designates the lower left
- ⌝ designates the lower right

Teeth are numbered (1-8) beginning at the median and extending distally in each quadrant. The letters (a-e) are used for deciduous teeth, in the same fashion. Because of its combination of numbers, symbols and letters, it is infrequently used in practice. A diagram of the Zsigmondy/Palmer method is shown:

FIG. 3 Zsigmondy/Palmer Method

Upper Right								Upper Left							
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
			e	d	c	b	a	a	b	c	d	e			
			e	d	c	b	a	a	b	c	d	e			
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
Lower Right								Lower Left							

Note: For example, the upper right second bicuspid would be designated as $4_{\lrcorner}$.

Standardization of Designation Systems for Teeth in Electronic Data Interchange: All dental records are based on the collection of certain basic information about patient signs and symptoms, clinical findings, treatment recommendations and the service(s) provided. For this information to be shared between providers or with paying agencies, a standard method of recording and transmitting essential information should be designed. Patient health records cannot be transmitted electronically unless the sender and receiver can decipher the message being sent. To do so requires a common syntax, format and language. Using multiple tooth designation systems is potentially problematic for electronic transmission.

The Association's position with respect to tooth designation systems is contained in two separate policy statements, System of Tooth Numbering and Radiograph Mounting (*Trans.*1968:25, 247), and Uniform Tooth Numbering System (*Trans.*1984:524), which read as follows:

5-1968-H. Resolved, that the System of Tooth Numbering and Radiograph Mounting be approved (*Trans.*1968:25, 247).

> Teeth should be numbered 1-32, starting with the third molar (1) on the right side of the upper arch, following around the arch to the third molar (16) on the left side, and descending to the lower third molar (17) on the left side, and following that arch to the terminus of the lower jaw, the lower right third molar (32). Consecutive upper case letters (A-T), in the same order as described in the numbering system, should be used to identify the primary dentition. Looking at the teeth from outside the mouth, radiographs should be viewed in the same manner and so mounted.

37H-1984. Resolved, that the American Dental Association develop a mechanism to institute universal acceptance of the system of tooth numbering and radiograph mounting (*Trans.*1968:25, 247) among its members, all accredited dental schools and agencies that process dental records and treatment records, and be it further

Resolved, that the ADA also develop a mechanism to institute universal acceptance of the nomenclature of *primary* (vs. deciduous) teeth and/or dentition among its members, all accredited dental schools and agencies that process dental and treatment records.

The Commission on Dental Accreditation's Curriculum Guidelines for Dental Schools also recommend that institutions teach and use the Universal Tooth Numbering System. However, this System is hardly "universal" in that its use outside the United States is virtually zero. As mentioned earlier, the International Standards Organization's (ISO) TC 106 adopted the international or FDI two-digit designation system for teeth and the oral cavity.

The International System is more versatile, as it does not use alphabetic characters for tooth numbering. In addition, more than just tooth numbers can be coded. Areas of the oral cavity (e.g. arches, quadrants, sextants) can also be designated by a code. The logical numbering sequence allows for easier data aggregation and research. As a result, it is believed that, *for purposes of electronic data interchange transmission*, the Universal/National System is inadequate because it is unable to capture all the necessary information and details in a coded form.

Computer systems accepting both the Universal or ISO/FDI Tooth Designation Systems have the ability to translate the universal tooth numbers and other details into the ISO/FDI System for sending the messages electronically. In fact, the approved ASC X12 claims processing standard (#837) contains computer instructions that encode claims information specifying which tooth designation system is being used so that the receiver can correctly identify the data.

Translational Programs: It is important to note that U.S. dentists will not need to change their dental record system with respect to tooth designation. The necessary changes to send these messages electronically can and will be done inside the computer via translational programs in the software. Not only is it impractical to alter all previous records into another system, it is unnecessary to do so. Any changes in the use of tooth designation systems cannot occur rapidly and would not likely be accepted by a majority of practitioners without some lengthy period of adjustment or training.

The Councils propose that oral health record software systems be designed so that dentists can specify the tooth designation system chosen for his or her office. To all intents and purposes, this will be a choice between the Universal/National or the ISO/FDI System. *For electronic data interchange purposes only*, the software program should designate the numbering system under which the clinical information is being sent.

Upon receipt of the electronic data information, the receiver's software program should be able to recognize the

sending code and translate it into the tooth designation system used by the receiver. Therefore, the Councils submit the following resolutions to facilitate electronic data interchange with respect to tooth designation systems and recommend their adoption.

Resolutions

50. Resolved, that the American Dental Association accepts the following definitions of the Universal/National Tooth Designation System and the International Standards Organization (ISO) TC 106 Designation System for Teeth and Areas of the Oral Cavity:

Universal/National Tooth Designation System

Permanent Dentition

Teeth are numbered 1-32, starting with the third molar (1) on the right side of the upper arch, following around the arch to the third molar (16) on the left side, and descending to the lower third molar (17) on the left side, and following that arch to the terminus of the lower jaw, the lower right third molar (32).

Primary Dentition

Consecutive upper case letters (A-T), in the same order as described for permanent dentition, should be used to identify the primary dentition.

International Standards Organization (ISO) TC 106 Designation System for Teeth and Areas of the Oral Cavity

Designation of Areas of the Oral Cavity

The oral cavity is designated by a two-digit number where at least one of the two digits is zero, as follows:

00 designates the whole of the oral cavity
01 designates the maxillary area
02 designates the mandibular area
10 designates the upper right quadrant
20 designates the upper left quadrant
30 designates the lower left quadrant
40 designates the lower right quadrant
03 designates the upper right sextant
04 designates the upper anterior sextant
05 designates the upper left sextant
06 designates the lower left sextant
07 designates the lower anterior sextant
08 designates the lower right sextant

Designation of Teeth

Teeth are designated by using a two-digit code. The first digit of the code indicates the quadrant and the second indicates the tooth in this quadrant:

a. First digit (quadrant)

Digits 1-4 are used for quadrants in the permanent dentition and digits 5-8 for those deciduous dentition, clockwise from the upper right quadrant.

b. Second digit (tooth)

Teeth in the same quadrant are designated by the second digit 1-8 (1-5 in the deciduous dentition); this designation is from the median line in a distal direction.

51. Resolved, that the American Dental Association recognizes that the two major systems used for tooth designation are the Universal/National System used primarily in the United States and the International Standards Organization (ISO) TC 106 method used in most other countries, and be it further
Resolved, that electronic oral health records should be designed to provide dentists the flexibility to select which tooth designation system best suits his or her office, and be it further
Resolved, that software intended for electronic transmission of clinical information should have the capability of translating this tooth designation information into either system, and be it further
Resolved, that the American Dental Association, through its activities as secretariat and sponsor of the Accreditation Standards Committee (ASC) MD 156, support the integration of the ISO/FDI Tooth Designation System into clinical computer systems to allow information on tooth designation and other areas of the oral cavity to be transmitted electronically, and be it further
Resolved, that the American Dental Association encourage all accredited dental schools to familiarize dental students with both the Universal and the ISO/FDI Systems for designation of teeth and areas of the oral cavity, and be it further
Resolved, that Resolution 5-1968-H (*Trans.*1968:25, 247), System of Tooth Numbering and Radiograph Mounting, and Resolution 37H-1984 (*Trans.*1984:524), Uniform Tooth Numbering System, be rescinded.

Joint Report of the Council on Dental Benefit Programs and the Council on Dental Practice

Summary of Survey of Infection Control and OSHA Compliance Costs

Background: The Association began providing dentists with materials concerning infection control as early as 1978 when the Association's Council on Dental Therapeutics and the Council on Dental Materials, Instruments and Equipment (formerly Council on Dental Materials and Devices), published a report in *The Journal* entitled "Infection Control in the Dental Office."

In the 1980s, the Centers for Disease Control (CDC) published several papers regarding infection control. Awareness of AIDS began to surface in 1981 and, in 1983, the CDC published precautions for health care workers exposed to the HIV virus and OSHA published a report regarding exposure to the HIV virus.

In April 1986, the CDC published for the first time *Recommended Infection Control Practices for Dentistry*. This document listed barrier techniques such as the use of gloves, masks, gowns, and eyewear and advised dentists to sterilize handpieces. In 1987, the CDC published a report entitled *Recommendations for Prevention of HIV Transmission in Health-Care Settings*, and in June 1988, the CDC published its *Update* on overall prevention of transmission of bloodborne pathogens. In 1993, CDC published an update of the recommendations for dentistry.

A joint report from the Association's Councils on Dental Materials, Instruments and Equipment; Dental Practice; and Dental Therapeutics entitled "Infection Control Recommendations for the Dental Office and the Dental Laboratory" was published in *The Journal* (1988, Vol.116, pp. 241-48).

Finally, the "OSHA Standard on Occupational Exposure to Bloodborne Pathogens" was printed in the December 6, 1991 *Federal Register*, Vol. 56, No. 235. The regulations stipulated that on or before June 6, 1992, dental practices were expected to have fully complied with OSHA requirements.

The costs associated with compliance with the infection control guidelines and with OSHA rules and regulations prompted some members to request a specific procedure code for reporting preparation of dental operatories and other infection control activities. With a procedure code, it was assumed that these additional costs would be reimbursed by patients' dental plans. However, a procedure code would not accomplish this objective, as explained by the Board of Trustees in its Report 6 to the 1992 House of Delegates (*Supplement* 1992:416).

Certainly, the issue of costs associated with compliance is an important one. Third-party payers have made it very clear that there would be no separate reimbursement for infection control and compliance costs because these costs were considered by the insurance industry and by plan purchasers to be costs of doing business.

The Council on Dental Benefit Programs, together with the Association's Survey Center (formerly the Bureau of Economic and Behavioral Research), had identified that dentists' fees had risen on average 8% between 1988 and 1990. However, without specific data, it was not possible to attribute those increases to compliance with infection control and OSHA.

In 1992, the Council on Dental Benefit Programs reported to the House of Delegates that it had included in its 1993 budget a recommendation to fund a comprehensive survey to determine the cost of compliance with state and federal regulations on infection control, the OSHA regulations and the Americans With Disabilities Act (AwDA) (*Reports 1992:40)*.

The reasons cited for the survey were:

- to inform the public and legislators precisely of the increases in the cost of dental care that are due to the compliance with new state and federal regulations;
- to provide the insurance industry with accurate information so that these increased costs can be reflected in renegotiated contracts with plan purchasers; and
- to identify costs associated with regulations that the Association deems inapplicable to the dental profession.

The survey instrument was developed by the Council on Dental Benefit Programs, the Council on Dental Practice, the Division of Legal Affairs and the Division of Legislative Affairs with the assistance of RRC, Inc. of Bryan, Texas. In designing the questionnaire it became apparent that, in order to collect detailed information specific to infection control guidelines and to OSHA rules and regulations, the section regarding the AwDA could not be accommodated in this survey. Questions related to the AwDA were included in the Association's annual Survey on Dental Practice.

Even with these edits, the final questionnaire was a lengthy eight-page survey form requiring considerable thought and time to complete.

Acknowledgment: The American Dental Association wishes to take this opportunity to thank all of the dentists who participated in this important project. The Association is deeply indebted to these members whose contribution of time will inure to the benefit of the public, which bears much of the financial burden of compliance with government rules and regulations, and to the dental profession in its efforts to prevent future unwarranted and costly regulation from being adopted.

Survey Process: The *Survey of Infection Control and OSHA Compliance Costs* (*Survey*) was administered by RRC, Inc. The questionnaire was mailed to a random sample of 6,048 private practitioners from across the country. The overall response rate for the survey was 35.2%. The survey contact process consisted of three mailings. The process of mailing, entering, verifying, and cleaning the surveys encompassed approximately six months beginning on August 23, 1993 and

ending on February 14, 1994. The *Survey* covered an 18-month period beginning in July 1992, when the Bloodborne Pathogens Standard was introduced, and ending in January 1994.

The first mailing, sent first class, included a survey and personalized introduction letter. An identification code was assigned to each survey and was used for accurate data entry and verification and to ensure a random sampling of respondents. A mailing code was used to describe whether the survey was mailed in the initial, first follow-up or second follow-up mailing. Disposition codes were employed to represent the response status of each survey returned. The surveys were then coded, entered and verified.

The first follow-up mailing was sent September 29, 1993 to 5,397 dentists who did not respond to the initial mailing. The second follow-up was mailed first class on November 29, 1993 to 3,692 dentists. The last survey was received on January 31, 1994. A series of consistency checks were made and where inconsistencies existed, dentists were called to verify the information. The cleaning and verification processes permitted accumulation of the most accurate information.

Two types of weighting were applied to the *Survey*:

- *Sample nonresponse weighting,* which is often applied in surveys where the response rate varies significantly among some subgroups of the total population. Chi-square and paired t-tests were performed to determine if any major subpopulation groups demonstrated differential response rates for the current survey. It was found that response varied significantly across three different population characteristics: gender, specialty and age of practitioner.
- *Practice weighting,* which means that the survey respondents were weighted to be representative of the population of dental practices in the U.S. rather than the population of dentists. While the weighting is extremely important, it is conceptually simple to derive and apply. The essence of the weighting method used in this *Survey* involved the over-sampling of multi-dentist practices which occurs when the dental population is sampled. The appropriate practice weights cause the sample to obtain the same relative distribution as the desired population (in this case the distribution of number of dentists in practices).

To completely weight an individual respondent both nonresponse and practice weighting were considered. While nonresponse weighting is based on adjustments to a known population distribution among the ex-post design cells, practice weighting is based on the extension of respondent practice size responses to the population of dentists. In addition, two final checks (wave response analysis and analysis of variance) on statistical validity were performed. On the basis of these analyses, it was concluded that there are no statistically significant differences between the response groups and that the overall group of respondents is also representative of the overall population.

Categories Surveyed: The questionnaire was divided into eight major categories which were specific to both infection control and to OSHA. The categories, in turn, were broken down into subcategories, as follows:

Supplies
- Incremental total supply cost

Housekeeping
- Incremental staff time
- Equipment purchased to comply
- Change operatory floor surface
- Patient visits lost due to conversion

PPE Use and Laundry
- Incremental time—glove change/hand wash
- Cost to purchase/install washer/dryer

Infection Control Plan
- Initial development—staff time
- Annual update—staff time
- Consultants to develop plan

Vaccinations
- Vaccinate current staff
- Vaccinate new staff
- Initial employee downtime
- Annual employee downtime
- Initial medical opinions
- Annual medical opinions

Training Program
- Development/modification—staff time
- Total dentist time reading and studying
- Current dentist time reading and studying
- Dentist time as trainer—initial training
- Dentist time as trainer—annual follow-up
- Dentist time as trainer—procedure change
- Consultant use—development
- Consultant use—initial training
- Consultant use—annual training
- Training materials or services
- Initial training—employee time
- Annual follow-up training—employee time
- Procedure change training—employee time

Compliance
- Consultant to inspect program initially
- Staff time assisting consultants
- Ongoing compliance consultant

Recordkeeping
- Initial set-up or modification—staff time
- Consultant to assist initially
- Maintain employee files—staff time
- Consultant for recordkeeping and storage

Sterilization of Handpieces
- Additional handpieces purchased
- Incremental repair cost due to sterilization
- Incremental sterilization—staff time

Exposure
- Exposure follow-up—staff time
- Tests and services
- Staff time lost to testing

Time Factor: One of the contentions made by the Association regarding the OSHA regulations is that they would be time-consuming, adding substantially to the cost of infection control while yielding no appreciable additional benefits. This has proved to be the case. In the above listed categories for which time was measured, the total annual cost of dentist and staff time attributed to OSHA compliance is $1.7 billion.

Sterilization of Handpieces Between Patients: According to the *Survey*, 92% of the dental practices in the U.S. currently sterilize handpieces between every patient. Another 5% disinfect handpieces, and another 3% adopt other miscellaneous methods and frequencies. Growth in the number of practices adopting the between-visit sterilization procedure coincided with adoption of the OSHA regulations. By the end of 1990, 20% of dental practices began sterilization of handpieces between patients and in 1991 an additional 20% of dentists adopted the same procedure.

The average number of handpieces owned by a practice is 8.3 high speed handpieces and 5.2 low speed handpieces. These numbers reflect the increased handpiece inventories needed to meet OSHA's requirement that instruments be decontaminated between use; more specifically, dental practices purchased four high speed and 1.7 low speed handpieces to comply with OSHA regulations.

Compliance: Evidence from the *Survey* show that dental practices have indeed undergone significant adjustments to increase the level of infection control efforts and to implement OSHA requirements. Results indicate that nearly all (94%) dental practices must spend extra time to comply with OSHA and more than half (56%) of practices have limited appointments accepted per week or month. Further, almost one-third (31%) of practices have hired additional staff simply to implement OSHA requirements.

Cost of Compliance: The total estimated per-practice expense for all infection control measures is $45,718 annually, of which an estimated $27,713 represents the cost of complying with OSHA rules and regulations. Applying these individual practice costs to an estimated 114,695 dental practices with employee exposure, the national annual OSHA compliance cost exceeds $2.7 billion. The total cost of all infection control is about $5.4 billion annually.

OSHA had projected the annual cost of compliance would be $87.4 million per year, with an estimated per-practice cost of $872.77 annually.

The following tables focus on incremental costs of OSHA compliance (Table 1), as well as the overall costs of infection control (Table 2).

Table 1

OSHA Compliance Costs Amortized Annually

Category	Per Practice	All Practices
Supplies	$ 4,980	$ 571,167,337
Housekeeping	5,354	614,105,474
PPE use and laundry	39	4,415,832
Infection control plan	214	24,540,028
Vaccinations	141	16,157,773
Training program	4,089	468,979,941
Compliance	51	5,866,420
Recordkeeping	1,355	159,646,838
Handpieces and sterilization	5,785	663,542,575
Exposures and testing	1,704	195,483,864
Annual Costs	**$23,712**	**$2,723,906,082**

Table 2

Total Infection Control Costs Amortized Annually

Category	Per Practice	Category Total
Supplies	$ 7,389	$ 875,576,006
Housekeeping	10,443	1,237,493,648
PPE use and laundry	11,058	1,310,397,485
Vaccinations	51	6,074,582
Handpieces and sterilization	8,527	1,010,445,455
Waste disposal	348	41,224,824
Subtotal	$37,816	$4,481,212,000
OSHA costs not listed above (infection control plan, training, recordkeeping, etc.)		936,515,717
Total Costs		$5,417,727,717
Infection Control Cost Per Practice:		$45,718
Annual Patient Visits Per Practice:		4,911
Infection Control Cost Per Patient Visit:		$9.31

Impact on Fees: Due to OSHA and other infection control guidelines, dental practices have implemented numerous changes in practice standards and work controls to protect both employees and patients against bloodborne diseases. These increased protective measures have, however, substantially increased the costs of treating patients in most dental practices. In order to meet these costs, some practices have found it necessary to adjust their fee structures.

The study shows that 84% of all practices had some change in their fee structure. The majority of practices (79%) either changed all or selected procedure fees, while some practices (8%) introduced a separate infection control fee. A separate infection control fee is charged consistently in certain demographic areas, especially those identified as chronic critical-care shortage areas or high poverty areas. The typical separate infection control fee is $7.75.

Total billing for a typical dental visit, according to the *Survey*, has increased an average of $8.74 to cover the costs of implementing OSHA requirements and infection control guidelines.

Third-Party Payer and Contractual Arrangements: Private dental benefit plans cover between 38% and 43% of the population and fund an estimated 43% of all dental expenditures.

There are three major groups of carriers that sell a variety of dental plans: the commercial carriers, e.g., CIGNA, and the service corporations, e.g., Blue Cross and Blue Shield (Blues) and Delta Dental Plans (Delta). Under the umbrella of managed care there are two major types of contractual arrangements: capitation plans and preferred provider organizations (PPOs).

The fee-for-service or indemnity plan remains the single most common arrangement in dentistry today. Other arrangements include individual practice associations (IPAs), buyer clubs, government programs (Medicaid) and other lesser-known arrangements.

The survey results offer a current estimate of the prevalence of differing arrangements across the groups of carriers. As shown in Table 3, relatively few practices participate in capitation plans sponsored by commercial carriers (11% of all practices). Only 5% of all practices participate in Blues-sponsored capitation plans, and 4% of all practices participate in Delta-sponsored capitation plans. Table 3 also shows that the percentage of patients involved in capitation plans is even smaller than the percentage of practices that participate in them.

Table 3

Practices with Contractual Arrangements and Percentage of Patients Enrolled

Item	Practices %	Patients %
Commercial carriers		
Capitation	11	20.5
PPOs	24	13.4
Fee-for-service	72	47.0
Blue Cross/Blue Shield		
Capitation	5	13.6
PPOs	18	11.8
Fee-for-service	65	19.6
Delta Dental Plans		
Capitation	4	14.6
PPOs	19	10.7
Fee-for-service	64	22.7
Other arrangements		
Medicaid	26	13.8
IPAs	3	9.2
Buyers' club	5	6.9
Charitable programs	22	3.0
Other	8	18.6

Some respondents reported that they have had to reconsider the advantages of contractual relationships with third-party payers in light of the increased costs of OSHA compliance. As shown in Table 4, the largest impact was on participation with capitation plans. A total of 14% of all practices reported that they terminated participation with commercial carrier capitation plans due to the costs of OSHA regulations. This exceeds the percentage that now participates in these plans. PPOs were similarly affected. A total of 8% of all practices terminated contracts with commercial carrier-sponsored PPOs. The impact on indemnity plans was significantly less with 2% of all practices terminating contracts with commercial carrier-sponsored plans.

Among the other third-party payers, a total of 17% of practices reported that they terminated relations with Medicaid programs; 5% terminated relations with buyers' clubs; and 5% terminated relations with miscellaneous types of payers.

Only 7% of dental practices terminated relations with charitable programs.

Table 4

Percentage of Practices Terminating Contractual Relationships with Third-Party Payers

Item	Practices %
Commercial Carriers	
Capitation	14
PPOs	8
Fee-for-service	2
Blue Cross/Blue Shield	
Capitation	4
PPOs	5
Fee-for-service	3
Delta Dental Plans	
Capitation	2
PPOs	5
Fee-for-service	3
Other arrangements	
Medicaid	17
IPAs	3
Buyers' club	5
Charitable programs	7
Other	5

Some plans offered suggested billing methods by which practices could recover at least a portion of the increased costs. Table 5 shows the percent of practices receiving suggestions from the third-party payers.

Table 5

Percentage of Practices Receiving Suggestions About Billing

Item	All Practices %
Commercial Carriers	
Capitation	36
PPOs	10
Fee-for-service	10
Blue Cross/Blue Shield	
Capitation	16
PPOs	11
Fee-for-service	11
Delta Dental Plans	
Capitation	17
PPOs	12
Fee-for-service	17
Other arrangements	
Medicaid	7
IPAs	8
Buyers' Club	21
Other	21

Although relatively few suggestions for billing methods were offered, those that were received among practices displayed an important pattern. *The most common suggestion was cost absorption by the contracting practices.*

For practices contracting with commercially sponsored capitation plans, a relatively high percentage (17%) of practices received recommendations to bill patients for additional costs. A smaller group (7%) was advised to increase fees (presumably to noncovered patients). Eleven percent of these practices were told that an interim stipend might be offered. A total of 18% of these practices were advised to absorb the additional costs.

PPOs also tended to suggest that practices should absorb the additional costs. For commercially sponsored PPOs that figure was 15%, for the Blues it was 17% and for the Deltas it was 16%.

PPOs were less likely to suggest billing the patient for the additional costs: 4% for commercially sponsored PPOs, 3% for the Blues and 2% for the Deltas.

Practices in fee-for-service plans, where the third-party payer's reimbursement level is accepted as payment in full, are caught in a cost squeeze wherein practice costs have risen due to OSHA regulations and infection control guidelines, but reimbursement rates through carriers may remain fixed. Among those practices receiving suggestions, the most common suggestion was cost absorption by the practice: 12% for commercially sponsored indemnity plans, 12% for the Blues and 15% for the Deltas (however, 10% were advised by the Deltas to increase fees).

Use of the Survey Data: The Association is in the process of carrying out its intended purposes for the *Survey*, as stated in the first part of this report.

> To inform the public and legislators precisely of the increases in the cost of dental care that are due to the compliance with new state and federal regulations.

A work group consisting of staff from the involved Association agencies has been established to consider the various segments of the *Survey* and report the findings back to their councils for appropriate action.

> To provide the insurance industry with accurate information so that these increased costs can be reflected in renegotiated contracts with plan purchasers.

The antitrust laws prohibit groups of competitors, such as the Association and its constituent and component societies, from taking action with regard to member fees or reimbursement levels. The antitrust laws do not prohibit a dental society from expressing the views of its members that particular fees and reimbursement levels are too low and from providing information to substantiate this claim. However, extreme care must be taken not to suggest, imply or threaten that members will refuse to participate in a plan unless reimbursement is increased. Suggesting a specific amount that reimbursement should be increased is especially dangerous if members subsequently demand that fee or threaten to departicipate if it is not met.

With these cautions in mind, the Association will hold a meeting with third-party payers, third-party payer organizations, health benefit consulting companies and plan purchasers later this summer to present the data contained in this *Survey*.

> To identify costs associated with regulations that the Association deems inapplicable to the dental profession.

The *Survey* results are already being used for this purpose.

This report, along with an article in the June 1994 edition of *The Journal*, are part of the dissemination of these materials. It will also be used in estimating costs of other types of similar regulatory activities.

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

Council on Dental Education

Supplemental Report 1: Response to Resolution 147H-1993 Regarding Alternatives to Use of Human Subjects in Clinical Licensure Examinations

Background: The 1992 ADA House of Delegates directed the Council on Dental Education to study the ethical and legal ramifications of using human subjects in dental clinical licensure examinations and report to the 1993 House (*Trans.* 1992:634). The Council reported to the 1993 House that the ethical and legal rights of patients are not being compromised, and that acceptable alternatives to the use of live patients do not currently exist for all procedures included in clinical examinations. However, the Council believed that the profession should continue to encourage development of testing methods that provide valid and reliable alternatives to the use of human subjects and proposed a resolution to that effect (*Reports* 1993:92).

The 1993 House considered several resolutions related to this issue and ultimately adopted a single resolution that encompassed several of the concepts contained in them. Further, the House supported continuation of the Association's cooperative efforts with the American Association of Dental Examiners (AADE) on matters related to licensure examinations and adopted Resolution 147H-1993 (*Trans.* 1993:700):

> **147H-1993. Resolved,** that the ADA, through the Council on Dental Education, work in concert with the American Association of Dental Examiners (AADE) to study appropriate alternatives to the use of human subjects for clinical dental licensure examinations and report to the 1994 House of Delegates, and be it further
> **Resolved,** that the ADA and the AADE encourage the regional and state dental clinical testing agencies to consider the alternatives to the use of human subjects for clinical dental licensure examinations, and be it further
> **Resolved,** that one of the alternatives to be studied should be the applicability of interactive computer-based patient simulations, and appropriate sources should be identified for the development of such technology.

To implement the resolution, the following joint ADA/AADE committee was appointed.

Dr. Patrick J. Ferrillo, Jr., chairman (ADA CDE member)
Dr. Charles Cartwright (AADE)
Dr. Richard J. Chichetti (ADA)
Dr. Olin A. Elliott (ADA)
Dr. Faustino S. Garcia (AADE)
Dr. Robert Pattalochi (AADE)

The committee met at the ADA Headquarters Building, Chicago, on June 17-18, 1994. During its discussion, the committee noted a number of positive changes in recent years that have affected the extent to which human subjects are used in initial licensure examinations. The committee also reviewed in detail a number of current and potential testing methods that do not rely on treatment of human subjects and weighed the applicability of each method to a valid and reliable evaluation of clinical skills.

The committee recognized the problems raised by patient-based clinical examinations, but concluded that no technology presently available can fully replace the use of human subjects. Nonetheless, some of these methods offer appropriate alternatives to human subjects in some portions of the examinations and their use by testing agencies should be encouraged through additional research and development.

A report of the committee's conclusions and recommendations was reviewed at the July 1994 meeting of the Council on Dental Education. The Council approved the following report for transmittal to the House in response to Resolution 147H.

Recent Changes in the Clinical Examination Process: Written and clinical licensure examinations were instituted in the early 1900s, largely to address the inconsistency in knowledge and skills among preceptor-trained dentists and the lack of uniform standards for dental education programs. In 1928, the National Board of Dental Examiners was organized, and by 1990 all licensing jurisdictions had accepted the National Board examination as meeting all or part of their written examination requirements. The clinical licensure examinations, however, remained the responsibility of individual state boards.

In an effort to address continuing concerns about interstate mobility of dentists, the regional testing agencies were formed by state boards that agreed to administer their clinical examinations simultaneously and to share examiners. The Northeast Regional Board (NERB) was established in 1969, with the Central Regional Dental Testing Service (CRDTS), the Southern Regional Testing Administration (SRTA) and the Western Regional Examining Board (WREB) following in the mid-1970s.

Participation in the regional groups has grown from eight states in 1969 to 39 in 1994. In 1994 the states of Oklahoma and Texas joined WREB, leaving only 14 remaining independent state testing agencies. Presently 40 (74%) of the nation's 54 dental schools are located within the participating states. In 1993, approximately 76% of dental students graduated from schools within the regional board states, as opposed to 24% who graduated from schools in states with individual clinical examinations.

Another recent change offers promise for further progress. In summer 1994, the two largest regional agencies, NERB and CRDTS, agreed to administer the Combined Regional Examination in Dentistry beginning in 1995. This examination will have the same content, use the same testing methods and procedures, and be administered by a shared pool of examiners for both regions. Thus, by next year the candidates for initial licensure in 25 states will take a single clinical examination.

Joint ADA/AADE Studies Related to Licensure Examinations: In 1988, the ADA House of Delegates called for an ADA/AADE study of the comparability of clinical examinations (*Trans.*1988:494). The report of the joint study (*Trans.*1990:117) concluded that clinical examinations for licensure were not, at that time, comparable. The report also concluded that the ADA and AADE should develop guidelines to assist testing agencies in enhancing the validity and reliability of the examination process.

In response to subsequent House resolutions (*Trans.*1989:527; 1990:553; 1991:600), the same ADA/AADE Licensure Committee developed *Guidelines for Valid and Reliable Dental Licensure Clinical Examinations* which included a recommended "minimum common core of requirements" for clinical examinations. In 1992, the *Guidelines* were disseminated widely to testing agencies.

Since 1992, at the direction of the ADA House (*Trans.*1992:629), the Council on Dental Education has monitored the testing agencies' efforts to comply with the *Guidelines* and the recommended minimum common core of test requirements. The Council reported that information from the testing agencies indicates a high degree of conformance with the *Guidelines* in terms of candidates' information, examination procedures, and the formal training and calibration of clinical examiners (*Reports* 1993:92; 1994:76).

Somewhat less conformance with the recommended minimum common core of test requirements has been demonstrated. However, there is evidence that testing agencies have updated the examination content to reflect current practice, based on survey data and input from the practicing community.

Review of Alternative Testing Methods: A growing number of agencies are turning to increased use of non-patient-based testing methods. A review of information from 17 of the 18 agencies in June 1994 (information from one state agency was not received) indicated that all require candidates to perform one or more operative procedures on patients. However, four agencies now use typodonts for part of the operative examination. All of the 13 agencies that examine on periodontal procedures require human subjects. By contrast, only five of the 16 agencies that test on prosthodontic procedures require treatment of live patients. Eleven agencies use typodonts or other simulation exercises to wholly or partially substitute for human subjects in the prosthodontics examination. Finally, all of the ten agencies that examine on endodontic procedures use extracted teeth or typodonts.

In response to the first clause of Resolution 147H, the ADA/AADE joint committee considered in-depth the non-patient-based examination methods currently being used by testing agencies, as well as potentially promising technologies. The committee's discussion of this topic was based on, but not limited to, the framework provided by the minimum common core of test requirements contained in the ADA/AADE Guidelines. Therefore, the committee focused on those methodologies that are available currently or potentially to assess candidates' skills related to restorative, removable prosthodontic, periodontic and endodontic procedures. The following section of this report describes briefly the appropriate applications for each method, as well as the method's advantages and limitations.

Typodonts, Manikins. The most common alternative testing or simulation method uses manikins, dentoforms, typodonts or extracted teeth. These patient simulation devices range in sophistication from highly realistic head-and-torso manikins with interchangeable dentitions, through typodonts with ivorine teeth, to extracted teeth. While the manikin offers the opportunity to test candidates' skills in a position that more closely resembles clinical treatment, the cost is much greater than for benchtop typodonts. In fact, the cost of the most sophisticated patient simulators could prohibit their widespread use for examination purposes for some years.

Patient/dentition simulators can be used to evaluate the psychomotor skills of test candidates and have the advantages of offering total consistency from one examination to the next. Thus, they offer a high degree of reliability (i.e., the extent to which the test measures the same skill each time). They are less expensive for candidates and eliminate the potential liability and ethical concerns raised by human subjects.

These methods have limited applicability in evaluating the candidates' clinical judgment and/or patient management skills, however. They represent the clinical practice environment to a limited degree and therefore may have lower validity (i.e., the degree to which the test measures what it was designed to measure). Finally, manikin exercises require examiners to evaluate the candidate's work outside the examiner's familiar frame of clinical reference and thus may lose some inter-rater reliability. Concern has also been expressed that over-reliance on manikin examinations may influence educational programs to provide fewer patient treatment experiences and more manikin practice for students preparing for board examinations.

Discrimination Examinations. A second type of frequently used simulation is the benchtop type of practical or "discrimination" test. Discrimination examinations usually consist of several test "stations" with displays or exhibits of clinical case-related material: radiographs, prosthodontic appliances, orthodontic appliances, restorations on typodonts. Candidates must observe each exhibit and answer related written examination questions.

Discrimination examination methods test clinical judgment and decision making, as well as theoretical knowledge of clinical techniques. These methods have the same advantages as manikins or typodonts in terms of high reliability, low costs, ease of administration and avoidance of the human subject issues.

Because benchtop discrimination tests do not measure psychomotor skills or patient management skills, they cannot completely replace the clinical performance examination. Discrimination tests may offer excellent validity in measuring certain clinical competencies, but they have not been widely used and therefore need additional experimentation and validation.

Standardized Patients. The medical profession has experimented extensively with "standardized patients (SP)," or live patient simulators, in performance examinations. Real patients (usually not professional actors) are recruited and coached to present a realistic, standardized set of symptoms and responses to diagnostic queries. They can be effectively used in a variety of settings to assess the candidate's interpersonal and communication skills, as well as diagnostic

and problem-solving abilities, but not psychomotor skills. Although SPs are widely used in medical and other professional education programs, the committee was aware of only one dental school that has attempted this method for teaching and evaluation.

Experiments have shown that SP simulations provide reasonable content and construct validity. They have been shown to be feasible on a surprisingly large scale, but the number of candidates tested by some of the larger dental testing agencies may pose a serious practical barrier to the widespread use of this method. Probably the major drawback to this type of test format is the cost of administration and scoring. It appears that the moderate level of reliability, high cost and general lack of portability of these examinations limits their usefulness for licensure evaluation purposes at this time.

Computer-Based Simulations. Interactive computer-based patient case simulations generally use computer technology to present the candidate with information (both visual and text) about a patient case. The examinee gathers information through a series of inquiries or actions, arrives at a differential diagnosis and develops a treatment plan. The microcomputer provides feedback about both the patient case and the problem-solving process itself. The computer-based patient simulations have potential applications in predoctoral education, continuing education, assessment for both initial licensure and continued competency, as well as self-assessment.

Computerized patient simulations can evaluate the individual's cognitive knowledge as well as clinical judgment and problem-solving skills related to diagnosis, treatment planning and patient case management. However, they cannot assess psychomotor or communication skills using presently available technology. Although computer-based simulations offer an exciting potential for valid and reliable tests, their applicability to the examination process is currently limited by both cost and the lack of experience in using them.

Satisfactory scoring methods have yet to be fully developed and tested. Further, only a handful of dental education institutions have developed computer-based patient cases, so that some candidates may not be familiar with this testing method. The initial development costs of computer simulations are very high—perhaps prohibitively so for individual testing agencies. Once developed, however, the costs of administering the computerized examinations should not be a significant barrier.

Advantages of Patient-Based Examinations. The committee recognized the problems inherent in the use of patient-based examinations. These include the lack of reliability due to variability among patients; the questionable ability of a single "snapshot" evaluation to measure competence; potential legal liability risks for candidates, testing agencies and testing sites; ethical issues and the potential for mistreatment of patients; and the economic and other hardships they impose on examinees.

Despite these concerns, the committee concluded that there is presently no technology that can fully duplicate human subjects in clinical examinations. The benefits of patient-based examinations include:

- Patient-based examinations allow the evaluation of clinical judgment, including such abilities as recognizing disease status; conducting a medical history and physical evaluation and applying this information to treatment planning; treatment planning; and patient behavioral management.
- Patient-based examinations allow the testing of skills/competencies beyond psychomotor skills and didactic knowledge, e.g. caries recognition, pain control, soft tissue management, material manipulation, occlusion.
- Patient-based examinations offer high content validity and clinical relevance.
- Initial research suggests that inter-examiner reliability is actually higher with human subjects, because the examiners are more familiar with the criteria for acceptable care of patients.

Potential for Computer-Based Simulation Examinations: In response to the third clause of Resolution 147H, the committee discussed in detail the potential applicability of interactive computer-based simulation methods. Although only limited work has been done to apply this technology to the examination process, significant steps have been taken toward development of the necessary infrastructure to support expansion of these efforts through the establishment of the Dental Interactive Simulation Corporation (DISC).

The DISC consortium was formed in September 1990 by eight major dental organizations including NERB, CRDTS, WREB, SRTA, the Joint Commission on National Dental Examinations (ADA), the AADE, the American Association of Dental Schools, and the Texas Dental Board. The American Board of Orthodontics became a corporate member in 1994.

DISC's purpose is to develop interactive electronic simulations in the field of dentistry which can be used for testing, education, examiner training and individual dentists' and auxiliaries' continuing education. It is expected to eventually be self-supporting through the sale of educational and testing products to institutions, licensing/certifying boards and individuals.

Limited start-up funds were provided by the member organizations as well as the American Fund for Dental Health. A number of foundations were approached for ongoing financial support, but these efforts were not successful. Therefore, the DISC Board of Directors concluded that the dental community itself is the only possible source of funding for the DISC project.

The DISC Board has proposed that each regional testing agency and the Joint Commission, beginning in 1995 and continuing for the next five years, dedicate $25 of each full examination fee collected from candidates to initially finance the development of prototype simulations suitable for testing purposes. Such contributions would represent essentially a redirection of the funds the agencies currently invest in test development. The funding agreements would contain the caveat that continued funding would depend on DISC demonstrating sufficient progress at the end of the first year to meet the expectations of the contributing agencies.

CRDTS, SRTA and WREB have agreed to provide the requested support, contingent on the participation of all five testing agencies. NERB will consider the proposal at its summer 1994 meeting. At its May meeting, the Joint Commission approved test candidate fee increases of $30 for

each dental candidate ($15 each for Part I and Part II of the dental examination) and $20 for each dental hygiene candidate. The Joint Commission will provide these funds between 1995 and 1999 on the condition that the other testing agencies contribute in an equivalent manner and that documented progress is made in development of the patient simulations (*Reports*:83).

With the expectation that funding might be available by 1995, the DISC Board in April 1994 approved the subject matter for the first three prototype simulations: periodontics, general dentistry and orthodontics. These will be interactive case history scenarios dealing with oral disease recognition, diagnosis, treatment planning and response to treatment. Testing versions of these prototype simulations would be used by DISC to develop a scoring mechanism acceptable to the testing agencies, while other applications might be developed for educational purposes.

Committee Conclusions and Recommendations: As noted previously, the joint study committee reviewed the existing technology related to patient simulations and concluded that there are presently no methods that can fully duplicate human subjects in clinical examinations. Many potential technological advances are occurring in dentistry and other health care fields that will allow the future development of effective simulation methods. However, the testing agencies lack the resources to track developments in examination methods and there is no appropriate national organization with this capability, other than the American Dental Association. Therefore, the committee offered and the Council concurred with the following recommendation:

> *Recommendation.* It is recommended that the ADA Council on Dental Education develop an ongoing mechanism to monitor and disseminate information on technologies that offer the potential for development of viable alternatives to use of human subjects in clinical licensure examinations.

The study committee also concluded that, although individual testing agencies have experimented with a variety of simulation methods, there is currently little research being conducted to assess these methods objectively. However, it appears that research data to verify the validity and reliability of these methods would encourage testing agencies to expand their use. Again, the committee believed that individual testing agencies often lack the staff and financial resources to conduct such research. Leadership by the Council is needed to encourage interest in and support of research to validate alternative testing methods. Therefore, the committee recommended that:

> *Recommendation.* The Council on Dental Education should encourage and support research related to the assessment of the validity and reliability of all testing methods used in clinical licensure examinations, including methods that provide alternatives to the use of human subjects, in order to assist testing agencies to enhance the validity and reliability of the examination process.

Finally, the committee determined that the DISC project offers the potential to develop valid, reliable and cost-effective testing methods, especially methods to assess clinical judgment (including diagnosis, treatment planning and case management competencies). The committee applauded the current efforts of the DISC Board to obtain start-up funds from the four regional testing agencies and the Joint Commission. While the committee concurred that testing agencies should invest some of their test development funds to support this cooperative venture, it also was concerned that such funding will come exclusively from students and new practitioners through examination fees.

The committee believed that the practicing dental profession also has a stake in the development of computer-based simulations, which offer a potential tool for practitioners' continuing education and assessment of continuing competency. Accordingly, the committee believed that the Association should consider contributing start-up funds that would enable DISC to develop a prototype simulation and thus demonstrate the applicability of this method to testing purposes. The committee directed that the DISC Board be requested to provide a business plan for consideration by the Council on Dental Education at its July 1994 meeting, in conjunction with the committee's report, and forwarded the following recommendation for consideration by the Council.

> *Recommendation.* It is recommended that the American Dental Association support the DISC project by providing sufficient start-up funds to enable DISC to develop specific, detailed plans for the project and three prototypes that demonstrate the feasibility of using computer technology to evaluate clinical judgment of candidates for initial licensure.

In making this recommendation, the committee also suggested that any contribution of start-up funding to the DISC project should have sufficient safeguards to ensure that the monies are well spent. Specific objectives and timelines for the initial phase should be identified, with mechanisms to oversee and evaluate the agency's progress in achieving these objectives.

Council Recommendations: At its July 1994 meeting, the Council reviewed the findings and recommendations of the joint study committee. The Council concurred with the committee that there are presently no patient simulation methods that can fully replace the use of human subjects in clinical examinations. However, examination technologies are being developed that offer the potential for viable alternatives. The Council believed that it would be appropriate for the Council to monitor development of examination technology and disseminate this information to clinical testing agencies, as suggested by the committee. At present, this monitoring activity can be accomplished with existing staff and budget resources of the Council. However, if research activity on testing methods increased substantially, additional resources might be needed in the future to manage this responsibility.

The Council also agreed with the committee's recommendation that research related to the validity and reliability of licensure examination methods should be encouraged and supported. However, the Council itself has neither the funds nor the expertise to conduct this type of research. The expertise needed is often available through psychometricians employed in higher education institutions, whereas the subjects and settings needed for examination research are available only through the dental testing

agencies. Clearly, a cooperative effort between individual agencies and psychometric researchers is needed.

It appears that the Council's appropriate role might be to assist testing agencies to identify individuals with expertise who would be interested in working with them. Further, the Council might help agencies to identify appropriate state and national sources of funding. Therefore, the Council supported the committee's recommendation and will inform testing agencies of its willingness to assist them in seeking support for appropriate research projects.

Finally, the Council determined that the DISC project offers great potential for the development of testing methods that will reduce the need for human subjects in clinical examinations. Computer-based simulations may also provide a valuable tool for continuing education and self-assessment for practicing dentists. For this reason, the Council agreed in principle with the committee's recommendation that the Association should support the DISC project financially.

The business plan provided by DISC requested financial support from the Association in the amount of approximately $300,000 over a two-year period, to assist in supporting the first phase of the project, prototype development. However, the Council was aware that financial support for the first two-year phase is likely to be available through the contributions of the five testing agencies. Whether these funds are sufficient, or will fall short of enabling DISC to achieve its goals, will become clearer as the project progresses. Therefore, the Council determined that the Association should monitor the DISC project and request additional information from DISC regarding its progress and financial needs prior to the Council's January 1995 meeting. At that time, the Council will consider inclusion of funds to support the DISC program in its 1996 budget proposal. Because the DISC project will require approximately five years to become self-supportive, the Council recognized that it would likely need to include support for DISC in subsequent annual budgets as well.

In conclusion, the Council commended the ADA/AADE joint study committee for its thorough study. The Council concurred with the committee's conclusion that, although progress has been made, there are currently no alternative testing methods that can completely eliminate the need for patient-based examinations. The Council will provide leadership and support toward the achievement of this goal by monitoring technological advances in the testing field, encouraging further research, and disseminating information to the clinical testing agencies. Finally, the Council will closely monitor the initial phase of the DISC project and consider including in its 1996 budget a request for financial support as needed to assist DISC in demonstrating the feasibility of using computer simulations in licensure examinations.

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

Council on Dental Education

Supplemental Report 2: Revised Definition of Pediatric Dentistry

Background: The Council considered a revised definition of pediatric dentistry submitted by the American Academy of Pediatric Dentistry (AAPD); the previous definition was approved by the Council in 1985 (*Reports* 1985:60), when the specialty was redesignated from pedodontics to pediatric dentistry. The specialty requested the revision in response to a Council request following its study of the real or perceived overlap in scope between orthodontics and pediatric dentistry (*Reports* 1990:108; 1991:116). The Council had requested the AAPD to consider revising the definition because it believed that the current definition was too broadly stated and did not adequately describe the scope of the specialty. The Council advised the AAPD that a revised definition needed to be more specific, and needed to include reference to the fact that the specialty is "age-related" and at the same time should include reference to the limitations associated with use of the term "age-related."

The Council reviewed proposed revised definitions in December 1991 and January 1994. Each time the proposed definitions were referred back to the AAPD and specific concerns were noted. At its July 1994 meeting, the Council considered another proposed revised definition submitted by the AAPD. In its consideration of this proposed revision, the Council concluded that all previous concerns had been addressed and was of the judgment that the revised definition appropriately described the specialty of pediatric dentistry.

In 1992, the Council adopted procedures for the development and revision of a specialty definition (*Reports* 1992:62). In adopting these procedures, the Council determined that the new procedures would not apply to any definitions currently under review; rather, they would apply to those definitions presented for initial consideration following the May 1992 Council meeting. Since proposed revisions to the definition of pediatric dentistry had been under consideration by the Council since December 1991, the revised procedures for adoption of a definition were not followed. Accordingly, the Council rescinded the 1985 definition which read as follows:

> Pediatric dentistry is the practice and teaching of comprehensive preventive and therapeutic oral health care for children from birth through adolescence. It shall be construed to include care for special patients beyond the age of adolescence who demonstrate mental, physical and/or emotional problems;

and approved the new definition of pediatric dentistry as follows:

> Pediatric dentistry is an age-defined specialty that provides both primary and specialty comprehensive preventive and therapeutic care for infants and children through adolescence, including those with special health-care needs.

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

Joint Report of the Council on Dental Education and the Council on Ethics, Bylaws and Judicial Affairs

Redesignation of the Specialty of "Orthodontics" to "Orthodontics and Dentofacial Orthopedics"

Background: As indicated in the Councils' 1994 annual report to the House (*Reports*:73, 99), in September 1993, the American Association of Orthodontists (AAO) submitted a letter formally requesting that the specialty designated "orthodontics" be redesignated "orthodontics and dentofacial orthopedics." In requesting this change, the AAO stated that the request was being made based on its belief that the name of the specialty requires updating to more accurately describe the specialty. Further, the AAO noted that it believes the proposed new designation is consistent with the definition of the specialty approved by the Council on Dental Education (CDE) and with the Commission on Dental Accreditation's current Standards for Advanced Specialty Education Programs in Orthodontics.

Because a revision in the *ADA Principles of Ethics and Code of Professional Conduct* (the *Code*) would be necessary if the changes in designation were approved, the AAO's request required consideration by both the CDE and the Council on Ethics, Bylaws and Judicial Affairs (CEBJA). At its January 1994 meeting, CEBJA reviewed AAO's request. The Council noted that the primary purpose of *Code* Section 5, Professional Announcement, is to ensure that dental patients have truthful and nondeceptive information they need to make an informed choice of dental services and providers. It concluded that, if CDE determines that the term "orthodontics and dentofacial orthopedics" accurately describes the nature of the practice and services provided by members of the specialty known as orthodontics, Section 5 of the *Code* will be satisfied.

In its consideration of this request, the CDE followed its established procedures for redesignation of a dental specialty. Accordingly the CDE directed that the proposed redesignation be circulated to the communities of interest for review and comment. The communities of interest include the sponsoring organizations and the certifying boards of the recognized dental specialties, constituent dental societies, the American Association of Dental Examiners, the American Association of Dental Schools, program directors, dental deans and the administrators of nondental school institutions offering advanced orthodontic training programs.

At its July 1994 meeting, the CDE reviewed all written comments and determined that it supports the AAO's request for the redesignation of the specialty. A limited number of comments were received. Respondents writing to support the redesignation cited that the redesignation is consistent with both current orthodontic practice and the orthodontic accreditation standards as the rationale for support. Respondents who do not support the redesignation cited that the redesignation appears redundant and that the public might find the redesignation confusing as the rationale for nonsupport. Following discussion, the CDE determined that the redesignation appropriately describes the nature of the practice and services provided by members of the specialty.

Further, the Council concluded that the new designation is appropriately supported by the definition and the accreditation standards for advanced education in orthodontics. For these reasons, the CDE and the CEBJA urge the House of Delegates to adopt the following resolution.

Resolution

73. Resolved, that the specialty currently designated "orthodontics" be redesignated "orthodontics and dentofacial orthopedics," and be it further

Resolved, that the documents and policies approved by the House of Delegates of the American Dental Association which refer to "orthodontics" be amended to reflect the change in designation to "orthodontics and dentofacial orthopedics" and be it further

Resolved, that the communities of interest be advised of the change in designation and be encouraged to utilize the new designation when referring to the specialty, and be it further

Resolved, that the Association's *Principles of Ethics and Code of Professional Conduct* be amended by deleting the second paragraph of Section 5-C, Announcement of Specialization and Limitation of Practice, in its entirety and substituting the following new second paragraph:

> The special areas of dental practice approved by the American Dental Association and the designation for ethical specialty announcement and limitation of practice are: dental public health, endodontics, oral pathology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics.

Council on Dental Practice

Supplemental Report 1: Study of Dental Support Personnel

Background: This report is intended as a summary of activities that were undertaken by the Council on Dental Practice in order to study the immediate needs of dentists for support personnel who can assist in providing limited dental hygiene services to patients. This investigation by the Council arose in response to House of Delegates Resolution 141H-1992 (*Trans.*1992:611), which focused attention on identifying alternate means to meeting the limited hygiene needs of patients. The text of Resolution 141H-1992 is as follows:

> **Resolved,** that the ADA undertake a study through the Council on Dental Practice, in concert with other appropriate communities of interest, of the immediate needs of dentists for support personnel who can assist in providing limited dental hygiene services to patients, and be it further
> **Resolved,** that the Board of Trustees allocate sufficient funds to conduct this study, and be it further
> **Resolved,** that the results of this study, or a progress report thereof, be submitted to the 1993 House of Delegates.

The Council appointed a working committee to study how best to implement the directive of the resolution. One method agreed on by the Working Committee that potentially could quickly gauge the interest, perception and special requirements dentists may deem appropriate for an individual performing these duties was to conduct a survey of dentists regarding those issues. In January 1993, the Working Committee from the Council met in Chicago and approved surveying dentists about themselves and relevant hygiene issues and practices.

An essential product of that meeting was formation, by the Committee, of a framework for developing questions. That is, the Working Committee prioritized information to be gathered as: 1) manpower considerations of support personnel; 2) those delegable dental duties which dentists most need accomplished by support personnel; 3) examining the adequacy or inadequacy of current training; 4) the level of training needed for various delegable dental services; 5) appropriate methods to provide training to support personnel; 6) degree of supervision needed for various delegable dental duties; and, 7) perception, desirability or degree of interest in different support personnel to provide certain of these services.

Accordingly, the actual survey characterized respondents and practices, examined manpower considerations, investigated educational/training issues and delegation of dental procedures, and probed attitudes and practices regarding supervision.

Sampling: The sample of the 1993 *Survey of Dentists* was selected from the Survey Center's (formerly Bureau of Economic and Behavioral Research) 1993 sampling frame of 144,385 active private practitioners. Before the sample was drawn, dentists listed as deceased, retired, suspended, or foreign were dropped from the file. In addition, dentists participating in the American Dental Association's *Quarterly Survey of Dental Practice* and the 1993 *Survey of Dental Practice* were also excluded from the sampling frame. The frame is based on the 1991 *Distribution of Dentists* with addresses updated weekly. The sample was chosen using simple random proportionate probability sampling techniques. The final sample contained 5,258 general practitioners (83% of total) and 1,075 specialists (17% of total), giving a total sample of 6,333 active private practitioners.

Data Collection: The first mailing of the 1993 *Survey of Dentists* occurred in April 1993. Two additional mailings to the nonrespondents occurred in May and June 1993, in approximately four-week intervals. In July 1993, telephone follow-ups were conducted with all dentists who had not responded. Coding, editing and data cleaning were completed during September and October 1993. The final response rate was calculated after excluding from the sample: participants who were retired, disabled, deceased, not in private practice or had unknown addresses. The adjusted final response rate was 62%. The aggregated data from this survey is contained in a separate publication, 1993 *Survey of Dentists*, available to members from the Survey Center.

Purpose of the Study: The purpose of this study was to collect and analyze data about the conditions and means of employing dental practice support personnel (i.e., dental hygienists and dental assistants).

Analyses were conducted in order to assess training requirements and to inquire into dentists' opinions about which level of supervision is necessary when delegating certain functions either to dental assistants or to dental hygienists. Also, in an effort to learn about current delegating patterns of dentists, the opinions of dentists were gathered and studied concerning their increasing delegations to dental assistants.

In particular, delegation of dental procedures was analyzed based on the identification by dentists of the procedures delegated to hygienists, assistants, dentists, or combinations of support personnel.

The aggregated data from the survey were used to examine manpower considerations including trends in employment, turnover of staff, reasons for turnover, success rates for hiring personnel and perceptions about manpower conditions for hygienists and dental assistants.

Characteristics of Respondents

All Dentist Respondents: Most of the respondents to this survey are general practitioners (85%), compared to 15% who identify themselves in one of the Association's recognized specialties. Eight percent of respondents are female and 92% are male. The average age of respondents is 46.9 years, with 30% under age 40, 45% age 40-54, and the remaining 25%, 55 years and older. Ninety-nine percent of the respondents indicate they are in private practice as their primary occupation.

About 89% of the dentists indicate they are owners in their own private practice either as the sole proprietor (78%) or as a partner (12%). Almost 37% identify their practice as incorporated and 63% are in unincorporated practices. Most of the dentists responding to the survey are in solo practice (71%), while an additional 19% are in practice with one other dentist. The average size practice (number of dentists) among respondents is 1.6 dentists.

Dentists in private practice spend about 48 weeks per year practicing, 37 hours per week in the office and 33 hours per week treating patients. General practitioners (GPs) treat, on average, about 52 patient visits per week (excluding hygiene visits) and six other visits including walk-in and emergency. GPs indicate they are in practices that average a total of 75 visits per week (not including hygiene visits) and eight other visits. Among GPs, total hygiene visits per week average about 30 visits (51 visits among those who employed hygienists).

Specialists treat, on average, about 92 patient visits per week (excluding hygiene visits) and five other visits including walk-in and emergency. Specialists indicate they are in practices that average a total of 130 visits per week (not including hygiene visits) and nine other visits. Among specialists, total hygiene visits per week average about 15 visits (68 visits among the 22% who indicate they employ hygienists).

Only about 11% of dentists indicate that their practice consists of multiple offices in different locations. The average number of office locations is 2.6 offices among those who had multiple offices. Dentists further indicate an average of 1.2 owner dentists in the practice (i.e., dentists who own or share in ownership of the practice) and 0.4 nonowner dentists (almost 20% of dentists indicate a nonowner dentist treats patients in their primary practice).

General Practitioner Respondents: The average age of GPs is 47.5 years, with 27% under the age of 40. About 47% of GPs are in the age group of 40-54 years and 26% are 55 years and older. Ninety-four percent of GP respondents are male and 6% are female.

About two of three GPs indicate that their practices are unincorporated and 89% indicate they are the sole proprietor within the practice. The remaining 11% are partners in a partnership practice. About 78% of the GPs are in solo practice (i.e, there are no other dentists in the practice) while 15% are in a practice with one other dentist. Three percent indicate they are in a practice with a total of four or more dentists.

The distribution of dentists by the nine U.S. Census regions shows that most dentists are located in the Middle Atlantic, East North Central, South Atlantic and Pacific regions.

Only about 8% of all dentists indicate they are too busy to treat all patients requesting appointments, while 20% indicate they provide care to all who request appointments, but do not describe themselves as overworked. Some 27% of dentists report not being busy enough. 72% indicate that they are providing care to all who request appointments and are not overworked.

The first portion of the survey characterized respondents and their practices, by seeking information about busyness, service area population, specific practice characteristics (number of locations, general or specialty designation, patient mix); staff attributes such as number, type, years of education and length of employment, salary and hours per week worked and duration of staff position vacancies.

The following listing highlights some of the key trends:

- The total number of practice staff members per dentist has remained relatively constant since 1985.
- The percent of general practitioners employing hygienists has risen from 56% a decade ago to 65% currently.
- Average annual growth in earnings of hygienists (adjusted for inflation) has been greater than growth in dentists' earnings while assistant average earnings have grown at about the same rate as dentist average earnings.
- Average amount of practice experience for hygienists is about 38% higher than it was a decade ago. Since 1987 the average length of experience of assistants has remained relatively constant.

Examination of Manpower Considerations

Turnover of Staff: Turnover of staff, trying to fill open positions and hiring of practice personnel locally were also examined using data from the survey. Responses of dentists to questions along this line are an indication of their manpower requirements.

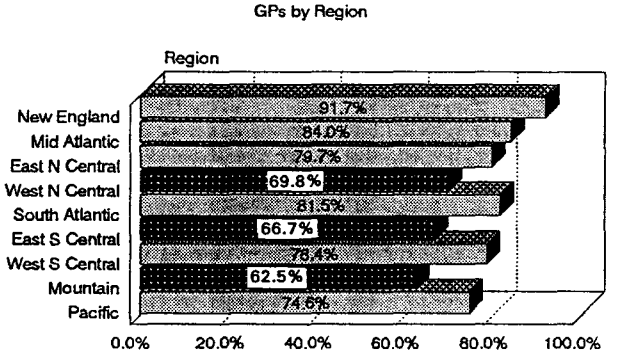
In general from the survey, dental assistants leave the practice at rates consistently higher than dental hygienists. The three most frequently cited reasons are: personal reasons (73%), dismissal (65%) and transfer of spouse or other relocation (55%). The reasons least frequently reported by GPs include dental career advancement (33%), salary inadequacies (32%) and better benefit package (38%).

Questions regarding turnover correspond to interest by the Working Committee in addressing suppositions and possible actions by dentists, such as:

- Employee vacancies in the last 2 years are getting worse.
- My practice made modifications in the benefits package in order to keep/hire qualified personnel.

The data reported in the survey concerning success in hiring hygienists, by census regions, range from as low as 62% of positions in the Mountain region, to as high as 92% hiring success in the New England region (see Figure 1).

Figure 1. Average % Hygienist Positions Filled

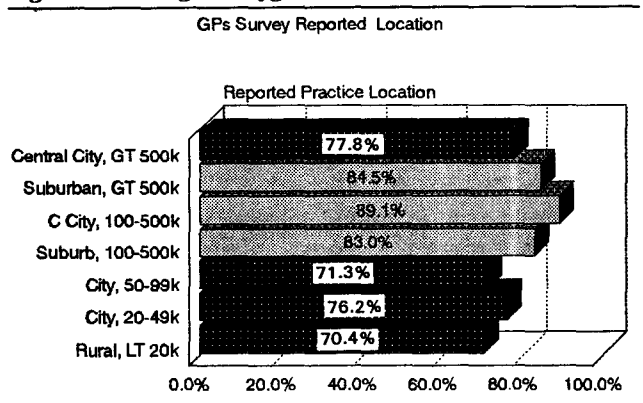


ADA, 1993 *Survey of Dentists*

Success in filling open positions ranges from a low of 70.4% for dentists located in rural areas, to 89.1% among

dentists located in the central city areas with population from 100,000 to 499,999 people. Not too unexpectedly, the greatest difficulty in hiring hygienists occurred to dentists that report a primary practice location within a rural area of less than 20,000 people (see Figure 2).

Figure 2. Average % Hygienist Positions Filled



ADA, 1993 *Survey of Dentists*

The discrepancy some rural dentists have postulated in successfully filling hygienist positions in these areas is verified in the survey data. Average success in hiring hygienists was lower in rural areas compared to more populated areas at a significance of p=.075. However, the location reported by dentists in the survey, and population size, are better predictors of hiring success.

The study shows that success in hiring hygienists is higher among dentists where the population per practitioner is lowest (p=.015). In the case of dental assistants, very little variance was shown in hiring success by regions, reported practice location, or by dentists grouped according to county population.

The Working Committee saw hiring success as a possible indication of the ease/difficulty with which a dentist might fill a vacancy. Surveyed dentists perceive that there is difficulty in hiring staff; varying levels of actual hiring success was demonstrated for doctors who tried to fill a vacancy.

Staff Size and Composition: Total staff size among general practitioners in private practice is about 4.8 staff members per practice and 3.6 per dentist. Only 3.5% of GPs indicate employing no staff and 93% of general practitioners indicate they employed up to nine practice staff members.

Sixty-six percent of GPs employ hygienists on a full- or part-time basis, with 36% employing full-time hygienists and 45% employing part-time hygienists. GPs employ an average of 1.0 hygienist per dentist overall and, among the dentists who employ hygienists, the average is almost 1.5 hygienists (full- or part-time).

Almost 25% of GPs indicate they employ expanded duty dental hygienists (EDH) on a full- or part-time basis. Among dentists that do, the average number is 1.3 and 93% employ no more than three. About 43% of GPs employ conventional hygienists with overall average employment per dentist equal to 0.6 hygienists. Among the dentists employing conventional hygienists, the average number employed (FT or PT) is about 1.5 per dentist and 91% employ no more than three hygienists.

Approximately 90% of general practitioners employ at least one dental assistant. The average number employed by general practitioners is nearly 1.4 dental assistants per dentist and close to 95% of GPs employ no more than four. Full-time assistants are employed by 75% of dentists and 34% employ part-time assistants.

Expanded duty dental assistants (EDA) are employed by approximately 38% of GPs on a full- or part-time basis. Among dentists that employ EDAs, the average number employed is 1.4 per dentist and about 96% employ no more than four expanded duty dental assistants. Sixty-one percent of GPs employ conventional assistants on a full- or part-time basis. For dentists employing conventional assistants, the average number is 1.4 per dentist. Ninety-four percent employ no more than three.

Other staff employed by GPs include dental laboratory technicians, secretary-receptionists and bookkeepers or business personnel. GPs in the survey employ an overall average of 1.9 other staff members and about 90% employ no more than three other types of support personnel.

Trends in Employment of Hygienists and Assistants: Since 1985, the number of staff members per practitioner has increased slightly from nearly 3.2 individuals per dentist to the current level of 3.6 per private practitioner. Since the late 1980s, the market for dental hygienists and dental assistants has been characterized as a shortage. Over the last decade the number of general practitioners employing hygienists has risen from about 56% in 1982 to almost 67% currently. Since 1985, the average length of employment for dental hygienists has also increased through both experience prior to the practice (at the time of the survey) and length of employment in the practice.

The average length of experience has increased and currently is 41% higher than in 1985, while length of time employed in the practice is about 20% higher. Dental hygiene wages, adjusted for inflation, have been rising since 1983 at an annual rate of 3.8% compared to an annual rate of 2.4% growth in dentist earnings from practice.

The proportion of dentists who believe that hygienists' education is appropriate for their practice is 85% of surveyed practitioners already employing at least one hygienist. A larger proportion of dentists who tried to hire staff also believe that hygienist education and training is appropriate for their needs.

As for dental assistants, 48% of GPs report that the highest level of education for this position in their practices is on-the-job training (OJT). Thirty-nine percent of GPs employ assistants who have received dental training encompassing six months or longer in a post-secondary school-based program.

A manpower concern of the Working Committee, and additional study area for the survey, was to historically examine data for any change in actual percentage of unfilled positions—both for hygienists and assistants. The dictum from the Committee:

- What historical data supports the position that the percentage of unfilled positions may be declining?

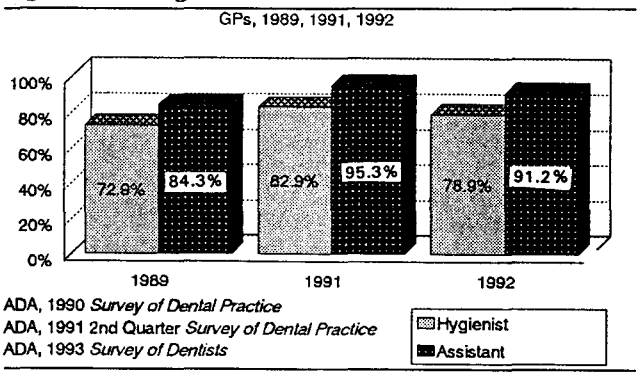
A single survey cannot suggest, track or document a trend. Appropriate scientific investigating requires corroboration using multiple observations over time. Quite naturally then, a

review was made of additional data, such as from other sources, in order to address whether the number of unfilled positions is increasing or declining.

Looking, for example, at the 1990 *Survey of Dental Practice*, which covers all of 1989; the 1991 2nd Quarter version of the *Quarterly Survey of Dental Practice*; and the *1993 Survey of Dentists*, it is possible to examine the average percent of hygiene and assistant vacancies that were filled for the years 1989, 1991 and 1992.

One observation is that successfully filling hygienist positions has increased from 72.9% in 1989, to 78.9% in 1992, with 1991 (quarterly survey) indicating that 82.9% of positions were filled. Similarly, for dental assistants, about 84% of positions were filled in 1989, which then grew to 91.2% in 1992 (see Figure 3). Results from the 1991 *Quarterly Survey* indicated that in the 2nd Quarter, 95% of vacant assistant positions that GPs were actively seeking to fill, were, in fact, filled. In studying the latter two years of the three periods, unfilled positions for hygienists and assistants have declined compared to 1989.

Figure 3. Average Percent of Positions Filled



ADA, 1990 *Survey of Dental Practice*
ADA, 1991 2nd Quarter *Survey of Dental Practice*
ADA, 1993 *Survey of Dentists*

Another manpower analysis suggested by the Working Committee attempted to detect any difference in the average percent of hygienist positions filled in relation to those areas where dental assistants perform coronal polishing.

The actual question, framed in a follow-up secondary examination of data, came from deliberations of the Working Committee examining preliminary findings of the survey and is as follows:

- Is there a difference in the vacancy rate for hygienists, across states, that correlates with individual states allowing or not allowing coronal polishing by dental assistants?

In order to successfully address that question, two different kinds of variables were created: the first variable grouped states into categories, e.g., 1) states that permit coronal polishing by dental assistants (they are: Arkansas, California, Colorado, Georgia, Idaho, Iowa, Louisiana, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Mexico, North Dakota, Oklahoma, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington, Wisconsin and Wyoming); and, 2) the remaining states that do not permit coronal polishing by assistants.

The second variable was specially developed after completing the survey. It is a variable that uses the seven logical permutation possibilities of dentist and staff, suggested by the dentists' own answers. The following chart depicts the results for these possible combinations (428 respondents met prescribed conditions for inclusion into this particular inquiry).

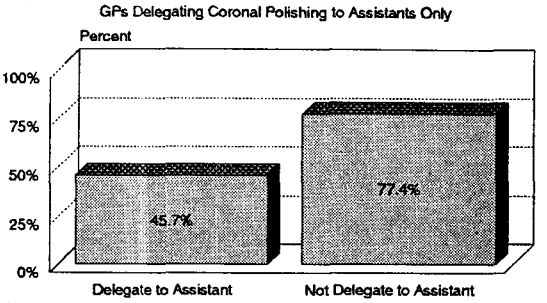
Performance and Delegation of Coronal Polishing by GPs Who Tried to Hire Hygienists

	Who Performs	Number	Percent
	DDS only	29	6.78
	Hyg only	222	51.87
	Ast only	23	5.37
DDS=dentist	DDS/Hyg only	73	17.06
Hyg=hygienist	DDS/Ast only	4	0.93
Ast=assistant	Hyg/Ast only	36	8.41
	DDS/Hyg/Ast only	41	9.58
	Total	428	100.00

Other results of this comparison include:

- the finding that the average percent of hygiene positions filled was 45.7% among dentists who delegate coronal polishing only to dental assistants. This was statistically different (p=.004) than the 77.4% of positions filled by GPs who do not delegate to assistants (see Figure 4);

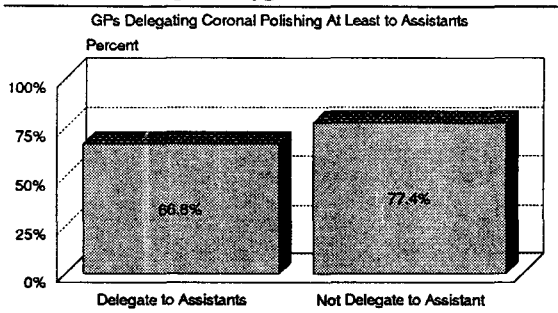
Figure 4. Average % Hygienist Positions Filled



ADA, 1993 *Survey of Dentists*
ADA, *Legal Provisions for Delegating Functions to Assistants and Hygienists, 1993*

- the average percent of hygiene positions filled was 66.8% for dentists delegating coronal polishing to "at least" dental assistants compared to the 77.4% of positions filled by dentists who do not delegate coronal polishing to dental assistants (a difference significant at p=.022 level)(see Figure 5);

Figure 5. Average % Hygienist Positions Filled



ADA, 1993 *Survey of Dentists*
ADA, *Legal Provisions for Delegating Functions to Assistants and Hygienists, 1993*

- among dentists who delegate, the average percent of positions filled was about 27.6 percentage points lower than for dentists not delegating (where delegating was just to the assistant), and 11.2 percentage points lower where delegating was "at least" to the assistant.

The average rate of success in hiring hygienists was 72.6% in states that permit coronal polishing by assistants and 76.6% in states that do not allow coronal polishing by assistants.

Dentists had lower success in hiring hygienists in states that allow coronal polishing by assistants; however, the difference could not be determined as statistically significant using data from this study.

It is postulated that dentists may not be actively trying to fill a hygiene position if they are already delegating coronal polishing to their dental assistants.

The data show that successfully filling hygienist positions has indeed increased from about 73% in 1989, to 78% in 1992, with 1991 (*Quarterly Survey*) indicating that 83% of positions were filled.

Delegation: Some 57% of dentists who already have a hygienist, indicate a desire to delegate more procedures to their dental hygienist. There is a relatively identifiable list of procedures delegated to hygienists by dentists who employ hygienists, which are not delegated to dental assistants (with the exception of exposing radiographs). These procedures include supragingival scaling, subgingival scaling, root planing, coronal polishing, closed gingival curettage, exposing radiographs, applying topical anticariogenic agents, and pit and fissure sealants.

Exactly how do dentists feel about delegating more of the hygienist's duties to dental assistants? Table 1 (*Supplement:*309) lists the procedures that more than 50% of surveyed dentists indicate are at least delegated to the dental hygienist.

Dentists are asked to indicate who actually performs these functions, and whether performing these tasks requires, in their opinion, on-the-job training or formal, school-based training.

According to GP respondents, the first four procedures will require school-based training if more of these procedures are to be delegated to dental assistants. Less than 50% of the dentists, however, believe these activities should be delegated more to assistants. Currently, these four procedures are not being delegated to assistants.

Finally, Table 2 (*Supplement:*309) identifies the nine procedures which more than 50% of dentists indicate need school-based training prior to their delegating more to dental assistants.

These nine procedures, according to respondents, each require school-based training; however, less than 50% of the dentists indicate that more of these procedures should be delegated to dental assistants. Furthermore, most of the procedures (except for closed gingival scaling, subgingival scaling and root planing) are not delegated either to dental assistants or to dental hygienists.

Taking preliminary dental impressions is the most frequently cited procedure delegated to dental assistants (34% of dentists) among the dentists who also employ dental hygienists. On the whole, dentists who employ only dental assistants delegate less to dental assistants compared to dentists who employ both assistants and dental hygienists.

Sixty-three percent of GPs believe the chairside assistant should be able to perform additional dental services if the dentist is present and evaluates the patient during the same patient visit.

Of interest is that while this study does not demonstrate support among dentists for a new category of support personnel trained on the job to do things that a dental hygienist currently performs, 61% of GPs indicate they would be willing to train on the job. Fifty-six percent are agreeable to supervising an approved OJT program that develops chairside assistants to deliver some hygiene services.

However, while dentists show a willingness to train on the job, they probably will not have much to do. For most procedures which dentists in the survey indicate could be delegated to assistants, they do not indicate that an increase in delegation requires only OJT (i.e., in most cases they indicate a need for more school-based training as previously stated in this report). A conclusion could be drawn that OJT is not the educational mechanism many dentists envision to take care of additional educational needs they may require of dental assistants and which would lead them to delegate more.

Supervision: Supervision is the authorization, direction, oversight and evaluation by a dentist of the activities performed by dental support personnel. In the survey, dentists were asked to respond to questions related to supervision under three levels:

- Level 1—The dentist is in the office and evaluates the patient during the same visit.
- Level 2—The dentist is in the office but may evaluate the patient at a later time.
- Level 3—The dentist has authorized the procedure but is not necessarily in the office.

Attempts to query dentists' attitudes toward support personnel providing services under varying levels of supervision is demonstrated in statements from the survey such as:

- Chairside assistants should be able to perform additional dental services not yet allowed by my state's law if I were present and evaluated the patient during the same patient visit.
- Chairside assistants should be able to perform additional dental services not yet allowed by my state's law if I were present and evaluated the patient at a later time.
- Chairside assistants should be able to perform additional dental services not yet allowed by my state's law if I authorize the procedure but am not necessarily in the office.
- My dental hygienist should supervise my chairside assistants performing hygiene functions.

Fifty-five percent of GPs believe the chairside assistant should, in fact, be able to perform additional dental services if the dentist is present and evaluates the patient at a later time. Also, fully 52% of GPs indicated in the survey that they would like to delegate more dental hygiene services to their support staff.

Currently, however, GPs who want to delegate more functions to their dental hygienist are delegating no differently than the dentists who do not want to delegate more. General practitioners who want to delegate more dental hygiene

Table 1: Procedures Ordinarily Delegated to Dental Hygienists

Procedure	% Wishing to Delegate More to Assistants	Who Currently Performs	Training Needed, if Delegated	
			School-Based	OJT
Closed Gingival Scaling	20.5	Hygienist	Yes	No
Root Planing	21.0	Hygienist	Yes	No
Perform Subgingival Scaling	25.5	Hygienist	Yes	No
Perform Supragingival Scaling	44.8	Hygienist	Yes	Some
Monitor Nitrous Oxide	55.9	Assistant	Some	Some
Computer Imaging Equipment	73.0	Assistant	Some	Some
Coronal Polishing	73.6	Hygienist	Some	Some
Apply Pit & Fissure Sealants	73.9	Hygienist	Some	Some
Apply Anticariogenic Agents	83.9	Hygienist	No	Some
Expose Radiographs	94.7	Assistant	Some	Some

Table 2: Nine Procedures Requiring School-based Training for Delegation to Dental Assistants

Procedure	% Wishing to Delegate More to Assistants	Who Currently Performs	Training Needed, if Delegated	
			School-Based	OJT
Carving Amalgams	35.9	Neither	Yes	Some
Closed Gingival Scaling	20.5	Hygienist	Yes	No
Place & Condense Amalgams	33.7	Neither	Yes	Some
Place Sutures	13.0	Neither	Yes	No
PF† Composite Resin Restoration	23.1	Neither	Yes	Some
Perform Subgingival Scaling	25.5	Hygienist	Yes	No
Root Planing	21.0	Hygienist	Yes	No
ALA††: By Infiltration	12.9	Neither	Yes	No
ALA: By Block	11.8	Neither	Yes	No

†PF = placing & finishing
††ALA= administering local anesthetic

services to clinical support staff are at present delegating only 0.9 procedures more than those who do not hold this opinion.

Conclusions

The Council continues to be extremely concerned about issues of shortages of dental support personnel in general and about the availability of dental hygienists in particular.

Indeed, the central purposes of this study were to characterize respondents and their practices and examine the success of dentists in meeting the dental hygiene needs of their patients. In performing this study a great deal of additional information was learned about which duties, both presently delegable and nondelegable, dentists would like to have accomplished by support personnel; the opinion of dentists about the adequacy or inadequacy of current training for support personnel; and the level of training needed for various delegable dental duties. It was also possible to examine the perception, desirability or degree of interest by dentists in different support personnel providing certain of these services.

A conclusion from this study is that a large number of dentists are still experiencing difficulty in hiring dental hygienists. That difference varies widely geographically and demographically and is most pronounced in rural areas. Surveyed dentists indicate a large desire to delegate more to trained and qualified personnel and would support a broader expansion of delegation of duties. Large numbers of dentists also agreed with a statement that patients' dental care would not be compromised if they were able to delegate additional hygiene services to support personnel other than a dental hygienist.

The Council interprets this data to suggest that the Association should look carefully at the applicability of policies with respect to delegation of function and expansion of duties. Expanding the permissible duties of dental auxiliaries to perform some of these duties is of great interest to a majority of dentists responding to the survey. The Council suggests that the Association should work closely with constituent dental societies wishing to communicate better with their state boards regarding delegable dental duties.

The Council believes that while the data indicate that dentists desire to expand delegation of certain dental hygiene services, doing so does not necessarily imply the development of a new category of personnel. In essence, it may be concluded that dentists are relatively satisfied with the present training and other qualifications of their support personnel, but believe that additional personnel, so trained, are needed to alleviate the shortage.

This conclusion would appear to support efforts by the Association to work with allied educational institutions in order to increase dental hygiene program flexibility and enrollment.

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

Joint Report of the Council on Dental Materials, Instruments and Equipment and the Council on Community Health, Hospital, Institutional and Medical Affairs

Precapsulated Amalgam Alloy

Background: Since 1984, the Council on Dental Materials, Instruments and Equipment (CDMIE), as part of its dental mercury hygiene recommendations, has recommended that dentists use only precapsulated amalgam alloy. CDMIE has long recognized that the use of precapsulated amalgam alloy decreases the potential of occupational exposure to mercury by eliminating the possibility of bulk mercury spills and leaky mercury dispensers. The benefit of using precapsulated amalgam alloy is clear. Research performed by the ADA Research Institute using data from the Association's Health Screening Program shows that dentists who use bulk mercury and bulk amalgam alloy are more likely to have higher mercury concentrations in their urine than dentists who do not. CDMIE has widely published its recommendation on use of precapsulated amalgam alloy. However, compliance by the profession remains below the desired goal of 100%. In a 1994 meeting of a Food and Drug Administration (FDA) Dental Product Panel, it was stated that about 8 to 10% of dental mercury and amalgam alloys are sold to dentists in bulk form.

In keeping with the Association's routine consideration of amalgam issues, CDMIE reviewed its recommendation on use of precapsulated amalgam alloy at its September 1994 meeting. Additionally, at its September 1994 meeting, the Council on Community Health, Hospital, Institutional and Medical Affairs (CCHHIMA) became aware of this problem in the course of its consultant reports on a variety of general interest issues.

The Councils agreed that elevating CDMIE's recommendation to the level of Association policy would give greater force and visibility to the recommendation and further improve practitioner compliance. It would also be consistent with CDMIE's decision at its September 1994 meeting that bulk mercury and bulk amalgam alloy will no longer be eligible for evaluation under the Association's Seal Program, since use of these products is not recommended by the Council. The Councils were also sensitive to concerns expressed about mercury and the environment.

Based on these considerations, CDMIE and CCHHIMA recommend adoption of the following resolution.

Resolution

93. Resolved, that the ADA recommends that dentists eliminate the use of bulk dental mercury and bulk amalgam alloy and that they use only precapsulated amalgam alloy in their dental practices.

Joint Report of the Council on Dental Materials, Instruments and Equipment and the Council on Dental Therapeutics

Revision of the Provisions for Acceptance of Products

Background: With the decision of the 1993 House of Delegates to combine the three scientific Councils of the American Dental Association into one council, the Council on Scientific Affairs, the Seal Program of the Council on Dental Therapeutics and the Council on Dental Materials, Instruments and Equipment are being combined. This action necessitates the development of new Provisions for Acceptance of Products by the Council on Scientific Affairs.

A copy of the revised Provisions is appended. These provisions represent a combination of the current Provisions for Acceptance of Products of the Council on Dental Materials, Instruments and Equipment and the Council on Dental Therapeutics. The major change in these provisions is the integration of the Certification Program of the Council on Dental Materials, Instruments and Equipment into the Acceptance Program of the new Council on Scientific Affairs. This is necessary based on reorganization of the Seal Program by the Board of Trustees. Other changes in these Provisions were made to eliminate minor differences in language in the Provisions of the two current Councils.

Both Councils reviewed the revised Provisions at their Council meetings in September 1994 and accepted the combined document. Therefore, the Councils request that the House of Delegates adopt the following resolution.

Resolution

94. Resolved, that the Provisions for Acceptance of Products by the Council on Scientific Affairs be adopted, and be it further

Resolved, that the Provisions for Acceptance of Products by the Council on Dental Therapeutics (1966:65, 323; 1968:263; 1972:644; 1975:744; 1983:554; 1984:533; 1986:534; 1987:482; 1989:569; 1990:574; 1992:647) and Evaluation Programs of the Council on Dental Materials, Instruments and Equipment (1966:140, 282, 322, 324; 1973:686; 1975:742; 1983:553: 1985:607) be rescinded.

APPENDIX

American Dental Association
Council on ~~Dental Therapeutics~~ Scientific Affairs

PROVISIONS FOR ACCEPTANCE OF PRODUCTS

BY THE COUNCIL ON ~~DENTAL THERAPEUTICS~~ Scientific Affairs

PURPOSE OF THE COUNCIL

Under the *Bylaws* of the American Dental Association, the Council on ~~Dental Therapeutics~~ Scientific Affairs studies, evaluates and disseminates information with regard to: the safety, efficacy, promotional claims, and proper use of dental therapeutic agents, their adjuncts and dental cosmetic agents used by the public or profession. ~~and aspects of the dental practice environment related to the health of dentists, dental auxiliaries and the public.~~ The Council also determines the safety and effectiveness of and disseminates information on materials, instruments and equipment that are offered to the public or the profession and further critically evaluates statements of efficacy and advertising claims.

Additionally, the Council maintains liaison with related regulatory, research and professional organizations, and encourages, establishes and supports research in the field of dental therapeutics and dental materials, instruments and equipment. Furthermore, the Council encourages development and improvement in materials, instruments and equipment by coordination of national and international standardization programs.

PRODUCTS CONSIDERED FOR ACCEPTANCE

Generally included within the responsibilities of the Council on ~~Dental Therapeutics~~ Scientific Affairs are all drugs and chemicals which are employed in the diagnosis, treatment or prevention of dental disease. Drugs are considered useful in the treatment of oral disease if they are effective in the treatment of disease of similar causation in other regions of the body. Fixed combination drugs are considered eligible for acceptance if each of the components makes a contribution to the claimed effect, and the dosage of each component is safe and effective for a significant patient population. Combinations having components added to enhance the safety or efficacy of the principal active component, or to minimize the potential for abuse are also eligible. Also considered are chemicals which may affect the health of dentists, dental auxiliaries and the public. The Council also considers for evaluation dental materials, instruments and equipment for which it has developed specific provisions or guidelines or which comply with the specifications which have been approved as official Specifications of the American Dental Association.

The Council does not consider for evaluation mouthwashes or dentifrices which do not claim therapeutic value.

~~Consideration of dental materials and devices is specifically assigned to the Council on Dental Materials, Instruments and Equipment of the American Dental Association. When these materials and devices possess therapeutic properties or claims for such properties are made, they are considered in cooperation with the Council on Dental Therapeutics. The Council on Dental Therapeutics assists or advises other councils or committees of the Association on matters which pertain to dental therapeutics.~~

Shading indicates additions.

~~Strikeouts~~ indicates deletions.

CLASSIFICATION OF PRODUCTS EVALUATED BY THE COUNCIL

Commercial products are evaluated upon the request of a distributor or manufacturer, or upon the initiative of the Council. Any firm may submit appropriate products to the Council for consideration for acceptance. Products which meet standards of acceptance with respect to safety, efficacy, composition and labeling, package inserts, advertising and other promotional material will be accepted. Once accepted, the products will be listed and may be described in suitable reports in *The Journal of the American Dental Association* and the manufacturer may then use the Council's Seal of Acceptance and may be required to use an authorized statement. Products are usually accepted for three years. Acceptance is renewable and may be reconsidered at any time. ~~If ownership of the product changes,~~ If there is a change in the manufacturer or distributor of a product, the period of acceptance expires automatically. Provisionally Accepted products consist of those which lack sufficient evidence to justify classification as Accepted, but for which there is reasonable evidence of safety and usefulness including clinical feasibility. These products meet the other qualifications established by the Council. The Council may authorize the use of a suitable statement to define specifically the area of usefulness of products classified as Provisionally Accepted. Classification in this category is reviewed each year and is not ordinarily continued for more than three years. Products which are obsolete, markedly inferior, ineffective or dangerous to the health of the user will be declared unaccepted. When it is in the best interest of the public or the profession, the Council may submit reports on unaccepted products to the Editor for publication in *The Journal of the American Dental Association*.

Decisions of the Council are based upon available scientific evidence and are subject to reconsideration at any time that a ~~substantial~~ significant amount of new evidence becomes available.

Communications with the Council shall be in writing and shall be transmitted through the Director of the Council. The Council will feel free to use the information in these communications subject to provisions on confidentiality set forth below.

~~After consideration of a product has been completed, the Council will classify the product as accepted or unaccepted.~~

~~Accepted products include those for which there is adequate evidence of safety and efficacy. They will be listed and may use the Seal of Acceptance and/or an authorized statement, unless otherwise provided.~~

~~Unaccepted products include those for which the Council has determined that there is no substantial evidence of efficacy, or that a question of safety exists.~~

GENERAL PROVISIONS FOR ACCEPTANCE

I. Composition, Nature and Function

A. *Required Information*: A quantitative statement of composition, including excipients, shall be provided to the Council. Adequate information on the properties of all ingredients shall also be provided. For instruments and equipment, a description of the materials used in the construction and the method of operation shall be provided.

B. ~~*Change in Composition*: Any change in composition of an accepted product must be submitted to the Council for review and approval before a modified product is marketed.~~ *Change in Composition, Nature and Function*: Any change in the composition, nature or function of an accepted product must be submitted to the Council for review and approval before a modified product is marketed.

C. *Manufacturing Standards*: The firm shall provide evidence that manufacturing and laboratory control facilities are under the supervision of qualified personnel, are adequate to assure purity and uniformity of products, and that products are produced in compliance with the Good Manufacturing Practice Code. The firm shall permit representatives of the Council to visit laboratories and factories upon request. For

products whose guidelines include an official American Dental Association Specification, the manufacturer shall conduct testing on a regular basis to determine continued compliance with the specification and shall make available to the Council on request these test records. In addition the manufacturer shall make available to the Council on request test records and data for any batch of an Accepted product.

D. ~~*Standards or Specifications:* Drugs shall conform to appropriate standards or specifications.~~ *Guidelines Containing Standards or Specifications:* The product shall conform to appropriate standards or specifications. For products which fall under the scope of official American Dental Association Specifications the following information shall be submitted: (1) the serial or lot number; (2) the physical properties as obtained by standard test methods; and (3) data covering every provision of the official specification. Responsibility for guaranteeing that the product complies with an official Specification lies solely with the manufacturer and not with the American Dental Association.

E. *Survey of Accepted Products*: For products whose guidelines include an official American Dental Association Specification, the Council, at any time and without notice to the manufacturer, may authorize the testing of any or all such products. In the event that a sample fails to comply with the appropriate specification, the product will be removed from the List of Accepted Products. Test samples will be procured at the expense of the manufacturer as indicated in Section III. If a product is removed from the List of Accepted Products it may subsequently be resubmitted provided adequate evidence is given that the product which did not comply with the specification has been removed from the market.

II. Name

A. *Established or Generic Names*: The selection and use of established or generic names must conform to the requirements of the Federal Food, Drug and Cosmetic Act.

B. *Trade Names*: Proprietary names will be acceptable to the Council provided the names meet certain professional standards:

1. *Misleading Names*: Names which are misleading or which suggest diseases or symptoms are not acceptable. This provision may not apply to certain biological products such as serums or vaccines.

   Explanatory Note: Since the uses of a drug may change, it is important that the name indicates the composition rather than a proposed use for the product. However, under certain circumstances the Council may accept a name which denotes a long-established physiological action or use, particularly for a mixture. Thus, the Council has accepted names such as _____ *Topical Anesthetic* and other names which similarly suggest actions, but not diseases. The Council will give individual consideration to requests for acceptance of such names, and its decision in each case will be materially influenced by the adequacy and prominence of the listing on labeling of the common names for the active ingredients.

2. *Numbers or Initials in Names*: The product name shall not include initials or numbers except when deemed necessary to designate the concentration or amount of active ingredient.

   Explanatory Note: The Council has recognized the use of letters or numerals in instances where the size of the label is so small and the full name of the product is so long as to otherwise prevent the inclusion of adequate information.

   This provision does not apply to the use of numbers in conventional price lists or catalogs. Nor does the provision apply to serial or code numbers whose position on the label or package clearly differentiates those numbers from the name of a product.

3. *Titles in Names*: Titles such as *Doctor* or *Dentist* or the designation *D.D.S.* or *D.M.D.* shall not be included in the name of a product.

III. Evidence of Safety and Efficacy

A. *Submission of Evidence*: Evidence pertaining to mechanical and physical properties, operating characteristics where applicable, actions, dosage, safety and efficacy shall be submitted by the firm. Information on acceptable standard test methods for physical properties may be secured on request to the Council on Scientific Affairs. In general, the data required on physical tests must include a brief description of the apparatus used in making the tests, a complete statement of the results obtained, the names of the observers and the date of the test.

B. *Nature of Evidence*: The firm shall provide objective data from critical clinical and laboratory studies. Extended clinical experience may be utilized, in part, as a basis for evaluation of a product. For products which fall under the scope of an official American Dental Association Specification these will be tested for compliance with the specification by the American Dental Association. Test samples unless otherwise indicated in the appropriate specification will be procured on the open market at the expense of the manufacturer. In the case of noble metal, any scrap remaining after testing will be returned to the manufacturer.

C. *Additional Evidence*: The manufacturer will also submit for review a list of all additional studies conducted using the final product. Additionally, the Association may, through use of its own laboratory facilities or use of other facilities, conduct any additional evaluation deemed necessary by the Council.

IV. Governmental Regulations

A. A product shall conform to all applicable laws and governmental regulations.

V. Labeling, Package Inserts, Advertising and Other Promotional Material

A. *Name*: The established or generic name of a product shall be displayed in a prominent manner in all material directed to the dental profession.

B. *Claims*: Claims of significance to dentistry for a product shall be clear and accurate.

C. *Review/Approval Before Use*: All dentally related product material must be submitted to the Council for review and approval prior to use in the public and dental media.

D. *Unwarranted Disparagement of Other ~~Drugs~~ Products*: Advertising of an accepted product shall not result in the disparagement of other useful ~~drugs~~ products.

E. *Point-of-Purchase Advertising*: The Association's name and the Seal and/or Statement of Acceptance may appear in point-of-purchase advertising if it is presented in good taste and professional dignity and is only part of the commercial message.

F. *Implied Acceptance*: An accepted product shall not be advertised or displayed with unaccepted products in a manner that implies acceptance of the unaccepted product. This provision does not apply to conventional price lists or catalogs.

G. *Responsibility*: The responsibility of providing substantiation of claims for safety and efficacy or claims of compliance with an official standard shall reside with the manufacturer and not with the American Dental Association.

G. H. Advertising must conform to the Advertising Standards of the Association.

VI. Reference to Council Acceptance or Provisional Acceptance

A. *Purpose*: Any reference to the Council in labeling, package inserts, advertising and other promotional material for an accepted or provisionally accepted product is permitted solely to indicate to the profession or public that the claims for product effectiveness in treating or preventing oral disease are valid.

B. The Seal of Acceptance, except as otherwise provided, may be used after acceptance of a product has first been announced in *The Journal of the American Dental Association, ADA News* or at the discretion of the Council. The Seal shall not appear in conjunction with the seal of any other investigative group unless approval for such display has been obtained from the Council. The Seal is to be used without comment on its significance unless such comment has been previously approved by the Council. The Seal shall be ~~eligible~~ legible and shall not be used in any manner which detracts from its dignity.

C. When a statement is authorized by the Council to specifically define the effectiveness of a product, or to indicate its acceptance status, the same principles established for the use of the Seal of Acceptance shall apply.

D. There shall be no reference to Council acceptance in labeling, package inserts, advertising and other promotional material for any nonprescription product which requires a professional diagnosis for appropriate dental use.

VII. Changes in Provisions for Acceptance

Any amendment to these Provisions for Acceptance which may be made after acceptance of a product shall not apply to such product until the current period of acceptance has terminated. At the end of this period, a product must comply with the amended Provisions for Acceptance if acceptance is to be renewed. This provision shall not apply to termination of acceptance of a product on the basis of new evidence regarding lack of safety or efficacy.

PROVISIONS FOR ACCEPTANCE IN SPECIAL CATEGORIES

In order to be accepted by the Council, products within the following categories must also meet the following special provisions:

I. Fixed Combination Drug

A. *Eligibility for Acceptance*: A fixed combination drug is eligible for acceptance when there is adequate evidence of effectiveness in the practice of dentistry, when each of the components makes a contribution to a claimed effect, and when the dosage of each component is safe and effective for a significant patient population. A combination having components added to enhance the safety or efficacy of the principal active component, or to minimize the potential for abuse is also eligible for acceptance.

B. *Active Components*: Separate consideration is required for any single active component.

C. *Labeling*: Labeling of an accepted fixed combination drug shall indicate the amount of each therapeutically active component in a stated quantity of product.

II. Nonprescription Analgesic

A pharmaceutical preparation which contains aspirin, acetaminophen or other suitable analgesics for nonprescription use will be considered for acceptance provided:

A. The amounts of active components in the product shall be stated in all advertisements and other promotional material to the dental profession.

B. Advertisements and other promotional material to the public shall not include misleading or unwarranted statements relating to dental use.

C. Labeling, package inserts, advertisements and other promotional materials to the public shall not include the Seal of Acceptance.

WITHDRAWAL OF ACCEPTANCE

I. Conditions for Withdrawal

The Council may on occasion find it necessary to review the status of a product's acceptance. Decisions of the Council are based upon available scientific evidence and are subject to reconsideration at any time that a ~~substantial~~ significant amount of new evidence becomes available. If current scientific evidence demonstrates that a product is no longer safe or effective, or if a product is obsolete, markedly inferior or dangerous to the health of the user, it will be declared unaccepted and Council acceptance will be withdrawn.

Any violation of these Provisions for Acceptance, the Advertising Standards of the American Dental Association, the Council's Rules for Use of the Seal of Acceptance, and/or individual contracts between the American Dental Association and product distributors/manufacturers will also be considered grounds for Council withdrawal of product acceptance. Further, any such violation during the period between notification of Council recognition of product safety and efficacy and approval of labeling, package inserts, advertising and other promotional material will be considered grounds for Council denial of product acceptance.

II. Reference to Council Acceptance

In the event that Council acceptance of a product is withdrawn, the Council may, at its election, immediately terminate or suspend without prejudice to any other rights which the Council may have the company's right to display the Seal of Acceptance and any Council-approved statement, and/or to refer to any manner whatsoever to Council acceptance in any labeling, package inserts, advertising or other promotional material, or other display of the product. Ordinarily, the company will have six months from the date of such withdrawal to use existing labeling, package inserts or similar supplies, but the Council reserves the right to require a shorter time frame for removal of the Seal and any Council-approved statement from such existing supplies if necessary from the standpoint of safety and efficacy of the product or if the reason for termination is company's misuse of the Seal of Acceptance or a Council-approved statement.

CONFIDENTIALITY OF SUBMISSION MATERIAL

It is the policy of the American Dental Association to treat the fact that a product has been submitted as well as the material submitted for an ADA Seal as confidential. The Association will refrain, without the company's prior approval, from voluntarily disclosing secret information to a third party (other than to the consultants the Council uses in its review of products). Secret information is information which is obtained by the ADA in confidence from the company and which is not already known to the ADA, already available to the public or subsequently acquired from other sources. The ADA requires its consultants to sign a Code of Conduct which prohibits them from disclosing to anyone outside the ADA any material designated as confidential. However, the Association is not liable to the company for any damages resulting from the acts or omissions of ADA consultants, including but not limited to their failure to abide by the Code of Conduct.

Council on Ethics, Bylaws and Judicial Affairs

Supplemental Report 1: Judicial Proceedings

Background: As noted in its annual report to the House (*Reports*:97), The Council at its May 1-2, 1994 meeting heard an appeal from Dr. George J. Wolff with respect to his dispute with the California Dental Association. The Council handed down its decision in this case on July 7, 1994. The decision is set forth below. A synopsis of this decision will be added to the Council's publication, *Official Summary, Appellate Disciplinary Decisions of the American Dental Association's Council on Ethics, Bylaws and Judicial Affairs.* Additional copies of the complete text of this decision are available on request to the Council.

Procedural Background: Dr. George J. Wolff (hereinafter Appellant), appealed to the ADA Council on Ethics, Bylaws and Judicial Affairs from a decision of the Judicial Council of the California Dental Association (JCCDA). The JCCDA charged the Appellant with a violation of the *Code of Ethics* of the California Dental Association (CDA). Section 3 provides that it is the duty of CDA members to comply with reasonable requests of duly constituted CDA committees. The full text of Section 3 of the CDA *Code of Ethics* provides:

> SECTION 3. COOPERATION WITH DULY CONSTITUTED COMMITTEES.
> It is the duty of the member to comply with the reasonable requests of a duly constituted committee, council or other body of the component society or of this association necessary or convenient to enable such a body to perform its functions and to abide by the decisions of such body. In the event a member is employed by another dentist, it shall be the duty of the member to provide satisfactory written assurance from the employer that the employed dentist will be able to meet this duty of compliance. Any violation of this duty constitutes unethical conduct.

Appellant was found guilty and sentenced to expulsion from the California Dental Association. He filed a timely appeal to the Council on Ethics, Bylaws and Judicial Affairs (CEBJA).

In accordance with the *Bylaws* of the American Dental Association, the function of CEBJA in this appeal is to: (1) review the decision of the California Dental Association to determine whether the evidence before the CDA was sufficient to reach the decision rendered and warrants the penalty imposed; and (2) review the procedures followed in the disciplinary proceeding to determine whether Dr. Wolff was afforded the rights to which he was entitled under all applicable bylaws.

Background of the Appeal: The Appellant practices general dentistry in San Mateo, California. In July 1991, a peer review proceeding was initiated by a patient of the Appellant with respect to the quality of crowns, partial denture and bridgework rendered by the Appellant. In July 1992, after extended peer review proceedings, which included one appeal, the peer review committee ordered Appellant to refund $2,000 to the patient and $2,100 to the patient's insurer. The refund was not made. On the Appellant's refusal to make the refund, the matter was referred to the Judicial Council of the California Dental Association (JCCDA), which instituted a charge against Appellant for failure to cooperate with a duly constituted committee of the California Dental Association.

A disciplinary hearing was conducted before a panel of JCCDA on October 1, 1993. On the basis of the evidence presented, the hearing panel found Appellant guilty and imposed the penalty of expulsion from the California Dental Association and the San Mateo County Dental Society. Appellant was informed of this decision by letter dated October 26, 1993.

On November 8, 1993, Appellant exercised his right to appeal to CEBJA. This automatically stayed enforcement of the disciplinary penalty pending the outcome of the appeal. CEBJA conducted an appellate hearing on May 1, 1994. Appellant and Respondent both waived their right to appear at the hearing and present oral argument.

In reaching the decision that follows, CEBJA relied on the record in the proceedings below, including a transcript of the disciplinary hearing before JCCDA (the "*Transcript*") and the written brief of Respondent-California Dental Association. Appellant did not submit a written brief. A letter from Appellant received three days before the hearing was not considered by the Council, since it was received long after the deadline for filing a written brief had passed and too late to allow Respondent to reply. In addition, CEBJA was satisfied that the letter merely repeated information already in the record and it did not need to refer to the letter to reach a fair decision.

Consideration of Appeal: The record shows that during the hearing before JCCDA, Dr. Wolff admitted: 1) he was aware of the peer review committee's request that he make the refund; and 2) he had not complied (*Transcript* at 37-38). This evidence is sufficient to prove a violation of Section 3 of the CDA *Code* and to justify the penalty of expulsion since there is nothing in the record to raise a question about the fairness of the peer review process, either substantively or procedurally.

Appellant does not dispute the fact that some of his work needed to be repaired and/or replaced. His appeal seems to be based on the argument that he should not be required to refund the fee for this work as directed by the peer review committee because, according to Appellant, the peer review committee either failed to acknowledge or did not properly weigh certain alleged facts. These facts are set forth in Appellant's testimony to JCCDA (*Transcript* at 34-37). Some are relevant to the quality of the work rendered by Appellant and, hence, to the peer review process; others are not.

For example, Appellant testified to JCCDA that he had gone to great lengths to help the patient obtain benefits from the patient's insurance company. While admirable, this fact is not relevant to the issue of whether Appellant's work was defective. More significant is Appellant's claim that the

dentist who referred the patient to Appellant did not provide Appellant with two letters from a periodontist bearing on the patient's oral health condition. Appellant has stated that if he had this correspondence when he treated the patient, his treatment plan might have been different.

However, it is clear from the record that all of these facts were available to the peer review committee. For example, Appellant provided the committee with a copy of the periodontist's correspondence by letter dated August 7, 1992 (Exhibit E to *Transcript*). The peer review committee clearly did not believe that it justified a different result. The Council on Dental Care of the California Dental Association reached the same conclusion when it upheld the decision of the peer review committee on appeal.

There is no evidence that the decision of the Peer Review Committee was tainted by improper procedure. On the contrary, the peer review procedure followed in this case appears to conform in all respects to ADA guidelines set forth in the manual *Peer Review in Focus: Dentistry's Dispute Resolution Program*. There was a hearing and an appeal, and Appellant was given an opportunity to present information and discuss the case with the hearing panel. There is no hint of bias on the hearing panel. Appellant himself does not assert he was denied any of his rights in the peer review process or the disciplinary proceeding which followed; he simply disagrees with the outcome.

CEBJA does not see its role as substituting the Council's judgment for the decision of a duly constituted peer review committee when that decision is arrived at fairly and is based on a good faith effort to ascertain the facts in the case. The peer review committee is in a much better position than CEBJA to ascertain the facts and make an informed decision. It is able to interview both dentist and patient and to conduct a clinical examination of the patient, all of which was done in this case.

As a voluntary membership organization, the ADA and its constituent and component societies may adopt and enforce reasonable requirements for membership, as long as they are applied fairly (*Pinkster v. Pacific Coast Society of Orthodontists*, 16 Cal. Rptr. 245, 1974). The Council has previously held that the requirement in Section 3 of the CDA *Code* requiring dentists to comply with the reasonable requests of a peer review committee is within the authority of the California Dental Association (see, e.g., *Appeal of Dr. Lawrence H. Turpen*, rendered May 10, 1983). Section 3 is consistent with the ADA *Bylaws*, Chapter I, Membership, Section 30, Definition of "In Good Standing" and supports the value of peer review to the public and the profession. Through the peer review process, the California Dental Association has made available to Appellant as a benefit of membership a quick, simple and inexpensive way to resolve disputes with patients and avoid potential litigation. In return for this benefit, CDA may require Appellant to comply with the reasonable requests of its duly constituted peer review committees in order to remain a member.

Decision: The Council upholds the order of the California Dental Association imposing the penalty of expulsion on Dr. George J. Wolff. The penalty of expulsion shall be stayed provided Dr. Wolff refunds $2,000 to the patient and $2,100 to the patient's insurer as directed by the California Dental Association in its letter to Dr. Wolff dated October 26, 1993. Failure to make the refund within 30 days of the date of this decision, will result in imposition of the penalty of expulsion from the American Dental Association, the California Dental Association and the San Mateo County Dental Society. The Council adopts this decision by unanimous vote.

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

Council on Governmental Affairs and Federal Dental Services

Supplemental Report 1: Recent Council Activities

Introduction: This supplemental report summarizes Council activities conducted since submission of its annual report in May.

Much of the Council's agenda at its June meeting was devoted to a review of health system reform issues. The Council believed it was necessary to revisit this issue because of the continuous and rapid congressional activity on federal health system reform (HSR) legislation. After the committees in the U.S. Congress have reported out their versions of HSR legislation, the leadership in both chambers will blend them into bills for floor debate and votes by the full House and Senate. Health system reform has the potential for passage before the November 1994 congressional elections—although the extent of reform remains unknown.

In light of these developments, the Council believed it was necessary to discuss the ramifications of various legislative proposals affecting Association policy and to recommend a course of action. These actions include maintenance of current policy in several areas, recommendations to the Board of Trustees and other Councils on particular issues and development of resolutions. In addition, the Council is submitting a number of resolutions not directly related to health system reform.

Health System Reform

Health System Reform Legislation—Utilization Review and Practitioner Due Process: Many federal health system reform provisions provide criteria to govern the actions of managed health care plans regarding utilization review and practitioner due process rights for those participating in the health plans. At its June meeting, the Council was requested by staff to consider whether the Association should participate in lobbying for such provisions in light of existing Association policy. The Association has general policy on utilization review, which states that procedures should be adopted for appeals of determinations not to certify an admission, procedure, service or extension of stay. The Council was aware of no specific policy on practitioner due process rights.

The Council believed that if Association legislative action were to be timely, it would be have to move quickly. As a result, the Council requested that a recommendation be sent to the Board of Trustees for its consideration at the August meeting. This recommendation will state that the Council believes the Association should engage in the dialogue of shaping utilization review and due process rights for providers in federal legislation. The recommendation will further request that the Board adopt any necessary interim policy to facilitate the formation of the Association's subject matter policy position concerning provider due process rights.

Health System Reform Legislation—Emergency Dental Care for All Individuals: At the June meeting, the Council engaged in a discussion concerning the inclusion of emergency dental care for *all* individuals in a comprehensive benefits package. The Council was informed that some health system reform proposals include this benefit in the standard benefits package. After lengthy discussion, the Council unanimously agreed to reject an expansion of current policy, which supports, at a minimum, the inclusion of emergency care for *indigent* persons in any health system reform proposal. The Council rejected an expansion of current policy for several reasons: 1. by including emergency dental care for all, it appears as if dentistry seeks inclusion into the standard benefits package; 2. questions inevitably will arise concerning the proper definition of emergency care; and 3. current Association policy does include emergency dental care coverage for the group most in need—the indigent population.

Continuation of Coverage for In-Progress Treatment: At its June meeting, the Council recommended that the Council on Dental Benefit Programs (CDBP) consider an important health system reform issue within CDBP's jurisdiction—continuation of coverage for in-progress treatment, pursuant to an original benefit agreement. The Council on Governmental Affairs and Federal Dental Services (CGAFDS) believes that dentists who receive authorizations to perform services pursuant to a predetermination of benefits from dental benefits plans should be entitled to payment for services performed, irrespective of the employment status of the patient. For example: When a dentist receives authorization to put in a crown and in the initial visit the tooth is prepared and an impression is taken and sent to the lab, the dentist should not be at financial risk if the patient loses coverage before the crown is cemented into the mouth. The Council believes the Association would benefit from closer study of this issue and will request the Executive Director to refer this matter to CDBP for its consideration.

Public Relations Campaign—The Dentist as the Primary Oral Health Care Provider: At its June meeting, the Council decided to recommend to the Executive Director that the appropriate agencies of the Association consider the establishment of an Association public relations campaign to underscore the dentist's role as the primary oral health care provider and gatekeeper to the dental care system. Within the health system reform debate in Congress, the Council is concerned that federal legislation might preempt the dentist's responsibility under state dental practice acts. The Council believes a public relations campaign promoting the dentist as the primary oral health care provider will help sensitize the public and legislators to this important issue.

Other Council Activities

Health System Reform Definitions: The 1993 House of Delegates adopted Resolution 150H-1993 (*Trans.*1993:691) which directs the appropriate agencies of the Association to develop definitions for the terms primary care, freedom of choice, fee-for-service, indigent, balance billing and any other appropriate terms not clearly defined in relevant health care reform proposals. As such, CGAFDS and CDBP were assigned joint jurisdiction in the development of these definitions.

At its June meeting, CGAFDS agreed to the definitions for fee-for-service, indigent and balance billing, as originally proposed by CDBP. Accordingly, the Council transmits the following resolutions with the recommendation that they be adopted.

55. Resolved, that the following be the definition of Fee-for-Service:

Fee-for-Service. A method of reimbursement to a dentist based on his or her charge for a specific procedure.

56. Resolved, that the following be the definition of Indigent:

Indigent. Those individuals whose incomes fall below a poverty line (no and low income) as defined by the federal government.

57. Resolved, that the following be the definition of Balance Billing:

Balance Billing. Billing a patient for the difference between the dentist's actual charge and the amount reimbursed under the patient's dental benefit plan.

CGAFDS and CDBP had different recommendations for the definitions of freedom of choice, primary dental care and primary dental care provider. CDBP recommended the definitions listed below.

Freedom of Choice. The right of a patient to choose any licensed dentist to provide his or her dental care.

Primary Dental Care. The evaluation, diagnosis, management and overall coordination and/or delivery of services, by a licensed dentist to meet the patient's oral health needs for the prevention and treatment of oral disease and injury and the restoration and maintenance of health.

Primary Dental Care Provider. A licensed dentist who accepts the professional responsibility for the evaluation, diagnosis, treatment, management and overall coordination of services to meet the patient's oral health needs consistent with the *ADA Principles of Ethics and Code of Professional Conduct.*

CGAFDS recommended modification to the above listed definitions. Accordingly, the Council transmits the following resolutions with the recommendation that they be adopted.

58. Resolved, that the following be the definition of Freedom of Choice:

Freedom of Choice. The right of a patient to choose any licensed dentist to provide his or her dental care, without economic discrimination.

59. Resolved, that the following be the definition of Primary Dental Care:

Primary Dental Care. The examination, evaluation, diagnosis, management and overall coordination and/or delivery of services, by a licensed dentist to meet the patient's oral health needs for the prevention and treatment of oral disease and injury and the restoration and maintenance of health.

and be it further
Resolved, that Resolution 13H-1981 (*Trans.*1981:564), Definition of Primary Dental Care, be rescinded.

60. Resolved, that the following be the definition of Primary Dental Care Provider:

Primary Dental Care Provider. A licensed dentist who accepts the professional responsibility for the examination, evaluation, diagnosis, treatment, management and overall coordination of services to meet the patient's oral health needs consistent with the *ADA Principles of Ethics and Code of Professional Conduct.*

and be it further
Resolved, that Resolution 14H-1981 (*Trans.*1981:564), Definition of Primary Dental Care Provider, be rescinded.

Cost-Containment and Health Insurance Simplification: The 1993 House of Delegates adopted Resolution 103H-1993 (*Trans.*1993:665), originally proposed by the Council, which states that the Association endorses the inclusion of the medical portion of workers compensation, auto insurance, and other liability insurance coverage in a universal plan of health coverage. The Council believed the inclusion of the above mentioned programs into a single health care coverage program would simplify the system, avoid duplication and reduce the overall cost to the employer who must help pay for coverage. The Council remains committed to this policy, but believes it requires further clarification to include coverage for the "**dental**" portion of workers compensation, liability and auto insurance coverage. In consultation with CDBP, the Council agreed that the term "personal injury and illness" would achieve this purpose. Accordingly the Council transmits the following resolution with the recommendation that it be adopted.

61. Resolved, that ADA policy on Health System Reform—Cost Containment and Health Insurance Simplification, Resolution 103H-1993 (*Trans.*1993:665), be revised to delete the references to "medical portion" and "medical injury portion" and substitute the words "personal injury or illness portions," so that the amended policy reads as follows:

The Association endorses the inclusion of the personal injury or illness portions of workers compensation, auto insurance or other liability insurance coverage in a universal plan of health care coverage.

Major General Rank for U.S. Air Force Director of Dental Services: The Council is aware of inequities among the services regarding the rank of their respective chief dental officers. Under current law, the chief dental officer for the Army shall have the rank of a Major General. The Navy must fill the position with a two-star flag officer. The Air Force, by contrast, may assign an officer of any grade above the rank of Major. The Council believes this is an inappropriate disparity which puts one branch of the services at a disadvantage. As such, it warrants the attention and assistance of the Association. Accordingly, the Council transmits the following resolution with the recommendation that it be adopted.

62. Resolved, that the Association actively seek a change in the law to require that the position of chief dental officer for the United States Air Force, titled the "Air Force Director of Dental Services," be held by a dentist with the rank of Major General.

Expansion of Dental Benefits for Military Retirees: Dependents of military active duty personnel currently enjoy a much-expanded dental benefits program. Improved benefits, and a subsequent increased participation rate, have not only had the immediate impact of better oral health for military families, but also a long-term benefit of sensitizing those individuals to the necessity of receiving good oral health care treatment beyond their years in the military. Unfortunately, military retirees and their dependents do not presently have access to the same or a similar benefits program. As a result, many may not seek dental care in a timely fashion at a time when their need for such services has increased. To provide for continuity of good oral health care for military retirees and their families, the Council recommends that the Association support federal legislative efforts to offer these individuals a dental benefits plan. While the Council decided it was appropriate to support legislation to expand coverage, it believes, at least as an initial step, that such legislation should not call for federal funding. Accordingly, the Council transmits the following resolution with the recommendation that it be adopted.

63. Resolved, that the Association supports legislative initiatives intended to offer a dental benefits plan covering military retirees and their dependents at no cost to the federal government.

Constituent Society Communication with the Department of State Government Affairs: The Council is very pleased that the Department of State Government Affairs (DSGA) is so effectively carrying out its mission. However, the Council believes that DSGA could be even more effective if all of the constituent dental societies routinely informed DSGA of legislative and regulatory developments in their states. Accordingly, the Council transmits the following resolution with the recommendation that it be adopted.

64. Resolved, that all constituent societies be requested to forward copies of all information (e.g., newsletters, bulletins) regarding legislative and regulatory activities in their respective states to the Department of State Government Affairs to assist the Department in identifying legislative and regulatory trends among the states; alerting and advising ADA leadership, staff and constituent societies on state legislation and regulation; and providing individualized assistance to constituent societies.

ADPAC Chairman as *Ex Officio*, Non-Voting Council Member: The chairman of the American Dental Political Action Committee (ADPAC) serves as an informational source for the Council on Governmental Affairs and Federal Dental Services with regard to specific legislative issues of interest to both ADPAC and the Council. Interaction with the chairman also serves to advance Association objectives through improved liaison with ADPAC. The educational and liaison functions of the ADPAC chairman should be reflected in ADA bylaws by the designation of his or her status as a nonvoting *ex officio* member of the Council. Accordingly, the Council transmits the following resolution with the recommendation that it be adopted.

65. Resolved, that Chapter X. COUNCILS, Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection A of the *Bylaws* be amended in the paragraph on the Council on Governmental Affairs and Federal Dental Services by adding to the end of the first sentence the words "without the power to vote," so that the amended paragraph reads as follows:

The Council on Governmental Affairs and Federal Dental Services shall be composed of one (1) member from each trustee district, and the chairman of the political action committee shall be an *ex officio* member of the Council without the power to vote. Members of the Council shall not be in the full-time employ of the federal government, and at least three (3) members shall be service veterans. Individuals called to active duty from the military reserves or national guard forces, providing such active duty has not been requested by the individual, shall not be considered to be in the full-time employ of the federal government.

Antitrust Reform: The Council reviewed current ADA policy on antitrust reform including the statement that the Association should make "efforts to keep dentistry removed from the proposed medical model of antitrust reform." The Council understands this provision was not intended to limit the Association's lobbying efforts to achieve any form of antitrust relief that would be beneficial to its members. Rather, the statement was designed to ensure that ADA's efforts are not limited to the medical model of antitrust reform, in light of the very different marketplace for medical and dental services. Accordingly, the Council transmits the following resolution with the recommendation that it be adopted.

66. Resolved, that the Association supports changes in federal antitrust laws that will enable dentists to compete effectively within the health care system, and be if further
Resolved, that the ADA initiative in antitrust reform includes: repeal of McCarran-Ferguson; relief to permit components

and/or constituent societies and the ADA recognized specialty organizations to form networks of dentists with the ability to negotiate and contract with area and regional health plans and health alliances; and reforms that are not limited to the proposed medical model of antitrust reform, but will provide effective relief to practicing dentists consistent with the unique aspects of the dental care marketplace, and be if further

Resolved, that Resolution 105H-1993 (*Trans.*1993:708) Federal Antitrust Laws, be rescinded.

Summary of Resolutions

55. Resolved, that the following be the definition of Fee-for-Service:

Fee-for-Service. A method of reimbursement to a dentist based on his or her charge for a specific procedure.

56. Resolved, that the following be the definition of Indigent:

Indigent. Those individuals whose incomes fall below a poverty line (no and low income) as defined by the federal government.

57. Resolved, that the following be the definition of Balance Billing:

Balance Billing. Billing a patient for the difference between the dentist's actual charge and the amount reimbursed under the patient's dental benefit plan.

58. Resolved, that the following be the definition of Freedom of Choice:

Freedom of Choice. The right of a patient to choose any licensed dentist to provide his or her dental care, without economic discrimination.

59. Resolved, that the following be the definition of Primary Dental Care:

Primary Dental Care. The examination, evaluation, diagnosis, management and overall coordination and/or delivery of services, by a licensed dentist to meet the patient's oral health needs for the prevention and treatment of oral disease and injury and the restoration and maintenance of health.

and be it further

Resolved, that Resolution 13H-1981 (*Trans.*1981:564), Definition of Primary Dental Care, be rescinded.

60. Resolved, that the following be the definition of Primary Dental Care Provider:

Primary Dental Care Provider. A licensed dentist who accepts the professional responsibility for the examination, evaluation, diagnosis, treatment, management and overall coordination of services to meet the patient's oral health needs consistent with the *ADA Principles of Ethics and Code of Professional Conduct.*

and be it further

Resolved, that Resolution 14H-1981 (*Trans.*1981:564), Definition of Primary Dental Care Provider, be rescinded.

61. Resolved, that ADA policy on Health System Reform—Cost Containment and Health Insurance Simplification, Resolution 103H-1993 (*Trans.*1993:665), be revised to delete the references to "medical portion" and "medical injury portion" and substitute the words "personal injury or illness portions," so that the amended policy reads as follows:

The Association endorses the inclusion of the personal injury or illness portions of workers compensation, auto insurance or other liability insurance coverage in a universal plan of health care coverage.

62. Resolved, that the Association actively seek a change in the law to require that the position of chief dental officer for the United States Air Force, titled the "Air Force Director of Dental Services," be held by a dentist with the rank of Major General.

63. Resolved, that the Association supports legislative initiatives intended to offer a dental benefits plan covering military retirees and their dependents at no cost to the federal government.

64. Resolved, that all constituent societies be requested to forward copies of all information (e.g., newsletters, bulletins) regarding legislative and regulatory activities in their respective states to the Department of State Government Affairs to assist the Department in identifying legislative and regulatory trends among the states; alerting and advising ADA leadership, staff and constituent societies on state legislation and regulation; and providing individualized assistance to constituent societies.

65. Resolved, that Chapter X. COUNCILS, Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection A of the *Bylaws* be amended in the paragraph on the Council on Governmental Affairs and Federal Dental Services by adding to the end of the first sentence the words "without the power to vote," so that the amended paragraph reads as follows:

The Council on Governmental Affairs and Federal Dental Services shall be composed of one (1) member from each trustee district, and the chairman of the political action committee shall be an *ex officio* member of the Council without the power to vote. Members of the Council shall not be in the full-time employ of the federal government, and at least three (3) members shall be service veterans. Individuals called to active duty from the military reserves or national guard forces, providing such active duty has not been requested by the individual, shall not be considered to be in the full-time employ of the federal government.

66. Resolved, that the Association supports changes in federal antitrust laws that will enable dentists to compete effectively within the health care system, and be if further

Resolved, that the ADA initiative in antitrust reform includes: repeal of McCarran-Ferguson; relief to permit components

and/or constituent societies and the ADA recognized specialty organizations to form networks of dentists with the ability to negotiate and contract with area and regional health plans and health alliances; and reforms that are not limited to the proposed medical model of antitrust reform, but will provide effective relief to practicing dentists consistent with the unique aspects of the dental care marketplace, and be if further

Resolved, that Resolution 105H-1993 (*Trans.*1993:708) Federal Antitrust Laws, be rescinded.

Council on Governmental Affairs and Federal Dental Services

Supplemental Report 2: Recent Council Activities

Introduction: This report provides an update on recent Council activities.

Federal Dental Services: As stated in its 1994 Annual Report, the Council on Governmental Affairs and Federal Dental Services (CGAFDS) has been actively involved in a cooperative effort with the military to satisfy the terms of Resolutions 109H-1993 (*Trans.*1993:709), Notice of "Remote Site" Designation for Military Installations, and 156H-1993 (*Trans.*1993:718), Immediate Notification of any Proposed Military Dental Plan Which Might Affect Civilian Dentists Within the Area. These resolutions were adopted by the 1993 House of Delegates to address potential problems with the establishment of on-base Army and Air Force Federal Exchange Service (AAFES) dental facilities for remote site military installations.

The resolutions direct the Association:

1. to take actions necessary to establish criteria to define the "remote site" designation for military installations;
2. to request that the Association (via CGAFDS) receive immediate notification of such designations by the military dental chiefs; and
3. to be provided the opportunity to work with the military and affected component/constituent societies to resolve any real or perceived access problems in a manner consistent with Association policies.

At a recent Tri-Service Dental Chiefs' meeting with Association staff, the dental chiefs agreed with the intent of Resolutions 109H-1993 and 156H-1993. Concerning procedures to address the potential for additional on-base dental facilities, the dental chiefs support dialogue with local practitioners and the ADA to promote understanding of future access problems and potential solutions.

At the same time, the chiefs believe that the AAFES dental contract, let at Ft. Hood, Texas, provides dental care for Army personnel who would not otherwise be able to receive care.

Practitioner Protections in Managed Care Plans: The Council believes that many dentists, especially new practitioners, are increasingly faced with the prospect of practicing within managed care organizations. It is important that dentists in managed care plans have the opportunity to continue to exercise sound professional judgment concerning patient care and are protected from unwarranted punitive measures. The Council believes it is necessary for adequate protections to be established in law to ensure uniformly fair treatment of all affected dentists. Consistent with its proposal, the Council proposes that the Association participate in state and federal legislation designed to protect the rights of dentists who choose to participate in managed care plans.

Therefore, the Council proposes the following resolution.

Resolution

92. Resolved, that the Association initiate and/or participate in the development of state and federal legislation necessary to protect the rights of dentists who choose to participate in managed care plans.

Council on Insurance

Supplemental Report 1: Term of Office of Members of the Council on Insurance

Background: In 1986, the House of Delegates adopted Resolution 34H-1986 (*Trans.*1986:490) which shortened the terms of office for ADA councils and commissions from two three-year terms to a single four-year term. The intent of this change was to improve opportunities for volunteer service. However, the Council on Insurance has found that the result is a frequency of turnover of its members that is proving problematic. Specifically, it denies the Council the insights and historical perspective that can only come with direct experience in overseeing programs of national scope. In addition, there are a very large number of financial agreements and operational protocols with which each member of the Council must be familiar. The complexity of these matters is such that an in-depth understanding of their purpose and effectiveness is not possible until an individual has participated in several meetings of the Council.

While most members of the Council have many years of service on constituent society insurance committees, the management of the ADA programs is appreciably more difficult. With combined assets currently in excess of $140 million, the ADA group life and health insurance plans are governed by more sophisticated financial arrangements than plans offered at the state or local level. The plans' large size also require the Council to exercise a higher degree of control over underwriting and reserving practices as well as product design and pricing.

Few, if any, constituent societies sponsor tax-qualified retirement investment programs for their members. However, new appointees to the Council immediately become Trustees of the ADA Members Retirement Program with attendant fiduciary responsibilities for member assets currently approaching $900 million. In addition to being of immense size, this Program is significantly more complicated to manage than it was when the current four-year term of service arrangement was implemented. In 1986, all services were provided by the Equitable Life Assurance Society and its subsidiary investment companies. Today, the Program has additional contractual relationships with the Metropolitan Life, Principal Life and John Hancock Life Insurance Companies, the investment management firms of Templeton International and State Street Global Advisors, as well as Dun & Bradstreet, Inc., which provides specialized administrative services.

The Council believes that its fiduciary obligations as well as the technically complex and nonclinical nature of the issues it addresses requires that there be as much continuity of service among its members as possible. This can be better accomplished by restoring the arrangement whereby a Council member can serve two terms of three years each. Toward this end, the Council submits the following resolution to the House of Delegates and respectfully recommends its adoption.

Resolution

85. Resolved, that Chapter X. COUNCILS, Section 60. TERM OF OFFICE, of the *Bylaws* be amended by deleting the words "Beginning in 1990" from the third sentence (line 1667), and by adding a new second paragraph pertaining to a six-year term for members of the Council on Insurance, so the amended Section 60 reads as follows:

> Section 60. TERM OF OFFICE: The term of office of members of councils shall be four (4) years except as otherwise provided in these *Bylaws*. The tenure of a member of a council shall be limited to one (1) term of four (4) years except as otherwise provided in these *Bylaws*. A member shall not be eligible for appointment to another council or commission for a period of two (2) years after completing a previous council appointment. The physician and the health care facility administrator nominated by the Board of Trustees for membership on the Council on Community Health, Hospital, Institutional and Medical Affairs, shall be elected for a one- (1) year term; however, such member shall not be limited as to the number of consecutive one- (1) year terms that he or she may serve. The representative nominated by the American Association of Dental Research and the research scientist nominated by the Board of Trustees for membership on the Council on Dental Research shall be elected for a one- (1) year term and shall be limited to four (4) one-year terms that they may serve. The current recipient of the Gold Medal Award for Excellence in Dental Research shall serve on the Council on Dental Research until the award is bestowed on the next honoree.
>
> The term of office of members of the Council on Insurance shall be one (1) term of three (3) years. The tenure of a member of the Council on Insurance shall be limited to two (2) terms of three (3) years each.* After completing two (2) three-year terms on the Council on Insurance, a member shall not be eligible for appointment to another council or commission for a period of two (2) years.
>
> *Only members of the Council on Insurance elected in 1994 and thereafter shall serve three-year terms and may be eligible to serve two three-year terms of office. Council members elected before the 1994 House of Delegates shall serve only one four-year term and shall not be eligible to serve on another council or commission for two years following their term on the Council on Insurance.

Council on Membership

Supplemental Report 1: Recent Council Activities

This supplemental report summarizes Council activities conducted since submission of its annual report in May.

Additional Responses to Assignments from the 1993 House of Delegates

Alternative Dues Payment Programs: Resolution 134-1993 (*Trans.*1993:684) was referred to the Council on Membership for investigation and study as to the feasibility of expanding the ADA Dues Payment Program to all full active members.

The ADA Dues Payment Program currently allows dentists who have graduated from dental school or graduate training within the last five years to charge their tripartite dues to a special account provided by MBNA America and to repay the loan over six months in interest-free installments. The interest that is incurred (based on the prime rate) is shared by the ADA and MBNA. The program requires members to hold, or apply and be approved for, an ADA or ASDA MBNA Credit Card. The Program is marketed by the ADA as a recruitment and retention tool to aid those most in need of financial assistance in the first few years out of dental school. To date, 2,683 dentists have used this program, or approximately 10% of the recent graduate population.

At its June 1994 meeting, the Council on Membership studied the feasibility of expanding the ADA Dues Payment Program to assist all full active members in paying their tripartite dues. Based on information provided by MBNA, the Council determined that if the program was expanded to all full active members (approximately 100,000), the interest expense to the ADA would be financially prohibitive, with the interest expense incurred reaching approximately $854,000. If only 10% of full active members (approximately 10,000) utilize the program, the ADA's portion of the interest expense would be $85,400. In addition, MBNA is unable to fund an expansion of the program to include all full active members due to public financial reporting requirements and administrative expenses.

Recommendation. Because of the financial impact to the ADA and MBNA of expanding the program to all full active members, the Council developed less costly alternatives that would still serve to facilitate the dues payment process. One alternative is to expand the Dues Payment Program only to those "new dentists" who have been out of dental school or postgraduate training for less than ten years. This is consistent with the Association's increased focus on boosting membership among new dentists. There are currently 28,000 new dentist members. If all 28,000 used the Program, the interest expense to the Association would be $214,600; with a 10% usage rate, ADA interest expense would be $21,460.

For members who have been in practice ten years or more, the Council believes use of MBNA's "Premium Access Checks" to pay their tripartite and specialty dues at a reduced interest rate (8.9% as of July 1994, with no transaction fee if used for dues payments) presents another option for some members. This would, in effect, enable members to charge their dues to their credit card while saving constituents and components the processing fees associated with accepting credit cards for dues payments. It also provides members with a cash alternative to paying dues if their respective dental societies do not accept credit cards as a form of dues payment. Approximately 66,000 ADA members currently have an MBNA account.

Based on its study, the Council on Membership recommends the following resolution to facilitate the dues payment process.

33. Resolved, that the Association expand the Dues Payment Program to include all eligible dentists out of dental school or postgraduate training for less than ten years and that the Program be reevaluated on an annual basis for cost implications to the Association.

Student Marketing Plan: The erosion of market share, particularly among recent graduates and dental students is endangering the overall, long-term ability of the Association to attract and retain members. In response to Resolution 78H-1993 (*Trans.*1993:686) the Council on Membership has developed and begun implementation of a comprehensive Student Marketing Plan. The primary goal of Resolution 78H-1993 is to effectively recruit 100% of predoctoral dental students in a manner that encourages commitment to organized dentistry and conveys the value of belonging to the American Dental Association throughout one's professional lifetime. This report will provide the House of Delegates with a summary of the Plan and recent marketing activities.

Development of the Plan. The Council reviewed the challenges related to educating recent graduates and dental students to the importance and benefits of membership in organized dentistry as well as the activities and efforts undertaken to address those challenges. The Council directly received input from the American Student Dental Association (ASDA), the Standing Committee on the New Dentist and the Academy of General Dentistry. Based on their collective input, analyses of critical data and results of previous marketing efforts, the Council developed a comprehensive, 20-page Student Marketing Plan.

The plan was developed as an addendum to the Recruitment and Retention Business Plan, thereby complementing and expanding the Association's current membership marketing activities targeted to this important membership segment. It should be noted that this plan was developed to supplement, not supersede, the Recruitment and Retention Business Plan which follows the recruitment and retention strategies outlined in the ADA's Strategic Plan. The activities of the Student Marketing Plan build upon the background and priorities of the Recruitment and Retention Business Plan and directly support the strategies identified in that document, especially Strategy 7, which specifically targets dental students and recent graduates.

The two groups directly impacted by the Student Marketing Plan are predoctoral dental students and recent graduates. The market share for both of these groups has experienced a serious decline in the past five years. In 1993, predoctoral student membership hit a record low of 70.7%, an 8% decline over a five-year span. Also in 1993, recent graduate market share (one to five years out of dental school) dropped an average of 3.8% from 1992. Most notable was the 8.7% drop in market share for recent graduates in the first full year out of dental school.

The decline in market share among dental students is particularly disturbing when the following factors are considered:

- Opinions formed during dental school can be carried through several years of a dentist's career.
- Dental students' dues are a small fraction of active membership dues but need to have a much higher perceived value to equal active dues.
- According to ASDA the $35 dues amount is perceived as a barrier; full active dues of $330 may pose a greater obstacle and challenge in conveying the value of membership.
- Dental students who are members have the opportunity to "explore" ADA membership and become educated to services and benefits of membership.
- Students who join as dental students and have a positive membership experience are more likely to join the ADA earlier than students who do not.

Recent graduate market share has been an ongoing problem for the ADA; the recent decline in dental student membership may foreshadow an even further decline in recent graduate market share, one the Association cannot afford.

1994-95 Student Marketing Plan. The Student Marketing Plan is designed to increase dental students' awareness of and membership in the American Dental Association, and increase the number of recent graduate members in the ADA. The Plan's ultimate goal is to increase ADA student market share to 100%, and establish a lifelong membership commitment to organized dentistry among students and recent graduates.

To achieve this goal, the Council on Membership identified four essential strategies which form the nucleus of the Plan. These strategies were developed to counter specific problems and/or challenges which will impact the Association's effectiveness in meeting the stated goal.

Strategy 1: *Increase direct communications with all predoctoral students to increase their awareness and understanding of ADA membership benefits.*

The first step in any marketing/communications effort must be education. Students must be made aware of the American Dental Association and recruited into membership. Activities include: expanding the student awareness program, conducting a student communications campaign, and conducting the ADA Transition Program. The Council expects an annual increase in student market share until 100% market share is achieved.

Strategy 2: *Coordinate membership marketing activities with ASDA.*

Given the joint membership structure outlined in the ADA *Bylaws*, membership messages for both organizations will be stronger and more effective if the membership messages are coordinated. The two organizations must strive to work together if an effective partnership is to become a reality. Activities include: membership articles in *ASDA News*; coordinating efforts between state and local new dentist committees and local ASDA chapters; increased dialogue between ASDA and the Office of Related Dental Groups and the Council on Membership. By building on the foundation established in early 1994, the Council expects that the value of ADA membership and benefits will be promoted to all ASDA members and 100% student membership will be achieved.

Strategy 3: *Educate students to tripartite structure and how to join organized dentistry.*

In order to convert student members to ADA members, students must understand the tripartite structure, realize its importance and value, and learn how to join after graduation. Activities include: expanding the ADA Transition Program; creating a "how-to" guide on recruiting and involving students and recent graduates; developing a universal membership application; developing a Recent Graduate Marketing Forum for dental society leadership; and encouraging tripartite participation in transition activities.

Strategy 4: *Increase the ADA's understanding of the needs and interests of dental students at each stage of their education.*

The ADA has marketed to dental students as an aggregate group for several years, although students identify differing needs and interests from year to year. A solid understanding of the concerns and interests of dental students is necessary in order to produce effective recruitment and retention messages and strategies, and to develop benefits and services that appeal to dental students and recent graduates. Activities include: research of student needs based on year of education; identification of dental student issues; needs and opinion research of member/nonmember students. The Council plans to compile a thorough and accurate picture of the needs and concerns of dental student members/nonmembers and recent graduates by the end of 1995.

Execution. The Student Marketing Plan is, necessarily, a combination of direct mail, personal and tripartite contacts, and reinforcement of membership value messages. Every dental student and recent graduate will receive a variety of messages from the ADA which will educate the dental student to the services and value of membership, increase the student's awareness of organized dentistry and reinforce the importance of continuing membership throughout one's career. Additionally, personal contact from the ADA, tripartite dental societies and the Standing Committee on the New Dentist will convey to dental students that they are truly valued, make intangible benefits tangible and more understandable, and engage students in dialogue. These efforts can be most effective if the ADA's message is reinforced by ASDA, ASDA publications, and ADA member faculty and dental school deans.

1994 Activities. In addition to the Student Awareness and Transition Programs funded through the original 1994 budget, Resolution 78H-1993 provided funding and staff support to create and carry out the Student Marketing Plan. The following activities have been completed in 1994:

- Student Communications Plan (four communications pieces sent to all dental students);
- expansion of the Student Awareness Program to include an ADA Member Card mailing to graduating senior members;
- increase in personal contact activities targeted to ASDA leaders at the dental schools;
- involvement of tripartite in transition activities;
- membership promotions through ASDA publications;
- preliminary research of dental student priorities; and
- letter to faculty dentists and deans.

Pending the approval of funding, proposed 1995 activities will build on the foundation developed during 1994. Some activities will be expanded, others added. Proposed 1995 programs include:

- Student Communications Plan (targeted by year, based on information gathered in 1994);
- expanded Recent Graduate Communications Program;
- revised Graduate Student Communications Program;
- Needs and Opinion Research on Member/Nonmember Dental Students; and
- faculty promotion (to support and complement student communications).

Evaluation. Each segment of the plan contains its own evaluation mechanism, providing direct input into each activity's effectiveness. Overall effectiveness of the plan will be evaluated by the impact the Association has on recruiting and retaining dental student members. End-of-year market share data will be compared to the 1993 benchmark statistics.

It should be noted that the activities conducted in 1994 provide a solid foundation for an ongoing student marketing program. However, the Council is firm in its opinion that one year of activities is not sufficient, nor can the Association expect to communicate once or twice with a dental student and expect a lifelong relationship to develop. The investment made in student marketing via Resolution 78H-1993 must be viewed as the first step in an ongoing commitment to membership marketing which will eventually have an impact on student market share.

Other Council Activities

Eligibility for Reappointment: In order to enhance the effectiveness of the new Council on Membership, the Council believes it is essential to retain Council members who have been instrumental in Council program development. The Council requests an amendment to the *Bylaws* that would allow the reappointment of four Council members whose term ends in 1995.

This request is based on the fact that the new Council on Membership was created by the 1993 House of Delegates, but the terms of the Council members were not properly adjusted to permit all members of this new agency to serve a full four-year term. Of the four members with terms expiring in 1995, two will have served only two years and two will have served three years.

If approved, this resolution won't alter the established appointment cycle for the Council. Furthermore, this resolution doesn't presume to guarantee that these four dentists will continue on the Council, but would simply allow the trustees the flexibility to reappoint these knowledgeable Council members in 1995.

Although two of the members were originally appointed in 1993 to the former Council on Membership and Communications, the Council believes that the initial year of service to the former agency should be discounted to allow these individuals to become eligible to stand for reappointment to a full four-year term on the new agency. The Council's consideration of critical membership issues was limited in 1993 because the focus and responsibilities of the combined Council included a great number of communications issues. Unfortunately this resulted in limited opportunities in 1993 for the Council to formulate and develop programs that impact the critical recruitment and retention activities of the Association. However, in 1994, the Council on Membership has begun to effectively address a number of critical membership issues. These priority programs require the expertise of Council members who have significant knowledge and experience. These priority areas include:

- development, implementation and monitoring of the Student Marketing Plan;
- directing the strategies and action plan involved with the incorporation of membership cultural diversity issues into the fabric of the ADA;
- recruitment programs aimed at increased market share;
- improved understanding of membership issues of concern to ASDA and other related dental groups;
- continuity in long-term recruitment efforts; and
- development and implementation of the ADA Strategic Plan relative to membership recruitment and retention.

Recommendation. Based on the 1993 House action which created the new Council on Membership, seven new members were appointed without the privilege of reappointment. The Council feels that this privilege should be extended to the four Council members from Districts 4, 9, 13, and 16.

The Council feels that the 1993 House of Delegates created a unique situation by creating two new agencies and that it is in the best interest of the Association to allow these four experienced Council members the opportunity to be reappointed. Expertise and continuity are vital to the Council's effectiveness in addressing membership issues and activities, and the Council recommends the following resolution.

34. Resolved, that the footnote to Chapter X, Section 20A (line 1607) of the ADA *Bylaws* be amended to allow for reappointment of four members of the Council on Membership from the 4th, 9th, 13th and 16th Trustee Districts whose terms are set to expire in 1995, so that the footnote reads:

> Council on Membership—The Council on Membership initially shall be composed of members of the former Council on Membership and Communications from

Districts 2, 8, 9, 10, 12, 14, 15, and 16, and eight (8) new members from Districts 1, 3, 4, 5, 6, 7, 11 and 13 respectively. In order to establish the required pattern of four (4) members retiring from the Council each year, the eight (8) new members of the Council shall begin their terms with the same privileges of reappointment (if any) and at the next period-in-time level that is applicable to members of the new Council on Communications from the same districts. The two Council members from Districts 9 and 16 who were former members of the Council on Membership and Communications and the two new Council members from Districts 4 and 13 shall be eligible for reappointment to full terms on the Council on Membership when their terms expire in 1995.

Summary of Resolutions

33. Resolved, that the Association expand the Dues Payment Program to include all eligible dentists out of dental school or postgraduate training for less than ten years and that the Program be reevaluated on an annual basis for cost implications to the Association.

34. Resolved, that the footnote to Chapter X, Section 20A (line 1607) of the ADA *Bylaws* be amended to allow for reappointment of four members of the Council on Membership from the 4th, 9th, 13th and 16th Trustee Districts whose terms are set to expire in 1995, so that the footnote reads:

> Council on Membership—The Council on Membership initially shall be composed of members of the former Council on Membership and Communications from Districts 2, 8, 9, 10, 12, 14, 15, and 16, and eight (8) new members from Districts 1, 3, 4, 5, 6, 7, 11 and 13 respectively. In order to establish the required pattern of four (4) members retiring from the Council each year, the eight (8) new members of the Council shall begin their terms with the same privileges of reappointment (if any) and at the next period-in-time level that is applicable to members of the new Council on Communications from the same districts. The two Council members from Districts 9 and 16 who were former members of the Council on Membership and Communications and the two new Council members from Districts 4 and 13 shall be eligible for reappointment to full terms on the Council on Membership when their terms expire in 1995.

Resolutions

Submitted by the Board of Trustees, Constituent Societies, Component Societies, Trustee Districts, Delegates and Other Agencies

Board of Trustees

Support Personnel Needs of Practicing Dentists

Background: The Board of Trustees reviewed the Council on Dental Practice's Supplemental Report 1 to the House of Delegates entitled Study of Dental Support Personnel (*Supplement*:304) with great interest. Because of the importance of these issues to practicing dentists, the Board believes that the information contained in this report should be used as a basis for a plan of action to address the support personnel needs of practicing dentists. The Board is aware of activities in other areas of the Association that are related to auxiliary personnel in the dental office. Therefore, the Board recommends adoption of the following resolution.

79. Resolved, that the Council on Dental Practice, utilizing the information contained in its Supplemental Report 1 to the 1994 House of Delegates entitled Study of Dental Support Personnel (*Supplement*:304) and in consultation with the Division of Education and other appropriate agencies of the Association, develop a plan of action to address the support personnel needs of practicing dentists, and be it further **Resolved,** that this plan of action be presented to the Board of Trustees at its February 1995 meeting.

Board of Trustees

Transferring Marketing and Seminar Services to the Council on Dental Practice

Background: Last year the House of Delegates followed the recommendation of the Board of Trustees and divided the Council on Membership and Communications into two councils (*Trans.*1993:671, 672). Following this action, the Council on Membership retained bylaws responsibility for development of practice marketing materials and continuing education seminars. However, with a second look at the overall responsibilities of the Council on Membership, it is the opinion of the Board that this Council has as its strategic responsibility membership recruitment and retention. In today's world, maintaining a strong and active membership is vital to the continued ability of the Association to provide worthwhile programs at an effective level.

At the same time, it seems to the Board that the Council on Dental Practice is the more natural place for these practice-enhancing programs to reside. In fact, the Council on Dental Practice has been providing volunteer guidance to marketing and seminar services since their inception. With these considerations in mind, the Board of Trustees believes that marketing and seminar services should be transferred from the Council on Membership to the Council on Dental Practice. Therefore, the Board recommends adoption of the following resolution.

88. Resolved, that Chapter X. COUNCILS, Section 110. DUTIES, of the *Bylaws* be amended by deleting the comma and phrase: ", including practice marketing materials and continuing education seminars," from Duty c (lines 1993-94) of Subsection M. COUNCIL ON MEMBERSHIP, and by adding that same comma and phrase to Duty c of Subsection G. COUNCIL ON DENTAL PRACTICE after the word "management" on line 1851, so the amended Duty c's of Subsections G and M, respectively, read as follows:

(Section 110, Duties, Subsection G, Council on Dental Practice)

c. To develop educational and other programs to assist dentists in improved practice management, including practice marketing materials and continuing education seminars, and to assist constituent and component societies and other dental organizations in the development of such programs so that dentists may continue to improve the delivery of their services to the public.

(Section 110, Duties, Subsection M, Council on Membership)

c. To support the development of membership benefits and services that respond to identified needs of members.

Arizona State Dental Association

Audit of Arizona Health Care Cost Containment System (AHCCCS)

The following resolution was submitted by the Arizona State Dental Association and transmitted on September 14, 1994 by Mr. Greg McFarland, executive director.

Background: The Arizona Health Care Cost Containment System (AHCCCS) was established as an experimental state alternative to Medicaid in 1982. The program is based on a requirement that all care be delivered through capitated, pre-payment delivery systems. Contracting health care entities bid for state contracts for the delivery of required health care services in Medicaid. The health care entities "manage" the delivery of health care through primary care gatekeeper *physicians*. With very few exceptions, dental care is not a provided service within the contracting entities. Included in the required health care services is a section referred to as the Early Periodic Screening Detection and Treatment (EPSDT) program. Dental care is required by the federal government

for children up to the age of 21 and emergency treatment for adults and elderly.

Requests for information regarding program cost, system procedures for dental referral, encounter data for AHCCCS, as well as contractor dental quality efforts and audits have been reportedly unavailable or nonexistent. The confused status of dental treatment is attributed to the absence of dental services within the contracting health care entity and a referral and treatment system through the physician-based gatekeepers.

Indigent children in the AHCCCS plan are required by federal law to be treated for dental disease in a comprehensive approach to treatment providing continuity of care. Many of these children have, and continue to experience, painful and potentially disfiguring dental disease.

Sporadically, there are references regarding the availability of episodic, palliative treatment. This would appear to contradict the continuity and comprehension reflected in the program title of Early Periodic Screening Detection and Treatment.

The ADA House of Delegates adopted a resolution directing that the Arizona AHCCCS experiment be monitored for the impact on indigent dental care needs (*Trans.* 1983:546). Obtaining accurate data necessary to monitor dental treatment will require Health Care Financing Administration (HCFA) audit authority and investigation. Further, the inherent conflicts of interest for AHCCCS create a barrier for auditing and investigating the contracting and subcontracting treatment, distribution of funds and quality assurance.

National significance emerges as federal health care reform advocates tout AHCCCS, based on AHCCCS representations, as a viable model for consideration nationwide. The *medical* implementation, in the absence of dental evaluation, may result in an unprecedented setback of dental health throughout the United States.

The following resolution calls for action by the ADA and the HCFA to investigate and audit the AHCCCS model in providing the federally required dental care.

Whereas, dental care is required under the EPSDT program of the federal Medicaid act, and
Whereas, the availability of encounter data, fund distribution and quality assurance examinations are unavailable, inconsistent or nonexistent, and
Whereas, indigent children have, and continue to experience, painful and systematically neglected dental disease; therefore, be it

87. Resolved, that the ADA directs a request for a Health Care Financing Administration (HCFA) audit of the Arizona Health Care Cost Containment System (AHCCCS) plan and contracting and subcontracting entity compliance with the dental provisions of the Early Periodic Screening Detection and Treatment (EPSDT) service, and be it further
Resolved, that this audit include cost accountability, distribution of funding and subcontracting in addition to the systematic operation and clinical evaluation for quality assurance.

Louisiana Dental Association

Policy on Stipends to Officers and Trustees

The following resolution was adopted by the Board of Directors of the Louisiana Dental Association on June 18, 1994 and transmitted on June 20, 1994 by Dr. Skip D. Buford, chairman of the delegation.

23. Resolved, that the ADA Board of Trustees be urged to rescind its policy of automatic annual raises in stipends to officers and trustees.

Louisiana Dental Association

Discount Fee Charged by MBNA America for Credit Card Dues Payments

The following resolution was adopted by the Board of Directors of the Louisiana Dental Association on June 18, 1994 and transmitted on June 20, 1994 by Dr. Skip D. Buford, chairman of the delegation.

24. Resolved, that the American Dental Association absorb on a proportional basis, the discount fee charged by Maryland Bank, NA, for credit card dues payments.

Missouri Dental Association

Amendment of *ADA Principles of Ethics and Code of Professional Conduct* Regarding Behavior of Clinicians and Professional Speakers

The following resolution was adopted by the Missouri Dental Association House of Delegates on June 3, 1994 and submitted on August 1, 1994 by Mr. Roger A. Weis, executive director, Missouri Dental Association.

Background: Every year, dentists attend continuing education programs to upgrade and update their professional skills in order to improve the care and services for the public they serve. There have been occasions when the clinicians and speakers have used inappropriate language and visuals which were offensive to some members of the audiences. Granted that while there is the right of free speech, there also is a responsibility to act in a professional manner.

The offended persons usually have been reluctant to bring their concerns to the attention of the appropriate officials or officers. It is time for the dental profession to address this issue and to assume the responsibility for upgrading the ADA's *Principles of Ethics and Code of Professional Conduct*. Essentially, professional speakers and clinicians should be required to refrain from using, displaying or suggesting in any form, profanity, pornography, sexism, racism or anything else of a tasteless manner, when introducing, conducting, or concluding their professional programs.

Therefore, the following resolution is submitted to address this issue.

77. Resolved, that the American Dental Association's *Principles of Ethics and Code of Professional Conduct*, Principle - Section 2, be amended under the *Code of Professional Conduct* by the addition of the following new Section 2-B which reads as follows:

2-B. BEHAVIOR OF CLINICIANS AND PROFESSIONAL SPEAKERS.

A dentist or other professional speaker or clinician who presents basic education, continuing education or other such informative professional programs to any assembly of dentists, dental hygienists, dental assistants, dental laboratory technicians, dental students, administrators, secretaries, spouses or other family members be encouraged to refrain from using, displaying or suggesting in any form, profanity, pornography, sexism, and/or racism, when introducing, conducting or concluding such professional presentations. Enforcement measures are to be at the discretion of each sponsoring entity.

New Mexico Dental Association

Authorizing a Study of Public Policies on Infectious Diseases as They Pertain to Dental Practice

The following resolution was adopted by the New Mexico Dental Association House of Delegates on July 5, 1994 and transmitted on August 5, 1994 by Marjorie E. Nelson, executive director, New Mexico Dental Association.

Background: The revelation that an HIV-infected dentist from Florida may have passed the disease to several patients has profoundly affected the way we practice and the way our patients receive care. The resulting scrutiny and regulation have cost our profession and patients literally billions of dollars and will continue to influence the way we are perceived by the public for some time to come. Were another similar case to occur, the effects on the practice of dentistry could be devastating.

Further complicating the issue is the recent identification of an HBV-infected orthopedic surgeon from Southern California who had passed the infection to a number of patients in spite of rigorous precautions. This incident suggests that universal precautions may be less effective at containing viral disease than many had previously thought.

At present, infectious disease agencies have identified a myriad of difficult-to-treat, potentially deadly diseases that will confront the practice of dentistry in coming years. Regulatory agencies continue to consider policies and regulations to contain these diseases, which will complicate and drive up the cost of dental treatment and may significantly discourage the public from seeking routine care. At the same time, current policies to contain the AIDS epidemic have been effective on only a limited basis and the number of cases continues to rise almost unchecked. It is essential that policies be reviewed and revised to reflect current knowledge and experience.

It is incumbent on the ADA to proactively address these issues associated with infectious disease as they pertain to dental practice. A comprehensive review of public policies related to the reporting of infectious diseases, issues of testing and disclosure and the classification of the infected state as a disease or disability, must be addressed on a regular basis and dealt with realistically in light of current knowledge. The ADA must be a leader to ensure that the dental health needs of our patients are being best served by the public policies that direct the nation's efforts to contain infectious disease.

Therefore, be it

78. Resolved, that the Councils on Dental Practice and Scientific Affairs, other appropriate agencies and the Board of Trustees evaluate and comment on current and emerging public policies on infectious diseases, particularly with regard to the issues of testing, reporting, disclosure and classification of these diseases as urgent public health and complex civil rights concerns, as they pertain to the practice of dentistry, and be it further

Resolved, that these agencies also evaluate ADA's policies on infectious diseases to ensure that they are up-to-date, thoughtful and proactive, and be it further

Resolved, that the Board of Trustees report back to the 1995 House of Delegates on these matters, including policies and strategies that will allow the ADA to play a key leadership role in influencing the development of infectious disease policies in the future.

The Dental Society of the State of New York

Protocol and Guidelines for Administration of Antibiotic Prophylaxis

The following resolution was submitted by The Dental Society of the State of New York and transmitted on July 25, 1994 by Mr. Roy Lasky, executive director.

Background: One of the most perplexing problems encountered by practicing dentists is the issue of antibiotic prophylaxis and its role in the prevention of bacterial endocarditis. The American Heart Association's published guidelines recommend that dentists pre-medicate patients with antibiotics to avoid risk of bacterial endocarditis. However, strict compliance with these guidelines by dentists leads often to the possibility of over-medicating patients for dental procedures very unlikely to cause bacteremia. This is done solely because the dentist fears legal repercussions in the unlikely event that the patient develops endocarditis. Such concern may cause dentists to over-medicate.

Dentists shoulder an inordinate burden of responsibility for the prevention of bacterial endocarditis, which, according to medical literature, is rarely due to dental treatment. Surveys have shown that compliance by dentists and physicians has been low, and efforts to educate dentists and physicians have very limited success. There is virtually no effort to educate the public of this so-called "health menace." At present, there

are no patient pamphlets from the ADA to explain, in layman terms, bacterial endocarditis and its presumed prevention.

The list of conditions that could predispose to bacterial endocarditis is unbelievably long. Some conditions include heart murmur, mitral valve prolapse and rheumatic fever history, all of which are very common in histories provided by patients. There is also a growing list of dental procedures that predispose to bacterial endocarditis, including suture removal, water pik home care and adjustment of orthodontic bands.

Adding to the confusion is the fact that currently, several different medical bodies support the use of antibiotic prophylaxis for a variety of reasons. For instance, all national medical groups recommend single-dose oral regimens, while the Swiss Working Group recommends multiple-dose amoxicillin for high-risk patients. Meanwhile, the American Heart Association promotes two-dose oral regimens for all at-risk patients. However, according to an article written by James W. Little, DMD, MS, Professor of Oral Diagnoses and Radiology, University of Minnesota, School of Dentistry, "No national or international medical groups recommended prophylaxis for patients with prosthetic joints."

The ADA must address this situation. It must provide its members and the public with specific information about the use of antibiotic prophylaxis, particularly with respect to prosthetic joints. Therefore, be it

74. Resolved, that the ADA establish protocol and guidelines with respect to proper administration of antibiotics to patients with artificial joints and shunts.

The Dental Society of the State of New York

Relief Fund Solicitation Disclosure

The following resolution was submitted by The Dental Society of the State of New York and transmitted on July 25, 1994 by Mr. Roy E. Lasky, executive director.

Background: In 1990, the House of Delegates approved a change in the organizing documents of the Relief Fund that authorized the Fund to make grants not only to dentists and their families, but also to other charitable, tax-exempt organizations (*Trans.*1990:549). This change enabled the Relief Fund to transfer more than $1 million to the newly created ADA Endowment and Assistance Fund, Inc. in 1991.

The money in the Relief Fund represents the contributions of member dentists (and the investment earnings from them) for the purpose of making relief grants. Some members have expressed the opinion that since this money was contributed by members for relief purposes, it should be used only for relief grants. The House, however, approved the change noted above and we, in fact, support the more comprehensive use of these charitable contributions.

One of the problems arising from transfers among charitable funds is the appropriate disclosure to member dentists when they are solicited for Relief Fund contributions. At the request of numerous members, the ADA modified its Relief Fund solicitation letter to include an acknowledgement of the possibility of grants being made to other charitable dental organizations. Last year's initial solicitation included the following disclosure:

> In addition, the ADA Relief Fund can award grants to qualifying dental organizations that have program activities consistent with the overall charitable purposes of the Fund.

While this sentence qualifies as a disclosure, our leadership felt that it was somewhat uninformative. In addition, subsequent solicitations to noncontributors during the campaign cycle failed to repeat the message.

We are submitting the following resolution to ensure that it is very clear to prospective Relief Fund contributors that their contributions could be used for other charitable purposes. Again, we are not arguing against the occasional transfer of relief funds to other charitable funds. We simply feel that there should be a clear and consistent disclosure of such potential transfers when we solicit contributions to the Relief Fund. Accordingly, we present the following resolution.

75. Resolved, that the ADA Commission on Relief Fund Activities more clearly state in each of its solicitations for contributions the possibility of relief funds being used for charitable purposes other than relief, and be it further **Resolved,** that such disclosures should also include examples of the alternative charitable purposes most likely to be funded if monies are transferred from the Relief Fund.

Pennsylvania Dental Association

Discontinuation of the ADA'S Continuing Education Recognition Program

The following resolution was adopted by the Pennsylvania Dental Association on May 22, 1994 and transmitted on September 9, 1994 by Dr. Marlin A. Miller, secretary.

Background: It is the perception of the Pennsylvania Dental Association (PDA) that the ADA's Continuing Education Recognition Program (CERP) has not been an effective vehicle. Several significant reasons for this lack of effectiveness are:

- It cannot meet the standards of eligibility for providers as published.
- It would be extremely difficult to deny the acceptance of any individual or organization application.
- The ADA program does not accurately track course attendance which is a vital function in the continuing education process.
- The cost factor for the application as well as the annual fee is significantly higher than other programs which are currently functioning effectively.

Therefore, be it

83. Resolved, that the American Dental Association discontinue the Continuing Education Recognition Program.

South Dakota Dental Association

Dental Vacuum System Standard

The following resolution was adopted by the South Dakota Dental Association Board of Trustees and submitted on September 9, 1994, by Ms. Trudy Feigum, executive director, South Dakota Dental Association.

Background:

- Usable dental vacuum system performance, measured at the point of use (the HVE valve), is the most important performance characteristic to dentistry.
- The point of use (the HVE valve) is the easiest location for dental personnel to verify vacuum system performance.
- The American Dental Association has developed a subcommittee to create a Standard (ANSI/ASC MD156) for Dental Vacuum. It has been recommended by ADA employees that this committee confine its efforts to creating a dental vacuum *pump* performance standard (measured at the vacuum pump) rather than a dental vacuum *system* standard based on performance measured at the point of use (the HVE valve).
- RAMVAC Corporation of Spearfish, South Dakota, has developed a simple device, the "Vacheck," capable of accurately indicating the presence or absence of a minimum level of performance at the point of use (the HVE valve). Production cost for the Vacheck is expected to allow a retail cost of $15 or less. RAMVAC has offered to give the device to the ADA. Non-dues revenue could be raised by the ADA from sale of the Vacheck.
- A study is underway at the Mechanical Engineering Department of South Dakota State University, Brookings, South Dakota, to investigate dental vacuum system performance. The relative performance of various type vacuum sources and the impact of piping systems is to be quantified. This information will allow manufacturers to rate vacuum pump performance in terms of providing a minimum level of performance at the point of use (the HVE valve) for a specific number of users through a specific piping system.
- No United States standard of performance exists for dental vacuum systems. Manufacturers have no standards by which to rate their products. Purchasers or designers must rely on advertising claims often based on random guesses by marketing departments. The capability of a given vacuum pump to serve the desired number of users through a specific piping system is not assured.

84. Resolved, that the American Dental Association recommends creation of a Dental Vacuum System Standard (ANSI/ASC MD156) to include:

1. recommended minimum performance measured at the point of use (the HVE);
2. requirement for ADA-approved dental vacuum systems to specify performance standards in terms of performance available at the point of use (the HVE valve); and
3. approval of an inexpensive, accurate, simple device that can be easily used by dental facility personnel to verify vacuum system performance at the point of use (the HVE valve).

Texas Dental Association

Evaluation of Need for Codes for the Complicated Extraction of Erupted Teeth

The following resolution was submitted by the Texas Dental Association and transmitted on July 20, 1994 by Mr. Ben White, executive director.

Background: The need to better communicate with third-party carriers is directly related to organized dentistry's ability to develop codes which would better define degrees of complicated extractions of erupted teeth; therefore, be it

69. Resolved, that the American Dental Association, through the appropriate agency, evaluate the need for additional insurance codes for the complicated extraction of erupted teeth.

Texas Dental Association

Definition of Freedom of Choice

The following resolution was submitted by the Texas Dental Association and transmitted on July 20, 1994 by Mr. Ben White, executive director.

Background: The right of a person to choose his or her own doctor must be an integral part of any health care system. The Freedom of Choice concept will help ensure quality of care and the well-being of the public; therefore, be it

72. Resolved, that the following be the definition of Freedom of Choice.

Freedom of Choice. The right of individuals to freely choose a doctor without incurring any economic penalties from an employer, third-party payer, or insurance or governmental agency.

Sacramento District Dental Society

Electronic Billing Process Fees

The following resolution was adopted by the Sacramento District Dental Society and submitted on September 26, 1994 by Ms. Melissa Laughlin-Guerra, executive director.

Background: Of the major technologies that are developing in dentistry, one that will potentially provide a positive benefit for all practicing dentists will involve the utilization of electronic billing. By electronically transmitting insurance

billing information and electronic payment in return, the workload in a dental office will be reduced.

Also, as a consequence of electronic billing, the insurance industry, which needs a large work force to keep up with billing volume from all across the country, will be able to reduce or eliminate costs related to the mountain of paperwork and postage that currently affects the way they do business.

Current practice in the billing process requires an intermediary which functions independently of the dental establishment and of the insurance establishment. The insurance company contracts with the intermediary to collect billing information and forwards the necessary documentation to the insurance company. The dental community is well aware that current billing methodology puts the entire cost of funding this service (between $.60 and $1.00 per claim submitted) on the shoulders of the dental office.

A more equitable solution needs to be established for the funding of this service. The greatest beneficiary of electronic billing is the insurance industry, because of the massive reductions in costs experienced as a result of being involved in this service. It is precisely because of tremendous savings that third parties realize that the processing of insurance billing will eventually be entirely via electronic means. It is, therefore, appropriate that restructuring of payment methods for the cost of the service should be undertaken.

Organized dentistry, as the most important force in the dental service process, should establish a policy regarding funding of the electronic billing process.

Therefore, be it

109. Resolved, that electronic billing process fees should be paid by the insurance carrier to the intermediary electronic billing company.

Hawaii County Dental Society

ADA *CDT-1* Copyright

The following resolution was submitted by the Hawaii County Dental Society and transmitted on October 4, 1994 by Dr. Patsy Fujimoto.

Background:

Whereas, the American Dental Association developed the *CDT-1* code at great expense to the membership, and
Whereas, the American Dental Association holds the copyright to the code, and
Whereas, the purpose of the code is to facilitate simple and accurate reporting of dental claims by its members, and
Whereas, many third-party payers modify the definitions of the *CDT-1* codes thereby undermining the intent of the codes; therefore, be it

124. Resolved, that the American Dental Association withhold the right to use its *CDT-1* codes from any entity which modifies or alters the copyrighted codes, and be it further

Resolved, that the violations of this copyright be pursued vigorously by the American Dental Association to safeguard the correct use of the *CDT-1* codes.

First Trustee District

Substitute for Resolution 74: Protocol and Guidelines for Administration of Antibiotic Prophylaxis

The following substitute for Resolution 74 (*Supplement*:334) was submitted by the First Trustee District and transmitted on October 3, 1994 by Dr. Arthur I. Schwartz, caucus coordinator.

Background: Under certain conditions, antibiotic prophylaxis is recommended for dental patients undergoing bacteremia-producing procedures. Patients requiring prophylactic coverage can include those with a history of rheumatic fever, heart murmur, mitral valve prolapse, heart valve replacement and prosthetic joint replacement.

There are many occasions when a patient with one of the preceding conditions presents for dental treatment and is unaware of the need for antibiotic coverage.

74S-1. Resolved, that the ADA urge all appropriate medical agencies to advise their members of the need to inform their patients of appropriate antibiotic prophylaxis prior to dental procedures, and be it further
Resolved, that the ADA Council on Scientific Affairs continue to monitor data on whether a cause and effect relationship exists between dental treatment and the development of late prosthetic joint infections, that it revise its guidelines as necessary to ensure that they remain consistent with these data, and that it advise the membership of any changes, and be it further
Resolved, that the ADA Council on Communications develop literature to be available to members for distribution to patients regarding the need for antibiotic prophylaxis prior to dental procedures for patients with certain medical conditions.

First Trustee District

Continuing Education for the Dental Assistant

The following resolution was adopted by the First Trustee District and transmitted on October 3, 1994 by Dr. Arthur I. Schwartz, caucus coordinator.

Background: The American Dental Assistants Association (ADAA) recently released a position paper relative to mandatory education and credentialing for clinical dental assistants which we conclude appears to be both an attempt to elevate the dental assistant to a new level (i.e., licensure) and create a reduced pool from which to hire, thus allowing supply and demand economics to drive up compensation and benefit levels.

The dentist would no longer have the option to hire and train individuals "off the street" to perform clinical dental assistant duties.

The ADAA Task Force recommends the following:

Recommendation 1: The ADAA should develop strategies to promote credentialing (certificate/registration) as a requirement for employment as a clinical dental assistant.

Recommendation 2: The ADAA should initiate dialogue with the ADA and other related agencies to develop approaches to implement credentialing as a requirement for employment as a clinical dental assistant.

Recommendation 3: The ADAA should communicate the benefits of mandatory credentialing for the clinical dental assistant to its members and nonmember dental assistants, and to all other communities of interest.

Recommendation 4: The ADAA should continue to support and promote the highest quality of education for dental assistants through traditional and nontraditional programs (such as home study or correspondence courses, course work at educational institutions, and on-the-job training modules) accredited by the ADA Commission on Dental Accreditation as the preferred pathway to the credentialing of dental assistants. Participants in alternative educational programs (non-ADA CDA accredited) must be evaluated by examination.

Recommendation 5: The implementation of mandatory credentialing should become a high priority activity of the ADAA. The Task Force envisions this as a long-term commitment of both financial and personnel resources.

Recommendation 6: The ADAA should disseminate this Position Paper to the various dental organizations and communities of interest for review and comment.

Therefore, be it

95. Resolved, that the American Dental Association recognizes and encourages the advancement of education and job qualifications for the clinical dental assistant on a voluntary basis, but does not favor mandatory credentialing.

First Trustee District

ADA Publications Disclaimer

The following resolution was submitted by the First Trustee District and transmitted on October 3, 1994 by Dr. Arthur I. Schwartz, caucus coordinator.

Background: The publications of the American Dental Association (*JADA, ADA News,* special issues) are seen and accepted as the showcase for the position of the profession on many subjects.

On occasion, articles have appeared in an ADA publication which have promoted a position or a philosophy that was in conflict with that of the American Dental Association and its House of Delegates. Printing of articles which are in conflict with the principles and philosophies of the profession cause confusion among readers, and convey the impression that those philosophies are embraced by the profession since they are in an Association document. Therefore, be it

96. Resolved, that the Board of Trustees be urged to work with ADA Publishing Co., Inc. to establish an editorial review board for the purpose of assuring that the content of articles in American Dental Association publications is not in conflict with the policies and principles of the dental profession. Op-ed pieces would be excluded from this review process. Articles that were found not to be supportive of the policies and positions of the House of Delegates would require a disclaimer that would identify that fact.

First Trustee District

Substitute for Resolution 96: ADA Publications Disclaimer

The following substitute for Resolution 96 was adopted by the First Trustee District and submitted on October 24, 1994, by Dr. Arthur I. Schwartz, caucus coordinator.

96S-1. Resolved, that the Board of Trustees be urged to work with the ADA Publishing Co. Inc., to establish an editorial review process that would review articles submitted for publication for the purpose of identifying articles whose content might be in conflict with current ADA Policy. Should conflict be encountered, an appropriate disclaimer would be inserted as a postscript to the article, and be it further
Resolved, that the disclaimer would identify those policies where conflict exists, and be it further
Resolved, that opinion and editorial pieces would be excluded from this process.

First Trustee District

Amendment of ADA *Bylaws* Regarding the President as a Voting Member of the Board of Trustees

The following resolution was submitted by the First Trustee District and transmitted on October 3, 1994 by Dr. Arthur I. Schwartz, caucus coordinator.

Background: Presently in the ADA *Bylaws* and included in the second resolving clause of Resolution 65-1993 (*Reports*:142), the President shall be an *ex officio* member of the Board without the right to vote. As an elected official, however, the President presides over a board and should have all rights to participate, deliberate and vote on issues. *Sturgis* on page 169 reads "...The president and other officers are usually *ex officio* members of the board of directors...."

97. Resolved, that CHAPTER VII. BOARD OF TRUSTEES, Section 10. COMPOSITION, be amended to read as follows:

Section 10. COMPOSITION: The Board of Trustees shall consist of one (1) trustee from each of the sixteen (16) trustee districts. Such sixteen (16) trustees, *the President*, the President-elect, and the two Vice Presidents shall constitute the voting membership of the Board of Trustees. In addition, the appointive officers of the Association, except as otherwise provided in the *Bylaws*, shall be *ex officio* members of the Board without the right to vote.

and be it further

Resolved, that the *Bylaws*, CHAPTER VII. BOARD OF TRUSTEES, Section 130Ba, be amended to read as follows:

a. CHAIRMAN. The Chairman shall preside at all meetings of the Board of Trustees.

First Trustee District

Expansion of Employee Retirement Income Security Act (ERISA) and Establishment of a Congressional Review Commission on ERISA

The following resolutions were adopted by the First Trustee District and submitted on October 3, 1994 by Dr. Arthur I. Schwartz, caucus coordinator.

Background: Utilization Review Organizations (UROs) were the insurance industry's answer to cope with the loss of business that resulted from plan purchasers' decisions to self-insure or self-fund their health benefits. UROs offered administrative services and techniques to control costs for these plans.

According to the Institute of Medicine's (IOM) Committee on Utilization Management by Third Parties, utilization management should be "a set of techniques used by or on behalf of purchasers of health care benefits to manage health care costs by influencing patient care decision making through case-by-case assessments of the appropriateness of care prior to its provision."

Apart from the cost-containment techniques of prior review and high-cost case management, the Committee also identified the following methods used by UROs to control costs:

- benefit design (including patient cost-sharing and coverage exclusions), consumer education, and other approaches that shape patient demand for care;
- financial incentives (e.g., capitation or bonuses) that are designed to reward physicians or institutions for providing less costly care;
- contracts with health care practitioners and institutions that establish limits on payment for care provided to health plan enrollees;
- use of gatekeeping, triaging, and other devices to manage patient flow to specialists and expensive services; and
- provider education and feedback on standards of care and patterns of practice.

The IOM's report* lamented the limited evidence on utilization management and called for more and better assessments. It noted, however, that such a demand faced several obstacles, some intrinsic to research problems, some reflecting common organizational behaviors and others involving particular pressures faced by market-driven organizations. The report also noted that "rigorous evaluation also tends to be quite expensive."

Clearly, the industry has no interest in or responsibility for evaluating itself. Its interest is in developing, selling and running programs rather than seeing if the programs are effective in contributing to quality patient care and goals for long-term patient health and well-being. It is also easier to collect data on inputs and procedures rather than data on outputs or outcomes.

Fortunately, the relatively recent demands by plan purchasers for outcomes information, and an increased role in the plan design and decision-making processes, are focusing attention on the role of UROs and their positive and negative impacts on the provision of and access to health care services.

With the lack of oversight and accountability of UROs, it was inevitable that patients harmed by the utilization review process would have no other recourse but to turn to the courts for assistance.

Providers bear the responsibility and liability for clinical decisions. However, two important legal cases hold UROs accountable for negligent decisions:

1. *Wickline v. State of California*, 192 Cal. App. 3d 1630(1986), involved a patient who developed postsurgical complications. The patient's physician requested an eight-day hospital stay extension for his patient but the URO approved only a four-day extension. The physician did not appeal this decision and his patient was later readmitted for an amputation of her right leg. The court stressed that the ultimate responsibility of medical decisions belongs to physicians. Accordingly, the *Wickline* court established a duty on the part of the physician to appeal UROs' decisions not consistent with the professional standard of care.
2. *Wilson v. Blue Cross of Southern California*, 222 Cal. App. 3d 660(1990), involved a hospitalized patient who suffered from severe depression, drug dependency and anorexia. Although the admitting physician submitted a treatment plan that required four weeks of in-patient care, the URO denied coverage for care beyond ten days. The patient committed suicide less than three weeks after being discharged from the hospital. The court expressly rejected the payer's claim that its action was a "benefit determination" as opposed to a "medical treatment" decision. The court stated that payers and UROs may be held liable for refusals to pay benefits where the payment decision was a substantial factor in causing injury to the person denied coverage.

Every state in the United States provides legal remedies to injured patients, including the right to recover compensation

**Controlling Costs and Changing Patient Care? The Role of Utilization Management*, Institute of Medicine, Committee on Utilization Management by Third Parties, National Academy Press, Washington, D.C. 1989.

for the negligent deprivation of necessary care; however, the ERISA federally preempts and supersedes state law, thereby interfering with existing legal scheme. In effect, ERISA allows all self-insured employer-provided plans to escape liability for negligent UR decisions.

The case of *Corcoran v. United Healthcare, Inc.*, 965 F 2d 1321 (5th Cir. June 26, 1992), involved a Southern Central Bell Telephone employee in her second pregnancy. The difficulty of the employee's first pregnancy placed her in a high-risk category. For her second pregnancy, her physician decided to hospitalize her before her due date to monitor the patient and the fetus around the clock. Her admission required approval by the URO. The URO determined that the hospitalization was not necessary and instead authorized ten hours per day of home nursing care. Almost two weeks later, when no nurse was on duty, the fetus went into distress and died. Because the benefit plan was self-funded, the case was moved to federal court.

Blue Cross and Blue Shield with its URO, United Healthcare, Inc., moved for summary judgment based on the fact that the patient's claim was preempted by ERISA and that ERISA provided the patient with exclusive remedy. *Unfortunately, the remedies under ERISA do not include compensation or punitive damages for negligence.* The Corcorans, and any other individuals whose plans are governed by ERISA, are left without any remedy for loss or harm.

The court reluctantly agreed with the defendants' claim. In its decision, the court recognized the outcome to be unjust and noted that Congress could not have foreseen a situation like this when it passed ERISA in 1974. The court further stated that "Congress, not the courts, must change ERISA to reflect post-1974 changes in employee benefit plans."

Until these changes are accomplished, UROs and payers have the legal power to escape virtually all liability for negligent URO decisions. To date, no health system reform proposal has addressed the problems of remedy and compensation created by ERISA for patients in self-funded plans. These problems must be addressed as quickly as possible.

Therefore, we recommend that the following resolutions be adopted.

98. Resolved, that the appropriate agencies of the American Dental Association seek federal legislation to expand the Employee Retirement Income Security Act (ERISA) to hold the payers and/or utilization review organizations accountable and responsible for any negligent utilization review decision and ensure meaningful remedies and fair compensation to patients who suffer as a result of negligent utilization review decisions, and be it further

Resolved, that the appropriate agencies of the American Dental Association work to ensure that any health system reform proposals address the problems of remedy and compensation created by ERISA for patients in self-funded plans.

99. Resolved, that the legislative agencies of the American Dental Association seek the establishment of a congressional review commission (similar to the Physician Payment Review Commission created by the Congress in 1985), to thoroughly examine the Employee Retirement Income Security Act (ERISA) and report to the Congress any recommendations for additions and revisions necessary to the ERISA to reflect post-1974 changes in employee benefit plans.

First Trustee District

Review of the *ADA Principles of Ethics and Code of Professional Conduct* as It Relates to Dental Benefits Plans

The following resolution was adopted by the First Trustee District and submitted on October 3, 1994 by Dr. Arthur I. Schwartz, caucus coordinator.

Background: The dental benefits marketplace has evolved considerably since the introduction of dental benefits plans. At this time, there are several varieties of dental benefits plans, some of which require contractual agreements between dentists and dental plan administrators. These contractual arrangements often cloud the determination of a dentist's usual fee for a dental service and complicate the distribution of liability for dental benefits where that liability is shared by multiple plans, the coordination of benefits. Oftentimes, this confusion adversely affects the reimbursement patients and dentists receive for dental treatment.

The Association provides guidance for dentists and dental plan administrators through its several policies regarding dental benefits plans. These policies are sometimes developed as practical applications of the *ADA Principles of Ethics and Code of Professional Conduct*. Many of the provisions of the *Code* were written when dental benefits plans initially came into the dental care system, when the distinction between patients was primarily those that were "insured" and those that were not. As the dental care marketplace evolved, the insured patients were covered by several types of dental "insurance."

The *Code* should be revisited to enable it to give dentists and dental benefits plans administrators clearer guidance in the representation of fees in the several types of dental plans now in the dental marketplace. This will allow for a more equitable and more realistic determination of dental benefits in the special situations that arise as a result of the multiple varieties of dental plans currently in the dental marketplace. Therefore, be it

100. Resolved, that the Association, through the appropriate agencies, review the *ADA Principles of Ethics and Code of Professional Conduct* as it applies to the area of dental benefits plans, and the effect of the *Code* on Association policies regarding dental benefits plans, and report their recommendations for modification of the *Code* or any related policies of the Association regarding dental benefits plans, if any, to the 1995 House of Delegates.

First Trustee District

Managed Care Programs' Administrative Costs, Profit and Treatment Expense

The following resolution was adopted by the First Trustee District and transmitted on October 3, 1994 by Dr. Arthur I. Schwartz, caucus coordinator.

Background: Due to the inability of consumers, labor organizations, employers, and health care professionals to determine the allocation of the premium dollars spent toward administration, profits, and treatment by HMOs, capitation programs, and PPOs and so that consumers can properly assess which benefit programs are most effective and attractive, be it

101. Resolved, that the appropriate agencies of the American Dental Association seek federal and state legislation that would require HMOs, capitation programs, and PPOs, both for-profit and nonprofit, to publicize in their marketing materials to plan purchasers and in written communications to their patients the percentage of premiums that go to profits, administrative costs, promotion and marketing and to treatment.

First Trustee District

Automatic Review of Denied Claims by Independent Dental and/or Medical Experts

The following resolution was adopted by the First Trustee District and transmitted on October 3, 1994 by Dr. Arthur I. Schwartz, caucus coordinator.

Background: In order that patients (consumers) receive the dental and medical care of which their premium dollars are spent and to ensure quality dental and medical care which is not compromised in the drive for profits of HMOs, capitation programs, and PPOs, be it

102. Resolved, that the appropriate agencies of the American Dental Association seek federal and state legislation so that if an HMO, capitation program, or PPO denies a claim for treatment or test required for treatment it considers unnecessary, the denial would be subject to automatic review by independent dental and/or medical experts.

First Trustee District

Standards for Managed Dental Care Programs

The following resolution was adopted by the First Trustee District and transmitted on October 3, 1994 by Dr. Arthur I. Schwartz, caucus coordinator.

Background: Managed dental care is steadily expanding as a system for administering and financing medical and dental health services. According to a 1993 survey by A. Foster Higgins and Co., enrollment in dental capitation programs had reached 14 million at the end of 1993. In addition, preferred provider organizations (PPOs) and Independent Practice Associations (IPAs) are growing steadily.

Irrespective of their structure and operation, managed care arrangements have several features in common which the American Dental Association defines as "a cost-containment system that directs the utilization of health benefits by: (a) restricting the type, level and frequency of treatment; (b) limiting the access to care; and (c) controlling the level of reimbursement for services" (*Trans.*1991:632).

A major concern is that the managed care system is primarily cost-driven and has not given attention to the type, appropriateness, timeliness, or quality of care (*Trans.*1991:632). With cost-control as the primary objective, the quality of care and interests of the patient can be compromised.

Standards of Care. Large employers have begun to address the issues of quality care through quality assessment and improvement programs, cost-effectiveness studies, and outcomes analysis. However, attempts at addressing quality of care are subject to the managed care industry's interest in cost control and profit margins. Thus, review criteria are tailored to the objectives of the managed care organization, are held closely as a proprietary interest of the organization and are protected from outside scrutiny.

Also, the cost-effectiveness studies and outcomes analysis conducted by managed care organizations are often based on research designs which support the objectives of the managed care system. For example, the cost-effectiveness studies frequently measure effectiveness only in the very short-term and do not examine a comprehensive spectrum of treatment benefits such as those related to social and demographic patient factors, intermediate and long-term oral health status, and general health status.

Costs are similarly measured as immediate monetary costs and do not include long-term costs of inadequate quality or the long-term costs associated with inequitable distribution of care. The approach continues to place the highest priority on reimbursing the least costly care rather than the care that best meets the individual patient's oral health needs. Quality assurance programs are most often touted as a marketing tool by managed dental care organizations. They are not required to define quality.

The process of selecting providers gives little consideration to the delivery of appropriate and high-quality care. Site visits to determine the fitness of the dental practices and their policies are not the norm. Providers are often selected based solely on their agreement to comply with the business objectives of the organization and to provide clinical service with a particular priority on cost-control. Their continued participation in the program is based on maintaining a practice pattern that supports the objectives of the managed care system, with insufficient recognition of the dentist's professional judgment. These managed care procedures lead

to deteriorating dental practices and inadequate overall quality of care.

To date, there is little objective oversight of the quality of oral health care delivered through the managed dental care industry. Managed dental care organizations continue to design benefit plans to meet cost-control objectives alone, do not seek outside consultation on quality of care decisions for oral health care, and maintain quality of care programs as a proprietary interest, not open to outside scrutiny.

In order for oversight to be objective, sound standards for managed dental care programs, based on dental practice recognized by the profession, are essential. Thus, it is proposed that the American Dental Association develop standards for managed dental care programs based on sound dental practice. Such standards would address practice and administrative issues regarding the delivery of oral health care.

Budget for the Project on Developing Standards for Managed Dental Care Programs. It is expected that the development of standards for managed dental care programs will be accomplished by a subcommittee of the Council on Dental Benefit Programs consisting of six members and three outside managed dental care consultants/experts. It is expected that the subcommittee will hold three, three-day meetings.

The following budget is proposed:

Volunteer Travel	9x$500x3	$13,500
Staff Travel	2x$500x2	2,000
Lodging	9x$150x3x3	12,200
Staff Lodging	2x$150x3x2	1,800
Per Diem	9x$60x3x3	4,900
Meals	12x$60x3x3	6,500
Registration Fees	3x$800x2	4,800
Resource Materials		1,800
Supplies		300
Postage		500
Telephone		1,500
Outside Printing		3,500
Total		$53,300

The First District recommends adoption of the following resolution.

108. Resolved, that the ADA Council on Dental Benefit Programs be directed to develop standards for managed dental care programs to promulgate such standards to employers interested in providing managed dental benefits and to managed dental care organizations, and be it further

Resolved, that the appropriate agencies of the American Dental Association seek federal and state legislative or regulatory actions to ensure the adoption of the ADA's standards for managed dental care programs by managed care plans, and be it further

Resolved, that the appropriate agencies of the American Dental Association seek changes to the Employee Retirement Income Security Act (ERISA) so that self-funded managed care plans are required to adhere to the same standards, and be it further

Resolved, that the budget for this project be approved.

First Trustee District

Guidelines on Coordination of Benefits for All Third-Party Payers

The following resolution was adopted by the First Trustee District and transmitted on October 3, 1994 by Dr. Arthur I. Schwartz, caucus coordinator.

Background: The current Guidelines on Coordination of Benefits (*Trans.*1991:635) states in part:

1. When a patient has coverage under two or more dental plans, the coverage from those plans should be coordinated so that the patient receives the maximum allowable benefit from each plan. The aggregate benefit should be more than that offered by any of the plans individually, but not such that the patient receives more than the total charges for the dental services received.
2. In determining order of payment for benefits, the following rules should apply:

   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 determination cannot be made in accordance with the above, the medical plan should be considered as primary.

3. In coordinating benefits with a 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. 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 benefits 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 benefits and the dentist's full fee.

It is not proper that when the patient has two dental insurance plans and the reduced-fee plan is primary, the participating dentist can only be paid the reduced fee, whereas the nonparticipating dentist can receive the full fee. However, if the reduced-fee plan is secondary, both participating and nonparticipating dentists can be paid their full fee.

Additionally, the patient paying the premium for the full-pay plan to cover their entire family is wasting premium monies. Firstly, the spouse who has the reduced-fee plan is not covered by the full-fee plan until benefits are exceeded in the reduced-fee plan. Secondly, if the spouse who has the full-pay plan happens to have a later birthday in the calendar year than the spouse with the reduced-fee plan, no dependent children are covered by the full-pay plan until their benefits are exceeded in the reduced-fee plan. This is to the benefit of the insurance companies. ADA policy should serve for the benefit of our patients and our member dentists, not insurance companies. Therefore, be it

116. Resolved, that the title of the current Guidelines on Coordination of Benefits (*Trans.* 1991:635) be amended and changed to Guidelines on Coordination of Benefits for All Third-Party Payers, and be it further
Resolved, that these Guidelines be amended by changing guideline 3. a. to read:

> When the reduced-fee plan is primary, and treatment is provided by a participating dentist, 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 benefits and the dentist's full fee.

First Trustee District

Member Advocacy

The following resolution was adopted by the First Trustee District and submitted on October 24, 1994 by Dr. Joan Allen, secretary/treasurer.

Background: In recent years, dental hygiene and health system reform issues have consumed a major portion of the ADA and state society resources. Resolution 152 of 1993 allows the ADA Council on Governmental Affairs and Federal Dental Services to assist constituent societies in dealing with legislative and regulatory activities on an "as necessary basis."

Establishment of advocacy teams in each region of the country would allow for rapid response to developments contrary to the goals of organized dentistry. This program would compliment the grassroots Campaign and provide expertise to constituents in a cost-effective manner in time of need. Therefore, be it

144. Resolved, that the ADA establish a pilot project to provide for an advocacy team composed of members from each Trustee District. The focus of the advocacy would be on dental hygiene and health system reform issues, and be it further
Resolved, that a survey be developed of constituent societies to determine the legislative and regulatory issues they are facing in their areas and their plans to confront them, and a survey which would result in developing a list of dentists with experience and expertise in legislative advocacy and procedural protocols, and be it further
Resolved, that the ADA offer the services of these advocates to aid constituent societies, at their request, in supporting constituent legislative activities, and be it further
Resolved, that this project fall under the responsibilities of the Council on Governmental Affairs and Federal Dental Services and be staffed through appropriate agencies.

Second Trustee District

First Meeting of ADA House of Delegates

The following resolution was submitted by the Second Trustee District and transmitted on October 3, 1994 by Mr. Roy E. Lasky, executive director, The Dental Society of the State of New York.

Background: In the last year, the American Dental Association has made a much needed effort to ensure that final distribution of resolution worksheets takes place prior to, not during, the first meeting of the House. This change will no doubt afford delegates the opportunity to thoroughly review and analyze the issues before them.

However, too little attention has been given to the possibility of scheduling the first meeting of the House immediately following the Opening Session. Such a move would enable the individual caucuses to meet all afternoon, to discuss and, when necessary, prepare new resolutions and to be better prepared for Sunday's reference committee meetings. In short, such a move would result in better decision making by the entire House and inure to the benefit of the entire membership.

The Second Trustee District has asked the ADA to consider rescheduling the first meeting and was presented a list of reasons as to why such a change was not feasible this year. That list includes the facts that some trustee districts caucus for the first time at the site of the annual meeting; that there are ten other trustee district caucuses already scheduled on Saturday morning; that other meetings, such as that of the constituent society executives, are historically scheduled at that time; that such a change would require a year-long coordination and cooperation with the ADA Council on ADA Sessions and International Relations and appropriate staff; that the Opening Session is not over until 9:30 a.m. at the earliest and the ADA/Colgate awards luncheon begins at 11:30 a.m.; that the President opens the Scientific and Technical portion of the meeting at 10:00 a.m.; and that the time period from 10:00 a.m. to 3:00 p.m. is provided for delegates to attend the Scientific and Technical event.

The considerations listed above are an indication of how the ADA has planned its meeting this year and in the past, but

necessity merits that change is in order. While the Scientific and Technical portion of the meeting is indeed important, the most significant reason that delegates attend the annual meeting is to set policy for the membership. Because of this charge, it is imperative that the ADA rethink its scheduling decision in order to allow the delegates the vital time to peruse the issues and chart the course for our future. Therefore, be it

110. Resolved, that the officers of the ADA House of Delegates be urged to schedule the first meeting of the House of Delegates immediately following the Opening Session.

Second Trustee District

Distribution of *CDT-2*

The following Resolution was adopted by the Second Trustee District and transmitted on October 13, 1994 by Mr. Roy E. Lasky, executive director, The Dental Society of the State of New York.

Background: In 1990, the ADA published the first edition of the *CDT-1: Current Dental Terminology*, which consists of procedure codes to unify and simplify the reporting of common dental procedures to third-party payers. The *CDT-1* text was published as a supplement in the January 1990 issue of *The Journal of the American Dental Association* (*JADA*) as a membership benefit. The text was also made available in a bound edition distributed by the Salable Materials Office of the ADA for less than $25 per copy. Making *CDT-1* readily available to the membership is appropriate since, as the ADA has affirmed on the record, the document is "essential to all dentists."

Unfortunately, the ADA is approaching the distribution of *CDT-2* as a nondues income event as opposed to a membership benefit. A decision has been made not to make the *CDT-2* available at no charge to members via the *JADA*. The only option left to the practicing dentist will be to purchase the *CDT-2*.

Nondues income is an attractive hazard for the ADA, the constituents and the components in light of the budgetary constraints being faced at all levels of organized dentistry. Dues income is decreasing at a time when membership needs are increasing. However, it is not appropriate for us to respond to this challenge by converting traditional member benefits into "salable" items. A member of the ADA should, first and foremost, be treated as a member, not a customer for goods and services. Sometimes it hurts to forego a nondues income opportunity, but the Second Trustee District believes it is time to exercise such restraint with respect to *CDT-2*. Therefore, be it

129. Resolved, that the *CDT-2* be published in *The Journal of the American Dental Association.*

Second Trustee District

Mortgage Program

The following resolution was adopted by the Second Trustee District and submitted on October 22, 1994 by Mr. Roy Lasky, executive director, The Dental Society of the State of New York.

Background: The ADA has endorsed the Prudential Home Mortgage Loan Program since 1989. Between July of 1989 and September of 1994, only 4,170 loans have been closed for ADA members. This suggests either that the program is not widely used, or that only a limited number of the applications made ultimately result in actual loans.

The program requires submission of a nonrefundable application fee of $300, prior to any initial review of an individual's "financial qualifications." In addition, the criteria for approval under this program are especially stringent. It is typical in the mortgage industry for a loan officer to review an applicant's basic financial data and advise the applicant as to the likelihood of approval prior to accepting an application and requiring a fee. Prudential, however, does not provide any preliminary indication to its applicants prior to accepting a formal application and fee. Our members have the right to expect Association programs to be among the best available (e.g., Great-West Life). We are a large organization with significant "bargaining power." Moreover, this program is no doubt used most heavily by our youngest members. These are the dentists who can least afford to lose the $300 application fee and who are potentially the least likely to be approved under this program. We can do better for our members.

135. Resolved, that within the constraints of existing contractual obligations, appropriate agencies of the Association investigate the residual mortgage market to identify programs that:

a. have more liberal approval criteria than that of the current ADA mortgage program;
b. offer markedly competitive rates; and
c. require no initial application fee.

Third Trustee District

Dental Identification Teams

The following resolution was adopted by the Third Trustee District on October 22, 1994 and transmitted by Dr. Marlin A. Miller, secretary.

Background:

Whereas, the members of the Pennsylvania Dental Association Dental Identification Team (PADIT) volunteered significant time and forensic expertise assisting in the recovery process and then determining the identification of 78 of the 132 victims following the U.S. Air Flight 427 disaster, and

Whereas, the Pennsylvania Dental Association recognizes the professionalism and selflessness of those men and women of the PADIT who strove to serve their fellow man by volunteering their forensic expertise; therefore, be it

133. Resolved, that the American Dental Association urge all constituents to develop dental identification teams that can be mobilized at times of need.

Third Trustee District

Definition of Pediatric Dentistry

The following resolution was adopted by the Third Trustee District and submitted on October 22, 1994 by Dr. Marlin A. Miller, secretary.

Background: The Council on Dental Education (CDE) requested the American Academy of Pediatric Dentistry (AAPD) to consider revising the definition of the specialty because the 1985 definition was too broad and needed to be more specific and reference the fact that it is age-related. The new definition is even broader and assumes two definitions that preclude each other.

The concept of any specialist also being a primary care provider is a contradiction because the terms are mutually exclusive. Such a view creates confusion for the dental consumer and, therefore, does not serve the public interest. It also creates confusion for the profession in understanding the scope of practice for various specialties and ethical referral protocol.

The new definition clearly implies that whatever dental treatment is necessary for the child, the pediatric dentist is the proper practitioner to render this treatment, ignoring those circumstances where it is, in fact, quite proper for the treatment to be rendered by the general practitioner or other specialists.

The CDE's new definition implies that pediatric dentists are recognized as qualified to provide comprehensive specialty care in all specialty areas, as well as primary care. The CDE, in adopting specialty definitions, is bound by ADA House and Board policy. It is beyond the CDE's jurisdiction to adopt a specialty definition that is inconsistent with other duly adopted ADA policy, and which, in this case, is not supported by the current education standards for that specialty.

Therefore, be it

134. Resolved, that the revised definition of pediatric dentistry as referenced in the CDE Supplemental Report 2 (*Supplement*:302), be reconsidered by the Council on Dental Education after the new definition has been circulated to the communities of interest for comment, and be it further

Resolved, that the 1985 definition of pediatric dentistry be used until the above process has been completed.

Fourth Trustee District

Dental Special Pay for Federal Service Dentists

The following resolution was submitted by the Fourth Trustee District on October 17, 1994 by Maryland State Dental Association.

Background: Dental Special Pay for Federal Service Dentists has not increased since 1980. Additionally, military pay continues to lag behind CPI. Lower salaries have a direct effect on recruiting and retention of dental officers. Most graduating dentists have incurred large dental school debts which cannot be paid off on a military income.

Recruiting and retaining quality dental officers has become a serious problem which threatens the Services' ability to provide care for its members. Legislation is needed to correct the large disparity in pay which exists between the federally employed dentists and the dentists in the civilian sector to ensure current and future dental manpower needs of the Services can be met.

127. Resolved, that the ADA actively seek legislative initiatives for increased compensation for federally employed dentists.

Fourth Trustee District

Federal Dental Service Representation in the House of Delegates

The following resolution was submitted by the Fourth Trustee District on October 17, 1994.

Background: The 1992 House of Delegates approved Resolution 129H-1992 (*Trans.*1992:643) which directed the Board of Trustees to develop a recommendation regarding distribution of additional delegates to achieve equitable representation for members of the federal dental services (FDS) in the House of Delegates. Further, Resolution 129H states that the FDS be accorded representation in the House of Delegates in proportion to the number of Association members in each of the respective service branches.

The Board of Trustees and House of Delegates devoted a considerable portion of their time during the three years to discussion of increased federal dental services representation in the House of Delegates. In 1990, Resolution 54B (*Trans.*1990:569) recommended bylaw amendments to increase the size of the House of Delegates to 423 members to provide for two allocated certified delegates, one elected by the general membership of each federal dental service. In 1991, Resolution 94 (*Supplement* 2, 1991:445) recommended

bylaw amendments to grant constituent society status to each of the five branches of the federal dental services for purposes of determining House of Delegates representation, and to increase the size of the House of Delegates to 430 members.

The 1991 House of Delegates supported a recommendation to request additional information from the federal dental services. In adopting Resolution 133H-1991 (*Trans.*1991:609), the House instructed the federal dental services to develop a mechanism for electing delegates that complies with current Association policies for constituent society delegate selection. Further, the resolution asked the Board of Trustees to review the process and report to the 1992 House of Delegates.

In response to Resolution 133H-1991, an interservice committee was formed to develop a unified response. Representatives of the Army, Navy and Air Force Dental Corps, the Public Health Service and Veterans Affairs met several times over a five-month period in order to research and discuss the methods currently used by constituent societies in selecting delegates. The committee submitted a report on May 1, 1992, which outlined the delegate selection mechanism for each service branch which complied with current ADA policy as exercised by constituent societies. This mechanism was outlined in Board Report 9 (*Supplement* 1992:442) and provided the basis for consideration of Resolution 129H-1992 which directs the Board of Trustees to develop a specific recommendation for more equitable FDS representation in the House.

The House of Delegates approved Resolution 40H-1993, increasing each service delegation by one delegate. The services fulfilled their obligation by electing the additional delegates to serve as constituent representatives at the 1994 House of Delegates.

The American Dental Association is a professional organization of, by, and for dentists. Its membership is represented in its decisions and actions as a body by delegates selected, through constituent societies, for that purpose. This proportionate representation has been the linchpin of the Association's services to the profession, allowing members to feel appropriately served in the House of Delegates' governing and legislative process.

Unlike constituent societies, however, federal dental service representation has been limited to two delegates, irrespective of the number of dental officers who are ADA members. In adopting Resolution 129H-1992, the House of Delegates has determined this policy to be unfair.

While Resolution 40H-1993 gave the services an opportunity to directly choose a delegate, it did not fully address the issue of proportionality. In reality, the services continue to be underrepresented in the House of Delegates. In order to correct this situation, the following resolution is submitted.

128. Resolved, that Chapter II. CONSTITUENT SOCIETIES, Section 100. PRIVILEGE OF REPRESENTATION, of the *Bylaws* be amended by deleting Section 100 in its entirety and by substituting in its place a new Section 100 to read as follows:

> Section 100. PRIVILEGE OF REPRESENTATION: Each constituent society shall be entitled to at least one delegate without regard to the number of members. The Air Force Dental Corps, the Army Dental Corps, the Navy Dental Corps, the Public Health Service and the Department of Veterans Affairs shall each be entitled to a minimum of two (2) delegates, one of whom shall be the service chief and the other(s) shall be elected by the members of the respective service. The remaining number of delegates, to the limit established in Chapter V, Section 10, shall be allocated to constituent societies and federal dental services proportionately to their number of active, life and retired members.
>
> Each constituent society and each federal dental service may select from among its active, life and retired members the same number of alternate delegates as delegates and shall designate the alternate delegate who shall replace an absent delegate.
>
> For the purpose of this section, the number of active, life and retired members of each constituent society and federal dental service shall be determined as of the last day of the calendar year preceding an annual session.

and be it further

Resolved, that Chapter V. HOUSE OF DELEGATES, Section 10. COMPOSITION, of the *Bylaws* be amended by deleting Section 10 in its entirety and by substituting in its place a new Section 10 to read as follows:

> Section 10. COMPOSITION: The House of Delegates shall be limited to four hundred twenty-three (423) voting members. It shall be composed of the officially certified delegates of each constituent society, a minimum of two (2) officially certified delegates from each of the five federal dental services and one (1) student member of the American Dental Association who is an officially certified delegate from the American Student Dental Association, and is a graduate of a dental school accredited by the Commission on Dental Accreditation.
>
> The elective and appointive officers and trustees of this Association shall be *ex officio* members of the House of Delegates without the power to vote. They shall not serve as delegates. Past presidents of this Association shall be *ex officio* members of the House of Delegates without the power to vote unless designated as delegates.
>
> Each constituent society shall be entitled to at least one (1) delegate without regard to the number of members. The Air Force Dental Corps, the Army Dental Corps, the Navy Dental Corps, the Public Health Service and the Department of Veterans Affairs shall be entitled to a minimum of two (2) delegates each, one of whom shall be the service chief and the other(s) shall be elected by the members of the respective service. The remaining number of delegates shall be allocated to constituent societies and federal dental services proportionally to their number of active, life and retired members. The "Method of Least Proportionate Error" shall be the formula used to calculate the number of delegates allocated annually to each constituent society and federal dental service.
>
> Each constituent society and federal dental service may select from among its active, life and retired members the same number of alternate delegates as delegates.
>
> For the purpose of this section, the number of active, life and retired members of each constituent society and federal

dental service shall be determined as of the last day of the calendar year preceding an annual session.

Fifth Trustee District

Substitute for Resolution 4: Statement on Nonpayment for Incomplete Dental Treatment in Summary Plan Descriptions

The following substitute for Resolution 4 (*Reports*:39) was adopted by the Fifth Trustee District and submitted on October 22, 1994 by Dr. Samuel Dorn, delegate, Florida.

4S-1. Resolved, that the Association work with plan purchasers and third-party payers to see that dental plans should provide appropriate benefits for incomplete dental treatment as a result of a patient discontinuing treatment for any reason.

Fifth Trustee District

Substitute for Resolution 21: Model Material Safety Data Sheet Form

The following substitute for Resolution 21 (*Reports*:120) was approved by the Fifth Trustee District and submitted on October 22, 1994 by Dr. Mervyn J. Dixon, alternate delegate.

Background: The following is submitted by the Fifth Trustee District to the 1994 ADA House of Delegates asking for consideration to amend by adding the fourth resolving clause as follows:

21S-1. Resolved, that the Association develop a model material safety data sheet (MSDS) form for products containing hazardous chemicals used in dental offices, and be it further

Resolved, that the model MSDS form be submitted to OSHA for review and comment, and be it further

Resolved, that after the model MSDS form has been determined by OSHA to satisfy its requirements, that the Association work with groups representing the dental industry to encourage all manufacturers to adopt the form, and be it further

Resolved, that the Council on Scientific Affairs be urged to add to its scientific criteria for product acceptance a requirement that dental manufacturers and suppliers comply with all OSHA labeling requirements, including the hazardous rating labels that are required by the Hazard Communication Standard.

Fifth Trustee District

Voting Record for ADA Councils and Committees

The following resolution was adopted by the Fifth Trustee District and submitted on October 4, 1994 by Mr. Robert M. Macdonald.

Background: It is a current administrative policy of the American Dental Association to publish the vote of each member of the Board of Trustees on those items of business which necessitate a formal action. By providing this information to constituent dental associations, the ADA membership is able to see how each elected leader has voted on various issues affecting the practice of dentistry.

Presently, the voting records for other ADA agencies (e.g., councils and committees) are not made available to the membership. In order to have the same knowledge of positions taken by elected representatives to councils and committees as with those persons elected to the Board of Trustees, it would be beneficial if these voting records were also available.

Therefore, the following is submitted by the Fifth Trustee District to the 1994 ADA House of Delegates for consideration, with a recommendation for adoption.

103. Resolved, that all reports and resolutions that will be sent forward to the House of Delegates of the American Dental Association from councils or committees shall include a recorded vote of all members, and be it further

Resolved, that the recording of the vote shall be in the same chart form (e.g., name of agency members, yes vote, no vote, abstain or absent) as used for actions taken by the Board of Trustees on all reports and resolutions.

Fifth Trustee District

Volunteer Participation at the ADA Level

The following resolution was adopted by the Fifth Trustee District and submitted on October 4, 1994 by Mr. Robert M. Macdonald.

Background: Practicing dentists provide a unique and vital insight into the direction of organized dentistry; their contributions are essential to the vitality of the Association. Without the input of member dentists, the ADA can neither fully serve nor adequately represent its members.

It is essential that all volunteer dentists and staff members understand the scope and responsibility of their involvement in ADA councils, commissions, committees and task forces.

While it is crucial that the ADA maintain a highly experienced staff with the necessary training and skills to provide support on any given issue, it is equally important that the staff seek input and guidance from the volunteer dentists.

Any one element of the team is deficient without the other. When the balance is lost between staff support and volunteers, the Association, the profession and the dentists suffer.

The ADA Strategic Plan addresses this issue, encouraging the Association to maximize the opportunities for volunteer dentists to build a working relationship with the staff. Therefore, in order to enact the ideals and principles set forth in the Strategic Plan, the following is submitted by the Fifth District to the 1994 ADA House of Delegates for consideration, with a recommendation for adoption.

104. Resolved, that the House of Delegates of the American Dental Association urges the ADA Board of Trustees and the ADA Officers to take whatever action necessary to ensure that volunteer dentists are assigned to each ADA council, commission, committee and interagency task force, and be it further

Resolved, that the volunteer dentists so assigned be active and involved in both the decision-making process and in policy implementation, and be it further

Resolved, that the Board of Trustees be urged to instruct the Executive Director to include practicing dentists in every aspect of the process when carrying out directives of the ADA Board of Trustees or the House of Delegates, and be it further

Resolved, that policy clearly delineating the roles of staff and volunteers be developed immediately with a progress report presented to the 1995 ADA House of Delegates.

Fifth Trustee District

Risk Assessment

The following resolution was adopted by the Fifth Trustee District and transmitted on October 4, 1994 by Mr. Robert M. Macdonald.

Background: Legislation is frequently enacted based on emotions rather than logic. Impassioned pleas citing threats to human health and the environment are often used to promote specific agendas. Many times, these "threats" have no scientific basis and are simply (and cynically) designed to help pass specific legislation with no real regard for the human and economic consequences.

Thousands of jobs have been lost and countless dollars spent to comply with federal guidelines which resulted from inadequately evaluated legislation. The consequences of such legislation are not considered until after they become law and then it is often too late.

There is no doubt that human health and the environment should be seriously considered whenever there is a real and imminent threat. However, we believe before such decisions are made, cost analysis versus cost benefit tests must be applied.

The cost of delivering health care has been dramatically affected by the enactment of OSHA regulations—regulations more suited to the manufacturing environment than the dental office. The same can be said of CDC rules and other bureaucratic agency regulations.

Therefore, the following is submitted by the Fifth Trustee District to the 1994 ADA House of Delegates for consideration, with a recommendation for adoption.

105. Resolved, that the American Dental Association be directed to support or initiate legislation requiring the appropriate federal agencies to conduct a cost analysis versus health benefits on all proposed legislation and/or changes in rules or regulations affecting dentistry and other forms of health care; such analysis shall be based upon established scientific methods, and be it further

Resolved, that the results of such analysis be made available to the public.

Fifth Trustee District

PAC Membership

The following resolution was adopted by the Fifth Trustee District and transmitted on October 4, 1994 by Mr. Robert M. Macdonald.

Background: Health care reform, OSHA regulations, tax reform and a myriad of other attempts by the federal government to unduly control and regulate the private practice of dentistry have clearly demonstrated the compelling need for dentists to be actively involved in the political process. Furthermore, the operation of well-funded political action committees by organized dentistry at the state and national levels are integral components of effective political action.

The financial impact to increase PAC membership will best be determined by the ADA and constituent dental associations following development of the recruitment program.

Therefore, the following is submitted by the Fifth Trustee District to the 1994 ADA House of Delegates for consideration, with a recommendation for adoption.

106. Resolved, that the American Dental Association Board of Trustees is hereby requested to encourage ADPAC, the ADA's Council on Governmental Affairs and Federal Dental Services, and the respective constituent PAC boards to develop and initiate a campaign designed to increase each constituent society's PAC membership to at least 50% of its total membership in organized dentistry.

Fifth Trustee District

Dentists' Choice of Practice Settings

The following resolution was adopted by the Fifth Trustee District and transmitted on October 4, 1994 by Mr. Robert M. Macdonald.

Background: Dentistry is the model for the delivery of health care to the public. It already embodies the ideals being

recommended to reform health care. Dentistry is health care that works in that:

- Nearly 80% of dental practitioners are general dentists.
- Dentistry serves all of health care as the architect of prevention.
- Dentistry remains, as always, an advocate for public health and access to care.
- Dental expenses are predictable, noncatastrophic in nature and have been the example in cost containment.

The public and purchasers of dental benefit plans have been subjected to aggressive, false and misleading information about health care reform. Moreover, third-party agents are often the only ones at the table when alternatives are discussed with plan purchasers. No one speaks on behalf of the consumer.

As a result, the marketplace is rapidly moving to managed care as the only health care delivery option without regard to the record of the dental profession.

One mission of the ADA (as stated in the preamble to the Strategic Plan) is to serve as an advocate for the public. To allow the current conditions in the market to go unanswered would represent a tremendous failure in the defined purpose of the American Dental Association.

Therefore, the following is submitted by the Fifth Trustee District to the 1994 ADA House of Delegates for consideration, with a recommendation for adoption.

117. Resolved, that the ADA support or initiate legislation to maintain the ability of dentists to freely choose a practice setting best suited to their style and training so they can assist patients in achieving the highest quality dental health.

Fifth Trustee District

Distribution of *CDT-2* and *JADA*

The following resolution was adopted by the Fifth Trustee District and transmitted on October 4, 1994 by Mr. Robert M. Macdonald.

Background: At this annual meeting of the ADA, *CDT-2*, the ADA's 1995 *Code on Dental Procedures and Nomenclature*, is being initially released to the members at an approximate cost of $24.95 per copy.

In 1990, *CDT-1* was released and sold to members and to other individuals and groups, computer vendors and third-party payers, at a sales price of $24.95 per copy. During the past five years, the ADA has sold about 30,000 copies of *CDT-1*, about half purchased by members of the Association and about half purchased by computer vendors and third-party payers. This sale of *CDT-1* produced approximately $748,500 in revenue for the Association, with about one-half of that amount, $374,250, going into net nondues revenue. The other half of the sales, $374,250, was the cost of producing the 30,000 volumes that were sold.

This year the Board of Trustees has decided to offer again the new code, *CDT-2*, to the members and to the dental insurance industry, and it has budgeted $40,000 for marketing with the hope that the Association can realize greater sales and a greater nondues revenue.

CDT-2 will not be published in *The Journal of the American Dental Association*, as it used to be (prior to 1990, the code numbers and their brief descriptors were published in the March issue of *The Journal* each year). The descriptors are now much more elaborate and important for the accurate reporting of actual services delivered. Because of the increased complexity of the *Code* and its descriptors, the Board of Trustees decided several years ago, apparently upon the recommendation of the Council on Dental Benefit Programs, to cease publication of the abbreviated form in *The Journal.*

The members now have no other source for the information contained in *CDT-2* other than the purchase of the book at approximately $24.95.

CDT-2 encompasses a large number of additions, changes and deletions made to the work found in *CDT-1*. On page 41 of the 1994 *Annual Reports and Resolutions*, in the Council on Dental Benefit Programs report, the following statement is made:

> The CDT-2 is the eighth revision of the ADA's *Code on Dental Procedures and Nomenclature* and will remain as the standardized system of coding dental procedures until it is revised again in the year 2000. There are 44 new codes, including a replacement of the examination codes with evaluation codes and a completely revised orthodontic section; 26 codes were deleted, the nomenclature of 32 codes was revised and many revisions were made to the descriptors. In order to accurately use the new codes, the descriptors are essential.

At its April 1994 meeting, the Council approved the final revision of *CDT-2*, making it ready for publication. The Council approved a resolution to the Board of Trustees that *CDT-2* be published in another form, a form like the several other special reports that have accompanied *The Journal* in recent years. The cost of providing *CDT-2* in a special section form was estimated at approximately $100,000 by the staff of the Council.

Though the resolution was not unanimous, the Council felt that providing *CDT-2* to every member of the Association would be a significant and valuable membership service, particularly with the additions, changes and deletions that are being made.

The Board of Trustees decided against the recommendation by the Council on Dental Benefit Programs that *CDT-2* be distributed to every member of the Association as a membership service. Apparently it was felt that this action would significantly dilute the opportunity for increased nondues revenue.

If the actual cost of producing the special section publication of *CDT-2* is approximately $100,000, and the soft cost of losing one-half of the profit on the approximately 15,000 copies of *CDT-1* that the membership purchased from 1990 until the present is approximately $187,125, the total cost for this significant and valuable membership service will be approximately $287,125; but the real cost will be only $100,000.

A special section supplement copy of *CDT-2* distributed to every member of the Association will not be a durable copy that will last the heavy users five years. Many of the members will purchase the $24.95 copy to have a durable and lasting copy for their office use. Therefore, the soft cost of providing this membership service will not be as great as estimated in the preceding paragraph.

CDT-2 becomes effective January 1, 1995. It is imperative that practicing dentists be in receipt of the new code as quickly as possible.

With the recent establishment of the ADA's ownership of the *Code* and the tremendous upheaval in the health care industry by national health reform, it is thought that now, more than ever before, all members of the Association should be given a complete and unabridged edition of *CDT-2* as a membership service.

Therefore, the following is submitted by the Fifth District to the 1994 ADA House of Delegates for consideration, with a recommendation for adoption.

118. Resolved, that the American Dental Association distribute a copy of *CDT-2*, complete and unabridged, as a special section of *The Journal of the American Dental Association*, sent with the January 1995 issue of *The Journal*, to every member of the Association as a membership service.

Fifth Trustee District

Identification of Claims Reviewers on Explanation of Benefit Statements

The following resolution was adopted by the Fifth Trustee District and transmitted on October 4, 1994 by Mr. Robert M. Macdonald.

Background: In 1990, the ADA House of Delegates adopted a resolution (*Trans.*1990:536) that deals with information which the Association recommends be published on patients' explanation of benefits statements. In reviewing this policy, the Fifth Trustee District recommends an amendment to ensure that the claims reviewer processing the claim be identified on the explanation of benefits statement. The addition of this language would further state the ADA's intent to facilitate claims settlement by citing the name of the person with whom the beneficiary can make contact with regard to questions which the patient may have on a particular claim.

The Fifth Trustee District recommends to the 1994 ADA House of Delegates that it amend this policy as follows.

119. Resolved, that Resolution 7H-1990 (*Trans.*1990:536), Explanation of Benefits Statement, be amended by the addition of the following resolving clause:

> **Resolved,** that in all correspondence between a third-party carrier and the patient regarding the patient's dental claims, the carrier should provide the name, area code and telephone number of the individual who is acting on behalf of the carrier.

so the amended policy will read as follows:

Resolved, that in all communications from a third-party payer or other benefits administrator which attempt to explain the reason(s) for a benefit reduction or denial to beneficiaries of a dental benefits plan, the following statement be included:

> Any difference between the fee charged and the benefit paid is due to limitations in your dental benefits contract. Please refer to (*insert pertinent provisions of summary plan description*) of your summary plan description for an explanation of the specific policy provisions which limit or exclude coverage for the claim submitted.

and be it further

Resolved, that in reporting the benefit determination to the beneficiary, the following information be reported on the explanation of benefits statement:

1. the treatment reported on the submitted claim by ADA procedure code numbers and nomenclature; and
2. the ADA procedure code numbers and nomenclature on which benefits were determined.

and be it further

Resolved, that the Council on Dental Benefit Programs work with third-party payers, plan purchasers, benefits consultants and government agencies to implement this policy, and be it further

Resolved, that in all correspondence between a third-party carrier and the patient regarding the patient's dental claims, the carrier should provide the name, area code and telephone number of the individual who is acting on behalf of the carrier.

Fifth Trustee District

Expansion of "Dentistry—Health Care That Works"

The following resolution was adopted by the Fifth Trustee District and transmitted on October 4, 1994 by Mr. Robert M. Macdonald.

Background: Dentistry is the model for the delivery of health care to the public. It already embodies the ideals being recommended to reform health care. Dentistry is health care that works in that:

- Nearly 80% of dental practitioners are general dentists.
- Dentistry serves all of health care as the architect of prevention.
- Dentistry remains, as always, an advocate for public health and access to care.
- Dental expenses are predictable, noncatastrophic in nature and have been the example in cost containment.

The public and purchasers of dental benefit plans have been subjected to aggressive, false and misleading information about health care reform. Moreover, third-party agents are

often the only ones at the table when alternatives are discussed with plan purchasers. No one speaks on behalf of the consumer.

As a result, the marketplace is rapidly moving to managed care as the only health care delivery option without regard to the record of the dental profession.

One mission of the ADA (as stated in the preamble to the Strategic Plan) is to serve as an advocate for the public. To allow the current conditions in the market to go unanswered would represent a tremendous failure in the defined purpose of the American Dental Association.

Therefore, the following is submitted by the Fifth Trustee District to the 1994 ADA House of Delegates for consideration, with a recommendation for adoption.

122. Resolved, that the ADA Board of Trustees, together with appropriate councils, commissions and other agencies, be directed to develop and implement a program to educate dentists (members), the dental consumer (public/patient) and plan purchasers (employers/the business community) about "Dentistry—Health Care That Works" through current ADA resources, the media and other public relations activities, and be it further

Resolved, that to achieve this end, the ADA should:

1. collect and aggressively disseminate information about the various prepaid dental plans and their economic impact on the practice of dentistry so the dentist and the public can make informed choices;
2. develop, compare and contrast models for PPO, DMO, capitation, fee-for-service (free enterprise), self-funded plans and direct reimbursement to clearly show the advantages and disadvantages of each;
3. develop and use educational materials to inform members and dental students about contract analysis and negotiations and the impact these contracts can have on the dental practice;
4. collect, develop and aggressively disseminate materials to plan purchasers to serve as an advocate for the patient (public/employee). These materials should accurately represent the true value of various plan options; and
5. develop training materials to be used by organized dentistry in identifying and educating corporate human resource specialists and other benefit plan purchasers.

Fifth Trustee District

Adjustments in 1995 Budget

The following resolution was adopted by the Fifth Trustee District and submitted on October 22, 1994 by Dr. D. W. Christian, Fifth Trustee District.

Background: In connection with the review of the ADA's 1995 budget, the following resolution is offered for consideration by the Fifth Trustee District.

132. Resolved, that the Annual Budget of Revenues and Expenditures including funded depreciation and capital expenditures be returned to the Board of Trustees with the recommendation that, after consideration of at least the following listed items, a budget be presented to the House of Delegates that has projected revenues equal to or exceeding projected expenses, without the use of reserve funds:

1. New and unfilled staff positions	reduce funding
2. Funded depreciation	reduce funding
3. FDI expense	reduce funding
4. Grants to Health Foundation	reduce increased funds
5. Compensation increase	reduce increase
6. Unbudgeted programs funded directly from reserves	remove
7. Evaluate latest projections of 1994 budget	transfer any surplus to 1995 revenue
8. Re-evaluate 1995 revenues considering Seal Program, credit card revenues and others	add to revenue

Sixth Trustee District

Amendment to Resolution 26: Recommended Dues Increase

The following amendment to Resolution 26 (*Supplement*:423) was submitted on October 18, 1994 by Mr. Richard D. Stevens, executive director, West Virginia Dental Association.

Background: During its September 30 caucus, the Sixth District Delegation to the American Dental Association passed a resolution to amend Resolution 26 by making the proposed $19 dues increase only effective during the three years of 1995, 1996 and 1997.

Therefore, the Sixth District submits the following amended Resolution 26 for consideration by the 1994 House of Delegates.

26S-1. Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS*, of the *Bylaws* be amended by deleting the words and number "three hundred thirty dollars ($330.00) due

January 1 of each year" (lines 306 and 307) and by substituting in their place the words and number "three hundred forty-nine dollars ($349.00) due January 1 of each of the years 1995, 1996 and 1997," to make the amended first sentence up to but not including the word "except" (line 307) read as follows:

> A. ACTIVE MEMBERS*. The dues of active members shall be three hundred forty-nine dollars ($349.00) due January 1 of each of the years 1995, 1996 and 1997*...

and be it further

Resolved, that the first footnote to Chapter I, Section 50A of the *Bylaws* be amended by adding a second sentence to read as follows:

> Effective January 1, 1998, the dues of active members shall be reduced by nineteen dollars ($19.00) from the level of active member dues in effect in 1997.

so the amended first footnote reads as follows:

> *Effective January 1, 1997, the dues of active members shall be reduced by fifty-five dollars ($55.00) from the level of active members dues in effect in 1996.
> Effective January 1, 1998, the dues of active members shall be reduced by nineteen dollars ($19.00) from the level of active member dues in effect in 1997.

Seventh Trustee District

Survey of All Dental Assisting Programs

The following resolution was adopted by the Seventh Trustee District and transmitted on September 21, 1994 by Ms. Nancy C. Quinn, executive director, Ohio Dental Association.

Background: Since the American Dental Association only monitors accredited dental assisting programs, there is little knowledge of programs that are not accredited. For organized dentistry to communicate with all dental assisting training programs offered in public, private, secondary and postsecondary educational institutions, a comprehensive listing must be obtained. Through the Commission on Dental Accreditation, the American Dental Association maintains a listing of public and private postsecondary institutions that offer Commission-accredited dental assisting programs. In addition to these 233 Commission-accredited programs, 36 postsecondary dental assisting programs sponsored by institutions accredited by the Accrediting Bureau of Health Education Schools/Programs (ABHES) and 56 postsecondary programs sponsored by institutions accredited by the Accrediting Commission of Career Schools and Colleges of Technology (ACCSCT) have also been identified.

At this point, the following types of dental assisting training programs have *not* been identified:

1. postsecondary programs not accredited by the Commission but offered in public community colleges and/or vocational technical institutes;
2. postsecondary programs offered in private institutions not accredited by ABHES and ACCSCT; and
3. secondary programs offered in high schools and vocational schools.

Information on *all* dental assisting training programs is needed. By utilizing the United States Department of Education's *Directory of State Personnel Responsible for Vocational-Technical Education*, 54 identified State Directors of Vocational-Technical Education could be surveyed to provide information on any educational institution providing dental assisting training in each state.

Each identified institution sponsoring a dental assisting program should then be surveyed regarding enrollment, graduates, length of program, curriculum, recruitment strategies, and support provided by the local dental community. The estimated cost of conducting this two-stage survey is $9,500.

89. Resolved, that the American Dental Association conduct a nationwide survey to gather information on all dental assisting training programs in the United States in order to evaluate the educational quality and financial viability of the programs and to develop a plan to increase the quality and quantity of dental assisting personnel, through cooperative national, constituent and component efforts.

Seventh Trustee District

Specialty Recognition

The following resolution was adopted by the Seventh Trustee District and submitted on October 25, 1994 by Dr. David Rummel, delegate.

Background: In light of the actions and concerns of this House of Delegates regarding specialty recognition, the following resolution is suggested to give the Council on Dental Education some guidance in regards to this difficult issue.

145. Resolved, that since the Council on Dental Education is currently considering the Requirements for Recognition of a Dental Specialty, the Council should consider no new specialty applications until the 1994 HOD has considered the new CDE recommendations regarding changes for specialty recognition.

Seventh Trustee District

Specialty Recognition

The following resolution was adopted by the Seventh Trustee District and submitted on October 25, 1994 by Dr. David Rummel, delegate.

Background: In light of the actions and concerns of this House of Delegates regarding specialty recognition, the

following resolution is suggested to give the Council on Dental Education some guidance in regards to this difficult issue.

146. Resolved, that the Council on Dental Education study the Requirements for Recognition of a Dental Specialty, with a report to the 1995 House of Delegates, and be it further
Resolved, that if the Council develops proposed changes to the criteria for recognition, any new applications that are submitted to the Council be held until after the 1995 House of Delegates, and be it further
Resolved, that if the council decides that the current criteria are valid and appropriate, then new applications be processed and considered in the usual course of business of the Council, and be it further
Resolved, that if the 1995 House of Delegates does not accept the Council on Dental Education's report on the new criteria for specialty recognition, as submitted, then any submitted applications will continue to be considered and processed to completion utilizing the current criteria and requirements for specialty recognition in a timely fashion.

Eighth Trustee District

Substitute for Resolution 74B: Protocol and Guidelines for Administration of Antibiotic Prophylaxis

The following substitute for Resolution 74B was submitted by the Eighth Trustee District and transmitted on October 10, 1994 by Mr. Robert A. Rechner, executive director, Illinois State Dental Society.

Background: The Eighth Trustee District wishes to amend Resolution 74B in the third line by addition of the phrase "secondary infections historically linked to that dental treatment such as bacterial endocarditis and" between the words "of" and "late" so that the amended Resolution 74B will read:

74BS-1. Resolved, that the Council on Scientific Affairs continue to monitor data on whether a cause and effect relationship exists between dental treatment and the development of secondary infections historically linked to that dental treatment such as bacterial endocarditis and late prosthetic joint infections, that it revise its guidelines as necessary to ensure that they remain consistent with these data, and that it advise the membership of any changes.

Eighth Trustee District

Standard for Acceptable Risk

The following resolution was adopted by the Eighth Trustee District and submitted on October 6, 1994, by Mr. Robert A. Rechner, executive director, Illinois State Dental Society.

Background: Dentistry, as in all other professions, is faced with a wide spectrum of risks ranging from the most serious to negligible for which we must allocate priorities and limited resources. We do not yet use a quantifiable benchmark for relative risk in infection control and other health concerns in which we can identify and respond to serious risk yet disregard the more remote and inconsequential risk. Recently, it has become fashionable to identify and exaggerate numerous theoretical, yet negligible, risks and to demand allocation of limited resources which could otherwise be better used.

At this time, dentistry has no officially recognized scientific way of quantifying the significance of these risks and thus, determination of the risk and priorities are often made through emotion, the news media and lobby groups. In the area of chemical carcinogens, for example, federal agencies like the Food and Drug Administration and the Environmental Protection Agency have employed the standard of 1:1,000,000 to define a "negligible risk" policy acceptable for purposes of public health. This resolution proposes to set the standards for assessment of acceptable risk in dentistry utilizing current scientific thought accepted by acknowledged agencies in the medical community.

111. Resolved, that the Council on Scientific Affairs and any other appropriate ADA agency investigate and determine, if appropriate, a standard for risk as it pertains to health concerns (e.g., infection control) related to the practice of dentistry, and be it further
Resolved, that the Council report its findings and determinations to the 1995 House of Delegates.

Eighth Trustee District

Dental Benefits for Military Reservists

The following resolution was adopted by the Eighth Trustee District and transmitted on October 6, 1994 by Mr. Robert A. Rechner, executive director, Illinois State Dental Society.

Background: The Eighth Trustee District agrees with Resolution 63 (*Supplement*:323) about dental benefits for military retirees, but also believes that the ADA should go on record as supporting benefits for reservists as well.

For all of the military services, selected reserve strength is approximately 989,000 people. It is well known that the dental health status of a significant percentage of these reservists is poor, and current law precludes dental treatment of reservists except in cases of emergency. Poor dental health can severely damage the readiness of our reserve forces.

We believe that the ADA should support a policy that permits reservists and their dependents to voluntarily select a program of dental benefits that is purchased with personal funds similar in nature to that which currently exists for active duty military dependents.

112. Resolved, that the Association supports legislative initiatives intended to offer a dental benefits plan covering selected military reservists and their dependents similar to that covering active duty military dependents.

Eighth Trustee District

Face Shields on Batting Helmets

The following resolution was adopted by the Eighth Trustee District and transmitted on October 6, 1994 by Mr. Robert A. Rechner, executive director, Illinois State Dental Society.

Background: The Eighth Trustee District recognizes that orofacial injuries occur during competitive and recreational sporting activities for both male and female participants. The ADA has had a policy for many years in support of mouth protection in contact sports, and current ADA policy (*Trans.*1989:541)states in part "the ADA endorses the use of oral/facial protectors by school-aged participants in sports activities with a significant risk of injury at all levels of competition including practice sessions, physical education and intramural programs." Promulgation of this type of beneficial policy to those outside of dentistry often needs direct action. Therefore, the Eighth District offers the following resolution.

120. Resolved, that the American Dental Association recommends the use of protective face shields on all baseball batting helmets.

Ninth Trustee District

Substitute for Resolution 23: Policy on Stipends to Officers and Trustees

The following substitute for Resolution 23 (*Supplement*:333) was submitted by the Ninth Trustee District on October 6, 1994 by Ms. Grace L. DeShaw-Wilner, Michigan Dental Association.

Background: The Board of Trustees of the American Dental Association established a policy of automatic annual raises in stipends to officers and trustees. The policy adopted allows for an automatic annual adjustment based upon the cost of living allowance (COLA) plus 2% with an annual maximum of 10%.

The 1995 budget, based on a COLA of 4% plus 2%, added $33,000 to officers' and trustees' expense allowances.

By adopting Resolution 23, no formal policy would exist. The Ninth District is in favor of maintaining a policy for annual raises in stipends to officers and trustees; however, the District believes that the policy should be based only upon COLA and should be policy of the ADA House of Delegates.

23S-1. Resolved, that the Board of Trustees be urged to adopt a policy that provides an automatic annual raise in stipends to officers and trustees equal to the U.S. Department of Labor Cost of Living Allowance, up to a maximum COLA increase of 6% in any given year.

Ninth Trustee District

Amendment of the Guidelines for Governing the Conduct of Campaigns for ADA Offices

The following resolution was submitted by the Ninth Trustee District and transmitted on September 13, 1994 by Dr. S. Timothy Rose, trustee, Ninth District.

90. Resolved, that the Guidelines for Governing the Conduct of Campaigns for ADA Offices be amended to read as follows:

Guidelines for Governing the Conduct of Campaigns for ADA Offices

In recent years, the House of Delegates established various guidelines and policies relating to campaign activities for ADA offices. The following incorporates House directives into one document which will be distributed to all candidates, delegates, alternate delegates, and other parties of interest.

1. Candidates, before announcing their candidacy, may freely campaign only within their own trustee district.
2. Candidates shall not formally announce for office until the final day of the annual session immediately preceding their candidacy. They shall not make any campaign appearances or give any presentations for election prior to their formal announcement.
3. ADA trustee districts are encouraged to caucus prior to the ADA annual session. Candidates should make only one visit to each ADA trustee district and are encouraged to attend trustee district caucuses for the purpose of presenting themselves for elective office. Caucus sponsors should make available to each candidate sufficient time for the candidate to meet and present his or her platform to the delegates and alternates from the trustee district.
4. Candidates shall not use social functions or hospitality suites on behalf of their candidacy prior to the first meeting of the House of Delegates in the year that they are seeking elected office.
5. Candidates shall limit the display of campaign signs and posters to the immediate area of their respective hospitality suites. (The ADA will provide prominent directories for all candidates' hospitality suites at the hotel and at the House of Delegates registration areas.)
6. All campaign social functions will be restricted to the candidate's officially designated hospitality suite at the annual session.
7. Candidates for office are encouraged to negotiate agreements between themselves to eliminate expensive promotional activities and gifts.
8. A limitation shall be placed on the number of printed campaign pieces that may be distributed during the course of the year. One printed campaign brochure shall

be allowed at the time of the candidate's announcement for election at the ADA House of Delegates. Two separate campaign literature mailings can be made during the course of the campaign. One final piece of printed material can be distributed at the ADA House of Delegates during the year of the election process. No material may be distributed to the House of Delegates without obtaining permission from the Secretary of the House. Materials to be distributed to the House of Delegates on behalf of a member's candidacy for office shall be limited to printed material only.

9. The ADA shall sponsor a Candidate Forum Night during the ADA annual session. This Candidate Forum Night shall resemble the national presidential debates. Each trustee district will be allowed to submit one question to be asked of all the candidates. The Speaker of the House of Delegates, unless he or she is a candidate, will act as the master of ceremonies for the Candidate Forum Night. If the Speaker is a candidate, the President-elect shall act as the master of ceremonies. The master of ceremonies shall select the questions at random. Each candidate will be afforded an opportunity to comment on each question. The candidates shall comment on the individual questions on a rotating method so that the order of comment is changed for each question. The night of the Candidate Forum, individual campaign suites will not be open for election campaigning.

Any questions regarding the guidelines should be directed to the office of the Executive Director for clarification.

Ninth Trustee District

Antitrust Limitations

The following resolution was submitted by the Ninth Trustee District on October 6, 1994 by Ms. Grace L. DeShaw-Wilner, director of Professional Review and Special Projects, Michigan Dental Association.

Background: Federal law precludes practitioners from collectively gathering to formalize and/or address dental benefit offerings. Under the FTC, dentists are viewed as competitors rather than colleagues and for that reason cannot join collectively in an effort to effect fees, reimbursement, or dental benefit offerings. Meanwhile, all health care professionals are being subjected to increased pressure from any third-party payers to reduce their fees, grant discounts or alter their practices.

Collective conduct by independently practicing dentists can result in illegal price-fixing or group boycott agreements under the antitrust laws. The McCarran-Ferguson Act and the Sherman Antitrust Act clearly prohibit competitors from banding together in order to discuss dental benefit contracts. Insurance companies have an exemption from these acts and for that reason insurance carriers and providers are not on a level playing field during negotiations for dental or medical benefits. In light of the relief from antitrust laws granted to others and the dominance of the market by large payers, the Ninth District urges the ADA to pursue exemptions for dentists in combining and taking concerted action when contracting for dental services.

113. Resolved, that the ADA Board of Trustees significantly increase its efforts and dedicate attendant resources to ensure more current, comprehensive, and continuing communications and advice to all ADA constituent societies concerning pertinent antitrust developments and related impact upon future actions of dentists, singly and through involvement with others, and be it further

Resolved, that the ADA Board of Trustees utilize appropriate resources to obtain legislative relief from antitrust laws to allow dentists to collectively negotiate with purchasers and administrators of dental benefits and health alliances.

Ninth Trustee District

Medical Savings Accounts

The following resolution was submitted by the Ninth Trustee District on October 6, 1994 by Ms. Grace L. DeShaw-Wilner, director of Professional Review and Special Projects, Michigan Dental Association.

Background: Medical savings accounts, purchased with pre-tax dollars, allow individuals the opportunity to supplement existing medical insurance coverage and to reduce premiums by funding higher deductibles.

The current trend in both medical and dental benefits requires larger co-pays and deductibles. Medical savings accounts are a cost-effective method of reducing these financial burdens.

114. Resolved, that the American Dental Association supports the concept of medical savings accounts as a component of health system reform.

Ninth Trustee District

Employer Mandates

The following resolution was submitted by the Ninth Trustee District on October 6, 1994 by Ms. Grace L. DeShaw-Wilner, director of Professional Review and Special Projects, Michigan Dental Association.

Background: Employer-based insurance reform has been proposed by members of Congress to provide universal insurance coverage for all Americans.

Current grassroots or legislative efforts by the ADA do not address the small business issue of mandatory purchasing of medical or dental benefits for employees by employer-dentists.

As small-business persons, dentists have opposed employer mandates as an intrusion into the employer-employee relationship.

115. Resolved, that the American Dental Association opposes employer mandates to purchase medical/dental benefits for employees as a component of health system reform.

Ninth Trustee District

Washington, D.C. Property

The following resolution was submitted by the Ninth Trustee District on October 6, 1994 by Ms. Grace L. DeShaw-Wilner, Michigan Dental Association.

Background: The Ninth District Delegation has grave concern over the ongoing negative cash flow of the Washington, D.C. property, not to mention the trend of decreasing rental income.

Resolution B-113-1992 resolved that the ADA Board of Trustees make provisions to fund the ongoing cash flow losses from ADREC up to $1.7 million annually. In 1994, $552,500 was budgeted, 1995 has $1,081,700 budgeted, and it is estimated that another $2.2 million will be needed in 1996. While the District realizes that, since the purchase of the building, the space rent for floors 11 and 12 and the ground rent was reduced from $280,000 to $1, the actual cost of owning and maintaining this building is much greater than the reduction in rent.

The Ninth District recommends that a three- to five-year cash flow projection be conducted. If the negative trend is expected to continue beyond that time frame, the ADA Board of Trustees and ADREC must determine whether the Association is in a position to continue to feed this losing venture. The Ninth District believes that ADA resources could be more appropriately utilized in other areas.

123. Resolved, that the Board of Trustees be urged to request the ADREC Board to undertake a cash flow study of the Washington, D.C. property, including but not limited to, the sale of the current building, in order to eliminate the continuing negative cash flow, and be it further

Resolved, that the ADA Board be urged to undertake a study to consider alternatives to ownership or lease space in Washington, D.C.

Ninth Trustee District

Study of the Impact of Managed Care on Dental Benefit Programs

The following resolution was adopted by the Ninth Trustee District and transmitted on October 6, 1994 by Ms. Grace L. DeShaw-Wilner, Michigan Dental Association.

Background: Independently of the health care reform movement, an increasing number of employers are utilizing managed care programs to limit the costs of health care benefits. According to a recent survey of major manufacturers by Ernst & Young, 65% of the companies will not wait for health care reform to implement cost-saving mechanisms in their health care benefit programs. As part of overall management of health care costs, many employers are pursuing managed dental care programs, such as capitation and contract fee schedule programs.

As increasing numbers of dentists receive marketing information from managed care programs, they are articulating concerns about how managed care organization rules will affect current dental care delivery models, quality of care, provider autonomy, patient choice, the dentist/patient relationship and other related issues. As a result, constituent and component dental societies are receiving increasing numbers of requests from their members for information to help them develop strategies to cope in the new managed care environment.

As dentists seek guidance on the best options available to respond to the rapid changes occurring in the marketplace, they are being forced to consider issues which are unfamiliar to those who have practiced solely within a fee-for-service model, for example:

- What effect do the rules of managed care organizations have on the oral health status outcomes of patients treated under such plans?
- What influence do managed care organization rules have on the dentist's selection of procedures to treat particular conditions?
- What effect does managed care have on the clinical quality of the care provider?
- How can dentists ethically respond when faced with unacceptable restrictions on treatment that are part of a health plan?
- What influence do managed care programs have on dental practice productivity?
- What is the economic impact of managed care contracts upon dental practice, including issues such as length of contracts, premium rates, proportion of managed care/fee-for-service patients in contracting practices, scope of covered services, utilization patterns?
- What types of financial, demographic, quality and performance data will managed care organizations require practitioners to maintain?
- What impact do antitrust issues have on strategic planning for managed care?
- Which dental care entities will be most affected by managed care programs?
- Which model of dental care delivery is best suited to compete in the managed care environment?
- What modifications in management techniques are required to integrate fee-for-service care and managed care?

As the health care industry goes through the current period of change, the Ninth District believes that the American Dental Association must commit its resources to keep its members well informed on the basic issues of managed care, and their impact on delivery of dental care services in the short- and long-term. We believe the Association must take the lead in providing complete, integrated services to help members develop sensible and usable solutions to the challenge of managed care that will allow them to maintain the principles of patient advocacy and quality of care that have been the cornerstone of the dental profession. Therefore,

in consideration of this urgent need, the Ninth District presents the following resolution.

125. Resolved, that the ADA Board of Trustees raise to the highest priority and utilize its resources to study the impact of managed care on the dental benefit delivery system and the individual practitioner, and be it further
Resolved, that the study be presented to the April 1995 meeting of the ADA Board of Trustees and then disseminated to all ADA members and constituent dental societies.

Ninth Trustee District

Fluoride Commemorative Project Support

The following resolution was adopted by the Ninth Trustee District and submitted on October 14, 1994.

Background: Fifty years ago, when Grand Rapids, Michigan became the first community in the world to fluoridate its water, the majority of Americans lost all of their teeth by age 25. The number one reason conscripts in World War II were rejected was because they did not even have six healthy, functional teeth. The postwar use of fluoride and fluoridated water have helped to significantly control dental caries. Today, a healthy mouth has become the norm. By this one simple, inexpensive measure, a major public health problem was eliminated and dentistry was brought into the modern age. The use of fluoride and fluoridated water is the single most effective public health initiative ever instituted in the United States.

The 1993 American Dental Association's House of Delegates adopted Resolution 130H-1993 (*Trans.*1993:693) which reads as follows:

> **Resolved,** that the American Dental Association declare the 50th Anniversary of Fluoridation in Grand Rapids, Michigan to be of national significance in the history of preventive dentistry, and be it further
> **Resolved,** that the Association identify appropriate opportunities to be visibly associated with this commemorative event.

A Commemorative Celebration is planned, which consists of a two-day international scientific symposium and a historic commemorative monument, both to be located in Grand Rapids, Michigan.

The symposium is slated for September 15 and 16, 1995. The program, coordinated by the University of Michigan, includes sections entitled "The Benefits of Fluoride Worldwide" and "The Brave New World After Fluoride." Scheduled speakers are: Dr. Ernest Newbrun, Dr. Harald Loe, Dr. Harold Slavkin, Dr. Irwin Mandel, Dr. Thomas Marthaler of Switzerland, Dr. Dennis O'Mullane of Ireland, Dr. Herschel Horowitz, Dr. Tom Reeves, Dr. Ray Stevens, Dr. Bruce Baum, Dr. Bo Krasse, Dr. Klaus Konig, and Dr. Harry Bohanon.

The commemorative monument is slated to be unveiled on September 15, 1995. It will consist of six white marble slabs approximately four feet wide rising out of a granite base. The monument is meant to honor those responsible for solving this universal public health problem, and educate future generations of the historical significance of water fluoridation.

A media team consisting of the American Dental Association, the Center for Disease Control, the Federation Dentaire Internationale, the Michigan Dental Association, and Mike Mullell, Public Health Informational Officer of Western Michigan, will coordinate a campaign to emphasize national and international exposure. Contact has been made with the National Institute of Dental Research and the World Health Organization to also join the media team.

Support has been building at many different levels in the public health and dental communities. The total budget consists of $363,430 of gifts and in-kind services. To date, the project is over 70% funded. In order to realize the end goals, and provide an opportunity for the ADA to be visibly associated with this event, it is requested that the ADA House consider financial support in the amount of $25,000 to reflect the leadership demonstrated by organized dentistry in solving this major public health problem. As future generations visit the monument and use the proceedings of the symposium for study, the leadership of the ADA will be evident.

126. Resolved, that the Board of Trustees be urged to allocate $25,000 to support the 50th Anniversary of Water Fluoridation Commemorative Celebration, slated for September 1995 in Grand Rapids, Michigan.

Tenth Trustee District

Substitute for Resolution 55: Definition of Fee-for-Service

The following substitute for Resolution 55 (*Supplement*:322) was adopted by the Tenth Trustee District and transmitted on October 7, 1994 by Dr. Michael J. Till, trustee, Tenth District.

Background: In reviewing Resolution 55 submitted by the Council on Governmental Affairs and Federal Dental Services, the Tenth Trustee District feels that the current definition of fee-for-service, "A method of paying practitioners on a service-by-service rather than a salaried or capitated basis" is preferable to the proposed definition. However, the current definition does not reflect how most dentists perceive or use the term fee-for-service. If a new definition is to be adopted, it should delineate the difference of being reimbursed on a service-by-service basis using a customary fee as opposed to a usual or reasonable fee.

Therefore, the following resolution is submitted:

55S-1. Resolved, that the following be the definition of Fee-for-Service:

> *Fee-for-Service.* The payment received by a dentist for his or her usual or reasonable fee on a service-by-service basis rather than on a customary or contract fee basis.

Twelfth Trustee District

Preservation of the Dental Practice Parameters

The following resolution was adopted by the Twelfth Trustee District and submitted on September 26, 1994 by Dr. Donald R. Toso, secretary-treasurer.

107. Resolved, that all amendments, changes or modifications to the Dental Practice Parameter documents will be approved by the ADA House of Delegates.

Twelfth Trustee District

Rescinding Resolution 62H-1993: Establishing Parameters

The following resolution was adopted by the Twelfth Trustee District and submitted on October 22, 1994 by Dr. Donald R. Toso, secretary-treasurer.

136. Resolved, that Resolution 62H-1993 (*Trans.* 1993:697), Development of Dental Practice Parameters, be rescinded.

Thirteenth Trustee District

Over-the-Counter Mouthwash Safety

The following resolution was submitted by the Thirteenth Trustee District and transmitted on July 27, 1994 by Mr. Mark D. Alcorn, assistant executive director, California Dental Association.

Background: The California Dental Association (CDA) recently became concerned about the safety of over-the-counter mouthwashes that contain more than 5% ethanol. Over-the-counter mouthwashes are portrayed as good-tasting and healthful, and certainly not as a poison. They are readily accessible to children and not packaged in child-resistant containers. Ethanol concentration in mouthwashes can be as high as 26.9%. Poison control centers nationwide received 12,043 reports of cases of accidental ingestion of these products from 1989 to 1993. It is important to note that the health benefit of mouthwash use by children has not been scientifically established.

The ADA, the American Academy of Pediatrics and the American Association of Poison Control Centers have all spoken in support of special packaging standards for mouthwashes containing more than 5% ethanol. Numerous manufacturers have already started to implement special labeling and product protection procedures. In addition, the ADA's Council on Dental Therapeutics revised the ADA Seal of Acceptance guidelines to provide that any mouthrinse with an ethyl alcohol content of more than 5% must be packaged in bottles with child-resistant caps. Therefore, be it

70. Resolved, that the American Dental Association actively review the matter of over-the-counter ethanol-containing mouthwashes, both with and without the ADA Seal of Acceptance, to assure that these materials have appropriate safety caps and warning labels.

Thirteenth Trustee District

Dental Hygiene Education

The following resolution was submitted by the Thirteenth Trustee District and transmitted on July 27, 1994 by Mr. Mark D. Alcorn, assistant executive director, California Dental Association.

Background: Over the course of the last 20 years, the dental hygiene needs of our society have grown significantly, yet there has been very little change in the number of hygienists matriculating from hygiene educational programs. Clearly, the need for dental hygiene services are geometrically greater today than they were in the past.

Nearly every dental constituent and component in the country has recognized serious shortages in dental hygiene manpower, and is struggling to find solutions to an already serious problem. Some dentists are forced to handle more hygiene and fewer restorative procedures, and to pay exorbitant fees for hygiene services. Further compounding the problem, public educational systems generally lack the financial resources necessary to help solve this problem.

The shortage of dental hygiene educational programs would be eased if more academic institutions were permitted to be accredited. However, Accreditation Standard 1 of the Accreditation Standards for Dental Hygiene Programs provides that only not-for-profit colleges and universities may be accredited. Although it is possible for proprietary schools to petition the Commission on Dental Accreditation for an exception to the "not-for-profit" rule, the Thirteenth District believes that if this standard is eliminated or lessened, the demand for these programs will result in new programs being established at proprietary colleges and universities across the country. Clearly, this would be beneficial to the profession and the public. Therefore, be it

71. Resolved, that the American Dental Association shall petition the Commission on Dental Accreditation to remove the words "not-for-profit" from Accreditation Standard 1 of the Accreditation Standards for Dental Hygiene Programs.

Thirteenth Trustee District

Expansion of an Electronic Dues Payment Program

The following resolution was submitted by the Thirteenth Trustee District and transmitted on September 14, 1994 by Mr. Mark D. Alcorn, assistant executive director, California Dental Association.

Background: In 1992, at the urging of the Thirteenth District, the ADA House of Delegates adopted Resolution 62H (*Trans.* 1992:589, 601). The resolution instructed the California Dental Association (CDA) to adopt an electronic

debit installment program for the purpose of members paying 1994 dues. Attached to this resolution is a final report on the California Dental Association's electronic dues payment (EDP) program including the various steps taken in establishing the program and a demographic overview of EDP participants (*Supplement*:360, 361, 362, 363).

Resolution 62H required a suspension of the *ADA Bylaws* in order for CDA to conduct this program, making it allowable for CDA members participating in the program to pay their dues over an eight-month program. Under Resolution 62H the suspension of these *Bylaws* will expire at the adjournment *sine die* of the 1994 House of Delegates, unless amendments are adopted with respect to all constituents.

With nearly 10% of CDA's members participating in the program, there is no question as to the value of a monthly dues program. CDA is currently preparing its 1995 dues billing and the EDP program is included as an option; an even greater response is anticipated this year.

The ADA Council on Membership reviewed the CDA EDP program and raised concerns over modification of the Association's *Bylaws* which would allow for payment of dues into June of each year. The *Bylaws* currently state that dues are due and payable on January 1 and that an individual ceases to be a member if dues have not been paid by March 31. However, because of late payments, the current dues payment system prevents the ADA from "officially" dropping a nonrenewing member until July of each year. If this is currently the situation, it does not appear that modifying the *Bylaws* to accommodate the EDP program will in reality effect the July drop date currently used by the ADA. The only members who will be allowed to "pay" beyond March 31 will be those participating in an automatic debit program. This in fact was the system employed this year in processing CDA EDP participants and it was accomplished with relative ease. Changing the *Bylaws* to reflect what is current practice does not seem unreasonable.

The issue of more critical concern to the Council on Membership was the ADA's potential revenue shortfall if an EDP program ran December through June. The delay in receiving the funds generated through the EDP program presents a budgeting challenge, but does not necessarily reflect a shortfall since all funds owed (perhaps more) will be paid, but over a longer period of time. Appropriate budget adjustments can accommodate this change.

If the ADA and its constituents are going to maintain the membership levels so diligently earned over the past few years, more flexibility in dues payment options will be required.

As dues continue to increase, our members expect and will benefit from methods of payment which allow them to spread the cost of being a member out over a period of time. For these reasons, the Thirteenth District recommends adoption of the following resolution.

86. Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS of the *Bylaws* be amended at line 307 as follows:

A. ACTIVE MEMBERS.* The dues of active members shall be three hundred thirty dollars ($330.00) due January 1 of each year** except that active and active life members may participate in a constituent-sponsored electronic debit installment plan with equal monthly installments commencing in December and payable in full by June 30 of each year. Any dentist, who satisfied the eligibility requirements for...

and be it further

Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection I. LOSS OF MEMBERSHIP AND REINSTATEMENT, of the *Bylaws* be amended at line 409 as follows:

I. LOSS OF MEMBERSHIP AND REINSTATEMENT.

a. An active, active life, retired or student member whose dues have not been paid by March 31 of the current year shall cease to be a member of this Association with the exception of those members participating in a constituent-sponsored electronic debit installment plan, who shall have until June 30 of the current year in which to pay their dues.

Exhibit 1

CALIFORNIA DENTAL ASSOCIATION

REPORT ON THE

PILOT ELECTRONIC DUES PAYMENT PROGRAM

CONDUCTED BY THE

CALIFORNIA DENTAL ASSOCIATION

1993-94

With the approval of the American Dental Association (Resolution 62H), the California Dental Association undertook the directive of the house by providing a dues option for its membership based upon an electronic dues payment (EDP) system.

Development of the EDP program began in earnest in May of 1993 and continued throughout the summer until a letter to the membership was mailed in mid-September. Joint meetings between CDA's finance, data processing and membership departments were held frequently to ensure that potential problems were identified and considered from the various perspectives.

The CDA program provided installment payments over a period of seven months (December to June). Eligibility to participate in the EDP program was extended to all members with an anticipated 1994 dues amount in excess of $168.00.

Eligible members were first notified of the program in September of 1993 via a letter from the CDA president and an application form (Attachment A). The application was a simple, one-page form which requested banking information and required that a voided check be affixed. The timeframe required that the application be returned to CDA by October 4, 1993.

A special invoice was mailed on October 18, 1993 to all those who returned their application by the deadline (Attachment B). The invoice listed the 1994 required and optional dues amounts. Members were asked to indicate the total amount they wished included in the EDP program. (Required dues plus optional dues amounts, i.e., CalDPAC, Alliance.) This document needed to be returned to us by November 12, 1993. No payment was required with the dues invoice.

The return of the special EDP invoice coupled with the already submitted bank information was all the information required from the member in determining their monthly debit.

Electronic debits began on December 15. The total dues amount indicated on the dues invoice was debited from their accounts via seven equal monthly installments. The final debit occurred on June 15, 1994.

1201 K Street Mall
Post Office Box 13749
Sacramento, CA 95853

Telephone
916/443-0505
800/736-8702

Fax
Number
916/443-2943

Attachments A and B, sample forms used in the EDP program, are not reproduced in this publication.

Exhibit 1 (continued)

Beginning with the first payment in December through the final payment in June, members were considered paid-in-full for purposes of membership benefits. The computer programming developed for purposes of this program reflected that these members were paid-in-full and therefore, granted benefits such as scientific sessions, insurance, etc. Membership cards were mailed to them after completion of the first debit.

A total of 1,967 doctors originally signed up to participate in the EDP plan. This figure represents approximately 12% of CDA's total membership. However, upon receipt of the dues billing, several members who had originally signed up to participate in the plan opted to pay their dues in full prior to the first debit.

The final number of participants on the EDP plan at the first debit was 1,660. The total number of participants still participating in the plan upon the June debit was 1,632. Some members were removed from the plan due to three non-sufficient fund notifications. Others simply paid their dues in full sometime between December and May.

Of the 1,632 members who participated in the plan, 84% were general dentists. Two-thirds (1,081) of the participants were age 35 - 54 with only 12% under age 34 and 22% over 55.

All thirty-two of CDA's component dental societies were represented in the EDP program. Additionally, 61% of our members who participated in a previous dues financing program through a local bank also participated in the EDP plan.

Prior to implementing the program in September of 1993, several tasks required completion. Listed below are the steps taken in development of the electronic dues payment program:

1. CDA invited a Request for Proposal from local financial institutions for handling of the EDP. Selection criteria were established which included a review of the services offered by the financial institution, the cost of those services and consideration of existing financial arrangements. Attachment C details the selection criteria employed by CDA in evaluating the proposals.

   Because of existing relationships with several banks, CDA chose to work with a current banking partner. As a result, the bank waived the set-up and maintenance fees normally associated with an electronic dues payment program.

2. A reprogramming of the CDA membership system was required to allow posting of partial dues payments. Other programming changes and modifications included:

   - Creation of a partial payment report
   - Modification of all other payment reports

Exhibit 1 (continued)

- Modification of political donation reporting procedures in relation to partial payments (i.e., reporting procedures to the Fair Political Practice Commission and the Federal Election Commission had changes)
- Creation of software to process payments with the financial institution
- Modification of the dues billing program
- Modification of ADA-CDA telecommunication procedures
- Modification of the existing dues payment posting program
- Modification to the membership drop procedures to allow EDP participants to continue payment after drop deadline of March 31.
- Modifications to component telecommunications regarding partial payments

3. In addition to programming and report modifications, the implementation of this program required decisions on several matters including:

   - Minimum dues amount for eligibility in the program
   - How to handle situations involving closed bank accounts and/or non-sufficient fund notifications
   - Modifications to the CDA billing process including developing of EDP billing statements and related materials and the costs associated with their development, i.e. printing, postage, etc.
   - Publication and announcement of program to membership through CDA *Update*

Costs associated with the program included those associated with the special mailing to eligible participants as well as costs from the financial institution. Some of these costs are outlined below:

Per Transaction:	Electronic debits - $.09/item
	Returned item report transmission - $5.00 per transmission
	Deletions - $15.00 each
	Reversals - $15.00 each

Another financial consideration for other constituents considering this program is computer programming costs. CDA used existing staff in developing computer programming. For those who do not have computer staff, additional costs may be associated.

Finally, there are financial considerations as a result of reduced interest earned when members pay over a period of time rather than all at one time.

A follow-up survey has been mailed to those participating in the EDP program to determine the level of membership satisfaction. Preliminary results reflect the membership perceives the EDP program as an excellent service and that they will participate in the program again in paying their 1995 dues.

Attachment C

California Dental Association
Electronic Dues Payment
Pilot Project

Financial Institution - Selection Criteria

1. Services offered:

    - Expertise in and experience with ACH transaction processing
    - Ability to implement project utilizing CDA-developed software
    - Reporting capabilities
    - Extent of technical support available

2. Cost of services:

    - Set-up
    - Maintenance
    - Transaction

3. Consideration of existing financial institution arrangements.

Thirteenth Trustee District

Management Responsibility of the Board of Trustees

The following resolution was submitted by the Thirteenth Trustee District and transmitted on October 20, 1994 by Mark D. Alcorn, assistant executive director, California Dental Association.

Background: In recent years, the ADA House of Delegates has seen a number of proposed resolutions declared "out of order" based on the rationale that the subject matter of the resolution is a "duty" and/or subject to the "management responsibility" of the ADA Board of Trustees. The makers of this resolution are concerned that the respective authority and duties of the House of Delegates and Board of Trustees in this area have, over time, become unclear. As a result, the authority of the House of Delegates to make policy and/or mandates appears to be eroding, while the authority of the Board of Trustees to manage the Association unfettered by House of Delegates' policy and/or mandates appears to be expanding.

To cite a specific example, Resolution 33 (*Supplement*:328), entitled "Expansion of the Dues Payment Program" resolves that the ADA expand the Dues Payment Program to include dentists out of school for less than ten years. The Board of Trustees' comment on Resolution 33 notes that "...Resolution 33 as written is not in order because it is the management responsibility of the Board of Trustees to direct decisions about the Association's financial services programs." The Board goes on to state that Resolution 33 "...would need to be amended to read that the Board of Trustees be *urged* to expand the Dues Payment Program as described" (emphasis added). In short, the Board seems to take the position that it has the exclusive right to make policy in areas of "management responsibility."

The makers of this resolution take no position regarding Resolution 33. Rather, they rely on the plain meaning of the *Constitution* and *Bylaws* as the basis for their belief that the Board does not have the exclusive right to make policy in areas of "management responsibility." Although fully supportive of the role of the Board to manage and administer the programs of the Association, they do not believe that the "management responsibility" of the Board takes precedence over policy and mandates of the House of Delegates.

Review of the following summary of authorities will assist delegates in analyzing this matter:

Role of the House of Delegates. The ADA House of Delegates is the "supreme authoritative body" of the Association (*Bylaws*, Chapter V, Section 40A). It is also described as "the legislative and governing body" of the Association (*Constitution*, Article IV, Section 10). As the supreme authoritative body, the House of Delegates "shall determine the policies which shall govern this Association in all of its activities" (*Bylaws*, Chapter V, Section 40C).

Role of the Board of Trustees. The Board of Trustees is "the administrative body" of the Association (*Constitution*, Article IV, Section 20). It is also the "managing body of the Association, vested with full power to conduct all business of the Association" (*Bylaws*, Chapter VII, Section 90). However, the powers of the Board of Trustees are expressly "subject to...the mandates of the House of Delegates" (*Bylaws*, Chapter VII, Section 90A). In no instance is the Board granted an exclusive right to make policy. In contrast, the authority of the House to make policy applicable to all Association activities is set forth expressly in the *Bylaws*.

Based on the above, it is clear that the House is empowered to make policy relating to any Association activity. It is also clear that the powers of the Board of Trustees, including the "management responsibility" and/or power to conduct the business of the Association, are subject to the mandates of the House. An exception would occur if an action or mandate of the House of Delegates is inconsistent with the *Constitution* or *Bylaws*, in which case the House would be required to change the *Bylaws* prior to enacting the mandate or policy.

Application of these principles to Resolution 33 results in a different conclusion than that reached by the Board: Expansion of the Dues Payment Program is clearly an "Association activity," which is subject to policy established by the House. The House has properly involved itself with alternative dues payment plans for years (*Trans.*1987:486; 1988:456; 1992:589, 601; 1984:515; 1990:530), notwithstanding the duty of the Board to oversee administration of those programs. The Board specified no provision of the *Constitution* or *Bylaws* violated by the proposed resolution. As such, there is no basis for the Board's claim that the proposed resolution is out of order because it encroaches on an area of "management responsibility" of the Board.

The same is true generally: The role of the House is to establish policy, and the role of the Board is to administer it. No provision in the *Constitution* or *Bylaws* grants the Board *exclusive* authority to establish policy in any area, as the Board seems to claim. In order to clarify this matter and prevent future misinterpretations of the *Bylaws* in this area, the following resolution is moved. Therefore, be it

130. Resolved, that Chapter VII. BOARD OF TRUSTEES of the *Bylaws* be revised by amending Section 90. POWERS, to read as follows:

Section 90. POWERS:
A. The Board of Trustees shall be the managing body of the Association, vested with full power to conduct all business of the Association, subject to the laws of the State of Illinois, the *Articles of Incorporation*, the *Constitution* and *Bylaws* and the mandates of the House of Delegates. The power of the Board of Trustees to act as the managing body of the Association shall not be construed as limiting the power of the House of Delegates to establish policy governing this Association in all its activities, including areas enumerated in these *Bylaws* as powers and/or duties of the Board of Trustees.

Thirteenth Trustee District

Annual Session Site Selection Criteria

The following resolution was submitted by the Thirteenth Trustee District and transmitted on October 20, 1994 by Mr. Mark D. Alcorn, assistant executive director, California Dental Association.

Background: The ADA, most ADA constituents and many components hold annual membership/scientific meetings. The ADA's annual session is held concurrent with its House of Delegates. Various constituents or societies within the constituents, e.g., California, Illinois, New York and Massachusetts, hold internationally acclaimed scientific sessions. In all instances these meetings represent critical membership activities, and the source of substantial revenues. For these reasons and others, the choice of site for each ADA annual session is of major interest, with ADA and constituents/components major stakeholders in this matter.

The matter of selecting a site for the ADA annual session has become increasingly complex over the last 15 years. Most constituents/components are willing to welcome an ADA annual session on occasion (for example, California's agreement to host the ADA meeting in San Francisco in 1993, 1998 and 2003) though some find the ADA meeting disruptive to their own major meeting.

It is recognized that ADA desires to select sites which will draw the largest number of dentists, vendors and other visitors. The need to select a "popular" meeting site can have a disproportionate negative impact, to the point of weakening some constituents' meetings and interfering with constituent/component meeting planning and contracting.

In light of the complexity and critical interests involved in these matters, the California Dental Association believes that site selection should be made with the consent of the constituent in which the annual session will be held. Current ADA policy (Resolution 87H-1990) states that procedures for selecting sites for its annual sessions include formal written notice to every constituent dental association with a site under initial or subsequent consideration by ADA, and that the constituent society be afforded the opportunity to participate in discussions leading to site selection. Adding to this policy a constituent's consent to hold an ADA annual session within that constituent will cultivate cooperation and coordination of the meetings, and protect the interests of constituents in their meeting planning arrangements. Adoption of this policy should have no adverse impact on ADA since numerous premium site options are available throughout the country.

For the reasons set forth above, the following resolution is proposed.

131. Resolved, that the annual session is a major benefit of membership of the American Dental Association, that the Association has an obligation to serve all its members by taking its annual session to all regions of the country, and that to attain the objective of offering the premier dental meeting of the world, the Board of Trustees shall determine and select the date and location of the annual session in accordance with the site selection criteria of the Council on ADA Sessions and International Relations and subject to the following guidelines:

1. ADA shall provide written notice to every constituent/component dental society having a site within its boundaries that is under initial or subsequent consideration by the ADA.
2. Upon receipt of a notice of site consideration by a constituent/component dental society, the constituent/component shall be afforded an opportunity to participate in ADA discussions relating to site selection.
3. The constituent/component dental society shall initiate an invitation to the ADA to hold its annual session at the site under discussion.
4. In the event that Guideline 3 cannot be achieved in good faith and in due diligence, because no constituent/component invitation is received, the site is not available on the appropriate dates, or a reasonable site rotation schedule cannot be achieved, the Board of Trustees shall not be precluded from exercising its *Bylaws* responsibility to select an appropriate site that meets the site selection criteria for an ADA annual session.

and be it further
Resolved, that Resolution 87H-1990 (*Trans.*1990:530) is rescinded.

Fifteenth Trustee District

Amendment to Resolution 35: Preamble to the Dental Practice Parameters

The following amendment to Resolution 35 (*Supplement*:273) was adopted by the Fifteenth Trustee District and submitted on October 22, 1994 by Dr. Fred Aurbach, delegate.

Background: Amend the last paragraph of the Preamble to the Dental Practice Parameters documents.

35S-1. Resolved, that the Preamble to the Dental Practice Parameters documents be amended by adding the phrase "in order to include all dental conditions and to accommodate" after the word "parameters,"; deleting the phrase "substantiating them, whenever possible, with oral health outcomes data, and with" in the second line of the last paragraph; and deletion of the last sentence, so that the amended last paragraph reads as follows:

> The Association intends to continually develop, revise and maintain parameters, in order to include all dental conditions and to accommodate advances in dental technology and science.

Fifteenth Trustee District

Substitute for Resolution 55: Definition of Fee-for-Service

The following substitute for Resolution 55 (*Supplement*:322) was adopted by the Fifteenth Trustee District and submitted on October 22, 1994 by Dr. Fred Aurbach, delegate.

Background: By the definition submitted, a dentist receiving 80% of his or her full fee would be practicing fee-for-service dentistry because the 80% is "based" on his or her fee. True fee-for-service is when the dentist establishes the fee and receives the fee in full from the patient, or the patient's representative. (There is no "third-party" discounting, questioning or otherwise interfering in the doctor/patient relationship.) Therefore, be it

55S-2. Resolved, that the following be the definition of Fee-for-Service:

> *Fee-for-Service.* A method of reimbursement by which the dentist establishes and expects to receive his or her full fee for the service performed.

Fifteenth Trustee District

Addition to Strategic Plan

The following resolution was submitted by the Fifteenth Trustee District on October 22, 1994 by Dr. Fred Aurbach, delegate.

Background: Even though the background statement to Board Report 8: Strategic Planning (*Supplement*:435) indicates that visioning is a part of proper strategic planning, the ADA Strategic Plan does not contain a vision for the ADA or for dentistry. A vision should be both directing and energizing; the vision should present the desired future for the American Dental Association and for the profession of dentistry. The vision should offer a clear image of what the ADA could and should become if it were to realize its full potential; therefore, be it

137. Resolved, that the Strategic Planning Committee of the ADA develop a Vision for Dentistry and the American Dental Association and that such vision be included in the Strategic Plan of the ADA.

Fifteenth Trustee District

Amendment to Strategic Plan

The following resolution was submitted by the Fifteenth Trustee District on October 22, 1994 by Dr. Fred Aurbach, delegate, Fifteenth Trustee District.

Background: The individuals identified in Objective 4 (*Supplement*:438) of the Strategic Plan may have "economic disadvantages, ranging from lack of private insurance, to a lack of availability of adequately funded public programs..."; to use the term "economic disadvantages" is enough said. Lack of private insurance or publicly funded programs does not constitute a barrier. Dentistry is a matter of priority in most instances. By relying on private insurance (usually provided by an employer), we are fostering the idea that dental care is the responsibility of someone other than the patient. We need to emphasize the personal responsibility and choice by the individual. Therefore, be it

138. Resolved, that the rationale section of Objective 4 of the Association's Strategic Plan be amended by deletion of the phrase "ranging from lack of private insurance, to lack of availability of adequately funded public programs" so the Rationale would read:

> These individuals may: 1) have economic disadvantages; 2) have medically complex or handicapping conditions; 3) be institutionalized or homebound; 4) have geographic barriers, including remote area residents, transients and migrant populations; 5) have educational barriers; 6) have cultural barriers, including language difficulties; and/or 7) have psychological barriers, ranging from mild anxiety to dental phobias.

Delegate James O. Henry, Jr., Texas

Substitute for Resolution 25: Approval of 1995 Budget

The following substitute resolution was submitted on October 24, 1994 by Dr. James O. Henry, Jr., delegate.

Background: See Board Report 2: ADA Operating Account Financial Affairs and Recommended Budget, Fiscal Year 1995 (*Supplement*:382). This substitute resolution is presented as a method to start our House of Delegates deliberations with a balanced budget. This would place a greater fiscal responsibility on the House of Delegates to then fund any new expenditures we approve during the remaining 1994 House of Delegates meeting.

The balancing of the budget would be accomplished by taking $2,073,000 from our Restricted Investment Account to balance the $1,900,000 deficit and the $173,000 approved by the Board of Trustees and added to the 1995 budget expenses in the Supplement to Board Report 2 (*Supplement*:424). At the end of Fiscal 1993, we had a budget surplus of $5,097,884 of which $2,459,789 was due to savings from employee compensation. Since the $1,900,000 projected deficit for 1995 was mainly due to a $2,651,900 increase in employee compensation, it seems to be a good fiscal move to use $2,073,000 from that money in our Restricted Investment Account to balance our 1995 budget.

25S-1. Resolved, that the Recommended Budget for Fiscal Year 1995 be referred back to the ADA Board of Trustees with the recommendation that the $2,073,000 budget deficit be funded by the use of $2,073,000 from our Restricted Investment Account instead of a dues increase.

American Academy of Implant Dentistry

Ethical Announcement of Credentials Earned from Bona Fide Entities

The following resolution was submitted by the American Academy of Implant Dentistry on October 6, 1994 and transmitted by Mr. J. Vincent Shuck, executive director.

Background: The current *ADA Principles of Ethics and Code of Professional Conduct* (the "*Code*") appears to prohibit the publication of credentials obtained from bona fide entities in nonrecognized specialty areas.

Section 5(A) of the *Code of Professional Conduct* relates to professional advertising. Advisory Opinion 4 states:

> A dentist using the attainment of a fellowship in the direct advertisement to the general public may be making a representation to the public which is false or misleading in a material respect. Such use of a fellowship status may be misleading because of the likelihood that it will indicate to the dental consumer the attainment of a specialty status. It may suggest that the dentist using such is claiming superior dental skills.

Accordingly, the opinion restricts the use of fellowship status to scientific papers, curriculum vitae, letterhead and stationery, etc.

Section 5(C), relating to the announcement of "specialization and limitation of practice," reflects a similar prohibition in Advisory Opinion 1. That opinion states:

> A dentist who announces in any means of communication with patients or the general public that he or she is certified or a diplomate in an area of dentistry not recognized by the American Dental Association or the law of the jurisdiction where the dentist practices as a specialty area of dentistry is engaged in making a false or misleading representation to the public in a material respect.

Therefore, a dentist who attains such credentialed status (certification or diplomate) from a bona fide organization is precluded by the *Code* from announcing these credentials to the public.

Recent judicial decisions have confirmed a professional's right to publish credentials obtained through bona fide entities [*Ibanez v. Florida Department of Business & Professional Regulation, Board of Accountancy*, ____U.S. ____, 114 S.Ct. 2084 (1994); *Peel v. Attorney Registration and Disciplinary Commission of Illinois*, 496 U.S. 91 (1990); et al.] Similarly, many state dental boards acknowledge a dentist's right to announce credentials obtained through bona fide entities. The aforementioned judicial decisions and state board pronouncements have all occurred since the Council on Dental Education/Council on Ethics, Bylaws and Judicial Affairs (CDE/CEBJA) submitted a joint report to the 1988 House of Delegates that reflected a diversity of opinion and a lack of general support for addressing this issue (*Reports* 1988:130).

Due to the ADA's support of ongoing education and achievement by dentists, the relevance of current case law dealing with the announcement of professional credentials and the benefit the public would derive by receiving truthful information concerning credentials obtained from bona fide entities, it is recommended that the ADA undertake a study concerning the feasibility of amending the *Code* to permit the truthful publication of credentials obtained from bona fide entities. In addition, the ADA should develop a mechanism through which it can delineate those credentials and/or entities it deems bona fide and provide guidelines to dentists in the proper use of these credentials.

121. Resolved, that the Council on Dental Education and the Council on Ethics, Bylaws and Judicial Affairs study the need to develop a mechanism to identify how dentists can use credentials earned through experience and examination that lead to special credentials, and be it further

Resolved, that a report describing the outcome of the study be submitted to the 1995 House of Delegates.

Report 1

Association Affairs and Resolutions

This is the first in a series of reports to be presented by the Board of Trustees to the House of Delegates at the 135th annual session.

Appreciation to the Council on ADA Sessions and International Relations and the 1994 Committee on Local Arrangements: The 1994 annual session will mark the fourth time that the Association has met in New Orleans. The Council, with the assistance of the Committee on Local Arrangements, has again created a meeting which gives a wide variety of the finest scientific programs while also providing numerous opportunities for recreation and fun. All those that attend this year's meeting are sure to have a most enjoyable and beneficial experience.

The Board of Trustees wishes to express its sincere appreciation to the members of the Council who under the most capable leadership of their chairman, Dr. Burton J. Kunik, have produced the annual session. Dr. Kunik and the entire Council (Dr. Angelo L. Bilionis, Dr. Morton L. Divack, Dr. Bernard J. Grothaus, Dr. John O. Hudgins, Dr. Edward Leone, Jr., Dr. Richard D. Leshgold, Dr. Patrick S. Metro, Dr. Donald J. Provenzale, Dr. Chris C. Scures, Dr. A. Ted Twesme, Dr. Terence E. Walsh and Dr. Morris C. Yates) should be justly proud of what they have accomplished.

The Board also wishes to specially recognize Dr. Terence E. Walsh, who has served on the Council as general chairman of the Committee on Local Arrangements since 1992, for his part in producing this year's meeting. Dr. Walsh was most capably assisted by Dr. Kenneth G. Schott, vice chairman; Dr. Louis G. Grush, chairman, Program Coordinating Committee; Dr. Vincent N. Liberto, vice chairman, Program Coordinating Committee; Dr. Randolph D. Green and Mrs. Angela Green, co-chairpersons, Committee on Social Activities; Dr. Terry F. Fugetta and Mrs. Cecilia Fugetta, co-chairpersons, Committee on Social Activities; Dr. Anthea L. Grogono, chairperson, Committee on Special Services, and Dr. Lisa P. Germain, vice-chairperson, Committee on Special Services.

The Board of Trustees commends the Council and the entire Committee for their success in producing such a wonderful meeting and, on behalf of all those who attended this year's meeting, applauds their effort.

Deaths of Former ADA Officials: Since the 1993 session of the House of Delegates, the following former official has passed away: Dr. Cyril L. Friend, Jr., ADA past trustee, 1984-1990. The Board of Trustees joins the members of the House in expressing sympathy to the family of our departed friend.

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

Mr. Colin Howard
Dr. Guy-Michel Kadouch
Professor Sir David K. Mason, CBE
Mr. George R. Rhodes
Dr. John W. Stanford
Dr. Declan Thompson
Stephen A. Weinstein, Esq.

Distinguished Service Award: The Distinguished Service Award was established by the Board of Trustees in 1970 and is the highest honor conferred by the Association's Board of Trustees. Only members of the dental profession are eligible for the Distinguished Service Award. Each year the Board of Trustees may select one recipient for the Award. The Board of Trustees takes great pleasure in announcing that the recipient of the 1994 Distinguished Service Award is Dr. James Burrows Edwards.

Dr. James Burrows Edwards, president of the Medical University of South Carolina, Charleston, is an individual who has carried the principle of service to the human race about as far as it will go. He has made lasting contributions to his community, state and country as an educator, former Governor of South Carolina, state senator and U.S. Secretary of Energy during the Reagan administration. While managing these responsibilities, Dr. Edwards also has always found time for his serious commitment to civic and philanthropic activities. His skills in raising charitable funds are legendary. Dr. Edwards is a graduate of the University of Louisville School of Dentistry and the Graduate Medical School of the University of Pennsylvania, Philadelphia, and a diplomate of the American Board of Oral and Maxillofacial Surgery. His numerous honors and awards include the Thomas P. Hinman Distinguished Service Medal, an elementary school in Mt. Pleasant, South Carolina that was named after him, and honorary degrees from ten American colleges and universities.

Retiring Officers and Trustees: The Board of Trustees wishes to express its gratitude to the following officers and trustees for services rendered to the Association during their tenure on the Board: Dr. James C. McGraw, first vice president; Dr. Charles L. Siroky, second vice president; Dr. Thomas O. Sweet, trustee, District 2; Dr. Walter F. Lamacki, trustee, District 8; Dr. William S. Ten Pas, trustee, District 11; and Dr. George S. Payne, trustee, District 13.

Appreciation to Employees: The Board of Trustees is pleased to bring to the attention of the House of Delegates 17 members of the Association staff for their years of service: Sharon A. Carr, Legal Affairs, 25 years; Norman L. Gross, Information Technology, 25 years; Timothy P. Gerster, Maintenance, 25 years; Laurence C. Chow, Paffenbarger Research Center, 25 years; Robert N. Czarnecki, ADA Health Foundation, 20 years; Gerald L. Vogel, Paffenbarger

Research Center, 20 years; Lois Schuhrke, Council on Dental Education, 20 years; James Y. Marshall, Council on Community Health, Hospital, Institutional and Medical Affairs, 20 years; Ming S. Tung, Paffenbarger Research Center, 20 years; Helen McK. Cherrett, Office of International Dental Health, 15 years; Kenneth H. Burrell, Council on Dental Therapeutics, 15 years; Annette Daniel, Information Technology, 15 years; Judy L. Friend, Testing Services, 15 years; Hwai-Nan Chou, Research Institute, 15 years; Theresa L. Campell, Accounting Department, 15 years; William Gasparac, Council on Dental Materials, Instruments and Equipment, 15 years; and Linda M. Banas, Department of State Government Affairs, 15 years.

Life Membership: Life members of the Association are automatically notified of their election to Life membership when they become eligible. ADA *Bylaws* (Chapter I, Section 20B) define a Life member as a member in good standing for thirty (30) consecutive or a total of forty (40) years of active and/or retired membership and has attained the age of 65. Life membership becomes effective the year following the year in which the requirements are fulfilled.

There are two categories of Life membership, Active and Retired. Active Life members are dentists who have qualified for Life membership, are still practicing dentistry and have paid Active Life membership dues. Retired Life members are dentists who have qualified for Life membership and are fully retired from dentistry. They pay no dues. In 1993, 1,569 members were elected to Life membership for 1994. As of June 15, 1994, the number of Active Life members is 7,497 and the number of Retired Life members is 17,528 for a total of 25,025 Life members.

1994 Life Members

Constituent	Active	Retired	Total
Air Force		36	36
Alabama	101	126	227
Alaska	3	4	7
Arizona	38	196	234
Arkansas	47	104	151
Army		42	42
California	782	1,919	2,701
Civil Service		6	6
Colorado	66	169	235
Connecticut	201	415	616
Delaware	24	25	49
District of Columbia	57	110	167
Florida	267	468	735
Georgia	90	232	322
Hawaii	93	76	169
Idaho	25	46	71
Illinois	341	831	1,172
Indiana	136	337	473
International	1	6	7
Iowa	73	245	318
Kansas	71	183	254
Kentucky	85	188	273
Louisiana	92	184	276
Maine	29	98	127
Maryland	129	257	386
Massachusetts	317	527	844
Michigan	282	768	1,050
Minnesota	86	412	498
Mississippi	52	91	143
Missouri	112	316	428
Montana	15	80	95
Navy	4	87	91
Nebraska	53	146	199
Nevada	15	30	45
New Hampshire	29	62	91
New Jersey	297	635	932
New Mexico	31	54	85
New York	1,143	2,875	4,018
North Carolina	155	258	413
North Dakota	13	46	59
Ohio	327	770	1,097
Oklahoma	86	164	250
Oregon	88	247	335
Pennsylvania	430	1,019	1,449
Public Health		24	24
Puerto Rico	21	30	51
Rhode Island	50	92	142
South Carolina	62	112	174
South Dakota	14	40	54
Tennessee	142	210	352
Texas	353	623	976
Utah	55	132	187
Vermont	17	44	61
Veterans Affairs	4	115	119
Virgin Islands	2	3	5
Virginia	164	287	451
Washington	143	412	555
West Virginia	57	100	157
Wisconsin	121	383	504
Wyoming	6	31	37
Total	7,497	17,528	25,025

Retired Membership: Active members of the Association may be elected to Retired membership status in accordance with ADA *Bylaws* (Chapter I, Section 20G). For 1994, 435 active members were granted Retired membership status. As of June 15, 1994 the total number of ADA Retired members is 2,216.

1994 Retired Members

Constituent Society	Total	Constituent Society	Total
Air Force	67	Illinois	103
Alabama	20	Indiana	41
Alaska	5	International	10
Arizona	23	Iowa	30
Arkansas	10	Kansas	13
Army	49	Kentucky	33
California	378	Louisiana	17
Civil Service	8	Maine	11
Colorado	32	Maryland	40
Connecticut	30	Massachusetts	48
Delaware	1	Michigan	102
District of Columbia	3	Minnesota	61
Florida	103	Mississippi	10

1994 Retired Members (continued)

Constituent Society	Total	Constituent Society	Total
Georgia	26	Missouri	31
Hawaii	4	Montana	13
Idaho	5	Navy	95
Nebraska	14	Rhode Island	3
Nevada	6	South Carolina	13
New Hampshire	6	South Dakota	6
New Jersey	25	Tennessee	27
New Mexico	6	Texas	56
New York	145	Utah	13
North Carolina	31	Vermont	5
North Dakota	7	Veterans Affairs	18
Ohio	85	Virgin Islands	1
Oklahoma	19	Virginia	44
Oregon	44	Washington	50
Pennsylvania	72	West Virginia	5
Public Health	28	Wisconsin	57
Puerto Rico	5	Wyoming	4
Total			2,216

Nominations to Councils and Commissions: In accordance with Chapter VII, Section 100(H) of the *Bylaws*, the Board of Trustees presents the following nominations for membership on the councils and commissions of the Association. In response to the directive from the House of Delegates (*Trans.*1980:588), the Board is submitting a brief statement of qualifications for each nominee.

Council on ADA Sessions and International Relations

Dickinson, Terry D., Texas, 1998: Dr. Dickinson's interest in meeting planning began in 1973 when the ADA's annual meeting was held in Houston, Texas. He served as chairman of the Preventive Dentistry Center at that meeting. Since that time he has spent seven years working with all aspects of the Greater Houston Dental Meeting and served as general chairman twice (1983, 1993). He was appointed as the first chairman of the Academy of General Dentistry's Council on Annual Meetings and International Conferences in 1984. He has served as chairman of that Council for a period of five years and in 1992 served as both Council chairman and local arrangements chairman of the AGD's annual meeting in San Antonio, Texas. His personal involvement in the exhibit portion of that meeting set a record for the number of booths sold at an annual meeting. During this same year he was general chairman of the first International Conference on Computers in Dentistry held in Houston, Texas. He currently is serving as chairman of the Lone Star Dental Conference held annually in Austin, Texas. His other accomplishments include serving as president of the Greater Houston Dental Society; director and vice president of the Texas Dental Association; member of the Texas State Board of Dental Examiners for six years; and was twice nominated for Texas Dentist of the Year. He is a member of both the American and International Colleges of Dentists.

Erickson, Jerome A., Minnesota, 1998: Dr. Erickson is a full-time general practitioner. He has been active in organized dentistry throughout his career and has served on many committees and councils of the Minneapolis District Dental Society, and the Minnesota Dental Association. He has been a long-term member and former chairman of the Minnesota Dental Association's Scientific and Annual Sessions Committee. This Committee is responsible for presenting the annual "Star of the North Meeting," which has evolved into a regional meeting for the upper Midwest. This meeting attracts approximately 9,000 registrants and more than 300 commercial exhibitors annually. In 1990 the Star of the North Meeting won the ADA Golden Apple Award for meeting excellence. Members of the Committee serve for six years and during their tenure participate in each of the major committee functions, including program development and organization, scouting other meetings and speakers, finance, commercial exhibits, and social events. Dr. Erickson has represented the Star of the North Meeting at the ADA Conference on Dental Meetings. In addition, he comes by his involvement in dental meetings genetically. His father, Dr. Donald Erickson was a distinguished member of CASIR for many years in the early 1970s.

Dr. Erickson also has considerable experience in international dentistry. He has lectured on clinical and practice administration topics in Scandinavia, and has spent six weeks as a volunteer dentist at a mission in Zaire. He is a recipient of the ADA Certificate of Recognition for Volunteer Service in a Foreign Country for his activities in Zaire.

Kirk, Ann B., Massachusetts, 1998: A magna cum laude graduate of Baltimore College of Dental Surgery, Dr. Ann B. Kirk has had 16 years of experience in planning and directing the various elements of one of the premier dental meetings in the country, the Yankee Dental Congress (YDC). Most recently, Dr. Kirk served as YDC's General Chairperson for 1994. Since 1983, Dr. Kirk has served as chairperson of several of the major components of the YDC, including the Education Program, Special Events and Hospitality, as well as serving as a member of the Scientific Committee. Her chairmanship of the 1994 YDC resulted in the largest and most comprehensive Congress in its 19-year history.

Her preparation for membership on the Council on ADA Sessions and International Relations (CASIR) is further strengthened by her work with the Local Arrangements Committee in its consultations with CASIR when the ADA annual session was held in Boston in 1990. That work allowed her to experience first-hand the complexities of changing venues, the blending of staff and solving the unique problems that arise each year. Additionally, Dr. Kirk also has personal experience in the delivery of dentistry in a third world country having served as medic/dentist in a remote Honduran village. That experience, combined with other international travel, enhances her preparation for the Council's responsibilities in the area of international relations.

A member of the L.D. Pankey Alumni Association, Dr. Kirk has recently qualified for her fellowship in the Academy of General Dentistry. These achievements, along with fellowship in the American College of Dentists and the Pierre Fauchard Academy and membership in the American Association of Women Dentists, signal her lifelong commitment to education and leadership within organized dentistry. Dr. Ann Kirk's unique blend of intelligence,

experience and commitment to continuing education make her an outstanding candidate for a position on the CASIR.

Council on Communications

Bowers, Donald F., Jr., Ohio, 1998: Dr. Donald Bowers' outstanding contribution to the Council on Communications makes him a natural for reappointment. He is a past president of the College of Diplomates American Board of Pediatric Dentistry and the Columbus Dental Society. He has been active in the House of Delegates of the Ohio Dental Association and ADA alternate delegate. Dr. Bowers has served as editor and columnist for many publications and has authored many books, monographs, papers, articles and abstracts. He received honorable mention from the International College of Dentists Golden Pen Journalism Award in 1983 and 1984 and the Golden Pencil Award in 1985. In 1983 and 1991 he received the William J. Geis Editorial Award.

Pitts, Dan, Alaska, 1998: Dr. Dan Pitts graduated from the University of Nevada, Las Vegas in 1967 and from Emory University School of Dentistry in 1974. He was a captain in the U. S. Air Force. Dr. Pitts was president of the Alaska Dental Society, a member of the Academy of General Dentistry and a delegate to the American Dental Association House of Delegates. He is a spokesperson for the Alaska Dental Society.

Dr. Pitts is on the Advisory Board for the Kenai Peninsula Boys and Girls Club, a member of Big Brothers of Alaska and a commercial pilot flight instructor. Currently, he is in private practice in Soldonta, Alaska. Dr. Pitts is married and has two daughters.

Dr. Pitts has served one year on the Council on Communications and is being nominated for a four-year term.

Smith, Richard A., Georgia, 1998: Dr. Richard A. Smith, a 1974 graduate of the University of Tennessee Dental School, maintains a practice of restorative dentistry in Atlanta, Georgia. Dr. Smith has exhibited his commitment to organized dentistry through many district and state offices. He is currently the president of the Georgia Dental Association (GDA). He has also been a member of the GDA Executive Committee since 1985; chairman of the GDA Information/Public Relations Committee for two years; past chairman of the GDA Ad Hoc Committee to Enhance Dentistry's Image; member of the Legislative Strategy Committee; and editor of the GDA journal for six years.

While serving as editor of the publication *GDA Action*, Dr. Smith received the Golden Pencil Award from the International College of Dentists. He has also been published in other periodicals: *ADA News, Chicago Review, L.D. Pankey Alumni News, Journal of the New Jersey Dental Association, Journal of the Vermont Dental Society* and *Update for Dental Editors*. For the past three years, Dr. Smith served as publications chairman for the Thomas P. Hinman Dental Meeting.

Dr. Smith also volunteers to serve on local and state committees. Some of these include: Georgia Secretary of State's Vision 2000; Georgia Oral Public Health Advisory Committee; and the Georgia Coalition for Tobacco Prevention and Control.

On the national level, Dr. Smith is currently serving on the ADA's Consensus Committee for Parameters Review and Council on Communications; he also chairs the ADA's Region IV Task Force to OSHA.

Council on Community Health, Hospital, Institutional and Medical Affairs

Lander, William W., American Medical Association, 1995: William W. Lander, M.D., is in family practice in Bryn Mawr, Pennsylvania. He is an active member of the American Medical Association's Hospital Medical Staff Section and alternate delegate to AMA's House of Delegates. He is a member of the American Academy of Family Physicians and graduate of the University of Pennsylvania School of Medicine.

Mouden, Lynn D., Missouri, 1998: Dr. Lynn D. Mouden is best known as the originator and spokesperson for the Missouri P.A.N.D.A. program, a program recognizing and reporting child abuse and neglect. He was in general private practice from 1975 to 1991 and is currently the associate chief of the Missouri Bureau of Dental Health and an associate clinical professor at the UMKC School of Dentistry. An active member of the Missouri Dental Association (MDA), Dr. Mouden has served on the Board of Trustees; as chairman of the Children's Dental Health Commission; and as chairman of the Public Relations Committee. He was president of the Northwest Missouri Dental Society and is a fellow of the International College of Dentists. He received the ADA Golden Apple Award and was named MDA Dentist of the Year in 1994.

Roberson, Theodore M., North Carolina, 1998: Dr. Roberson received a bachelor of science degree from the University of North Carolina and subsequently graduated from the University of North Carolina Dental School and was inducted into OKU. Dr. Roberson is professor of operative dentistry at the University of North Carolina at Chapel Hill as well as a private practitioner at the school. He is coeditor of the *Art and Science of Operative Dentistry* and has received numerous teaching awards.

He is past president of the Durham-Orange County Dental Society and the Third District Dental Society, and he is currently vice president of the North Carolina Dental Society. Also, he is a member of the American Association of Dental Schools and American Association for Dental Research, and is a fellow of the Academy of General Dentistry, International College of Dentists and the American College of Dentists.

Staley, John, American Hospital Association, 1995: Dr. John Staley is the deputy administrator of the University of Iowa Hospitals and Clinics. He has expertise in managing hospital-based dental programs as part of his responsibilities at the University of Iowa. He also participated in a Robert Wood Johnson Foundation program for expanding hospital-based dental residencies. Other professional activities include involvement in the American Association of Dental Schools.

Stubbs, Paul E., Texas, 1998: While in full-time general dental practice, Dr. Paul Stubbs' volunteer activities in district and state dental organizations are numerous. His

accomplishments and leadership as president of the Texas Dental Association brought legislative accord in the state dental practice act. He has shown broad understanding of health care issues while serving on the Title XIX Dental Care Advisory Board and dental liaison to the Advisory Board of the Texas Institute of Medical Assessment.

After spending time in volunteer dental clinics in Haiti, he became organizer and director of several dental mission trips to the Texas/Mexico border as well as to the Yucatan, Mexico. He is currently a dental staff member of a local hospital and participates locally in dental-related research projects.

Zeringue, Curtis J., Louisiana, 1998: Dr. Curtis Zeringue is a 1968 graduate of Loyola School of Dentistry. Upon graduation, he served two years of active duty in the Army Corps as a general dentist. During his time in the Army he received extensive training in hospital dentistry. Dr. Zeringue continues to use this training in his general dentistry practice. He has been active in his state and local dental associations. He has served on many committees and currently serves as president of the Louisiana Dental Association. Dr. Zeringue has served as an alternate and delegate to the ADA House. Because of his involvement with access programs in his state association, he would be a valuable member to the Council on Community Health, Hospital, Institutional and Medical Affairs.

Council on Dental Benefit Programs

Bates, Bruce D., Minnesota, 1998: Dr. Bates is a full-time general practitioner. He is a former president of the Minnesota Dental Association, and prior to attaining that office, he held several important committee positions in his state and district dental societies, including president of the Minnesota Academy of Practice Administration and chair of the MDA Executive Director Search Committee. Dr. Bates is serving in his second three-year term as an ADA delegate from Minnesota. On two occasions, he has served on the Reference Committee on Dental Care, Practice and Health. He is very familiar with the intricacies of the American Dental Association and its council structure.

Dr. Bates has dealt extensively and effectively with many issues of importance to the ADA, including dental practice and benefits, health systems reform, OSHA, auxiliary recruitment and retention, and insurance. He has earned the respect of his peers and no doubt would demonstrate the same degree of dedication and expertise as a member of this council.

Cohlmia, Ray, Oklahoma, 1998: Dr. Ray Cohlmia is a graduate of Baylor Dental College. Since graduation he has maintained a highly successful general practice. Dr. Cohlmia has been continuously involved in organized dentistry. He has served in all of the offices of the Oklahoma Dental Association (ODA) and has served on many ODA councils. He has been a member of the Council on Dental Care Plans for a number of years and has served as chairman of this Council. Dr. Cohlmia is a preceptor for the Oklahoma University College of Dentistry. He also represents Oklahoma as a member of the Dental Foundation for Research and Education. Dr. Cohlmia's leadership abilities and his previous professional activities ensure that he would be an asset to the Council on Dental Benefit Programs.

Spencer, James E., New York, 1998: Dr. Spencer is a member of OKU at New York University (NYU) College of Dentistry and is a general practitioner in private practice in an area with very diverse dental payment programs. In addition to being a former instructor at NYU, he is a former instructor in the New Jersey College of Dentistry and Medicine's Department of Community Medicine. His activity in continuing education led to several positions of responsibility within the Greater New York Dental Meeting organization and eventually resulted in his being named general chairman. He is also a past president of his component society and a former ADA delegate. Dr. Spencer is currently a member of the ADA's CERP Committee.

Since peer review is an extremely important program within the purview of this Council, Dr. Spencer's experience as chairman of the Dental Society of the State of New York's Peer Review Committee should be of particular interest to the Council. While in that position, he furthered the standardization of the process by personally visiting the components.

Dr. Spencer is well prepared to be an effective member of the Council on Dental Benefit Programs.

Webb, Leslie S., Jr., Virginia, 1998: Dr. Leslie Webb received a bachelor of science degree from the University of Richmond, where he was inducted into Phi Beta Kappa and Omicron Delta Kappa. He received his dental education at the Medical College of Virginia and was inducted into Omicron Kappa Upsilon. He then entered the private practice of general dentistry in Richmond, Virginia.

He has been president of the Richmond Dental Society and will be president of the Virginia Dental Association for 1994-95. Also, he has served as chairman of the Virginia Fellows Committee and has been Virginia chairman of the Pierre Fauchard Academy.

Dr. Webb has been an alternate delegate to the ADA House of Delegates since 1987 and is currently secretary-treasurer of the Sixteenth Trustee District Caucus.

He has served as a member of the Virginia Secretary of Human Resources Task Force to Study Health Needs of School Age Children in Virginia, and he was a member of the Governor's Task Force on Child Health.

Council on Dental Education

Broussard, Jack S., Jr., California, 1998: Dr. Broussard graduated from the University of California, Los Angeles in 1976, and maintains a private practice in Pasadena. He has served his local component, the San Gabriel Valley Dental Society, as a volunteer in various positions, serving as president in 1989. Dr. Broussard has served on the California Dental Association's (CDA) Communications Committee since 1989, having served as its chairman from 1990-92. He currently serves CDA as a Board of Trustees member and delegate to the ADA House of Delegates. Dr. Broussard continues to serve education as a lecturer and research associate at both the University of California, Los Angeles and the University of Southern California. His broad experience and communication skills will make him an

outstanding contributor as a member of the Council on Dental Education.

Council on Dental Practice

Ragan, Robert T., Mississippi, 1998: Dr. Robert T. Ragan received his dental degree from the University of Loyola New Orleans School of Dentistry in 1964. He is in private general practice in Cleveland, Mississippi. During his professional career he has served in several elected positions in the Mississippi Dental Association, including president. He is a fellow of the Pierre Fauchard Academy, International College of Dentists and American College of Dentists. He is currently serving as a regent of the American College of Dentistry and is also a member of the American Academy of Dental Practice Administration.

Dr. Ragan is a past member and chairman of the ADA Commission on Relief Fund Activities. He is currently serving as treasurer of the ADA Fifth Trustee District and as a delegate to the ADA. He has been active in civil and religious organizations in his community, including past president of the Cleveland Rotary Club and the Cleveland Arts Council.

Sherwood, Richard J., New York, 1998: Dr. Sherwood is a general practitioner in a computerized, private suburban practice with a high percentage of time devoted to crown and bridge services. He teaches his staff the laboratory skills such services demand. He is an avid student of continuous education, particularly in the areas of technique and practice management.

Dr. Sherwood is on the staff in the Crown and Bridge Department in the General Practice Residency program of St. Joseph's Hospital. He is a past president of his component society and currently is on his constituent society's Council on Dental Benefit Programs. He served two years as an alternate delegate to the ADA House. He has been a vocal supporter of fee-for-service dentistry. He is a member of both the American College of Dentists and the International College of Dentists.

As to community service, he coached Little League Baseball for four years and Pop Warner Football for four years. He has been a member of the Rotary Club for 28 years and was vice president of the Downhill Ski Racing Club. Dr. Sherwood is also a member of Conservation Developments, Inc. He should be a valuable asset on the Council.

Smith, A. J., Utah, 1998: Dr. A. J. Smith is a practicing general dentist in Salt Lake City, Utah. He graduated from the University of the Pacific School of Dentistry in 1974. Dr. Smith is the immediate past president and currently a trustee of the Utah Dental Association (UDA). He currently serves as a member of the ADA's Consensus Conference on parameters of care. He is the past president of the Academy of LDS Dentists and the Salt Lake District Dental Society. He is a fellow of the International College of Dentists and the Pierre Fauchard Academy.

Dr. Smith is a teaching associate at the L. D. Pankey Institute for Advanced Dental Education and serves as a clinical instructor at the University of Utah. He is also an evaluator for Clinical Research Associates.

Dr. Smith currently chairs a task force on health care reform for the UDA. He is a strong advocate of fee-for-service private practice dentistry.

Werschky, Jay A., Michigan, 1998: Dr. Jay A. Werschky is a 1976 graduate of the University of Michigan School of Dentistry. He currently maintains an active general dental practice in Flint, Michigan. He has served as the president of the Genessee District Dental Society and is a past president of the Michigan Dental Association. In that capacity he had oversight responsibilities for a large number of programs that directly impacted the practicing dentist in Michigan. He has been a delegate to the ADA House of Delegates for the last seven years. He has a keen interest and a broad, in-depth knowledge of those issues that currently and in the future will affect dental practice.

Council on Ethics, Bylaws and Judicial Affairs

Gallagher, William L., California, 1998: Dr. William Gallagher is a 1965 graduate of the University of the Pacific and practices full time in San Francisco. Ethics has been a continuing interest for Dr. Gallagher, who served five years on the Ethics Committee of the San Francisco Dental Society and was chairman for the last three years. Following this, Dr. Gallagher served six years on the Judicial Council of the California Dental Association, including four years as chairman. Other activities include the University of San Francisco and the University of the Pacific alumni groups. He also holds fellowships in the American and International Colleges of Dentists. Dr. Gallagher will make a strong member of the Council on Ethics, Bylaws and Judicial Affairs.

Gillespie, M. Joan, Virginia, 1998: Dr. Joan Gillespie graduated from Trinity College in Washington, D.C. and received her dental education at the Georgetown University Dental School. Subsequently she received a master's in periodontology and was an assistant professor at the Georgetown University Dental School.

Dr. Gillespie served two terms on the Virginia State Board of Dentistry, including two terms as president. She is a fellow of the Virginia Dental Association, the American College of Dentists and the International College of Dentists. Additionally, she is past president of the Northern Virginia Dental Society, Greater Washington Society of Periodontology, Alexandria Dental Society, Fairfax Dental Society and the American Association of Women Dentists. Dr. Gillespie currently serves as an alternate delegate to the ADA House of Delegates.

Mitchell, Lewis, Jr., Alabama, 1998: Dr. Lewis Mitchell, Jr. is a 1973 graduate of the University of Alabama School of Dentistry. After serving two years in the U.S. Public Health Service, he established his dental practice in Gadsden, Alabama in 1975. He is married and he and his wife, Anne, have two children.

Dr. Mitchell has served organized dentistry in numerous capacities in the last 19 years, including president of the Alabama Dental Association in 1992-93, and the Delta Dental

of Alabama in 1979-81. From 1984-94 he served on the Executive Board of the University of Alabama School of Dentistry, and he was the president of the Alumni Association in 1988-89. He served as an ADA alternate delegate from 1990-92.

Dr. Mitchell has also been honored with fellowship in the International College of Dentists (1992) and the American College of Dentists (1994).

His civic and community activities have been quite extensive, including the Kiwanis Club, Quarterback Club, Chamber of Commerce, United Way, YMCA and church activities.

Singer, Lawrence J., Connecticut, 1998: Dr. Lawrence Singer has served the Connecticut State Dental Association (CSDA) for many years as an officer of the Association, president 1978-79, and as a charter member of the CSDA House of Delegates. He is currently serving his second two-year term on the Board of Governors of CSDA. Dr. Singer has been a delegate to the ADA House of Delegates for ten years and an alternate delegate many times. He has been chairman of a special task force that worked to develop a model dental practice act for Connecticut. He is the driving force in the development of a new judicial council for CSDA and has carried out this work with the cooperation and guidance of the ADA Council on Ethics, Bylaws and Judicial Affairs (CBJA). Dr. Singer has developed a means to focus the efforts of the CSDA Council of Ethics, Quality of Care, Peer Review and Dentist's Health Committee so Connecticut dentists might be assured due process when relating with the Connecticut State Licensing Bureau, the Department of Public Health and Addiction Services. Dr. Singer has collaborated with the American College of Dentists' First District Ethics Committee in developing ethics workshops in New England. He directed a New England ethics workshop in cooperation with the Massachusetts Dental Society and the ADA CBJA in 1992. Dr. Singer has served on the CSDA Councils on Ethics, Constitution and Bylaws. He was instrumental in the development of the first peer review manual for the CSDA. Dr. Singer's record of service and experience prepares him well for membership on this council.

Council on Governmental Affairs and Federal Dental Services

Crinzi, Richard, Washington, 1998: Dr. Richard Crinzi graduated from the University of Washington Dental School. He completed his internship and residency at the University of Chicago. He is a diplomate of the American Board of Oral and Maxillofacial Surgery. Dr. Crinzi was president of the Western Society of Oral and Maxillofacial Surgeons. He is on the Washington State Dental Association (WSDA) Dent Pac Board. He is a member of the WSDA Executive Committee and has been president of the Seattle-King County Dental Society.

Dr. Crinzi is in private practice in Redmond, Washington. He is married and has a young daughter.

Kennedy, Scott C., Kansas, 1998: Dr. Scott Kennedy is a 1975 graduate of the University of Missouri at Kansas City School of Dentistry. Upon graduation, he started his general dentistry practice and has been in active practice since. Dr. Kennedy has served in all the offices of the Kansas Dental Association (KDA). He is currently past president. His other KDA affiliations include membership in the Council on Legislation, the Council on Dental Care Programs and the Membership Committee. Dr. Kennedy served as chairman of the Council on Legislation from 1984 to 1986. He served on the Board of Directors of the Kansas Dental Political Action Committee. He was program chairman for the 1993 Dental Association State Meeting. For this meeting, Kansas was awarded the American Dental Association Golden Award for meeting excellence. From 1987 to 1993, Dr. Kennedy served as liaison for the Young Dentist Committee for Kansas. He has served as an alternate and delegate to the ADA House. From 1987 to 1991, he served on the Commission for the Young Professional.

Dr. Kennedy would be an asset to the Council on Governmental Affairs and Federal Dental Services.

Rich, William, Kentucky, 1998: Dr. William "Ken" Rich has been in general practice in Williamstown, Kentucky since his graduation from the University of Louisville in 1975. As an active member of the Kentucky Dental Association (KDA), he has served as: a member of the Executive Board; general chairman of the Kentucky Annual Meeting; chairman of the Council on Legislation; and delegate to the ADA House of Delegates. For the state of Kentucky, he has served on the Governor's Medicaid Advisory Council, the Governor's Task Force on Medicaid and on regional conferences representing the state. He is a deacon of his church, director of his bank and past chairman of the District Board of Health. Dr. Rich is a fellow of the American and International Colleges of Dentists. He received the KDA Presidential Citation Award, Fellowship Award and Outstanding Service Award.

Sykes, Murray D., Maryland, 1998: Dr. Murray Sykes is currently in the full-time practice of general dentistry, in the same location in Silver Spring, Maryland, for the last 26 years. He graduated from Georgetown Dental School in 1964. At this time, he is the president-elect of the Maryland State Dental Association, having just served five years as the speaker of the House of Delegates. He is past chairman and vice chairman of the legislative committee for the years of 1987-93. He has been a delegate to the ADA since 1988. Dr. Sykes is an active Board member of the Donated Dental Services program in Maryland. He is a fellow of the American College of Dentists and the International College of Dentists.

Council on Insurance

Abelson, Sigmund E., California, 1995: Dr. Sigmund Abelson is a 1966 graduate of the University of the Pacific School of Dentistry and an active participant in organized dentistry since then. His contributions to organized dentistry include service in all major chairs of the Los Angeles Dental Society; as a delegate to CDA's House of Delegates since 1973; as a member of CDA's Council on Insurance (1988-94), including service as chairman; as a member of the Board of Directors of CDA's subsidiary, The Dentists Insurance Company; and currently as CDA's Speaker of the House. Dr. Abelson is considered one of CDA's foremost authorities on matters of insurance and business.

Akerson, Harvey A., South Dakota, 1998: Dr. Akerson is a private practice oral surgeon in Sioux Falls. He has a long history of involvement in organized dentistry at the state and local levels as well as in his specialty organization. He has been a member of and has chaired several important committees in these organizations, and, at present, serves as president of the South Dakota Dental Association.

At the state and local levels, Dr. Akerson has been involved in many activities, including peer review, quality assurance, member benefits, insurance and political action. He was a leading force in revising the South Dakota Dental Practice Act in accordance with actions directed by the South Dakota Dental Association's House of Delegates.

Dixon, Mervyn J., Florida, 1998: Dr. Mervyn J. Dixon is in general practice in Fort Lauderdale, Florida. During his professional career he has served his profession in many capacities. During the past 14 years, Dr. Dixon has served as either an ADA delegate or alternate delegate. He has served in numerous capacities in Florida including president of his affiliate and component dental associations; member/chairman/trustee liaison to the Florida Dental Association Council on Association Affairs and trustee of the Florida Dental Association.

He served four years as a member and two years as president of the Florida Dental Association, Inc., the for-profit subsidiary of the Florida Dental Association. This subsidiary deals with numerous member insurance programs in Florida. He holds honorary fellowship in both the American College of Dentists and the Pierre Fauchard Academy.

Niedhamer, Albert C., Ohio, 1998: Dr. Albert C. Niedhamer is a general dentist from Cincinnati and a former president of the Cincinnati Dental Society, having been extremely active in both the Cincinnati Dental Society and the Ohio Dental Association (ODA) for many years and serving frequently in the ODA House of Delegates.

He had held the chairmanship of the Committee on Insurance for the Cincinnati Dental Society since 1968 and had been a member or consultant to the ODA Insurance Committee since 1971. He is a second generation authority on insurance, having succeeded his father (a past president of the ODA) who also was a long-time member of dental insurance committees. Dr. Niedhamer brings a tradition of dedication and expertise to the Council on Insurance.

Sarandria, Donald C., Pennsylvania, 1996: Dr. Donald C. Sarandria is a general practice dentist, a 1957 graduate of the University of Pittsburgh School of Dental Medicine. After graduation he served as a lieutenant commander in the U.S. Naval Dental Corps from 1957-59 and completed a Bethesda Naval Rotating internship in 1958. Upon completion of his military service, he established his practice in Coraopolis, Pennsylvania.

Dr. Sarandria has been consistently active in organized dentistry. He served as treasurer, secretary and president of two different local dental societies, and is currently treasurer of his component, the Dental Society of Western Pennsylvania (DSWP). He has served on the Education Committee, the Government Relations Committee, Professional Assessment Committee and the Insurance Committee. Dr. Sarandria has been on the DSWP Board of Directors since 1980 and held the position of second vice president, choosing then to become treasurer and maintain that position for the Society.

At the state (district) level he has been a delegate to the Pennsylvania Dental Association since 1980. He has served on the PDA Insurance Council since 1979, during some very difficult years, and has an excellent understanding of the insurance field relative to the dental profession.

Dr. Sarandria was on the St. John's Hospital dental staff from 1960 to 1972, and was chief of dental staff in 1965. He is on the Ohio Valley General Hospital Dental staff where he has been affiliated from 1972 to the present.

He served as a clinical instructor at the University of Pittsburgh School of Dental Medicine from 1960-68. He was a dental consultant for Prudential Insurance Company from 1985-89. He has volunteered his expertise as dental consultant to Moon Area School District between 1979 and 1984, and the West Hills Health Care Center from 1984-89.

Stifter, Ronald P., Wisconsin, 1998: Dr. Ronald P. Stifter is a 1967 graduate of the Marquette University School of Dentistry. He is a part-time professor of dentistry at Marquette University and was named the outstanding alumnus at the Marquette University School of Dentistry in 1994. He currently maintains a general dental practice in Milwaukee, Wisconsin. He is past president of the Wisconsin Dental Association (WDA). In that capacity he had oversight responsibilities of the WDA Insurance Program, Inc., which markets and administers various types of insurance programs to the members of the WDA. He served on the Governor's Special Committee on the Future of Dentistry and currently serves on the IOM Study on the Future of Dental Education. He has been a delegate to the ADA House of Delegates for the last seven years and has served on several House of Delegates reference committees. Dr. Stifter brings to the Council on Insurance a broad knowledge of those issues and problems facing the practicing clinical dentist.

Council on Membership

Aronson, I. Leon, Georgia, 1998: Dr. I. Leon Aronson received his dental degree from Emory University School of Dentistry and completed his residency in orthodontics at Saint Louis University. After serving in the Air Force, Dr. Aronson began a practice in Savannah, Georgia. Dr. Aronson has demonstrated his commitment to both the profession and organized dentistry at the component, constituent and ADA level. He was president of the Savannah Dental Society, the Southeastern District Dental Society, Georgia Orthodontic Association and Orthodontic Education and Research Foundation. In 1991, he was president of the Georgia Dental Association (GDA) and promoted member participation and the dental team with his theme, "Harmony, Unity, Teamwork." On the national level, Dr. Aronson has served as an ADA alternate delegate and is currently serving on the ADA Council on Membership.

As GDA president, Dr. Aronson demonstrated his creative thinking in many areas. He was instrumental in the development of a legislative alert audio tape that was mailed to each member. He worked long and hard to negotiate with factions outside of dentistry to arrive at a team solution to problems confronting the profession. His energetic style of leadership coupled with his cheerful disposition made him a welcomed speaker throughout the state.

Dr. Aronson is well versed in membership procedures of the tripartite structure. He has served as chairman of many GDA committees: Annual Meeting, Liaison Committee, Ad Hoc Committee to Study Dental Hygiene Shortage and Ad Hoc Committee to Study Legislative and Political Activities.

Kenneally, Joseph R., Maine, 1996: Dr. Joseph R. Kenneally graduated summa cum laude from the University of New England in 1976. After doing graduate work in microbiology at the University of Maine, he received his dental degree from Tufts University in 1981. Dr. Kenneally is a member of both the Pierre Fauchard Academy and the Academy of General Dentistry.

From the earliest days of his practice, Dr. Kenneally has been interested in and committed to organized dentistry. Completing the offices of his local constituent society by 1986, he became a member of the Maine Dental Association's (MDA) Executive Council in 1987. He rose quickly through the offices of MDA, becoming president of the Association in 1992. In 1993, MDA selected him to become only its second Long Term Delegate to the ADA. Additionally, he chaired the MDA Ethics Committee and served as a panelist on the Institute of Medicine's study, Educating Dentists for the Future. Dr. Kenneally served on the First Trustee District Reference Committee on Dental Care in 1991 and as chairman of the ADA Reference Committee on Dental Care, Practice and Health in 1992. He was a finalist for the Commission on the Young Professional Leadership Award in 1992.

Among the several MDA councils on which Dr. Kenneally has served, his work as member and chairman of the Membership Council has been extremely important. As chairman, he:

- Directed MDA to cross-reference its membership list with the list of all licensed dentists in Maine. He then sent letters promoting membership to all nonmembers, stimulating additional membership to bring Maine up to a 90% level of participation.
- Expanded the new member welcome packet to better reflect Association services.
- Arranged with the Maine Board of Dental Examiners to send a promotional flyer for the Association to all new licensees.
- Initiated and hosted a Membership Benefits Reception and a Young Dentist Breakfast for Maine's annual meeting.

With an early and proven track record such as this, it is clear that Dr. Kenneally's energy, creativity and initiative will serve the new ADA Council on Membership well.

Laing, Kevin, Ohio, 1998: Dr. Kevin Laing is a bright, articulate 37-year-old dentist who is recognized as a strong, respected voice in the House of Delegates of the Ohio Dental Association (ODA). He is a past president of the Northwest Ohio Dental Society, having served on numerous committees including the membership committee. He is a member of the Ad Interim Committee and the Council of Communications and Public Service of the ODA. He has served as an alternate delegate to the ADA House. The good reports concerning his effectiveness during his short interim term on this committee are clear evidence that he deserves reappointment.

Lee, William E., Kentucky, 1996: Dr. William Lee is in full-time private practice in Lexington, Kentucky with two partners, one of whom is his wife. He is a 1981 graduate of the University of Kentucky College of Dentistry and has a bachelor's degree from Vanderbilt University.

Dr. Lee is staff dentist for the Good Samaritan Hospital Extended Care Facility. He has maintained an appointment to the part-time faculty at the University of Kentucky College of Dentistry since 1986 and has been an active member of the American Dental Association, Kentucky Dental Association and the Bluegrass Dental Society. He has chaired numerous standing committees of his component society including the Executive Board (1988-89) and is currently in his second term as secretary/treasurer. Dr. Lee also has held several positions with the Kentucky Dental Association, including chairs of the Membership Committee and 1993 Fall Meeting Host Committee, as well as delegate from the Bluegrass Dental Society and president of Dental Benefits of Kentucky, Inc. (for-profit corporation of the Kentucky Dental Association for the promotion and marketing of direct reimbursement dental plans to employers of Kentucky). Other professional activities include charter member and founding president of the Kentucky Academy of Laser Dentistry, Sausalito Academy for Oral Rehabilitation and the Bluegrass Study Club. He has lectured to various civic and professional groups on lasers in dentistry, implants and dental benefits.

McGuire, Eugene J., Pennsylvania, 1996: Dr. Eugene J. McGuire is a board certified pediatric dentist, a 1976 graduate of Temple University, practicing in Allentown, Pennsylvania. He belonged to the honor societies in periodontics, pediatrics, oral surgery, and crown and bridge during his years at Temple. He was a member of the American Student Dental Association and is a member of the American Dental Association, Pennsylvania Dental Association, American Academy of Pediatric Dentistry and the American Society of Dentistry for Children.

Dr. McGuire has been on the Executive Committee as well as the Membership Committee of the Lehigh Valley Dental Society since 1978. He has been on the Membership Committee of the Second District Dental Society since 1989. He was 1993 president of the Second District Dental Society of District 3 (Pennsylvania).

He has chaired many committees, state and local, in his dental career, including Pennsylvania Children's Dental Health in 1985 and 1986, and Second District Committees on the Young Dentist and on Women in Dentistry in 1989-91. He has served as delegate to both the PDA and ADA annual sessions.

Dr. McGuire is on the Temple University School of Dentistry Board of Governors and chairman of the ADA Membership Task Force for the Second District Dental Society of Pennsylvania. He is on both the active and the teaching staff at Sacred Heart Hospital in Allentown.

His activities outside dentistry include the Committee for the Annual Bishop's Appeal for the Allentown Diocese since 1987 and the South Parkland Youth Association.

Morgenstern, Thomas F., New Jersey, 1995: Dr. Thomas Morgenstern earned his D.M.D. as a 1966 graduate of the University of Pennsylvania. Following his release from the U.S. Army (1966-68), he completed an orthodontic residency at Columbia University in 1970. Dr. Morgenstern is an active

member of the ADA, the New Jersey Dental Association, the Mercer Dental Society, the American Association of Orthodontics, the New Jersey Orthodontic Society, and the Middle Atlantic Orthodontic Society. He is a member of the American Society of Dentistry for Children, and a charter member of the American Lingual Orthodontic Association. Dr. Morgenstern has held various offices in his state and local dental societies, including Executive Committee member, treasurer and president of the Mercer Dental Society (NJ); and Executive Committee member and trustee of the New Jersey Dental Association. He has served as a delegate to both the New Jersey Dental Association and the ADA.

Sakuma, Karen, Washington, 1998: Dr. Karen Sakuma is a 1979 graduate of the University of Washington School of Dentistry. She has served on and chaired the Public Information Committee of the Washington State Dental Association. Dr. Sakuma has served on the ADA Planning Committee for the annual session, the ADA Strategic Planning Committee, ADA SELECT Partner, consultant to the ADA Commission on the Young Professional, member and chair of the ADA Council on Membership and Communications and is currently a member of the Council on Membership. She was the recipient of the ADA Golden Apple Award for Young Dentists in 1990.

Dr. Sakuma is a fellow of the International College of Dentists and the Pierre Fauchard Academy. She is on the clinical staff of the Harborview Medical Center and the clinical staff of the University of Washington School of Dentistry.

Torchia, James S., Oklahoma, 1998: In 1957, Dr. James Torchia received his dental degree from the University of Missouri at Kansas City School of Dentistry. He received his master's degree in orthodontics in 1959. Since graduation, he has been in continuous practice of orthodontics in Tulsa, Oklahoma. Dr. Torchia has been president of both his component and state dental associations. He has been chairperson of numerous Oklahoma State Dental Association councils including the Council on Membership Recruitment and Retention. He has served as an alternate delegate to the ADA House and is currently a delegate. Dr. Torchia has been active in his dental school alumni association and is serving as a trustee to the alumni association. He has been awarded fellowship in the American College of Dentists and the International College of Dentists. Dr. Torchia has served on the ADA Council on Membership and is being renominated for this position.

Webb, Russell I., California, 1995: Dr. Russell I. Webb is an oral and maxillofacial surgeon who graduated from UCLA in 1978 and completed his surgical residency there in 1981. He has held all the offices of his component, including president in 1991-92. His service includes coordination of his component Mentor Program and member, California Dental Association Council on Membership Services, as well as numerous other committee appointments at the component and constituent level.

Additionally, Dr. Webb is the recipient of numerous awards and honors. He has the skills and interest to serve the ADA as a member of the Council on Membership.

Joint Commission on National Dental Examinations

Johnson, Jane A., West Virginia, 1998: Dr. Jane Johnson graduated from the West Virginia University with a degree in dental hygiene and a D.D.S. degree in 1979, O.K.U. She has been in private general practice in Lewisburg, West Virginia since 1985. Dr. Johnson has served on the State of West Virginia Dentist Provider Medicaid Enhancement Board, was president of the Greenbrier Valley Dental Association. She also served on the Executive Council and is former chairperson of the Committee on the Young Professional of the West Virginia Dental Association.

Committee on the New Dentist

Mericle, Penny, Pennsylvania, 1998: Dr. Penny Mericle has a B.S. in pharmacy from Temple University School of Pharmacy (1980) and a D.M.D. from Temple (1985) as well as an M.S.D. in orthodontics from St. Louis University Medical Center (1987).

She has published and coauthored articles on microbiology, biochemistry and orthodontics/rheumatology. In addition to Alpha Lambda Delta National Honor Society and Rho Chi Honor Society, she was elected to Omicron Kappa Upsilon and the Pierre Fauchard Academy. Along with her American Dental Association membership, she is a member of the American Association of Orthodontists. Dr. Mericle has been an active member of organized dentistry since she was in dental school. She is the first woman ever to be elected president of the Luzerne County Dental Society (local of PDA District 3) and the first female officer in the Third District of the Pennsylvania Dental Association, where she currently serves as treasurer.

She has been an active promoter of and recruiter for organized dentistry. She has had the experience of arranging the programs and speakers for the Third District Dental Society meetings; has served as an alternate delegate to the Pennsylvania Dental Association for the last 5 years; and is very active in the ongoing legislative activities in Pennsylvania.

Dr. Mericle is enthusiastic, persistent and creative; she initiates and follows through with programs and contributes good ideas to any organization.

Robinson, Julie, Alaska, 1998: Dr. Julie Robinson is a 1985 graduate of the University of the Pacific School of Dentistry. She is a general dentist in private practice in Anchorage, Alaska. Dr. Robinson has served as secretary, president-elect and president of the Alaska Dental Society. She also served as president of the South Central Dental Society. Dr. Robinson is a part-time contract dentist with the Anchorage Neighborhood Health Center. She is the mother of two children and is married to fellow dentist, Dr. David L. Nielson.

Stratigopoulos, George J., California, 1998: Dr. Stratigopoulos is a 1985 graduate of the University of Southern California School of Dentistry, where he was the American Student Dental Association representative. In the intervening years, Dr. Stratigopoulos has demonstrated

leadership abilities in his community and professional life. He joined ADA/CDA immediately upon graduation, chairing committees and dedicating himself to the San Diego County Dental Society. The culmination of this endeavor is his service as president in 1994. In addition, Dr. Stratigopoulos serves on the State Board of Dental Examiners as a member of the Committee on Dental Auxiliaries' Site Evaluation Team. His active interest in issues of the new dentist and value as a role model uniquely qualify him for membership on the Standing Committee on the New Dentist.

Welsh, Debra L., Maryland, 1998: Dr. Debra L. Welsh is a 1991 graduate of the University of Maryland Dental School. In 1993, Dr. Welsh earned a certificate in periodontics at the Louisiana State University School of Dentistry. Also, Dr. Welsh is a 1976 graduate of the School of Allied Health Sciences, University of Vermont. Her professional affiliations include membership in the Eastern Shore Dental Association, Maryland State Dental Association, American Dental Association and American Academy of Periodontology. Dr. Welsh is currently an associate in a practice limited to periodontics.

Commission on Relief Fund Activities

Hernandez Oquendo, Francisco, Puerto Rico, 1995: Dr. Francisco Hernandez Oquendo graduated from the University of Puerto Rico with a bachelor of science degree in 1958, a dental degree in 1962 and a master's in public health in 1965. In 1967 he earned a graduate certificate in ecological dentistry from Harvard University School of Dentistry and in 1983 received his Juris Doctor from the Interamerican University of Puerto Rico School of Law. Dr. Hernandez Oquendo has served as chancellor, Medical Sciences Campus, University of Puerto Rico (1992-93); dean, University of Puerto Rico School of Dentistry (1991-92); and director, Department of Ecological Dentistry. He has also served on many committees and boards at the University of Puerto Rico. He is the recipient of the President Award of the American College of Legal Medicine (1994) for Outstanding Services. Currently, he is in a private law practice and serves as Counsellor to the Chancellor of the Medical Science Campus, University of Puerto Rico and legal advisor, Committee on University Law Reform, Academic Senate, Medical Science Campus, University of Puerto Rico.

Sprowl, Harvey D., New York, 1998: During his recent term as president of the Dental Society of the State of New York (DSSNY), Dr. Harvey Sprowl became aware of the increased need for relief fund activities as well as the required documentation, the screening and the limitations. His experience as a teacher of ethics, the moral principles by which a person is guided, is consistent with the philosophy of the Commission.

As DSSNY's treasurer, he became familiar with the system and problems of funding. Because of his experience as chairman of the DSSNY's Board Committee on Constitution and Bylaws he is knowledgeable about the restrictions and regulations as they apply to the Commission and the limited options available. With this depth of background, Dr. Sprowl should be a valuable asset to the Commission.

Wessinger, N. Carl, South Carolina, 1998: Dr. Carl Wessinger received his dental education at the Medical College of Virginia and is a member of the Piedmont District Dental Society, South Carolina Dental Association (SCDA), Academy of General Dentistry (AGD) and the American Dental Association. Dr. Wessinger has been recognized for fellowship by the AGD, American College of Dentists, International College of Dentists and Pierre Fauchard Academy.

He has been president of his district and state associations, president of the South Carolina Chapter of the AGD and delegate to the AGD. He is currently a delegate to the ADA House of Delegates and chairman of the South Carolina delegation. Dr. Wessinger has served on the South Carolina State Board of Dentistry, including a term as president. He is the recipient of the George P. Hoffman Award from SCDA for distinguished service to the profession.

Council on Scientific Affairs

Byrne, B. Ellen, Virginia, 1998: Dr. Ellen Byrne has a unique background. Following her undergraduate education at Mary Washington College, Dr. Byrne completed advanced education programs in both dentistry and pharmacology at the Medical College of Virginia. Her general dentistry experience includes a one-year general practice residency and a faculty appointment in the Department of Restorative Dentistry. Interest in the specialty of endodontics led to a five-year combined dentist-scientist award from the National Institutes of Health which resulted in a certificate in endodontics and a Ph.D. in pharmacology and toxicology. Dr. Byrne's research interests combine this unique dentistry/pharmacology background and give her a real insight into practical applications of pharmacology in the clinical practice of dentistry. She is sharing this practical information with the dental profession by providing up-to-date outstanding continuing education courses in the use of analgesics and antibiotics to control dental pain and infections. Her current area of research involves looking at THC (Tetrahydrocannabinol) binding in the spinal cord and its possible interaction with morphine antagonists.

Dr. Byrne is a member of the American Dental Association, International Association for Dental Research, Virginia Pharmaceutical Association, American Association of Endodontics and the Academy of General Dentistry. She has also been recognized by Omicron Kappa Upsilon, Sigma Zeta and Rho Chi.

Ciancio, Sebastian G., New York, 1998: Qualifications desired in nominees for appointment to this council focus on a broad-based research background that includes funding and practice-related projects as well as on the desirability of experience in pharmacology, statistics, therapeutics and material sciences.

The curriculum vitae of well-known Dr. Sebastian G. Ciancio cites numerous examples of his familiarity with biostatistics. He has experience on the American Fund for Dental Health's Grants and Allocations Committee as well as on the Funding Committee for an organized research center for the State University of New York at Buffalo where he functions in many capacities, including director of the Center

for Clinical Studies. He has either been the author or coauthor of approximately 100 published articles. Dr. Ciancio has lectured extensively locally, nationally and internationally on pharmacology and periodontology and yet he has found time to serve as president of his alumni association as well as the president of the American Academy of Periodontology and chairman of Buffalo's Department of Periodontology. He is also a professor in the Department of Pharmacology.

Dr. Ciancio has served as a consultant to the ADA's Commission on Accreditation and the FDI's Commission on Dental Materials, Instruments, Equipment and Therapeutics. He received his dental degree in 1961 and chaired the ADA's Council on Dental Therapeutics from 1976-78.

He has had many honors bestowed upon him and should be a major asset to the Council on Scientific Affairs. Dr. Ciancio is highly recommended.

Rothwell, Bruce, Washington, 1998: Dr. Bruce Rothwell is a 1973 graduate of the University of Oregon School of Dentistry and a 1977 graduate of the University of Washington School of Dentistry with a master's degree in oral medicine. He practices general dentistry in an intramural practice at the University of Washington Medical Center.

Dr. Rothwell has served on the Executive Council of the Seattle-King Dental Society, on the Health Services Relations Committee and as delegate to the Washington State Dental Society. He is a fellow of the American College of Dentists and American Academy of Forensic Sciences, and is a diplomate of the American Board of Oral Medicine.

Dr. Rothwell has been awarded numerous grants including two Ryan White HIV/AIDS Dental Reimbursement grants. He also has published widely including articles on "Prevention and Treatment of the Oral-facial Complications of Radiotherapy" and "Odontogenic Infections." He has authored numerous book reviews on dental pharmacology and abstracts including one on "The Effect of Continued Mobilization on Jaw Growth After Fracture of the Condyle."

Dr. Rothwell has had faculty appointments at the London Hospital Medical College, been a consultant to the Head and Neck Tumor Board at the Virginia Mason Hospital and is currently chairman of the Department of Restorative Dentistry at the University of Washington School of Dentistry.

Schallhorn, Robert G., Colorado, 1998: Dr. Robert Schallhorn is a 1956 graduate of the Marquette University School of Dentistry. He has a master of science degree in biochemistry and a certificate in periodontology from the University of California. He is a diplomate of the American Board of Periodontology.

Dr. Schallhorn is a retired colonel in the United States Army Dental Corps. He is a professor and has been the chairman of periodontology at the University of Colorado School of Dentistry. He has served as a consultant to the United States Army and Air Force, the Department of Veterans Affairs, and the National Institute of Dental Research.

Dr. Schallhorn is currently in full-time private practice in Aurora, Colorado. He is a member of a number of professional and scientific organizations and associations. He is the past president of the American Academy of Periodontology and the American Board of Periodontology. He has been a consultant to several ADA councils and commissions.

Throughout his professional life he has been actively involved in dental research, in the areas of dental materials, biochemistry, basic sciences, and various aspects of periodontal scientific research. He has lectured both nationally and internationally and has contributed more than 50 articles to the refereed scientific literature. He is a recipient of the American Academy of Periodontology Clinical Research Award and its highest award, the Gold Medal Award. He is currently a finalist for the ADA's 1994 Norton Ross Award for Excellence in Clinical Research.

Dr. Schallhorn will bring to the new Council on Scientific Affairs a wealth of scientific research knowledge. His past experiences in organized dentistry and organized dental research will be an immense help to the council as it begins to chart its new course. I highly recommend Dr. Schallhorn for appointment to the new Council on Scientific Affairs.

53. Resolved, that the nominees for membership on the councils, commissions and standing committee of the Association, submitted by the Board of Trustees in accordance with Chapter VII, Section 100(H), of the *Bylaws*, be elected.

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

ADA Sessions and International Relations
Morton L. Divack, NY
John O. Hudgins, IL
Burton J. Kunik, TX
Terence E. Walsh, LA

Community Health, Hospital, Institutional and Medical Affairs
Samuel H. Adams, TX
Thomas M. Daniel, FL (AMA)
Richard Haught, OK
Richard E. Jabbour, SC
James C. Murphy, KY

Dental Benefit Programs
Terry L. Duncan, KS
Myron L. Pudwill, NE
H. John Schutze, NY
Ron L. Tankersley, VA

Dental Education/Dental Accreditation
W. Kenneth Horwitz, TX
Lindsay M. Hunt, Jr., VA
Kent G. Palcanis, AL
Lewis Williams, GA

Dental Materials, Instruments and Equipment
John H. Hembree, Jr., MS
Morris A. Hicks, AZ
J. Michael Leary, IA
Kenneth D. Rudd, TX
Robert G. Smith, KS
Larz S. Spangberg, CT
Robert C. Vessels, OH

Dental Practice
Robert W. Baker, Sr., NY
Charles R. Hall, AL
Amy A. Ogawa, HI
James L. Van Miller, WI

Dental Research
Gordon J. Christensen, UT
David W. Eggleston, CA
Robert J. Genco, NY
Karl F. Leinfelder, AL
Sally J. Marshall, CA (AADR)
Joan A. Phelan, NY
W. Eugene Roberts, IN
Harvey A. Schenkein, VA
John W. Stamm, NC

Dental Therapeutics
Robert W. Bowman, MT
Augusto Elias, PR
William Maixner, NC
Nathanial H. Rowe, MI
Thomas E. Van Dyke, NY

Ethics, Bylaws and Judicial Affairs
Donald I. Cadle, Jr., FL
Fitzhugh N. Hamrick, SC
Frank A. Sessa, CT
Lawrence J. Warner, CA

Governmental Affairs and Federal Dental Services
Everett W. Bowling, WV
Howard F. Curtis, OR
Carl Langbert, NJ
Tommy G. Roebuck, AR

Insurance
John A. Breza, MI
John H. Gerstenmaier, OH
Jack Owens, CA
A. Howard Sather, MN
Michael A. Scott, FL
John W. Staubach, PA

National Dental Examinations
Richard J. Chichetti, FL
Sally Ann Deck, MI (ADHA)
Peter Piche, MI
Francis Sarro, DE

Relief Fund Activities
John Q. Long, Jr., TX
A. Miles Olson, IA
Rafael A. Ramirez Brunet, PR

Standing Committee on the New Dentist
Daniel M. Castagna, CA
David Donatelli, PA
Richard D. Isaacson, NJ
Timothy E. Thompson, ID

Responses to Assignments from the House of Delegates

Publication of Fees by Insurance Companies and Referral Services: Resolution 90H-1993 (*Trans.*1993:706) requested the Division of Legal Affairs to explore the legal ramification of insurance companies and dental referral services publishing their established fees, with particular attention to possible antitrust violations. The resolution further requested that the information from this evaluation be made available to constituent and component dental societies.

In response to Resolution 90H-1993, the ADA General Counsel requested the Association's outside legal counsel to analyze whether insurance companies and referral agencies legally may publish their established dental fees. An opinion letter was issued by outside counsel with a conclusion that "the dissemination of established fee schedules by insurance companies or referral agencies does not violate the antitrust laws." The opinion letter, which provides an analysis of the issue and explains the rational for the conclusion, was provided to constituent and component society executives as directed by Resolution 90H-1993.

Electronic Technology Activities: The Department of Dental Informatics reported to the Board of Trustees that in response to Resolution 133H-1993 (*Trans.*1993:695) which directs the Association to intensify its efforts in the area of electronic technology and informatics and to provide services through the appropriate Association agencies, the Association is involved in several national electronic data interchange (EDI) planning panels and continues to play a leadership role in the development of many of the standards for electronic claims processing, computer-based patient records, and other electronic technology used in dental practice.

The standards-setting area is extremely important at this time in order to establish the framework to make electronic data interchange a reality to exchange business information in a standardized format.

Resolution 133H-1993 also opposes mandatory participation in electronic data interchange for dental claims processing. None of the Association's dental informatics activities require mandatory participation of members.

Donation of ADA Library Materials: Resolution 139H-1993 (*Trans.*1993:684) directed that the ADA donate its excess and outdated library materials to Medical Books for China International or any other organization that is in need of these materials. The Department of Library Services notes that it keeps a list of organizations that are in need of donations of scientific literature. Medical Books for China International is included on this list. Copies of duplicate journal issues are provided to organizations on this list as well as to libraries with specific requests. Persons calling the Library to ask about places to donate outdated or duplicate literature are referred to the organizations on this list. During the past year, duplicate copies of dental books were also provided directly to the School of Stomatology, Beijing Medical University.

Because the Association's Library functions as a resource library, a source that other libraries use when they need dental information, very little material is withdrawn from the library collection. Copies of all dental books and journals, older editions as well as current materials, are acquired and usually retained.

Reporting of Manpower Data: The 1981 House of Delegates adopted Resolution 124H (*Trans.*1981:571) requiring the Association to examine and report data related to the number of licensed dentists, the rate of increase (growth) in the number of licensed dentists, the number of dentists being graduated, and projected trends in the number of new graduates and relate the information to the amount and trends in dental disease. A final report to Resolution 124H was prepared in 1982 (*Supplement 2*, 1982:390). This report is in response to reporting issues related to dental manpower on a continuous basis as required by the resolution.

The Number and Projected Trends in Dental School Graduates. A survey of all dental schools is conducted annually by the Association's Survey Center (SC). The survey contains a six-part questionnaire to collect: (1) general data; (2) faculty data; (3) financial statistics; (4) data on advanced education programs; (5) enrollment and graduates statistics; and (6) curriculum information. A summary of information collected in the 27th *Survey of Predoctoral Dental Educational Institutions* is contained in the published *Annual Report on Dental Education* 1993/94. As a supplement to the *Annual Report on Dental Education*, the SC will prepare and publish *Dental Education Trend Analysis* containing historical and current statistics on undergraduate dental education in the United States. Several topics are addressed in the report, including the number of applications to dental schools, first-year enrollment statistics and projections, dental school attrition, dental school graduates, tuition and fees, advanced specialty education and licensure examination data.

Forecasts of the Supply of Dentists.[1] Over the past decade, dentistry has generally witnessed a decline in the number of applicants to dental school (begun in 1975), a decline in first-year enrollments in dental school (begun in 1978), a leveling off of the number of graduates but declining since 1983, dental school closings and a relatively constant number of graduates from advanced specialty programs. Even with these trends, it has been projected that the total number of dentists will continue to increase throughout most of the remainder of the century although at a diminished rate of growth. The dental manpower projections are derived from the Dental Manpower Model (DMM) which was developed for the American Dental Association by RRC, Inc., an economic research firm located in Bryan, Texas.

The following are selected results obtained about the number and projected trends in dental school graduates:

a. The estimated number of applicants to the nation's dental schools has generally declined relative to 1980. The number of applicants declined to an estimated 4,964 in 1989 from a level of 9,601 in 1980. The number of applicants has increased since 1989 to 6,761 in 1993.
b. Estimates for 1993 suggest the number of applicants will increase slightly over the 1992 level.
c. From 1970 to 1978, the number of first-year enrolled dental students increased by 38% or about 4.1% per year. Between 1978 and 1993, first-year enrollment has declined by an average of 2.2% per year. This includes the increases in enrollment that occurred in 1990 and 1993.
d. The number of women dental graduates in 1993 reached 1,333 representing 35.3% of the graduating class. Women also represented 36.6% of the 1993-94 first year enrollment and 36.9% of the total predoctoral enrollment in dental schools.

Resolution

53. Resolved, that the nominees for membership on the councils, commissions and standing committee of the Association, submitted by the Board of Trustees in accordance with Chapter VII, Section 100(H), of the *Bylaws*, be elected.

[1] The forecasts of the supply of dentists is in the process of being updated using results from the 1993/94/95 *Distribution of Dentists* survey.

Report 2

ADA Operating Account Financial Affairs and Recommended Budget, Fiscal Year 1995

Introduction: In accordance with its *Bylaws* duties, the Board of Trustees presents the proposed operating budget for the Association in 1995. This report also provides the House of Delegates with comparative financial data on a programmatic and natural account basis over a three-year-period. Finally, it includes background commentary and an analysis of significant budget changes for 1995. The Board is recommending a 1995 operating budget of $50,505,200 in revenue, offset by $52,405,200 in expenses, generating a net revenue deficit from operations of $1,900,000. The Board of Trustees analyzed approximately 280 budget requests using the Zero Based Budgeting Technique and made judgments as to whether these activities were essential, discretionary or could be eliminated. This proved to be a difficult process resulting in financial support being withheld from many meritorious programs. Using the ADA Strategic Plan as a background document, the Board has endeavored to contain costs without compromising the strategic goals of the Association.

Given the challenges facing dentistry today, the Board believes that the membership will be best served by moving forward with initiatives on the legislative front and bolstering communications and educational activities. The programs contemplated in the proposed 1995 budget are meant to preserve and advance a strong and effective Association. In order to balance the proposed budget, the Board is recommending a dues increase of $19. Other than the $55 temporary dues increase through 1996, specifically restricted to the Capital Improvement Project, membership dues have not risen since 1990 even though costs have increased and programs have expanded. The Board of Trustees determined that a dues increase represents a more prudent approach to offsetting the 1995 deficit than compromising the Association's reserve position.

In response to a suggestion by the Reference Committee on Budget and Administrative Matters at the 1993 House of Delegates, the following changes were made to the format of this report. Two years of budget information are now displayed instead of three, and a variance column has been added to display the percentage change between the 1995 and 1994 budgets. This revision will permit the reader to more easily ascertain where funds have been reallocated between the current and upcoming budget years.

With regard to the financial information presented herein, 1993 actual figures have not been reclassified to reflect the Executive Director's Association restructure, which did not become effective until November 1, 1993. However, 1994 budget information has been recast in light of the reorganization. The budget developed for 1995 fully considers the impact of the revised organizational alignment, discussed further below.

Organizational Restructure: The staff side of the Association was restructured with the ultimate goal of contemporizing the organization. In an effort to achieve greater effectiveness and a clearer focus on membership needs, common or duplicative areas were centralized to enhance and standardize operations. The revised structure limits direct reports to the Executive Director, promotes horizontal communications and separates policy from process or support functions.

Highlights of the restructure are as follows:

- The Office of the Executive Director is now called the Division of Administration and Policy, more accurately reflecting its scope and responsibilities.
- A new Department of Quality and Strategic Planning, a direct report to the Executive Director, will serve as a resource helping senior management integrate quality and strategic planning throughout the Association.
- Though they remain separate entities, the divisions of Education and Science now report to a single Associate Executive Director for Education and Science.
- Also reporting to the Associate Executive Director for Education and Science will be a new ADA Survey Center, established to centralize diverse survey activities formerly carried out in several different Association agencies.
- The former Division of Finance and Business Affairs is now the Division of Finance, Planning and Business Management. The newly constituted division includes a Department of Business Planning and Management to serve as a resource for the development of new revenue opportunities, as well as negotiating business-related contracts. The Council on Insurance and Internal Audit were also transferred into this division.
- The Department of Salable Materials, which produces print, video and other materials for dentists and consumers, has been established as a stand-alone department reporting to the deputy executive director. The department had been part of the Communications Division.
- The Office of International Affairs has moved and also has a new name. Now known as the Department of International Dental Health, the department has been established as a stand-alone unit, no longer part of Conference and Meeting Services. It will report to the Assistant Executive Director of Administration and Policy, while maintaining close ties to the Executive Director.
- The new Division of Information Technology, reporting to the Deputy Executive Director, will help the Association keep in step with the latest in computer systems, telecommunications, database management and other technological developments.

- Related Dental Groups, placed within the Division of Membership and Dental Society Services, will be the liaison with related dental organizations, such as dental specialty organizations, but not constituent and component societies or international groups.
- A Department of Dental Informatics within the Division of Dental Practice will assist dentists with such developments as electronic data interchange. The department will coordinate its activities with the Information Technology unit.
- Also in Dental Practice, a Health Policy Resource Center has been created to coordinate health policy planning.
- Two units, Marketing Services and Seminar Services, have been moved out of Membership and into Dental Practice for a more logical fit.
- Finally, the library is no longer a bureau, but rather, a department, moved into Education from Conference and Meeting Services.

Budgeting Process

The technique of zero based budgeting (ZBB) was applied to the 1995 budget process, representing the third year this strategy was utilized. The process requires a thorough review of all Association activities to prioritize those that would be of the most benefit to the general membership and the public.

Using this approach, all councils, commissions and agencies developed "base budgets," which were intended to provide the minimum funding necessary to achieve the mission of the program. These base level budgets were supplemented by "decision packages" which were requests for additional resources either for new programs or to make current activities more effective.

Each budget package described a specific program in such a manner that it could be evaluated and ranked against other activities competing for funds. It further noted the program's purpose and objectives; its relationship to the ADA Strategic Plan; performance measurements; a listing of activities for comparison to the 1994 approved budget; and alternative ways of operating. The ZBB process also allowed for discontinuing a current activity or proposing a new one. Budget packages were reviewed and prioritized at the department and divisional levels in order of importance to the Association.

While these initial phases of the budgeting process can be described in several paragraphs, this is not indicative of the days spent in self-study and preparing the budget packages for management and administrative review. The process also required that budget preparers examine other ways of achieving program objectives and further identified common problems or opportunities among departments.

From March through the beginning of May, the President-elect, Treasurer and the Executive Director, acting as the Administrative Review Committee, thoroughly assessed and ranked all budget requests. This was subsequently done in concert with senior management who had an opportunity to present the agencies' proposed budgets and respond to questions. From these discussions, and additional analysis with the Finance Committee, the Administrative Review Committee revised or selected alternative budget packages reducing initial budgetary requests by $4,638,827.

All base budgets and decision packages were categorized "A," "B," or "C." An "A" was assigned to programs that were essential to the Association, a "B" for those considered to be somewhat discretionary and a "C" signified no funding based upon current priorities.

1994 Budget Overview

Revenues

Membership dues continue to account for approximately 59% of the Association's operating revenue exclusive of subsidiary company operations. For 1995 the budget anticipates $20,351,600 in non-dues revenue or more than a 5% increase over 1994. Highlights of various revenue categories are provided below:

Membership Dues: The 1995 budget forecasts $29,328,600 in net dues or less than 1% under 1994. These projections assume nearly 100,000 full dues paying members. All dues revenue amounts presented are exclusive of the $55 increase restricted to the Capital Improvement Project. These funds projected at $5,898,790 are held in a separate fund to finance the Headquarters Building renovation.

Rental Income: This revenue category includes rental income from the Headquarters Building and exhibit space at the annual session. The anticipated increase of $603,700 results largely from higher exhibit space income.

Sales Income: This source of revenue is budgeted to decrease by $376,900 or 8.3%. This is primarily attributable to a declining demand for OSHA-related materials that have dominated catalog sales over the last three years.

Testing Fee Income: Revenues from testing fees are expected to increase by $268,300, or 10%, as a result of an upward adjustment in the fees for the National Board Dental Examination, Part I and Part II; Dental Hygiene Examination; and the Optometry Admission Testing Program.

Grants and Contributions: Income from grants and contributions is expected to decline by $221,700 or 46%. The principal factor in this decline is the transfer of the SUCCESS Seminar series, funded by corporate grants, to the ADA Health Foundation.

Registration Income: Projected income from registration fees is up $201,900 or 33%. This growth is mainly attributable to a new Clinical Computer Conference as well as increased fees for other conferences sponsored by the Division of Dental Practice.

Investment Income: Projected revenues of $300,000 represents investment earnings on cash flow within the operating account. This anticipated income has been decreased

by $100,000 or 25% from 1994 based upon the returns in more recent years. Actual results may vary depending upon the timing of cash receipts and the prevailing interest rates during 1995. All dues revenue related to the improvement of the Headquarters Building are segregated in a designated account and do not contribute to Association investment income.

Miscellaneous Income: This category is composed of miscellaneous revenue which cannot be properly included within any of the previous categories. Projected revenue of $6,387,400 is $678,800 or 12% above 1994. The largest single increase results from a change in the Seal Program, becoming effective in July of 1995, to charge manufacturers submitting products for review. This is expected to generate an additional $535,200 of revenue during the last six months of the year.

Expenses

Staff Compensation: Expenses for staff compensation, excluding proposed salary increases for 1995, were budgeted at $1,980,200 over 1994 levels. This increase is primarily attributable to three key factors. The first is the reclassification of the President, President-elect and Treasurer from volunteers to salaried employees of the Association, in compliance with tax regulations. The second is the more than 15 new positions created from the organizational restructure and new programs under consideration for 1995. Lastly, the 1995 budget anticipates significantly less compensation savings due to open positions.

In 1995 the Association will continue to budget cash contributions to the qualified and supplemental pension plans as determined by an independent actuary instead of the amount computed as expense for accounting purposes.

Meeting and Travel Expenses: Expenses for meeting and travel are up $262,500 or 4.6% from the 1994 budget. This is partly due to an increase in budget cost guidelines for lodging and meals and specific items such as travel expenses related to the FDI International meeting held in Hong Kong for 1995. Additionally, within the Division of Dental Practice, new conferences, an additional council meeting and a new department resulted in increased meeting and travel costs.

Facility and Utility Costs: The majority of these expenses can be attributed to the management operations, maintenance, insurance and property taxes of the ADA Headquarters Building. An increase of $417,100 or 12.3% in 1995 anticipates increased taxes, utilities and labor costs for engineers, janitors and security guards. Additionally, budgeted funds are necessary for maintenance of the fire/life safety system and periodic testing of building air quality due to the presence of asbestos.

Office Expenses: The expenses in this category are budgeted to increase by $88,600 or 3.3%.

Professional Services: The actual decrease in this category across the Association is nominal. The apparent $285,200 decrease is not a true reduction in the budget, but the result of not continuing certain grassroots activities in 1995, and the reclassification of officer stipends mentioned earlier.

Publications and Projects: Once again, the decrease of $2,338,500 is partially due to grassroots-related activities. Approximately 12% or $290,500 of the decrease consists of cost reductions anticipated in Salable Materials.

Grants to Health-Related Groups: The Association's grant support to various organizations was increased by $455,800 or 27%. There was a general increase in funding for ADA Health Foundation activities of $474,700. This was offset by decreases in the following entitlement grants in an effort to conserve Association resources:

- A decrease of a grant to the National Foundation of Dentistry for the Handicapped from $70,000 to $50,000 in 1995, in accordance with a three-year schedule to phase out financial support to this organization.
- An elimination of a $15,000 grant to support the Federation of Special Care Organizations in Dentistry.

In future years, the Board would consider awarding grants for specific projects where the Association could work cooperatively with such organizations. Finally, the grant to support the Hillenbrand Fellowship will remain at $17,000 for 1995.

Depreciation/Amortization: These items increased by $100,000, or 15.4% from the 1994 budget. This change is to adjust depreciation for the increase in purchases of computer software and hardware, to replace aging equipment.

Interest Expense: In conjunction with MBNA America, the ADA offers a dues payment program that enables young dentists to charge their annual membership dues interest-free on their MBNA credit card. Costs for this program are shared by the ADA and MBNA America. For 1995 the interest expense of approximately $3,000 has been netted against the royalty income generated from this program and is reflected in the Central Administration budget.

Other Expenses: Expenses not categorized elsewhere are expected to increase $370,400 over the 1994 budget. However, of this amount, $350,000 is not an actual increase but rather reflects the method of accounting for the Contingent Fund in Central Administration. Specifically, as supplemental appropriations requests are approved by the Board of Trustees during the year, the funds are transferred from the Contingent Fund into separate cost centers. This depletes the balance of the Contingent Fund and creates the appearance of a variance in the ensuing year's budget request. In actuality, the $350,000 Contingent Fund provision for 1995 is the same as the 1994 amount.

Compensation Increase: A separate line was developed for staff compensation which provides for a $1,000,000 increase in salary and related fringe benefit dollars which will be distributed among employees based upon performance rather than an across-the-board adjustment for inflation. This

estimate is based upon a percentage increase of approximately 4.6%.

Investment in ADREC: In March 1993 the American Dental Real Estate Corporation (ADREC) refinanced the mortgage on the Washington Office building through a 12-year unsecured note in the amount of $9.2 million purchased by Great-West Life. The American Dental Association serves as guarantor under the note agreement.

Recognizing that income generated from building rentals was insufficient to support future interest and principal payments, the Board further approved funding of ADREC's cash flow losses up to $1.7 million annually. The expense shown as Investment in ADREC in the amount of $552,500 in 1994 is in keeping with this commitment. For 1995 the anticipated cash loss of $1,081,700 will be funded from reserves given that this property was initially acquired as a long-term investment.

Funded Depreciation: Until 1993, the Association had not set aside funds for building repairs or renovation. It budgeted depreciation expense, from which there is no outflow of cash, as a source of funding. While this is not an unusual practice, it is not always reflective of the capital spending requirements of the organization. The need for long-range capital planning and a more disciplined approach in managing the Headquarters Building resulted in the Board's decision to fund depreciation via an allocation of monies to a separately designated Building Fund.

These budgeted funds, $1,000,000 for 1995, are meant to financially underwrite future capital improvements to the Headquarters Building. This level of funding was selected based upon projected depreciation expense for 1995 plus a provision for future building enhancements and replacements of equipment as recommended by Venterra Management Corporation. A capital budget for the 1995 fiscal year appears at the end of this report.

Dividend: An $825,000 dividend is projected to be received from the ADA Holding Company, Inc. which is consistent with 1994. In the 1994 budget, the dividend was included in the revenue budget for Central Administration. However, in 1995, this dividend is budgeted "below the line," recognizing that dividends from the for-profit subsidiaries are considered a transfer from Reserves to the Operating Account and, as such, are not accounted for as revenue.

Grassroots Campaign: The amount of $195,500 represents programs in 1995 that have been identified as grassroots-related activities that agencies will account for within their divisions but will be funded from a $2 million reserve allocation as previously recommended by the 1993 House of Delegates.

Retiree Medical Plan: Due to an accounting rule change (FAS 106), the Association must allocate additional funds to meet the anticipated liability for future benefits for retirees consistent with the strategy selected by the Board. Within the Central Administration budget under Group Medical Cost, $625,000 was included in the 1995 budget of which $197,600 represents expected current costs with the remaining $427,400 being committed to the Restricted Reserve Account to help defer future liabilities. Essentially, retiree medical costs will be actuarially determined and funded similar to a pension plan.

American Dental Association
1995 Budget Summary Worksheet

NATURAL ACCOUNTS	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
REVENUES				
Membership Dues	$29,338,953	29,404,800	29,328,600	(<1%)
Rental Income	4,075,173	4,882,500	5,486,200	12%
Sales Income	4,144,740	4,536,400	4,159,500	(8%)
Testing Fee Income	2,557,290	2,678,000	2,946,300	10%
Grants & Contributions	517,315	482,600	260,900	(46%)
Registration Income	576,659	609,400	811,300	33%
Investment Income	315,719	400,000	300,000	(25%)
Miscellaneous Income	8,827,527	5,708,600	6,387,400	12%
TOTAL REVENUES	50,353,376	48,702,300	49,680,200	2%
EXPENSES				
Staff Compensation	18,427,611	21,452,900	23,433,100	9%
Meeting/Travel Expenses	5,601,289	5,775,400	6,043,900	5%
Facility & Utility Costs	3,206,576	3,385,900	3,803,000	12%
Office Expenses	2,359,406	2,726,000	2,814,600	3%
Professional Services	4,639,309	4,486,100	4,200,900	(6%)
Publication & Project Costs	5,106,580	7,970,500	5,632,000	(29%)
Grants-Related Health Groups	1,544,453	1,669,500	2,125,300	27%
Depreciation & Amortization	777,347	650,000	750,000	15%
Interest Expense	13,601	-	-	-
Other Expense	1,086,511	1,407,500	1,777,900	26%
TOTAL EXPENSES	42,762,683	49,523,800	50,580,700	2%
NET REVENUE/(EXPENSE) BEFORE INCOME TAXES	7,590,693	(821,500)	(900,500)	10%
Income Taxes	19,149	20,000	20,000	0%
NET REVENUE/(EXPENSE) AFTER INCOME TAXES	7,571,544	(841,500)	(920,500)	9%
Major Medical Refund	(2,500,000)	-	-	
Funded by Transfer from Reserves	255,940	-	195,500	100%
Compensation Increase	-	-	(1,000,000)	100%
Funded Depreciation	(1,054,600)	(1,454,600)	(1,000,000)	(31%)
Investment in ADREC	-	(552,500)	- *	(100%)
Dividends Received	825,000	-	825,000	100%
NET REVENUE/(EXPENSE)	$ 5,097,884	(2,848,600)	(1,900,000)	(33%)

* The anticipated 1995 cash loss of $1,081,700 will be funded from reserves. If this subsidy were taken from the 1995 operating budget, the total net deficit would be ($2,981,700).

American Dental Association
1995 Budget Summary Worksheet—Divisional Summary

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
REVENUES				
House, Board, Administration & Policy, Quality & Strategic Planning	$ -	8,500	21,500	>100%
Legal Affairs	23,875	15,600	19,600	26%
Government Affairs	4,605	30,700	5,700	(81%)
Communications	47,122	63,600	21,600	(66%)
Salable Materials	3,999,472	4,350,900	4,034,000	(7%)
Membership and Dental Society Services	381,634	123,800	178,400	44%
Conference and Meeting Services	4,418,055	3,644,500	4,278,900	17%
Finance & Planning	338,728	931,000	804,900	(14%)
Headquarters Building	1,868,561	2,354,500	2,378,500	1%
Central Services	305,718	1,000	1,000	0%
Central Administration	35,465,578	33,347,800	33,025,500	(1%)
Dental Practice	696,525	510,600	574,200	12%
Education	2,748,503	2,889,000	3,400,300	18%
Science	-	-	535,200	100%
Health Foundation	55,000	133,800	18,900	(86%)
Survey Center	-	45,500	86,000	89%
Information Technology	-	251,500	296,000	18%
TOTAL REVENUES	50,353,376	48,702,300	49,680,200	2%
EXPENSES				
House, Board, Administration & Policy, Quality & Strategic Planning	4,140,143	5,782,600	4,235,600	(27%)
Legal Affairs	1,841,704	1,685,200	1,883,200	12%
Government Affairs	2,187,268	2,950,300	2,796,400	(5%)
Communications	2,144,053	2,549,000	2,465,900	(3%)
Salable Materials	2,749,016	3,262,500	3,060,600	(6%)
Membership and Dental Society Services	3,122,299	3,599,500	3,617,800	<1%
Conference and Meeting Services	5,403,197	3,527,200	4,124,800	17%
Finance & Planning	1,432,498	2,202,000	2,333,800	6%
Headquarters Building	3,637,544	3,903,300	4,297,500	10%
Central Services	2,299,107	816,800	842,400	3%
Central Administration	2,661,241	2,444,300	3,171,600	30%
Dental Practice	4,148,281	3,642,100	3,826,700	5%
Education and Science	-	-	294,200	100%
Education	4,297,999	5,532,900	5,296,900	(4%)
Science	1,326,619	2,020,800	1,913,100	(5%)
Health Foundation	1,390,863	1,490,700	1,965,400	32%
Survey Center	-	1,353,000	1,656,900	22%
Human Resources	-	942,700	866,900	(8%)
Information Technology	-	1,838,900	1,951,000	6%
TOTAL OPERATING EXPENSES	42,781,832	49,543,800	50,600,700	2%
NET REVENUE/(EXPENSE) BEFORE OTHER ITEMS	7,571,544	(841,500)	(920,500)	9%
OTHER ITEMS				
Funded by Transfer From Reserves	255,940	-	195,500	100%
Major Medical Refund	(2,500,000)	-	-	
Dividends from ADAHC	825,000	-	825,000	100%
Compensation Increase	-	-	(1,000,000)	100%
Funded Depreciation	(1,054,600)	(1,454,600)	(1,000,000)	(31%)
Investment in ADREC	-	(552,500)	-	(100%)
NET REVENUE/(EXPENSE)	$ 5,097,884	(2,848,600)	(1,900,000)	(33%)

American Dental Association
1995 Budget Summary Worksheet—Divisional Summary (continued)

Financial Implication Recap: The following recap is presented to reconcile total revenues and total expenses to the financial implication at the beginning of this report.

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
TOTAL REVENUES	$50,353,376	48,702,300	49,680,200	
Dividends Received	825,000	-	825,000	
TOTAL REVENUES	51,178,376	48,702,300	50,505,200	4%
TOTAL EXPENSES	42,781,832	49,543,800	50,600,700	
OTHER ITEMS				
Funded by Transfer from Reserves	(255,940)	-	(195,500)	
Major Medical Refund	2,500,000	-	-	
Compensation Increase	-	-	1,000,000	
Funded Depreciation	1,054,600	1,454,600	1,000,000	
Investment in ADREC	-	552,500	-	
TOTAL EXPENSES	$46,080,492	51,550,900	52,405,200	2%

Division of House, Board, Administration & Policy, Quality & Strategic Planning

The proposed 1995 budget for this Division reflects several structural changes made as a result of the Executive Director's Association restructure. This division now includes funding for all the activities related to the House of Delegates, Board of Trustees, President, President-elect, Executive Director as well as the Division of Administration and Policy, the Department of Quality and Strategic Planning, the Department of International Dental Health and the FDI.

The last several years have seen a marked increase in the issues and activities confronting the Association. One such on-going activity is the health system reform effort which the Association leadership has attempted to address in a very proactive manner. As such, certain administrative costs like telephone, office photocopy and stationery and supplies for officers, the Board of Trustees and the Executive Director have increased beyond normal inflation. Also, the 1993 House of Delegates recommended up to $2 million to spearhead a grassroots campaign related to dentistry's position in health care reform. This one-time $2 million allocation is reflected in the Executive Director's 1994 budget to ensure proper administration.

Other budget variances include a savings in miscellaneous professional fees due to the Board's elimination of the use of a stenographer to record all meetings of the Board of Trustees; an increase in travel expenses to the 1995 FDI World Dental Federation Congress reflective of the 1995 Hong Kong location versus the 1994 Vancouver, BC location; and the reclassification of the stipends for the President, President-elect and Treasurer from professional services to compensation.

The increased emphasis on strategic planning and a renewed focus on the Quality Improvement Process through the establishment and staffing of a separate Department of Quality and Strategic Planning increases funding levels most notably for staff compensation, professional services, registration fees and special events.

Another variance in the 1995 budget relates to the House of Delegates. Pending the final identification of meeting location (convention center vs. hotel), the funding in outside services has increased to cover the possible room and sound system rental fees and the purchase of carpeting in the event the House utilizes space in the convention center.

Division of House, Board, Administration & Policy, Quality & Strategic Planning—Divisional Summary Worksheet

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
NATURAL ACCOUNTS				
REVENUES				
Miscellaneous Income	$ -	8,500	21,500	153%
TOTAL REVENUES	-	8,500	21,500	153%
EXPENSES				
Staff Compensation	1,459,770	1,063,100	1,587,200	49%
Meeting/Travel Expenses	793,693	980,800	1,072,500	9%
Office Expenses	263,120	243,900	292,800	20%
Professional Services	1,033,682	1,135,000	899,500	(21%)
Publication & Project	219,060	2,174,400	195,000	(91%)
Other Expenses	370,818	185,400	188,600	2%
TOTAL EXPENSES	4,140,143	5,782,600	4,235,600	(27%)
NET REVENUE/(EXPENSE)	(4,140,143)	(5,774,100)	(4,214,100)	(27%)
DEPARTMENTS				
REVENUES				
Executive Director	-	-	13,000	100%
Department of International Dental Health	-	8,500	8,500	0%
TOTAL REVENUES	-	8,500	21,500	>100%
EXPENSES				
Executive Director	1,008,108	2,976,600	1,115,000	(63%)
Board of Trustees-Administration	1,148,671	1,288,200	1,265,100	(2%)
Strategic Plan	8,145	-	-	-
Internal Audit	89,739	-	-	-
Office of the President	274,364	315,100	358,000	14%
Office of the President-elect	189,361	216,100	232,000	7%
Office of the Past President	13,041	13,600	14,400	6%
Office of the Treasurer	43,324	48,000	52,600	10%
House of Delegates	531,329	608,300	631,500	4%
Human Resources Department	834,061	-	-	-
Quality & Strategic Planning	-	-	245,700	100%
Department of International Dental Health	-	111,500	89,000	(20%)
FDI World Dental Federation	-	205,200	232,300	13%
TOTAL EXPENSES	4,140,143	5,782,600	4,235,600	(27%)
NET REVENUE/(EXPENSE)	$(4,140,143)	(5,774,100)	(4,214,100)	(27%)

Division of Legal Affairs

The Division of Legal Affairs continues to divide its time between its crucial roles of providing advice to the Association on legal issues and protecting the Association from liability exposure and legal advocacy on behalf of the dental profession. There are many aspects to the Division's role of providing legal advice to the Association and protecting the Association from liability exposure. The principal activities in this area are providing legal advice to the House, Board and councils, commissions, committees and subsidiaries of the Association; drafting legal documents, such as contracts, leases, bylaws provisions, and the like; and supervising litigation (developing litigation strategies; producing documents and witnesses; supervising outside counsel; controlling outside legal fees) involving the Association as a business.

There also are a number of ongoing legal projects related to the advocacy role. The most significant of these activities currently are: the FTC's threatened enforcement action against the Association pertaining to the 1982 consent decree; third-party issues; antitrust issues, which are heightening with legislative and marketplace health care reform efforts; ongoing involvement in OSHA matters; legal issues pertaining to HIV and other infectious diseases in the dental office; the Americans with Disabilities Act; and dental office waste. In addition, each year there are numerous unanticipated advocacy projects that can be significant. For example, in 1993, the Division fielded over 2,000 calls, and expended approximately $48,000 in outside legal fees on behalf of the profession, to assist members in the Healthco bankruptcy. Finally, the Council on Dental Benefit Programs' Contract Analysis Service is housed in the Division of Legal Affairs, where in 1993 the Service received 403 different dental plan contracts to analyze for the profession. The Service continues to grow in popularity, having received approximately double the number of contracts received in prior years.

The overall proposed 1995 budget for the Division of Legal Affairs is slightly higher than 1994. There are several reasons for the increase. First, the proposed 1995 budget includes an increase of $85,000 in outside legal fees. This increase was necessary in order to bring outside fees back to their 1992 and 1993 levels ($510,000 and $500,000 respectively), and to provide sufficient funding for the current activities, the most significant of which is the matter involving the Federal Trade Commission.

Second, there is a modest increase in the compensation line items due to a staffing change. During the 1993 internal Association restructure, the Division gave up a secretarial position and gained a manager for the Contract Analysis Service and Council on Ethics, Bylaws & Judicial Affairs. This new position resulted in a modest increase in the compensation line items for 1995 because of the difference in salary between a secretary and a manager. It should be noted that this new position has allowed the Contract Analysis Service to decrease the 1993 backlog of contracts, and should allow the Service to meet the increased current demand, which is particularly important as the number of contracts to be analyzed has grown significantly.

Third, although the amount is small ($1,300), it is worth noting one other activity that represents an increase from the 1994 budget: a one-day workshop on legal issues in the dental profession for the attorneys who handle legal matters for the constituent dental societies. The Division has very successfully hosted this type of workshop in previous years, most recently in 1992. The participants requested that the workshop be held again on a regular basis, such as once every 2-3 years.

Division of Legal Affairs—Divisional Summary Worksheet

NATURAL ACCOUNTS	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
REVENUES				
Miscellaneous Income	$ 23,875	15,600	19,600	26%
TOTAL REVENUES	23,875	15,600	19,600	26%
EXPENSES				
Staff Compensation	1,030,192	1,054,800	1,164,100	10%
Meeting/Travel Expenses	74,189	84,100	77,400	(8%)
Office Expenses	30,184	25,100	28,200	12%
Professional Services	661,070	466,000	553,100	19%
Publication & Project	25,324	35,300	38,200	8%
Other Expenses	20,745	19,900	22,200	12%
TOTAL EXPENSES	1,841,704	1,685,200	1,883,200	12%
NET REVENUE/(EXPENSE)	(1,817,829)	(1,669,600)	(1,863,600)	12%

Division of Legal Affairs—Divisional Summary Worksheet (continued)

DEPARTMENTS	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
REVENUES				
Office of AED/Legal Affairs	22,465	15,000	15,000	0%
Council on Ethics, Bylaws & Judicial Affairs	1,310	-	1,300	100%
Contract Analysis Service	100	600	3,300	>100%
TOTAL REVENUES	23,875	15,600	19,600	26%
EXPENSES				
Office of AED/Legal Affairs	1,598,411	1,433,000	1,586,800	11%
OSHA Task Force	11,236	-	-	-
Mercury in the Water	26,650	-	-	-
Council on Ethics, Bylaws & Judicial Affairs	106,089	128,300	163,700	28%
Contract Analysis Service	99,318	123,900	132,700	7%
TOTAL EXPENSES	1,841,704	1,685,200	1,883,200	12%
NET REVENUE/(EXPENSE)	$(1,817,829)	(1,669,600)	(1,863,600)	12%

Division of Government Affairs

As expected, initiatives at the federal and state levels affecting the Association and its members have intensified in 1994. As a result, the Division's legislative, regulatory and political activities—advocacy, monitoring of federal and state legislation and regulation, legislative analysis and research, coalition building, fundraising and political intelligence and support—have markedly increased. In addition, the Division has had primary responsibility for the development and implementation of the expanded and enhanced grassroots program.

The proposed 1995 Division budget expenditures represents a decrease of $153,900 over the 1994 approved budget.

Clearly, the Division will be asked to do more with less. A highlight of the proposed 1995 budget is listed below:

- A proposed grassroots conference in 1995 (one and a half days in Washington, DC) to expand and continue all education and political advocacy efforts initiated in the grassroots program in 1994. This will present the first opportunity for the 435 team leaders to be educated about the new Congress, its issues, changes in leadership and the individual freshmen members. Although the conference is being funded through reserves, the Division of Government Affairs will maintain primary responsibility. The $125,500 expense is allocated to the office of the Associate Executive Director and accounts for most of the variance in that line item.

Division of Government Affairs—Divisional Summary Worksheet

NATURAL ACCOUNTS	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
REVENUES				
Registration Income	$ 4,605	30,700	5,700	(81%)
TOTAL REVENUES	4,605	30,700	5,700	(81%)

Division of Government Affairs—Divisional Summary Worksheet (continued)

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
EXPENSES				
Staff Compensation	1,424,747	1,811,000	1,833,600	1%
Meeting/Travel Expenses	327,081	497,500	513,200	3%
Facility & Utility Costs	7,318	13,000	12,000	(8%)
Office Expenses	131,523	148,500	144,800	(2%)
Professional Services	185,204	340,500	166,000	(51%)
Publication & Project	47,438	79,300	60,000	(24%)
Other Expenses	63,957	60,500	66,800	10%
TOTAL EXPENSES	2,187,268	2,950,300	2,796,400	(5%)
NET REVENUE/(EXPENSE)	(2,182,663)	(2,919,600)	(2,790,700)	(4%)
DEPARTMENTS				
REVENUES				
State Government Affairs	4,605	5,700	5,700	0%
Washington Office—Public Affairs Conference	-	25,000	-	(100%)
TOTAL REVENUES	4,605	30,700	5,700	(81%)
EXPENSES				
Office of AED/Government Affairs	351,903	399,300	591,200	48%
Council on Government Affairs & Federal Dental Services	317,861	371,600	316,000	(15%)
State Government Affairs	454,984	599,700	549,200	(8%)
ADPAC	305,690	386,900	372,800	(4%)
Washington Office—Administration	226,729	250,800	259,200	3%
Congressional Affairs	393,957	639,200	503,600	(21%)
Federal Affairs	104,780	160,800	204,400	27%
Washington Office—Communications	31,364	72,000	-	(100%)
Washington Office Public Affairs Conference	-	70,000	-	(100%)
TOTAL EXPENSES	2,187,268	2,950,300	2,796,400	(5%)
NET REVENUE/(EXPENSE)	$(2,182,663)	(2,919,600)	(2,790,700)	(4%)

Division of Communications

Division of Communications expenses will decrease 3% or $83,100 in 1995. Estimated revenues will decrease 66% or $42,000.

Communications activities will continue to fall under three departments: Media and Creative Services, Professional Communication, and Public Information and Education. Continuing a trend begun in mid-1994, however, communications programs and projects increasingly will be staffed by interdepartmental teams. This often will affect the precision of staffing resource allocations specified in the budget.

To improve the Division's ability to respond to a variety of public information needs and to shape health promotion campaigns to meet those needs, the preliminary budget reflects a reorganization of the Department of Public Information and Education. Two primary activities within that department, health promotions and consumer programs, are combined. The primary activity of health promotions had been National Senior Smile Week (NSSW); for consumer programs the primary activity was National Children's Dental Health Month. The new organization will allow the Division to select the most appropriate health promotion campaign each year. The budget reflects discontinuation of NSSW, the school film distribution program and radio PSAs for a net savings of $196,000.

In response to health system reform, the Division has worked more closely with the Washington Office, providing communications support on an as-needed basis. These activities have included the "Dentistry: Health Care that Works" grassroots kit and collateral material for dental offices, "The Dental Advocate" grassroots newsletter and ongoing editorial assistance on congressional testimony and

Division of Communications (continued)

other written products. The 1995 budget reflects addition of a Washington communications director (reporting to the Assistant Executive Director, Communications) to provide on-site assistance with such projects and to establish a media relations presence in Washington.

The 1995 budget reflects continuation of the retainer for public relations consultant Burson-Marsteller. This consulting relationship is meant to foster the ADA's position as the central source of information on dental issues and to develop ongoing tactics that will enable the Association to anticipate and respond to critical issues facing the profession.

Division of Communications—Divisional Summary Worksheet

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
NATURAL ACCOUNTS				
REVENUES				
Grants & Contributions	$ -	20,000	-	(100%)
Registration Income	20,805	43,600	21,600	(50%)
Miscellaneous Income	26,317	-	-	-
TOTAL REVENUES	47,122	63,600	21,600	(66%)
EXPENSES				
Staff Compensation	939,240	1,166,100	1,199,800	3%
Meeting/Travel Expenses	46,760	137,200	145,400	6%
Office Expenses	35,729	47,500	44,100	(7%)
Professional Services	184,991	317,900	327,200	3%
Publication & Project	932,222	873,500	742,000	(15%)
Other Expenses	5,111	6,800	7,400	9%
TOTAL EXPENSES	2,144,053	2,549,000	2,465,900	(3%)
NET REVENUE/(EXPENSE)	(2,096,931)	(2,485,400)	(2,444,300)	(2%)
DEPARTMENTS				
REVENUES				
Professional Communication	20,805	43,600	21,600	(50%)
Creative Services	26,317	20,000	-	(100%)
TOTAL REVENUES	47,122	63,600	21,600	(66%)
EXPENSES				
Office of AED/Communications	28,092	286,800	335,500	17%
Professional Communications	315,714	375,000	429,300	14%
Public Information/Education Administration	118,782	80,500	77,300	(4%)
Consumer Programs	620,038	516,300	492,100	(5%)
Health Promotions	166,554	208,000	-	(100%)
Media Relations	452,429	573,000	623,000	9%
Creative Services	370,661	431,700	432,800	<1%
Audiovisual Services—Administration	71,783	77,700	75,900	(2%)
TOTAL EXPENSES	2,144,053	2,549,000	2,465,900	(3%)
NET REVENUE/(EXPENSE)	$(2,096,931)	(2,485,400)	(2,444,300)	(2%)

Salable Materials

Salable Materials has projected a revenue level of $4,034,000 for 1995, with corresponding expenses of $3,060,600 for a resulting net revenue of $973,400. This net activity is slightly under the 1994 budgeted level by $115,000.

When comparing sales from the 1994 to 1995 budget, a major decline is now being realized in areas such as scientific materials, which had peaked in 1992 exceeding $1.5 million. For 1995, the scientific category is expected to generate only $375,000, and the primary source of these earnings will come from the Update Service to the *Regulatory Compliance Manual* with subscriptions committed through year-end. Although staff continue to monitor changes in governmental regulations and regularly apprise the membership of them through various products, new demand for resources in this category has been lagging and this trend has generally been reflected in the industry.

There are 16 cost centers that comprise the Salable Materials base budget, and the leading revenue sources anticipated include dental health education material—$1,794,500, followed by dental practice material—$573,500, and audiovisual material—$450,500. Other categories not yet mentioned which expect to generate sales greater than $100,000 each are the *ADA Directory*, the *Index to Dental Literature*, the ADA Appointment Books, and the Salable Materials Administrative Center.

There are several new products planned for 1995, and one of the most awaited items will be the premier book in the dental market on insurance coding, *Current Dental Terminology—2nd edition*, scheduled for availability in January. A new publication in the practice management series addressing effective office design is also forecasted in addition to revised medical history and dental claim form records. A major initiative to help rebuild the aging ADA's audiovisual sales library is currently underway with numerous productions in development. Several patient education treatment videos on root canal, extraction, baby bottle tooth decay, periodontal disease, veneers, and mouth protectors are within final stages, as well as a new animated production on nutrition's effect on oral health. And, three new patient video offerings will be geared for the Spanish audience. A select assortment of externally developed products that complement the current ADA product line will also be carried. These lines range from smokeless tobacco models for school and office demonstrations, "Mr. Gross Mouth" and "Mr. Dip Lip," to practice reference resources such as the *Physician's Desk Reference* on CD-ROM.

The program's 1995 budget reflects a reduction of two staff positions with an increase in part-time personnel to allow more flexible scheduling and enhancements to the customer service function. Additionally, a staff writer was added to accelerate the product development process. Further, budget compromises to the Salable Materials base level activities were necessary in order to receive approval for a limited portion of its decision packages calling for investment in research and development, the conversion of select resources to computer disk, and new audiovisual product funding.

Salable Materials—Summary Worksheet

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
NATURAL ACCOUNTS				
REVENUES				
Sales Income	$ 3,991,165	4,350,900	3,989,500	(8%)
Miscellaneous Income	8,307	-	44,500	100%
TOTAL REVENUES	3,999,472	4,350,900	4,034,000	(7%)
EXPENSES				
Staff Compensation	649,223	682,500	725,800	6%
Meeting/Travel Expenses	50,616	54,200	56,900	5%
Office Expenses	67,672	101,000	163,600	62%
Professional Services	9,600	15,000	12,000	(20%)
Publication & Project	1,881,479	2,292,600	2,002,100	(13%)
Other Expenses	90,426	117,200	100,200	(15%)
TOTAL EXPENSES	2,749,016	3,262,500	3,060,600	(6%)
NET REVENUE/(EXPENSE)	1,250,456	1,088,400	973,400	(11%)

Salable Materials—Summary Worksheet (continued)

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
DEPARTMENTS				
REVENUES				
Salable Material Administration	3,999,472	4,350,900	4,034,000	(7%)
TOTAL REVENUES	3,999,472	4,350,900	4,034,000	(7%)
EXPENSES				
Salable Material Administration	2,749,016	3,262,500	3,060,600	(6%)
TOTAL EXPENSES	2,749,016	3,262,500	3,060,600	(6%)
NET REVENUE/(EXPENSE)	$ 1,250,456	1,088,400	973,400	(11%)

Division of Membership and Dental Society Services

The proposed budget for the Division of Membership and Dental Society Services reflects a less than 1% increase ($18,300) in expenses compared to the 1994 budget and decrease of 1% ($36,300) of net funding requested. This reflects the impact of 1994 reorganization and the subsequent movement of programs. An increase of $15,000 in corporate grants for the National Conference on the New Dentist and an increase in Division conference registration fees account for the anticipated increase in revenue of $54,600.

The proposed 1995 budget for the Division of Membership and Dental Society Services includes the budget for the Council on Membership and the Standing Committee on the New Dentist. The Council oversees and evaluates the Association's Recruitment and Retention Business Plan and those Division programs relating to membership marketing. The 1995 budget maintains the support of the successful Field Services Program which has continued to improve membership recruitment and retention and generated increased market share and decreased nonrenew rates in most field sites. The Council oversees the student communications program activities, to enhance the successful transition of student members to full active members. Strong communications and relations with constituent and component organizations will continue to be key in these membership marketing efforts.

The 1995 budget includes support for the Committee on the New Dentist, a Standing Committee of the Board. The Board has directed that members of this Committee be appointed as *ex officio* members of ADA Councils that address issues germane to new dentists. The 1995 budget also includes activities relating to the National Conference on the New Dentist and membership marketing activities that complement the student transition to membership efforts of the Council on Membership, including promotion of alternate dues payment programs to recent graduates. It is anticipated that the focus on the recruitment and retention of new dentists (less than ten years out of dental school) will result in increased dues revenues from this membership category.

The Division's 1995 strategic activities also include further promotion of the value of membership, providing dental society membership resources, expanding field service information through regional Field Service Program Conferences, and increasing liaison and communications with related dental organizations.

Division of Membership and Dental Society Services—Divisional Summary Worksheet

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
NATURAL ACCOUNTS				
REVENUES				
Grants & Contributions	$ 117,000	67,000	82,000	22%
Registration Fee	265,115	56,800	96,400	70%
Miscellaneous Income	(481)	-	-	-
TOTAL REVENUES	381,634	123,800	178,400	44%
EXPENSES				
Staff Compensation	1,739,186	2,113,000	2,033,400	(4%)
Meeting/Travel Expenses	443,706	521,100	513,800	(1%)
Office Expenses	323,091	377,200	383,600	2%
Professional Services	219,740	97,500	146,300	50%
Publication & Project	384,192	472,300	512,800	9%
Other Expenses	12,384	18,400	27,900	52%
TOTAL EXPENSES	3,122,299	3,599,500	3,617,800	<1%
NET REVENUE/(EXPENSE)	(2,740,665)	(3,475,700)	(3,439,400)	(1%)
DEPARTMENTS				
REVENUES				
Department of Membership Services	(661)	3,000	-	(100%)
Marketing & Seminar Services Department	267,954	-	-	-
Dental Society Services	13,495	22,800	43,800	92%
Council on Membership—Program	32,000	32,000	32,000	0%
Commission on Young Professional	68,846	-	-	-
Committee on New Dentist	-	66,000	102,600	55%
TOTAL REVENUES	381,634	123,800	178,400	44%
EXPENSES				
Office of AED/Membership	146,194	225,300	219,800	(2%)
Department of Membership Services	608,063	1,160,900	324,900	(72%)
Marketing & Seminar Services Department	390,714	-	-	-
Membership Marketing	-	-	440,000	100%
Dental Society Services	256,691	372,700	454,100	22%
Council on Membership—Program	831,870	931,300	564,900	(39%)
Call Center	324,316	382,300	391,500	2%
Commission on Young Professional	321,681	-	-	-
Committee on New Dentist	-	373,800	234,600	(37%)
Council on Membership—Administration	44,496	153,200	57,400	(63%)
Field Services Program	198,274	-	400,700	100%
Membership Financial Services	-	-	83,500	100%
Membership Information	-	-	446,400	100%
TOTAL EXPENSES	3,122,299	3,599,500	3,617,800	<1%
NET REVENUE/(EXPENSE)	$(2,740,665)	(3,475,700)	(3,439,400)	(1%)

Division of Conference and Meeting Services

The 1995 expense budget for the Division is $597,600 above the 1994 budgeted level. Income is projected at $634,400 above 1994.

This budget attempts to accurately reflect the increased expense and income resultant from the annual session's growth in scope over the last two years. This growth has resulted in increased expenses in outside services, speaker fees, equipment rental, printing and artwork. In addition, two new staff positions have been added; Exhibit Manager and Conference Service Support Staff. The expense budget also includes $173,900 in 1996 annual session expenses which will be spent in 1995 due to hosting the FDI for the 1996 ADA/FDI World Dental Congress. Promotion for the meeting must begin in 1995.

Revenue from the annual session is projected to increase significantly in the areas of exhibit sales and ticket sales. The net revenue from the 1995 annual session is projected at $1,373,500, 12.9% above 1994 projected.

The Audiovisual Coordinator Budget and Meeting Room Management Budget have been consolidated into one center number.

Division of Conference and Meeting Services—Divisional Summary Worksheet

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
NATURAL ACCOUNTS				
REVENUES				
Rental Income	$ 2,396,994	2,539,000	3,090,000	22%
Sales Income	152,103	175,000	160,000	(9%)
Grants & Contributions	200,576	100,000	100,000	0%
Registration Income	155,110	171,200	173,100	1%
Miscellaneous Income	1,513,272	659,300	755,800	15%
TOTAL REVENUES	4,418,055	3,644,500	4,278,900	17%
EXPENSES				
Staff Compensation	1,522,972	980,000	1,147,100	17%
Meeting/Travel Expenses	2,173,535	1,382,200	1,399,700	1%
Facility & Utility Costs	61,460	59,100	62,000	5%
Office Expenses	218,278	167,100	198,300	19%
Professional Services	694,263	382,700	551,600	44%
Publication & Project	563,323	524,100	743,300	42%
Other Expenses	169,366	32,000	22,800	(29%)
TOTAL EXPENSES	5,403,197	3,527,200	4,124,800	17%
NET REVENUE/(EXPENSE)	(985,142)	117,300	154,100	31%
DEPARTMENTS				
REVENUES				
Office of AED/Conference	8,571	-	-	-
CASIR Program	3,329,359	3,204,700	3,803,100	19%
AS-Social/Special Events	718,028	196,000	260,000	33%
Conference Services	170,656	202,800	174,800	(14%)
Department of International Affairs	9,234	-	-	-
FDI	117,190	-	-	-
Meeting Room Management	20,015	41,000	41,000	0%
Library Services	45,002	-	-	-
TOTAL REVENUES	4,418,055	3,644,500	4,278,900	17%

Division of Conference and Meeting Services—Divisional Summary Worksheet (continued)

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
DEPARTMENTS (continued)				
EXPENSES				
Office of AED/Conference	230,468	262,400	258,200	(2%)
CASIR Program	2,543,888	1,988,300	2,429,600	22%
CASIR Administration	143,264	142,700	29,900	(79%)
AS-Social/Special Events	728,330	196,000	260,000	33%
A.S. Staff Travel	166,825	231,400	226,400	(2%)
A.S. Hosting	45,388	84,500	65,300	(23%)
Conference Services	520,436	535,100	579,000	8%
Department of International Affairs	125,668	-	-	-
ADA Volunteer Service	37,311	39,900	42,700	7%
FDI	280,649	-	-	-
1996 World Dental Congress	-	-	173,900	100%
National Council for International Health	-	-	11,000	100%
A/V Coordination	35,173	36,400	-	(100%)
Meeting Room Management	13,047	10,500	48,800	>100%
Bureau of Library Services	532,750	-	-	-
TOTAL EXPENSES	5,403,197	3,527,200	4,124,800	17%
NET REVENUE/(EXPENSE)	$ (985,142)	117,300	154,100	31%

Division of Finance, Planning & Business Management

The overall role of this Division is to provide the Association with leadership in managing the financial, business and administrative affairs of the Association. Historically, this has focused on the budget process, which serves as a short-term planning mechanism and a blueprint for how limited resources will be allocated among Association programs. The 1993 organizational restructure found the Division divesting itself of information technology responsibilities and assuming a broader role in strategic and policy matters through the inclusion of internal audit and membership insurance programs, as well as an increased emphasis on business planning and management.

Finance and Planning

Office of the Assistant Executive Director: Among the duties of Finance and Planning are oversight of budget preparation, accounting for monies and assets, internal audit, management of real estate holdings and business planning. It is anticipated that expenses for the Office of AED, Finance will rise $13,100 or 4% over the 1994 budget reflecting additional administrative costs associated with supporting the Finance Committee of the Board of Trustees. Projected revenues of $300,000 represent investment earnings on cash flow within the operating account. This anticipated income has been decreased by $100,000 or 25% from 1994 based upon the more recent returns on short-term securities. Actual results may vary depending upon the timing of cash receipts and the prevailing interest rates during the year.

Business Planning and Management: This new Department emerged from the organizational restructure and will focus its efforts on business planning, including assessment and development of new revenue generating activities. In addition to these future-oriented projects, the manager will be responsible for negotiating and administrating business-related contracts, and will function as a resource for monitoring short- and long-term financial goals. This budget package of $138,700 primarily reflects staff salaries, travel and outside consulting as may be required.

Accounting Department: The Accounting Department is responsible for processing payables, receivables, payroll, fixed asset management, inventory controls, billings, cash receipts, and general ledger reporting. Staff assigned to this administrative area are instrumental in developing operating and capital budgets for the Association, tracking actual financial performance, instituting financial controls to safeguard its monies and assets as well as monitoring the investment of all funds. Additionally, the Department prepares the financial statements for the Association and its subsidiaries.

Expenditures within the Accounting Department are expected to increase by only 1.5% in 1995. Miscellaneous income of $25,000 is derived from a charge back of accounting services to the Relief and Endowment funds.

Council on Insurance: The Council on Insurance develops and manages group insurance and retirement programs which are key components in the Association's efforts to recruit and retain members. Its objective is to encourage greater participation in these offerings through superior value in coverage, pricing, and customer services offered by these plans. The budget of the Council, including certain overhead costs, is totally reimbursed from the sponsored insurance and retirement programs and thus is revenue neutral.

Internal Audit: The internal audit function reports to the Board of Trustees and administratively through the Assistant Executive Director, Finance, Planning and Business Management. This individual serves as an extension of the Board-appointed Audit Committee in carrying out its fiduciary responsibilities with regard to internal controls and the financial reporting process. Additionally, this activity is intended to offer constructive suggestions for improving the effectiveness of Association operations. Projected costs of $101,400 for the audit function are less than 1% higher than the 1994 budget.

Division of Finance, Planning & Business Management—Divisional Summary Worksheet

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
NATURAL ACCOUNTS				
REVENUES				
Investment Income	$ 315,719	400,000	300,000	(25%)
Miscellaneous Income	23,009	531,000	504,900	(5%)
TOTAL REVENUES	338,728	931,000	804,900	(14%)
EXPENSES				
Staff Compensation	1,223,597	1,678,600	1,796,400	7%
Meeting/Travel Expenses	4,569	95,700	99,200	4%
Office Expenses	60,860	81,800	80,100	(2%)
Professional Services	96,845	186,000	173,000	(7%)
Publication & Project	46,168	53,600	85,000	59%
Other Expenses	459	106,300	100,100	(6%)
TOTAL EXPENSES	1,432,498	2,202,000	2,333,800	6%
NET REVENUE/(EXPENSE)	(1,093,770)	(1,271,000)	(1,528,900)	20%
DEPARTMENTS				
REVENUES				
Office of AED/Finance	315,719	400,000	300,000	(25%)
Accounting Department	23,009	23,000	25,000	9%
Council on Insurance	-	508,000	479,900	(6%)
TOTAL REVENUES	338,728	931,000	804,900	(14%)
EXPENSES				
Office of AED/Finance	338,979	347,500	360,600	4%
Accounting Department	1,093,519	1,234,900	1,253,200	1%
Business Planning & Management	-	-	138,700	100%
Council on Insurance	-	519,100	479,900	(8%)
Internal Audit	-	100,500	101,400	1%
TOTAL EXPENSES	1,432,498	2,202,000	2,333,800	6%
NET REVENUE/(EXPENSE)	$(1,093,770)	(1,271,000)	(1,528,900)	20%

Association Headquarters Building

This budget forecasts the costs for maintaining the Headquarters Building in a manner that provides an efficient work place for Association staff and will attract tenants to the facility. Expenses of $4,297,500 encompass compensation for the engineering staff, utilities, taxes, janitorial and other maintenance services, as well as fees paid to the building manager. The expected costs associated with the facility were increased by 10% for 1995 as a result of escalating union wages, an anticipated rise in utilities and taxes, in addition to higher maintenance costs on aging mechanical and electrical equipment. Rentals and other miscellaneous building income of $2,378,500 are approximately 1% above budgeted revenues for 1994.

Promotions and contacts with outside brokers are part of a continuing effort to attract additional tenants to the building. Despite these initiatives the glut of office space in Chicago is a competitive reality that has resulted in declining rental rates and other concessions. This problem is compounded by the length of time needed for demolition, asbestos removal and building out space as tenants are identified. Continued economic growth and declining vacancy rates for office buildings are crucial to a recovery in the real estate market and an improved financial picture for the ADA Headquarters facility.

Headquarters Building—Summary Worksheet

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
NATURAL ACCOUNTS				
REVENUES				
Rental Income	$ 1,822,081	2,324,500	2,336,500	<1%
Miscellaneous Income	46,480	30,000	42,000	40%
TOTAL REVENUES	1,868,561	2,354,500	2,378,500	1%
EXPENSES				
Staff Compensation	327,894	387,500	366,900	(5%)
Facility & Utility Costs	3,134,992	3,313,800	3,729,000	13%
Office Expenses	98,833	110,300	114,400	4%
Professional Services	56,936	71,900	59,600	(17%)
Publication & Project	18,350	17,500	22,500	29%
Other Expenses	539	2,300	5,100	>100%
TOTAL EXPENSES	3,637,544	3,903,300	4,297,500	10%
NET REVENUE/(EXPENSE)	(1,768,983)	(1,548,800)	(1,919,000)	24%
DEPARTMENTS				
REVENUES				
Headquarters Building	1,868,561	2,354,500	2,378,500	1%
TOTAL REVENUES	1,868,561	2,354,500	2,378,500	1%
EXPENSES				
Headquarters Building	3,637,544	3,903,300	4,297,500	10%
TOTAL EXPENSES	3,637,544	3,903,300	4,297,500	10%
NET REVENUE/(EXPENSE)	$(1,768,983)	(1,548,800)	(1,919,000)	24%

Central Services

Central Services is an administrative support agency for other departments within the organization. The purchasing area is a link between the Association and its suppliers, seeking cost efficiencies through competitive bidding, aggressive negotiations and progressive buying practices. The Department also includes shipping and receiving, mail room, inventory storage and control, and duplicating functions. The 1995 projected costs for Central Services as a whole are up $25,600 over the current year, primarily reflecting the addition of a Print Facilitator to assist in the selection of design and print vendors in an effort to minimize these costs. The $62,500 expense related to this position was offset by certain reorganizational efficiencies that stemmed from the Early Retirement Program.

Central Services—Summary Worksheet

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
NATURAL ACCOUNTS				
REVENUES				
Sales Income	$ 1,110	-	-	-
Miscellaneous Income	304,608	1,000	1,000	0%
TOTAL REVENUES	305,718	1,000	1,000	0%
EXPENSES				
Staff Compensation	1,805,158	746,400	786,300	5%
Meeting/Travel Expenses	10,278	1,300	1,300	0%
Office Expenses	439,970	37,100	32,700	(12%)
Professional Services	10,015	6,000	-	(100%)
Publication & Project	41,436	24,200	20,300	(16%)
Other Expenses	(7,750)	1,800	1,800	0%
TOTAL EXPENSES	2,299,107	816,800	842,400	3%
NET REVENUE/(EXPENSE)	(1,993,389)	(815,800)	(841,400)	3%
DEPARTMENTS				
REVENUES				
Information Technology	301,678	-	-	-
Central Services	4,040	1,000	1,000	0%
TOTAL REVENUES	305,718	1,000	1,000	0%
EXPENSES				
Information Technology	1,488,154	-	-	-
Central Services	148,655	156,800	183,800	17%
Duplicating	212,280	199,800	203,000	2%
Shipping & Receiving	450,018	460,200	455,600	(1%)
TOTAL EXPENSES	2,299,107	816,800	842,400	3%
NET REVENUE/(EXPENSE)	$(1,993,389)	(815,800)	(841,400)	3%

Central Administration

Central Administration combines into one cost center those revenue and expense activities that do not directly relate to any one division but rather reflect upon the Association in its entirety. These include retiree fringe benefits, Association membership dues, grants, depreciation on furniture, equipment and the like.

For 1995 the expenditure budget is $3,171,600 compared to $2,444,300 for 1994. Revenues are expected to decline from $33,347,800 to $33,025,500 primarily as a result of a reporting change in which the contribution from reserves for the for-profit subsidiary dividend ($825,000 budgeted for 1995) is not included in central administration revenue but is reflected as a "below the line" item on the Association's overall budget summary.

The following explains each account used in this budget and any significant variances from 1994.

Central Administration—Revenue—Divisional Summary Worksheet

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
REVENUES				
Membership Dues	$29,502,313	29,625,000	29,490,100	(<1%)
Dues for Capital Improvement Program	5,878,424	5,925,000	5,898,790	(<1%)
Transfer of Dues	(5,878,424)	(5,925,000)	(5,898,790)	(<1%)
Dues Rebate	(61,300)	(90,000)	(90,000)	0%
ASDA Coupons	(102,060)	(130,200)	(71,500)	(45%)
Equipment Leasing Income	15,004	15,000	-	(100%)
Overhead Income	750,068	550,000	750,000	36%
Royalties	2,846,772	2,503,000	2,896,900	16%
Contribution from Invest	-	825,000	-	(100%)
Major Medical Refund	2,500,000	-	-	-
Miscellaneous Income	14,781	50,000	50,000	0%
TOTAL REVENUE	$35,465,578	33,347,800	33,025,500	(1%)

Membership Dues: Since member dues are the result of all activities of the Association they are recorded in this Division. Despite a 20% dues increase in 1993 to support the building renovation program, this category of income is not expected to change materially in 1995. This assumption is based upon a relatively small increase in membership levels in the future. The $29,490,100 projection does not include the $55 dues increase relating to the Capital Improvement Program, Res. 110H-1992 (*Trans.*1992:587). These dues monies are budgeted in Central Administration and subsequently transferred out of the General Fund to the Capital Improvement Account.

Dues Rebate: When constituent dental societies submit their dues to the Association in December, January or February they receive an economic incentive in the form of interest on these funds through March 31. Based upon recent participation and prevailing interest rates the amount of this rebate is expected to remain constant at $90,000.

ASDA Coupons: The Dues Coupon Program was established to grandfather all 1989 through 1992 junior and senior student members of ASDA into the reduced dues structure which was in effect in 1991. Each year, for a four-year period, these coupons are sent directly to eligible individuals, who pay the regular dues rate and a check in the amount of $20 is mailed back to them. The budget is being reduced by $58,700 to reflect the declining number of eligible members.

Equipment Leasing: This account has recorded charges to ADA Publishing Company, Inc. (ADAPCO) for the rental of certain equipment from the Association. The agreement has been in effect since the creation of the subsidiary companies and the actual amount has decreased as the equipment has aged and has been taken out of service. The budget has been reduced to zero to reflect the fact that all of the equipment leased to the subsidiary operation from the ADA has been retired from service.

Overhead Income: When the Association conducts research for the federal government it is reimbursed for actual costs. It does, however, incur various overhead expenses related to this activity such as data processing costs, utilities, etc. Based upon preestablished criteria, certain of these costs can be recouped. The Association also recovers certain overhead expenses from the insurance carriers who participate in the members' insurance program.

Royalty Income: The ADA earns royalties from financial arrangements with various third parties. For 1995, royalty income is projected to increase by $393,900. The composition of royalty income is outlined below:

Credit Card Revenue. Affinity card and related product revenue under the relationship with MBNA America is expected to generate $2,642,500 of revenue in 1995, compared to 1994 budgeted income of $2,278,000. This projected increase in credit card revenue encompasses the majority of the growth in total royalty income.

Hertz Royalty Revenue. The Association projects 1995 revenue of $31,400 as a result of the members' utilization of the Hertz rental program.

Membership Service Royalty. This $100,000 revenue item pertains to royalty fees from the Prudential Home Mortgage Program. Budgeted 1995 revenue is consistent with 1994.

Lease Program Royalty. Royalty income of $123,000 is projected in 1995 from the equipment leasing program versus the 1994 budget of $80,000.

Contribution from Investments: This account reflects dividends from the for-profit subsidiaries which are considered a transfer from Reserves to the Operating Account and, as such, are not recorded as income. All such transactions must be authorized by the Board of Trustees. They are, however, recorded at the bottom of the Association's financial statements as a dividend. The 1995 budget anticipates a dividend from the for-profit subsidiaries of $825,000, which is consistent with 1994.

Miscellaneous Income: Includes many small items of revenue which are generated throughout the year and do not relate directly to any specific Association activity. There is no change budgeted for this revenue in 1995.

Expenses: Expenses in Central Administration are largely compensation related. Other costs pertain to program activities within the Association as well as grants to various related organizations.

Central Administration—Expenses—Divisional Summary Worksheet

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
EXPENSES				
Salaries	$ 57,502	(622,400)	(309,000)	(50%)
Payroll Taxes	4,716	(56,900)	(24,700)	(57%)
Fringe Benefits	37,665	(123,400)	(52,500)	(57%)
Chargeback—Taxes & Benefits	(4,025,677)	(4,205,600)	(4,532,800)	8%
FICA Payroll Tax	1,294,817	1,193,300	1,343,800	13%
SUI Payroll Tax	100,741	75,300	110,900	47%
FUI Payroll Tax	26,585	26,500	29,300	11%
Pension Fund	1,397,179	1,942,900	2,000,000	3%
Life Insurance—Salary Continuation	161,819	207,700	199,000	(4%)
Group Medical Cost	983,995	1,239,700	1,436,800	16%
Dental Insurance Cost	280,108	312,000	312,100	0%
401K	108,315	132,000	125,500	(5%)
Agency Compensation Adjustment	61,750	262,000	262,000	0%
TOTAL COMPENSATION	489,515	383,100	900,400	>100%

Central Administration—Expenses—Divisional Summary Worksheet (continued)

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
EXPENSES (continued)				
Telephone	52,516	140,000	140,000	0%
Repairs/Maintenance	86,834	110,000	110,000	0%
Outside Services	63,079	24,000	24,000	0%
General Insurance	247,423	296,600	326,300	10%
Office & Storage Rental	2,159	2,500	2,500	0%
Contract Fee—ADAPCO	760,000	760,000	760,000	0%
Misc Professional Fees	-	48,000	48,000	0%
Hillenbrand Fellowship	6,500	17,000	17,000	0%
National Foundation of Dentistry	45,000	70,000	50,000	(29%)
Alliance to the ADA	20,000	20,000	20,000	0%
ASDA Delegate to Annual Session	-	-	3,400	100%
Federation of Special Care Organizations	24,000	15,000	-	(100%)
Depreciation Fixtures	777,249	650,000	750,000	15%
Interest on Loans	13,601	-	-	-
Income Taxes	19,149	20,000	20,000	0%
Overhead	(444,690)	(561,900)	(450,000)	(20%)
Contingent Fund	235,652	350,000	350,000	0%
Funded by Reserves	255,940	-	-	-
Miscellaneous Expense	7,214	100,000	100,000	0%
TOTAL PROGRAM/ACTIVITY	2,171,726	2,061,200	2,271,200	10%
TOTAL EXPENSE	2,661,241	2,444,300	3,171,600	30%
NET REVENUE/(EXPENSE)	$32,804,337	30,903,500	29,853,900	(3%)

Compensation Savings: In 1995, compensation (salaries, payroll taxes and fringe benefits) savings of $386,200 are projected as a result of normal staff turnover. This is significantly less than the $802,700 compensation savings budgeted in 1994 from open positions attributable to the Early Retirement Program in 1992 and a subsequent moratorium on hiring. The 1995 budget anticipates the filling of currently open positions.

Chargeback of Taxes and Benefits: Budgeted fringe benefits and payroll taxes for all employees are accumulated in the Central Administration budget. After the total is determined, each individual employee's actual cost is allocated back to the respective operating unit. This line item provides the mechanism for such transactions.

Payroll Taxes: As an employer the Association must pay social security tax (FICA) and federal and state unemployment taxes (FUI and SUI) for all employees. The increases from the 1994 budget are meant to more accurately estimate these costs in relation to expected salary costs.

Pension Fund: Projected pension expense in 1995 of $2 million is $57,100 higher than allocated in the 1994 budget. Both the 1994 and 1995 budgeted amounts include $100,000 for the supplemental pension fund, with the remainder attributed to the qualified fund. Historically, the ADA has budgeted the cash contributions to the pension plan as determined by the Association's independent actuary. This practice was again followed in 1995.

Life Insurance: It has been the policy of the Association to provide term life insurance to current employees in proportion to their salary. This amount has been reduced for 1995 by $8,700.

Group Medical Insurance: The Association provides current and retired employees with group medical insurance on a shared cost basis. As a result of an accounting rule change (FAS 106) the Association must allocate additional funds to meet the anticipated liability for future benefits for retirees. In response to this accounting change the Board of Trustees adopted at its December, 1993 meeting Resolution B-117-1993 to modify the retiree medical plan. Based upon calculations by the Association's independent actuary, annual cash funding in the amount of $625,000 was determined to be required to meet these anticipated retiree benefit costs. This amount (net of payments for the benefit of current retirees) will be physically segregated into the Restricted Reserve account to offset the anticipated liability. The $197,100 increase over 1994 of total group medical insurance reflects

the impact of this $625,000 in required funding offset by anticipated reductions in costs attributed to current employees.

Dental Insurance: The Association provides current and retired employees with dental coverage based upon a direct reimbursement plan. Expenses are expected to remain relatively constant based upon past utilization.

401(K): All full-time employees may contribute to this plan with the Association providing limited matching based upon established guidelines. The 1995 budget reflects the anticipated cost savings resulting from the selection of a new program administrator.

Agency Compensation Adjustment: These funds are to be used exclusively by the Executive Director to provide compensation increases for mid-year evaluations of new employees and position upgrades of current employees. No increase has been budgeted for 1995.

Telephone Expense: Costs of the Association's outbound long distance service, its charge for local telephone service and other expenses related to telephone usage are included in this item. No increase has been budgeted for 1995 since the Association has purchased its own switching equipment.

Repairs and Maintenance: This line item is for general repair and maintenance costs for Association space. Although specific expenses cannot be identified, this line item provides funding for such activities. No increase is budgeted for 1995.

Outside Services: This account includes the cost of the Association's coffee service.

General Insurance: Reflects the costs of insuring the Association against all major risks. The increase of $29,700 is for inflationary increases and does not reflect any changes in coverage.

Office and Storage Rental: The Association rents space outside of the Headquarters Building to store items that are used infrequently such as the annual session packing crates. No increase has been budgeted for 1995.

Contract Fee—ADA Publishing Company, Inc (ADAPCO): These expenses of $760,000 pertain to the various publishing services the ADAPCO subsidiary performs for the Association. No increase has been budgeted for 1995.

Miscellaneous Professional Fees: The fees relate to consulting services in evaluating and negotiating an expanded menu of financial products to be made available to the membership.

Hillenbrand Fellowship: The Board believed that this activity was sufficiently important to be funded at the 1994 level of $17,000.

National Foundation of Dentistry for the Handicapped: Support for the National Foundation of Dentistry for the Handicapped was reduced from $70,000 to $50,000 in 1995 as part of a three-year program to phase out financial support to this organization.

Alliance to the American Dental Association: Funding to the Alliance for 1995 will remain at the 1994 level of $20,000.

ASDA Delegation to ADA Annual Session: This grant, to support ASDA representation at the ADA annual session, is new for 1995. This grant is meant to provide participation by the delegate, delegate-elect and executive director.

Federation of Special Care Organizations in Dentistry: No funding was provided for a grant to this organization in 1995 as part of the Association's policy of reducing financial support to external organizations.

Depreciation—Fixtures: Relates to depreciation for all non-building items such as desks, chairs, computer software, etc. The $100,000 budgetary increase is partly attributable to the purchase of telephone switching and computer equipment.

Income Tax: The Association is subject to tax on income deemed as unrelated to its exempt purpose such as the sale of mailing lists, parking fee income and other fees. This taxable income is offset in part by losses from the ADREC subsidiary. The net effect of these transactions is a $20,000 budgeted income tax expense for 1995 which is unchanged from 1994.

Overhead: The overhead expenses in this line item are listed as negative amounts because they are expenses which are recovered from subsidiary operations. This account also includes the allocation of various overhead costs relating to the Council on Insurance whose budget is reimbursed by insurance companies. The decrease in this item relates to a lower level of recovered expenses from both of these sources.

Contingent Fund: During the course of the year situations may arise which require funding not contemplated in the budget. In these circumstances the Board of Trustees may authorize a transfer of monies from the contingent fund to address these needs. The $350,000 budgeted for this purpose was not increased for 1995.

Miscellaneous Expenses: This category includes small items of expense incurred throughout the year that do not relate directly to any specific Association activity, such as bank wire transfer fees. No increase has been budgeted for 1995.

Central Administration—Divisional Summary Worksheet

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
NATURAL ACCOUNTS				
REVENUES				
Membership Dues	$29,338,953	29,404,800	29,328,600	(<1%)
Rental Income	(147,502)	15,000	-	(100%)
Registration Fee Income	-	-	-	-
Investment Income	-	-	-	-
Miscellaneous Income	6,274,127	3,928,000	3,696,900	(6%)
TOTAL REVENUES	35,465,578	33,347,800	33,025,500	(1%)
EXPENSES				
Staff Compensation	489,515	383,100	900,400	>100%
Meeting/Travel Expenses	111,839	42,700	-	(100%)
Facility & Utility Costs	2,806	-	-	-
Office Expenses	400,369	548,100	576,300	5%
Professional Services	428,533	249,600	72,000	(71%)
Publication & Project Costs	609	12,000	-	(100%)
Grants—Related Health Groups	100,500	122,000	90,400	(26%)
Depreciation/Amortization	777,347	650,000	750,000	15%
Interest Expense	13,601	-	-	-
Other Expenses	316,973	416,800	762,500	83%
EXPENSES SUB-TOTAL	2,642,092	2,424,300	3,151,600	30%
Income Taxes	19,149	20,000	20,000	0%
TOTAL EXPENSES	2,661,241	2,444,300	3,171,600	30%
NET REVENUE/(EXPENSE)	32,804,337	30,903,500	29,853,900	(3%)
DEPARTMENTS				
REVENUES				
Central Administration	35,465,578	33,347,800	33,025,500	(1%)
TOTAL REVENUES	35,465,578	33,347,800	33,025,500	(1%)
EXPENSES				
Central Administration	2,661,241	2,444,300	3,171,600	30%
TOTAL EXPENSES	2,661,241	2,444,300	3,171,600	30%
NET REVENUE/(EXPENSE)	$32,804,337	30,903,500	29,853,900	(3%)

Division of Dental Practice

Council on Community Health, Hospital, Institutional and Medical Affairs: The 1995 proposed budget for the Council reflects two major changes. The first change is the transfer of the Office of Quality Assurance (now the Office of Quality Assessment and Improvement) to the Council on Dental Benefit Programs. The second modification is the phase out of the Council's cosponsorship with the Federation of Special Care Organizations in Dentistry of the National Conference on Special Care Issues in Dentistry.

Council on Dental Benefit Programs: The Council on Dental Benefit Programs' 1995 budget reflects many changes. First, the Council will offer a National Peer Review Conference in 1995 and this Conference, plus the expansion of peer review assistance programs, accounts for the increase in the 1995 budget. This Conference is needed to emphasize the

importance of bringing state dental society peer review programs into a uniform, national design, with the exception of those areas where state laws require different processes. Without a uniform peer review system, the profession is vulnerable and may eventually be required to submit to professional review systems developed by regulatory agencies.

Second, the Office of Quality Assessment and Improvement (OQA&I) has been moved to the Council. The 1995 budget is difficult to compare with the 1994 budget in that personnel needed to staff the department are not reflected in the 1994 budget. In reality, activities reflected in the 1995 budget for this cost center are less than those reflected in the 1994 budget. The Council's administrative budget reflects increased line items in subscriptions, postage, office supplies, etc. to support the OQA&I.

Third, as can be seen by the budget for this cost center, the Purchaser Information Service has dropped several of the trade shows at which direct reimbursement and fee-for-service dental plans have been promoted and exhibited in the past years. This is not an economy move, per se. It is part of the Council's overall review of the effectiveness of its programs. Some of the trade shows are no longer useful vehicles for the Association. As other shows are identified, they will be factored into future budgets.

It is unlikely that the Council will offer a Dental Benefits Conference in 1995 based on the inability to raise appropriate funding for the program. The Council will make its decision regarding the 1995 Conference in December 1994.

Council on Dental Practice: The proposed 1995 budget for the Council on Dental Practice contains funding for several new activities such as support for a 1995 national conference on well-being, a national conference on computers in clinical dentistry, and advisory committees on dental team issues and the content elements of the computer-based patient dental record. Further, the budget includes the ability to conduct OSHA regional task force meetings to update the regional OSHA task force chairs about ongoing OSHA activities.

Under the reorganization plan, the Departments of Marketing and Seminar Services have been moved to the Division of Dental Practice (under the purview of this Council). Budget variances are shown for these two cost centers since they were developed conjointly in 1994 and separately in 1995, under the agency restructuring plan.

Department of Dental Informatics: The Department of Dental Informatics has been monitoring efforts of the health care informatics industry and participating in standard-setting activities for the past few years. Expenses for 1995 will increase because the activities for 1995 will expand, requiring more staff participation in standards-setting groups such as computer-based patient records, electronic data interchange and computer-based information technologies. In addition, three task groups for clinical information systems have now been established by the Association to promote the concept of a computerized clinical work station and allow the integration of different software and hardware components into one system. The groups will be writing technical reports, guidelines and standards on electronic technologies used in dental practice.

Health Policy Resource Center: Under the reorganization, a new department has been added to the Division of Dental Practice. This Department, the Health Policy Resource Center, includes staffing for a director and administrative secretary, and will be responsible for gathering and collating data on health systems to meet the needs of the Association. This Department is not revenue-producing to the Association.

Division of Dental Practice—Divisional Summary Worksheet

NATURAL ACCOUNTS	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
REVENUES				
Rental Income	$ 3,600	4,000	59,700	>100%
Sales Income	362	500	-	(100%)
Grants & Contributions	117,439	256,000	60,000	(77%)
Registration Fee Income	70,389	247,100	414,500	68%
Miscellaneous Income	504,735	3,000	40,000	>100%
TOTAL REVENUES	696,525	510,600	574,200	12%
EXPENSES				
Staff Compensation	2,202,928	1,936,800	2,001,700	3%
Meeting/Travel Expenses	586,974	794,400	917,100	15%
Office Expenses	115,605	115,700	130,600	13%
Professional Services	840,040	253,800	242,800	(4%)
Publication & Project	403,750	496,100	452,300	(9%)
Other Expenses	(1,016)	45,300	82,200	81%
TOTAL EXPENSES	4,148,281	3,642,100	3,826,700	5%
NET REVENUE/(EXPENSE)	(3,451,756)	(3,131,500)	(3,252,500)	4%

Division of Dental Practice—Divisional Summary Worksheet (continued)

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
DEPARTMENTS				
REVENUES				
Council on Dental Practice—Administration	120,295	154,100	139,100	(10%)
CDP—Dental Practice Marketing	-	268,000	-	(100%)
CDP—Seminars	-	-	327,800	100%
Council on Dental Benefit Programs—Administration	21,405	-	-	-
Code on Dental Procedures, Third Party Issues	14,034	-	104,300	100%
Purchaser Information Service	-	3,000	3,000	0%
CCHHIMA	52,800	85,500	-	(100%)
Council on Insurance	391,286	-	-	-
BEBR	96,705	-	-	-
TOTAL REVENUES	696,525	510,600	574,200	12%
EXPENSES				
Office of AED/Dental Practice	252,723	254,000	257,400	1%
Council on Dental Practice—Administration	681,559	717,600	660,100	(8%)
CDP—Dental Practice Marketing	-	440,900	170,200	(61%)
CDP—Seminars	-	-	344,200	100%
OSHA Update	-	16,300	16,600	2%
Council on Dental Benefit Programs—Administration	258,307	269,900	299,800	11%
Code on Dental Procedures, Third Party Issues	281,763	273,500	327,800	20%
Purchaser Information Service	386,682	488,100	381,200	(22%)
CCHHIMA	689,335	785,500	660,100	(16%)
Council on Insurance	396,744	-	-	-
BEBR	1,091,884	-	-	-
Department of Dental Informatics	109,284	228,300	248,000	9%
Dental Practice Parameters	-	168,000	256,000	52%
Health Policy Resource Center	-	-	205,300	100%
TOTAL EXPENSES	4,148,281	3,642,100	3,826,700	5%
NET REVENUE/(EXPENSE)	$(3,451,756)	(3,131,500)	(3,252,500)	4%

Education and Science

Education and Science was created in 1994 to have administrative oversight to the Division of Education, the Division of Science, the Survey Center and the Health Foundation. This is a new budget line for the Association.

The 1995 budget for this office includes the salaries of the Associate Executive Director and Staff Associate as well as those liaison activities required for the administration and operation of this office.

Education and Science—Summary Worksheet

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
NATURAL ACCOUNTS				
EXPENSES				
Staff Compensation	-	-	$ 268,900	100%
Meeting/Travel Expenses	-	-	11,200	100%
Office Expenses	-	-	4,700	100%
Publication & Project	-	-	1,500	100%
Other Expenses	-	-	7,900	100%
TOTAL EXPENSES	-	-	294,200	100%
NET REVENUE/(EXPENSE)	-	-	(294,200)	100%
DEPARTMENTS				
EXPENSES				
Education & Science	-	-	294,200	100%
TOTAL EXPENSES	-	-	294,200	100%
NET REVENUE/(EXPENSE)	-	-	$ (294,200)	100%

Division of Education

The Division of Education is made up of three agencies with *Bylaws* authority: the Council on Dental Education, the Commission on Dental Accreditation, and the Joint Commission on National Dental Examinations; and two departments: the Department of Testing Services and the Department of Library Services. Among its responsibilities, the Council on Dental Education provides oversight for the Continuing Education Recognition Program (CERP), Career Guidance, and the Dental Admission Testing Program (DAT).

The 1995 budget projects an increase in revenue ($511,300), primarily from testing fees, accreditation fees, and CERP fees. The Commission on Dental Accreditation, for the first time, will be charging a fee for all of its accredited programs. Testing fees have been increased to meet the increased costs of the testing programs, and increased CERP revenues are anticipated as more providers of continuing dental education apply for recognition.

The 1995 budget projects a decrease in expenses ($236,000), primarily due to decreases in overall salary costs related to the relocation of the Department of Educational Surveys to the newly created Survey Center and the completion of the development of allied dental personnel career videos.

New activities proposed for 1995 include the development of a pilot case-based examination for the National Board Dental Hygiene Examination, revision of predoctoral and GPR accreditation standards, and training of additional consultants for accreditation. A continuing House-directed activity included in the budget is the study of the roles of allied dental personnel.

The Joint Commission on National Dental Examinations (JCNDE) has approved a candidate assessment to create a research and development fund earmarked for the Dental Interactive Simulations Corporation (DISC). The JCNDE represents the Association on the DISC Board of Directors and has joined other members of DISC in assessing test candidates for the purpose of funding DISC's development of computer-based patient simulations. The action of the JCNDE approves the assessment from 1995 through 1999. This assessment will be added to the increase in candidate fees required to meet the costs of the National Board Examinations. The assessments for 1995 are estimated to approximate $275,000. As the assessments are received after each testing period, the same amount will be forwarded to DISC. Therefore, this activity will have no budgetary impact for the Association and will not be included in the detailed budget report. The JCNDE will monitor the progress of DISC annually in order to justify the continuation of this assessment through 1999.

Division of Education—Divisional Summary Worksheet

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
NATURAL ACCOUNTS				
REVENUES				
Sales Income	$ -	10,000	10,000	0%
Testing Fee Income	2,557,290	2,678,000	2,946,300	10%
Grants & Contributions	82,300	-	-	-
Registration Fee Income	60,635	60,000	100,000	67%
Miscellaneous Income	48,278	141,000	344,000	>100%
TOTAL REVENUES	2,748,503	2,889,000	3,400,300	18%
EXPENSES				
Staff Compensation	2,481,573	3,231,400	3,116,900	(4%)
Meeting/Travel Expenses	882,563	1,018,500	1,037,000	2%
Office Expenses	124,245	171,400	162,700	(5%)
Professional Services	214,241	259,500	261,700	1%
Publication & Project	518,980	728,700	583,000	(20%)
Grants—Related Health Groups	48,090	51,800	64,500	25%
Other Expenses	28,307	71,600	71,100	(1%)
TOTAL EXPENSES	4,297,999	5,532,900	5,296,900	(4%)
NET REVENUE/(EXPENSE)	(1,549,496)	(2,643,900)	(1,896,600)	(28%)
DEPARTMENTS				
REVENUES				
Council on Dental Education	1,820	-	-	-
Dental Education Accreditation	20	-	250,000	100%
Continuing Education	57,300	60,000	106,000	77%
Testing—National Boards	1,550,031	1,669,800	1,763,400	6%
Testing—Admissions	1,052,364	1,036,200	1,215,900	17%
Educational Surveys & Administrative Affairs	2,968	-	-	-
Career Guidance	84,000	-	-	-
Library Services	-	123,000	65,000	(47%)
TOTAL REVENUES	2,748,503	2,889,000	3,400,300	18%
EXPENSES				
Office of AED/Education	260,835	271,100	328,000	21%
Council on Dental Education—Administration	269,120	648,900	424,700	(35%)
Dental Education Accreditation	1,382,068	1,460,000	1,396,900	(4%)
Continuing Education	20,677	134,800	148,500	10%
Testing—National Boards	1,247,984	1,266,600	1,311,400	4%
Testing—Admissions	693,715	778,600	822,200	6%
Educational Surveys & Administrative Affairs	236,562	-	-	-
Career Guidance	187,038	271,900	175,000	(36%)
Library Services	-	701,000	690,200	(2%)
TOTAL EXPENSES	4,297,999	5,532,900	5,296,900	(4%)
NET REVENUE/(EXPENSE)	$(1,549,496)	(2,643,900)	(1,896,600)	(28%)

Division of Science

The Division of Science is composed of the Council on Scientific Affairs with a 1995 budget of $1,913,100. The merging of the three Councils realizes a savings of $107,700 from the 1994 budget of $2,020,800. These savings are due to reduced number of volunteers required to attend council meetings along with a reduction in costs associated with laboratory equipment purchases and special outside services. An increase in revenue of $535,200 is projected in anticipation of a submission and maintenance fee being established in July 1995 for the Seal Programs.

The Council will continue to evaluate dental products, develop standards and guidelines for product evaluation, and respond to the critical issues that have arisen in recent years including the safety of amalgam, fluoride mechanisms, infection control, infectious disease transmission (HIV, HBV, HCV and TB in the dental office), compliance with OSHA's Bloodborne Pathogens Standard, and a commitment to contribute updates for the *ADA Regulatory Compliance Manual.* Additional issues involve handpieces, a study of mercury in wastewater, an assessment of amalgam separators for the dental office, latex sensitivity, and the proper handling of medical waste from the dental office.

Division of Science—Divisional Summary Worksheet

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
NATURAL ACCOUNTS				
REVENUES				
Miscellaneous Income	$ -	-	535,200	100%
TOTAL REVENUES	-	-	535,200	100%
EXPENSES				
Staff Compensation	1,131,616	1,655,800	1,636,700	(1%)
Meeting/Travel Expenses	95,486	130,700	157,900	21%
Office Expenses	49,927	111,600	61,600	(45%)
Professional Services	4,149	75,000	6,000	(92%)
Publication & Project	24,249	23,600	24,100	2%
Grants—Related Health Groups	5,000	5,000	5,000	0%
Other Expenses	16,192	19,100	21,800	14%
TOTAL EXPENSES	1,326,619	2,020,800	1,913,100	(5%)
NET REVENUE/(EXPENSE)	(1,326,619)	(2,020,800)	(1,377,900)	(32%)
DEPARTMENTS				
REVENUE				
Office of AED/Science	-	-	535,200	100%
TOTAL REVENUES	-	-	535,200	100%
EXPENSES				
Office of AED/Science	202,080	559,200	390,700	(30%)
Council on Dental Therapeutics	491,320	533,200	1,522,400	>100%
CDMIE	612,165	815,300	-	(100%)
Council on Dental Research	21,054	113,100	-	(100%)
TOTAL EXPENSES	1,326,619	2,020,800	1,913,100	(5%)
NET REVENUE/(EXPENSE)	$(1,326,619)	(2,020,800)	(1,377,900)	(32%)

American Dental Association Health Foundation

The American Dental Association Health Foundation (Foundation) provides administrative support for the Research Institute and Instrument Facility located in Chicago, Illinois, and the Paffenbarger Research Center (PRC) located in Bethesda. As a 501 (c)(3) tax-exempt corporation, the Foundation conducts fund-raising activities supporting dental research, education and charitable projects conducted by the American Dental Association.

Research projects currently being conducted by the Research Institute include: amalgam in wastewater, subgingival plaque acids and Hepatitis B and HIV Seroprevalence. The Institute is also working closely with the Council on Dental Therapeutics reviewing fluoride dentifrices. Through its Health Screening activities at the Association's annual session, the Institute also assesses mercury levels in participating dentists.

The PRC is comprised of four components: Dental Chemistry, Clinical Research, Polymer Chemistry and Dental Crystallography. Results of PRC research are disseminated through presentations to dental groups and publications in journals. Grants by the National Institute of Dental Research support approximately 90% of the scientific staff of the PRC.

The Instrument Facility supports the equipment needs of the research areas of the Association. The staff member of the Facility is supported by both the Foundation and the Association.

The Board of Trustees of the American Dental Association has asked that the Foundation broaden its activities to assure that the Foundation becomes the dental profession's premier charitable corporation. To that end, a staff task force developed a business protocol which was considered by the Board of Trustees and forwarded to the Foundation's Board of Directors for consideration during its June 1994 meeting. Included in the business plan was a recommendation to increase the size of the Foundation's staff by one individual and conduct meetings of a Development Committee whose purpose is to recommend fund-raising strategies.

The 1995 budget request was developed to implement the expanded role of the Foundation as set forth in the business plan. This necessitated staffing the Foundation director's office, which had previously been vacant. Outside legal fees, required to manage patent and royalties generated by Association and required government report filing, has increased considerably in recent years. To accurately reflect these legal expenses, a $115,000 decision package was included in the budget package. Finally, in adopting the business plan, the Board of Trustees approved an additional decision package which provided funding for the additional staff member who will be conducting fund-raising activities. In defining a new Board of Directors structure, meeting costs and travel expenses which had not been reported for previous budget requests also had to be added to the final 1995 budget.

ADA Health Foundation—Summary Worksheet

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
NATURAL ACCOUNTS				
REVENUES				
Grants & Contributions	-	39,600	18,900	(52%)
Miscellaneous Income	$ 55,000	94,200	-	(100%)
TOTAL REVENUES	55,000	133,800	18,900	(86%)
EXPENSES				
Grants—Related Health Groups	1,390,863	1,490,700	1,965,400	32%
TOTAL EXPENSES	1,390,863	1,490,700	1,965,400	32%
NET REVENUE/(EXPENSE)	(1,335,863)	(1,356,900)	(1,946,500)	43%

ADA Health Foundation—Summary Worksheet (continued)

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
DEPARTMENTS				
REVENUES				
ADA Health Foundation	55,000	94,200	-	(100%)
Research Institute	-	-	-	-
Paffenbarger Research Center	-	39,600	18,900	(52%)
TOTAL REVENUES	55,000	133,800	18,900	(86%)
EXPENSES				
ADA Health Foundation	93,369	96,100	465,500	>100%
Research Institute	442,959	480,200	480,200	0%
Instrument Facility	36,825	40,500	39,600	(2%)
Paffenbarger Research Center	817,710	873,900	980,100	12%
TOTAL EXPENSES	1,390,863	1,490,700	1,965,400	32%
NET REVENUE/(EXPENSE)	$(1,335,863)	(1,356,900)	(1,946,500)	43%

Survey Center

The Bureau of Economic and Behavioral Research was merged with the Department of Educational Surveys in November 1993. The base budget reflects this merger. The biennial Legal Provisions Survey will be conducted in 1995. The increase in staff compensation relates to the relocation of three exempt and one non-exempt staff from the Department of Educational Surveys. The increase in revenue is projected from the sale of survey results.

Survey Center—Summary Worksheet

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
NATURAL ACCOUNTS				
REVENUES				
Miscellaneous Income	-	$ 45,500	86,000	89%
TOTAL REVENUES	-	45,500	86,000	89%
EXPENSES				
Staff Compensation	-	684,400	848,000	24%
Meeting/Travel Expense	-	14,000	14,600	4%
Office Expense	-	48,400	57,600	19%
Professional Services	-	559,700	690,100	23%
Publication & Project	-	42,800	41,000	(4%)
Other Expenses	-	3,700	5,600	51%
TOTAL EXPENSES	-	1,353,000	1,656,900	22%
NET REVENUE/(EXPENSE)	-	(1,307,500)	(1,570,900)	20%

Survey Center—Summary Worksheet (continued)

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
DEPARTMENTS				
REVENUES				
Educational Surveys and Administrative Affairs	-	4,500	-	(100%)
BEBR	-	41,000	-	(100%)
Survey Center	-	-	86,000	100%
TOTAL REVENUES	-	45,500	86,000	89%
EXPENSES				
Educational Survey and Administrative Affairs	-	251,400	-	(100%)
BEBR	-	1,101,600	-	(100%)
Survey Center	-	-	1,656,900	100%
TOTAL EXPENSES	-	1,353,000	1,656,900	22%
NET REVENUE/(EXPENSE)	-	$(1,307,500)	(1,570,900)	20%

Human Resources

The 1994 budget for the Department of Human Resources includes the expenses for the Quality Improvement Process (QIP), which in 1995 were transferred to the Department of Quality and Strategic Planning. After subtracting the QIP budgeted expenses from the 1994 budget, the Department of Human Resources 1995 budget reflects a slight decrease. All budget packages reflect some inflationary increases with no change in programs or benefits offered to staff.

Human Resources—Summary Worksheet

	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
NATURAL ACCOUNTS				
EXPENSES				
Staff Compensation	-	$ 468,700	454,000	(3%)
Meeting/Travel Expense	-	17,500	6,000	(66%)
Office Expense	-	12,000	11,500	(4%)
Professional Services	-	30,000	10,000	(67%)
Publication & Project	-	116,000	104,400	(10%)
Other Expenses	-	298,500	281,000	(6%)
TOTAL EXPENSES	-	942,700	866,900	(8%)
NET REVENUE/(EXPENSE)	-	(942,700)	(866,900)	(8%)
DEPARTMENTS				
EXPENSES				
Human Resources	-	942,700	866,900	(8%)
TOTAL EXPENSES	-	942,700	866,900	(8%)
NET REVENUE/(EXPENSE)	-	$ (942,700)	(866,900)	(8%)

Information Technology

The Division of Information Technology seeks to provide cost-effective and reliable computer information systems, telephone services, training and support of Association operations. These services are essential to the membership related activities, crucial to revenue-generating programs like Salable Materials and Dental Testing Services (DTS), as well as an integral part of the information needs of virtually every agency in the Association. The budget requested for 1995 of $1,951,000 is 6% more than the current year budgeted expenses. Allocations within this cost center continue to reflect the move to new technology and the emphasis in computer training and support of Association staff. The lower budgeted cost for repair and maintenance within the office expenses category was accomplished through contract negotiation and completion of financing payments in 1994. The $17,200 increase in meeting/travel expense reflects anticipated staff travel to different meetings for the purpose of articulating the role of information technology in association management. Additionally, that budget category provides for staff travel to conduct computer training classes at the Washington, D.C. and Gaithersburg locations. Estimated revenues of $296,000 are primarily related to the sale of mailing lists and labels. This revenue projection has been increased by $44,500, based upon heightened demand by advertisers for membership mailing lists.

Information Technology—Summary Worksheet

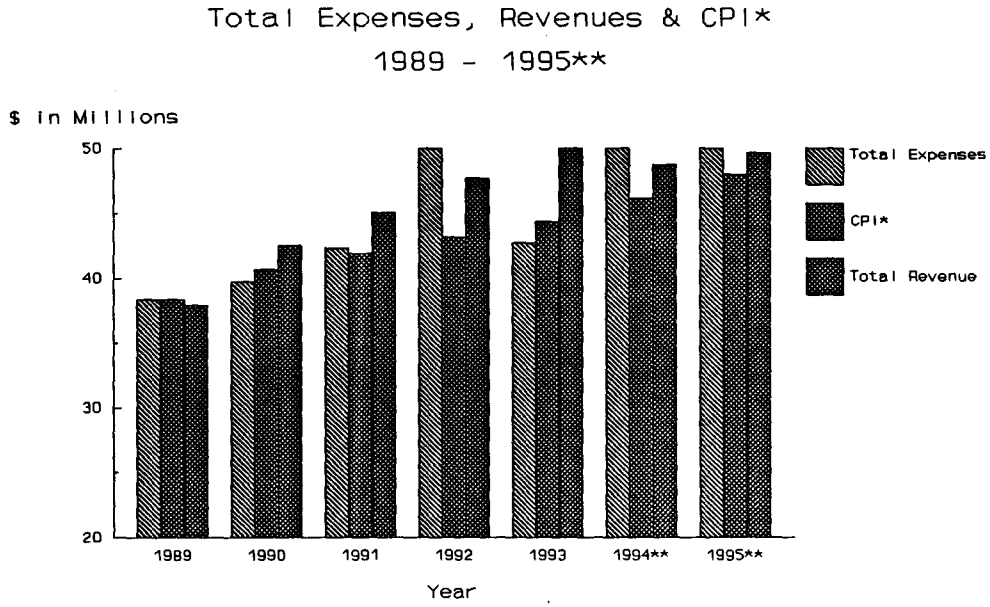
	1993 ACTUAL	1994 BUDGET	1995 BUDGET	PERCENT VARIANCE
NATURAL ACCOUNTS				
REVENUES				
Miscellaneous Income	-	$ 251,500	296,000	18%
TOTAL REVENUES	-	251,500	296,000	18%
EXPENSES				
Staff Compensation	-	1,409,700	1,565,900	11%
Meeting/Travel Expense	-	3,500	20,700	>100%
Office Expenses	-	379,300	327,000	(14%)
Professional Services	-	40,000	30,000	(25%)
Publication & Project	-	4,500	4,500	0%
Other Expenses	-	1,900	2,900	53%
TOTAL EXPENSES	-	1,838,900	1,951,000	6%
NET REVENUE/(EXPENSE)	-	(1,587,400)	(1,655,000)	4%
DEPARTMENTS				
REVENUES				
Information Technology	-	251,500	296,000	18%
TOTAL REVENUES	-	251,500	296,000	18%
EXPENSES				
Information Technology	-	1,838,900	1,951,000	6%
TOTAL EXPENSES	-	1,838,900	1,951,000	6%
NET REVENUE/(EXPENSE)	-	$(1,587,400)	(1,655,000)	4%

Consumer Price Index

The preparation of the following chart was directed by the House of Delegates (*Trans.*1983:572). Its original purpose was to provide a comparison for a seven-year period of Association expenses and revenues to the Consumer Price Index (CPI) as compiled by the Bureau of Labor Statistics.

In development of the chart, the financial information for prior years were restated to exclude publishing activities which were transferred to a for-profit subsidiary in 1990.

Please note that while the chart compares the Association's budgetary patterns to a standardized index, the composition of Association costs differs significantly from the CPI. Furthermore, this illustration does not depict changes in program activity within the Association over this seven-year-period.



* CPI has been adjusted to equal 1989 expenses to facilitate comparison.

** Projected (Assuming 4.0% Annual CPI Increase)

Association Reserves

The purpose of the reserve fund is to enable the Association to finance, over an extended period of time, unanticipated expenditures or income losses of extraordinary magnitude. By maintaining this fund, the Board of Trustees seeks to avoid dramatic fluctuations in the amount of membership dues from year to year as well as the costs of short-term borrowing from financial institutions. It is the availability of reserves that give the organization the flexibility to respond to a crisis and meet new challenges that arise.

Association leadership attempts to balance the need for reserve funds against maintaining an affordable membership dues structure. At the end of 1993, reserves totaled $18,955,854. It should be noted that $4,827,963 in reserves represents capital investments in the Washington property and for-profit subsidiaries. These assets are not easily liquidated and therefore not available for emergency situations. Furthermore, at December 31, 1993, $3,500,000, plus interest earned thereon of $107,333, included in reserves, represents a loan to the Capital Improvement Program for asbestos removal and renovation of the Headquarters Building.

A two-year comparison of monies held in ADA Reserves is shown below:

	December 31	
	1993	1992
Operating Division Investment Account	$ 3,814,349	3,965,571
Restricted Investment Account*	10,313,542	9,011,467
Capital Formation Account	4,827,963	1,586,866
Total Reserves	$18,955,854	14,563,904

*The Restricted Investment Account balance includes the $3,500,000 loan and interest earned thereon, to the Capital Improvement Program for asbestos removal and renovation of the Headquarters Building.

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

Operating Division Investment Account. The Operating Division Investment Account earned $104,718 in investment income, for a 2.7% average rate of return in 1993. Subsequent to the 1992 audit, the Board of Trustees approved a withdrawal of $255,940 from the Operating Division Investment Account to fund costs related to the Executive Director Search conducted by Russell Reynolds and the Organizational Effectiveness Study prepared by Coopers & Lybrand. This transaction is reflected in the 1993 financial statements.

Restricted Reserve Investment Account. Several transactions affected the Restricted Reserve Account during 1993 as summarized below:

Balance, December 31, 1992	$ 9,011,467
Investment Income Net of Management Fees	207,251
Interest on $3.5 million loan	107,333
Additions:	
Excess Major Medical Refund	2,500,000
1992 Surplus Transfer	909,514
Withdrawals:	
Transferred to pay ADREC Loans	(2,422,023)
Balance, December 31, 1993	$10,313,542

The Account increased its value by $207,251 or 3.62% through capital appreciation and dividends in 1993. This rate was substantially below the S&P 500 index performance of 10%.

At its December 1992 meeting, the Board of Trustees adopted Resolution B-97-1992 (*Trans.*1992:567) to liquidate $3.5 million in the Restricted Reserve Account and temporarily transfer the funds to the Capital Improvement Program to lessen borrowing from outside financial institutions for the asbestos abatement and renovation of the Headquarters Building. These monies will be repaid with interest at the time the project can be sustained by the $55 dues income specifically allocated to it. At December 31, 1993, interest of $107,333 had accrued on this loan.

The Board of Trustees also adopted Resolution B-98-1992 (*Trans.*1992:567) authorizing transfer of the major medical refund from Great-West Life Annuity and Insurance Company to the Restricted Reserve Account upon its receipt. These funds, which total $2,500,000, and represent the unclaimed surplus from this plan, were received in 1993.

The existing ADREC mortgage and working capital loans were refinanced for $9.2 million in March 1993. As directed by the Board in Resolution B-113-1992 (*Trans.*1992:574), $2,422,023 of Restricted Reserve Investment funds were used to repay the residual loan balances not covered by the refinancing, and related legal and other expenses.

Finally, subsequent to the 1992 audit, the Board of Trustees adopted Resolution B-29-1993 authorizing the transfer of $909,514 in surplus funds to the Restricted Reserve Account.

A review of the Reserve Restricted Account indicates it has more than doubled during the last five years from market appreciation and surpluses generated by Association operations. Investments in this account, which are almost exclusively in stocks, are managed by Lake Shore Bank. The average annual return on these securities over the three years ending December 31, 1993 was 15.8% which was below the S&P 500 index of 17.5% for the same period.

Capital Formation Account. The Capital Formation Account, which holds the investments in the Association's subsidiary operations, showed net income of $819,074 in 1993. The Association's for-profit subsidiaries realized 1993 income of $1,294,502. From this surplus, dividends totalling $825,000 were declared and paid to the Operating Account. However, the favorable result from the for-profits was offset by the $475,429 loss from the American Dental Real Estate Corporation (ADREC), increasing its accumulated deficit to $2,947,201. Funds in the amount of $2,422,023, transferred from the Restricted Reserve Investment Account in connection with the ADREC refinancing, were treated as additional investment in the subsidiary.

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

	December 31 1993	1992
Land in Washington, D.C.	$3,030,000	3,030,000
Investment in ADREC	(525,078)	(2,471,672)
Investment in ADA Holding Company, Inc. and Subsidiaries	1,739,038	1,269,536
Dividend Receivable	425,000	-
Due from (to) Operating Division Operating Account	159,003	(240,998)
	$4,827,963	1,586,866

Uses of Association Reserves—1993

In 1993, the Association was faced with additional expenditures for activities not previously budgeted. In March 1993, the existing mortgage and working capital loans of ADREC were refinanced for $9.2 million. At the Board's direction, $2,422,023 of reserve funds were used to repay the residual loan balances not covered by the refinancing and related legal and other expenses. This action will result in lower future interest costs for ADREC and deferred further payment of principal on the corporation's debt until 1996. This capital infusion was reflected as an additional equity investment in ADREC.

In addition, the Board directed that $255,940 of the reserve fund be used to complete the search for a new Executive Director and cover expenses related to the Organizational Effectiveness Study conducted by Coopers & Lybrand. Although these items were expected to reduce reserves, net revenues at year-end were sufficient to absorb these costs. Actual expenditures for these items totaled $265,938 and consequently reduced the 1993 year-end surplus by this amount.

1993 Financial Results

The approved 1993 budget projected a funded deficit of $194,905. Actual results show net income after income taxes of $7,571,544. This favorable variance to budget was partly due to savings of $2,459,789 in employee compensation, taxes and benefits which were budgeted but not required due to open staff positions arising from the Early Retirement Program and a moratorium on hiring. Ultimately, up to 60 staff positions were open within the Association at various points in time during 1993.

Also contributing to the favorable variance to budget were two unanticipated revenue sources. Royalty income of approximately $1,700,000 in excess of budget was received in 1993, primarily from the ADA Credit Card Program. In addition, $2,500,000 was received from Great-West Life Annuity and Insurance Company as a refund from the terminated excess major medical program.

Of the $7,571,544 excess surplus generated in 1993, $3,554,600 had already been transferred to other Association funds during the year. These transfers included the excess major medical program refund previously described allocated to the Restricted Reserve Account, and $1,054,600 budgeted as Funded Depreciation and transferred to the Building Fund Account. The remaining operating surplus of $4,016,944 was combined with dividends of $825,000 received from ADA Holding Co., Inc., and funds previously transferred from reserves of $255,940, to arrive at a total of $5,097,884. This balance was committed to Association reserves by the Board of Trustees through Resolution B-40-1994.

While budgetary restraint continues to be the watchword, the Association will invariably face demands for additional services or expenditures not previously budgeted. As case in point, the Association is only now, in 1994, beginning to realize the cost of bringing the message of organized dentistry in health care reform to the public. Additionally, the replacement of antiquated computer technology within the Association is expected to require a multi-million dollar investment and the subsidy of cash shortfalls relating to the Washington, D.C. property will continue to require resources. These future demands will invariably command the use of reserve funds.

Status of the Washington, D.C. Property

Background: The Washington, D.C. property owned by the American Dental Real Estate Corporation (ADREC) is a modern 12-story office building located in the nation's capital. It contains 5,426 square feet per floor or approximately 65,000 square feet in total. The Association occupies the 11th and 12th floors of the facility.

In 1984, the ADA purchased the land on which the Washington Office building was constructed at a cost of $3,030,000. Subsequently, in February of 1989 the Board of Trustees, in consultation with real estate advisors, outside counsel and staff, accepted a recommendation to buy the building.

One of the primary considerations presented to the Board was that the limited partnership which owned the facility intended to file a bankruptcy petition under Chapter 11. Such a proceeding would have necessarily involved ADA in an anticipated two or three years of expensive litigation in an effort to protect its interests in the land and ground lease, with some real concern that the status of the Association would be reduced to that of a general creditor. Therefore, at least in part, the decision to purchase the building was a defensive move to protect the $3,030,000 investment in the land, and to avoid the costs of litigation.

The Board had previously been involved in discussions to buy the building from the same limited partnership. The purchase price discussed was $2.5 million in addition to the assumption of the $8 million mortgage. Those negotiations took place in 1986 before certain changes in the tax law, passed the same year, were fully appreciated. Limited partnerships were hard hit by the new tax laws, which permit an investor to deduct passive losses only from passive gains. In February 1989, the purchase price was $1 million less than in 1986.

Under the terms of the ground lease, ADA was entitled to receive ground rent from the building owners of $270,000 per year. As a tenant in the building, ADA paid rent of approximately $140,000 per floor per year. After the land and building were both controlled by ADA, the $280,000 in space rent for floors 11 and 12 and the ground rent were each reduced to $1.

A summary of the actions taken by the ADA as a result of the trustees' decision to acquire the building in February 1989 are described below.

- The trustees authorized the acquisition of the building by the ADA or a wholly-owned subsidiary for $1.5 million plus assumption of the existing mortgage of $8.0 million.
- ADREC was organized to acquire title to the building on behalf of the ADA.
- ADA funds were not used to acquire the building; however, the ADA guaranteed the performance of its subsidiary, as borrower.
- ADREC entered into a mortgage with Great-West Life Assurance Company for $9,550,000 at 9.125% for 20 years renewable every 5 years.
- ADREC also had an agreement with American Security Bank, N.A., a subsidiary of MBNA America, to fund the building's cash shortfalls. During 1992, a line of credit of $1.8 million was called upon. An unsecured debt of this amount became problematic to the bank and it was seeking a commitment to pay down this obligation. The need for permanent financing was apparent and alternatives available to the Association were researched.

Refinancing of the Washington, D.C. Property: In October 1992, the Board of Trustees requested that the debt structure of ADREC be reevaluated in light of a declining interest rate market. Toward that end, a financial advisor was engaged to solicit proposals from investment banking firms, as well as Great-West Life, to refinance the Washington building. The intent was to assess the economics of replacing the current $9.5 million mortgage at 9.125% due June 1995 with a long-term unsecured note at a more favorable rate of interest.

Four firms, including the First National Bank of Chicago; William Blair & Company; Rodman & Renshaw, Inc.; and Great-West Life, who held the then existing mortgage, were requested to submit proposals. Each of these institutions found the Association to be very creditworthy and believed that the debt could be placed through private investors at costs below

a more traditional mortgage instrument. Under such an arrangement, the American Dental Association would serve as guarantor of the note, requiring that it maintain certain liquidity and other financial ratios demonstrating solvency.

Following a series of meetings and evaluation of written proposals, Great-West Life emerged as the preferred bidder with the following competitive advantages:

- Great-West would be the actual purchaser of the note, so that rates quoted would not be merely an indication of the cost but a commitment on the part of the carrier. Whereas, the investment banking firms would have to solicit participation in the note which would introduce timing and market risk.
- The 60-year relationship with the company would add an element of flexibility in document preparation and in negotiating conditions of the loan that would restrict future borrowings, as well as require maintenance of certain liquidity and financial solvency ratios.
- The company was also willing to waive the mortgage prepayment penalty on the then existing mortgage through an interest rate adjustment.
- Since the debt would be financed directly by Great-West, ADREC would avoid approximately $120,000 in outside investment banking fees.
- Finally, costs related to the issuance and closing of the note would be less under this arrangement.

Great-West presented three financial options, differing only in the interest rate, term and amortization schedule; the shorter the loan's amortization period or average life, the lower the interest rate.

While each of these alternatives was attractive, an interest rate of 7.79% was ultimately achieved by selecting a 12-year term. This option was structured with interest-only payments for two years, improving the cash flow of ADREC during a period characterized by declining occupancy and rental rates in the marketplace.

In addition to refinancing the mortgage, the ADREC Board also considered the need to reduce working capital loans from two banking institutions and arrange funding for negative cash flows in the future. These issues were addressed in a report to the ADA Board of Trustees resulting in the adoption of Resolution B-113-1992 (*Trans*:1992:574).

> **Resolved,** that the Association serve as guarantor of the note to refinance the current debt of the American Dental Real Estate Corporation (ADREC) in an amount approximating $10 million, and be it further
> **Resolved,** that the ADA Board of Trustees will make provision to fund the ongoing cash flow losses from ADREC up to $1.7 million annually, and be it further
> **Resolved,** that $2.5 million in Association reserves be used to pay down a like sum of borrowings that ADREC is obligated to pay to various financial institutions.

After the above action was taken, discussions were held with Great-West Life to finalize the terms of the arrangement and the financial covenants sought by the lender to protect its interests. As expected, a balance was achieved between the safeguards required by the company and the need for flexibility in managing Association finances.

Subsequently, language was drafted to reduce these mutual understandings into a formalized document. This entailed negotiation of various business and legal issues and extended over three months. The loan closed on March 18, 1993.

As directed by the Board, $2,422,023 in reserve monies were used to pay down working capital loans of $301,100 with Lake Shore National Bank and $1,805,062 with American Security Bank. The residual was applied to the existing mortgage with Great-West Life and related legal and advisory fees. Interest payments to Great-West Life on the new mortgage commenced in March 1993.

Approval of Proposed 1995 ADREC Budget: The 1995 budget was initially developed by Borger Management who directly supervises the building's operation in Washington, D.C. and these cost and revenue projections were subsequently reviewed internally and found to be reasonable. The Board of ADREC was convened on June 13, 1994 to review and approve projected revenues and expenses for calendar year 1995. The budget reflects a cash flow loss of $1,081,700 for 1995, which includes expenditures for building improvements totalling $640,600. These estimated capital costs consist of modifications for the handicapped and fire/life safety systems that are mandated by federal or local laws as well as funding earmarked for space improvements for future tenants.

During 1995, current active leases encompassing three full floors in the building will expire. A decline in rental income of $205,000 is anticipated given the prospects for temporary vacancies on these floors as well as lower rates being offered for comparable space within the surrounding area. In spite of the cash flow loss projected for 1995, please note that the Association continues to occupy two floors in the building free of rent and pass-through expenses, having an imputed value of $350,000 annually.

Capital Improvement Program

The Association is proceeding with a major renovation of the Headquarters Building which also involves the removal of asbestos-containing materials. This report provides background information on the abatement process and the scope of the project as well as its estimated costs and funding.

When the Headquarters Building was constructed, the building code for the City of Chicago specified the use of insulation asbestos as a fire retardant. The mere presence of asbestos in a building does not necessarily mean that the health of its occupants is endangered. However, if these materials are damaged or disturbed, fibers can be released and create a possible hazard to building occupants. There are numerous federal and state regulations governing exposure to asbestos, including those promulgated by the Environmental Protection Agency (EPA) and OSHA. The first EPA regulations, the National Emission Standards for Hazardous Air Pollutants, were issued in 1973 under the Clean Air Act. While largely directed at asbestos-related industries, they also restricted the use of such materials in new construction and established procedures for handling asbestos during demolition. As the Association was about to embark on a major remodeling of tenant space, a study was performed to

assess the extent to which this potential hazard existed in the building.

The results of this analysis prepared by an environmental consultant showed asbestos-containing materials were used widely throughout the building. Of greatest concern was the spray-on fireproofing found on the corrugated metal deck and beams of each floor. Through air corrosion, water leaks and aging, the condition of the asbestos materials was deteriorating and would worsen with time. It was, therefore, decided to be in the best interest of the Association to begin an asbestos management program as soon as possible.

The survey made it apparent that asbestos removal would have to precede any major remodeling of the property. Priority areas were identified based on potential hazards and the immediate needs for space by the Association and certain tenants. The consultants were then directed to proceed with development of technical specifications for the removal project. Prior to the actual abatement, all appropriate government agencies were notified.

Elaborate precautions are taken by the contractor in order that asbestos be removed safely. The work area is totally contained in plastic sheeting. Under negative pressure, the air in the containment is filtered continuously and exhausted outside to assure that asbestos fibers do not escape into the building. All those entering the work area are fully equipped with protective gear including respirators. Before exiting the containment they undergo an extensive decontamination process.

An area is released for reoccupancy *only* if airborne fiber levels inside the sealed space are equal to or less than the air samples taken outside the containment. Following the asbestos removal work and clearance of the area, non-asbestos fireproofing material is applied to the overhead deck.

Given the significant financial resources required to totally renovate and abate the building, the process was undertaken in phases extending over a long period. Priorities were established based upon commitments to existing tenants but included conference and meeting facilities as well as other areas that presented some immediate environmental hazard. It is noteworthy that the Association's largest tenant, occupying two floors, was unwilling to renew its lease without a contractual agreement to abate the space. In the Chicago real estate market, failure to proactively implement asbestos removal can directly affect occupancy levels and depress rental rates.

The first three phases of the building improvement project include ten floors and the mezzanine, which is an area used for storage. The specific floors include:

- Phase 1—mezzanine, first, second and seventh floors; (completed)
- Phase 2—third floor (mechanical), fourteenth, fifteenth and sixteenth floors; (underway) and
- Phase 3—tenth, eleventh and twelfth floors (underway).

At the end of Phase 3, the only tenant areas remaining to be abated would be the 8th, 9th and 13th floors. These floors will not be remodeled prior to the expiration of the current tenants' leases, some of which run through 1998.

The cost of construction is estimated at $18.5 million of which approximately 70% represents remodeling and the remainder asbestos-related costs. Significant long-term operational savings may be realized by improving the infrastructure of the building. Specifically, the estimates include installation costs for a new, more efficient heating, ventilating and air conditioning system. Ceiling tiles and existing light fixtures are replaced as these experience disrepair following demolition. Remodeled space is equipped with a sprinkler system which not only improves occupant safety but anticipates changes in Chicago's building code.

Redesign of the second floor has greatly enhanced the Association's meeting facilities, creating a fine amenity for the building, as well as providing space for the staff of the Division of Conference and Meeting Services. This move will ultimately make an additional floor available for rental to tenants. Utility floors have also been scheduled for abatement to assure the safety and continued well-being of those who use the building. In summary, to maintain the building as a viable income-producing asset for future years, it was necessary to initiate the abatement project and renovate the space to attract and retain tenants.

Assuming the real estate market rebounds from its current depressed state, one can reasonably expect that the cost of leasehold improvements will be recoverable over time from rental income. However, ten years or more may pass before sufficient tenant revenue is generated to offset both leasehold improvements and asbestos-related costs. This did not coincide with the immediate need for cash that building construction requires; therefore, the Board considered several alternatives for financing these activities. Based upon the Board's analysis, it was apparent that some form of debt financing, combined with a dues increase, would likely be required to meet the Association's cash needs and yet preserve its equity position. The 1992 House of Delegates wished to lessen the Association's reliance on outside financing and structured the terms of a dues increase accordingly. The resulting Resolution 35H-1992 (*Trans.*1992:583) increased membership dues by $55 for a four-year period, 1993 to 1996. Use of these monies was restricted by Resolution 110H-1992 (*Trans.*1992:587) to the Capital Improvement Program. The 1992 House of Delegates further proposed that the Board of Trustees liquidate $3.5 million in the Restricted Reserve Account and temporarily transfer the funds to the Capital Improvement Program. This subsequent action by the Board, Resolution B-97-1992 (*Trans.*1992:567) served to minimize borrowings from outside financial institutions for the asbestos abatement and renovation of the Headquarters Building. These monies will be repaid with interest when the project can be sustained by the $55 dues income specifically allocated to it. The House also requested an annual project report which the paragraphs below are intended to satisfy.

The following disclosure of costs related to the asbestos abatement and remodeling program for the Association's Headquarters Building was extracted from the 1993 consolidated financial statements of the Association and its subsidiaries.

	December 31	
	1993	1992
Asbestos abatement	$2,893,105	2,311,974
Remodeling	6,094,104	2,699,869
	8,987,209	5,011,843
Less accumulated depreciation	(425,656)	(48,093)
	$8,561,553	4,963,750

These costs are largely related to abatement and construction activities for Phases 1 and 2 of the project which encompass the mezzanine and first, second, seventh, fifteenth and sixteenth floors. Also included in these costs is demolition and asbestos removal charges for the tenth and eleventh floors, part of the Phase 3 costs.

The program will likely extend through the year 2000, and require total capital expenditures of $18.5 million, plus interest on any bank or reserve borrowings used to finance the project. As stated earlier, in 1992, the House of Delegates approved a four-year $55 dues increase for Association members, effective from 1993 to 1996, specifically for this program. These revenues, estimated to be $5,898,800 in 1995, are restricted for the specific purpose of financing asbestos abatement and remodeling activities and as such are classified, along with related assets, liabilities and expenses, in the Capital Improvement Account.

The following table summarizes future anticipated capital expenditures under the program for 1994:

Asbestos abatement	$ 419,000
Remodeling	3,695,000
	$4,114,000

This cost projection assumes remodeling of the tenth, eleventh and fourteenth floors as well as abatement of the third floor mechanical areas.

Below is a summary of project transactions:

ADA Capital Improvement Account
Cumulative Cash Activities
As of December 31, 1993
Unaudited

Dues	$5,878,424
Loan Proceeds	3,500,000
Capital Acquisitions	(8,987,209)
Interest Expense	(107,333)
Interest Income	29,623
Proceeds Available for Capital Expenditures	$ 313,505

Notes:

1. Cumulative collections through December 1993, of the dues increase restricted to this program, total $5,878,424. This income combined with the initial $3,500,000 advance from reserves have funded project expenditures of $8,987,209 through December 31, 1993.
2. In addition to segregating project monies for recordkeeping purposes, a separate brokerage account has been established to credit interest earnings during periods when there is a positive balance. Interest income of $29,623 was earned through December 31, 1993. Additionally, interest expense totalling $107,333 has been calculated on the $3,500,000 balance due the ADA Reserve Division.

Capital Budget for the Building Fund

Prior to 1993, the Association had not set aside funds for building repairs or renovation. The need for long-range capital planning, and a more disciplined approach in managing the building resulted in the Board's decision to establish the Building Fund Account. In addition to building assets of $7,997,509, budgeted monies of $1,054,600 were transferred to the Building Fund Account from the Operating Account. During 1993, capital expenditures of $621,622 were made. At December 31, 1993, after reflecting all financial activity for the year, the Building Fund held short-term investments of $507,138 for future capital expenditures. Monies budgeted for 1994 of $1,454,600 represent an excess of almost $642,000 over planned expenditures of $813,000. These combined funds will provide a base for future replacements as well as provide a cushion to absorb the shock of any unanticipated expenses.

Historically, a capital budget has been prepared for consideration and approval by the Board of Trustees. During discussions of the 1993 operating budget by the House of Delegates, a resolution was put forth directing that a description of all proposed capital expenditures exceeding $25,000 be incorporated into the report of the Board on financial matters. The following schedule and explanatory narrative is intended to comply with this requirement.

Capital expenditures were requested for routine maintenance as well as replacement of mechanical equipment and mandated remodeling of the Headquarters Building. Monies needed to financially underwrite these projects were provided in the 1995 budget through the $1,000,000 cash contribution to the Building Fund. *Please note that the costs shown in this report are not related to the asbestos removal and renovation program.*

Description	
Mechanical Systems Changes and/or Replacements	$255,000
Sidewalk & Plaza Repairs	21,400
Caulking the Exterior of the Headquarters Building	368,600
Modifications for Americans with Disabilities Act	100,000
Second Floor Canopy Roof Replacement	80,000
Life Safety Modifications	75,000
Total	$900,000

Mechanical Systems Changes and/or Replacements: Based on engineering studies to be completed in 1994, $255,000 has been committed to replace obsolete but essential systems and equipment during 1995. These changes principally affect the building's heating, ventilating and air conditioning systems. The completed studies will provide a comprehensive master plan to schedule the necessary change outs and replacements over a number of years.

System Modifications. These changes are intended to modernize and improve the efficiency of the systems. Specific proposals include: design and installation of digital temperature controls for all systems; engineer a cooler condenser riser to provide supplemental cooling in certain areas of the building; install control valves for the perimeter fin tube heating system on all renovated floors; review operation of the present 22nd floor dedicated fan chiller/tower unit for possible replacement by a direct expansion unit; connect the basement to the main cooling system; and, restore laboratory support systems.

Repairs and Replacements. These changes are proposed to replace machinery that may not meet Environmental Protection Agency standards as well as worn-out or obsolete equipment. Planned changes include: replace weather-tight dampers and controls on the building's fan systems; change refrigerants for the chillers and supplementary equipment; replace heating, ventilating and air conditioning control compressors on the 23rd floor; repair perimeter heating risers where anchoring mechanisms and expansion compensators have failed.

Sidewalk and Plaza Repairs: Costs for this architectural and engineering study are budgeted at $21,400 for 1995. This evaluation will incorporate the design of repairs to be undertaken in 1996 to curb water leakage into the basement from exterior sidewalk and plaza areas.

Caulking the Exterior of the Headquarters Building: Expansion and contraction of the building arising from variations in temperature and other weather conditions compels that it be sealed by caulking the exterior. As noted in the budget for 1994, some of the pre-cast window joints may also require flashing work. Some of the caulking and repairs recommended by Desman Associates, an outside architectural and engineering firm, are scheduled to be completed in 1994. However, due to financial constraints and the time available to complete the work, a substantial portion of this project is scheduled for 1995. An amount of $368,600 has been budgeted in 1995 for completion of this work.

Modifications to Comply with the Americans with Disabilities Act (AwDA): For 1995, $100,000 has been budgeted for additional modifications needed to comply with the Americans with Disabilities Act. These changes, described in a special AwDA survey presently under review, will be made in accordance with government guidelines. The budgeted amount includes provisions for signage changes, hardware modifications and alterations to the elevator panels.

Second Floor Canopy Roof Replacement: In connection with its review of the exterior of the building, Desman Associates identified the second floor canopy roof as another source of water infiltration. It was recommended that this roof be replaced when feasible. When the caulking repairs have been completed in 1995, a roof consultant will be retained and the work bid out for this replacement. The 1995 budget apportions $80,000 for this purpose.

Life Safety Modifications: Venterra Sales & Management, manager of the building, has recommended the Association engage an expert consultant to review the building's exiting plan and comment on the advisability of a battery-backup lighting system in the lobbies, corridors and stairwells in the event of an emergency. The budget provides $75,000 for this study and modernization of certain security systems.

Not included in the 1995 capital budget is a provision for miscellaneous or other unknown repairs or alterations to the building. These might encompass recabling of certain elevators, upgrading electrical wiring, and repaving the alley. These projects would only be undertaken if dictated by governmental regulatory requirements or necessitated by safety considerations and approved by the Board of Trustees.

Capital Budget for Operating Equipment and Furnishings

A capital budget was also prepared for the acquisition of office and technical equipment necessary to support programs and administrative activities. While most individual purchases are under the $25,000 threshold set forth by the House, these costs have been aggregated into broad categories accompanied by a discussion of what purchases are being contemplated.

Description	
Office Equipment and Furniture	$ 56,600
Computer Hardware and Software	403,000
Duplicating Equipment	183,900
Specialty Equipment	106,500
Total	$750,000

Office Equipment and Furniture: This category represents recommended upgrades for obsolescent office equipment and furniture replacement. Much of the furniture in the Association is 15 or more years old and has exceeded its useful life. As a result, desks, chairs and tables which are beyond repair are being systematically replaced. Additional chairs are also being purchased for the conference room facilities.

Computer Hardware and Software: In 1995 more than one third of the Association's personal computers will be over four years old. The major portion of funding in this category will be used to: 1) replace and upgrade at least one-fifth of the existing computers that are antiquated or in such disrepair as to impede normal operations; 2) enhance the capabilities of the Association's Local Area Network (LAN) by expanding the use of personal computers beyond word processing and electronic mail; and 3) improve the volume efficiency of centralized computer operations by acquiring a high-speed laser printer to replace the current, obsolete model.

Duplicating Equipment: Based on a study of photocopying needs it was determined that three copiers were needed to replace older machines with excessive down-time. Also provided in the budget for 1995 is one high-speed copier and a new printing press for the Duplicating Department. These acquisitions are intended to allow the Association to continue in-house printing at current and enhanced levels. Printing

work in-house results in an estimated 50% savings over having the work printed outside.

Specialty Equipment: This category includes requests to acquire a folder/inserter for use in shipping operations, replace the current Salable Materials trade show exhibit and acquire video computer projectors and podiums for conference and meeting uses. The current Salable Materials trade show exhibit will be eight years old in 1995 and is showing signs of extensive wear and tear. Both the folder/inserter for the mail room and the conference equipment acquisitions were recommended to enhance services provided by their respective operations. In addition, these acquisitions are expected to reduce reliance on rentals or outside vendors.

The 1995 budgeted depreciation expense of $750,000, from which there is no outflow of cash, will be the source of funding these proposed purchases.

Resolutions

25. Resolved, that the 1995 Annual Budget of revenues and expenses, including funded depreciation and capital expenditures, be approved.

26. Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS*, of the *Bylaws* be amended by deleting the words and number "three hundred thirty dollars ($330.00)" (line 306) and by substituting in their place the words and number "three hundred forty-nine dollars ($349.00)," to make the amended first sentence up to but not including the word "except" (line 307) read as follows:

> A. ACTIVE MEMBERS*. The dues of active members shall be three hundred forty-nine dollars ($349.00) due January 1 of each year**...

and be it further
Resolved, that the increased active members dues become effective January 1, 1995, and be it further
Resolved, that this increase does not affect the footnote to Chapter I, Section 50A, pertaining to the $55 dues increase for the Capital Improvement Project.

Supplement to Report 2

Financial Affairs and Recommended Budget for Fiscal Year 1995, Amendment of the Proposed 1995 Budget

The Board of Trustees, at its annual session meeting on October 16-19, 1994 approved a plan to modernize and automate the Association library to include electronic access to the catalog of library resources. This proposed expenditure contemplates the purchase of computer hardware and a library software package, as well as support personnel for the retrospective conversion of records and to service member requests.

As a consequence, Board Report 2 (*Supplement*:382) has been amended to increase expenditures by $173,000 within the Department of Library Services.

The proposed 1995 budget, in summary form, that is now being recommended by the Board of Trustees is as follows:

Original 1995 Budgeted Revenues	$50,505,200
Original Budgeted Expenses	52,405,200
Automation of Association Library Services	173,000
Revised 1995 Budgeted Expenditures	$52,578,200

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

Report 3

Compensation and Contract of Executive Director

Background: This report is in response to Resolution 34H-1993 (*Trans.* 1993:682), which was adopted at the 1993 meeting of the House of Delegates.

> **Resolved,** that beginning in 1994, the ADA Board of Trustees shall submit annually to the House of Delegates an informational report on compensation and employment contracts, and be it further
> **Resolved,** that this report shall contain the following information:
>
> 1. total compensation, including salary benefits, bonuses and accrual or payment of deferred benefits, including retirement benefits for the Executive Director; and
> 2. basic information about any contracts of employment or extensions to contracts of employment entered into with the ADA Executive Director or other appointive officers or employees, including specifically the signing, beginning and termination dates of the contract and any extensions to the contract.
>
> and be it further
> **Resolved,** that this resolution shall not in any way be construed to lessen or adversely affect the ADA Board's management responsibility, nor shall it interfere in any manner with the Executive Director's authority under Chapter IX, Section 50A of the *Bylaws*.

Contract of Executive Director: The Board of Trustees entered into an employment contract with the current Executive Director on February 14, 1993, with an effective date of April 1, 1993. The contract expires on March 31, 1996. At the end of the first two years of the agreement (March 31, 1995), the term of employment may be extended an additional two years, by mutual agreement in writing. It should be noted that the Executive Director is the only member of the ADA staff with an employment contract.

The contract provides that the Executive Director's performance is to be reviewed by the Board on an approximate semi-annual basis or as deemed appropriate by the Board. The first performance appraisal of the new Executive Director took place in December 1993; the second review took place in August 1994.

Should the Executive Director die during his employment, the agreement terminates automatically and the Association has no further obligations pursuant to the agreement. Should the Executive Director become disabled during the term of the agreement, the ADA's standard disability benefits go into effect. If a disability extends for a period in excess of one year, then the agreement is null and void and the Association is no longer obligated to retain the individual as executive director.

Compensation and Benefits: The Executive Director's current annualized salary is $275,000. His salary during the first year of his contract was $250,000.

As an employee of the Association, the Executive Director is covered as a participant under the ADA Employees' Qualified Retirement Plan under which he accrued a pension benefit with a contribution value of approximately $34,000 (this amount represents a reduction of around 50% due to late 1993 tax law changes).

The Omnibus Budget Reconciliation Act of 1993 reduced future covered pension benefits for any employee (of for-profit and not-for-profit organizations) whose earnings exceeded $150,000. To compensate the Executive Director and several members of the executive staff for their loss in benefits for the year, which were previously covered under the ADA's qualified plan provisions before the tax change, an amount of $52,600 has been set aside under a new Executive Parity Plan of which $35,000 is allocable to the Executive Director. These benefits would have otherwise been payable under the qualified retirement plan had the government not imposed the earnings cap of $150,000.

Like virtually all for-profit corporations, and other Chicago-based professional associations (such as the AMA and the ABA), the Board decided to recompense its senior executives for this unplanned and unfair reduction in pension benefits. The Executive Parity Plan was established as the mechanism for restoring the value of lost benefits for the few senior ADA executives who suffered benefit reductions because of the tax laws. Depending upon the employee's age and service, reduction in retirement benefits for ADA employees range from around 20% to more than 60%. The Plan allows the Compensation Committee of the Board to set aside, on an annual basis, a specified cash amount to be paid upon vesting. The set asides are strictly restorative and are funded from the savings in the qualified pension plan contributions which result because of the reduction in executive covered benefits under the qualified plan.

As reported last year, the Executive Director also receives a car allowance of $600 per month; a $5,000 annual contribution to the Great West Universal Life Insurance Plan; $1,000 per year toward tax planning services; membership/initiation fees and annual dues in one country club and one city club in the Chicago area; nonresident membership in the Congressional Club and University Club in Washington, D.C. (no initiation fees); the premiums toward an additional $500,000 term life insurance policy, with a current contribution of $1,166; the reasonable expenses of installing and maintaining a car telephone in one automobile, and the reasonable expenses of purchasing and maintaining a cellular telephone, for business use only; a parking space in the ADA Headquarters Building; and the reasonable expenses for spousal travel to the ADA annual session, the Board of Trustees planning meeting, and other occasional business travel, as deemed appropriate under the circumstances by the Board.

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

Report 4

Amendment of the *ADA Bylaws* Dealing With Reappointment of Council, Commission and Committee Members

Background: The Association was reorganized in 1986 based on recommendations of the Board of Trustees dealing with the structure and organization of the Board, the House of Delegates and ADA councils and commissions (*Trans.* 1986:299;1986:312). One of the primary principles underlying the reorganization was the desire to expand membership participation and representation in Association leadership positions. Accordingly, the Board recommended, and the House approved, that the terms of trustees and council and commission members should be limited to one four-year term of office.

Several times since then the question has arisen whether an individual who is appointed to fill a vacancy on the Board or on a council or commission is eligible to stand for reappointment to a full four-year term. The *ADA Bylaws* clearly provide an answer in the case of a trustee. However, they are silent with regard to council and commission members. This has opened the door to different possible interpretations and requires clarification.

Discussion: Chapter VII. BOARD OF TRUSTEES, Section 80. VACANCY, states in part:

> If the term of a vacated trustee position has less than fifty percent (50%) of a full four-year term remaining at the time the successor trustee is appointed or elected, the successor trustee shall be eligible for election to a new, consecutive four-year term. If fifty percent (50%) or more of the vacated term remains to be served at the time of the appointment or election, the successor trustee shall not be eligible for another term.

No comparable language appears in the chapters on councils, commissions or the Standing Committee on the New Dentist. In cases where the *Bylaws* are silent, the Association looks to *Sturgis* for guidance. *Sturgis* provides that where the bylaws restrict the number of terms to which a member may be elected to a particular office, a member who fills a vacancy in that office for a partial term is **not** barred from being elected to a full term, unless the bylaws provide otherwise. Strict application of this rule would mean that council, commission and standing committee members are always eligible for reappointment when the initial appointment was to fill a vacancy because the *ADA Bylaws* do not provide otherwise.

Considerations of consistency and policy favor amending the *Bylaws* to adopt a "50% rule" for ADA council and commission members and the Standing Committee on the New Dentist, identical to the rule for trustees. This would promote the policy underlying term limits—increased member participation in leadership positions—and at the same time give a member with less than two years' service on a council or commission the opportunity to develop more experience, increasing his or her value to the organization. To this end, the Board recommends the resolutions set forth below.

As an additional housekeeping matter, the Board notes that the reference to the Council on Dental Research in Chapter X. COUNCILS, Section 70. VACANCY, was overlooked when the *Bylaws* were amended last year to create the new Council on Scientific Affairs. This oversight would be corrected by the resolution below.

Resolutions

27. Resolved, that Chapter X. COUNCILS, Section 70. VACANCY of the *ADA Bylaws* be amended by adding a new second paragraph to read:

> If the term of the vacated council position has less than fifty percent (50%) of a full four-year term remaining at the time the successor member is appointed or elected, the successor member shall be eligible for election to a new, consecutive four-year term. If fifty percent (50%) or more of the vacated term remains to be served at the time of the appointment or election, the successor member shall not be eligible for another term.

so the amended Section 70 reads as follows:

> Section 70. VACANCY: In the event of a vacancy in the membership of any council, the President shall appoint a member of the Association possessing the same qualifications as established by these *Bylaws* for the previous member, to fill such vacancy until a successor is elected by the next House of Delegates for the remainder of the unexpired term. In the event such vacancy involves the chairman of the council, the President shall have the power to appoint an *ad interim* chairman. In the event it is the current recipient of the Gold Medal Award for Excellence in Dental Research who cannot serve on the Council on Dental Research, the President, in consultation with the Board of Trustees shall have the power to appoint a prominent research scientist who shall serve until the award is bestowed on the next honoree.
>
> If the term of the vacated council position has less than fifty percent (50%) of a full four-year term remaining at the time the successor member is appointed or elected, the successor member shall be eligible for election to a new, consecutive four-year term. If fifty percent (50%) or more of the vacated term remains to be served at the time of the appointment or election, the successor member shall not be eligible for another term.

28. Resolved, that Chapter XIV. COMMISSIONS, Section 70. VACANCY, of the *ADA Bylaws* be amended by adding a new Subsection D to read:

> D. If the term of the vacated commission position has less than fifty percent (50%) of a full four-year term remaining at the time the successor member is appointed or elected, the successor member shall be eligible for election to a

new, consecutive four-year term. If fifty percent (50%) or more of the vacated term remains to be served at the time of the appointment or election, the successor member shall not be eligible for another term.

so that the amended Section 70 reads as follows:

Section 70. VACANCY: In the event of a vacancy in the office of a commissioner, the following procedure shall be followed:

A. In the event the member of a commission, whose office is vacant, is or was a member of and was appointed or elected by this Association, the President of this Association shall appoint a member of this Association possessing the same qualifications as established by these *Bylaws* for the previous member, to fill such vacancy until a successor is elected by the next House of Delegates of this Association for the remainder of the unexpired term.

B. In the event the member of a commission whose office is vacant was selected by an organization other than this Association, such other organization shall appoint a successor possessing the same qualifications as those possessed by the previous member of the commission.

C. In the event such vacancy involved the chairman of the commission, the President of this Association shall have the power to appoint an *ad interim* chairman, except as otherwise provided in these *Bylaws*.

D. If the term of the vacated commission position has less than fifty percent (50%) of a full four-year term remaining at the time the successor member is appointed or elected, the successor member shall be eligible for election to a new, consecutive four-year term. If fifty percent (50%) or more of the vacated term remains to be served at the time of the appointment or election, the successor member shall not be eligible for another term.

29. Resolved, that the ADA *Bylaws* be amended by deleting the words "Council on Dental Research" wherever they appear and by substituting in their place the words "Council on Scientific Affairs."

68. Resolved, that Chapter VII, BOARD OF TRUSTEES, Section 140. COMMITTEES of the ADA *Bylaws* be amended by adding the following provision at the end of paragraph three (line 1356):

If the term of the vacated Committee position has less than fifty percent (50%) of a full four-year term remaining at the time the successor member is selected, the successor member shall be eligible for selection to a new, consecutive four-year term. If fifty percent (50%) or more of the vacated term remains to be served at the time of selection, the successor member shall not be eligible for another term.

so that the amended paragraph reads as follows:

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

Report 5

Supplemental Activities of American Dental Association Health Foundation

Background: This report summaries specific developments and activities of importance that are not found in the 1994 annual report of the American Dental Association Health Foundation (*Reports:126*).

Board of Trustees Action: At its February 1994 meeting the Board voted to phase out the Association's relationship with the American Fund for Dental Health, recognizing that after a long and valued relationship, the time had come to devote ADA resources to its own foundation.

In April, the Board explored options to increase its education, research and charitable activities. The Board discussed the creation of a new entity and the expansion of existing Association entities. The Board decided to expand the existing ADA Health Foundation (ADAHF) as the Association's principal charitable foundation.

The ADAHF currently manages bequests and memorial funds and serves as a mechanism for holding award monies. It also manages funds for the Research Institute and Paffenbarger Research Center at the National Institute of Standards and Technology.

At its June meeting, the Board discussed a business protocol for the expansion of the Foundation. The protocol included governance, management, marketing, budget and funding priorities. Decisions regarding these topics are summarized in the following sections.

Governance: The Foundation will be governed by a seven-member Board of Directors, with four members drawn from the current ADA Board of Trustees and three members-at-large from industry, education, research or the business community. The Board President, elected by the ADA Board of Trustees, is an ADA member who is not an ADA trustee or officer. The Foundation Secretary is the ADA Executive Director.

The Foundation will be managed by an in-house Director of Administration, Director of Development, and an administrative support staff member and will report through the Associate Executive Director for Education and Science to the Foundation Board. Special oversight committees will be formed from the Board of Directors to assist in the efficient and effective administration of development, finance and audit, and grant activities.

Programs: The Foundation is dedicating its efforts to four areas:

1. research, including activities that support or encourage the research environment;
2. education, which includes activities that are important to the dental education system:
3. development, which includes pilot projects needing start-up or supplemental funding on a time-limited basis; and
4. charitable assistance, which includes grants and involvement with access pilot programs and other philanthropic endeavors.

Present major activities include the research activities undertaken at the Paffenbarger Research Center and the Research Institute; the Health Screening conducted at annual session; and the SUCCESS Seminar Program. The expanded role of the ADAHF will enhance and augment current activities as well as fund new initiatives.

Funding Priorities: Projects must meet at least four of the following criteria for funding consideration: worthiness; sound project design; demonstrable need for start-up, interim or supplemental funding on a time-limited basis; disassociation from product research and development activities of a commercial interest; U.S.-based project design; or inability to obtain funding from other sources. There must be sufficient funds available in the Foundation to contribute meaningfully to the project. Funding of a project should have a positive effect on future contributors to the Foundation. In addition, all projects must comply with IRS requirements for 501(c)(3) organizations.

House of Delegates Action: There are two ADA House of Delegates resolutions regarding the American Fund for Dental Health (formerly named Fund of Dental Education, Inc. and American Fund for Dental Education) that need rescinding. The first House action, submitted by the American Association of Dental Schools, was adopted by the House in 1957 (*Trans.*1957:221):

> **16-1957-H. Resolved,** that the Fund for Dental Education, Inc. be approved as a worthy recipient and competent distributor of funds received for the furtherance of dental education, and be it further
> **Resolved,** that the individual members of the American Dental Association be urged to initiate and participate in continuing programs to make new support available for dental education through the facilities of the Fund for Dental Education, Inc.

The second action by the ADA House of Delegates regarding the Fund was adopted in 1965 (*Trans.*1965:373). The following resolution, submitted by the American Association of Dental Schools, requested voluntary contributions to the Fund.

> **40-1965-H. Resolved,** that component dental societies be urged to solicit, in their annual billings of membership dues, a voluntary contribution of $10.00 from each of their members for support of the American Fund for Dental Education.

Resolutions

30. Resolved, that Resolution 16-1957-H (*Trans.*1957:221), Support for American Fund for Dental Health, be rescinded.

31. Resolved, that Resolution 40-1965-H (*Trans.*1965:373), Request for Voluntary Contributions to American Fund, be rescinded.

Report 6

ADA'S Vision of Future Dental Education

Background: The 1993 House of Delegates adopted Resolution 159H-1993 (*Trans.*1993:719) which states:

> **Resolved,** that the House of Delegates urge the Board of Trustees to appoint a special committee to develop a model for future dental education which will be the ADA contribution to the Institute of Medicine study on dental education. This report will be presented to the Institute of Medicine before its March deadline, and be it further **Resolved,** that this committee would present its report for approval by the Board of Trustees by February 1, 1994 and would present its report to the 1994 House of Delegates.

At its November 1993 meeting, the Board of Trustees appointed a special Board committee to study this resolution. Board members appointed to the committee were Dr. Richard D'Eustachio, chairman; Dr. George Payne; Dr. Thomas Sweet; Dr. Michael Till; and Dr. David Whiston. The committee held two meetings at the ADA Headquarters in Chicago; the first on December 2, 1993 and the second on January 21, 1994.

Intent of Resolution: During its first meeting, the committee spent time discussing the intent of the resolution and the time constraints associated with the resolution's directive that a report be presented to the Board by February 1, 1994. The committee concluded that a report could be prepared which would provide the Board with a suggested position on major issues governing future dental education. However, the committee further concluded that finalization of this report would require the Board's consensus on a number of important issues facing the profession.

The committee concluded that Resolution 159H provides the Association with a unique opportunity to enhance the Association's September 1993 report to the Institute of Medicine (IOM) and focus on several key issues. Further, the resolution provides the Association the opportunity to formally update the IOM on actions taken by the 1993 House that may influence the IOM as it continues its study. Following the Board's consideration of this report at its February 1994 meeting, the Association presented the information in correspondence to the IOM with the intent that it be reviewed by the IOM Committee at its next meeting scheduled for April 1994.

Summary of the Committee's Deliberations: This report focuses on the issues identified by the committee during its deliberations. A progress report was presented to the Board for discussion at its December 1993 meeting. At that time, the Board offered its support for the direction in which this committee was proceeding.

In its discussions, the committee determined that it would identify major headings and address the appropriate issues under each heading. The headings were selected because of their correlation with the major topics under study by the IOM.

Throughout its deliberations, the committee was sensitive to the intent of Resolution 159H and was mindful of its responsibility to develop a report that would address concerns expressed by members of the House during its consideration of this resolution. The committee believes that its report appropriately meets the intent of the resolution.

During its discussions, the committee viewed the issues in relation to the potential impact that health care reform will have on the profession. Further, another major concern addressed in several areas of this report relates to the issues concerning pathways for practitioners to become life-long learners and mechanisms for bringing the practitioner and educational communities together.

Board Action: As directed by the resolution, the following report was presented to the Board for consideration at its February 1994 meeting. Based on discussion and review of the document submitted by the special committee, modifications were suggested and the Board was assured that the modifications would be made before its transmittal to the IOM. Subsequently, the Board adopted a resolution directing that the report of the special committee be approved and forwarded to the IOM for review and consideration with its study of dentistry and that the report of the committee be forwarded to the 1994 House of Delegates.

The appended report of the special committee was transmitted in correspondence dated February 22, 1994, from Dr. John S. Zapp, executive director, to Marilyn J. Field, Ph.D., study director, Institute of Medicine.

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

APPENDIX

Supplemental Report of the American Dental Association to the Institute of Medicine Committee on the Future of Dental Education February 1994

Dental students of today and in the future are not just learning to treat oral diseases but to *prevent* oral diseases. The reduced incidence of dental caries in children and the prevention and treatment of periodontal disease are some of dentistry's best examples of preventive health care.

As noted in the Association's September 1993 comments to the IOM, the ADA regards the education of its professionals and of other members of the dental team as one of the most important aspects in promoting the oral health of the public. The educational community and organized dentistry at all levels need to find ways to learn more about each other and participate in full partnerships with each other.

Issues

Curriculum: There is a need to redesign the four-year predoctoral curriculum with a goal of eliminating unnecessary instruction; more effectively coordinating the basic and behavioral sciences; requiring greater clinical application of the basic and behavioral sciences throughout the four-year sequence of instruction; and, defining the competencies of a dental school graduate.

- Greater integration of the dental and medical curriculum is desirable. It could be a more cost-effective method of providing education, allowing for interfacing with other health care team members and promoting the sharing of resources specifically related to the provision of the basic and behavioral science components of the curriculum. It should be noted that such integration would be difficult to achieve and it must be stressed that such integration must not compromise the quality of dental education.

  The clinical phases of the dental curriculum should remain distinct from medical education. Further, integration of the basic and behavioral science portions of the curriculum must include greater emphasis on and application of the basic and behavioral science components within the clinical dental curriculum. Dental students must demonstrate their application of this knowledge in developing the required clinical competencies.
- Restructuring the predoctoral curriculum should be viewed as a continuing evolution; a dynamic rather than a fixed process. The predoctoral curriculum will require restructuring and the content should be directed toward being more competency-based, rather than discipline-based.
- The competencies required of a dental school graduate must be defined and should reflect the technological, social and economic changes in the delivery of dental care. These competencies could be different in each school depending upon their stated goals and objectives. The predoctoral curriculum of the future must be sufficiently flexible to allow for innovation and to reflect the needs of the community served by the dental school.
- The Association believes that the dental education experience does not require a *mandatory* postgraduate year of training (PGY-1). However, the Association supports the availability of postgraduate general dentistry programs and believes there should be a sufficient number of programs in existence to support all qualified applicants who might wish to apply. With greater integration of the basic and behavioral science content, and the subsequent emphasis on reshaping the curriculum, new topics can be incorporated into the curriculum and also still allow for the additional necessary time required to achieve clinical competency prior to graduation.
- The predoctoral curriculum should include increased emphasis on critical thinking, ethical patient care and business management skills. Consideration should be given to establishing more flexible pre-dental curriculum requirements. Efforts should be focused toward more effective use of the undergraduate years that precede entry into the predoctoral curriculum.

Faculty: Faculty members should be appointed based on scientific, technical and educational competence. Enhanced professional development opportunities for faculty should be encouraged and provided.

- Future dental education will require clinical faculty to acquire advanced technological skills. Dental schools need to provide opportunities for clinical faculty to upgrade clinical skills and access, interpret and apply new information—some of which will come from the practice setting.
- Future dental education will require all faculty to acquire teaching skills.
- Innovative programs should be established to appropriately fund faculty development activities.
- Recognizing that clinical faculty make significant contributions to the education of a dentist, promotion and tenure opportunities should be provided for clinical faculty consistent with opportunities provided to basic science research faculty.
- The trend toward periodic performance review for all tenured faculty should be supported and encouraged.
- Dental faculty have a responsibility to teach students how to learn and to instill the desire for dental graduates to become life-long learners. Teaching must change from acquiring knowledge by learning facts to inquiry-based learning and preparation of students to continue their educational experience beyond the doctoral program. Dental faculty should be role models for continuous learning and curricula should be designed with this in mind.
- There is need for greater integration of, and communication between, full- and part-time dental school faculty.
- There is a need for greater cooperation and communication between faculty, examiners and the practicing profession.

Cost of Dental Education: The cost of dental education will continue to increase. In an effort to address these rising costs, attention must be directed toward the following:

- The recognition that financial limitations impede every issue related to reshaping the dental curriculum.
- Reform of the health care system requires increased funding for education. Increased funding is necessary to enhance the quality of the education provided through increasing the numbers of full- and part-time faculty, faculty salaries, establishing ongoing mechanisms for faculty training and calibration, establishing a competency-based curriculum, implementing enhanced teaching methods and by achieving more effective use of instructional time. In return, dental schools should focus on the elimination of outdated or redundant material; more efficient teaching methods, including self-paced learning strategies; and the use of electronic technology to provide greater flexibility to the curriculum and streamlining staff support.
- Establishing mechanisms to decrease dental schools' dependence on producing clinic income in order to support the dental education program.
- Dental schools should receive adequate funding from the state in which they are located. However, *all* states have an obligation to share in the responsibility for funding dental education; especially for private institutions that provide dentists in those states without a dental school.
- Allocating funds (perhaps through federal subsidies) to assist dental schools in delivering care to special patient populations in community-based settings. Interest on student loans should be tax deductible. Federal support incentives should be established for graduates to establish practices in underserved areas.
- With regard to dental specialty education, increased attention should be directed to regionalization/integration of advanced training programs. This would allow sponsoring institutions to maximize resources; e.g., facilities, faculty, patients, etc. This approach would more equitably distribute the costs of specialty dental education.
- Practitioners and the academic community should be actively seeking ways to enhance their working relationships. Dental schools and the practicing community need to develop partnerships in a variety of ways, including the sharing of resources in planning and presenting continuing education activities, through active involvement of alumni on school-wide committees and through the sharing of facilities. The practicing community must learn to recognize the dental school as an ongoing valuable resource to the dental community, and dental schools must realize their responsibility in serving in this capacity.

Continued Competency: Members of the dental profession have a responsibility to maintain clinical competence to ensure the health and welfare of the public.

- The concept of continuing competency of dental practitioners should be strongly encouraged. This is the practicing profession's responsibility; however, the schools should be a major resource for implementation. The relationship between continuing education and competency should be comprehensively studied.

Accreditation: The accreditation process and its standards must continue to be viewed as an evolutionary process and will require an ongoing commitment to outcomes assessment and evaluation of the educational product.

- In consort with its commitment to ensure the health of the public, the American Dental Association has a responsibility to support the accreditation of dental and dental-related education programs. The Association believes that the accreditation of dental and dental-related educational programs should be conducted by a single agency.
- The operating policies of the Commission on Dental Accreditation are developed solely by the Commission itself. The authority to develop standards, policies and procedures; to implement an evaluation mechanism; and to make accreditation decisions rests solely with the Commission and is not subject to review by a higher-level authority, except the United States Department of Education (USDOE). The Association supports this agency's responsibility to function independently.
- The USDOE requirements for specialized accrediting agencies mandate continued emphasis on outcomes assessment and evaluation of the educational product rather than the educational process. Thus, the Commission's evaluation process will require greater focus on measuring outcomes. These efforts should be supported and encouraged.
- The Commission encourages innovation by the accredited programs and has developed its accreditation standards in such a way as to state the desired end result (outcomes) while leaving the educational programs the prerogatives of determining methods to achieve these outcomes. Competencies achieved by students should be evaluated throughout the educational process as part of outcomes assessment.
- The Commission has sharpened its focus on issues related to the cost of the accreditation process. The Commission is currently considering recommendations related to decreasing expenditures and increasing revenues. Additionally, efforts to streamline the process in order to decrease costs to accredited programs as well as improve the qualitative aspects of the process are also in progress. The Association supports the Commission's efforts to address these concerns.

Licensure: The Association supports maintaining the dental licensing authority at the state level.

- Until comparability in the licensure examination process is achieved, it will be difficult to align the educational and licensure processes and eliminate barriers to professional mobility. The standardized assessment of clinical skills should be a goal and not be eliminated. In support of this position, the ADA's 1993 House adopted Resolution 49H-1993 (*Trans.*1993:702) calling for the development of a prototype for a standardized national clinical licensure examination. Implementation of issues related to establishing competency standards for dental school graduates will require a long-term commitment from the educational and licensure communities to work toward a common goal.

Further, in support of efforts related to the reliable assessment of dental school graduates, strong consideration should be given to requiring successful completion of Parts I and II of the National Board Dental Examination as a requirement for graduation from dental school and to establishing this as an accreditation standard.

- Issues contained in the Association's September 1993 response to IOM describe the ADA position with regard to licensure. However, the November 1993 House adopted Resolution 147H-1993 (*Trans.*1993:700), related to the use of human subjects in dental clinical licensure examinations. This resolution calls for the Association's Council on Dental Education to work in concert with the American Association of Dental Examiners (AADE) to study appropriate alternatives to the use of human subjects. Further, it requests the Association and the AADE to encourage the regional and state dental clinical testing agencies to consider alternatives to the use of human subjects.

  Additionally, the resolution suggests that the applicability of interactive computer-based patient simulations be studied and sources be identified for the development of such technology. Progress on the implementation of this resolution will be reported to the Association's 1994 House of Delegates.

Allied Health Professionals: In order to ensure the ongoing delivery of quality dental health care to the public, shortages related to the availability of dental assistants, dental hygienists and dental laboratory technicians must be addressed.

- Future availability of allied dental personnel is of significant concern.
- Health care reform proposals appear to require the delegation of more tasks to allied personnel. As the primary care providers in the dental profession, the Association supports this concept. Accordingly, the Association is committed to the concept of the team approach to the delivery of dental care. Efforts to maximize this approach will require appropriate changes in predoctoral, advanced and allied dental education with special attention directed toward nontraditional pathways and concepts related to management of the dental team.
- Federal support should be sought to increase enrollment in allied dental programs to ensure that the dental profession has a sufficient number of competent allied dental professionals to ensure the health of the public.

Demographics: Issues related to demographics must continue to be monitored and appropriate adjustments must be made to ensure that the dental health care needs of the public continue to be met.

- The percentage of practicing dentists who are specialists is approaching 20%. The ratio appears to support the needs and demands of the public. Further, the present ratio of generalists-to-specialists further supports the general dentist's role as being the primary care provider in dentistry. One of the greatest strengths of the dental profession is that dental care is primarily provided by generalists in an out-patient setting.
- The projected ratio of dentists-to-population over the next two decades needs to be further addressed. Specifically, this includes issues related to the productivity of all dentists, the fact that practice patterns may change as dentists' needs change, a decline in the projected numbers of dental graduates, more extensive delegation of duties to allied dental personnel with appropriate supervision by the dentist, and the relatively constant number of advanced specialty education graduates versus decline in the number of generalists. The scope of practice of the specialties needs to be monitored through the definition of the dental specialties and the accreditation standards.
- Capacity utilization measures have been developed to reflect the extent to which dentists are able to treat more patients if enough patients present themselves for care. These measures indicate that currently dentists are operating at about 60% of capacity. There is a question whether this is by choice or an actual reflection of lack of busyness. The current number of dentists will be sufficient to meet any significant future increase in demand for dental care.

Report 7

AIDS Update 1994

Background: In 1991, a Task Force on AIDS was established to address and manage Human Immunodeficiency Virus (HIV)-related issues. However, in view of the emerging tuberculosis (TB) epidemic, and its association with the immunocompromised host, a Task Force on AIDS and Tuberculosis has been established. The Divisions of Scientific Affairs, Legal Affairs and Dental Practice are represented on this task force and their representatives have provided the major knowledge base through which the Association has been able to efficiently confront AIDS and TB related concerns.

AIDS Surveillance Case Definition: All 50 states, the District of Columbia, U.S. dependencies and possessions and independent nations in free association with the U.S. report AIDS cases to the Centers for Disease Control and Prevention (CDC) using a uniform case definition and case report form. The original definition was modified in 1985 (*Morbidity and Mortality Weekly Report* 1985;34:373-5), in 1987 (*MMWR* 1987;36[Suppl. No. 1S]:1S-15S), and again in 1993 (*MMWR* 1992;41[No.RR-17]:1-19). Each revision incorporated a broader range of AIDS-indicator diseases and conditions, and used HIV diagnostic tests to improve the sensitivity and specificity of the definition.

In addition to the 23 clinical conditions in the 1987 AIDS case definition, the 1993 expanded case definition for adults and adolescents includes HIV-infected persons with CD4+ T-lymphocyte counts of less than 200 cells/microliter or a CD4+ percentage of less than 14; and HIV-infected persons diagnosed with pulmonary tuberculosis, recurrent pneumonia and invasive cervical cancer.

As of September 30, 1993 a total of 339,250 AIDS cases had been reported to the CDC.

Transmission of the Human Immunodeficiency Virus (HIV) in Health Care Settings: A discussion of the transmission of the HIV virus in health care settings may be divided into four subject areas:

- *HIV Transmission from Provider to Patient in a Florida Dental Practice.* Previous reports have described the alleged transmission of HIV to six patients receiving care from an HIV-infected dentist in Florida.

  There has been much speculation in the media as to how these six patients became infected with HIV; the predominant hypothesis is that Dr. Acer deliberately infected these individuals. However, a recent article published in *Lears Magazine* (April 1994) provides an entirely different angle to this puzzling case. The article revealed depositions, medical records, and investigators' reports compiled for the Acer lawsuits; these documents had never previously been aired, as settlements were reached out-of-court. In short, the article suggests that the evidence for provider-patient transmission is circumstantial; and further, that some of those infected clearly had other risk factors for HIV infection. These risk factors included aspects of the infected individuals' medical, sexual and drug-use histories. The DNA sequencing experimentation used by the CDC to link the virus from the dentist, to those of his patients, also comes under attack. The article refers to another study (as yet unpublished) in which five HIV-infected individuals from the same area were identified whose HIV-DNA sequences were close to Dr. Acer's; yet preliminary follow-up interviews with two of the five show no link to Dr. Acer, or the six persons he allegedly infected (the remaining three individuals have still to be interviewed). This study could bring into question the reliability of the CDC's DNA-sequencing study, the one "concrete" piece of evidence upon which this case is based; we await its publication and peer review.
- *HIV Transmission from Provider to Patient (excluding the Florida Dental Practice).* Excluding the Acer case in Florida, retrospective studies of HIV-infected HCWs have not identified a single instance of viral transmission from a HCW to a patient (*JAMA* 1993;269:1795-1801; *JAMA* 1993;269:1801-6; *JAMA* 1993;269:1807-11). These results are consistent with previous assessments that suggest the risk of HIV transmission, from infected HCW to patient, is very small (*JADA* 1992;123:36-44).
- *HIV Transmission from Patient to Provider.* As of September 30, 1993, there were a total of 39 HCWs with documented seroconversions following occupational exposure to HIV. The majority of these seroconversions were associated with laboratory technicians, nurses and physicians; there has been no documented seroconversion associated with the practice of dentistry. Of the 39 occupational seroconversions, most HCWs received percutaneous exposures to hollow bore needles containing blood.

  The CDC has further identified 81 HCWs with *possible* occupationally-acquired HIV infection. Of these 81 cases, six were associated with dental HCWs (their positions within the dental office were not reported). Additionally, the Association's Health Screening Program has tested a cumulative total of approximately 10,000 dentists since 1986; to date only two HIV-infected dentists have been identified who reported having no risk factors for nonoccupational exposure to HIV.

  A total of 339,250 AIDS cases have been reported to the CDC (as of September 30, 1993). To date, there has been no documented case of HIV transmission from a patient to dental HCW. These figures provide clear evidence that the delivery of dental health care to patients carries with it a very low risk of acquiring HIV.
- *HIV Transmission from Patient to Patient.* A preliminary report (*The Lancet* 1993;342:1548-1549) suggests the transmission of HIV between five patients, in a specialist surgeon's practice, during minor surgical procedures. These transmissions allegedly occurred in Sydney, Australia. These five individuals received minor surgery in the same consulting room on the same day. Four of the individuals, allegedly infected, were women with no identifiable risk factors for HIV infection; the fifth

individual was male who, due to his low CD4+ cell count, is suspected to be the source individual. The attendance sequence of the five cases is unknown; however, it is suspected the virus was transmitted from the male patient, to the other four patients, through some breakdown in infection control procedures. Further investigations are underway.

Household Transmission of HIV in the Apparent Absence of Sexual or Percutaneous Exposure: Two incidents where HIV was apparently transmitted between household contacts were reported in December 1993.

The first report of household transmission of HIV described transmission between two adolescent brothers with hemophilia. The investigation failed to determine precisely how the virus was transmitted; however, the brothers recalled sharing a razor on one occasion when they both cut themselves and bled slightly when shaving. Other factors accounting for an increased likelihood of blood contact included possible bleeding related to hemophilia or its treatment, the presence of used needles in the home, and the close physical contact between the brothers.

The second report described transmission between two young children. No clear exposure incident was recorded; however, there were several opportunities for such exposure: Child one (HIV-infected) had frequent nosebleeds associated with the use of a nasal steroid inhaler; gum bleeding occurred almost daily with toothbrushing; and there was frequent otitis media with purulent otorrhea. Throughout most of the period immediately prior to child two seroconverting, child two had a rash consisting of five to 20 discrete pruritic, papulovesicular lesions that were frequently excoriated from scratching. Occasionally, the two children bit each other, slept in the same bed, and were thought to have used the same toothbrush. Again, while the exact mode of transmission was not identified, there was ample opportunity for exchange of potentially infectious body fluids.

Considerable epidemiological evidence indicates that transmission in the household in the absence of sexual or percutaneous exposure is rare. Nonetheless, the blood and bloody body fluids of HIV-infected persons are infectious, and care should be exercised in all settings, including the home, to prevent exposure to blood.

Ethical Treatment and Referral of Patients Infected with the HIV and/or *Mycobacterium Tuberculosis*: Resolution 92H-1992 (*Trans.* 1992:650) directed appropriate agencies of the Association to investigate the risk of HIV-infected patients acquiring opportunistic infections as a result of specific dental procedures, and further directed the Association to develop guidelines to assist the practicing dentist in the interpretation of laboratory test results associated with HIV infection, and their significance in relation to performance of dental procedures.

Draft guidelines have been prepared in collaboration with the American Academy of Oral Medicine. It is hoped that these guidelines will be available to members of the Association by the fall of 1994.

In light of the emerging problem of MDR-TB, Resolution 92H-1992 also directed appropriate agencies of the Association to prepare guidelines on infection control related to TB in the dental office. The Task Force on AIDS and TB has aggressively attacked this assignment, and expects the guidelines to be available to members sometime during late summer of 1994.

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

Report 8

Annual Report of Strategic Planning Activities

Background: In 1993, the House of Delegates approved Resolution 63H-1993 (*Trans.*1993:666), which approved the *Strategic Plan, American Dental Association, 1993*. In response to this as well as to its obligation to fulfill Resolution 104H-1990 (*Trans.*1990:570), the Board of Trustees has developed the following annual progress report on Association Strategic Planning activities. In compliance with that assignment, the Board of Trustees is pleased to share with the House of Delegates the attached summary document reflecting the progress of the Board in developing a strategic direction for the Association.

The Board of Trustees reaffirmed its belief that the strategic planning process itself is of the utmost value to those responsible for the leadership and management of the American Dental Association. It requires the Association to examine itself, its environment and the needs of those it serves and to be held accountable for its efforts and results.

The Board of Trustees acknowledged that ongoing strategic planning yields future benefits. The plan is intended to evolve in order to contribute continuity despite the turnover of volunteer leadership. Proper strategic planning includes visioning, values clarification, goal setting, prioritizing, implementing, and evaluation—and then repeating the cycle. It was agreed that the time had come to repeat the cycle and take steps to expand the strategic planning process in order to further its integration into Association activities. The Board's commitment is to carry the strategic planning process forward so that the American Dental Association can realize its full potential as a relevant and indispensable organization to those it serves.

The Board of Trustees commends the Strategic Planning Committee for its efforts and for its contributions to developing the Association's Strategic Planning Process.

Chronology: President James H. Gaines appointed a Strategic Planning Committee, chaired by President-elect Richard D'Eustachio, to develop further recommendations to expand the implementation and utilization of the Association's Strategic Plan. The Committee met on February 17-18, 1994 and May 17, 1994 in Chicago. The Committee reviewed data related to the working objective to achieve better integration of the American Dental Association and its constituent and component societies. Using the evolving strategic plan document, the Committee incorporated its work for consideration by the Board of Trustees. In addition, the Committee developed an action plan for the Board of Trustees' consideration to further the integration of the strategic planning process throughout the activities of the Association and its tripartite network.

Proposed 1994 Strategic Plan Document: The summary document, *Strategic Plan, American Dental Association, 1994*, reflects the annual progress of the Board's work. The document identifies those amendments to the plan that require House review and approval. The Board believes the Plan would be strengthened by the revision of the introduction to make it current and clear. The Board also developed one objective, namely building effective partnerships between the ADA and its constituent and component societies. It is added without prioritization. This concludes the development of working objectives as previously identified. The Board recommends that in a repeat of the strategic planning process cycle that all objectives be reviewed during the coming year for relevancy and that all Association agencies be encouraged to suggest new strategic planning ideas for development.

Future Strategic Planning Activities: The Board believes that even though all current working objectives have been developed, the Plan is an evolving document and is in its initial stages. To further the Plan's continued development and its purpose and use throughout all Association activities, the following actions will be taken during 1995:

- The Strategic Planning Committee, comprised of ADA Board of Trustees and ADA members, will be expanded from six to ten members in order to better assure diversity, depth and breadth of insight and opinion in the scope of strategic issues being explored.
- The Strategic Planning Process and the Association's Strategic Plan will be addressed at the December 1994 Board of Trustees' meeting in order to establish short-term and long-term planning considerations. Short-term planning considerations include direction on prioritization of resources in the development of the 1996 budget, and long-term planning considerations include the identification of emerging trends that will have future impact on the work of the Association.
- The Strategic Planning Process will be expanded to include educational sessions and/or materials on strategic planning at a variety of forums. Strategic Planning will be offered in the New Board Orientation in December 1994; informational materials will be provided to the Board of Trustees for its consideration and discussion just prior to its annual budget deliberations; informational materials will be provided to the House of Delegates prior to its annual budget considerations.
- Beginning in 1995, all annual reports will include an informational section on how the activities of the agency support the Association's Strategic Plan.
- The 1995 budget process will be enhanced to better assist the Board of Trustees and House of Delegates in deciding upon its annual funding priorities.
- Input into the planning process will again be sought through a process of disseminating the plan to all Association agencies and national dental organizations.
- All Association agencies will be engaged in an educational process on strategic planning in order to facilitate the further development of their own strategies that complement and support the Association's objectives.

The Board also considered submitting a resolution asking the House to amend the *Manual of the House of Delegates* to require that all makers of resolutions for House consideration, beginning in 1995, be required to include a rationale for how

the substance of the resolution supports the Association's Strategic Plan or to include a rationale on what emerging trend demonstrates that the organization should redirect resources in support of the resolution. Although the Board agrees that makers of resolutions should give thoughtful consideration to the ADA Strategic Plan when proposing resolutions, it believes that requiring such would prohibit rather than enhance the House of Delegates' decision-making process.

The Board believes that the strategic objectives within the Association's Strategic Plan should not restrict it from funding programs, but rather provide it with reference points regarding what the House of Delegates determines is important at its annual review intervals. The modifications presented at this time are offered to enhance, rather than markedly change, the focus of the 1993 document.

Quality and Strategic Planning: The Office of Quality and Strategic Planning was created as part of the Executive Director's internal Association restructure process in order to assist those responsible for Association leadership and management. The Office will provide staff support to the Strategic Planning Committee and assist it in meeting its goals while it also assists management in working toward its goals to integrate quality and strategic planning management principles throughout its activities.

Therefore, the Board recommends adoption of the following resolution.

Resolution

54. Resolved, that the revised introduction of the Strategic Plan as presented in the progress report entitled "Strategic Plan, American Dental Association, 1994" be approved, and be it further

Resolved, that the new Objective 12, Constituent and Component Dental Societies, be approved.

Strategic Plan
American Dental Association
1994

Introduction

The Strategic Plan of the American Dental Association charts the ADA's future direction as a strong, progressive organization. The Plan reflects a belief that the Association can respond to change in a way that enhances the stature and effectiveness of the ADA and its members.

The Plan addresses issues that will profoundly affect the future of the dental profession and the ADA. The Plan directs the ADA to allocate limited resources to essential core initiatives, identified by the membership, while avoiding nonessential program development.

The Plan acknowledges that change is constant and that the dental profession must position itself to anticipate and respond. For this reason, the Plan is a living document, updated annually. A committee with members from the Board of Trustees and the general membership guides that process of continual review. Interested parties are invited to help shape the Plan. Even though its scope is long-range, the Plan also accommodates shorter-term, annually revised action agendas. The Plan recognizes the importance of ongoing self study through analysis of trends, member needs and Association accountability and performance.

Through its Strategic Plan, the Association communicates its purpose and goals as expressed in its **Mission Statement**. The common convictions and heritage that unite the dental profession are presented in the Plan's **Guiding Principles, Values and Beliefs**. Prioritized objectives set future direction. The Plan does not suggest specific strategies to achieve objectives; this is the responsibility of ADA councils and agencies and is subject to Board of Trustees approval. The Plan reflects an organization prepared to respond to crisis through new and innovative working objectives.

The Board, in fulfilling Association management responsibilities, directs ADA agencies through the annual budget process. The Plan embodies the Association's commitment to its mission and the methods it will use to accomplish that mission.

The American Dental Association envisions, in the 21st century, a well-informed public with access to high-quality oral health care, and a successful profession, realizing professional growth and unity through membership in the ADA.

ADA Mission Statement

The American Dental Association is the professional association of dentists dedicated to serving both the public and the profession of dentistry.

The American Dental Association promotes the public's health through commitment of member dentists to provide quality dental care, accessible to everyone.

The American Dental Association promotes the profession of dentistry by enhancing the integrity and ethics of the profession; strengthening the patient/dentist relationship; and making membership the foundation of successful practice.

The American Dental Association fulfills its public and professional mission by providing services; and through its initiatives in education, research, advocacy and the development of standards.

Guiding Principles, Values and Beliefs

The American Dental Association believes that:

1. Dental care is an integral component of health care. Enhancing the quality, utilization, availability and affordability of dental care, benefits the public's general health and well-being. The American Dental Association is concerned, therefore, with all relevant health issues.
2. The strength of the dental profession is directly linked to the public's health. Actions by the American Dental Association that support the public's health will strongly support the Association in carrying out its mission. Indeed, it is impossible to effectively serve the dental profession without active promotion of public health.
3. The dentist is the primary dental health care provider.
4. The quality and cost-effectiveness of dental care is enhanced when provided by a coordinated team composed of dentists, hygienists, assistants, office personnel and laboratory technicians. The American Dental Association addresses the needs of the entire team and, in so doing, involves team members in various Association activities, publications and programs.
5. The quality, supply and distribution of dental team members, as well as the demand for dental services, are appropriate concerns of the American Dental Association. The American Dental Association will promote excellence and consistency in the education and evaluation of team members; develop and communicate timely information on the demand for dental services and the number, distribution and productivity of all members; and strive to eliminate barriers to the utilization of dental service.
6. A variety of dental care delivery systems are currently attempting to meet the needs of a diverse population of patients and dentists. The American Dental Association will encourage research on current and emerging dental care delivery systems and support those systems that are shown to: deliver quality, accessible and affordable care; and allow both patient and dentist to make informed choices about treatment and practice setting.
7. The mission of the American Dental Association presents a significant opportunity to improve the public's health and the well-being of the entire dental profession. For this mission to be achieved, however, substantial and stable financial support will be needed. Thus, all dentists should be members of the American Dental Association, since its mission benefits all dentists and since universal membership will provide an affordable, predictable dues structure. While member dues should continue to make a significant contribution to the mission, growth in nondues funding sources should be pursued.

8. Access to leadership positions should be open to all members in accordance with their talents and interests. American Dental Association leaders should be responsive to the multiple and diverse needs and perspectives of its membership.
9. Motivated dentists and staff will successfully direct Association resources and energies toward the accomplishment of the stated mission by working together in a close, honest, and collegial relationship.

The ADA must attract and employ skillful and dedicated staff members—individuals of the highest ability and integrity. They must be recognized and compensated according to their contributions to the achievement of Association goals.

Objectives

Objective 1: Legislative and Regulatory Advocacy

Increase the effectiveness of the Association's legislative and regulatory advocacy efforts on behalf of the public and the profession at all levels.

Rationale: The legislative and regulatory environment has become increasingly complex and challenging to the practice of dentistry. ADA initiatives, often highly technical in nature, must be rapidly coordinated across Association lines. Successful advocacy requires that dentistry's message be unified and clear. Increased access and influence is needed with respect to governmental agencies. More involvement by the members and a better definition of roles within the Association would enhance effectiveness. The Association's ability to shape public health policy is vital to its mission.

Objective 2: Association Program and Financial Plan

Institute innovative business plans to increase the cost-effectiveness of Association programs and focus financial resources on core activities.

Rationale: Long range projections incorporating membership trends and future financial obligations suggest that the Association will be hard pressed to continue present mandated programs to meet future anticipated demands. The Association's membership share of all dentists continues to erode while the market size itself is not expected to grow significantly. Diversity within the Association membership increases the variety of services members have come to expect. While dues revenue is budgeted to provide basic Association programs and core services, user fees will be needed to support discretionary membership services. Seeking additional sources of revenue and reducing costs is required.

The combined dues of the tripartite structure should be analyzed as a whole for their impact on the member dentist, and all three levels must avoid duplication of services to ensure the most cost-effective membership support. While recognizing its heritage as a nonprofit voluntary professional association, the ADA must employ contemporary business management strategies to thrive in the 21st century.

Objective 3: Membership Recruitment and Retention

In cooperation with constituent and component societies, develop and implement cost-effective recruitment and retention programs to maintain and increase membership market share.

Rationale: While enjoying a healthy market share of 73.4% of all U.S. dentists, that share has been steadily declining since 1980. In addition, the lowest market shares are represented by the fastest growing segments of the membership: 63% for women dentists; 67.8% for young dentists; 56% for minority dentists; and 50.5% for foreign-trained dentists. It is acknowledged that greater utilization of services and participation in Association offerings is key to enhancing the value of membership, but automated tracking of this involvement by individual members is not currently in place. In addition, the needs of the membership should continually be assessed. Perhaps the greatest determinant of the success or failure of any recruitment and retention activity is the degree of cooperation received from the constituent and component societies; therefore, future efforts should emphasize the symbiotic relationship throughout the tripartite structure in membership marketing activities.

Objective 4: Access to Dental Care

Support the Association's commitment to the public by removal of barriers to access to dental care.

Rationale: For a variety of reasons, individuals may not be able to access and receive dental care. These individuals may: 1) have economic disadvantages, ranging from lack of private insurance, to lack of availability of adequately funded public programs; 2) have medically complex or handicapping conditions, 3) be institutionalized or homebound; 4) have geographic barriers, including remote area residents, transients and migrant populations; 5) have educational barriers; 6) have cultural barriers, including language difficulties; and/or 7) have psychological barriers, ranging from mild anxiety to dental phobias.

Over half of the population visit the dentist annually. While this proportion has been increasing, there is a critical need for the remainder of the population to receive care. There is also a need for programs and services to be developed and targeted for these diverse population groups who are increasing in number and not receiving care.

Objective 5: Dental School Education and Board Examinations

Improve the quality of dental education and the uniformity of board examinations.

Rationale: In order to ensure excellence in the education and qualification of dentists in the 21st century, the Association must play a leadership role in dental education concerns. The quality of the educational experience varies. The techniques used in the qualification of dentists are not uniform. Incentives for excellence are lacking. There is little agreement

regarding continued competence of dentists. The entire process could be improved through integration of education and examination, and planning for quality outcomes. Association advocacy in this area would significantly contribute to the needs of contemporary dental practice, the freedom of movement of dentists, and the health of the public.

Objective 6: Professional Image

Maintain the excellent image the profession has historically enjoyed as being made up of ethical, compassionate dentists, engaged in the delivery of dental services in a manner designed to be safe, of maximum benefit to the patient, and in the most cost-efficient manner possible.

Position the American Dental Association as the most credible, accessible information source on dental issues for both governmental agencies and the media.

Rationale: The profession traditionally has enjoyed a highly favorable image; however, the impact of HIV, amalgam, fluoride and the crisis in health care costs will constitute a more hostile climate in the 1990's than that of the '80s. The image of the profession is of greater importance than the image of the Association, with the most important audiences for each being the public in general for the profession, and the media and government for the Association. The ADA should determine the appropriate roles of agencies, staff and volunteer dentists for managing appropriate Association communications efforts in the most cost-effective manner possible. Consumer research is needed in order to monitor dentistry's image; and the ADA's credibility as a source of information and advice with the media and other opinion leaders should be assessed.

Objective 7: Dental Practice Income

Improve the financial well-being of member dentists by providing them the means to improve their practice and financial management skills.

Rationale: Dental education costs, government and regulatory intervention, practice economics and the increasing involvement of third-party payers in patients' dental benefits plans are placing an escalating financial burden on the member. The Association must demonstrate its ability to be of real value to the dentist in his or her ability to manage the business aspects of the practice, including management of the dental team, management of third-party payers' administrative processes, and the financial planning for his or her retirement. The Association should be innovative in the area of practice and financial planning services to greatly increase the value of membership.

Objective 8: Research

Effect sound research on issues that significantly impact the oral health of the public, the health of the dental team, and the practice of dentistry.

Rationale: There are issues of significance to the public's oral health and the practice of dentistry that should be addressed as priority research projects. Although its influence upon the research agenda is limited as it neither finances nor conducts comprehensive projects, the Association must act to ensure that researchers in government, universities and private enterprise be responsive to these priority research projects. The Association should stimulate the efficient transfer of research information to the practicing dentist. Association-wide review, prioritization and integration of ADA research and funding methods are needed.

Objective 9: Governance

Position the American Dental Association and its constituents and components to achieve a membership that is representative of the changing demographics of the profession at large and to allow for representative leadership.

Rationale: The demographic makeup of the profession is changing rapidly as greater numbers of minorities and women enter the practice of dentistry, yet these emerging membership segments join organized dentistry at a lower percentage than dentists overall—as do all dentists under 40. Since there are fewer students graduating from dental school than in former years, this situation constitutes a shrinking market share of a smaller emerging market. These membership segments—young, women, minority and foreign-trained, are also under-represented in leadership positions at the state and national levels.

While it cannot be proven that there is a positive correlation between lower representation at leadership levels and lower market share of these segments, it is clear that the Association must take action to solicit the input of these under-represented dentists, both as members and as leaders.

Objective 10: Associated Organizations

Enhance relationships with associated organizations.

Rationale: Enhanced relationships and greater involvement with associated organizations would strengthen the profession and expand the Association's presence and leadership in the dental community. While the Association recognizes that the scope and complexity of these relations may vary, improved coordination of efforts will enhance the Association's ability to respond to issues of mutual concern.

Objective 11: Dental Team

Improve the quality of relationships and effectiveness of the whole dental team.

Rationale: It is strategically important for the Association to understand the needs and enhance the effectiveness of the team of individuals who provide oral health care to the American public. The needs of the public and the individual dental team member are best met through the dental team concept. It must be clearly defined how the Association can help to develop and maintain a strong, unified dental team that is committed to a shared vision of a successful practice to enhance career fulfillment, promote office efficiency and provide affordable quality care for all.

Objective 12: Constituent and Component Societies

Build an effective partnership between the ADA and its constituent and component societies to anticipate and meet our members' needs.

Rationale: The ADA must foster the belief that if it is not in the best interest of the total, it is truly not in the best interest of anyone or any group. It is well acknowledged that the strength of organized dentistry is due to its tripartite organization which allows for governance structures with member involvement at every level. However, an inherent tension also exists with this structure that can produce duplication of services and divisiveness when inherent conflicts of interest emerge. Greater cooperation can be achieved through clarification of appropriate roles and an emphasis on a shared ownership of organized dentistry. This role clarification and partnering through greater cooperation will also contribute to the membership's increased effectiveness in leading the profession through its elected delegates to the ADA House of Delegates.

Implementation and Utilization of ADA Strategic Plan

The ADA's strategic plan was developed to assist the Association in shaping its future. It is paramount that the plan be fully integrated into the Association's operational structure. To make certain that the plan is utilized to the fullest possible extent, the following practices will be instituted.

1. A long-range planning committee, made up of Board of Trustee members, other Association members and staff, will continue to review the dental profession's environment by analyzing trends, assessing membership expectations, and other valuable data. Based on their annual review, recommendations shall be made to the Board of Trustees at its December planning meeting regarding plan updates and action plans for the year ahead. Further, the Committee will monitor the implementation of the plan by the agencies of the Association.
2. The strategic plan will be integrated throughout the Association's agencies, councils, and programs by having the plan and its updates provided to these groups as they execute their own annual planning processes. ADA programs, services, and projects must move the Association towards the established mission statement and objectives of the Association.
3. The guiding principles and objectives contained in the Association's strategic plan and its updates shall provide the primary basis for the annual budget development by agencies, staff, and Board of Trustees. Financial resources shall be shifted towards areas of greatest priority.

The above stated practices make clear the intent of the Association that the Strategic Plan and its annual updates shall be the statement of strategic direction for the American Dental Association.

Shading indicates additions

Acknowledgements

The following members served on the 1994 Strategic Planning Committee: Dr. Walter F. Lamacki, Dr. David Whiston, Dr. David Neumeister, Dr. Richard D'Eustachio, *chair*, Dr. Gary J. Newman, Dr. James H. Gaines, *ex officio*, Dr. Leslie W. Seldin and Dr. James F. Mercer, *ex officio*.

The following members served on the initial Strategic Planning Committee: Dr. Richard D'Eustachio, Dr. David Whiston, Dr. Richard Lewis, Dr. Geraldine Morrow, *ex officio*, Dr. David Neumeister, Dr. Jack Harris, *ex officio*, Dr. Rene Rosas, Dr. Eugene Truono, *ex officio*, Dr. Karen Sakuma, Dr. John Hinterman, *chair*, and Dr. William Ten Pas

The following staff were present during portions of the 1994 Committee meetings and contributed significantly to the process: Ms. Sharon Colwell, Mr. Jerry Herb, Mr. Paul Jarr, Ms. Karen Murphy, Ms. Judy Pulice, Mr. Barry Ranallo, Ms. Bess Reimnitz and Dr. John S. Zapp.

In addition, numerous other Association staff contributed to data collection and development of reports. The participation of these individuals is acknowledged with appreciation.

Report 9

Response to Resolution 75H-1993 Regarding Duties of the Council on Community Health, Hospital, Institutional and Medical Affairs

Background: In 1992 the American Dental Association's Board of Trustees commissioned a management study of the Association by the national accounting firm of Coopers & Lybrand (C&L). The objective of the study was "to ensure that the ADA is structured to promote flexibility and responsiveness to membership needs and requirements and the internal and external challenges facing the profession in the next five to ten years."

The report from the study recommended that some councils change their size, refocus their activities and enhance their efficiency. Regarding the Council on Community Health, Hospital, Institutional and Medical Affairs (CCHHIMA), the C&L study recommended elimination of the Council altogether and the subsequent merging of its programs with other agencies and councils.

In its Report 11 to the 1993 House of Delegates regarding the C&L study recommendations (*Supplement* 1993:431), the Board expressed its opinion that certain of the activities and programs assigned over the years to CCHHIMA are vital to the best interests of the Association. The Board concluded "that at this critical and highly political time in the health care arena, it is important to maintain visibility that comes with a separate council for two key activities of this group: access to care and public health." However, the report noted that certain activities are perceived to "have been assigned without consistency."

House of Delegates Action: The 1993 House of Delegates considered the Board's opinion and adopted Resolution 75H-1993 (*Trans:*1993:666), regarding CCHHIMA within the context of the C&L report, which reads as follows:

> **Resolved,** that the Council on Community Health, Hospital, Institutional and Medical Affairs develop recommendations for consideration by the Board of Trustees in 1994, regarding whether all of the Council's current duties fit within the Strategic Plan and whether certain of their activities would be housed more appropriately with other councils within the Association, for presentation to the 1994 House of Delegates.

This report constitutes the Council's and Board's response to Resolution 75H. The Council welcomed the opportunity to do a self-assessment of its role and also to clarify its function and purpose on behalf of the Association and the dental profession. An ad hoc committee of the Council was formed by the former chairman, Dr. Richard Tempero. The Committee was composed of Drs. Samuel H. Adams, Victor J. Barry, Wm. Richard Haught, Richard E. Jabbour, Joseph G. Kalil, Frank A. Maggio and James C. Murphy. The report was approved by the full Council at its March 11-12, 1994 meeting.

Similarly, the Board of Trustees appointed an ad hoc committee to review the report of the Council regarding its role and function. The Committee was composed of Dr. Richard W. D'Eustachio, chairman, Dr. William B. Finagin and Dr. Walter F. Lamacki. The Committee met on June 1. The report was approved by the Board at its August 7-10, 1994 meeting.

Origin of CCHHIMA: The Board members believe it is important for the House of Delegates to recall the origins of CCHHIMA. In 1986, Board Report 8—Association Structure and Organization (*Supplement 1*, 1986:299), was presented to the House of Delegates. Its intent was similar to that of the Coopers & Lybrand study, although not quite as far reaching. As a result of Board Report 8, the Council on Hospital and Institutional Dental Services was merged with the Council on Dental Health and Health Planning to form CCHHIMA.

Board Report 8 revealed that the Board believed there was an identified need to broaden the scope of dental care in interdisciplinary health care settings such as hospitals, ambulatory care centers and long-term care facilities and to strengthen dental care in the management of certain medical diagnosis categories. With a rapidly growing elderly population, the cooperative interdisciplinary management of medically compromised patients became an issue of increasing significance to the dental profession. The Board believed that a consolidation of these two councils would provide a single focus and assure coordination of these related activities. The new combined council would also have continued responsibility for access and community health issues, preventive dentistry, and dental care for developmentally disabled and elderly persons.

Subsequently, the following Council bylaws were adopted in 1986 and later updated to reflect this broader scope.

a. To recommend policies and formulate programs relating to community dental health, including dental health planning, dental manpower resources, preventive dentistry, fluoridation and nutrition issues.
b. To assist constituent and component societies, public health agencies and others in the management and coordination of local resources or programs for dental health planning, preventive dentistry and other community health programs.
c. To maintain liaison with dental health agencies and special interest organizations on community dental health and manpower resource issues.
d. To serve as liaison for the Association with the Joint Commission on Accreditation of Healthcare Organizations and with JCAHO corporate members and other national health care organizations.
e. To recommend policy on issues pertaining to the relationship of dentistry and medicine, including interdisciplinary patient management, dentist-physician relations, the oral health needs of medically compromised patients and the role of physical evaluation and medical risk management in dental practice.
f. To conduct activities to improve the health outcomes of patients requiring cooperative dental-medical management.

g. To conduct activities to increase patient access to dental care and to increase access to the benefits of cooperative dental-medical management in hospitals, ambulatory care centers, long-term care facilities and other interdisciplinary health care settings.

The Board believes that today's overall health care environment demands even more Association attention to these responsibilities than was the case in 1986.

Council Structure: In order to carry out CCHHIMA's *Bylaws* responsibilities, the Council membership has been divided into three subcommittees which are respectively assigned responsibility for three focus areas. The Council members are assigned to subcommittees based on their expertise and interests. The subcommittees report back to the Council as a whole; consider special and follow-up actions on issues that need to be addressed throughout the year; and provide consultation to staff on issues addressed by the Council and subcommittees.

The Council receives written reports from invited consultants and guests. The Council studies and acts on issues raised in these reports. Consultants are invited to participate in the subcommittee meetings of the Council. Appendix 1 contains the revised agenda from the March 11-12, 1994 Council meeting as an example of the problems and issues covered by the members.

Throughout the year, the Council maintains liaison with other consultants and organizational representatives. A list of organizations with which CCHHIMA liaises and/or collaborates is attached as Appendix 2.

The three focus areas are: 1) access to oral health care and community health activities; 2) fluoridation and preventive health activities; and 3) health care facilities and interprofessional affairs. These areas are discussed in the following sections.

Access to Oral Health Care

The Council's goal regarding access to oral health care is to ensure that special population groups which need and want oral health care are able to receive it. To meet this goal, CCHHIMA identifies and promotes innovative programs to make oral health care more accessible to the economically disadvantaged (especially children and the elderly), handicapped, homebound and institutionalized.

The Council recognizes that, until such time as society acknowledges the importance of oral health care for these disadvantaged people, they will be dependent upon the goodwill of the profession to find innovative ways to meet their needs. It also recognizes that the Association itself cannot deliver care but rather serves to identify oral health needs and to foster appropriate outreach programs to meet those needs consistent with the Association's policies.

An ancillary objective is to quantify the humanitarian service of the profession so that this story can be told both by the Association and the member dental societies. The general public, as well as public policy leaders, need to be reminded of the efforts made by the profession.

Primary Activities: Primary activities include:

- promoting public awareness of the oral health needs of special populations;
- recommending and reviewing legislation aimed at improving the availability of oral health care services to special patients;
- providing technical assistance and counseling to dental societies, dental schools and others interested in the development, implementation and/or maintenance of access initiatives;
- consulting and liaising with national advocacy organizations representing various under- and unserved constituencies on oral health care issues;
- coordinating the Council-sponsored Awards Programs to recognize contributions made by individuals and organizations in the areas of community preventive dentistry, geriatric oral health care and access to oral health care;
- developing educational resources for oral health professionals, other health care providers, health care facility administrators, consumers and others to inform them about the oral health needs of special patients; includes development of health promotion materials and technical resources;
- coordinating the Association's efforts with individual access initiatives such as the Caring Program for Children; the Special Athletes, Special Smiles Program; and the various activities of the ADA-affiliated organization, the National Foundation of Dentistry for the Handicapped; and
- sponsoring of continuing education activities for oral health professionals treating special patients.

Resources:

Access Program Surveys. National biennial surveys of dental society-sponsored access programs targeting special population groups.

Oral Health Care in the Nursing Facility. Guidelines for dentists and health care facility administrators establishing an oral health program in nursing homes and long-term care facilities. Includes outline for in-service training.

Portable Dentistry Information. A resource for oral health professionals interested in establishing a portable or mobile oral health program. Highlights several operating programs and includes a list of equipment manufacturers.

Award Program Compendiums. Program descriptions of the award winning entries of the annual Geriatric Dental Health Care Award and Community Preventive Dentistry Award. Includes name and address of the program administrator and affiliated organizations.

Geriatric Dentistry Resource Package. Articles, patient education brochures, technical assistance resources, policy statements and model program ideas.

Access Program Resource Package. Model program ideas, policy statements, articles and patient education brochures.

Relationship to Strategic Plan: Within the "Mission Statement," this program area addresses:

1. the promotion of the public's health through commitment of member dentists to provide quality dental care, accessible to everyone. This is done specifically by encouraging and supporting development of national, state and local access programs that respond to the unmet oral health needs of the public;
2. the promotion of the profession of dentistry by recognizing and rewarding the individual and collaborative efforts of dentists responding to the challenge of providing oral health care services to under- and unserved population groups. Additionally, through liaison with national advocacy organizations representing underserved constituencies; and
3. the fulfillment of the Association's public and professional mission by providing services through its initiatives in education and advocacy. Specifically, by sponsoring continuing education for dentists treating special patients and by advocating for the oral health care needs of under- or unserved population groups.

The Access and Community Affairs Program is applicable to the following Strategic Plan Objectives:

Objective 1. Legislative and Regulatory Advocacy—The legislative and regulatory agenda of the Association is furthered by the activities of the Access and Community Affairs Program and its advocacy for under- and unserved population groups.

Objective 2. Financial Plan—Salable materials developed with the cooperation of CCHHIMA contribute to the Association's non-dues revenue. Corporate support for the Awards Programs as well as the annual National Conference on Special Care Issues in Dentistry are also sources of non-dues revenue.

Objective 3. Membership—The technical assistance provided through the Program as well as the resources developed through the Program are valuable membership services.

Objective 4. Access—There is a direct correlation between the activities of the Access and Community Affairs Program and Strategic Plan Objective 4.

Objective 5. Education—Sponsorship of continuing education activities for oral health professionals treating special patients. The National Conference on Special Care Issues in Dentistry and the annual Council-sponsored scientific programs at the annual session are evidence of such activities.

Objective 6. Professional Image—The professional image of the Association is enhanced by the activities of the Access and Community Affairs Program. The Awards Programs promote dentistry's benevolence by highlighting its volunteer efforts. Liaison activities with national advocacy organizations representing underserved constituencies also enhances the Association's professional image by acknowledging and addressing shared oral health care concerns.

Objective 10. Associated Organizations—Active involvement with organizations such as the Federation of Special Care Organizations in Dentistry, the National Foundation of Dentistry for the Handicapped, the National Alliance for Oral Health and the National Commission on Correctional Health Care, strengthen the profession and expand the Association's presence and leadership in the oral health community.

Fluoridation and Preventive Health Activities

The goal of the Council is to support disease prevention activities and to foster the benefits of oral health promotion for members and the public. This commitment is reflected in the Council's attention to such significant health issues as community water fluoridation, school fluoride rinse and supplement programs, pit and fissure sealants, tobacco education and cessation, sports dentistry and nutrition.

Primary Activities: Primary activities include:

- maintaining a clearinghouse of information on preventive oral health measures; such as fluorides, fluoridation, sealants, tobacco cessation and smokeless tobacco;
- promoting preventive dentistry measures to the public and the health care community;
- developing and assisting dental societies with local fluoridation campaigns;
- representing the Association's interests in the Healthy People 2000 initiatives;
- encouraging appropriate legislative and research activities;
- promoting an awareness of the hazards of tobacco use;
- coordinating the efforts of public and private agencies promoting preventive dentistry programs; and,
- promoting an awareness of sports dentistry issues and encouraging the widespread use of oral/facial protectors.

Resources:

Fluoridation Campaign Package. Scientific background and campaign strategy information on water fluoridation.

Water Fluoridation Campaign Manual. Forty-page "how to" guide for dental societies and community groups.

Fluoridation Facts. Comprehensive booklet stating facts and fallacies about community water fluoridation.

Fluoridation/Fluoride Brochures. "Facts about Fluoride," "Fluoride Helps Prevent Tooth Decay," and "Why we Recommend Fluoridation."

Fluoridation Audiovisuals. Film and slide tape presentations on community water fluoridation for professional and public audiences.

Pit and Fissure Sealant Resource Package. Scientific articles and other resource documents on sealants.

Tobacco Cessation Resource Package. Scientific articles, reports and data on cessation programs.

Smokeless Tobacco Resource Package. Scientific articles, reports and legislative activity on smokeless tobacco.

Baby Bottle Tooth Decay Information. Educational and scientific information on baby bottle tooth decay.

Relationship to Strategic Plan: Within the "Mission Statement," this program area addresses:

1. serving the public and the profession of dentistry through promoting scientifically proven preventive oral health programs and procedures to members and the public;
2. promotion of the profession of dentistry through liaison with the U.S. Public Health Service (USPHS), Centers for Disease Control and Prevention (CDC), National Institute of Dental Research (NIDR), National Cancer Institute (NCI), Association of State and Territorial Dental Directors (ASTDD) and related dental organizations;
3. strengthening the dentist/patient relationship by providing the most current information on preventive interventions for use in private offices and community-based programs; and
4. initiatives in education, research and advocacy by development of the Caries Prevention Guide, tobacco education resources, cosponsorship of the Dietary Fluoride Supplement Workshop and management of the National Fluoridation Advisory Committee.

The Fluoridation and Preventive Health Program Activities are applicable to the following Strategic Plan Objectives:

Objective 1. Legislation and Regulatory Advocacy—the Council initiates Association policy related to preventive oral health; the Council is also the preventive health content expert that works with other Association agencies to promote our legislative agenda especially relating to fluoridation and tobacco issues.

Objective 3. Membership—the vast resource materials provided to members relating to preventive oral health issues are unique membership benefits and serve to actively demonstrate the Association's commitment to disease prevention and health promotion.

Objective 4. Access—liaison with public health associations and state dental directors relate directly to improving the general population's access to preventive oral health programs and fluoridated water.

Objective 6. Professional Image—promoting the Association through joint ventures with the Department of Health and Human Services, USPHS, CDC, NIDR, NCI and Association of State Territorial Health Officials especially facilitating the achievement of the Healthy People 2000 goals and advancing the goals of the National Dental Tobacco Free Steering Committee.

Objective 10. Associated Organizations—close working relationships with American Public Health Association, American Association of Public Health Dentistry and Association of State and Territorial Dental Directors will expand the Association's presence and leadership in the oral health community.

Health Care Facilities and Interprofessional Affairs

The Council's goal with regard to health care facilities and interprofessional affairs is to represent the interests of the dental profession in an expanding arena of nontraditional delivery settings and professional relationships. For example, the Council sponsored the development of a series of oral health guidelines for use by physicians and dentists. These are intended to serve as a starting point for both disciplines to understand the clinical interactions between dentistry and medicine in patients with complex medical conditions.

The Council also serves to assure that the rights and prerogatives of the 40,000 dentists with hospital privileges are protected within the hospital setting and in the standards developed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The Council provides an oral health orientation for JCAHO surveyors and participates in several Joint Commission advisory committees and national meetings.

Annually, the Council organizes a conference on issues of interest to hospital dental directors. The Council maintains guidelines for hospital dental departments and a policy statement on the delineation of clinical dental procedures in the hospital. Additionally, the Council maintains regular liaison with the American Medical Association (AMA) and the American Hospital Association (AHA) and provides input to those organizations on issues of interest to dentistry.

Primary Activities: Primary activities include:

- recommending policy on issues relating to dental/medical interrelationships;
- enhancing the involvement of dentists in the joint management of medically compromised patients;
- preparing protocol guidelines on the oral health management of medically compromised patients;
- making the medical community aware of the benefits of oral health consultation;
- serving as the ADA's primary link with major health organizations, e.g., AMA, AHA and JCAHO; and
- resolving hospital medical staff issues related to oral health care.

Resources:

Oral Healthcare Guidelines. A series of documents devoted to selected medical conditions or treatment modalities that have oral health consequences, e.g., cancer chemotherapy, cardiovascular disease, and HIV/AIDS.

Oral Health Services in Hospitals. Historical survey information on the extent and nature of hospital dentistry.

Guidelines for Hospital Dental Departments. Recommendations for policies and administrative procedures for dental departments.

Information for Dentists in Nontraditional Settings. Information on nonclinical dental careers, oral health personnel shortage areas and the National Health Service Corps is available.

Relationship to Strategic Plan: Within the "Mission Statement," this program area addresses:

1. the promotion of quality care through the Oral Health Care Guidelines and through assuring the appropriateness of JCAHO standards related to dentistry;
2. the promotion of the profession of dentistry through liaison with the AMA, the AHA, JCAHO; and

3. advocacy for dentistry by assuring that dentists are not discriminated against in health care facility settings by virtue of their professional degree.

The Health Care Facilities and Interprofessional Affairs Program is applicable to the following Strategic Plan Objectives:

Objective 1. Legislation and Regulatory Advocacy—The cooperative relationships maintained by the Council with organizations such as the AMA, AHA and JCAHO help facilitate the Association's legislative agenda.

Objective 2. Financial Plan—The Program's Oral Health Care Guidelines series contributes to non-dues revenue.

Objective 3. Membership—The Program's assistance to members seeking nonclinical dental careers is a unique membership benefit and serves to retain members who are considering leaving dentistry.

Objective 4. Access—Health care facility liaison and the Oral Health Care Guidelines series relate directly to improving the general population's access to appropriate oral health care.

Objective 6. Professional Image—Ongoing liaison with AMA, AHA and corporate membership in JCAHO enhances the profession's stature in the health care community.

Objective 10. Associated Organizations—Program issues often necessitate good working relationships with related specialty organizations.

Council's Recommendations and Comments: The Council offered the following recommendations and comments for the Board's consideration. These represent the Council's examination and study of its assigned responsibilities.

1. The Council understands and supports the administrative decision to move the Office of Quality Assessment and Improvement (formerly Office of Quality Assurance) from CCHHIMA to the Council on Dental Benefit Programs. It is conceivable that, although the quality assurance area is relevant to CCHHIMA's interests, it may have been one activity that seemed misaligned during the C&L study.
2. The Council's Nonclinical Dental Career Program has provided unique resource information and guidance to members who, for one reason or another, are compelled to consider leaving clinical or traditional dental practice. This service, although valuable, may be more appropriately placed elsewhere in the Association's council structure.
3. The *Bylaws* reference to manpower encompasses the Council's ongoing monitoring and liaison function with the U.S. Public Health Service National Health Service Corps (NHSC) program. As a public health program which has an impact on access to care, the oral health component of the NHSC is clearly relevant to the Council's mission. The *Bylaws*, however, should be amended to include the current terminology which is "dental health personnel" rather than "manpower."
4. Change "dental health" to "oral health" throughout the Council's bylaws to update the current terminology.
5. The Council members are concerned that the current name, Council on Community Health, Hospital, Institutional and Medical Affairs, is overly complex and functionally cumbersome. It believes that a shorter name would be more appropriate and consistent with other Association councils. Therefore, the Council recommends a new name, "Council on Community Oral Health."

Discussion: In general, the Board agrees with the Council's recommendations and comments. The Board, however, offers the following recommendations and comments for consideration.

1. The Board is concerned with the perception many members have that the Council members are primarily oral and maxillofacial surgeons and therefore focus on hospital issues. An examination of the Council make-up revealed there were five oral and maxillofacial surgeons, six general practitioners, three periodontists, one pediatric dentist, one state dental director, one hospital administrator and one physician.

   To address this concern the Board offers the following recommendations.

   a. While the current make-up of the Council is well balanced, the Board directs that the Council revise its criteria for Council nominees to ensure this balance in the future.
   b. The Board discussed the membership of the hospital administrator and physician on the Council and concluded that the benefits of having them on the Council outweigh any disadvantages.
   c. The Board requests that the Council consider separating health care facilities and interprofessional affairs into two distinct areas.

2. The Board agrees with the Council that its current name is complex and functionally cumbersome. The Board feels the proposed new name, Council on Community Oral Health, while an improvement, still does not readily capture the nature of the Council's responsibilities. The Board recommends that the House of Delegates adopt the name Council on Access, Prevention and Interprofessional Relations.
3. The Board understands the logic of putting the various focus areas of the Council together. The Board notes that the success of the Council's activities often requires the cooperation of several Association agencies and volunteers. The Board urges that these interactions be enhanced.
4. The Board carefully reviewed the Coopers & Lybrand report as it pertains to the Council. The Board concluded that the authors of the report did not understand the mission and activities of the Council nor the interrelationship of its focus areas. The Board feels that the Council is effective and that parcelling its activities to other agencies would not serve the membership or public well.

Conclusion: The Board, after careful and thoughtful review of its mission and function, respectfully concludes that the Council's existence and its duties enumerated herein, remain vital to the Association and the profession of dentistry. This is particularly true in this critical time of health system reform. Clearly, the Council's programs related to access and to oral health care serve the public and profession well.

The Board believes adoption of a new name would be more reflective of the Council's mission and activities. The name change should signify the more aggressive profile in:

1) access to oral health care and community health activities; 2) fluoridation and preventive health activities; and 3) health care facilities and interprofessional affairs.

The Board trusts that the members of the House of Delegates will agree that this Council best serves the public and related health organizations. Further, the report demonstrates the strong relationship of its programs with the Association's Strategic Plan.

The Council's long-term liaison with oral health agencies and special interest organizations, combined with its historically diverse, national representation from all trustee districts gives the Council the ability to be an effective advocate for organized dentistry in its focus areas. Therefore, the Board endorses the current composition as specified in the *Constitution and Bylaws* which reads, "one (1) member from each trustee district, one (1) member who is a physician and one (1) member who is a health care facility administrator nominated by the Board of Trustees."

This self study, called for by the House of Delegates, has caused the Council to look to the future with new energy and focus. The ADA, its members and the public will benefit from the Council's higher profile and more aggressive advocacy.

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

Resolution

67. Resolved, that the *Bylaws* be amended by deleting the name "Council on Community Health, Hospital, Institutional and Medical Affairs" wherever it appears and by substituting in its place the name "Council on Access, Prevention and Interprofessional Relations," and be it further

Resolved, that Chapter X. COUNCILS, Section 110. DUTIES, Subsection C. COUNCIL ON COMMUNITY HEALTH, HOSPITAL, INSTITUTIONAL AND MEDICAL AFFAIRS, of the *Bylaws* be amended by deleting Subsection C in its entirety and substituting in its place a new Subsection C to read as follows:

C. COUNCIL ON ACCESS, PREVENTION AND INTERPROFESSIONAL RELATIONS. The duties of the Council shall be:

a. To recommend policies and formulate programs relating to community oral health, including oral health planning, dental health personnel resources, preventive dentistry, fluoridation and nutrition issues.
b. To assist constituent and component societies, public health agencies and others in the management and coordination of local resources or programs for oral health planning, preventive dentistry and other community health programs.
c. To maintain liaison with oral health agencies and special interest organizations on community oral health and dental health personnel resource issues.
d. To serve as liaison for the Association with the Joint Commission on Accreditation of Healthcare Organizations and with JCAHO corporate members and other national health care organizations.
e. To recommend policy on issues pertaining to the relationship of dentistry and medicine, including interdisciplinary patient management, dentist-physician relations, the oral health needs of medically compromised patients and the role of physical evaluation and medical risk management in dental practice.
f. To conduct activities to improve the health outcomes of patients requiring cooperative dental-medical management.
g. To conduct activities to increase patient access to dental care and to increase access to the benefits of cooperative dental-medical management in hospitals, ambulatory care centers, long-term care facilities and other interdisciplinary health care settings.

and be it further

Resolved, that Chapter X. COUNCILS, Section 10. NAME, and Section 110. DUTIES, of the *Bylaws* be amended editorially to place the councils in alphabetical order.

APPENDIX 1

Revised Agenda
Council on Community Health, Hospital, Institutional and Medical Affairs

American Dental Association
Headquarters Building, Chicago

March 11-12, 1994

I. Call to Order by Chairman Haught at 8:30 a.m., Board Room

II. Roll Call (Drs. Richard Haught, Samuel H. Adams, Steven G. Ashman, Victor J. Barry, Thomas M. Daniel, Michael W. Fallon, John S. Fridley, Robert P. Gardner, Richard J. Hastreiter, Richard E. Jabbour, Joseph G. Kalil, Frank A. Maggio, George W. May, Wallin E. McMinn, James C. Murphy, Jeffery E. Persons, John H. Staley and Peter F. Steinhauer)

III. Preliminary
- A. Opening Remarks of Council Chairman
- B. Adoption of Agenda
- C. Affirmation of Mail Ballots
- D. Conflict of Interest Statement
- E. Rule on Sexual Harassment
- F. Copyright Assignment Forms
- G. Standing Rules for Councils and Commissions
- H. Election of Vice Chairman

IV. Report of Associate Executive Director, Division of Dental Practice, Dr. Albert H. Guay

V. Report of Director, Mr. John S. Klyop
- A. Director's Report
- B. Report on Implementation of Action Items
- C. Resolutions from 1993 House of Delegates

VI. Other Association Reports
- A. Washington Office
- B. Department of State Government Affairs
- C. Office of Quality Assessment and Improvement

VII. Invited Reports from Consultants, Organizational Representatives and Guests
- A. Chief Dental Officer, USPHS—Dr. Robert J. Collins
- B. Centers for Disease Control and Prevention—Dr. Donald Marianos
- C. National Institute of Dental Research—Dr. William Kohn
- D. American Association of Oral and Maxillofacial Surgeons—Dr. William C. Donlon
- E. Association of State and Territorial Dental Directors—Dr. Dean Perkins
- F. Federation of Special Care Organizations in Dentistry—Dr. John Rutkauskas
- G. National Commission on Correctional Health Care
- H. National Foundation of Dentistry for the Handicapped

VIII. Report of ADA Commissioner, Joint Commission on Accreditation of Healthcare Organizations—Dr. John F. Helfrick

Access Subcommittee Will Meet In Conference Room 2D

IX. Report of Subcommittee on Access to Dental Care (Dr. Richard E. Jabbour, chairman; Dr. Michael W. Fallon; Dr. John S. Fridley; Dr. Wallin E. McMinn; Dr. James C. Murphy; Dr. Peter F. Steinhauer; and Dr. Richard Haught, *ex officio*)

TAB

Jabbour A. Report on the National Foundation of Dentistry for the Handicapped

Murphy B. Report on 1994 Telephone Access Survey

McMinn C. Report on Cooperative Activities with the Department of Salable Materials

Fallon D. Report on Liaison Activities
1. National Alliance for Oral Health
2. National Council on the Aging
3. National Oral Health Information Clearinghouse
4. National Commission on Correctional Health Care

Fallon E. Report on the Council Award Programs
1. Access Recognition Award
2. Community Preventive Dentistry Award
3. Geriatric Dental Health Care Award
4. Council's Choice Award

Steinhauer F. Report on the Special Athletes, Special Smiles Program

Jabbour G. New Business
1. Report on the Caring Program for Children
2. Request for Association Support of the Children's Dental Clinic

Institutional Subcommittee Will Meet In Conference Room 2B

X. Report of the Subcommittee on Institutional Dental Care (Dr. Samuel H. Adams, chairman; Dr. Steven G. Ashman; Dr. Thomas M. Daniel; Dr. George W. May, Jr.; Dr. Jeffery E. Persons; Dr. John H. Staley; and Dr. Richard Haught, *ex officio*)

TAB

H. Report on the Joint Commission on Accreditation of Healthcare Organizations Activities

Ashman 1. Revised Surveyor Training Seminar
Ashman 2. Hospital Dental Directors Conferences
Ashman 3. Health Care Network Advisory Group
Adams 4. PTAC Appointments
Adams 5. Commissioner's Report

I. Report on American Medical Association (AMA) and American Hospital Association (AHA) Liaison

Daniel 1. AMA Interim Meeting Report
Daniel 2. AMA Leadership Conference
Daniel 3. Recommendations for Revisions to AMA Hospital Bylaws
Staley 4. AHA Annual Convention
Staley 5. Hospital Dental Department Survey Information

Adams J. Letter to American Association of Dental Examiners

May K. Revisions to Hospital Privileges Document

Persons L. New Business

Preventive Dentistry Subcommittee Will Meet In Conference Room 2C

XI. Report of Subcommittee on Preventive Dentistry (Dr. Joseph G. Kalil, chairman; Dr. Victor J. Barry; Dr. Robert P. Gardner; Dr. Richard J. Hastreiter; Dr. Frank A. Maggio; and Dr. Richard Haught, *ex officio*)

TAB

Barry M. Report on Fluoridation Issues

Gardner Mc. Consideration of Dietary Fluoride Supplement Workshop Outcomes

Maggio N. Status Report on Caries Prevention Guide

Barry O. Report on 1994 National Oral Health Conference

Hastreiter P. Report on Tobacco Issues

Maggio Q. Status Report on Healthy People 2000 Initiative

Kalil R. Status Report on National Coordinating Committee on School Health

Barry S. Report on National High Blood Pressure Education Program Activities

Gardner T. Report on Family Violence Issues

Hastreiter U. Report on Sports Dentistry Issues

Kalil V. New Business
1. Report on 1994 Sealant Workshop on Practice Guidelines

XII. Council on Community Health, Hospital, Institutional and Medical Affairs Report to the Board of Trustees and House of Delegates: Response to Resolution 75H-1993

XIII. Report on World Health Day/Year of Oral Health—1994 Activities

XIV. Report on the 1994 Sixth National Conference on Special Care Issues in Dentistry

XV. Report on the 1993, 1994 and 1995 Scientific Program at ADA Annual Session

XVI. Consideration of 1995 Consultants

XVII. Future Meeting Dates

XVIII. New Business
1. Report on Fund-raising for Access Initiatives
2. Ideas for the Good of the Council
3. Submission of Bullet Page for Interagency Communications

XIX. Adjournment

APPENDIX 2

Organizations With Which CCHHIMA Liaises and/or Collaborates

Academy of Dentistry for the Handicapped
Academy of Sports Dentistry
American Academy of Family Physicians
American Association for World Health
American Association of Homes for the Aging
American Association of Hospital Dentists
American Association of Oral and Maxillofacial Surgeons
American Association of Public Health Dentistry
American Dietetic Association
American Hospital Association
American Medical Association
American Public Health Association
American Red Cross
American Society of Geriatric Dentistry
American Student Dental Association
Association of State and Territorial Dental Directors
Centers for Disease Control and Prevention
Healthy Mothers/Healthy Babies Coalition
Federation of Special Care Organizations in Dentistry
Joint Commission on Accreditation of Health Care Organizations
Joint Commission on Sports Medicine and Science
National Alliance for Oral Health
National Cancer Institute
National Commission on Correctional Health Care
National Council on the Aging
National Foundation for Ectodermal Dysplasias
National Foundation of Dentistry for the Handicapped
National Health Education Consortium
National Health Service Corps
National Heart, Lung and Blood Institute
National High Blood Pressure Education Program Coordinating Committee
National Institute of Dental Research
National Network for Oral Health Access
National Oral Health Information Clearinghouse Coordinating Committee
Sjögrens Syndrome Foundation
U.S. Olympic Committee
U.S. Public Health Service
U.S. Surgeon's Office
World Health Organization

Report 10

ADA Seal Program

Background of House and Board Actions: At its October 1993 meeting, the House of Delegates adopted Resolution 151H-1993 (*Trans.* 1993:679) which directed the Board of Trustees to study the feasibility of making the ADA Seal Program revenue neutral, with a report to the 1994 House of Delegates.

In response to Board direction at its December 1993 meeting, an ADA staff Task Force on a Revenue Neutral Seal Program was appointed by the Executive Director and directed to examine this issue and report to the February 1994 Board meeting. The guiding principles for this report were: 1) The fee system should be fair; 2) it should be structured not to discourage manufacturer participation; and 3) its administration should not be unduly complex. After this report was presented, the Board endorsed the concept of a revenue neutral Seal Program, and directed that an implementation plan be prepared with industry input for the April 1994 Board meeting. Consequently, the Executive Director appointed a second Task Force on a Revenue Neutral Seal Program, and its report was presented to the April Board. As a result of these studies, the Board endorsed a resolution that reasonable fees be adopted for companies that participate in the ADA Seal Program. Fees would be assessed for the purpose of recovering all of the direct costs and a portion of the indirect costs of running the Seal Program, and would be charged for new submissions together with a maintenance fee for products already in the Seal Program, with an implementation date of July 1, 1995. Necessary changes in the Provisions for Acceptance will be reviewed by the Council on Dental Materials, Instruments and Equipment and submitted to the Board of Trustees and House of Delegates for consideration and adoption in a separate report.

The following is a review of the factors discussed by the Board, both from the Task Force reports and from manufacturer comments, which examine the feasibility of making the ADA Seal Program revenue neutral.

Historical Perspective: In 1987, at the direction of the Board, an examination of establishing a fee structure for the Seal Program was conducted. Both manufacturers and members of the Council on Dental Therapeutics (CDT) and the Council on Dental Materials, Instruments and Equipment (CDMIE) were asked to comment. Manufacturers were not supportive of a fee structure, many saying they would drop out of the program if a fee were charged. In addition, in a report to the August 1987 Board, both CDT and CDMIE voted, for numerous reasons, against the imposition of a fee system for the Seal Program. As a result, the 1987 Board decided not to pursue a fee system for the Seal. The issue was not raised again until six years later with Resolution 151H.

Discussion of the Benefits and Drawbacks of Fee Assessment: In response to Resolution 151H, the Board reviewed the following benefits and drawbacks that could result from charging a fee for the Seal versus not charging a fee.

Proposed "Fee-for-Service, Revenue Neutral" Seal Program:

Benefits:

Sharing the cost could enhance the perceived benefit of the Seal with the additional non-dues revenue providing a mechanism for improving the Seal Program and its image in the eyes of the consumer, the manufacturers, and the profession.

Drawbacks:

Decreased Image of the Seal and ADA. Possible unfavorable image with the public, the profession, government agencies, some manufacturers, and the media, because of the possible appearance that the Seal can be bought. It might also appear that larger companies would be able to obtain or "buy" the Seal more easily than smaller companies.

Decreased Knowledge About Dental Products. A decreased manufacturer participation in the Seal Program could result in a decrease in the detailed information known by the ADA about current and future dental products. This would hinder the ADA's ability to be an information resource on dental products for the public and the profession.

Charging Too Many Fees. Some manufacturers mistakenly believe that at least part of the fees charged for advertisements appearing in ADA publications and for annual session exhibit booths go towards support of the Seal Program. Charging them yet another fee might be considered unfair or unwarranted.

Current "No Charge" Seal Program:

Benefits:

Favorable Image of the ADA. Gives the ADA a favorable image with the public, the profession, regulatory agencies, governmental agencies and the media, because this is a no charge service which directly benefits the public and the profession.

Enhances Seal Credibility. The Seal has great credibility, partly due to the fact that this voluntary process has no fee attached.

Encourages Manufacturer Participation. Encourages manufacturers to participate in these voluntary evaluation programs, thus providing the ADA with up-to-date information on current dental products, which can then be passed on to the profession and the public.

Drawbacks:

No Direct Income Generation. The Seal Program currently does not directly generate non-dues revenue and thereby has little opportunity of an influx of resources to improve the quality of the Seal Program or the service it provides without increasing the percentage allocation of dues dollars. Reports by Coopers & Lybrand and Dr. Larry Meskin were persuasive in suggesting that unless the Seal Program could be supported in a manner that would assure a quality program, consideration should be given to phasing it out.

Conclusion: In weighing the benefits and drawbacks of charging versus not charging the Seal participants, the Board feels that the increased revenue from charging would provide the opportunity of improving the Seal Program and thereby enhance its value in the eyes of the manufacturers and consumers. Proper program promotion and handling of the fees could prevent the perception that the Seal could be bought. Further, improved programs should not reduce participation by the manufacturers but ultimately increase it.

Other Issues of Consideration

Increased Expectations of Manufacturers. The Board believes that if a fee system is implemented, manufacturers should expect that the process for reviewing and approving products will be made more efficient. This is what the FDA has agreed to do in return for the fees they are now charging pharmaceutical manufacturers for their New Drug Approval process. Industry is reported to be pleased with the FDA system. Serious consideration needs to be given to ways in which the Seal Program can be made to run more efficiently and meet manufacturers' increased expectations.

Seal Program Efficiency. The Board noted that staffing levels in the Division of Scientific Affairs have decreased over the past several years, while the workload has increased. This has already adversely affected the efficiency of submission turnaround and general functioning of the Seal Program.

Results of Member Surveys. The Board examined four member surveys, which were conducted between 1989 and 1993 by the Association, on the importance and benefits of the ADA Seal Program (Strategic Planning Committee Report, 1992; Survey of Dental Practice, Special Version for Dental Scientists and Educators, 1992; Meskin's DSA Program Review, 1993; and the public Smile America Program, 1989). The Seal Program has repeatedly demonstrated in these surveys to be beneficial to the practicing dentist and to the public.

Types of Fee Structures Used by Other Organizations. The Board examined the fee structures of the following three organizations:

1. FDA's New Drug Approval process for prescription drugs;
2. Underwriter's Laboratories; and
3. Canadian Dental Association.

Involvement of the Manufacturers in Any Decision. The Board believed strongly that manufacturers needed to be consulted prior to any final decisions and implementation of any fee structure. To this end, a meeting with industry representatives for input and consultation was convened by the President.

Indirect Costs. The Board decided that if a fee system were to be implemented, the direct costs plus a portion of the indirect costs of running the Seal Program should be recovered so that it would be a shared responsibility.

Board Decision: After considering the above factors, the Board adopted a resolution that the ADA should charge a fee for the Seal in order to recover the direct costs and a portion of the indirect costs for running the Seal Program.

Factors Considered in Development of a Specific Fee Structure

The following describes the factors considered in developing the fee system.

Seal Program Expenses to ADA: Expenses to the ADA for the Seal Program are incurred by CDT, CDMIE and the Departments of Chemistry and Toxicology (whose budgets are combined into one Research Institute [RI] budget), all in the Division of Scientific Affairs. In examining options for the proposed fee structure, the following information was used:

- The 1993 direct costs for CDT, CDMIE and the RI:

CDT	=	$ 509,300
CDMIE	=	$ 859,100
RI	=	$ 435,000
TOTAL		$1,803,400

- It is estimated that approximately 50% of CDT's and CDMIE's time and effort, and 25% of the RI's resources, are devoted to the Seal Program. Therefore, to be revenue neutral, a fee program would need to recover:

CDT	=	$ 254,650
CDMIE	=	$ 429,550
RI	=	$ 108,750
TOTAL		$ 792,950

Extent of Manufacturer Participation:

Number of Products in the Seal Program at End of 1993

Council	Consumer OTC	Consumer Rx	Professional	Total
CDT	182	154	191	527
CDMIE	272	0	955	1,227
TOTAL	454 OTC		1,300 NOTC	1,754

(NOTE: OTC = over-the-counter products, e.g., toothpastes, mouthrinses and toothbrushes
NOTC = Non-OTC, which consists of consumer prescription and professional products, e.g., prescription analgesics, antibiotics and amalgams)

Numbers of Submissions and Resubmissions in 1993

Council	Submissions		Resubmissions	
CDT	33 OTC	25 NOTC	61 OTC	115 NOTC
CDMIE	100 OTC	31 NOTC	91 OTC	318 NOTC
Totals	133 OTC	56 NOTC	152 OTC	433 NOTC

Companies Participating in Seal Program at End of 1993

Council	Consumer OTC	Consumer RX	Professional	Total
CDT	101	28	62	191
CDMIE	136	0	190	326
Totals	237 OTC	280 NOTC		517

Fee System Factors: There are a number of important factors that the Board considered regarding the development of a fee system:

Whether Products are OTC Versus NOTC. Corporate profits and consumer spending for consumer OTC products, in general, are considerably higher than for NOTC products.

Amount of ADA Volunteer and Staff Time and Resources Required to Process a Submission. This is determined by many factors, including the type of data needed to demonstrate safety and efficacy (i.e., laboratory versus clinical), amount of in-house laboratory testing that must be done, whether consultant review is needed, how complete a submission is and whether additional data will be required and whether it is a new submission or a resubmission, etc.

Amount of Staff Time Required to Maintain Products in the Program. The main determinant of this is the amount of advertising a manufacturer does. All advertising for Seal Program products must be reviewed and approved by Council staff and, if necessary, the Advertising Review Committee. For OTC products, the time required is often considerable because there are many different and frequently changing advertising campaigns, and advertisements are created for both television and print media. Another time-consuming activity is the daily creation and maintenance of administrative records necessary to keep the program functioning.

Gross Sales of a Manufacturer. The Board discounted this approach for two reasons. First, it would be difficult to determine equitable gross sales cutoff points on which to base fees. Also, a strong determinant of which companies submit products might become their financial status. This last issue would lend strong support to the appearance that the Seal can be bought if a company is willing to pay enough.

Gross Sales in a Specific Product Category. This aspect was also ruled out by the Board for reasons mentioned above.

Number of Submissions From a Single Manufacturer. This might be addressed by a sliding scale with a cap on the amount charged after a certain number of products are accepted. (This option has not been figured in the fee structures to follow).

Types of Fee Systems. A fee system could be established based on the following:

1. submission fee only;
2. maintenance fee only;
3. membership fee for a company to be in the Seal Program which is not related to the type or number of products submitted, size of company, etc.; and
4. submission and maintenance fees.

Fee Structure Options: The following six possible fee structures were examined:

1. charge product submission fees only, and OTC and NOTC products charged the same;
2. charge maintenance fees only, and OTC and NOTC products charged the same;
3. charge submission fees only, and charge OTC products more than NOTC products;
4. charge maintenance fees only, and charge OTC products more than NOTC products;
5. charge a "Membership" fee per manufacturer, and charge OTC companies more than NOTC companies; and
6. charge submission and maintenance fees, and charge OTC products more than NOTC products, and charge submissions more than maintenance fee.

Board Decision: Of all the options examined, the Board determined that Fee Structure No 6. (or one of its modifications) would be the most equitable for manufacturers, while at the same time returning to the ADA a fee appropriate to the type of product being evaluated and maintained in the Seal Program. The benefits of this option are:

1. It recognizes that more ADA time and resources are involved in the submission process than in maintaining products;
2. It charges for both submission and maintenance, thereby compensating the ADA for its activities in each activity;
3. There is a clear distinction between the additional ADA time and resources required for OTC submissions versus NOTC products, as well as recognition of the greater financial benefit of the Seal to OTC products;
4. It allocates the costs of the Seal Program based on several factors which relate to the time and resources needed to process submissions and maintain products; and
5. Administration of this fee structure would be more complex than the other options but not unduly so.

Costs to Recover with a Fee Structure: The Board believes that additional staff (over and above the Division of Scientific Affairs staff shortages that currently exist which also need to be filled) would need to be hired to handle the increased accountability requirements that a fee structure would impose, and proposes $50,000 to cover this expense. The Board also believes that an additional 37.5% of the direct costs should be recovered to account for a portion of the indirect costs. Therefore, the revised fee structure would incorporate $792,950 in direct costs, an additional 37.5% of $792,950 to cover a portion of the indirect costs, and $50,000 for staff, making the total to be recovered approximately $1,160,000.

Results of a May 11, 1994 Meeting with Manufacturers: At its April 1994 meeting, the Board decided that more input would be needed from manufacturers on the proposed fee structures and other issues related to a fee structure. At the Board's direction, a meeting was held where manufacturers were invited to attend and comment. Dr. James H. Gaines, ADA president, and several Board members were in attendance. In a letter to all manufacturers after the meeting, Dr. John S. Zapp, ADA executive director, summarized the meeting as follows:

- The proposal to organize the Seal Program into categories of over-the-counter and professional use was well received. Industry representatives believed this approach will be easier for everyone to understand.
- The new advertising review process in which all products that appear in ADA publications would be reviewed by one advertising committee also was seen as a step forward to improving ADA/industry relations.
- Future guidelines and those already developed should be written in a manner that makes them easier to interpret. It was hoped that fewer misunderstandings would result.
- The ADA should educate its members on what the Seal means. According to manufacturers of professional use products, dentists do not realize that the Seal represents a level of quality, safety, and effectiveness that may not be the case with non-Accepted products.
- There should be some mechanism whereby the FDA approval process could be eased and expedited as a result of receiving the ADA's Seal. Further, the ADA should work with organizations throughout the world to make the ADA Acceptance reciprocal with other forms of approval so that industry can more easily gain access to foreign markets.
- There was support for a fee structure that made a distinction between professional use and over-the-counter products, that the proposed fee for application and annual maintenance for over-the-counter products could be higher, while the proposed fee for professional products should be less.
- There seemed to be a call for a fee cap based on gross percentage of sales for small companies producing over-the-counter products.
- The ADA should share in the costs of maintaining the Seal Program instead of requiring industry to bear all of the burden. The term "revenue neutral" should be replaced with a term such as "cost sharing."
- Industry and the ADA should continue to keep the lines of communication open. An ad hoc ADA/industry committee to discuss the status of the Seal Program as well as other issues should be formed.

Final Proposed Fee Structure: Taking into account the May 11, 1994 manufacturers' comments and the June 1994 report of the Task Force on the Seal Program, the Board adopted the following recommendations:

- a fee structure that would charge:
  NOTC Maintenance = $ 100 Annual Fee
  OTC Maintenance = $1,500 Annual Fee
  NOTC Submission = $ 500 One Time Fee
  OTC Submission = $9,000 One Time Fee
- attempt to develop a fair and equitable fee cap.
- charge private label OTC products the NOTC maintenance fee.
- drop the term "revenue neutral" in favor of the term "cost sharing."
- develop a program to inform ADA Members of the meaning and value of the Seal for professional products.
- work with FDA and international counterparts to find ways of easing and expediting the regulatory process as a result of reviewing the Seals.
- create an ad hoc Association/industry committee to discuss Seal Program issues on an ongoing basis.

The Board finally adopted Resolution B-58, which states:

> **B-58-1993. Resolved,** that the recommendations of the Task Force on the Seal Program be adopted, and be it further
> **Resolved,** that the Task Force coordinate the development of a comprehensive plan to implement the recommendations and other decisions concerning the Seal Program previously adopted by the Board of Trustees, for consideration by the Board at its August 1994 meeting.

At the August 1994 meeting, the Board reviewed the comprehensive plan as submitted by the Task Force and voted to approve its implementation.

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

Report 11

The Grassroots Program

Introduction: The grassroots program, approved through House of Delegates Resolution 153H-1993 (*Trans.*1993:677), is a success. At the time of the writing of this report, over 12,000 dentists and spouses have volunteered to be members of the grassroots action teams in their congressional districts.

"I'm getting flooded with letters from dentists. I certainly know where you stand," said a senior aid to a leading Senator when she met with the ADA's antitax coalition. Another staffer during another meeting with the coalition said that her Senator has probably "heard from every dentist in his state." When the Washington Office staff pursued a meeting with a prominent member of the Ways and Means Committee, her staff said that she had met several times with dentists, both in her district and in Washington, that she was also getting many calls and letters, and that she was very clear about dentistry's position. When one of the ADA's consultants went into an influential Democrat's office, he saw the ADA's ad directed at the Congressman sitting on a staffer's desk. These scenarios are just what the ADA wants to hear from Capitol Hill and reflects the outcomes wanted by the House of Delegates when it passed Resolution 153H-1993.

Background: Resolution 153H-1993 called on the Board of Trustees to "marshall the resources of the appropriate agencies of the Association and outside consultants to undertake a grassroots political and educational campaign to promote the Association's health care reform policies." The Board determined that the needs of the Association could best be furthered by building a grassroots network that had as its first priority health system reform (as called for in the resolution), but which would also serve the Association as the basis for legislative advocacy and political action activities on diverse issues into the next century.

To begin building the grassroots network, in January, more than 38,000 dentists in 36 states were invited to participate in the first phase of the Association's grassroots program. Phase one focused on the 121 congressional districts of members of Congress who serve on committees of the House of Representatives with primary jurisdiction over health system reform legislation: the Committees on Ways and Means, Energy and Commerce, and Education and Labor.

The decision to implement the grassroots program on an incremental basis provided the Association with the opportunity to thoroughly review the cost effectiveness of alternative presentations of solicitation techniques and to evaluate and fine tune these activities as the program evolved. At the end of Phase one, over 7,000 dentists and spouses had volunteered to be active participants in the grassroots network by becoming part of the grassroots action teams in the 121 targeted congressional districts.

Leaders for each of these teams were chosen by the constituent executive directors, in consultation with their state leadership and ADA trustees, and review by representatives of the Council on Governmental Affairs and Federal Dental Services and ADPAC. The grassroots leader serves as the point person and coordinator for the activities of each congressional district action team. Training for the grassroots team leaders was provided in four regional workshops, where the team leaders discussed with ADA leadership and staff from the Washington Office the duties and responsibilities of the action team leaders and the anticipated activities of the action teams.

Phase two was initiated in June, when the initial solicitation was expanded to dentists who live in the congressional districts of the Committee on Rules and the majority and minority leadership in the House of Representatives. In July, as part of Phase three, the Association mailed invitations to join the grassroots network to dentists living in the remaining 314 congressional districts. By the time the House convenes in New Orleans, every ADA member will have been asked to join a grassroots action team, and a team will have been established for all 435 congressional districts. The respective action teams for each state's congressional districts serve, collectively, as the voice of dentistry in conveying the profession's message to members of the Senate.

Grassroots Budget: In December 1993, the Board of Trustees authorized the President and President-elect to approve expenditures of funds for the grassroots program with regular reports to the Board summarizing the expenditures. The Board recognized that the House had authorized the expenditure of up to $2 million from reserves for this activity. The Board, however, determined that the amount stipulated was a limit only and that they would be prudent in their approval of expenditures so that only necessary and cost-effective projects would be funded.

The grassroots expenditures budgeted through August 1 are as follows:

- The initial grassroots direct mail campaign to recruit ADA action team volunteers, which included the mailing of solicitations to over 38,000 dentists, as well as telemarketing to nonrespondents in targeted congressional districts.
  Budgeted: $132,109.00
- Phase two mailing to 5,800 ADA members in the congressional districts of members on the Committee on Rules and the five House majority and minority leaders.
  Budgeted: $13,079.00
- Phase three mailing to the approximately 100,000 ADA members not yet contacted to become action team members.
  Budgeted: $38,235.00
- The development, production and dissemination costs of an information/education kit on health system reform. This kit included a 2-pocket folder containing a booklet on dentistry's successes and reform priorities, ten detailed resource papers, speech, lapel button and poster for dental offices. The kit was distributed to action team members, participants in the March Public Affairs Conference in Washington, D.C., etc.
  Budgeted: $47,946.00
- Contracts with three outside consultants for strategic and political advice and member contact. The consultants were

chosen for their specific focus either on Republicans, specifically in the Senate; or Democrats, specifically in the House and the administration. The contracts run through the end of 1994.

Budgeted: $352,500.00

- Action alert telegrams to all action team dentists for Ways and Means Committee members and for three holdout members of Energy and Commerce urging them to vote against taxing health benefits.

  Budgeted: $5,701.50
- Letter to all members of the Minnesota Dental Association (MDA) explaining the ADA's involvement with MDA's administration concerning Minnesota's health system reform legislation and regulatory activity.

  Budgeted: $1,200.00
- Placement of ads in newspapers in selected congressional districts of Ways and Means and Energy and Commerce members. These ads included the names of the action team members in the targeted congressional districts. Included in this expenditure is the cost of distributing grassroots ad "slicks" to constituent and component societies for their use.

  Budgeted: $59,120.00
- May legislative alert urging an estimated 33,000 dentists in 20 states to contact members of the Senate Finance Committee and express opposition to the taxation of health benefits, especially dental benefits.

  Budgeted: $12,000.00
- July follow-up letter to 7,000 grassroots team members asking them to call, write and, if possible, meet with their Senators. (Because of earlier mailing error, vendor assumed the cost of this mailing).
- A 14-minute video to accompany and reinforce health system reform materials to grassroots network: distribution to 600 constituents and components.

  Budgeted: $28,000.00
- Design, production and dissemination of new grassroots monthly newsletter, *The Dental Advocate*, to all action team members.

  Budgeted: $25,191.00
- Prepare and print 10,000 brochures on health system reform, with focus on state issues. Half for use at National Conference of State Legislatures (NCSL) Annual Meeting; half for constituent use.

  Budgeted: $4,611.00
- Production of 700 grassroots manuals to be given to the 435 action team leaders, ADA trustees and constituent executives. Manual is a "how-to" guide to legislative advocacy and political action. Looseleaf format allows for information updates.

  Budgeted: $4,642.00
- Four one-day regional workshops for grassroots team leaders. Bulk of this expenditure is to defray cost of travel for the team leaders. Meetings held in New York, San Francisco and Chicago. ADPAC wanted to provide financial support for this program. The funds provided were used for a fourth workshop in Atlanta.

  Budgeted: $75,000.00

Total budgeted expenditures: $799,334.00

(Total actual expenditures for the grassroots program activities will be reported to the House of Delegates in the Board's report on health care reform. This report will be forwarded to the House in October.)

Future Activities: The newly established grassroots network of action teams provides the Association with the ability to mobilize quickly cadres of informed dentists on critical issues and to implement their legislative advocacy and political action activities in a cost-effective manner. Rather than having to take a shotgun approach to grassroots activities, the Association now has the capacity to target those specific members of Congress who are pivotal to a particular desired legislative result. For example, the Association was able to place advocacy advertisements in the newspapers of specific members of Congress, primarily those on the Ways and Means Committee, and to use the names of the members' constituents in the ads. Also, ADA sent letters to the action team members who live in the 20 states represented by Senators on the Finance Committee, asking them to write and call their Senators to oppose the taxation of dental benefits.

The Association believes that this capability will be enhanced as we build upon the early phases of the grassroots program and recruit even more dentists to participate. *The Dental Advocate*, the monthly grassroots newsletter, will be the primary vehicle for communication with all action team members. The Board has agreed to hold a Grassroots Conference in March 1995, which will be an educational and informational program for the grassroots team leaders. The Conference, which is budgeted at $125,500, will focus on grassroots techniques to nurture the action teams, recruit new members, develop new skills and programs for increased political action, etc.

Clearly, the health system reform issue is what led the Association to establish the grassroots network. At the time of the writing of this report, it is unclear whether health reform legislation will pass the 103rd Congress. Whether final health care legislation is signed by the President or not, dentistry will be actively involved in the issue for years to come. In addition, federal activities in other issues, such as mercury in wastewater, interest on student loans, ergonomics, etc. will continue to affect the dental profession. The new grassroots network provides an excellent foundation for the Association to well meet these new challenges.

In order to provide the House of Delegates with the most recent information, the Board of Trustees will prepare a report on the status of health care reform for distribution to the House in October.

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

Report 12

Dental Office Wastewater

Background: The Association, through its multi-division staff Waste Management Task Force headed by the Divisions of Science and Legal Affairs, has continued to monitor various dental office waste issues and investigate the scientific basis of certain actual and potential environmental regulations. At its December 1993 meeting, the Board of Trustees determined that the Association would be best served by appointing two trustee liaisons to the Task Force, for volunteer input. The Task Force has provided the Board with regular reports on this emerging issue. Based on the need to address these issues, the Board approved two supplemental requests for funding the Association's waste management activities in 1994, totalling $125,000. This brings the Association's commitment to this issue to in excess of $400,000 the past few years, exclusive of resources committed through division budgets, e.g., for staff and in-house research.

This report summarizes the current posture and potential further developments regarding the key waste issue addressed by the Association this past year: dental office wastewater discharged down the pipes to treatment plants. As reported in Report 21 to the 1993 House (*Supplement* 1993:502), an increasing number of constituent and component societies have been confronted with potential wastewater regulations in recent years. The regulatory activity typically begins when local wastewater treatment plants become concerned about not meeting their discharge limits for mercury, silver, copper and other substances, or are considering reducing discharges of these substances to their immediate environment. As a readily identifiable source of those substances, dentists are often a prime target of regulatory efforts offered to meet those limits. A key reason is that the regulators sometimes jump to the conclusion that amalgam breaks down in the waste stream and releases its components. As part of dentistry's commitment to the protection of the environment, the Association has assisted societies throughout the tripartite addressing these issues, and has also taken the scientific lead to ascertain whether such regulation is warranted.

By early 1994, it was apparent that dentistry was confronted with two possible types of wastewater regulation: 1) bans or effective bans on amalgam wastewater discharge, and/or 2) the mandated use of pretreatment technology, such as amalgam separators. Factors leading to these twin concerns included federal, state and local implementation of the existing federal Clean Water Act ("CWA"); proposed amendments to the CWA, which called for a "toxics phase-out" that could lead to a ban on discharges of amalgam and other substances in wastewater; federal hazardous waste regulations; and separate and sometimes stricter state and local laws. While most of the focus of such regulation was on mercury, some regulations also targeted silver.

On January 25, 1994, the Association convened a half-day meeting to address wastewater issues. Participants included outside scientific, legal and communications consultants, the Task Force and its two Board liaisons, the Executive Director and key senior management and staff. The attendees overwhelmingly concluded that while an unqualified exemption from regulation for amalgam or other substances in dental wastewater would be desirable, the fact that amalgam contains mercury made obtaining an exemption highly unlikely. As a result, the best approach seemed to be to seek a temporary moratorium on the application of existing or proposed wastewater regulations to dental office wastewater discharges to publicly owned treatment works (POTWs), in order to allow sufficient time to study environmental and public health impacts (e.g., cost of and access to dental care) of discharge bans or pretreatment requirements for amalgam in dental wastewater and other substances.

Subsequent to the January 25 meeting, and after discussion with the Board, the Association carried the following wastewater message to Congress, the EPA, the membership and, as appropriate, the public: 1) the Association is committed to determining whether there is, in fact, an environmental problem posed by dental office wastewater; 2) the Association has taken the lead in addressing this issue, as evidenced by the resources that it has devoted and continues to devote to investigate potential environmental issues; 3) bans on the discharge of amalgam wastewater to POTWs (e.g., as a result of the "toxics phase-out" contemplated for the CWA) could have profound negative impacts, including reduced access to dental care; 4) there is a need for further science to justify such bans; 5) a moratorium on further regulation of dental office wastewater is warranted until that science can be developed; and 6) that the science may address removal technology (e.g., source reduction techniques), the appropriateness of which should be considered on a local, site-specific basis.

Ongoing Activities: Throughout the balance of 1994, the Association has continued its scientific activity pertaining to wastewater with studies to characterize and quantify the amount of amalgam in wastewater, the effects of disinfectants on amalgam in wastewater, and the efficacy of various treatment technologies. On the legislative front, lobbying efforts successfully led to both the House and the Senate appropriations committees including report language recommending that EPA study the environmental effect, if any, of amalgam discharged in dental office wastewater; however, the committees did not appropriate any money for such studies, and the EPA had previously advised the Association that it would not have the money to study amalgam unless Congress appropriated funds to do so. The Association also continued to communicate developments on wastewater issues, including a comprehensive memorandum to the constituent and component societies. The Association has continued to work closely with constituent and component societies in areas facing potential wastewater regulation. Each of these developments is described below.

Summary of Scientific Findings: The Association's research on dental office wastewater continued throughout the year. Some of these studies focused on what environmental effects, if any, are attributable to dental office wastewater. Others characterized and quantified amalgam in wastewater, and explored possible means to reduce the amount of amalgam discharged into wastewater. What follows is a summary of the knowledge gained to date from these studies.

Characterization and Quantification of Amalgam in Wastewater. As reflected in Report 21 of the Board of Trustees to the 1993 House of Delegates, a key step in assessing the twin issues of discharge and removal was to characterize the particle size distribution and chemical composition of the amalgam in wastewater and to quantify the amount of amalgam discharged in dental office wastewater. By sharing this information with regulatory agencies, many of whom had different and sometimes inaccurate information, the Association has helped constituent and component societies dissuade some regulators from imposing unwarranted regulation.

In its ongoing study of dental office wastewater, the Association assayed samples of dental office wastewater, which were collected chairside, for amalgam particle size distribution. The average percent of amalgam particles (measured as mercury) at different particle sizes were: > 210 micrometers (um) (50%), > 105 um (10%), > 53 um (14%), > 20 um (11%), > 10 um (5%) and < 10 um (10%).

The amounts of amalgam particulate (measured as total mercury) in samples of effluent from dental office wastewater lines, as based upon outside studies, is about 45 mg per day. This is about 8% of the amount of amalgam particulate discharged per dental office per day. A worst case scenario, assuming that *all* particulate entering into the vacuum suction would be discharged, would result in amalgam particles contributing about 600 mg of mercury (measured as total mercury). However, not all of this particulate may be discharged into wastewater treatment plants since most of the amalgam particles appear to settle along the pipes. This suggests a further point of discussion with regulators in areas where treatment of dental wastewater has been or may be proposed, and the potential for periodic maintenance of affected piping to serve as an alternative to proposed amalgam removal technologies. Settled amalgam material may also be subject to waste management regulations, particularly in states which have gone beyond the federal hazardous waste program. Further, settled amalgam material may emerge as an issue in private business contexts, such as the transfer, lease, valuation or financing of a dental facility.

Evaluation of Treatment Technologies. Preliminary results of Association studies indicate that most of the amalgam particles discharged into dental wastewater, excluding particulate in colloidal suspension and dissolved mercury, settle to the bottom of experimental low-tech holding tanks. Methods of separating the settled particles from the liquid in the holding tanks, without discharging the settled amalgam particles into the waste stream, are being explored.

Preliminary analysis showed that wastewater samples collected as effluent from commercially available amalgam separators contain amalgam particles. The results suggest that while commercially available amalgam separators remove a fairly high fraction of larger amalgam particles, they do not remove colloidal particles or dissolved mercury.

In other Association studies, secondary screens were installed in dental unit wastewater lines to remove amalgam particles that were not captured in the traps currently present in dental units. Preliminary results showed that additional amounts of amalgam particles could be retained in the secondary screens, used in series with the primary traps, and the performance of the vacuum suction was not compromised. Based on the characterization of amalgam in wastewater it is estimated that an additional 50% of amalgam particles would be removed if 0.2 mm screens were used. It appears feasible to maintain the two traps during regular maintenance of the dental unit.

Effect of Wastewater Treatment Plant Process on Amalgam. A simulated treatment model study, commissioned by the Association in 1991, explored whether amalgam would degrade or be broken down by aerobic and anaerobic wastewater treatment processes. The study found no detectable mercury from amalgam subjected to conventional wastewater treatment simulation at a mercury detection limit of 1 ppb.

Aquatic Life Studies. The Association commissioned studies to determine the effects of amalgam and inorganic mercury on selected species of freshwater marine life. The results of these preliminary studies on the effects of amalgam or inorganic mercury on aquatic life have yielded mixed results. Additional study is needed. Certain high levels of amalgam or inorganic mercury can result in acute toxic effects under certain circumstances. The tested circumstances most likely do not represent actual environmental conditions. Preliminary data indicate that the presence of organic material appears to reduce or eliminate the potential for acute toxic effects. In that the composition of sediment varies from site to site, it appears that the environmental effects of amalgam, if any, are site-specific. Particulate material, whether amalgam or sand, may have some physical toxic effect on aquatic life.

Effects of Disinfectants on Amalgam in Wastewater. The Association has conducted investigations on the effects of disinfectants on amalgam particulate. Some local regulators have expressed concern that some disinfectants may enhance the dissolution of amalgam particles, as disinfectants are found in the waste stream and often flushed from dental offices through wastewater lines. Preliminary results show that the smaller particles may partially dissolve in contact with, for example, hypochlorite. The dissolution rate appears to increase with contact time. Further investigation is underway. It is not known how much mercury may be released from amalgam due to the use of disinfectants in waste lines, nor whether such release has any environmental effects.

Other Mercury Sources. The Association is continuing its investigation of other mercury sources to assist in regulatory matters. A good example is a recent report published by the Minnesota Pollution Control Agency's Mercury Task Force, titled "Strategies for Reducing Mercury in Minnesota," the Executive Summary of which states that "[v]irtually all of this mercury [contamination] is a result of atmospheric deposition." The presence of significant other mercury sources suggests that the regulatory focus could and should be elsewhere than dentistry.

Federal Legislative Activities: At the federal level, the Association lobbied on the congressional appropriations bills and the Clean Water Act. The House passed H.R. 4264, which provides Fiscal Year 1995 appropriations for the EPA. The Association was successful in securing the following report language urging the EPA to conduct a study on the subject of amalgam in wastewater:

> The Agency is urged to consider research on the potential effects of dental amalgam on wastewater and the environment. The Committee has been made aware that there is growing interest in this area and believes that this issue deserves review. The Committee encourages EPA to conduct a study to determine whether wastewater-derived amalgam causes an environmental impact. The Agency should keep the Committee apprised of its progress in this area.

While this committee language was favorable, no money was appropriated for such studies due to tight budget constraints on Congress.

The Association was able to secure similar language on the Senate side, in the Senate Appropriations Committee report which includes the following language urging the EPA to study the environmental impact of dental amalgam in wastewater:

> The Committee is aware that claims have been made in recent months that wastewater containing mercury from dental offices may be contributing measurably to wastewater discharges in the Nation's water bodies, yet no studies have been conducted to verify this assertion. EPA is urged to support a study to examine the presence and environmental impact of dental amalgam in wastewater.

Again, however, no funding was appropriated.

The Association's efforts regarding the Clean Water Act are focused on preventing amalgam in wastewater from being regulated at a national level unless and until it can be established that amalgam poses environmental problems. In the Senate, the full committee completed markup on May 10, and the CWA is awaiting action on the floor. In the House, the CWA continues to remain controversial and thus no markup has yet been scheduled. There is an increasing likelihood that the CWA will not pass this year.

State and Local Developments: The Association has worked closely with constituent and component societies in pockets around the country that are facing potential wastewater regulation. The following examples reflect how this issue arises and has been handled on a state and local basis.

Washington, D.C. Dental office wastewater discharge into the Potomac River provides a good example of a potential discharge ban. After exceeding its discharge limits, the local regulator requested assistance from dentistry to help curb discharges in lieu of further regulation, which the regulator indicated might have included a total ban. The regulator asked for ADA input and also asked the constituent dental societies in the affected region for assistance in alerting members to the issue. It is hoped that by helping to educate the regulator, the ADA assisted the constituents in achieving a moratorium on regulation based on voluntary source reduction.

Seattle, Washington. The Association has continued its work with the Washington State Dental Association and Seattle-King County Dental Society regarding Seattle Metro, the first regulator to say it will mandate the use of treatment technologies, if a rule is passed for dentistry. Staff met with the Washington State Dental Association to discuss these issues, and also appeared on a panel at a conference in Seattle on amalgam in dental wastewater. This conference addressed the issue of reducing the amount of amalgam discharged from dental offices, and included commercial exhibits of amalgam separators.

San Francisco. The Association has worked closely with the California Dental Association and the San Francisco Dental Society to address potential wastewater regulation. The Association has met with the constituent and component societies and local regulators to share the available scientific information, and to explore the prospect of further studies. An issue specifically addressed was the possibility of source reduction, including through the possible use of secondary screens to further remove larger amalgam particles. The Association has also had ongoing contact with the outside consultant retained by California Dental Association to address the potential regulation.

Great Lakes Region. The states in the Great Lakes region are likely to be among the first affected by the EPA's upcoming Great Lakes protocol, which may provide a critical model for regulation throughout the country. This regional protocol, which is expected to be finalized within the year, may trigger local discharge limits that dentistry would be hard-pressed to meet. States in this region may already be moving to such standards. For example, Michigan is reportedly considering limits that would amount to an effective ban. This has led some Michigan dentists to privately study "closed systems," in which no amalgam would be discharged down the pipes. In Indiana, the state regulatory authority has drafted a questionnaire directed to dentists; this was the first such form the Association has seen prepared at the state level, although similar questionnaires have been sent to dentists by local regulators in other states. The Association assisted the Indiana Dental Association in developing a response to this regulatory activity and will continue to monitor this and similar developments across the country.

Communications Issues: The Association has communicated information about wastewater developments to membership in several ways, including a June 6, 1994, report to presidents and executive directors of constituent and component dental societies, describing the ADA's ongoing efforts with respect to dental office wastewater issues and including a separate background briefing paper. In addition, a session on dental office waste was presented at the Leadership/Management Conference held in July 1994; this tracked a shorter program presented at the President-elect's Conference in January. A program on waste management will also be offered at the 1994 Scientific Session in New Orleans. And waste is now a subject regularly covered by the *ADA News*.

In view of the ongoing activities related to dental office wastewater, there has been heightened public awareness about the issue and the Association's positions. Early examples are interviews that the Association has given for the *San Francisco Chronicle*, *Health Magazine* and "Preview Media"—a syndicated television service that produces environmental stories for approximately 50 stations nationwide. Media interest is expected to increase over time. It should be noted that the press and the public often link amalgam wastewater issues together with stories on amalgam health issues, which adds a new element to that issue as well. The Association responds to media inquiries on amalgam by invoking the research summarized in last year's federal government report on amalgam safety, along with messages

emphasizing the profession's commitment to further research and patient safety. These issues and others are addressed through the Association's Critical Issues Task Force, a cross-divisional committee that meets monthly to discuss strategy on crucial issues facing the Association and the profession.

Conclusions: The recent developments described above, especially on the scientific and legislative fronts, led the Board to make and implement various decisions concerning wastewater. The Board's consideration of three key issues is summarized below.

1. Should the Association conduct studies on the "fate" of amalgam in wastewater? Regulators and the media frequently presume that amalgam wastewater poses environmental problems. However, the fate of amalgam (e.g., its effect on aquatic life) is not well understood. The simulated waste treatment study commissioned by the Association provided some favorable results; the preliminary aquatic life studies provided inconclusive results. The Association was able to secure language from both the Senate and House appropriations committees indicating that the EPA should conduct fate studies. However, no money was appropriated for such studies, and it is anticipated that EPA will not conduct them absent congressional funding. The Association will schedule a meeting with the EPA once the appropriations bills have been enacted by Congress.

In view of these developments, the Board determined not to expend additional funds pertaining to the fate of amalgam. Among the principal reasons are that these studies are very expensive (probably *at least* $2 million, depending upon the sophistication of the studies), likely to be site-specific at best, and absent EPA involvement could be subject to criticism because they were conducted by the ADA. In view of the congressional appropriations language regarding the desirability of study by EPA, the Association will continue its endeavor to have EPA conduct such studies. Instead of studying fate, the Board believes that ADA resources would be more appropriately focused on source reduction (see 3, below).

There are two immediate exceptions to this decision. First, the Board decided to commission the organization that conducted the simulated waste treatment study to write its report by including more quantitative data, so the report will be more suitable to share with regulators. Second, the Board decided to commission another phase of the aquatic life study to clarify the results of the preliminary studies. It is believed that these two endeavors will provide added useful information regarding the potential environmental impact of wastewater discharges. The Association will consider other fate studies as warranted.

2. Should the Association continue to emphasize that the issue of amalgam in dental wastewater is best addressed on a site-specific basis? The Board believes that it is important for the Association to continue to emphasize site-specific considerations. Accordingly, the Board believes that the Association should not support a pretreatment standard at this time.

The Board's belief that amalgam wastewater issues must be assessed on a site-specific basis is borne out by the existing scientific studies; e.g., the roles that sludge may have played in the simulated treatment study, and that the presence of sediment played in the aquatic life studies. Further, environmental conditions and concerns vary from city to city, depending upon the sources and extent of waste contribution. In addition, the capability of any given treatment plant to handle its waste load will depend on the age and condition of the plant. And the discharge limits that a plant must meet are not uniform, in part because of differences among various state and local requirements. A site-specific approach, while potentially subject to criticism for lack of uniformity, also seems desirable on wastewater issues because of the extreme range of regulatory approaches that have been seen to date: no or little regulation in some areas; significant pretreatment requirements or bans on discharges in other areas.

3. Would the Association accept a "source reduction" approach based on currently available information? The Board believes that the ADA should focus its wastewater efforts on source reduction. Specifically, except for the aquatic life studies noted above, further science should be directed to source reduction. Association research and testing of amalgam removal technology is ongoing and further studies may be proposed as warranted.

Source reduction is often mentioned by regulators as their aim in reducing the amount of mercury (mostly meaning amalgam particulate) discharged in dental office wastewater. The range of potential source reduction options includes but is not limited to the following:

a. continue to use existing technology;
b. lowest tech: filters (secondary screens with finer mesh sizes, if technically practical);
c. low tech: holding tanks (if prototypes are made commercially available);
d. high tech: separators (the commercially available models, e.g. from Europe);
e. higher tech: electrical and chemical approaches (which could address all of the discharge and not just the particulate);
f. amalgam alternative(s) (which do not address removals of existing amalgams); and
g. closed systems (if feasible).

The Board supports the use of source reduction methods appropriate to the location in question. Further, the Board believes that where warranted, source reduction options (as low tech as possible) should be considered by locality depending on site-specific factors. The Association will continue to provide guidance, as appropriate, to constituent and component societies, including education efforts on a priority basis.

The Board has also directed the development of practice management recommendations as another method of source reduction; e.g., not discharging amalgam particulate collected in the trap into the wastewater. These recommendations will offer a practical approach that may satisfy some state and local regulators; they will also be consistent with the spirit of EPA's contemplated "common sense initiative." The recommendations will evidence ADA's commitment to the environment in a proactive way, without endorsing any uniform pretreatment standard.

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

Report 13

Amendment of Section 4-A to the *Code of Professional Conduct* on Advertising of Exclusive Methods or Techniques

Background: The footnote to Section 5, Professional Announcement of the *ADA Principles of Ethics and Code of Professional Conduct* ("*Code*") reads in part:

> Advertising, solicitation of patients or business, or other promotional activities by dentists or dental care delivery organizations shall not be considered unethical or improper, except for those promotional activities which are false or misleading in any material respect. Notwithstanding any *ADA Principles of Ethics and Code of Professional Conduct* or other standards of dentist conduct which may be differently worded, this shall be **the sole standard** [emphasis added] for determining the ethical propriety of such promotional activities...

This footnote was added as part of the settlement of the Federal Trade Commission (FTC) complaint against the ADA filed in January 1977. The complaint was directed against the ADA, two constituent and two component dental societies involving, among other things, the issue of past prohibitions on advertising by dentists.

In 1979, the ADA entered into a settlement agreement with the FTC pursuant to which an interim consent order was entered. The consent order provided that ethical proscriptions with regard to advertising were limited to advertising that was "false or misleading in a material respect." The *Code* was subsequently revised to reflect this standard. The final consent order was entered in 1982 and modified in 1983.

On November 2, 1993, the FTC notified the American Dental Association of alleged violations of the 1983 consent order. One of these alleged violations concerns *Code* Section 4-A, Devices and Therapeutic Methods, which reads:

> 4-A. DEVICES AND THERAPEUTIC METHODS. Except for formal investigative studies, dentists shall be obliged to prescribe, dispense, or promote only those devices, drugs, and other agents whose complete formulae are available to the dental profession. Dentists shall have the further obligation of not holding out as exclusive any device, agent, method, or technique.

In its letter, the FTC asserted that the second sentence, dealing with advertising of exclusive methods or techniques, conflicts with the consent order because it could be interpreted to prohibit truthful, nondeceptive advertising. According to the FTC, if a dentist in fact possesses a unique method or technique (for example, because he or she is the only dentist in the geographic area to have adopted it), then advertising that fact would not be false or deceptive.

In its answer to the FTC dated June 21, 1994, the ADA replied that the FTC had misconstrued Section 4-A. Section 4-A is not intended to restrict information unless it is false and deceptive. The response was based on discussion of this issue by the Council on Ethics, Bylaws and Judicial Affairs at its May 1994 meeting and by the Board of Trustees in June. In the opinion of both the Board and the Council, a dentist's claim to possess an exclusive method or technique is likely to be false or misleading, since the first sentence in Section 4-A requires dentists to prescribe only treatments that are available to the entire profession. However, both the Board and the Council agreed that they would have no objection to amending Section 4-A to clarify this meaning.

Accordingly, the Board recommends adoption of the following resolution. The Board believes it is reasonable and prudent to resolve items of controversy between the ADA and the FTC through simple clarification of relatively minor issues, where—as here—it can be done without compromising the integrity of the profession's ethical standards. The proposed change would still allow constituent and component dental societies to review members' claims of exclusivity on a case-by-case basis and to discipline those whose claims are false or misleading in a material respect.

Resolution

91. Resolved, that Section 4-A, DEVICES AND THERAPEUTIC METHODS, be amended by adding to the end of the second sentence the statement, "if that representation would be false or deceptive in any material respect," so that the section would read as follows:

> 4-A. DEVICES AND THERAPEUTIC METHODS. Except for formal investigative studies, dentists shall be obliged to prescribe, dispense, or promote only those devices, drugs, and other agents whose complete formulae are available to the dental profession. Dentists shall have the further obligation of not holding out as exclusive any device, agent, method, or technique if that representation would be false or deceptive in any material respect.

Report 14

Information Technology Project

Introduction: In February 1994, the Board of Trustees received a report on the status of the Association's information technology system along with a proposal to develop a comprehensive technology strategy for the Association. At that time, the Board authorized the Executive Director to secure the services of an outside consultant to assist the Association with the completion of this plan at an expenditure up to $315,000. The balance of this report provides the details of this Information Technology Project and the subsequent actions of the Board of Trustees.

Background: The ADA began the process of revamping its information technology systems in March 1994. This was necessary for several reasons. The ADA currently is using an antiquated IBM 4381 mainframe and associated software to support its core applications. Most of the systems are more than ten years old and increasingly difficult and expensive to maintain. The current environment and obsolete programming tool set make it exceedingly difficult to provide staff, constituents and others timely access to vitally needed information. IBM has notified the Association that it soon will no longer support the Association's outdated mainframe software. The technology infrastructure is a significant barrier to achieving required service levels and does not position the ADA for the future.

At its February meeting, the Board of Trustees authorized the Executive Director to retain Andersen Consulting to assist the Association in preparing an Information Technology strategic plan. A team was formed composed of ADA staff members and Andersen Consulting, and chartered with three major objectives:

- Identify a computer technology infrastructure that will replace the current outdated mainframe system with a state-of-the-art, reliable, user friendly, and easily upgradeable technology that can meet the diverse requirements of the different agencies within the Association, as well as supporting all of the mission critical services in a more efficient manner.
- Align the ADA's information technology strategy with the objectives defined for the ADA in the *Strategic Plan: American Dental Association, 1992* and its addendum.
- Establish an implementation plan for an electronic communication structure that can foster better communications between the different ADA agencies and their constituents and customers.

The Project began on March 7, 1994 and included six major tasks:

1. document business strategy;
2. define business requirements;
3. develop application strategy;
4. develop technical architecture strategy;
5. select hardware and software; and
6. develop implementation plan.

Technology Vision: As a result of this effort the future technology infrastructure of the ADA is viewed to consist of five major components:

1. *Entity Database.* This will be an electronic repository of information about members and other areas of interest to the ADA. It will be accessible to all authorized personnel and professionally managed by ADA Information Technology staff.
2. *Customer Service Center.* This facility will provide centralized broad-based support for handling member inquiries. This center will be staffed by highly trained personnel who would be supported by "content specialists" within the ADA departments responsible for fielding inquiries requiring special expertise.
3. *Integrated Application Software.* The team believes it is imperative to ensure that the data within the entity database and the information available through the service center and clearinghouse are accurate. The means chosen to do this must give the ADA Information Technology division the ability to integrate easily all "feeder" systems (membership, financial, subscriptions, etc.) with each other and with the central database.
4. *Information Clearinghouse.* This is an index as well as a way of accessing all information available at the ADA. Information such as survey results, library archives, research activities, and statistical information will be easily accessible.
5. *Communications Infrastructure.* This facility will allow outside access to the Information Clearinghouse and ADA information by constituents and, potentially, all ADA members. It also facilitates two-way communication between all parties.

Recommendation: The Andersen Consulting, ADA Information Technology, and User Group team completed a high level review of the ADA's business processes and future requirements. More than 100 interviews composed of ADA senior management, Board members, staff, constituents and members were conducted. Based on the information gathered, the team surveyed commercially available software packages with a bias toward "off the shelf" solutions as opposed to internally developed software. This produced two viable candidates. The team then checked references, attended user group conferences and talked to customers, before narrowing the choice to one.

At the August ADA Board of Trustees session, Andersen Consulting recommended the purchase and implementation of the MEI Software Systems, Inc. Association Management software package, Progress database, and associated tool set. This recommendation was based on the fact that MEI was moving its Association Management package to a Windows based environment, was tightly integrated to a centralized database, would be quicker to implement, and would provide the ADA with a single point of contact for technical assistance. The Progress database and tool set also will

provide a rich developmental environment that will serve the ADA's future requirements.

Recommendations also were made as to Information Technology structure, staffing levels, training and hardware investments.

The team identified high level Information Network requirements but, outside of identifying the usefulness of information service providers such as CompuServe and ADA-based phone mail, deferred selection of specific technologies until a separate effort could be launched.

A new Chief Information Officer began August 19 and is in the process of reorganizing the ADA's Information Technology Division. This reorganization will involve training and reassignment of current Information Technology staff within the Division as well as hiring additional professionals. It is anticipated that the Information Technology project will be launched during the first quarter of 1995.

Financial Implication: The cost for the Information Technology Project is estimated at $5.6 million over three years. This expenditure is for training; the purchase, modification and installation of software; and the purchase of hardware. The Board, in authorizing these funds, directed that the project be funded from the Restricted Investment Account of the Reserve Division. The Board also directed that quarterly status reports be submitted that will include an accounting of the funds spent and a comparison of actual costs against the project budget.

Benefits to the Membership: Implementing the recommendations will replace antiquated, costly IBM mainframe peripheral equipment and software with a more cost-effective client server solution. This will go a long way towards improving the ADA's operating effectiveness, making staff more responsive to the membership.

The establishment of a central repository data base will make it easier to get at information requested by members. The Customer Service Center concept can be used for directing questions and complaints to the appropriate personnel, processing orders for salable materials, handling subscription orders and renewals and processing meeting registrations.

The Information Clearinghouse can include information such as survey results, library archives, research activities and statistical information, all accessible to the membership. A communication strategy involving wide area access to ADA databases will allow for electronic mail and access to bulletin boards containing late-breaking news and information on dentistry-related issues.

The Board of Trustees and staff are working to position the ADA technologically so as to be responsive to future ADA requirements.

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

Report 15

Health System Reform and the Grassroots Program

Health System Reform: Congressional efforts to reach agreement on health system reform legislation in 1994 officially ended on September 26th. Senate Majority Leader George Mitchell (D-ME) conceded the obvious by announcing: "It is clear that health insurance reform cannot be enacted this year." The decision to bury health reform ended a two-year struggle that began with optimistic calls by the White House for sweeping change and concluded with fruitless attempts to forge a consensus around a series of scaled-down, compromise proposals.

The inability of Congress to forge a political consensus on health reform in 1994, as in the past, stems directly from deep and unresolved divisions within American society and the Congress between those who favor a radical overhaul of the existing system and those who advocate an incremental market-based approach. It is unlikely that the coming election will produce a public referendum on this fundamental question. There was, at the beginning of the 103rd Congress, general agreement that *a* problem existed. But each of the major players in health system reform pursued a different solution to fix his or her own perception of the problem. Everyone had a remedy: the White House plan for comprehensive reform; a single-payer system; managed competition; four separate Committee approved bills; conflicting House and Senate Democratic Leadership proposals; the Mainstream Coalition approach (three versions); bipartisan, incremental insurance reform; and, the last to appear, a Senate health plan for children. These numerous and largely incompatible health reform measures simply cancelled each other out. The public became confused and, in an uncertain election year, the Congress became reluctant to act without a clear signal from the voters. Policy gridlock was the result. One observer described the death of health system reform as resembling a Boston political funeral in which half of the attendees came to mourn and the other half brought hat pins to make sure the corpse had passed on.

President Clinton and top congressional Democrats have indicated they will pursue health system reform in 1995. "The fight will go on," the President said. "We are not giving up on our mission to cover every American and to control health care costs." Senate Republican Leader Bob Dole agrees that health reform will be on next year's legislative agenda; but the focus will more likely be on incremental insurance and marketplace reform than on a comprehensive overhaul of the existing health delivery system. The expected GOP gains in the November election will add a further moderating influence on the 1995 health care debate.

In the interim, the failure of Congress to approve health reform has sparked the "blame game" with recriminations and accusations coming from all quarters. House and Senate Democrats are predictably pointing the finger at "cynical obstructionist Republicans and demagogic special interest groups," while their GOP counterparts say it was the public that stopped reform. "American democracy at its best," responded Texas Republican Phil Gramm. A more partisan view comes from Rush Limbaugh, who informed his radio audience, "If there are any mainstream, inside-the-beltway, lap-dog, willing-accomplices-of-the-administration journalists listening to this show, let me tell you real simple what killed Clinton health care reform: It's called Clinton health care reform."

Dentistry has emerged from the debate on health system reform with a more positive *and visible* political profile. That's the opinion expressed by many Senators and Representatives over the past four weeks. The congressional view of the profession is, in part, the product of a concerted effort by the Association to educate lawmakers on the strengths of the dental care delivery system. Health reform was initially dominated by hospital, medical and insurance issues. Problems which were perceived to exist in one discipline were automatically presumed to exist in all. Common solutions—one size fits all—were proposed without regard to the very real differences that separate medicine and dentistry. The Association responded to that challenge with a clear and consistent message: Dentistry, Health Care that Works. Relevant policies on health system reform were adopted by the House of Delegates which formed the basis of a successful legislative campaign. Every member of Congress received the ADA position and recommendations on health system reform. Association leaders testified before the White House Task Force on Health Care Reform and congressional panels. Meetings were held with more than 400 Representatives and Senators. The Association was instrumental in the formation of a diverse coalition of more than 200 business, labor, insurance, health and civic groups who actively lobbied against a tax on health benefits. A separate coalition of major, national dental organizations—led by the ADA—also played an important role in the effort to preserve the tax deductibility of dental benefits. Constituent and component dental societies, combined with the newly created dental grassroots action teams, generated thousands of letters to members of Congress. Targeted advertisements were placed in the local newspapers of members of key congressional committees. All of these communications stressed the positive accomplishments of the dental care delivery system in expanding access, disease prevention, cost-containment, primary care and cost-savings to the public.

By every measure, the voice of dentistry was heard in Washington. Important decisions on health system reform were reached in 1994 which should serve as a basis for possible future action. They included:

- continued tax deductibility of employer-paid dental benefits;
- a restructured Medicaid program administered in the private sector;
- tax credits for dentists and physicians who practice in underserved areas;
- freedom-of-choice protection allowing patients to seek services outside a managed care network;
- a ban on discrimination by degree of provider;
- tort reform; and
- federal assistance for health professions education.

The new 104th Congress, which convenes next January, will be more Republican, more conservative, and probably more partisan. Health care reform will return, but it will be approached cautiously and incrementally. There is little momentum outside of the White House for another battle over sweeping health care change. It probably will require the passage of time and the 1996 Presidential election before any enthusiasm can be generated for another campaign on universal coverage. Most observers expect the next Congress to limit its actions to several less ambitious but nonetheless contentious areas. ERISA waivers will likely be a major battleground as the states seek greater flexibility in implementing their own health reform agendas. A growing number of governors are concerned with the rising costs of health care in their home states. More of them will seek Medicaid values, which in turn will accelerate the conversion of Medicaid to a managed care/capitation program. They will try for more sweeping changes, including state single-payer initiatives, employer mandates, price controls and premium taxes. Opposing these state rights efforts are large, multijurisdiction employers, insurers and labor unions. These groups insist upon uniform national standards, contending that it would be impossible to comply with and administer national health benefit programs with differing state requirements.

The so-called "incremental" health care reform proposals from this year are likely to be among the first to resurface in 1995. Among their main elements are insurance reform (addressing problems in eligibility, renewal and portability), as well as tort law change, possible antitrust relief for providers, freedom-of-choice protections, medical savings accounts, and a full tax deduction for self-employed health insurance.

Experience has shown, however that small reforms can often be as difficult to achieve as major ones. The debate over the past 24 months has focused for the most part on broad questions of cost-containment, universal coverage, employer mandates and the taxation of benefits. With the end of comprehensive reform and the shift of discussion to incremental change, critics have predictably found fault with these more modest proposals. Limited reform without structural change would, they argue, compound existing problems of access and cost.

The push for incremental reform will be undertaken in individual pieces of legislation. The expectation, however, is that there will once again be two massive bills that could include changes to the health care system: a budget bill (referred to as a reconciliation bill) and a tax bill. These types of legislation often become big "Christmas tree" bills upon which members of Congress affix their favorite programs. The bills are also often vehicles to pass controversial proposals because when they reach the House or Senate floors, they usually are restricted to an up or down vote. It is in this manner that a tax on health benefits may once again be raised. The Association will need to be vigilant to make sure that it can build upon this year's success on this issue. And that means that the grassroots will be needed more than ever.

The Grassroots Program: Report 11, The Grassroots Program (*Supplement*:454), provides the House with a report on the Grassroots Program. To date, nearly 14,000 dentists and spouses have volunteered to participate on the grassroots action teams. There are now action teams in all 435 congressional districts and team leaders are in the process of being identified.

The four regional workshops for the team leaders from the first round of action teams were very successful. Every team leader and every state constituent society (except Hawaii) from the original 121 key congressional districts had the opportunity to attend a grassroots workshop. Plans are being developed to expand this program in 1995. A grassroots workshop for all 435 team leaders is scheduled for March 20-21, 1995 in Washington, D.C.

It cannot be underscored enough that the Grassroots Program was instrumental in educating members of Congress and their staffs about the successes and differences of the dental payment and delivery system. Hearing from the folks back home in significant numbers on a specific issue has an incredibly strong effect on how a member of Congress views an issue. The Association will continue to build upon and mobilize the grassroots network in support of the many issues of importance to the dental profession and our patients.

As promised in Report 11, below are the actual expenditures through 8/31/94 for the Grassroots Program activities:

- The initial grassroots direct mail campaign to recruit ADA action team volunteers, which included the mailing of solicitations to over 38,000 dentists, as well as telemarketing to nonrespondents in targeted congressional districts.
  YTD Actual: $132,507
- Phase two mailing to 5,800 ADA members in the congressional districts of members on the Committee on Rules and the five House majority and minority leaders.
  YTD Actual: $15,012
- Phase three mailing to the approximately 100,000 ADA members not yet contacted to become action team members.
  YTD Actual: $38,748
- The development, production and dissemination costs of an information/education kit on health system reform. This kit included a 2-pocket folder containing a booklet on dentistry's successes and reform priorities, ten detailed resource papers, speech, lapel button and poster for dental offices. The kit was distributed to action team members and participants in the March Public Affairs Conference in Washington, D.C., etc.
  YTD Actual: $56,504
- Contracts with three outside consultants for strategic and political advice and member contact. The consultants were chosen for their specific focus either on Republicans, specifically in the Senate; Democrats, specifically in the House; and the administration. The contracts run through the end of 1994.
  YTD Actual: $197,528 (Contract invoices are paid on a monthly basis.)
- Action alert telegrams to all action team dentists for Ways and Means Committee members and for three holdout members of Energy and Commerce urging them to vote against taxing health benefits.
  YTD Actual: $5,413
- Letter to all members of the Minnesota Dental Association (MDA) explaining the ADA's involvement with MDA's administration, concerning Minnesota's health system reform legislation and regulatory activity.
  YTD Actual: $125

- Placement of ads in newspapers in selected congressional districts of Ways and Means and Energy and Commerce members. These ads included the names of the action team members in the targeted congressional districts. Included in this expenditure is the cost of distributing grassroots ad "slick" to constituent and component societies for their use.
  YTD Actual: $68,145
- May legislative alert urging an estimated 33,000 dentists in 20 states to contact members of the Senate Finance Committee and express opposition to the taxation of health benefits, especially dental benefits.
  YTD Actual: $14,857
- July follow-up letter to 7,000 grassroots team members asking them to call, write and, if possible, meet with their Senators. (Because of earlier mailing error, vendor assumed the cost of this mailing).
- A 14-minute video to accompany and reinforce health system reform materials to grassroots network: distribution to 600 constituents and components.
  YTD Actual: $27,464
- Design, production and dissemination of new grassroots monthly newsletter, *The Dental Advocate*, to all action team members.
  YTD Actual: $5,529 (All invoices have not been received.)
- Prepare and print 10,000 brochures on health system reform, with focus on state issues. Half for use at National Conference of State Legislatures (NCSL) Annual Meeting; half for constituent use.
  YTD Actual: $4,596
- Production of 700 grassroots manuals to be given to the 435 action team leaders, ADA trustees and constituent executives. Manual is a "how-to" guide to legislative advocacy and political action. Looseleaf format allows for information updates.
  YTD Actual: $2,952 (All invoices have not been received.)
- Four one-day regional workshops for grassroots team leaders. Bulk of this expenditure is to defray cost of travel for the team leaders. Meetings held in New York, San Francisco and Chicago. ADPAC wanted to provide financial support for this program. The funds provided were used for a fourth workshop in Atlanta.
  YTD Actual: $4,126 (All invoices have not been received.)

  Total actuals through 8/31/94: $573,506

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

Interim Response to Resolution 99H-1992

Dental Manpower

Background: Resolution 99H, adopted by the 1992 House of Delegates (*Trans.*1992:597), reads as follows:

> **Resolved,** that the appropriate agencies of the Association undertake a study of the relationship between current and future capacity to provide dental care and effective demand for care, with a particular focus on the implications for younger practitioners, and be it further
> **Resolved,** that the results of this study be used to develop appropriate recommendations that would make better use of existing capacity and expand dental care through the year 2010, and be it further
> **Resolved,** that the Association make available its analysis and information to the communities of interest so that it may be used as a resource for planning to meet the nation's future needs and requirements for dental care, and be it further
> **Resolved,** that this information be reported to the 1993 House of Delegates.

Board of Trustees' Interim Response: The Board of Trustees has forwarded the Manpower Report to the Council on Community Health, Hospital, Institutional and Medical Affairs and the Council on Dental Practice for analysis and the development of recommendations on the better use of existing capacity and the expansion of dental care through the year 2010. The Manpower Report has also been forwarded to the Council on Dental Education, to be used as a resource for its study of the future needs for allied personnel. With the completed Manpower Report and the report on allied personnel needs, the 1995 House of Delegates will have a comprehensive picture of the manpower status in dentistry and the treatment capacity of the dental care system. In addition, a report on the activities of the Association in response to Resolution 99H-1992 will be submitted to the 1995 House of Delegates.

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

Appendix

Notes

Index to Resolutions

Res. 1	*Reports:*13	**Council on ADA Sessions and International Relations** Amendment of ADA *Bylaws* Regarding Council Name and Duties
Res. 2	*Reports:*39	**Council on Dental Benefit Programs** Support for Individual Practice Associations (IPAs)
Res. 3	*Reports:*39	**Council on Dental Benefit Programs** Eligibility and Payment Dates for Endodontic Treatment
Res. 4	*Reports:*39	**Council on Dental Benefit Programs** Statement on Nonpayment for Incomplete Dental Treatment in Summary Plan Descriptions
Res. 4S-1	*Suppl.:*347	**Fifth Trustee District** Substitute for Resolution 4
Res. 5	*Reports:*40	**Council on Dental Benefit Programs** Amendment of Statement on Preventive Coverage in Dental Benefits Plans
Res. 6	*Reports:*42	**Council on Dental Benefit Programs** Rescission of Policy, Comprehensive Care for the Handicapped
Res. 7	*Reports:*42	**Council on Dental Benefit Programs** Rescission of Policy, Inclusion of Dental Care Services in Medicare Programs
Res. 8	*Reports:*42	**Council on Dental Benefit Programs** Rescission of Policy, Improvements in Medicaid Program
Res. 9	*Reports:*42	**Council on Dental Benefit Programs** Rescission of Policy, Funding for Mandated Dental Benefits
Res. 10	*Reports:*49	**Council on Dental Practice** Amendment of ADA *Bylaws* Regarding Council Duties
Res. 11	*Reports:*63	**Council on Dental Education** Request for Recognition of Dental Anesthesiology as a Dental Specialty
Res. 12	*Reports:*68	**Council on Dental Education** Request for Recognition of Oral and Maxillofacial Radiology as a Dental Specialty
Res. 13	*Reports:*73	**Council on Dental Education** Rescission of Policy, Recognition of Special Areas of Dental Practice
Res. 14	*Reports:*76	**Council on Dental Education** Revision of the Statement of Statutory Regulation of Dental Specialty Practice and Dental Specialists
Res. 15	*Reports:*102	**Council on Ethics, Bylaws and Judicial Affairs** Amendment of the ADA *Bylaws* Relating to the Name of the Joint Commission on Accreditation of Healthcare Organizations
Res. 16	*Reports:*102	**Council on Ethics, Bylaws and Judicial Affairs** Amendment of the ADA *Bylaws* Concerning Removal of a Trustee for Cause
Res. 17	*Reports:*102	**Council on Ethics, Bylaws and Judicial Affairs** Amendment of the ADA *Bylaws* Concerning Removal of an Elective Officer for Cause
Res. 18	*Reports:*103	**Council on Ethics, Bylaws and Judicial Affairs** Amendment of the ADA *Bylaws* Concerning Substitution of "Chairperson" for "Chairman"

Res. 19	*Reports:*103	**Council on Ethics, Bylaws and Judicial Affairs** Amendment of ADA *Bylaws* Concerning Removal from One Jurisdiction to Another
Res. 20	*Reports:*103	**Council on Ethics, Bylaws and Judicial Affairs** Amendment of ADA *Bylaws* Concerning Transfer from One Component to Another
Res. 21	*Reports:*120	**Council on Dental Materials, Instruments and Equipment** Model Material Safety Data Sheet Form
Res. 21S-1	*Suppl.:*347	**Fifth Trustee District** Substitute for Resolution 21
Res. 22	*Reports:*141	**Delegate Emanuel W. Michaels, Virginia** Study of the Marketing of Dental Care Services to Health Alliances
Res. 23	*Suppl.:*333	**Louisiana Dental Association** Policy on Stipends for Officers and Trustees
Res. 23S-1	*Suppl.:*354	**Ninth Trustee District** Substitute for Resolution 23
Res. 24	*Suppl.:*333	**Louisiana Dental Association** Discount Fee Charged by MBNA America for Credit Card Dues Payments
Res. 25	*Suppl.:*423	**Board of Trustees: Report 2 to House** Approval of 1995 Budget
Res. 25S-1	*Suppl.:*366	**Delegate James O. Henry, Jr., Texas** Substitute for Resolution 25
Res. 26	*Suppl.:*423	**Board of Trustees: Report 2 to House** Recommended Dues Increase
Res. 26S-1	*Suppl.:*351	**Sixth Trustee District** Amendment to Resolution 26
Res. 27	*Suppl.:*426	**Board of Trustees: Report 4 to House** Amendment of ADA *Bylaws* Regarding Vacancy on Councils
Res. 28	*Suppl.:*426	**Board of Trustees: Report 4 to House** Amendment of ADA *Bylaws* Regarding Vacancy on Commissions
Res. 29	*Suppl.:*426	**Board of Trustees: Report 4 to House** Amendment of ADA *Bylaws* Regarding Council on Scientific Affairs
Res. 30	*Suppl.:*428	**Board of Trustees: Report 5 to House** Rescission of Resolution 16-1957-H
Res. 31	*Suppl.:*428	**Board of Trustees: Report 5 to House** Rescission of Resolution 40-1965-H
Res. 32	*Suppl.:*265	**Council on Communications: Supplemental Report 1** Amendment of ADA *Bylaws* Regarding Council Duties
Res. 33	*Suppl.:*328	**Council on Membership: Supplemental Report 1** Expansion of the Dues Payment Program
Res. 34	*Suppl.:*330	**Council on Membership: Supplemental Report 1** Amendment of ADA *Bylaws* Regarding Eligibility for Reappointment to the Council on Membership
Res. 35	*Suppl.:*273	**Council on Dental Benefit Programs: Supplemental Report 1** Preamble to the Dental Practice Parameters

Res. 35S-1	*Suppl.*:365	**Fifteenth Trustee District** Substitute for Resolution 35
Res. 36	*Suppl.*:273	**Council on Dental Benefit Programs: Supplemental Report 1** Patient Requiring a Comprehensive Oral Evaluation
Res. 37	*Suppl.*:273	**Council on Dental Benefit Programs: Supplemental Report 1** Patient of Record Requiring a Periodic Evaluation
Res. 38	*Suppl.*:273	**Council on Dental Benefit Programs: Supplemental Report 1** Patient Requiring a Limited Evaluation of a Specific Problem
Res. 39	*Suppl.*:273	**Council on Dental Benefit Programs: Supplemental Report 1** Patient Requiring a Detailed and Extensive Evaluation for a Specific Problem(s)
Res. 40	*Suppl.*:273	**Council on Dental Benefit Programs: Supplemental Report 1** Dental Caries
Res. 41	*Suppl.*:273	**Council on Dental Benefit Programs: Supplemental Report 1** Periodontium Without Clinically Apparent Inflammation
Res. 42	*Suppl.*:273	**Council on Dental Benefit Programs: Supplemental Report 1** Gingival Inflammation Without Loss of Periodontal Attachment (Gingivitis)
Res. 43	*Suppl.*:273	**Council on Dental Benefit Programs: Supplemental Report 1** Gingival Inflammation With Loss of Connective Tissue Attachment (Periodontitis)
Res. 44	*Suppl.*:273	**Council on Dental Benefit Programs: Supplemental Report 1** Partially Edentulous Arch(es)
Res. 45	*Suppl.*:273	**Council on Dental Benefit Programs: Supplemental Report 1** Edentulous Arch(es)
Res. 46	*Suppl.*:273	**Council on Dental Benefit Programs: Supplemental Report 1** Fractured/Cracked Tooth
Res. 47	*Suppl.*:273	**Council on Dental Benefit Programs: Supplemental Report 1** Patient Without Clinical Signs or Symptoms of Oral Disease Following Evaluation
Res. 48	*Suppl.*:286	**Council on Dental Benefit Programs: Supplemental Report 2** Authorization of Benefits
Res. 49	*Suppl.*:286	**Council on Dental Benefit Programs: Supplemental Report 2** Amendment to the Guidelines on the Use of Radiographs in Dental Care Programs
Res. 50	*Suppl.*:291	**Council on Dental Benefit Programs, Council on Dental Materials, Instruments and Equipment and Council on Dental Practice: Joint Report** Definitions of Tooth Designation Systems
Res. 51	*Suppl.*:291	**Council on Dental Benefit Programs, Council on Dental Materials, Instruments and Equipment and Council on Dental Practice: Joint Report** Recognition of Tooth Designation Systems for Electronic Data Interchange (EDI)
Res. 52	*unassigned*	
Res. 53	*Suppl.*:379	**Board of Trustees** Nominations to Councils and Commissions and Standing Committee
Res. 54	*Suppl.*:435	**Board of Trustees: Report 8 to House** Approval of New Objective 12, Constituent and Component Dental Societies, ADA Strategic Plan
Res. 55	*Suppl.*:322	**Council on Governmental Affairs and Federal Dental Services: Supplemental Report 1** Definition of Fee-for-Service

Res. 55S-1	*Suppl.*:357	**Tenth Trustee District** Substitute for Resolution 55
Res. 55S-2	*Suppl.*:366	**Fifteenth Trustee District** Substitute for Resolution 55
Res. 56	*Suppl.*:322	**Council on Governmental Affairs and Federal Dental Services: Supplemental Report 1** Definition of Indigent
Res. 57	*Suppl.*:322	**Council on Governmental Affairs and Federal Dental Services: Supplemental Report 1** Definition of Balance Billing
Res. 58	*Suppl.*:322	**Council on Governmental Affairs and Federal Dental Services: Supplemental Report 1** Definition of Freedom of Choice
Res. 59	*Suppl.*:322	**Council on Governmental Affairs and Federal Dental Services: Supplemental Report 1** Definition of Primary Dental Care
Res. 60	*Suppl.*:322	**Council on Governmental Affairs and Federal Dental Services: Supplemental Report 1** Definition of Primary Dental Care Provider
Res. 61	*Suppl.*:322	**Council on Governmental Affairs and Federal Dental Services: Supplemental Report 1** Amendment of ADA Policy on Cost-Containment and Health Insurance Simplification
Res. 62	*Suppl.*:323	**Council on Governmental Affairs and Federal Dental Services: Supplemental Report 1** Major General Rank for U.S. Air Force Director of Dental Services
Res. 63	*Suppl.*:323	**Council on Governmental Affairs and Federal Dental Services: Supplemental Report 1** Expansion of Dental Benefits for Military Retirees
Res. 64	*Suppl.*:323	**Council on Governmental Affairs and Federal Dental Services: Supplemental Report 1** Constituent Society Communications with the Department of State Government Affairs
Res. 65	*Suppl.*:323	**Council on Governmental Affairs and Federal Dental Services: Supplemental Report 1** Amendment of ADA *Bylaws* Regarding ADPAC Chairman as *Ex officio* Non-voting Council Member
Res. 66	*Suppl.*:323	**Council on Governmental Affairs and Federal Dental Services: Supplemental Report 1** Rescission of Policy on Antitrust Reform
Res. 67	*Suppl.*:446	**Board of Trustees: Report 9 to House** Amendment of ADA *Bylaws* Regarding the Name and Duties of the Council on Community Health, Hospital, Institutional and Medical Affairs
Res. 68	*Suppl.*:426	**Board of Trustees: Report 4 to House** Amendment of ADA *Bylaws* Regarding Vacancy on Committees
Res. 69	*Suppl.*:336	**Texas Dental Association** Evaluation of Need for Codes for the Complicated Extraction of Erupted Teeth
Res. 70	*Suppl.*:358	**Thirteenth Trustee District** Over-the-Counter Mouthwash Safety
Res. 71	*Suppl.*:358	**Thirteenth Trustee District** Dental Hygiene Education
Res. 72	*Suppl.*:336	**Texas Dental Association** Definition of Freedom of Choice
Res. 73	*Suppl.*:303	**Council on Dental Education and Council on Ethics, Bylaws and Judicial Affairs: Joint Report** Redesignation of the Specialty of "Orthodontics" to "Orthodontics and Dentofacial Orthopedics"

Res. 74	*Suppl.*:334	**The Dental Society of the State of New York** Protocol and Guidelines for Administration of Antibiotic Prophylaxis
Res. 74S-1	*Suppl.*:337	**First Trustee District** Substitute for Resolution 74
Res. 74BS-1	*Suppl.*:353	**Eighth Trustee District** Substitute for Resolution 74B
Res. 75	*Suppl.*:335	**The Dental Society of the State of New York** Relief Fund Solicitation Disclosure
Res. 76	*Suppl.*:266	**Commission on Dental Accreditation: Supplemental Report 1** Revision of the *Rules of the Commission on Dental Accreditation*
Res. 77	*Suppl.*:333	**Missouri Dental Association** Amendment of *ADA Principles of Ethics and Code of Professional Conduct* Regarding Behavior of Clinicians and Professional Speakers
Res. 78	*Suppl.*:334	**New Mexico Dental Association** Authorizing a Study of Public Policies on Infectious Diseases as they Pertain to Dental Practice
Res. 79	*Suppl.*:332	**Board of Trustees** Support Personnel Needs of Practicing Dentists
Res. 80	*Suppl.*:253	**Standing Committee on Credentials, Rules and Order** Approval of Minutes of 1993 Session of the House of Delegates
Res. 81	*Suppl.*:253	**Standing Committee on Credentials, Rules and Order** Adoption of Agenda
Res. 82	*Suppl.*:253	**Standing Committee on Credentials, Rules and Order** Referrals of Reports and Resolutions
Res. 83	*Suppl.*:335	**Pennsylvania Dental Association** Discontinuation of the ADA's Continuing Education Program
Res. 84	*Suppl.*:336	**South Dakota Dental Association** Dental Vacuum System Standard
Res. 85	*Suppl.*:327	**Council on Insurance** Term of Office of Members of the Council on Insurance
Res. 86	*Suppl.*:358	**Thirteenth Trustee District** Expansion of an Electronic Dues Payment Program
Res. 87	*Suppl.*:332	**Arizona State Dental Association** Audit of Arizona Health Care Cost Containment System (AHCCCS)
Res. 88	*Suppl.*:332	**Board of Trustees** Transferring Marketing and Seminar Services to the Council on Dental Practice
Res. 89	*Suppl.*:352	**Seventh Trustee District** Survey of All Dental Assisting Programs
Res. 90	*Suppl.*:354	**Ninth Trustee District** Amendment of the Guidelines for Governing the Conduct of Campaigns for ADA Offices
Res. 91	*Suppl.*:460	**Board of Trustees: Report 13 to House** Amendment of Section 4-A to the *Code of Professional Conduct* on Advertising of Exclusive Methods or Techniques
Res. 92	*Suppl.*:326	**Council on Governmental Affairs and Federal Dental Services: Supplemental Report 2** Practitioner Protections in Managed Care Plans

Res. 93	*Suppl.*:311	**Council on Dental Materials, Instruments and Equipment and Council on Community Health, Hospital, Institutional and Medical Affairs: Joint Report** Precapsulated Amalgam Alloy
Res. 94	*Suppl.*:312	**Council on Dental Materials, Instruments and Equipment and Council on Dental Therapeutics: Joint Report** Revision of the Provisions for Acceptance of Products
Res. 95	*Suppl.*:337	**First Trustee District** Continuing Education for the Dental Assistant
Res. 96	*Suppl.*:338	**First Trustee District** ADA Publications Disclaimer
Res. 96S-1	*Suppl.*:338	**First Trustee District** Substitute for Resolution 96
Res. 97	*Suppl.*:338	**First Trustee District** Amendment to ADA *Bylaws* Regarding the President as a Voting Member of the Board of Trustees
Res. 98	*Suppl.*:339	**First Trustee District** Expansion of Employee Retirement Income Security Act (ERISA)
Res. 99	*Suppl.*:339	**First Trustee District** Establishment of a Congressional Review Commission on ERISA
Res. 100	*Suppl.*:340	**First Trustee District** Review of the *ADA Principles of Ethics and Code of Professional Conduct* as It Relates to Dental Benefits Plans
Res. 101	*Suppl.*:341	**First Trustee District** Managed Care Programs' Administrative Costs, Profit and Treatment Expense
Res. 102	*Suppl.*:341	**First Trustee District** Automatic Review of Denied Claims by Independent Dental and/or Medical Experts
Res. 103	*Suppl.*:347	**Fifth Trustee District** Voting Record for ADA Councils and Committees
Res. 104	*Suppl.*:347	**Fifth Trustee District** Volunteer Participation at the ADA Level
Res. 105	*Suppl.*:348	**Fifth Trustee District** Risk Assessment
Res. 106	*Suppl.*:348	**Fifth Trustee District** PAC Membership
Res. 107	*Suppl.*:358	**Twelfth Trustee District** Preservation of the Dental Practice Parameters
Res. 108	*Suppl.*:341	**First Trustee District** Standards for Managed Dental Care Programs
Res. 109	*Suppl.*:336	**Sacramento District Dental Society** Electronic Billing Process Fees
Res. 110	*Suppl.*:343	**Second Trustee District** First Meeting of the ADA House of Delegates
Res. 111	*Suppl.*:353	**Eighth Trustee District** Standard for Acceptable Risk

Res. 112	*Suppl.*:353	**Eighth Trustee District** Dental Benefits for Military Reservists
Res. 113	*Suppl.*:355	**Ninth Trustee District** Antitrust Limitations
Res. 114	*Suppl.*:355	**Ninth Trustee District** Medical Savings Accounts
Res. 115	*Suppl.*:355	**Ninth Trustee District** Employer Mandates
Res. 116	*Suppl.*:342	**First Trustee District** Guidelines on Coordination of Benefits for All Third-Party Payers
Res. 117	*Suppl.*:348	**Fifth Trustee District** Dentists' Choice of Practice Settings
Res. 118	*Suppl.*:349	**Fifth Trustee District** Distribution of *CDT-2* and *JADA*
Res. 119	*Suppl.*:350	**Fifth Trustee District** Identification of Claims Reviewers on Explanation of Benefit Statements
Res. 120	*Suppl.*:354	**Eighth Trustee District** Face Shields on Batting Helmets
Res. 121	*Suppl.*:367	**American Academy of Implant Dentistry** Ethical Announcement of Credentials Earned from Bona Fide Entities
Res. 122	*Suppl.*:350	**Fifth Trustee District** Expansion of "Dentistry—Health Care That Works"
Res. 123	*Suppl.*:356	**Ninth Trustee District** Washington, D.C. Property
Res. 124	*Suppl.*:337	**Hawaii County Dental Society** ADA *CDT-1* Copyright
Res. 125	*Suppl.*:356	**Ninth Trustee District** Study of the Impact of Managed Care on Dental Benefit Programs
Res. 126	*Suppl.*:357	**Ninth Trustee District** Fluoride Commemorative Project Support
Res. 127	*Suppl.*:345	**Fourth Trustee District** Dental Special Pay for Federal Service Dentists
Res. 128	*Suppl.*:345	**Fourth Trustee District** Federal Dental Service Representation in the House of Delegates
Res. 129	*Suppl.*:344	**Second Trustee District** Distribution of *CDT-2*
Res. 130	*Suppl.*:364	**Thirteenth Trustee District** Management Responsibility of the Board of Trustees
Res. 131	*Suppl.*:365	**Thirteenth Trustee District** Annual Session Site Selection Criteria
Res. 132	*Suppl.*:351	**Fifth Trustee District** Adjustments in 1995 Budget
Res. 133	*Suppl.*:344	**Third Trustee District** Dental Identification Teams

Res. 134	*Suppl.*:345	**Third Trustee District** Definition of Pediatric Dentistry
Res. 135	*Suppl.*:344	**Second Trustee District** Mortgage Program
Res. 136	*Suppl.*:358	**Twelfth Trustee District** Rescinding Resolution 62H-1993: Establishing Parameters
Res. 137	*Suppl.*:366	**Fifteenth Trustee District** Addition to Strategic Plan
Res. 138	*Suppl.*:366	**Fifteenth Trustee District** Amendment to Strategic Plan
Res. 144	*Suppl.*:343	**First Trustee District** Member Advocacy
Res. 145	*Suppl.*:352	**Seventh Trustee District** Specialty Recognition
Res. 146	*Suppl.*:352	**Seventh Trustee District** Specialty Recognition

1993 Resolutions

Res. 65-1993	*Reports:*142	**Board of Trustees** Officers Corps
Res. 65S-1-1993	*Reports:*144	**Twelfth Trustee District** Substitute for Resolution 65-1993
Res. 65S-2-1993	*Reports:*144	**Eighth Trustee District** Amendment to Resolution 65-1993
Res. 65S-3-1993	*Reports:*145	**Rhode Island Dental Association** Amendment to Resolution 65-1993
Res. 84-1993	*Reports:*19	**Seventh Trustee District/Council on Membership** Associate Member Dues

Resolutions 139 through 143 will be indexed in *Transactions*, 1994.

Notes

Notes

Notes

Notes