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1996 Supplement

American Dental Association

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Supplement to Annual Reports and Resolutions

137th Annual Session

Orlando, Florida

September 28-October 2, 1996

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House of Delegates

Notes

Standing Committee on Credentials, Rules and Order

Minutes of 1995 Session of the House of Delegates: The minutes of the 1995 session of the House of Delegates have been published (*Trans.*1995:595-664) 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.

88. Resolved, that the minutes of the 1995 session of the House of Delegates, as published in *Transactions, 1995*, pages 595-664, 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.

89. Resolved, that the agenda as printed in the *Manual of the House of Delegates and Supplemental Information, 1996*, 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.

90. 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, 1996* 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 mid-August.

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, 1996*, 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 mid-August.

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 1997.

Hearings of Reference Committees: The reference committees will hold hearings Sunday, September 29, in various rooms of the Orange County Convention Center, Orlando, Florida. The list of reference committee hearing rooms appears in the *Manual of the House of Delegates and Supplemental Information*.

Sunday, September 29, 1996

8:00 a.m. to 10:00 a.m.	Dental Education and Related Matters
8:30 a.m. to 10:30 a.m.	Dental Benefits, Practice and Health
9:00 a.m. to 11:00 a.m.	Scientific Matters
9:30 a.m. to 11:30 a.m.	President's Address and Administrative Matters
10:00 a.m. to 12:00 noon	Budget and Business Matters
10:30 a.m. to 12:30 p.m.	Communications and Membership Services
11:30 a.m. to 1:30 p.m.	Legal and Legislative 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 6, 7, 10 and 16 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 315B of the Orange County Convention Center on Tuesday, October 1, 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 1, from 12:00 noon to 2:00 p.m. Members should bring their credentials and vote early in order to avoid a 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 2, as the first item of business with the time to be specified by the Speaker of the House of Delegates.

Introduction of New Business: The Committee calls attention to the *Bylaws*, Chapter V, Section 130(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. The member should then state his or her name, district and state for the benefit of the official reporter. If all members of the House follow this procedure, work will be expedited and all who wish 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 him/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, 1996*. 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 September 27-30 and will be located on Level Four of the Orange County Convention Center, Valencia Foyer. 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.

Amendment to the "Rules of the House of Delegates" Regarding Executive Sessions: The Committee notes that the "Rules of the House of Delegates" contained in the *Manual of the House of Delegates* refer to the conduct of an executive session only as it pertains to the general procedures for reference committees. No mention is made in the "Rules" of executive sessions of the House of Delegates. The Committee believes that a new section of the "Rules" is necessary to

formalize the conduct of executive sessions of the House of Delegates.

The Committee notes that the Speaker of the House of Delegates will be referring this issue to the Reference Committee on President's Address and Administrative Matters to enable a full hearing by members of the House.

91. Resolved, that the "Rules of the House of Delegates" contained in the *Manual of the House of Delegates* be amended by adding after the section entitled "Motion to Recommit or Refer to an Agency" a new section entitled "Executive Session" to read as follows:

> **Executive Session:** An executive session is any meeting or portion of a meeting of the House of Delegates with limited attendance in order to consider a highly confidential matter. An executive session may be held if agreed upon by general consent of the House or by a majority vote of the delegates present at the meeting at which the executive session would take place. In an executive session, attendance is limited to officers and members of the House, and the elective and appointive officers, trustees and general counsel of the Association. In consultation with the Secretary of the House, the Speaker may invite other persons with an interest in the subject matter to remain during the executive session. In addition to senior management, this is likely to include members and staff of the council(s) or commission(s) involved with the matter under discussion. For attorney-client sessions, the Speaker and Secretary shall consult with the General Counsel. No official action may be taken nor business conducted during an executive session.

Summary of Resolutions

88. Resolved, that the minutes of the 1995 session of the House of Delegates, as published in *Transactions, 1995*, pages 595-664, be approved.

89. Resolved, that the agenda as printed in the *Manual of the House of Delegates and Supplemental Information, 1996*, be adopted as the official order of business for this session.

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Report of President

Notes

Report of the President

Dr. William S. Ten Pas

As your president, I am pleased to report that this has been a year in which we have strengthened our unity and made measurable progress on issues that are vital to the future of the profession.

Licensure: Through the years, certainly no issue has tested our unity and our resolve more than the issue of dental licensure. The ADA made remarkable progress this year as a facilitator in this area, beginning with the meeting the ADA hosted in January to bring all the regional testing agencies together. Board Report 7 in your delegate materials outlines this and other initiatives.

In this report, I particularly want to call your attention to the strong resolutions the Board adopted in July, in response to recommendations from a special Board committee on licensure issues. This committee was diverse and widely representative, and the rights of state dental boards and clinical testing agencies were part of its operating principles. The goal is not to have a federal license or some single form of license but to have uniformity in the examining process and to treat people with the professional respect they deserve. We must not continue to allow our future colleagues to be treated unprofessionally. Exams must be fair and reliable, and the ADA must help the examining community to facilitate the necessary changes.

Diversity: Another area in which we made notable progress this year is in recognizing and appreciating the growing diversity of our profession and realizing the strength that is inherent in this diversity. One step I believed could be taken toward this end was to open the doors to ADA Board meetings for representatives from other organizations. The Board invited the leadership of the National Dental Association, the Hispanic Dental Association and the American Association of Women Dentists, all of whom accepted. Frank and open discussions with these groups highlighted the need to work together for our patients and the profession.

We are better for those discussions. We need to continue opening doors, always remembering that in diversity there is strength. It goes beyond gender and ethnic background to include the equally rich diversity of career choices available to dentists—research, education, serving in the Federal Dental Services, solo or group practice, general dentistry or a specialty, and the choice to practice in areas where managed care may be dominant.

For those who choose to be dental educators, the challenge is great—to make sure that current and future research are transferred to dental practice and lead to better care for patients.

For those who choose to serve in the Federal Dental Services, the ADA must advocate for further benefits, including interest and loan payment deferment and loan forgiveness. America provides these benefits for the Indian Health services, and rightly so! Why not for those who protect our freedom?

Councils and Commissions: Another issue that received close scrutiny this year was the soundness and effectiveness of the Association's council and commission structure. A special committee was appointed to study this issue, chaired by immediate past president Dr. Richard D'Eustachio. At its July meeting, the Board reviewed a report from this committee and took several actions to reassign responsibilities and make more effective use of council and commission resources. Before you is Board Report 15, which outlines those actions and presents resolutions for council and commission restructuring that requires the approval of this House.

Other questions raised in the Committee's report remain to be addressed. For instance, is it right to assume that one council has the ability to adequately direct the Association's Health Volunteers Overseas program? Currently this responsibility resides with the Council on ADA Sessions and International Programs. Since the focus for Health Volunteers Overseas is access, I believe it makes sense to involve CAPIR, the ADA council that has specific *Bylaws* responsibility for that issue.

We must continually question and reevaluate everything we do. Examination of the Association's governance must be an ongoing process—not just once every five years or ten years but *always*, and always with an eye to improvement. No matter how proud we are of what we have accomplished, we can always be better.

Marketplace Changes/Managed Care: No discussion of the past year in the history of the ADA would be complete without mention of our ongoing initiatives to help members cope with today's changing marketplace—and to position the ADA as a vital source of information in this marketplace.

Wherever I have visited with members over the past year, I have heard enthusiastic comments about the Association's Contract Analysis Service, our managed care resource packet, and other ADA resources to help them make sound practice decisions.

In addition, in response to a directive from the 1995 House of Delegates, a major new marketplace initiative this year has promoted the advantages of direct reimbursement plans to a target audience of employers and benefits managers. Before you is a resolution proposing that this plan be expanded over the next three years.

I believe the window of opportunity is three to five years, so we must do this right. First, every member must realize that we must all be willing to provide the financial support, even though not all of us will notice immediate benefits. Also, we must not be in such a hurry that we do not have adequate infrastructure and support.

As the marketplace continues to evolve, we must remember that information is the greatest asset for everyone concerned—dentists, the public, and the benefits community. And the ADA must be at the forefront in the electronic data interchange area.

We must also remember that managed care is not the enemy. The enemy is clauses in contracts—when they interfere with what we can say to our own patients, when they

shift the focus from comprehensive care to cutting costs, and when they make the dentist more an employee than an advocate for patients.

We also need to be clear on the issue of who owns and runs dental practices. When nonprofessionals are at the wheel, the patient's best interests may be sacrificed to the bottom line.

Recommendations for Action: As we address these and other concerns and prepare for the 21st century, we also need to be certain that our own decision-making process as an organization is as sound as possible. At the Board level, this means careful analysis of issues must always override any political considerations.

I believe this important basic principle could be better served by changing the *ADA Bylaws*—to stipulate that no sitting member of the ADA Board can be a candidate for president-elect. To be fair to the current Board and those members who will begin their terms next Wednesday, the effective date for this *Bylaws* change could be postponed to the appropriate date.

It is also imperative that your leaders be able to have candid discussions with our outstanding ADA staff. This is a membership organization. Staff participation and consultation should never be inhibited. Your officers should always be responsible for the operation of the ADA. The ADA is bigger than any one person, and hence the agenda should be the Association's.

I want to make one further recommendation to this House relating to the decisions you have to make this week. With all due respect, I am concerned about certain resolutions which have come forward in connection with the issue of treating HIV-positive patients. I believe and must say that these resolutions are self-serving. They fly in the face of science, and they would also undermine the commitment to all our patients that is the heart of our Code of Ethics. If science were to point to the need for a subspecialty or question the effectiveness of infection control procedures, I would say so be it. But nothing *other* than science should drive our decisions in this area.

I am grateful to all of you for the responsibility you placed in my hands this past year.

It is a responsibility the president can meet only with input from volunteers and staff, to whom I am also grateful.

And Kathy joins me in thanking everyone across the country who has hosted us and extended such kindness to us this past year.

It has been a wonderful experience—not just this year but these past ten years—starting on the Committee on the Young Dentist, coming to the then Council on Legislative Affairs and Federal Dental Services, and serving on the Strategic Planning Committee and the Board of Trustees.

I hope I have served you well. I look forward to being of further service in any way I can as all of us work together to make the greatest profession in America even greater and ever stronger.

Supplemental Reports and Resolutions

Notes

Council on Communications

Supplemental Report 1: Recent Council Activities

This report contains two parts. The first deals with a recommendation for a marketing campaign, the second with a proposed bylaws change relating to Council member rotation.

National Marketing Campaign. Resolution 112-1995 (*Trans.*1995:604) was submitted to the House of Delegates as follows:

> **Resolved,** that the American Dental Association pursue an advertising campaign in business print media publications to inform the business community leaders that dentistry works, and be it further
>
> **Resolved,** that the Board of Trustees be urged to allocate an initial sum of $2.5 million to the development and execution of said advertising campaign, with a report of program activities made available to the 1996 House of Delegates.

Background on the resolution described the recommended campaign as a first step in reaching employee benefits purchasers with messages relating to quality and choice, "the shortcomings of managed care," the dentist as patient advocate and the ADA as a resource in selection of dental benefit plans.

Board comment on the resolution noted its merit but found it "overly prescriptive in defining the parameters of a possible campaign." The Board saw a need for further study, including analysis of financial implications.

The Board recommended, and the House concurred with, referral to the Council on Communications.

The Council on Communications met twice in 1996, in January and June, and devoted significant portions of both meetings to discussion of Resolution 112-1995.

At its January meeting, the Council focused on campaign message, audience and duration. The first step in that process was an exercise to identify the most pressing issue facing dentistry. The result was identification of managed care and marketplace issues as the profession's foremost concern and, therefore, the most appropriate theme for an advertising campaign. Taking the exercise to the next level, the Council determined that, because consumers have little control over their employers' selection of dental benefit plans, the most appropriate audience for a managed care/marketplace message was those who make benefit purchasing decisions. Finally, the Council recommended that any marketing campaign entered by the ADA be at least three years long.

At its June meeting, the Council focused on narrowing the managed care/marketplace theme and identifying an appropriate funding level for a national campaign. To assist in its decision-making process, the Council invited Foote, Cone & Belding (FCB) Direct, the agency conducting the ADA's campaign to promote Direct Reimbursement, to serve as a resource.

After lengthy discussion of alternatives, the Council concluded that the most cost-effective marketing strategy that met the previously identified parameters—managed care/marketplace theme, benefit purchaser and consultant audience—was to build on the Direct Reimbursement campaign already in place as a result of Resolution 129H-1995 (*Trans.*1995:621). Further, the Council identified an appropriate funding level as $2.5 million per year for at least three years.

FCB offered the Council a preliminary estimate of how those funds might be allocated:

- $1,100,000—advertising in trade and consumer print media. Current advertising in *Business Insurance, Employee Benefit News* and *Human Resource Executive* would be continued throughout the year. The *Wall Street Journal, Inc.* and *CFO* magazines would be added to current advertising at strategic points during the year.
- $1,400,000—direct mail. Building on current direct mail initiatives in six target markets, six mailings during the year to 200,000 prospects would be added. Over three years, 30% of potential prospects would be reached at this funding level.
- An interactive computer diskette used in both the advertising and direct mail components of the current campaign would be integrated in any continuing campaign.

To accompany its report, the Council forwards the following resolution to the House of Delegates.

47. Resolved, that the ADA conduct a three-year national marketing campaign to promote Direct Reimbursement, targeted to benefits purchasers and consultants, and funded at $2.5 million annually, which builds on the program implemented in response to Resolution 129H-1995 (*Trans.*1995:621).

Amendment of ADA *Bylaws* Regarding the Council on Communications: The Council on Communications has carefully reviewed the agency's rotation cycle and determined that under the present cycle several districts will unfairly receive more frequent representation on the Council while others will have a delay of several years before representation.

Chapter X. COUNCILS, Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection A, third paragraph of the ADA *Bylaws* as adopted by the House of Delegates reads:

> Council on Communications shall be composed of eight (8) members who shall be selected on a rotational basis by trustee district.*

The footnote to this paragraph reads:

> Council on Communications—Members of the Council on Membership and Communications from the 1st, 3rd, 4th, 5th, 6th, 7th, 11th and 13th Trustee Districts shall be

transferred to the new Council on Communications. In order to achieve a new quarterly rotation for the Council, a lottery will be conducted to extend the term of one (1) member completing his/her term [in 1996 to 1997. A lottery will determine which two] (2) districts from the 4th, 9th, 13th and 16th districts will have appointments in 1995 to the Council on Communications, the two (2) remaining districts will have appointments in 1996. A lottery will determine which two (2) districts from the 1st, 3rd, 6th and 10th districts will have appointments in 1997 to the Council on Communications, the two (2) remaining districts will have appointments in 1998. A lottery will determine which two (2) districts from the 2nd, 8th, 14th and 15th districts will have appointments in 1999 to the Council on Communications, the remaining two (2) districts will have appointments in the year 2000. A lottery will determine which two (2) districts from the 5th, 7th, 11th and 12th districts will have appointments in 2001 to the Council on Communications, the two (2) remaining districts will have appointments in 2002. [Material in brackets appears in the 1994 edition of the *Bylaws* but was omitted from the 1995 and 1996 editions through a typographical error.]

The current ADA volunteer assignment sequence for the Council on Communications is as follows:

	1996	1997	1998	1999	2000	2001	2002
Off	1, 3	6	5, 7, 11	4, 9	13, 16	1, 3	6, 10
On	13, 16	1, 3	6, 10	2, 8	14, 15	5, 7	11, 12

The Council forwards the following resolution to the House of Delegates.

48. Resolved, that at adjournment *sine die* of the 1996 House of Delegates, Chapter X. COUNCILS, Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection A of the *Bylaws* be amended by deleting in its entirety the footnote at the bottom of page 36 on the Council on Communications and substituting in its place a new footnote to read:

Council on Communications—Members of the Council on Membership and Communications from the 1st, 3rd, 4th, 5th, 6th, 7th, 11th and 13th Trustee Districts shall be transferred to the new Council on Communications. In order to achieve a new four-year rotational schedule for the Council, the following districts will have nominations to the Council in the years indicated: 1997—2nd and 8th districts; 1998—14th and 15th districts; 1999—11th and 12th districts; 2000—1st and 3rd districts; 2001—6th and 10th; 2002—5th and 7th; 2003—4th and 9th; 2004—13th and 16th.

This footnote shall expire at adjournment *sine die* of the 2004 House of Delegates.

Summary of Resolutions

47. Resolved, that the ADA conduct a three-year national marketing campaign to promote Direct Reimbursement, targeted to benefits purchasers and consultants, and funded at $2.5 million annually, which builds on the program implemented in response to Resolution 129H-1995 (*Trans.*1995:621).

48. Resolved, that at adjournment *sine die* of the 1996 House of Delegates, Chapter X. COUNCILS, Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection A of the *Bylaws* be amended by deleting in its entirety the footnote at the bottom of page 36 on the Council on Communications and substituting in its place a new footnote to read:

Council on Communications—Members of the Council on Membership and Communications from the 1st, 3rd, 4th, 5th, 6th, 7th, 11th and 13th Trustee Districts shall be transferred to the new Council on Communications. In order to achieve a new four-year rotational schedule for the Council, the following districts will have nominations to the Council in the years indicated: 1997—2nd and 8th districts; 1998—14th and 15th districts; 1999—11th and 12th districts; 2000—1st and 3rd districts; 2001—6th and 10th; 2002—5th and 7th; 2003—4th and 9th; 2004—13th and 16th.

This footnote shall expire at adjournment *sine die* of the 2004 House of Delegates.

Council on Dental Benefit Programs

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

Background: The quality of oral health care continues to play a major role in balancing cost containment strategies, delineating necessary care and protecting patient interests. The dental profession, through its dental practice parameters, provides the foundation on which the quality of oral health care can be monitored and protected.

Dental Practice Parameters Development: During 1996, dental practice parameters for nine additional oral health conditions were developed. Those oral health conditions are:

- Orofacial Anomalies;
- Radicular and/or Periradicular Lesion(s);
- Salivary Gland Dysfunction;
- Orofacial Trauma;
- Orofacial Infection(s);
- Implant Fixtures and/or Components Needing Replacement or Modification;
- Orofacial Pain of Non-Dental Origin;
- Inflammations and/or Infections Associated With Implant Fixtures and/or Components (Peri-implantitis/peri-implant infections); and
- Orofacial Osseous Lesions.

These documents are attached as Appendices 1-9.

In addition, Resolution 33-1995 (*Trans.*1995:615), Temporomandibular (Craniomandibular) Disorders, was referred back to the Dental Practice Parameters Committee (DPPC) by the House of Delegates to gain further consensus on the full range of appropriate diagnostic and treatment options and to revise the parameters on Temporomandibular (Craniomandibular) Disorders as necessary.

The DPPC received comments pertaining to parameters on Temporomandibular (Craniomandibular) Disorders. Based on the comments made during the Reference Committee and in the 1995 House of Delegates (*Trans.*1995:616), and the comments received in the process of reviewing the document, the parameters document was revised. Following the established mechanism for the development of dental practice parameters, the revised draft was then reviewed and recommendations were made by the dental practice parameters consensus conference and the mail review panel. Based on the review and recommendations, the Dental Practice Parameters Committee developed the parameters on Temporomandibular (Craniomandibular) Disorders.

The dental practice parameters document, Temporomandibular (Craniomandibular) Disorders, is attached as Appendix 10. An appropriate resolution, which is being forwarded to the House as a substitute for Resolution 33-1995, is also recommended for adoption.

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

Resolutions

26. Resolved, that the dental practice parameters document entitled Orofacial Anomalies be adopted.

27. Resolved, that the dental practice parameters document entitled Radicular and/or Periradicular Lesion(s) be adopted.

28. Resolved, that the dental practice parameters document entitled Salivary Gland Dysfunction be adopted.

29. Resolved, that the dental practice parameters document entitled Orofacial Trauma be adopted.

30. Resolved, that the dental practice parameters document entitled Orofacial Infection(s) be adopted.

31. Resolved, that the dental practice parameters document entitled Implant Fixtures and/or Components Needing Replacement or Modification be adopted.

32. Resolved, that the dental practice parameters document entitled Orofacial Pain of Non-Dental Origin be adopted.

33. Resolved, that the dental practice parameters document entitled Inflammations and/or Infections Associated with Implant Fixtures and/or Components (Peri-Implantitis/Peri-Implant Infections) be adopted.

34. Resolved, that the dental practice parameters document entitled Orofacial Osseous Lesions be adopted.

35. Resolved, that the dental practice parameters document entitled Temporomandibular (Craniomandibular) Disorders, as revised by the Dental Practice Parameters Committee, be adopted.

Appendices 1-10

Appendix 1

Orofacial Anomalies

The key element in the design of this set of parameters for orofacial anomalies 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.

Following evaluation of the patient (see limited, comprehensive, periodic, detailed and extensive evaluation parameters), the dentist should provide the patient with information about orofacial anomalies prior to obtaining consent for further evaluation and/or treatment.

The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of orofacial anomalies.

The dentist should utilize a process of differential diagnosis when evaluating orofacial anomalies.

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

The dentist should consider that the etiology of orofacial anomalies may be multifactorial.

The dentist should consider that the orofacial anomalies may be evidence of systemic disease or medical conditions.

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 the dentist determines that it is in the best interest of the patient.

An interdisciplinary approach may be utilized in the treatment of complex orofacial anomalies.

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

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

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing a treatment plan.

Restorative implications, pulpal/endodontic status, tooth position, and periodontal status and prognosis should be considered in developing a treatment plan.

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

The dentist should counsel the patient that orofacial anomalies are often managed, rather than resolved.

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 should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions.

After consideration of the individual circumstances, the dentist should decide whether the dental anomalies should be monitored or treated.

The dentist should consider the individual needs and desires of each patient in selecting material(s) and treatment(s).

The dentist should recommend treatment; present treatment options, 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.

Relevant and appropriate information about the patient and any necessary coordinated treatment 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 diseases through patient education in preventive oral health practices.

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

The dentist should be responsible for educating the patient about maintaining good oral hygiene, appropriate for the patient's condition.

The dentist should consider, and inform the patient, that treatment for orofacial anomalies may include multiple phases of treatment.

The dentist should consider that orofacial anomalies may develop or become clinically apparent at any time during an individual's lifetime.

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

The dentist may prescribe and/or administer pharmacological agents.

Resective or reconstructive surgical procedures may be performed by the dentist.

Oral orthopedic treatment may be utilized.

Dental sealants may be applied.

Alteration of tooth morphology and/or placement of restorations may be performed.

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

Endodontic therapy may be performed by the dentist.

Surgical management of this condition may include the removal of teeth, and other intra-oral and extra-oral surgical approaches. The patient should be informed of appropriate treatments to maintain space and/or replace teeth.

Fixed, removable or implant-supported prosthesis(es) may be used by the dentist.

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

The dentist should consider the compatibility of the selected treatment with the surrounding oral tissues and should provide an environment accessible for maintenance.

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

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.

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 2

Radicular and/or Periradicular Lesion(s)

The key element in the design of this set of parameters for radicular and/or periradicular lesion(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 dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the management of radicular and/or periradicular lesion(s).

Following evaluation of the patient (see limited, comprehensive, periodic, detailed and extensive evaluation parameters), the dentist should provide the patient with information about radicular and/or periradicular lesion(s) prior to obtaining consent for further evaluation and/or treatment.

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.

When recommending treatment, the dentist should recognize that radicular and/or periradicular lesion(s) can occur in singular or multiple sites, and the rates of progression may vary and can be predisposing to other conditions.

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing the treatment plan.

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 should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions.

The dentist should utilize a process of differential diagnosis when evaluating radicular and/or periradicular lesion(s) and developing a treatment plan.

Additional diagnostic tests relevant to the radicular and/or other periradicular lesion(s) of the patient may be performed and used by the dentist in diagnosis and treatment planning.

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.

In developing a treatment plan, the dentist should consider that the underlying etiology may be multifactorial.

Factors affecting the patient's speech, function, and orofacial aesthetics 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 and behavioral habits should be considered by the dentist.

Restorative and reconstructive implications, pulpal/endodontic status, tooth position, and periodontal status and prognosis should be considered in developing a treatment plan.

The dentist may counsel the patient concerning the potential effects of the patient's health, medication use, and behaviors and/or habits on his or her oral health.

After consideration of the individual circumstances, the dentist should decide whether the radicular and/or periradicular lesion(s) should be monitored or treated.

The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.

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

The dentist should recommend treatment, present treatment options, if any, and discuss the probable benefits, prognosis, 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.

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

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

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

The dentist should consider the compatibility of the selected treatment with the surrounding oral tissues and should provide an environment accessible for maintenance.

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

The dentist may prescribe and/or administer pharmacological agents.

Local etiologic factors should be removed.

Counseling and/or therapy for parafunctional behaviors and/or habits which can contribute to radicular and/or periradicular lesion(s) may be performed.

Surgical management of this condition, which may include the removal of teeth, and other intra-oral and extra-oral surgical approaches may be utilized. The patient should be informed of appropriate treatments to maintain space and/or replace teeth.

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

Treatment designed to reduce pulpal symptoms and/or protect the pulpal tissue of the tooth in question may be utilized by the dentist.

Pulpal/endodontic therapy and/or root resection may be performed by the dentist. Endodontic therapy may be performed in multiple stages.

The dentist may alter tooth morphology and/or position, and/or modify occluding, articulating, adjacent or approximating teeth, or the tooth in question, to facilitate treatment or reduce symptoms.

Fixed, removable and/or implant-supported restorations (prostheses) and/or appliances may be repaired, modified or replaced as determined by the dentist.

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

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

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

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 radicular and/or periradicular lesion(s).

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 3

Salivary Gland Dysfunction

The key element in the design of this set of parameters for salivary gland dysfunction 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.

Following evaluation of the patient (see limited, comprehensive, periodic, detailed and extensive evaluation parameters), the dentist should provide the patient with information about salivary gland dysfunction prior to obtaining consent for further evaluation and/or treatment.

The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of salivary gland dysfunction.

The dentist should utilize a process of differential diagnosis when evaluating salivary gland dysfunction.

The dentist should consider that the etiology of salivary gland dysfunction may be mechanical, developmental, the result of infection, medication, radiation therapy, systemic disease, and/or benign or malignant neoplasms.

The dentist should consider that the etiology of salivary gland dysfunction may be multifactorial.

The dentist should determine the need for, and/or type of diagnostic procedures, including, but not limited to, biopsy or cytological evaluation.

The dentist should consider that salivary gland dysfunction may be self-limiting, and episodic and/or progressive and may recommend that the patient return for further evaluation.

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 the dentist determines that it is in the best interest of the patient.

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

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing a treatment plan.

Functional and restorative implications of reduced salivary flow should be considered when developing a treatment plan.

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

Since salivary gland dysfunction may persist or recur intermittently, the dentist should counsel the patient that salivary gland dysfunction is often managed, rather than resolved.

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 should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions.

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

The dentist may monitor or recommend treatment; present treatment options; 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.

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

The dentist should consider the effects of salivary gland dysfunction in selecting material(s) and treatment(s).

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

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

The dentist should be responsible for educating the patient about maintaining good oral hygiene when the salivary gland dysfunction and/or treatment limits the patient's ability to achieve an appropriate level of oral hygiene.

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

The dentist may prescribe and/or administer pharmacological agents.

When chemotherapy and/or radiotherapy affect salivary gland function, the sequencing, frequency and type of palliative and/or preventive dental treatment should be determined by the dentist.

Resective or reconstructive surgical procedures may be performed by the dentist.

When the dentist performs resective surgical procedures, a microscopic evaluation of the excised tissue must be considered.

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

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.

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 4

Orofacial Trauma

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

In a patient presenting with orofacial trauma, medical stabilization takes precedence over dental treatment.

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

When possible, the dentist should instruct the patient on the protocol for managing the orofacial trauma prior to evaluation.

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

Following evaluation of the patient (see limited, comprehensive, periodic, detailed and extensive evaluation parameters), when possible, the dentist should provide the patient with information about orofacial trauma prior to obtaining consent for further evaluation and/or treatment.

The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of orofacial trauma.

The dentist should utilize a process of differential diagnosis when evaluating orofacial trauma.

The dentist should consider that the cause of orofacial trauma may be multifactorial and may affect multiple sites with differing degrees of severity.

The dentist should consider the possibility that the patient may be the victim of physical abuse and/or neglect.

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 the dentist determines that it is in the best interest of the patient.

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

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing a treatment plan.

Dental restorative implications, pulpal/endodontic status, tooth position, and periodontal status and prognosis should be considered in developing a treatment plan.

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

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 should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions.

After consideration of the individual circumstances the dentist should decide whether the orofacial trauma should be monitored or treated.

Following evaluation, treatment priority should be given to the management of emergency conditions, pain and anxiety.

The dentist, when possible, should recommend treatment; present treatment options, if any; and discuss the probable benefits, limitations and risks associated with treatment and the probable consequences of no treatment.

When possible, 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.

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

The dentist should consider the individual needs of each patient in selecting material(s) and treatment(s) to be utilized.

The dentist should be responsible for educating the patient about maintaining good oral hygiene, appropriate for the patient's condition.

The dentist should consider, and inform the patient, that treatment for orofacial traumas may include multiple phases of treatment.

The dentist may prescribe and/or administer pharmacological agents.

Foreign matter may be removed from the trauma area.

Lacerations may be repaired.

Alteration of tooth morphology and/or modification or placement of restorations may be performed by the dentist to facilitate treatment or reduce symptoms.

Resective and/or reconstructive surgical procedures may be performed by the dentist.

Endodontic therapy may be performed by the dentist.

Transitional or provisional restorations may be used by the dentist to facilitate treatment.

The dentist may utilize manipulation and/or stabilization techniques to facilitate treatment.

Surgical management of this condition may include the removal, repositioning, and/or reimplantation of teeth, and other intra-oral and extra-oral surgical procedures. The patient should be informed of appropriate treatments to maintain space and/or replace teeth, as determined by the dentist.

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

The dentist should emphasize the prevention of oral trauma through patient education in preventive oral health practices, which may include orofacial protective appliances.

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.

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 5

Orofacial Infection(s)

The key element in the design of this set of parameters for orofacial infection(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 dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the management of orofacial infections.

Following evaluation of the patient (see limited, comprehensive, periodic, detailed and extensive evaluation parameters), the dentist should provide the patient with information about orofacial infection(s) prior to obtaining consent for further evaluation and/or treatment.

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

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 should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions.

The dentist should utilize a process of differential diagnosis when evaluating orofacial infection(s) and developing a treatment plan.

Additional diagnostic tests relevant to orofacial infection(s) of the patient may be performed and used by the dentist in diagnosis and treatment planning.

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

In developing a treatment plan, the dentist should consider that the etiology of orofacial infection(s) may be bacterial, viral and/or fungal in nature.

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

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing the treatment plan.

Restorative implications, carious lesions, pulpal/endodontic status, tooth position, and periodontal status and prognosis should be considered in developing a treatment plan.

The dentist may counsel the patient concerning the potential effects of the patient's health, medication use, and behaviors and/or habits on his or her oral health.

After consideration of the individual circumstances, the dentist should decide whether the orofacial infection(s) should be monitored or treated.

The dentist should recommend treatment, present treatment options, if any, and discuss the probable benefits, prognosis, 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.

The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.

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

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

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

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

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 or reduce symptoms.

The dentist may modify occluding, articulating, adjacent, or approximating teeth or the tooth/teeth in question to facilitate treatment or reduce symptoms.

The dentist may prescribe and/or administer pharmacological agents.

Counseling and/or therapy for parafunctional behaviors and/or habits which can contribute to orofacial infection(s) may be performed to facilitate treatment.

Endodontic therapy, including surgical and nonsurgical approaches, may be performed by the dentist.

Surgical management, which may include the removal of teeth/implants, and other intra-oral and/or extra-oral surgical approaches may be utilized. The patient should be informed of appropriate treatment to maintain space and/or replace any removed teeth.

Fixed, removable and/or implant-supported restorations (prostheses) and/or appliances may be repaired, modified or replaced as determined by the dentist.

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

The dentist should consider the compatibility of the selected treatment with the surrounding oral tissues and should provide an environment accessible for maintenance.

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

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 orofacial infection(s).

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 6

Implant Fixtures and/or Components Needing Replacement or Modification

The key element in the design of this set of parameters for implant fixtures and/or components needing replacement or modification 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 prognosis, progression and management of this condition.

Following evaluation of the patient (see limited, comprehensive, periodic, detailed and extensive evaluation parameters), the dentist should provide the patient with information about implant fixtures and/or components needing replacement or modification prior to obtaining consent for further evaluations and/or treatment.

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

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

The dentist should utilize a process of differential diagnosis when evaluating this condition.

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 should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions.

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.

In developing a treatment plan, the dentist should consider that the etiology of this condition may be multifactorial. Further consideration should be given to craniofacial, musculoskeletal, stomatognathic, and/or dental interrelationships that are dynamic throughout life.

The restorative implications and prognosis should be considered 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 selection of the materials, implant fixtures and components, and in the design of the restoration.

The relationship of osseous and soft tissue defects to the implant should be noted and considered in the development of a treatment plan.

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

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing a treatment plan.

The dentist may counsel the patient concerning the potential effects of the patient's health, medication use, and behaviors and/or habits on this condition.

The dentist should recommend treatment, present treatment options, if any, and discuss the probable benefits, prognosis, 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.

The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.

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

Therapy for parafunctional behaviors that may contribute to this condition may be performed to facilitate treatment.

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

The dentist should promote the prevention and early detection of oral diseases through patient education and individual patient oral health preventive measures.

Orofacial hygiene instructions should be provided based on the patient's needs.

The dentist should determine the frequency and type of preventive treatment.

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

Local etiologic factors may be removed.

The dentist may prescribe and/or administer pharmacological agents.

Placement, modification, replacement, and/or removal of restorations and/or prosthesis(es) may be performed to facilitate treatment or reduce symptoms.

Following occlusal analysis, the dentist may modify occluding, articulating, adjacent or approximating teeth, or the restoration on the implant(s) in question to facilitate treatment or reduce symptoms.

Occlusal guards may be used.

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

Resective, regenerative, augmentative and/or reconstructive surgical procedures may be performed.

Surgical management of this condition may include removal of teeth, and other intra-oral and extra-oral surgical approaches. The patient should be informed of appropriate treatment(s) to maintain space and/or replace teeth.

Implant fixtures and/or components may be replaced, and/or additional implant fixtures and/or components may be placed.

The dentist may choose not to remove or utilize the implant fixtures and/or components when such removal or utilization would compromise the well being of the patient.

The dentist should consider the compatibility of the selected treatment with the surrounding tissues and orofacial implant fixtures and components. When applicable, the dentist should provide an environment accessible for maintenance.

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

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 implant.

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 record.

Appendix 7

Orofacial Pain of Non-Dental Origin

The key element in the design of this set of parameters for orofacial pain of non-dental origin 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.

Following evaluation of the patient (see limited, comprehensive, periodic, detailed and extensive evaluation parameters), the dentist should provide the patient with information about orofacial pain of non-dental origin prior to obtaining consent for further evaluation and/or treatment.

The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of orofacial pain of non-dental origin.

The dentist should consider that orofacial pain of non-dental origin may be influenced by craniofacial, musculoskeletal, stomatognathic, neurological, vascular, and/or psychological factors that are dynamic throughout life and that the etiology of orofacial pain of non-dental origin may be multifactorial.

The dentist should consider a differential disease classification of orofacial pain that may include neurogenic pain, neurovascular pain, neuromuscular, and sympathetic and/or referred pain involving the trigeminal and oropharyngeal systems, when developing a treatment plan.

The dentist should consider that orofacial pain of non-dental origin may be the result of medical conditions which contribute to or mimic other disorders.

The dentist should consider the possibility that the patient may be the victim of physical abuse and/or neglect.

The dentist should consider that orofacial pain of non-dental origin may be self-limiting, and episodic and/or progressive, and 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, and the nature and severity of the patient's orofacial pain.

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 the dentist determines that it is in the best interest of the patient.

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

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

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing a treatment plan.

The dentist may counsel the patient concerning the potential effects of the patient's health, medication use, and behaviors on oral health.

The dentist should counsel the patient that orofacial pain situations are often managed, rather than resolved, and that symptoms may persist or recur intermittently.

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

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions.

After consideration of the individual circumstances, the dentist should decide whether the orofacial pain should be monitored or treated.

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

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

Initially the dentist should select the least invasive and most reversible therapy that may ameliorate the patient's pain and/or functional impairment.

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 evaluate the effectiveness of initial therapy prior to considering more invasive and/or irreversible therapy.

Before initiating invasive and/or irreversible therapy, the dentist should attempt to determine and inform the patient of the likelihood of its therapeutic success, and expected and/or potential side effects.

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

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

The dentist should be responsible for educating the patient about maintaining good oral hygiene when orofacial pain and/or treatment limits the patient's ability to achieve an appropriate level of oral hygiene.

The dentist should be responsible for educating the patient concerning self-management and the elimination of behaviors that may contribute to orofacial pain of non-dental origin.

The dentist should consider, and inform the patient, that treatment for orofacial pain of non-dental origin may include multiple phases of treatment.

The dentist should consider that orofacial pain of non-dental origin requiring treatment may develop at any time during an individual's lifetime, regardless of the patient's previous treatment history.

The dentist may prescribe or administer physical medicine (therapy) modalities.

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

The dentist may prescribe and/or administer pharmacological agents.

Anesthetic injections may be performed for diagnostic and/or therapeutic purposes.

The dentist should periodically evaluate the patient's medication regimen to determine the effectiveness and appropriateness of continued pharmacological therapy.

Following diagnosis of orofacial pain of non-dental origin, the treatment of dental conditions may be performed.

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

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

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 orofacial pain.

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

Inflammations and/or Infections Associated with Implant Fixtures and/or Components (Peri-Implantitis/Peri-Implant Infections)

The key element in the design of this set of parameters for inflammations and infections associated with implant fixtures and/or components (peri-implantitis/peri-implant infections) 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 prognosis, progression and management of the inflammation and/or infection.

Following evaluation of the patient (see limited, comprehensive, periodic, detailed and extensive evaluation parameters), the dentist should provide the patient with information about inflammations and infections associated with implant fixtures and/or components prior to obtaining consent for further evaluations and/or treatment.

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

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

The dentist should utilize a process of differential diagnosis when evaluating this condition.

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 should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions.

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.

In developing a treatment plan, the dentist should consider that the etiology of this condition may be multifactorial.

The relationship of osseous and soft tissue defects to the implant should be noted and considered in the development of a treatment plan.

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

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing a treatment plan.

The dentist may counsel the patient concerning the potential effects of the patient's health, medication use, and behaviors and/or habits on this condition.

After the consideration of the individual circumstances, the dentist should decide whether the inflammations and infections associated with implant fixtures and/or components should be monitored or treated.

The dentist should recommend treatment, present treatment options, if any, and discuss the probable benefits, prognosis, 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.

Therapy for parafunctional behaviors that may contribute to this condition may be performed to facilitate treatment.

The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.

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

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

The dentist should promote the prevention and early detection of oral diseases through patient education and individual patient oral health preventive measures.

Orofacial hygiene instructions should be provided based on the patient's needs.

The dentist should determine the frequency and type of preventive treatment.

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

Local etiologic factors may be removed.

The dentist may prescribe and/or administer pharmacological agents.

Placement, modification, replacement, and/or removal of restorations and/or prosthesis(es) may be performed to facilitate treatment or reduce symptoms.

Following occlusal analysis, the dentist may modify occluding, articulating, adjacent or approximating teeth, or the restoration on the implant(s) in question to facilitate treatment or reduce symptoms.

Occlusal guards may be used.

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

Resective, regenerative, augmentative and/or reconstructive surgical procedures may be performed.

Surgical management of this condition may include removal of teeth, and other intra-oral and extra-oral surgical approaches. The patient should be informed of appropriate treatment(s) to maintain space and/or replace teeth.

The dentist may remove, modify, and/or replace implant fixtures and/or components, and/or place additional implant fixtures and/or components.

The dentist should consider the compatibility of the selected treatment with the surrounding tissues and orofacial implant fixtures and/or components. When applicable, the dentist should provide an environment accessible for maintenance.

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

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 implant.

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 record.

Appendix 9

Orofacial Osseous Lesions

The key element in the design of this set of parameters for orofacial osseous lesions 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.

Following evaluation of the patient (see limited, comprehensive, periodic, detailed and extensive evaluation parameters), the dentist should provide the patient with information about orofacial osseous lesions prior to obtaining consent for further evaluation and/or treatment.

The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of orofacial osseous lesion(s).

The dentist should utilize a process of differential diagnosis when evaluating orofacial osseous lesion(s) and developing a treatment plan.

In developing a treatment plan, the dentist should consider that the etiology of osseous lesions can be multifactorial, and that these lesions could be benign, premalignant or malignant.

The dentist should consider that orofacial osseous lesion(s) may be self-limiting, and episodic and/or progressive and may recommend that the patient return for further evaluation.

The dentist should consider that clinical manifestations of orofacial osseous lesion(s) may not coincide with cytological changes.

The dentist should inform the patient that an osseous lesion has the potential for cytological change and should be monitored and/or evaluated through diagnostic procedures.

The dentist should determine the need for, and/or type of diagnostic procedure(s), including, but not limited to, biopsy or cytological evaluation.

When an osseous lesion has been diagnosed as malignant, the dentist should consider that malignant lesions have the

potential for rapid growth and metastasis, and may be primary or metastatic.

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 the dentist determines that it is in the best interest of the patient.

After consideration of the individual circumstances, including microscopic evaluation, if any, the dentist should decide whether the orofacial osseous lesion should be monitored or treated.

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

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing a treatment plan.

Restorative implications, pulpal/endodontic status, tooth position, and periodontal status and prognosis should be considered in developing a treatment plan.

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

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions.

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

The dentist should recommend treatment; present treatment options, 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 patient compliance with prescribed treatment and recommendations for behavioral modifications. Lack of compliance should be recorded.

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 diseases through patient education in preventive oral health practices.

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

The dentist should be responsible for educating the patient about maintaining good oral hygiene when the orofacial osseous lesion(s) and/or treatment limits the patient's ability to achieve an appropriate level of oral hygiene.

The dentist should consider, and inform the patient, that treatment for orofacial osseous lesions may include multiple phases of treatment.

The dentist should consider that orofacial osseous lesions requiring treatment may develop at any time during an individual's lifetime, regardless of the patient's previous treatment history.

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

When chemotherapy and/or radiotherapy are used in treating orofacial osseous lesion(s), the sequencing, frequency and type of palliative and/or preventive dental treatment should be determined by the dentist.

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

Surgical management of this condition may include removal of teeth, and other intra-oral and extra-oral surgical approaches. The patient should be informed of appropriate treatments to maintain space and/or replace teeth.

The dentist may resect or ablate the orofacial osseous lesions with or without associated structures.

Surgical reconstruction may be performed primarily or secondarily by the dentist.

Maxillofacial restoration(s) (prostheses), including implant-supported restoration(s) (prostheses), may be used for therapy and reconstructive purposes.

Fixed, removable and implant-supported restoration(s) (prostheses) may be placed, repaired, modified or replaced, as determined by the dentist.

Endodontic therapy and/or root resection may be performed by the dentist.

Local etiologic factors may be removed.

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

The dentist may alter tooth morphology and/or position by modifying occluding, articulating, adjacent or approximating teeth to facilitate treatment or reduce symptoms.

Placement of restoration(s) (prostheses), and modification or replacement of restoration(s) (prostheses) may be performed to facilitate treatment or reduce symptoms.

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

When the dentist removes an osseous lesion, a microscopic evaluation must be considered.

The dentist may prescribe and/or administer pharmacological agents.

The dentist should consider the characteristics and requirements of each patient in selecting material(s) and treatment(s).

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

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.

Documentation of findings, 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

Temporomandibular (Craniomandibular) Disorders

The key element in the design of this set of parameters for temporomandibular (TM) disorders 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.

Following evaluation of the patient (see limited, comprehensive, periodic, detailed and extensive evaluation parameters), the dentist should provide the patient with information about TM disorders prior to obtaining consent for further evaluation and/or treatment.

The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of TM disorders.

The dentist should consider that TM disorders are characterized by craniofacial, musculoskeletal, stomatognathic and/or dental interrelationships, and/or psychological influences that are dynamic throughout life and that the etiology of TM disorders may be multifactorial.

The dentist should consider a differential disease classification that may include neuromuscular pain, myofascial pain, neurogenic pain, neurovascular pain, sympathetic and/or referred pain involving the trigeminal and/or oropharyngeal systems, or other medical conditions, which may contribute to or mimic TM disorders.

Following oral evaluation and consideration of the patient's needs, the dentist is responsible for providing the patient with information about the nature of TM disorders prior to obtaining consent for treatment.

The dentist should consider that TM disorders may be self-limiting, episodic and/or progressive and 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, and the nature and severity of the patient's disorder.

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 the dentist determines that it is in the best interest of the patient.

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

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

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing a treatment plan.

Restorative implications, pulpal/endodontic status, tooth position, and periodontal status and prognosis should be considered in developing a treatment plan.

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

The dentist should counsel the patient that TM disorders are often managed, rather than resolved, and that symptoms of TM disorders may persist, change, or recur intermittently.

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

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 should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions.

After consideration of the individual circumstances, the dentist should decide whether the TM disorders should be monitored or treated.

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

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

The dentist should treat patients for TM disorder only when there is associated craniomaxillofacial pain and/or functional impairment.

Initially the dentist should select the least invasive and most reversible therapy that may ameliorate the patient's pain and/or functional impairment.

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 evaluate the effectiveness of initial therapy prior to considering more invasive and/or irreversible therapy.

Before initiating invasive and/or irreversible therapy, the dentist should attempt to determine the likelihood of its therapeutic success.

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

The dentist should consider the individual needs and desires of each patient in selecting material(s) and treatment(s).

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

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

The dentist should be responsible for educating the patient about the increased difficulty of maintaining good oral hygiene when TM disorders limit the range of jaw motion, and for instruction in methods to achieve an appropriate level of oral hygiene.

The dentist should be responsible for educating the patient concerning self-management and the elimination of behaviors that may contribute to TM disorders.

The dentist should consider, and inform the patient, that treatment for TM disorders may include multiple phases of treatment and multiple health care disciplines.

The dentist should consider that TM disorders requiring treatment may develop at any time during an individual's lifetime, regardless of the patient's previous treatment history.

The dentist may prescribe or administer physical medicine (therapy) modalities.

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

When articular derangement and/or condylar dislocation has been determined to be the etiology of the patient's pain and/or functional impairment, manual manipulation of the mandible may be performed by the dentist.

The dentist may prescribe and/or administer pharmacological agents.

The dentist should periodically evaluate the patient's medication regimen to determine the effectiveness and appropriateness of continued pharmacological therapy.

Oral orthotics (guards/splints) may be used by the dentist to enhance diagnosis, facilitate treatment or reduce symptoms.

The dentist should periodically evaluate oral orthotics (guards/splints) for their effectiveness, appropriateness and possible risks associated with continued use.

Before restorative and/or occlusal therapy is performed, the dentist should attempt to reduce, through the use of reversible modalities, the neuromuscular, myofascial and temporomandibular joint symptoms.

The dentist may replace teeth, alter tooth morphology and/or position by modifying occluding, articulating, adjacent or approximating surfaces, and by placing or replacing restorations (prostheses) to facilitate treatment.

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

Intracapsular and/or intramuscular injection, and/or arthrocentesis may be performed for diagnostic and/or therapeutic purposes.

Orthodontic therapy may be utilized to facilitate treatment.

Orthognathic surgery may be performed to facilitate treatment.

When internal derangement or pathosis has been determined to be the cause of the patient's pain and/or functional impairment, arthroscopic or open resective or reconstructive surgical procedures may be performed by the dentist.

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

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 TM disorder.

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 Recent Activities

Background: The following reports on Council activities that were completed after the publication of the 1996 annual report to the House of Delegates.

Purchaser Information Service: A special meeting of constituent and component dental society staff with responsibility for promoting direct reimbursement dental plans was held on Thursday, July 11, 1996. Over 100 individuals attended the meeting to hear the following presentations:

- The DR Team: Pivotal Roles;
- Organized Dentistry on Parade: We Can Work Together;
- DR Software Allows Self-Administration to be User-Friendly;
- Making the First Call;
- Getting Brokers Involved;
- Employers Who Use DR—Testimonies with Uniqueness;
- A Vision of the Future; and
- Questions and Wrap-Up.

Dental Benefits Conference: The Councils on Dental Benefit Programs, Dental Practice, and Governmental Affairs and Federal Dental Services cosponsored this year's Conference on July 12-13, 1996 in Chicago. The Conference was entitled "Dental Benefit Plans: The Employer/Employee Part of the Equation."

Dr. William S. Ten Pas, ADA president, opened the Conference and welcomed the attendees. Dr. Ten Pas also presented a Presidential Citation award to Dr. W. Kelly Carr for his efforts in developing and promoting the concept of direct reimbursement.

The Conference was attended by 238 individuals, including representatives of constituent and component dental societies, national dental organizations, university faculty and administrators, third-party payer organizations, dental consultants, benefit managers and consultants. In addition, members of the Association's Board of Trustees and members of various agencies of the Association also attended.

The following programs were presented at the Conference:

- Direct Provider Contracting;
- Employer Purchasing Coalitions;
- Citizen Action Groups;
- Incentives and Fraud;
- Legislative Activities;
- Quality Expectations; and
- Direct Reimbursement Companies.

A period for questions and answers followed each segment of the program.

The keynote speakers were Dr. John M. Burns and Mr. Joseph T. Brophy. Dr. Burns is president of The Burns Group, Inc., a private health care consulting firm. Dr. Burns was formerly with Honeywell International where he was responsible for the planning and designing of health care strategies for providing quality services to Honeywell's employees. Mr. Brophy is a senior financial services sector executive. He was formerly president of The Travelers Insurance Company.

Council Meeting: The Council held its second meeting on July 14, 1996. Representatives of dental organizations, the insurance industry and service corporations were invited to meet with the Council. Issues of mutual concern and interest were discussed.

Composite Resin Restoration Study: At its April 12-14, 1996 meeting, the Council discussed the problems members and plan purchasers are having with insurance companies refusing to cover composite resin restorations. The insurance companies cite the position of the Council on Scientific Affairs (CSA), first developed and published in 1986 and restated in 1994 (see "Posterior Composite Resins," Council on Dental Materials, Instruments and Equipment, *JADA*, Vol.112, May 1986, pp. 707-709; and "Choosing Intracoronal Restorative Materials," Council on Dental Materials, Instruments and Equipment, *JADA*, Vol.125, January 1994, pp. 102-103). Inappropriately interpreting and citing these reports, patients' claims for composite resin inlays and onlays for posterior teeth have been denied.

The Council on Dental Benefit Programs requested the CSA to discuss the possibility of conducting studies on materials used for these types of restorations. At its meeting in September, CSA will consider resolutions for submission to the 1996 House of Delegates that will request approval for a laboratory study to focus on the ability of composite resins to withstand various levels of stress. In addition, the CSA will request approval for an in-depth, long-term clinical study of composite resins.

Following the laboratory study, the CSA and the Council on Dental Benefit Programs will jointly sponsor a conference that will bring in experts from the various communities of interest to attempt to arrive at a consensus on the appropriate use of resin restorations in posterior teeth.

Dental Office Involvement with Dental Benefit Plan Problems: The Council considered a report it had directed staff to develop based on discussion of dental office involvement with dental benefit plan problems by the Council at its April 1996 meeting. The Council believes that dentists are adding substantial overhead costs in their practices by trying to solve patients' problems with their dental benefit plans. Many dental practices have hired staff specifically to deal with insurance problems, even though the dentists are not contractually involved with those plans. This has resulted in patients becoming reliant on their dentists to run interference with the insurance companies, rather than taking their problems back to the employers and/or benefits managers who purchased the plans.

The Council is of the opinion that the costs associated with trying to solve patients' problems include hiring a staff member to deal with the insurance companies, and also

carrying claims for both insurance companies and patients for up to six months and sometimes longer. In short, dental offices have assumed the role of banker as well as patient ombudsman to the third-party payers. The Council has requested that questions designed to determine these costs be added to a future edition of the Association's *Quarterly Survey of Dental Practice*.

The Council believes the Association should take every opportunity to encourage dentists to stay out of the insurance and banking aspects of their patients' dental plans. Instead, patients should be directed to go back to their employers where the plans were selected and purchased. It is not up to dentists to make poorly designed and/or badly administered plans work. It would be far more helpful for dentists to see that their patients inform the employers that the dental plans are not working or are being administered incorrectly.

In support of this recommendation, earlier this year the Association sponsored focus groups of benefits managers who represented companies with as few as eight employees up to companies with 96,000 employees. Without exception, these decision-makers said that they would help employees with their benefits problems, but if the problems were constant, they would quickly seek a new plan and carrier.

For these reasons, the Council recommends that the following resolution be adopted.

43. Resolved, that the American Dental Association make every effort to encourage dentists not to intervene on behalf of their patients with third-party payers in order to try and solve patients' problems with their dental benefit plans, and be it further

Resolved, that dentists provide their patients with accurate statements of services rendered and when plan payments are too low or denied, or when other administrative problems arise with the plans, that patients be directed to take their problems back to the plan purchasers for resolution.

Quality Assessment and Improvement—Performance Indicators for Oral Health Care: As managed care organizations and other insurance plans attempt to contain the costs of care and provide greater access to care, the need to balance these objectives with that of maintaining the quality of care is essential. The need for balance is recognized by the purchasers of care, patients and accrediting bodies, such as the National Committee for Quality Assurance (NCQA) and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). It is also recognized by the dental profession and other direct health care providers. The quality of care must be defined, monitored and improved.

Two growing issues regarding quality assessment require particular attention. The first issue is that benefit plans focus on the quality assessment of preventive services and ignore the quality assessment of the largest bulk of service: diagnosis and direct treatment. The second issue is that administrative factors within benefit plans can affect quality of care and need to be addressed. For example, the timeliness and convenience of access to dental specialty care can have a bearing on the quality of oral health care. Currently, the NCQA addresses administrative factors in its quality accreditation standards for managed care organizations; however, additional administrative factors should be addressed.

Regarding the first issue, quality assessment of clinical care has not focused on those services that are representative of most of the services delivered to the plan's enrollees or that are most relevant to health status. Quality assessment has focused almost exclusively on preventive services, such as cholesterol screening, childhood immunizations, mammography and dental evaluation. Typically, benefit plans report the proportion of the eligible enrollees who receive these services. For example, a plan can report the percentage of children enrolled in the plan who received a dental examination within a specified time period. However, there would be no information on the oral health services received as a result of, or subsequent to, that exam.

Preventive services are a necessary and valuable component of health care services, and they contribute to the health status of patients, but they do not constitute the majority of service delivered and their impact on health status is equivocal. The majority of service involves diagnosis and direct treatment. Therefore, the assessment that has been conducted by benefit plans, to date, has failed to supply quality of care information on the bulk of services which enrollees receive or on the services that have a significant impact on the health status of the enrollees.

This limitation is acknowledged by the NCQA as well as benefit plans, purchasers and providers. Recently, steps have been taken to rectify this limitation. For example, the NCQA is revising its accreditation standards for 1997 and will spur benefit plans to develop quality assessment programs which monitor services that are high volume, high cost, or are directly related to health status. The NCQA has begun the development of performance indicators for clinical care and anticipates that it will begin the development of indicators specifically for oral health care toward the end of 1996 or beginning of 1997.

Regarding the second issue, administrative factors within benefit plans can have an impact on dental treatment and decision making. Some of these factors are reflected in the Association's Requirements For Managed Care Programs (*Trans.*1995:627), which concerns plan design and legislative/regulatory issues. For example, the patient's freedom to select a dentist outside of the plan, at a reasonable point of service cost, can affect the patient's likelihood of seeking needed oral health care and, eventually, can affect the patient's oral health status. Performance indicators need to be developed on administrative factors such as this, that have particular impact on the quality of care.

Performance Indicators. Performance indicators are assessment tools used to monitor and evaluate the quality of clinical care; indicators can also be used to monitor and evaluate the governance, management and support functions in an organization. Indicators are defined, measurable variables that address a specific aspect of care which is thought to be important to providing the overall care, or is of interest because it is often a problematic area. Thus, indicators do not measure the entire process of care for a given condition, but assess only the most important aspect of care or key aspect of care. For example, an indicator of the quality of treatment of periodontal disease might assess only whether periodontal charting was completed, rather than assessing every aspect of all the care that was done during diagnosis and treatment. Because indicators should capture the key aspects of care, clinical expertise is needed to judge what might be a key aspect of care.

To be measurable, indicators are usually expressed as rates or percentages. The numerator is the number of times an activity or event (such as periodontal charting) has taken place. The denominator includes all those cases in which it theoretically should have taken place or might have occurred.

Ultimately, indicators yield data that must be subsequently analyzed to determine where quality can be improved.

Planning for Indicator Development. It is timely that the dental profession, through the American Dental Association, position itself to objectively demonstrate and substantiate its contributions in an increasingly competitive health arena. It is prudent that the dental profession clarify its position on how the quality of oral health care is most accurately assessed and monitored. Such clarification would position the Association to consult and guide the effort of accrediting bodies, dental plans and other organizations, for the benefit of dental patients and the dentists who work within dental plans.

The Council on Dental Benefit Programs proposes that the American Dental Association, through the Council on Dental Benefit Programs, formulate a plan for developing performance indicators for oral health care. The indicators could be used by dentists, accrediting bodies and similarly interested parties to assess the quality of dental care that is provided through managed care and other benefit plans. The advantage of the Association taking an active role in performance indicator development is that the indicators would provide more valid assessment of the quality of oral health care and would balance the vested interests of the benefit plans.

For these reasons, the Council recommends that the following resolution be adopted.

44. Resolved, that the American Dental Association, through its appropriate agencies, formulate a plan for developing performance indicators for oral health care.

Summary of Resolutions

43. Resolved, that the American Dental Association make every effort to encourage dentists not to intervene on behalf of their patients with third-party payers in order to try and solve patients' problems with their dental benefit plans, and be it further

Resolved, that dentists provide their patients with accurate statements of services rendered and when plan payments are too low or denied, or when other administrative problems arise with the plans, that patients be directed to take their problems back to the plan purchasers for resolution.

44. Resolved, that the American Dental Association, through its appropriate agencies, formulate a plan for developing performance indicators for oral health care.

Council on Dental Benefit Programs

Supplemental Report 3: Update on Council Activities

Background: The following report contains information on Council activities that were completed after the publication of the Council's Supplemental Report 2 to the House of Delegates.

Purchaser Contact Program: The Purchaser Contact Program has been quite active. As stated in its annual report to the 1996 House, the Council had decided to concentrate its efforts on two categories of companies:

- those with publicly stated commitments to quality of product and to value of employees; and
- those companies whose well-being is tied directly to the health of dental practices (e.g., manufacturers of dental equipment).

Companies contacted as of this writing are as follows:

- L. L. Bean, Portland, Maine;
- Bath Ironworks, Bath, Maine;
- Marriott Corporation, Bethesda, Maryland;
- Order of St. Francis Hospital, Peoria, Illinois; and
- Ohio State University system, Columbus, Ohio.

These employers have been very receptive to learning about the concept of direct reimbursement (DR). At the same time that the Council is educating employers about DR, a great deal is being learned about the unique needs of each company's employee group. For instance, each of the companies visited so far have large segments of their employees whose incomes are lower and where the up-front payment would be, at best, a difficult requirement for the employers to impose. Many of their employees have neither bank accounts nor credit cards. In one instance, a large percentage of the employees do not speak English. For one company, in a 12-month period there is a 100% turnover in one category of employees which represents 80% of the company's employees.

The PINSERV has begun investigating the possibility of developing a mechanism that patients can use in the dentist's office to cover any up-front payments required. Although several technical and system design problems quickly became apparent, these problems are being worked on and discussions are continuing.

The variables specific to each company's employee group must be factored into the DR cost projections in order to make the estimates as realistic as possible. The Council is in the process of determining what additional factors are needed to provide cost projections for very large plans and nationwide plans.

The problem of up-front payment by patients has prompted the Council to explore several alternatives that will lead to the development of a mechanism designed specifically to alleviate this problem. The Council has long believed that the administration of a DR plan should be a simple banking-type transaction. Developing such a mechanism has greatly appealed to the employers talked to so far.

In addition to the one-on-one employer contacts, there have been several productive meetings with groups of employers who have been invited to participate in programs sponsored by state and local dental societies as well as individual dentists.

During the remainder of this year, the Council plans to meet with several major dental suppliers.

All of the meetings with the above named companies were arranged with the assistance of Association members who identified the key decision-makers. The Council wishes to express its appreciation to these members for their participation in the Purchaser Contact Program.

Explanation of Dental Reimbursement Mechanisms: In response to Resolution 58H-1995 (*Trans.*1995:609), the Council had hoped that, by the 1996 House of Delegates, it could have completed a compilation of several glossaries of dental benefit terms contained in various Association publications. The Glossary of Dental Benefit Terms is in process and will be ready by November 1996.

The Glossary will be reviewed by the Council at its November 1996 meeting and submitted to the Board of Trustees for review.

The Council believes that the Glossary should be maintained in an electronic database and made available to dentists in several formats, such as computer disk, hard copy and through the ADA ONLINE.

Information on Calculation of Benefits: Resolution 74-1995 (*Trans.*1995:648) was referred to the Council, with input from the Council on Governmental Affairs and Federal Dental Services (CGAFDS). The CGAFDS reported its activity related to support of Resolution 74-1995 in its 1996 annual report to the House of Delegates (*Reports:*108). The CGAFDS "strongly endorsed Resolution 74-1995, noting that H.R. 2400 requires all health plans (insured and self-funded) to provide expansive amounts of plan information to beneficiaries." However, the Council, as part of its ongoing policy review, has reviewed the Association's Statement on Determination of Usual, Customary and Reasonable Fees (*Trans.*1991:633). The opening paragraph states that "The legitimate interests of insured patients are best served by use of precise, accurate and publicly announced methodologies for determining ranges of fees for all dental services." This supports the intent of Resolution 74-1995. The Statement continues with very specific requirements for standards, disclosures and explanations associated with fee screens developed by third-party payers to determine customary reimbursement levels.

The Association's agencies will continue to work with the National Association of Insurance Commissioners to see that the Statement is considered in any model regulations dealing with the way usual, customary and reasonable fees are determined.

Because of the difference of opinion between the Council and the CGAFDS, the Council is transmitting Resolution 74-1995 to the House of Delegates for its action, with a recommendation to vote no.

Resolution

74-1995. Resolved, that the American Dental Association believes all beneficiaries are entitled to know the basis upon which their benefits are calculated, whether covered by an insured plan or by an ERISA plan, and be it further **Resolved,** that the ADA pursue legislative or regulatory changes to assure the patient's right to this information on a timely basis.

Council on Dental Education

Supplemental Report 1: Request for Recognition of Oral Medicine as a Dental Specialty

Background: On January 1, 1996 the American Academy of Oral Medicine (AAOM) submitted an application for recognition of oral medicine as a dental specialty. The application included information and documentation relating to the sponsoring organization and to the six requirements for dental specialty recognition specified in the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists.*

In accordance with Council policy, notification of receipt of the application was transmitted to ADA constituent and component societies, recognized specialty organizations and certifying boards, the American Association of Dental Examiners and the American Association of Dental Schools through a letter from the Council Director dated January 10, 1996. A notice to the profession regarding receipt of the application was published in the January 22, 1996 issue of the *ADA News.* Comments on the application from interested individuals and organizations were invited.

The Council reviewed the application during its meeting on April 20, 1996. The Council determined that the application failed to demonstrate compliance with all requirements for recognition as specified in the *Requirements.*

Following its consideration of the AAOM application, a detailed report dated April 23, 1996, was transmitted to the AAOM. In accordance with established procedures, the AAOM, in correspondence dated May 20, 1996, requested special appearances before the Committee on Specialty Recognition (Committee G) and the Council on Dental Education. In addition, the AAOM provided a written response dated June 13, 1996 and distributed additional written materials during the special appearance before Committee G. In its deliberations, the Council carefully considered the written response and all information presented during the July 26, 1996 special appearance, as well as the information presented during the special appearance before Committee G held on June 27, 1996.

All submitted information was evaluated in light of the established requirements for the sponsoring organization and for specialty recognition to determine the extent to which compliance with each requirement had been demonstrated. It should be noted that the Council's task was to review the application submitted by the American Academy of Oral Medicine, not the field of oral medicine in a broader sense beyond the application. The burden of proof regarding compliance with the requirements rests with the sponsoring organization and was assessed on the basis of the specific information submitted in the application and comments on the application.

Assessment of Compliance With Each Requirement:

Requirement 1. In order for an area to be recognized as a specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.

After review of all information submitted, the Council concluded that the membership of the AAOM is a nationally and internationally recognized organization in the field of oral medicine. The AAOM membership is actively involved in promoting the art and science of this discipline and in promoting training and research for dentists in oral medicine at the predoctoral, advanced and continuing education levels. The Council noted that in 1955, the AAOM founded and implemented the American Board of Oral Medicine (ABOM).

In discussion of this section, the Council noted that the AAOM demonstrated a stable and long-standing membership within the ten-year period between 1986 and 1995. However, the Council noted that the organization's issues are not limited to the area of the proposed specialty. Rather, the membership reflects many diverse areas, including oral and maxillofacial pathology, oral and maxillofacial surgery, oral and maxillofacial radiology and TMD. And, in fact, in response to the requirement that a specialty's sponsoring organization demonstrate that its membership reflects its area of dental practice, the AAOM provided a "representative sample" of members' publications grouped according to ten categories of different disciplines of dentistry, including some specialties.

Additionally, the Council believed that the parameters of care may be overly broad and that the parameters demonstrated considerable overlap with the specialty of oral and maxillofacial pathology. The Council, however, believed that the AAOM had provided sufficient documentation to demonstrate its membership is reflective of oral medicine and has documented to the Council's satisfaction the ability to establish a certifying board. For these reasons, the Council concluded that the AAOM had demonstrated compliance with this requirement.

Requirement 2. A specialty must be a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards.

In the Council's judgment, the application failed to compare and contrast the predoctoral accreditation standards with the advanced knowledge required for the practice of the proposed specialty. However, the AAOM's written response dated June 13, 1996, provided detailed information comparing and contrasting the predoctoral accreditation standards with the advanced knowledge required for the practice of the specialty. Based on the information included in the written response, the Council believes that sufficient information has been provided to demonstrate that oral medicine is a distinct field which requires knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards.

The AAOM's June 13, 1996 written response also compared and contrasted the advanced skills and levels of proficiency expected of a graduate of the specialty. The Council noted that these areas were broadly stated. The Council believes that these areas should be more distinctly defined as the nature of the curriculum evolves. The AAOM reported that efforts to standardize the oral medicine curriculum throughout all existing training programs has recently begun. Based on its review of the information provided in response to Requirement 2, the Council urges continued refinement of the oral medicine curriculum to delineate areas of proficiency versus competency as well as to identify additional areas that distinguish the discipline from predoctoral education.

The Council also noted that the application's response to Requirement 2 regarding unique knowledge and skills required of a specialist offered a convincing argument that the scope of training outlined in the application goes beyond the scope of the predoctoral accreditation standards. At the same time, the information presented indicates that the proposed specialty overlaps with a number of recognized dental specialties such as periodontics, pediatric dentistry, oral and maxillofacial surgery and oral and maxillofacial pathology.

For example, the scope of oral medicine as defined by the AAOM under Requirement 2 is similar in scope and overlaps with the definition of oral and maxillofacial pathology. The scope of oral medicine is defined by the AAOM as "a primarily non-surgical dental specialty that includes the evaluation, diagnosis, therapeutic management and research into medically-related oral diseases." Information provided in the application gives more specific examples of the diseases. In the same section, the scope of oral and maxillofacial pathology is described as the discipline that deals with "the nature, identification, and management of diseases affecting the oral maxillofacial regions," which "investigates the causes, processes, and effects of these diseases," and the practice of which includes "research and diagnosis of diseases." Issues related to overlap with recognized dental specialties are addressed under the next requirement.

In the Council's judgment, based on information contained in the application and the AAOM's written response, evidence was presented to demonstrate that the advanced knowledge and skills required for the proposed specialty are beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards. The Council concluded that the AAOM has demonstrated that oral medicine is a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral dental accreditation standards. Accordingly, the Council believes that this requirement has been met.

Requirement 3. The scope of the specialty: (a) is separate and distinct from any recognized specialty or combination of recognized specialties; (b) cannot be accommodated through minimal modification of a recognized specialty or combination of recognized specialties.

The Council believed the accreditation standards for advanced education in each of the recognized dental specialty areas require knowledge and skills in oral medicine beyond the predoctoral level. For this reason, the Council believed there was substantial overlap between the proposed specialty and existing specialties such as pediatric dentistry, periodontics, oral and maxillofacial surgery, and, in particular, oral and maxillofacial pathology.

The application, however, suggested that dentistry and the currently recognized specialties are primarily "surgical" in nature, whereas oral medicine "is both surgical and medical." The public, the application noted, routinely approaches the medical profession for treatment of oral disorders and diseases only to be referred to dentist practitioners of oral medicine. Therefore, the application suggested, there is a demonstrated need for oral medicine as an area of specialty practice which would incorporate a more in-depth medical component within dentistry, a component which the AAOM suggests is currently lacking. In the Council's opinion, this assertion mischaracterizes dentistry and the specialty areas of dentistry. The Council believed that the application's distinction in this regard was not a convincing argument for demonstrating that this requirement has been met.

The AAOM's written response and information presented during the special appearance further addressed the AAOM's position that oral medicine can be distinguished from the recognized dental specialties. In the Council's judgment however, the information provides further evidence of the amount of overlap between the recognized specialties and the discipline of oral medicine. Further, the Council noted that as the curriculum of the currently recognized dental specialties and predoctoral dental education continues to evolve, greater emphasis is being placed on the need for all dental practitioners to have increased medical knowledge.

During the special appearance, the AAOM representatives noted disagreement with the comments contained in the Council's April 1996 report which noted that dentistry has been mischaracterized by the AAOM. The AAOM believes that the information contained in its application and in the written response to the Council's January 1996 report documents the need for a specialty in oral medicine. The AAOM stressed during the special appearance that oral medicine specialty practitioners are needed to prepare practitioners for treating more medically complicated patients. The Council disagrees with this assertion. Rather, the Council believes that it is more likely that the practitioners' needs in this area will be accommodated through evolving changes in the curriculum for predoctoral and advanced specialty education.

In conjunction with remarks regarding Requirement 3, the AAOM representatives noted actions recently taken by the Canadian Dental Association's (CDA) Council on Education regarding oral medicine as a dental specialty in Canada. The AAOM provided information concerning the CDA action in correspondence dated June 10, 1996 from the Canadian Academy of Oral Medicine. Subsequently, the Council received formal notification of this action from the CDA in correspondence dated June 26, 1996, from the Council chairman, Dr. David Donaldson.

Based on review of the AAOM written response and the information provided during the special appearance, the Council concluded that the applicant failed to present sufficient evidence to demonstrate that this requirement has been met. Rather, the Council believed the information provided further demonstrates the amount of overlap that currently exists between oral medicine and some recognized dental specialties.

Additionally, the Council noted that the application states that oral medicine "could conceptually be incorporated within

the scope of an enlarged diagnostic/pathology specialty." The Council believed a strong case had been presented showing that, in fact, oral medicine could be incorporated into the specialty of oral and maxillofacial pathology, based on the information provided in the application. For these reasons, and taking into consideration the information provided above in this report under Requirement 2 regarding overlap in scope with several dental specialties, the Council was of the opinion that the application and all additional information provided failed to present a compelling argument that oral medicine is separate and distinct from any recognized specialty or combination of recognized specialties, or that the proposed specialty cannot be accommodated through minimal modification of a recognized specialty or combination of recognized specialties. Accordingly, the Council concluded that the AAOM failed to demonstrate compliance with this requirement.

Requirement 4. In order to be recognized as a specialty, substantial public need and demand for services which are not adequately met by general practitioners or dental specialists must be documented.

In the Council's judgment, the data presented in the application did not present a convincing argument for the need for services provided by this area of practice. It was noted that the application appears to reflect that the required services are being provided by others. Although the data presented reflects some demand for oral medicine services, the data appears to reflect that these services are being provided by the general dentist or the dental specialist. The application notes that medically compromised and geriatric patients represent populations to be served by dentists appropriately trained in oral medicine. However, the application goes on to note that services to these patient populations are currently being provided by both general dentists and specialists, particularly by the oral and maxillofacial surgeon and the pediatric dentist.

As noted under Requirement 3, the application stated that the public routinely approaches the medical profession for treatment of oral disorders and diseases only to be referred to dentist practitioners of oral medicine. Therefore, the application suggested, because the medical profession routinely refers the public to the dentist oral medicine practitioner, there is a demonstrated need for oral medicine as an area of dental specialty practice. However, the Council noted that the application's documentation of referral patterns specified only the source of the referral, the percentage and frequency of referrals, failing to specify the actual disease, the setting or the category of practitioner to which those referrals were made. The Council concluded that sufficient evidence was not presented regarding the need for the dental specialty of oral medicine.

Additionally, in considering the number of dentists currently devoting full-time to the practice of the proposed specialty, the Council noted with concern the extremely low numbers of full-time practitioners of oral medicine. Because the numbers are significantly low, the Council questioned the application's contention that there is overwhelming need and demand for the proposed specialty.

The AAOM written response noted a 1996 survey distributed at a recent AAOM meeting. The final results of the survey were noted by the Council during the AAOM's special appearance. The survey information was compiled to demonstrate that Requirement 4 has been met; however, information was also included in the presentation regarding requirements 2 and 3. Based on the information provided, the Council believes that the oral medicine practices described in the survey data are highly diverse, given that they represent a variety of private settings (university faculty practice/dental school clinic), private practice, government clinic, medical center and nursing home.

The Council believed that the data presented reflects that many patient populations remain underserved; however, no data was presented to indicate that people in underserved areas are suffering due to the lack of care provided by oral medicine practitioners. The Council determined that insufficient documentation was provided to demonstrate that this requirement has been met.

Accordingly, in the Council's judgment, the AAOM failed to present sufficient evidence to document that there is substantial public need and demand for services which are not adequately met by general practitioners or specialists.

In the area of projected need for practitioners in the specialty over the next five years, taking into account disease trends, demographic changes and other pertinent factors, the Council noted that the data provided in the application were more anecdotal rather than actual data. The narrative provided regarding this requirement addressed the issue in relation to the projected increasing geriatric and medically-compromised patient population, suggesting increasing medical and dental complications related in particular to the patient's age and HIV and AIDS status.

Based on the information provided, the Council concluded that the AAOM failed to demonstrate that there is substantial public need and demand for the services provided by the dentist who practices oral medicine.

Requirement 5. A specialty must directly benefit some aspect of clinical patient care.

The Council noted that the proposed specialty includes clinical practice, providing a health service to the public in private practice, the hospital, laboratory, institutional and community health setting. The services provided include physical diagnosis, radiograph technique and interpretation, treatment planning, management of medically compromised patients, diagnosis and management of head and neck pain, and treatment of oral soft tissue lesions. Based on the information provided in this section of the application, the Council agreed that the sponsoring organization has demonstrated that the proposed specialty directly benefits some aspect of clinical patient care. Accordingly, the Council concluded that this requirement has been met.

Requirement 6. Formal advanced education programs of at least two years beyond the predoctoral curriculum as defined by the Commission on Dental Accreditation's *Standards for Advanced Specialty Education Programs* must exist to provide the special knowledge and skills required for the practice of the specialty.

In its review of this section of the application, the Council noted that there are ten programs in the United States of at least two years of length that provide special knowledge and skills required for the practice of the proposed specialty. The

sample curricula provided supports the advanced knowledge and skills as described elsewhere in the application. Further, based on the curricula provided, the Council believed that the proposed training requires at least two years beyond the predoctoral curriculum. For these reasons, the Council concluded that the AAOM has demonstrated compliance with this requirement.

Summary: Following careful review of the application for recognition of oral medicine as a dental specialty, the Council determined that:

The AAOM has **demonstrated** that it is represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.

The AAOM has **demonstrated** that oral medicine is a distinct and well-defined field which requires knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards.

The AAOM has **not demonstrated** that the scope of oral medicine (a) is separate and distinct from any recognized specialty or combination of recognized specialties; and (b) cannot be accommodated through minimal modification of a recognized specialty or combination of recognized specialties.

The AAOM has **not demonstrated** substantial public need and demand for oral medicine services which are not adequately met by general practitioners or dental specialists.

The AAOM has **demonstrated** that oral medicine directly benefits some aspect of clinical care.

The AAOM has **demonstrated** that formal advanced education programs of at least two years beyond the predoctoral curriculum as defined by the Commission on Dental Accreditation's *Standards for Advanced Specialty Education Programs* exist to provide the special knowledge and skills required for practice of the specialty.

For these reasons, the Council approved the following resolution for transmittal to the Association's 1996 House of Delegates.

Resolution

80. Resolved, that the American Academy of Oral Medicine's request for the recognition of oral medicine as a dental specialty be denied.

Council on Dental Education

Supplemental Report 2: Issues Related to Overlap in Scope Between Oral Medicine, Oral and Maxillofacial Radiology and Oral and Maxillofacial Pathology

Background: In conjunction with its consideration of two applications for specialty recognition during 1996, the Council on Dental Education and its Committee on Specialty Recognition (Committee G) noted the significant areas of overlap that repeatedly appeared between the two disciplines requesting specialty recognition and the specialty of oral and maxillofacial pathology. Additionally, the application materials submitted by the American Academy of Oral Medicine (AAOM) and the American Academy of Oral and Maxillofacial Radiology (AAOMR) noted degrees of overlap with the specialty of oral and maxillofacial pathology. Having completed its consideration of both applications, the Council believes that issues related to overlap require further study.

Past experiences to bring the three areas together as a combined, broader specialty were described in both the AAOM and the AAOMR specialty recognition applications. The Council believes it has a responsibility to the profession to be proactive in discussing this matter with the representatives of the three organizations. The Council is prepared to take the necessary steps to address this important matter.

Further, the Council believes there is sufficient rationale to support the need for the Council to conduct a study since these issues impact on the scope of practice of dentistry. For these reasons, at its July 1996 meeting, the Council determined that it should begin to address this issue at its next meeting scheduled for October 1996. Further, the Council directed that the Board and the House be advised of the Council's intent to study issues related to the overlap in scope between oral medicine, oral and maxillofacial radiology and oral and maxillofacial pathology. Additionally, the Council believes that the discipline of oral facial pain should be included in its study.

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

Council on Dental Practice

Supplemental Report 1: Seamless Electronic Patient Record

Background: In August 1990, the Department of Dental Informatics (DDI) was created to focus greater attention on the emerging informatics industry and to participate in standards-setting activities affecting administrative and clinical applications in dental practice.

The field of dental informatics is rapidly evolving as a discipline. Regardless of how broadly or narrowly dental informatics is defined, the primary goals of dental informatics are to improve patient care and increase dental office administration efficiency.

The DDI manages and coordinates various projects related to dental informatics for the Councils on Dental Benefit Programs, Dental Practice and Scientific Affairs. The following information represents some of the Association's dental informatics activities.

Computer-Based Patient Record: With the capability of collecting and organizing vast amounts of clinical information into longitudinal paper records, providers of health care can get a better view of all the encounters their patients have had with the delivery system. By building clinical databases, researchers will be able to study treatment patterns and the outcomes of care.

Therefore, as directed by the House of Delegates and managed by the Council on Dental Practice, the Association participates with a number of organizations working on the development of national standards for a computer-based patient record. The Association's participation in these projects is crucial in order to coordinate the dental informatics activities with the other national standards being developed in health care. Without the Association's efforts, standards would be modified *to* dentistry rather than developed specifically *for* the profession.

Computer-Based Oral Health Record (COHR): It is important for certain patient health information to be available to all practitioners who provide health care, regardless of their profession, discipline or specialty. In fact, it is critical that there be data compatibility throughout the health care system so that there will be significant benefits to all patients, practitioners and other system users.

In 1994-95, the Council created a Subcommittee on Computer-Based Oral Health Records to establish the basic content elements of the COHR. The Subcommittee included volunteer members who had expertise in paper-based dental records systems and computer applications in clinical care, and experience developing computer-based records systems in academia and the government. The Subcommittee's objective was to develop COHR features which offered the greatest utility to the profession as a whole, addressed issues of open architecture and would be independent of the technology used.

In July 1995, the Subcommittee released a working draft called the COHR Concept Model Version 0.9. Comments were received and revisions were recommended. The baseline version 1.0 of the COHR Concept Model was released in February 1996. It represents the consensus of a large body of reviewers.

The COHR Concept Model was prepared based upon the clinical process and it was determined that the following areas needed to be incorporated into the Concept Model:

Step 1: Acquiring data about the patient and creating a patient database;

Step 2: Analyzing the data and determining the diagnosis;

Step 3: Developing the treatment plan;

Step 4: Intervention and collection of treatment data; and

Step 5: Assessment of the effectiveness of the treatment plan and the treatment provided to patients under professional management.

The COHR Concept Model was prepared based upon the data requirements of these five steps. The key segment of the model is the encounter where professional services are provided. The Concept Model is patient-focused, which means that is was designed around the patient, the treatment plan and the services provided to the patient. Additional segments of the model identify the data required to process patient specimens and provide supporting functions, such as patient registration and communications.

The COHR Subcommittee has completed its work and made its recommendations. The next procedure is to create standard specifications for a COHR through the development of a logical model. The logical model is being developed by the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) MD156. The Association is the sponsor and secretariat of the ASC MD156. The ASC MD156 is developing interfaces for a computer-based oral health record based upon a design that will allow access to all segments of the health care system. This is referred to as an open architecture information design. The purpose is to allow the integration of different health care components into one system to allow a clinician easy and timely access to all information needs.

The result of the Association's efforts will be a computer-based oral health record standard adopted by ANSI, a "blueprint," against which commercial vendors can build uniform practice management systems. The Association's work in this area is the fundamental step necessary to ensure data compatibility among systems and all health care professionals. This is the first step on the journey toward creating data exchange without barriers for authorized health care professionals.

On the national level, standard development efforts continue and are aimed at designing an overall computer-based patient record. The computer-based oral health record is conceived to be an integrable, compatible portion of the comprehensive patient medical record. The Association will continue to

participate in the activities associated with all aspects of its development.

Health care information has value in the context of its contribution to a beneficial outcome of patient care. Five criteria characterize information for timely and economical delivery of quality health services:

- Quality—complete and accurate information must be available;
- Utility—information must be presented in a form suitable to the user;
- Proximity—information must be available at the time and place of care;
- Accessibility—information must be available to all authorized health care professionals, with no electronic barriers because of profession, specialty, discipline, or type of delivery setting; and
- Confidentiality—access to information must be limited to only those authorized parties having patient consent.

It is important that the Association establish as its policy the concept that the computer-based patient health record should be developed in an open architecture format so there are no electronic barriers to communication between the different segments of the health care system. The computer-based oral health record should be easily integrated into the patient's overall health record.

Based upon the information in this report, the Council recommends adoption of the following resolution.

Resolution

92. Resolved, that the American Dental Association believes that, for optimal patient benefit, appropriate health information should be available to practitioners authorized by the patient at the time and place of care through the development of a computer-based patient health record whose architecture is open and compatible with all segments of the health care system, with no barriers based upon profession, specialty or discipline of the provider or the type of care delivery setting.

Council on Ethics, Bylaws and Judicial Affairs

Supplemental Report 1: Recent Council Activities

Background: The following reports on Council activities completed after publication of the Council's 1996 annual report to the House of Delegates. Included in the report are actions taken on the following House resolutions: 138-1995 (*Trans.*1995:607); 15H-1995 (*Trans.*1995:660) and 100H-1994 (*Trans.*1994:638).

Meetings: The Council held its second meeting of the year on June 1-3, 1996 at the Headquarters Building in Chicago. Dr. Robert M. Anderton, Fifteenth District trustee, attended the meeting as liaison to the Council for the Board of Trustees.

Judicial Procedures: At its June meeting, the Council heard the appeal of a member from the disciplinary decision of her constituent society expelling her from membership for unethical billing practices and failure to timely comply with the reasonable requests of a duly constituted committee of her constituent and component societies. The decision and opinion of the Council will be provided in a subsequent report.

Response to Assignments from the 1995 House of Delegates:

Definition of "Elect" as Found in the Bylaws. At the request of the Council on Membership (CM), the Council identified every place where the word "elect" in one of its forms is used in the ADA *Bylaws*. Based on this review, the Council advised CM about what the effect would be of defining the word "elect" as proposed in Resolution 138-1995 (*Trans.*1995:607), to mean to select by vote. The Council recommended to CM that the councils forward alternative language to the 1996 House of Delegates for its consideration. This recommendation is presented in the Joint Report of the Council on Ethics, Bylaws and Judicial Affairs and the Council on Membership: Definition of the Word "Elect" as Found in the *Bylaws* to Mean "Select" by Vote.

Sunset Review of Association Policy. Pursuant to Resolution 15H-1995 (*Trans.*1995:660), the Council at its June meeting reviewed 18 Association policies relating to ethics.

The Council concluded that certain policies dealing with dental advertising are out-of-date, refer to Association policy that no longer exists or have been superseded by other Association policy. The Council recommends that these policies be rescinded as follows.

54. Resolved, that the following resolutions relating to advertising by dentists be rescinded:

Resolution 71H-1977 (*Trans.*1977:947), Advertising by Members;

Resolution 72H-1977 (*Trans.*1977:948), Advertising by Dentists; and

Resolution 48-1971-H (*Trans.*1971:530), Ethical Announcement as a Specialist.

The Council also recommends rescission of Resolution 61-1975-H (*Trans.*1975:728), Fourth-Party Franchise Dental Delivery Systems, since this policy relies on a section of the *ADA Principles of Ethics and Code of Professional Conduct* (the *Code*) that no longer exists. Accordingly, the Council transmits the following resolution.

55. Resolved, that Resolution 61-1975-H (*Trans.*1975:728), Fourth-Party Franchise Dental Delivery Systems, be rescinded.

By recommending that Resolution 61-1975-H be rescinded, the Council is not implying that there are no ethical ramifications involved in dentists working for nondentists. Any practice arrangement that interferes with the dentist's ability to exercise his or her independent professional judgment raises an ethical concern. Of course, this can also be a problem when one dentist is employed by another. The Council plans to discuss the ethical aspects of ownership of practice at its next meeting in January 1997.

Finally, the Council recommends that Resolution 3H-1977 (*Trans.*1977:922), Announcement in More Than One Special Area of Practice, be updated as follows.

56. Resolved, that Resolution 3H-1977 (*Trans.*1977:922), Announcement in More Than One Special Area of Practice, be amended by deleting the first resolving clause and, in the second sentence of the second resolving clause, by reversing the order of the words "announcing" and "ethically;" inserting the word "former" before the words "Section 18;" and inserting the words "of the *Principles of Ethics*" after the words "Section 18," so the amended resolution reads as follows:

Resolved, that the educational criteria for announcement of limitation of practice in additional specialty areas be the successful completion of an educational program accredited by the Commission on Dental Accreditation in each area for which the dentist wishes to announce. Dentists who are presently ethically announcing limitation of practice in a specialty area, and who wish to announce in an additional specialty area and who are qualified educationally in more than one recognized dental specialty by virtue of three years of advance training in oral and maxillofacial surgery or two years of advance training in one of the other recognized dental specialties prior to the accreditation of such programs in 1967, but who were not permitted to announce limitation of practice in more than one area prior to the 1974 revision of former Section 18 of the *Principles of Ethics*, must submit documentation to the appropriate constituent society of successful completion of the requisite education in programs listed by the Council on Dental Education in each area for which they wish to announce or their certification as diplomates in each special area they wish to announce.

Response to Assignment from the 1994 House of Delegates:

Review of Effect of Code on ADA Policies Regarding Dental Benefits Plans. The Council continued work on Resolution 100H-1994 (*Trans.*1994:638) dealing with the ethical implications of dental benefits plans. Earlier Council actions implementing this resolution are described in the Council's annual reports to the 1995 and 1996 House of Delegates. In June, the Council discussed four issues that were identified for further study by a joint Council on Ethics, Bylaws and Judicial Affairs (CEBJA)/Council on Dental Benefit Programs (CDBP) work group: patient abandonment, confidentiality of patient records, cost-shifting and informed consent.

With regard to patient abandonment, the Council directed staff to develop an amendment to the *Code* for consideration by the Council and possible presentation to the 1997 House of Delegates. The purpose of the amendment will be to make clear that it is unethical for a dentist to discontinue treatment of a patient without giving the patient adequate notice and the opportunity to obtain the services of another dentist. Termination of a contract relationship with a third-party payer to provide services to a group of patients does not excuse the dentist from the ethical obligation not to abandon patients.

The Council agreed that confidentiality of patient records is adequately addressed in the *Code* but recognized that members may not be aware of how the *Code* applies in specific situations, such as audits of patient records by third parties. The Council directed that an article providing guidance to the membership on this subject be prepared for publication.

The Council considered whether it is ethical for dentists to shift costs between groups of patients. Cost-shifting may be defined as allocating the cost of services unequally among patients so that selected groups of patients pay proportionately less of the cost of dental services than other patients do for the same services. The Council believes that questions about the amount that dentists charge their patients and how those fees are structured are individual business decisions and not a proper subject for ethical regulation. On the other hand, the Council believes that how dentists represent their fees to patients and third-party payers has significant ethical ramifications which are addressed in the *Code*, Section 1-L. REPRESENTATION OF FEES. Section 1-L states that dentists shall not represent the fees being charged for providing care in a false or misleading manner. The Council concluded that cost-shifting is not something that should be regulated by the *Code* unless misrepresentation of fees is involved.

Finally, the Council considered whether a dentist has an ethical obligation to inform patients of the features of a dental plan, and, in particular, of any financial incentives that might influence the dentist's treatment recommendations. The Council noted that the *Code* places on dentists an ethical obligation to put the patient's welfare first. This obligation is the same regardless of whether the dentist engages in fee-for-service, managed care or some other practice arrangement. Dentists may not allow dental plan design or operation to interfere with the exercise of their independent judgment about what is in the patient's best interest. The Council also noted that the *Code*, Section 1-M. PATIENT INVOLVEMENT, requires dentists to inform patients of the proposed treatment, and any reasonable alternatives, in a manner that allows the patient to become involved in treatment decisions. The Council acknowledged that situations might arise that would require the dentist to disclose to the patient some information about a dental plan that was needed to facilitate the patient's informed decision making. This might include information about a withhold or bonus arrangement, gatekeeper provision or least expensive alternative treatment (LEAT) clause.

However, the Council questioned how useful such information would be to the patient if provided by the dentist at the time of treatment. In the Council's opinion, information about a dental benefit plan would be much more meaningful to the patient if it was made available at the time the patient selected the particular dental plan. Also, those who design or purchase a dental plan are in the best position to understand and explain the plan's features. For these reasons, the Council believes that the better option is the approach taken by the Board of Trustees earlier this year which would legislate disclosure by plan purchasers of the financial incentives agreed to between a health plan and its providers. The Council also supports the Board's interim policy calling for a ban on so-called "gag" clauses in dental provider contracts, since these clauses are a potential obstacle to the dentist's ability to provide information which the patient needs to become involved in treatment decisions.

Council Activities:

Review of Council Seminars. The Council agreed to make three Council-sponsored seminars available in the coming year: 1) the ethics component of the SUCCESS Program for junior and senior dental students ("Starting Your Dental Practice: An Ethical Perspective"); 2) a seminar for general dental audiences which uses a case study approach to managed care ("Ethical Issues in Managed Care"); and 3) a training program on the judicial process for members of constituent/component society ethics and judicial committees. The Council agreed to ask the Committee on the New Dentist for help in recruiting speakers for the increasingly popular SUCCESS Program.

Sale of Products by Dentists. The Council responded to a request for guidance from a constituent society concerning the scope of the Council's recent advisory opinion on the sale of products by dentists to their patients (Advisory Opinion 2 to Section 4-A. DEVICES AND THERAPEUTIC METHODS of the *Code*). The advisory opinion cautions dentists who engage in the sale of dental products to their patients to take care not to exploit the trust inherent in the dentist-patient relationship for their own financial gain. It prohibits dentists from inducing their patients to buy dental products by misrepresenting the product's therapeutic value. The constituent society asked for guidance on whether vitamins and nutritional supplements are covered by the advisory opinion. The Council decided that the term "dental products" applies to any product that is recommended in connection with a dental condition. Vitamins and nutritional supplements would be covered by the advisory opinion if they met this definition.

The Council also considered a request from the Board of Trustees to reconsider Advisory Opinion 2 to Section 4-A to take into account the issue of professionalism. After conducting a thorough review of the advisory opinion, the Council concluded that it properly addresses the dentist's

professional relationship to his or her patients. The Council noted that the advisory opinion is designed to protect patients from abuse of the trust inherent in the dentist-patient relationship. Patients trust the dentist's judgment about dental matters; they expect the dentist to have special expertise in all things relating to dentistry. This trust places on dentists an affirmative duty to be impartial, open and strictly accurate in the representations they make to their patients about dental products and services. On the other hand, recommendations the dentist may make about nondental products would not generally implicate the dentist-patient relationship, since they are not founded on the dentist's professional expertise. Absent exceptional circumstances, the Council is of the opinion that such recommendations are not a proper subject of a code of professional conduct.

Advertising by Dentists. A constituent society asked the Council to review a proposed advisory opinion to the constituent's code of ethics dealing with use of the phrase "practice limited to" by general dentists. The *Code* provides that the constituent societies may adopt additional ethical requirements or interpretations of their ethics codes as long as these are not inconsistent with the *Code*. The Council discussed the constituent's request at its June meeting and determined that the proposed advisory opinion was not inconsistent.

The proposed advisory opinion to the constituent society's ethics code would require general dentists who announce that their practices are limited to a particular area of dentistry to disclose that the services were being provided by a general dentist. In addition, if the area of practice was not a specialty recognized by the Association, the dentist would be required to state that fact. Section 5-D. GENERAL PRACTITIONER ANNOUNCEMENT OF SERVICES, of the *Code* prohibits general dentists from advertising services in a manner that is false or misleading by, for example, making statements that express or imply specialization where none exists. Nothing in the *Code* expressly addresses use of the phrase "practice limited to" by general dentists.

The Council believes that the phrase "practice limited to" has assumed a secondary meaning because of its common usage by dental specialists. In the Council's opinion, the phrase has become so closely associated in the public's mind with the ADA-recognized specialties, that its use by general dentists is likely to mislead consumers about the general dentist's education and training. The use of disclaimers of the type proposed by the constituent society could be effective in some contexts for avoiding deception. The use of a disclaimer is consistent with the stipulation in the *Code* that general dentists may announce services available in their practices but shall state that the services are being offered by general dentists. However, any claim must be viewed in the context of the advertisement as a whole. A disclaimer might not be sufficient to avoid deception in all cases. The touchstone for all promotional activity by dentists under the *Code* will continue to be whether the activity is false or misleading in a material respect. Dentists should also be aware that at least one state dental board (Ohio) has determined that use of the term "practice limited to" by a general dentist is inconsistent with that state's system of regulating dental specialties and specialists.

Medicaid Referrals. The Council considered a request from a constituent society for advice on Medicaid referral practices. The constituent received a complaint that some general dentists were making inappropriate referrals of Medicaid patients for services which the general dentists could, and normally would, provide themselves. According to the complaint, the general dentists performed an initial oral examination and a prophylaxis. If the examination revealed that the patient needed restorative work, the patient was referred to a pediatric dentist for care. The alleged motive for the referral was solely financial, although the Council noted that there was no objective evidence to corroborate this allegation. It is true that restorative services are reimbursed at a lower rate than preventive services under the Florida Medicaid program.

The Council looked to the *Code*, Section 1-E. CONSULTATION AND REFERRAL, which provides general guidance on the circumstances in which dentists are obliged to seek consultation and make referrals when doing so would be in the patient's best interest. Section 1-D does not address the circumstances in which referrals might be inappropriate. The Council discussed the extreme difficulty of proving an improper motive for making a referral decision. The "General Guidelines for Referring Dental Patients" of the Council on Dental Practice list a number of accepted reasons for making patient referrals that are not related to the dentist's competence. The Council concluded that the practice of making referrals based purely on economic reasons rather than on the dentist's competence is distasteful, but agreed that the problem in this case could best be resolved through the legislative or regulatory process by seeking adequate Medicaid reimbursement for restorative services.

Editorial Review of ADA Constitution and Bylaws. In 1994, the Council appointed a Subcommittee on ADA *Constitution and Bylaws* to undertake, among other things, a comprehensive editorial review of the ADA *Bylaws*. In 1995, the Council wrote to other ADA councils and commissions asking them for their input on the project and received several suggestions. The Council also requested and received guidance from the Board of Trustees. The Subcommittee completed its review in 1996 and submitted its recommendations to the Council in June. Based on these recommendations, the Council is forwarding the resolution below for the House's consideration. The amendments it contains would only make editorial changes in the *Bylaws* to improve their consistency, clarity and style. No substantive changes to the *Bylaws* are proposed in this resolution.

57. Resolved, that the following editorial changes to the ADA *Constitution and Bylaws* be approved:

Amend Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection A. ACTIVE MEMBER, by deleting the word "doctor" in line 85 and substituting in its place the word "physician."

Amend Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection B. LIFE MEMBER, in the first sentence of the first paragraph by adding the numeral "1" in parentheses between the words "who" and "has" and adding the numeral "2" in parentheses between the words "and" and "has."

Amend Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection C. STUDENT MEMBER, by adding the words "eligible to be" after the word "be" on line 143 and by deleting the word "may" on line 153 and substituting in its place the words "shall be eligible to be."

Amend Chapter V. HOUSE OF DELEGATES, Section 80. SPECIAL SESSIONS, by deleting in the first sentence the word "of" from between "President" and "three-fourths" and substituting in its place the words "on a."

Amend Chapter VII. BOARD OF TRUSTEES, Section 20. QUALIFICATIONS, by deleting the number "80" in line 1134 and substituting in its place the number "90."

Amend Chapter VII. BOARD OF TRUSTEES, Section 40. NOMINATION, Subsection B. MULTIPLE CONSTITUENT DISTRICTS, by deleting in the second paragraph the word "considered" on line 1160 and substituting in its place the word "reconsidered."

Amend Chapter VII. BOARD OF TRUSTEES, Section 60. ELECTION, Subsection B., by deleting the number "140" on line 1186 and substituting in its place the number "150."

Amend Chapter VII. BOARD OF TRUSTEES, Section 100. POWERS, Subsection C., by deleting the number "70" on line 1237 and substituting in its place the number "80."

Amend Chapter VII. BOARD OF TRUSTEES, Section 100. POWERS, Subsection I., by deleting at the end of the subsection the phrase "and that all interim actions of the Board must be approved by the House of Delegates" and substituting in its place the phrase "subject to the requirement that all interim actions of the Board must be approved by the House of Delegates."

Amend Chapter VII. BOARD OF TRUSTEES, Section 110. DUTIES, Subsection E., by deleting the number and letter "40B" on line 1276 and substituting in their place the number and letter "50B."

Amend Chapter XII. PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT AND JUDICIAL PROCEDURE, Section 20. DISCIPLINE OF MEMBERS, Subsection D. APPEALS, Paragraph c. BRIEFS, by deleting the word "elect" in the last sentence and by substituting in its place the word "choose."

Authority for Mail Ballots. The Association has adopted *Sturgis Standard Code of Parliamentary Procedure* to govern ADA agencies in cases where the ADA *Bylaws* are silent on a point of procedure. *Sturgis* recommends that if an organization uses mail ballots to make decisions between meetings, the use of mail ballots should be expressly authorized in the organization's bylaws. The ADA *Bylaws* do not expressly authorize mail ballots. This appears to be an oversight, since mail ballots are widely used by ADA agencies, and procedures for mail ballots are provided for in the *Standing Rules for Council and Commissions* and *Organization and Rules of the Board of Trustees*. In conformance with *Sturgis*, the Council proposes the following amendment.

58. Resolved, that Chapter VII. BOARD OF TRUSTEES, Section 100. POWERS, of the ADA *Bylaws* be amended by the addition of a new letter J to read:

> J. It shall have the power to transact its business by mail ballot in accordance with the laws of the State of Illinois, to authorize the councils, commissions and committees of this Association to transact their business by mail ballot, and to establish rules and procedures for itself and for councils, commissions and committees of this Association to govern the use of mail ballots.

The Council intends the term "mail ballot" to include the use of facsimile (fax) transmission. The Council considered a proposal that the *Bylaws* authorize balloting by electronic transmission (e-mail), but decided that the law governing the authenticity of electronic documents is too unsettled for the Association to adopt this procedure at the present time.

Advisory Opinions: In the course of reorganizing the *Code*, the Council determined that certain of its advisory opinions would benefit from editorial changes to give them greater clarity and consistency. The Council adopted these changes, set forth below, at its June meeting. The changes will be reflected in the next edition of the *Code* scheduled for publication in January 1997.

Removal of Amalgam Restorations. The Council deleted the second paragraph of Advisory Opinion 1 to the *Code*, Section 1-K. REPRESENTATION OF CARE, because the requirement of a fair hearing before a dentist may be found to have breached the *Code* applies to all ethical obligations, not just the removal of amalgam restorations. The deleted paragraph has been inserted in the section on "Interpretation and Application" of the reorganized ADA *Code* which the Council is proposing to the 1996 House of Delegates (Supplemental Report 2: Reorganization of *ADA Principles of Ethics and Code of Professional Conduct*). As amended by the Council, the advisory opinion reads (deleted material is struck through):

> 1. Based on available scientific data, the ADA has determined through the adoption of Resolution 42H-1986 (*Trans.*1986:536) that the removal of amalgam restorations from the non-allergic patient for the alleged purpose of removing toxic substances from the body, when such treatment is performed solely at the recommendation or suggestion of the dentist, is improper and unethical. ~~The Council reminds constituent and component societies that before a dentist can be found to have breached any ethical obligation the dentist is entitled to a fair hearing.~~

Examples of "False and Misleading." The Council deleted the first sentence of Advisory Opinion 2 to the *Code*, Section 5-A. ADVERTISING, and repositioned a portion of it to the second sentence. The Council determined that most of the first sentence was self-evident and added no additional meaning to the advisory opinion. As amended, Advisory

Opinion 2 reads (deleted language is stricken; new language is shaded):

2. ~~The Council on Ethics, Bylaws and Judicial Affairs believes it would be of service to the members to provide some insight into the meaning of the term "false and misleading in a material respect." Therefore,~~ The following examples are set forth to provide insight into the meaning of the term "false or misleading in a material respect." These examples are not meant to be all-inclusive. Rather, by restating the concept in alternative language and giving general examples, it is hoped that the membership will gain a better understanding of the term. With this in mind, statements shall be avoided which would: a) contain a material misrepresentation of fact, b) omit a fact necessary to make the statement considered as a whole not materially misleading, c) be intended or be likely to create an unjustified expectation about results the dentist can achieve, and d) contain a material, objective representation, whether express or implied, that the advertised services are superior in quality to those of other dentists, if that representation is not subject to reasonable substantiation.

Subjective statements about the quality of dental services can also raise ethical concerns. In particular, statements of opinion may be misleading if they are not honestly held, if they misrepresent the qualifications of the holder, or the basis of the opinion, or if the patient reasonably interprets them as implied statements of fact. Such statements will be evaluated on a case by case basis, considering how patients are likely to respond to the impression made by the advertisement as a whole. The fundamental issue is whether the advertisement, taken as a whole, is false or misleading in a material respect.

Summary of Resolutions

54. Resolved, that the following resolutions relating to advertising by dentists be rescinded:

Resolution 71H-1977 (*Trans.*1977:947), Advertising by Members;

Resolution 72H-1977 (*Trans.*1977:948), Advertising by Dentists; and

Resolution 48-1971-H (*Trans.*1971:530), Ethical Announcement as a Specialist.

55. Resolved, that Resolution 61-1975-H (*Trans.*1975:728), Fourth-Party Franchise Dental Delivery Systems, be rescinded.

56. Resolved, that Resolution 3H-1977 (*Trans.*1977:922), Announcement in More Than One Special Area of Practice, be amended by deleting the first resolving clause and, in the second sentence of the second resolving clause, by reversing the order of the words "announcing" and "ethically;" inserting the word "former" before the words "Section 18;" and inserting the words "of the *Principles of Ethics*" after the words "Section 18," so the amended resolution reads as follows:

Resolved, that the educational criteria for announcement of limitation of practice in additional specialty areas be the successful completion of an educational program accredited by the Commission on Dental Accreditation in each area for which the dentist wishes to announce. Dentists who are presently ethically announcing limitation of practice in a specialty area, and who wish to announce in an additional specialty area and who are qualified educationally in more than one recognized dental specialty by virtue of three years of advance training in oral and maxillofacial surgery or two years of advance training in one of the other recognized dental specialties prior to the accreditation of such programs in 1967, but who were not permitted to announce limitation of practice in more than one area prior to the 1974 revision of former Section 18 of the *Principles of Ethics*, must submit documentation to the appropriate constituent society of successful completion of the requisite education in programs listed by the Council on Dental Education in each area for which they wish to announce or their certification as diplomates in each special area they wish to announce.

57. Resolved, that the following editorial changes to the ADA *Constitution and Bylaws* be approved:

Amend Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection A. ACTIVE MEMBER, by deleting the word "doctor" in line 85 and substituting in its place the word "physician."

Amend Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection B. LIFE MEMBER, in the first sentence of the first paragraph by adding the numeral "1" in parentheses between the words "who" and "has" and adding the numeral "2" in parentheses between the words "and" and "has."

Amend Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection C. STUDENT MEMBER, by adding the words "eligible to be" after the word "be" on line 143 and by deleting the word "may" on line 153 and substituting in its place the words "shall be eligible to be."

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Amend Chapter VII. BOARD OF TRUSTEES, Section 110. DUTIES, Subsection E., by deleting the number and letter "40B" on line 1276 and substituting in their place the number and letter "50B."

Amend Chapter XII. PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT AND JUDICIAL PROCEDURE, Section 20. DISCIPLINE OF MEMBERS, Subsection D. APPEALS, Paragraph c. BRIEFS, by deleting the word "elect" in the last sentence and by substituting in its place the word "choose."

58. Resolved, that Chapter VII. BOARD OF TRUSTEES, Section 100. POWERS, of the ADA *Bylaws* be amended by the addition of a new letter J to read:

J. It shall have the power to transact its business by mail ballot in accordance with the laws of the State of Illinois, to authorize the councils, commissions and committees of this Association to transact their business by mail ballot, and to establish rules and procedures for itself and for councils, commissions and committees of this Association to govern the use of mail ballots.

Council on Ethics, Bylaws and Judicial Affairs

Supplemental Report 2: Reorganization of the *ADA Principles of Ethics and Code of Professional Conduct*

This report consists of the recommendations of the Council on Ethics, Bylaws and Judicial Affairs for the comprehensive reorganization of the *ADA Principles of Ethics and Code of Professional Conduct* (the *Code*) around true ethical principles. The Council also recommends that the preamble and the "Interpretation and Application" section of the *Code* be revised and that an introduction and table of contents be added.

The Council is not proposing any substantive changes to the *Code of Professional Conduct* at this time. The existing sections of the *Code* would simply be reorganized to fall under the ethical principles which best serve as their foundation. Similarly, no substantive changes have been made in the Council's advisory opinions interpreting the *Code*. At its June 1996 meeting, the Council made minor editorial changes in two advisory opinions which are reflected in the proposed *Code* appended to this report. These changes are reported in the Council's Supplemental Report 1: Recent Council Activities.

Background: This report represents the culmination of a two-year Council effort to develop a more practical and user-friendly ethics code. As practicing dentists, Council members are well aware of the limitations of the present *Code* as a guide to dentists who are looking for practical answers to the ethical problems they confront on a daily basis. Through its experience with the ethics component of the SUCCESS Program for junior and senior dental students, the Council has also come to recognize the *Code*'s shortcomings as a teaching tool. In 1994, the Council appointed the ADA *Constitution and Bylaws* Subcommittee (subsequently renamed the Editorial Review Subcommittee) to spearhead the *Code* reorganization project.

The subcommittee began by researching the theories of leading thinkers on dental ethics about the purpose and structure of modern ethics codes. It was determined that an ethics code should serve three general purposes: to inspire, to educate and to regulate. The *Code* inspires by articulating the aspirational tenets, or principles, upon which professional conduct is founded. It educates dental students and new dentists about what it means to be a professional by enunciating the ethical commitments which dentists make to their patients and to society. The *Code* regulates by clearly articulating the standards of professional conduct and, in the absence of a specific obligation, provides principles to which the dentist can look for guidance.

Based on its research, the subcommittee prepared a draft of the *Code* reorganization which was sent to the ethicists for review and comment. The subcommittee worked on succeeding drafts throughout 1995 and 1996 with periodic guidance from the Council. The subcommittee presented a final draft to the Council in June 1996. The Council conducted a careful line-by-line review of the document and made a number of changes. The proposed *Code* reorganization, as approved by the Council in June, is attached to this report as Appendix 1. Each word and phrase of the proposed *Code* was carefully chosen by the Council after consideration of all the relevant ethical and legal ramifications.

Recommendations: The changes recommended by the Council can be summarized as follows:

- the old topical headings would be replaced with true ethical principles;
- a new contents section would be added to help identify and locate relevant *Code* sections and advisory opinions;
- a new introduction would be added to provide a clear explanation of the *Code*'s subject matter;
- the existing preamble would be revised to emphasize ethics; and
- the "Interpretation and Application" section would be revised to clarify the appropriate source for questions on ethics.

The Council believes that all of these changes would increase the *Code*'s value as an inspirational, educational and regulatory document. However, reorganization of the *Code* under true ethical principles is the key recommendation. The *Code* is currently organized under topical headings, not true principles. Although true ethical principles are implied in the *Code*, they are not expressed. The proposed *Code* would place true ethical principles at the heart of the *Code* and organize the code of professional conduct around them. The result would be a new focus on the core tenets to which the profession aspires. For example, the sections of the *Code* that currently fall under the heading of "Professional Announcement" would be grouped in the proposed *Code* under the principle of veracity. The explanation that followed would make clear that all the rules dealing with advertising stem from the concept that professionals have a duty to be honest and trustworthy in their dealings with people.

The *Code* reorganization comes at a critical time for the profession. Dentistry has long recognized that there exists a tension between commercialism and professionalism. In 1986, the American Dental Association Special Committee on Professionalism and Ethics, in its report to the Board of Trustees, discussed the then-prevailing economic and legislative pressures on dentistry and stated:

> Dentists must resist those economic pressures on professionalism and ethics which are detrimental to the health of the public. Dentists are central to the delivery of the high standard of health care to which this Nation has become accustomed. In the final analysis, the dentists themselves must maintain the professional and ethical standards under which the public is served. If the profession keeps the patient's welfare foremost in mind when implementing its code of ethics, it will be successful

in mandating a high degree of professionalism among its ranks.

This statement is as relevant today as it was in 1986. The Council believes that the reorganized *Code* will help to place the emphasis in dentistry where it belongs: on professionalism and ethics.

For the reasons stated above, the Council is pleased to forward the following resolution to the House of Delegates.

59. Resolved, that the *ADA Principles of Ethics and Code of Professional Conduct* be amended in accordance with Supplemental Report 2 of the Council on Ethics, Bylaws and Judicial Affairs.

Special Acknowledgment: The Council wishes to take this opportunity to acknowledge with great appreciation the efforts of the members of the Editorial Review Subcommittee: Dr. Robert Rosen, subcommittee chairman; Dr. Juliann S. Bluitt-Foster; Dr. M. Joan Gillespie; Dr. Gerry L. Kaufman; and Dr. Robert E. McDonnell, former subcommittee member. The Council expresses appreciation to the six ethicists who served as consultants: Dr. Muriel J. Bebeau, Dr. Jeff Hollway, Dr. John G. Odom, Dr. David T. Ozar, Dr. Donald E. Patthoff and Dr. Robert M. Veatch. The Council also thanks Dr. Charles F. Landis, former chairman; Ms. Kathleen M. Todd, director; Ms. Wendy J. Wils, manager; and Mr. Earl Sewell, administrative secretary.

Resolution

59. Resolved, that the *ADA Principles of Ethics and Code of Professional Conduct* be amended in accordance with Supplemental Report 2 of the Council on Ethics, Bylaws and Judicial Affairs.

Appendix 1

Proposed
ADA Principles of Ethics and Code of Professional Conduct

CONTENTS

Appendix 1 (continued)

Appendix 1 (continued)

I. INTRODUCTION

The dental profession holds a special position of trust within society. As a consequence, society affords the profession certain privileges that are not available to members of the public-at-large. In return, the profession makes a commitment to society that its members will adhere to high ethical standards of conduct. These standards are embodied in the *ADA Principles of Ethics and Code of Professional Conduct* (*ADA Code*). The *ADA Code* is, in effect, a written expression of the obligations arising from the implied contract between the dental profession and society.

Members of the ADA voluntarily agree to abide by the *ADA Code* as a condition of membership in the Association. They recognize that continued public trust in the dental profession is based on the commitment of individual dentists to high ethical standards of conduct.

The *ADA Code* has three main components: The **Principles of Ethics**, the **Code of Professional Conduct** and the **Advisory Opinions**.

The **Principles of Ethics** are the aspirational goals of the profession. They provide guidance and offer justification for the *Code of Professional Conduct* and the *Advisory Opinions*. There are five fundamental principles that form the foundation of the *ADA Code*: patient autonomy, nonmaleficence, beneficence, justice and veracity. Principles can overlap each other as well as compete with each other for priority. More than one principle can justify a given element of the *Code of Professional Conduct*. Principles may at times need to be balanced against each other, but, otherwise, they are the profession's firm guideposts.

The **Code of Professional Conduct** is an expression of specific types of conduct that are either required or prohibited. The *Code of Professional Conduct* is a product of the ADA's legislative system. All elements of the *Code of Professional Conduct* result from resolutions that are adopted by the ADA's House of Delegates. The *Code of Professional Conduct* is binding on members of the ADA, and violations may result in disciplinary action.

The **Advisory Opinions** are interpretations that apply the *Code of Professional Conduct* to specific fact situations. They are adopted by the ADA's Council on Ethics, Bylaws and Judicial Affairs to provide guidance to the membership on how the Council might interpret the *Code of Professional Conduct* in a disciplinary proceeding.

The *ADA Code* is an evolving document and by its very nature cannot be a complete articulation of all ethical obligations. The *ADA Code* is the result of an ongoing dialogue between the dental profession and society, and as such, is subject to continuous review.

Although ethics and the law are closely related, they are not the same. Ethical obligations may—and often do—exceed legal duties. In resolving any ethical problem not explicitly covered by the *ADA Code*, dentists should consider the ethical principles, the patient's needs and interests, and any applicable laws.

Appendix 1 (continued)

II. PREAMBLE

The American Dental Association calls upon dentists to follow high ethical standards which have the benefit of the patient as their primary goal. Recognition of this goal, and of the education and training of a dentist, has resulted in society affording to the profession the privilege and obligation of self-government.

The Association believes that dentists should possess not only knowledge, skill and technical competence but also those traits of character that foster adherence to ethical principles. Qualities of compassion, kindness, integrity, fairness and charity complement the ethical practice of dentistry and help to define the true professional.

The ethical dentist strives to do that which is right and good. The *ADA Code* is an instrument to help the dentist in this quest.

Appendix 1 (continued)

III. PRINCIPLES, CODE OF PROFESSIONAL CONDUCT AND ADVISORY OPINIONS

Section 1—PRINCIPLE: PATIENT AUTONOMY ("self-governance"). The dentist has a duty to respect the patient's rights to self-determination and confidentiality.

This principle expresses the concept that professionals have a duty to treat the patient according to the patient's desires, within the bounds of accepted treatment, and to protect the patient's confidentiality. Under this principle, the dentist's primary obligations include involving patients in treatment decisions in a meaningful way, with due consideration being given to the patient's needs, desires and abilities, and safeguarding the patient's privacy.

CODE OF PROFESSIONAL CONDUCT

1.A. PATIENT INVOLVEMENT.

The dentist should inform the patient of the proposed treatment, and any reasonable alternatives, in a manner that allows the patient to become involved in treatment decisions.

1.B. PATIENT RECORDS.

Dentists are obliged to safeguard the confidentiality of patient records. Dentists shall maintain patient records in a manner consistent with the protection of the welfare of the patient. Upon request of a patient or another dental practitioner, dentists shall provide any information that will be beneficial for the future treatment of that patient.

ADVISORY OPINIONS

1.B.1. COPIES OF RECORDS. A dentist has the ethical obligation on request of either the patient or the patient's new dentist to furnish, either gratuitously or for nominal cost, such dental records or copies or summaries of them, including dental X-rays or copies of them, as will be beneficial for the future treatment of that patient. This obligation exists whether or not the patient's account is paid in full.

1.B.2. CONFIDENTIALITY OF PATIENT RECORDS. The dominant theme in Code Section 1-B is the protection of the confidentiality of a patient's records. The statement in this section that relevant information in the records should be released to another dental practitioner assumes that the dentist requesting the information is the patient's present dentist. The former dentist should be free to provide the present dentist with relevant information from the patient's records. This may often be required for the protection of both the patient and the present dentist. There may be circumstances where the former dentist has an ethical obligation to inform the present dentist of certain facts. Dentists should be aware, however, that the laws of the various jurisdictions in the United States are not uniform, and some confidentiality laws appear to prohibit the transfer of pertinent information, such as HIV seropositivity. Absent certain knowledge that the laws of the dentist's jurisdiction permit the forwarding of this information, a dentist should obtain the patient's written permission before forwarding health records which contain information of a sensitive nature, such as HIV seropositivity, chemical dependency or sexual preference. If it is necessary for a treating dentist to consult with another dentist or physician with respect to the patient, and the circumstances do not permit the patient to remain anonymous, the treating dentist should seek the permission of the patient prior to the release of data from the patient's records to the consulting practitioner. If the patient refuses, the treating dentist should then contemplate obtaining legal advice regarding the termination of the dentist/patient relationship.

Appendix 1 (continued)

Section 2—PRINCIPLE: NONMALEFICENCE ("do no harm"). The dentist has a duty to refrain from harming the patient.

This principle expresses the concept that professionals have a duty to protect the patient from harm. Under this principle, the dentist's primary obligations include keeping knowledge and skills current, knowing one's own limitations and when to refer to a specialist or other professional, and knowing when and under what circumstances delegation of patient care to auxiliaries is appropriate.

CODE OF PROFESSIONAL CONDUCT

2.A. EDUCATION.

The privilege of dentists to be accorded professional status rests primarily in the knowledge, skill and experience with which they serve their patients and society. All dentists, therefore, have the obligation of keeping their knowledge and skill current.

2.B. CONSULTATION AND REFERRAL.

Dentists shall be obliged to seek consultation, if possible, whenever the welfare of patients will be safeguarded or advanced by utilizing those who have special skills, knowledge, and experience. When patients visit or are referred to specialists or consulting dentists for consultation:

1. The specialists or consulting dentists upon completion of their care shall return the patient, unless the patient expressly reveals a different preference, to the referring dentist, or, if none, to the dentist of record for future care.

2. The specialists shall be obliged when there is no referring dentist and upon a completion of their treatment to inform patients when there is a need for further dental care.

ADVISORY OPINION

2.B.1. SECOND OPINIONS. A dentist who has a patient referred by a third party for a "second opinion" regarding a diagnosis or treatment plan recommended by the patient's treating dentist should render the requested second opinion in accordance with this Code of Ethics. In the interest of the patient being afforded quality care, the dentist rendering the second opinion should not have a vested interest in the ensuing recommendation.

2.C. USE OF AUXILIARY PERSONNEL.

Dentists shall be obliged to protect the health of their patients by only assigning to qualified auxiliaries those duties which can be legally delegated. Dentists shall be further obliged to prescribe and supervise the patient care provided by all auxiliary personnel working under their direction.

2.D. PERSONAL IMPAIRMENT.

It is unethical for a dentist to practice while abusing controlled substances, alcohol or other chemical agents which impair the ability to practice. All dentists have an ethical obligation to urge chemically impaired colleagues to seek treatment. Dentists with first-hand knowledge that a colleague is practicing dentistry when so impaired have an ethical responsibility to report such evidence to the professional assistance committee of a dental society.

ADVISORY OPINION

2.D.1. ABILITY TO PRACTICE. A dentist who becomes ill from any disease or impaired in any way shall, with consultation and advice from a qualified physician or other authority, limit the activities of practice to those areas that do not endanger the patients or members of the dental staff.

Appendix 1 (continued)

Section 3—PRINCIPLE: BENEFICENCE ("do good"). The dentist has a duty to promote the patient's welfare.

This principle expresses the concept that professionals have a duty to act for the benefit of others. Under this principle, the dentist's primary obligation is service to the patient and the public-at-large. The most important aspect of this obligation is the competent and timely delivery of dental care within the bounds of clinical circumstances presented by the patient, with due consideration being given to the needs, desires and values of the patient. The same ethical considerations apply whether the dentist engages in fee-for-service, managed care or some other practice arrangement. Dentists may choose to enter into contracts governing the provision of care to a group of patients; however, contract obligations do not excuse dentists from their ethical duty to put the patient's welfare first.

CODE OF PROFESSIONAL CONDUCT

3.A. COMMUNITY SERVICE.

Since dentists have an obligation to use their skills, knowledge and experience for the improvement of the dental health of the public and are encouraged to be leaders in their community, dentists in such service shall conduct themselves in such a manner as to maintain or elevate the esteem of the profession.

3.B. GOVERNMENT OF A PROFESSION.

Every profession owes society the responsibility to regulate itself. Such regulation is achieved largely through the influence of the professional societies. All dentists, therefore, have the dual obligation of making themselves a part of a professional society and of observing its rules of ethics.

3.C. RESEARCH AND DEVELOPMENT.

Dentists have the obligation of making the results and benefits of their investigative efforts available to all when they are useful in safeguarding or promoting the health of the public.

3.D. PATENTS AND COPYRIGHTS.

Patents and copyrights may be secured by dentists provided that such patents and copyrights shall not be used to restrict research or practice.

3.E. CHILD ABUSE.

Dentists shall be obliged to become familiar with the perioral signs of child abuse and to report suspected cases to the proper authorities consistent with state laws.

Section 4—PRINCIPLE: JUSTICE ("fairness"). The dentist has a duty to treat people fairly.

This principle expresses the concept that professionals have a duty to be fair in their dealings with patients, colleagues and society. Under this principle, the dentist's primary obligations include dealing with people justly and delivering dental care without prejudice. In its broadest sense, this principle expresses the concept that the dental profession should actively seek allies throughout society on specific activities that will help improve access to care for all.

CODE OF PROFESSIONAL CONDUCT

4.A. PATIENT SELECTION.

While dentists, in serving the public, may exercise reasonable discretion in selecting patients for their practices, dentists shall not refuse to accept patients into their practice or deny dental service to patients because of the patient's race, creed, color, sex or national origin.

Appendix 1 (continued)

ADVISORY OPINION

4.A.1. HIV POSITIVE PATIENTS. A dentist has the general obligation to provide care to those in need. A decision not to provide treatment to an individual because the individual has AIDS or is HIV seropositive, based solely on that fact, is unethical. Decisions with regard to the type of dental treatment provided or referrals made or suggested, in such instances should be made on the same basis as they are made with other patients, that is, whether the individual dentist believes he or she has need of another's skills, knowledge, equipment or experience and whether the dentist believes, after consultation with the patient's physician if appropriate, the patient's health status would be significantly compromised by the provision of dental treatment.

4.B. EMERGENCY SERVICE.

Dentists shall be obliged to make reasonable arrangements for the emergency care of their patients of record. Dentists shall be obliged when consulted in an emergency by patients not of record to make reasonable arrangements for emergency care. If treatment is provided, the dentist, upon completion of treatment, is obliged to return the patient to his or her regular dentist unless the patient expressly reveals a different preference.

4.C. JUSTIFIABLE CRITICISM.

Dentists shall be obliged to report to the appropriate reviewing agency as determined by the local component or constituent society instances of gross or continual faulty treatment by other dentists. Patients should be informed of their present oral health status without disparaging comment about prior services. Dentists issuing a public statement with respect to the profession shall have a reasonable basis to believe that the comments made are true.

ADVISORY OPINION

4.C.1. MEANING OF "JUSTIFIABLE." A dentist's duty to the public imposes a responsibility to report instances of gross or continual faulty treatment. However, the heading of this section is "Justifiable Criticism." Therefore, when informing a patient of the status of his or her oral health, the dentist should exercise care that the comments made are justifiable. For example, a difference of opinion as to preferred treatment should not be communicated to the patient in a manner which would imply mistreatment. There will necessarily be cases where it will be difficult to determine whether the comments made are justifiable. Therefore, this section is phrased to address the discretion of dentists and advises against disparaging statements against another dentist. However, it should be noted that, where comments are made which are obviously not supportable and therefore unjustified, such comments can be the basis for the institution of a disciplinary proceeding against the dentist making such statements.

4.D. EXPERT TESTIMONY.

Dentists may provide expert testimony when that testimony is essential to a just and fair disposition of a judicial or administrative action.

ADVISORY OPINION

4.D.1. CONTINGENT FEES. It is unethical for a dentist to agree to a fee contingent upon the favorable outcome of the litigation in exchange for testifying as a dental expert.

4.E. REBATES AND SPLIT FEES.

Dentists shall not accept or tender "rebates" or "split fees."

Appendix 1 (continued)

Section 5—PRINCIPLE: VERACITY ("truthfulness"). The dentist has a duty to communicate truthfully.
This principle expresses the concept that professionals have a duty to be honest and trustworthy in their dealings with people. Under this principle, the dentist's primary obligations include respecting the position of trust inherent in the dentist-patient relationship, communicating truthfully and without deception, and maintaining intellectual integrity.

CODE OF PROFESSIONAL CONDUCT

5.A. REPRESENTATION OF CARE.

Dentists shall not represent the care being rendered to their patients in a false or misleading manner.

ADVISORY OPINIONS

5.A.1. DENTAL AMALGAM. Based on available scientific data the ADA has determined through the adoption of Resolution 42H-1986 (*Trans.*1986:536) that the removal of amalgam restorations from the non-allergic patient for the alleged purpose of removing toxic substances from the body, when such treatment is performed solely at the recommendation or suggestion of the dentist, is improper and unethical.

5.A.2. UNSUBSTANTIATED REPRESENTATIONS. A dentist who represents that dental treatment recommended or performed by the dentist has the capacity to cure or alleviate diseases, infections or other conditions, when such representations are not based upon accepted scientific knowledge or research, is acting unethically.

5.B. REPRESENTATION OF FEES.

Dentists shall not represent the fees being charged for providing care in a false or misleading manner.

ADVISORY OPINIONS

5.B.1. WAIVER OF COPAYMENT. A dentist who accepts a third party* payment under a copayment plan as payment in full without disclosing to the third party* that the patient's payment portion will not be collected, is engaged in overbilling. The essence of this ethical impropriety is deception and misrepresentation; an overbilling dentist makes it appear to the third party* that the charge to the patient for services rendered is higher than it actually is.

5.B.2. OVERBILLING. It is unethical for a dentist to increase a fee to a patient solely because the patient has insurance.

5.B.3. FEE DIFFERENTIAL. Payments accepted by a dentist under a governmentally funded program, a component or constituent dental society sponsored access program, or a participating agreement entered into under a program of a third party* shall not be considered as evidence of overbilling in determining whether a charge to a patient, or to another third party* in behalf of a patient not covered under any of the aforementioned programs constitutes overbilling under this section of the Code.

5.B.4. TREATMENT DATES. A dentist who submits a claim form to a third party* reporting incorrect treatment dates for the purpose of assisting a patient in obtaining benefits under a dental plan, which benefits would otherwise be disallowed, is engaged in making an unethical, false or misleading representation to such third party.*

Appendix 1 (continued)

5.B.5. DENTAL PROCEDURES. A dentist who incorrectly describes on a third party* claim form a dental procedure in order to receive a greater payment or reimbursement or incorrectly makes a non-covered procedure appear to be a covered procedure on such a claim form is engaged in making an unethical, false or misleading representation to such third party.*

5.B.6. UNNECESSARY SERVICES. A dentist who recommends and performs unnecessary dental services or procedures is engaged in unethical conduct.

*A third party is any party to a dental prepayment contract that may collect premiums, assume financial risks, pay claims and/or provide administrative services.

5.C. DISCLOSURE OF CONFLICT OF INTEREST.

A dentist who presents educational or scientific information in an article, seminar or other program shall disclose to the readers or participants any monetary or other special interest the dentist may have with a company whose products are promoted or endorsed in the presentation. Disclosure shall be made in any promotional material and in the presentation itself.

5.D. 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 misleading in any material respect.

ADVISORY OPINIONS

5.D.1. REPORTING ADVERSE REACTIONS. A dentist who suspects the occurrence of an adverse reaction to a drug or dental device has an obligation to communicate that information to the broader medical and dental community, including, in the case of a serious adverse event, the Food and Drug Administration (FDA).

5.D.2. SALE OF PRODUCTS. Dentists who engage in the sale of dental products to their patients must take care not to exploit the trust inherent in the dentist-patient relationship for their own financial gain. Dentists should not induce their patients to buy a dental product by misrepresenting the product's therapeutic value. It is not enough for the dentist to rely on the manufacturer's representations about a product's safety and efficacy. The dentist has an independent obligation to enquire into the truth and accuracy of the manufacturer's claims and verify that they are founded on accepted scientific knowledge or research. Dentists should disclose to their patients all relevant information the patient needs to make an informed purchase decision, including whether the product is available elsewhere.

5.E. PROFESSIONAL ANNOUNCEMENT.

In order to properly serve the public, dentists should represent themselves in a manner that contributes to the esteem of the profession. Dentists should not misrepresent their training and competence in any way that would be false or misleading in any material respect.*

5.F. ADVERTISING.

Although any dentist may advertise, no dentist shall advertise or solicit patients in any form of communication in a manner that is false or misleading in any material respect.*

Appendix 1 (continued)

ADVISORY OPINIONS

5.F.1. ARTICLES AND NEWSLETTERS. If a dental health article, message or newsletter is published under a dentist's byline to the public without making truthful disclosure of the source and authorship or is designed to give rise to questionable expectations for the purpose of inducing the public to utilize the services of the sponsoring dentist, the dentist is engaged in making a false or misleading representation to the public in a material respect.

5.F.2. EXAMPLES OF "FALSE OR MISLEADING." The following examples are set forth to provide insight into the meaning of the term "false or misleading in a material respect." These examples are not meant to be all-inclusive. Rather, by restating the concept in alternative language and giving general examples, it is hoped that the membership will gain a better understanding of the term. With this in mind, statements shall be avoided which would: a) contain a material misrepresentation of fact, b) omit a fact necessary to make the statement considered as a whole not materially misleading, c) be intended or be likely to create an unjustified expectation about results the dentist can achieve, and d) contain a material, objective representation, whether express or implied, that the advertised services are superior in quality to those of other dentists, if that representation is not subject to reasonable substantiation. Subjective statements about the quality of dental services can also raise ethical concerns. In particular, statements of opinion may be misleading if they are not honestly held, if they misrepresent the qualifications of the holder, or the basis of the opinion, or if the patient reasonably interprets them as implied statements of fact. Such statements will be evaluated on a case by case basis, considering how patients are likely to respond to the impression made by the advertisement as a whole. The fundamental issue is whether the advertisement, taken as a whole, is false or misleading in a material respect.

5.F.3. UNEARNED, NONHEALTH DEGREES. The use of an unearned or nonhealth degree in any general announcements to the public by a dentist may be a representation to the public which is false or misleading in a material respect. A dentist may use the title Doctor, Dentist, DDS, or DMD, or any additional earned advanced degrees in health service areas. The use of unearned or nonhealth degrees could be misleading because of the likelihood that it will indicate to the public the attainment of a specialty or diplomate status.

For purposes of this advisory opinion, an unearned academic degree is one which is awarded by an educational institution not accredited by a generally recognized accrediting body or is an honorary degree. Generally, the use of honorary degrees or nonhealth degrees should be limited to scientific papers and curriculum vitae. In all instances state law should be consulted. In any review by the council of the use of nonhealth degrees or honorary degrees the council will apply the standard of whether the use of such is false or misleading in a material respect.

5.F.4. FELLOWSHIPS. A dentist using the attainment of a fellowship in a 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. However, when such use does not conflict with state law, the attainment of fellowship status may be indicated in scientific papers, curriculum vitae, third party payment forms and letterhead and stationery which is not used for the direct solicitation of patients. In any review by the council of the use of the attainment of fellowship status, the council will apply the standard of whether the use of such is false or misleading in a material respect.

Appendix 1 (continued)

5.F.5. REFERRAL SERVICES. There are two basic types of referral services for dental care: not-for-profit and the commercial. The not-for-profit is commonly organized by dental societies or community services. It is open to all qualified practitioners in the area served. A fee is sometimes charged the practitioner to be listed with the service. A fee for such referral services is for the purpose of covering the expenses of the service and has no relation to the number of patients referred. In contrast, some commercial referral services restrict access to the referral service to a limited number of dentists in a particular geographic area. Prospective patients calling the service may be referred to a single subscribing dentist in the geographic area and the respective dentist billed for each patient referred. Commercial referral services often advertise to the public stressing that there is no charge for use of the service and the patient may not be informed of the referral fee paid by the dentist. There is a connotation to such advertisements that the referral that is being made is in the nature of a public service. A dentist is allowed to pay for any advertising permitted by the *Code*, but is generally not permitted to make payments to another person or entity for the referral of a patient for professional services. While the particular facts and circumstances relating to an individual commercial referral service will vary, the council believes that the aspects outlined above for commercial referral services violate the *Code* in that it constitutes advertising which is false or misleading in a material respect and violates the prohibitions in the *Code* against fee splitting.

5.F.6. HIV TEST RESULTS. An advertisement or other communication intended to solicit patients which omits a material fact or facts necessary to put the information conveyed in the advertisement in a proper context can be misleading in a material respect. An advertisement to the public of HIV negative test results, without conveying additional information that will clarify the scientific significance of this fact, is an example of a misleading omission. A dental practice should not seek to attract patients on the basis of partial truths which create a false impression.

5.G. NAME OF PRACTICE.

Since the name under which a dentist conducts his or her practice may be a factor in the selection process of the patient, the use of a trade name or an assumed name that is false or misleading in any material respect is unethical. Use of the name of a dentist no longer actively associated with the practice may be continued for a period not to exceed one year.*

ADVISORY OPINION

5.G.1. DENTIST LEAVING PRACTICE. Dentists leaving a practice who authorize continued use of their names should receive competent advice on the legal implications of this action. With permission of a departing dentist, his or her name may be used for more than one year, if, after the one year grace period has expired, prominent notice is provided to the public through such mediums as a sign at the office and a short statement on stationery and business cards that the departing dentist has retired from the practice.

5.H. ANNOUNCEMENT OF SPECIALIZATION AND LIMITATION OF PRACTICE.

This section and Section 5-I are designed to help the public make an informed selection between the practitioner who has completed an accredited program beyond the dental degree and a practitioner who has not completed such a program. The

Appendix 1 (continued)

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 and maxillofacial pathology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics. Dentists who choose to announce specialization should use "specialist in" or "practice limited to" and shall limit their practice exclusively to the announced special area(s) of dental practice, provided at the time of the announcement such dentists have met in each approved specialty for which they announce the existing educational requirements and standards set forth by the American Dental Association. Dentists who use their eligibility to announce as specialists to make the public believe that specialty services rendered in the dental office are being rendered by qualified specialists when such is not the case are engaged in unethical conduct. The burden of responsibility is on specialists to avoid any inference that general practitioners who are associated with specialists are qualified to announce themselves as specialists.

GENERAL STANDARDS.

The following are included within the standards of the American Dental Association for determining the education, experience and other appropriate requirements for announcing specialization and limitation of practice:

1. The special area(s) of dental practice and an appropriate certifying board must be approved by the American Dental Association.

2. Dentists who announce as specialists must have successfully completed an educational program accredited by the Commission on Dental Accreditation, two or more years in length, as specified by the Council on Dental Education, or be diplomates of an American Dental Association recognized certifying board. The scope of the individual specialist's practice shall be governed by the educational standards for the specialty in which the specialist is announcing.

3. The practice carried on by dentists who announce as specialists shall be limited exclusively to the special area(s) of dental practices announced by the dentist.

STANDARDS FOR MULTIPLE-SPECIALTY ANNOUNCEMENTS.

Educational criteria for announcement by dentists in additional recognized specialty areas are the successful completion of an educational program accredited by the Commission on Dental Accreditation in each area for which the dentist wishes to announce. Dentists who completed their advanced education in programs listed by the Council on Dental Education prior to the initiation of the accreditation process in 1967 and who are currently ethically announcing as specialists in a recognized area may announce in additional areas provided they are educationally qualified or are certified diplomates in each area for which they wish to announce. Documentation of successful completion of the educational program(s) must be submitted to the appropriate constituent society. The documentation must assure that the duration of the program(s) is a minimum of two years except for oral and maxillofacial surgery which must have been a minimum of three years in duration.*

ADVISORY OPINION

5.H.1. DIPLOMATE STATUS. 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 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 representation to the public in a material respect.

5.H.2. DUAL DEGREED DENTISTS. Nothing in Section 5-H shall be interpreted to prohibit a dual degreed dentist who practices medicine or osteopathy under a valid state license from announcing to the public as a dental specialist provided

Appendix 1 (continued)

the dentist meets the educational, experience and other standards set forth in the *Code* for specialty announcement and further providing that the announcement is truthful and not materially misleading.

5-I. GENERAL PRACTITIONER ANNOUNCEMENT OF SERVICES.

General dentists who wish to announce the services available in their practices are permitted to announce the availability of those services so long as they avoid any communications that express or imply specialization. General dentists shall also state that the services are being provided by general dentists. No dentist shall announce available services in any way that would be false or misleading in any material respect.*

*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 for determining the ethical propriety of such promotional activities. Any provision of an ADA constituent or component society's code of ethics or other standard of dentist conduct relating to dentists' or dental care delivery organizations' advertising, solicitation, or other promotional activities which is worded differently from the above standard shall be deemed to be in conflict with the *ADA Principles of Ethics and Code of Professional Conduct.*

IV. INTERPRETATION AND APPLICATION OF *PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT.*

The foregoing *ADA Principles of Ethics and Code of Professional Conduct* set forth the ethical duties that are binding on members of the American Dental Association. The component and constituent societies may adopt additional requirements or interpretations not in conflict with the *ADA Code*.

Anyone who believes that a member-dentist has acted unethically may bring the matter to the attention of the appropriate constituent (state) or component (local) dental society. Whenever possible, problems involving questions of ethics should be resolved at the state or local level. If a satisfactory resolution cannot be reached, the dental society may decide, after proper investigation, that the matter warrants issuing formal charges and conducting a disciplinary hearing pursuant to the procedures set forth in the ADA *Bylaws*, Chapter XII. PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT AND JUDICIAL PROCEDURE. The Council on Ethics, Bylaws and Judicial Affairs reminds constituent and component societies that before a dentist can be found to have breached any ethical obligation the dentist is entitled to a fair hearing.

A member who is found guilty of unethical conduct proscribed by the *ADA Code* or code of ethics of the constituent or component society, may be placed under a sentence of censure or suspension or may be expelled from membership in the Association. A member under a sentence of censure, suspension or expulsion has the right to appeal the decision to his or her constituent society and the ADA Council on Ethics, Bylaws and Judicial Affairs, as provided in Chapter XII of the ADA *Bylaws*.

American Dental Association Council on Ethics, Bylaws and Judicial Affairs 211 East Chicago Avenue Chicago, Illinois 60611

With official advisory opinions revised to January 1996.

Council on Governmental Affairs and Federal Dental Services

Supplemental Report 1: Recent Council Activities

Background: This report summarizes the activities of the Council on Governmental Affairs and Federal Dental Services since submission of its annual report in May.

Right-to-Know Legislation: The Council recommends rescission of this ADA policy concerning right-to-know legislation for several reasons. First, the policy is ambiguous and does not define or describe what is meant by right-to-know legislation. Second, the right-to-know legislation has an entirely different meaning now than it had when it was originally adopted.

At the time the policy was adopted in 1986, 33 states had enacted burdensome legislation concerning the use and labeling of hazardous chemicals in the workplace, then popularly known as right-to-know laws. The intent was to encourage states to attempt to gain an exemption from such laws for dentists or to assist dentists with compliance. These laws are no longer a major issue since they were superseded by the OSHA Hazard Communication Standard, which was expanded to apply to nonmanufacturing employers in 1967.

At present, the term right-to-know refers to the patient's "right-to-know" information regarding the coverage and limitations of health insurance plans. Therefore, the Council submits the following resolution with a recommendation that it be adopted.

42. Resolved, that Resolution 97H-1986 (*Trans.*1986:529), Right-to-Know Legislation, be rescinded.

Dentistry as an Independent Profession: Resolution 98H-1995 (*Trans.*1995:640), stressed that dentistry should continue to be a profession of its own and should not become a medical specialty. The Council fully supports this resolution. For years, the ADA has consistently advocated dentistry's unique message—*"Dentistry: Health Care That Works"* to the United States Congress, and the federal Executive Branch, including the President, state legislatures and regulatory agencies. This message encapsulates the Association's position that dentistry is not a medical specialty, rather it is a distinctive discipline, with a health care delivery system very different from medicine. The oral health of the American public has benefited from dentistry's emphasis on preventive and primary care; historically, oral care costs have not risen as fast as medical expenses; and dentistry has demonstrated that patient-centered health care decision making effectively delivers quality, cost-effective care. Today, the Association continues to use this message as it addresses issues concerning managed care organizations in its lobbying efforts with Congress and the Clinton administration.

States' Rights Affecting the Practice of Dentistry: Resolution 100-1995 (*Trans.*1995:649), requires that the Association support the authority of each state government to adopt and enforce laws and rules that regulate the practice of dentistry and enhance the oral health of the public within its jurisdiction.

At its June meeting, the Council reviewed Resolution 100, which was referred to it for its assessment of the legislative impact of this resolution. The Council determined that it is important to continue to support state government authority to adopt and enforce laws that regulate the practice of dentistry. The Council recognizes that this is an area typically reserved to the states and agrees that the states must retain their control.

The Council is concerned, however, that Resolution 100 fails to allow for instances where federal legislative action is desirable. To cite two examples, maintaining a dental care "safety net" as Congress considers reform of Medicaid and comprehensive tort reform are federal legislative initiatives fully supported by ADA policy. Finally, concerning the issue of licensure, the Council will comment further after it reviews the recommendations of the Board Committee on Licensure.

Legislative Separation of Medicine and Dentistry: Resolution 106-1995 (*Trans.*1995:649) requires that the American Dental Association work to assure that dentistry is addressed separately in any legislation that affects health care, rather than be included as a part of medicine. This resolution was referred to the Council for study and report to the 1996 House of Delegates with a recommendation.

The Council fully supports this resolution. The same rationale presented in response to Resolution 98H-1995 applies to this resolution. Therefore, the Council recommends that Resolution 106-1995 be adopted.

106-1995. Resolved, that the American Dental Association work to assure that dentistry is addressed separately in any legislation that affects health care, rather than be included as a part of medicine.

Antitrust Reform: In light of changes in the health care marketplace, the Council recently reviewed the status of current antitrust laws and provided the staff with guidance concerning the Association's legislative and regulatory advocacy on antitrust matters. The Council's overriding objective was to support actions designed to create options for dentists competing in the health care marketplace.

The Council agreed that the ADA should continue its ongoing efforts to enable dentists to compete effectively by:

- recommending support for H.R. 2925, sponsored by Representative Hyde (R-IL), a bill which would remove many unnecessary antitrust impediments facing providers who choose to compete through provider-sponsored networks;
- investigating the possibilities of pursuing the establishment of mechanisms to empower constituent or component

societies to negotiate on behalf of their members on contractual matters, except fees;

- initiating discussions with federal agencies that are investigating potential abuses by managed care companies; and
- continuing to lobby the Federal Trade Commission to amend guidelines on antitrust to use a market power approach in defining "safe harbors."

Summary of Resolutions

42. Resolved, that Resolution 97H-1986 (*Trans.*1986:529), Right-to-Know Legislation, be rescinded.

106-1995. Resolved, that the American Dental Association work to assure that dentistry is addressed separately in any legislation that affects health care, rather than be included as a part of medicine.

Council on Governmental Affairs and Federal Dental Services

Supplemental Report 2: Recent Council Activities

Background: This report summarizes the activities of the Council on Governmental Affairs and Federal Dental Services since submission of its Supplemental Report 1 in July.

Response to Assignments from the 1995 House of Delegates:

States' Rights Affecting the Practice of Dentistry. Resolution 100-1995 (*Trans.*1995:649) was referred to the Council for study and report back to the 1996 House of Delegates. The resolution would require the Association to support the authority of each state government to adopt and enforce laws and rules that regulate the practice of dentistry and enhance the oral health of the public within its jurisdiction.

At its June meeting, the Council reviewed Resolution 100 for an assessment of its legislative effect. The Council determined that it is important to continue to support the states' authority to adopt and enforce laws that regulate the practice of dentistry. The Council recognizes that this is an area typically reserved to the states and agrees that the states must retain their control. Therefore, the Council recommends that Resolution 100-1995 be adopted.

100-1995. Resolved, that the American Dental Association supports the authority of each state government to adopt and enforce laws and rules that regulate the practice of dentistry and enhance the oral health of the public within its jurisdiction.

Regulation of Amalgam Discharge to Wastewater. Resolution 121H-1995 (*Trans.*1995:651) requires the Association to take steps to ensure that federal regulations potentially affecting the discharge of amalgam to wastewater are based upon sound science. The resolution directs the Association to adopt a strong proactive advocacy program to convince the Environmental Protection Agency (EPA) that, based on current scientific evidence, there is no legal basis for regulating amalgam waste from dental offices.

The Council reported on this resolution in its annual report to the House of Delegates. Key developments that have occurred since that time are reported below.

On July 16, 1996 an Association delegation led by Dr. David Whiston, trustee of the Sixteenth District, met with Mr. Robert Perciasepe, the EPA's Assistant Administrator for Water, and other Agency staff. At the meeting, and in subsequent communications with the Agency, the Association stated that it remains committed to supporting sound science as the basis for any action concerning dental amalgam.

The Association made it very clear that it believes there is no significant legal basis under the Clean Water Act (CWA) to support regulation of excess or scrap amalgam in dental office wastewater for the simple reason that no adverse environmental effects from such material have been shown.

The Association furnished the Agency with the final version of the Association-funded research, which investigated whether any amalgam material in Publicly Owned Treatment Works (POTWs) would break down and release its mercury component. The study indicates that no such breakdown was detected. The Association stressed that unless the bioavailability of the mercury component of amalgam is shown and an adverse effect on aquatic life is adequately demonstrated, regulation of amalgam material in wastewater is unwarranted under the CWA.

Other factors mentioned that weigh against regulation of amalgam are that very low quantities of amalgam material are discharged from dental offices to POTWs; mercury water quality issues are due primarily to air deposition; and amalgam is an extremely durable, cost-effective dental restorative material.

For all of the above stated reasons, the Association requested that the EPA recognize that there is no sound basis for regulating amalgam material in dental wastewater and communicate this position to the appropriate officials at the state and local level.

The Association also stated that, as a good citizen, it has an obligation to respond to public concerns, even those that do not justify regulation. As such, the Association is taking a number of voluntary steps to educate its members on the proper handling and disposal of mercury. For example, Association policy recommends the use of precapsulated amalgam alloy in lieu of bulk mercury and bulk alloy. The Association has also disseminated examples of best practice management techniques to constituent and component societies upon request to use as they deem appropriate.

Report of the Task Force on Anesthesiology: The Council reviewed state statutes concerning regulation of the use of conscious sedation to determine the potential impact of the Report of the Association Anesthesiology Task Force.

The Council noted the following:

- conscious sedation is regulated in all states and requires postdoctoral education, specified equipment, staffing and, in most instances, an in-office inspection which may include demonstration of emergency techniques, office personnel, records and equipment;
- 11 states require dentists to have a permit in order to administer nitrous oxide/oxygen;
- 11 states expressly provide that the administration of nitrous oxide/oxygen is not considered conscious sedation;
- irrespective of permit requirements, eight states require a course beyond that of dental school (from eight to 16 hours) prior to administering nitrous oxide/oxygen, although most of those have "grandfather" provisions;
- four states specify that nitrous oxide/oxygen used in conjunction with a single oral sedative equals conscious

sedation and is thereby regulated as such (except one which does require a permit); and
- three states specifically exclude nitrous oxide/oxygen used in conjunction with a single oral sedative as equivalent to conscious sedation.

The Council believes that both the proposed revision to the Association's current policy "The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry" (*Trans.*1985:577; 1993:88; 1994:74) and the proposed Guidelines for the Use of Sedation, Deep Sedation and General Anesthesia for Dentists could be interpreted as suggesting that any use of nitrous oxide, alone or in combination with local anesthetics, constitutes conscious sedation.

Further, the Guidelines state that previously "grandfathered" individuals should not be exempt from educational and inspection requirements. At least 39 states, therefore, could be expected to consider imposition of previously nonexistent statutory and/or regulatory requirements, and the other 11 could seek to impose additional educational, equipment and inspection requirements.

As stated in Association testimony, nitrous oxide/oxygen is an extremely safe modality which has been of enormous assistance in rendering of comprehensive dental care to tens of thousands of patients. The Council believes there is no demonstrated hazard to patients when nitrous oxide/oxygen is used alone or in combination with local anesthetics by licensed dentists.

Therefore, the Council can see no reason for increased regulation of administration of nitrous oxide/oxygen by licensed dentists as possibly implied in the Task Force report. Policies and guidelines issued by the Association, the recognized authority, are used by state dental boards and legislative bodies as the basis for oversight of the profession. In its role as adviser on state government affairs, the Council offers the following suggested amendment to Resolution 78 (*Supplement*:328) with the recommendation that it be adopted.

78S-1. Resolved, that the revised Association policy, "The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry," be amended by adding the following sentence at the end of the fourth paragraph of the "Introduction":

> The term "inhalation conscious sedation," however, is not intended to include nitrous oxide/oxygen, when used alone and/or with local anesthetics, and not in combination with other sedative agents.

and be it further
Resolved, that the revised Association policy, "The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry," as amended, be adopted, and be it further
Resolved, that Resolution 24H-1985 (*Trans.*1985:576), establishing the previous policy, be rescinded.

Update on Federal Issues: This report serves as an update on some key legislative issues that were mentioned in the Council's annual report to the House of Delegates.

Health Coverage Availability and Affordability Act of 1996 (H.R. 3103). At the time of the Council's annual report in May, the House and Senate passed differing versions of the health insurance reform legislation. On August 21, President Clinton signed the conference report (H.R. 3103), which among other things would allow people to move from job to job without the threat of losing their health insurance coverage.

The bill establishes a four-year medical savings account (MSA) demonstration program with a limit on the number of policies issued. The Association was successful in assuring that MSA dollars could be used to purchase dental services and that those choosing the MSA option would be allowed to maintain a free-standing dental plan.

Working with a coalition of business groups, the Association also fought to ensure that H.R. 3103 allows self-employed business owners to deduct 80% of their health care costs from their federal income taxes. The deduction would be phased in, reaching 80% by the year 2006. Under the current system, most small businesses can deduct 30%, while incorporated businesses enjoy a 100% deduction.

The bill also contains provisions to help eliminate fraud and abuse in America's health care system. Association-endorsed language was included in the bill to ensure that only health care providers who "knowingly and willfully" defraud the system could be subject to criminal penalties.

All health care providers will be required to comply with federal standards concerning electronic data interchange (EDI) within the next two years. The law names the American Dental Association as an organization that must be consulted before standards are established. The law is focused only on moving claims processing into EDI (essentially a banking transaction), although the Association anticipates that ultimately the entire patient record will be entered into the EDI system.

Small Business Job Protection Act of 1996 (H.R. 3448). President Clinton signed legislation to provide tax relief to small businesses, as well as an increase in the minimum wage. H.R. 3448 included an Association-supported provision to enhance the tax deduction a small business could claim for the purchase of capital equipment. The tax deduction would be phased in from $17,500 to $25,000 over the next six years.

Defense Authorization Bill for Fiscal Year 1997 (H.R. 3230). The House of Representatives passed a defense authorization bill prior to the August recess by a vote of 285-132. Although the bill contains many provisions important to military dentists, it includes spending levels that are reportedly unacceptable to the White House. The Senate is expected to approve the bill, but because of the increased spending beyond the president's recommendation, the legislation's future is in doubt.

The Association-supported provisions in the measure include:

- increasing "special pay" for junior officers and Board Certified Pay for senior officers in the active duty dental corps;
- establishing a $30,000 accession bonus for dentists entering military service;

- reestablishing special pay for dentists in the reserve components;
- increasing special pay for Public Health Service dentists;
- establishing a military retiree dental benefits program; and
- mandating the Department of Defense to report to Congress on the feasibility of increasing the scholarships offered under the Armed Forces Health Professions Scholarship Program.

Antitrust Reform. At its August meeting, the Council discussed aspects of the newly proposed Department of Justice/Federal Trade Commission provider network guidelines. One of the changes in the new guidelines is that networks that do not share the kind of substantial financial risk necessary to qualify for a safety zone (i.e., safe harbor) may still be legal under a rule of reason (and thereby reach an agreement on price) if the network achieves "efficiencies" associated with clinical and functional integration.

Summary of Resolutions

100-1995. Resolved, that the American Dental Association supports the authority of each state government to adopt and enforce laws and rules that regulate the practice of dentistry and enhance the oral health of the public within its jurisdiction.

78S-1. Resolved, that the revised Association policy, "The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry," be amended by adding the following sentence at the end of the fourth paragraph of the "Introduction":

> The term "inhalation conscious sedation," however, is not intended to include nitrous oxide/oxygen, when used alone and/or with local anesthetics, and not in combination with other sedative agents.

and be it further
Resolved, that the revised Association policy, "The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry," as amended, be adopted, and be it further
Resolved, that Resolution 24H-1985 (*Trans.*1985:576), establishing the previous policy, be rescinded.

Council on Membership

Supplemental Report 1: Recent Council Activities

This report summarizes Council activities since submission of its annual report in May.

Response to Assignments from 1994 and 1995 Houses of Delegates

California Dental Association Electronic Dues Payment Program: In 1992, the House of Delegates adopted Resolution 62H-1992 (*Trans.*1992:602), which amended the ADA *Bylaws* to permit the California Dental Association (CDA) to pilot an electronic debit dues installment plan, referred to as the Electronic Dues Payment Program (EDP). The pilot program allowed members the option to pay dues in eight equal monthly payments, commencing in November and continuing until June via electronic debiting of the member's qualified bank account.

In 1994, the House of Delegates adopted Resolution 86H-1994 (*Trans.*1994:617), which extended the pilot EDP program through 1996, and required the CDA to report the results of the pilot program to the appropriate agency for evaluation and report to the 1996 House of Delegates. On May 1, 1996, the CDA submitted a comprehensive report which was presented to the Council at its June meeting.

The Council analyzed the report and strongly supports the EDP concept. The program has provided CDA members with a valuable service that has proven to be a successful tool for both recruiting and retaining members.

CDA reports that since its inception in 1994, program participation has increased 51%, from 1,632 members to 2,471. A survey of participants revealed high member satisfaction with 99% stating that the program should be continued.

In 1992, the pilot program was implemented successfully at the ADA with the current computer system and personnel. The delay in receiving funds generated through the EDP program, which had been a concern at the outset, has been accommodated through budget planning and has not reflected a shortfall since all funds owed have been paid by June. However, in order to accommodate the program, both the ADA and CDA invested considerable staff time and resources to complete the necessary programming changes to allow the membership system to accept the installment payments.

The Council considered CDA's recommendation to expand the EDP to other constituents but is unable to support expansion at this time. The Council is very sensitive to the fact that the Association is currently involved with implementing new computer technology, which involves moving to a new computer software package for Association management and converting the ADA Micromembership system currently used by constituent and component societies. Until this new system is available, the ADA will not have the staff or monetary resources necessary to make the extensive changes to the present system required to implement the EDP program on a national basis.

The Council has requested, through the Executive Director, that measures be taken to ensure that the Association's new computer system be created with the ability to accept partial payments. Although it would not be fiscally or managerially feasible to expand the program at this time, the Council believes that the California Dental Association should be allowed and encouraged to continue to offer the EDP program. Therefore, the Council recommends adoption of the following resolution.

60. Resolved, that the ADA *Bylaws* be amended to allow the California Dental Association to continue the current electronic debit installment program for two more years through the 1998 billing year, with the second footnote to Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* amended to read as follows:

** Dues of all members of the California Dental Association are payable January 1, except that active and active life members may participate in an electronic debit installment plan during 1996-97 and 1997-98. The plan shall require equal monthly installments to commence in November 1996 and November 1997, with full payment of the current dues amount to be fully paid by June 30, 1997 and June 30, 1998, respectively. No interest may be charged members participating in the plan. However, penalties may be imposed, prorated to the American Dental Association (ADA) and California Dental Association, for expenses incurred as a result of missed installments. The electronic debit installment plan shall provide for expeditious transfer of the ADA portion of the members' dues, and any late payment penalties, to the account of the ADA as soon as commercially feasible.

Development of Financial Planning Publication for Dental Students: Resolution 108-1995 (*Trans.*1995:644) was assigned to the Council with assistance from the Council on Dental Practice. This resolution sought the development of a financial planning resource targeted to first-year dental students which would help them manage the costs of their dental education. In collaboration with the Council on Dental Practice, a prototype brochure was developed with the overall message of "don't borrow more than you need." The publication, *Financial Planning Issues for Dental Students*, provides practical advice and incorporates photos with testimonials from recent graduates.

At its June 1996 meeting, the Council on Membership reviewed the prototype and approved the content and distribution plan for the new financial planning publication for dental students. Pending legal review, production of this publication will be authorized with initial distribution targeted to the 1,300 member Predental and Prehealth Advisors Network. The Council intends to investigate the feasibility of

also mailing directly to predental students upon acceptance to dental school as well as having the publication available to students during freshman orientation.

The Council believes that the timely distribution of the brochure is key in addressing the intent of the resolution. A variety of strategies will be explored to reach students either before they enter dental school or, at the latest, early in the first semester of dental school. The Council will evaluate the effectiveness of the financial planning publication and report its analysis to the House of Delegates.

Review of Association Policies: As directed by Resolution 15H-1995 (*Trans.*1995:660), the Council reviewed current policies for which it has oversight responsibility. The following policies were reviewed in accordance with Resolution 15H-1995.

Allied Dental Organization Membership Contingent on ADA Membership. The Council was concerned that the term "allied" as used in the policy (*Trans.*1985:610) is not clearly defined, and that the second resolving clause is confusing as it attempts to direct the manner by which other organizations verify ADA membership. Therefore, the Council recommends adoption of the following resolution.

61. Resolved, that Resolution 33H-1985 (*Trans.*1985:610), Allied Dental Organization Membership Contingent on ADA Membership, be amended by deleting the word "Allied" from the title; replacing the word "allied" in the first resolving clause with the word "other"; and deleting the word "allied" from the second resolving clause so that the amended policy reads as follows:

> **Dental Organization Membership Contingent on ADA Membership**
>
> **Resolved,** that the American Dental Association enter into dialogue with other dental organizations to encourage them to adopt and utilize procedures with respect to continuing membership in their organizations being contingent upon maintenance of ADA membership, and be it further
> **Resolved,** that dental organizations which currently require members or applicants to also hold membership in the American Dental Association be encouraged to annually confirm their members' current ADA membership status.

Dentists Retired from Federal Service. In reviewing this policy (*Trans.*1963:285), it was brought to the Council's attention that some constituent and component societies do not count years of direct ADA membership toward the years required to qualify for their societies' life membership status, thus discouraging many members from transferring to tripartite membership upon retirement from the federal dental service. Therefore, the Council recommends adoption of the following resolution.

62. Resolved, that Resolution 28-1963-H (*Trans.*1963:285), Dentists Retired from Federal Service, be amended by the addition of a second resolving clause so that the amended policy reads as follows:

> **Resolved,** that dentists who have retired from the federal dental services and who engage in some form of nonfederal occupation associated with dentistry be urged to take membership in both constituent and component societies if such exist and where there are no provisions of the bylaws which prohibit such membership, and be it further
> **Resolved,** that constituent and component societies be encouraged to change their bylaws requirements to recognize years of federal dental service membership in the criteria for component and constituent life member status.

Allied Organizations' Support for ADA Recruitment and Retention Activities. The Council believes that the concept of universal support for organized dentistry is important and has increased relevance for the Association. However, the term "allied" is problematic since it is not defined. Therefore, the Council recommends adoption of the following resolution.

63. Resolved, that Resolution 41H-1989 (*Trans.*1989:540), Allied Organizations' Support for ADA Recruitment and Retention Activities, be amended by deleting the word "allied" wherever it appears and substituting it with the word "other" so the amended resolution reads as follows:

> **Resolved,** that the American Dental Association urge other dental organizations to support membership recruitment and retention activities of organized dentistry, and be it further
> **Resolved,** that the American Dental Association encourage those organizations that require maintenance of ADA membership to exchange current information on membership and specialty status with the ADA on an annual basis.

Qualifications for Membership. The Council believes that the intent of this policy (*Trans.*1959:219) is bogged down with unnecessary limitations. Therefore, the Council recommends adoption of the following resolution.

64. Resolved, that Resolution 31-1959-H (*Trans.*1959:219), Qualifications for Membership, be amended by deleting the qualifying phrase "if he is engaged, on a full-time basis, as a teacher in a dental school or as an administrative officer in an activity associated with the ethical dental profession" so that the amended resolution reads as follows:

> **Resolved,** that the constituent societies be requested to examine their bylaws with a view to making any change in the qualifications for active membership to permit a dentist licensed in another state to become an active member.

Student Membership. The Council supports the intent of this policy (*Trans.*1977:957) and believes that predoctoral student membership will provide a solid foundation for future active membership in organized dentistry. The Council's recommended amendment deletes a resolving clause from the 1977 policy which directs the Board of Trustees to develop programs to recruit dental student members. The Council believes this policy has been superseded by Resolution 78H-1993 (*Trans.*1993:686), which directed the Council on Membership to develop and implement a comprehensive Student Marketing Plan. Therefore, the Council recommends adoption of the following resolution.

65. Resolved, that Resolution 121H-1977 (*Trans.*1977:957), Student Membership, be amended in the first resolving clause by addition of the word "dental" before the word "students"; deleting the word "full-fledged" and the phrase "while they are in dental school," and be it further
Resolved, that the second resolving clause be amended by addition of "/ADA" after "ASDA," and be it further
Resolved, that the third resolving clause be deleted, so that the amended policy reads as follows:

> **Resolved,** that all dental students who are preparing themselves to become members of the dental profession be urged to become active members of the American Student Dental Association and the American Dental Association, and be it further
> **Resolved,** that all deans and faculties of dental schools be requested to encourage membership in ASDA/ADA.

Other Council Activities

Student Marketing Plan Update: This report is intended to apprise the House of Delegates of several dental student related activities which have developed since the Council's annual report was submitted in May.

In response to several years of decline in membership market share of dental students and recent graduates, the 1993 House of Delegates approved Resolution 78H-1993 (*Trans.*1993:686), which resulted in the development of the Student Marketing Plan. The ADA's Office of Student Affairs (OSA) has implemented many marketing and communications efforts to increase student awareness and understanding of the Association and the benefits of membership. The OSA coordinates a number of activities with the American Student Dental Association (ASDA) and is focusing on establishing a stronger presence in the dental schools by working with many local societies and new dentist committees. Reported here is a summary of recent OSA activities and 1995-96 student membership statistics.

Student Market Share Report. The 1995-96 Student Membership Market Share Report indicates a significant one-year market share increase of 5.2%. Calculated annually on July 1, 1996, the 1995-96 ADA/ASDA membership market share is 72.2% (11,775 members) compared to the 1994-95 market share of 67% (10,968 members). Although the Council has not had the opportunity to conduct an in-depth analysis on this recently released data, several contributing factors might be considered as having a positive impact on 1995-96 student membership. These include: substantial support for student activities by the ADA officers and Board of Trustees and House of Delegates (including the approved increase in student representation in the House); outreach initiatives to dental schools by constituent and component societies, new dentist committees and Association leaders; automatic dues billing by dental schools; increased emphasis on student-to-student recruitment by many ASDA chapters; and improved communication and coordination between ADA and ASDA staff. These activities will be tracked by the Office of Student Affairs as it continues to centralize and coordinate resources for ASDA/ADA leaders and members.

Office of Student Affairs. To expedite the process of communicating with freshman students, OSA coordinated a "Welcome to the Profession" letter from President Ten Pas. This letter was personalized using freshman lists collected from dental school deans. As of July 10, 1996, 30 dental schools have responded and provided freshman student lists to OSA. Other activities include: a series of planning sessions with ADA and ASDA to better communicate and coordinate student member activities; a freshman survival kit piloted at the dental schools in New York; and the development of a constituent and component resource kit to enhance tripartite student outreach.

Association Support for Members Participating in Various Reimbursement Systems: One of the responsibilities of the Council on Membership, as stated in the ADA *Constitution and Bylaws*, is "to identify and monitor trends and issues that affect membership recruitment and retention, particularly among underrepresented segments, and to encourage membership involvement throughout organized dentistry."

Since 1993, the Council has identified and responded to numerous issues that directly affect the Association's ability to recruit and retain members. Many issues affecting membership are of local concern or confined to the needs of a specific target group and are usually addressed by developing new strategies or adjusting the Council's marketing plan. However, issues of national scope that impact nearly all dentists often require a multiagency response.

The changes in the marketplace continue to evoke a strong emotional response among dentists. Established dentists and new practitioners alike are concerned about their ability to deliver dental care in the practice setting of their choice. Younger dentists and recent graduates must find a way to repay student loans and need the support of their colleagues and local dental society while exploring practice opportunities that may include capitation and other managed care type programs. At its June meeting, Council members discussed reports from volunteer recruiters who feel they would be more effective if they could approach nonmembers with an ADA policy statement that supports its members in the delivery of quality dental care regardless of their reimbursement system or practice setting.

The strength of the profession is directly linked to the Association's ability to meet the needs of a diverse population of patients and dentists. The Council believes that an expression of support from the House of Delegates on this issue will alleviate a threat to the Association's membership support. Therefore, the Council recommends adoption of the following resolution.

66. Resolved, that the American Dental Association supports all of its members regardless of how they choose to be reimbursed (e.g., private pay, managed care, etc.) and encourages their active participation in the Association.

Summary of Resolutions

60. Resolved, that the ADA *Bylaws* be amended to allow the California Dental Association to continue the current electronic debit installment program for two more years through the 1998 billing year, with the second footnote to

Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* amended to read as follows:

** Dues of all members of the California Dental Association are payable January 1, except that active and active life members may participate in an electronic debit installment plan during 1996-97 and 1997-98. The plan shall require equal monthly installments to commence in November 1996 and November 1997, with full payment of the current dues amount to be fully paid by June 30, 1997 and June 30, 1998, respectively. No interest may be charged members participating in the plan. However, penalties may be imposed, prorated to the American Dental Association (ADA) and California Dental Association, for expenses incurred as a result of missed installments. The electronic debit installment plan shall provide for expeditious transfer of the ADA portion of the members' dues, and any late payment penalties, to the account of the ADA as soon as commercially feasible.

61. Resolved, that Resolution 33H-1985 (*Trans.*1985:610), Allied Dental Organization Membership Contingent on ADA Membership, be amended by deleting the word "Allied" from the title; replacing the word "allied" in the first resolving clause with the word "other"; and deleting the word "allied" from the second resolving clause so that the amended policy reads as follows:

Dental Organization Membership Contingent on ADA Membership

Resolved, that the American Dental Association enter into dialogue with other dental organizations to encourage them to adopt and utilize procedures with respect to continuing membership in their organizations being contingent upon maintenance of ADA membership, and be it further
Resolved, that dental organizations which currently require members or applicants to also hold membership in the American Dental Association be encouraged to annually confirm their members' current ADA membership status.

62. Resolved, that Resolution 28-1963-H (*Trans.*1963:285), Dentists Retired from Federal Service, be amended by the addition of a second resolving clause so that the amended policy reads as follows:

Resolved, that dentists who have retired from the federal dental services and who engage in some form of nonfederal occupation associated with dentistry be urged to take membership in both constituent and component societies if such exist and where there are no provisions of the bylaws which prohibit such membership, and be it further
Resolved, that constituent and component societies be encouraged to change their bylaws requirements to recognize years of federal dental service membership in the criteria for component and constituent life member status.

63. Resolved, that Resolution 41H-1989 (*Trans.*1989:540), Allied Organizations' Support for ADA Recruitment and Retention Activities, be amended by deleting the word "allied" wherever it appears and substituting it with the word "other" so the amended resolution reads as follows:

Resolved, that the American Dental Association urge other dental organizations to support membership recruitment and retention activities of organized dentistry, and be it further
Resolved, that the American Dental Association encourage those organizations that require maintenance of ADA membership to exchange current information on membership and specialty status with the ADA on an annual basis.

64. Resolved, that Resolution 31-1959-H (*Trans.*1959:219), Qualifications for Membership, be amended by deleting the qualifying phrase "if he is engaged, on a full-time basis, as a teacher in a dental school or as an administrative officer in an activity associated with the ethical dental profession" so that the amended resolution reads as follows:

Resolved, that the constituent societies be requested to examine their bylaws with a view to making any change in the qualifications for active membership to permit a dentist licensed in another state to become an active member.

65. Resolved, that Resolution 121H-1977 (*Trans.*1977:957), Student Membership, be amended in the first resolving clause by addition of the word "dental" before the word "students"; deleting the word "full-fledged" and the phrase "while they are in dental school," and be it further
Resolved, that the second resolving clause be amended by addition of "/ADA" after "ASDA," and be it further
Resolved, that the third resolving clause be deleted, so that the amended policy reads as follows:

Resolved, that all dental students who are preparing themselves to become members of the dental profession be urged to become active members of the American Student Dental Association and the American Dental Association, and be it further
Resolved, that all deans and faculties of dental schools be requested to encourage membership in ASDA/ADA.

66. Resolved, that the American Dental Association supports all of its members regardless of how they choose to be reimbursed (e.g., private pay, managed care, etc.) and encourages their active participation in the Association.

Council on Membership

Supplemental Report 2: Report of Dues Structure Study

Background: Resolution 39H-1995 (*Trans.*1995:604) directed that the Association conduct a comprehensive review of the effectiveness of the current dues structure with input from the appropriate communities of interest and report the findings to the 1996 House of Delegates. The resolution requires that any recommendations for modifying the current dues structure include a financial and membership impact analysis.

Survey Design: Implementation of the study was assigned to the Council on Membership, the agency that initially proposed the need for a periodic review of the Association's membership policies. At its February 1996 meeting, the Council approved a list of leadership and volunteer groups to receive the questionnaire. In addition to the dental society representatives, the Council acknowledged the opportunity to obtain the member perspective on these issues and directed that a random sample of 1,000 members also be surveyed.

At the Council's request, the ADA Survey Center developed two survey documents designed to gather opinions and evaluate perceptions of the current ADA dues structure and its effect on membership recruitment and retention. The Council was particularly interested in the opinions regarding the impact and effectiveness of the dues policies implemented in 1991 as the Dues Equity Plan (*Trans.*1989:510). Accordingly, the Council sought the perspective of leaders who experienced the implementation of the Dues Equity Plan, and also requested that the 1993 and 1995 constituent society presidents be surveyed.

The survey cover letter included a reminder of the goals of the Dues Equity Plan: to aid recruitment and retention; to be equitable so that the dues burden would be distributed to all segments of the membership; and to provide the Association with sufficient financial strength to deliver the desired programs and services needed for the profession. For purpose of comparison, several questions in the survey were identical to questions asked of dental society leaders in the 1989 dues equity survey.

Data Collection: In May 1996, a total of 1,443 questionnaires were either faxed or mailed to staff and leadership of constituent and component societies, the American Student Dental Association, specialty societies, and representatives of various agencies and committees familiar with membership policies and issues. As of the June 20 Council meeting, the society leadership survey yielded 386 returned questionnaires for a 27% response rate. The following is the distribution of respondents grouped by category:

- 55.5% represent constituent society leadership (president, president-elect, past president, executive director or federal dental service chief);
- 25% represent component society leadership (president or executive director);
- 16.1% represent councils or committees (members of ADA Committee on the New Dentist, chairmen of ADA councils, and members of constituent and component membership and new dentist committees); and
- 3.4% represent ASDA officers/board members and delegates, presidents and executive directors of recognized specialty organizations.

A second survey document was also mailed in May 1996 to a random sample of 1,000 member dentists. As of June 20, 293 members returned questionnaires resulting in a 29.3% response rate. Survey data from late returns continue to be tabulated and final results will be available from the ADA Survey Center.

Findings: At its June meeting, the Council reviewed the preliminary data report provided by the Survey Center from the questionnaire, and a summary of the survey results and Council analysis follows. As previously indicated, several questions were identical to key questions asked of dental society leaders in a 1989 questionnaire. The opinions expressed in the 1989 survey influenced the development of the Dues Equity Plan which was implemented in 1991.

Impression of Dues Structure. Dental society leaders and members were asked their general impression of the overall dues structure. A summary of selected opinions are as follows with comparison responses from the 1989 survey of dental society leaders if available.

- Most societies and members do not believe the current structure is difficult to understand.

  Less than 40% of societies and 36% of members feel the current dues structure is complicated. In 1989, over 68% of dental societies felt the previous dues structure was too complicated.

  Nearly one-half (48%) of the society leaders feel the current dues structure has no effect on recruiting and retaining members. The percentage that feels the dues structure has a positive or negative effect is approximately equal, at about 25% each.

  Twenty-seven percent (27%) of the dental societies think the current dues structure has a negative effect on their ability to recruit and retain members. This is a considerable improvement from 1989 when 45% of dental society leaders perceived the former dues structure to have a negative effect on their membership activities.

- Societies and members favor continuing to offer zero dues to certain membership groups.

  The majority of societies and members indicated that the ADA should continue to offer zero dues to some membership groups. Those groups that received the most support for zero dues were dentists with a disability (88.5% of dental societies; 85.9% members); first-time active members in the year of graduation (91.8% of dental societies; 84.9% members); relief fund recipients (86.8%

of dental societies; 83.9% members); and retired life members (85.2% of dental societies; 83% members).

- Most of the dental societies indicate that they have identical dues structure as the ADA for active life members and retired life members. About 83.2% of the dental societies held the same dues structure for active life members, and about 91.1% for retired life members.

  Concerning active life members, about 77.3% of the dental societies feel the current dues rate (50% of full dues) should not change for these members. Although 10.4% thought dues should be decreased, 12.3% felt the dues rate should be increased.

- The goal of the ADA dues structure should be to maximize membership.

  Two thirds (68.8%) of dental societies and 61.4% of members believe the most important goal of the dues structure is to maximize the number of members. Respondents indicated that the least important goal is to minimize the number of dues categories. In 1989, 56% of dental societies agreed the most important goal was to maximize membership.

Reduced Dues for Special Groups: Dental societies and members were asked to consider specific membership categories that currently require a reduced payment. The majority of opinions supported maintaining dues reductions for all groups.

Groups That Pay Zero Dues. At least 70% of the dental societies indicated that the ADA should continue to offer zero dues to the membership groups currently eligible. Dentists with financial hardships (77.9%) and the first-time active members in the first year of licensure who graduated from a foreign dental school (70%) are the categories that received support from the fewest respondents.

A similar pattern exists when the dental societies were asked whether their dental society also offers zero dues to the same membership groups. The membership groups with the smallest percentages at zero dues are again dentists with financial hardships (79.3%) and first-time active members in the first year of licensure who graduated from a foreign dental school (66.3%). The majority of dental societies offer zero dues to the remaining membership groups.

Groups That Pay Partial Dues. While the vast majority of the dental societies feel that each current membership group should maintain the same percentage reduction of full dues, a number of dental societies indicated that the level of dues of certain groups should be increased or decreased. Dental societies indicated that charitable practitioners (25%) and graduate students (19%) should pay higher dues rates. Eighteen percent (18%) indicated a preference for further dues rate reductions for recent graduates in their first and second years of practice and twenty-one percent (21%) indicated further dues reductions for retired members. Approximately 75% of the dental societies indicated that their dental societies offered the same percentage of dues reduction to these membership groups.

Reduced Dues for Additional Membership Groups. From a list of membership groups that have previously been recommended for reduced dues, many dental societies and members were asked if they would be supportive of the ADA dues reduction for each group. Two groups received relatively more support than other groups: dentists married to dentists (40.5%), and dentists just entering employment (50.5%). Membership groups that received the least support to receive possible reduced dues are dentists in group practice (2.9%) and foreign-trained dentists (4.0%).

Most dental societies suggested at least one membership group to receive possible dues reduction when asked to cite three. The most common membership groups cited across the three choices are dentists just entering employment (23.1%), dentists married to dentists (17.4%) and full-time faculty (17.1%). Dentists in group practice and foreign-trained dentists were chosen by less than 2% of the respondents.

Council Discussion and Analysis. The Association continues to receive an increasing number of requests from a variety of sources to consider establishing a reduced dues category for a particular group of dentists with special needs. Knowledgeable membership recruiters have indicated a preference to amend the Association dues policies to allow dues reductions for groups that they believe deserve special consideration. These special groups include: part-time practitioners (which encompass women and older semi-retired practitioners); full-time faculty; dentists married to dentists; and limited income dentists, including new practitioners with high debt and small revenues, as well as those dentists who serve special population groups for a minimal salary on a full-time basis.

In addition, the Council has recently received requests from state and federally employed dentists to reduce dues rates. The Council acknowledged that the dues burden is currently reduced for federally employed dentists as they are eligible for direct ADA membership. Further, dentists employed by a state or local government agency can benefit themselves and the profession by becoming actively involved in organized dentistry. Although the dues study indicated that 79.2% of dental societies and 79.4% of members were not supportive of a dues reduction for state or local government employed dentists, dues waivers for financial hardship are available to those members in need.

The Council has reviewed and discussed one or more of these requests at each of its meetings and a summary of the discussions regarding the unique circumstances and needs of one of these groups follows.

Spousal Membership. Noting that the incidence of dentists married to dentists has been rising steadily over the past ten years, the Council has spent considerable time analyzing the issue of a spousal membership category. In the development of the Dues Equity Plan in 1989 the Association considered a dues reduction for dentists married to dentists but did not recommend a national spousal reduction. However, state and local societies were encouraged to consider developing such a category if appropriate. Since that time, only the Michigan Dental Association has implemented a special classification and dues reduction for dentists married to dentists.

The Council studied the Michigan Dental Association's spousal membership category which seems to have been a cost-effective means in attracting additional spousal couples into membership.

The Council analyzed trend data and received estimates indicating that nationally the number of dentists married to

dentists could be as high as 5,000. The Council considered many options including offering reduced dues to one or both spouses, waiving the dues allocation for ADA publications for one spouse, and offering a spousal membership on a pilot basis. However, none of the options addressed several fundamental concerns.

- Individual Membership. The Council noted that ADA membership is an individual membership and benefits cannot be divided and shared by spousal dentists any more than these can be divided and shared by dentists in a group practice.
- Value of Membership. All member dentists receive the benefits of ADA efforts on behalf of the profession; the Council stated that reducing the dues for dentists married to dentists solely on the basis of their marital status would devalue these benefits for member dentists who are not married to dentists.
- Precedent. The Council questioned that if spouses are eligible for reduced membership, it would set a precedent for additional dues discount arrangements for other family practices such as father/daughter practices or sibling arrangements.
- Administration. The Council was concerned with the logistics and costs of administration: record keeping, receipt of publications, verification of marital status and incidence of divorce.
- Dues Structure Study. The Council noted that the majority of members (76.5%) and societies (59.5%) do not support offering reduced dues to dentists married to dentists.

The Council also noted that mechanisms exist for providing dues relief when one spouse is not working for a period of time. An individual taking an educational sabbatical or time off to care for children or parents can apply for retired membership status; couples with financial difficulties can apply for financial hardship dues waivers. In fact, the Council has made several recommendations in the past two years to increase the promotion of dues waivers options, including updating the dues waiver section of the *ADA Membership Manual* for constituent and component societies, and the promotion of dues waivers and dues options that address changes in membership status through the Council's Membership Chair Network. Therefore, the Council does not recommend the creation of a national spousal membership category.

Reduced Dues for Recent Graduates: The current dues structure offers a rate of 25% of full dues for dental school graduates one year out of dental school and a dues rate of 50% of full dues for those two years out of school. In order to qualify for the two years of reduced ADA dues, recent graduates must maintain continuous membership following graduation.

Most of the dental societies (70.5%) feel that the current dues structure for graduates of either dental school or an advanced education program has a positive effect on the member's willingness to renew membership after the two years. However, only 51% of the members responding to the survey who actually took advantage of the reductions felt the two-year schedule had a positive effect on their membership renewal.

Council Discussion and Analysis. The Council discussed the financial plight of many new graduates and noted that data collected in the dues structure study indicated that 53.9% of members believe that dentists just entering employment should receive reduced dues. Of the dental societies, 64.1% indicated that recent graduates should continue to receive two years of reduced dues and 35.9% recommended changing the structure. Virtually all of the respondents who indicated changing the structure recommended extending the number of years. The average length of reduced dues recommended was 2.5 years.

The Council received input from the American Student Dental Association (ASDA) consultants indicating that dental students from all parts of the country have expressed concern to their ASDA leadership about the cost of continuing membership in organized dentistry. ASDA strongly urged the Council to expand the reduced dues structure and minimize the dues burden for recent graduates. Although the Association lacks quantifiable data that suggests that the current dues structure is a primary barrier to membership, the Council is conducting a major research effort this year that will gather opinions from a large sampling of members, nonmembers and former members. The Field Service Program participants regularly report that their hands-on recruitment efforts would be even more successful if dues were made more affordable to new practitioners. Many critics of the current dues structure suggest a four- to seven-year reduced dues schedule to delay the impact of full dues for new dentists.

Although most (80%) constituent societies currently maintain a similar two-year reduced dues schedule, the Council is aware that several state societies are in the process of increasing dues reductions for recent graduates. For example, the Nebraska Dental Association has approved a four-year reduced dues schedule; the Pennsylvania Dental Association is considering a three-year schedule; and The Dental Society of the State of New York is considering a five-year reduced dues schedule. The Council also noted that the California Dental Association and the Michigan Dental Association have maintained the Association's previous four-year reduced dues schedule.

The Council reviewed end-of-year 1995 membership reports and noted the continual decline in market share for recent graduates one to five years out of dental school. Although the overall national ADA market share has stabilized at 73.2%, the average market share percentage of new dentists one to five years after graduation was 57.6% in 1995.

In reviewing this data and the membership and financial impact of extending reduced dues, the Council determined that extending the reduced dues structure from two to three years would positively impact the Association's ability to attract and retain recent graduate members. This change will communicate the Association's recognition of the debt burden sustained by today's recent graduates and support the tripartite's coordinated efforts to recruit new dentists.

Membership and Financial Implications. The Council discussed a number of alternative dues schedules, their potential impact on membership and the financial implication of each. The Council utilized 1995 membership data and an estimated full dues amount of $291, which represents a $55 reduction from the 1996 full dues amount of $346.

The Council calculated that the additional year of dues reduction would affect 1,245 members and result in a loss of $89,640 in dues revenue. These estimated 1,245 members would pay $219 (75%) instead of the full dues amount of $291 or $72 less. (1,245 x $72 = $89,640)

Although the Council expects that the adoption of a three-year reduced schedule will result in an increase in the number of members who join or retain membership, no estimate is projected.

Council Recommendation. The Council recommends that a three-year reduced dues structure for recent graduates be implemented in 1998, offering 25% of full dues the first year after graduation from dental school, 50% of full dues the second year, 75% the third year, and full dues the fourth year. The Council also recommends that recent dental school graduates maintain continuous membership following graduation in order to qualify for the three years of reduced dues. Therefore, the Council recommends adoption of the following resolution.

67. Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* be amended in condition (1) by deleting the phrase "and 100% in the third year and thereafter" and by substituting in its place a new phrase that reads "75% in the third year and 100% in the fourth year and thereafter," so the amended condition (1) reads as follows:

> (1) On a one-time basis, the dentist, when awarded a D.D.S. or D.M.D. degree, shall be exempt from the payment of active member dues for the remaining period of that year, and shall pay 25% of active member dues for the first full calendar year following the year in which the degree was awarded, 50% of active member dues in the second year, 75% in the third year and 100% in the fourth year and thereafter.

and be it further

Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* be amended in condition (4) by deleting the phrase "and 100% in the third year and thereafter" and by substituting in its place a new phrase that reads "75% in the third year and 100% in the fourth year and thereafter," so the amended condition (4) reads as follows:

> (4) On a one-time basis, a new graduate of a non-accredited dental school who has recently been licensed to practice dentistry in a constituent dental society of the American Dental Association shall be exempt from payment of active member dues for the remaining period of the year upon receipt of a dental license. The newly licensed graduate of a non-accredited school shall pay 25% of active member dues the first full calendar year following the year in which the license was obtained, 50% of active member dues in the second year, 75% in the third year and 100% in the fourth year and thereafter.

and be it further

Resolved, that the aforementioned, reduced active member dues shall be effective January 1, 1998, and be it further

Resolved, that constituent and component dental societies be encouraged to offer the same three-year reduced dues structure to recent graduates.

The Council realizes that the proposed bylaw amendments require a two-thirds majority vote while the fourth resolving clause requires only a simple majority for adoption. The Council believes that implementation of the fourth resolving clause is contingent upon adoption of the bylaw amendments and the fourth resolve will be moot if the amendments are not approved. On that basis the Council believes it is appropriate to include all four resolving clauses in this one resolution.

Provisional Members: The ADA currently maintains a provisional membership category for recent graduates who are not licensed or practicing; this membership allows the dentists to maintain direct ADA membership for up to 18 months after graduation. Established with the adoption of Resolution 47H-1985 (*Trans.*1985:580), this category of membership was developed to assist recent graduates in making the transition from student to active membership. Only dentists not qualified for tripartite membership are eligible and provisional status allows these members access to essential ADA resources and benefits. The Council is aware of the problems associated with the ineligibility of recent graduates to secure membership and believes an increasing number of new dentists experience a delay beyond 18 months following graduation before securing a license and beginning a practice.

Citing the high licensure examination failure rates, the mobility of the recent graduates, and the importance of reaching out to new dentists, the Council believes that an extended eligibility period for ADA provisional status would afford recent graduates the opportunity to stay connected to organized dentistry until they are licensed and eligible for tripartite membership. The Council believes that an extension of the provisional membership category would also provide the Association with the means to counter the perception among many new dentists that the American Dental Association is "responsible" for their difficulties with the licensing process. Noting that once a dentist is licensed or practicing he/she is no longer eligible for provisional membership and that few individuals would be affected (194 provisional members in 1995), the Council supports extending the eligibility period to 30 months.

Membership and Financial Implications. Although the Council was unable to estimate the number of dentists affected by extending the eligibility for provisional membership, there will not be a negative financial result. Additional revenue could be generated because only currently ineligible nonmembers will qualify and, therefore, a positive financial impact would result.

Council Recommendation. The Council believes that this recommendation will have a positive impact on new dentists while having no negative financial impact on the Association. Therefore, the Council submits the following resolution.

68. Resolved, that Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection H. PROVISIONAL MEMBER, of the *Bylaws* be amended by deleting the last sentence and by substituting in its place a new last sentence to read as follows:

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

so the amended Subsection H reads as follows:

H. PROVISIONAL MEMBER. To be a provisional member, a dentist:

1. Shall have received the degree of D.D.S. or D.M.D. from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association;
2. Shall not have established a place of practice; and
3. Shall have applied for provisional membership within 12 months of graduation.

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

Summary of Resolutions

67. Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* be amended in condition (1) by deleting the phrase "and 100% in the third year and thereafter" and by substituting in its place a new phrase that reads "75% in the third year and 100% in the fourth year and thereafter," so the amended condition (1) reads as follows:

(1) On a one-time basis, the dentist, when awarded a D.D.S. or D.M.D. degree, shall be exempt from the payment of active member dues for the remaining period of that year, and shall pay 25% of active member dues for the first full calendar year following the year in which the degree was awarded, 50% of active member dues in the second year, 75% in the third year and 100% in the fourth year and thereafter.

and be it further
Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* be amended in condition (4) by deleting the phrase "and 100% in the third year and thereafter" and by substituting in its place a new phrase that reads "75% in the third year and 100% in the fourth year and thereafter," so the amended condition (4) reads as follows:

(4) On a one-time basis, a new graduate of a non-accredited dental school who has recently been licensed to practice dentistry in a constituent dental society of the American Dental Association shall be exempt from payment of active member dues for the remaining period of the year upon receipt of a dental license. The newly licensed graduate of a non-accredited school shall pay 25% of active member dues the first full calendar year following the year in which the license was obtained, 50% of active member dues in the second year, 75% in the third year and 100% in the fourth year and thereafter.

and be it further
Resolved, that the aforementioned, reduced active member dues shall be effective January 1, 1998, and be it further
Resolved, that constituent and component dental societies be encouraged to offer the same three-year reduced dues structure to recent graduates.

68. Resolved, that Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection H. PROVISIONAL MEMBER, of the *Bylaws* be amended by deleting the last sentence and by substituting in its place a new last sentence to read as follows:

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

so the amended Subsection H reads as follows:

H. PROVISIONAL MEMBER. To be a provisional member, a dentist:

1. Shall have received the degree of D.D.S. or D.M.D. from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association;
2. Shall not have established a place of practice; and
3. Shall have applied for provisional membership within 12 months of graduation.

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

Council on Membership and Council on Ethics, Bylaws and Judicial Affairs

Joint Report: Response to Resolution 138-1995, Definition of the Word "Elect" as Found in the *Bylaws* to Mean "Select" by Vote

Background: Last year the Council on Ethics, Bylaws and Judicial Affairs gave its opinion that the word "elect," as used in the *Bylaws* to describe the process by which the constituent and component societies choose their members, means to select by whatever means the constituent/component societies deem appropriate. The Council based its opinion on the context in which the word "elect" is used in Chapter II. CONSTITUENT SOCIETIES, and Chapter III. COMPONENT SOCIETIES to describe the powers of the constituent and component societies over membership decisions. The Council noted that in both places the word "elect" is used in the context of a broad grant of authority to the constituent and component societies to determine their membership and that of the ADA. The only limit on their authority is the requirement that members must meet the qualifications for membership set forth in the ADA *Bylaws*. The Council concluded that it was reasonable to interpret the word "elect" as used in this context to mean to select for membership by whatever method the constituent and component society deems appropriate, as long as the method is fair and nondiscriminatory. The Council further concluded that constituents and components that use a method other than a vote to determine their membership are not in conflict with the ADA *Bylaws*.

Resolution 138-1995 (*Trans.*1995:607) calls on the House of Delegates, as the ultimate authority on the meaning of the ADA *Bylaws*, to override the Council on Ethics, Bylaws and Judicial Affairs and to define the word "elect" as found anywhere in the *Bylaws* to mean to select by vote. Resolution 138-1995 was referred to the Council on Membership with input from the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) for study and report back to the 1996 House of Delegates.

Both councils considered the resolution at their respective 1996 meetings. At its February 1996 meeting, the Council on Membership supported CEBJA's position, noting that some societies use an administrative process, rather than an actual vote, to select their members. This was verified by a survey of constituent societies completed in December 1995 which documented current methods of determining membership. The Council on Membership believes that if a vote was made mandatory, many constituent and component societies would have to change their current procedures, with possible negative consequences. At its June meeting, the Council on Membership considered a comprehensive review conducted by CEBJA of every place where the word "elect" in one of its forms is used in the ADA *Bylaws*. The Council on Ethics, Bylaws and Judicial Affairs advised the Council on Membership that, with the exception of the places in the *Bylaws* dealing with membership decisions, defining the word "elect" as called for in Resolution 138 would not affect the procedures used by the ADA or its constituent and component societies.

Recommendation: The Council on Membership and the Council on Ethics, Bylaws and Judicial Affairs agree that it would be desirable to clarify the meaning of the word "elect" as used in the ADA *Bylaws* while, at the same time, preserving the right of the constituent and component societies to exercise reasonable discretion over their membership decisions. Therefore, the Council on Membership and the Council on Ethics, Bylaws and Judicial Affairs jointly recommend that the House adopt the following resolution in lieu of Resolution 138.

Resolution

51. Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection H. MEMBERS ELECTED AFTER JULY 1 AND OCTOBER 1, of the ADA *Bylaws* by amended by substituting the word "selected" for the word "elected" wherever it appears in the subsection, so the amended subsection reads:

> H. MEMBERS SELECTED AFTER JULY 1 AND OCTOBER 1. Those members selected to active membership in this Association after July 1, except for those where membership has lapsed for failure to pay the current year's dues, shall pay one half (1/2) of the current year's dues, and those selected after October 1, shall pay one-quarter (1/4) of the current year's dues; except that a student member, upon classification as an active member by a constituent society shall pay no further dues for the remainder of the calendar year in which the member was entitled to the benefits of student membership.

and be it further
Resolved, that Chapter II. CONSTITUENT SOCIETIES, Section 30. POWERS AND DUTIES, of the ADA *Bylaws* be amended by substituting the word "select" for the word "elect" in Subsection A, so that the amended subsection reads as follows:

> A. A constituent society shall have the power to select its active, life, and retired members as active members of this Association within the limits of Section 40 of this Chapter.

and be it further
Resolved, that Chapter III. COMPONENT SOCIETIES, Section 20. POWERS AND DUTIES, of the ADA *Bylaws* be amended by substituting the word "select" for the word "elect" in Subsection A, so that the amended subsection reads as follows:

A. A component society shall have the power to select its active, life, and retired members as active members of the constituent society in accordance with Chapter II, Section 40, of these *Bylaws*.

and be it further
Resolved, that the word "elect" as found everywhere else in the *Bylaws* be defined to mean to select by vote.

Council on Scientific Affairs

Supplemental Report 1: Recent Council Activities

Revision of the Provisions for Acceptance of Products: At its meeting in June 1996, the Council on Scientific Affairs recommended that the Provisions for Acceptance of Products by the Council on Scientific Affairs (*Trans.*1994:676) be revised to address two concerns of the Council. The first involves clarifying Section III.C. of the Provisions to indicate that all proprietary studies using the product must be provided as part of the product submission. The second involves products currently Accepted by the Council and the means by which the Council can assess their continued acceptable clinical performance. In order to address these concerns, the Council recommends adoption of the following resolution.

69. Resolved, that the Provisions for Acceptance of Products by the Council on Scientific Affairs (*Trans.*1994:676) be amended in Section III. Evidence of Safety and Efficacy, by deleting the existing Subsection C. Additional Evidence, and replacing it with a new Subsection C. to read:

> C. *Additional Evidence*: The manufacturer will also submit for review all proprietary studies for the product as well as a list of all other 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.

and be it further
Resolved, that the Provisions for Acceptance of Products by the Council on Scientific Affairs be further amended in Section III. Evidence of Safety and Efficacy, by adding a new Subsection D. Postmarketing Surveillance, to read:

> D. *Postmarketing Surveillance*. For renewal of Acceptance the manufacturer may be required to submit evidence demonstrating continued acceptable clinical performance of the product. This evidence may be in the form of new clinical studies, reports of adverse reactions or follow-up investigations of previously submitted clinical studies.

Amendment of ADA Policies to Reference the Council on Scientific Affairs: At its June 1996 meeting, the Council on Scientific Affairs reviewed current Association policies. The Council noted that reference is made to the three former scientific Councils (Council on Dental Therapeutics; Council on Dental Materials, Instruments, and Equipment; and Council on Dental Research) in certain of these policies. As these Councils were merged to form a single Council, the Council on Scientific Affairs, adoption of the following resolution is recommended.

70. Resolved, that current Association policies be reviewed and any reference to the Council on Dental Therapeutics, the Council on Dental Materials, Instruments and Equipment, and the Council on Dental Research be replaced with reference to the Council on Scientific Affairs.

Disclaimer Policy for ADA Advertisers and Exhibitors: Pursuant to the directions as set forth by the House of Delegates in Resolution 15H-1995 (*Trans.*1995:660), at its June 1996 meeting, the Council on Scientific Affairs began its review of Association policies relating to scientific affairs. This review of Association policies will continue at future meetings.

The Council determined that the policy on the Nonendorsement of Products Advertised or Exhibited (*Trans.*1983:570) was too narrow in its scope, as it does not differentiate between non-Seal products and Seal products that have been accepted into the Seal Program based on evaluation of their safety and efficacy. The Council, therefore, recommends the following resolution which is consistent with current policy, but in addition, differentiates between Seal and non-Seal products. The resolution is also consistent with the disclaimer currently used for advertising in Association publications.

71. Resolved, that the ADA adopt a disclaimer for all of its publications and for its annual session which clearly states that the ADA does not endorse directly or indirectly the product or service that is the subject of the advertisement or exhibit unless the advertisement or exhibit specifically includes an authorized statement that such approval or endorsement has been granted, and be it further
Resolved, that Resolution 66H-1983 (*Trans.*1983:570), Nonendorsement of Products Advertised or Exhibited, be rescinded.

Efficacy of Universal Precautions: The Centers for Disease Control and Prevention (CDC) has issued recommendations for preventing the transmission of the human immunodeficiency virus (HIV) and hepatitis B virus (HBV) in health care settings.[1] These recommendations specify that infection-control programs should incorporate the principles of universal precautions, which include appropriate use of hand washing, protective barriers, and care in the use and disposal of needles and other sharp instruments for all patients regardless of medical history. Policy of the American Dental Association also supports the principles of universal precautions (*Trans.*1991:591, 592), and the Association has long advocated the use of universal precautions to its members.[2] Both the Association and the CDC take the position that the application of these principles will assist in minimizing the risk of transmission of HIV and other bloodborne diseases from patient to dental care worker, from dental care worker to patient and from patient to patient.

1. Centers for Disease Control. Recommendations for preventing transmission of human immunodeficiency virus and hepatitis B virus to patients during exposure-prone invasive procedures. *MMWR* 1991;40(RR-8);1-7.
2. Council on Scientific Affairs and Council on Dental Practice, American Dental Association. Infection control recommendations for the dental office and dental laboratory. *JADA* 1996;127:672.

Consistent with its practice of periodically reviewing the scientific literature on which Association policy is based, the Council on Scientific Affairs at its June 1996 meeting conducted a thorough review of the scientific literature on infection control. On the basis of this review, the Council concluded that the data continue to support the effectiveness of universal precautions in significantly reducing exposures to blood and, as a result, the risk of bloodborne disease transmission. Included in the Council's review were articles on percutaneous and nonparenteral exposures, epidemiological and serological studies and outbreak investigations, as well as data from the Association's Health Screening Program. These studies, and the Council's conclusions based on the studies, are discussed below.

- Reduction in Percutaneous Exposures

A number of studies evaluated reports of percutaneous exposures before and after the implementation of universal precautions.[3-6] All studies report a sustained decrease in percutaneous injury rates following the implementation of universal precautions. Several studies report decreases in needlestick injury rates ranging from 60% to 70% over a three- to four-year period.[4-6] Studies conducted by the ADA demonstrate a consistent decrease in the number of annual percutaneous injuries among dentists from 1987 through 1993.[7,8] Dentists reported an average annual injury rate of approximately 11 in 1987, as compared with approximately three in 1993, for an overall decrease in percutaneous injury rate of approximately 70%.

Conclusion. Whereas barriers, such as gloves, are not intended to prevent percutaneous injuries, adherence to other "non-barrier" recommendations encompassed by the concept of universal precautions (e.g., careful handling and disposal of sharps) significantly lowers these exposures.

- Reduction in Nonparenteral Exposures

A number of studies implemented before and after the institution of universal precautions demonstrate a notable reduction in rates of nonparenteral exposures to blood and body substances.[3,9,10] In one observational study of emergency department workers, skin-blood contact rates are 11.2 per 100 procedures for ungloved workers and only 1.3 for gloved workers.[10] Another study, looking directly at the barrier efficacy of gloves during patient encounters, reports gloving protects against hand contamination 87% of the time.[11] The study further reports that there is not a strong correlation between glove leaks and microbial contamination of the hands. This is primarily due to the fact that gloves with leaks still prevent hand contamination 77% of the time. The practice of changing gloves between patients, and routine hand washing, is also associated with decreases in nosocomial colonization and cross-infection rates among patients.[11]

Conclusion. The literature supports the efficacy of gloves in reducing the risk of nonparenteral exposures to blood and other body fluids.

- Retrospective Epidemiological and Serological Studies

Hepatitis B Virus. Data gathered at the ADA's annual Health Screening Program between 1983 and 1995 show an overall increase in the frequency of vaccination (22% to 86%) among dentists, accompanied by decreasing trends in serological evidence of HBV infection (14% to 9%).[12,13] This latter trend is likely to be a result of increases in vaccine use, in combination with the institution of universal precautions.

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3. Wong ES, Stotka JL, Chinchilli VM, et al. Are universal precautions effective in reducing the number of occupational exposures among healthcare workers? A prospective study of physicians on a medical service. *JAMA* 1991;265:1123.
4. Beekman SE, Vlahov D, Koziol DE, et al. Temporal association between implementation of universal precautions and a sustained, progressive decrease in percutaneous exposures to blood. Clin Infect Dis 1994;18:562.
5. Linneman CC, Cannon C, DeRonde M, Lanphear B. Effect of educational programs, rigid sharps containers, and universal precautions on reported needlestick injuries in healthcare workers. Infect Control Hosp Epidemiol 1991:12;214.
6. Haiduven DJ, DeMaio TM, Stevens DA. A five year study of needlestick injuries: significant reduction associated with communication, education, and convenient placement of sharps containers. Infect Control Hosp Epidemiol 1992;13:265.
7. Siew C, Gruninger SE, Miaw C-L, Neidle EA. Percutaneous injuries in practicing dentists. *JADA* 1995;126:1227.
8. American Dental Association, Annual Session, Health Screening Program, 1993 (unpublished data).
9. Fahey BI, Koziol DE, Bands SM, Henderson DK. Frequency of nonparenteral occupational exposures to blood and body fluid before and after universal precautions. Am J Med 1991;90:145.
10. Marcus R, Culver DH, Bell DM, et al. Risk of human immunodeficiency virus infection among emergency department workers. Am J Med 1993;94:393.
11. Olsen RJ, Lynch P, Coyle MB, et al. Examination gloves as barriers to hand contamination in clinical practice. *JAMA* 1993;270:350.
12. Cleveland JL, Siew C, Lockwood SA, et al. Trends in hepatitis B vaccination and infection among U.S. dentists, 1983-1992. (Submitted for publication).
13. American Dental Association. HIV occupational risk appears low. Screening program reports testing results from session. ADA News 1996;27(1):1 and 12

Hepatitis C Virus. Most studies suggest that the prevalence of anti-HCV antibodies in both general dentists and oral surgeons is similar to that for the general population (0.7% to 1.4%).[14-16] These studies are most important because, unlike HBV, there is no vaccine against HCV, and health care workers can only rely on the use of universal precautions as a means to reduce the risk of disease transmission.

Human Immunodeficiency Virus. As of January 1, 1995, investigations of 64 HIV-infected health care workers had been reported to the CDC. Epidemiological and laboratory follow-up of 22,171 of their patients did not reveal any health care worker to be a source of HIV for any of these patients.[17] As of December 31, 1995 no dental worker has been documented as occupationally acquiring HIV infection.[18]

Conclusion. Epidemiological and serological studies indicate low rates of occupational bloodborne disease transmission among dental workers, which gives further support to the efficacy of universal precautions.

- Outbreak Investigations

Since the early 1970s, hepatitis B is known to have been transmitted during invasive procedures from 34 infected health care providers, including nine dentists and oral surgeons, to at least 350 patients. However, since 1987, when dentists began routinely wearing gloves, no outbreaks have been associated with the practice of dentistry.

Two recent reports of HBV and HCV transmission from infected health care workers to patients identify circumstances and procedural events which may increase the risk of transmission despite any deficiencies in infection control practices.[19,20] These circumstances and procedural events include shear injuries to fingers during prolonged suture tying and punctures inflicted by bone edges during sternal closure.

Conclusion. While these reports provide useful information for further defining the epidemiology of blood contacts, they do not identify a new mode of disease transmission and they do not bring into question the efficacy of universal precautions in further reducing the already low risk of bloodborne disease transmission in the dental office.

In summary, the scientific literature demonstrates that the application of universal precautions assists in minimizing the risk of transmission of HIV and other bloodborne diseases from patient to dental health care worker, dental health care worker to patient and patient to patient. More specifically, the literature demonstrates that the implementation of universal precautions results in:

- sustained decreases in the number of percutaneous exposures experienced by health care workers;
- sustained decreases in the number of nonparenteral exposures experienced by health care workers;
- decreasing trends in serological evidence of HBV infection among dentists;
- similar anti-HCV seroprevalence rates between dentists and the general population;
- no evidence of HIV transmission from infected health care workers to their patients (excluding the alleged Acer case); and
- no evidence of HIV transmission from infected patients to dentists.

The concept of universal precautions is evolving and will be further refined as knowledge of occupational bloodborne disease transmission advances. The Council believes that efforts at prevention should not focus on the infection status of the health care provider, or the patient, but on eliminating the proximate cause of blood contacts: accidental percutaneous injuries sustained during invasive procedures. The studies discussed above demonstrate that most intraoperative percutaneous injuries can be prevented and changes in surgical technique, improved barrier materials, and the use of blunt suture needles may all contribute to further reducing the already low risk of occupational disease transmission. However, the Council believes it is important to make clear that universal precautions will never create a "zero-risk" environment. The provision of health care will always carry, as it always has, a degree of risk, however small, for occupational infection.

Although the efficacy of universal precautions is reflected in existing ADA policy dealing with HIV infection and AIDS, current policy does not address the efficacy of universal precautions in preventing exposure to other bloodborne pathogens. The Council believes that expanding the policy to cover other bloodborne pathogens is scientifically justified and would provide useful guidance to the membership. With this in mind, the Council recommends adoption of the following resolution.

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14. Kuo MY, Hahn LJ, Hong CY, et al. Low prevalence of hepatitis C virus infection among dentists in Taiwan. J Med Virol 1993;40:10.
15. Herbert AM, Walker DM, Davies KJ, Bagg J. Occupationally acquired hepatitis C infection. Lancet 1992;339:305.
16. Thomas DL, Gruninger SE, Siew SE, et al. Occupational risk of hepatitis C infections among general dentists and oral surgeons in North America. Am J Med 1996;100:41.
17. Robert LM, Chamberland ME, Cleveland JL, et al. Investigations of patients of health care workers infected with HIV. The Centers for Disease Control and Prevention database. Annals Intern Med 1995;122:653.
18. Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report 1995, vol. 7, No. 2.
19. Harpaz R, Seidlein LV, Averhoff FM, et al. Transmission of hepatitis B virus to multiple patients from a surgeon without evidence of inadequate infection control. N Engl J Med 1996;334:549.
20. Esteban JI, Gomez J, Martell M, et al. Transmission of hepatitis C by a cardiac surgeon. N Engl J Med 1996;334:555.

72. Resolved, that based on current scientific and epidemiological data, universal precautions continue to be an effective means of reducing blood contacts that can result in disease transmission, minimizing even further the already low risk of bloodborne disease transmission in the dental office, and be it further

Resolved, that dentists are strongly urged to adhere to universal precautions in their practices, as set forth in the current infection control recommendations of the American Dental Association and the Centers for Disease Control and Prevention, and be it further

Resolved, that patients with bloodborne diseases may be safely treated in the private dental office when appropriate infection control procedures are employed.

Color Coding for Local Anesthetics: Resolution 31H-1993 (*Trans.*1993:717) directed the ADA, in cooperation with local anesthetic manufacturers, to pursue the development and implementation of a uniform system of color coding for local anesthetic cartridges. The color coding system was primarily intended to identify the type and concentration of local anesthetics and vasoconstrictors, as well as to ensure a legible and durable print on the cartridges.

The resolution was communicated to the Accredited Standards Committee MD156 Working Group on Cartridges, Needles, and Syringes. The Working Group, whose members consist of representatives from the profession, dental schools and industry, developed the following color coding system, which was circulated to all interested parties.

The Council on Scientific Affairs approved the color coding system after the review of comments submitted. Manufacturers of local anesthetic cartridges will be notified of the color coding system and the system will be incorporated into the ADA Acceptance Program. The color coding system will also be submitted to the International Organization for Standardization (ISO) for consideration as an international standard.

PRODUCT	PMS* COLOR CODE
Lidocaine 2% and Epinephrine 1:100,000	Red: 185, 186, 199, or 200
Lidocaine 2% and Epinephrine 1:50,000	Green: 347, 348, 355, or 356
Mepivacaine 2% with Levonordefrin 1:20,000	Brown: 477, 478, 498, or 499
Mepivacaine 3%	Light blue: 291, 292, or 2905
Prilocaine 4% with Epinephrine 1:200,000	Yellow: 108, 109, 115, or 116
Prilocaine 4% Plain	Black
Bupivacaine HCL Epinephrine Inj.	Blue: 300 or 301
Etidocaine HCL 1.5% with Epinephrine	Orange: 1505 or 151
Lidocaine HCL Inj. Plain	Gray: 430 or 431

*Colors per Pantone Matching System, Pantone, Inc.

Summary of Resolutions

69. Resolved, that the Provisions for Acceptance of Products by the Council on Scientific Affairs (*Trans.*1994:676) be amended in Section III. Evidence of Safety and Efficacy, by deleting the existing Subsection C. Additional Evidence, and replacing it with a new Subsection C. to read:

> C. *Additional Evidence*: The manufacturer will also submit for review all proprietary studies for the product as well as a list of all other 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.

and be it further
Resolved, that the Provisions for Acceptance of Products by the Council on Scientific Affairs be further amended in Section III. Evidence of Safety and Efficacy, by adding a new Subsection D. Postmarketing Surveillance, to read:

> D. *Postmarketing Surveillance*. For renewal of Acceptance the manufacturer may be required to submit evidence demonstrating continued acceptable clinical performance of the product. This evidence may be in the form of new clinical studies, reports of adverse reactions or follow-up investigations of previously submitted clinical studies.

70. Resolved, that current Association policies be reviewed and any reference to the Council on Dental Therapeutics, the Council on Dental Materials, Instruments and Equipment, and the Council on Dental Research be replaced with reference to the Council on Scientific Affairs.

71. Resolved, that the ADA adopt a disclaimer for all of its publications and for its annual session which clearly states that the ADA does not endorse directly or indirectly the product or service that is the subject of the advertisement or exhibit unless the advertisement or exhibit specifically includes an authorized statement that such approval or endorsement has been granted, and be it further
Resolved, that Resolution 66H-1983 (*Trans.*1983:570), Nonendorsement of Products Advertised or Exhibited, be rescinded.

72. Resolved, that based on current scientific and epidemiological data, universal precautions continue to be an effective means of reducing blood contacts that can result in disease transmission, minimizing even further the already low risk of bloodborne disease transmission in the dental office, and be it further
Resolved, that dentists are strongly urged to adhere to universal precautions in their practices, as set forth in the current infection control recommendations of the American Dental Association and the Centers for Disease Control and Prevention, and be it further
Resolved, that patients with bloodborne diseases may be safely treated in the private dental office when appropriate infection control procedures are employed.

Report of Anesthesiology Task Force

Response to Resolution 107H-1995

Background: Resolution 107H-1995 (*Trans.*1995:644) reads as follows:

> **107H-1995. Resolved,** that the President, with the concurrence of the Board of Trustees, appoint a task force to develop guidelines for the administration of pain and anxiety control in dentistry that will meet the needs of dental patients, and be it further
> **Resolved,** that the task force obtain input from all interested parties within dentistry and from the appropriate representatives of the American Society of Anesthesiologists, and be it further
> **Resolved,** that the task force utilize the approved ADA Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry (*Trans.*1992:610) as a foundation for its deliberations, and be it further
> **Resolved,** that the task force be encouraged to develop guidelines that will provide for patient safety without significantly increasing health care costs through unnecessary regulation, and be it further
> **Resolved,** that the task force recommend, if appropriate, that parameters be developed for conscious sedation, deep sedation and general anesthesia in dentistry, utilizing input for all communities of interest, and be it further
> **Resolved,** that a full and complete report be presented to the 1996 House of Delegates.

As directed by Resolution 107H-1995, the President, with the concurrence of the Board of Trustees, appointed an Anesthesiology Task Force to study this resolution. Members appointed to the Task Force include Dr. William A. Finagin, Fourth District trustee, chairman; Dr. Peter K. Doyle; Dr. Ralph H. Epstein; Dr. J. Theodore Jastek; Dr. Thomas R. Osterlind; Dr. Leonard S. Tibbetts; and Dr. Stephen Wilson. The Task Force held two meetings at the ADA Headquarters in Chicago; the first was held on March 29-30, 1996; the second was held on May 9, 1996. All members were in attendance at both meetings as well as several Association staff. In addition, Jeffrey B. Gross, M.D., chairman, American Society of Anesthesiologists' (ASA) Task Force on Sedation and Analgesia by Non-Anesthesiologists met with the Task Force on March 29, 1996. In addition, five members of the committee, including the chairman, met by telephone conference call on July 22, 1996.

Summary of the Committee's Deliberations: During its initial meeting, the Task Force carefully reviewed and discussed Resolution 107H-1995. The Association's policy, The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry (*Trans.*1985:577), and its Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry (*Trans.*1992:610) were also considered.

Following review of the ASA's newly adopted Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, and in response to the directive in the resolution calling for ASA input, the Task Force had in-depth discussion of the document with Dr. Jeffrey Gross, who attended the meeting as the ASA's representative.

As a result of its discussion, the Task Force concluded that:

- there was a need to revise the Association's policy, The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry;
- there was a need to draft ADA guidelines for the use of sedation and analgesia by dentists; and
- it was important that the ADA guidelines reflect appropriate content contained in the ASA document.

The Task Force benefited greatly from the contributions Dr. Jeffrey Gross, chairman of the ASA Task Force on Sedation and Analgesia by Non-Anesthesiologists, made during the Task Force's deliberations at its first meeting. Dr. Gross aided the Task Force in gaining a better understanding of the ASA's rationale for developing its guidelines for non-anesthesiologists. Specifically, it was stressed that the ASA document was developed at the request of hospital anesthesia departments who were looking for guidance in establishing guidelines for their specific hospital. According to Dr. Gross, when the ASA document was drafted, dentistry was included as part of the broader picture; however, dentistry's role was not a primary consideration. Rather, the ASA document's intended audience was within the hospital arena.

In discussing the ADA's proposed draft documents, Dr. Gross stated that, in his opinion, the proposed ADA guidelines would be viewed by the ASA as supplemental and complementary information to aid hospitals in developing their own specific guidelines.

Draft Documents: Appendix 1 is a proposed revision of an existing Association document, The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry. The original document was approved by the House of Delegates in 1985, with editorial revisions in 1994. Appendix 2 is a proposed draft of the guidelines called for in Resolution 107H-1995. The Task Force believes that, when completed, the two documents should be distributed together as a single document with the policy statement preceding the guidelines.

In presenting the proposed documents for consideration, the Task Force believes these documents establish a reasonable and appropriate level of guidance to allow all dentists (generalists and specialists) who administer these pain control modalities to provide their patients with the benefits of anxiety and pain control in a safe and efficacious manner. Further, the Task Force believes that the proposed guidelines will not seriously impact the practitioner's ability to use these modalities. The Task Force further believes that the proposed guidelines provide for patient safety without significantly increasing health care costs.

Call for Comments: Although the Task Force was comprised of both general dentists and specialists, the Task Force believed that it was important that the proposed documents be

circulated to the communities of interest prior to adoption by the House. Accordingly, at its June 1996 meeting, the Board directed that the documents be transmitted to the communities of interest. The documents were subsequently transmitted in correspondence from Dr. John Zapp dated June 20, 1996. The communities of interest included constituent dental societies, state boards of dentistry, dental specialty organizations and certifying boards, national dental organizations and the American Society of Anesthesiology. The deadline for receipt of comments was July 10, 1996. A total of 28 comments were received.

The Anesthesiology Task Force reviewed all comments received. Subsequently, the documents have been revised to reflect changes made as a result of the call for comments. Comments received were extremely complimentary of the Association's efforts to develop these documents for the profession. The comments primarily focused on the Guidelines document, although a few minor editorial comments were received regarding the Association's policy statement.

State Regulation: The following information is presented as background information concerning the legislation of the pain control modalities discussed in the proposed documents.

General Anesthesia/Conscious Sedation. Currently, 49 states regulate the use of general anesthesia (GA) by dentists; 48 regulate the use of conscious sedation (CS). Regulation of GA and CS generally requires issuance of a permit. Permit prerequisites frequently include postdoctoral training for the dentist, on-site inspections including demonstration of emergency procedures, mandated equipment, record-keeping requirements for drugs and patients, continuing education and payment of substantial fees. A few states mandate the presence of additional trained personnel in the operatory while GA or CS is administered.

Nitrous Oxide. Twenty-nine states regulate nitrous oxide in some way; 21 do not regulate it in any manner.

Seven states define conscious sedation as including use of nitrous in combination with another agent, while several states specifically exclude nitrous oxide from the definition of conscious sedation.

Of the 29 states which regulate nitrous oxide, only 13 require a permit and, of those, six may require an on-site inspection. The remainder of the states impose requirements such as use of fail-safe and/or scavenger devices on nitrous oxide tanks, training in use of nitrous oxide, or training in cardiopulmonary resuscitation (CPR).

Thirteen states permit dental hygienists to administer nitrous oxide analgesia. Additionally, at least 34 states permit dental hygienists to monitor nitrous oxide analgesia, and 24 permit dental assistants to do the same.

Parameters: Resolution 107H-1995 directed the Task Force to consider whether or not parameters should be developed for conscious sedation, deep sedation and general anesthesia. The Task Force gave careful consideration to this matter and urges that consideration be given to the development of practice parameters to complement the proposed guidelines. In discussing this issue, the Task Force noted that the ADA's approved practice parameters are conditioned-based parameters and this format may not easily lend itself to the development of pain and anxiety control parameters. Nonetheless, the Task Force believes the Association should have parameters in this area for use by the dental profession. At its June 1996 meeting, the Board recommended that the Dental Practice Parameters Committee be requested to consider developing appropriate parameters for the use of conscious sedation, deep sedation and general anesthesia in dentistry.

Summary: This report details the actions taken to address the directives contained in Resolution 107H-1995. The final documents are appended.

Resolutions

78. Resolved, that the revised Association's policy, The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry, be adopted, and be it further
Resolved, that Resolution 24H-1985 (*Trans.*1985:576), approving the previous policy, be rescinded.

79. Resolved, that the proposed Guidelines for the Use of Sedation and Analgesia by Dentists be approved.

Appendix 1

THE USE OF CONSCIOUS SEDATION, DEEP SEDATION AND GENERAL ANESTHESIA IN DENTISTRY

Introduction

Dentists have had both a historic and specific continuing expertise in providing anesthetic, sedative and other anxiety and pain control procedures for their patients. The effective control of anxiety and pain has been an integral part of dental practice since the early development of the profession. Use of a wide variety of anxiety and pain control techniques has enabled the profession to extend oral health care to millions of individuals who would otherwise remain untreated. Without effective anxiety and pain control, numerous dental procedures are virtually impossible and many patients do not seek needed dental treatment. In addition, both anxiety and pain control techniques are often essential for the management of special patients, young children and the mentally and physically challenged. The use of anxiolytic sedative and anesthetic techniques by appropriately trained dentists in the dental office and other settings continues to have a remarkable record of safety.

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

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

This policy statement addresses the use of conscious sedation, deep sedation and general anesthesia, as defined in the Association's Guidelines for

Appendix 1 (continued)

Teaching the Comprehensive Control of Pain and Anxiety in Dentistry. These terms refer to the effects upon the central nervous system and should not be confused with any route of drug administration.

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

Education

Dentists who have received appropriate formal education in conscious sedation, deep sedation and general anesthesia are qualified to use these modalities in practice. Training to competency in conscious sedation techniques may be acquired at the predoctoral, postgraduate, graduate, or continuing education level. Dentists who wish to utilize conscious sedation are expected to successfully complete formal training which is structured in accordance with the Association's educational Guidelines, "Part One: Teaching the Comprehensive Control of Pain and Anxiety to the Dental Student" and/or "Part Three: Teaching the Comprehensive Control of Pain and Anxiety in a Continuing Education Program."

The knowledge and skills required for the administration of deep sedation and general anesthesia are beyond the scope of predoctoral and continuing education. Only dentists who have completed an advanced education program structured in accordance with "Part Two: Teaching of Pain Control and Management of Related Complications at the Advanced Education Level" of the Guidelines or equivalent advanced education are considered educationally qualified to use deep sedation and general anesthesia in practice.

Appendix 1 (continued)

The dental profession's continued ability to control anxiety and pain effectively is dependent on maintaining a strong educational foundation in the discipline. While many practicing dentists may elect not to use conscious sedation, deep sedation or general anesthesia, it is critical that those who wish to do so have access to adequate training. The Association supports efforts to expand the availability of courses and programs at the predoctoral, advanced and continuing educational levels which are structured in accordance with its educational Guidelines in anxiety and pain control. It urges dental schools to expand opportunities for predoctoral students to receive training and clinical experience in conscious sedation techniques. It urges continuing education sponsors to offer comprehensive courses in accordance with the Guidelines in conscious sedation techniques which include sufficient opportunity for supervised clinical experience to enable participants to achieve competency in these techniques. Finally, it urges sponsors of advanced dental education to develop programs at the postgraduate level which are designed to train individuals in conscious sedation deep sedation and general anesthesia.

The objective of educating dentists to utilize conscious sedation, deep sedation and general anesthesia is to enhance their ability to provide oral health care.

Risk Management

Appropriate educational preparation, while necessary, is not by itself sufficient to ensure safe and effective use of conscious sedation, deep sedation and general anesthesia. There is some degree of risk associated with the use of any drug, even when administered by trained individuals. Dentists who are qualified to utilize conscious sedation, deep sedation and/or general anesthesia have a responsibility to minimize risk to patients undergoing dental treatment by:

Appendix 1 (continued)

- Using only those drugs and techniques with which they are thoroughly familiar, i.e., understand the indications, contraindications, adverse reactions and their management, drug interactions and proper dosage for the desired effect;

- Limiting use of these modalities to patients who require them due to such factors as the extent and type of the operative procedure, psychological need or medical status;

- Conducting comprehensive preoperative evaluation of each patient to include a comprehensive medical history, assessment of current physical and psychological status, age and preference for and past experience with sedation and anesthesia;

- Conducting physiologic and visual monitoring of the patient as needed from onset through recovery of patient management.

- Having available appropriate emergency drugs, equipment and facilities and maintaining competency in their use;

- Maintaining fully documented records of drugs used, dosage, vital signs monitored, adverse reactions, recovery from the anesthetic, and, if applicable, emergency procedures employed;

- Utilizing sufficient support personnel who are properly trained for the functions they are assigned to perform;

- Treating high risk patients in a setting equipped to provide for their care.

The Association expects that patient safety will be the foremost consideration of dentists who use conscious sedation, deep sedation and/or general

Appendix 1 (continued)

anesthesia. Dentists who use these modalities should take all necessary measures to minimize risk to patients.

State Regulation

State dental boards have a responsibility to ensure that only dentists who are properly trained, experienced, and currently competent are permitted to use conscious sedation, deep sedation and general anesthesia within their jurisdictions. For this reason, the Association strongly urges state dental boards to regulate dentists' use of these modalities. In addition to identifying educational requirements which are consistent with the Association's Guidelines, state dental boards should consider evaluation of dentists who apply to use conscious sedation, deep sedation and/or general anesthesia to ensure that the protocol, procedures, facilities, drugs, equipment and personnel utilization meet acceptable standards for safe and appropriate use. Special attention should be directed to assessing the adequacy of patient monitoring and emergency care capabilities.

States introducing regulation of conscious sedation, deep sedation and/or general anesthesia may elect to identify a period of time during which practitioners without the specified educational qualifications may apply and be evaluated for the use of these modalities. These practitioners should have demonstrated competence in the use of the regulated modalities over an extended period of time as determined by the state dental board.

Research

The use of conscious sedation, deep sedation and general anesthesia in dentistry will be significantly affected by research findings and advances in these areas. The Association strongly supports the expansion of both basic and clinical research in anxiety and pain control. It urges institutions and agencies that fund and sponsor research to place a high priority on this type

Appendix 1 (continued)

of research, which should include: 1) epidemiological studies which provide data on the number of these procedures performed and on morbidity and mortality rates, 2) clinical studies of drug safety and efficacy, 3) basic research on the development of safer and more effective drugs and techniques, 4) studies on improving patient monitoring and 5) research on behavioral and other non-pharmacological approaches to anxiety and pain control.

Appendix 2

PROPOSED
GUIDELINES FOR THE USE OF CONSCIOUS SEDATION, DEEP SEDATION
AND GENERAL ANESTHESIA FOR DENTISTS

I. Introduction

A. ADA Policy Statement on Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry

B. Purpose

The purpose of these guidelines is to allow dentists to provide their patients with the benefits of anxiety and pain control in a safe and efficacious manner.

II. Definitions

Methods of Anxiety and Pain Control

analgesia - the diminution or elimination of pain

anxiolysis - the diminution or elimination of anxiety

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

conscious sedation[1] - a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command and that is produced by a pharmacological or non-pharmacological method or a combination thereof.

In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of conscious sedation.

deep sedation - an induced state of depressed consciousness accompanied by partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or to respond purposefully to verbal command, and is produced by a pharmacological or non-pharmacological method or a combination thereof.

general anesthesia - an induced state of unconsciousness accompanied by partial or complete loss of protective reflexes, including the inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, and is produced by a pharmacological or non-pharmacological method or a combination thereof.

Routes of Administration

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

[1] Parenteral conscious sedation may be achieved with the administration of a single agent or by the administration of more than one agent.

Appendix 2 (continued)

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

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

inhalation - a technique of administration in which a gaseous or volatile agent is introduced into the pulmonary tree and whose primary effect is due to absorption through the pulmonary bed (e.g., nitrous oxide/oxygen sedation).

Terms

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

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

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

continual - repeated regularly and frequently in a steady succession.

continuous - prolonged without any interruption at any time.

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

Levels of Knowledge

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

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

Levels of Skill

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

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

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

immediately available - on site in the facility and available for immediate use

III. Patient Physical Status Classification

ASA I - A normal healthy patient. *(ASA = American Society of Anesthesiologists)*

ASA II - A patient with mild systemic disease.

ASA III - A patient with severe systemic disease.

Appendix 2 (continued)

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

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

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

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

IV. Educational Requirements

A. Inhalation Conscious Sedation.

1. To administer inhalation conscious sedation, the dentist must satisfy one of the following criteria:

   a. Must have completed training consistent with that described in Part I or Part III of the ADA *Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry*.

   b. Completion of an ADA accredited post-doctoral training program which affords comprehensive and appropriate training necessary to administer and manage inhalation conscious sedation.

   c. This should not exclude individuals who would be grandfathered by individual state laws.

2. The following guidelines shall apply to the administration of inhalation conscious sedation in the dental office:

   a. Provision of inhalation conscious sedation by another duly qualified dentist or physician requires the operating dentist and his/her clinical staff to maintain current expertise in Basic Life Support (BLS).

   b. When a Certified Registered Nurse Anesthetist (CRNA) is permitted to function under the supervision of a dentist, provision of inhalation conscious sedation by a CRNA shall require the operating dentist to have completed training in inhalation conscious sedation, commensurate with these guidelines.

   c. A dentist administering inhalation conscious sedation must document current successful completion of a Basic Life Support (BLS) course.

B. Parenteral Conscious Sedation:

1. To administer parenteral conscious sedation, the dentist must satisfy one of the following criteria:

   a. Completion of a comprehensive training program in parenteral conscious sedation that satisfies the requirements described in Part III of the ADA *Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry* at the time training was commenced.[2]

[2] Prior to July 1, 1993, the ADA *Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry* required only 40 hours of a comprehensive course in parenteral conscious sedation. Since July 1, 1993, that requirement has been increased to 60 hours in addition to laboratory experience and supervised management of 20 patients.

Appendix 2 (continued)

b. Completion of an ADA accredited post-doctoral training program (e.g., general practice residency) which affords comprehensive and appropriate training necessary to administer and manage parenteral conscious sedation.

c. This should not exclude individuals who would be grandfathered by individual state laws.

2. The following guidelines shall apply to the administration of parenteral conscious sedation in the dental office:

a. Provision of parenteral conscious sedation by another duly qualified dentist or physician requires the operating dentist and his/her clinical staff to maintain current expertise in Basic Life Support (BLS).

b. When a Certified Registered Nurse Anesthetist (CRNA) is permitted to function under the supervision of a dentist, provision of parenteral conscious sedation by a CRNA shall require the operating dentist to have completed training in parenteral conscious sedation, commensurate with these guidelines.

c. A dentist administering parenteral conscious sedation must document current, successful completion of a Basic Life Support (BLS) course. ACLS or its age-appropriate equivalent is encouraged.

C. Deep Sedation/General Anesthesia:

1. To administer deep sedation/general anesthesia, the dentist must satisfy one of the following criteria:

a. Completion of an advanced training program in anesthesia and related subjects beyond the undergraduate dental curriculum that satisfies the requirements described in Part II of the ADA *Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry* at the time training was commenced.[3]

b. Completion of an ADA accredited post-doctoral training program (e.g., oral and maxillofacial surgery) which affords comprehensive and appropriate training necessary to administer and manage deep sedation/general anesthesia, commensurate with these guidelines.

c. This should not exclude individuals who would be grandfathered by individual state laws.

2. The following guidelines shall apply to the administration of deep sedation/general anesthesia in the dental office:

a. Provision of deep sedation/general anesthesia by another duly qualified dentist or physician requires the operating dentist and his/her clinical staff to maintain current expertise in Basic Life Support (BLS).

[3] Prior to July 1, 1993, the prescribed length of training described in the *ADA Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry* was of one year's duration. As of July 1, 1993, the prescribed length of training was extended to two years.

Appendix 2 (continued)

b. When a Certified Registered Nurse Anesthetist (CRNA) is permitted to function under the supervision of a dentist, provision of deep sedation/general anesthesia by a CRNA shall require the operating dentist to have completed training in deep sedation/general anesthesia, commensurate with these guidelines.

c. A dentist administering deep sedation/general anesthesia must document current, successful completion of an Advanced Cardiac Life Support (ACLS) course (or its age-appropriate equivalent).

V. Clinical Guidelines

A. Inhalation Conscious Sedation

1. Patient Evaluation

Patients subjected to inhalation conscious sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this may be simply a review of their current medical history and medication use. However, with individuals who may not be medically stable or who have a significant health disability (ASA III, IV) consultation with their primary care physician or consulting medical specialist regarding potential procedure risk is desirable.

2. Pre-procedure Preparation, including Informed Consent

- The patient and/or guardian must be advised regarding the procedure associated with the delivery of the inhalation agent and the appropriate informed consent should be obtained
- The inhalation equipment must be evaluated for proper operation and delivery of inhalation agents prior to use on each patient.
- Determination of adequate oxygen supply must be completed prior to use with each patient.
- Baseline vital signs may be obtained at the discretion of the operator depending on the medical status of the patient and the nature of the procedure to be performed.

3. Personnel and Equipment Requirements

<u>Personnel</u>:

- During administration of inhalation conscious sedation, at least one additional person should be present, in addition to the dentist.

<u>Equipment</u>:

- Must have a fail-safe system that is appropriately checked and calibrated.
- If nitrous oxide and oxygen delivery equipment capable of delivering less than 25% oxygen is used, an in-line oxygen analyzer must be used.

Appendix 2 (continued)

- The equipment must have an appropriate scavenging system.

4. Monitoring and Documentation

Monitoring:

- Direct clinical observation of patient during administration must occur.

Documentation:

- Should document individuals present during administration.
- Must document maximum concentration administered.

5. Recovery and Discharge

Recovery:

- Recovery from inhalation conscious sedation, when used alone, should be relatively quick, requiring only that the patient remain in an operatory chair as needed.
- Patients who have unusual reactions to inhalation conscious sedation should be assisted and monitored either in an operatory chair or recovery room until stable for discharge.

Discharge:

- Dentist must determine that patient is appropriately responsive prior to discharge.

6. Special Situations (to include multiple/combination techniques and types of special patients)

- Whenever inhalation conscious sedation is utilized in combination with any other sedative agent, including over the counter (OTC) medications, consideration should be given to using guidelines as outlined below in Section B), Parenteral Conscious Sedation or Section C), Deep Sedation/General Anesthesia.

7. Emergency Management

- The dentist, personnel and facility must be prepared to treat emergencies that may arise from the administration of inhalation conscious sedation.

B. Parenteral Conscious Sedation

1. Patient Evaluation

Patients subjected to parenteral conscious sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this may be simply a review of their current medical history and medication use. However, with individuals who may not be medically stable or who have a significant health disability (ASA III, IV) consultation with their primary

Appendix 2 (continued)

care physician or consulting medical specialist regarding potential procedure risk or special monitoring requirements is desirable.

2. Pre-procedure Preparation
- Informed Consent

- The patient and/or guardian must be advised regarding the procedure associated with the delivery of any sedative agents and the appropriate informed consent should be obtained.
- If inhalation equipment is used in conjunction with parenteral conscious sedation, the equipment must be evaluated for proper operation and delivery of inhalation agents prior to use on each patient.
- Determination of adequate oxygen supply must be completed prior to use with each patient.
- Baseline vital signs should be obtained unless the patient's behavior prohibits such determination.
- Pretreatment physical evaluation must be performed as deemed appropriate.
- Specific dietary restrictions must be delineated based on the technique used and patient's physical status.
- Appropriate verbal or written instructions must be given to the patient and/or guardian.
- An intravenous line which is secured throughout the procedure must be established (see exceptions: special situations).

3. Personnel Requirements and Equipment

Personnel:

- During administration of parenteral conscious sedation, the dentist and at least one other individual who is currently competent in Basic Life Support (BLS), or its equivalent, must be present.

Equipment (if appropriate for procedure):

- Must have a fail-safe system that is appropriately checked and calibrated.
- If nitrous oxide and oxygen delivery equipment capable of delivering less than 25% oxygen is used, an in-line oxygen analyzer must be used.
- The equipment must have an appropriate scavenging system.
- Regardless of procedure, a positive pressure oxygen system suitable for patients being treated must be available.

4. Monitoring and Documentation

Appendix 2 (continued)

Monitoring:

- Direct clinical observation of patient during administration must occur.

Oxygenation:

- Color of mucosa, skin or blood should be continually evaluated.
- Oxygen saturation must be evaluated continuously by pulse oximetry.

Ventilation:

- Must observation of chest excursions and/or auscultation of breath sounds.

Circulation:

- Must continually evaluate blood pressure and heart rate.
- Continuous EKG monitoring of patients with significant cardiovascular disease must be accomplished.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained.
- Should document individuals present during the administration of parenteral conscious sedation.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available in the recovery area and/or operatory.
- Continual monitoring of oxygenation, ventilation and circulation when the anesthetic is no longer being administered; patient must have continuous supervision until oxygenation, ventilation and circulation are stable and the patient is appropriately responsive for discharge from the facility.
- Must determine and document that oxygenation, ventilation and circulation are stable prior to discharge.
- Must provide explanation and documentation of postoperative instructions to the patient and/or a responsible adult at the time of discharge.
- The dentist must determine that the patient has met discharge criteria prior to leaving the office.

6. Special Situations (to include multiple/combination techniques and types of special patients)

In selected circumstances, parenteral conscious sedation may be utilized without establishing an indwelling intravenous line. These circumstances include sedation for very brief

Appendix 2 (continued)

procedures; young children managed entirely by non-intravenous techniques; or the establishment of intravenous access after sedation has been induced due to poor patient cooperation.

7. Emergency Management

- The anesthesia permit holder/provider is responsible for the anesthetic management, adequacy of the facility, and treatment of emergencies associated with the administration of parenteral conscious sedation, including immediate access to pharmacologic antagonists and appropriately sized equipment for establishing a patent airway and providing positive pressure ventilation with oxygen.

C. Deep Sedation/General Anesthesia

1. Patient Evaluation

Patients subjected to deep sedation/general anesthesia must be suitably evaluated prior to the start of any sedative/anesthetic procedure. In healthy or medically stable individuals (ASA I, II) this may be simply a review of their current medical history and medication use. However, with individuals who may not be medically stable or who have a significant health disability (ASA III, IV) consultation with their primary care physician or consulting medical specialist regarding potential procedure risk is desirable.

2. Pre-procedure Preparation, including Informed Consent

- The patient and/or guardian must be advised regarding the procedure associated with the delivery of any sedative agents and the appropriate informed consent should be obtained.
- If inhalation equipment is used in conjunction with parenteral conscious sedation, the equipment must be evaluated for proper operation and delivery of inhalation agents prior to use on each patient.
- Determination of adequate oxygen supply must be completed prior to use with each patient.
- Baseline vital signs should be obtained unless the patient's behavior prohibits such determination.
- Pretreatment physical evaluation must be performed as deemed appropriate.
- Specific dietary restrictions must be delineated based on the technique used and patient's physical status.
- Appropriate verbal or written instructions must be given to the patient and/or guardian.
- An intravenous line which is secured throughout the procedure must be established (see exceptions: special situations).

Appendix 2 (continued)

3. Personnel and Equipment Requirement

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

- A dentist qualified, in accordance with Part IV, Section C of this document, to administer the deep sedation/general anesthesia, shall be designated to be in charge of the administration of the anesthesia care.
- Two individuals who are currently competent in Basic Life Support (BLS) or its equivalent, one of whom is trained in patient monitoring.
- When the same individual administering the deep sedation/general anesthesia is performing the dental procedure, a second individual trained in patient monitoring and who is currently competent in Basic Life Support (BLS) or its equivalent.

Equipment:

- Equipment suitable to provide advanced airway management and advanced life support should be on premises and available for use.

4. Monitoring and Documentation

Monitoring:

- Direct clinical observation of patient during administration must occur.

Oxygenation:

- Color of mucosa, skin or blood should be continually evaluated.
- Oxygenation saturation must be evaluated continuously by pulse oximetry.

Ventilation:

- Intubated patient: Must auscultate breath sounds and monitoring of end-tidal CO_2.
- Non-intubated patient: Auscultation of breath sounds or monitoring of end-tidal CO_2.

Circulation:

- Continuous EKG monitoring of all patients throughout the procedure with electrocardioscopy must occur.
- Must take and record blood pressure and pulse continually at least every five (5) minutes.

Temperature:

Appendix 2 (continued)

- A device capable of measuring body temperature should be readily available, if needed, during the administration of deep sedation/general anesthesia.
- When agents implicated in precipitating malignant hyperthermia are utilized, continual monitoring of body temperature must be performed.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained.
- Should document individuals present during the administration of deep sedation/general anesthesia.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available in the recovery area and/or operatory.
- Continual monitoring of oxygenation, ventilation, circulation and temperature, as indicated, when the anesthetic is no longer being administered; patient must have continuous supervision until oxygenation, ventilation, circulation and temperature, as indicated, are stable and the patient is appropriately responsive for discharge from the facility.
- Must determine and document that oxygenation, ventilation, circulation and temperature, as indicated, are stable prior to discharge.
- Must explain and document postoperative instructions to the patient and/or guardian at the time of discharge.
- The dentist must determine that the patient has met discharge criteria prior to leaving the office.

6. Special Situations (to include multiple/combination techniques and types of special patients).

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

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

Appendix 2 (continued)

7. Emergency Management

- The anesthesia permit holder/provider is responsible for the anesthetic management, adequacy of the facility, and treatment of emergencies associated with the administration of parenteral conscious sedation, including immediate access to pharmacologic antagonists and appropriately sized equipment for establishing a patent airway and providing positive pressure ventilation with oxygen.

- Advanced airway equipment, resuscitation medications and a defibrillator must also be immediately available

- Intravenous Dantrolene Sodium must be immediately available if known triggering agents of malignant hyperthermia are part of the anesthesia plan.

Report of Committee on Campaign and Cost Study

Response to Resolution 127H-1995: Study of ADA Campaign Process and Costs

Background: The 1995 House of Delegates adopted the following Resolution 127H (*Trans.*1995:652).

> **Resolved,** that the President appoint a special task force to study ways to reduce the cost and increase the opportunity for quality communications in campaigns for elective office, and be it further
> **Resolved,** that the task force consider as part of the study the elimination of individual candidate hospitality suites to be replaced by an ADA-sponsored hospitality room and candidates' forum, and be it further
> **Resolved,** that the task force report the results of the study and any recommendations to the 1996 ADA House of Delegates.

Accordingly, President Ten Pas appointed a committee consisting of Dr. Walter F. Lamacki, Illinois, chairman; Dr. James T. Fanno, Ohio; Dr. Richard T. Grubb, Washington; Dr. Matthew J. Messina, Ohio; and Dr. Gary Rainwater, Texas. The Committee met at the ADA Headquarters Building, Chicago, on Thursday and Friday, March 28-29, 1996. Dr. Rainwater was unable to attend due to other Association commitments.

Review of Past House of Delegates Actions Related to Campaign Reform: The Committee reviewed the history related to campaign costs, reform, candidate forums and the development of guidelines. These issues have been addressed by the House of Delegates with some regularity since 1971. The Committee was pleased to note that its review revealed a progression which, over the years, has yielded a reasonable set of campaign guidelines and a gradual reduction in campaign hospitality activities. Given the Committee's current charge to "study ways to reduce the cost and increase the opportunity for quality communications," the Committee viewed its job as further refinement of these activities.

Campaign Travel Activities: The Committee believes that the only way to significantly reduce the expenses associated with campaigning is to limit the time candidates devote to this activity and the kinds of meetings they include in their campaigns.

A review of constituent annual meeting dates revealed that significant activity begins in March. As such, the Committee believes that campaign activities should not begin prior to March 1 and that candidate travel should be limited to those district caucuses who formally invite candidates to participate in specific member forums at their annual meetings. **Within those districts that do not caucus prior to the ADA annual session, travel to state annual meetings upon invitation would also be eligible.**

The Committee believes that placing these reasonable limitations on campaign travel could result in reducing the potential number of trips by 50% without disenfranchising any state or district.

Enhanced Communications Opportunities: In its discussions of district caucus campaign travel, the Committee also discussed the need to ensure that this travel provides meaningful opportunities for candidate participation. To accomplish this, the Committee felt that those caucuses (or constituent societies as appropriate) choosing to invite the candidates should be encouraged to:

- structure forums to allow all candidates an opportunity to make appropriate presentations;
- provide an opportunity for the caucus leadership to pose a set of standardized questions to all candidates;
- allow each candidate to respond to the questions without the other candidates present; and
- time permitting, allow candidates to respond to other questions from the audience.

The Committee believes that delaying the onset of campaign activities, limiting the meetings the candidates attend and encouraging the inviting district caucuses to use the suggested meeting format will result in reduced travel expenses for all candidates while improving the opportunities for meaningful communications with the membership.

ADA-Sponsored Hospitality Room and Candidates' Forum: In responding to the idea of an ADA-sponsored hospitality room and candidates' forum, the Committee believes that aside from the difficulty in scheduling such an event to be attractive to a significant number of delegates and alternates, the opportunity for candidates to meet one-on-one with members at district caucuses and in hospitality suites is a far more effective communications vehicle. In addition, the Committee was concerned that a general forum where all candidates were asked to respond to identical questions would not yield the same benefits.

Candidate Agreements: In an effort to address some of the concerns related to the expenses of campaigns, particularly in the area of hospitality suites, the Committee drew on the experience of a recent House contest in which all the candidates voluntarily met to discuss and agree on the level of food and beverage they would offer in their campaign suites. Though never formalized beyond the meeting, the agreement served to reduce the escalation in these hospitality expenses.

The Committee believes that these kinds of informal agreements could serve in general to reduce costs related to campaign literature, promotional activities and gifts, hospitality, and activities in the area of emerging electronic communications. Accordingly, the Committee is recommending that the Executive Director meet with all candidates to facilitate the negotiation of agreements that would enhance the cost-effectiveness of all campaign activities.

Expanded *ADA News* Coverage: The Committee also discussed the print opportunities for candidate coverage,

specifically those in the *ADA News*. While the *News* does provide some coverage, the Committee felt that expanded coverage for all candidates would allow the membership a better opportunity to study the candidates' qualifications and positions on issues and to subsequently provide feedback to their voting members of the House of Delegates.

Conclusion: The Committee believes that much of what it is recommending for the consideration of the House of Delegates can be accomplished through an amendment to the current campaign guidelines document. Expansion of the *ADA News* coverage is addressed in a separate action.

Resolutions

52. Resolved, that the "Guidelines Governing the Conduct of Campaigns for ADA Offices" be amended to read as follows:

Guidelines 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, may freely campaign 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 presentation for election prior to ~~their formal announcement~~ March 1.

NEW

3. Campaign travel shall not begin before March 1 and shall be limited as follows:
   a. to district caucus meetings only (EXCEPTION: within those districts that do not caucus prior to the ADA annual session, travel to annual state meetings upon invitation would also be eligible.), and
   b. by invitation of the district caucus (or constituent society as appropriate) only.

NEW

4. District caucuses (or constituent societies as appropriate) issuing invitations to candidates are requested to provide an appropriate opportunity for the candidates to meet with their members. It is recommended that such forum be structured:
   a. to allow all candidates to make appropriate presentations;
   b. to provide for the caucus leadership to pose a core set of standardized questions to all candidates; and
   c. to allow each candidate to respond to the questions without the other candidates present.

FORMERLY #6

5. The Executive Director shall meet with all candidates to negotiate cost-effective agreements on campaign issues such as the level of hospitality in suites, promotional activities and gifts, campaign literature, and activities related to emerging electronic communications.
6. ~~Candidates for office are encouraged to negotiate agreements between themselves to eliminate expensive promotional activities and gifts.~~

NO CHANGE—FORMERLY #3

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

NO CHANGE—FORMERLY #4

7. Candidates shall limit the display of campaign signs and posters to the immediate area of their respective hospitality suites. (The ADA will provide a prominent directory of all candidates' hospitality suites in the hotel and House of Delegates registration areas.)

NO CHANGE—FORMERLY #5

8. Campaign suites shall only be open on the two nights prior to the election. All campaign social functions will be restricted to the candidate's officially designated hospitality suite at the annual session.

NO CHANGE—FORMERLY #7

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

Any questions regarding the guidelines should be directed to the Office of the Executive Director for clarification.

53. Resolved, that the *ADA News* be urged to expand the coverage of candidates for ADA office in an issue or issues in advance of the annual session.

Resolutions

Submitted by the Board of Trustees, Constituent Societies, Component Societies, Trustee Districts, Delegates and Other Agencies

Board of Trustees

Spouse Members of Alliance of the American Dental Association

Background: The Board acknowledges with appreciation the complementary efforts of the Alliance of the American Dental Association to support organized dentistry at every level. Current Association outreach to dental students presents an excellent opportunity to involve the spouses of dental students as they begin a lifelong relationship with organized dentistry. The Alliance has indicated a willingness to invite student spouses into membership. Current ADA *Bylaws* do not provide for student Alliance membership. In addition, in reviewing the *Bylaws*, the Board determined that this section would benefit from additional clarification. Therefore, be it

136. Resolved, that Chapter XVIII. ALLIANCE OF THE AMERICAN DENTAL ASSOCIATION, Section 10. RECOGNITION, 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.* RECOGNITION: The Association recognizes the Alliance of the American Dental Association as an organization of the spouses of active, life, retired or student members in good standing of this Association, and of spouses of such deceased members who were in good standing at the time of death.

Board of Trustees

Duties of the Standing Committee on the New Dentist

Background: As a standing committee of the Board, the Committee on the New Dentist is charged with submitting reports and proposals to the Board of Trustees for deliberation and action. The Committee met in Cleveland, Ohio, on July 23-25, 1996. The Committee recommends, through the Board of Trustees, that Chapter VII. BOARD OF TRUSTEES, Section 150 of the ADA's *Bylaws* be amended. In particular, "less than ten years out of dental school" should be used consistently throughout this section.

140. Resolved, that Chapter VII. BOARD OF TRUSTEES, Section 150. COMMITTEES, of the *Bylaws* be amended in the first duty of the Committee on the New Dentist (lines 1391-1393) by deleting duty a. in its entirety and substituting in its place a new duty a. to read as follows:

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

Illinois State Dental Society

Adoption of Annual Dues by the House of Delegates

The following resolution was submitted by the Illinois State Dental Society on September 13, 1996 by Mr. Robert A. Rechner, executive director.

Background: Any change in dues of active members has traditionally been submitted to the House of Delegates by the Board of Trustees whenever the financial condition of the Association dictated such a change. Most times, such a change was delayed until all other means were exhausted, and many times such a proposal was met with extensive and, at times, hostile comments and debate by the membership and/or the House of Delegates. In the last two years, the Board of Trustees has found it necessary to submit a $1.00 dues increase to satisfy the notice requirements for a *Bylaws* change in order to allow the House of Delegates to decide what, if any, increase should be enacted to cover the cost of the budget and any additional financial commitments that are necessary due to the actions of the current House of Delegates. In order to expedite the establishment of dues to meet the financial needs of the Association, it is necessary for the House of Delegates to establish the dues of the membership of the Association on an annual basis.

123. Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* be amended by deleting the first footnote and from lines 306 and 307 deleting the words and number: "three hundred forty-six dollars ($346.00) due January 1 of each year" and by substituting in their place the following words and comma: "the amount established annually by the House of Delegates in accordance with the procedure set forth in Chapter V. Section 130Ad of these *Bylaws*," so the amended Section 50 up to and including the colon following the word *Bylaws* on line 314 reads as follows:

> A. ACTIVE MEMBERS. The dues of active members shall be the amount established annually by the House of Delegates in accordance with the procedure set forth in Chapter V, Section 130Ad of these *Bylaws*, except that any dentist, who satisfies the eligibility requirements for active membership under Chapter I, Section 20A, of these *Bylaws* and who satisfies any of the following conditions shall be entitled to pay the reduced active member dues listed under such satisfied condition so long as such dentist maintains continuous membership, subject to the further reductions permitted under the provisions of Chapter I, Section 50H, of these *Bylaws*:

and be it further

Resolved, that Chapter V. HOUSE OF DELEGATES, Section 50. DUTIES, of the *Bylaws* be amended in duty "E" by adding the words "and establish the dues of active members for the following year," so the amended duty "E" reads:

E. To adopt an annual budget and establish the dues of active members for the following year.

and be it further
Resolved, that Chapter V. HOUSE OF DELEGATES, Section 130. RULES OF ORDER, Subsection A. STANDING RULES AND REPORTS, of the *Bylaws* be amended by relettering rules "d" and "e" as "e" and "f" and by adding a new rule "d" to read as follows:

d. APPROVAL OF THE DUES OF ACTIVE MEMBERS. The dues of active members of this Association shall be established by the House of Delegates as the last item of business at each annual session. The resolution to establish the dues of active members the following year shall be proposed at each annual session by the Board of Trustees in accordance with the procedures set forth in this rule. The resolution shall contain a blank space for the amount of these dues and shall read as follows: "Resolved, that except as otherwise provided in these *Bylaws*, the dues of active members of this Association for the next calendar year shall be _____dollars ($___.__) due January 1." The blank space shall be filled by allowing delegates to propose amendments to this resolution. When all suggestions have been offered, the Speaker shall call for a vote on each in the order of their proposal. The amount receiving the highest affirmative vote shall be inserted in the blank. After the blank has been filled, a vote shall be taken on the motion as a whole. The resolution establishing the full dues of active members for the following year shall be adopted by a two-thirds (2/3) majority vote of the members present and voting. If necessary, this procedure shall be repeated until the amount of dues of active members has been established in accordance with this rule.

and be it further
Resolved, that Chapter VII. BOARD OF TRUSTEES, Section 110. DUTIES, of the *Bylaws* be amended by adding to duty "F" the words "and to present for action by each House of Delegates the resolution set forth in Chapter V, Section 130Ad of these *Bylaws*" so the amended duty "F" reads as follows:

F. To prepare a budget for carrying on the activities of the Association for each ensuing fiscal year and to present for action by each House of Delegates the resolution set forth in Chapter V, Section 130Ad of these *Bylaws*.

and be it further
Resolved, that Chapter XX. AMENDMENTS, Section 20. AMENDMENT RELATING TO DUES, of the *Bylaws* be amended by deleting Section 20 in its entirety and by substituting in its place a new Section 20 to read as follows:

Section 20. AMENDMENT AFFECTING THE PROCEDURE FOR ESTABLISHING THE DUES OF ACTIVE MEMBERS: An Amendment of these *Bylaws* affecting the procedure for establishing the dues of active members may be adopted only if the proposed amendment has been presented in writing at least ninety (90) days prior to the first day of the session of the House of Delegates at which it is to be considered. Notice of such a resolution shall be sent by a certifiable method of delivery to each constituent society not less than ninety (90) days before such session to permit prompt, adequate notice by each constituent society to its delegates and alternate delegates to the House of Delegates of this Association, and shall be announced to the general membership in an official publication of the Association at least sixty (60) days in advance of the annual session.

Amendments affecting the procedure for establishing the dues of active members may also be adopted by a unanimous vote provided that the proposed amendment has been presented in writing at a previous meeting of the same session.

Louisiana Dental Association

Legislation Recognizing AIDS as a Communicable Disease

The following resolution was adopted by the Louisiana Dental Association Board of Directors on June 8, 1996 and submitted on June 19, 1996 by Dr. Edward P. Roberson, secretary/ treasurer, Louisiana Dental Association.

39. Resolved, that the American Dental Association, through the appropriate political action initiative, develop and support the necessary legislation to have the medical condition known as AIDS recognized as a communicable disease.

Louisiana Dental Association

Subspecialty Training for Treatment of the Infectious Disease Patient

The following resolution was adopted by the Louisiana Dental Association Board of Directors on June 8, 1996 and submitted on June 19, 1996 by Dr. Edward P. Roberson, secretary/ treasurer, Louisiana Dental Association.

40. Resolved, that dental subspecialty training be recognized for treatment of the infectious disease patient along with guidelines providing for the delineation of discretionary referral of these patients in contradiction to discrimination.

Louisiana Dental Association

Amendment of ADA Policy on Effectiveness of Universal Precautions

The following resolution was adopted by the Louisiana Dental Association Board of Directors on June 8, 1996 and submitted on June 19, 1996 by Dr. Edward P. Roberson, secretary/ treasurer, Louisiana Dental Association.

Background: Recently there has been much discussion in the journals about the plights of our colleagues Dr. Morvant and Dr. Bragdon. Both were found guilty under the Americans with Disabilities Act of discrimination for referring HIV positive patients to a treatment facility. Dr. Morvant reports that after his "referral," his office was contacted via telephone by new patients who stated they were HIV positive, as a test for his response. Those calls were documented and used by the prosecution against Dr. Morvant. Dr. Morvant's attorney stated that the position of our ADA (its policy and neutrality) did more for the prosecution than it did for the defense. The ADA's position should be driven by current scientific knowledge *and* predicated on the intellectual, physical, and emotional elements of the doctor-patient relationship. Neutrality should not be a position of the ADA in cases such as these and the member dentist should reap the benefit of ADA's resources. The ADA policy states, "Current scientific and epidemiologic evidence indicates that there is little risk of transmission of infectious diseases through dental treatment if recommended infection control procedures are routinely followed. Patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed."

It is the law that we must treat patients in our offices because universal precautions "work." This law was also enacted to dispel fear. We cannot operate as a profession from the viewpoint of fear or discrimination, but we must take a hard look at reality. Nowhere in this policy does it state that universal precautions *eliminate* the transmission of infectious diseases. Current scientific knowledge states that recommended infection control procedures simply *reduce* the risk of transmission of infectious diseases. Who establishes something as personal as an acceptable level of risk for a fatal disease, and then by law forces us to assume that risk? Do we opt for neutrality to placate politically correct government agencies? Does this law render as discrimination professional judgment and discretion?

Two more cases have now come forward that question the effectiveness of universal precautions. A "no risk group" patient, married for 18 years, is suing a Maine dentist claiming he contracted the AIDS virus during routine dental procedures (Sharp v. Breglio). The dentist claims he has always followed recommended infection control guidelines. A Boston cardiologist recently passed the hepatitis B virus to 19 of his patients despite wearing gloves and following all other usual precautions. Investigators found no extenuating circumstances for this outbreak. It seems new scientific data may be emerging. We as a profession do not want any more martyrs in the courtroom. The LDA recommends that we approach this from two avenues. The first is to question the efficacy of universal precautions; the second, to recognize subspecialty training for treatment of the infectious disease patient. We urge the members of this House to help pass a meaningful resolution for submission to the ADA for their immediate action.

Therefore, be it

41. Resolved, that the American Dental Association amend its policy on the effectiveness of universal precautions based on the emerging scientific data, integrated with the ethical professional principles of the doctor-patient relationship.

The Dental Society of the State of New York

Accreditation of Undergraduate and Post-Graduate Dental Training Institutions

The following resolution was submitted by The Dental Society of the State of New York on August 19, 1996 by Mr. Roy E. Lasky, executive director.

Background: The ADA Commission on Dental Accreditation is responsible for certifying the quality of dental training programs throughout the United States. Approval by this body has significant consequences. The Commission's approval signifies that dentists receive appropriate undergraduate and post-graduate training experiences. State licensing boards and health certifying agencies also rely on the Commission to identify those settings in which the public may seek care from trainee-dentists under the tutelage and supervision of qualified instructors. In New York state, as dental residents are not exempt from licensure requirements, the State Education Department is charged with issuing limited permits for employment in residencies. The basis for issuing these limited permits is the ADA's accreditation of the setting as an approved training site, i.e., residency. New York is now seeking applications from dentists who believe they are enrolled in residency programs which may be little more than satellite clinics with no true training component.

The health care environment is changing. One notable change has been the expansion of new and alternative settings for health care delivery. In addition to the traditional hospital, clinic, medical and dental school, and private office settings, proprietary or commercial settings are now emerging. In particular, the recent growth in the managed care industry and expansion of facilities owned or operated by health maintenance organizations, other self-funded benefit providers and hospitals themselves have resulted in the emergence of alternative practice settings. To meet state licensing requirements, some facilities have sought affiliation with existing hospitals and universities. Along with these changes have come questions about the appropriateness of having undergraduate students and residents treat patients in facilities which are accredited to provide care under the umbrella of an accredited school or hospital program but are not appropriate residency training sites in and of themselves.

Further, when such programs are offshoots of established universities or hospitals accredited by the ADA as AEGD, Advanced Education in General Dentistry, they may also receive federal funding. The increasing importance of graduate training for dentists, amid calls for cost-containment and the attendant proliferation of hospital ambulatory treatment centers and HMO clinics, brings a need for greater surveillance of training programs. The fundamental question concerns the quality of the training experience gained by such students when treating patients in a setting which is not designed to be, nor functioning as, a training setting.

Dental students and residents enter training programs to acquire professional expertise under the guidance of qualified instructors, not to provide a source of low-cost professional labor. It has been a tacit assumption of the hospital or school that their accreditation carries over to all settings in which care is provided to patients. The ADA Commission on Dental

Accreditation must now recommend policies defining whether or not this should be the case.

This resolution calls for a review of accreditation standards and site visit protocols to mandate that all dentists in undergraduate and graduate training programs treat patients in settings designated primarily to provide appropriate training. At a minimum, it is imperative that these protocols now include site visits to review all satellite locations where students and/or residents treat patients.

94. Resolved, that the ADA Commission on Dental Accreditation be urged to review and revise existing accreditation standards and site visit protocols for graduate and undergraduate dental education programs to include mandated visits to sites where students and/or residents provide patient care.

The Dental Society of the State of New York

Dues Reduction Program for Recent Graduate Members

The following resolution was submitted by The Dental Society of the State of New York on August 19, 1996 by Mr. Roy E. Lasky, executive director.

Background: According to the ADA's Recruitment and Retention report for end-of-year 1995, 64% of ADA members and 35% of nonmembers are under the age of 40. It has become clear to the Second Trustee District that retaining new dentist members, that is, dentists who are fewer than 10 years out of dental school, is becoming increasingly more difficult. One obvious factor for the decline in new dentist members is the level of dues, which is high when viewed in conjunction with educational and postgraduation business debts.

Although more must be done to educate these new dentists about the services and programs available through organized dentistry, we cannot lose sight of the fact that average student loan debt far exceeds the debt of graduates ten, or even five years ago. This postgraduate debt, coupled with the high cost of membership dues, dissuades many new dentists from becoming members.

By implementing a five-year dues reduction plan for graduates, the ADA would be establishing a program to ease the new practitioner into organized dentistry with more manageable dues payments. In addition, the longer six-year transition period is needed for new dentists to become oriented to organized dentistry, take part in dental society activities and use the services offered as they establish their practice.

95. Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* be amended by deleting conditions (1) and (4) in their entirety and by substituting in their place new conditions (1) and (4) to read as follows:

(1) On a one-time basis, the dentist, when awarded a D.D.S. or D.M.D. degree, shall be exempt from the payment of active member dues for the remaining period of that year, and shall pay 25% of active member dues for the first full calendar year following the year in which the degree was awarded, 50% of active member dues in the second and third years, 75% of active member dues in the fourth and fifth years, and 100% in the sixth year and thereafter.

(4) On a one-time basis, a new graduate of a nonaccredited dental school who has recently been licensed to practice dentistry in a constituent dental society of the American Dental Association shall be exempt from payment of active member dues for the remaining period of the year upon receipt of a dental license. The newly licensed graduate of a nonaccredited school shall pay 25% of active member dues the first full calendar year following the year in which the license was obtained, 50% of active member dues in the second and third years, 75% of active member dues in the fourth and fifth years, and 100% in the sixth year and thereafter.

so the amended Subsection A reads as follows:

A. ACTIVE MEMBERS.* The dues of active members shall be three hundred forty-six dollars ($346.00) due January 1 of each year** except that any dentist, who satisfies the eligibility requirements for active membership under Chapter I, Section 20A, of these *Bylaws* and who satisfies any of the following conditions shall be entitled to pay the reduced active member dues listed under such satisfied condition so long as such dentist maintains continuous membership, subject to the further reductions permitted under the provisions of Chapter I, Section 50H, of these *Bylaws*:

(1) On a one-time basis, the dentist, when awarded a D.D.S. or D.M.D. degree, shall be exempt from the payment of active member dues for the remaining period of that year, and shall pay 25% of active member dues for the first full calendar year following the year in which the degree was awarded, 50% of active member dues in the second and third years, 75% of active member dues in the fourth and fifth years, and 100% in the sixth year and thereafter.

(2) The dentist who is engaged full-time in (a) an advanced training course of not less than one academic year's duration in an accredited school or residency program in areas neither recognized by this Association nor accredited by the Commission on Dental Accreditation or (b) a residency program or advanced education program in areas recognized by this Association and in a program accredited by the Commission on Dental Accreditation shall pay thirty dollars ($30.00) due on January 1 of each year until December 31 following completion of such program. For the dentist who enters such a course or program within one (1) year of the award of D.D.S. or D.M.D. degree and who pays dues of thirty dollars ($30.00) per annum while in such a program, the applicable foregoing condition (1) shall toll until completion of that program. Upon completing the program, the dentist shall pay dues for active members at the next period-in-time level that is applicable under condition (1).

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

(4) On a one-time basis, a new graduate of a nonaccredited dental school who has recently been licensed to practice dentistry in a constituent dental society of the American Dental Association shall be exempt from payment of active member dues for the remaining period of the year upon receipt of a dental license. The newly licensed graduate of a nonaccredited school shall pay 25% of active member dues the first full calendar year following the year in which the license was obtained, 50% of active member dues in the second and third years, 75% of active member dues in the fourth and fifth years, and 100% in the sixth year and thereafter.

Texas Dental Association

Dues Structure for Recent Graduates

The following resolution was submitted by the Texas Dental Association, and transmitted on July 22, 1996 by Ms. Mary Kay Linn, executive director.

Background: A significant percentage of the Association's nonrenews is composed of dentists entering their third year of practice, owing full dues. The increase from one-half dues to full dues is staggering to many members and consequently, they choose not to renew their membership. Given this situation, coupled with the changing economic times and the fact that students graduate today with a substantial debt, the Texas Dental Association believes it would benefit the Association and encourage membership by changing the dues structure to ease the economic burden. Therefore, be it

77. Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* be amended by deleting condition (1) in its entirety (lines 315 through 321) and by substituting in its place a new condition (1) to read as follows:

(1) On a one-time basis, the dentist, when awarded a D.D.S. or D.M.D. degree, shall be exempt from the payment of active member dues for the remaining period of that year and the first full calendar year following the year in which the dental degree was awarded, and shall pay 25% of active member dues in the second year following the year in which the degree was awarded, 50% of active member dues in the third year, 75% of active member dues in the fourth year, and 100% of active member dues in the fifth year and thereafter.

and be it further
Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* be amended by deleting condition (4) in its entirety (lines 352 through 361) and by substituting in its place a new condition (4) to read as follows:

(4) On a one-time basis, a new graduate of a non-accredited dental school who has recently been licensed to practice dentistry in a jurisdiction in which there is a constituent dental society of the American Dental Association shall be exempt from payment of active member dues for the remaining period of that year and the first full calendar year following the year in which the license was issued, and shall pay 25% of active member dues in the second year following the year in which the license was issued, 50% of active member dues in the third year, 75% of active member dues in the fourth year, and 100% of active member dues in the fifth year and thereafter.

and be it further
Resolved, that constituent and component dental societies of this Association be encouraged to adopt the same reduced dues programs for new active members.

Wisconsin Dental Association

Dues Waiver for Dentists in Financial Distress

The following resolution was submitted by the Wisconsin Dental Association and transmitted on July 19, 1996 by Mr. Dennis J. McGuire, executive director.

Background: The ADA has recently requested that waiver of dues be used to aid in recruitment of new dentists into organized dentistry. The ADA presently offers only 100% or 75% dues waiver. The Wisconsin Dental Association (WDA) Membership Committee has found it useful to offer a 50% dues waiver as a more equitable tool because the new dentists feel they are paying their way and the ADA and state component are not losing as much revenue. It would be the intention of this resolution to offer 50%, 75% and 100% dues waiver at the discretion of the component membership committees.

Whereas, the ADA has suggested that component dental associations use waiver of dues to aid in recruitment and retention of new dentists,

Whereas, the WDA Membership Committee feels a 50% dues waiver would be a good option to offer a new dentist in financial distress, and

Whereas, the ADA only offers 75% and 100% dues waivers, therefore be it

76. Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection K. DUES OF MEMBERS WHO SUFFER FINANCIAL HARDSHIP, of

the *Bylaws* be amended by inserting the words "fifty percent (50%)," before the words "seventy-five percent (75%)" in the first sentence, so that the amended Subsection K reads as follows:

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

First Trustee District

Substitute for Resolution 43: Dental Office Involvement with Dental Benefit Plan Problems

The following substitute for Resolution 43 (*Supplement*:273) was submitted by the First Trustee District on September 9, 1996 by Dr. Arthur Schwartz, caucus coordinator.

43S-1. Resolved, that the American Dental Association encourage dentists to provide their patients with accurate statements of services rendered and when plan payments are too low or denied, or when other administrative problems arise with the plans, that patients be directed to take their problems back to the plan purchasers for resolution.

First Trustee District

Amendment to Resolution 45RC: Revised Comprehensive Policy Statement on Dental Auxiliary Personnel

The following amendment to Resolution 45RC was submitted by the First Trustee District on September 30, 1996, by Dr. Daniel Ferraris, chairman, District One Reference Committee on Dental Education.

Background: Resolution 45RC serves to delete the definition of "General Supervision" from the text of the revised Policy Statement on Dental Auxiliary Personnel while continuing to use the term within the document itself. The inclusion of a definition of a term referred to in a document by no means advocates the concept embodied in that definition.

To exclude the definition of the term "General Supervision" while including the definitions of all other forms of supervision will lead to confusion.

Therefore, it should be the position of the House to support the intent of Resolution 45RC with the addition of the following modification:

- modify the second resolving clause to allow the definition of "General Supervision" to remain in the document for clarity.

45RCS-1. Resolved, that ADA continue its strong opposition to unsupervised practice of dental auxiliary personnel, and be it further

Resolved, that the proposed revision Comprehensive Policy Statement on Dental Auxiliary Personnel be further revised as follows:

- *Supplement*:468, line 15—deleting the word "assistants" and substituting the word "auxiliaries;"
- *Supplement*:468, line 16—adding the word "However," before the word "licensed;"
- *Supplement*:468, line 16—deleting the words "may be permitted" and adding the words "are permitted in some states,"

and be it further

Resolved, that the proposed Comprehensive Policy Statement on Dental Auxiliary Personnel be adopted with the aforementioned changes found in the second resolving clause above, and be it further

Resolved, that Resolution 10H-1988 (*Trans.*1988:462), Comprehensive Policy Statement on Dental Auxiliary Personnel, be rescinded.

First Trustee District

Substitute for Resolution 46: Preventive Dental Assistant Personnel Category

The following substitute for Resolution 46 (*Supplement*:464) was submitted by the First Trustee District on September 9, 1996 by Dr. Arthur Schwartz, caucus coordinator.

46S-1. Resolved, that the Council on Dental Education be directed to develop, with input from appropriate agencies of the Association, a proposal for a new clinical responsibility to become available for the dental assistant, and be it further

Resolved, that the proposal include the recommended duties (including coronal scaling and polishing and other preventive services) and education for this new clinical responsibility, and be it further

Resolved, that a report of progress toward development of this proposed clinical responsibility be provided to the 1997 House of Delegates.

First Trustee District

Substitute for Resolution 50: Recommended Dues Increase

The following substitute for Resolution 50 (*Supplement*:440) was adopted by the First Trustee District and submitted on September 9, 1996 by Dr. Arthur Schwartz, caucus coordinator.

Background: The ADA Washington office building has become a significant burden to the finances of our organization for many years (Board Report 4, *Supplement*:442). The building cannot be sold because the offers tendered to date have been much less than the current mortgage ($8,280,000).

For the past several years, the members have paid a $55 assessment along with their dues for the asbestos abatement program in the Chicago building. This assessment is due to end this year.

If we instituted a $43 assessment for two (2) more years with specific instructions earmarking the monies collected to pay off the mortgage of the Washington Building (with prepayment penalties, it will total $8,526,000), not only would the ADA have much more financial flexibility, but members would have, not an increase, but a $12 decrease in their dues next year, and a $43 decrease in 1999. Therefore, be it

50S-1. Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* be amended in the first sentence by deleting the words and number "three hundred forty-six dollars ($346.00)" from line 306 and by substituting in their place the words and number "three hundred thirty-four dollars ($334.00)" so the first sentence of the amended Subsection A up to but not including the word "except" in line 307 reads as follows:

> A. ACTIVE MEMBERS.* The dues of active members shall be three hundred thirty-four dollars ($334.00) due January 1 of each year** . . . .

and be it further
Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* be amended by deleting the first footnote in its entirety and by substituting in its place a new first footnote to read as follows:

> Effective January 1, 1999, the dues of active members shall be reduced by forty-three dollars ($43.00) from the level of active member dues in effect in 1998.

and be it further
Resolved, that the Board of Trustees be urged to create a Washington Building restricted fund to be used only for paying off the senior notes issued by American Dental Real Estate Corporation on the Washington Building, and be it further
Resolved, that the Board of Trustees be urged to place $43 of each active member's dues for the years 1997 and 1998 in this Washington Building restricted fund and use all monies and income from this fund for the purpose of retiring the senior notes on the Washington Building, and be it further
Resolved, that the Board of Trustees report the use of these monies to the 1998 House of Delegates.

First Trustee District

Substitute for Resolution 72: Efficacy of Universal Precautions

The following substitute for Resolution 72 (*Supplement*:325) was submitted by the First Trustee District on September 9, 1996 by Dr. Arthur Schwartz, caucus coordinator.

72S-1. Resolved, that based on current scientific and epidemiological data, universal precautions continue to be an effective means of reducing blood contacts that can result in disease transmission, minimizing even further the already low risk of bloodborne disease transmission in the dental office, and be it further
Resolved, that dentists are strongly urged to adhere to universal precautions in their practices, as set forth in the current infection control recommendations of the American Dental Association and the Centers for Disease Control and Prevention, and be it further
Resolved, that with regard to transmission of bloodborne disease, treatment may be safely administered in the private dental office when appropriate infection control procedures are employed.

First Trustee District

Definition of the Term *Quality* in Dental Care

The following resolution was submitted by the First Trustee District on September 9, 1996 by Dr. Arthur Schwartz, caucus coordinator.

Background: Webster defines the word *quality* as: 1. essential characteristic or nature; 2. an inherent or distinguishing attribute or property; 3. a degree or grade of excellence.

The measurement of quality is not foreign to the public. Manufacturers and service providers have traditionally been interested in the evaluation of their products. Value-addition should be the goal of providers of goods and services.

Health care providers can be measured by the degree of benefit their service brings to the betterment of the lives of the public in the physical or clinical sense. Industry would perform a paradigm shift, and suggest that quality is an issue defined by the efforts one takes in the delivery of those goods and services, rather than the expression of the service providers' skills and intellect.

Health care providers are often certified by industry by the application of quality evaluation criteria which have no relevance to the level of physical or clinical benefits desired or required. Therefore, be it

97. Resolved, that the term *quality*, when used in the description of services provided by dentists or at their direction shall be considered in terms of the clinical and physical value that is provided to recipients of those services.

First Trustee District

Distribution of *Current Dental Terminology*

The following resolution was submitted by the First Trustee District on September 9, 1996 by Dr. Arthur Schwartz, caucus coordinator.

Background: Currently, *Current Dental Terminology (CDT)* codes and any changes to codes appear to be available to

members of the American Dental Association only upon payment of a fee to receive a 35-page booklet.

The American Dental Association is a nonprofit organization, whose purpose is to provide service to its members. The councils and committees of the ADA whose purpose is to update, define and codify the *CDT* codes are composed of members of the ADA who volunteer their time to provide this service. It is of the utmost importance to the members of the ADA to have current, updated and properly defined *CDT* codes. Therefore, be it

98. Resolved, that as of January 1, 1997, the American Dental Association shall provide, at no charge, a copy of the *CDT-2* to all active, life, retired and provisional members, and be it further

Resolved, that each update of the code shall be similarly sent to the membership.

First Trustee District

Expansion of ADA Efforts to Educate Dental Professionals in Recognizing and Reporting Abuse and Neglect

The following resolution was submitted by the First Trustee District on September 9, 1996 by Dr. Arthur Schwartz, caucus coordinator.

Background: The problem of abuse has reached epidemic proportions in the United States. Each year, 2 million cases of child abuse and neglect are reported; 2 to 4 million women are battered; 700,000 to 1.1 million elderly are abused; and a serious, but unknown, number of disabled people between the ages of 18 and 59 are abused. A national domestic violence hotline—(800)799-SAFE—has been established by presidential decree.

Domestic violence in all forms appears to be increasing in this country. In October 1990, the Massachusetts Dental Society announced, at the ADA annual meeting in Boston, the formation of the Dental Coalition to Prevent Abuse and Neglect.

This unique coalition is made up of dental professionals, members of allied health fields and representatives from corporate America. The membership of the coalition at its initial meeting included representatives of Boston University Goldman School of Dental Medicine, Delta Dental Plan of Massachusetts, Harvard School of Dental Medicine, Massachusetts Academy of Pediatric Dentistry, Massachusetts Board of Dental Examiners, Massachusetts Dental Hygienists Association, Massachusetts Dental Society, Massachusetts Department of Social Services and Tufts University School of Dental Medicine. Representatives from the Massachusetts Attorney General's Office and the Disabled Persons Protection Commission have since joined.

Because, as oral health professionals, we often are the first to see the consequences of abuse and neglect, and because other dental-oriented programs exist, and because at least one state requires, as a condition of licensure, training in recognizing and reporting abuse, be it

99. Resolved, that the ADA expand existing efforts to educate dental professionals to recognize abuse and neglect beyond that of children alone, to include women, elders, people with developmental disabilities, the physically challenged and any other person who might be the object of abuse or neglect, and encourage training programs on how to report such abuse and neglect to the proper authorities as required by state law, and be it further

Resolved, that the ADA initiate a dialogue with other professional organizations, such as the American Medical Association, to ensure that all health care professionals are working toward the same goals, and be it further

Resolved, that these actions will not diminish any existing programs and that the ADA seek out existing programs in the dental community to try to coordinate them on a national level.

First Trustee District

Maintenance of Multi-Pathway Options for Dental Assistants

The following resolution was submitted by the First Trustee District and transmitted on September 9, 1996 by Dr. Arthur Schwartz, caucus coordinator.

Background: The primary purpose of dentists' delegating functions to dental auxiliaries (as stated in *Current Policies 1954-95*) is to increase the capacity of the profession to provide patient care. It is therefore essential to have an adequate supply of dental assistants. Currently, there is a national shortage of dental hygienists and regional shortages of dental assistants. While the varied and complex reasons for the shortages include the cost of providing facilities for such education and the perceived greater value placed on four-year degree programs over one- or two-year technical ones, the bottom line is that the present dental auxiliary education system is not able to supply current needs and hasn't been for some time. This is even more true in underserved, rural areas where educational facilities are not as readily available.

For these reasons it is vital to maintain the pathway whereby a dental assistant can be trained in-office by a dentist. Currently, a suitable, locally available person can be trained, using a combination of on-site experience and formal courses, to attain the status of a dental assistant. This provides an opportunity for such a person to become a member of the dental health professional team. By using an "in place" person—someone who probably has lived in the community many years—there is also the advantage of stability.

It can afford a career opportunity for the "nontraditional" dental assistant candidate to get into the field—e.g., a person who may be a little older, who got married, started a family and then, at a certain point, decided to rejoin the workforce. Unless that person lives within 30 miles of a school, he or she is not going to be able to leave a spouse and family and take one or two years off to return to school for a formal education. It is therefore essential that the doorway always be open for a dentist to be able to train an assistant "in-office," if he or she so chooses.

Realizing this, the Dental Assisting National Board, Inc. (DANB), the certification board for dental assistants

(*Trans.*1990:551), encourages a multi-pathway approach to achieving certification. For example, three pathways are available to become a CDA (Certified Dental Assistant); four pathways to become a COMSA (Certified Oral and Maxillofacial Surgery Assistant); and four pathways to become a COA (Certified Orthodontic Assistant).

100. Resolved, that, similar to the multi-pathway mechanism used by the Dental Assisting National Board, more than one pathway always be available for a candidate to become a dental assistant, including any new category of dental assistant that may be created in the future.

First Trustee District

Policy Statement on HIV/AIDS as an Infectious and Communicable Disease

The following resolution was submitted by the First Trustee District and transmitted on September 9, 1996 by Dr. Arthur Schwartz, caucus coordinator.

Background: During the past 11 years, the American Dental Association has adopted comprehensive, multifaceted policies dealing with the complex scientific (medical), legal, ethical and political issue which is HIV/AIDS.

Numerous times over that 11-year period, the ADA has been asked or had the opportunity to comment on these policies (the latest being the friend of the court brief filed on behalf of the appeal of Dr. Randon Bragdon of Maine). The comments generally concentrate on the legal, ethical and political aspects of the issue. Seemingly lost is the ADA policy stipulating that HIV is an infectious, communicable disease (*Trans.*1992:650).

As an organization composed of and representing medically affiliated scientists, the Association needs to be a leader in discussing the scientific (medical) realities of HIV. While the ADA has done a good job disseminating this information to members with the recent distribution of the handbook, *Dental Management of the HIV-Infected Patient*, and the attention which the Council on Scientific Affairs has paid to updating information on infection control, it needs to take that discussion to the courts, the legislature and the public whenever possible. The Association must stress at every opportunity that HIV is indeed an infectious, communicable disease which can have disabling and debilitating effects. It also needs to stress that because of this, an HIV-infected patient must be viewed as is every other potentially medically compromised patient.

103. Resolved, that the American Dental Association take every opportunity to publicly state the current ADA policy which supports the classification of HIV/AIDS as an infectious and communicable disease (*Trans.*1992:650) which may have disabling effects.

First Trustee District

Amendment of *Bylaws* Regarding Dues Increase

The following resolution was submitted by the First Trustee District on September 30, 1996 by Dr. Arthur Schwartz, caucus coordinator.

159. Resolved, that Chapter XX. AMENDMENTS, Section 20. AMENDMENT RELATING TO DUES of the *Bylaws* be amended in the first paragraph by adding "(a)" between the colon and the word "An" on line 2597, and by adding a new subsection (b) at the end of Section 20 to read:

(b) Any dues increase directly associated with a program developed from an action of the House of Delegates shall be assigned an expiration date which shall be noted as a footnote to Chapter I, Section 50A of these Bylaws. The wording of such a footnote shall be: Effective _(date)_, the dues of active members shall be reduced by _(amount)_ dollars (_) from the level of active member dues in effect in _(year)_.

First Trustee District

Amendment of the *Rules of the House of Delegates* on Resolutions on Creation of New Programs

The following resolution was submitted by the First Trustee District on September 30, 1996 by Dr. Arthur Schwartz, caucus coordinator.

160. Resolved, that the section titled "Resolutions on Creation of New Programs" of the *Rules of the House of Delegates* be amended by adding a new second sentence to read: "If a new program will be ongoing, the future financial implications associated with the program also shall be identified" so the amended section reads as follows:

Resolutions on Creation of New Programs: Any resolutions submitted to the House of Delegates which call for creation of new programs, special committees or studies must be accompanied by estimates of the financial impact on the Association and the potential source of funds. If a new program will be ongoing, the future financial implications associated with the program also shall be identified. The Executive Director of the Association will assist in determining the cost estimates of such new programs.

Second Trustee District

Substitute for Resolution 47: National Marketing Campaign

The following substitute for Resolution 47 (*Supplement*:257) was submitted by the Second Trustee District on September 28, 1996 by Mr. Roy E. Lasky, executive director, The Dental Society of the State of New York.

Background: This is in reference to Report 22 of the Board of Trustees to the House of Delegates: Update on Resolution 129H-1995—Direct Reimbursement (*Supplement*:510) and Resolution 47. The individuals of the committees, councils, staff agencies, boards and outside organizations have done yeoman's duty in accomplishing the seemingly impossible task of designing and conducting a marketing campaign for direct reimbursement (DR) in less than one year. They have given the House preliminary assessments, updated to within days of our meeting, as directed by the 1995 House. The samples of advertisements and mailings are indeed both professional and impressive. The ADA can be proud of these efforts.

Grassroots membership, on the one hand, wants a proactive response to the onerous inroads of often underfunded managed care programs. A substantial number of members, former, current, and potential, are also very sensitive to the so-called "sticker shock" mentality associated with the cost of membership, a fact to which this House has always been sensitive. Emotionally, it can be all too easy to respond to the renewed effort in DR promotion by throwing "all of our guns at it." But, enthusiasm must be tempered by practical assessment of results—the number of implemented DR programs and the number of covered patients. Members' perception of success will be determined by the results they see in their everyday practice. We should not pursue an expensive, marginally effective program which has no effect on the marketplace.

A three- to five-year "window of opportunity" is alluded to in the report. This "window of opportunity" might be a reference to a potential swing in the pendulum of managed care caused by the public constantly publicizing its concern about the underprovision and unavailability of care. Perhaps, in this atmosphere, benefits managers and business owners will lend a more interested ear to the DR message. But the competition the ADA faces is the huge insurance and benefits industry which knows something of DR and, for the most part, does not recognize it as a viable, competitive threat.

A DR plan may compete successfully against insurers' usual and customary fee-for-service plans. But, the chances of persuading a purchaser to pick DR over an underfunded, *low* cost plan, where dental providers are providing treatment at deep discounts, are less likely. Despite the dental profession's altruistic view of the quality treatment that DR can provide, will cash-squeezed employers in this "window" of the pendulum swing take the high road and fund a higher cost plan to gain quality and choice? This remains to be answered.

Finally, selling any new dental benefits in today's sluggish market is a gargantuan task, and it must be clear that results are likely, in the beginning, to be painfully slow. Adequate time is needed for true evaluation of plans implemented or converted, number of beneficiaries covered and the cost benefit to ADA membership.

Setting a one-year deadline with a definitive report has worked well, and it would be prudent to continue this approach as we pursue this critical matter. As we approach the 18-month average it often takes to "complete the sale," a report to the 1997 House would have more meaningful and definitive figures. It behooves us to focus and concentrate our efforts in light of limited resources to those areas where staff is now in place to proceed.

The resolution we are proposing is also cost-effective, employing the $500,000 currently in the budget augmented by $500,000 from the Reserve Fund.

Therefore, it is

47S-1. Resolved, that the ADA conduct a national marketing campaign to promote direct reimbursement (DR), funded at $1 million, and that the Board of Trustees be urged to derive $500,000 of such funding from the Reserve Fund, and be it further

Resolved, that a report of the DR plans implemented and the costs needed to achieve such implementation be reported to the 1997 House for its deliberations on continuation and future funding.

Second Trustee District

Substitute for Resolution 47RC: National Marketing Campaign

The following substitute for Resolution 47RC was adopted by the Second Trustee District and submitted on September 30, 1996 by Mr. Roy E. Lasky, executive director, The Dental Society of the State of New York.

47RCS-1. Resolved, that the ADA conduct a national marketing campaign to promote Direct Reimbursement (DR), targeted to benefits purchasers and consultants, and funded at $2 million which builds on the program implemented in response to Resolution 129H-1995 (*Trans.*1995:621), and be it further

Resolved, that an annual statistical analysis and business report be provided to the House of Delegates, and be it further

Resolved, that the Board of Trustees be urged to fund this campaign from reserves.

Third Trustee District

Nicotine Use by the Motion Picture and Television Academies

The following resolution was submitted by the Third Trustee District and transmitted on September 13, 1996 by Dr. Raymond R. Lancione, Pennsylvania Dental Association.

Background: Whereas, nicotine use contributed to the untimely demise of many famous members of the Academies of Motion Pictures and Television; and several of those members made personal film and television testimonies just prior to their death urging their colleagues not to portray nicotine use through the film and television media, and

Whereas, currently the use of nicotine-containing products is again being portrayed through the art of motion pictures and television;

Therefore, be it

117. Resolved, that the American Dental Association express its disappointment and displeasure with the members of the Motion Picture and Television Academies who enable nicotine use to be portrayed appealingly through their highly influential media.

Third Trustee District

Development of Specific Guidelines for Salaries, Raises and Other Benefits for the Association's Executive Director

The following resolution was submitted by the Third Trustee District and transmitted on September 21, 1996 by Dr. Raymond R. Lancione, secretary, Pennsylvania Dental Association.

Background: The dental profession is acutely aware that it must take a hard look at becoming a more efficient business by increasing productivity while concurrently reducing or at least stabilizing office overhead. This philosophy should apply not only to our individual practices, but also to our collective responsibility in monitoring the operational expenses of the American Dental Association.

Board of Trustees' Reports 2 and 3 (*Supplement*:402; 441) list staff compensation without clearly stating how these salaries and benefits are determined and what they are. Such a nebulous approach engenders the need for a clear and concise presentation of the managerial decisions made by both the executive director and the Board of Trustees. Members are questioning the validity of the numbers. The complete financials must be made available so they can be interpreted and understood.

Some of the members' questions include:

- Are there meritorious raises?
- Are raises based on longevity of service?
- Are there across-the-board cost of living allowances?
- Are there objective and well-defined mechanisms currently in place to formulate salaries and benefits?
- Are there ceilings on all salaries?

It is not the intent of the following resolution to, in any way, usurp or lessen the ADA Board of Trustees' ability to manage or oversee the salary and benefits of the executive director, nor is there any attempt to hinder the executive director's capacity to grant salaries and raises; however, it is vital, for clarification purposes, that guidelines be developed in order to better track overall staff compensation as a function of, and for inclusion in, the budgetary process. Therefore, be it

138. Resolved, that the House of Delegates urges the American Dental Association Board of Trustees, through the appropriate agencies, to assemble information about the guidelines used to determine the salary and benefits for the American Dental Association Executive Director, and which will be included in future contracts with any executive director, and be it further

Resolved, that if such guidelines are not in place, the House of Delegates urges the American Dental Association Board of Trustees to develop such guidelines, and be it further

Resolved, that the House of Delegates urges the American Dental Association Board of Trustees to distribute these recommended guidelines for the determination of the salary and benefits for the Executive Director to the 1997 House of Delegates of the American Dental Association in the Board Report on Budget and Business Matters.

Fourth Trustee District

ADA Membership List Provided as a Member Service

The following resolution was submitted by the Fourth Trustee District and transmitted on September 10, 1996, by Ms. Elza Harrison, executive director, Maryland State Dental Association.

Background: Recognizing that the Internet is being used more and more on a daily basis and is a vital communication link, ADA and several constituents and components have already instituted their own Web sites. These communication tools have become of great value to the membership. One vital document not on the site now, nor contemplated to be on the site, is the ADA Membership Directory.

This valuable document should be supplied to our members at no cost, as a benefit of dues. It is conceded that the ADA produces revenue from the sale of the Directory and also from the sale of mailing labels. This income can be protected by offering the member list to members only. The technology to do this is readily available. Sales of printed directories and mailing labels to nonmembers and to commercial entities can therefore continue, thereby making the membership list yet another member service.

116. Resolved, that the American Dental Association take all necessary steps to include the complete ADA membership list on its Web site as a members-only benefit.

Fourth Trustee District

Commission's Recognition of Programs that Exceed Accreditation Standards

The following resolution was submitted by the Fourth Trustee District and transmitted on September 10, 1996 by Ms. Elza Harrison, executive director, Maryland State Dental Association.

Background: Board Report 18 (*Supplement*:497) indicates that the Commission on Dental Accreditation has agreed to adopt many of the recommendations of the Second Special Presidential Committee to Study the Accreditation Process. However, the Commission has not adopted B-72-1996. Under the present and future accreditation processes, no mechanism exists to distinguish between those programs that substantially exceed the minimal requirements and those that just barely meet the requisites. A mechanism is required that focuses attention on those programs barely exceeding the requirements and for whom the accreditation process can serve to upgrade their program. Such a mechanism is embodied in the option of variegated accreditation cycles.

119. Resolved, that the Commission on Dental Accreditation, in its consideration of the new United States Department of Education (USDOE) criteria regarding the accreditation cycle, be once again urged to consider adding a category to recognize those programs that substantially exceed the minimum accreditation standards, and be it further

Resolved, that the new accreditation cycle for exceptional programs be eight years, so that the resulting options for accreditation status would be approval for two, four, six or eight years.

Fourth Trustee District

Financial Statements of For-Profit Subsidiaries

The following resolution was submitted by the Fourth Trustee District on September 10, 1996, by Ms. Elza Harrison, executive director, Maryland State Dental Association.

Background: The for-profit subsidiaries of the ADA are separate entities that operate independently with their own boards and budgets. These subsidiaries are dependent upon the ADA for financial support and potentially could adversely impact the financial health of the ADA. Losses in these organizations must be funded by the ADA House of Delegates.

The House of Delegates presently receives a brief general accounting of the financial picture of these for-profit subsidiaries in the budget under the heading of the Capital Formation Account (*Supplement*:434). The potential liabilities are too great for the House to make informed decisions without adequate information.

120. Resolved, that complete itemized financial statements of all for-profit subsidiaries of the ADA be presented under separate cover with the annual pre-annual session budget information.

Fourth Trustee District

Membership Category for Spouses

The following resolution was submitted by the Fourth Trustee District and transmitted on September 10, 1996, by Ms. Elza Harrison, executive director, Maryland State Dental Association.

Background: As dental education expenses grow, and as the cost for establishing a dental practice grows, more and more new dentists find it difficult to fund their membership dues to the American Dental Association in the early years of their practices. This is a special hardship for married couples, both of whom are dentists.

The state of Michigan has a successful experiment in dues reduction for dental spouses that has worked effectively and has encouraged married couples to become participants in organized dentistry sooner than they might have.

Because membership is so important to the ADA, any opportunity to make it more attractive to join should be taken.

135. Resolved, that Chapter I. MEMBERSHIP, Section 40. PRIVILEGES, Subsection A. ACTIVE MEMBERS, of the Bylaws be amended by deleting provision "a" in its entirety and by substituting in its place a new provision "a" to read as follows:

a. An active member in good standing shall receive annually a certificate of membership and shall be entitled to attend any scientific session of this Association and receive such other services as are provided by the Association. In addition, an active member shall receive *The Journal of the American Dental Association* and any other official publications of the Association, the subscription price of which shall be included in the annual dues. Active members who are married to each other and who pay the reduced active-member dues provided for in Chapter I, Section 50A(5) of these *Bylaws*, shall receive single issues of *The Journal of the American Dental Association* and any other official publications of the Association.

and be it further

Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* be amended by adding a new condition "(5)" to read as follows:

(5) Except as otherwise provided in this Section 50, active members who are married to each other shall each pay seventy-five percent (75%) of the full dues of active members of this Association, due January 1 of each year, provided the members' constituent and component societies, if any, shall provide the same proportionate waiver of their dues as that provided by this Association.

Fifth Trustee District

Substitute for Resolution 44B: Development of Performance Indicators for Oral Health Care

The following substitute for Resolution 44B was submitted by the Fifth Trustee District on September 10, 1996 by Dr. Richard A. Smith, secretary.

Background: Even though the ADA provided background information on Resolution 44B, the information is not sufficient as it relates to answers to key questions which are critical to voting responsibly. A well-informed House can make better decisions. The following excerpts from the Council on Dental Benefit Programs' Supplemental Report 2 (*Supplement*:272) illustrate our concerns.

NCQA is revising its accreditation standards for 1997 and will spur benefit plans to develop quality assessment programs which monitor services that are high volume, high cost, or are directly related to health status. The NCQA has begun the development of performance indicators for clinical care and anticipates that it will begin the development of indicators specifically for oral health care toward the end of 1996 or the beginning of 1997.

Performance indicators are assessment tools used to monitor and evaluate the quality of clinical care...

Ultimately, indicators yield data that must be subsequently analyzed to determine where quality can be improved.

In other venues, we are told that diagnostic codes are being developed to facilitate the use of outcomes data and members understood very little about diagnostic codes.

The Association should provide voting members with more information and precise definitions which would demonstrate the interrelationship of performance indicators and outcomes data and their impact on practicing dentists.

Following are the areas that need further clarification:

- More information on the use, benefits and disadvantages of developing performance indicators.
- If performance indicators are developed and approved by the ADA House of Delegates, can there be any limiting aspects or controls placed on dentists?
- How is this related to the delivery of dental care through managed care plans or other dental benefit plans?

Since a well-informed House can make better decisions and we do not have enough information on the related uses and/or abuses of developing performance indicators, therefore, be it

44BS-1. Resolved, that the American Dental Association, through its appropriate agencies, develop a report for the 1997 House of Delegates that clearly defines the objectives, goals and current progress of the Association's efforts in the areas of outcomes data development, diagnostic codes, quality assessment and performance indicators and how they impact dentistry.

Fifth Trustee District

Substitute for Resolution 102RC: Dental Hygiene Workforce

The following substitute for Resolution 102RC was adopted by the Fifth Trustee District and submitted on September 30, 1996 by Dr. Richard Chichetti, delegate, Florida.

102RCS-1. Resolved, that the 1996 House of Delegates urge the Board of Trustees to appoint a special committee comprised of two members of the Board of Trustees, two members of the Council on Dental Practice and two ADA members who are practicing general dentists, for the purpose of conducting a study of existing alternate pathways for training dental hygienists, and be it further

Resolved, that this committee's findings and recommendations be reported to 1997 House of Delegates.

Fifth Trustee District

Annual Session Registration Fee

The following resolution was submitted by the Fifth Trustee District on September 9, 1996 by Dr. Richard A. Smith, secretary.

Background: Membership has traditionally looked upon its Association annual meeting as a valued benefit. Whereas registration fees have the potential to create discontent among members,

126. Resolved, that the Board of Trustees be urged not to charge a registration fee to members of the ADA for attendance at the annual session of the Association.

Fifth Trustee District

Sale of the Washington, D.C. Property

The following resolution was submitted by the Fifth Trustee District and transmitted on September 10, 1996 by Dr. Richard A. Smith, secretary.

Background: The Board of Trustees has committed up to $1.7 million per year from reserves to pay the annual losses incurred with the Washington Office Building for nine more years...the life of the mortgage.

Anticipated losses from the sale of the building would be approximately $5.5 million which could be paid by spending from reserves, in lump sum, approximately three years of the Board's annual commitment of $1.7 million. Therefore, be it

127. Resolved, that the Board of Directors of American Dental Real Estate Corporation and Board of Trustees of American Dental Association be urged to sell the ADA Washington property for the best offer available within a reasonable period of time and that the remaining notes be paid from ADA Reserves.

Fifth Trustee District

Request for Proposals for a National Media Campaign to Increase Demand for Dental Care

The following resolution was submitted by the Fifth Trustee District and transmitted on September 10, 1996 by Dr. Richard A. Smith, secretary.

Background: In the last three years the American Dental Association has taken action to strengthen dentistry's position within the health care industry. It has allocated funds to start a "grassroots" program to raise the awareness of the importance of dental care to the public with state and federal legislators. It has allocated funds to investigate and continue support for direct reimbursement as the "preferred" reimbursement method for delivering dental care to the public.

Paid public awareness programs have been discussed by the ADA Board and House of Delegates in the past. However, none have been implemented due to the potential costs. There is a need for action on this matter today, in order to foster competition in the marketplace.

Faced with a similar problem of slumping sales of beef, due to negative health publicity, the National Cattlemen's Beef Association (NCBA) undertook an aggressive marketing campaign ("Beef—it's what's for dinner") to make the public

more aware of the importance of beef in a person's diet. The cost of the campaign was $20,000,000 for print media and TV and radio advertising. The results: 510 million more pounds of beef were sold between May and September of 1996. Representatives from the NCBA said that the campaign was the most effective and efficient way of getting the message to the public.

The membership of the ADA would benefit from the Association taking immediate action to enhance the public's awareness of dentistry's capability of changing people's lives by increasing self-esteem, which in turn can enhance corporate image, personal success and sex appeal. The ADA should take on a vigorous consumer awareness campaign that would positively impact the public's health and welfare through a greater demand for dental services, which would positively impact public perception of our outstanding profession.

128. Resolved, that the American Dental Association publish Requests for Proposal (RFPs) for several nationally recognized advertising agencies for a comprehensive national media campaign aimed at increasing consumer demand for dental services, and be it further

Resolved, that the resultant proposals indicate what forms of dentistry are most marketable services for public demand, and be it further

Resolved, that the proposals explore all forms of media including, but not limited to, TV and radio commercials, national magazines, and other forms of print and electronic media, and be it further

Resolved, that the proposals identify costs, effective media mix and projected success rate for each medium, recommended duration of such a campaign, best target market, and report the findings and recommendations to the 1997 House of Delegates in Washington, and be it further

Resolved, that the ADA in all its publicity regarding the National Media Campaign Requests for Proposal, communicate to the members their benefit from the potential impact from increased demand for dental care which may occur due to this national program's ability to market innovative dental services to the public.

Sixth Trustee District

Promoting Dental Science to Allied Health Disciplines

The following resolution was adopted by the Sixth Trustee District and submitted on September 30, 1996 by Dr. Ed Kendrick, alternate delegate.

Background: A well-developed and successfully implemented campaign to promote dental health awareness among allied care disciplines and health organizations has the possibility to introduce and enlist significant numbers of patients into dental care. Physician referrals of patients for dental evaluation should be a common occurrence in the day-to-day practice of dentistry.

The significance of dental pathology in overall health should not be minimized as it has been. Physicians, nurses, chiropractors and other health care personnel need to serve as role models in the appropriate treatment and referral of patients needing dental care. By some estimates, 20% of sinusitis presentations, 50-80% of headache presentations, and significant numbers of uncontrolled diabetic conditions have dental etiologies which are too often not considered. Prescription drugs (nearly 400 drugs), with oral side effects alone, should account for significant numbers of patients who need dental counseling and/or consultation with the patient's dentist of record.

Dentistry should be asking itself and others what is the best way to provide oral health, in the context of total health, to our society. Oral health, in its broad terms, certainly deserves a valued place at the health care table. If dentistry is not a participant to represent oral health, it will have abrogated its role in society and others, such as the Institute of Medicine (IOM) will decide our place.

Our new President, Gary Rainwater, said, "The American Dental Association is really the only true voice of science for dentistry." Therefore, the ADA should have readily available resources which present and promote the important relationships of oral health to overall health.

Resolution 147-1995 (*Trans.*1995:661), entitled Interdisciplinary Practice Parameters, which was introduced at the Las Vegas meeting, was referred to the Dental Practice Parameters Committee (DPPC). However, the DPPC reported only about one portion of Resolution 147-1995, that parameters of dentistry are being scrutinized to assure consistency with allied health science. The *converse*, that the science of dentistry be reflected in the parameters of allied health disciplines, *was not addressed* in the DPPC report.

158. Resolved, that in order to promote interprofessional relations and effective patient care, the appropriate agencies of the ADA assess the scientific relationships of dental health and disease to overall health, and be it further

Resolved, that the appropriate Association agencies develop and distribute survey instruments to quantify existing patterns of patient cross-referral between allied medical disciplines and dentistry, and be it further

Resolved, that the appropriate Association agencies promote "Oral Health is Integral to Total Health" to local and state medical, nursing, osteopathic, chiropractic and other nondental health organizations through the Association's expert spokespersons and educational literature.

Seventh Trustee District

Substitute for Resolution 60: California Dental Association Electronic Dues Payment Program

The following substitute for Resolution 60 (*Supplement*:311) was submitted by the Seventh Trustee District and transmitted on September 26, 1996 by Mr. Douglas M. Bush, executive director, Indiana Dental Association.

Background: The Seventh District feels that the pilot Electronic Dues Payment (EDP) program implemented by the California Dental Association (CDA) clearly demonstrates the EDP program is an outstanding member benefit, as well as a powerful recruitment and retention tool.

Although sensitive to ADA administrative concerns about conversion of its internal and Micromembership system, we

feel that the development of a more "member friendly" dues collection system must be a top priority of the ADA and constituent societies. While organized dentistry seems to intellectually recognize the hardships facing young dentists with $100,000-plus dental school debts, practice start-up costs, and increasingly narrow profit margins, the profession seems slow in its response to these financial pressures. The EDP program is no panacea, but a dues system that allows dentists to better manage their membership expense by paying dues in periodic installments is a significant step in the right direction, at minimal expense to the ADA or constituents. As the CDA report states, this payment system could actually increase revenues by allowing dentists to join who might otherwise consider membership unaffordable. The ADA cannot afford to delay expansion of a program that has already been successfully tested for four years. While it may be that only a few states have the administrative capability of implementing an EDP program prior to the release of the new Micromembership program, those that can implement EDP should be encouraged to do so and ADA should support these efforts. The additional experience garnered from these states would undoubtedly assist the ADA in developing its national EDP policy in 1998.

The Seventh District offers a substitute to Resolution 60 that would allow other states the option of joining the pilot project modeled by the California Dental Association. This would allow a two-year transition period for states to join the pilot program as they develop needed administrative capabilities. Further, it directs the ADA to continue its plan to develop a national EDP policy and make any needed adjustments to the new computer system. We also recommend that when developing this national policy, the ADA consider expanding the program to allow dues to be paid in 12 monthly installments and including a service charge to offset lost interest income experienced as a result of the EDP program.

60S-1. Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* be amended by deleting the second footnote in its entirety and by substituting in its place a new footnote to read as follows:

** Dues of all members of constituent dental societies of this Association are payable January 1, except that active and active life members may participate in an electronic debit installment plan during 1996-97 and 1997-98. The plan shall require equal monthly installments to commence in November 1996 and November 1997, with full payment of the current dues amount to be fully paid by June 30, 1997 and June 30, 1998, respectively. No interest may be charged members participating in the plan, however, penalties may be imposed, prorated to the American Dental Association and the participating constituent dental society, for expenses incurred as a result of missed installments. The electronic debit installment plan shall provide for expeditious transfer of this Association's portion of the members' dues, and any late payment penalties, to the account of this Association as soon as commercially feasible.

Seventh Trustee District

ADA Positions, Policies and Definitions in ADA Publications

The following resolution was submitted by the Seventh Trustee District and transmitted on September 26, 1996 by Mr. Douglas M. Bush, executive director, Indiana Dental Association.

Background: ADA publications and papers frequently refer to, directly or indirectly, official ADA positions, policies and definitions. It is critical that consistency and accuracy be maintained when referencing these items.

Occasionally, articles, statements and definitions relating to other organizations, agencies and institutions appear in ADA publications. Positions and opinions of these outside organizations are often referenced, using their preferred terminology. At this point, it becomes difficult for ADA members to differentiate an ADA position, policy or definition from that of the group being referenced.

For example, ADA's *CDT-2* publication included insurance industry definitions and terminology. Fee-for-Service is defined in *CDT-2* (page 87) as, "a method of paying practitioners on a service-by-service rather than a salaried or capitated basis." In contrast, the official ADA definition of Fee-for-Service (*Current Policies, 1954-1995*, page 70) is, "A method of reimbursement by which the dentist establishes and expects to receive his or her full fee for the specific service(s) performed."

In order to assure ADA positions, policies and definitions are communicated to members in a consistent manner, the Seventh District recommends adoption of the following resolution.

141. Resolved, that in all ADA publications, ADAPCO be urged to clearly identify references to positions, policies or definitions that differ from the official ADA positions, policies or definitions in a manner that assures clear, consistent communication to members.

Eighth Trustee District

Substitute for Resolution 43: Dental Office Involvement with Dental Benefit Plan Problems

The following substitute for Resolution 43 (*Supplement*:273) was submitted by the Eighth Trustee District on September 25, 1996 by Mr. Robert A. Rechner, executive director, Illinois State Dental Society.

Background: The Eighth Trustee District does not agree with the first resolving clause of Resolution 43 since it appears to discourage dentists from assisting their patients with benefit problems as the dentist sees fit. This does not seem to be an appropriate message to take to the public. However, the Eighth District appreciates the comments made by the Board of Trustees relative to dentists being advocates for their patients, and wishes to carry that message as well in a public manner. For these reasons, the Eighth District offers the following substitute resolution to delete the first resolving

clause in Resolution 43 and add a new first resolving clause patterned after the Board's comment.

43S-4. Resolved, that dentists continue to be the advocate for their patients, in those instances where intervention on the behalf of their patients with third-party payers is important and appropriate, and be it further

Resolved, that dentists provide their patients with accurate statements of services rendered and when plan payments are too low or denied, or when other administrative problems arise with the plans, that patients be directed to take their problems back to the plan purchasers for resolution.

Eighth Trustee District

Commission on Dental Accreditation Membership

The following resolution was submitted by the Eighth Trustee District and transmitted on September 27, 1996 by Dr. Richard P. Perry, president, Illinois State Dental Society.

142. Resolved, that Chapter XIV. COMMISSIONS, Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection A. COMMISSION ON DENTAL ACCREDITATION, of the *Bylaws* be amended by deleting Subsection A in its entirety and by substituting in its place a new Subsection A to read as follows:

A. COMMISSION ON DENTAL ACCREDITATION. The number of members and the method of selection of the members of the Commission on Dental Accreditation shall be governed by the *Rules of the Commission on Dental Accreditation* and these *Bylaws*.

Twelve (12) of the members of the Commission on Dental Accreditation shall be selected as follows:

(1) Four (4) members shall be nominated by the Board of Trustees from the active, life or retired members of this Association, no one of whom shall be a member of a faculty of a school of dentistry or a member of a state board of dental examiners. The members nominated by the Board of Trustees shall be elected by the House of Delegates.

(2) Four (4) members who are active, life or retired members of this Association shall be selected by the American Association of Dental Examiners from the active membership of that body, no one of whom shall be a member of a faculty of a school of dentistry.

(3) Four (4) members who are active, life or retired members of this Association shall be selected by the American Association of Dental Schools from its active membership. These members shall hold positions of professorial rank in dental schools accredited by the Commission on Dental Accreditation and shall not be members of any state board of dental examiners.

and be it further

Resolved, that Chapter XIV. COMMISSIONS, Section 40. ELIGIBILITY, of the *Bylaws* be amended by deleting Subsection D. CHAIRMEN in its entirety and by substituting in its place new Subsections D and E to read as follows:

D. No member of the Council on Dental Education of this Association may serve concurrently as a member of the Commission on Dental Accreditation.

E. CHAIRMEN. The commissions of this Association shall elect their own chairmen who shall be active, life or retired members of this Association.

Ninth Trustee District

Substitute for Resolution 50: Recommended Dues Increase

The following substitute for Resolution 50 (*Supplement*:440) was submitted by the Ninth Trustee District and transmitted on September 12, 1996 by Mr. Dennis J. McGuire, executive director, Wisconsin Dental Association.

Background: In recent years there has been a growing concern over the financing and the negative impact that the Washington, D.C. office has on the reserves. Resolution 139H-1995 (*Trans.*1995:604) was adopted by the House of Delegates at the Las Vegas meeting. The resolution directed the Board to examine financial options addressing the Washington, D.C. property. Board Report 4 (*Supplement*:442) is the response to Resolution 139H-1995.

The Ninth District delegation feels that the current method of utilizing ADA reserves to fund ADREC's cash flow losses of approximately $1.7 million is not a prudent use of Association reserves. As mentioned in Report 4, a depletion of Association reserves compromises the strength of the Association to address future contingencies. Selling the Washington, D.C. facility at a substantial loss would not be in the best interest of the Association either.

In light of the substantial savings realized with the dues increase for the asbestos abatement program at the ADA headquarters, the same concept should be considered to address the Washington, D.C. office cash flow problem. The ADA Division of Finance and Operations was asked and developed three dues funding alternatives to pay down the Washington Office debt. The data provided are as follows.

The financial implications and the length of time the temporary dues would be in effect are illustrated below. Also listed is the potential interest savings that would result from an early retirement of the debt on the Washington property. It should be noted that ADA staff is in the process of contacting Great-West Life for its assessment of these alternatives, which would allow for a more refined estimate of the prepayment penalty. **Such penalties cannot be determined with any certainty as they are a function of interest rate levels at the time of the cash payment.**

Scenario 1

Two-Year Paydown of Debt
Proposed payment option assumes temporary dues increase of $44 per year

	1997	1998
Principal Retirement	$(8,280,000)	$(4,135,000)
Prepayment Penalty	(255,000)	(255,000)
Debt Service	**(8,535,000)**	**(4,390,000)**
Special Dues Assessment	4,400,000	4,400,000
Remaining Principal Balance	**$(4,135,000)**	**$ 10,000**

Interest Savings Calculation
Assuming temporary dues increase of $44 per year

	1997	1998*	Total	Scheduled Paydown Under Terms of the Notes	Interest Savings From Early Paydown
Interest	$376,000	$ 27,000	$403,000	$ 3,279,000	$2,876,000
Prepayment Penalty	255,000	255,000	510,000	0	(510,000)
Total Interest Paid	**$631,000**	**$282,000**	**$913,000**	**$3,279,000**	**$2,366,000**

Scenario 2

Three Year Paydown of Debt
Proposed payment option assuming temporary dues increase of $30 per year

	1997	1998	1999
Principal Retirement	$(8,280,000)	$(5,454,000)	$(2,628,000)
Prepayment Penalty	(174,000)	(174,000)	(174,000)
Debt Service	**(8,452,003)**	**(5,626,002)**	**(2,802,000)**
Special Dues Assessment	3,000,000	3,000,000	3,000,000
Remaining Principal Balance	**$(5,452,003)**	**$(2,626,002)**	**$ 198,000**

* The terms of the Notes as to Early Repayment require payments be made on February 1; therefore, payments in the final year of each proposal reflect interest for only one month.

Interest Savings Calculation
Assuming temporary dues increase of $30 per year

	1997	1998	1999*	Total	Scheduled Paydown Under Terms of the Notes	Interest Savings From Early Paydown
Interest	$479,000	$240,000	$ 17,000	$ 736,000	$3,279,000	$2,543,000
Prepayment Penalty	174,000	174,000	174,000	522,000	0	(522,000)
Total Interest Paid	**$653,000**	**$414,000**	**$191,000**	**$1,258,000**	**$3,279,000**	**$2,021,000**

Scenario 3

Four Year Paydown of Debt
Proposed payment option assuming temporary dues increase of $22 per year

	1997	1998	1999	2000
Principal Retirement	$(8,280,000)	$(6,208,000)	$(4,136,000)	$(2,064,000)
Prepayment Penalty	(128,000)	(128,000)	(128,000)	(128,000)
Debt Service	**(8,408,000)**	**(6,336,000)**	**(4,264,000)**	**(2,192,000)**
Special Dues Assessment	2,200,000	2,200,000	2,200,000	2,200,000
Remaining Principal Balance	**$(6,208,000)**	**$(4,136,000)**	**$(2,064,000)**	**$ 8,000**

Interest Savings Calculation
Assuming temporary dues increase of $22 per year

	1997	1998	1999	2000*	Total	Scheduled Paydown Under Terms of the Notes	Interest Savings from Early Paydown
Interest	$537,000	$362,000	$188,000	$ 13,000	$1,100,000	$3,279,000	$2,179,000
Prepayment Penalty	128,000	128,000	128,000	128,000	512,000	0	(512,000)
Total Interest Paid	**$665,000**	**$490,000**	**$316,000**	**$141,000**	**$1,612,000**	**$3,279,000**	**$1,667,000**

* The terms of the Notes as to Early Repayment require payments be made on February 1; therefore, payments in the final year of each proposal reflect interest for only one month.

50S-2. Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* be amended in the first sentence by deleting the words and number "three hundred forty-six dollars ($346.00)" from line 306 and by substituting in their place the words and number "three hundred twenty-one dollars ($321.00)" so the first sentence of the amended Subsection A up to, but not including, the word "except" in line 307 reads as follows:

> A. ACTIVE MEMBERS.* The dues of active members shall be three hundred twenty-one dollars ($321.00) due January 1 of each year** . . . .

and be it further
Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* be amended by deleting the first footnote in its entirety and by substituting in its place a new first footnote to read as follows:

> Effective January 1, 2000, the dues of active members shall be reduced by thirty dollars ($30.00) from the level of active member dues in effect in 1999.

and be it further
Resolved, that the Board of Trustees be urged to create a Washington Building restricted fund to be used only for paying off the senior notes issued by American Dental Real Estate Corporation on the Washington Building, and be it further
Resolved, that the Board of Trustees be urged to place $30 of each active member's dues for the years 1997, 1998 and 1999 in this Washington Building restricted fund and use all monies and income from this fund for the purpose of retiring the senior notes on the Washington Building, and be it further
Resolved, that the Board of Trustees report the use of these monies to the 1999 House of Delegates.

Ninth Trustee District

Comprehensive Study of Dental Student Educational Debt

The following resolution was submitted by the Ninth Trustee District and transmitted on September 12, 1996 by Mr. Dennis J. McGuire, executive director, Wisconsin Dental Association.

Background: Dental students now face debt repayment ranging from $60,000 to $100,000. This mounting debt hampers the new dentist from obtaining financing to set up and/or purchase a dental practice.

The Ninth District delegation feels there is a need to study the feasibility of offering financial counseling and practice management skills in the dental school curriculum. This counseling will need to be offered as early as the recruitment phase and continued through graduation.

In addition, this study should include a three-pronged approach which should address loan consolidation, debt retirement and tax deductibility of interest expense.

Current demographics indicate that there will be a greater number of dentists retiring within ten to fifteen years and new dentists entering the market. Therefore, consideration should be given to developing a system which would match the practicing dentists nearing retirement with new dentists wishing to establish themselves in practice.

107. Resolved, that the American Dental Association, through its appropriate agencies, formulate a plan to assist and educate dental students and recent graduates to better manage their educational debt, thereby providing them with a greater variety of practice modalities, and report to the 1997 ADA House of Delegates.

Ninth Trustee District

ADA New Dentist Leadership Award Guidelines

The following resolution was submitted by the Ninth Trustee District on September 12, 1996 by Mrs. Grace DeShaw-Wilner, Michigan Dental Association.

Background: Until 1995, member dentists under the age of 40, regardless of numbers of years from graduation, were eligible to be nominated for the ADA Golden Apple/Young Dentist Leadership Award. In 1995, the ADA revised its eligibility guidelines for the renamed ADA New Dentist Leadership Award, removing the age requirement. Under the new guidelines, a candidate must be no more than ten years past his or her graduation date regardless of age. As a result, none of Michigan's nominees, all under 40 years of age but out of school more than ten years, were eligible for the award. Michigan, in order to recognize its young leaders, decided to use the original guidelines and accepted the nomination of dentists under the age of 40.

The new ADA nomination criteria excludes many qualified young candidates. Member dentists under the age of 40 should be eligible for both the Michigan Dental Association and the ADA young/new dentist leadership awards. It is understood that the criteria are determined by the ADA Standing Committee on the New Dentist and a communication has been forwarded to the Committee on September 3, 1996. However, the Ninth District believes the Committee may appreciate knowing the House's position on this topic. Therefore, the following resolution is proposed for adoption.

108. Resolved, that the ADA Standing Committee on the New Dentist consider revising paragraph two of the ADA Golden Apple/New Dentist Leadership Award guidelines to read as follows:

> The American Dental Association will present the annual New Dentist Leadership Award to recognize an ADA member dentist under the age of 40 and/or graduated from dental school after 19__ who has demonstrated outstanding leadership initiative. The ADA Committee on the New Dentist will serve as the sole judge for this award.

Eleventh Trustee District

Increase Term of Treasurer from Two Years to Four Years

The following resolution was submitted by the Eleventh Trustee District and transmitted on September 20, 1996 by Mr. Stephen Hardymon, executive director, Washington State Dental Association.

Background: The position of Treasurer requires more in-depth knowledge of the finances of the ADA than any other office. In order to allow sufficient time to become thoroughly effective and efficient and to provide even more independence, be it

129. Resolved, that Chapter IX. APPOINTIVE OFFICERS, Section 40. TERM OF OFFICE AND SALARY, of the *Bylaws* be amended in the third sentence on line 1528 by changing the word and number "two (2)" to the word and number "four (4)," so the amended third sentence reads:

> The tenure of appointment for any Treasurer shall not exceed four (4) years.

so the amended Section 40 reads as follows:

> *Section 40.* TERM OF OFFICE AND SALARY: The Board of Trustees shall determine the salary, if any, and the tenure of each appointive officer. The tenure of each appointment for any Executive Director shall not exceed three (3) years. The tenure of appointment for any Treasurer shall not exceed four (4) years. A Treasurer may not be appointed for more than two (2) consecutive terms. The completion of the full term of any appointment shall be at the discretion of the Board of Trustees.

Eleventh Trustee District

Extend Term for Speaker of the House from One Year to Two Years

The following resolution was submitted by the Eleventh Trustee District and transmitted on September 20, 1996 by Mr. Stephen Hardymon, executive director, Washington State Dental Association.

Background: Traditionally the Speaker of the House of Delegates has served more than one term. It seems silly to take up space in the *ADA News* and any time at the annual session each year for an unopposed election. Therefore, be it

130. Resolved, that Chapter VIII. ELECTIVE OFFICERS, Section 60. TERM OF OFFICE, of the *Bylaws* be amended by deleting Section 60 in its entirety and by substituting in its place a new Section 60 to read as follows:

> *Section 60.* TERM OF OFFICE: The President, President-elect and the Vice Presidents shall serve for a term of one (1) year, except as otherwise provided in this chapter of the *Bylaws*, or until their successors are elected and installed. The Speaker of the House of Delegates shall serve for a term of two (2) years.

Eleventh Trustee District

Marketing of the ADA Financial Impact Analysis Program

The following resolution was submitted by the Eleventh Trustee District on September 20, 1996 by Mr. Stephen Hardymon, executive director, Washington State Dental Association.

Background: The ADA has created an excellent decision-making tool in the Financial Impact Analysis Program for use by dentists in determining the impact of managed care on their practices. The challenge is to gain wide distribution and use, if the program is to be successful. It seems that if the program were in the hands of as many certified public accountants as possible that the impact would be far more significant. Therefore, be it

131. Resolved, that the ADA pursue joint marketing agreements with the American Institute of Certified Public Accountants, the National Association of Tax Practitioners, the American Finance Association and other ancillary organizations to promote the purchase and use of the Financial Impact Analysis Program.

Eleventh Trustee District

Oral Health Needs and Access for the Growing Elderly Population

The following resolution was submitted by the Eleventh Trustee District on September 20, 1996 by Mr. Stephen Hardymon, executive director, Washington State Dental Association.

Background: There is currently a massive increase in the elderly population, which will continue to grow with the aging of the baby-boomer generation. Dentistry is neither prepared for nor planning action to treat the elderly population. Presently, Medicare does not address oral health care, and the newly proposed budgets may drastically reduce the dollars available for Medicaid. Access for the elderly continues to be severely limited.

The demand for oral care service is certainly recognized but not being met under the current delivery system. At the 1995 White House Conference on Aging, little discussion centered on the dental needs of the increasing elderly population. However, elderly groups are presenting demands for access and coverage for dental care now. These needs will only continue to grow in the coming years.

Therefore, be it

132. Resolved, that the appropriate ADA agencies identify and study the existing programs aimed at addressing the oral care needs of the elderly and design a model program for implementation at the constituent level, taking into consideration areas such as, but not limited to, identifying the

particular needs of the elderly and the potential avenues for addressing those needs; the tools needed to educate both the aging individual and the dental community on the special oral health needs of this population; and the financial and workforce implications of a delivery system designed to address the oral care needs of older Americans, and be it further

Resolved, that a report be forwarded to the 1997 ADA House of Delegates.

Eleventh Trustee District

Modify the Nominations Process

The following resolution was submitted by the Eleventh Trustee District and transmitted on September 20, 1996 by Mr. Stephen Hardymon, executive director, Washington State Dental Association.

Background: Each year a great deal of time is consumed by nominating speeches for candidates for ADA office without hearing directly from the candidate. In order to streamline the process, avoid irrelevant speeches and provide an opportunity for the delegates to hear and observe candidates in action in front of a large audience, be it

133. Resolved, that Chapter VII. BOARD OF TRUSTEES, Section 40. NOMINATION, of the *Bylaws* be amended by deleting item "d" from Subsection B and by adding a new Subsection C. NOMINATING PROCEDURE to read as follows:

> C. NOMINATING PROCEDURE. Candidates for the office of trustee shall be nominated from the floor of the House of Delegates. Seconding a nomination is not permitted. Following the nomination, each candidate shall present an acceptance speech of four (4) minutes.

and be it further

Resolved, that Chapter VIII. ELECTIVE OFFICERS, Section 30. NOMINATIONS, of the *Bylaws* be amended by deleting the second and third sentences and by adding in their place three new sentences to read:

> Candidates for elective offices shall be nominated from the floor of the House of Delegates. Seconding a nomination is not permitted. Following the nomination, each candidate shall present an acceptance speech of four (4) minutes.

so the amended Section 30 reads as follows:

> *Section 30.* NOMINATIONS: Nominations for the offices of President-elect, First Vice President, Second Vice President and Speaker of the House shall be made in accordance with the order of business. Candidates for elective offices shall be nominated from the floor of the House of Delegates. Seconding a nomination is not permitted. Following the nomination, each candidate shall present an acceptance speech of four (4) minutes.

and be it further

Resolved, that the section entitled "Nomination Procedures" of the *Rules of the House of Delegates* be amended by deleting the first two paragraphs and by substituting in their place two new paragraphs to read as follows:

> **Nomination Procedures:** Candidates for President-elect, First Vice President, Second Vice President and Speaker of the House of Delegates shall be nominated from the floor of the House of Delegates at the first meeting. Seconding a nomination is not permitted. Following the nomination, each candidate shall present an acceptance speech of four (4) minutes.
>
> Candidates for the office of district trustee shall be nominated from the floor of the House of Delegates at the first meeting. The details of the nomination procedure are set forth in Chapter VII, Section 40, of the *Bylaws*. Seconding a nomination is not permitted. Following the nomination, each candidate shall present an acceptance speech of four (4) minutes.

so the amended section entitled "Nomination Procedures" reads as follows:

> **Nomination Procedures:** Candidates for President-elect, First Vice President, Second Vice President and Speaker of the House of Delegates shall be nominated from the floor of the House of Delegates at the first meeting. Seconding a nomination is not permitted. Following the nomination, each candidate shall present an acceptance speech of four (4) minutes.
>
> Candidates for the office of district trustee shall be nominated from the floor of the House of Delegates at the first meeting. The details of the nomination procedure are set forth in Chapter VII, Section 40, of the *Bylaws*. Seconding a nomination is not permitted. Following the nomination, each candidate shall present an acceptance speech of four (4) minutes.
>
> The nominations for membership to councils and commissions by the Board of Trustees shall also be made at the first meeting. The nomination of council and commission members is governed by the provisions of Chapter X, Section 20, and Chapter XIV, Section 20, respectively, of the *Bylaws*.
>
> No additional nominations will be accepted after the first meeting.

Eleventh Trustee District

Change in Status for Personal Services Corporations

The following resolution was submitted by the Eleventh Trustee District and transmitted on September 20, 1996 by Mr. Stephen Hardymon, executive director, Washington State Dental Association.

Background: Several years ago the ADA was successful in exempting solo practitioners from reporting requirements to the National Practitioner Data Bank. Approximately 40% of ADA members, however, are incorporated and are not exempt. Therefore, be it

134. Resolved, that the appropriate agencies of the ADA actively pursue legislation and/or regulatory relief for the 40% of members who are incorporated so that Personal Services Corporations are no longer considered "entities" which have to report to the National Practitioner Data Bank.

Twelfth Trustee District

Development of a Wellness Advisory Committee

The following resolution was submitted by the Twelfth Trustee District on September 16, 1996 by Dr. Richard Haught, secretary.

Background: The current Dentists Well-Being Advisory Committee (DWAC), a subcommittee of the ADA's Council on Dental Practice, concentrates its activities on chemical dependency (alcohol and drug abuse) and support for dentists with HIV/AIDS. There are many individuals in our profession who have other types of physical and medical disabilities and who are looking to the ADA for direction. The Well-Being manager has been receiving numerous phone calls requesting advice and direction on these issues and has to tell the callers that the ADA cannot help them.

A Wellness Advisory Committee could be established similar to the DWAC. An ADA staff person would be needed to act as coordinator. An expert panel, with seven members, would be selected to include dentist representatives from the Council on Dental Practice, a physician with expertise in rehabilitation medicine including ergonomic injuries, a physician with expertise in depression and stress management, a general medical physician and a hearing specialist.

One function of the Wellness Advisory Committee would be to educate our members on prevention of ergonomic injuries. Ergonomic issues are of serious concern to our dentists with the increasing numbers of repetitive motion injuries that are occurring on a national level. The possible OSHA regulations concerning ergonomic injuries for dental team members should also be raising our level of awareness on ways to prevent these painful and expensive injuries.

Stress and depression are serious problems which affect the dental profession. The huge changes that have occurred in our profession with increasing governmental interference and managed care are very difficult for many people to handle. The practice of dentistry itself requires us to constantly manage patients who are stressed and, of course, requires very fine, painstaking techniques which we are taught have to be perfect. The Wellness Advisory Committee would provide referral services and wellness activities.

Hearing impairment is a common disability among dentists. The Wellness Advisory Committee would provide referral services, prevention and wellness activities and possibly screening for hearing impairments.

Information and education on alternative career choices for dentists who have developed physical or medical disabilities that inhibit them from continuing their previous practice of dentistry will be an important function of the Wellness Advisory Committee.

122. Resolved, that a Wellness Advisory Committee be established to provide the Council on Dental Practice with state-of-the-art direction on issues of ergonomics, hearing acuity, physical and medical disabilities, stress management and alternative career choices.

Twelfth Trustee District

Amendment of ADA *Bylaws* to Delete Chapter XX., Section 20

The following resolution was submitted by the Twelfth Trustee District on September 16, 1996 by Dr. Richard Haught, secretary, Twelfth District.

Background: For the past two years, the Board of Trustees, by proposing a $1.00 dues increase to the House of Delegates, has negated the intent of Section 20 of Chapter XX of the *Bylaws* of this Association.

124. Resolved, that Chapter XX. AMENDMENTS, Section 20. AMENDMENT RELATING TO DUES, of the *Bylaws* be deleted.

Twelfth Trustee District

State Dental Board as Regulating Body for Dentistry

The following resolution was submitted by the Twelfth Trustee District and transmitted on September 16, 1996 by Dr. Richard Haught, secretary, Twelfth District.

Background: At the present time the Arkansas Medical Board has a lawsuit pending against the Arkansas Dental Board. The reason for this suit is because the Arkansas Dental Board ruled that maxillofacial surgery is within the scope of the oral surgeons, and the Medical Board contends it is within the realm of ENT and plastic surgeons. This is considered to be a precedent-setting legal case because if the Medical Board wins they will literally be able to dictate to the Dental Board, a situation we do not feel is desirable. This resolution affirms our position that the individual state board should be the regulating body for dentistry within that state.

125. Resolved, that the American Dental Association provide legal and legislative assistance to prevent a state medical regulating board from encroaching upon the practice of a recognized dental specialty, and be it further

Resolved, that the American Dental Association reconfirm that the state regulating board be the approving agent, and have the authority to define the scope of that dental specialty, based upon training, state and federal laws, and within American Dental Association ethical standards of care.

Twelfth Trustee District

Registration of All Preferred Provider and Managed Care Organizations with the National Data Bank

The following resolution was submitted by the Twelfth Trustee District and transmitted on September 28, 1996 by Mr. Carl Schmitthenner, Jr., CAE, executive director, Kansas Dental Association.

Background: Managed care and preferred provider organizations continue to increase their control of the delivery of health care. Patients seeking care in this delivery system have less freedom of choice both in their selection of health care provider and their choice of treatment for personal health.

The quality of care provided by these organizations is a reflection of the care provided by the participating providers. In order for purchasers of health plans to evaluate these plans they should be included in the National Practitioner Data Bank.

144. Resolved, that the American Dental Association, through its appropriate agencies, seek to have all preferred provider and managed care organizations registered with the National Practitioner Data Bank with a requirement to submit the names of all providers with whom they have either contracting, participating or employment agreements. All complaints against these providers would become a part of the PPO/MHC organization's complaint history.

Thirteenth Trustee District

Amendment to Resolution 68: Provisional Membership Category

The following amendment to Resolution 68 (*Supplement*:318) was submitted by the Thirteenth Trustee District on September 30, 1996, by Mr. Mark Alcorn, California Dental Association.

68S-1. Resolved, that Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection H. PROVISIONAL MEMBER, of the *Bylaws* be amended by deleting the last sentence and by substituting in its place a new last sentence to read as follows:

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

so the amended Subsection H reads as follows:

> H. PROVISIONAL MEMBER. To be a provisional member, a dentist:
>
> 1. Shall have received the degree of DDS or DMD from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association;
> 2. Shall not have established a place of practice; and
> 3. Shall have applied for provisional membership within 12 months of graduation.
>
> Provisional membership shall terminate December 31 of the second full calendar year following the year in which the degree was awarded,

and be it further

Resolved, that Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection H. PROVISIONAL MEMBER, of the *Bylaws* be amended by deleting the period at the end of the third qualification and adding a comma and the word "or" in its place, and by adding a fourth qualification to read as follows:

> 4. Shall be a new graduate of an unaccredited dental school who has recently been licensed to practice dentistry in a jurisdiction in which there is a constituent dental society.

Thirteenth Trustee District

Electronic Dues Payment Plan

The following resolution was submitted by the Thirteenth Trustee District and transmitted on July 22, 1996 by Mr. Mark D. Alcorn, assistant executive director, California Dental Association.

Background: In 1992 the ADA House of Delegates authorized the California Dental Association (CDA) to implement an electronic debit installment plan as a pilot program (*Trans.*1992:602). CDA first implemented the program in 1994. After reviewing the status report of the payment plan (*Supplement* 1994:358-363), the ADA authorized CDA to continue the program for an additional two years and report to the ADA House of Delegates in 1996 (*Trans.*1994:617). This is the Thirteenth District's report to the 1996 ADA House of Delegates.

The Electronic Dues Payment (EDP) program is a payment option that allows members with anticipated dues in excess of $168.00 to spread their annual dues over seven months, with the first debit in December and the last debit in June. The program is considered by CDA to be a membership service and is provided free of interest charges, processing fees and down payments.

Program Success: The success of the EDP program has been profound. In 1994, 1,632 members participated. In 1995, 2,145 members participated (an increase of 31.5%). For 1996, approximately 2,471 members are participating, representing a 15% increase over 1995 figures. Thus, *15% of all dues-paying CDA members currently participate in the program*, and the percentage of California dentists who are members of organized dentistry continues to grow notwithstanding difficult economic times and substantial managed care presence in California.

The EDP program has been a valuable tool in retaining current members and recruiting new members. The result of a follow-up survey administered to participants in the 1994 EDP program clearly validates this fact. In that survey, *55% of the*

respondents indicated that the EDP made it possible for them to renew their membership and 99% stated that the program should be continued. Moreover, records show that 1,098 members, 44.4% of members currently participating, have been on the program for three continuous years. During those three years, the attrition rate of CDA has consistently been low (2%). The majority of participants are age 35-54 years. Nine percent are 34 or younger, and 24% are 55 years or older. Annual tripartite dues range from $1,008 to $1,365.

Financial Considerations: The total cost of operating the program in 1994 was $10,096.11, and $12,003.79 in 1995 (excluding fixed/overhead costs). The cost for 1996 will not be available until after the last debit. *Per Capita* cost to operate the program in 1994 and 1995 was $6.19 and $5.60 respectively. These costs exclude expenditures such as postage, mailing house service and printing of statements and envelopes, which would be incurred even without the EDP program.

Of course, the EDP program entails a delay in receipt of dues revenues, thereby affecting the cash flows of the Association. However, the EDP payment option also *increases revenues* by making it possible for members to renew their membership. Had this option not been available, it is evident that CDA (and therefore ADA) would have experienced a loss in membership. The cost of the cash flow delay is significantly less than the loss resulting from a reduction in membership.

Based on the survey results mentioned above, participants have indicated that if this program were to be discontinued, as many as 1,098 members from California would not be able to renew their membership in organized dentistry. The potential revenue loss to the ADA is $346,000.

It should be noted that members start paying their dues in December and by the March delinquent date, four installment payments have already been remitted to the ADA. With only three installment payments remaining, the cash flow problem should not be a serious problem.

Organized dentistry must continue to do everything possible to improve membership benefits, and make it easy and practical for dentists to remain a part of the Association. The fact that this service can be offered at no cost to the participating dentist is a valuable member benefit. 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 necessary. Based on CDA's experience, the EDP program is a great success. Participation has continued to increase, and the program makes it possible for financially burdened members to renew their membership. While the implementation of the EDP may have some financial impact on the ADA (as it has on CDA), the problem is minor and temporary in nature. However, if the program is discontinued, the potential revenue loss from nonrenewing members would definitely be revenue foregone, perhaps permanently.

Although the program would be voluntary, the Thirteenth District highly recommends that ADA constituents implement an electronic dues payment program.

Therefore be it,

75. Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* be amended by adding the following phrase to the first sentence beginning after the word "that" on line 307:

> (1) active members may participate in an electronic debit installment payment plan sponsored by their constituent dental society with equal monthly installments commencing in December and finishing by the following June 30, and (2)

so the amended Subsection A up to the word "*Bylaws*" on line 314 reads as follows:

> A. ACTIVE MEMBERS. The dues of active members shall be three hundred forty-six dollars ($346.00) due January 1 of each year except that (1) active members may participate in an electronic debit installment payment plan sponsored by their constituent dental society with equal monthly installments commencing in December and finishing by the following June 30, and (2) any dentist, who satisfies the eligibility requirements for active membership under Chapter I, Section 20A, of these *Bylaws* and who satisfies any of the following conditions shall be entitled to pay the reduced active member dues listed under such satisfied condition so long as such dentist maintains continuous membership, subject to the further reductions permitted under the provisions of Chapter I, Section 50H, of these *Bylaws*:

and be it further

Resolved, that the second footnote to Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection A. ACTIVE MEMBERS, of the *Bylaws* pertaining to the California Dental Association's electronic debit installment payment plan, and which is designated by two asterisks, be deleted in its entirety, and be it further

Resolved, that Chapter I. MEMBERSHIP, Section 50. DUES AND REINSTATEMENT, Subsection B. LIFE MEMBERS, of the *Bylaws* be amended in Category "a." Active Life Members by adding the following phrase at the end of the sentence (line 368):

> except that active life members may participate in an electronic debit installment payment plan sponsored by their constituent dental society with equal monthly installments commencing in December and finishing by the following June 30.

so the amended Category "a" reads as follows:

> a. Active Life Members. Regardless of a member's previous classification of membership, the dues of life members who have not fulfilled the qualifications of Chapter I, Section 20G of these *Bylaws* with regard to income related to dentistry shall be fifty percent (50%) of the dues of active members, due January 1 of each year, except that active life members may participate in an electronic debit installment payment plan sponsored by their constituent dental society with equal monthly installments commencing in December and finishing by the following June 30.

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 by adding a comma and the following phrase to the end of part "a:"

> unless that member is participating fully in his or her constituent dental society's sponsored electronic debit installment payment plan pursuant to Chapter I, Section 50A or 50B of these *Bylaws*, in which case that member's dues shall be paid in full not later than June 30 of the current year.

so the amended part "a" reads as follows:

> 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, unless that member is participating fully in his or her constituent dental society's sponsored electronic debit installment payment plan pursuant to Chapter I, Section 50A or 50B of these *Bylaws*, in which case that member's dues shall be paid in full not later than June 30 of the current year.

Thirteenth Trustee District

Separation of ADA House of Delegates from ADA Scientific Session

The following resolution was submitted by the Thirteenth Trustee District on September 13, 1996 by Mr. Mark D. Alcorn, assistant executive director, California Dental Association.

Background: The ADA House of Delegates meeting is currently held in conjunction with the ADA scientific session and has been for many, many years. However, the leadership of many constituents believe that the disadvantages of holding both meetings at the same time far outweigh the advantages of doing so. This resolution proposes separating the ADA House of Delegates meeting from the ADA scientific session to gain these advantages.

For purposes of this resolution, and in order to be consistent with ADA *Bylaws*, the ADA House of Delegates meeting is referred to herein as "House" and the scientific meeting and convention is referred to as the "scientific session."

The matter was put before the ADA House of Delegates in 1991 in Resolution 121 (*Trans.*1991:612). Citing the "enormous amount of time involved and travel by ADA staff," that "much money could be saved...by not having to move materials, equipment and personnel if the...meeting were to be held in Chicago," and that House attendees are "for the most part precluded from attending the Annual [Scientific] Session," the Eleventh Trustee District submitted the resolution.

The ADA Board of Trustees unanimously recommended that the matter be referred by the 1991 House to the Board for further study. The 1991 House of Delegates referred the matter to the Board of Trustees for study and report to the 1992 House of Delegates. The result was a report of the Board of Trustees to the 1992 ADA House of Delegates (*Supplement* 1992:397). The report notes that the Council on ADA Sessions and International Relations opposed separation of the House of Delegates from the scientific session because doing so would "isolate the leadership from the membership," "preclude the general member from being informed about and involved in the policy making process," and make it "unlikely that the delegates could benefit from the scientific session." The ADA Board of Trustees agreed with the Council and noted that the financial considerations were not great enough to warrant separation of the scientific session from the House. No action was brought forth to the 1992 House of Delegates.

Discussion: The proponents of this resolution disagree with the conclusions reached in 1992 by the Council on ADA Sessions and International Relations and the Board of Trustees. The main points are as follows.

Flexibility. Separation of the House meeting from the scientific session expands the number of venues available for the scientific session. Currently, only five or six venues that meet the needs of the combined meetings are available. Should the need for major meeting rooms be lessened, many more locations should have sufficient facilities for the scientific session. Greater variety of location of the scientific session should increase member interest in attending the sessions.

Separation of the meetings would also result in greater flexibility in terms of the timing of both meetings. Although the scientific sessions are firmly set for the next five to ten years, the dates of future meetings could be established to maximize membership participation in the particular venue selected. Also, the date of the House meeting could be scheduled as desired by the delegates.

Cost Savings. While the exact cost savings of separating the House from the scientific session is not known, it is believed to run in the hundreds of thousands of dollars, part of which is paid by the constituents and delegates themselves. Some estimated areas of cost savings of separating the meetings are as follows: hotel (for 30-55 ADA staff, 5 to 12 nights); travel (air fare for 30-55 ADA staff, plus increased cost for travel to non-hub resort areas for 600-800 volunteers including delegates, alternates and various support personnel); equipment (the cost of moving House of Delegates equipment and fixtures both directions); printing services (savings reported by ADA to be in the range of $50,000); and other fees (scientific sessions registration fee for 600-800 volunteers and staff). As such, cost savings will be in the range of $250,000 to $500,000. Additionally, it is believed that other cost saving opportunities, which have not been identified above, may exist.

Convenience. As stated in Resolution 121-1991, delegates and alternate delegates are unable to attend the scientific meeting to any significant degree or attend portions of the session at the expense of their duty as a delegate. As a result, delegates are essentially isolated from the session, even when the session is held in the same facility.

Delegates, alternate delegates and other House meeting attendees also experience difficulties getting rooms and flights due to the massive attendance at the scientific session. Separating the meetings will make the House meeting experience much less of an ordeal than it has been in the past.

Chicago offers unusual convenience in the sense that it is a centrally located air hub; has the widest range of connection-free commercial airline flights available; has numerous cultural, hotel and dining options; and has extensive meeting facilities to meet House needs. Travel to a Chicago meeting will be more convenient and less expensive.

In terms of planning the meeting, the matter is greatly simplified (in terms of logistics, staff and support) if the meeting is held in Chicago.

It is also possible that if the meetings are separated, the House meeting could be streamlined and span fewer days.

Timing Issues. The Thirteenth District is cognizant of the fact that ADA scientific sessions and House of Delegates meetings are planned, and sites booked, years in advance of each respective meeting. Revision of currently contracted arrangements is neither necessary nor practical. As such, the form of resolution proposed below provides that the changes requested take effect in a specific year to be determined by the Board of Trustees and Council on ADA Sessions and International Programs.

Lack of Justification for a Joint Meeting. In 1992, the Council on ADA Sessions and International Relations and Board of Trustees raised the following points in recommending the House and scientific session should continue to be held jointly.

1. Financial considerations are not great enough to justify separation.

The financial implications of separating the House meeting from the scientific session are considerably more than estimated by the Board and Council in 1992. Those cost estimates related to some ADA expenses only and did not include expenses incurred by delegates and constituents themselves. In fact, the cumulative added cost of holding the House in conjunction with scientific sessions is believed to be in the range of $250,000 to $500,000 to ADA, its delegates and the constituent societies. Absent a very compelling reason for joining the meetings, it is difficult to justify this additional expense.

2. ADA fiscal year would have to change.

Separating the House meeting from the scientific session will not require a change of ADA's fiscal year. In fact, a change in fiscal year is neither requested nor advocated by this action.

The following resolution is presented.

118. Resolved, that Chapter V. HOUSE OF DELEGATES, Section 70. ANNUAL SESSION, of the *Bylaws* be amended by adding the phrase "in the City of Chicago, County of Cook, State of Illinois" so the amended Section 70 reads as follows:

> *Section 70.* ANNUAL SESSION: The House of Delegates shall meet annually in the City of Chicago, County of Cook, State of Illinois.

and be it further

Resolved, that Chapter VII. BOARD OF TRUSTEES, Section 110. DUTIES, of the *Bylaws* be amended by deleting duty "C" in its entirety and by substituting in its place a new duty "C" to read as follows:

> C. To determine the date for convening the annual session of the House of Delegates, and to determine the date and place and provide for the management and general arrangements of each scientific session as provided in Chapter XV of these *Bylaws*.

and be it further

Resolved, that Chapter XV. SCIENTIFIC SESSION, Section 20. TIME AND PLACE, of the *Bylaws* be amended by adding a comma and the following phrase to the end of the first sentence: "which shall not be in conjunction with the annual session of the House of Delegates," so the amended Section 20 reads as follows:

> *Section 20.* TIME AND PLACE: The scientific session of the Association shall be held annually at a time and place selected by the Board of Trustees, which shall not be in conjunction with the annual session of the House of Delegates. Such selection shall be made at least one (1) year in advance.

and be it further

Resolved, that the foregoing amendments to the *Bylaws* become effective with the annual session of the House of Delegates and the scientific session of this Association to be held in the year 2004.

Fourteenth Trustee District

Substitute for Resolution 17: ADA Dental Manpower Studies

The following substitute for Resolution 17 (*Reports*:56) was submitted by the Fourteenth Trustee District on September 9, 1996 by Mr. Thomas J. Oberle, executive director, Colorado Dental Association.

Background: The intent of the substitute resolution is to clarify that the policy statement to be amended, Recognition of Dental Manpower/Dental Demand Imbalance, refers only to dentists and is not intended to include ancillary personnel.

17S-1. Resolved, that Resolution 105H-1984 (*Trans.*1984:537), Recognition of Dental ~~Manpower~~ Workforce/Dental Demand Imbalance, be amended by the deletion of the first and third resolving clauses and by deletion of the words "dental ~~manpower~~ workforce" in the second resolving clause, so that the amended policy reads as follows:

> **Resolved,** that the ADA continue to conduct studies and compile the necessary data and statistics on the number of dentists and dental graduates needed to serve the demand for care and disseminate this information to the appropriate agencies.

Fourteenth Trustee District

Substitute for Resolution 43: Dental Office Involvement with Dental Benefit Plan Problems

The following substitute for Resolution 43 (*Supplement*:273) was submitted by the Fourteenth Trustee District on September 9, 1996 by Mr. Thomas J. Oberle, executive director, Colorado Dental Association.

Background: Resolution 43 suggests that the ADA undertake a program to keep dentists from assisting patients in resolving problems with third-party payers. The ADA Board of Trustees recommends defeat of the resolution pointing out that dentists may be the advocate for patients where appropriate and important. The following substitute resolution is submitted as a compromise between the two opposing positions.

43S-3. Resolved, that the American Dental Association recognizes that it is the primary responsibility of the patient to resolve conflicts regarding their dental benefit plans, and that the dentist assist only when appropriate, and be it further **Resolved,** that dentists provide their patients with accurate statements of services and/or treatment proposed and/or rendered and when plan payments are too low or denied, or when other administrative problems arise with the plans, that patients be encouraged to take their problems back to the plan purchasers for resolution.

Fourteenth Trustee District

Use of Professional Judgment when Dealing with Infectious Diseases

The following resolution was submitted by the Fourteenth Trustee District on September 9, 1996 by Mr. Thomas J. Oberle, executive director, Colorado Dental Association.

Background: Current thinking suggests that the conscientious use of personal protective equipment and "universal" precautions reduces the already low risk of bloodborne disease transmission in the dental office. At the same time there is no evidence which suggests that the risk has been eliminated, only that the risk has been reduced. The quandary for the profession has been to convince a public made wary by Kimberly Bergalis that "safe enough" is adequate, when we, like the public, wish we could guarantee "absolute safety." As scientists, we know that in the real world "absolute" anything is unattainable, and for those very same reasons must accept the fact that "universal precautions" could never be as universally applicable as the name implies. The truth be told, "universal" precautions are a set of guidelines which appear to provide adequate safety at a reasonable cost, most of the time—none of which could be construed as anywhere close to "universal" or "absolute." Understanding that definition of "universal" precautions, we may be willing to accept that even greater safety may be attained at a less reasonable cost through more elaborate precautions, higher technology, or by referral and testing of high-risk patients. In fact, recent research implies that this is not only possible, but may be necessary for more virulent strains of hepatitis B and tuberculosis. The need to weigh the benefits of a protocol against reasonableness of the cost is made on a case-by-case basis which factors in both cost and benefit, but ultimately the judgment is determined by the values of the person making the decision.

Unfortunately, dentists need not worry about the benefits, costs, values or anything else to do with taking precautions against infectious diseases, because the CDC, through its guidelines; Congress, through the Americans with Disabilities Act; and judges, through their rulings, have made the decision that so-called "universal" precautions provide the solution to all problems in all situations. To use our judgment and vary from this protocol, even in a more cautious direction, is a violation of federal law.

In the real world (i.e., the one we live in) we recognize that the solution to a problem is as unique as the set of circumstances that created it. The laws and guidelines on infectious diseases strip us of our individual judgment as dental professionals and leave us as compliant robot dental providers. Indeed, the Americans with Disabilities Act actually discriminates by placing all infectious/disabled patients into the same category and requiring that they all be treated the same regardless of the situation. The profession must take responsibility for the care of these special needs patients and the safety and well-being of our employees and ourselves. If we fail to preserve professional judgment in dentistry, both we and our patients will suffer.

Whereas, there has been shown to be little risk of transfer of infectious disease from practitioner to patient when universal precautions are used, but some studies and cases have shown that there is a small but significant risk of infectious disease transfer from patient to practitioner even when universal precautions are used, and

Whereas, all available evidence suggests that the conscientious use of universal precautions reduces the low risk of transfer of bloodborne diseases in the dental office, current epidemiologic evidence suggests that the use of universal precautions does not eliminate the risk of transfer of infectious diseases, and

Whereas, the American Dental Association believes that a federal law is not necessary to ensure that HIV-positive patients, or any infectious patient, will receive dental care, and in light of the fact that dentistry has a long history of treating infected and disabled patients with compassion and dignity, and

Whereas, while infectious diseases may be disabling, the disease must first be treated as an infectious disease due to risks, however small, to the staff, other non-infected patients, the dentist, and the already challenged immune system of the infected patients themselves, and

Whereas, allowing dentists to use their scientific training and professional judgment will only increase the safety and quality of dentistry that is already the safest and highest quality in the world.

Therefore, be it

101. Resolved, that the American Dental Association supports the right and responsibility of each dentist to exercise his or her best professional judgment in all situations, based on his or her own personal skills and training, as to when and how to treat and whether to refer each patient regardless of the

patient's health status, including infectious status or disabled status, and be it further

Resolved, that the American Dental Association will pursue legal and legislative means to effect changes to existing statutes, guidelines and interpretations (including the Americans with Disabilities Act) which limit the appropriate exercise of the dentist's professional judgment in the treatment of persons with disabilities and infections, or which include infectious diseases as disabilities, which limits the use of accepted public health measures to contain the infection, and be it further

Resolved, that the American Dental Association, when appropriate, will provide assistance to dentists who are unfairly prosecuted for exercising appropriate professional judgment in the treatment of patients with infectious diseases.

Fourteenth Trustee District

Dental Hygiene Workforce

The following resolution was submitted by the Fourteenth Trustee District on September 9, 1996 by Mr. Thomas J. Oberle, executive director, Colorado Dental Association.

Background: Whereas, an insufficient hygiene workforce exists in some regions of the United States, and

Whereas, access to preventive dental care is essential for our patients, and

Whereas, it is important that all attempts at resolving the shortage of hygienists be thoroughly evaluated in order to discover the most effective solutions, therefore be it

102. Resolved, that the 1996 House of Delegates directs the appropriate ADA agencies to conduct an analysis, within the existing budget, regarding the appropriateness of establishing hygiene preceptor-type programs, similar to the Alabama model, and report to the 1997 House of Delegates on their findings.

Fourteenth Trustee District

Membership Notification of Pending Resolutions

The following resolution was submitted by the Fourteenth Trustee District on September 9, 1996, by Mr. Thomas J. Oberle, executive director, Colorado Dental Association.

Background: Few rank and file ADA members attend the reference committee hearings which are their only chance to have direct input into the deliberations of the House of Delegates, or the actions of their association. The reason for this lack of participation is that most members are not aware of the resolutions being considered. Most ADA members have little idea or information about the reports and resolutions that will be discussed at the ADA reference committee hearings or during the House of Delegates. Most members do not realize that they may testify at the reference committee hearings or understand the importance of such testimony. By informing the ADA members of the broad array of subjects to be considered and the opportunity for non-delegate members to voice their opinions, the ADA would greatly increase membership's knowledge of "what the ADA does for them" as well as gain broader based input into the reference committees for the House to use in its deliberation. Therefore be it

105. Resolved, that ADA Publishing Co., Inc. be urged to publish as soon as possible (concurrent with the first printing of resolutions and reports for delegates), in the *ADA News* a listing of reports and resolutions by title along with a three-to-four word description of the topic of the report or resolution, and be it further

Resolved, that this listing of titles and topics be divided by reference committee to which they are assigned, along with the time and place that each reference committee hearing will take place, and be it further

Resolved, that this report to the membership be prefaced with a brief description of the purpose of the reference committee process, including the fact that all members are encouraged to attend and participate.

Fourteenth Trustee District

Constituency Status for Guam Dental Society

The following resolution was submitted by the Fourteenth Trustee District and transmitted on September 12, 1996, by Mr. Thomas J. Oberle, executive director, Colorado Dental Association.

Background: The members of the Guam Dental Society (GDS) have petitioned the American Dental Association House of Delegates to amend appropriate ADA *Bylaws* to allow chartering GDS as a constituent society of the ADA and have forwarded the resolutions associated with that petition through the Fourteenth District of the American Dental Association to the ADA House of Delegates. The GDS feels the closest affinity to the Fourteenth District because of the proximity of Guam to the state of Hawaii.

Guam Dental Society's petition desiring ADA constituency lists the following reasons.

1. Guam Dental Society currently has 20 ADA members out of 44 civilian GDS members under the category of unorganized membership. In a discussion with Ms. Helen McK. Cherrett, director, Department of International Dental Health, we are not considered international members. This is interesting that GDS has approximately 41% of its membership carry ADA membership even though GDS is not a constituent society. We would like to be represented and involved in the actions and decision-making process of our nation's organized dental institution.
2. ADA constituency would allow for support in maintaining the prestige and respect of the dental profession. We abide by the same standard of care, morals and ethics of our colleagues in the ADA. Our dental laws require all licensed dentists to be recipients of a dental degree from one of the accredited dental schools in the nation. Dentists with foreign dental education may qualify for examination for licensure on Guam only if they have completed an ADA-approved graduate training program or a two-year

residency program approved by the Guam Board of Examiners in Dentistry. The dental profession on Guam is being challenged on the same issues organized dentistry faces in the States. With support, experience and resources from ADA, we would have the ability to better answer these issues.

3. The private practice dentists on Guam are representing the nation politically through involvement in the dental needs of the Micronesian Islands in the Western Pacific. These island nations are involved in the "Compact of Free Association" with the United States. GDS, along with the University of Hawaii Medical School, U.S. Public Health Service, U.S. Armed Forces and private health care missions, supports the health care commitment of our nation to the residents of those islands. Additional support from other ADA members in the form of experience, advice or care delivery would be very much appreciated.
4. Though we currently hold a seat in the FDI World Dental Federation as a voting member and membership in the Asia Pacific Dental Federation (APDF), we are willing to forfeit those seats and direct membership in FDI and APDF if we are to become an ADA constituent society. The benefits of associating with ADA outweigh our current situation. Also, our standards in care, morals and ethics in dentistry are congruent with ADA.
5. A comparison of dentistry, medicine and law on Guam is noteworthy. The Guam Medical Society is a constituent society of the American Medical Association (AMA). The Guam Bar Association is chartered through the National Bar Association. The dental profession on Guam is not recognized by our national organization for organized dentistry. We would very much appreciate the association of our organization with American Dental Association, which we feel supports and maintains our profession in a moral, ethical and respectable manner.
6. With an overwhelming majority of GDS members seeking constituency status, the number of ADA members will definitely increase which would be advantageous for GDS and ADA. Of the members who are not currently ADA members, the majority of them were members in the past. The most common reason for not continuing their membership in ADA was that Guam was not a constituent society; therefore, the benefits of being an ADA member would not fully pertain to us.

The petition is signed by 39 members of the GDS, including the ADA members who reside there, 17 of which are verified by the ADA Department of Membership Information. In support of the petition, the Fourteenth Trustee District submits the following resolutions.

109. Resolved, that Chapter II. CONSTITUENT SOCIETIES, Section 10. ORGANIZATION, of the *Bylaws* be amended by deleting the words and number "one hundred (100)" and by inserting in lieu thereof the words and number fifteen (15) so the amended section reads as follows:

> Section 10. ORGANIZATION: A constituent society may be organized and chartered, subject to the approval of the House of Delegates, upon application of at least fifteen (15) dentists, practicing in any state, District of Columbia, the Commonwealth of Puerto Rico, or a dependency of the United States (including, until December 31, 1999, the Panama Canal area where citizens of the United States are assigned by the United States Government and reside) who are active, life or retired members of the Association in good standing. No such society shall be charted in any state, District of Columbia, the Commonwealth of Puerto Rico, or a dependency of the United States in which a constituent society is already chartered by this Association.

Fourteenth Trustee District

Approval of Constituency Status for Guam Dental Society

The following resolution was submitted by the Fourteenth Trustee District on September 12, 1996, by Mr. Thomas J. Oberle, executive director, Colorado Dental Association.

Background: (*See* Constituency Status for Guam Dental Society, Resolution 109, page 376)

110. Resolved, that the Guam Dental Society be chartered as a constituent society of the American Dental Association on the date of the enactment of this resolution ____, 1996, and be it further

Resolved, that Chapter II. CONSTITUENT SOCIETIES, Section 110. CHARTERED CONSTITUENT SOCIETIES, of the *Bylaws* be amended by inserting in the appropriate alphabetic place in the list of the chartered constituent societies the name "Guam Dental Society," and be it further

Resolved, that Chapter IV. TRUSTEE DISTRICTS, Section 30. COMPOSITION, of the *Bylaws* be amended by inserting in the appropriate place under District 14 the name "Guam Dental Society."

Fourteenth Trustee District

Constituency Status for Guam Dental Society: Amendment of ADA *Bylaws* Regarding the Composition of the House of Delegates

The following resolution was submitted by the Fourteenth Trustee District on September 12, 1996, by Mr. Thomas J. Oberle, executive director, Colorado Dental Association.

Background: (*See* Constituency Status for Guam Dental Society, Resolution 109, page 376)

111. Resolved, that Chapter V. HOUSE OF DELEGATES, Section 10. COMPOSITION, of the *Bylaws* be amended in the first paragraph by deleting the words and number "four hundred twenty-seven (427)" and inserting in lieu thereof the words and number "four hundred twenty-eight (428)" to make the amended paragraph read as follows:

> Section 10. COMPOSITION: The House of Delegates shall be limited to four hundred twenty-eight (428) voting members. It shall be composed of the officially certified delegates of each constituent society, two (2) officially certified delegates from each of the five (5) federal dental

services and five (5) student members of the American Dental Association who are officially certified delegates from the American Student Dental Association.

Fourteenth Trustee District

Reconsideration of Predoctoral Dental Accreditation Standards

The following resolution was adopted by the Fourteenth Trustee District and submitted on September 28, 1996 by Mr. Thomas J. Oberle, executive director, Colorado Dental Association.

Background: It is recognized that the American Dental Association has no authority or jurisdiction over actions of the Commission on Dental Accreditation. However, the accreditation standards utilized by the Commission to evaluate dental education programs serve as the cornerstone of a process used to assure the quality of dental education.

Recently, the Commission has initiated a regular review of the predoctoral dental accreditation standards. The Commission appointed an ad-hoc standards revision subcommittee to review the current standards and propose possible revisions. In July 1995, proposed revised standards were approved by the Commission for circulation to the communities of interest. A response deadline of April 1, 1996 was set.

The proposed draft standards were included in the Commission's 1995 Annual Report with notice of opportunity to present comments during 1995 reference committee at ADA Annual Session. An open hearing was held at AADS Annual Session in March 1996. In addition, approximately twenty-five written comments were received.

Most comments received were related to further reduction in the number of standards, and many of the comments were implemented in the revision. Because no new standards were added to the draft and many of the comments received were implemented, the committee recommended implementation without another circulation. In July 1996 the Commission adopted the revised standards with effective implementation date of January 1998.

While the review process has been thorough, there is a belief among several communities of interest that further discussion is warranted.

The Second Special Presidential Committee to Study the Dental Accreditation Process thoroughly reviewed the proposed revised accreditation standards. This committee, appointed by the ADA Board of Trustees, was composed of representatives from the practicing, educational and examining communities. The committee also received input from several dental specialty organizations.

While the Second Special Presidential Committee to Study the Dental Accreditation Process appreciated the efforts of the Commission's ad-hoc standards revision subcommittee, it believed that the standards revision process needed to be carried much further. Based on extensive discussion, the Second Special Presidential Committee believed that accreditation standards should be clearly stated in discrete, objective and measurable terms; that the standards should be outcomes based, to include both outcomes prescribed by the Commission on Dental Accreditation and outcomes generated by the accredited programs; and that accreditation standards must reflect the minimum essentials to ensure quality educational programs.

The Second Special Presidential Committee believed that the accreditation standards were crucial to the effectiveness of the accreditation process, and therefore recommended that the Board of Trustees urge the Commission to delay final approval of the predoctoral standards until there has been additional opportunity for full discussion and consensus by the communities of interest.

The Board of Trustees received the report of the Second Special Presidential Committee, and adopted Resolution B-36, which urged the Commission on Dental Accreditation to delay final approval of the predoctoral accreditation standards.

The American Association of Orthodontists (AAO) has expressed concern about Standard 2-25 in the current approved revision of the predoctoral standards. This standard states that graduates must be competent in providing oral health care within the scope of general dentistry, **as defined by the school**, in areas such as the restoration of teeth, the replacement of teeth, periodontal therapy, pulpal therapy, hard and soft tissue surgery and malocclusion and space management.

According to AAO, this now leaves the question of what should be taught in these subject areas entirely up to each school since they can decide what they consider to be the scope of general dentistry. This could lead to wide variations in dental curricula. While it is recognized that schools must have the freedom to develop their curricula according to institutional goals and objectives, there is some need to maintain a degree of uniformity in qualifications for general dental practice. Issues such as uniformity in entry level licensure examinations, licensure by credentials, and continued competency will be dependent to some extent on common standards for dental education.

In April, 1996 the American Association of Dental Schools (AADS) circulated a draft document, titled "Competencies for the New Dentist." This document is viewed as a resource for dental schools to use as a foundation for a competency-based approach to curriculum development. It would replace the current behavioral-based curriculum guidelines. As one of the communities that was asked to comment on the AADS document, the ADA Board of Trustees appointed a working group to review the document. Among its other recommendations regarding the AADS document, the working group believed that the competencies statements should be related to, and consistent with, the accreditation standards for predoctoral education programs. In order to avoid conflicts and confusion for dental schools attempting to develop competency-based curricula, the working group believed the standards and the competency definitions should be as consistent as possible.

Finally, requirement number two in the current *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists* states that a specialty "must be a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates as **defined by the predoctoral accreditation standards.**" Since each dental school could define the scope of general dentistry in its own way, this could lead to confusion relative to the requirements for recognizing dental specialties.

The responsibility of the Commission on Dental Accreditation is extremely important. The accreditation standards are critical to the future of the dental profession. In its own mission statement, the Commission recognizes the importance of the standards "that are developed and agreed upon by the various communities of interest." For these reasons, and because of concerns expressed above, the Fourteenth District believes it is important to allow for further review of the predoctoral accreditation standards, and submits the following resolution.

143. Resolved, that the Commission on Dental Accreditation be urged to recirculate the recently adopted *Accreditation Standards for Dental Education Programs* to permit additional consideration and comment by the communities of interest.

Fifteenth Trustee District

Substitute for Resolution 17RC: ADA Dental Manpower Studies

The following substitute for Resolution 17RC was adopted by the Fifteenth Trustee District and submitted on September 30, 1996 by Dr. Richard Eklund.

Background: Resolution 17RC, as proposed by the Reference Committee, totally changes the substance of the original policy as stated in Resolution 105H-1984 (*Trans.*1984:536). It would be much more appropriate to rescind that original policy and accept the proposed new resolving clause as the new policy. Therefore, be it

17RCS-1. Resolved, that the ADA continue to conduct studies and compile the necessary data and statistics regarding the dental workforce needed to serve the demand for care and disseminate this information to the appropriate agencies, and be it further
Resolved, that Resolution 105H-1984 be rescinded.

Fifteenth Trustee District

Substitute for Resolution 43: Dental Office Involvement with Dental Benefit Plan Problems

The following substitute for Resolution 43 (*Supplement*:273) was submitted by the Fifteenth Trustee District on September 28, 1996 by Dr. Fred E. Aurbach, vice chairman, Fifteenth District Delegation.

Background: Due to the fact that many dentists are intervening on their patients' behalf when there are problems in settling a claim, many employers and/or their benefits advisors are unaware of the problems their employees are having with dental benefits claims. While we as dentists wish to help our patients, the spending of additional unnecessary time in resubmitting claims, and/or redundant explanations to third-party payers begins to affect the economics of our practices, and gives the employer a false sense of success in the benefit plan that he/she has selected. In addition, it seems that employers and/or subscribers have no systematic method of communicating or tracking a level of satisfaction for the plans in which they participate, or are considering participating. To this end, the Fifteenth Trustee District encourages the development of a form, standardized for the industry for data analysis, to be called an "Adverse Claim Determination Form." This form would be supplied in reproducible form by the employer in the benefits booklets given to the employee, or by the dentist to be used by the employee as a feedback mechanism to the employer on the relative performance (satisfactory/unsatisfactory) of the dental plan. Possible information for the form may include:

- the same identifying information that the patient fills out at the top of the dental claim form
- the name of the Parent Company payer
- the name of the third-party administrator, when known
- a checklist for listing the ten most common complaints
- a check box for "Other"

The Ten Most Common Complaints are (Check with ADA or TDA CDCP on this):

- Denial of the claim in error resulting in wrongful delay in settlement.
- Loss of claim/denying receipt of claim.
- Requesting information already at its (the company's) disposal (already sent!).
- Requesting unnecessary information.
- Late payment.
- Poor or non-coordination of benefits.
- Having to make additional requests for payment.
- Loss of pre-treatment estimate request.
- Not listing an estimate for all benefits requested (stops giving benefits estimate because end-of-year "maximum" has been reached on the estimate; denies the patient the ability to determine work to be done in that benefit year based on eligible benefits. ALL ELIGIBLE BENEFITS SHOULD BE ESTIMATED WITH A CAVEAT OF THE MAXIMUM BENEFITS PAYABLE IN A BENEFIT YEAR).
- In bulk payments: not listing enough information, or incorrect information, so that credit can be made to the proper account at the doctor's office.
- Other.

Therefore, be it

43S-5. Resolved, that dentists continue to be encouraged to provide patients with all information necessary for the third-party benefits provider to determine the proper resolution of the claim, and be it further
Resolved, that when the third-party benefits provider requests specific information not included with the original claim, and necessary for benefits determination, that the dentist provide such information to/for the patient, and be it further
Resolved, that dentists should encourage their patients to contact the patient's employer to resolve adverse settlements/determinations, and be it further
Resolved, that the Council on Dental Benefit Programs design an "Adverse Claim Determination Form" for use by covered employees whenever they feel they have received an unfair determination or settlement of their dental benefits, and be it further

Resolved, that the appropriate Association agency develop language for the American Dental Association and/or the constituent dental societies to use to lobby at the federal and state government levels (legislatures or regulatory agencies) to require this form to be included in the employee benefits booklet in reproducible form for covered employees' use.

Fifteenth Trustee District

Amendment to Resolution 44B: Development of Performance Indicators for Oral Health Care

The following amendment to Resolution 44B was submitted by the Fifteenth Trustee District on September 13, 1996 by Ms. Mary Kay Linn, executive director, Texas Dental Association.

Background: Amend Resolution 44B by the addition of the words "as defined in the Council on Dental Benefit Programs' Supplemental Report 2 (*Supplement 1996*:272)" after the word "care" so that the amended resolution reads as follows.

44BS-2. Resolved, that the American Dental Association, through its appropriate agencies, draft a plan for developing performance indicators for oral health care, as defined in the Council on Dental Benefit Programs' Supplemental Report 2 (*Supplement 1996*:272), and report to the 1997 House of Delegates.

Fifteenth Trustee District

Substitute for Resolution 45: Revised Comprehensive Policy Statement on Dental Auxiliary Personnel

The following substitute for Resolution 45 (*Supplement*:464) was submitted by the Fifteenth Trustee District on September 13, 1996 by Ms. Mary Kay Linn, executive director, Texas Dental Association.

45S-1. Resolved, that Resolution 45 be amended in the first resolving clause by deleting the words "and without opposition to general supervision of hygienists," and by deleting the third and fourth resolving clauses in their entirety, so that the amended resolution reads:

> **Resolved,** that ADA policy strongly support supervision of auxiliaries without specifying the level, and be it further,
> **Resolved,** that the ADA continue its strong opposition to unsupervised practice of dental auxiliary personnel.

Fifteenth Trustee District

Amendment to Resolution 63: Allied Organizations' Support for ADA Recruitment and Retention Activities

The following amendment to Resolution 63 (*Supplement*:312) was submitted by the Fifteenth Trustee District and transmitted on September 13, 1996 by Ms. Mary Kay Linn, executive director, Texas Dental Association.

63S-1. Resolved, that Resolution 41H-1989 (*Trans.*1989:540), Allied Organizations' Support for ADA Recruitment and Retention Activities, be amended by deleting the word "allied" wherever it appears and substituting it with the word "other"; by deleting the words "organized dentistry" in the first resolving clause and substituting in its place "the American Dental Association"; by adding in the second resolving clause the word "dental" before the word "organizations"; and by deleting in the second resolving clause the words "that require maintenance of ADA membership" so the amended resolution reads as follows:

> **Other Organizations' Support for ADA Recruitment and Retention Activities**
>
> **Resolved,** that the American Dental Association urge other dental organizations to support membership recruitment and retention activities of the American Dental Association, and be it further
> **Resolved,** that the American Dental Association encourage those dental organizations to exchange current information on membership and specialty status with the ADA on an annual basis.

Fifteenth Trustee District

Substitute for Resolution 81: Associate Membership Category

The following substitute for Resolution 81 (*Supplement*:482) was submitted by the Fifteenth Trustee District on September 30, 1996 by Dr. Richard Eklund.

81S-1. Resolved, that Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection F. ASSOCIATE MEMBER, of the *Bylaws* be amended by deleting Subsection F in its entirety and by substituting in its place a new Subsection F to read as follows:

> F. ASSOCIATE MEMBER. A person, not eligible for any other type of membership in this Association, who contributes to the advancement of the objectives of this Association, is employed full-time in dentally-related education or research by an accredited institution of higher education and has not met the educational requirements for licensure as a dentist anywhere in the United States, upon application to and approval by the component society, constituent society, and the American Dental Association Board of Trustees, shall be classified as an associate member of this Association.*

and be it further
Resolved, that a footnote be added to Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection F. ASSOCIATE MEMBER, of the *Bylaws* to provide as follows:

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

and be it further
Resolved, that Chapter I. MEMBERSHIP, Section 40. PRIVILEGES, Subsection F. ASSOCIATE MEMBER, of the *Bylaws* be amended by deleting Subsection F in its entirety and by substituting a new Subsection F to read as follows:

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

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 by adding a new part "c" to read as follows:

c. An associate member whose dues have not been paid by March 31 of the current year shall cease to be a member of this Association. An associate member who terminates full-time employment in dentally-related education or research at an accredited institution of higher education shall cease to be an associate member of this Association December 31 of that calendar year.

Fifteenth Trustee District

Substitute for Resolution 84: Restructure of the Council on Dental Education and the Commission on Dental Accreditation

The following substitute for Resolution 84 (*Supplement*:490) was submitted by the Fifteenth Trustee District and transmitted on September 13, 1996 by Ms. Mary Kay Linn, executive director, Texas Dental Association.

84S-1. Resolved, that Chapter X. COUNCILS, Section 10. NAME, of the *Bylaws* be amended by adding the words "and Licensure" to the name "Council on Dental Education," so the amended Section 10 reads as follows:

Section 10. NAME: The councils of this Association shall be:

Council on Access, Prevention and Interprofessional Relations
Council on ADA Sessions and International Programs
Council on Communications
Council on Dental Benefit Programs
Council on Dental Education and Licensure
Council on Dental Practice
Council on Ethics, Bylaws and Judicial Affairs
Council on Governmental Affairs and Federal Dental Services
Council on Insurance
Council on Membership
Council on Scientific Affairs

and be it further
Resolved, that in all other places in the *Bylaws* where the name "Council on Dental Education" appears, the name be changed editorially to the "Council on Dental Education and Licensure," and be it further
Resolved, that Chapter X. COUNCILS, Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, of the *Bylaws* be amended in Subsection A by deleting the provisions dealing with the Council on Dental Education and by substituting in their place new provisions specifying the composition and organization of the new Council on Dental Education and Licensure, to read as follows:

Council on Dental Education and Licensure shall be composed of sixteen (16) members selected as follows:

a. Nominations and Selection.

(1) Eight (8) members shall be nominated by the Board of Trustees on a rotational system by trustee district from the active, life or retired members of this Association, no one of whom shall be a full-time member of a faculty of a school of dentistry or a member of a state board of dental examiners. A person shall be considered to be a full-time member of a faculty if he or she works for the school of dentistry more than ~~two (2) days or sixteen (16) hours per week~~ one (1) day or eight (8) hours per week.

(2) Four (4) members who are active, life or retired members of this Association shall be selected by the American Association of Dental Examiners from the active membership of that body, no one of whom shall be a member of a faculty of a school of dentistry.

(3) Four (4) members who are active, life or retired members of this Association shall be selected by the American Association of Dental Schools from its active membership. These members shall hold positions of professorial rank in dental schools accredited by the Commission on Dental Accreditation and shall not be members of any state board of dental examiners.

b. Election. The eight (8) members of the Council on Dental Education and Licensure nominated by the Board of Trustees shall be elected by the House of Delegates from nominees selected in accordance with this section.

c. Committees. The Council on Dental Education and Licensure shall establish a standing Committee on Dental Education and Educational Measurements and a standing Committee on Licensure, each consisting of eight (8) members selected by the Council. The Council may establish additional committees when they are deemed essential to carry out the duties of this Council.**

** Council on Dental Education and Licensure—To increase the number of members chosen by this Association in 1997, the term of the Council member from the 10th Trustee District shall be extended by one year to 1998, while the term of the Council member elected in 1996 from the 3rd Trustee District shall be three years. Council members from the 7th and 11th Trustee Districts elected in 1997 shall each serve a three-year term. The Council members from the 6th and 12th Trustee Districts elected in 1997 shall each serve a four-year term. All Council members elected subsequently shall serve four-year terms. This footnote shall expire at adjournment *sine die* of the House of Delegates in the year 2000.

and be it further
Resolved, that Chapter XIV. COMMISSIONS, Section 40. ELIGIBILITY, of the *Bylaws* be amended by deleting Subsection D. CHAIRMEN in its entirety and by substituting in its place new Subsections D and E to read as follows:

D. No member of the Council on Dental Education and Licensure of this Association may serve concurrently as a member of the Commission on Dental Accreditation.

E. CHAIRMEN. The Commissions of this Association shall elect their own chairmen.

and be it further
Resolved, that the amendments to the *Bylaws* set forth in this resolution become effective at adjournment *sine die* of the 1997 House of Delegates.

Fifteenth Trustee District

House of Delegates' Action on Referred Resolutions

The following resolution was submitted by the Fifteenth Trustee District on September 13, 1996, by Ms. Mary Kay Linn, executive director, Texas Dental Association.

Background: The House of Delegates is the final authority on all matters of the Association. Every year resolutions are brought to the House that are referred to councils or committees for investigation and study. Many times the report is sent back to the House with the resolution enclosed in the report but there is no action on the resolution by the House of Delegates. This disenfranchises the House of Delegates on its responsibility to act on all resolutions. The House has an obligation to act with a positive or negative response on every resolution it receives even after it is referred, therefore be it

106. Resolved, that any resolution referred from the House of Delegates to councils, committees, staff or other entity must return to the next appropriate House of Delegates in resolution form for action by the House of Delegates.

Fifteenth Trustee District

Associate Membership Category: Proposed Amendment of *Bylaws*

The following resolution was submitted by the Fifteenth Trustee District and transmitted on September 13, 1996 by Ms. Mary Kay Linn, executive director, Texas Dental Association.

Background: American Dental Association *Bylaws* allow for associate membership in the Association. Presently, solicitation letters are sent by the ADA President inviting certain individuals to become associate members. When the application is returned to the ADA Board of Trustees, a letter is sent to the constituent society executive director for signature prior to ADA Board approval. This procedure does not give appropriate consideration in the process to local components and constituent society; therefore, be it

121. Resolved, that Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection F. ASSOCIATE MEMBER, of the *Bylaws* be amended after the word "the" in line 168 by adding the phrase: "component society board of directors, constituent society board of directors and the American Dental Association" so the amended Subsection F reads as follows:

F. ASSOCIATE MEMBER. A person, not eligible for any other type of membership in this Association, who contributes to the advancement of the objectives of this Association and has not met the educational requirements for licensure as a dentist anywhere in the United States, upon application to and approval by the component society board of directors, constituent society board of directors and the American Dental Association Board of Trustees, shall be classified as an associate member of this Association.

Fifteenth Trustee District

Increase in Size of the Council on Communications

The following resolution was submitted by the Fifteenth Trustee District and transmitted on September 13, 1996 by Ms. Mary Kay Linn, executive director, Texas Dental Association.

137. Resolved, that Chapter X. COUNCILS, Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, Subsection A, of the *Bylaws*, be amended by deleting lines 1581-1583 concerning the composition of the

Council on Communications and by substituting a new provision that increases the size of the Council to 16 members, which reads as follows:

> Council on Communications shall be composed of one (1) member from each trustee district.*

and be it further

Resolved, that Chapter X. COUNCILS, Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, of the *Bylaws*, the footnote to Subsection A regarding the composition of the Council on Communications be deleted in its entirety and in its place a new footnote be substituted which reads as follows:

> * Council on Communications—In order to increase the size of the Council to 16 members and establish the required pattern of four (4) members retiring from the Council each year, current members from the 1st and 3rd Trustee Districts shall have their terms extended by one year, and each shall be eligible for reelection to a new four-year term that begins in 1997. A new member from the 12th Trustee District shall be added to the Council for the 1996-97 year, and this individual shall be eligible for reelection to a new four-year term that begins in 1997. In 1996, new Council members from the 13th, 14th, 15th and 16th Trustee Districts shall be elected to serve four-year terms. In 1996, a new Council member from the 10th Trustee District shall be elected to serve a two-year term and shall be eligible for reelection to a new four-year term that begins in 1998. The term of the Council member from the 6th Trustee District shall finish in 1997, and a new Council member from the 6th District shall be elected in 1997 to serve a new four-year term. The term of the Council members from the 5th, 7th and 11th Trustee Districts shall finish in 1998, and new members from these same districts shall be elected in 1998 to serve new four-year terms. In 1996, new Council members from the 2nd and 8th Trustee Districts shall be elected to serve three-year terms. At the completion of their terms, these two retiring Council members will not be eligible to serve on another council or commission for two years. In 1999, new Council members from the 2nd and 8th Trustee Districts shall be elected to serve four-year terms. The term of the Council members from the 4th and 9th Trustee Districts shall end in 1999, and new Council members from these districts shall be elected in 1999 to serve four-year terms. This footnote shall expire at adjournment *sine die* of the 2001 House of Delegates.

Fifteenth Trustee District

Single Accreditation Program

The following resolution was submitted by the Fifteenth Trustee District and transmitted on September 28, 1996 by Dr. Fred E. Aurbach, vice chairman, Fifteenth District Delegation.

Background: In January 1995 the IOM published its report *Dental Education at the Crossroads: Challenges and Change.* There were several concerns voiced by resolution during the 1995 House of Delegates meeting in Las Vegas. These resolutions were subsequently submitted to a Special Board Committee to be included in its study of the IOM report.

Board Report 6 is the report of the Special Board Committee. The report is submitted to the House of Delegates without comment or resolution. IOM recommendation 14 suggests a separate program for the ambulatory care facility(ies) of a dental school.

The separate accreditation program would separate the patient care from the mission of educating the students. The Special Board Committee determined that the separated accreditation is unnecessary and should not be pursued. Therefore be it

145. Resolved, that the American Dental Association support a single accreditation program for dental schools and their associated facilities in which ambulatory patient care is delivered.

Fifteenth Trustee District

Curricular Changes to Maintain Dentistry as an Autonomous Independent Health Profession

The following resolution was submitted by the Fifteenth Trustee District and transmitted on September 28, 1996 by Dr. Fred E. Aurbach, vice chairman, Fifteenth District Delegation.

Background: In January 1995 the IOM published its report *Dental Education at the Crossroads: Challenges and Change.* There were several concerns voiced by resolution during the 1995 House of Delegates meeting in Las Vegas. These resolutions were subsequently submitted to a Special Board Committee to be included in its study of the IOM report.

Board Report 6 is the report of the Special Board Committee. The report is submitted to the House of Delegates without comment or resolution. IOM Recommendation 5 deals with the integration of dentistry with medicine. Medicine as a profession has traveled a road that has virtually eliminated patient choice and doctor patient relationships. Dentistry, however, still has the opportunity not to follow the same road that our medical colleagues did; therefore, be it

146. Resolved, that the American Dental Association urge the Commission on Dental Accreditation, in cooperation with the American Association of Dental Schools and individual dental schools to stimulate curricular changes that will integrate appropriate medical knowledge into the dental curriculum in such a manner that dentistry remains an autonomous independent health profession.

Fifteenth Trustee District

Use of Human Subjects in Clinical Licensure Exams

The following resolution was submitted by the Fifteenth Trustee District and transmitted on September 28, 1996 by

Dr. Fred E. Aurbach, vice chairman, Fifteenth District Delegation.

Background: The Association's policy is clearly delineated in Resolution 99H-1995 (*Trans.*1995:640), which states that the mission of a dental school is to educate students competent in the art and science of dentistry. Recommendation 6 involves making patient care an end in itself, and not a means to an end.

Board Report 6 (*Supplement*:450) is the report of the Special Board Committee. The report is submitted to the House of Delegates without comment or resolution. Institute of Medicine (IOM) recommendation 19 contains steps toward national licensure, continued competency, elimination of live patients in examinations, and other violations of states' rights. The Special Committee of the Board reported that the implementation of many of these items is already underway. This course is in direct conflict with the ADA policy adopted by the 1995 House of Delegates (*Trans.*1995:643), which cautioned against implementation of any recommendations of the IOM report until after the ADA completed its study of the report and any recommendations have been approved by the 1996 House of Delegates.

The report calls for the "minimization of the use of human subjects in clinical licensure examinations." Since the practice of dentistry deals primarily with ambulatory, basically healthy human beings, the capability of dealing with the anxiety, fears, human reflexes and other emotions needs to be demonstrated. It is extremely important that a human subject be part of the examination process. Therefore, be it

147. Resolved, that the Association supports the concept of dental students providing direct patient care under the direct and indirect supervision of qualified faculty as a method of learning clinical skills and patient care including the ability to deal with the anxiety, fears, reflexes and other emotions of the "human" aspects of dental treatment, and be it further
Resolved, that the House strongly supports the position of the Council on Ethics, Bylaws and Judicial Affairs as stated in the Council's annual report to the 1993 House of Delegates (*Reports* 1993:109) that, although the use of human subjects in licensure examinations raises certain ethical concerns, the practice is not in and of itself unethical, and be further
Resolved, that the clinic program in which the testing is conducted be prepared to assume the responsibility for follow up care on any human patient that is utilized in the licensing examination.

Fifteenth Trustee District

Analysis of Appropriate Number and Location of Dental Schools

The following resolution was submitted by the Fifteenth Trustee District and transmitted on September 28, 1996 by Dr. Fred E. Aurbach, vice chairman, Fifteenth District Delegation.

Background: In January 1995 the IOM published its report *Dental Education at the Crossroads: Challenges and Change.* There were several concerns voiced by resolution during the 1995 House of Delegates meeting in Las Vegas. These resolutions were subsequently submitted to a Special Board Committee to be included in its study of the IOM report.

Board Report 6 is the report of the Special Board Committee. The report is submitted to the House of Delegates without comment or resolution. IOM recommendations 16 and 17 deal with financial management of dental schools.

In the early 1970s, many dental schools enlarged their facilities and faculties to accommodate large classes in response to the government programs to produce more dentists to offset a perceived shortage. Since this tactic has resulted in a gross oversupply of dentists the opposite reaction occurred; the class sizes were lowered rather than closing schools. This has resulted in large, overbuilt facilities with large faculties, producing a much lower number of dentists per year. The result is larger operational costs which contribute directly to the costs of dental education.

Therefore, in an attempt to lower the cost of dental education, be it

148. Resolved, that the appropriate agencies of the Association work with the AADS to analyze the appropriate number and location of the dental schools of the United States, develop and recommend to the House of Delegates a plan to eliminate duplication of facilities, programs and faculties; and be it further
Resolved, that until this study is complete and a report is made to the House of Delegates, the Association will withhold support for any new dental schools that fall within the jurisdiction of the Commission on Dental Accreditation.

Sixteenth Trustee District

Substitute for Resolution 43: Dental Office Involvement with Dental Benefit Plan Problems

The following substitute for Resolution 43 (*Supplement*:273) was submitted by the Sixteenth Trustee District on September 9, 1996 by Ms. Faye K. Marley, executive director, North Carolina Dental Society.

43S-2. Resolved, that the American Dental Association encourage dentists to make a reasonable attempt to assist patients with their third-party payer problems, and be it further
Resolved, that if this effort is unsuccessful, that dentists provide their patients with accurate statements of services recommended or rendered and advise patients to take their problems back to the plan purchaser for resolution.

Sixteenth Trustee District

Substitute for Resolution 45: Revised Comprehensive Policy Statement on Dental Auxiliary Personnel

The following substitute for Resolution 45 (*Supplement*:464) was adopted by the Sixteenth Trustee District and submitted on October 1, 1996 by Dr. Carroll Player.

45S-2. Resolved, that, because the ADA strongly supports supervision of auxiliaries and opposes the unsupervised practice of dental auxiliary personnel, the proposed revised Comprehensive Policy Statement on Dental Auxiliary Personnel be further revised by:

- inserting the word "local" on *Supplement*:466, line 14 after "administering," and before "parenteral" and
- inserting on *Supplement*:468, line 14, the following: "General supervision is not acceptable to the American Dental Association because it fails to protect the health of the public." and
- deleting the word "assistants" on *Supplement*:468, line 15 and inserting "auxiliaries" and
- revising lines 16-18 on *Supplement*:468 to read: "However, in some states, licensed dental hygienists are permitted to perform duties, except for intraoral expanded functions, under general supervision, as delegated by the supervising dentist."

and be it further
Resolved, that the revised Comprehensive Policy Statement on Dental Auxiliary Personnel be adopted as amended and be it further
Resolved, that Resolution 10H-1988 (*Trans.*1988:462), Comprehensive Policy Statement on Dental Auxiliary Personnel, be rescinded.

Sixteenth Trustee District

Participation in Science Fair Competitions

The following resolution was submitted by the Sixteenth Trustee District on September 9, 1996 by Ms. Faye K. Marley, executive director, North Carolina Dental Society.

Background: Our profession has recognized the need to attract highly qualified individuals in order to secure its future. The ADA SELECT program is a genuine effort to fill this need. Many of our science-oriented high school students are naturals for dentistry and they are exactly the type of individuals that we want in the profession. The science competitions in which they participate so enthusiastically offer a unique opportunity for the ADA to promote dentistry as a career.

Today's science fair competitions are characterized by research projects often worthy of publication or doctoral theses. In order for the dental profession to successfully compete for talented and qualified candidates it must join the numerous scientific organizations, the military, the government, industry and the American Medical Association in active recruitment at every level of science competition.

Contemporary dental research encompasses virtually every area of science. Likewise, our country's finest high school science researchers span the entire spectrum of science. Science competition is intense at the local level. As the culling process advances students to state, regional, national and international levels, this intensity reaches truly dramatic proportions. Awards and honors are equally impressive.

Even at the regional levels students are awarded jobs, trips, scholarships, equipment and cash on the spot. At the International Science and Engineering Fair (ISEF) the grand prize winners are awarded a trip to the Nobel Prize ceremonies in Stockholm each year. The U.S. Military sponsors their winners on science oriented trips to Great Britain, Europe, Japan and military facilities in the United States. Separate science competitions in addition to the ISEF include the Westinghouse Science Talent Search, the Naval National Science Awards Program and the Junior Symposium on Humanities and Science conducted by the Army.

The ISEF and Westinghouse competitions are administered under the aegis of Science Service in Washington, D.C. Its affiliates include private and public school systems at local, regional, state and international levels. It is a nonprofit institution involving literally thousands of volunteers and co-sponsors. Over 70 professional and scientific organizations participate in the national and regional awards programs. The ADA as a "Special Awards" sponsor would pay a $500 fee for each annual ISEF, provide its own judges, award at least $500 each fair and commit to a three-year term.

The ADA's commitment to the ISEF program would provide a fresh and exciting means to (1) compete on a level playing field for prospective highly qualified students in dentistry; (2) promote dentistry within the scientific community; (3) promote dentistry to parents, counselors and teachers of talented science students; (4) promote dentistry to the viewing public at local, regional, state and international levels; (5) gain valuable media coverage for organized dentistry; and (6) provide another way for dentists to contribute to their community.

The ADA's involvement in high school competition and awards programs could reap significant benefits for the dental profession. If carefully planned these benefits would far outweigh the modest investment required.

Dentistry's future is now and now is the time for the ADA to sponsor the future. Now is the time to make the ADA Science Talent Awards Program a reality.

104. Resolved, that the American Dental Association participate in Science Fairs throughout the states, and be it further
Resolved, that the American Dental Association encourages its constituent societies to participate in judging of such fairs, and be it further
Resolved, that the appropriate Association agencies develop formal policies, recommendations and strategies for implementing an ADA Science Talent Awards Program, and be it further
Resolved, that the appropriate Association agencies propose full funding and program details to be presented to the 1997 ADA Board of Trustees for its consideration.

Delegate Emanuel W. Michaels, Virginia

Rebuttal of Unfair Criticism of the ADA

The following resolution was submitted on July 22, 1996 by Dr. Emanual W. Michaels, delegate, Virginia.

Background: Perception being reality in the '90s, the ADA needs to take an aggressive stance whenever it is maligned with misinformation regarding supposed sins of commission

or omission. In the past few years, the number of articles, editorials and letters to the editor that take the ADA to task seems to have been increasing. Without rebuttal, these claims may well be taken at face value by readers.

How often are the authors of such material nonmembers who feel free to be critical while they will not help to support our efforts? How often do members who know how their dues help dentistry feel frustrated when they read of our supposed failures?

I have seen this House and Board be more proactive and aggressive than their predecessors. There are few occasions on which we need to let such criticism go by without comment.

Therefore, be it

74. Resolved, that wherever and whenever possible, the ADA rebut articles and letters that unfairly castigate the ADA based on information that is contrary to fact.

American Association of Orthodontists

Substitute for Resolution 52B: Amendment of "Guidelines Governing the Conduct of Campaigns for ADA Offices"

The following substitute for Resolution 52B was submitted by the American Association of Orthodontists on September 13, 1996 by Mr. Ronald S. Moen, executive director.

Background: For the past six years, candidates for President-elect and Speaker of the House of Delegates of the ADA have been invited to attend the American Association of Orthodontists' (AAO) Annual Session to address its House of Delegates; to participate in a candidate's forum with several hundred of AAO's key state, regional and national leaders; and to meet with AAO members who are active in ADA leadership positions at the local, state and national levels. These forums for candidates have been an excellent opportunity to develop and maintain effective communication with AAO, especially since AAO requires ADA membership. This activity has been widely recognized as highly effective and mutually beneficial. This amendment would make it clear that candidates can continue to meet with the AAO and the other recognized dental specialty organizations.

52BS-1. Resolved, that the "Guidelines Governing the Conduct of Campaigns for ADA Offices" be amended to read as follows (Strikeout indicates deleted material. Shading indicates new material.):

Guidelines 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, may freely campaign 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 presentation for election prior to March 1.
3. Campaign travel shall not begin before March 1 and shall be limited as follows:

   a. to district caucus meetings only (EXCEPTION: within those districts that do not caucus prior to the ADA annual session, travel to annual state meetings upon invitation would also be eligible.)~~, and~~
   b. by invitation of the district caucus (or constituent society as appropriate) and the New England Dental Leadership Conference (NEDLC) only~~.~~, ~~and~~
   c. by invitation of a recognized dental specialty organization to their annual session.

4. District caucuses (or constituent societies as appropriate) issuing invitations to candidates are requested to provide an appropriate opportunity for the candidates to meet with their members. It is recommended that such forum be structured:

   a. to allow all candidates to make appropriate presentations;
   b. to allow caucuses freedom to assess candidates any way they deem appropriate; and
   c. to allow each candidate to respond to the questions without the other candidates present.

5. The Executive Director shall meet with all candidates to negotiate cost-effective agreements on campaign issues such as the level of hospitality in suites, promotional activities and gifts, campaign literature, and activities related to emerging electronic communications.
6. Candidates shall not use social functions or hospitality suites on behalf of their candidacy prior to the first meeting of the House of Delegates.
7. Candidates shall limit the display of campaign signs and posters to the immediate area of their respective hospitality suites. (The ADA will provide a prominent directory of all candidates' hospitality suites in the hotel and House of Delegates registration areas.)
8. Campaign suites shall only be open on the two nights prior to the election. All campaign social functions will be restricted to the candidate's officially designated hospitality suite at the annual session.
9. No material may be distributed in the House of Delegates without obtaining permission from the Secretary of the House. Materials to be distributed in the House of Delegates on behalf of any member's candidacy for office shall be limited to printed matter on paper only and nothing else. (A single distribution per candidate will be made. However, this distribution could consist of more than one piece of printed matter as long as the materials are secured together.)

Any questions regarding the guidelines should be directed to the Office of the Executive Director for clarification.

American Association of Orthodontists

Independent Research Study of Fraud and Abuse in Dental Benefit Claims

The following resolution was submitted by the American Association of Orthodontists and transmitted on September 3, 1996 by Mr. Ronald S. Moen, executive director.

Background: The insurance industry uses fraud and abuse in the filing of dental benefit claims as a major part of their tactics to discourage employers from implementing direct reimbursement dental plans and to advance their contention that strong utilization review is vital to a successful dental plan. A study by an independent organization which documents the incidence of fraud and abuse in dental benefits would be invaluable to the ADA's efforts to promote direct reimbursement dental plans.

96. Resolved, that the American Dental Association provide funds, or identify funds available from other agencies or organizations, for a research study by an independent outside agency or organization to document the actual incidence of fraud and abuse in dental benefit claims.

American Student Dental Association

Successful Completion of National Board Dental Examinations Part I and II as a Dental School Graduation Requirement

The following resolution was submitted by the American Student Dental Association and transmitted on September 13, 1996 by Ms. Karen S. Cervenka, secretary and executive director, American Student Dental Association.

Introduction: Since 1994, the American Student Dental Association (ASDA) has maintained a Task Force on Dental Licensure Reform, which has pursued the following goals in regard to dental licensure examinations:

1. Creation and acceptance of one content-uniform clinical licensure examination that is valid, reliable, anonymous and fair.
2. Reduction of candidate stress and intimidation of candidates by examiners and the process of examination.
3. Creation of a more candidate-friendly examination and the addition of humanizing elements to the examination process.
4. Substitution of successful completion of the National Board Dental Examinations Part I and II for all written examinations except jurisprudence.
5. Minimizing the use of human subjects in dental licensure examination.
6. Making state jurisprudence examinations available via remote-site computer in order to facilitate access, allow for immediate disclosure of results, and decrease costs.
7. Implementation of pre-graduation clinical licensure examinations at all dental schools.
8. Creation of dental school-based remediation programs for candidates in need of them.
9. Better education of students concerning the purpose and process of licensure examination.
10. Improved opportunities for candidates, patients and other involved parties to comment and offer suggestions concerning the examination process.
11. Reduction and control of costs associated with dental licensure examinations for all parties involved.

In pursuit of these goals, ASDA has initiated or participated in numerous efforts to effect change in the process of dental licensure, through meetings and contact with the regional dental testing agencies and unaligned states, the American Association of Dental Examiners, the American Dental Association and the American Association of Dental Schools. ASDA would like to thank ADA President William Ten Pas for inviting student representatives to participate in many licensure-related meetings sponsored by the American Dental Association this year.

In an unprecedented step, ASDA leaders met with the Steering Committee of the Central Regional Dental Testing Service (CRDTS) to present suggestions for improving the administration of the CRDTS examination. ASDA expects to hold similar meetings with other regional testing agencies later in the year.

In related activities, ASDA sent letters to dental school deans, ADA leaders and licensure testing agencies communicating ASDA goals for licensure reform, protesting the dissolution of the Combined Regional Examination (CORE) and encouraging reconciliation, and requesting meetings between testing agencies and ASDA leaders. The ASDA task force also prepared a working paper outlining the components of an ideal dental clinical licensure examination.

From these communications and meetings, ASDA leaders developed 18 recommendations to present to various agencies in accordance with their organizational scope and sphere of influence. Among these are three resolutions which are appropriate for consideration by the American Dental Association House of Delegates.

Background: It is well-documented that the National Board Dental Examinations Part I and II are tests which are valid and reliable. Such national standardized examinations are necessary and important because they help to gauge whether dental students possess a minimum level of comprehension of the basic and clinical sciences curriculum.

Despite the fact that nearly every state requires successful completion of the National Board Dental Examinations Part I and II as a requirement for dental licensure, only 16 U.S. dental schools currently include successful completion of these examinations as a graduation requirement. Dental schools offer the best environment to prepare students to pass these examinations. Therefore, the American Student Dental Association recommends adoption of the following resolution.

112. Resolved, that the appropriate agency(s) of the American Dental Association pursue actions to encourage the successful completion of the National Board Dental Examinations Part I and Part II as a graduation requirement for all U.S. dental schools, and be it further

Resolved, that the appropriate agency(s) of the American Dental Association encourage all U.S. dental schools and other appropriate providers to regularly offer both preparatory

and remediation courses for candidates taking the National Board Dental Examinations.

American Student Dental Association

Substitution of the National Board Dental Examinations Part I and II for Written Portions of Licensure Examinations

The following resolution was submitted by the American Student Dental Association and transmitted on September 13, 1996 by Ms. Karen S. Cervenka, secretary and executive director, American Student Dental Association.

Background: The National Board Dental Examinations Part I and II are accepted by most dental educational institutions and the practicing community as valid and reliable instruments to measure an individual's knowledge of the basic and clinical sciences. However, some of the regional testing agencies and states that administer independent licensure examinations continue to require applicants to take written examinations on subjects covered by the National Board Dental Examinations. This is done even though successful completion of these examinations is a requirement for licensure in most states. Such duplication only creates additional expense and stress for candidates and should be eliminated. Therefore, the American Student Dental Association recommends adoption of the following resolution.

113. Resolved, that the appropriate agency(s) of the American Dental Association pursue actions to encourage universal acceptance of successful completion of the National Board Dental Examinations Part I and II in place of additional written examinations (except for jurisprudence) by regional testing agencies and individual states that administer independent licensure examinations.

American Student Dental Association

Option to Take State Jurisprudence Examinations Via Computer at Remote Sites

The following resolution was submitted by the American Student Dental Association and transmitted on September 13, 1996 by Ms. Karen S. Cervenka, secretary and executive director, American Student Dental Association.

Background: Most state boards of dentistry require applicants for dental licenses to take a jurisprudence examination, which evaluates knowledge of the state's dental practice act. In many instances, applicants must travel to take these examinations, a process which can be both time consuming and expensive. Currently existing technology, such as that used to administer the Graduate Record Examination (GRE), could be used to allow jurisprudence examinations to be given via computer at commercial learning centers. The advantages to such an option include savings of travel time and expenses, increased flexibility in scheduling an exam date, and immediate availability of results. Therefore, the American Student Dental Association recommends adoption of the following resolution.

114. Resolved, that the appropriate agency(s) of the American Dental Association work with state boards of dentistry that require jurisprudence examinations to promote the development of a pilot program to offer such examinations at commercial learning centers via computer.

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 137th annual session.

Appreciation to the Council an ADA Sessions and International Programs and the Committee on Local Arrangements: The 137th annual session being held as part of the 1996 American Dental Association/FDI World Dental Federation World Dental Congress in Orlando is the second time the Association has met in that city and the first time since 1988 that the Association has met jointly with the FDI. With the support of the Dental Society of Greater Orlando, the Central District Dental Association and the Florida Dental Association, and with the most capable assistance of this year's Committee on Local Arrangements, the Council on ADA Sessions and International Programs, working with the FDI Congress Education Committee, has planned a schedule of scientific programs of the highest quality to be found anywhere. In addition, the Council and the Committee have scheduled a vast array of tours and special events highlighting the wonderful attractions to be found in the Orlando area, which will appeal to young and old alike.

The Board of Trustees wishes to recognize the members of the Council and to express its profound gratitude to them, who under the most capable leadership of its chairman and the general chairman of the Congress, Dr. Patrick S. Metro, have produced this year's meeting. Dr. Metro and the entire Council, Dr. Angelo L. Bilionis, Dr. Raymond A. Cohlmia, Dr. Terry D. Dickinson, Dr. Jerome A. Erickson, Dr. Gerrit C. Hagman, Dr. Kathryn A. Kell, Dr. Ann B. Kirk, Dr. Stephen L. Kondis, Dr. John G. Lee, Dr. Edward Leone, Jr., Dr. Donald J. Provenzale, Sr., Dr. Alan H. Singer, and Dr. Morris C. Yates, are all to be applauded for their efforts in producing such an outstanding meeting.

The Board also wishes to acknowledge Dr. John G. Lee, who has served on the Council as general chairman of the Committee on Local Arrangements, and to the chairpersons of the Committee who so capably assisted him: Dr. Roger Nofsinger, vice chairman; Dr. Hutson McCorkle, chairman, and Dr. Neil Powell, vice chairman of the Program Coordinating Committee; Dr. Carter and Mrs. Beverly Greear, co-chairpersons of the Hospitality Committee; and Dr. Richard Altman, chairman and Dr. Robert Pellarin, vice chairman of the Registration and Special Services Committee.

On behalf of all those who attended this World Dental Congress, the Board wishes to commend the Council and the entire Local Arrangements Committee for having produced such a successful meeting and wishes to thank them for a job well done.

Deaths of Former ADA Officials: Since the 1995 session of the House of Delegates, the following former officials have passed away: Dr. Robert H. Griffiths, ADA president (1981-82), treasurer (1979-80) and trustee (1974-80); Dr. H. Curtis Hester, ADA vice president (1984-85); and Dr. Louis A. Saporito, ADA president (1972-73), trustee (1965-71) and vice president (1963-64). The Board of Trustees joins the members of the House in expressing sympathy to the families of our departed friends.

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.

Professor Umberto Bar
Marye Feldman
Dr. Makoto Nakao
Representative John E. Porter (R-IL)
Barry E. Rice
Dr. Katsuo Tsurumaki

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. Each year the Board of Trustees may select one recipient for the Award. The Board of Trustees takes great pleasure in announcing that the joint recipients of the 1996 Distinguished Service Award are Ken and Joan Austin.

Ken and Joan Austin are co-owners of A-dec, Inc., one of the world's premiere dental equipment manufacturers. The company headquarters are located in Newberg, Oregon, where Ken serves as president, and Joan, his wife, serves as senior vice president and treasurer.

A-dec began in Broomfield, Colorado, in 1964, when Ken Austin developed the company's first product, the Air Vacuum System (AVS). The following year, Ken and his family moved back to their home town of Newberg to manufacture the system. Joan Austin directed her efforts toward managing the administrative, personnel, financial and legal areas of the company, while Ken directed his efforts to the engineering and manufacturing operations. With nine employees by year's end, Ken and Joan had three new products to offer and had successfully built a small company that was already helping doctors perform healthier, more efficient dentistry. Today, more than 30 years later, the Austins continue to provide leadership to a company that has grown into one of the three largest dental equipment manufacturers in the world. A-dec now manufactures a complete line of dental operatory equipment—from dental chairs and delivery systems, to lights, dental furniture and handpieces—and markets to the United States, Canada and more than 90 countries internationally.

Both Ken and Joan Austin also serve as active members of the management team and executive committee that meets weekly to direct the operations of the company. And, currently with 38 U.S. patents to his name, Ken Austin still enjoys creating new A-dec solutions for dentists throughout the world.

The Austins have a keen sense of community involvement. They are very active in nonprofit organizations in their home town of Newberg, as well as the entire state. They are both trustees of Oregon colleges and participate in numerous

philanthropic organizations within the state. Joan Austin holds the distinction of being the first woman chairperson of Associated Oregon Industries, a statewide business organization that plays a key role in Oregon's political and economic processes. Last fall, Ken Austin was appointed to the board of directors of the American Dental Association Health Foundation, an organization that provides grants for the advancement of dental health research and educational programs.

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. Stuart B. Fountain, first vice president; Dr. Robert L. Bartheld, second vice president; Dr. James F. Mercer, treasurer; Dr. Karl W. Lange, trustee, Sixth District; Dr. John A. Rahe, trustee, Seventh District; Dr. Michael J. Till, trustee, Tenth District; and Dr. David A. Whiston, trustee, Sixteenth District.

Appreciation to Employees: The Board of Trustees is pleased to bring to the attention of the House of Delegates 24 members of the Association staff for their years of service.

Twenty-five years. Emma J. Lawson-Dunn, Division of Information Technology; Patricia A. Gaca, Office of the Executive Director; and Josephine M. Szymczyk, Department of International Dental Health.

Twenty years. Tomisena Y. Cole, Office of the Deputy Executive Director; Mary A. Garrett, Accounting Department; Conrad A. Naleway, Division of Scientific Affairs; Lalita Pittman, Division of Membership and Dental Society Services; Ruth Schultz, Department of Library Services; and Cindy J. Simms, Division of Governmental Affairs.

Fifteen years. Richard M. Berry, Division of Legal Affairs; David R. Dwyer, Council on Insurance; Thomas Haile, Division of Information Technology; Tyree Hayden, Duplicating Department; Judith L. Jakush; ADAPCO; Edward T. Jeske, Council on ADA Sessions and International Programs; Katherine L. Kugel, Division of Education; Lenore Merchant, Accounting Department; Joan M. Reiser, Division of Scientific Affairs; Quang Trieu, Duplicating Department; Mary Ellen Turner, Council on Insurance; Clifford W. Whall, Jr., Division of Scientific Affairs; Patrick C. Williamson, Department of Dental Society Services; Charlotte Winters, Council on Insurance; and Jessie Elie-Young, Division of Scientific Affairs.

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 1995, 1,762 members were elected to Life membership for 1996. As of June 12, 1996, the number of Active Life members is 7,976 and the number of Retired Life members is 18,725 for a total of 26,701 Life members.

1996 Life Members

Constituent	Active	Retired	Total
Air Force		43	43
Alabama	107	165	272
Alaska	9	6	15
Arizona	38	204	242
Arkansas	44	110	154
Army		46	46
California	903	2,087	2,990
Civil Service	1	10	11
Colorado	101	201	302
Connecticut	227	427	654
Delaware	30	31	61
District of Columbia	58	115	173
Florida	311	539	850
Georgia	91	254	345
Hawaii	91	79	170
Idaho	20	57	77
Illinois	346	872	1,218
Indiana	153	354	507
International	-	6	6
Iowa	76	284	360
Kansas	79	183	262
Kentucky	91	199	290
Louisiana	101	190	291
Maine	27	107	134
Maryland	150	284	434
Massachusetts	331	551	882
Michigan	303	829	1,132
Minnesota	89	447	536
Mississippi	57	101	158
Missouri	118	326	444
Montana	19	91	110
Navy	4	97	101
Nebraska	51	150	201
Nevada	25	34	59
New Hampshire	29	64	93
New Jersey	322	633	955
New Mexico	26	57	83
New York	1,118	2,959	4,077
North Carolina	153	293	446
North Dakota	11	43	54
Ohio	355	830	1,185
Oklahoma	84	184	268
Oregon	97	272	369
Pennsylvania	427	1,080	1,507
Public Health	-	28	28
Puerto Rico	17	38	55
Rhode Island	48	99	147
South Carolina	54	129	183
South Dakota	18	42	60
Tennessee	158	217	375
Texas	401	638	1,039
Utah	50	153	203

1996 Life Members (continued)

Constituent	Active	Retired	Total
Vermont	23	47	70
Veterans Affairs	7	118	125
Virgin Islands	2	3	5
Virginia	174	314	488
Washington	168	439	607
West Virginia	71	103	174
Wisconsin	102	435	537
Wyoming	10	28	38
Total	7,976	18,725	26,701

Retired Membership: Active members of the Association may be elected to Retired membership status in accordance with ADA *Bylaws* (Chapter I, Section 20G). For 1995, 389 active members were granted Retired membership status. As of June 12, 1996 the total number of ADA Retired members is 2,210.

1996 Retired Members

Constituent Society	Total	Constituent Society	Total
Air Force	65	Montana	12
Alabama	29	Navy	85
Alaska	4	Nebraska	11
Arizona	16	Nevada	3
Arkansas	8	New Hampshire	8
Army	55	New Jersey	32
California	320	New Mexico	9
Civil Service	9	New York	152
Colorado	41	North Carolina	44
Connecticut	27	North Dakota	7
Delaware	1	Ohio	99
District of Columbia	5	Oklahoma	22
Florida	101	Oregon	57
Georgia	32	Pennsylvania	61
Hawaii	9	Public Health	25
Idaho	9	Puerto Rico	1
Illinois	115	Rhode Island	8
Indiana	45	South Carolina	13
International	7	South Dakota	5
Iowa	38	Tennessee	26
Kansas	11	Texas	60
Kentucky	31	Utah	8
Louisiana	17	Vermont	5
Maine	14	Veterans Affairs	22
Maryland	33	Virginia	41
Massachusetts	60	Washington	52
Michigan	87	Wisconsin	41
Minnesota	64	Wyoming	5
Mississippi	11		
Missouri	32	Total	2,210

Nominations to Councils and Commissions: In accordance with the *Bylaws,* Chapter VII, Section 110(H), the Board of Trustees presents the following nominations for membership on ADA councils and commissions and Standing Committee on the New Dentist. In accordance with a directive from the House of Delegates (*Trans.*1980:588), the Board is submitting a brief statement of qualifications for each nominee.

Council on Access, Prevention and Interprofessional Relations

Lander, William W., American Medical Association, 1997: Dr. Lander received his medical degree from the University of Pennsylvania in 1949. After serving in the Navy from 1950-1952, he did his residency in internal medicine at the Bryn Mawr Hospital. In 1988, he received a Distinguished Service Award from the Department of Medicine of the Bryn Mawr Hospital. He has been the Bryn Mawr Hospital representative to the American Medical Association—Organized Medical Staff Section since its inception in 1983. Since 1992, he has been a member-at-large of the Governing Council of the Pennsylvania Medical Society—Hospital Medical Staff Section, and alternate delegate to the AMA from the Pennsylvania Medical Society. He is currently chairman of the Board of Directors of the Montgomery County Medical Society.

McFarland, Kimberly K., ad interim, Nebraska, 1997: Dr. McFarland received her dental degree from Creighton University School of Dentistry. She also holds a master's degree in Health Services Administration. At present, she is the dental director for the Nebraska Department of Health. Her previous positions include dental director for the Omaha Tribe in Nebraska, as well as private dental practice. Dr. McFarland is extremely well versed in access programs and other preventive dentistry endeavors. She is an accomplished clinician, teacher and researcher.

Dr. McFarland has been very active in the affairs of her constituent and component dental societies, as well as in the American Public Health Association and the Association of State and Territorial Dental Directors. She has held several important committee posts and either has served or is currently serving on the executive councils of societies with which she is affiliated.

Nessif, Richard J., Maryland, 2000: Information to follow.

Paulson, Peter L., Illinois, 2000: Peter L. Paulson graduated from Southern Illinois School of Dental Medicine in 1978. Dr. Paulson resides in Decatur, Illinois with his wife, Julie, who is also a dentist, and their three children. Dr. Paulson has served on the Board of Directors of the Macon County Chapter of the American Cancer Society and is past chairman of the American Cancer Society Golf Championship. He has served on the Medical Advisory Board of the Central Illinois Chapter of Easter Seals and has actively participated for several years in fund-raising for the Easter Seal Telethon.

Dr. Paulson has been a member of the American Dental Association, Illinois State Dental Society (ISDS), and the Decatur District Dental Society since establishing his practice in Decatur. He has served the ISDS as trustee of the Central Eastern District, as treasurer, secretary and currently as vice president. On the component level, he has served as program chairman and in each elected office, culminating in his year as president in 1987-1988. He is currently serving his fifth year as chairman of his component's Peer Review Committee.

Dr. Paulson is very concerned about access to care by all individuals in the community. He is involved with ISDS's Total-Dent Program, which gives to those individuals who are economically disadvantaged a minimum 20% discount on fees. He is an active participant in the American Retired Teachers' Association denture referral program, which provides for dentures, partial dentures and repairs at greatly reduced fees. Dr. Paulson is also a participant in the Illinois Foundation of Dentistry for the Handicapped, which provides free dental services for referred patients. Dr. Paulson was instrumental in the establishment of a dental clinic in the Macon County Health Department Building and was one of the first dentists to provide oral health care for Macon County's public aid and medically indigent population.

Scott, Edward R., II, Florida, 2000: Dr. Scott is a 1975 graduate of Florida A&M University, where he graduated magna cum laude in three years. He subsequently went to Harvard University School of Dental Medicine, graduating in 1979 before entering the Navy. While in the Navy, Dr. Scott was evaluated in the top 1% of all lieutenants in the Naval Dental Corps when on active duty.

Dr. Scott is currently involved in numerous national and state dental organizations. He is on the Florida Board of Dentistry, where he has served as a past chairman. Dr. Scott has previously served on the Board of Directors for the Florida Medical, Dental and Pharmaceutical Association. He is currently on the Board of Trustees of the National Dental Association, and a member of the American Dental Association. Dr. Scott is a current member of the American Association of Dental Examiners. He is also a current member of the Florida Dental Association and the Leon County Dental Association.

Dr. Scott is on the Board of Governors for the Florida Property and Casualty Joint Underwriting Association.

Civically, Dr. Scott is a past president of the National Boosters of Florida A&M University. He is on the Board of Trustees at Bethel A.M.E. Church, where he is also an active member. Dr. Scott is a member of Kappa Alpha Psi and is current President of the Tallahassee Chapter of Kappa Alpha Psi in addition to being a former Man of the Year.

Strayer, Michael, Ohio, 2000: Dr. Strayer is currently a tenured associate professor and the director of geriatric dentistry at the Ohio State University College of Dentistry. He is well-known for his extensive work to improve access to oral health care for all segments of society.

For the Ohio Dental Association (ODA), he has served in the following leadership roles: as 1991 chairman of the ODA Task Force on Access to Dental Care; as 1991-94 chairman of the ODA Subcouncil on Access to Dental Care and as a member of the Subcouncil since 1991; and as a member of the ODA Task Force on Health System Reform in 1993-94.

Dr. Strayer is a fellow of the American Society for Geriatric Dentistry and a member of its Board of Directors. He is a member of the American Association of Public Health Dentistry and the American Association for Dental Research. He currently serves the Columbus Dental Society as a member of the Executive Council, the Nursing Home Consultants Committee and the Dental Public Relations and Communication Council.

Council on ADA Sessions and International Programs

Breeland, Nona I., North Carolina, 2000: Dr. Breeland received a B.S. in dental hygiene from the University of North Carolina (UNC) and an M.S. in dental hygiene from Columbia University before graduating from the UNC at Chapel Hill School of Dentistry in 1987.

In addition to serving as president of her component dental society, Dr. Breeland has been recognized by numerous professional organizations, including Outstanding Young Women of America, Sigma Phi Alpha Honor Society, University of North Carolina Educational Foundation and the International College of Dentists.

Dr. Breeland has also demonstrated civic leadership by membership on the Board of Directors for First Citizens Bank and Trust, Chapel Hill Chamber of Commerce, Jaycee International, North Carolina Museum of Art, North Carolina Zoological Society, North Carolina Commission on the Status of Women and the Governors Club of Chapel Hill, North Carolina.

In addition to these activities, she has been a member of the Bicentennial Observance Planning Committee of the UNC School of Dentistry; chairperson of the Council on Dental Society Services; and program chair for her component and constituent societies, as well as annual session chair for the North Carolina Dental Society. This experience has prepared Dr. Breeland to contribute to the work of the Council.

Kell, H. Lindy, California, 2000: Major qualification specific to Dr. Kell's application for the Council on ADA Sessions and International Programs is service on the California Dental Association Council on Scientific Sessions since 1988. Three of those years Dr. Lindy served as chairman of the Council, and he currently holds the position of consultant.

The responsibility of the Council is the organization and presentation every year of two of the largest dental scientific sessions in the world. Through service on this Council, Dr. Kell has scouted all of the major programs in the United States and has formed strong working relationships with the most respected meeting planners, speakers and exhibitors.

In addition to this experience, Dr. Kell currently serve as trustee at the state level, representing the Santa Barbara-Ventura County Dental Society. He is also a member of the six-person Screening Committee, which evaluates the other councils and the leadership of the California Dental Association. Because of this service, Dr. Kell has become very aware of issues, opportunities and problems facing dentistry today, both locally and nationally.

Service in dentistry at the national level seems the next step. Dr. Kell will bring experience, commitment and contacts to the Council on ADA Sessions and International Programs.

Vuchetich, Thomas, Michigan, 2000: Dr. Vuchetich is a 1973 graduate of the University of Detroit School of Dentistry. He maintains a full-time general practice in East Lansing, Michigan. He has been a member of the House of Delegates of the Michigan Dental Association (MDA) since 1987. He has also served as a member of the MDA Dental Care Programs Committee since 1982 and as a member and the chairman of the MDA Annual Sessions Committee since 1989. He served as the general chairman of the MDA Annual Meeting in 1993, for which the MDA was awarded the

Golden Apple Award. Dr. Vuchetich has served as an officer of his component dental society, the Central District Dental Society of the MDA. He currently serves on the East Lansing Community College Advisory Committee for the Dental Assisting and Dental Hygiene Training Programs. Dr. Vuchetich will bring to the Council on ADA Sessions and International Programs a significant degree of knowledge on the planning, staging and implementation of large dental meetings.

Council on Communications

Hewitt, Richard F., South Carolina, 2000: Dr. Richard F. Hewitt was a magna cum laude graduate of Furman University in Greenville, South Carolina, and an OKU graduate of Emory University School of Dentistry prior to obtaining his master of science in orthodontics, ranked first in his class.

Dr. Hewitt has served as president of his local, component and constituent dental societies, as well as being past president of the South Carolina Association of Orthodontists. Additionally, Dr. Hewitt is a member of the South Carolina Academy of Dental Practice Administration and is a fellow of the American College of Dentists.

Dr. Hewitt has been an excellent spokesperson for the above mentioned dental organization, as well as serving on area United Way campaigns, as Dental Chair of the YMCA Board of Directors, on the American Cancer Society Board of Directors and as past president of the Speech, Hearing, and Learning Center Board of Directors.

Dr. Hewitt has communicated public messages on behalf of all these groups and is prepared to contribute to the activities of the Council on Communications.

Rosen, Sherwin, California, 2000: Dr. Rosen's active involvement in the Communications Committee of his component society for six years and now with the California Dental Association (CDA) will allow him to bring some experience and expertise to the ADA Council on Communications. In addition to serving in these capacities Dr. Rosen also serves in a leadership role as a CDA trustee. Dr. Rosen has some strong feelings in the area of communications and hopes his enthusiasm is what the ADA is looking for. Dr. Rosen is most anxious to serve in this arena and hopes to contribute in a positive way.

Council on Dental Benefit Programs

Sawyer, Ansley W., III, Maine, 2000: Dr. Ansley W. Sawyer of Augusta, Maine recently served on the ADA Practice Parameters Reading Committee and participated in the Consensus Conferences. He was also a member of last year's ADA House of Delegates Dental Benefits Reference Committee.

Dr. Sawyer has had a wide range of experience in dentistry which uniquely qualifies him for council service. Prior to establishing his private general practice in 1986, he served as director of a dental clinic for underprivileged children. He has been a consultant to the Maine Department of Human Services and has dealt extensively with dental Medicaid issues. He served as a director of Delta Dental Plan of Maine and was a member of the Health Professions and Benefits subcommittees of the Maine Health Care Reform Commission. After holding every major office in the Maine Dental Association (MDA), he is now completing his term as MDA president.

Smith, Mary Krempasky, Washington, 2000: After her much-admired work on the Parameters project, Dr. Smith will "hit the ground running" when she moves on to this Council. While serving as president of her local component, she was elected to the Washington State Dental Association (WSDA) Executive Council. Her past committee assignments in these organizations include Peer Review, Budget and Finance, Program and Task Force on the Young Professional. She has been an alternate delegate to the ADA since 1993 and a delegate since 1995. She has served in many access programs and on advisory boards for dental assisting and dental hygiene programs. She has been the team dentist for the Spokane Chiefs hockey team since 1982, the year she graduated from the University of Minnesota School of Dentistry. She was appointed to the Washington State Legislature's Select Committee on Oral Health this year. She is a fellow of both the Pierre Fauchard Academy and the American College of Dentists, maintains a private practice in a partnership setting and has a young family.

Stoner, Donald A., Pennsylvania, 2000: Dr. Stoner has been in the private practice of general dentistry in Oakmont, a suburb of Pittsburgh, Pennsylvania, since his 1968 graduation from the University of Pittsburgh School of Dental Medicine. In addition to his dental degree, he holds a Pennsylvania anesthesia permit. He is on staff at Citizen's General Hospital and on the Board of Directors of the newly formed Pennsylvania Dental Association Insurance Services, Inc. He has served as president of the 1,300-member Dental Society of Western Pennsylvania (DSWP), after years of service on many of the DSWP committees and on its Board of Directors. At the state level, he has been a delegate to the Pennsylvania Dental Association (PDA) since 1980, and has also been a delegate to the American Dental Association. He has been involved on the Quality Assessment Guidelines Committee and the Subcommittee on Peer Review and is now chairing the Council on Dental Care Programs of the PDA. He was president of the MAGD Study Club of Western Pennsylvania in 1986.

Dr. Stoner is a fellow in the American College of Dentists, International College of Dentists, Academy of General Dentistry and the Pierre Fauchard Academy. In addition to those associations, he belongs to the Academy of Dentistry International and the Equilibration Society. His commitment to dentistry includes volunteer service in 1996 to the Medical Mission in Miraj, India.

His civic activities include Rotary Club (Oakmont Past President); Chamber of Commerce; on-call dentist for the US Opens in '83, '92 and '94 at Oakmont Country Club; American Fund for Dental Health; Allegheny County Health-O-Rama screenings; Oakmont Centennial Committee; local school district dental health lectures; Cubmaster; and U.S. Naval Reserves from 1964-1982.

His concern for the highest standards of dental care have kept him actively involved in all facets of organized dentistry. He is also an excellent representative of the profession in his community.

Tuber, Harry M., New Jersey, 2000: Information to follow.

Vaclav, Michael D., ad interim, Texas, 1997: Dr. Michael D. Vaclav a general dentist from Amarillo, was elected president of the Texas Dental Association at the Association's annual convention. Dr. Vaclav is the 127th president of the Association, which was chartered in 1871 and represents 77% of the Texas dentists.

To the office of president he brings many years of leadership and experience. Dr. Vaclav's tenure on the board of the Association began in 1987, when he was elected as a director and went on to serve as a vice president over a three-year tenure. From 1990 through 1995, he served as the president of the very successful for-profit subsidiary of the Association, TDA Financial Services, Inc.

Dr. Vaclav has been in private practice for 22 years. He is a member of the Panhandle District Dental Society, the American Dental Association and the Pierre Fauchard Academy. He is a fellow of the American College of Dentists and the Academy of Dentistry International.

He is a past board member of DENPAC, the Texas Dental Association's political action committee, and he has served on the TDA's peer review council and the Committee on the Dental Practice Act.

A former U.S. Navy lieutenant, Dr. Vaclav's involvement at the civic level includes being chairman of the West Texas AAU Boys Basketball and serving on the board of the Southwest Amarillo Basketball Association.

A 1974 graduate of Baylor College of Dentistry, he is the father of three children and is married to Marilyn Louise Bangsund Vaclav.

Council on Dental Education

Baker, Arnold, ad interim, Michigan, 1999: Dr. Arnold Baker received his D.D.S. from the University of Michigan (U of M) School of Dentistry in 1968 and a master's in fixed prosthodontics in 1976. He currently maintains a private practice. He was an assistant professor at the U of M School of Dentistry from 1971 to 1977. He served as a captain in the U.S. Army and has held all the offices of his component dental society. He served as a trustee, as treasurer for three terms and as president of the Michigan Dental Association (MDA). He has been a member of the Michigan delegation to the ADA House of Delegates for eleven years and was appointed to the Reference Committee on Budget and Administrative Matters in 1991. He is a fellow in the American and International Colleges of Dentists and the Pierre Fauchard Academy.

Koch, Robert W., Pennsylvania, 2000: Robert W. Koch, D.M.D., M.Ed., Rear Admiral Dental Corps, United States Navy (Ret.), is a graduate of Washington University in St. Louis, with a master's degree in education from George Washington University with emphasis in curriculum development. Dr. Koch is president-elect of the 1,300-member Dental Society of Western Pennsylvania, and chairman of the Council on Professional Affairs for the Pennsylvania Dental Association (PDA), delegate to the PDA and past Chairman of the local Ethics Committee. He also chairs the Western Pennsylvania Three Rivers Dental Conference. In addition, he has also served as a Cabinet Member for the Greater Pittsburgh United Way. He is in private practice of periodontics in Oakmont, Pennsylvania.

As a Rear Admiral in the Dental Corps of the United States Navy, his Washington administrative assignments included Director for Fiscal Facility and Manpower, Office of the Surgeon General and Chief of Naval Operations. He also served as Deputy Commander, Naval Medical Command, directing worldwide dental health operations for the entire Navy, with nearly 1,800 dentists and 4,000 dental auxiliaries in 200 clinics worldwide. Additionally, he was president of the American Academy of Periodontology.

In his position as director/manager, he interfaced daily with federal resource sponsors and Congress to build and procure the more than $3.5 billion dollar annual budget, requiring oversight of five fiscal years at the same time. He was responsible for the procurement, education, training and appropriate balancing of 45,000 health care professionals (physicians, nurses, dentists, administrators and 32,000 auxiliaries). Admiral Koch provided health care testimony for Congress, as well as treating our political leaders during his clinical and administrative assignments.

He is a fellow of the American College of Dentists, International College of Dentists, a diplomate of the American Board of Periodontology and 1985 Distinguished Alumnus from Washington University. He was chosen for the first advisory council at CDC to develop infection control guidelines and has continued his activity in this area.

His educational qualifications, in addition to the master's degree in education, include the position of Executive Associate Dean and Professor in Periodontics at the University of Pittsburgh and Director of Dental Medicine at Allegheny General Hospital. He was Director of the Graduate Program in Periodontics at the National Naval Dental Center, with additional faculty positions at Washington University, University of South Carolina and Old Dominion University and Medical College of Pennsylvania. All naval graduate programs under his direction have always achieved full accreditation.

Dr. Koch has had educational, administrative and clinical experience at the highest possible levels and is totally familiar with the entire spectrum of health care. He has the desire to use his ability, experience and skill to update, communicate with and educate all persons involved so they can strategically plan for the current and future needs, including educational, of their profession, students, faculty, practitioners and the community.

Council on Dental Practice

Keim, Douglas K., Minnesota, 2000: Dr. Keim is a full-time general practitioner. He is a graduate of the University of Minnesota School of Dentistry. At present, he is in his second term as a member of the Board of Trustees of the Minnesota Dental Association (MDA), representing the St. Paul District Dental Society.

Dr. Keim's involvement at the district and state levels is extensive and impressive. He has been a delegate or alternate to the MDA for almost 20 years and to the ADA for eight years. He has chaired the MDA Legislative Committee and served on the Board of Directors of MINDENPAC. Moreover, he chaired the MDA Ad Hoc Committees on Health Care Systems and on Student District Implementation. Dr. Keim also serves on the Minnesota Department of Human Services Task Force on Dental Access.

In recognition of Dr. Keim's contributions to the dental profession, he received the Minnesota Dental Association Outstanding Service Award in 1995.

In addition to dental association activities, Dr. Keim has been very active in community affairs. He served on the Roseville Community Services Advisory Committee for several years and was awarded the Distinguished Service Award by that organization in 1984. He also chaired the Council on Health of the St. Paul School District. He has been an active member of his church and has served on and chaired several committees.

Dr. Keim's nomination to the Council on Dental Practice is endorsed by the Minnesota Dental Association.

Peterson, Janet, Oregon, 2000: Dr. Peterson received her D.M.D. from the Oregon Health Sciences University in 1983 after earning a Ph.D. in zoology from Oregon State University. She served as editor and president of her component society before being elected to the Board of Trustees of the Oregon Dental Association (ODA) in 1995. Her experience includes many committee positions in both organizations, including Strategic Planning, Government Relations and Dental Care. In addition to raising a family and maintaining a busy private practice, Dr. Peterson is committed to community involvement and three study clubs, and she was chosen last year to serve on the dental subcommittee of the Oregon Health Services Commission. Her expansive experience will bring a vital perspective to this critical council.

Smith, Jeffery W., California, 2000: Dr. Smith has held a number of leadership positions in the California Dental Association, which has given him vast experience to bring to the Council on Dental Practice. He is a very productive worker and will be an effective addition to the Council.

Smith, Richard Duff, West Virginia, 2000: Dr. Richard Duff Smith is a private general practitioner in Charleston, West Virginia. He is a graduate of the West Virginia College of Dentistry and has a master's degree in anatomy. Dr. Smith is past president of the Kanawha Valley Dental Society and the West Virginia Dental Association. He has served as editor of the West Virginia Dental Journal; as an alternate delegate and delegate to the American Dental Association House of Delegates; ADA Reference Committee member in 1995; and on the ADA Dental Practice Parameters Consensus Conference. He is a member of the Academy of Operative Dentistry, OKU, and a fellow of the International College of Dentists.

Council on Ethics, Bylaws and Judicial Affairs

Eklund, Richard A., Texas, 2000: Dr. Eklund received his D.D.S. from the University of Texas Dental Branch, Houston in 1964. He is a fellow of the Academy of General Dentistry, the American College of Dentists and the International College of Dentists and received the Texas Dental Association (TDA) Distinguished Service Award in 1984. He has served his component society, the San Antonio District Dental Society, as director, parliamentarian, secretary-treasurer, vice president, and president. He has served on the TDA Council on Public Affairs and the Strategic Planning Committee and has been chairman of the Council on Constitution and Bylaws. He is a past director and a past president of the TDA and is currently Speaker of the TDA House of Delegates.

Fields, Dean S., Jr., Michigan, 2000: Dr. Fields is a graduate of the University of St. Louis School of Dentistry. He has maintained an active practice in general dentistry in Rochester Hills, Michigan for more than 30 years. He has served in the House of Delegates of the Michigan Dental Association (MDA) for ten years. In addition, he has been a member of the MDA Peer Review and Ethics Committee for ten years and served as its chairman in 1991 and 1992. He has also served in a number of positions in his component dental society and is currently chairman of the Grievance and Professional Relations Committee of the Oakland County Dental Society. He has been active in a number of local civic organizations. His long experience in the area of peer review and ethics in the MDA will be very helpful to the Council on Ethics, Bylaws and Judicial Affairs.

Fields, Gerald L., South Dakota, 2000: Dr. Fields is a full-time general practitioner who has been involved in organized dentistry throughout his entire career. He has practiced in both Minnesota and South Dakota and has served on several committees and in each of the offices, including president, of his component societies in both states. Presently, he is president of the South Dakota Dental Association. Dr. Fields also has been a long-term participant in Tenth District caucus activities and has served as an alternate delegate to the ADA annual meeting.

Long active in local service organizations, Dr. Fields has served as president of his Kiwanis Club and is a member of the Chamber of Commerce. He was a Boy Scout leader for several years. In addition, he has held numerous offices within his church and currently serves as a lay leader for his congregation.

Roberts, Gary L., Louisiana, 2000: Dr. Roberts received a B.S. from Louisiana State University in 1973 and a D.D.S. from Baylor in 1977. He has practiced general dentistry in Shreveport since 1977. He is a member of the Northwest Louisiana Dental Association, the Louisiana Dental Association (LDA), the ADA, the Pierre Fauchard Academy, the American Association of Dental Editors and the Ark-La-Tex Academy of Dentists, as well as a fellow of the International College of Dentists.

He has been secretary and president of the Northwest Louisiana Dental Association. He has also been a member of the LDA Legislative Committee; editor of the Journal of the Louisiana Dental Association for the past nine years; Board of Directors for nine years; a delegate to the LDA House of Delegates; and an alternate delegate to the ADA House of Delegates. He is also president-elect of the Louisiana Dental Association.

Because of his interest and involvement in organized dentistry, he is well qualified to be a member of the Council on Ethics, Bylaws and Judicial Affairs.

Council on Governmental Affairs and Federal Dental Services

Dumas, James Russell, Jr., Mississippi, 2000: Dr. James Russell Dumas, Jr. is a graduate of Loyola University School of Dentistry and practices general dentistry in Prentiss, Mississippi. He has served in active positions with the Mississippi Dental Association (MDA) since 1974. He served as president of his district, has been a continuous member of the MDA Board of Trustees since 1979, served as an officer of the MDA and on the Legislative council since 1983, and held the office of president of the MDA in 1986. He was named chairman of the Legislative council in 1989, a position he still holds. He has been actively serving on the MDPAC Board of Trustees since 1989, served as an alternate delegate to the ADA in 1985 and 1986 and was elected ADA delegate in 1989, and is still serving in that position.

Dr. Dumas is very knowledgeable on many issues that effect the dental profession. He was active in getting a dental school established in Mississippi in 1984, and worked in the legislature to keep the school open when the state legislative body attempted to close it several years ago.

In addition to his dental responsibilities, Dr. Dumas has served as county Republican chairman for more than 20 years and has traveled to Washington, D.C. to work with the Mississippi congressional delegation. He understands how things work politically on the local, state and national levels. Respected by his colleagues, friends and political acquaintances for his political expertise, Dr. Dumas has that indefinable spark to deal with all levels of people and personalities. His expertise and personal touch are assets to our profession and its future.

Eddy, Arthur F., Massachusetts, 2000: Dr. Arthur F. Eddy has been a member of the Massachusetts Dental Society Committee on Legislation for over ten years. During that time he has met with every Massachusetts congressman and, for the past several years, he has served as an officer of the Massachusetts Dentists Interested in Legislation.

Dr. Eddy's interest in the political process began at age 11 when he worked on Senator Edward Kennedy's first senatorial campaign. He was a precinct captain in Boston before he graduated from college. He has been a major fundraiser for several political campaigns. Two of his children have been nominated to be Congressional Pages.

Dr. Eddy will bring to the Council not only expertise in the political sphere, but also extensive experience in banking, insurance, military service and community involvement.

Manning, Dennis E., Illinois, 2000: Dr. Dennis E. Manning is a graduate of Loyola University School of Dentistry and the current president-elect of the Chicago Dental Society. Early in his career, Dr. Manning became involved in politics. He truly understands the political process because he has worked on various political campaigns in Lake County, Illinois. In the dental circles he is involved in LICIDS's Governors Club, which helps promote dental concerns to our state legislators. As far as his knowledge of the federal dental services, you could not have a better person. Dr. Manning, upon separation from active Naval duty, continued his Naval Reserve career, affiliating with the Naval Air Station in Glenview, Illinois. In 1982 Captain Manning received the Rear Admiral William J. H. Vaughn Award as the "Outstanding Naval Reserve Dental Officer." Dr. Manning will give 100% to help the ADA's causes on the Washington scene.

Sadowski, John L., Wisconsin, 2000: Dr. Sadowski is a 1968 graduate of Marquette University School of Dentistry. He served on active military duty as a dental corps officer in the United States Navy from 1968 to 1970. He has been in active general practice in Manitowoc, Wisconsin since 1970. Dr. Sadowski is the immediate past president of the Wisconsin Dental Association (WDA). He has served as a delegate to the American Dental Association House of Delegates since 1987. In his capacity as a leader of the WDA, Dr. Sadowski has chaired numerous committees, including its Legislative Committee. He will bring a wide breadth of knowledge to the Council on Governmental Affairs and Federal Dental Services.

Council on Insurance

Broadbent, Charles D., ad interim, Arizona, 1997: Dr. Charles Broadbent earned his dental degree from the University of Nebraska and immediately completed a dental internship at Boston Naval Hospital. After practicing general dentistry for more than 25 years, Dr. Broadbent sold his private practice and now serves as a prison dentist working for the Arizona Department of Corrections.

Dr. Broadbent served as a member of Arizona State Dental Association's (ASDA) Council of Insurance for five years and was the chairman his last two years. Additionally, Dr. Broadbent is treasurer of the Central Arizona Dental Society (CADS), serves on the CADS Board of Directors and is a CADS delegate to the ASDA House of Delegates. Other professional involvements include: president of the South Side Study Club; instruction for Phoenix College Dental Hygiene Program; a fellow of both the Pierre Fauchard Academy and the International College of Dentists; and a member of the United States Naval Reserves, Delta Sigma Delta and Omicron Kappa Upsilon.

In addition to Dr. Broadbent's various professional commitments, he is very active in his church, family and community. Dr. Broadbent is extremely thorough, dependable, fair and knowledgeable. He would be a valuable asset to the Council on Insurance.

Feldman, Mark J., New York, 2000: Dr. Feldman is a graduate of Tufts University School of Dental Medicine. He completed a general practice residency and an endodontic residency at The Nassau County Medical Center and is certified as a diplomate of the American Board of Endodontics. He currently maintains a practice limited to endodontics in Garden City and Forest Hills, New York. Dr. Feldman's leadership and dedication to organized dentistry are evident at all levels of the tripartite.

He is a past president of his component dental society where he has chaired numerous committees and has been chairman or adviser to the Committee On Insurance for the past 15 years.

At the state level, Dr. Feldman has served as chairman of the Council on Insurance, the Risk Management Program, and the Finance, Budget and Audit Committees. He is a member of both the Dental Society State of New York Administrators, Inc., and the Medical Liability Mutual Insurance Company Board of Directors. Dr. Feldman currently serves as the

secretary/treasurer of the Dental Society of the State of New York (DSSNY).

Dr. Feldman has devoted considerable energy to the business side of organized dentistry. His selection as chairman of the ADA Reference Committee on Budget and Business Matters speaks to his level of expertise. He is a recognized authority on dental malpractice and is responsible for the current version of the DSSNY Risk Management Program.

A review of Dr. Feldman's C.V. will confirm the qualifications for this appointment. His professionalism and understanding of the issues has made him an outstanding speaker for the profession. His leadership skills are well-recognized and appreciated by those who have served with him in the various positions he has held. He has served as a delegate to the ADA House for ten years.

Dr. Feldman is a fellow in both the American and International Colleges of Dentists and has received citations from the town of Hempstead and Nassau County.

Kenney, Lawrence M., Pennsylvania, 2000: Dr. Lawrence Kenney, a 1977 graduate of Fairleigh-Dickinson University School of Dental Medicine, is in the general practice of dentistry in New Castle, Pennsylvania. He became a member of the Ninth District Dental Society of the Pennsylvania Dental Association (PDA) in 1977. He has served in many offices of his local society, including president of the Lawrence County Dental Society and president of the Ninth District Dental Society. He has been a delegate or alternate delegate to the PDA since 1986.

He is also a member of the American Society of Dentistry for Children and the American Orthodontic Society. Dr. Kenney received a Presidential Citation from the PDA president in 1986; the ADA Commission on the Young Professional Recognition Award in 1989; and the PDA Golden Apple Award in 1990.

Dr. Kenney was local and state Children's Dental Health chairman, as well as chair of the Patient Relations Committee. He was a member of the PDA Insurance Committee for seven years and served as chairman for four years, through 1991. He was again appointed to the PDA Insurance Committee in 1995.

Dr. Kenney's community service reflects well on his ethical and professional standards. He was on the New Castle Jaycees Board of Directors and the American Cancer Society Board of Directors; he was also president of the American Cancer Society. He is still serving on the Health Advisory Board for Project Head Start. He is also a member of his township planning commission; a high school Boys Varsity Soccer coach; a referee for the Pennsylvania Interscholastic Athletic Association, and the District Representative for the Pennsylvania Soccer Coaches Association.

His responsive commitment, knowledge and service to his profession and his community will be carried over to his appointment to the Council on Insurance.

Malinowski, Andrew S., Delaware, 2000: Information to follow.

Wandell, Timothy E., Washington, 2000: Dr. Wandell graduated in 1975 from the University of Washington and maintains a private practice in Hoquiam on the Washington coast. He served as president of his component society and is "going through the chairs" of the Washington State Dental Association (WSDA). Dr. Wandell's strong suit is budget and finance, after service on that WSDA committee starting in 1984, the last year as chair. He has also served on the Strategic Planning Committee and the Executive Council. He was elected secretary-treasurer of WSDA in 1994. An ADA delegate for four years (1988 in the "young dentist" slot), Dr. Wandell is a fellow of the Pierre Fauchard Academy and a member of the Academy of General Dentistry and the Academy of Sports Dentistry. He currently sits on the Board of WDIA, the WSDA insurance subsidiary. Along with local community involvement, he is active in sports and other activities of his three teenage sons.

Council on Membership

Davis, Gary S., Pennsylvania, 2000: Dr. Gary S. Davis is a 1988 graduate of Georgetown University who is in the private practice of general dentistry. Dr. Davis has been an active member of organized dentistry since he was in dental school, where he first learned about the importance of supporting his profession through the Associations. He feels that membership in these organizations gives him insight into events which are shaping the future of dentistry and health care.

His particular interest, since becoming active in the Pennsylvania Dental Association (PDA), has been membership, and he became deeply involved in issues pertaining to membership. He was instrumental in organizing and gaining PDA House of Delegates approval for the New Dentist Committee of the PDA and currently serves as a consultant to this committee. He was responsible for recruiting the young future leaders of the PDA to attend the two successful ADA Leadership Workshops held under his organizational auspices in 1996.

Dr. Davis took an active interest in the Fifth District Dental Society of the PDA and was elected vice president of the Fifth District Dental Society. He promotes and recruits for organized dentistry and arranges programs and speakers for local meetings. He has been a delegate to the PDA annual session for the last four years and has already served twice on reference committees of the PDA. He serves on the Council on Administrative Affairs and chairs the PDA Subcommittee on Membership. He has been president of his local organization and vice president of "Dental Power of Southcentral Pennsylvania."

His community activities include serving on and chairing the Boro Authority. He is on his parish council and a member of the Shippensburg Rotary. He continues to act on a strong commitment to his community and the people in it.

Dr. Davis is enthusiastic, articulate, persistent, creative and persuasive. He is receptive to new ideas and follows through on each of his commitments. He has initiated a membership newsletter for distribution and continually encourages involvement from all districts of the PDA and their representatives. He typifies the best of the future of our leadership with his energy and optimism about the profession of dentistry.

Dohm, Otto W., North Dakota, 2000: Dr. Dohm is a 1985 graduate of the University of Nebraska. He completed his specialty training in periodontics at the University of Iowa in 1987. Since that time he has engaged in private practice in Bismarck, North Dakota.

Dr. Dohm has been active in his constituent and component dental societies. He has served as a delegate to the North Dakota Dental Association for several years and now holds the office of secretary/treasurer. He also has been active in his specialty society, having served on various committees and participated as a lecturer in continuing education courses for both the Midwest Society of Periodontics and the Minnesota Association of Periodontics.

In addition to his private practice, since 1992 Dr. Dohm has served as a part-time instructor in the Dental Auxiliaries Department of the North Dakota State College of Science, where he is involved in both the clinical and academic programs.

Smith, Maria A., Connecticut, 2000: Dr. Maria A. Smith has been a member of the Connecticut State Dental Association's (CSDA) Membership Committee for seven years and recently served as its Chair. During that period the CSDA has enjoyed a market share of over 86% membership among eligible dentists. Not satisfied with this enviable record, Dr. Smith created a program called "90 for the 90's" in an effort to increase CSDA membership to over 90% by the end of the decade.

Dr. Smith has also served as a member of the Task Force on Professionalism and on the CSDA New Dentist Committee, and she was recently elected to the CSDA Board of Governors. She has been a presenter in several symposia on Women in Professions and volunteers as an in-service trainer for the nursing staff of her local hospital.

Dr. Smith is in private practice in general dentistry in Shelton, Connecticut.

Smith, Marlene K., Kentucky, 2000: Dr. Marlene Smith received an associate of applied science degree in dental hygiene in 1982 and graduated from the University of Kentucky College of Dentistry in 1985. She has a private practice in Campbellsville, Kentucky.

Dr. Smith's community involvement has included being a member of the Jaycees, the Younger Women's Club and the Taylor County Junior Miss Program. In 1989, Dr. Smith received the Citation of Honor from the National Federation of Business and Professional Women's Clubs.

Dr. Smith's professional commitment to dentistry started while she was in dental school and an active member of ASDA. She has served as vice president and president of the South Central Dental Society; as a delegate to the Kentucky Dental Association (KDA) House of Delegates; and on numerous committees and councils, including the KDA Manpower Committee and Budget and Finance Committee. In 1994, she received the Presidential Citation Award from the KDA. She is currently serving on the KDA Executive Board (Board of Trustees) and was chairperson of the Board in 1993 and again in 1995. Dr. Smith has been on the KDA Membership Council since 1993 and is currently serving a second term as chairperson of this Council.

Committee on the New Dentist

Hinrichs, R. Mark, Nebraska, 2000: Dr. Hinrichs is a 1992 graduate of the University of Nebraska where he served as president of his class during both his second and third years. At present he is in full-time general practice in Lincoln, Nebraska.

Dr. Hinrichs' contributions to organized dentistry began even before graduation. He was active in the University of Nebraska ASDA chapter and, after completing his dental degree, began immediately to assume positions of responsibility in his component and constituent societies. At present, he serves on the Nebraska Dental Association (NDA) Membership Committee and has been a member of the NDA Committee on Young Professionals since 1992. In 1994 he became chairman of that committee and will complete his two-year term in 1996. Dr. Hinrichs was an alternate to the 1993 NDA House of Delegates, and subsequently he was elected as a delegate for the period 1994-97. As a result of these activities, he has been a leader in planning and presenting both ADA Transition Programs and SUCCESS Programs for dental students in Nebraska.

Dr. Hinrichs is also active in community affairs. He serves on the Board of Directors of the Lancaster County chapter of the American Cancer Society, and he has chaired the National Children's Dental Health Month for Lincoln, Nebraska. He is a volunteer faculty member in the Southeast Community College Dental Assisting Program and has served on several committees for his church.

Holifield, Mark E., Tennessee, 2000: Dr. Mark E. Holifield is a private general practitioner in Parsons, Tennessee. He is a graduate of the University of Louisville School of Dentistry. Dr. Holifield is the past West Tennessee chairman and the present state chairman of the Tennessee Dental Association's (TDA) New Dentist Committee, as well as an alternate delegate for the Seventh District, TDA. Dr. Holifield is also district chairman for Ducks Unlimited and past president of the Parsons Lions Club.

Shoemaker, Eugene Bruce, Wisconsin, 2000: Dr. Shoemaker has been actively involved as a member of a number of committees of the Wisconsin Dental Association (WDA) since his graduation from the Marquette University School of Dentistry in 1989. He has served on the WDA Membership Committee and has been the chairman of the New Dentists Committee since 1994. In his position as chairman of the New Dentists Committee, he has attended two national New Dentist Conventions. He has been actively involved in the development and implementation of a mentorship program for dental students at the Marquette University School of Dentistry. In that capacity, he has helped to create a guide for recent graduates dealing with selection of practice locations and the establishment of a private dental practice. Dr. Shoemaker has been a member of the WDA annual session since 1985. He served as a delegate to the ADA annual session in 1995. He has been on the Board of Directors of Waukesha County Dental Association and currently serves as the editor of that component's newsletter.

Swinney, Paul G., Jr., Texas, 2000: Dr. Swinney graduated with a D.D.S. from the University of Texas Dental Branch, Houston in 1987. Since graduation, he has been continuously active in organized dentistry. In the Smith County Dental Society, he held the offices of secretary-treasurer, vice-president, and finally president in 1995. He has served the East Texas District Dental Society on the Membership Recruitment and Retention Committee; as secretary-treasurer, placement officer and director; and as Young Dentist Committee Chairman. He has served the Texas Dental

Association (TDA) as a delegate and an alternate delegate to the TDA House, was a Young Dentist of the Year nominee in 1993 and 1994; and was nominated for the New Dentist Leadership Award in 1996.

Commission on Relief Fund Activities

Cavalaris, C.J., Ohio, 2000: Dr. Cavalaris is recognized for his commitment to and expertise in finance, having served as a member of the Ohio Dental Association (ODA) Finance Committee and trustee of the ODA Relief Fund for the past eight years; as treasurer of the ODA from 1989 to 1991; and as treasurer of the Columbus Dental Society from 1981 to 1985. He is very familiar with the ADA Commission on Relief Fund Activities.

His many other ODA leadership roles include: member of the House of Delegates, 1978-89; member of the ODA Executive Committee, 1989-91; Annual Session Committee member, 1988; Task Force on Dental Specialty Groups, chair 1991-92; and Council on Dental Specialty Groups, chair, 1992-95 and member, 1992-98 .

Pickett, Charles, California, 2000: Dr. Pickett has served for a number of years on the Relief Committee for the California Dental Association and has chaired the Committee for the past two years. Needless to say, California has had myriad disasters in the past few years that have given Dr. Pickett vast knowledge and responsibility in dealing with these issues. Without question he will be an asset to the Relief Fund for the American Dental Association.

Council on Scientific Affairs

Austin, B. Peter, ad interim, 1997: Dr. Austin is Associate Professor of Endodontics and Acting Head of the Division of Endodontics, Marquette University School of Dentistry. He received his Ph.D. degree in Anatomy in 1974 from the State University of New York, Upstate Medical Center, Syracuse, NY; his D.D.S. in 1987 from Marquette University School of Dentistry; and his certificate in Endodontics in 1995 from Marquette University School of Dentistry.

His expertise is in the areas of bone metabolism and osseous reactions to various agents used in dentistry. Dr. Austin's training and background make him highly qualified to be a member of the Council on Scientific Affairs.

Gage, Tommy W., Texas, 2000: Dr. Gage received his D.D.S. from Baylor College of Dentistry in 1961. He graduated with a B.S. in pharmacy from the University of Texas in 1957 and received a Ph.D. in physiology and biochemistry from Baylor University in 1969. He also received certification in classical physiology from Baylor College of Medicine in 1968 and in neurophysiology from Southwestern Medical School in 1967. He has lectured extensively on pharmacology and physiology throughout the United States, as well as internationally, and has published numerous articles, books and abstracts throughout the world. He has been the recipient of many research and teaching grants.

Dr. Gage is currently professor and vice chairman of the Department of Oral and Maxillofacial Surgery and Pharmacological Sciences at Baylor College of Dentistry in Dallas, Texas and is a clinical pharmacist at Baylor University Medical Center. He served as a consultant to the ADA Council on Dental Therapeutics and is now serving as consultant to the Council on Scientific Affairs. He adds to the Council on Scientific Affairs his extensive knowledge, expertise and experience in the areas of pharmacology and physiology.

Hand, Jed S., Iowa, 2000: Dr. Hand is an oral epidemiologist who is professor and chairman of the Department of Preventive/Community Dentistry at the University of Iowa. He earned his dental degree and master's degree in Dental Care Administration at the University of Michigan. His expertise in the field of oral epidemiology is recognized throughout the world.

Dr. Hand's background includes private general practice, education, research and international dentistry. He has been an active member and contributor to the ADA and to the constituent and component societies in each of the states in which he has resided. These include the Michigan Dental Association and the Resort District Dental Society, and the Dental Society of the State of New York and the Third District Dental Society. He has served on several committees of the Iowa Dental Association and the University District Dental Society. Dr. Hand is a consultant to the ADA Commission on Dental Accreditation and serves on the ADA Advisory Committee on Dental Electronic Nomenclature, Indexing and Classification. He is a consultant to the Centers for Disease Control on dental disease preventive activities and, in 1993, was awarded an AADS Legislative Fellowship.

Dr. Hand has extensive international experience in the field of oral epidemiology. He has directed programs at the National Defense Medical Center Dental School in the Republic of China and the University of Science and Technology in Jordan.

As evidence of Dr. Hand's recognition by his peers, he is a reviewer of scientific articles for the journals of the American Dental Association, Dental Research, Gerondontology, Periodontology, Public Health Dentistry and Health Care Financing Review. In addition, he has published more than 70 articles and abstracts on oral epidemiology, dental caries, prevention and other oral health topics.

Dr. Hand's nomination to the Council on Scientific Affairs is endorsed by the Iowa Dental Association.

Thompson, Van P., Maryland, 2000: Now Professor of Restorative Dentistry at the Dental School of the University of Maryland and a member of the clinical staff at Johns Hopkins Hospital, Dr. Thompson received his Ph.D. from Rensselaer Polytechnic Institute in 1971 and immediately joined the faculty at the University of Maryland to initiate a research program in biomaterials. He completed his D.D.S. training at Maryland in 1979 while a faculty member. Since that time he has conducted laboratory and clinical research on dental composites, adhesive resins, etching of alloys and bonding to tooth structure, metals and ceramics. Co-developer of the etched casting resin-bonded retainer, Dr. Thompson has co-authored the text Etched Cast Restorations: Clinical and Laboratory Techniques (Quintessence). He has served on the American Dental Association Council on Dental Materials, Instruments and Equipment and on NIH Study Sections. His current research areas include adhesion to metals, to ceramics and to sound and carious dentin. Additional research interests include CAD/CAM of restorations and the effect of

machining damage on ceramic strength, fatigue and wear, as well as development of an intraoral hearing aid. Dr. Thompson is the Chairman of the 1997 Gordon Conference on The Science of Adhesion and the 1997 Ralph Phillips Memorial Lecturer for the Academy of General Dentistry Annual Meeting.

Verhagen, Connie M., Michigan, 2000: Dr. Connie Verhagen is a graduate of the University of Michigan School of Dentistry and maintains an active general dental practice in Muskegon, Michigan. Since the time of her graduation, she has been actively involved on a number of committees in the Michigan Dental Association (MDA). Her particular expertise is in the MDA Health and Hazardous Waste Committee, which she has chaired. She has given a number of lectures both locally and nationally concerning precautions for dealing with hazardous waste in the dental office. In 1995 Dr. Verhagen represented the American Dental Association and testified before Congress. Dr. Verhagen will bring to the Council on Scientific Affairs a wide knowledge of those scientific issues that affect the clinical practice of dentistry.

73. Resolved, that the nominees for membership on ADA councils and commissions and the Standing Committee on the New Dentist, 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.

Access, Prevention and Interprofessional Relations
Steven G. Ashman, MD
Alfred T. Bean, IL
Robert P. Gardner, OH
George W. May, Jr., MS

ADA Sessions and International Programs
Patrick S. Metro, OH
Angelo L. Bilionis, MA
John G. Lee, FL
Edward Leone, Jr., CO

Communications
Julie Ann Barna, PA
Christine E. Niekrash, CT

Dental Benefit Programs
Kevin J. McNeil, MA
Steven M. Bruce, ID
Joseph L. Perno, NJ
William D. Schmitt, PA

Dental Education/Dental Accreditation
Richard D. Wilson, VA
Don-N. Brotman, MD
Dominick P. DePaola, TX
Madonna Cord Matheson, CA
Rosemary Monehen, FL
Henry J. Van Hassel, OR

Dental Practice
Roger Kiesling, MT
Stanley W. Kaczkowski, WV
Calvin S. Lau, CA
James F. Rundle, IA

Ethics, Bylaws and Judicial Affairs
Skip D. Buford, LA
Frederick J. Bauer, WI
Robert E. McDonnell, MN
Robert C. Meador, TX

Governmental Affairs and Federal Dental Services
Zack Studstill, AL
Leo R. Finley, Jr., IL
Ronald J. Paler, MI
Dennis P. Pellegrino, NH

Insurance
James L. Cain, OR
William A. Orlacchio, NJ
Anthony E. Piana, NY
Donald C. Sarandria, PA

Membership
Joseph R. Kenneally, ME
Lisa P. Howard, MN
William E. Lee, KY
Eugene J. McGuire, PA

National Dental Examinations
Jared R. Fortman, MO
Donald W. Legler, FL
Martin H. Zais, HI
Ross G. Wyman, ME

New Dentist
Olin A. Elliott, II, KY
James K. Cantwil, MI
C. Roger Macias, Jr., TX
Michael J. Perpich, MN

Relief Fund Activities
Raymond J. Patenaude, ME
Samuel J. Cascio, IL

Scientific Affairs
William F. Slagle, TN
Robert H. Ahlstrom, NV
Alan A. Boghosian, IL
Billie Sue Kyger, OH

Response to Assignments from the House of Delegates

Recognition of Religious Diversity: Resolution 41H-1995 (*Trans.*1995:606), which recognizes the religious diversity of the ADA membership, has been included in the most recent edition of *Current Policies*.

Review of Reports and Studies by the ADA Board of Trustees: Resolution 73H-1995 (*Trans.*1995:652), which directs that all council and committee reports and studies requested by the House of Delegates or ADA Board of Trustees be reviewed and acted upon by the Board before any dissemination to "communities of interest," has been included in the most recent edition of *Current Policies*. Additionally, council/commission reports and statements have been approved by the Board prior to dissemination or have been circulated with clear notation that they were pending Board approval.

Behavior of Clinicians and Professional Speakers in Educational Settings: Resolution 84H-1995 (*Trans.*1995:650), directed that all ADA agencies that present speakers to dental audiences adopt uniform standards established by the Council on ADA Sessions and International Programs to sensitize the speakers to potential diversity in the audience. In response, the ADA Executive Director circulated the Statement to Sensitize Speakers to the Potential Diversity in the Audience to all ADA agencies along with this House of Delegate directive. In addition, this statement has been circulated to all constituents and components urging them to adopt similar standards.

Promotion of ADA Annual Session Benefits to Cities: The 1995 House of Delegates Resolution 90H-1995 (*Trans.*1995:605), directed the Council on ADA Sessions and International Programs to develop documents to be used in a competitive bidding process directed at cities that might host the ADA annual session in future years. The Council is in the process of developing this material and completing this assignment and will report to the House of Delegates in 1997.

Primary Care Providers: Resolution 140H-1995 (*Trans.*1995:610), which recognizes that dentists in general practice are primary care providers regardless of the age of the patient, has been included in the most recent edition of *Current Policies*.

Clarification of ADA Policy: The 1995 House of Delegates adopted Resolution 146H-1995 (*Trans.*1995:661), which reaffirmed that resolutions directing the Association to initiate or support legislative activity on a particular issue are also establishing Association policy on the issue. Further, Resolution 146H directed that such policies should be appropriately cross-referenced in the Association's publication, *Current Policies*.

Accordingly, several changes were made to the publication to create a more useful reference document and satisfy the intent of Resolution 146H-1995. As the book was updated to include policies adopted in 1995, some section headings were modified and new sections were added to make it easier to locate policies on specific issues.

In addition, the latest edition of *Current Policies* (July 1996) contains an expanded index in which all policies that refer to legislation are double-posted, or listed under more than one subject heading (e.g., the Association's policies regarding antitrust legislation can be found by looking in the index under **Legislation** or **Antitrust**).

Resolution

73. Resolved, that the nominees for membership on ADA councils and commissions and the Standing Committee on the New Dentist, submitted by the Board of Trustees in accordance with Chapter VII, Section 100(H), of the Bylaws, be elected.

Report 2

ADA Operating Account Financial Affairs and Recommended Budget, Fiscal Year 1997

Introduction: In accordance with its *Bylaws* duties, the Board of Trustees presents the proposed operating budget for the Association in 1997. 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 1997. The Board is recommending a 1997 operating budget of $55,103,050 in revenues and dividends, offset by $55,077,150 in expenses, generating a net revenue from operations of $25,900. The Board of Trustees analyzed approximately 400 budget requests using the modified 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.

Although a balanced budget is being presented, a proposed $1 dues increase is being sought to provide the House of Delegates with a funding mechanism in the event that resolutions with significant financial impact are approved by the Delegates. The use of the $1 figure is to meet the 90-day notification requirement to the constituent societies. This amount can be amended during the course of the annual meeting to coincide with House actions that collectively might result in a budgetary deficit. The options of appropriating reserve funds or further curtailing proposed expenditures to accommodate new House initiatives are also available to match revenues with program costs.

Budgeting Process

The technique of modified zero-based budgeting (ZBB) was applied to the 1997 budget process, representing the fifth 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; consequences of not approving funds; and a listing of activities for comparison to the 1996 approved budget. The ZBB process also allowed for discontinuing a current activity or proposing a new one. Budget packages for councils, commissions and committees were reviewed and prioritized by council chairs and other volunteer leadership 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 time 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 end of May, the President-elect, the Treasurer and the Executive Director, acting as the Administrative Review Committee, thoroughly assessed and ranked all budget requests following telephone conversations with council and commission chairs. A similar review was 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 input from the Finance Committee, the Administrative Review Committee revised or selected alternative budget packages reducing initial budgetary requests by $5,236,725.

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.

1997 Budget Overview

Revenues

Total revenues and dividend income are being forecast at $55,103,050 for 1997 compared with $55,053,600 for 1996. Membership dues account for approximately 58% of the Association's operating revenue exclusive of subsidiary company operations and dividends. The 1997 budget anticipates $22,560,950 in nondues revenue, a 1% decline from 1996. Highlights of various revenue categories are provided below.

Membership Dues: The 1997 budget forecasts $31,217,100 in dues income net of rebates offered to state societies as an incentive to encourage prompt payment of member monies to the Association. These projections assume nearly 100,000 full dues paying members. The 1997 budget reflects the scheduled discontinuance of the $55 interim dues increase previously authorized by Resolution 35H-1992 (*Trans.*1992:583). Monies previously collected and unspent are held in a separate fund for future planned construction as described in a later section of this report.

Rental Income: This revenue category includes rental income from the Headquarters Building and exhibit space at the

annual session. An anticipated decline of 6%, from $6,028,000 to $5,655,400, mainly results from lower exhibit space income as the Washington, D.C. meeting does not enjoy the benefit of the FDI World Dental Congress, previously held in conjunction with the 1996 annual session.

Sales Income: Total sales are budgeted at $4,543,700, or an 8% increase over the 1996 budget of $4,197,700. This essentially reflects Salable Materials' efforts to enhance its catalog offerings with new and updated products.

Testing Fee Income: Revenues from testing fees are expected to rise $997,950 from $3,169,400 to $4,167,350 due to an increase in the number of test candidates.

Grants and Contributions: Income from grants and contributions is expected to increase from $292,300 to $735,700, a $443,400 rise. This is partially a reflection of more corporate funding anticipated related to annual session.

Registration Income: Projected income from 1997 registration fees of $2,081,750 is down $885,250 from the current year. This decline of 30% reflects the separation of the ADA and FDI 1996 World Dental Congress meetings next year.

Investment Income: Projected revenues of $510,000 for 1997 represent investment earnings on cash flow within the operating account. Expected income has been increased by $110,000 or 28% from 1996 based upon the interest rates and cash flow in more recent years. Actual results may vary depending upon the timing of cash receipts and the prevailing interest rates during 1997.

Miscellaneous Income: This category is composed of miscellaneous revenue which is not included within any of the previous categories. Projected revenue of $4,867,050 is 15% below the 1996 level of $5,737,800. The largest single decline results from the elimination of $700,000 received from the Major Medical Surplus in 1996 that represented the final payout of unclaimed funds from the plan's termination. Also contributing to this budgeted decrease are lower revenues from Seal Program submission and maintenance fees and reduced ticket sales for annual session events in 1997 when compared with the joint ADA and FDI 1996 World Dental Congress meeting. This shortfall is partially offset by an anticipated increase in royalty revenue from the member financial services program and greater cost sharing on the part of dental schools in the accreditation process.

Expenses

Staff Compensation: Expenses for staff compensation are budgeted at $24,902,300 or $512,720 above the 1996 level of $24,389,580.

In 1997 the Association will continue to budget cash contributions to the qualified, supplemental and executive parity 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 decreased to $5,911,000 from the 1996 budget of $6,641,010. The $730,010 anticipated decline is mainly due to overall travel savings budgeted in Central Administration in recognition of previous years' favorable variances resulting from favorable airline fares and changes in travel plans. Additionally, Resolution 119H-1995 (*Trans.*1995:650) pertaining to the Family Health Care Fairness Act of 1995 contained over $150,000 in travel-related expenses for 1996 that are not included in the 1997 budget.

Facility and Utility Costs: The majority of these expenses can be attributed to management oversight, operations, maintenance and real estate taxes for the ADA Headquarters property. The 1997 budget of $3,156,050 anticipates savings in utilities, cleaning and maintenance costs of 302,550 or 9% less than the current year.

Office Expenses: The expenses in this category are budgeted to decrease from $3,021,900 to $2,960,300, a change of $61,600 or 2%.

Professional Services: The $299,350 decrease in this category is related to Resolution 62H-1995 (*Trans.*1995:620), *Study of the Effect of Low Reimbursement Levels on Dental Care Delivery Systems*; and Resolution 119H-1995 (*Trans.*1995:650), *Family Health Care Fairness Act of 1995*, which were incorporated in the 1996 budget but are not included in 1997. This decrease is partially offset by an increase in outside services related to outsourcing Salable Materials order processing and fulfillment work.

Publications and Projects: The increase of $400,600 from $5,846,750 to $6,247,350 is mainly related to producing new products, as well as updating the ADA video library for Salable Materials.

Grants to Related Health Groups: The Association's grant support to various organizations increased from $2,750,350 to $2,886,400, a $136,050 or 5% rise. This is mainly a result of increase in funding for ADA Health Foundation activities.

Depreciation and Amortization: These items increased by $139,300, or 17% from the 1996 budget of $800,000. This change reflects an adjustment in depreciation for computer-related equipment from a five-year to a four-year useful life.

Other Expenses: Expenses not categorized elsewhere are expected to rise by $217,300 to $1,956,200. This increase primarily reflects the method of accounting for the Contingent Fund in Central Administration and is not an actual variance. Specifically, as supplemental appropriations requests are approved by the Board of Trustees, the funds are transferred from the Contingent Fund into separate cost centers and accounts. This depletes the balance of the Contingent Fund and creates the appearance of a variance in the ensuing year's budget request.

Since 1996 the Contingent Fund has been set by the Board at 1% of the previous year's operating expense budget. The 1997 appropriation of $536,100 is $13,000 greater than the 1996 level of $523,100.

Other Budget Items For 1997

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 to fund ADREC's cash flow losses up to $1.7 million annually. For 1997, the anticipated cash loss of $1,636,600, which includes a principal payment of $920,000 and $392,000 of capital improvements, will again be funded from reserves given that this property was initially acquired as a long-term investment. Although this represents a substantial cash shortfall, it is relevant to note that the Association does not pay rent on the space it occupies in Washington, an imputed value of over $250,000. Please refer to Board Report 4 (*Supplement:*442) for additional background on ADREC.

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, $1,454,600 for 1997, are meant to financially underwrite future capital improvements to the Headquarters Building. This level of funding was selected based upon projected depreciation expense for 1997 plus a provision for future building enhancements and replacements of equipment as recommended by the building management, Compass Management Corporation. A capital budget for the 1997 fiscal year appears at the end of this report.

Dividend: A $1,325,000 dividend, in 1997, is being projected from the ADA Holding Co., Inc., of which $825,000 is derived from earnings of ADAPCO and $500,000 from earnings of FINCO.

Retiree Medical Plan: In accordance with accounting rules (specifically, FAS 106), the Association must allocate 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, $722,000 was included in the 1997 budget, a portion of which represents expected current costs with the remainder being committed to the Reserve Division Restricted Investment Account to help defer future liabilities. Essentially, retiree medical costs will be actuarially determined and funded similar to a pension plan.

American Dental Association
1997 Budget Summary Worksheet

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Membership Dues	$29,457,371	30,897,400	31,217,100	1%
Rental Income	5,462,104	6,028,000	5,655,400	(6%)
Sales Income	5,412,082	4,197,700	4,543,700	8%
Testing Fee Income	3,296,271	3,169,400	4,167,350	31%
Grants and Contributions	406,113	292,300	735,700	>100%
Registration Income	879,985	2,967,000	2,081,750	(30%)
Investment Income	555,401	400,000	510,000	28%
Miscellaneous Income	5,055,761	5,737,800	4,867,050	(15%)
TOTAL REVENUES	50,525,088	53,689,600	53,778,050	<1%
EXPENSES				
Staff Compensation	22,101,360	24,389,580	24,902,300	2%
Meeting/Travel Expenses	5,420,673	6,641,010	5,911,000	(11%)
Facility and Utility Costs	3,081,262	3,458,600	3,156,050	(9%)
Office Expenses	2,468,554	3,021,900	2,960,300	(2%)
Professional Services	4,680,314	4,943,000	4,643,650	(6%)
Publication and Project Costs	5,579,213	5,846,750	6,247,350	7%
Grants—Related Health Groups	2,345,379	2,750,350	2,886,400	5%
Depreciation and Amortization	827,207	800,000	939,300	17%
Other Expense	1,371,655	1,738,900	1,956,200	12%
TOTAL EXPENSES	47,875,617	53,590,090	53,602,550	<1%
NET REVENUE/(EXPENSE) BEFORE INCOME TAXES	2,649,471	99,510	175,500	76%
Income Taxes	24,954	20,000	20,000	0%
NET REVENUE/(EXPENSE) AFTER INCOME TAXES	2,624,517	79,510	155,500	96%
Funded Depreciation	(1,000,000)	(1,454,600)	(1,454,600)	0%
Dividends	700,000	1,364,000	1,325,000	(3%)
ADREC Cash Flow Loss	(335,580)	-	-	-
Deferral of ADREC Capital Expenditures	(272,939)	-	-	-
Pension Funding	(389,885)	-	-	-
ADA ONLINE 2000	(521,824)	-	-	-
Grassroots Activities	(195,500)	-	-	-
Ohio/Alabama Litigation	(17,877)	-	-	-
Due from Reserves:				
Grassroots Activities	195,500	-	-	-
Ohio/Alabama Litigation	17,877	-	-	-
NET REVENUE/(EXPENSE)	$ 804,289	(11,090)	25,900	(>100%)

Note: The anticipated 1996 and 1997 cash flow loss from the American Dental Real Estate Corporation (ADREC) of $1,679,600 and $1,636,600, respectively, will be funded from reserves.

American Dental Association
1997 Budget Summary Worksheet—Divisional Summary

	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
House, Board, Administration and Policy, Quality and Strategic Planning	$ 837	9,500	9,500	0%
Legal Affairs	38,514	21,600	22,000	2%
Government Affairs	8,265	21,600	8,000	(63%)
Communications	19,000	12,600	10,000	(21%)
Membership and Dental Society Services	167,501	217,050	262,000	21%
Conference and Meeting Services	5,033,182	7,173,200	5,977,775	(17%)
Finance and Operations	972,375	919,000	985,000	7%
Headquarters Building	2,284,817	2,608,000	2,494,150	(4%)
Salable Materials	5,304,415	4,041,400	4,366,200	8%
Survey Center	88,642	89,500	90,000	1%
Central Administration	31,819,426	33,048,500	33,057,000	<1%
Information Technology	305,408	296,000	296,000	0%
Dental Practice	505,163	523,750	725,475	39%
Education	3,759,663	3,656,000	4,934,950	35%
Science	218,240	920,600	415,000	(55%)
ADA Health Foundation	-	131,300	125,000	(5%)
TOTAL REVENUES	50,525,088	53,689,600	53,778,050	<1%
EXPENSES				
House, Board, Administration and Policy, Quality and Strategic Planning	3,580,369	4,221,600	4,392,100	4%
Legal Affairs	1,950,650	2,037,300	2,051,050	1%
Government Affairs	2,748,923	2,964,210	3,186,500	7%
Communications	2,324,846	2,394,850	2,414,450	1%
Membership and Dental Society Services	3,334,726	3,656,570	3,803,900	4%
Conference and Meeting Services	4,590,660	5,025,700	4,109,300	(18%)
Finance and Operations	3,780,552	4,102,750	4,039,950	(2%)
Headquarters Building	3,584,453	4,037,200	3,749,000	(7%)
Salable Materials	2,942,140	2,930,400	3,178,800	8%
Survey Center	1,449,795	1,597,600	1,683,950	5%
Central Administration	3,142,181	3,092,500	3,114,000	1%
Information Technology	1,938,049	2,325,930	2,648,400	14%
Dental Practice	3,581,828	5,341,380	4,547,950	(15%)
Education and Science	128,056	-	-	-
Education	5,149,795	5,570,800	6,036,950	8%
Science	1,503,113	1,759,350	1,958,450	11%
ADA Health Foundation	2,170,435	2,551,950	2,707,800	6%
TOTAL OPERATING EXPENSES	$47,900,571	53,610,090	53,622,550	<1%

American Dental Association
1997 Budget Summary Worksheet—Divisional Summary (continued)

	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
NET REVENUE/(EXPENSE) BEFORE OTHER ITEMS	$2,624,517	79,510	155,500	96%
OTHER ITEMS				
Funded Depreciation	(1,000,000)	(1,454,600)	(1,454,600)	0%
Dividends	700,000	1,364,000	1,325,000	(3%)
ADREC Cash Flow Loss	(335,580)	-	-	-
Deferral of ADREC Capital Expenditures	(272,939)	-	-	-
Pension Funding	(389,885)	-	-	-
ADA ONLINE 2000	(521,824)	-	-	-
Grassroots Activities	(195,500)	-	-	-
Ohio/Alabama Litigation	(17,877)	-	-	-
Due from Reserves:				
Grassroots Activities	195,500	-	-	-
Ohio/Alabama Litigation	17,877	-	-	-
NET REVENUE/(EXPENSE)	$ 804,289	(11,090)	25,900	(>100%)

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.

	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
TOTAL REVENUES	$50,525,088	53,689,600	53,778,050	
Dividends Received	700,000	1,364,000	1,325,000	
TOTAL REVENUES	51,225,088	55,053,600	55,103,050	<1%
TOTAL EXPENSES	47,900,571	53,610,090	53,622,550	
OTHER ITEMS				
Funded Depreciation	1,000,000	1,454,600	1,454,600	
ADREC Cash Flow Loss	335,580	-	-	-
Deferral of ADREC Capital Expenditures	272,939	-	-	-
Pension Funding	389,885	-	-	-
ADA ONLINE 2000	521,824	-	-	-
Grassroots Activities	195,500	-	-	-
Ohio/Alabama Litigation	17,877	-	-	-
Due from Reserves:				
Grassroots Activities	(195,500)	-	-	-
Ohio/Alabama Litigation	(17,877)	-	-	-
TOTAL EXPENSES	$50,420,799	55,064,690	55,077,150	<1%

Division of House, Board, Executive Director, Administration and Policy, Quality and Strategic Planning

The budget for the Division of House, Board, Executive Director, Administration and Policy, Quality and Strategic Planning supports the administration, travel, meeting and staffing for the activities of the House of Delegates, Board of Trustees, the Executive Director, Deputy Executive Director, Quality and Strategic Planning, International Dental Health activities and the FDI.

The proposed 1997 budget for the Division represents a net increase of $170,500 from the 1996 net approved budget. This increase of 4% is due in large part to the FDI World Dental Federation budget which reflects an increase of $70,200 or 44%. This variance is attributable to increased travel-related expenditures for the Association's delegation to the 1997 Congress being held in Korea. The 1996 budget was scaled back significantly since the Congress was planned as a joint meeting with the Association's annual session in Orlando.

The remaining variance of $100,300 reflects increased volunteer involvement in liaison, task force and committee activities including Strategic Planning; increased office or administrative expenses such as postage and telecommunications; and a modest 2.9% increase in officer and trustee stipends. With these exceptions, the overall activity level of these generally administrative areas is in keeping with 1996 budgetary levels.

House, Board, Executive Director, Administration and Policy, Quality and Strategic Planning—Divisional Summary Worksheet

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Miscellaneous Income	$ 837	9,500	9,500	0%
TOTAL REVENUES	837	9,500	9,500	0%
EXPENSES				
Staff Compensation	1,449,009	1,765,100	1,767,100	<1%
Meeting/Travel Expenses	824,442	949,900	1,101,600	16%
Office Expenses	201,232	290,800	307,400	6%
Professional Services	798,603	881,800	875,200	(1%)
Publication and Project	136,370	165,800	173,100	4%
Other Expenses	170,713	168,200	167,700	(<1%)
TOTAL EXPENSES	3,580,369	4,221,600	4,392,100	4%
NET REVENUE/(EXPENSE)	(3,579,532)	(4,212,100)	(4,382,600)	4%
DEPARTMENTS				
REVENUES				
Department of International Dental Health	837	9,500	9,500	0%
TOTAL REVENUES	$ 837	9,500	9,500	0%

House, Board, Executive Director, Administration and Policy, Quality and Strategic Planning—Divisional Summary Worksheet (continued)

DEPARTMENTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
EXPENSES				
Executive Director	$1,010,422	1,251,800	1,231,300	(2%)
Quality and Strategic Planning	68,750	186,050	203,500	9%
Board of Trustees	1,197,396	1,255,100	1,340,650	7%
Office of the President	273,530	353,100	370,300	5%
Office of the President-elect	214,383	242,000	241,200	(<1%)
Office of the Immediate Past President	14,517	14,900	15,350	3%
Office of the Treasurer	40,019	63,250	65,650	4%
House of Delegates	471,930	594,300	594,050	(<1%)
Department of International Dental Health	86,926	99,900	98,700	(1%)
FDI World Dental Federation	202,496	161,200	231,400	44%
TOTAL EXPENSES	3,580,369	4,221,600	4,392,100	4%
NET REVENUE/(EXPENSE)	$(3,579,532)	(4,212,100)	(4,382,600)	4%

Division of Legal Affairs

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

In regard to the advocacy role, there are a number of projects underway at any one time. Among the current activities are: the FTC's threatened enforcement action against ADA pertaining to the 1982 consent decree (notably specialty announcements); FTC's action against the California Dental Association in regard to ethical standards related to advertising; antitrust issues generally; antitrust and disparagement issues regarding marketplace and managed care; ongoing involvement in OSHA matters; HIV and other infectious diseases in the dental office; the Americans with Disabilities Act; and dental office waste. In 1996, Division attorneys with the help of outside counsel also are providing the legal component of some 16 managed care seminars around the country. In addition, the Division answers hundreds of member inquiries each month on all aspects of professional practice and dental care.

Finally, the very popular Contract Analysis Service (offered by the Council on Dental Benefit Programs) is housed in the Legal Division. In 1995, the Service received over 540 different dental plan contracts to analyze. That is nearly a 20% increase over 1994 and a 30% increase over 1993. As a result, the Service has expanded its staff to accommodate the ever-increasing demand.

The overall 1997 proposed expense budget for the Division of Legal Affairs is less than 1% above 1996.

The budget proposed by the Council on Ethics Bylaws and Judicial Affairs is 13% higher than in 1996. The majority of the increase will enable the Council to respond to the increased demand for the Ethics Component of the SUCCESS Program for junior and senior dental students. In 1996, the demand for the one-half day ethics component exceeded available funding.

Legal Affairs—Divisional Summary Worksheet

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Miscellaneous Income	$ 38,514	21,600	22,000	2%
TOTAL REVENUES	38,514	21,600	22,000	2%
EXPENSES				
Staff Compensation	1,082,949	1,317,000	1,317,000	0%
Meeting/Travel Expenses	60,652	76,800	84,750	10%
Office Expenses	27,049	32,500	30,650	(6%)
Professional Services	732,261	552,350	552,200	(<1%)
Publication and Project	24,159	36,950	43,750	18%
Other Expenses	23,580	21,700	22,700	5%
TOTAL EXPENSES	1,950,650	2,037,300	2,051,050	<1%
NET REVENUE/(EXPENSE)	(1,912,136)	(2,015,700)	(2,029,050)	<1%
DEPARTMENTS				
REVENUES				
Office of AED/Legal Affairs	36,575	15,000	15,000	0%
Council on Ethics, Bylaws and Judicial Affairs	1,939	1,500	1,900	27%
Contract Analysis Service	-	5,100	5,100	0%
TOTAL REVENUES	38,514	21,600	22,000	2%
EXPENSES				
Office of AED/Legal Affairs	1,638,050	1,715,350	1,708,750	(<1%)
Council on Ethics, Bylaws and Judicial Affairs	173,292	160,200	180,600	13%
Contract Analysis Service	139,308	161,750	161,700	(<1%)
TOTAL EXPENSES	1,950,650	2,037,300	2,051,050	<1%
NET REVENUE/(EXPENSE)	$(1,912,136)	(2,015,700)	(2,029,050)	<1%

Division of Government Affairs

The 104th Congress, even though the members stayed in late and worked very long hours, has produced very little in the way of substantive legislation. While the 103rd Congress saw 473 bills enacted into law, the 104th Congress produced less than a third as many. The Association, however, seized every opportunity to advocate the ADA's positions on the issues and to move proactively on the Association's priorities. Toward this end, in addition to the aggressive one-on-one lobbying carried on by the ADA lobbyists, the Association sent a record number of letters and statements for the record to the Hill, and submitted comments on a myriad of regulatory issues. Of particular importance has been the introduction of H.R. 2400, the Family Health Care Fairness Act, introduced by Representative Charlie Norwood (R-GA) and Representative Bill Brewster (D-OK), which seeks to guarantee freedom of choice and other protections for patients and providers; and the acceptance in legislation of the phone/fax method for complaint resolution and other OSHA reforms. It is unclear whether final legislation will be signed into law on these matters this year. If that does not happen, the Association has been successful in bringing attention to these issues and developing an excellent basis for legislation next year.

On the state front, the Department of State Government Affairs has played a very important role in helping states raise concerns about the problems of certain managed care plans and advocate for provider protection legislation by providing a list of provisions that might be included in such legislation, developing specific legislative language and helping with the evaluation of pending legislation.

The proposed 1997 Division budget primarily reflects the ongoing activities of the Division to promote the Association's legislative and regulatory agenda. The Division will build on the success of the grassroots workshops and seminars conducted in 1996 and will host the second Grassroots

Conference for Action Team Leaders. With action on a new attempt at health system reform anticipated in 1997 (including Medicare and Medicaid reform), this cadre of activist dentists will be ready to carry forth dentistry's message to members of Congress. The Lobbyists Conference is a very well-regarded activity that provides an excellent opportunity for state lobbyists to share information on what works and what doesn't work as they advocate on behalf of dentists in state legislatures. This will be very important if the federal government returns more responsibilities to the states. Finally, the Division is poised to implement the provisions of Resolution 119H-1995 (*Trans.*1995:650), once the study mandated by Resolution 62H-1995 (*Trans.*1995:620) is completed.

Government Affairs—Divisional Summary Worksheet

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Registration Income	$ 8,265	21,600	8,000	(63%)
TOTAL REVENUES	8,265	21,600	8,000	(63%)
EXPENSES				
Staff Compensation	1,923,241	2,004,000	2,052,600	2%
Meeting/Travel Expenses	448,878	474,110	532,650	12%
Facility and Utility Costs	9,999	15,000	15,000	0%
Office Expenses	146,918	145,300	182,150	25%
Professional Services	111,817	155,000	192,000	24%
Publication and Project	59,531	88,200	129,800	47%
Other Expenses	48,539	82,600	82,300	(<1%)
TOTAL EXPENSES	2,748,923	2,964,210	3,186,500	7%
NET REVENUE/(EXPENSE)	(2,740,658)	(2,942,610)	(3,178,500)	8%
DEPARTMENTS				
REVENUES				
State Government Affairs	8,265	6,600	8,000	21%
Public Affairs Conference	-	15,000	-	(100%)
TOTAL REVENUES	8,265	21,600	8,000	63%
EXPENSES				
Office of AED/Government Affairs	579,076	586,490	589,250	<1%
Council on Government Affairs and Federal Dental Services	303,267	308,500	313,000	1%
State Government Affairs	548,532	609,850	611,700	<1%
ADPAC	367,010	486,270	754,600	55%
Washington Office—Administration	273,879	286,000	303,500	6%
Congressional Affairs	468,602	419,400	407,500	(3%)
Public Affairs Conference	(19)	70,000	-	(100%)
Federal Affairs	208,576	197,700	206,950	5%
TOTAL EXPENSES	2,748,923	2,964,210	3,186,500	7%
NET REVENUE/(EXPENSE)	$(2,740,658)	(2,942,610)	(3,178,500)	8%

Division of Communications

Division of Communications expenses are projected to increase 1% or $19,600 in 1997. Estimated net expenses also will increase 1%. This follows a 5% budgeted decrease in expenses in 1996.

Communications activities are conducted by three departments: Professional Communications, Media and Creative Services, and Public Information and Education.

The ADA's integration of "new" media—specifically, its World Wide Web site—into its traditional communications vehicles continues to be the most significant trend influencing the Division. Subtracting funding for new activities related to ADA ONLINE, the Division's budget would be smaller in 1997 than in 1996. An ADA ONLINE manager was added to Department of Professional Communications authorized staffing in 1996, and the 1997 budget includes a request to fund an ADA ONLINE coordinator. Also new in the 1997 budget are ADA ONLINE promotional activities and online audio and video programs.

It also is anticipated that significant Communications Division staff resources will be applied in 1997 to ongoing direct reimbursement promotion mandated under Resolution 129H-1995 (*Trans.*1995:623). Staff from the Associate Executive Director's office and from Public Information and Education will be involved in these activities.

Communications—Divisional Summary Worksheet

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Registration Income	$ 19,000	12,600	10,000	(21%)
TOTAL REVENUES	19,000	12,600	10,000	(21%)
EXPENSES				
Staff Compensation	1,177,238	1,348,400	1,359,250	1%
Meeting/Travel Expenses	97,776	109,050	145,150	33%
Office Expenses	52,392	44,300	49,900	13%
Professional Services	273,689	145,100	134,000	(8%)
Publication and Project	713,100	740,700	718,000	(3%)
Other Expenses	10,651	7,300	8,150	12%
TOTAL EXPENSES	2,324,846	2,394,850	2,414,450	1%
NET REVENUE/(EXPENSE)	(2,305,846)	(2,382,250)	(2,404,450)	1%
DEPARTMENTS				
REVENUES				
Professional Communications	19,000	12,600	10,000	(21%)
TOTAL REVENUES	19,000	12,600	10,000	(21%)
EXPENSES				
Office of AED/Communications	296,412	460,900	458,650	(<1%)
Professional Communications	396,855	393,350	455,400	16%
Media Relations	605,089	469,950	496,550	6%
Creative Services	429,620	566,550	502,500	(11%)
Audiovisual Services—Administration	67,018	-	-	-
Public Information/Education Programs	529,852	504,100	501,350	(1%)
TOTAL EXPENSES	2,324,846	2,394,850	2,414,450	1%
NET REVENUE/(EXPENSE)	$(2,305,846)	(2,382,250)	(2,404,450)	1%

Division of Membership and Dental Society Services

The proposed budget for the Division of Membership and Dental Society Services reflects an increase of 4% or $147,330 in expenses compared with the 1996 budget, and an increase of 21% or $44,950 in revenue. This results in an increase of 3% or $102,380 of net funding requested. An increase in corporate sponsorship anticipated for the 1997 National Conference on the New Dentist accounts for the increase in revenue.

The proposed 1997 budget for the Division of Membership and Dental Society Services includes the budget for the Council on Membership. The Council oversees and evaluates the Association's Recruitment and Retention Business Plan, makes recommendations regarding membership policy, and reviews those programs relating to membership marketing. The Council oversees student marketing and new dentist recruitment activities to enhance the successful transition of student members to full active members. The proposed budget includes targeted activities of the Office of Student Affairs.

The 1997 budget also supports the 1997 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 the ADA councils that address issues germane to new dentists. The 1997 budget includes the National Conference on the New Dentist as well as membership marketing activities that complement student transition efforts of the Council on Membership.

The 1997 budget focuses on conveying the value of membership throughout the tripartite, including: development of benefits resources and providing support to constituent and component leaders, volunteers and staff; through the Field Service Program and Membership Conference, and the Transition Program which carries the message of organized dentistry to dental students from new dentists, tripartite leaders and staff.

The Division's 1997 strategic activities also include the development of dental society membership resources; liaison and communications with tripartite and other dental organizations; leadership and management forums for dental society leaders and staff; maintenance of the integrity of the Association's membership database; and evaluation of current membership systems and policies to ensure that these continue to meet member and Association needs.

Membership and Dental Society Services—Divisional Summary Worksheet

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Grants and Contributions	$ 95,500	106,000	172,000	62%
Registration Fee	69,470	99,750	80,600	(19%)
Miscellaneous Income	2,531	11,300	9,400	(17%)
TOTAL REVENUES	167,501	217,050	262,000	21%
EXPENSES				
Staff Compensation	2,028,857	2,165,500	2,253,250	4%
Meeting/Travel Expenses	443,789	478,870	485,200	1%
Office Expenses	317,550	300,100	302,450	1%
Professional Services	118,458	212,700	152,650	(28%)
Publication and Project	410,586	488,500	597,950	22%
Other Expenses	15,486	10,900	12,400	14%
TOTAL EXPENSES	3,334,726	3,656,570	3,803,900	4%
NET REVENUE/(EXPENSE)	(3,167,225)	(3,439,520)	(3,541,900)	3%
REVENUES				
Department of Membership Services	3,725	17,300	15,800	9%
Dental Society Services	25,510	47,750	25,450	(47%)
Field Service Program	1,000	-	-	-
Council on Membership—Programs	32,006	36,000	36,000	0%
Committee on New Dentist	105,260	116,000	184,750	59%
TOTAL REVENUES	$167,501	217,050	262,000	21%

Membership and Dental Society Services—Divisional Summary Worksheet (continued)

DEPARTMENTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
EXPENSES				
Office of AED/Membership and Dental Society Services	$220,939	238,835	229,550	(4%)
Department of Membership Services	293,404	308,535	330,700	7%
Membership Financial Services	76,111	82,850	81,700	(1%)
Dental Society Services	343,514	459,950	450,850	(2%)
Field Service Program	424,172	417,000	420,300	1%
Council on Membership—Programs	513,963	610,150	514,950	(16%)
Call Center	328,223	296,700	297,400	<1%
Committee on New Dentist	216,582	288,090	395,900	37%
Council on Membership—Administration	50,917	54,210	51,600	(5%)
Department of Membership Marketing	424,445	383,000	508,400	33%
Department of Membership Information	442,456	517,250	522,550	1%
TOTAL EXPENSES	3,334,726	3,656,570	3,803,900	4%
NET REVENUE/(EXPENSE)	$(3,167,225)	(3,439,520)	(3,541,900)	3%

Division of Conference and Meeting Services

The 1997 expense budget for the Division of Conference and Meeting Services is down 18% from 1996 budget levels, while revenue is down 17%. In both cases, budgeted expense and revenue levels for 1996 came about from the expansion of the 1996 annual session to include the FDI World Dental Congress.

The 1997 expense budget returns to 1995 actual levels of spending. Income increases over 1995 actuals are a result of the continuation of registration fees initiated for the 1996 annual session.

Conference and Meeting Services—Divisional Summary Worksheet

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Rental Income	$ 3,194,335	3,450,000	3,165,000	(8%)
Sales Income	113,171	166,000	170,000	2%
Grants and Contributions	187,517	100,000	370,000	>100%
Registration Income	319,369	2,280,300	1,371,375	(40%)
Miscellaneous Income	1,218,790	1,176,900	901,400	(23%)
TOTAL REVENUES	5,033,182	7,173,200	5,977,775	(17%)
EXPENSES				
Staff Compensation	1,172,959	1,215,300	1,208,400	(1%)
Meeting/Travel Expenses	1,619,186	2,095,200	1,522,400	(27%)
Facility and Utility Costs	44,847	55,000	47,250	(14%)
Office Expenses	182,952	316,600	192,200	(39%)
Professional Services	791,545	734,800	510,150	(31%)
Publication and Project Costs	718,571	587,900	600,300	2%
Other Expenses	60,600	20,900	28,600	37%
TOTAL EXPENSES	4,590,660	5,025,700	4,109,300	(18%)
NET REVENUE/(EXPENSE)	$ 442,522	2,147,500	1,868,475	(13%)

Conference and Meeting Services—Divisional Summary Worksheet (continued)

DEPARTMENTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
CASIP—Program	$4,240,059	4,974,400	5,420,275	9%
CASIP—Administration	20	-	-	-
Annual Session—Social/Special Events	534,475	260,000	270,000	4%
Conference Services	115	-	-	-
Executive Dining Room	119,601	171,500	171,500	0%
Management Conference Reception	20,557	-	-	-
Meeting Room Management	36,331	41,000	41,000	0%
1996 World Dental Congress	-	1,651,300	-	(100%)
Specialty Shop	82,024	75,000	75,000	0%
TOTAL REVENUES	5,033,182	7,173,200	5,977,775	(17%)
EXPENSES				
Office of AED/Conference	249,503	272,200	276,200	1%
CASIP—Program	2,612,526	2,402,000	2,545,900	6%
CASIP—Administration	30,671	22,000	17,600	(20%)
Annual Session—Social/Special Events	584,448	260,000	260,000	0%
Annual Session—Staff Travel	180,667	224,900	224,900	0%
Annual Session—Hosting	56,760	55,300	55,300	0%
Conference Services	363,957	414,400	417,900	1%
Executive Dining Room	180,095	196,500	195,400	(1%)
Management Conference Reception	20,468	-	-	-
Meeting Room Management	39,369	23,100	23,100	0%
ADA Volunteer Service	48,829	32,000	34,800	9%
NCIH	8,207	8,200	8,200	0%
1996 World Dental Congress	157,281	1,065,100	-	(100%)
Specialty Shop	57,879	50,000	50,000	0%
TOTAL EXPENSES	4,590,660	5,025,700	4,109,300	(18%)
NET REVENUE/(EXPENSE)	$ 442,522	2,147,500	1,868,475	(13%)

Division of Finance and Operations

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.

Office of the Associate Executive Director: Among the duties of Finance and Operations 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 increase by $131,850 or 35% when compared with the 1996 budget. This reflects the inclusion of a Business Planning and Management position and related activities within the cost center. This Department emerged from the 1994 organizational restructure and was intended to focus its efforts on business planning, including assessment and development of new revenue-generating activities. Cost-cutting measures necessitated that compensation, travel and other expenditures be deleted from the proposed 1996 budget. In recognition of its potential contribution to the Association, funding of this activity is included in the 1997 budget.

Projected revenues of $510,000 represent investment earnings on cash flow within the operating account. This revenue stream has been increased by $110,000 or 28% over 1996 based upon higher returns on short-term securities. Actual results may vary depending upon the timing of cash receipts and the prevailing interest rates during the year.

Accounting Department: The Accounting Department is responsible for processing payables, receivables, payroll, cash disbursements and receipts as well as fixed asset management, inventory controls, and general ledger reporting. Employees 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 investment of all funds. Additionally, the

Department prepares the financial statements for the Association and its subsidiary and affiliated operations.

Miscellaneous income of $25,000 is derived from a charge back of accounting services to the Relief and Endowment Funds and remains unchanged from the current year. Expenditures are expected to increase by 3% or $35,900 in 1997 in comparison with 1996. The increase primarily relates to consulting costs anticipated for an indirect cost study to revise the allocation of administrative charges to related entities and government research agreements. Such a study has not been conducted for several years.

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 Associate Executive Director, Finance and Operations. 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, it is intended that this activity will offer recommendations for improving the effectiveness of Association operations. Projected costs of $91,500 for the internal audit function in 1997 are 1% lower than the 1996 budget.

Human Resources: The Department of Human Resources budget for 1997 reflects a slight decrease in the number of staff recognition awards for long-term service and staff development expenses in 1997, with expenses for recruiting increasing slightly along with some inflationary increases, and no additional programs or benefits offered to staff.

Central Services: Central Services is an administrative support agency for other departments within the organization. The purchasing area provides the link between the Association and its suppliers, seeking cost efficiencies through volume discounts, competitive bidding, aggressive negotiations and progressive buying practices. The 1997 projected costs for Central Services as a whole are down 3% or $3,700 over the current year.

Duplicating Department: Duplicating is an administrative support agency for other departments within the Association providing copies and in-house printing services including color press, collating and binding, which result in net expenditure reductions averaging over 50% from outside print vendors. The 1997 projected costs for this department are up less than 1%, reflecting a nominal increase in the cost of supplies.

Mailroom Operations: Mailroom operations is an administrative support agency for other departments in the Association providing mail services, including sorting, distribution, processing, packaging, receiving, office supply distribution, records retention management, relocation for Annual Session and special automated processing for folding, inserting and labeling of membership material. The main objectives in providing centralized services are achieving maximum allowable postal discounts through familiarization with postal guidelines, and reducing overall Association staff labor hours and outside costs through automated document processing. The 1997 projected costs for Mailroom operations are down 33% or $165,350, reflecting the reduction of six employees resulting from increased automation and the outsourcing of Salable Materials order processing and fulfillment to enhance member service.

Finance and Operations—Divisional Summary Worksheet

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Investment Income	$ 544,726	400,000	510,000	28%
Miscellaneous Income	427,649	519,000	475,000	(8%)
TOTAL REVENUES	$ 972,375	919,000	985,000	7%

Finance and Operations—Divisional Summary Worksheet (continued)

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
EXPENSES				
Staff Compensation	$ 2,888,389	3,124,800	3,027,150	(3%)
Meeting/Travel Expenses	63,971	81,550	76,100	(7%)
Office Expenses	124,523	138,400	117,250	(15%)
Professional Services	104,974	107,500	166,000	54%
Publication and Project	164,545	206,500	207,200	<1%
Other Expenses	434,150	444,000	446,250	1%
TOTAL EXPENSES	3,780,552	4,102,750	4,039,950	(2%)
NET REVENUE/(EXPENSE)	(2,808,177)	(3,183,750)	(3,054,950)	(4%)
DEPARTMENTS				
REVENUES				
Office of AED/Finance	544,726	400,000	510,000	28%
Accounting Department	24,998	25,000	25,000	0%
Council on Insurance	396,081	493,000	449,000	(9%)
Central Services	6,570	1,000	1,000	0%
TOTAL REVENUES	972,375	919,000	985,000	7%
EXPENSES				
Office of AED/Finance	346,729	374,200	506,050	35%
Accounting Department	1,189,497	1,312,900	1,348,800	3%
Council on Insurance	396,081	503,900	449,000	(11%)
Internal Audit	85,560	92,400	91,500	(1%)
Human Resources	964,610	953,450	947,100	(1%)
Central Services	124,801	143,600	139,900	(3%)
Duplicating Department	198,045	219,400	220,050	<1%
Mailroom Operations	475,229	502,900	337,550	(33%)
TOTAL EXPENSES	3,780,552	4,102,750	4,039,950	(2%)
NET REVENUE/(EXPENSE)	$(2,808,177)	(3,183,750)	(3,054,950)	(4%)

Association Headquarters Building

This budget reflects the costs for maintaining the Headquarters Building in a manner that provides an efficient workplace for Association staff and will attract tenants to the facility. Expenses of $3,749,000 include 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 decreased by 7% for 1997 as a result of anticipated savings in utilities, cleaning and maintenance costs. Rentals and other miscellaneous building income of $2,494,150 are estimated to be approximately 4% or $113,850 below budgeted revenues for 1996. This reflects tenant vacancies on the 8th floor of the building in anticipation of its demolition and abatement.

Promotions and contacts with outside brokers are part of a continuing effort to attract additional tenants to the property. 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.

Association Headquarters Building—Summary Worksheet

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Rental Income	$ 2,252,769	2,578,000	2,490,400	(3%)
Miscellaneous Income	32,048	30,000	3,750	(88%)
TOTAL REVENUES	2,284,817	2,608,000	2,494,150	(4%)
EXPENSES				
Staff Compensation	352,282	387,100	354,000	(9%)
Facility and Utility Costs	3,026,416	3,388,600	3,093,800	(9%)
Office Expenses	113,813	126,200	113,400	(10%)
Professional Services	47,176	67,300	66,800	(1%)
Publication and Project	16,140	25,500	25,500	0%
Other Expenses	28,626	42,500	95,500	>100%
TOTAL EXPENSES	3,584,453	4,037,200	3,749,000	(7%)
NET REVENUE/(EXPENSE)	(1,299,636)	(1,429,200)	(1,254,850)	(12%)
DEPARTMENTS				
REVENUES				
Headquarters Building	2,284,817	2,608,000	2,494,150	(4%)
TOTAL REVENUES	2,284,817	2,608,000	2,494,150	(4%)
EXPENSES				
Headquarters Building	3,584,453	4,037,200	3,749,000	(7%)
TOTAL EXPENSES	3,584,453	4,037,200	3,749,000	(7%)
NET REVENUE/(EXPENSE)	$(1,299,636)	(1,429,200)	(1,254,850)	(12%)

Salable Materials

Salable Materials is projecting revenue of $4,366,200 in 1997 which represents an 8% increase over the current year.

In August 1996, Salable Materials order processing and fulfillment was outsourced to a vendor in St. Charles, IL. Consequently, the 1997 budget reflects reductions in staffing and customer service related expenses. The in-house cost reductions are offset by an increase in outside service expense. Outsourcing of this area will provide improved telephone support to members, faster turnaround on orders and tighter inventory controls. In addition, costs to the ADA will be determined on a per order basis, thus only paying for services used rather then incurring the costly overhead of maintaining a fully staffed department during slow order periods.

The 1997 catalog will be mailed several weeks prior to the 1996 annual session. It offers 325 items of which 33 are new and 27 are revisions of existing products. Patient education materials continue to be well received by the membership and represent over $1 million in annual sales. The following top performing brochures have been revised for the upcoming catalog: *Periodontal Diseases; Basic Brushing; Basic Flossing; Why Do I Need a Crown?*; and *Why Do I Need a Bridge?*

In addition several new patient education brochures will be introduced including: *Ask Your Dentist About White Fillings; Why Are Baby Teeth Important?; Dental Lasers; Do You Have a Cracked Tooth?; Mouth Sores*; and *Smile Power for Smart Kids.*

The Department will continue to focus on providing members with relevant practice management and marketing materials. In that regard, the *Practice Management Series* will display an updated look and two new marketing books will be offered; *How to Increase Referrals* and *Sample Articles for Patient Newsletters*. Also a new marketing video, "How to Market Your Practice," is in development.

Finally, to address requests for school and community presentation products, a speakers flip chart will be available for purchase in conjunction with a new school teaching guide.

Salable Materials—Summary Worksheet

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Sales Income	$ 5,298,711	4,030,900	4,355,700	8%
Miscellaneous Income	5,704	10,500	10,500	0%
TOTAL REVENUES	5,304,415	4,041,400	4,366,200	8%
EXPENSES				
Staff Compensation	696,887	805,900	517,100	(36%)
Meeting/Travel Expenses	52,312	59,900	60,800	2%
Office Expenses	103,877	106,600	27,350	(74%)
Professional Services	15,344	67,000	575,000	>100%
Publication and Project	1,944,450	1,799,800	1,933,550	7%
Other Expenses	129,270	91,200	65,000	(29%)
TOTAL EXPENSES	2,942,140	2,930,400	3,178,800	8%
NET REVENUE/(EXPENSE)	2,362,275	1,111,000	1,187,400	7%
DEPARTMENTS				
REVENUES				
Salable Materials	5,304,415	4,041,400	4,366,200	8%
TOTAL REVENUES	5,304,415	4,041,000	4,366,200	8%
EXPENSES				
Salable Materials	2,942,140	2,930,400	3,178,800	8%
TOTAL EXPENSES	2,942,140	2,930,400	3,178,800	8%
NET REVENUE/(EXPENSE)	$ 2,362,275	1,111,000	1,187,400	7%

Survey Center

The Survey Center's 1997 budget reflects costs associated with managing the department providing survey research Association-wide. Ongoing House of Delegates mandated research projects include the *Survey of Dental Practice, Distribution of Dentists,* and the *Survey of Recent Dental Graduates*. The *Quarterly Survey of Dental Practice*, a panel survey of private practitioners and surveys conducted for the Division of Dental Education and the Commission on Dental Accreditation including the *Survey of Predoctoral Educational Programs, Survey of Allied Educational Programs,* and the *Survey of Advanced Dental Educational Programs* are also ongoing.

New in 1997 are the periodic House of Delegates mandated *Survey of Dental Fees* (to update 1995 data) and the periodic *Survey of Current Issues in Dentistry,* an Association-wide mechanism for collecting needed information for program and policy planning.

Other Association initiatives, such as the annual *Survey of Constituent and Component Dental Societies* and the Division of Communication's Opinion Poll will be conducted. Increased marketing efforts, as well as the increased use of the ADA's Web page to promote the availability of information collected from surveys offered for sale, should contribute to a modest increase in revenues.

Survey Center—Summary Worksheet

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Miscellaneous Income	$ 88,642	89,500	90,000	1%
TOTAL REVENUES	88,642	89,500	90,000	1%
EXPENSES				
Staff Compensation	609,767	787,300	789,300	<1%
Meeting/Travel Expense	8,756	20,500	10,900	(47%)
Office Expense	49,804	123,200	128,450	4%
Professional Services	709,526	550,000	633,350	15%
Publication and Project	71,338	111,000	119,350	8%
Other Expenses	3,604	5,600	2,600	(54%)
TOTAL EXPENSES	1,449,795	1,597,600	1,683,950	5%
NET REVENUE/(EXPENSE)	(1,361,153)	(1,508,100)	(1,593,950)	6%
DEPARTMENTS				
REVENUES				
Survey Center	88,642	89,500	90,000	1%
TOTAL REVENUES	88,642	89,500	90,000	1%
EXPENSES				
Survey Center	1,449,795	1,597,600	1,683,950	5%
TOTAL EXPENSES	1,449,795	1,597,600	1,683,950	5%
NET REVENUE/(EXPENSE)	$(1,361,153)	(1,508,100)	(1,593,950)	6%

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 Association membership dues, royalty income, retiree fringe benefits, depreciation on furniture and equipment, grants and the like.

For 1997 the expense budget is $3,114,000 compared with $3,092,500 for 1996. Revenues are expected to increase from $33,048,500 to $33,057,000 primarily resulting from an increase of royalty income offset by the elimination of the Major Medical Surplus which was a one-time occurrence in 1996. Please note that expected dividends from the for-profit subsidiaries of $1,325,000 in 1997 and $1,364,000 in 1996 are not included in the Division of Central Administration revenue, but are reflected as "below the line" items on the Association's overall budget summary.

The following explains each account used in this budget and any significant variances from 1996.

Central Administration Revenue—Divisional Summary Worksheet

	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Membership Dues	$29,650,468	31,083,400	31,362,100	1%
Dues for Capital Improvement Program	5,930,094	5,864,700	-	(100%)
Transfer of Dues	(5,930,094)	(5,864,700)	-	(100%)
Dues Rebate	(145,097)	(155,000)	(145,000)	(6%)
ASDA Coupons	(48,000)	(31,000)	-	(100%)
Equipment Leasing Income	15,000	-	-	-
Overhead Income	693,013	750,000	650,000	13%
Interest Income	10,675	-	-	-
Royalties	1,597,932	651,100	1,139,900	75%
Major Medical Surplus	-	700,000	-	(100%)
Miscellaneous Income	45,435	50,000	50,000	0%
TOTAL REVENUES	$31,819,426	33,048,500	33,057,000	<1%

Revenue

Membership Dues: Since member dues are the result of all activities of the Association they are recorded in this cost center. This category of income is not expected to change materially in 1997. The temporary $55 dues increase for the Capital Improvement Program Resolution 110H-1992 (*Trans.*1992:587) expires at the end of 1996. Previously, these dues were budgeted in Central Administration and transferred out of the general Fund to the Capital Improvement Program 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 levels, this rebate is expected to decrease from $155,000 to $145,000 in 1997.

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. There is no budget in 1997 for this activity because this program expires in 1996.

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. In 1997 this is estimated to be $650,000, which is $100,000 less than the 1996 budget, reflecting continuing government challenges to the reimbursement rates.

Royalty Income: The ADA earns royalties from financial arrangements with various third parties. For 1997, royalty income is projected to increase by $488,800. This growth in revenue is attributable to the member financial services program in conjunction with Mellon Bank and ADA Financial Services Co. which is expected to demonstrate increased activity in 1997. The composition of royalty income is outlined below.

- *Credit Card and Other Financial Services Revenue.* Affinity card and related product earnings under the relationship with Mellon Bank are expected to generate $1,047,900 of revenue in 1997, compared with 1996 budgeted income of $526,100.
- *Hertz Royalty Revenue.* Based on members' utilization of the Hertz rental program in 1995, projected revenue for 1997 has been reduced to $57,000 from a 1996 budgeted level of $72,000.
- *Lease Program Royalty.* Royalty income of $35,000 is projected in 1997 from the AT&T equipment leasing program versus the 1996 budget of $53,000. The decline in revenue is predicated on 1995 experience.

Excess Major Medical Insurance Plan Surplus: The Excess Major Medical Plan, underwritten by the Great-West Life Assurance Company, was implemented in January 1975 in accordance with Resolution B-117-1973 (*Trans.*1973:556) and was intended to offer protection against catastrophic medical care expenses. However, after the Plan's inception, insurance products were developed which offered coverage for catastrophic as well as routine medical expenses, thus rendering stand-alone excess major medical coverage unnecessary for most dentists. Acting upon the recommendation of the Council on Insurance, the Board of Trustees adopted Resolution B-37-1983 (*Trans.*1983:467) calling for termination effective July 1, 1985.

With the passage of time, it became apparent that the Plan's reserves were more than enough to pay all outstanding claims and surplus funds would be available. Accordingly, a protocol was accepted by the Council on Insurance to allow former participants in the Excess Major Medical Plan to claim a share of these funds, with unclaimed amounts to be distributed to the Association. Notices were published in two consecutive issues of the *ADA News* in July and August 1992

to alert members who participated in the Plan that they were eligible to claim a share of the surplus during a 90-day period.

Of the unclaimed money, $2.5 million was distributed to the Association to be used for the benefit of the entire membership, as determined by the Board of Trustees. The balance of the surplus was to be retained by Great-West Life and paid in March of 1996 when all claims and any other liabilities had been determined. These residual monies of $700,000 are shown as revenue only for 1996.

Miscellaneous Income: This category 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 1997.

Expenses

Expenses in Central Administration are largely compensation related. Other costs pertain to program activities within the Association, depreciation of Association assets, as well as grants to various related organizations.

Central Administration Expenses—Divisional Summary Worksheet

	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
EXPENSES—COMPENSATION				
Salaries	$ 439	(336,100)	(640,000)	90%
Payroll Taxes	4,778	(25,900)	(56,000)	>100%
Fringe Benefits	6,663	(58,100)	(112,000)	93%
Compensation Increase	-	-	1,000,000	100%
Chargeback—Taxes and Benefits	(4,250,221)	(5,239,200)	(5,698,300)	9%
FICA Payroll Tax	1,376,159	1,327,600	1,364,400	3%
SUI Payroll Tax	109,927	123,500	122,100	(1%)
FUI Payroll Tax	23,478	23,500	20,550	(13%)
Pension Fund	1,390,757	2,250,000	2,435,000	8%
Life Insurance	180,819	209,000	189,000	(10%)
Group Medical Cost	1,410,285	1,662,500	1,678,000	1%
Dental Insurance Cost	324,547	337,200	344,000	2%
401(k)	91,888	112,600	204,500	82%
Agency Compensation Adjustment	212,514	262,000	262,000	0%
TOTAL COMPENSATION	882,033	648,600	1,113,250	72%
EXPENSES—PROGRAM/ACTIVITY				
Volunteer Travel	-	-	(161,000)	(100%)
Staff Transportation	-	-	(107,000)	(100%)
Staff Lodging	-	-	(164,500)	(100%)
Volunteer Lodging	-	-	(67,500)	(100%)
Telephone	61,601	100,000	100,000	0%
Repairs/Maintenance	58,889	92,500	75,000	(19%)
Stationery and Supplies	5,873	-	5,000	100%
Outside Services	10,044	24,000	15,000	(38%)
General Insurance	274,320	326,300	326,300	0%
Office and Storage Rental	2,035	2,500	2,500	0%
Contract Fee—ADAPCO	760,000	760,000	760,000	0%
Miscellaneous Professional Fees	22,799	48,000	45,000	(6%)
Hillenbrand Fellowship	17,000	17,000	-	(100%)
National Foundation of Dentistry for the Handicapped	50,000	50,000	50,000	0%
Alliance to the ADA	20,000	20,000	20,000	0%
ASDA Delegate to Annual Session	3,400	3,500	-	(100%)
National Museum Grant	-	25,000	25,000	0%
Depreciation—Fixtures	827,207	800,000	939,300	17%
Income Taxes	24,954	20,000	20,000	0%
Overhead	(555,650)	(498,000)	(537,500)	8%
Contingent Fund	634,690	523,100	536,100	2%
Miscellaneous Expense	42,986	130,000	119,050	(8%)
TOTAL PROGRAM/ACTIVITY	2,260,148	2,443,900	2,000,750	(18%)
TOTAL EXPENSE	3,142,181	3,092,500	3,114,000	1%
NET REVENUE/(EXPENSE)	$28,677,245	29,956,000	29,943,000	(<1%)

Compensation Savings: In 1997, compensation (salaries, payroll taxes and fringe benefits) savings of $808,000 are projected as a result of normal staff turnover, which is an increase of $387,900 from the 1996 budget. Previous years' experience has allowed an increase to expected compensation savings.

Compensation Increase: A separate line was developed for staff compensation within Central Administration which provides for a $1 million increase in salary and related payroll taxes and fringe-benefit dollars, which is consistent with 1996's level. This estimate is based upon a merit increase of approximately 4%.

The apparent variance of $1 million merely reflects the presentation of this item as a component of Central Administration in 1997, whereas, upon its approval, the 1996 increase of $1 million was spread throughout all the divisions.

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. These costs are not expected to vary significantly from the 1996 budget.

Pension Fund: Projected pension expense in 1997 of $2,435,000 is $185,000 higher than allocated in the 1996 budget. Both years include $100,000 for the supplemental pension fund, with the remainder attributed to the qualified fund and the Executive Parity Plan, $2,185,000 and $150,000 respectively. 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 for 1997.

The Executive Parity Plan was created in response to the Omnibus Budget Reconciliation Act of 1993, which reduced future covered pension benefits for any employee (of for-profit and not-for-profit organizations) whose earnings exceeded $150,000. The Board decided to recompense its senior executives for this reduction in pension benefits, through establishment of this Plan. 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.

Life Insurance: It has been the policy of the Association to provide term life insurance to current employees in proportion to their salary. The cost of this benefit has decreased by $20,000 for 1997, based upon recent experience.

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 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 (*Trans.*1993:648) to modify the retiree medical plan. Based upon calculations by the Association's independent actuary, 1997 cash funding in the amount of $722,000 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 Reserve Division Restricted Investment Account to offset the anticipated liability. Overall, total group medical insurance for 1997 is projected to increase $15,500 over 1996.

Dental Insurance: The Association provides current and retired employees with dental coverage based upon a direct reimbursement plan. Expenses are expected to rise modestly in 1997.

401(k): All full-time employees may contribute to this plan which was first implemented in 1986, with the ADA matching 25 cents for each dollar invested to a maximum of $250 per year. In ten years, the rate of inflation and the cost of living have both increased, while the ADA's 401(k) match has not changed during that time which limits the potential savings of the 401(k) participant. For 1997 the match was doubled and the related budget increased to $204,500.

Agency Compensation Adjustment: These funds are to be used exclusively by the Executive Director to provide compensation increases, severance benefits and position upgrades of current employees. No increase has been budgeted for 1997.

Travel Savings: For 1997, Association-wide travel savings of $500,000 are projected. Invariably, actual travel costs incurred and trips taken do not coincide with budgeted levels due to continued competition in the airline industry, staff turnover or changing priorities. These events are difficult to estimate on a divisional basis and have resulted in favorable budget variances in the past. Therefore, this category has been created to estimate such savings projected for the Association as a whole.

Telephone Expense: Costs of the Association's outbound long distance service, its charge for local telephone service and other expenses related to the telephone usage are included in this item. The 1997 budgeted costs have not changed from the 1996 budget.

Repairs and Maintenance: This line item is for general repair and maintenance costs for Association space. Although specific expenses cannot be identified, this account provides funding for such activities. A decrease has been budgeted based upon recent favorable experience.

Stationery and Supplies: A small budget amount of $5,000 is included in this category based on past experience.

Outside Services: This account includes the cost of the Association's coffee service.

General Insurance: Protecting the Association against major insurable risks is reflected in this expense. No increase in premium is anticipated in 1997.

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 1997.

Contract Fee—ADA Publishing Co., 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 1997.

Miscellaneous Professional Fees: The fees relate to consulting services in continuing to evaluate the financial products to be made available to the membership. A modest decrease is anticipated for 1997.

National Foundation of Dentistry for the Handicapped: Funding in the amount of $50,000 is being provided for the National Foundation of Dentistry for the Handicapped in 1997, which is consistent with the 1996 level.

Alliance of the American Dental Association: Funding to the Alliance for 1997 will remain at the 1996 level of $20,000.

ASDA Delegation to ADA Annual Session: There was no request of funds for 1997.

National Museum of Dentistry Grant: The Dr. Samuel D. Harris National Museum of Dentistry in Baltimore, Maryland has been provided a $25,000 grant for 1997. This is the second year of a five-year agreement with the Museum to fund an aggregate amount of $125,000 through the year 2000. The American Dental Association will have a prominent display in the Museum.

Depreciation—Fixtures: This expense relates to depreciation for all non-building items such as desks, chairs, computers, etc. The $139,300 budgetary increase incorporates a four-year useful life of computers as opposed to a five-year schedule which was used in 1996. This revised schedule is a more accurate reflection of the changing technology environment.

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 1997, which is unchanged from 1996.

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 increase in this line item of $39,500 relates to a higher level of recovered expenses from subsidiaries.

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. In keeping with last year's approach, the 1997 contingent fund is 1% of the 1996 approved operating expense budget, a $13,000 increase from the 1996 Contingent Fund level.

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 fees. A modest decrease of $10,950 has been budgeted for 1997.

Central Administration—Divisional Summary Worksheet

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Membership Dues	$29,457,371	30,897,400	31,217,100	1%
Rental Income	15,000	-	-	-
Investment Income	10,675	-	-	-
Miscellaneous Income	2,336,380	2,151,100	1,839,900	(14%)
TOTAL REVENUES	$31,819,426	33,048,500	33,057,000	<1%

Central Administration—Divisional Summary Worksheet (continued)

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
EXPENSES				
Staff Compensation	$ 987,070	648,600	1,113,250	72%
Meeting/Travel Expenses	65,715	140,250	(500,000)	(>100%)
Office Expenses	449,877	522,500	506,300	(3%)
Professional Services	330,439	111,750	60,000	(46%)
Publication and Projected Costs	108,367	33,200	-	(100%)
Grants—Related Health Groups	90,400	121,500	95,000	(22%)
Depreciation/Amortization	827,207	800,000	939,300	17%
Other Expenses	258,152	694,700	880,150	27%
EXPENSES SUB-TOTAL	3,117,227	3,072,500	3,094,000	1%
Income Taxes	24,954	20,000	20,000	0%
TOTAL EXPENSES	3,142,181	3,092,500	3,114,000	1%
NET REVENUE/(EXPENSE)	28,677,245	29,956,000	29,943,000	(<1%)
DEPARTMENTS				
REVENUES				
Central Administration	31,819,426	33,048,500	33,057,000	<1%
TOTAL REVENUES	31,819,426	33,048,500	33,057,000	<1%
EXPENSES				
Central Administration	3,142,181	3,092,500	3,114,000	1%
TOTAL EXPENSES	3,142,181	3,092,500	3,114,000	1%
NET REVENUE/(EXPENSE)	$28,677,245	29,956,000	29,943,000	(<1%)

Information Technology

The Division of Information Technology (IT) provides cost-effective technology support to the ADA. This is done through a number of mainframe and LAN-based core systems that support all of the ADA's divisions. Additionally, IT provides telephone services, hotline support and training. These services are crucial to the ADA's revenue-generating programs such as Salable Materials, Dental Testing and the Mailing List.

The coming year (1997) will be a transition year for the Information Technology Division. It is the last year of a three-year project to modernize the ADA's technical infrastructure and core systems. In addition to replacing all of the ADA's association management tools with MEI association management software and Microsoft Office Software, the Division will be asked to support other systems such as a Web server (member/nonmember differentiation) and a new version of the Micromembership System for constituent/component dental societies, as well as be an active participant in the ADA's role in the newly defined Dental Information Network. This will assure the Association's leadership position relative to other associations and within organized dentistry. The 1997 proposed budget is $322,470 above the 1996 level.

Department of Application Reengineering (DARE): An additional staff person plus 20 trips are needed to support the Micromembership rollout to the states/constituents. This individual will be the project manager, whose focus will be on remote sites and coordination activities with other staff members working on the MEI installation. The 20 trips are being proposed to facilitate training and installation. Funds are also required to pay for hotline support and periodic updates to the new payroll/human resources software already installed. A modest amount of consulting is also anticipated.

Department of Information Technology (DIT): Connectivity to the D.C. facilities (Government Affairs and Paffenbarger Research Center) will be required to facilitate LAN access. This will allow for e-mail exchange as well as remote management capabilities. Additionally, "T1" speed access will be needed connecting local staff to the Internet. Maintenance on the newly installed file servers is needed to provide 24-hour protection against breakdowns.

Department of End User Support (EUS): The Microsoft Office suite of products will be provided to approximately 333 ADA staff members in Chicago and D.C. locations. The cost of $180 per year per user is required to ensure upgrades to Microsoft Windows, word-processing, spreadsheet, presentation, e-mail, calendaring and scheduling components. It is anticipated that at least two of these products will be upgraded by Microsoft each year. It is imperative that the Association remain current on these software products. The telephone cabling management software (proposed funding from 1997 capital budget) will enable the Association to proactively manage the phone network in the same way as it will monitor the local area network. Intermittent errors will be detected well in advance of becoming a problem.

Department of Information Technology and Strategic Planning (DITSP): The scope of the Director of IT Strategy and Planning has been broadened to include the management and implementation of the Dental Information Network (DIN). Additionally, this position will enhance the ADA's participation in the development of standards on behalf of organized dentistry. Funding is required in anticipation of the need for consulting services for the development and implementation of the DIN.

Information Technology—Divisional Summary Worksheet

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Miscellaneous Income	$ 305,048	296,000	296,000	0%
TOTAL REVENUES	305,048	296,000	296,000	0%
EXPENSES				
Staff Compensation	1,439,248	1,777,280	1,903,750	7%
Meeting/Travel Expense	15,803	23,450	46,850	100%
Office Expenses	356,133	484,000	610,900	26%
Professional Services	101,296	35,000	80,000	>100%
Publication and Project	22,654	4,200	4,200	0%
Other Expenses	2,915	2,000	2,700	35%
TOTAL EXPENSES	1,938,049	2,325,930	2,648,400	14%
NET REVENUE/(EXPENSE)	(1,633,001)	(2,029,930)	(2,352,400)	16%
DEPARTMENTS				
REVENUES				
Mailing List	305,048	296,000	296,000	0%
TOTAL REVENUES	305,048	296,000	296,000	0%
EXPENSES				
Office of AED	230,229	211,400	231,200	9%
Mailing List	48,527	83,150	85,550	3%
Department of Application Reengineering	288,209	387,800	509,800	31%
Department of Information Technology	653,442	791,180	891,400	13%
Department of Application Development	363,320	386,400	387,700	<1%
Department of End User Support	324,065	290,650	301,050	4%
Department of Information Technology Strategic Planning	30,257	175,350	241,700	38%
TOTAL EXPENSES	1,938,049	2,325,930	2,648,400	14%
NET REVENUE/(EXPENSE)	$(1,633,001)	(2,029,930)	(2,352,400)	16%

Division of Dental Practice

Office of the Associate Executive Director, Dental Practice: Transferred from this budget is funding for the Dental Economic Advisory Group. Expenses for this program are being proposed in the budget of the Health Policy Resource Center.

Council on Dental Practice: The proposed 1997 budget includes administrative and program support to develop additional resources dedicated to managed care marketplace member support materials and data collection. This is through the gathering of managed care patient research and a new "Managed Care Financial Practice Analysis" service.

Other new programs include a well-being training institute training program for counselors; a national conference on the dental team with respect to team development, employee motivation and leadership and management skills; and an expansion of the seminar services offerings in both practice management and the clinical arena.

Council on Dental Benefit Programs: The Council's 1997 budget covers administrative and program support for identified programs, including the purchaser contact program and the enhanced DR marketing promotion directed by the 1995 House of Delegates. The Council will seek outside funding for mediation training workshops at the national level.

Council on Access, Prevention and Interprofessional Relations: For the first time, the proposed 1997 budget for the Council contains four base budgets with respective decision packages for its program areas. The four base budgets reflect an administrative base plus the three focus areas: (1) health care facilities and interprofessional affairs; (2) access to oral health and community health activities; and (3) fluoridation and preventive health activities. Deleted from the 1997 budget was $20,000 for corporate dues to the Joint Commission on Accreditation of Healthcare Organizations, as this is no longer required by them.

Department of Dental Informatics: Since its establishment, the Department of Dental Informatics (DDI) has monitored efforts of the health care informatics industry and participated in standard-setting activities affecting administration and clinical applications in dentistry. The primary goals of dental informatics are to improve patient care and increase dental office administration efficiency.

The Association, through the Accredited Standards Committee MD156, has established five working groups to standardize clinical information systems to promote the concept of a computerized clinical work station that allows components to be integrated into one system. Technical reports, guidelines and standards for computerized work stations used in dental practice are being written by the groups.

In addition, the Dental Informatics budget supports the activities of the Council on Dental Benefit Programs' Advisory Committee on Dental Electronic Nomenclature, Indexing and Classification (ACODENIC). The Advisory Committee is developing dental vocabulary to be used in an electronic environment. Expenses for the 1997 base budget and decision packages include resources to meet these Association objectives.

Health Policy Resource Center: This department is currently listed with the Division of Dental Practice awaiting reorganization. The Health Policy Resource Center includes staffing for the director, a manager and a secretary. Responsibilities consist of gathering and collating data on health systems to meet the needs of the Association. This department will also have oversight responsibility for the Dental Economic Advisory Group as well as the Survey Center's research initiatives.

Dental Practice—Divisional Summary Worksheet

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Sales Income	$ -	-	15,000	100%
Grants and Contributions	123,096	70,000	193,700	>100%
Registration Income	379,171	442,750	483,775	9%
Miscellaneous Income	2,896	11,000	33,000	>100%
TOTAL REVENUES	$505,163	523,750	725,475	39%

Dental Practice—Divisional Summary Worksheet (continued)

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
EXPENSES				
Staff Compensation	$1,889,853	2,210,300	2,223,600	1%
Meeting/Travel Expenses	712,360	966,080	802,200	(17%)
Office Expenses	109,155	143,000	137,000	(4%)
Professional Services	225,756	1,016,300	294,200	(71%)
Publication and Project	564,146	954,500	1,058,350	11%
Other Expenses	80,558	51,200	32,600	(36%)
TOTAL EXPENSES	3,581,828	5,341,380	4,547,950	(15%)
NET REVENUE/(EXPENSE)	(3,076,665)	(4,817,630)	(3,822,475)	(21%)
DEPARTMENTS				
REVENUES				
Council on Dental Practice—Administration	19,455	133,750	246,175	84%
Council on Dental Practice—Dental Marketing	-	5,000	7,000	40%
Council on Dental Practice—Seminars	342,576	362,000	323,600	(11%)
SUCCESS Seminars	111,096	-	120,000	100%
Council on Dental Benefit Programs	14,751	-	-	-
Code on Dental Procedures and Third Party Issues	18,754	-	28,700	100%
Purchaser Information Service	(484)	3,000	-	(100%)
CAPIR—Access and Community Affairs	-	20,000	-	(100%)
Department of Dental Informatics	(985)	-	-	-
TOTAL REVENUES	505,163	523,750	725,475	39%
EXPENSES				
Office of AED/Dental Practice	263,866	323,050	285,300	(12%)
Implications of Managed Care	284,285	-	-	-
Council on Dental Practice—Administration	552,493	666,700	777,700	17%
Council on Dental Practice—Dental Marketing	141,157	232,950	156,050	(33%)
Council on Dental Practice—Seminars	335,567	358,250	374,100	4%
SUCCESS Seminars	112,162	-	120,000	100%
Council on Dental Benefit Programs	318,900	309,000	285,750	(8%)
Code on Dental Procedures and Third Party Issues	235,093	249,530	254,050	2%
Purchaser Information Service	343,559	1,973,300	967,950	(51%)
Office of Quality Assessment	161,648	192,350	152,000	(21%)
CAPIR—Administration	514,481	247,150	286,750	16%
CAPIR—Fluoridation	46,529	156,800	135,050	(14%)
CAPIR—Interprofessional Relations	54,532	153,550	123,550	(20%)
CAPIR—Access and Community Affairs	4,037	148,950	115,950	(22%)
Department of Dental Informatics	213,519	223,050	298,700	34%
Health Policy Resource Center	-	106,750	215,050	>100%
TOTAL EXPENSES	3,581,828	5,341,380	4,547,950	(15%)
NET REVENUE/(EXPENSE)	$(3,076,665)	(4,817,630)	(3,822,475)	(21%)

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 ADA Health Foundation.

As a result of a realignment of duties of this office in 1995, the 1996 and subsequent years' budgets have been eliminated.

Education and Science—Summary Worksheet

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
EXPENSES				
Staff Compensation	$116,647	-	-	-
Meeting/Travel Expenses	4,109	-	-	-
Office Expenses	626	-	-	-
Publication and Project	201	-	-	-
Other Expenses	6,473	-	-	-
TOTAL EXPENSES	128,056	-	-	-
NET REVENUE/(EXPENSE)	(128,056)	-	-	-
DEPARTMENTS				
EXPENSES				
Education and Science	128,056	-	-	-
TOTAL EXPENSES	128,056	-	-	-
NET REVENUE/(EXPENSE)	$(128,056)	-	-	-

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) and the Dental Admission Testing Program (DAT).

The 1997 budget projects an increase in revenue of $1,278,950, primarily from testing fees, CERP fees, and anticipated increases in accreditation fees.

In 1997, the Commission on Dental Accreditation will be in its third year of charging fees to all of its accredited programs. A financial assessment of accredited programs began in 1995, based on achieving approximately 15% of the Commission's budget from this assessment. As a result, the Association has provided approximately 85% of the total direct costs of conducting accreditation activities during 1995 and 1996.

With the 1997 budget, the Board again considered its level of financial support for dental accreditation. The proposed 1997 budget includes funding for the Commission on Dental Accreditation at a level of 65% of direct costs, and anticipates that the Commission will increase its own revenue to the 35% funding level.

Testing fee income is higher due to an increase in the number of candidates taking the various examinations, and increased CERP revenues are anticipated as more providers of continuing dental education apply for recognition.

The 1997 budget projects an increase in expenses of $466,150, primarily due to increased costs related to activities of the National Board Dental Examinations and Admission Testing programs. The 1997 budget projects increases in revenues of 23% and 41% in the areas of National Board Dental Examinations and Admission Testing, respectively.

New activities proposed for 1997 include the establishment of a Research and Development committee related to National Board Examination activities, administration of the computer-based Dental Admission Test, development of a pilot admission test for dental hygiene programs and completion of a validation study for its use in the admission process, and the administration of a pilot case-based examination for the National Board Dental Hygiene Examination. In addition, new activities proposed are the revision of allied dental education accreditation standards, continued monitoring of compliance with the Guidelines for Valid and Reliable Dental Licensure Clinical Examinations, working with state dental boards and testing agencies to develop alternative methods for conducting initial clinical licensure examinations, and continuation of the library automation project.

Education—Divisional Summary Worksheet

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Sales Income	$ 200	800	3,000	>100%
Testing Fee Income	3,296,271	3,169,400	4,167,350	31%
Registration Income	84,710	110,000	128,000	16%
Miscellaneous Income	378,482	375,800	636,600	69%
TOTAL REVENUES	3,759,663	3,656,000	4,934,950	35%
EXPENSES				
Staff Compensation	3,030,378	3,327,200	3,380,950	2%
Meeting/Travel Expenses	891,336	1,037,900	1,366,050	32%
Office Expenses	173,006	193,100	184,600	(4%)
Professional Services	315,636	289,200	336,800	16%
Publication and Project	581,468	580,000	610,300	5%
Grants—Related Health Groups	79,544	70,900	77,600	9%
Other Expenses	78,427	72,500	80,650	11%
TOTAL EXPENSES	5,149,795	5,570,800	6,036,950	8%
NET REVENUE/(EXPENSE)	(1,390,132)	(1,914,800)	(1,102,000)	(42%)
DEPARTMENTS				
REVENUES				
Council on Dental Education	89,805	126,000	134,400	7%
Commission on Dental Accreditation	261,760	268,500	539,950	>100%
National Board Dental Examinations	1,887,647	1,784,800	2,194,600	23%
Admission Tests	1,467,648	1,423,900	2,011,000	41%
Career Guidance	21	-	-	-
Library Services	52,782	52,800	55,000	4%
TOTAL REVENUES	3,759,663	3,656,000	4,934,950	35%
EXPENSES				
Office of AED/Education	290,084	320,150	320,450	<1%
Council on Dental Education	538,958	518,350	525,050	1%
Commission on Dental Accreditation	1,317,153	1,578,950	1,542,750	(2%)
National Board Dental Examinations	1,377,923	1,382,450	1,578,200	14%
Admission Tests	833,930	896,200	1,195,400	33%
Career Guidance	102,913	-	-	-
Library Services	688,834	874,700	875,100	<1%
TOTAL EXPENSES	5,149,795	5,570,800	6,036,950	8%
NET REVENUE/(EXPENSE)	$(1,390,132)	(1,914,800)	(1,102,000)	(42%)

Division of Science

The Division of Science addresses critical issues and conducts research through the Council on Scientific Affairs (CSA). The Division has an expense budget of $1,958,450 for 1997, with projected revenue of $415,000, primarily from the submission and maintenance fees established for the Council's Seal Program.

The 1995 budgeted amount for the Council's Seal Program was based on a 1994 report to the Board prepared by the Revenue Neutral Seal Program Task Force. This report attempted to present a fee system that would recover the direct costs and a portion of the indirect costs of running the Seal Program. The new fee system was based on the number of products in the Seal Program at the end of 1993, the rates of new submissions in 1993, and that all companies in the program in 1993 would remain in the program. A more realistic revenue estimation has been projected for the 1997 budget.

The CSA addresses research issues of importance to the practicing dentist and the profession through the Research Agenda. The Research Agenda was developed by the CSA and approved by the Board of Trustees. This agenda enumerates specific procedures for enhancing the process by which science is transferred into clinical application. The Association uses the Research Agenda to facilitate the national dental research effort, including promotion of adequate funding for the research, research training and science transfer programs conducted by the ADA Health Foundation and other national foundations or institutions which support or conduct research related to the oral health sciences.

The Council continually reviews issues of patient and provider safety, including governmental alerts and ethical/legal topics; health services research; including social behavioral issues; and treatment-oriented research of immediate and emerging importance in the management of oral diseases. This includes the evaluation of dental products, the development of standards and guidelines for product evaluation, and the development of Association policy relating to controversial issues facing the dental profession (e.g., infectious diseases and infection control, safety of dental materials, dental wastewater, etc.)

Science—Divisional Summary Worksheet

NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Miscellaneous Income	$ 218,240	920,600	415,000	(55%)
TOTAL REVENUES	218,240	920,600	415,000	(55%)
EXPENSES				
Staff Compensation	1,256,586	1,505,800	1,635,600	9%
Meeting/Travel Expenses	111,588	127,450	176,350	38%
Office Expenses	59,647	55,300	70,300	27%
Professional Services	6,794	17,200	15,300	(11%)
Publication and Project	43,587	24,000	26,000	8%
Grants—Related Health Groups	5,000	6,000	6,000	-
Other Expenses	19,911	23,600	28,900	22%
TOTAL EXPENSES	1,503,113	1,759,350	1,958,450	11%
NET REVENUE/(EXPENSE)	(1,284,873)	(838,750)	(1,543,450)	84%
DEPARTMENTS				
REVENUES				
Office of AED/Science	40	-	14,000	100%
Council on Scientific Affairs	218,200	920,600	401,000	(56%)
TOTAL REVENUES	218,240	920,600	415,000	(55%)
EXPENSES				
Office of AED/Science	342,250	430,550	510,850	19%
Council on Scientific Affairs	1,160,863	1,328,800	1,447,600	9%
TOTAL EXPENSES	1,503,113	1,759,350	1,958,450	11%
NET REVENUE/(EXPENSE)	$(1,284,873)	(838,750)	(1,543,450)	84%

American Dental Association Health Foundation

The American Dental Association Health Foundation includes three administrative components. The Office of Development and Sponsored Research and the Research Institute are located in Chicago, Illinois, at the Headquarters Office. The Paffenbarger Research Center (PRC) is located in Gaithersburg, Maryland, within the National Institute of Standards and Technology facility. As a 501(c)(3) tax-exempt corporation, the Foundation solicits financial support, sponsors and/or conducts dental research, education, access and other worthy charitable projects.

In addition to conducting the solicitation activities of the Foundation, the Office of Development and Sponsored Research manages grant requests directed to the Foundation's Board of Directors, the legal requirements necessary to sustain Foundation patents, and provides administrative support to the Research Institute and Paffenbarger Research Center. As the administrative support component of the Foundation, the Office of Development and Sponsored Research facilitates the meetings and activities of the Foundation's oversight body, the Health Foundation Board of Directors.

The Institute's current scientific research activities include studies in the following areas: amalgam in wastewater, cariostatic effects of different fluoride compounds, ceramic restorative materials, oxide formation on porcelain-metal systems and the metabolic profiles of local anesthetics. The Institute's activities also include the review of bleaching agents, fluoride dentifrices and standards for evaluating dental materials. Through its research activities, the Institute is able to provide data enabling the profession to establish policy positions based upon scientifically sound research results.

In 1997, the Institute will initiate an extensive review of current data regarding dental epidemiology. This activity will include a literature review of scientific data and the gathering of additional data elements to provide a better insight in several areas of research of importance to the practicing dentist.

The Paffenbarger Research Center is comprised of four components: Dental Chemistry, Clinical Research, Polymer Chemistry and Dental Crystallography. Current research activities being conducted at the PRC include: micro equipment fabrication, calcium phosphate cements, remineralization and acid calcium phosphate fluoride treatments. Results of PRC research are disseminated through presentations to dental groups and publications in journals.

American Dental Association Health Foundation—Divisional Summary Worksheet

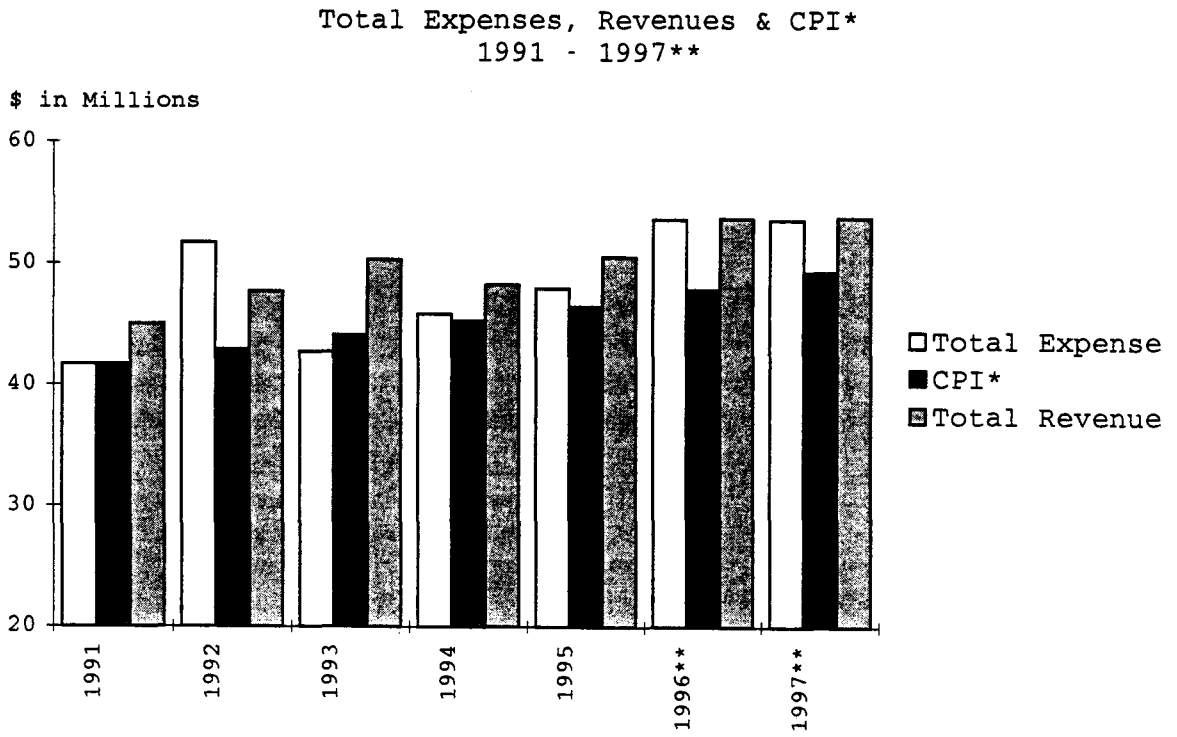
NATURAL ACCOUNTS	1995 ACTUAL	1996 BUDGET	1997 BUDGET	PERCENT VARIANCE
REVENUES				
Grants and Contributions	$ -	16,300	-	(100%)
Miscellaneous Income	-	115,000	125,000	9%
TOTAL REVENUES	-	131,300	125,000	(5%)
EXPENSES				
Grants—Related Health Groups	2,170,435	2,551,950	2,707,800	6%
TOTAL EXPENSES	2,170,435	2,551,950	2,707,800	6%
NET REVENUE/(EXPENSE)	(2,170,435)	(2,420,650)	(2,582,800)	7%
DEPARTMENTS				
REVENUES				
ADAHF Office of Sponsored Research	-	115,000	125,000	9%
Paffenbarger Research Center	-	16,300	-	(100%)
TOTAL REVENUES	-	131,300	125,000	(5%)
EXPENSES				
ADAHF Development Office	506,028	334,850	298,400	(11%)
ADAHF Office of Sponsored Research	-	230,300	249,900	9%
Research	251,652	339,050	458,000	35%
Research—Toxicology	255,640	266,650	320,250	20%
Research—Chemistry	252,927	255,500	308,900	21%
Paffenbarger Research Center	904,188	1,125,600	1,072,350	(5%)
TOTAL EXPENSES	2,170,435	2,551,950	2,707,800	6%
NET REVENUE/(EXPENSE)	$(2,170,435)	(2,420,650)	(2,582,800)	7%

Consumer Price Index

The preparation of the following chart was directed by the House of Delegates Resolution 87H-1983 (*Trans.*1983:573). Its original purpose was to provide a comparison 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 1991 expenses to facilitate comparison.
** Projected (assuming 3.0% 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 gives 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 1995, reserves totaled $27,377,138. It should be noted that $4,328,051 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.

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

	December 31	
	1995	1994
Operating Division Investment Account	$ 4,169,398	3,964,247
Restricted Investment Account*	18,879,689	14,569,169
Capital Formation Account	4,328,051	4,973,952
Total Reserves	$27,377,138	23,507,368

* The Restricted Investment Account balance as of December 31, 1994 includes a $3,500,000 loan and interest earned thereon, to the Capital Improvement Program for asbestos removal and renovation of the Headquarters Building. This loan and accrued interest was repaid by the Capital Improvement Account in May 1995.

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

Operating Division Investment Account. The Operating Division Investment Account earned $205,151 in investment income, for a 5.04% average rate of return in 1995.

Capital Formation Account. The Capital Formation Account, which holds the investments in the Association's subsidiary operations, demonstrated a net loss of $645,901 in 1995. The Association's for-profit subsidiaries generated a 1995 net loss of $41,389 largely attributable to the operations of ADA Financial Services Company, Inc., which is phasing in its product offerings for marketing and administrative purposes, as well as decreased earnings of ADA Publishing Co., Inc. During 1995, $700,000 of dividends were declared to the Operating Account. Additionally, the American Dental Real Estate Corporation (ADREC) experienced a $604,513 loss, increasing its accumulated deficit to $4,169,635.

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	
	1995	1994
Land in Washington, D.C.	$3,030,000	3,030,000
Investment in ADREC	(1,453,102)	(1,142,999)
Investment in ADA Holding Company, Inc. and Subsidiaries	936,558	1,677,947
Dividend Receivable	700,000	400,000
Due from Operating Division Operating Account	1,114,595	1,009,004
	$4,328,051	4,973,952

Reserve Division Restricted Investment Account. Several transactions affected the Reserve Division Restricted Investment Account during 1995 as summarized below.

Balance, December 31, 1994	$14,569,169
Investment Income Net of Management Fees	2,439,474
Additions:	
1994 Surplus Transfer	1,871,046
1994 and 1995 funding for Executive Parity Plan	105,042
Partial 1995 funding for Retiree Medical Plan liability	325,000
Liabilities:	
Liability for Executive Parity Plan	(105,042)
Liability for Retiree Medical Plan	(325,000)
Balance, December 31, 1995	$18,879,689

Investments in this account are currently allocated among mutual funds and managers with differing investment strategies. This approach diversifies the overall portfolio and distributes the risk. The average return on these monies in 1995 was 17.49%.

Subsequent to the 1994 audit, the Board of Trustees adopted Resolution B-57-1995 (*Trans.*1995:505) authorizing the transfer of $1,871,046 in surplus funds to the Reserve Division Restricted Investment Account.

The Board of Trustees approved awards under the Executive Parity Plan of $105,042, covering 1994 and 1995, for transfer to the Reserve Division Restricted Investment Account. The liability for future payments to recipients which would occur upon vesting is segregated for recordkeeping purposes as a commitment against reserves.

An accounting rule change requires the recognition of a liability for expected future retiree medical benefits based on actuarial calculations. During 1995, $325,000 was transferred to the Reserve Division Restricted Investment Account as partial funding to offset this anticipated obligation.

In addition to the above matters which resulted in increases to the Reserve Division Restricted Investment Account, several activities were authorized for funding from reserves. During 1995, those expenditures, which are described in the following section, were subsidized by the Operating Account and the annual surplus transfer to reserves was adjusted accordingly.

1995 Financial Results

The 1995 budget approved by the House of Delegates projected a funding deficit of $2,608,500. Actual results show net income after taxes of $2,624,517.

This surplus from 1995 operations resulted in a transfer of $804,289 from the ADA General Fund to the Reserve Division Restricted Investment Account in accordance with Board Resolution B-54-1996. A reconciliation of surplus funds and the amount transferred to reserves is shown below.

1995 Surplus	$2,624,517
Less:	
Funded Depreciation (already transferred)	1,000,000
Provision for ADREC cash flow loss	335,580
Provision for deferral of ADREC capital expenditures	272,939
Provision for 1995 spending on information technology project	521,824
Due from reserves— Ohio Dental Association litigation **	17,877
Due from reserves— Grassroots Campaign **	195,500
Adjustment for pension expense	389,885
Add:	
Dividends Received from ADAHC	700,000
Restore amounts due from reserves— Ohio Dental Association litigation **	17,877
Restore amounts due from reserves— Grassroots Campaign **	195,500
Available Funds for Transfer to Reserves	$ 804,289

**These expenses were initially made from the Operating Account, reducing its surplus, and were to be reimbursed by the Reserve Restricted Account. Given the 1995 surplus, reserve monies meant to support these activities will be replenished.

The above transfer recognized certain activities that were supported by the Operating Account during 1995, although ultimate funding was authorized from reserves, as follows:

- The Association has committed to funding ADREC's cash flow losses up to $1.7 million annually. After deducting interest expense and capital expenditures from operating results, ADREC experienced a cash flow loss of $335,580 in 1995. An additional $272,939 represents unspent capital appropriations for a fire-life safety system deferred into 1996 awaiting District government approval of its design.
- Reserve funds are meant to support an investment up to $5.6 million for upgrading computer capabilities to increase productivity and enhance member services. Expenditures of $521,824 were incurred in 1995 for this project.
- The Board designated reserve funds to provide financial assistance to the Ohio and Alabama Dental Associations regarding ongoing litigation. Although expenses were incurred for both activities in 1994, only the Ohio suit required spending in 1995.
- Lastly, monies were expended on the Grassroots campaign to promote the Association's health care reform policy. This program, to be funded from reserves up to $2 million, was initiated by Resolution 153H-1993 (*Trans.*1993:678) of the House of Delegates. It should be noted that grassroots initiatives to communicate the Association's message in 1997 are incorporated in the budget without reserve funding.

The surplus transfer was made with full recognition that present and prospective commitments exist for the use of these funds. Specifically, it is anticipated that such monies may be required to absorb an expected cash-flow shortfall of $1,081,700 and $1,636,600 relating to the Washington, D.C. property in 1996 and 1997, respectively, and continued investment in new computer technology.

The favorable variance of 1995 operating results to budget was principally the result of the following items. Employee compensation, taxes and benefits were $2,260,782 under budget, which is mainly attributable to open staff positions throughout the Association during 1995. These savings also reflect pension expense reported in the financial statements of $389,885 less than the required pension cash contribution upon which the budget is based. The difference in pension cost relates to the actuarial assumptions prescribed for accounting versus funding purposes. The category of meeting and travel expense exhibited a $712,927 savings against budget which was a by-product of open staff positions and favorable rates for air travel. Additionally, savings of $721,738 were realized in facility and utility costs and underspending of $679,687 occurred in publications and project expenses.

With regard to revenue, sales of educational and professional materials exceeded budget by $1,252,582 primarily driven by the success of *CDT-2*. Also contributing to the favorable variance was increased participation levels in educational testing which resulted in receipts exceeding budget by $349,971. Conversely, royalty income, primarily from the ADA Credit Card Program, fell short of the budget by $1,333,968 due to the early termination of the MBNA contract.

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 to ensure that the asbestos is 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 re-occupancy 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 the following ten floors:

- Phase 1—mezzanine, first, second and seventh floors; (completed)
- Phase 2—third floor (mechanical), fourteenth, fifteenth and sixteenth floors; and
- Phase 3—tenth and eleventh floors

At the end of Phase 3, the only tenant areas remaining to be reconstructed would be the eighth, ninth, twelfth and thirteenth floors. These floors will not be remodeled prior to the expiration of the current tenants' leases, some of which run through 1998. Asbestos remediation will begin on the eighth floor in the fall of 1996.

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 has made 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 Reserve Division Restricted Investment 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 were repaid with interest in May 1995. 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 1995 consolidated financial statements of the Association and its subsidiaries.

	December 31	
	1995	1994
Asbestos abatement	$3,169,442	2,903,860
Remodeling	7,365,827	7,116,974
	10,535,269	10,020,834
Less accumulated depreciation	(1,697,246)	(1,027,417)
	$8,838,023	8,993,417

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, fourteenth, fifteenth and sixteenth floors. Also included in these costs is demolition and asbestos removal charges and partial tenant build-out on the tenth and eleventh floors, part of the Phase 3 costs.

The program will likely extend beyond the year 2000, and require total capital expenditures projected at $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 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. In addition to segregating project monies for recordkeeping purposes, a separate brokerage account has been established to generate interest earnings.

Following is a summary of project transactions.

ADA Capital Improvement Account
Cumulative Cash Activities
As of December 31, 1995

Unaudited

Dues	$17,713,881
Loan Proceeds	3,500,000
Loan Payoff	(3,500,000)
Capital Acquisitions	(10,535,269)
Interest Expense	(337,554)
Interest Income	532,380
	7,373,438
Adjustments to reconcile to available investment balance:	
Due from/to affiliated entities	(797,903)
Accounts payable	181,280
Deferred revenue	827,446
Proceeds Available for Capital Expenditures	$ 7,584,261

As the above summary shows, cumulative collections through December 1995 of the dues increase restricted to this program total $17,713,881. This income combined with the initial $3,500,000 advance from reserves has funded project expenditures of $10,535,269 through December 31, 1995. The advance was repaid in May 1995 with accrued interest once accumulated funds became sufficient to sustain the project.

Project Outlook: The Headquarters renovation project, as initially defined, is proceeding on schedule and should be completed in the year 2000, assuming tenant leases can be negotiated for new space. While the real estate market remains depressed, the expansion of the Northwestern Hospital complex and the construction of the Museum of Contemporary Art has given higher visibility to neighboring properties and increased broker inquiries regarding rental opportunities in the Association building.

Although such interest bodes well for the future, recent discussions with prospective tenants find these companies seeking higher allowances to build-out space than initially contemplated in the budget. While these costs can be recaptured over time through escalating rental rates, it increases the initial investment of money in the space and extends the time necessary to achieve a positive cash flow from the lease.

The insidious effects of inflation on labor and material costs over the next five years adds another dimension of complexity to managing a construction project and its attendant expenses. Competitive bidding and the use of an independent project manager has proven invaluable in limiting change orders and assuring quality workmanship. Although these protocols will continue as the work progresses, more stringent safety guidelines for asbestos workers will invariably increase the cost of removing this hazardous substance.

In summary, the future holds many uncertainties that will eventually determine the commitment of funds necessary to successfully compete for tenants in the marketplace. The Association and its advisors will seek out economies and strive to keep aggregate expenses near previously budgeted levels.

Reconstructing Space Occupied By the Association: Ultimately, those portions of the building occupied by Association staff would also benefit from reconstruction. The current layout was largely predicated on office needs as defined in 1964. The advent of desk-top computers and modular furnishings offer the potential for efficiencies in space utilization and staff productivity. Towards that end, consideration is being given to retaining an architect to design a prototype floor, as well as to identify opportunities to increase rentable floors through the consolidation of Association space.

This strategy holds great promise for expanding revenue while providing an effective yet pleasing work environment for employees. Although it is premature to speculate on the expenses related to such an initiative, it is clear that construction activities of this magnitude could not be reasonably absorbed within the operating budget without a temporary dues increase or a substantial draw against Association reserves. It is envisioned that a long-range construction plan, with related costs and revenue enhancements will be presented to the 1997 House of Delegates with funding recommendations.

With the exception of perhaps the scientific area, renovation of the Association occupied space would not likely commence until 1999 or thereafter, given an already demanding construction schedule and the ongoing replacement of mechanical and other equipment necessary to provide basic services to the building.

The science area may require more immediate attention than other ADA space to accommodate a research agenda that reflects contemporary issues confronting dentistry.

More specifically, the American Dental Association has faced an unprecedented demand for scientific evaluations and studies on a variety of professional subjects. The Council on Scientific Affairs (CSA) has directed the Division of Science to provide professional information to the Association on issues that affect the individual practitioner, health care staff, consumer and public at the local, state, national and international levels. Critical scientific issues that have been addressed by ADA laboratories underscore the need for continued performance excellence by the ADA Division of Science and its laboratories.

The Association's Research Agenda is an orderly approach to dental risk assessment, prevention, disease management and therapy. New and innovative methods for the collection, analysis and dissemination of information to improve oral health should continue to be explored. The overriding philosophy remains to bring to the practicing dentist current information of clinical interest that is meaningful, reliable and relevant. The research agenda is designed for ADA research to continually address issues related to infection control, health services, management of oral diseases, safety and effectiveness and the transfer of science.

The ADA needs to maintain scientific expertise on its staff and in the Research Institute (RI) to conduct, evaluate and anticipate new research of importance to the practitioner; to test new methodologies, develop standards and establish guidelines for acceptance of various dental products; to resolve issues relative to acceptance and safety; and to address other critical issues. ADA research serves as a model of effective public and private collaboration and should

continue to evaluate technologies and materials of greatest benefit to the public and the profession.

ADA laboratories have recently studied issues of patient and provider safety, including governmental alerts and ethical/legal topics; health services research, including social behavioral issues; and treatment-oriented research of immediate and emerging importance in the management of oral diseases. CSA believes that these are the issues which have short- and long-term impact on the quality of patient care and the continuing development of dental practice. ADA laboratories should continue to develop specific procedures for enhancing the process by which science is transferred into clinical application. It is the consensus of the CSA that one of the most vital roles of the ADA is in the area of knowledge and technology transfer, and in assuring that the profession is continuously kept abreast of scientific and technological advancements. Through the integration of ADA research activities into a consolidated laboratory, the ADA will continue to address the following research issues in a timely and comprehensive manner.

- Develop procedures to identify systematically critical research issues, and present them for discussion at professional forums in order to increase the awareness of the research community of clinical problems important to the practicing dentist.
- Continue research to improve procedures for the protection of patients and providers against air- and blood-borne pathogens (TB, HIV, HBV, etc.)
- Evaluate the need for and the cost/effectiveness of chemical collection devices and other aspects of waste management in dental practice.
- Study contamination of waterlines in dental equipment and develop methodologies to assure high quality water in coolant and irrigant systems.
- Promote studies aimed at ascertaining what, if any, health effects in patients, practitioners and allied health personnel from exposure to dental materials such as mercury-containing dental amalgam, nitrous oxide and other chemicals in the work place.
- Study the safety of tooth whitening procedures and the long-term effectiveness of tooth bleaching and other whitening procedures and products as they occur.
- Promote research and development of effective mercury-free biocompatible dental materials for posterior restorations.
- Expand the research on the infectious nature of caries and periodontal disease in order to develop appropriate individual patient risk-based assessments for their treatment and prevention.
- Continue research on the mechanisms of action of fluorides and the total fluoride exposure in order to re-evaluate optimal fluoride levels in various prevention protocols.
- Assess the impact of systemic diseases and medications on oral health and the clinical management of the systemically ill patient.
- Study the application of novel biologics and technologies in dental practice, including diagnostics, therapeutics and restorative materials.
- Develop research for indications and treatment protocols for repair and replacement of dental restorations.
- Promote currently existing protocols for the prescription of various regimens for the prevention of caries in infants, children, adults and elderly.
- Develop a communication strategy that can be used to improve public and professional understanding of important issues, such as waterline contamination, amalgam safety and infection control.

To accomplish these objectives, the problems coincident with an aging laboratory designed for a different purpose must be addressed. The current space allocation for the Division of Science encompasses most of the fourth and fifth floors with dedicated mechanical support located on floor three.

Plans are in the developmental stage to consolidate all of Science onto one floor in renovated space and freeing up an additional floor for tenant leasing. This would allow for utilization of new technologies to fulfill the new mission for the Division in environmentally safe surroundings.

Attempting to address the deteriorating condition of the current equipment (i.e. ventilation, vacuum lines) in view of the current corroding pipes, aging pumps and inefficient or nonworking fumehoods would be difficult, if not impossible to achieve in the current setting. In addition, the cost of doing this project in a makeshift fashion would ultimately exceed a well-planned facility in newly abated space.

To fully inform the Board and House, a separate report will be prepared in 1997 outlining the current state of the laboratories, the requirements to fulfill the vision of the Division and the alternatives that could be considered to meet this need.

Upon completing this report, cost estimates will be solicited with recommendations as to the source of funding. Depending upon the magnitude of the project, monies might be appropriated from reserves or perhaps even from the $55 temporary dues increase, which has been set aside for asbestos remediation and related construction. The viability of this option will be determined by reforecasting expected future costs over the next five years of the project and calculating what residual funds, if any, would be available to underwrite this work.

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. Consistent with that philosophy building assets of $7,997,509 were transferred to the Building Fund Account from the Operating Account in 1993. Beginning in that year, monies were budgeted for transfer to this separate account from which major capital expenditures to improve and repair the facility are made. In years where the annual appropriation exceeds planned expenditures, a base is provided for future replacements as well as a cushion to absorb the shock of any unanticipated expenses. At December 31, 1995, after reflecting all financial activity for the year, the Building Fund held short-term investments of $2,154,396 for future capital expenditures. Monies budgeted for 1996 of

$1,454,600 were originally planned to support $895,000 of expenditures. Based on the results of engineering studies and priorities, 1996 expenditures were reforecast at $1,440,000. The 1997 budget includes an appropriation of $1,454,600 to support planned spending of $1,270,000.

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 based on the results of engineering studies for routine maintenance as well as system and equipment modifications to improve Building operations and increase energy cost efficiency levels. Monies needed to financially underwrite these projects were provided in the 1997 budget through the $1,454,600 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.*

1997 Building Fund Capital Budget

Description	
Heat Riser Repairs	$ 80,000
Fan System Replacement	290,000
Motor Control Center Replacement	75,000
Ventilator System Conversion (8 floors)	160,000
Main Cooling Tower Replacement—Phase II	180,000
Emergency Generator Phase II	125,000
Second Floor Common Area Carpet Replacement	20,000
Security/Identification Card Access	55,000
Lobby Revolving Door Replacement	100,000
Canopy Roof Replacement	40,000
Project Cost Contingency	145,000
Total	$1,270,000

Heat Riser Repairs: Based upon the results of a 1995 engineering survey conducted by the firm of Grumman Butkus and investigation of existing Building conditions, it was determined that all the compensators, anchors and guides associated with the perimeter heating system must be replaced. A two-year phased approach to performing this contract work originally began in 1995. The 1997 capital allowance of $80,000 anticipates completion of the final phase on the south perimeter.

Fan System Replacement: According to the Grumman Butkus engineering study, the vast majority of the fans which support the building's heating, ventilating and air conditioning systems are in need of replacement. The 1997 capital allowance of $290,000 is intended to support the design and replacement of fan units that will be prioritized for replacement next year.

Motor Control Center Replacement: Given the proposed replacement of certain fan units, the 1997 capital budget also includes $75,000 in funds necessary to replace the corresponding electrical motor control center which supports those systems.

Ventilator System Conversion (8 full floors): The ventilating systems on all abated floors were designed with variable air volume (VAV) controls. The unabated space throughout the Building remains with the original constant air volume (CAV) system design. The presence of two separate systems has created an engineering imbalance which makes it difficult to evenly control the distribution of heat and cooling throughout the Building. Compass Management has recommended that retrofit devices be installed to convert the remainder of the unabated floors to the variable air volume system. The capital budget assumes conversion of the remaining eight floors throughout the Building at an estimated cost of $160,000. This conversion will likely have a positive long-term effect on the Building's energy costs.

Main Cooling Tower: As a result of the Grumman Butkus engineering study, it was determined that the building's main cooling tower which supports the Building's air conditioning systems, has exceeded its service life expectancy and must be replaced. Funds were appropriated in 1996 to complete the engineering redesign of a new system. The 1997 budget anticipates replacement of the cooling tower at an approximate cost of $180,000.

Emergency Generator Phase II: The Headquarters Building does not have an emergency generator that would allow operation of certain mechanical and electrical systems in the event of a power outage. In 1996, $125,000 of capital funds were appropriated to design and initiate efforts to install a new generator system. The total value of this system is estimated at $250,000. The 1997 budget allowance of $125,000 represents the final installation work to complete this project.

Second Floor Common Area Carpet Replacement: The second floor was renovated in 1992 to create additional conference and meeting room space within the Association Headquarters Building. The carpeting through the common area hallways and elevator corridors is in need of replacement given the high volume of traffic to and from the conference facilities. It is recommended that this area of the floor be recarpeted in 1997 at an estimated cost of $20,000 as it is a high profile area of the building to both conference attendees and outside tenants.

Security/Identification Card Access: The 1997 capital budget includes $55,000 reserved for installation of a new Association identification card reader security system. This system will enhance security on the ADA floors and eliminate the need for individual keys to be held by all employees.

Lobby Revolving Door Replacement: The 1996 lobby renovation project contemplates design upgrades to improve overall appearance of the ADA property and promote success in marketing the building to prospective tenants in the Chicago commercial real estate market. Additionally, the redesign recognizes enhancements necessary to comply with the Americans With Disabilities Act.

The 1996 budget funded the new design and certain of these lobby modifications. The final phase is expected to be completed in 1997 with the replacement of the revolving doors, estimated to cost $100,000.

Canopy Roof Replacement: The capital budget anticipates $40,000 for the replacement of the second floor canopy roof. This project was originally funded in 1995 but deferred due to inclement weather and engineering design complications.

Project Cost Contingency: The capital budget forecast will be further refined upon development of project design specifications and competitive bidding among qualified contractors. The contingency allowance serves to account for unforeseen costs that may develop during construction such as compliance with government regulations, change orders, concealed conditions as well as construction management fees and asbestos or environmental related costs.

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 of Delegates in Resolution 132H-1992 (*Trans.*1992:588), these costs have been aggregated into broad categories accompanied by a discussion of what purchases are being contemplated.

Description	
Office Equipment and Furniture	$194,100
Audio-Visual Equipment	169,600
Computer Hardware and Software	452,000
Duplicating Equipment	60,000
Scientific Equipment	63,600
Total	$939,300

Office Equipment and Furniture: This category represents recommended upgrades for obsolescent office equipment and furniture replacement for the facilities in Chicago, Washington and PRC. Much of the furniture in the Association has exceeded its useful life. As a result, desks, chairs and tables which are beyond repair are being systematically replaced.

Audio-Visual Equipment: Installation of enhanced audio-video sound and voting systems in the Board Room is the primary component of this appropriation. Modernizing these mechanical systems and introducing new capabilities should increase the effectiveness of the room.

Computer Hardware and Software: It has been the Association's practice to systematically replace and upgrade a portion of existing computer equipment on an annual basis in recognition of technical obsolescence and excessive repair. Given the rapid pace of technological improvements the cycle for replacement will be accelerated from 20% to 25% each year. Funds provided from this capital budget for computer needs will supplement monies allocated for hardware within the ADA Online 2000 Project which will commit up to $5.6 million over three years to re-engineer the Association's systems.

Duplicating Equipment: The 1997 budget provides for replacement of copiers.

Scientific Equipment: This category includes requests to acquire various scientific equipment for replacement and increased efficiency.

The 1997 budgeted depreciation expense of $939,300, from which there is no outflow of cash, will be the source of funding these proposed purchases.

Resolutions

49. Resolved, that the 1997 Annual Budget of revenues and expenses, including funded depreciation and capital expenditures, be approved.

50. 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 forty-six dollars ($346.00)" (line 306) and by substituting in their place the words and number "two hundred ninety-two dollars ($292.00)," 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 two hundred ninety-two dollars ($292.00) due January 1 of each year**...

and be it further
Resolved, that the new active members dues become effective January 1, 1997.

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 executed the First Amendment of the employment agreement with the current Executive Director on May 1, 1995. The current agreement has been extended for one year to March 31, 1997. 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 semiannual basis or as deemed appropriate by the Board. In keeping with this commitment, a performance appraisal of the Executive Director took place in December 1993, August 1994, April 1995, October 1995 and June 1996.

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 $300,000, which is unchanged from the prior year.

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 $32,000 (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 whose earnings exceeded $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 the Executive Director and other affected 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. An amount of $104,376 has been set aside under the Executive Parity Plan for accruals in calendar year 1996 of which $41,249 is allocable to the Executive Director.

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 Variable Annuity Plan; $1,000 per year toward tax planning services; the premiums toward an additional $500,000 term life insurance policy, with a current contribution of $1,469; the reasonable expenses of installing and maintaining a car telephone in one automobile; and the reasonable expenses of purchasing and maintaining a 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); 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

American Dental Real Estate Corporation, Financial Options Available for the Washington, D.C. Property

Introduction: The financial impact of the Washington, D.C. property on the Association is an ongoing consideration of the Board of Trustees. The facility continues to incur cash flow losses resulting mainly from debt service and mandated capital improvements. In recognition of this situation, the Association's Board of Trustees has committed to funding ADREC's cash flow losses up to $1.7 million annually. Prior to 1995 this support has been provided through the annual operating budget, but subsequently is being funded from reserves.

The 1995 House of Delegates, through Resolution 139H-1995 (*Trans.*1995:604) requested an annual report beginning in 1996 to summarize the financial options available for the Washington property. This document is presented to satisfy that request.

To provide a proper perspective, the history of the facility is also discussed herein.

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 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 & Annuity Insurance Co. 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. Towards 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 1996 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, the terms of the arrangement and related financial covenants were finalized with Great-West and 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. The first principal payment of $920,000 was made on February 1, 1996.

Solicitation of Bids for the Washington Office Building: Over the years, concerns regarding continuing deficits for operation of the building have prompted suggestions for disposal of the property. Through Resolution 123H-1994 (*Trans.*1994:608), the ADA and ADREC Boards were requested to continue the periodic study of this property, including the economics of selling the building. Internally prepared analyses comparing the costs of holding versus selling the building in the current depressed real estate marketplace have concluded that retaining the property is still the more economically viable option. To prove or refute this evaluation, a decision was made in late 1994 to formally test the market value of the property by soliciting bids from prospective buyers.

Offers to Purchase the Property: At the direction of the ADREC Board, six months of intensive promotional effort was initiated by Larsen, Ball & Gould, Inc., a local real estate broker, on behalf of the building. The campaign has included the mailing of 100 introductory letters with offering brochures forwarded to 12 real estate groups or investors, canvassing organizations that are considered potential prospects and conducting cold calls. This activity resulted in two written offers to purchase the property, ranging in price from $4.1 to $4.6 million, which are summarized below.

Borger Management, Inc. Offer: An initial offer of $4.1 million was submitted by Borger Management Inc., the Washington building manager, to acquire the property. This bid was largely based upon a conventional pricing approach known as "capitalized value," which ostensibly assesses the future average cash flow from the building and divides this amount by the investment return anticipated by the purchaser. In the case of Borger Management, the firm estimated the property will generate $450,806 in cash annually. When this figure is divided by the 9.5% expected rate of return, it suggests a value of approximately $4,745,000, which was then adjusted downward to reflect expected capital expenditures and existing leave concessions.

Moreover, the proposal contained a five-year space lease requirement imposed on the Association at a rental rate well above market with no improvements to the space.

An internal analysis determined that the cash benefits from the sale price may only yield $3.9 million, after commissions and legal fees of $123,000 and $100,000, respectively. Sale of the property would have required liquidation of the corporation's debt of $9.2 million and an early prepayment penalty estimated at $281,000 in the analysis. Also, $294,000 would be needed for space rental and operating expenses. These cash outlays immediately following the sale would have totaled $9.8 million. Thus the use of $5.9 million in Association Reserves or some form of dues increase would be required to cover these costs.

From an economic perspective this was an unsatisfactory offer. Simply stated, the Association could have chosen to sell and pay out $5.9 million with no opportunity for capital appreciation and the obligation to pay rent exceeding $240,000 annually, or retain the property and continue to

make payments over time in hopes of higher renewal rates or a rebound in the real estate market for Class B buildings.

Cambridge Property Group Offer. A written offer of $4.6 million was also submitted from the Cambridge Property Group, representing A&A Properties, Inc. This arrangement contemplated a $1.6 million downpayment with the Association financing the remaining $3.0 million for a term of three years based on a 25-year amortization schedule at 8.5%.

Moreover, the offer sought a ten-year space lease requirement on the part of the Association, at a base rental rate of $24. This is well above market and offers no improvements to the space. Finally, the proposal provided the buyer with a 30-day study period, during which it has the right to cancel the agreement at its discretion.

Additional analysis found that the immediate cash benefits from the sale price may only approximate $1.3 million, after commissions and legal fees of $230,000 and $100,000 respectively. Such a sale of the property would require paydown of the corporation's outstanding debt, as well as a prepayment penalty estimated at $281,000. Also $301,000 would be needed for space rental and operating expenses. These cash outlays immediately following such a sale would have totaled $9.8 million. Thus the use of $8.5 million in Association Reserves, outside borrowing or some form of dues increase would have been necessary to cover this outflow of funds.

Although this arrangement would have resulted in $3.0 million of deferred payments and $751,000 in accrued interest over the next three years, this would have done little to alleviate our initial cash flow dilemma. Financing a prospective buyer seemed to be an unreasonable demand, particularly in light of the modest offer put forth by the broker. Therefore, this bid was also not deemed economically viable.

As illustrated above, both of these proposals were analyzed in depth, and perceived as unacceptable to all interested parties. Ultimately it would be the Association, as guarantor of the loan, that must pay down the Great-West notes.

While promotional efforts have continued throughout 1996, no additional offers have been forthcoming. The market for Class B buildings in the District of Columbia continues to depress rental income and consequently any proposed purchase price.

The Association's first scheduled principal payment of $920,000 was made in February of 1996, which alters the cash outlays required should a decision be made to sell the building.

Property Appraisal: For purposes of further determining the value of this real estate, an appraisal of the property was conducted by Arthur Andersen & Co. The scope of work performed by the firm included an analysis of the competitive position of the building within the District of Columbia office market based upon recent sales comparisons and the projected income that might be generated in future years.

In the opinion of the firm, following an inspection of the property and forecasting cash flow over a ten-year period, the facility has a value of $4.7 million. Although this appraised value is somewhat higher than the $4.1 to $4.6 million offers previously received, it falls considerably below the $8.3 million of third-party debt on this asset and suggests that a cash outflow of approximately $4.4 million or more would be required should a sale be consummated.

Options for the Property

The fundamental economic decision facing the Association and its real estate subsidiary is whether to hold or sell the Washington facility. These options must be examined in the context of the prices currently being offered in the marketplace while considering the building's operating results and debt service.

The following tables summarize the relative merits and shortcomings of holding or selling the property in Washington, D.C.

THE MERITS AND SHORTCOMINGS OF HOLDING
THE WASHINGTON, D.C. PROPERTY

ADVANTAGES	DISADVANTAGES
• The current debt structure spreads principal payments over the next nine years. • Retaining the property avoids a sale in the midst of a severely depressed real estate market. • The Association pays no rent for two floors of space (10,852 square feet) having an imputed value of approximately $250,000. • Continuing to hold the building offers the prospects of capital appreciation should demand for space among Class B buildings increase in the District of Columbia. Lower vacancy levels in the area would push rental rates upward and thus escalate the value of the building. • The facility is well maintained and has made significant strides in complying with the American with Disabilities Act and fire/life safety ordinances adopted by the District, which should enhance its prospective value. • The Association retains a clear presence in the District as a property holder.	• Continued depletion of Association reserves to support the building compromises the strength of the Association to address future contingencies. • Real estate values could continue to be suppressed if the federal government is downsized or if the economics of the District government is further weakened and cannot provide basic services. This could accentuate the movement to suburban locations and continue the downward spiral of rental rates and building values. • The building is not considered to be in a prime location and the prospects of an improved neighborhood seem to be years into the future. • The opportunity to recapture building depreciation would be lost if a sale was consummated in the near term.

THE MERITS AND SHORTCOMINGS OF SELLING
THE WASHINGTON, D.C. PROPERTY

ADVANTAGES	DISADVANTAGES
• Avoid any future business risks of holding the property and their related costs. • Establish a ceiling on the losses to emanate from the property. • A sale eliminates the need to retain outside managers and consultants to help oversee the building, rent space and refurbish the facility as required to meet lease obligations and replace outmoded equipment. • A sale would mitigate the need for a separate subsidiary and the internal administrative support attendant to overseeing these building operations. • At some future point, the Washington Office staff could move from the building and consolidate its operations on a single floor, which offers some managerial and operational advantages. A choice of district or suburban locales could be determined based upon business needs and rental rates.	• Selling the property would generate a substantial cash flow loss at closing in excess of $4.4 million, based on an estimated market value of $4.4 million. • Any sale would likely be contingent upon the Association remaining in the building for five to ten years as a rent-paying tenant. • The opportunity to potentially capture building appreciation would be lost if a sale was consummated. • The profile of the Association may be somewhat diminished by relinquishing its landlord status.

Funding

This comparison can be quantified by examining the future operating revenues, expenses and capital improvements if ADREC continues as a landlord versus sales proceeds and space leasing expense if the property is sold.

This forecast will use an 11-year horizon through the year 2007 to help smooth out the cyclical nature of real estate pricing. The development of such numbers for holding the property incorporates assumptions regarding rent and expense growth rates and vacancy levels, as well as a projected building value of $7,550,000 at the end of the time frame to reflect the expectation of continuing equity in the property.

The financial analysis of selling the property assumes an expected sales price of $4.4 million currently plus commissions and closing costs, as well as future rental payments for office space.

The assumptions used in these models were derived from information included in the appraisal performed by Arthur Andersen. These underlying factors reflect historical trends and the future outlook for real estate investments. Any one or all of these variables may not prove accurate when tested against a long-term horizon. Nonetheless, it offers a mechanism for making a decision today about an unknown future.

The numbers developed using the above methodology were further refined to reflect the timing of cash payments. In the parlance of the economic community this analytical tool is known as discounted cash flow. Its purpose is to establish the present value of business alternatives having different future cash flows. This approach favors decisions where existing resources are spent later rather than earlier in the transaction, the rationale being that monies held by the organization can be used for investment purposes and provide a return until spent.

When this tool is used in the evaluation, the business solution producing the highest present value is theoretically viewed as the most optimal.

Conducting such an analysis, exclusive of financing considerations, yields the following results, which indicate that holding the property is preferable to selling and renting space.

Course of Action	Discounted Cash Flows
HOLD	$3,764,000
SELL	$1,743,000

Exhibit I (see page 448) provides further detail on the components of the above numbers.

Given this result, the next step is to integrate the funding of debt service into the equation.

The net present value of future debt service under the loan's original term is $8,115,000. This amount can be compared to the immediate cash outlay necessary to pay the note and related prepayment penalty aggregating $8,526,000.

In light of the favorable interest rate on the debt of 7.79%, it would not seem prudent to use reserve monies to pay down the loan early. Such a measure would certainly lessen the ability of the Association to respond to a crisis or undertake initiatives that are crucial to the profession and the public it serves. Moreover, a declining corpus of funds will inhibit the growth of investment earnings as the Association moves into the future.

Other alternatives would include a temporary dues increase as a new source of funding without compromising the reserve level. Via this mechanism, future interest costs on the debt could be saved and the property could operate in a self-sustaining manner.

Linking the hold versus sell decision to the financing alternatives results in the following options.

Course of Action	Source of Funding	Discounted Cash Flows
Hold property, retire debt early	Temporary Dues Increase of $8,526,000	3,764,000
Sell property	Sales proceeds of $4,080,000 and Temporary Dues Increase of $4,446,000	(2,337,000)
Status quo, hold property, retire debt over term	Reserves	(4,351,000)
Hold property, retire debt early	Reserves	(4,762,000)
Sell property	Reserves	(6,783,000)

Conclusion: In the absence of a House initiative proposing a temporary dues increase that would underwrite the cash flow losses from a potential sale of the building or retirement of its outstanding debt, the Board is not advocating a change in its present policy of paying down the outstanding obligations over the remaining nine years of the current loan agreement.

The use of reserve funds for this purpose does not appear to be a practical option given the amounts of money necessary to permit the sale or debt repayment of this asset. While none of these alternatives are particularly attractive, they are reflective of depressed real estate markets for office buildings throughout major metropolitan areas.

It is also recommended that the income tax implications of paying down the debt on the property be reviewed. The ability to utilize tax losses generated by the property will affect cash flow decisions, and the financial statement effective tax rate. Whether the property generates taxable income or loss may affect recommendations regarding the appropriate corporate structure. The income tax consequences may also be impacted by the decision to retain or sell the property.

The Board invites the opinions and suggestions of the delegates as this report is considered by the Reference Committee and subsequently the House of Delegates.

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

Exhibit I

Assumptions:	Rounding Factor
Continued Operation of Building	
Rental Growth Rate	3.49%
Expense Growth Rate	3.10%
Vacancy Rate	4.00%
Interest Rate on Notes	7.79%
Face Value of Notes	$9,200,000
Monthly Rental Income	$91,044
Monthly Operating Expenses	$50,062
New Tenant Deferred Cost (per sq. ft.)	$24.19
Rentable Space in Building (sq. ft.)	62,275
Sale of Building and Rental of Office Space	
Potential Sale Price for Property	$4,400,000
Capitalization Rate for Value of Property	10.00%
Discount Rate for Prepayment Penalty	7.50%
Commission Rate on Sale of Property	5.00%
Investment Rate of Interest	8.00%
Beginning Rental Rate (per sq. ft)	$23.08
Operating Costs to Tenants (per sq. ft.)	$9.65
Space Occupied By ADA (sq. ft.)	10,852
Moving Cost (per sq. ft.)	$15.00
Property Basis-Tax (January 1, 1996, est.)	$11,265,000

American Dental Real Estate Corporation
Calculation of Property-Related Cash Flows
As at January 1, 1997

	«Budget» 1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total	Value
Proposal I: Hold the Property													
Cash Flows From Holding the Property:													
Rental Income	848,000	878,000	908,000	940,000	973,000	1,007,000	1,042,000	1,078,000	1,116,000	1,155,000	1,195,000	11,140,000	
Rental Expenses	(584,000)	(602,000)	(621,000)	(640,000)	(660,000)	(680,000)	(701,000)	(723,000)	(746,000)	(769,000)	(793,000)	(7,519,000)	
Building Improvement Costs	(168,000)	(100,000)	(103,000)	(106,000)	(110,000)	(113,000)	(116,000)	(120,000)	(124,000)	(128,000)	(132,000)	(1,320,000)	
Tenant Leasing & Improvement Costs	(248,000)	(62,000)	(64,000)	(66,000)	(68,000)	(70,000)	(72,000)	(75,000)	(77,000)	(79,000)	(82,000)	(963,000)	
Cash Flows From Rental Operations	(152,000)	114,000	120,000	128,000	135,000	144,000	153,000	160,000	169,000	179,000	188,000	1,338,000	
Sale Price Based on Capitalized Cash Flows											7,550,000	7,550,000	
Potential Sale Commission											(378,000)	(378,000)	
Other Potential Sale Costs											(151,000)	(151,000)	
Residual Value of Property	0	0	0	0	0	0	0	0	0	0	7,021,000	7,021,000	
Total Cash Flows From Holding the Property	(152,000)	114,000	120,000	128,000	135,000	144,000	153,000	160,000	169,000	179,000	7,209,000	8,359,000	3,764,000
Proposal II: Sell the Property													
Cash Flows From Selling the Property:													
Sale Proceeds	4,400,000											4,400,000	
Sale Commissions	(220,000)											(220,000)	
Appraisal and Closing Costs	(100,000)											(100,000)	
Cash Flows From Sale	4,080,000	0	0	0	0	0	0	0	0	0	0	4,080,000	
Space Rental	(250,000)	(259,000)	(268,000)	(278,000)	(287,000)	(297,000)	(308,000)	(318,000)	(330,000)	(341,000)	(353,000)	(3,289,000)	
Expense Escalation	0	(3,000)	(7,000)	(10,000)	(14,000)	(17,000)	(21,000)	(25,000)	(29,000)	(33,000)	(37,000)	(196,000)	
Moving Expenses	(163,000)											(163,000)	
Cash Flows of Renting Space	(413,000)	(262,000)	(275,000)	(288,000)	(301,000)	(314,000)	(329,000)	(343,000)	(359,000)	(374,000)	(390,000)	(3,485,000)	
Total Cash Flows From Selling the Property	3,667,000	(262,000)	(275,000)	(288,000)	(301,000)	(314,000)	(329,000)	(343,000)	(359,000)	(374,000)	(390,000)	595,000	1,743,000
Difference Between Proposal I and Proposal II													2,021,000
Proposal III: Retire Debt on Scheduled Basis													
Cash Flows of Scheduled Debt Retirement:													
Interest	(651,000)	(579,000)	(508,000)	(436,000)	(364,000)	(293,000)	(221,000)	(149,000)	(78,000)	0	0	(3,279,000)	
Principal Retirement	(920,000)	(920,000)	(920,000)	(920,000)	(920,000)	(920,000)	(920,000)	(920,000)	(920,000)	0	0	(8,280,000)	
UBIT (Tax)/Savings	15,000	21,000	21,000	22,000	23,000	23,000	24,000	25,000	26,000	0	0	200,000	
Total Cash Flows of Scheduled Debt Retirement	(1,556,000)	(1,478,000)	(1,407,000)	(1,334,000)	(1,261,000)	(1,190,000)	(1,117,000)	(1,044,000)	(972,000)	0	0	(11,359,000)	(8,115,000)
Proposal IV: Retire Debt Immediately													
Cash Flows of Immediate Debt Retirement:													
Principal Retirement	(8,280,000)											(8,280,000)	
Prepayment Penalty	(246,000)											(246,000)	
Total Cash Flows of Immediate Debt Retirement	(8,526,000)	0	0	0	0	0	0	0	0	0	0	(8,526,000)	(8,526,000)
Difference Between Proposal III and Proposal IV													411,000

Report 5

Managed Care Issues—Gag Clauses and Incentives

Background: At its meeting in April 1996, the Council on Dental Benefit Programs developed three proposed resolutions.

The first resolution requested that the Association oppose the inclusion of language in third-party payer contracts that would restrict providers from discussing with patients, public officials and agencies any matter regarding the patient's treatment, treatment options, payment policies, grievance procedures and appeal processes, etc.

The second resolution requested the Association to seek federal legislation and encourage state societies to seek state legislation requiring that health plans not refuse to contract with or otherwise compensate for covered services of providers who have discussed the terms, provisions or requirements of health plan products as they relate to the needs of patients.

The third resolution requested the Association to seek federal legislation and encourage state societies to seek state legislation supporting the concept of requiring that a full and complete explanation be provided to subscribers by plan purchasers on seven important points, ranging from who actually will manage the patient's care to a full disclosure of the financial incentives agreed to between the health plan and its providers to annual disclosure of the percentage of each premium dollar that goes to the provider for treatment.

The Council felt that these issues were of such importance that it asked the Board of Trustees to adopt the proposed resolutions as interim policy of the Association.

The Board agreed with the Council's request and while the resolutions were adopted as interim policy, the Board also directed that, prior to being submitted to the 1996 House of Delegates, the policies be reviewed by the Council on Governmental Affairs and Federal Dental Services to be sure that the policies were worded appropriately for legislative action.

The Council on Governmental Affairs and Federal Dental Services fully supported the interim policy recommendations but did adjust the wording of the resolutions to make it possible for the Association to seek legislative action while, at the same time, leave intact the specific requirements outlined in the policies.

The Board reviewed and approved the changes recommended by the Council, and, therefore, recommends adoption of the following resolutions.

Resolutions

36. Resolved, that the Association opposes the use of contractual language that restricts providers from fulfilling their legal and ethical duties to appropriately discuss with patients, public officials or public agencies, any matter relating to treatment of patients, treatment options, payment policies, grievance procedures, appeal processes, and financial incentives between any health plan and the provider, and be it further

Resolved, that the appropriate agencies of the Association seek federal legislation and encourage constituent societies to seek state legislation implementing the intent of this policy.

37. Resolved, that the appropriate agencies of the American Dental Association seek federal legislation and encourage constituent societies to seek state legislation requiring that health plans not refuse to contract with or otherwise compensate for covered services, of otherwise qualified providers or nonparticipating providers, solely because the providers have, in good faith, communicated with their current or prospective patients regarding the provisions, terms or requirements of health plan products as they relate to the needs of the providers' patients.

38. Resolved, that the appropriate agencies of the Association seek federal legislation and encourage constituent societies to seek state legislation supporting the concept requiring that a full and complete explanation of the following points associated with any health plan be provided to subscribers by plan purchasers:

1. A written statement fully describing how dental treatment, including specialty treatment, will be managed and by whom. The statement must include any and all limitations and restrictions.
2. Names and telephone numbers of health plan representatives giving subscribers direct access to assistance during the subscribers' normal working hours, taking into consideration those subscribers who work on shifts.
3. A full disclosure of the financial incentives agreed to between the health plan and its providers, including but not limited to, bonuses and withholds related to specialty referrals, limited treatment options, denial of treatment, deferred treatment, paced treatment, least expensive alternative treatment, and any and all other circumstances which could result in financial gain for the providers and/or the health plan.
4. A complete listing of all points agreed to between the plan purchaser and the health plan, and the health plan and its providers, that in any way relate to subscribers' access to care, e.g., hours for appointments; recall and scheduling of appointments; limitation and pacing of treatment, etc.
5. A thorough accounting of provider and patient disenrollment rates for the preceding five years.
6. Disclosure of the percentage of enrollees who annually utilize the plan.
7. Annual disclosure of the percentage of each premium dollar that goes to the provider for treatment and the percentage of each premium dollar taken out by the third-party payer for sales, taxes, profits, administrative and other costs.

Report 6

Report on the Association's Study of the Recommendations Contained in the Institute of Medicine Report

Background: In January 1995, the Institute of Medicine (IOM) released a comprehensive report, *Dental Education at the Crossroads: Challenges and Change*. As reported previously (*Supplement* 1993:318, *Trans.*1993:718, *Reports* 1995:71), the Association has had an ongoing role in this activity.

Appointment of a Special Board Committee: At its February 1995 meeting, the Board determined that a Special Board Committee should be appointed to review the IOM report. It was intended that the Special Committee would serve as the coordinating committee relative to the Association's role in addressing issues contained in the report. The Board members appointed to the Special Committee in 1995 were Dr. William S. Ten Pas, chairman; Dr. Karl W. Lange, Dr. Frank A. Maggio, Dr. Michael J. Till and Dr. David A. Whiston. Dr. Richard D. Wilson, chairman of the Council on Dental Education (CDE) and Commission on Dental Accreditation (CDA) also served as a member of the Committee. The Committee met twice in 1995; on April 21 and on May 30.

Following the 1995 ADA House of Delegates, the Committee was expanded to include Dr. John S. Eads and Dr. Gary Rainwater. In 1996, the Committee met at the Association Headquarters Building on March 10, with all members in attendance, and by telephone conference call on May 28. Dr. Gary Rainwater and Dr. Richard Wilson were unavailable to participate in the call.

A report of the Committee's activities was presented to the Board for consideration at its June 1995 meeting. Subsequently, the Board adopted two resolutions; B-75-1995 and B-76-1995. The first resolution directed the Committee to disseminate recommendations to appropriate Association agencies for review, discussion and, if appropriate, implementation. The second resolution directed the Committee to solicit comments from the recognized dental specialty organizations, the American Association of Dental Schools and the American Association of Dental Examiners.

Charge to the Committee: During the Committee's initial meeting on Friday, April 21, 1995, Dr. Richard D'Eustachio, then ADA president, directed that this Committee serve as the coordinating body for the Association regarding the review of the IOM Report. Further, Dr. D'Eustachio directed that this Committee review the 22 IOM report recommendations to determine:

- if the recommendation falls under the ADA's purview for study and implementation;
- which Association agency(ies) has responsibility to address the recommendation and why;
- what priority should be given to addressing the recommendation and why; and
- if there are financial implications related to implementing the recommendation.

1995 ADA Annual Session/House of Delegates IOM Report Activities: An open hearing on the IOM report was conducted on October 6, 1995 during the 1995 annual session in Las Vegas. The hearing was chaired by Dr. William S. Ten Pas; approximately 90-100 persons attended all or portions of the open hearing. Committee members were also in attendance.

The 1995 House considered several resolutions which pertained to recommendations contained in the IOM report (Resolutions 91H, 98H, 99H, 102, 104H, 105, 108H, 126 and 140H-1995 (*Trans.*1995:640,642-645). Specifically, Resolutions 102, 105 and 126 were referred to the Committee for study.

Format Used for Discussion of the 22 Recommendations in the IOM Report: During its initial meeting, each Committee member was assigned specific recommendations to summarize for presentation at the Committee's second meeting. Committee members were requested to address each item listed above in their presentations. Additionally, during the presentation of the summary reports at the May 30, 1995 meeting, the Committee was also requested to consider whether a recommendation was appropriate for consideration by the Association. Further, if it was concluded that a recommendation was not within the Association's purview to address, consideration was given to whether or not its implementation might ultimately affect the ADA and, if so, how.

Following each summary report presented at its May 30, 1995 meeting, the Committee discussed, prioritized and reached consensus on identifying the appropriate Association agency(ies) for distribution of each recommendation. Further, during its discussion of the recommendations, the Committee identified three important areas that are related to topics addressed in the report; however, these topics were not specifically identified in the study. These include: dental ethics, student indebtedness and advancement in technology. The Committee believes that discussion of these topics can appropriately be incorporated as part of the implementation of related recommendations and these areas are noted in the summary that follows. The Committee believes these topics to be significant issues related to dental education and urges that the appropriate agencies of the Association include these topics in their discussions of assigned recommendations.

At its March 1996 meeting, the Committee reviewed responses received from the following Association agencies assigned to review selected IOM recommendations: Council on Governmental Affairs and Federal Dental Services; Council on Access, Prevention and Interprofessional Relations; Council on Dental Practice; Council on Dental Education; Commission on Dental Accreditation; Council on Scientific Affairs; Council on Membership; and the Survey

Center. Additionally, the Committee reviewed responses received from the following outside agencies: the American Association of Dental Examiners, the American Academy of Periodontology, the American Academy of Pediatric Dentistry, the American Association of Public Health Dentistry, the American College of Prosthodontists, and the American Association of Endodontists.

Additionally, in considering each of the IOM recommendations, the Committee gave careful consideration to the three resolutions referred by the 1995 House: Resolutions 102-1995, 105-1995 and 126-1995. In the following section of this report, the Committee's discussions and recommendations concerning review of these resolutions are reflected under the comments pertaining to specific IOM Recommendations 3, 5 and 7.

The Committee believes responsibility for comprehensive discussion and detailed proposals for implementation of the recommendations falls to various Association agencies. In addition, the Committee did not believe it could discuss financial implications associated with these recommendations. Rather, it believes this would need to be addressed as detailed proposals for implementation are brought forward for the Board's consideration.

Summary of the Committee's Discussion of Each Recommendation: The highlights of the Committee's discussion are summarized in bullets following each recommendation. The Committee identified Association agencies as well as outside agencies that could play a part in implementation of specific recommendations. These agencies are indicated in the parenthesis following the bullets.

IOM Recommendation 1: To support effective and efficient oral health services that improve individual and community health, the committee recommends that dental educators work with public and private organizations to

- *maintain a standardized process in the U.S. Department of Health and Human Services to regularly assess the oral health status of the population and identify changing disease patterns at the community and national levels;*
- *develop and implement a systematic research agenda to evaluate the outcomes of alternative methods of preventing, diagnosing, and treating oral health problems; and*
- *make use of scientific evidence, outcomes research, and formal consensus processes in devising practice guidelines.*

Committee Discussion

- The ADA is urged to facilitate implementation of this recommendation through sustained lobbying efforts both at the state and national levels indicating support for maintenance of a standardized process.
- Baseline data are essential.
- The ADA is urged to support and assist in establishing a research agenda.
- The ADA is urged to call for public and private sectors to work together on issues related to oral health assessment.
- The ADA should continue developing practice parameters.
- Significant funds will be needed for lobbying efforts. (CGAFDS, CAPIR, Survey Center, ADA Health Foundation, CDP, CDE; outside: HHS)

IOM Recommendation 2: To increase access to care and improve the oral health status of underserved populations, dental educators, practitioners, researchers, and public health officials should work together to

- *secure more adequate public and private funding for personal dental services, public health and prevention programs, and community outreach activities, including those undertaken by dental school students and faculty, and*
- *address the special needs of underserved populations through health services research, curriculum content, and patient services, including more productive use of allied dental personnel.*

Committee Discussion

- Significant lobbying efforts are required.
- The ADA is urged to provide guidance to outside agencies to address these issues.
- Elements are being addressed by various Association agencies (e.g., access issues, use of allied personnel).
- Public funding for dental health issues is important to the profession and collaboration is needed. (CGAFDS, CAPIR, CDP, CDE; outside: HHS)
- Caution should be exercised in addressing this recommendation; the need for care does not necessarily translate to demand for care.
- Recognizing that the dentist is the leader of the dental team, productive and appropriate use of allied personnel, with the delegation of functions that is consistent with state licensing laws, is encouraged.
- Reasonable and appropriate compensation should be provided to those responsible for delivering care to special patient populations.

IOM Recommendation 3: To improve the availability of dental care in underserved areas and to limit the negative effects of high student debt, Congress and the states should act to increase the number of dentists serving in the National Health Service Corps and other federal or state programs that link financial assistance to work in underserved areas.

Committee Discussion

In conjunction with this recommendation, the Committee gave careful consideration to Resolution 102-1995 (*Trans.*1995:642), which addresses formulating alternative methods of funding and reducing the cost of dental education, and urges:

- Alternate suggestions for loan forgiveness/loan access should be addressed including a review of federal policies regarding military service.
- Organized dentistry is urged to address this issue at the national, state and local levels.

- Lobbying efforts should continue with emphasis on increasing the number of service corps/loan forgiveness positions.
- Federal agencies, which designate and place the National Health Service Corps (NHSC), should consult with ADA constituent and component dental societies before making such designations and placements in accordance with Association policy (*Trans.*1988:488; 1992:599).
- NHSC's commitment to dentistry must be maintained and strengthened with emphasis on participation in the NHSC state and community-based programs.
- Efforts should be consistent with the Association's position that supports voluntary public service.
- ADA will continue submitting comments in support of voluntary "public service" for dental graduates. (CGAFDS, FINCO; outside: AADS, ASDA)
- Appropriate ADA agency(ies) are urged to present financial seminars to freshman dental students to address issues related to indebtedness.

IOM Recommendation 4: To stimulate progress toward curriculum goals long endorsed in dental education, the committee recommends that dental schools set explicit targets, procedures, and timetables for modernizing courses, eliminating marginally useful and redundant course content, and reducing excessive course loads. The process should include steps to

- *design an integrated basic and clinical science curriculum that provides clinically relevant education in the basic sciences and scientifically based education in clinical care;*
- *incorporate in all educational activities a focus on outcomes and an emphasis on the relevance of scientific knowledge and thinking to clinical choices;*
- *shift more curriculum hours from lectures to guided seminars and other active learning strategies that develop critical thinking and problem-solving skills;*
- *identify and decrease the hours spent in low priority preclinical technique, laboratory work, and lectures; and*
- *complement clinic hours with scheduled time for discussion of specific diagnosis, planning, and treatment-completion issues that arise in clinic sessions.*

Committee Discussion

- Support for this activity is essential if efforts to improve dental education are to be achieved.
- The activity needs input from the private practice community; dental schools are urged to establish a formal mechanism to ensure that this occurs.
- Dental schools are urged to establish formal methods for seeking input from the practicing community to enhance the clinical curriculum.
- Dental schools are urged to be careful *not* to eliminate curricular content associated with skills and knowledge that are essential to the practice of dentistry.
- Curricular content related to dental ethics has not specifically been addressed—the Committee believes curricular content in ethics should be expanded.
- The Association and its CDE are committed to addressing this issue with the American Association of Dental Schools (AADS). In 1995, the Association contributed to the financial support for an AADS competency study. (CDE, CDA; outside: AADS)

IOM Recommendation 5: To prepare future practitioners for more medically based modes of oral health care and more medically complicated patients, dental educators should work with their colleagues in medical schools and academic health centers to

- *move toward integrated basic science education for dental and medical students;*
- *require and provide for dental students at least one rotation, clerkship, or equivalent experience in relevant areas of medicine, and offer opportunities for additional elective experience in hospitals, nursing homes, ambulatory care clinics, and other settings;*
- *continue and expand experiments with combined M.D.-D.D.S. programs and similar programs for interested students and residents; and*
- *increase the experience of dental faculty in clinical medicine so that they—and not just physicians—can impart medical knowledge to dental students and serve as role models for them.*

Committee Discussion

- The Committee believes there is a need to increase the medical education of dental students and the medical knowledge of dental faculty.
- In consideration of Resolution 105-1995 (*Trans.*1995:643), regarding eliminating programs that integrate dentistry into medicine, the Association urges greater integration of medical knowledge into the dental curriculum so long as dentistry, as a health profession, maintains appropriate autonomy.
- The Committee urges increased collaboration between dental educators and colleagues in medical schools with the goal of increasing medical knowledge *within* the dental curriculum; likewise, the Committee urges increased collaboration with medical colleagues with the goal of increasing dental knowledge in the medical curriculum. (CDE, CDA—all aspects of the recommendation; bullet 2 only: CDP, CAPIR; outside: AADS—all aspects of the recommendation)
- Cost factors will be a natural impediment to implementation of several aspects of this recommendation.

IOM Recommendation 6: To prepare students and faculty for an environment that will demand increasing efficiency, accountability, and evidence of effectiveness, the committee recommends that dental students and faculty participate in efficiently managed clinics and faculty practices in which

- *patient-centered, comprehensive care is the norm;*
- *patients' preferences and their social, economic, and emotional circumstances are sensitively considered;*
- *teamwork and cost-effective use of well-trained allied dental personnel are stressed;*

- *evaluations of practice patterns and of the outcomes of care guide actions to improve both the quality and the efficiency of such care;*
- *general dentists serve as role models in the appropriate treatment and referral of patients needing advanced therapies; and*
- *larger numbers of patients, including those with more diverse characteristics and clinical problems, are served.*

Committee Discussion

- This recommendation is closely associated with implementation of Recommendation 12; they should be addressed together.

IOM Recommendation 7: The committee recommends that postdoctoral education in a general dentistry or specialty program be available for every dental graduate, that the goal be to achieve this within five to ten years, and that the emphasis be on creating new positions in advanced general dentistry and discouraging additional specialty residencies unless warranted by shortages of services that cannot be provided effectively by other personnel.

Committee Discussion

- Organized dentistry is urged to continue its efforts to sustain existing PGY-1 positions and to secure additional positions.
- The Committee believes implementation of this recommendation should be focused on creating postdoctoral general dentistry positions *for all who desire* and are qualified to enter the additional training program rather than for every dental student.
- The Association is not supportive of a *mandatory* postdoctoral year of training.
- Studies are needed to assess need and demand for the services provided by dental specialists, generalists versus specialists ratios and demographics of dental specialists. (CDP, CGAFDS, CDE, CDA, Survey Center, constituents; outside: specialty organizations, AADS)
- In consideration of Resolution 126-1995 (*Trans.*1995:645), regarding a study of the ratio of general dentists to specialty trained dentists, the Association should compile trend data on enrollments in all accredited advanced specialty education programs over the past ten years and disseminate the information to the appropriate communities of interest.

IOM Recommendation 8: To permit faculty hiring and promotion practices that better reflect educational objectives and changing needs, the committee recommends that dental schools and their universities supplement tenure-track positions with other full-time nontenured clinical or research positions that provide greater flexibility in achieving teaching, research, and patient care objectives.

Committee Discussion

- The Committee supports the intent of this recommendation but believes that ADA's role in implementation is minimal.

- It is suggested that the ADA ask the AADS if/how it can assist in addressing this issue. (AADS)

Please note that Recommendations 9-11, which follow, were considered in unison.

IOM Recommendation 9: To expand oral health knowledge and to affirm the importance of research and scholarship, each dental school should

- *support a research program that includes clinical research, evaluation and dissemination of new scientific and clinical findings, and research on outcomes, health services, and behavior related to oral health;*
- *extend its research program, when feasible, to the basic sciences and to the transformation of new scientific knowledge into clinically useful applications;*
- *meet or exceed the standard for research and scholarship expected by its parent university or academic health center;*
- *expect all faculty to be critically knowledgeable about scientific advances in their fields and to stay current in their teaching and practice; and*
- *encourage all faculty to participate in research and scholarship.*

IOM Recommendation 10: To build research capacity and resources, as well as foster relationships with other researchers, all dental schools should develop and pursue collaborative research strategies that start with the academic health center or the university and extend to industry, government, dental societies, and other institutions able to support or assist basic science, clinical, or health services research.

IOM Recommendation 11: To strengthen the research capacity of dental schools and faculty, the committee recommends that the National Institute of Dental Research

- *continue to evaluate and improve its extramural training and development programs;*
- *focus more resources on those extramural programs with greater demonstrated productivity in strengthening the oral health research capacity of dental schools and faculties; and*
- *preserve some funding for short-term training programs intended primarily to increase research understanding and appreciation among clinical teaching faculty and future practitioners.*

Committee Discussion

- The Committee agreed that a broad-based education is an essential element of the success of a dental student both in dental school and in the profession.

- Dentistry values the quality educator as well as the quality researcher; therefore, dentistry needs to promote interest in and opportunities for clinical dental research among dental faculty.
- The ADA should reaffirm commitment to research and should stress the value of clinical research.
- Opportunities exist and should be fully explored to foster relationships that will lead to cooperative agreements between dental schools, other institutions, government agencies and industry.
- The ADA must be an active player in these cooperative agreements.
- Funding is needed for these activities and should be pursued.
- The proposed revised predoctoral accreditation standards have been strengthened to better address the dental school's role in research. (CSA, CDA, CGAFDS, ADA Health Foundation; outside: NIDR, NIH, AADS)

IOM Recommendation 12: To affirm that patient care is a distinct mission, each dental school should support a strategic planning process to

- *develop objectives for patient-centered care in areas such as appointment scheduling, completeness and timeliness of treatment, and definition of faculty and student responsibilities;*
- *identify current deficiencies in patient care processes and outcomes, along with physical, financial, legal, and other barriers to their correction; and*
- *design specific actions—including demonstration projects or experiments—to improve the quality, efficiency, and attractiveness of its patient services.*

Committee Discussion (comments related to Recommendations 6 and 12)

- A dental school's role in providing patient services needs to be carefully reassessed and aligned with its primary responsibility of educating dental students.
- The ADA's primary role related to Recommendations 6 and 12 should be to serve as a friendly, persistent catalyst in implementation of the various aspects of these two recommendations.
- It is essential that dental schools adopt procedures for good patient care in preparation for the changing health care environment.
- The ADA-approved dental practice parameters will allow dental education institutions to focus on establishing efficiently managed clinics and faculty practices.
- Patients in dental schools need to receive comprehensive care whenever possible and be treated in an ethical manner.
- A dental school must be prepared to objectively assess its ability to implement established strategic plans. (CDE, CDA; outside: AADS)
- Dental schools should be encouraged to seek formal input from the practicing dental community.
- The ADA's position is clearly delineated in Resolution 99H-1995 (*Trans.*1995:641), which states that the mission of a dental school is to educate students competent in the art and science of dentistry, and that patient care and research are important to that mission.
- As directed by Resolution 104H-1995 (*Trans.*1995:643), the Association urges that dental school graduates be competent in evaluating the advantages and disadvantages of different models of oral health care management and delivery and assessing the benefits and risks associated with personal, social, professional, legal and ethical perspectives for the patient and the dentist.
- The Association believes that dental school instruction in practice management should include the traditional private practice fee-for-service model.

IOM Recommendation 13: To ensure that dental education and services are considered when academic institutions evaluate their role in a changing health care system, the committee recommends that dental schools coordinate their strategic planning processes with those of their academic health centers and universities.

Committee Discussion

- The Committee concluded that this recommendation should be addressed in conjunction with Recommendation 15.

IOM Recommendation 14: To respond to changes in roles and expectations for providers of outpatient health services including dental school clinics, the Commission on Dental Accreditation and the American Association of Dental Schools should

- *reexamine processes for assessing patient care activities in dental schools and ensure the quality of care, and*
- *begin to evaluate new options such as eventual participation by dental schools in separate accreditation programs for their ambulatory care facilities.*

Committee Discussion

- The intent of the first bullet should be supported and addressed as part of the revision of the predoctoral accreditation standards.
- This issue should also be addressed along with Recommendations 6 and 12. (CDA; outside: AADS)
- Dental schools' participation in separate accreditation programs for review of the school's ambulatory facilities is viewed as unnecessary and should not be pursued.

IOM Recommendation 15: To consolidate and strengthen the mutual benefits arising from the relationship between universities and dental schools, each dental school should work with its parent institution to

- *prepare an explicit analysis of its position within the university and the academic health center;*
- *evaluate its assets and deficits in key areas including financing, teaching, university service and visibility, research and scholarly productivity, patient and community services, and internal management of change; and*

- *identify specific objectives, actions, procedures, and timetables to sustain its strengths and correct its weaknesses.*

Committee Discussion

- Recommendations 13 and 15 address common issues.
- Dental schools should actively seek input and support from organized dentistry in implementing issues influencing the academic health science center arena.
- Success in addressing this issue is paramount to the survival of dental education.
- There is need for information sharing between dental schools.
- Schools can learn from those who have successfully established mutually beneficial relationships with parent institutions. (CDA; outside: AADS)

IOM Recommendation 16: To provide a sound basis for financial management and policy decisions, each dental school should develop accurate cost and revenue data for its educational, research, and patient care programs.

Committee Discussion

- This recommendation impacts on the successful implementation of several other recommendations in this report.
- Greater application and analysis of the financial information the Association annually collects from dental schools could be used to aid schools in addressing this issue.
- The ADA is currently developing an analysis of managed care programs for use by dental schools and their universities. (CDE, Survey Center; outside: AADS)

IOM Recommendation 17: Because no single financing strategy exists, the committee recommends that dental schools individually and, when appropriate, collectively evaluate and implement a mix of actions to reduce costs and increase revenues. Potential strategies, each of which needs to be guided by solid financial information and projections as well as educational and other considerations, include the following:

- *increasing the productivity, quality, efficiency, and profitability of faculty practice plans, student clinics, and other patient care activities;*
- *pursuing financial support at the federal, state, and local levels for patient-centered predoctoral and postdoctoral dental education, including adequate reimbursement of services for Medicaid and indigent populations and contractual or other arrangements for states without dental schools to support the education of some of their students in states with dental schools;*
- *rethinking basic models of dental education and experimenting with less costly alternatives;*
- *raising tuition for in- and out-of-state students if current tuition and fees are low compared to similar schools;*
- *developing high quality, competitive research and continuing education programs; and*
- *consolidating or merging courses, departments, programs, and even entire schools.*

Committee Discussion

- This issue is related to the whole issue of cost of dental education.
- Student indebtedness and advancement in technology is not specifically addressed as part of this recommendation; however, it should be included as part of the discussion.
- With regard to bullet 4—raising tuition—the Committee agreed this is not the message the ADA should want to convey and support; rather, the Committee supports the concept that tuition levels should be substantiated by program costs, as opposed to being compared to similar schools.
- The ADA needs to encourage further discussion/ investigation of this proposal if the profession is to effectively address the costs associated with dental education. (CDP, CAPIR, CGAFDS, CSA, CDE, CDA; outside: AADS)

IOM Recommendation 18: To protect students and the public from inferior educational programs and to reduce administrative burdens and costs, the committee recommends that the Commission on Dental Accreditation involve concerned constituencies in a sustained effort to

- *expand the resources and assistance devoted to schools with significant deficiencies, and decrease the burden imposed on schools that meet or exceed standards;*
- *increase the emphasis on educational outcomes rather than on detailed procedural requirements; and*
- *develop more valid and consistent methods for assessing clinical performance for purposes of student evaluation, licensure, and accreditation.*

Committee Discussion

- The CDA has begun to address these issues. Specifically, this includes changes in the accreditation process to reduce the cost of accreditation both to the Commission and its accredited programs, reducing the total amount of time spent on-site, reformatting the site visit schedule and revision of site visit materials. Additional changes will be made to streamline the process as the Commission's electronic technology capabilities are enhanced beginning in late 1996.
- Implementation of recommendations contained in the report of the Second Presidential Committee to Study Accreditation is urged. The Association should support the recommendations and take appropriate measures to assist in their implementation.
- The Committee urges sustained efforts to recognize excellence and encourages opportunities for information sharing between schools that excel in identified areas and those that could benefit from such consultation. (CDA, CDE; outside: AADS, AADE)

IOM Recommendation 19: To improve the current system of state regulation of dental professionals, the committee

recommends that the American Association of Dental Examiners, American Association of Dental Schools, professional associations, state and regions boards, and specialty organizations work closely and intensively to

- *develop valid, reliable and uniform clinical examinations and secure acceptance of the examinations by all state licensing boards as replacements for state or regional clinical examinations and as complements to current National Dental Board Examinations;*
- *accelerate steps to eliminate examinations using live patients and replace them with other assessment methods, such as the use of "standardized patients" for evaluating diagnosis and treatment planning skills and simulations for evaluating technical proficiency;*
- *strengthen and extend efforts by state boards and specialty organizations to maintain and periodically evaluate the competency of dentists and dental hygienists through recertification and other methods;*
- *remove barriers to the movement of dental personnel among states by developing uniform criteria for state licensure except in areas where variation is legitimate (e.g., dental jurisprudence); and*
- *eliminate statutes and regulations that restrict dentists from working with allied dental personnel in ways that are productive and consistent with their education and training.*

Committee Discussion

- Many aspects associated with this recommendation are underway.
- The Committee urges the ADA's continued support of ADA policy in implementing all phases of this recommendation. (CDE, CDP, SGA, HOD; outside: AADS, AADE, ADHA, ADAA)
- The Committee urges support for the February 1996 action of the Board of Trustees to study the issue of continued competency.
- The Committee believes use of the term "recertification" in bullet 3 is unclear.
- The ADA is opposed to recertification of general dentists.

Please note that Recommendations 20-21, which follow, were considered in unison.

IOM Recommendation 20: Because the prospects for a future oversupply or undersupply of dental personnel are uncertain and subject to unpredictable scientific, public policy, or other developments, the committee recommends that public and private agencies

- *avoid policies to increase or decrease overall dental school enrollments; and*
- *maintain and strengthen programs to forecast and monitor trends in the supply of dental personnel and to analyze information on factors affecting the need and demand for oral health care.*

IOM Recommendation 21: To respond to any future shortage of dental services and to improve the effectiveness, efficiency, and availability of dental care generally, educators and policy makers should

- *continue efforts to increase the productivity of the dental work force, including appropriately credentialed and trained allied dental personnel;*
- *support research to identify and eliminate unnecessary or inappropriate dental services; and*
- *exercise restraint in increasing dental school enrollments unless other, less costly, strategies fail to meet demands for oral health care.*

Committee Discussion

- The Committee urges support for the directives contained in Recommendation 20.
- These two recommendations relate to Recommendation 1 and the need for updated data concerning the future need and demand for dental services. (CGAFDS, Survey Center, CDP; outside: NIDR, NIH, other appropriate federal agencies, AADS)
- The ADA will continue to support the dentist as the leader of the dental team.

IOM Recommendation 22: To build a dental work force that reflects the nation's diversity, dental schools should initiate or participate in efforts to expand the recruitment of under-represented minority students, faculty and staff, including

- *broad-based efforts to enlarge the pool of candidates through information, counseling, financial aid, and other supportive programs for precollegiate, collegiate, predoctoral, and advanced students and*
- *national and community programs to improve precollegiate education in science and mathematics, especially for under-represented minorities.*

Committee Discussion

- The Committee urges support for implementation of these directives based on established criteria and procedures.
- The Committee supports the admission of students into the dental profession based on established criteria and procedures. Further, the Committee urges that previous academic performance and/or performance on standardized national scholastic tests should be utilized as primary criteria in selecting students.
- Priority should be given to establishing an all-inclusive environment in the dental profession; accordingly, the Committee urges that the Association's recruitment activities be expanded to include recruitment efforts in all areas of dentistry that will ensure a representative dental work force that is all-inclusive and reflects this nation's diversity.
- The Committee urges study of this using a task force/committee with broad-based representation.
- Priority should be given to identifying funding for this activity. (ADA leadership, CDE, CDP, CM; outside: AADS, NDA, AAWD)

Summary: In developing its report, the IOM concluded that its recommendations were intended for implementation over a broad span of time; the more demanding even expanding to a 10- to 20-year horizon. Some recommendations appear idealistic, others more pragmatic. Some have mutual benefits and lead to strengthening other aspects of dental education and research. This must all be taken into account when discussing implementation.

In disseminating its report, the IOM also recommended that a conference or workshop be convened to bring interested parties together, within a year after the report's publication to assess the initial impact of the report. On May 11, 1996, the IOM convened a symposium for this purpose. Dr. William S. Ten Pas, president, and Dr. Gary Rainwater, president-elect, represented the Association at this meeting. The agenda included several plenary sessions for presentation on perspectives from the educational, professional, research and academic health center communities. Additionally, reports were presented from three dental schools about how they had utilized the report as a strategic planning tool.

The afternoon session was devoted to discussion groups assigned to review specific topics; curriculum, research, patient care, managed care and community outreach, university environment and work force regulation. The IOM hopes to publish the proceedings from its symposium in a future issue of the AADS *Journal of Dental Education.*

The Committee purposefully chose not to rank the IOM recommendations in order of priority to the Association. It believes that the recommendations should continue to be reviewed and discussed by various Association agencies. With the completion of the Special Board Committee's review, it is now possible to fully implement Resolution B-75 adopted by the Board in June 1995, which states:

> **Resolved,** that the recommendations contained in the January 1995 report of the IOM, along with the Special Board of Trustees Committee comments, be disseminated to the appropriate Association agencies for review, discussion and, if appropriate, proposed implementation, and be it further
>
> **Resolved,** that each agency assess how any proposed implementation of the recommendations would fit into the Association's Strategic Plan, and be it further
>
> **Resolved,** that if an agency of the Association develops proposed implementation plans for dealing with the recommendations in the IOM report, those proposed implementation plans will be forwarded to the Board of Trustees for review prior to any action.

Additionally, the Committee encourages cooperative activities/action plans when recommendations fall under the purview of more than one agency.

June 1996 Board Action: At its June meeting, the Board carefully considered the report of the Special Board Committee. The Board directed that the report be transmitted to the 1996 House of Delegates. The Special Board Committee also considered Resolutions 102, 105 and 126 (*Trans.*1995:642, 643, 645), and its comments concerning these resolutions appear in this report following IOM Recommendations 3, 5 and 7. Additionally, the Board adopted a resolution directing the ADA Survey Center to compile a trend analysis across the past ten years to assess enrollment trends in all accredited advanced specialty education programs. Further, the resolution directs that following Board review of the trend analysis data, the information be distributed to the communities of interest. The Board also adopted a resolution directing the appropriate ADA agency to explore the feasibility of developing and presenting financial/indebtedness seminars to entering freshman dental students preferably in early fall.

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

Report 7

Licensure-Related Activities

Background: The Association has undertaken a variety of activities related to licensure issues, through the Board of Trustees and the Council on Dental Education. This report summarizes the current status of these activities.

January 19, 1996 Meeting of Regional Testing Agencies: The American Dental Association sponsored a meeting of the four regional testing agencies in Chicago on Friday, January 19, 1996. In addition, the presidents of the American Association of Dental Schools (AADS), the American Association of Dental Examiners (AADE) and the American Student Dental Association (ASDA) attended the meeting.

The purpose of the meeting was to discuss the current and future cooperative efforts of the regional testing agencies to enhance the comparability of clinical licensure examinations. Agenda topics included the development and acceptance of standardized valid and reliable dental licensure examinations; methods to assist the licensure candidate who fails, including resources for support and remediation; relationships between clinical competency of dental school graduates and the validity/reliability of licensure examinations; increased faculty involvement in the examination process; use of human subjects in clinical testing; use of the National Board Examination in lieu of a separate written examination; appropriate roles for the key organizations in future dialogue on licensure issues; and possible issues for discussion at an anticipated meeting of testing agencies on March 12, 1996.

It was agreed that a common, uniform entry-level licensure examination is a goal shared by all of the participating organizations. There was general agreement that such an examination must be fair, valid and reliable, and that the examination should focus on preventing incompetent practitioners from entering dental practice. All the agencies agreed that the 1992 ADA/AADE *Guidelines for Valid and Reliable Clinical Dental Licensure Examinations* provide appropriate guidance for the content and administration of a common licensure examination.

Even though the Combined Regional Examination in Dentistry (CORE) agreement between Northeast Regional Board (NERB) and the Central Regional Dental Testing Service (CRDTS) had been dissolved, representatives of both agencies still expressed support for the principle of a common examination. Representatives from the Western Regional Examining Board (WREB) and the Southern Regional Testing Agency (SRTA) informed the group that those two agencies had agreed to administer a common examination in 1996. While member states in each region will not recognize the results of the 1996 examination administered in the other region, the goal is to offer a mutually-accepted common examination in 1997.

The question of high examination failure rates was discussed. Educators noted that high failure rates have caused the educational community to question the validity and reliability of the examination itself. The dental schools believe they provide an evaluation of the students over a relatively long period of time using a wide variety of methods, but that the licensure examinations provide just a "snapshot" of a candidate's overall ability.

By contrast, the examiners expressed concern that, while the examining community spends a good deal of time and effort on examiner training and calibration, it is not clear that a similar formal effort exists to calibrate dental school faculty who conduct clinical evaluations. It was suggested that there is a wide variation among dental schools relative to the methods used to assess students' clinical competency, and that the educational process would benefit from a more systematic approach to faculty calibration and student evaluation.

The testing agencies agreed that dialogue between the agencies should be continued. They expressed an interest in more involvement on the part of students and faculty, and suggested that the ADA could provide financial support for new endeavors such as the development of clinical simulation exercises.

March 12 Meeting of Clinical Testing Agencies: As an outgrowth of previous cooperative efforts of the ADA and the AADE, including development of the *Guidelines for Valid and Reliable Clinical Dental Licensure Examinations*, the ADA sponsored a national invitational conference for clinical testing agencies on March 12, 1996. Representatives were invited from each of the four regional and 12 unaligned state testing agencies, as well as the AADE, AADS and ASDA. The invitational conference was hosted by Dr. William S. Ten Pas, ADA president. It was attended by 22 individuals representing the four regional testing agencies, seven state testing agencies, ADA, AADE, AADS and ASDA.

Following formal presentations related to current activities in clinical licensure testing, the participants broke into discussion groups to focus on three key topics:

- Working Toward a Common Licensure Examination;
- The National Board Examination: Is it Sufficient; and
- Participation in a Regional Testing Agency.

Pass/Fail Rates for Repeat Candidates: As reported to the 1995 House (*Supplement* 1995:433), the Committee on the New Dentist raised issues related to dental licensure examination pass/fail rates. The Committee's concerns were based on anecdotal reports of recent dental school graduates who fail the clinical licensure examination on the first attempt but pass the same examination on the second attempt with no additional clinical experience or remediation. The Committee reported its concerns to the Board of Trustees.

The Board noted that concrete statistics to support or refute these allegations do not exist. However, the Board was concerned that candidates who must retake the examinations lose practice time, may lose offers of employment, must face additional expenses and may harbor negative feelings toward organized dentistry in general. Therefore, the Board directed the Council on Dental Education to obtain the licensing examination pass/fail rates for individuals taking examinations for the first and second time, and the final licensing percentage. The Board also determined that it would continue

to monitor this issue and report to the House annually until the information is regularly and routinely obtained.

The Council sent correspondence to the regional and state clinical testing agencies requesting the aggregate pass/fail rates for candidates within their examining purview who repeat the examinations across time. The Council requested data on the examination results for the spring/summer 1995 testing cycle, including:

- the total number of individuals who attempted the spring/summer 1995 examination for the first time, the number who successfully completed each part of the examination, and the overall passing rate for these candidates;
- the total number of the individuals in the initial candidate pool who repeated any portion of the examination in summer/fall 1995 and, for each part of the examination, the number of candidates who attempted that part, the number who successfully completed the part, and the overall passing rate for the repeat candidates;
- the most common reasons for failure on each part of the examination, as well as the frequency of these reasons;
- the total number of initial candidates who successfully completed the clinical examination and became eligible for initial licensure.

As of June 1996, responses were received from all of the 16 agencies (four regional testing agencies and 12 unaligned state agencies). A summary of the responses received is presented in the table appended to this report (see page 462).

At its April 1996 meeting, the Council on Dental Education reviewed the data and noted that it was incomplete in some instances, perhaps because testing agencies do not routinely track examination candidate data on the basis requested by the Council. Further, the data in some cases reflect a slightly different time period than was specified in the Council's original request. Therefore, the Council determined that it would explore the feasibility of requesting this data on an annual basis, as well as issues related to development of a candidate tracking mechanism to improve future reporting of examination results.

The Board reviewed the data reported by the Council on Dental Education and directed that it be reported to the 1996 House. The Board also determined that the Association needs to communicate the profession's concern regarding the failure rates on clinical examinations and urge the testing community to ensure that the examinations are valid and reliable measures of candidates' competencies. The Board acknowledged that these concerns cannot be resolved by the Association acting alone, but will require the concerted efforts of the entire community of interests.

Board of Trustees' Licensure Committee: At its December 1995 planning session, the Board directed the appointment of a Board Committee on Licensure, to review licensure in its broadest sense and make recommendations to the Board on possible Association initiatives. The Licensure Committee's charge included the identification of changes needed to enhance the initial licensure process and ways the Association can facilitate more rapid adoption of these improvements by the licensure community.

The following key issues were discussed by the Committee.

Pursuit of a National Standardized Examination. In response to a request from the Committee on the New Dentist (CND), the Licensure Committee discussed the feasibility of an ADA-administered national clinical licensure examination. The Committee noted that a national examination would address some of the current concerns related to initial dental licensure. On the other hand, there are many compelling reasons why the centralized administration of clinical examinations under the purview of the ADA would not be feasible. Such an effort would be very costly, especially during the exam development phases, and would undermine relationships with the licensing community. Further, it would only transfer many of the current concerns regarding the validity, reliability, objectivity and fairness of the clinical examination process from the testing agencies to the ADA, without necessarily resolving these issues. The Committee concluded that a national examination administered by the ADA would not be feasible or desirable.

Instead, the Committee believed that the Association should work toward development of a national standardized examination which would be administered by the individual clinical testing agencies. Such an examination would have common content and be administered and scored in the same way by each testing agency. Therefore, the Association should work in cooperation with the AADE and the clinical testing agencies to develop support for a common content clinical examination, to be accepted by all licensing jurisdictions by the year 2000.

Improvements in the Current Examination Process. The Licensure Committee recommended, and the Board concurred, that the Association should define and focus on achievable goals, such as acceptance by all jurisdictions of the National Board Examination in lieu of the written diagnosis and treatment planning portions of clinical examinations. Other possible goals might include development of standardized calibration criteria and forms, development of guidelines and consultation to help testing agencies improve their examination administration and scoring, and identification of ways to make the examinations more candidate-friendly.

Examiner Calibration. Appropriately conducted, standardized calibration of clinical examiners is one key to improved standardization of the examinations. National guidelines and procedures for examiner calibration would support national acceptance of a common clinical examination to be administered by the individual testing agencies. By offering its resources, the ADA could assist the licensing community to accomplish a significant improvement in the clinical examination process.

The relationship between the examination process and the accreditation of educational programs was discussed. Both examinations and the educational process need to be standardized and validated if licensure by credentials is to be accepted by the profession. The Committee supported increased participation by educators in the examination process, in order to improve communication and cooperation between educators and examiners.

Candidate-Friendly Examinations. Examination candidates would like to see a more "candidate-friendly" examination that gives greater control to the candidate. A number of

suggestions for making examinations more candidate-friendly were endorsed by the Committee. These included more flexibility in time allocations during the examination; improved advance information for candidates; improved examiner orientation and training; minimizing the use of human subjects; establishing a candidate assistance center at each testing site; speeding the notification of results to the candidates, to maximize their opportunities for retesting or appeal; and revising policies on appeals/retakes.

Notification and Appeals Process. The Licensure Committee noted that testing agencies vary considerably in their appeals policies and procedures. Although there are valid reasons for such policies, the negative impact on candidates can be serious. Therefore this issue needs to be addressed by the examining community.

Testing agencies also vary greatly in the length of time taken to notify candidates of their examination results. The Committee recognized the financial and administrative reasons why scores cannot be issued immediately, but believed that with current data processing methods there should be no reason why notification requires five or six weeks. The Committee believed that testing agencies should take steps to minimize the time needed to notify candidates of test results.

Use of the National Board Examination. Although the National Board Dental Examination, Part II now contains case-based clinically-oriented questions and is criterion-referenced, some testing agencies still include an additional written component in their clinical examinations. Of the 16 current testing agencies, two regions (WREB and SRTA) and four states have no written component in their clinical examinations.

The Committee concluded that the Association should work with the testing community to encourage more agencies to discontinue use of the separate written examination components. Information about the current content and format of the National Board Examination, Part II, as well as the results of validity and reliability studies on it, should be shared with the licensing community.

Pass/Fail Data. Although the examining community generally believes that the clinical examinations are reliable and valid, the lack of published data on examination results raises concerns within the profession. The Licensure Committee discussed in depth the implications of high failure rates on some of the clinical examinations.

The Committee concluded that the Association needs to communicate the profession's concern regarding the failure rates on clinical examinations and urge the testing community to ensure that the examinations are valid and reliable measures of candidates' competencies. Further, the Committee believed that the variances among dental schools could be lessened by increasing the involvement of faculty in the examination process.

Remediation Programs in Dental Schools. The lack of specific information regarding which dental schools offer remediation programs for candidates who fail the clinical examinations, and the nature of the programs offered, was noted. The committee was aware that many dental schools have financial, logistic or philosophical reasons for not offering such programs. In addition, the schools are often hampered in their ability to design effective remediation programs by the lack of information on why the candidates failed a portion of the examination.

The Licensure Committee concluded that this is not an issue to be solved by the examining community, but one that should be referred to the American Association of Dental Schools (AADS). The Committee proposed, and the Board adopted, a resolution urging AADS to encourage all dental schools to offer remediation programs.

The Use of Human Subjects in Clinical Examinations. The Committee discussed the ethical, legal and professional issues related to the use of human subjects during clinical licensure examinations. The Committee noted that the use of human subjects is currently unavoidable, as there are no valid alternatives available. However, the Committee agreed that the number of patient procedures on the examinations should be reduced to the minimum necessary to assure a valid and reliable examination, based on appropriate psychometric research.

Pregraduation Examinations. In spring 1995, the Southern Regional Testing Agency (SRTA) conducted a pregraduation clinical licensure examination at the University of Tennessee. To determine whether pregraduation examinations would prove feasible and desirable for other testing agencies, the Council on Dental Education encouraged several regional testing agencies to emulate the SRTA/Tennessee experiment. Three regional agencies (NERB, WREB and SRTA) agreed to conduct pregraduation examinations at four dental schools (Case Western Reserve University, Ohio State University, University of Texas at San Antonio and Virginia Commonwealth University) in spring 1996.

To formally evaluate the examinations at these four test sites, the Council engaged a consultant who developed questionnaires to be completed by the candidates, dental school faculty and administrators, and examiners at each site. In addition, focus groups were conducted for candidates at each test site to obtain their perspectives on the examination experience. A report of the consultant's data analysis and evaluation was reviewed at the Council's July 1996 meeting, prior to dissemination to the Board and the examining and education communities.

Licensure by Credentials. Thirty-one jurisdictions currently implement licensure by credentials. The Committee concurred that development of a national standardized clinical examination administered by each testing agency would resolve many of the problems associated with licensure by credentials.

Future Meeting Plans: The Licensure Committee agreed that further changes are needed to enhance the initial licensure process. Although change comes slowly with such complex issues, the ADA should serve as a catalyst to stimulate more rapid advancements. The Committee acknowledged that licensure matters, including the clinical examination process, are the province of state dental boards and the clinical testing agencies. Therefore, the ADA's role should be one of facilitating improvement through cooperative efforts with the licensing community.

In order to capitalize on the momentum initiated by the presidential meetings held in early 1996, as described in this

report, the Licensure Committee developed an action plan for ongoing meetings with representatives of the examining community. The Committee recommended holding two meetings per year: one in conjunction with the AADE Mid Year Meeting in March of each year and one in late summer or early fall. A request for funds to support these meetings in 1997 has been included in the proposed 1997 budget.

The Committee also recommended that a two-day kick-off meeting be held during 1996, to share the Association's concerns with the examining community and encourage the participants to address those concerns. The action plans and priorities adopted by participants would serve as the agenda for future meetings.

Board Actions: Based on the report and recommendations of the Licensure Committee, at its June 1996 meeting the Board adopted the following resolutions.

B-58-1996. Resolved, that the American Dental Association work in cooperation with the American Association of Dental Examiners and the clinical testing agencies to develop support for a common content clinical examination, to be accepted by all licensing jurisdictions by the year 2000.

B-59-1996. Resolved, that the American Dental Association undertake the following activities, to facilitate improvements in the clinical licensure process, in cooperation with the licensing jurisdictions, the clinical testing agencies, the American Association of Dental Examiners, the American Association of Dental Schools and the American Student Dental Association:

1. promote the acceptance by all licensing jurisdictions of the National Board Dental Examination in lieu of a separate written examination on oral diagnosis and treatment planning;
2. work in cooperation with the clinical testing agencies to develop and promote the acceptance of guidelines for standardized examiner calibration and administration of a common clinical examination;
3. with the clinical testing agencies, develop and promote policies and procedures to make clinical licensure examinations more candidate-friendly;
4. develop educational processes for the candidate pool regarding clinical examination logistics and protocol, to assist the candidates in preparing for the examinations;
5. promote further study of the pregraduation examinations by the clinical testing agencies and encourage the testing agencies and dental schools to work together to offer the pregraduation examinations;
6. work with testing agencies to involve the dental school faculty in the clinical examination process to the greatest extent possible and encourage dental school faculty to participate in clinical examiner calibration activities;
7. minimize the use of human subjects in clinical licensure examinations;
8. request the testing agencies to minimize the time needed to notify candidates of examination results;
9. request the testing agencies to improve and standardize their appeals process;
10. request the testing agencies to address the profession's concerns regarding the failure rates on clinical examinations and ensure that the examinations are valid and reliable measures of candidates' clinical competencies.

B-60-1996. Resolved, that the American Dental Association urge the American Association of Dental Schools to encourage all dental schools to offer remediation programs for candidates who fail the clinical licensure examinations.

In addition, the Board noted that licensure matters are, and will remain in the future, of great importance to the profession and the Association. It will be critical to have a specific agency assigned to oversee these issues, to ensure that the Association's agenda is pursued vigorously and the momentum for change is maintained.

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

Table 1

RESULTS ON CLINICAL LICENSURE EXAMINATIONS FOR FIRST-TIME CANDIDATES

Revised 6/20/96

	# First-Time Candidates	# Passing First Time	First Time Pass Rate	# Repeat Candidates	# Passing 2nd Time	# Licensed by 1/1/96	
CRDTS	505	325	64%	132	75	400	(79%)
NERB	1,516	906	60%	397	326	1,213	(80%)
SRTA	343	210	61%	86	74	284	(83%)
WREB	735	663	90%	47	31	694	(94%)
Alabama	75	75	100%	0	0	75	(100%)
California	678	472	70%	101	66	538	(79%)
Delaware	16	11	69%	1*	1	12	(75%)
Florida	222	163	73%	27	16	179	(81%)
Hawaii	14	7	50%	4	2	9	(64%)
Indiana	68	59	87%	8	7	66	(97%)
Louisiana	62	46	74%	16	14	60	(97%)
Mississippi	33	32	97%	1*	1	33	(100%)
Nevada	15	10	67%	1	0	10	(67%)
North Carolina	141	65	46%	clinical 14 juris. 46	clinical 12 juris. 46	123	(87%)
South Carolina	61	50	82%	N/A	N/A	N/A	N/A
Puerto Rico	45	29	64%	16	16	45	(100%)

* Repeat exam taken in 1996; Delaware and Mississippi offer the exam only once per year.

Report 8

Review of the Comprehensive Policy Statement on Dental Auxiliaries

Background: The Board appointed a Committee to Review the Comprehensive Policy Statement on Dental Auxiliaries. Members were Dr. Kay Thompson, chairperson; Dr. Stanley Kaczkowski, Dr. T. Carroll Player, Dr. Lisa P. Howard and Dr. Newell H. Yaple. The Committee presented its report at the June 1996 meeting of the Board, where it was amended and approved.

The Board asked the Committee to Review the Comprehensive Policy Statement on Dental Auxiliaries to undertake three activities:

1. review the ADA Comprehensive Policy Statement on Dental Auxiliaries (*Trans.*1988:462);
2. study a recommendation that the House of Delegates establish auxiliary section membership for dental hygienists, dental assistants, in-office laboratory technicians and business office staff within the ADA and encourage every constituent to do likewise; if appropriate, develop a proposed definition of the scope of auxiliary section membership; and
3. recommend avenues for the constituents to initiate efforts with the legislature and state boards to approve dental assistants to perform coronal polishing and other delegable duties.

The Committee reviewed the Comprehensive Policy Statement on Dental Auxiliaries and noted that it has been eight years since the statement was adopted. Therefore, a review of the policy statement is appropriate, especially in light of the directive by the 1995 House (*Trans.*1995:660) that all Association policies adopted seven years ago or more should be reviewed.

The Committee discussed the status of auxiliary manpower and state laws governing settings and functions of auxiliary personnel. It was acknowledged that ADA policy regarding supervision is not in accordance with the majority of state dental practice acts, nor is it in accordance with many states regarding expanded functions. The Committee discussed the shortage of dental hygiene personnel in some geographic areas, and noted that the members look to the ADA for action that addresses this problem.

The Committee reviewed activities and recommendations of the various ADA agencies, task forces, committees and work groups which have studied auxiliary issues. Specifically, it reviewed the work of the 1994 Task Force on Dental Hygiene, and found that most of the recommendations had been implemented or were outside budgetary constraints as determined by the Board of Trustees.

Information was obtained regarding member utilization of auxiliary personnel in treating institutional patients and about use of certain preventive procedures. The Committee sought input from appropriate ADA agencies such as: Councils on Access, Prevention and Interprofessional Relations; Communications; Dental Benefit Programs; Dental Practice; Governmental Affairs; Membership; and Scientific Affairs; as well as ADAPCO, the Survey Center and the Strategic Planning Committee. The Committee also heard a report of sentiments expressed by constituent lobbyists at the 1995 Lobbyist Conference.

There was consensus among members of the Committee and the Board that the ADA membership expects a change in ADA policies toward auxiliary personnel and that actions which provide greater access to care while protecting the patient will be supported by the membership. The Board noted with particular interest that 30 jurisdictions now permit general supervision and that 22 states currently permit dental hygienists to administer local anesthetics.

Recommendations:

Comprehensive Policy Statement. The Committee recommended, and the Board agreed, that the Comprehensive Policy Statement should be revised. It was adopted by the 1988 House of Delegates and was at that time a compilation of many previously adopted ADA policies. As a result, a rewrite for the sake of clarity and brevity is in order. In addition, two substantive policy changes are recommended.

First, ADA policy should strongly support supervision of auxiliaries without specifying the level and without opposition to general supervision of hygienists. This action reflects changes in state laws which currently allow general supervision. The ADA should continue its strong opposition to unsupervised practice.

Second, because it does not reflect current dental practice, the desire of the membership, or legal requirements in many states, the list of "non-delegable" duties should be deleted from the policy. In its place, the Committee recommended a positive statement regarding delegation of functions which are reversible, and can be safely performed by auxiliaries with appropriate education and training.

The Board agreed that the policy should affirm that two years is an appropriate length of study to prepare individuals to perform clinical dental hygiene services.

A suggested revision of the Comprehensive Policy Statement is provided as Appendix 1.

Membership. The Committee agreed, and the Board concurred, that because the issue of auxiliary section membership in the ADA had been studied by various agencies and rejected by the House for valid reasons, it would make no recommendation regarding auxiliary section membership. That decision does not in any way constitute opposition to auxiliary membership at the constituent society level.

Manpower. In its attempt to address the third activity recommended by the Board, the Committee recommended, and the Board agreed, that the ADA should begin development of a Preventive Dental Assistant personnel category in order to increase access to preventive care services for patients. Implementation of this idea requires development of educational standards, best accomplished through the Council on Dental Education. Development of this category is widely supported in the profession.

Legislative. The Committee believed, and the Board concurred, that there are many hygienists who oppose fragmentation of the dental team and can be important allies in the legislative process. These hygienists should have an opportunity to express their point of view, and the Board agreed that the ADA should give broad exposure to this type of legislative activity.

Based on the above information, the Board of Trustees transmits the following resolutions to the House of Delegates.

Resolutions

45. Resolved, that ADA policy strongly support supervision of auxiliaries without specifying the level and without opposition to general supervision of hygienists, and be it further

Resolved, that the ADA continue its strong opposition to unsupervised practice of dental auxiliary personnel, and be it further

Resolved, that the proposed revised Comprehensive Policy Statement on Dental Auxiliary Personnel be adopted, and be it further

Resolved, that Resolution 10H-1988 (*Trans.*1988:462), Comprehensive Policy Statement on Dental Auxiliary Personnel, be rescinded.

46. Resolved, that the Council on Dental Education be directed to develop, with input from appropriate agencies of the Association, a proposal for a new Preventive Dental Assistant personnel category, and be it further

Resolved, that the proposal include the recommended duties (including coronal scaling and polishing and other preventive services) and education for this new personnel category, and be it further

Resolved, that a report of progress toward development of this proposed personnel category be provided to the 1997 House of Delegates.

Appendix 1

PROPOSED AMERICAN DENTAL ASSOCIATION COMPREHENSIVE POLICY STATEMENT ON DENTAL AUXILIARIES

General Principles

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

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

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

Delegation of Functions

The primary purpose of dentists delegating functions to dental auxiliaries is to increase the capacity of the profession to provide patient care while retaining full responsibility for the quality of care. This responsibility includes identification of the need for specific types of auxiliaries and establishment of appropriate controls on the patient care services provided by auxiliaries.

Appendix 1 (continued)

The dental profession has the responsibility to provide guidance to all agencies, organizations and governmental bodies, such as state dental boards and legislatures, that have an interest in, or responsibility and authority for, decisions on utilization, education, and supervision of dental auxiliaries. In this context, the primary responsibility is to assure that decisions on auxiliary utilization will not adversely affect the health and well-being of the public or cause an increased risk to the patient. In meeting these responsibilities, dentists must also identify those functions or procedures that require the knowledge and skill of the dentist and therefore must be performed only by a licensed dentist. These functions and procedures include, but are not limited to: examination, diagnosis and treatment planning; prescribing work authorizations; surgical or cutting procedures on hard or soft tissue; prescribing drugs and other medications; and administering parenteral, inhalational, or general anesthesia. Nothing in this statement should be interpreted to limit a dentist from delegating to a properly trained auxiliary responsibility for assisting the dentist in the performance of these functions under the dentist's supervision and in accordance with state law, if, in the dentist's professional judgment, this is in the patient's best interest. The transfer of permissible functions from the dentist to the auxiliary must not result in a reduced quality of patient care. In all cases, the authority and responsibility of the dentist for the overall oral health of the patient must be maintained to assure cost-effective delivery of services to the patient and avoid fragmentation of the dental team.

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

Appendix 1 (continued)

Delegation of Expanded Functions

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

Supervision of Dental Auxiliaries

In all instances, a dentist assumes responsibility for determining, on the basis of diagnosis, the specific treatment patients will receive and which aspects of treatment may be delegated to qualified personnel. The degree of supervision required to assure that treatment is appropriate and does not jeopardize the systemic or oral health of the patient varies with the nature of the procedure and the medical and dental history of the patient.

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

Personal supervision: a dentist is personally operating on a patient and authorizes the auxiliary to aid treatment by concurrently performing a supportive procedure.

Direct supervision: a dentist is in the dental office or treatment facility, personally diagnoses the condition to be treated, personally authorizes the procedures and remains in the dental office or treatment

Appendix 1 (continued)

facility while the procedures are being performed by the auxiliary and, before dismissal of the patient, evaluates the performance of the dental auxiliary.

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

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

Personal, direct, and indirect supervision are appropriate for delegation of duties to dental assistants providing direct patient care.

Licensed dental hygienists may be permitted to perform duties, except for intraoral expanded functions, under general supervision, as delegated by the supervising dentist. In order to assure the safety of the patient, the following criteria must be followed whenever functions are performed under general supervision:

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

Appendix 1 (continued)

2. The dentist must provide to the dental hygienist prior written authorization to perform clinical dental hygiene services for that patient of record. Such authorization should remain in effect for a limited time period as specified by state law.
3. The dentist shall examine the patient following performance of clinical services by the dental hygienist. Such examination shall be performed within a reasonable time as determined by the nature of the services provided, the needs of the patient and the professional judgment of the dentist.

Appropriate Settings for Dental Hygiene Services

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

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

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

Dental Auxiliary Education

All personnel who participate in the provision of oral health care must have appropriate education and training and meet any additional criteria needed to assure competence. The type and length of education needed to

Appendix 1 (continued)

prepare auxiliary personnel to perform specific delegated patient care procedures should be specified in state dental practice acts and regulations.

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

Dental hygiene education programs are designed to prepare a dental hygienist to provide preventive care services under the direction and supervision of the dentist. Two academic years of study in an education program accredited by the Commission on Dental Accreditation are appropriate to prepare the dental hygienist to perform clinical dental hygiene services.

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

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

Licensure of Dental Hygienists

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

Appendix 1 (continued)

Constituent Legislative Activities

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

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

Glossary of Terminology Related to Dental Auxiliary Personnel Utilization and Supervision

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

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

Community Dental Health. (1) The overall oral health status of a geographically based population group, (2) the branch of dentistry concerned

Appendix 1 (continued)

with the distribution and causes of oral diseases in the population and the management of resources for their prevention and treatment and (3) commonly used to refer to programs which are designed to improve the oral health status of the population as a whole and conducted under the direction of a dentist (such as access programs, education programs, fluoridation and school-based mouthrinse programs).

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

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

Dental Auxiliary Personnel. Individuals who assist the dentist in the provision of oral health care services to patients, including dental assistants, dental hygienists and dental laboratory technicians who are employed in dental offices or other patient care facilities.

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

Appendix 1 (continued)

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

Dental Laboratory Technician. An individual who may or may not have completed an accredited dental laboratory technology education program and who is skilled in the fabrication of dental appliances and prostheses in accordance with a dentist's laboratory work authorization. To avoid misleading the public, no occupational title other than dental laboratory technician should be used to describe this auxiliary.

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

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

Appendix 1 (continued)

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

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

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

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

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

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

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

Appendix 1 (continued)

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

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

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

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

Report 9

Activities of the Standing Committee on the New Dentist

Background: The Board believes it would be helpful for delegates and members to receive this report to keep them abreast of the activities of the Committee and the New Dentist Committee Network, and to further educate the profession about the commitment the Board of Trustees and the Association have made to serving the needs of new dentists. Therefore, the Board submits the following report.

Committee Composition: The following individuals served as members of the Standing Committee on the New Dentist during 1996: Dr. O. Andy Elliott, Kentucky, chairman; Dr. Elizabeth A. Shapiro, Illinois, vice chair; Dr. Albert R. Arcand, Rhode Island; Dr. Karen D. Barwick, North Carolina; Dr. James K. Cantwil, Michigan; Dr. Raymond A. Cohlmia, Oklahoma; Dr. David K. Curtis, Mississippi; Dr. Anita W. Elliott, Arizona; Dr. Susan B. Goodman, Maryland; Dr. C. Roger Macias, Jr., Texas; Dr. Penny M. Mericle, Pennsylvania; Dr. Michael J. Perpich, Minnesota; Dr. Azam M. Qadri, Ohio; Dr. Julie M. Robinson, Alaska; Dr. George J. Stratigopoulos, California; and Dr. Timothy P. Sweet, New York.

Meetings: The Committee on the New Dentist (CND) met at the Hyatt Regency Alicante in Anaheim, CA, August 8-10, 1995 and at the ADA Headquarters Building in Chicago, January 11-13, 1996. The Committee divided its work into three subcommittees: Leadership and Dental Society Liaison, Conference Activities and New Graduate Transition. The Committee reported to the Board of Trustees on three occasions: August 1994, October 1994, and April 1995.

Personnel: At the January 1996 meeting, the Committee elected Dr. Elizabeth A. Shapiro as vice chair. The 1996 annual session brings to an end the terms of four valued members of the Committee: Dr. O. Andy Elliott, Dr. C. Roger Macias, Dr. James K. Cantwil and Dr. Michael J. Perpich.

The Strategic Plan of the American Dental Association: The Committee on the New Dentist's recent activities, as described in this annual report, support many of the objectives of the Strategic Plan, including Objectives 3, 5 and 9.

Objective 3: Membership Recruitment and Retention. The focus of the Committee on the New Dentist is the integration of dentists less than ten years out of dental school into organized dentistry. The Committee provides the ADA Board of Trustees and councils and commissions with insight into the perspectives, trends, needs and interests of the new dentist. The Committee works through the New Dentist Committee Network (NDCN) to assist the new dentist in making the transition to active membership in organized dentistry.

The ADA's Transition Programs, which are conducted at half of the dental schools every other year, also supports Objective 3. The Transition Program, like the NDCN, assists dental students in making the transition to active membership in organized dentistry.

Objective 5: Education and Licensing. The National Conference on the Young Dentist provides an excellent membership benefit for new/young dentists by providing an opportunity for affordable continuing education on practice management, and clinical, leadership and professional issues. In addition, the networking and sharing of ideas during the Conference by the new/young dentist leaders encourages new members to become active participants in organized dentistry at the state and local levels, which also supports Objective 3. The Committee also supports the Association's consideration of the development and administration of a national clinical licensure examination, and will continue to share the new dentist's perspective on licensure issues with the Board of Trustees and the Association.

Objective 9: Governance. The New Dentist Committee Network consists of 42 state and 73 local new dentist committees. The NDCN provides the ADA the opportunity to receive input from new dentists, which then allows the ADA and its constituents and components to be proactive and representative of the changing demographics of the profession.

Ex Officio Members: The following Committee members served as *ex officio* members, without the power to vote, to ADA councils: Dr. Karen Barwick, Council on Ethics, Bylaws and Judicial Affairs; Dr. Raymond A. Cohlmia, Council on ADA Sessions and International Programs; Dr. Anita W. Elliott, Council on Dental Practice; Dr. Susan B. Goodman, Council on Membership; Dr. Elizabeth A. Shapiro, Council on Dental Benefit Programs; Dr. George J. Stratigopoulos, Council on Governmental Affairs and Federal Dental Services; and Dr. Timothy P. Sweet, Council on Dental Education and Commission on Dental Accreditation.

Several issues related to new dentists were discussed at these council meetings with input from the *ex officio* members; these and other issues were addressed by the Committee. The *ex officio* members have reported that they have been welcomed as full members of the councils on which they serve and that they believe they have offered concrete and valuable input to these agencies on the issues affecting new dentists and how decisions made by an agency can and/or will impact new dentists.

The original goal of the *ex officio* positions was to ensure new dentist perspectives are represented in agencies dealing with issues impacting this membership segment. Added benefits of Committee member participation on other ADA agencies have been an increased awareness of the issues and challenges facing the Association and the profession and the tremendous progress being made on behalf of the members, and an increase in communication between ADA agencies. This is being conveyed through the network and has certainly impacted the individual committee members' effectiveness

both in their deliberations with the Standing Committee and in their roles as regional representatives.

National Conference on the Young Dentist: The Ninth National Conference on the Young Dentist was held in Anaheim, CA in August 1995. In 1995, the Committee increased corporate sponsorship by 7% over 1994, which represents a 78.6% increase since 1993. Expenses were reduced by 8% from 1994, which represents a 19.9% decrease from 1993. The Committee is pleased to report that it is well on its way to achieving its goal of a revenue-neutral conference by 1998. The Tenth National Conference on the Young Dentist, A Decade of Excellence, will be July 25-27, 1996 in Cleveland and will include clinical practice management and leadership development programming.

New Dentist Committee Network: The Committee is pleased to report continued growth in the NDCN, which now includes more than 115 state and local new dentist committees. These committees are making significant contributions to organized dentistry by attracting, retaining and involving new dentists and ensuring that the tripartite organization is aware of and addressing the needs of this market.

The Committee has developed and will be piloting several strategies to strengthen and support the NDCN in the coming years. For example, the Board of Trustees has approved a New Dentist Committee Award of Excellence. In addition, there will be targeted educational sessions for New Dentist Committee Network members at the National Conference on the Young Dentist.

Transition Program: The New Dentist Transition Program was conducted by Committee members and staff in 27 schools in spring 1996. This program has been very well received by students and dental school administrations. In addition to conveying how to join organized dentistry, the program has been very effective in communicating the more intangible benefits of membership in organized dentistry.

New Dentist Issues: As outlined in the *Constitution and Bylaws*, it is the responsibility of the Standing Committee on the New Dentist to identify the needs and concerns of the new dentist, and to provide the Board of Trustees with expertise on the issues affecting new dentists. The Committee has identified the following as the primary areas of concern among new dentists.

Managed Care/Marketplace Issues. The Committee discussed managed care/marketplace issues at length and these issues have been the primary topic of discussion at new dentist committee meetings across the country. The substance of these discussions falls into three primary areas of concern:

- Membership—Of the many new dentists working in a managed care environment, a good number are deciding to not join the dental society. Some of these new dentists have reported that they feel alienated and not welcome at dental society meetings because they are in managed care programs. Many new dentists involved in the larger managed care programs also report that they have no need for the Association benefits as their employer provides insurance and continuing education.
- Education—New dentists, because they often lack a solid practice base and have a high debt load, may be particularly attracted to join managed care programs. The new dentist is in the position of making decisions without all of the facts and without practical experience on which to base decisions. The Committee believes the economic model developed by the Dental Economic Advisory Group and the Council on Dental Practice to help dentists evaluate the financial realities of managed care programs will be a tremendously important resource for the new dentist.

  The Committee identified an additional educational opportunity to assist new dentists. The Committee has recommended that the Association develop a course in debt management, cash flow, contract negotiation and personal finance, targeted to new dentists, in order to prepare them to make informed decisions concerning the financial and legal aspects of managed care participation. Such a course will provide new dentists with sound management principles that will enable them to make successful financial decisions which, in turn, will help them manage the stress that accompanies financial pressure.
- Ethics—Committee members, state and local New Dentist Committee members, and attendees at the National Conference on the Young Dentist have described difficult ethical decisions and pressures experienced as a result of participation in some managed care programs. New dentists often find themselves working for other dentists; in some cases new dentists have reported being assigned all of the managed care patients and feeling pressure from both the employer and the managed care provider to make recommendations based on considerations other than the patients' best interest. A question asked by new dentists is whether or not it is ethical to charge one patient one fee because he or she is enrolled in a plan, and charge another patient not in the plan a higher fee.

In addition to this discussion of the new dentist perspective on these issues, the Committee expressed appreciation to the Board for its prompt and thorough attention to these managed care and marketplace issues, for the significant progress being made, and for recognizing the impact these issues are having on new dentists and the patients they serve.

Debt Management. Managing a debt burden of, on average, close to $60,000 remains the greatest problem for new dentists. This problem relates to and is often the underlying cause of all other problems encountered by the new dentist. For example, new dentists feel additional pressures to join managed care programs because they must find a way to finance their debt payments. New dentists may feel pressure to accept a job, any job, rather than practice the type of dentistry they would like to, in order to meet their financial obligations. New dentists continue to cite financial burdens as the primary obstacle to membership. The Committee recognized the scope of this issue, and urged the Board and the Association to continue to search for opportunities to reduce the tremendous costs associated with obtaining a dental education. The Committee added its support of the Association's lobbying activities to reinstate the tax deductibility of student loans.

Licensure. Licensure by credentials continues to be an important issue to many new dentists who feel they should be

allowed freedom of movement. This is a diverse group, with many women, minorities and second career dentists, who often must relocate due to family circumstances and must be relicensed several times. This item is an ongoing issue at most state and local new dentist committee meetings and at the open forum and leadership idea exchanges at the National Conference on the Young Dentist. The Committee recognizes the tremendous progress that has been made on this issue in recent years and has taken an active role in educating new dentist committees and members to the realities and limitations of what the ADA can and cannot do regarding licensure. The Committee supported the Association's continued activities and discussions related to expanding licensure by credentials.

Licensure Examination Pass/Fail Rates. The Committee supported the Board's Resolution B-177-1995 (*Trans.*1995:581), which directed the Council on Dental Education to investigate methods for candidates who have failed the boards to have access to educational clinical facilities, and Resolution B-178-1995 (*Trans.*1995:581), which encouraged the ADA President to meet with representatives from the regional licensing boards to discuss issues including the pass/fail rates.

The Committee recognized that action must be taken to support those students who fail the licensing examinations, especially in light of the large numbers of individuals affected. Those graduates who must retake an examination lose practice time, may lose offers of employment, must face additional expenses associated with retaking the exam, and may even harbor negative feelings toward the ADA as a result of the experience.

Any program designed to assist students who have failed a board examination faces a significant barrier: students failing their exams understandably want that information kept confidential and may not share with anyone the fact that they have failed. Although it recognizes that the Association cannot directly aid an individual, particularly if that individual does not wish to let the Association know he or she failed, the Committee was determined to address this issue and recommended that the Association let all recent graduates know that the ADA is committed to addressing the issue.

With the Board's support and direction, the Committee developed a strategy to reach out to these recent graduates. The Committee has proposed a support program be established for dentists who fail their boards. This proposed program for 1997 consists of a mailing to all senior dental students prior to graduation that includes a nonpersonalized letter from the regional CND representative; information about the ADA and ADA membership, explaining that membership is still available if a student does not pass his or her examination; the universal membership application; provisional membership application; information regarding dues and dues waivers; a telephone number for students to call to obtain information about future board examination dates and locations; and information about ADA financial services. The letter also notes the difference between the ADA and the licensure boards and assures the student that if they or a colleague calls for assistance, the ADA will not volunteer information about the student's status.

National Clinical Licensing Examination. The Committee discussed the problems new dentists face with multiple testing agencies and the impact the dissolution of the agreement between the Northeast Regional Board and the Central Regional Dental Testing Service will have on new dentists. The Committee commended the Board for addressing the licensure issue, acknowledged the progress that the Association has made on behalf of the profession, and conveyed its appreciation for convening the Board of Trustees' Committee to Study Licensure and for appointing a CND member to that committee. The Committee also discussed the possibility of the Association revisiting the concept of developing a national clinical licensure examination and requested that the appropriate agency identify the ramifications associated with this concept.

Manpower. The Committee continues to assess the impact of the changing marketplace on new dentists and the implications of these changes related to manpower. The Committee, as part of its ongoing discussion of this issue, requested that additional information be compiled incorporating information on employee dentists and factoring educational debt repayment amounts into the data previously reported to the Committee.

Membership. The Committee acknowledged that 25 of the 29 states with an increase in new dentist market share in 1995 have active new dentist committees, and it commends these Committees for their efforts.

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

Report 10

AIDS Update 1996

Background: In 1991, a Task Force on AIDS was established to address and manage Human Immunodeficiency Virus (HIV)-related issues. The Divisions of Science, 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 concerns.

AIDS Surveillance: The HIV epidemic continues to grow and expand into unsuspecting populations. Through December 1995, 513,486 AIDS cases had been reported to the Centers for Disease Control and Prevention (CDC), and more than 300,000 people had died from the disease. The findings for 1995 indicate that among men reported with AIDS, male-to-male sexual contact again accounted for the largest proportion of cases (51%), followed by injecting drug use (24%). Women accounted for 19% of adult/adolescent AIDS cases in 1995, the highest proportion yet reported among women. Most women acquired HIV infection through injecting drug use (38%) or sexual contact with a man with, or at risk for, HIV infection (38%). The epidemic among women is reflected in the epidemic in children, nearly all of whom acquired HIV infection perinatally.

Transmission of the Human Immunodeficiency Virus 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.* In an article published in the *Annals of Internal Medicine* (1994; 121 (11):886-888) the CDC defended its study of the Acer case, and repeated its contention that the scientific evidence indicates that the Florida dentist transmitted HIV to six of his patients. The CDC further stated that reports presented by "60 Minutes," as well as other magazine and newspaper articles, omitted pertinent epidemiologic and laboratory evidence that shows that no other sources of HIV infection could be documented for the six dental patients.
- *HIV Transmission from Provider to Patient.* Other than the alleged Acer case in Florida, retrospective studies of HIV-infected health care workers (HCW) have not identified a single instance of viral transmission from infected HCW to a patient (*Annals of Internal Medicine* 1995;122:653). 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 December 1995, there were a total of 49 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 49 occupational seroconversions, most HCWs received percutaneous exposures.

  The CDC has further identified 102 HCWs with *possible* occupationally-acquired HIV infection. Of these 102 cases, seven 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 over 15,000 dentists since 1986; to date only two HIV-infected dentists have been identified who reported having no risk factors for nonoccupational exposure to HIV.

  Out of over 500,000 AIDS cases reported to the CDC, 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.* There is no documented evidence of patient-to-patient HIV transmission in the dental office.

In short, epidemiological studies demonstrate that the risk of HIV transmission in the dental office from provider to patient, patient to provider, and patient to patient is very low.

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

Report 11

Awareness Advertising Plan

Background: The Board of Trustees at its June meeting requested that the Division of Communications develop a report for the July Board session providing information on potential costs and parameters of a public image marketing campaign. Staff consulted with FCB Direct, the ADA's marketing agency of record, to meet the Board's request.

Discussion: The marketing objective of an awareness or image campaign would be to change consumer behavior, influencing them to visit the dentist more often and consume more oral health care services. A parallel goal would be to enhance dentists' image in the public eye. Behavioral modification is a difficult marketing challenge, dictating that marketing efforts be broad in reach and that messages be delivered frequently over an extended time.

The target audience for such an effort would be family oral health care decision makers, most likely women age 25-54 with emphasis on those with children living at home, high school and/or college graduates, with household income of $30,000 or more annually.

A multimedia communications plan would be developed to maximize reach against the target audience, using television and print to build and maintain awareness over time. Television would be the primary communication medium because of its ability to educate consumers about new dental techniques, remind them about the benefit of regular care and enhance perceptions of dentistry. Print would be used as a secondary medium to reach working mothers and take advantage of the "how to" editorial environment common to women's service publications. Maximizing the long-term benefit of awareness building would require at least three years.

Possible elements of the media plan would be a mix of prime time and daytime television, as well as print publications selected from a menu including: *Parenting, Working Mother, Women's Day, Better Homes & Gardens, Family Circle, Good Housekeeping, McCall's* and *Redbook.*

The media plan is designed to reach 94% of the potential audience in each of three years at a frequency of 31.5 times in year one, 27.75 times in year two and 24 times in year three. More dollars would be allocated in year one to maximize initial awareness building, with frequency reduced in years two and three.

The budget required to achieve these results follows (figures are in millions).

	Television	Print	Research & Production	Total
Year 1	$30	$3	$2	$35
Year 2	25	3	2	30
Year 3	20	3	2	25

The plan includes extensive research to identify services most appropriate to promote and messages that best influence the consumer. Baseline tracking would measure current perception, overall awareness and awareness of specific services. Yearly tracking would be included.

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

Report 12

Associate Membership Category

Background: In August 1993 the Board of Trustees asked the Council on Membership to review the current associate membership category and recommend appropriate changes if necessary. During 1994-95, the Council spent considerable time exploring the feasibility and need for the Association to create specific nondentist categories of associate membership and ultimately recommended against the expansion of the associate category. However, at its June 1995 meeting the Council supported the planned special promotion of the current associate membership category to educators that was initiated by the Board of Trustees.

In April 1995, the leadership of the American Dental Association and the American Association of Dental Schools (AADS) agreed to support a joint recruitment effort for ADA associate membership. The purpose of the ADA's effort to recruit this group of dental school faculty was significant for several reasons: 1) a recruitment effort of this type would enhance ADA's relationships with members of AADS and provide the opportunity for nondentist faculty to show their commitment to the ADA; 2) the then incoming president of AADS was a nondentist and supported this effort. A letter signed by President Richard D'Eustachio and Dr. Lisa Tedesco, president of AADS, was mailed September 5, 1995 to 960 nondentist members of AADS. The Association received 41 applications for associate membership from this pilot recruitment effort. In reviewing this group of associate applications, the Board found the application and approval process very awkward. This report recommends improvements to the process which will ensure appropriate review and verification while improving the process.

Summary of Board Recommendations: This report includes Board recommendations intended to narrow the criterion to limit educators and researchers for associate membership and several new strategies to streamline the approval process. Although the Board recommends the *Bylaws* be amended to accurately reflect that associate members receive *JADA* as a privilege of membership, this is not a new privilege. Associate members have always received *JADA* as a benefit of membership and no changes in the current benefits or dues for associate members are recommended. In summary, the recommendations are as follows:

1. revise qualifications for associate membership to limit eligibility to nondentists employed full-time in dentally-related education or research by an accredited institution of higher learning;
2. establish provision for loss of membership status for associate members if full-time employment is terminated at a qualified institution or if dues are not paid by March 31 of the current year;
3. establish "grandfather" provision that allows current associate members to maintain their status until such time as they terminate their current employment; and
4. revise privilege section to clarify that associate members receive *The Journal of the American Dental Association*, the subscription price of which shall be included in the annual dues.

Current Application Process: Except for the administrative procedure followed in the recent AADS campaign, applications for associate membership have been forwarded to the ADA Board of Trustees for approval after the following information has been obtained or reviewed.

- The ADA Masterfile is checked to ensure that the applicant is a nondentist.
- The application must contain a signature or letter of recommendation from an ADA member.
- The application is forwarded to the constituent dental society executive director for review and signature.
- After receiving a response from the constituent society, the application is forwarded to the ADA trustee for reference and review.
- Following receipt of all information, the application is then forwarded to the next Board of Trustees meeting for final approval.

Board Discussion: The Board has noted that most applications have been processed and approved within three months but often the process can take six months or more. The Board of Trustees has occasionally expressed frustration with procedures for processing associate member applications and has explored the benefits and drawbacks of the above procedures as well as the current qualifications for associate membership. The Board specifically noted:

- obtaining comment and/or approval from constituents is the best source for verifying the information received from applicants;
- a review of past applications shows that the Board has not made a decision against a constituent recommendation;
- the majority of current associate members are involved in dental education or dental research and the Board believes that maintaining positive relationships with these groups is of primary consideration; and
- amending the qualifications for associate membership to require specific educational or employment criteria may eliminate the above concerns regarding the review of associate applications. This could then allow for streamlining of the approval process.

The Board understands the need to verify the credentials of applicants for associate membership, and at the same time wants to improve the verification process. The Board believes this can be accomplished by establishing new application procedures and amending the *Bylaws* definition for associate members.

Proposed Changes for Associate Membership Application: As previously noted, the current application requires signatures of an ADA member and the constituent dental society executive director. The proposed new application

would require three signatures prior to Board of Trustees approval:

1. university dean or provost: to verify full-time employment and acknowledge that the applicant's occupation contributes to the advancement of the objectives of the Association;
2. component dental society executive director or president: for notification and opportunity to communicate objection to the approval of the applicant, and to facilitate communication between faculty and local society; and
3. constituent dental society executive director: for notification and opportunity to communicate objection to the approval of the applicant, and to facilitate communication between faculty and state society.

The Board is confident that application procedures can be implemented which require a thorough review and verification process that will ensure only appropriate and qualified applicants will be accepted as associate members.

Current Associate Members: The Board is cognizant of potential problems involving the membership status of current associates who do not meet the proposed eligibility requirements. As previously noted, the majority of current associate members are involved in dental education or research and therefore would not be adversely affected by the proposed changes. However, the Board believes that several current associates employed in other dental-related professions should be "grandfathered" and allowed to maintain their associate member status until such time as they change their employment unless qualified under new eligibility criteria. It is estimated that 15 of the current 89 associate members would not meet the proposed eligibility criteria.

The Board appreciates the longtime support of many current associate members and believes that it is in the best interest of the Association to allow these individuals the opportunity to continue their affiliation.

Loss of Membership: The Board reviewed the *Bylaws* and notes that there is no provision for termination or loss of membership status for associate members. The Board believes that the *Bylaws* should expressly provide for the removal of associate members for cause.

Conclusion: The Board is extremely supportive of the Association's Strategic Plan, which is designed to focus the attention of volunteer leaders on key issues which will impact the future of the Association and the practice of dentistry. In this regard, the Board's recommendations are designed to limit associate membership to a key group of nondentist educators and to improve verification and confirmation procedures. The Board strongly urges the House to support the recommended changes to the associate member category. The Board recommends that the House adopt the following resolution.

Resolution

81. Resolved, that Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection F. ASSOCIATE MEMBER, of the *Bylaws* be amended by deleting Subsection F in its entirety and by substituting in its place a new Subsection F to read as follows:

> F. ASSOCIATE MEMBER. A person, not eligible for any other type of membership in this Association, who contributes to the advancement of the objectives of this Association, is employed full-time in dentally-related education or research by an accredited institution of higher education and has not met the educational requirements for licensure as a dentist anywhere in the United States, upon application to and approval by the Board of Trustees, shall be classified as an associate member of this Association.*

and be it further
Resolved, that a footnote be added to Chapter I. MEMBERSHIP, Section 20. QUALIFICATIONS, Subsection F. ASSOCIATE MEMBER, of the *Bylaws* to provide as follows:

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

and be it further
Resolved, that Chapter I. MEMBERSHIP, Section 40. PRIVILEGES, Subsection F. ASSOCIATE MEMBER, of the *Bylaws* be amended by deleting Subsection F in its entirety and by substituting a new Subsection F to read as follows:

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

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 by adding a new part "c" to read as follows:

> c. An associate member whose dues have not been paid by March 31 of the current year shall cease to be a member of this Association. An associate member who terminates full-time employment in dentally-related education or research at an accredited institution of higher education shall cease to be an associate member of this Association December 31 of that calendar year.

Report 13

Proposed Organizational Restructure of the ADA CERP Committees

Background: In a report to the 1995 House of Delegates (*Supplement* 1995:325), the Board of Trustees noted that the American Dental Association's Continuing Education Recognition Program (ADA CERP) had developed since its inception. Therefore, the Board believed it was appropriate to review the original structure and function of the program's governing committees and perhaps formalize the position of the ADA CERP committees within the Association's governing structure.

Based on the Board's recommendation, the 1995 House adopted Resolution 133H-1995 (*Trans.*1995:646), which urged the Board to direct a review of ADA CERP, including the structure and function of its supporting committees. This review was to include the feasibility of making the CERP program a function of the Council on Dental Education (CDE) pursuant to the Council's *Bylaws* authority. The Board was given the authority to restructure the CERP Policy Board and the CERP Review Committee as subcommittees of the CDE, if the Board determined such a restructure would be appropriate.

A Special Board Committee on ADA CERP was assigned responsibility for reviewing the structure and function of the CERP committees. Members of the Special Board Committee included Dr. Gary Rainwater (chair), Dr. Lewis J. Turchi, Dr. David A. Whiston and Dr. William S. Ten Pas (ex officio). The Special Board Committee considered several options for relocating the ADA CERP Policy Board and Review Committee within the Association's organizational structure. These options included making the CERP Policy Board a standing committee of the Board, similar to the Committee on the New Dentist; making the Policy Board a standing committee of the CDE while retaining its current composition and autonomy; and delegating the Policy Board's functions to the CDE while reconstituting the Review Committee as a subcommittee of the Council.

Original CERP Structure: The CERP governing structure was established by a special Board-appointed committee representing the communities of interest. In its report to the 1992 House of Delegates (*Reports* 1992:141), the committee attempted to balance the need for broad representation of all interested parties against the need for a smaller body to manage the program operations efficiently. The result was two governing bodies for CERP: the 18-member Steering Committee (now renamed the Policy Board), which sets the standards and policies related to program governance, and the eight-member Review Committee, which conducts the provider reviews and manages program operations. The representative structure and assigned duties of these two bodies were adopted by the 1992 House (*Trans.*1992:613).

It should be noted that early efforts to create a single governing body for CERP, which would have broad representation but a more workable size, were not successful. The specialty organizations, especially, believed that each specialty must have its own representative. The current membership of the Policy Board was designed to meet the specialties' concerns and still provide a balance of generalists and specialists.

The CERP Policy Board includes two representatives each from the American Dental Association, the American Association of Dental Schools, the American Association of Dental Examiners, and the Academy of General Dentistry, and one representative from each of the eight ADA-recognized specialties, continuing education (CE) providers and the public. These members are appointed by their respective organizations to four-year terms. A member of the ADA CDE serves as chair. The Policy Board meets once per year and members' travel expenses are paid by the appointing organizations.

The Policy Board's current structure affords a voice to all of the major interest groups in continuing dental education and thus assures that the needs of all constituencies are addressed. Participation in the governance of the program has generally strengthened these organizations' commitment to CERP. Because ADA CERP is structured to meet the needs of the entire dental profession and functions autonomously, the program's credibility is enhanced for state dental boards with CE requirements as well as for individual members and CE providers.

The drawbacks to the broadly-representative membership of the Policy Board are its size and the fact that it meets only once per year in an effort to keep down costs to the governing organizations. Therefore, it has some difficulty in responding to issues in a timely fashion. However, the primary concerns raised by the current Policy Board structure are based on its undefined position within the ADA's organizational structure, with resulting unclear lines of communication.

The eight CERP Review Committee members are appointed by the chairman of the CDE from among the Policy Board members. An effort is made to balance the representation on the Review Committee between general dentists and specialists, while still providing for representation of as many communities of interest (e.g., educators, examiners, practitioners) as possible. The CDE member of the Policy Board also serves as chair of the Review Committee. The Review Committee meets twice per year and members' travel expenses are paid by the ADA.

The Review Committee also serves a second function, as a standing committee of the Council to review and make recommendations on matters of Association policy related to continuing dental education. When CERP was created by the House, the Council's existing standing committee on CE was replaced by the Review Committee to avoid duplication and reduce the number of consultants needed. It is this additional role that requires that the CDE chair selects the Review Committee members and that the committee reports routinely to CDE.

Proposed Restructure of CERP Program: As noted previously, the current responsibilities of the CERP Policy Board include establishing the standards for recognition of CE providers and adopting policies related to the governance of the program. In the proposed restructure, these

responsibilities would be transferred to the CDE, which represents the practice, education and licensure communities. The present CERP Policy Board would no longer exist.

The current eight-member Review Committee, which is now a subcommittee selected from among the Policy Board members, would become a subcommittee of the Council. Under the proposed restructure, the members of the committee would still be appointed by the chair of the CDE. However, the size of the Review Committee would be increased to a (potential) total of 15 members, representing the following communities:

1	American Association of Dental Schools
1	American Association of Dental Examiners
4	American Dental Association (at least 2 of whom shall be general dentists)
8	ADA-recognized dental specialty organizations
1	Canadian Dental Association (if approved by the 1996 House)
15	Total (potential)

It should be noted that the size of the Review Committee could vary depending on the number of ADA-recognized specialties and other factors such as their decisions to participate as recognized CE providers.

The members of the CERP Review Committee are presently selected from among the Policy Board members, who are appointed by their respective organizations without further approval by the ADA. Under the proposed restructure, the Review Committee members would be selected in much the same way as all other CDE subcommittees. Based on their subject matter expertise and membership in the appropriate communities, they would be appointed as Council consultants subject to approval by the Board, as specified by the *Standing Rules for Councils and Commissions*.

The *Standing Rules* indicate that subcommittees "may include approved consultants to assist the subcommittee in developing a recommendation for full council/commission action. Only those consultants who are subject matter experts, not organizational representatives, shall be permitted to vote on subcommittee matters." Therefore, it would not be possible for the CERP Review Committee members to be appointed as organizational representatives, as that would negate their voting rights. However, the communities of interest will be requested to submit nominations for appointment as Council consultants/Review Committee members, so that they will have significant input into the selection process.

At present, the CERP Review Committee has authority to make final decisions on the recognition status of applicant CE providers. This authority was granted by the 1992 House (*Trans.*1992:613) to ensure the committee's independence from potential political influences. However, the *Standing Rules* specify that subcommittees are empowered only to make "recommendations within their specific area for consideration by the entire council or commission." Accordingly, the Review Committee would review the provider applications for CERP recognition and forward its recommendations for review and approval by the CDE.

Because the Review Committee currently has final recognition authority, the CDE was designated as the appeals body for the CERP program. Under the proposed restructure, a different appellate mechanism would be necessary, as the Council could not hear appeals of its own adverse actions. Therefore it is recommended that an appeals body consisting of five members representing the ADA, AADE, AADS and two specialty organizations be created for this purpose. The members of the appeals body would be different from the members of the CDE and the Review Committee.

Implications for Proposed Participation by the Canadian Dental Association: At its March 1996 meeting, the CERP Policy Board approved the proposed agreement for the Canadian Dental Association's participation in ADA CERP. Further, the Policy Board directed that a report, with a resolution to accomplish the agreement, be provided to the Board with a request that it be forwarded to the 1996 House. The agreement has been ratified by the CDA's Council on Education and awaits final action by the CDA Board of Governors in August 1996.

The proposed agreement, which was reviewed at the February 1996 meeting of the Special Board Committee on CERP, specifies that the CDA would appoint a representative to both the Policy Board and the Review Committee, so that the CDA—like the other governing organizations—would be able to participate in the standards-setting process as well as the provider evaluation process.

Under the proposed restructure, the Policy Board would be eliminated and its functions, including setting the CERP standards, transferred to the Council. However, under the current ADA *Bylaws*, it would not be possible for a CDA member to be appointed as a voting member of an ADA council. Therefore, the CDA would have no voice in the establishment of the CERP standards. Similarly, if the Review Committee becomes a subcommittee of the Council, the CDA would not be able to appoint its own representative, although it would nominate an individual for appointment.

Whether the revised structure would continue to be acceptable to the CDA is a question that would need to be explored. However, if the proposed reorganization of CERP is supported by the ADA Board, it appears appropriate that the Canadian Dental Association be informed of the potential changes and given an opportunity to renegotiate the proposed agreement if necessary.

Proposed *Bylaws* Revisions: The CERP was created by action of the 1992 House as a program to be conducted by an independent agency representing the communities of interest under the administrative aegis of the ADA. Resolution 133H-1995 gives the Board the authority to make CERP "a function of the Council on Dental Education...." However, the proposed changes go beyond the revised reporting relationships envisioned by the 1995 House. The elimination of the Policy Board and restructuring of the Review Committee as a subcommittee of the Council approved by the Board significantly alters the participation by the current governing organizations. For these reasons, these changes require House action to amend Resolution 25H-1992 (*Trans.*1992:614).

Other Considerations: The House should be aware of other possible implications of the proposed restructure of ADA CERP. The changes in the autonomy of the program and the level of representation afforded the communities of interest

may or may not impact the participating organizations' support for the program.

Similarly, the perceptions on the part of CE providers that the ADA CERP program offers an objective and impartial review may or may not be affected by making it a function of the CDE. ADA CERP is now perceived by many specialty groups, dental schools and CE providers as having a significant advantage over other existing national CE review programs, in that it provides opportunities for input by the major groups within the profession. The proposed changes could impact the number of applications/reapplications from providers and the resulting program revenues.

The Academy of General Dentistry currently automatically accepts credits awarded by ADA CERP-recognized CE providers toward its fellowship and mastership awards. Therefore, many providers have opted to apply for ADA CERP recognition in order to receive the benefits of recognition by both organizations based on a single application/fee. Significant changes in the program's governing structure could lead the AGD to reconsider its policy on acceptance of ADA CERP recognition, which in turn could impact the level of participation in CERP.

Financial Implications: The suggested restructuring has a financial implication of $8,700 in 1997. The current Policy Board meets annually, while the Review Committee meets twice per year. The ADA pays the meeting attendance expenses of the Review Committee members, plus the ADA and public members of the Policy Board (a total of 17 volunteer trips in 1996-97). The other organizations represented on the Policy Board now pay the expenses of their representatives. Under the revised committee structure, the ADA would pay the travel costs of the entire CDE subcommittee for two one-day meetings per year, as it does for all council subcommittees. Therefore, the costs associated with the CERP committee meetings would increase from 17 volunteer trips ($11,400) to 30 trips ($20,100) per year.

Board Recommendation: The Special Board Committee on CERP determined, and the Board concurred, that the CERP Policy Board should be disbanded and the CERP Review Committee restructured as a subcommittee of the Council on Dental Education, to formalize the position of the program within the ADA's organizational structure. The Board recommends that the following resolution be adopted by the 1996 House.

Resolution

82. Resolved, that responsibility for the conduct of the American Dental Association's Continuing Education Recognition Program (ADA CERP) be transferred from the existing ADA CERP Policy Board to the Council on Dental Education, and be it further

Resolved, that a continuing education subcommittee of the Council be created to facilitate the conduct of the ADA CERP by developing expertise and making recommendations regarding continuing education provider recognition for consideration by the Council, and be it further

Resolved, that the continuing education subcommittee shall have the following initial composition: one consultant each representing the dental education community, the dental licensure community, the parent organizations of the ADA-recognized dental specialties and the dental profession in Canada, and four consultants representing dental practice, at least two of whom shall be general dentists, and be it further

Resolved, that the Council on Dental Education shall have the authority, with the concurrence of the Board of Trustees, to alter the composition of the continuing education subcommittee as needed to ensure the effective management of the ADA CERP, and be it further

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

Report 14

Request from the Canadian Dental Association to Participate in ADA CERP

Introduction: The Board of Trustees considered the following report regarding participation of the Canadian Dental Association in ADA CERP. The Board's comments and recommendation regarding this request appear at the end of the report and are transmitted to the House of Delegates for action.

Background: In March 1995, the Policy Board of the American Dental Association's Continuing Education Recognition Program (ADA CERP) discussed means to encourage the participation of Canadian-based continuing education providers in the ADA CERP. The *CERP Standards and Procedures* indicate that providers must be based in the United States or Canada to be eligible for recognition. Several Canadian providers have received recognition, although CERP has not been widely publicized in Canada.

The Policy Board believed the support of the Canadian Dental Association (CDA) would be beneficial in marketing CERP to Canadian providers. Therefore, correspondence was sent to the CDA regarding the feasibility of possible cooperative efforts, such as (1) a reciprocal agreement between ADA and CDA regarding the evaluation of CE providers or (2) cooperative marketing activities.

The response from the Canadian Dental Association indicated an interest in developing cooperative ties with the ADA CERP. The CDA has no continuing education evaluation process in place at this time. Therefore, the CDA proposed to collaborate with the ADA evaluation process rather than attempt to develop a separate approval process for Canadian providers.

The CDA believed that ADA and CDA member dentists cross the border between the countries in both directions to attend continuing education courses. Further, both ADA and CDA have the same concerns regarding establishing standards and monitoring the performance of continuing education providers. Therefore, the CDA Board of Governors concluded that it makes good sense to have a single mechanism for recognition of continuing education providers in both countries.

In keeping with the suggested U.S./Canadian partnership, the CDA has requested representation on the CERP Policy Board and Review Committee. In addition, the CDA requested that a means be identified to cover the costs of CDA's representation on the CERP governing bodies through CERP revenues. For its part, the CDA would agree to accept CERP-recognized providers and assist in actively marketing CERP to Canadian providers, as well as encourage acceptance by the provincial licensing authorities. In August 1995, the CDA Board of Governors directed staff to enter into negotiations regarding participation in the ADA CERP.

The ADA Council on Dental Education considered this matter at its October 1995 meeting and supported the concept of a collaborative partnership with the CDA, provided a suitable agreement could be negotiated. At its December 1995 meeting, the ADA Board of Trustees concurred with the Council that a U.S./Canadian partnership for continuing education evaluation would benefit the individual members of both associations. Further, by encouraging the Canadian provincial licensing bodies to accept ADA CERP approvals, CDA would enhance the value of the program for U.S.-based recognized providers and for licensed dentists in both countries. It would also help ADA CERP to grow more quickly by opening a broader pool of potential applicant providers. Accordingly, a detailed proposal was drafted for negotiation with the CDA in January 1996.

Provisions of the Proposed Agreement: The provisions of the proposed agreement for Canadian Dental Association participation in ADA CERP are briefly summarized as follows. Under the proposed agreement, the CDA will appoint a representative to serve on the ADA CERP Policy Board and Review Committees. Thus the CDA, like the other governing organizations of CERP, will be able to participate in the standards-setting process as well as the provider evaluation process. Also like the other eligible CERP governing organizations, the CDA has agreed to apply for CERP recognition as a continuing education provider.

The agreement proposes that the annual costs of meeting attendance for the CDA representative (approximately $1,500 for two meetings) will be paid from the CERP budget. CERP will retain all revenues generated from Canadian providers, and use those funds to offset the costs of CDA participation. It appears that the additional revenue generated from Canadian providers will be more than adequate to compensate for the additional expenses.

Canadian-based providers will have to demonstrate that they meet the ADA CERP standards by following the same process for evaluation and recognition as U.S. providers. Recognized Canadian providers will be included in the published list of ADA CERP-recognized providers.

The CDA will actively market ADA CERP recognition to Canadian providers, through mailings, advertisements in CDA publications, and presentations to inform the CDA membership about the program. The program materials will be provided by the ADA but costs of distribution will be borne by the CDA.

ADA CERP recognition is currently accepted by 32 of the 41 U.S. licensing jurisdictions that require CE for licensure renewal. Canada has 10 provincial licensing jurisdictions, 90% of which require CE. CDA would support international acceptance of ADA CERP providers by informing the Canadian provincial authorities of the CERP program's objectives and procedures, and encouraging them to accept credits from ADA CERP-recognized CE providers.

Beginning in 1998, the agreement between the ADA and CDA will be reviewed annually. This review will include the continued need for permanent CDA representation on the Policy Board and Review Committee; the extent of participation by Canadian CE providers; the marketing activities implemented by the CDA; the degree of acceptance by the Canadian provincial licensing authorities; and whether the funding arrangement remains equitable for both parties.

If the proposed agreement is approved by the 1996 House of Delegates, a letter of agreement could be signed following the

October annual session. Publicity and marketing activities could be implemented immediately, with an implementation date of January 1997. The CDA representative would participate at the March 1997 Review Committee and Policy Board meetings.

In March 1996, the ADA CERP Policy Board approved the establishment of a collaborative agreement between the CDA and ADA CERP, as outlined above. On the Canadian side, the CDA Committee on Continuing Education approved the proposed agreement in May 1996, and the CDA Council on Education added its endorsement in June. The Board of Governors, which meets in August 1996, is expected to grant final approval.

Board Recommendation: Because the composition of the CERP Policy Board and Review Committee were established by action of the 1992 House (*Trans.*1992:614), changes in those bodies require the approval of the ADA House. Accordingly, the CERP Policy Board adopted a resolution regarding the participation of the Canadian Dental Association and directed that it be forwarded to the Board of Trustees. The Board reviewed this request and concurred that a U.S./Canadian collaboration would benefit the members of both associations. Therefore, the Board recommends the adoption of the following resolution.

It should be noted that Board Report 13 (see page 483) proposes a revised organizational structure for the ADA CERP committees. The special Board committee that developed the revised structure was cognizant of the Canadian request and therefore included representation for the Canadian Dental Association in the proposed new CERP committee. If the 1996 House supports the revised committee structure by adopting Resolution 82 as proposed in Board Report 13, then the following resolution will become moot. However, if the House does not support the proposed revised structure and instead elects to retain the current structure of the CERP Policy Board and Review Committee, the following resolution should be adopted to implement the Canadian Dental Association's participation in ADA CERP.

Resolution

83. Resolved, that the participation of the Canadian Dental Association in the American Dental Association Continuing Education Recognition Program (ADA CERP) be approved, and be it further

Resolved, that the membership of the ADA CERP Policy Board and the ADA CERP Review Committee be expanded to include one representative of the Canadian Dental Association.

Report 15

Restructure of Association Councils and Commissions

Background: It was reported to the 1995 House of Delegates that the Board of Trustees directed the President to appoint a committee to review the size, composition and function of each council within the Association and provide a report for consideration by the Board. It further directed that, upon approval of the Board, the report with appropriate suggested *Bylaws* changes be forwarded to the 1996 House of Delegates for action.

Following the 1995 annual session, President Ten Pas appointed past president Dr. Richard W. D'Eustachio to serve as chairman of the Committee to Study Association Councils and Commissions. He further appointed the following individuals to serve on the committee: Dr. S. Joan Allen, New London, CT; Dr. Lewis S. Earle, Winter Park, FL; Dr. Thomas C. Harrison, Katy, TX; Dr. Eugene Sekiguchi, Monterey Park, CA; and Dr. Stephen B. Towns, Chicago; Dr. S. Timothy Rose, Ninth District Trustee, was appointed to serve as the committee's liaison to the Board of Trustees.

The Committee's recommendations were received by the Board on June 17 but were not acted upon until its July 29 meeting. In the interim, the Board circulated the Committee's report for comment by constituent, component and specialty dental societies; the Association's past presidents and all members of its councils and commissions; the chiefs of the Federal Dental Services; the American Student Dental Association; the National Dental Association; and the National Foundation of Dentistry for the Handicapped. Some of these individuals and organizations submitted written comments to Dr. Ten Pas and Dr. Zapp. These written commentaries were made available for review by each member of the Board. Other individuals contacted one or more members of the Board to share their views directly. These comments were reported to the full Board during the course of its discussion on July 29.

The Board commended the Committee for the conscientious and thorough manner in which it approached its difficult task. It noted that the Committee was called upon to address a large number of diverse issues ranging from questions of organizational structure to the application of new technologies in the conduct of the Association's business. Although some issues were politically sensitive and have been the subject of considerable debate, the Board found the Committee's comments to be straightforward and concise. It was pleased to note that while the Committee identified shortcomings of the council and commission system, it believes that the system has generally served dentistry well. The Board also agrees with the Committee that there are no remedies that will resolve all problems and that the improvement of the council/commission system should be an ongoing process.

In evaluating the Committee's specific observations and recommendations, the Board gave careful consideration to the views expressed by the various communities of interest. However, its judgments and recommendations also reflect the Board's experience in working with the councils and commissions and its in-depth knowledge of the challenges and tasks before each agency.

The Committee's written report was organized in two sections. The first focused on observations and recommendations pertaining to the council/commission system in general and the way in which agencies interacted with each other and with the Board. The second section offered the Committee's recommendations on specific agencies.

Part I
Recommendations on Council/Commission System

In the first section of its report, the Committee offered its insights and perspectives on a broad range of issues and offered eleven specific recommendations for the Board's consideration. These recommendations focused on: the process by which volunteers are selected and then oriented to fulfill their *Bylaws* duties; the appointment of task forces and special committees to address specific issues and the relationship of these work groups to the council/commission system; the importance of long-term planning and suggestions on how agencies might coordinate their activities with those of the Board in terms of strategic planning and budgeting; and the application of new technologies to facilitate the conduct of the Association's business.

As the proposals set forth in the first section of the Committee's report would not raise immediate *Bylaws* issues, and as certain of these recommendations have far-reaching implications and the potential to impact a broad range of Association activities, the Board elected to defer action on these recommendations until future meetings.

Part II
Recommendations on Specific Councils/Commissions

The second section of the Committee's report offered observations and recommendations on various councils and commissions. The Board believes that the Committee's views triggered a self-evaluation of these agencies as well as a discussion among the Association's leadership that was healthy and thought-provoking. While the Board was not supportive of all of the Committee's suggestions and observations, it believed that the following proposals should be supported. (It should be noted that the structure changes requiring amendment to the *Bylaws* would take effect at the close of the 1997 House of Delegates.)

Council on Dental Education: The Board is aware that there is a widespread expectation among the Association's leadership that the Committee's study will result in recommendations that will address the extended dispute that has focused on the structure of the Council on Dental Education (CDE). The Board shares the Committee's concern that, if no changes are made to the current structure of the CDE, the debate over its structure will continue. The Board is also not confident that there is any way of structuring the CDE that will satisfy all the concerns of all parties.

The Board observed that the Committee considered all realistic options for structuring the CDE. They included a

proposal to simply double the number of Association-appointed members of the CDE as well as the establishment of a separate council on licensure. In addition, the Committee suggested a way of not only balancing the interests of all communities of interest but also repositioning the CDE to more effectively discharge its *Bylaws* duties. Specifically, the Committee recommended that the CDE be expanded to 16 members* as has previously been proposed (Resolution 65-1995, *Trans.1995*:635) and renamed the Council on Dental Education and Licensure (CDEL). However, to assure that the views of the American Association of Dental Schools (AADS) and American Association of Dental Examiners (AADE) are effectively voiced, the Committee suggested that the CDEL should have at least two standing committees. One committee would focus on issues of dental education and educational measurement and the other on issues of licensure. The Board agrees with the Committee that this approach would provide the additional representation sought for the practicing dentist community while maintaining a balance with the AADS and AADE in their respective areas of expertise. The Board recommends that the CDEL be allowed the discretion to determine which of its members will serve on each committee. The Council would also have discretion to establish additional committees to focus on specialty issues, allied issues, etc.

The Board was also supportive of the Committee's recommendation that Board nominees to serve on the CDEL could include dentists who work as members of a faculty of a dental school. However, it recommends that such dentists should not work as members of a faculty of a dental school for more than two days/week or 16 hours/week.

Commission on Dental Accreditation: The Board agrees with the Committee that the current arrangement for appointing the Association's representatives on the Commission on Dental Accreditation (CDA) should be changed. Currently, the CDE also serves as members of the CDA along with eight additional individuals who are selected by organizations other than the American Dental Association. However, with the proposed number of Association-appointed members of the CDEL, the Board agrees there should not be a corresponding increase in the number of Association-appointed members of the CDA.

Furthermore, the Board shares the Committee's judgment that to call upon volunteers to serve on both the CDE and CDA diminishes their ability to work to maximum effectiveness. This double assignment requires the devotion of a tremendous amount of time to volunteer service. Also, the Board concurs with the Committee that there needs to be a separation of those who represent the profession's interests with respect to dental education and licensure generally and those who actually conduct the accreditation process.

For these reasons, the Board supported the Committee's recommendation that the *Bylaws* be amended to provide that members of the CDE shall not be permitted to concurrently serve as members of the CDA. This would necessitate that the Association as well as the AADS and the AADE each appoint four members of the CDA who would be different from those serving on the CDE. The composition of CDA is determined by the *Rules* of the Commission which must be approved by the House of Delegates.

Council on Insurance: The Board agreed with the Committee that it is not necessary for a member from each trustee district to serve on the Council on Insurance at all times. In the past, the Association sponsored a national professional liability insurance program that was politically sensitive and a focus of membership concerns. With the termination of this program, the Association no longer has any sponsored insurance or retirement plans in which the cost or scope of the products and services varies geographically. For this reason, the Board believes that the Council on Insurance should be among the Association agencies that are served by eight rather than 16 members. It further recommends that this be accomplished by attrition of eight trustee district seats as the incumbents complete their terms. Thereafter, each trustee district should nominate a member to the Council every other four-year cycle.

The Board further directed that a report be prepared describing the fiduciary duties of the Council on Insurance and how they compare to those of the Commission on Relief Fund Activities and the Finance Committee.

Council on Governmental Affairs and Federal Dental Services: The Board was supportive of many of the Committee's recommendations and observations regarding the operation of the Council on Governmental Affairs and Federal Dental Services (CGAFDS). It agreed with the Committee that a review should be made of the method by which the CGAFDS develops the Association's legislative agenda and the process by which the agenda is submitted for the Board's consideration. The intent will be to identify opportunities to enhance the effectiveness and timeliness of this process.

The Board also agreed with the Committee's observation that issues relating to state legislation are critical to the profession and that the CGAFDS should enhance the Association's ability to disseminate information that will assist the constituent and component dental societies in this arena. The Committee recommended that the Council take a more active role in promoting the utilization of the information and resources that are made available through the Association's Department of State Government Affairs.

The Committee further recommended that oversight activities relating to the National Practitioner Data Bank should be assigned to the CGAFDS. Currently, these activities are assigned to CDBP. The Board agrees that, since the Data Bank is operated by an agency of the federal government, oversight and advocacy activities should be coordinated by the CGAFDS and supported by the Washington Office staff.

Although not proposed by the Committee, the Board recommends that the name of the Council be changed. It observed that the reference to the federal dental services in the current name suggests that, among the Association's councils and commissions, the CGAFDS alone represents the interests of these members. The Board believes that all agencies of the Association have responsibility for representing the interests of the federal dental services within their respective areas of expertise. Therefore, the Board

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* 8 representing the ADA
4 representing the AADE
4 representing the AADS

recommends that the reference to federal dental services be removed from the name of the agency. It further directed that this recommendation be explained in a letter from the President. With this change and in recognition of the increased emphasis on state governmental affairs, the Board recommends that the CGAFDS be renamed the Council on Federal and State Governmental Affairs (CFSGA).

Council on Dental Benefit Programs and Council on Dental Practice: The Board considered the views of the Committee with respect to the Council on Dental Benefit Programs (CDBP) and Council on Dental Practice (CDP). The Committee had observed that the challenge presented by managed care is of such complexity that it impacts upon the *Bylaws* duties and activities of both CDBP and CDP. The Board agreed with the Committee that there will likely be need for increased cooperation between these agencies in the future, particularly with respect to managed care issues. For this reason, the CDBP and CDP were requested to do a self-study and report to the Board which provides a detailed analysis of their respective areas of expertise as well as their activities relating to managed care issues.

Joint Commission on National Dental Examinations: The Committee offered no recommendations with respect to the Joint Commission on National Dental Examinations (JCNDE). However, the Board believes that a review should be made of the Association's involvement with this agency. It requested that a report be prepared describing the JCNDE's duties and activities.

Committee on Information Technology: Further study will be given to a recommendation that a committee of the Board be developed to oversee the Association's activities that involve the application of information technologies to dental practice, education, etc. It was suggested that the duties of such a Board committee would be to provide strategic guidance to the activities of the various Association agencies addressing issues relating to information technologies as well as to serve as their advocate with respect to the utilization of the resources of the Department of Information Technology.

The Board directed that a report be prepared describing alternative ways in which such a committee might be formed. Although it had been suggested that there be a standing committee of eight members, consideration will also be given to forming an ad hoc committee. In addition, the Board will evaluate the desirability of appointing the committee for a single year or multi-year term of service. The Board also directed that the report comment on the specific duties of the committee and how they would relate to activities involving information technology that are currently being managed by councils and/or task forces.

Resolutions

84. Resolved, that Chapter X. COUNCILS, Section 10. NAME, of the *Bylaws* be amended by adding the words "and Licensure" to the name "Council on Dental Education," so the amended Section 10 reads as follows:

Section 10. NAME: The councils of this Association shall be:

Council on Access, Prevention and Interprofessional Relations
Council on ADA Sessions and International Programs
Council on Communications
Council on Dental Benefit Programs
Council on Dental Education and Licensure
Council on Dental Practice
Council on Ethics, Bylaws and Judicial Affairs
Council on Governmental Affairs and Federal Dental Services
Council on Insurance
Council on Membership
Council on Scientific Affairs

and be it further
Resolved, that in all other places in the *Bylaws* where the name "Council on Dental Education" appears, the name be changed editorially to the "Council on Dental Education and Licensure," and be it further
Resolved, that Chapter X. COUNCILS, Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, of the *Bylaws* be amended in Subsection A by deleting the provisions dealing with the Council on Dental Education and by substituting in their place new provisions specifying the composition and organization of the new Council on Dental Education and Licensure, to read as follows:

Council on Dental Education and Licensure shall be composed of sixteen (16) members selected as follows:

a. Nominations and Selection.

(1) Eight (8) members shall be nominated by the Board of Trustees on a rotational system by trustee district from the active, life or retired members of this Association, no one of whom shall be a full-time member of a faculty of a school of dentistry or a member of a state board of dental examiners. A person shall be considered to be a full-time member of a faculty if he or she works for the school of dentistry more than two (2) days or sixteen (16) hours per week.

(2) Four (4) members who are active, life or retired members of this Association shall be selected by the American Association of Dental Examiners from the active membership of that body, no one of whom shall be a member of a faculty of a school of dentistry.

(3) Four (4) members who are active, life or retired members of this Association shall be selected by the American Association of Dental Schools from its active membership. These members shall hold positions of professorial rank in dental schools accredited by the Commission on Dental Accreditation and shall not be members of any state board of dental examiners.

b. Election. The eight (8) members of the Council on Dental Education and Licensure nominated by the Board

of Trustees shall be elected by the House of Delegates from nominees selected in accordance with this section.

c. Committees. The Council on Dental Education and Licensure shall establish a standing Committee on Dental Education and Educational Measurements and a standing Committee on Licensure, each consisting of eight (8) members selected by the Council. The Council may establish additional committees when they are deemed essential to carry out the duties of this Council.

** Council on Dental Education and Licensure—To increase the number of members chosen by this Association in 1997, the term of the Council member from the 10th Trustee District shall be extended by one year to 1998, while the term of the Council member elected in 1996 from the 3rd Trustee District shall be three years. Council members from the 7th and 11th Trustee Districts elected in 1997 shall each serve a three-year term. The Council members from the 6th and 12th Trustee Districts elected in 1997 shall each serve a four-year term. All Council members elected subsequently shall serve four-year terms. This footnote shall expire at adjournment *sine die* of the House of Delegates in the year 2000.

and be it further
Resolved, that Chapter XIV. COMMISSIONS, Section 40. ELIGIBILITY, of the *Bylaws* be amended by deleting Subsection D. CHAIRMEN in its entirety and by substituting in its place new Subsections D and E to read as follows:

D. No member of the Council on Dental Education and Licensure of this Association may serve concurrently as a member of the Commission on Dental Accreditation.

E. CHAIRMEN. The Commissions of this Association shall elect their own chairmen.

and be it further
Resolved, that the amendments to the *Bylaws* set forth in this resolution become effective at adjournment *sine die* of the 1997 House of Delegates.

85. Resolved, that Chapter X. COUNCILS, Section 10. NAME, of the *Bylaws* be amended by changing the name of the Council on Governmental Affairs and Federal Dental Services to the Council on Federal and State Governmental Affairs, so the amended Section 10 reads as follows:

Section 10. NAME: The councils of this Association shall be:

Council on Access, Prevention and Interprofessional Relations
Council on ADA Sessions and International Programs
Council on Communications
Council on Dental Benefit Programs
Council on Dental Education
Council on Dental Practice
Council on Ethics, Bylaws and Judicial Affairs
Council on Federal and State Governmental Affairs
Council on Insurance
Council on Membership
Council on Scientific Affairs

and be it further
Resolved, that in all other places in the *Bylaws* where the name "Council on Governmental Affairs and Federal Dental Services" appears, the name be changed editorially to the "Council on Federal and State Governmental Affairs," and be it further
Resolved, that the amendments to the *Bylaws* set forth in this resolution become effective at adjournment *sine die* of the 1997 House of Delegates.

86. Resolved, that Chapter X. COUNCILS, Section 20. MEMBERS, SELECTIONS, NOMINATIONS AND ELECTIONS, of the *Bylaws* be amended in Subsection A (lines 1623-1624) by changing the composition of the Council on Insurance from one member from each trustee district to a total of eight members selected on a rotational system by trustee district, so the amended provision reads as follows:

Council on Insurance shall be composed of eight (8) members who shall be selected on a rotational system by trustee district.***

*** Council on Insurance—To achieve a new quarterly rotation for the Council, a lottery will determine which two trustee districts from the 1st, 14th, 15th and 16th will have nominations in 1997; the two (2) remaining trustee districts will have nominations in 1998. A lottery will determine which two trustee districts from the 5th, 7th, 9th and 10th will have nominations in 1999; the two remaining trustee districts will have nominations in 2000. A lottery will determine which two trustee districts from the 6th, 8th, 12th and 13th will have nominations in 2001; the two (2) remaining trustee districts will have nominations in 2002. A lottery will determine which two trustee districts from the 2nd, 3rd, 4th and 11th will have nominations in 2003; the two remaining trustee districts will have nominations in 2004.

and be it further
Resolved, that the amendments to the *Bylaws* set forth in this resolution become effective at adjournment *sine die* of the 1997 House of Delegates.

Report 16

Use of Carbamide Peroxide-Based Bleaching Products

Introduction: This report is being forwarded to the House of Delegates by the Board of Trustees to keep it informed of issues relative to the use of carbamide peroxide-based bleaching products.

Background: This report is being presented at the direction of the Board of Trustees in response to the following resolution adopted by the Board at its February 1996 meeting.

> **B-26-1996. Resolved,** that the appropriate agencies of the ADA should study and report on the ramifications of the scope of practice issues around the use of carbamide peroxide-based bleaching products, including diagnosis of the need for such agents, prevention of side effects and home treatment, and be it further
> **Resolved,** that all aspects of delivery of this modality, including fabrication of custom trays, education of the patient, and directed self-administration of external vital teeth bleaching agents should be studied for the purpose of developing guidelines, and be it further
> **Resolved,** that the report should include recommendations for either an advisory opinion by the Council on Ethics, Bylaws and Judicial Affairs or referral to the Council on Dental Benefit Programs for development of a practice parameter, and be it further
> **Resolved,** that a progress report on the study should be given to the 1996 House of Delegates.

Discussion: Peroxide-containing oral hygiene products currently on the market can be classified into three basic categories. The first category includes short-term use products (2 to 7 days) such as oral antiseptic agents and debriding/oral wound cleansers. Most of these products have been approved by the FDA and contain 10 to 15% carbamide peroxide, which is equivalent to 3.0 to 4.5% of hydrogen peroxide. The second category includes dentifrices which have low concentrations of hydrogen peroxide (0.75%) or calcium peroxide (0.5%) often in combination with baking soda. The third category is comprised of whiteners or bleaching agents. These may be dispensed by dentists and used by patients at home (generally 3.0% hydrogen peroxide or 10% carbamide peroxide) or they may be available over the counter (OTC) and contain up to 6% hydrogen peroxide.

Questions have been raised regarding potential adverse effects at the local and systemic level that might result from long-term use of the products in the second and third categories.[1-3]

These effects might include genotoxicity, carcinogenicity, delayed wound healing, oral soft tissue irritation, alteration of dental hard tissues, adverse effects on pulp and the consequences of internal and external resorption.

For this reason, the former Council on Dental Therapeutics (now the Council on Scientific Affairs) developed and maintains guidelines for evaluating the safety and effectiveness of bleaching agents containing hydrogen peroxide. These guidelines have been used to evaluate dentifrices and are currently being revised to include the evaluation of all dental products containing hydrogen peroxide.

Although the concentrations of hydrogen peroxide or carbamide peroxide in tooth bleaching agents are similar to those in the FDA-approved antiseptic and debriding/oral wound cleansers, the safety of peroxide-containing tooth whiteners and dentifrices still needs to be established as substantial differences exist in the manner of application between the at-home tooth bleaching materials and the FDA-approved oral health products. The bleaching process usually takes two to four weeks, and requires daily use for times ranging from one or two hours to overnight use. The contact time of the material with oral tissues, therefore, is much longer but at lower levels when compared with the oral antiseptic agents and debriding/oral wound cleansers. In addition, tooth bleaching agents and dentifrices are usually a mixture of various ingredients, and possible interactions with other ingredients may occur due to the active nature of peroxide. The FDA has traditionally classified bleaching products as cosmetics, although this classification is currently undergoing review. As cosmetics, such products have not been subjected to the type of safety and efficacy review that would be required for a drug.

A literature search on tooth bleaching agents revealed a number of *in vivo* animal studies reporting no significant systemic or local adverse effects of various dentist-dispensed/patient-applied at-home bleaching products.[4,5] Other studies would support these findings. They show that the degree of the cytotoxicity associated with bleaching products containing 10% carbamide peroxide or 3% hydrogen peroxide is very low and appears comparable to many agents and materials which are commonly used in dentistry, such as eugenol, dentifrices, mouthrinses and composite resins.[6]

1. American Dental Association (1992). Statement concerning tooth whiteners intended for home use. ADA Council on Dental Therapeutics. January 14, 1992.
2. Berry J (1990). What about whiteners? Safety concerns explored. *JADA* 121:223-225.
3. Boland TW (1991). Home bleaching—a cause for concern. ADA News Bulletin, June 1991;3-5.
4. Woolverton CJ, Haywood VB, Heymann HO (1991). A toxicologic screen of two carbamide peroxide tooth whiteners. *JDR* 70:558.
5. Adam-Rodwell G, Kong BM, Bagley DM, Tonucci D, Christina LM (1994). Safety profile of Colgate Platinum Professional Toothwhitening System. Compend Contin Educ Dent Suppl 17:S622-S626.
6. Li Y, Martin MJ, Noblitt T, Stookey G (1994). Cytotoxicity of hydrogen peroxide and peroxide-containing bleaching gels. Proceedings of the Second Annual Research Day, Indiana University School of Dentistry and Indiana Section, American Association for Dental Research, Indianapolis, Indiana, USA.

Further research, recently undertaken within the Division of Science, also supports the low cytotoxicity of bleaching products, as only minimal cytotoxic oxygen radical formation was found in rats exposed to a tooth whitener product containing 10% carbamide peroxide.[7]

In short, there have been no documented significant adverse effects associated with dentist-monitored at-home bleaching products, and available scientific evidence would suggest that these bleaching products can be safely used when appropriately applied. Mild clinical side effects have been reported and include mild tooth sensitivity to temperature changes or ulceration/irritation of the oral mucosa. However, the increased tooth sensitivity often occurs only during the early stages of bleaching treatment, and in most cases the mucosal irritations are caused by the tray rather than the bleaching material.

In contrast to dentist-dispensed home-use whiteners, a case report describes severe loss of enamel tissues in a 13-year old boy who used an OTC three-step bleaching system for two months.[8]

Due to the potential for consumer misuse of OTC whitening products and the serious consequences that might result, the Council on Scientific Affairs (CSA) recommends their use only under a dentist's supervision. This recommendation is reflected in the patient education brochure made available by the Division of Communications entitled "Ask Your Dentist About Tooth Whitening," which states:

> Over-the-counter products that are self-administered are not recommended. Although they may appear to cost less, bleaching treatments should only be done under the supervision of a dentist following a proper examination and diagnosis of the discolored teeth.

The guidelines developed by the Council for the Association's Acceptance Program apply only to dentist-dispensed/home-use bleaching products. The Division of Science will continue to monitor future research into the appropriate usage of these products and will provide information to appropriate Association agencies to enable them to update their recommendations and guidelines as needed.

The background statement to Resolution B-26-1996 expresses concern over the possibility of dental auxiliaries and other nondentists setting up as "bleaching therapists," presumably in independent practice. No state is known to recognize this category of practitioner. Arguably, such services, including making impressions and fabricating custom bleaching trays, fall within the scope of the practice of dentistry and may not be performed by a nondentist, except under a dentist's supervision or with a dentist's prescription. Should a nondentist provide unsupervised tooth whitening services to the public, he or she could be open to a charge of practicing dentistry without a license. The outcome would depend on the state's statutory definition of the practice of dentistry and how it was interpreted by the authorities in that state.

Two dental boards that are known to have considered this issue have agreed that tooth whitening is part of the practice of dentistry. In a June 1996 advisory opinion to a dentist who wished to open a "tooth whitening center," the New Jersey State Board of Dentistry determined that:

> [T]ooth whitening is within the practice of dentistry and therefore falls under all the requirements of the Dental Practice Act and the Board's Regulations. Tooth whitening agents may be dispensed only by a dentist. Each location where this process is performed, requires a branch office registration.

Last year, a Washington dental hygienist requested a ruling on the legality of unlicensed persons performing in-office bleaching procedures on patients with direct or indirect supervision and without the supervision of a dentist. At its March 1995 meeting, the Washington State Dental Health Care Quality Assurance Commission gave its opinion that "when bleaching or whitening of teeth is done, this procedure can be done by both unlicensed persons and dental hygienists under the close supervision of a dentist."

In addition, a "bleaching therapist" could be held liable for any negligence that caused a client harm.

Resolution B-26-1996 also requests that this report include recommendations to the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) for an advisory opinion. The background statement to Resolution B-26-1996 questions what duties, if any, of the bleaching modality a dentist may reasonably delegate to a dental hygienist or a dental assistant under the dentist's supervision. The *ADA Principles of Ethics and Code of Professional Conduct* addresses delegation of functions to dental auxiliaries in Section 1-G, which reads:

> Dentists shall be obliged to protect the health of their patients by only assigning to qualified auxiliaries those duties which can be legally delegated. Dentists shall be further obliged to prescribe and supervise the patient care provided by all auxiliary personnel working under their direction.

From time to time, the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) develops advisory opinions that interpret the *Code* by applying it to specific fact situations that might come before the Council on review in a disciplinary proceeding. It is unknown at the present time the extent to which dentists delegate duties that involve the use of carbamide peroxide bleaching products to dental auxiliaries, what these duties are and under what level of supervision they are performed. Also, no reports have been received to date of any harm resulting from improper delegation. It would be premature to ask CEBJA to issue an advisory opinion until more information is available about the specific practice situations that might give rise to an ethical problem.

As an alternative to an advisory opinion, Resolution B-26-1996 suggests that the Council on Dental Benefit Programs could be asked to develop a practice parameter for the use of bleaching agents in dental practice. The 1995 House of Delegates adopted a parameter, *Patients With Orofacial*

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7. Miaw C, Chen P, Gruninger S, et al. Quantification of free radical generation from a tooth whitener. *JDR* 1996;75:431 (Abstrt. 3306).
8. Cubbon T, Ore D (1991). Hard tissue and home tooth whiteners. CDS Review June 1991;32-35.

Aesthetic Concerns, that addresses the use of bleaching agents in dental practice (*Suppl.*1995:259, *Trans.*1995:615). The ADA Parameters are condition-based and do not discuss individual treatment procedures, so a parameter that solely discusses bleaching procedures or a specific bleaching agent would not be appropriate.

Options: The Council on Scientific Affairs will continue to assess the appropriateness of the current guidelines to evaluate all dental products containing hydrogen peroxide for safety and efficacy. The Council should promote research to further scientific understanding of the safety of these dental products, monitor their use in dental practices and provide guidance to the Food and Drug Administration. The Council will provide an updated report to the Board when new information becomes available.

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

Report 17

Proposed Continuing Education Registry Program

Background: In July 1995, the Board of Trustees requested a report on the feasibility of developing an ADA-administered continuing education (CE) record-keeping, or registry, program. At its October 1995 meeting, the Board determined that such a program would provide a valuable service for ADA members and directed the development of an implementation plan for a CE registry program. A Continuing Education Registry Task Force was appointed; members included president-elect Dr. Gary Rainwater and trustees Dr. Lewis Turchi and Dr. David Whiston, as well as staff of the Divisions of Education, Membership and Information Technology.

The Association previously offered a Continuing Education Registry program from 1971 until 1986. The Registry was intended to assist the states that adopted CE requirements for dentists' licensure renewal. Participants were enrolled through a state board of dentistry, state dental association or federal dental service, to which their CE records were reported. At its peak, the Registry had 13 states and two federal dental services participating, with an enrollment of approximately 28,000. The program was funded through per capita fees paid by the participating states.

In 1983 the Registry was converted to a national individual-based format. At this time, several states discontinued comprehensive record keeping via the Registry in favor of less-expensive random audits of compliance with their licensure requirements. Efforts to promote the Registry to individual members met with little success and participation dropped considerably. By 1986, with enrollment at approximately 8,000 participants, the program was discontinued.

Environmental Changes Since 1986: The chief change in the CE environment during the past decade has been the growth in the number of states with mandatory CE for licensure renewal. In 1986, when the Registry was discontinued, only 14 licensing jurisdictions had CE requirements. That number has now grown to 43 states with requirements or enabling legislation. The great majority of these state boards require licensees to report their CE credits on their license renewal forms, and to produce detailed verification on request or as a result of random audit. Given that many dentists are licensed in more than one state, it seems likely that nearly all ADA members are currently subject to some form of licensure requirement.

Beyond evidence of compliance with CE requirements, dentists might want a record of earned CE credits to comply with tax regulations for education expenses or to meet hospital requirements to maintain their medical staff privileges. And a number of specialty and other certifying boards require CE credits to maintain current certification.

The Academy of General Dentistry (AGD) is the only national organization that currently offers a CE registry service for its members. In response to a survey, only five constituent dental societies reported that they have developed state-level record-keeping services for their members.

Therefore, the Board believed that the Association could meet a significant need by offering a national, voluntary CE registry service. By assisting dentists to demonstrate compliance with state and other CE requirements, a registry service could offer an important benefit for all ADA members, both generalists and specialists, and thus enhance the perceived value of ADA membership.

Program Design Specifications: As a first step toward estimating the costs for the proposed Registry program, the Task Force developed basic program design specifications. These specifications were approved by the Board at its February 1996 meeting and include the following:

- All ADA members will be eligible to participate in the program as a benefit of ADA membership, at no additional cost. Nonmembers will be able to participate at the cost of $700 per year.
- Participants will be required to specifically enroll in the program so that program information can be targeted only to interested members, and to allow members to authorize the transmission of their CE credit information to the ADA.
- Participants will receive one free transcript of credits per year. A modest fee will be charged for any additional transcripts requested.
- Course information will be accepted only for courses offered by providers approved by the ADA Continuing Education Recognition Program (ADA CERP). Currently, there are approximately 300 approved providers, and that number is growing rapidly as the CERP program expands.
- Course credit information will be accepted from the provider organizations/institutions, and from individual participants in the event that the provider does not submit the credits.

Data Submission Methods: The CE Registry Task Force considered carefully several alternative methods to capture and record CE credit information. A data submission method was sought that would be user-friendly, promote member acceptance and provider compliance, and also be cost-effective and staff-efficient.

Two potential methods for data submission were considered: (1) fully electronic transmission of data via PC/modem or diskette, and (2) electronic-scan paper forms containing machine-readable optical mark fields. Following extensive review of current technology as well as the Association's available resources, the Task Force recommended that the method of data input should initially be limited to scannable paper forms.

Scannable forms have the advantage of being readily available to all providers and participants, without requiring a PC/modem or other computer equipment and software. Thus they offer maximum flexibility and member satisfaction. In addition, the paper forms offer the most adaptable method for CE providers, which have widely varying levels of technological resources. The scannable forms do not require individual key-entry and are thus not overly staff-intensive. Further, the ADA already has scanning equipment. Thus scan

forms will allow the Association to initiate the program quickly and at a relatively low cost. As the Registry program grows and gains in member acceptance, and as the technology available to the ADA, the CE providers and member dentists expands, it should be possible to add electronic "paperless" methods of data collection as program enhancements.

Estimated Implementation Costs: As directed by the Board, the Task Force obtained bids for both start-up and ongoing maintenance of the program by outside vendors, for comparison with the costs of developing and managing the program using in-house resources. At its April 1996 meeting, the Board reviewed detailed cost estimates and determined that it would be most cost-effective to implement the program in-house.

Estimated start-up costs to develop the CE Registry system in-house include design and testing of the databases necessary to operate the system. Further, the Registry system must interface with the ADA membership database in order to produce credit transcripts. The first stage of the development of the infrastructure to support the Association's financial and membership databases is projected for mid-1996, with implementation of the new computer system to be completed during the ensuing 18 months. Therefore, in order to proceed more quickly, the CE Registry will be designed as a stand-alone system operated by staff of the Division of Education.

Given the size and potential complexity of the CE Registry project, current staff will not be able to undertake all aspects of the Registry program development in addition to their ongoing responsibilities. Therefore, outside consulting services will be needed to develop the databases, design reports, program the scanner set-up and LAN connections, and to develop the membership marketing/participation materials, at an estimated cost of $40,000. An additional $20,000 will be required to purchase the necessary hardware, including work stations and other equipment upgrades.

Initial expenses in the Division of Education will include a non-exempt staff position, which will be required to ensure that the program is conducted in accord with the Association's standards of member service. This individual will perform data entry functions, provide customer support services, support communication with CE providers and constituents, and distribute program materials/credit transcripts. Additionally, start-up funds will be required for printing and distribution of the electronic scan forms, program brochures and information for members and CE providers, and self-mailer transcript forms, as well as other administrative expenses. The total 1997 start-up costs are estimated at $228,300.

Following the start-up phase in 1997, ongoing expenses (assuming an initial enrollment level of approximately 10,000 members) will include the non-exempt staff position, printing and distribution of additional forms and informational materials, and routine administrative and communication activities. The expenses for 1998 are estimated at $99,000. This figure includes approximately 100 hours for an outside systems consultant at $100/hour, or $10,000, to maintain and upgrade the Registry software.

Implementation Time Lines: If a decision to implement the CE Registry program is made by the House in October 1996, the design phase would need to begin early in 1997. It is anticipated that the database and operating system design will be completed by June 1997. Membership marketing activities could be initiated in late spring, with enrollment opened to the membership in June 1997. The system could be ready to accept course records beginning July 1, 1997, with the first transcripts to include credits earned during calendar year 1997.

Board Request for Input from Dental Organizations: At its April 1996 meeting, the Board directed that constituent dental societies, state dental boards with CE requirements, and the specialty organizations and certifying boards be consulted regarding the potential impact of a CE Registry program. Accordingly, surveys were sent to these organizations in June 1996, to obtain data on CE record-keeping programs currently offered at the state or national level, as well as input on the potential value of an ADA-administered program for their members or licensees. Among those responding to the survey, six constituent societies reported that they currently offer CE record-keeping programs for their members, as did five state boards and three specialty organizations/certifying boards.

In response to a question asking how beneficial an ADA record-keeping service would be for their members, about 60% of the responding constituent societies believed the service would be very or somewhat beneficial, while 32% believed it would be not too beneficial or not beneficial at all and 8% did not offer an opinion. Opinions of the 30 state dental boards and eight specialty groups responding to the survey were mixed. About half believed an ADA record-keeping service would help their licensees or certificants demonstrate compliance with state or certifying board requirements, while half believed it would not be helpful or did not know.

The Board reviewed this data as well as input from individual members and concluded that the proposed Continuing Education Registry program would meet a membership need that is not being broadly addressed through existing state or national programs. Therefore, the Board recommends that the following resolution to implement the CE Registry program be adopted by the 1996 House.

Resolution

87. Resolved, that an ADA-administered Continuing Education Registry program be implemented as a member benefit in 1997, as proposed by the Board of Trustees.

Report 18

Study of the Commission on Dental Accreditation

Background: The 1994 House of Delegates referred Resolution 76-1994 (*Trans.*1994:613) to the Board of Trustees for a study of the Commission on Dental Accreditation. As a result, the President appointed a special committee to review dental accreditation. The goal of this first committee was to identify concerns with the accreditation process, and to begin to prioritize areas for enhancement. This first committee recommended the formation of a second, more broadly representative group to continue the review process. As a result, the President, in consultation with the President-elect, appointed the Second Special Presidential Committee to Study the Dental Accreditation Process: Dr. J. Bernard Machen (chair), Dr. Lillian H. Bachman, Dr. Herbert B. Dolinsky, Dr. Fred C. Fielder, Dr. Henry W. Fields, Jr., Dr. W. Kenneth Horwitz, Dr. Henry J. Van Hassel, Dr. Richard D. Wilson and Dr. Arthur L. Yeager. This second committee held meetings in Chicago at the ADA Headquarters on September 22-24, 1995; February 9-10, 1996; and March 8-9, 1996, with a final meeting conducted via telephone conference call on April 26, 1996.

Charge to the Committee: The Committee was charged to make recommendations for improving the dental accreditation process in order to assure prospective students and the public of the quality of the dental educational system. The Committee studied topics such as the purpose of accreditation and the application of accreditation standards, consistency within the accreditation review process, the supporting committee structure of the Commission, the training and role of site visit evaluators, the use of evaluation instruments during site visits, and current policies of the Commission. The Committee also discussed how the Commission might devote its resources more to those programs in need. The Committee developed reports for the Board of Trustees and the 1996 House of Delegates.

Board Actions on the Committee's Recommendations: Initially, the Committee developed six recommendations for consideration by the Board of Trustees. The chairman of the Committee, Dr. J. Bernard Machen, gave an oral presentation of the Committee's report to the Board of Trustees at its April 1996 meeting.

The Board considered the resolutions and, with minor changes, unanimously adopted Resolutions B-33 through B-38. The Board directed that the resolutions be forwarded to the Commission on Dental Accreditation.

The Committee's final report was presented to the Board of Trustees at its June 1996 meeting. The report contained several final recommendations for the Board's consideration related to accreditation standards, the accreditation cycle and the continued review and enhancement of the accreditation process. The Board unanimously adopted Resolutions B-66 through B-73 and B-88 and directed that they also be forwarded to the Commission.

Consideration by the Commission on Dental Accreditation: As requested by the Board of Trustees, the Commission on Dental Accreditation carefully considered each of the resolutions at its July 1996 meeting. The following describes the action taken by the Commission in regard to each resolution.

- **B-33-1996. Resolved,** that the Commission on Dental Accreditation be urged to replace its current advisory and standing committee structure with 13 discipline-based advisory committees representing the predoctoral programs, the eight dental specialties, postdoctoral general dentistry, dental hygiene, dental assisting and dental laboratory technology, and be it further
Resolved, that the dental specialty organizations and the certifying boards be urged to continue to provide financial support for their representatives on the advisory committees, and that the American Association of Dental Schools and the American Association of Hospital Dentists be requested to share the costs of the postdoctoral general dentistry committee.

  Commission Action: The Commission adopted this resolution.

- **B-34-1996. Resolved,** that the Commission on Dental Accreditation be urged to study the feasibility of developing a system of paid independent contractor site visit evaluators to conduct site visits for accredited programs, and be it further
Resolved, that this system of independent evaluators be utilized first for predoctoral general dentistry, postdoctoral general dentistry and advanced specialty programs, and finally for allied programs, and be it further
Resolved, that the Commission be urged to implement an intensive orientation, training and calibration program for these evaluators, and be it further
Resolved, that the additional costs to pay for these "professional" evaluators be shared by the sponsoring organizations and the accredited programs.

  Commission Action: The Commission adopted the first resolving clause of the resolution and directed that resolving clauses two through four be included in the feasibility study.

- **B-35-1996. Resolved,** that the Commission on Dental Accreditation be urged to develop and utilize more objective scoring systems, where applicable, to improve the reliability and validity of the evaluation process, and be it further
Resolved, that the Commission be urged to consider current evaluation systems such as that used by the Joint Commission on Accreditation of Healthcare Organizations or other accrediting bodies as examples, and be it further
Resolved, that the Commission be urged to utilize these objective scoring systems not only to evaluate accredited programs, but to monitor and calibrate site visit evaluators and advisory committees.

Commission Action: The Commission adopted this resolution and noted that it endorsed a two-year pilot study calling for the use of a scoring grid in the evaluation of accredited oral and maxillofacial surgery programs. The Commission will review a progress report on the pilot study at its January 1997 meeting.

- **B-36-1996. Resolved,** that the Commission on Dental Accreditation be urged to delay final approval of the predoctoral accreditation standards until the accreditation review committee's input can be considered and there has been additional opportunity for full discussion and consensus by the communities of interest, and be it further **Resolved,** that the Second Special Presidential Committee to Study the Accreditation Process be directed to further refine its recommendations regarding the proposed revised predoctoral accreditation standards, finalize those recommendations, and forward the final recommendations for consideration at the June Board of Trustees meeting.

  Commission Action: The Commission carefully considered this resolution, but believed that the adoption and implementation of the revised Accreditation Standards for Dental Education Programs *should not be delayed in order to provide the standards to programs as early as possible. The proposed revised standards were adopted with an implementation date of January 1, 1998. Programs to be site visited in the fall of 1997 will be given the option of using the revised standards.*

- **B-37-1996. Resolved,** that the Commission on Dental Accreditation be urged to evaluate the Canadian Clinical Outcomes Review and Evaluation (CORE) principles for utilization in its accreditation process.

  Commission Action: The Commission considered a report related to this issue and directed that policies be drafted codifying the relationship between itself and the Commission on Dental Accreditation of Canada for consideration at its January 1997 meeting. The Commission directed that predoctoral site visit teams be increased by one member to include a national representative of the licensure community. The Commission reaffirmed its current mechanism for a representative of the state board of dental examiners to participate in site visits.

- **B-38-1996. Resolved,** that the Commission on Dental Accreditation be urged to review its current policies and, where necessary, revise those policies to more clearly mandate action to be taken by the Commission to address issues including, but not limited to, major programmatic changes, instances when problems develop within a program, or situations when there is evidence of falsification of information during the accreditation process.

  Commission Action: The Commission adopted this resolution.

- **B-66-1996. Resolved,** that the Commission on Dental Accreditation be urged to include a statement encouraging formal liaison between the dental school and the practicing dental community in a preface to the predoctoral accreditation standards document.

  Commission Action: The Commission adopted this resolution.

- **B-67-1996. Resolved,** that the Commission on Dental Accreditation be urged to ensure that each accreditation standard be stated clearly and concisely, and, where appropriate, be accompanied by a statement of intent, that explains the rationale, meaning and significance of the standard.

  Commission Action: The Commission adopted this resolution.

- **B-68-1996. Resolved,** that the Commission be urged to consider, where appropriate, providing examples of evidence of performance for individual accreditation standards, which may include sources a site visitor may seek or that the program may present as evidence of compliance with the standard, and be it further **Resolved,** that the Commission be urged to consider, where appropriate, implementing a scoring section for individual accreditation standards to help the program focus on the performance expectation stated in the standard; and be it further **Resolved,** that the Commission be urged to consider, where appropriate, the use of a grid scoring system to express the overall performance of a program in meeting expected accreditation standards.

  Commission Action: The Commission adopted this resolution.

- **B-69-1996. Resolved,** that the Commission be requested to delay final approval of the predoctoral accreditation standards until there has been additional opportunity for full discussion and consensus by the communities of interest.

  Commission Action: The Commission's action regarding this issue has been reported under Resolution B-36-1996.

- **B-70-1996. Resolved,** that, if another draft of the proposed revised predoctoral accreditation standards is circulated, the ADA Board of Trustees provide the Second Presidential Committee an opportunity to comment on the proposed standards.

  Commission Action: No action was required.

- **B-71-1996. Resolved,** that the Commission on Dental Accreditation be urged to consider the implementation of recommendations similar to those outlined in Resolutions B-66, B-67 and B-68, as appropriate, for the accreditation standards used to evaluate the other 13 dental-related disciplines accredited by the Commission.

  Commission Action: The Commission adopted this resolution.

- **B-72-1996. Resolved,** that the Commission on Dental Accreditation, in its consideration of the new United States Department of Education (USDOE) criteria regarding the accreditation cycle, be urged to consider adding a category to recognize those programs that substantially exceed the minimum accreditation standards, and be it further
Resolved, that the new accreditation cycle for exceptional programs be ten years, so that the resulting options for accreditation status would be approval for two, seven or ten years.

  Commission Action: The Commission, as well as its advisory and standing committees, did not support this resolution.

- **B-73-1996. Resolved,** that the Commission on Dental Accreditation be urged to develop and implement its own formal program of outcomes assessment, including an evaluation of the degree to which its goals are being met through ongoing and systematic measurements, and be it further
Resolved, that the Commission be urged to document its use of the results of its outcomes assessment process in evaluating its effectiveness.

  Commission Action: The Commission adopted this resolution.

- **B-88-1996. Resolved,** that the Commission on Dental Accreditation be urged to consider, where appropriate, utilizing quantifiable measures of student outcomes in the accreditation standards, including, but not limited to, pass rates on Dental National Board examinations Part I and Part II; pass rates on state or regional entry level licensure examinations; and student attrition.

  Commission Action: The Commission adopted this resolution.

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

Report 19

Annual Report of Strategic Planning Activities

Background: To fulfill its annual progress report obligation as required by Resolution 104H-1990 (*Trans.*1990:570), the Board of Trustees has developed the following report on Association strategic planning activities.

The Board of Trustees reaffirmed that the strategic planning process is of the utmost value to 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 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. The Board's commitment is to carry the strategic planning process forward so that the American Dental Association can continue and further expand its role 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 revitalizing the Association's strategic planning process. Members of the 1996 Committee, appointed by the President, Dr. William S. Ten Pas, included: Dr. D. Gregory Chadwick; Dr. Stuart B. Fountain, first vice president; Dr. H. Raymond Klein, fifth district trustee; Dr. Michael Koufos; Dr. Roger Macias; Dr. David Neumeister (chair); Dr. Michael Schafhauser; Dr. Jane Smydo; and Dr. Bruce Valentine, with Dr. James F. Mercer, treasurer, serving as the ex-officio member.

Chronology: The Committee met on April 14-15, 1996 in Chicago and on August 2, 1996 via conference call. At the request of the President, Dr. Neumeister made a presentation to the ADA Board of Trustees at its June 1996 meeting, where he provided background information on the development of strategic planning within the Association, outlined some current concerns with the process and proposed several options for revitalizing the Association's strategic planning process. Outcomes measurement, periodic environmental analysis (emerging issues research) and longer terms for members of the Strategic Planning Committee to promote consistency were identified as key factors for successful planning. Following Dr. Neumeister's presentation, a committee of trustees and senior staff was appointed to formulate a recommendation to the Board on the direction the Association should take regarding strategic planning. This initial report was modified with input from the President-elect and submitted to and accepted by the Board at its July 1996 meeting.

Strategic Planning Process: The Board believes that, in a repeat of the strategic planning process cycle, all objectives should be reviewed during the coming year for relevancy and a revised ADA Strategic Plan should be created since the current Plan is now three years old. The Board approved an emerging issues scan to be conducted in the third and fourth quarters of 1996 to identify environmental conditions and issues as objective information upon which to base ADA's planning activities.

Future Strategic Planning Activities: The guiding principles for the strategic planning process are as follows.

1. The strategic planning functions of the Association should be assumed by the officers, trustees and senior staff of the Association. It is impractical for the Board as a whole to conduct in-depth planning sessions due to its size; however, the Board is responsible for the approval of the Plan and for monitoring its implementation.
2. The basis of planning activities must be objective information and data which are analyzed in relation to their relevance to the ADA's future.
3. Sufficient time must be allotted to create a credible strategic plan and to reexamine it every three to four years. This includes sufficient number of meetings and sufficient time to plan the process of planning.
4. A critical piece of the planning process is the creation and implementation of action plans supporting the ADA's Strategic Plan. Therefore, the process, during its implementation cycle, must appropriately involve all ADA parties who are accountable for such ADA activities.
5. There should be a predetermined mechanism that allows the Board of Trustees, the Executive Director and senior management to quantitatively measure implementation activities resulting from the strategic plan directives.

To further the Plan's continued development and its purpose and use throughout all Association activities, the following actions will be taken during 1997.

1. Strategic Planning Committee's Function: The Strategic Planning Committee will analyze the information from the emerging issues scan and will present this analysis and any related recommendations for the Board and senior management to consider as it proceeds with its activities. This analysis will also be the basis for the new ADA Strategic Plan. This committee will be established as a Standing Committee of the Board.

2. Strategic Planning Committee Membership: Continuity and increased trustee representation in the membership of this committee are key to a smooth planning process. The committee must also contain adequate non-trustee members to allow for new and different viewpoints. The overall size of the committee will not exceed its current size of ten members to ensure productivity. Whenever possible, the appointments will be made for four years, ensuring continuity and reflecting the terms of the trustees and the cycle of planning. The following is the Strategic Planning Committee structure approved by the Board of Trustees.

- **Four trustees:** One trustee from each class will be appointed to serve on the Committee until the end of his or her term on the Board, thus ensuring continuity and

trustee representation. One of the trustees will also be an ADA Holding Company Board member to ensure incorporation of an important strategic arm of the ADA.

- **ADA President-elect:** Each year, the President-elect will serve on the Strategic Planning Committee to ensure input from Association leadership.
- **Two members-at-large:** To provide additional member input in the strategic planning process, two members-at-large will be appointed to the Committee. The terms of these members will last for the four-year planning cycle or alternate at the discretion of the President.
- **One member-at-large who is a recent alumni or a current member of the Standing Committee on the New Dentist:** The appointment of a current or recent member of the Committee on the New Dentist will allow new and fresh input. This member's term may alternate annually or continue at the discretion of the President.
- **Two ADA senior management staff:** The Executive Director and a senior manager appointed by the Executive Director (preferably for a four-year term) will also serve on the Committee. This will ensure continuity and the involvement of key implementors.
- **Committee facilitator:** The Director of Strategic Planning will function as the facilitator of the process because of its unique nature and requirements. The facilitator's duties will encompass designing and monitoring the full planning process, including facilitating and supporting the Committee meetings; communicating with the necessary ADA agencies and staff groups about the process; and monitoring the necessary linkages between planning and other relevant ADA activities.

3. Function of Planning Meetings: Three meetings of the Strategic Planning Committee will be held in 1997 to analyze the emerging issues scan and to track ongoing changes and results. In addition, this committee will make recommendations towards a new ADA Strategic Plan for the Board and senior management to consider. The Board will then review, discuss, approve and apply the Strategic Plan with the support of senior management.

4. Action Plans and Implementation: As soon as the Board approves a new Strategic Plan in 1997, appropriate implementation bodies will be advised on the new Plan and guided through the development of their related action plans in the implementation process, including any appropriate linkages to the budgeting process.

5. Strategic Plan Monitoring: Beginning in December 1997 a portion of every December Board of Trustees planning session will be devoted to evaluating the progress of annual action plans in relation to the strategic plan objectives and to start goal-setting for the next annual cycle.

Quality and Strategic Planning: The Office of Quality and Strategic Planning provides staff support to the Strategic Planning Committee and assists it in meeting its goals to integrate quality and strategic planning management principles throughout its activities.

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

Report 20

Protocol for Maintenance of Dental Practice Parameters

Background: The dental profession, as a self-regulating profession, has had a long-standing commitment to monitoring and improving the quality of oral health care. Toward improving the quality of care, the dental profession advances the science of dentistry; practitioners continually educate themselves to maintain their skills and knowledge; and dentists act in the best interests of their individual patients as well as advocate the broader interests of the public's oral health. However, during the last several decades, as health care became a defined part of the private, competitive marketplace, the dental profession has been faced with demands for more information about diagnosis and treatment and more information about what constitutes appropriate care.

The public and third-party payers seek information about oral health care to make decisions in designing health benefit plans and establishing reimbursement criteria. Patients seek information to decide between available treatment options. The public and payers seek information to learn more about the value of oral health care.

The profession and the American Dental Association recognized that a need for information is a component of a competitive marketplace. They also recognized that the quality of care should not be diminished in an effort to meet cost containment objectives, and that government regulation, to fill information gaps on what constitutes quality, could be cumbersome. Thus, the dental profession, with its long-standing commitment to improving the quality of oral health care and advocating the best interests of its patients and the public, was the most credible and knowledgeable body to provide needed information on what constitutes appropriate oral health care for given oral health conditions.

Thus, in 1993, through Resolution 62H-1993 (*Trans.*1993:697), the Association decided that it was advisable for the ADA to develop dental practice parameters. Resolution 62H-1993 directed that the Board of Trustees establish a protocol for the implementation and ongoing evaluation of the appropriateness, application and impact on professional performance of these parameters. By adoption of Resolution 62H-1993, the House of Delegates modified Report 9 of the Board of Trustees to the House of Delegates: Dental Practice Parameters (*Supplement* 1993:392) to include specific directives regarding the Dental Practice Parameters Committee (DPPC), the application of existing dental practice parameters and the development of new parameters (see Appendix 1, page 504). The resolution 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 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 of 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.

Based on the directive from the House of Delegates, the development of dental practice parameters was implemented. The parameters were drafted by the Dental Practice Parameters Committee (DPPC). The DPPC is composed of seven dentists: three appointed from the Council on Dental Benefit Programs; two from the Council on Dental Education; and two from the Council on Dental Practice. The drafts were reviewed first by a consensus conference of 35 dentists and then by a mail review panel of approximately 45 dentists approved by the Board of Trustees. The dentists in both the consensus conference and the mail review panel represented a cross section of the country and included a majority of general dentists and practitioners, as well as representation of specialties and educators. The final parameters were based on the recommendations of the consensus conference and the mail review panel and submitted to the House of Delegates for approval.

During 1994-95, parameters for 24 oral health conditions were developed and were published as a supplement to *The Journal of the American Dental Association (JADA)*. During 1996, parameters for an additional ten oral health conditions were developed and, pending the approval of the House of Delegates, will also be published as a supplement to *JADA*. The parameters have been available, free of charge, to dentists and other interested parties through the Council on Dental Benefit Programs' Office of Quality Assessment and Improvement.

The parameters that have been developed to date represent the bulk of oral health conditions for which parameters would be developed. The oral health conditions are those that dentists encounter frequently and those that have been perplexing and perhaps controversial within the profession. In addition to the professional consensus, which was the mainstay of the parameters' content, literature reviews were solicited, as needed; parameters developed by specialty groups were also reviewed by the DPPC, and, in one case, specialty groups met and consulted with the DPPC.

Throughout the past two years that the American Dental Association has had parameters, the documents have been useful in substantiating the dental profession's stand on what constitutes appropriate oral health care. They have been used in developing dental school curricula. On several occasions, the parameters were sought by state agencies as a reference for developing health reforms in state legislation, defining benefit programs, or developing quality assessment programs. Additionally, the Office of Quality Assessment and Improvement continually receives requests for the parameters from dentists and other interested parties.

Subject to review and approval by the Board of Trustees, additional parameters will be developed, for approval by the House of Delegates, as the profession identifies the need to address additional conditions. The major task before the Association is to maintain the current parameters documents. They will require revision as scientific knowledge changes, as practice changes, or as editorial changes become necessary. In addition to maintaining up-to-date parameters, the use of these documents will have to be more specifically delineated, and their impact will need to be monitored and evaluated (see Appendix 2, page 505).

The American Dental Association's dental practice parameters explicitly present the profession's statement on appropriate oral health care. This has never been more critical than it is in today's health care environment, where a multitude of changes in the delivery and financing of care have the potential to either expand access to appropriate care or jeopardize the quality of care for all.

To assure that the dental practice parameters are used as intended, the DPPC developed guidelines for the use of dental practice parameters and an accompanying cover letter, which would be sent to any organization or entity outside of the profession that requests the use of the American Dental Association's dental practice parameters. The guidelines are attached as Appendix 3 (see page 506).

Mission and Tasks of the Dental Practice Parameters Committee: The primary role of the DPPC has evolved from an intense effort to develop parameters and refine the mechanism for their development to the maintenance of the documents and the ongoing evaluation and supervision of their application within the profession and within the health care arena generally. In addition, the original members of the DPPC have gradually rotated off the Committee and within a year the membership of the Committee will have changed entirely. Although such a rotation is essential to the vitality of the project, the memory of the Committee's basic mission can fade. For this reason, the DPPC developed a mission statement and tasks to guide subsequent members of the Committee. The mission and tasks appear in Appendix 4 (see page 506).

Maintenance of Dental Practice Parameters: In accordance with Resolution 62H-1993 the DPPC proposed a protocol for evaluating the impact and use of dental practice parameters, and for updating and/or revising the dental practice parameters. The protocol was subsequently adopted by the Board in June 1996 and is described in Appendix 2. Such a protocol is necessary to maintain dental practice parameters that reflect advances in dental technology and science and that enable the dental profession to advocate the quality of oral health care within the health care environment generally. To accomplish this purpose, the protocol focuses on maintaining current, accurate and comprehensive dental practice parameters; monitoring the use of parameters; and providing dentists with information and a route through which they can communicate their questions and comments about parameters.

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

Appendix 1

Mechanism for Parameters Development

The consensus panel format will be utilized in the development of dental practice parameters.

A seven-member Dental Practice Parameters Committee (DPPC) made up of three members from the Council on Dental Care Programs and two members each from the Councils on Dental Practice and Dental Education will be appointed by the Chairman of each Council. A chairman of the Committee, who will have a vote, will be elected by the Committee. This Committee will develop and maintain the Association's dental practice parameters.

A Consensus Conference, of approximately 35 conferees, appointed by the Board of Trustees from nominations submitted by the DPPC, will be convened to review, discuss and modify the parameters submitted by the DPPC.

The parameters development project will be housed in the Office of Quality Assurance within the Council on Dental Care Programs, with administrative support by that Council.

Existing Parameters Documents

The process will begin with Association staff who will be responsible for preparing draft parameters from the current library of parameters documents developed by other organizations. ADA staff dentists will play a major role in this initial process and local expertise would be sought on an as-needed basis.

Drafts of the parameters newly developed from existing parameters documents will be reviewed by the DPPC prior to being forwarded to the Consensus Conference of selected authorities. The role of the Consensus Conference will be to discuss the draft parameters and make appropriate modifications for the preparation of the draft parameter(s).

Each draft will be mailed to a panel of approximately 35 reviewers, other than the conferees, selected by the Board of Trustees for review and recommendations for any additional modifications to the draft parameter(s).

The DPPC will make final modifications to the draft parameter(s) and submit the final parameter(s) to the Board of Trustees for review and submission to the House of Delegates for adoption.

New Parameters

The DPPC will identify any conditions for which parameters should be developed by the Association. The DPPC will assimilate data and, if necessary, will commission a paper to be written by a recognized authority on the subject for each new parameter area. That paper will be reviewed by another independent authority. Both the authors and reviewers will be nominated by the DPPC and selected by the Board of Trustees.

Based upon the reviewed paper, Association staff will prepare a draft parameter using local experts on an as-needed basis. The draft parameter will be reviewed by the DPPC and submitted to the Consensus Conference. The completion and adoption of the new parameter will proceed as described above.

Appendix 2

Example A

The Impact and Use of Dental Practice Parameters

The following proposed methods are directed toward monitoring the impact and use of parameters, soliciting comment and participation from the dental community on the use and improvement of parameters, and educating and informing members about the use of parameters.

- The Dental Practice Parameters Committee (DPPC) will biennially solicit dentists to comment on:

  a. the accuracy, comprehensiveness and contemporary appropriateness of the information presented in the parameters; and
  b. the need for parameters on other oral health conditions.

     1. The DPPC will determine whether there is a need for a new parameter.
     2. New parameters, when needed, will be drafted by the DPPC.
     3. New parameters will be refined through the same consensus conference and mail review processes as the original parameters, as outlined by the House of Delegates.
     4. New parameters will be submitted to the House of Delegates for adoption.

- Comments will be solicited by mailing a questionnaire to constituent dental societies, dental schools and dental specialty organizations.
- The annual *Survey of Dental Practice* will include questions on the use of parameters in dental practice.
- To comprehensively evaluate the use and impact of parameters outside of direct dental practice, the Committee will develop data and documentation on the use and impact of parameters:

  a. on negotiations with third-party payers;
  b. in litigation;
  c. in state and/or federal legislation and regulations; and
  d. in the development of dental quality assessment and improvement instruments.

- To continue to inform and educate the profession on the meaning and use of parameters in today's health care environment, the DPPC will:

  a. publish articles in dental journals and newsletters regarding the:

     1. Association's process for parameters development and revision;
     2. use and impact of parameters within the profession; and
     3. use and impact of parameters in the total health care environment.

  b. provide presentations to interested dental groups on the Association's parameters development process and/or the use and impact of dental practice parameters.

Example B

Updating and/or Revising Parameters

The dental practice parameters will be monitored and updated and/or revised when appropriate, subject to review and comment by the Board of Trustees.

- The DPPC will review parameters either two years after their approval by the House of Delegates or two years after their latest revision or review, whichever is most recent. The DPPC will evaluate the documents for accuracy, consistency and clarity of language and relevance to current practice.

  a. Substantive changes to the parameters documents will be drafted by the Dental Practice Parameters Committee and refined through the consensus conference and mail review process.
  b. Substantive changes in the parameters will be submitted to the House of Delegates for approval.
  c. Editorial changes will be reported through the Board of Trustees to the House of Delegates as informational items.

- Parameters which have been updated and/or revised will be published and disseminated to the membership and will be accessible to the dental community at large.

Appendix 3

Guidelines for the Use of the ADA's Dental Practice Parameters

1. These parameters describe the range of acceptable treatment modalities and are intended as educational resources and not as legal requirements.
2. The parameters can be used as a reference in the development of similar documents by other organizations and entities.
3. Each parameter has been developed as a separate document and, therefore, the Preamble must accompany each document.
4. These parameters or any part of the parameters documents may not be used to support guidelines, standards, or parameters developed by any other organization to restrict treatment or contain costs.
5. These parameters are condition based and are not designed to describe or delineate clinical techniques, procedures or materials used for treating certain conditions.
6. These parameters may not be used in any way that will limit or restrict the professional judgment of the dentist.
7. The individual statements within a parameter may not be used out of context or apart from the entire document.
8. One parameter may refer to another parameter when the conditions are interrelated.
9. These parameters may not be used in any way to eliminate the patient from the decision-making process in the choice of treatment.
10. Documents may use the ADA dental practice parameters as a reference. Any other use must be approved by the American Dental Association before publication and/or distribution.

Appendix 4

Mission and Tasks of the Dental Practice Parameters Committee

In order to clarify its responsibilities in the development and maintenance of dental practice parameters, the Dental Practice Parameters Committee identified its mission and tasks as follows.

Mission

- The mission of the Dental Practice Parameters Committee is to develop and update condition-based practice parameters on behalf of the profession and the public; to preserve the primacy of the professional judgment of the attending dentist in a manner that remains consistent with the range of acceptable treatment modalities derived from a consensus of the profession and allows for the evolution of the practice of dentistry for the benefit of the patients it serves.

Tasks

- To protect the professional judgment of the attending dentist as the basis upon which dental treatment plans are developed.
- To ensure that the parameters are written in a consistent format and are easily understood.
- To ensure that the parameters are relevant to clinical practice.
- To safeguard and implement the development process instituted by the House of Delegates in Resolution 62H-1993.
- To protect the ADA's ownership of its parameters through review of other documents to determine whether there are any violations of the ADA's copyright; and referral of any potential violations of the ADA's copyright to the ADA's Division of Legal Affairs.
- To ensure that when other entities ask to use the ADA parameters the ADA has final approval of the manner in which they will be used.
- To ensure coordination between agencies of the ADA that have any involvement with the parameters.
- To maintain and update existing parameters based on changes in the health care environment and the scope of dental practice.
- To determine the applicability of outcomes data to clinical practice and the need to modify existing parameters based on that information.
- To widely disseminate the parameters and educate the dental community regarding their value and use.
- To monitor the impact of parameters on the profession and the practice of dentistry.
- To identify additional oral health conditions for which parameters should be developed.
- To monitor the development of parameters by dental specialty groups and parameters dealing with oral health conditions developed by other health care disciplines.

Report 21

Update on Resolutions 62H-1995 and 119H-1995

Background: Concerned about the impact that underfunded and low reimbursement level dental benefit plans potentially have on the adequate and timely delivery of necessary dental care, and the effects that managed care dental benefit plans have on the delivery of dental care and the oral health status of the public, the 1995 House of Delegates adopted Resolutions 62H-1995 (*Trans.*1995:619) and 119H-1995 (*Trans.*1995:650) which read as follows:

> **62H-1995. Resolved,** that the American Dental Association commission an independent study of the effect of underfunding and low reimbursement levels on dental health care delivery and report this study with its findings and recommendations to the Board of Trustees for further action, and be it further
> **Resolved,** that the findings be reported to the 1996 House of Delegates, and be it further
> **Resolved,** that the cost of the study not exceed $500,000.
>
> **119H-1995. Resolved,** that for the benefit of the oral health of the American public, the ADA immediately initiate an aggressive lobbying campaign in Congress to advance the provisions of "The Family Health Care Fairness Act of 1995" as originally introduced, and be it further
> **Resolved,** that the ADA compile data on the effects of managed care on the oral health of the American public including, but not limited to, the effects of managed care on the cost, accessibility and quality of oral health care, and be it further
> **Resolved,** following the adjournment of the 1995 House of Delegates, the ADA develop strategies through its appropriate agencies to introduce legislation concerning requirements governing managed care, and be it further
> **Resolved,** that from the above data a lobbying campaign message be immediately developed emphasizing the effects that the objectives and ramifications of managed care have on the oral health of the American public.

A total of $500,000 was appropriated by the House to implement Resolution 119H-1995.

Because of the similarities of the information required by the resolutions, administratively those aspects of both resolutions were combined.

The Coordinating Committee on Resolutions 62H-1995 and 119H-1995 was appointed, with the following members: Dr. Richard Mascola, trustee, Second District; Dr. Michael Till, trustee, Tenth District; Dr. Leo Finley, member, Council on Governmental Affairs and Federal Dental Services (CGAFDS); Dr. Roger Kiesling, chairman, Council on Dental Practice (CDP); Dr. Kenneth Lange, ADA member, California; and Dr. Kevin McNeil, chairman, Council on Dental Benefit Programs (CDBP). Association staff assigned to the Committee are: Dr. Clifford Miller, deputy executive director; Ms. Dorothy Moss, associate executive director, Government Affairs; Ms. Carol Overman, assistant executive director, Administration and Policy, project coordinator; Dr. James Bramson, director, CDP; Mrs. Marye Feldman, director, CDBP; Mr. Mark Rubin, associate general counsel, Legal Affairs; Ms. Karen Schaid Wagner, director, Survey Center; and Dr. Albert Guay, associate executive director, Dental Practice, lead staff.

Designing and carrying out a study with such a broad scope and such a short time frame appeared to be a daunting task. As of the writing of this report, the study has been designed, a request for proposal has been circulated to the research community, responses have been evaluated, a contractor has been retained and the first phase of the study has begun. The RAND Corporation, Santa Monica, California, has been selected by the Committee to conduct the research.

The entire Committee has met twice in Chicago and once by conference call; the staff component of the Committee has met twice. A consultant, Dr. Marvin Marcus of the UCLA School of Dentistry, has assisted the Committee, without compensation. Appropriate Association staff has visited RAND to complete final details of the research project.

Great care was taken in the design of the research and several Association agencies were consulted in the process. The Council on Dental Benefit Programs and the Council on Governmental Affairs and Federal Dental Services discussed the project and provided their comments.

The Dental Economic Advisory Group discussed an important aspect of the research design and its comments resulted in a modification of the project. The resolutions from the House speak to "underfunded" and "low reimbursement" level dental benefit plans. Since there is no agreed-upon definition of those terms, and since, from an economics viewpoint, there are no "underfunded" plans, the research project will be directed toward studying dentist and patient behavior in response to varying levels of reimbursement in dental benefit plans. The information sought by the House in Resolutions 62H-1995 and 119H-1995 can be gathered in this format by comparing both ends of the reimbursement distribution curve without classifying plans as "underfunded" or having "low reimbursement levels."

Resolution 119H-1995 also calls for compiling "data on the effects of managed care on the oral health of the American public." This requirement can best be fulfilled with a prospective oral health status study of relatively stable patient populations. The Board believes that such a prospective study should be undertaken using the first phase of this retrospective study as the baseline. No such baseline currently exists for this comparison at this time. A three- to five-year prospective study of the sample gathered and classified in the initial effort will provide the information required in Resolution 119H-1995.

The final results of the retrospective portion of this study will not be available for the 1996 House of Delegates. The project is too complex and requires more time to complete. However, this comprehensive status report will provide adequate information to the 1996 House. The Board is confident that the 1996 House will look favorably upon this approach to implementing these resolutions.

The time line for implementation of Resolutions 62H-1995 and 119H-1995 is very ambitious. It is anticipated that the entire first phase of the study will be completed in September 1997 and reported to the 1997 House of Delegates. If approved, the prospective part of the study will begin immediately after the completion of the first phase.

A brief description of the project follows.

Project Background: Anecdotal information indicates that dentists and patients may modify their behavior in dental benefit plans in response to the level of reimbursement in those plans. In plans that can be categorized as "managed care" plans, the level of reimbursement is often reduced, and/or the dentist may agree to assume the financial risk for the costs of dental care required by the beneficiaries of the plan.

The financial incentives operating upon dentists may be to provide an increased amount of treatment (discounted fee-for-service plans), or to provide a reduced amount of treatment (capitation plans) for patients who are enrolled in managed care plans. Patients may respond to the level of out-of-pocket and opportunity costs (transportation costs, parking fees, cost of baby sitters, lost wages and so forth) they must pay for the dental care they elect to receive.

As decisions are being made about the level of reimbursement dental benefit plans will incorporate and to which the parties will agree, it is important that all parties understand the responses on the part of dentists and patients that adjustments in the level of reimbursement may promote.

Behavior modification as an immediate response to changes in reimbursement levels may have long-term effects on the oral health of dental plan beneficiaries. Some appraisal of these potential long-term effects will be important in understanding the true cost/benefit relationship of modifications in the level of reimbursement in dental benefit plans.

Study Objective: The Association seeks to enumerate and quantify the potential changes in dentists' and patients' behavior related to the level of reimbursement in dental benefit plans. Do dentists modify their office policies concerning the type of dental services provided, the amount of services provided, and the access to dental care, for example, when reimbursement levels are reduced and/or the dentist assumes the financial risk for the dental needs of a covered population? Do patients respond to changes in the amount of money they must pay out-of-pocket and/or increases in the opportunity costs to receive dental care, for example?

The Association would like to understand the behavior of dentists and patients in relation to reimbursement levels in dental benefit plans as a part of its current analysis of the dental health care market. In addition, the ADA would like to be able to offer objective information to patients, dental benefit plan purchasers and dentists about the potential effects of varying reimbursement levels in the dental benefit plans they utilize, purchase for their employees or in which they agree to participate.

The Association would like to know about long-term effects on the oral health of dental plan beneficiaries resulting from changes in dentist and patient behavior as a response to changes in dental plan reimbursement levels.

Research Overview: To fulfill the objectives of this investigation, there may well be a need for two interrelated studies: a retrospective look at behavior changes related to changes in reimbursement levels in dental benefit plans and a prospective study of appropriate populations with dental benefits over time. A great deal of the data that would be garnered from the retrospective part of the study would be valuable to the prospective part of the study, providing the baseline from which changes can be judged.

It is clear that the assembly of appropriate sample populations may be difficult. Nonetheless, such a task will be a critical factor in the success of the project. In addition, data may be difficult to gather in capitation funded dental plans because reimbursement is not based upon the provision of services. Records may not be as complete as in service-based reimbursement plans.

It will be important that, in the several categories of dental plans in the study sample, plans with varying reimbursement levels and funding levels be included. Comparisons will be made **between plan types**, for example, between capitation plans (CAP) and discounted preferred provider organization (PPO) plans, and between **plans within the same category**, for example, between CAP plans with relatively high monthly payments and those with relatively low monthly payments. Comparisons will also be made with patients who have no dental benefit plan.

A useful approach to the organization of the study will be to divide the data gathering into four activities:

1. the typology of the plans, to clearly determine their individual characteristics and gather data about utilization rates, costs, numbers and distribution of providers, out-of-plan utilization, etc.;
2. patient interviews, to determine satisfaction, appointment information, demographics, etc. Eligible nonusers will also be interviewed to determine their attitudes;
3. provider interviews, including providers who have disenrolled from plans, to determine satisfaction, financial impact, reasons for maintaining or rescinding participation status, etc.; and
4. records reviews, to approximate the "quality" of the care provided, using specific indicators, or proxies, for care quality and observation of recall examination experiences.

Some indication of the overall performance of the various dental benefit plans will be obtained by classifying the various types of treatment recorded on patient charts into several categories, i.e., episodic or emergency, initial, completed initial and maintenance; and mapping the migration of patients into these categories as treatment progresses.

In assessing the long-term effects of changes in dentist and patient behavior on the oral health of the patients studied, some type of oral health index will be useful. The length of time required for the prospective study to yield valid information will be between three and five years. Comparisons with patients who have no dental benefit plan will also be made.

What appeared to some to be a project that could not be accomplished, especially in the time frame required, has evolved into an interesting, achievable project. The Board is enthusiastic about this research.

Interim reports, as information becomes available, will be presented to the Board so that it can be used by the Association in its lobbying activities as quickly as possible.

Lobbying activities related to "The Family Health Care Fairness Act of 1995" (HR 2400) have been aggressively pursued by the CGAFDS and reported on throughout the year, including a press conference at the time of its introduction.

Much activity, including consideration by the House of Delegates of regulations for managed care organizations and their registration and control by the state governments, is ongoing in the area of regulation of managed care organizations.

Budget: A combined total of $1 million was allocated by the 1995 House for implementing Resolutions 62H-1995 and 119H-1995. Administratively, $750,000 was projected for the research portion of the implementation and $250,000 for lobbying efforts. The contract with RAND for the initial research efforts has a fixed cost of $554,494.

Thirteen research organizations were invited to bid on this research. Four organizations responded with comprehensive bids. The Committee unanimously recommended the selection of the RAND proposal.

Because of the extended nature of this project, the funds appropriated for these resolutions will not be expended in 1996.

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

Report 22

Update on Resolution 129H-1995—Direct Reimbursement

Background: The 1995 House of Delegates determined that, in view of new opportunities in the dental care marketplace, the Association should increase its efforts in the promotion of direct reimbursement (DR). The House adopted Resolution 129H-1995 (*Trans.*1995:621), which reads as follows:

> **Resolved,** that the ADA aggressively continue its efforts to investigate and consider support to a wide variety of direct reimbursement programs and investigate the experience of organizations currently involved in the promotion of direct reimbursement nationally, and be it further
> **Resolved,** that the ADA Board of Trustees support these efforts at a level up to an additional $500,000 for the fiscal year 1996, and be it further
> **Resolved,** that a progress report shall be presented to the 1996 House of Delegates.

An interagency Coordinating Committee for Resolution 129—Direct Reimbursement was appointed by Dr. William Ten Pas, ADA president, to implement this resolution. The members of the Committee are: Dr. Steven Bruce, member, Council on Dental Benefit Programs (CDBP), chairman of CDBP's Purchaser Information Service Subcommittee (PINSERV); Dr. Stuart Fountain, ADA first vice president; Dr. T. Howard Jones, member, CDBP PINSERV; and Dr. Elizabeth Ward, chairman, Council on Communications. ADA staff members of this Committee, appointed by Dr. John Zapp, ADA executive director, are: Mr. Clayton Mickel, associate executive director, Division of Communications; Ms. Patricia Newton, associate executive director, Division of Membership and Dental Society Services; Ms. Carol Overman, assistant executive director, Administration and Policy, project coordinator; Mrs. Marye Feldman, director, CDBP; and Dr. Albert Guay, associate executive director, Division of Dental Practice, lead staff.

This resolution has been interpreted as being a marketing project, not a DR plan development project. Activities designed to implement this resolution supplemented the planned activities of the CDBP PINSERV and did not duplicate its efforts or infringe upon its responsibilities. The Committee was charged to make recommendations for the implementation of Resolution 129H-1995 to the Board of Trustees. The Board of Trustees authorized the recommended activities at its April 1996 meeting.

Since Resolution 129H-1995 calls for the ADA to "investigate the experience of organizations currently involved in the promotion of direct reimbursement," work began in November 1995, in conjunction with the Survey Center, on the development of a survey instrument to gather such information.

A meeting of the staff component of the Committee was held on December 4, 1995 to refine the survey instrument and to develop reference materials, a discussion guide and agenda for a full Committee conference call. An estimated time line for implementation activities was also developed.

On December 8, 1995, the entire Committee met through a conference call. The Committee further refined the work plan, made recommendations for modifications of the draft DR survey and approved the work time line.

The DR survey was sent out to all of the state dental societies, selected component dental societies and the specialty organizations during the first week of January 1996. All of the state societies completed and returned the survey instrument.

The full Committee met on March 15, 1996 at the ADA Headquarters Building. The Committee reviewed and discussed the results of the DR survey. Ms. Karen Schaid Wagner, director, and Ms. Christine Santini, research associate, of the Survey Center, reported on the survey. Representatives from the American Association of Orthodontists (AAO) made a very thorough presentation concerning the extensive experience of the AAO in its 12-year DR promotion efforts. Mr. Douglas Bush, executive director of the Indiana Dental Association, where DR was "born," and former director of the California Dental Association and the Alabama Dental Association's direct reimbursement promotional efforts, reported on the experiences of those organizations. Representatives of two of the four marketing groups that submitted proposals for this project were invited to present their proposals to the Committee.

The Committee discussed the information it had heard and developed recommendations for a plan to implement Resolution 129H-1995. The Association's Executive Director reviewed the implementation plan developed by the Committee and recommended that the Board accept the plan and the choice of the designated marketing firm.

Implementation of the ADA direct reimbursement (DR) promotional activities began on June 1, 1996. They represent an integrated marketing campaign aimed toward a specific, targeted audience.

Strategy: The strategy involves two primary efforts: 1) increasing the awareness of DR in the national dental benefits market, and 2) generating "leads" in specific markets where adequate follow-up resources exist.

Audience: There are two audiences to whom the promotional campaign is targeted: 1) business prospects, and 2) key dental constituencies.

The primary target audience is people in business who make the decisions about dental benefit plans: human resource benefit managers, chief financial officers, chief executive officers, owner/presidents of small companies and entrepreneurs. They are the "customers."

The secondary target audience is key dental constituencies: the ADA membership in general and the constituent and component dental societies. They are the local "sales force" and "service departments."

Vehicles: The primary audience has been addressed by an innovative national advertising campaign conducted in three phases:

1. Print advertisements in trade publications that are read by the targeted business people: *Business Insurance*, *Employee Benefit News* and *Human Resource Executive*. These ads provide information about DR, invite inquiry of the ADA and solicit requests for the "DR disk" developed for this campaign. These publications have combined circulations of approximately 55,000.
2. Print advertisements in selected markets that have the "DR disk" included with the *Business Insurance* publication. The "DR disk" is an interactive computer disk that reinforces the message of the print ads for use by readers at their leisure. This distribution was selected **by markets** and included a circulation of about 11,000 people.
3. A direct mail campaign in six states (California, Georgia, Indiana, Minnesota, Texas and Virginia) selected by the Committee through several specific criteria, the most important of which was the ability of the local dental societies to promptly and adequately respond to inquiries. The direct mailing will include the DR disk. This distribution was selected **by industry** in those states. As the promotional campaign matures, additional markets for a direct mailing campaign will be selected.

These several components were rolled out in a planned sequence to maximize the impact on the targeted audience and to efficiently utilize the services of the Association and the respective state societies in responding to the inquiries generated.

The ADA has also, through CDBP's PINSERV, increased its presence in appropriate trade shows and organizational conventions attended by members of the primary target audience.

Efforts to reach the secondary audience included enhancing direct communications with dental societies to encourage their participation and supplying them with materials for use in local promotions. The *ADA News* has been an important instrument in providing information to the general membership. Through an organized steady stream of news articles on DR, the *ADA News* has informed members about the campaign, encouraged members to participate in the promotion and invited requests for promotional materials from the ADA, including copies of the DR disk.

The editors of constituent and component dental societies will play an important role in reaching this secondary audience. The Association will enlist their assistance by providing copy for the editors to use to promote these activities.

An enhanced "DR Day" was held at the ADA Headquarters Building on July 11, 1996 in conjunction with the CDBP Dental Benefits Conference. Attendance was the highest ever, with over 100 attendees. The Conference also targeted the primary audience, its theme being "The Employer/Employee Part of the Equation." Dental societies that are active in DR promotion met for a day and shared their experiences.

Educational and promotional materials have been developed specifically for this campaign.

The ADA cost projection model has been updated to reflect current market factors. The actuarial firm of Milliman & Robertson (M&R), Seattle, provided these services to the Association. M&R conducted a training workshop for local dental society staff in the use of the new model on July 10, 1996. Fifteen local dental societies sent staff to participate. ADA staff traveled to the Milliman & Robertson office in Denver on August 13, 1996 to begin work on expansion of the model to include large purchasers.

Tracking: It is critical that "leads" generated have efficient follow-up, or the campaign will generate more ill will in the business community than good will. The ADA must carefully track each of the responses to the promotion.

All inquiries will come to the Association and either be followed up by the ADA or referred to local dental societies. Tracking will also be an important part of the ongoing evaluation of the effectiveness of the campaign.

In addition, it is important to begin the development of a comprehensive database on DR plans and their experiences in order for the ADA to be of maximum assistance to the local dental societies and to prospective DR plan developers.

Measures of Effectiveness: It is important to be able to measure the effectiveness of this campaign as well as possible, both to judge the ultimate value received for the resources expended and to make mid-course corrections to the program itself as it is being conducted. This campaign has a "study as you do" aspect to it. Although many of the benefits of this campaign will not become evident for some time, certain measures can serve as indicators for campaign effectiveness, such as the number of inquiries received, purchaser contacts made, DR cost projections made, DR plans implemented or converted and the number of beneficiaries covered.

Post-Advertising Research: Effective use of the funds appropriated for the DR promotional campaign, and any future DR promotional activities, requires a study of the effectiveness of the several components of the current campaign. To that end, post-advertising research is underway. Results will be available to the House immediately before it convenes. A more complete description of the research protocol will be presented with the publication of the research findings to the House.

Budget: All aspects of the campaign have been integrated. A general budget has been developed, as outlined below.

Marketing agency	$ 400,000
Administration	4,000
Purchaser contact and support	11,000
Materials development and manufacture	25,000
Tracking	10,000
Trade shows	25,000
"DR Day"	25,000
Total	$ 500,000

It is anticipated that the majority of the funds appropriated for this promotional campaign will be expended during 1996. In the event that there are any significant funds that are unexpended in 1996, a request will be made to carry them over to 1997.

Campaign Results: The response to the promotional campaign, at the time of the writing of this report, has been good, and interesting. Over 250 responses have been received at the Association. As a reflection of the changes in the dental marketplace and the new audience targeted by the campaign,

the character of the companies responding has expanded. Large employers and benefits consultants are seeking information on DR now; in the past inquiries have been overwhelmingly from small purchasers.

General: All of the activities related to this promotional campaign have been conducted with the approval of the Division of Legal Affairs.

The Association acknowledges the assistance of the Alliance for Dental Reimbursement Plans by its making available to the ADA its then-executive director, Mr. Philip Pfeiffer, for visitations and for DR Day planning.

There has been a close working relationship between the Divisions of Dental Practice and Communications, and their Councils, in the design and implementation of the activities related to Resolution 129H-1995.

It has become clear to the Board that the ultimate success of any DR campaign rests with the local dental societies. Their ability and willingness to devote personnel and other resources to any DR promotional campaign for the long term will be critical. The Association can only drive any such campaign, develop resources, coordinate national activities and offer counsel and support.

It is the Board's estimate that there is a three- to five-year window of opportunity for DR to move in the current marketplace, at best, given the rapid nature of marketplace developments currently. The Association's aggressive posture regarding DR promotion must continue, with adequate resources devoted to this promotional campaign. Barring any significant penetration of the dental benefits market during that time, the Association must reevaluate its position regarding the use of Association resources in DR promotion.

The Board feels that this campaign, characterized by scientific study in its design, use of cutting-edge marketing tools, identification of the proper target audience, and scientific evaluation of its effectiveness, has an excellent chance of being successful.

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

Supplement to Report 22

Update on Resolution 129H-1995—Direct Reimbursement

The objectives of the direct reimbursement (DR) advertising campaign were to build awareness and educate business executives about direct reimbursement and its advantages as a dental plan for employees, and to generate inquiries to the Association about DR plan development by individual businesses. Post-campaign research into the effectiveness of the advertising efforts was seen as a critical factor in the campaign if the results of future efforts were to be maximized. This learn-as-you-do approach was an important innovation in Association DR promotional efforts.

Background: The purpose of the post-advertising campaign research was to evaluate the effectiveness of the overall campaign and to determine the relative effectiveness of the several vehicles and combination of vehicles employed. This information will be useful in designing future advertising campaigns.

Research conducted before the ADA campaign indicated that the awareness level about DR amongst employers was effectively zero. Any increase in this awareness level could be attributed to the advertising campaign.

Total print media costs were $86,000, reaching an audience of 76,434, for a contact cost of $1.13 per individual. Total costs of the direct mail campaign were $102,422, reaching 23,000 businesses, for a contact cost of $4.45 per business.

The advertising campaign was conducted during the months of June, July and August. This is generally considered to be the most difficult time of the year in which to conduct such a campaign.

Research Methodology: Approximately 3,500 telephone contacts were made among two groups of individuals:

- those who contacted the ADA on the 1-800 number; and
- those who did not contact the ADA:

  1. subscribers to *Business Insurance* and *Employee Benefit News* (they were exposed to the ADA advertisements)
  2. recipients of the direct mail materials.

All were screened to be certain that the interviewer was speaking to the benefits decision-maker. Of those called, 58% of those who were exposed to the print ads were decision-makers, while 75% of those who received the direct mail materials were decision-makers. This is a very high yield in the target audience. In-depth interviews were conducted with 54 decision-makers. Half had seen the ads only, and half had received the direct mail materials. Interviews were conducted with 25 individuals who had called the ADA 1-800 number.

Research Results:

- As of September 12, 501 calls were received at the ADA; 291 requested cost projections for their companies and 210 asked that we send them the ADA DR interactive disk. The print ad campaign ran from June 3 to July 31. The direct mail campaign began on August 9. Immediately following the print campaign, the ADA had received 240 calls, 155 requesting disks and 85 requesting cost projections.

  Discussion: The response rate was excellent for a campaign of this nature conducted in the summer months. The response rate was significantly greater for the direct mail campaign and the type of requests made was also significantly different. More cost projection requests were made by recipients of the direct mail materials. These requests obviate the need for an initial mailing and the costs attendant, as well as, potentially, a site visit to obtain cost projection data.

- May and November are the peak months during the year when benefit plan decisions are made.

  Discussion: Focused direct mail campaigns should be timed to reach benefits decision-makers in a more timely manner.

- Of those individuals who were interviewed who were exposed to the print ads only, we achieved a 14% awareness. An awareness rate of 5% is the industry norm for such a campaign. A 57% awareness rate was found in the group who received the direct mail materials. An awareness rate of 35% is the industry expectation for this type of campaign. Those who both saw the printed ad and received the direct mail had a 33% higher awareness level. *These industry norms reflect awareness levels generally seen with a one-year program. This program was a three-month program.*

  Discussion: Awareness of DR was one of the primary goals of the advertising campaign. Awareness rates were significantly above those anticipated. The cost to reach one individual with print ads was $1.13, while the cost to reach one business by direct mail was $4.45. It would appear that the cost of direct mail is about four times that of print ads. However, the cost to generate one "aware" individual is more significant. With print ads only, it cost $8.07 to generate one aware individual, while it cost $10.36 to generate such an individual through direct mail only. It cost $7.79 to generate one aware individual if that individual received the direct mail material and also saw the print ad. (When we know the implementation rate, we will be able to calculate the costs for developing one DR plan.)

  It is apparent that a combination of print ads and direct mailings provide the most effective and cost-efficient means to attain the objectives of the advertising campaign. Including the disk in with Business Insurance *was only marginally effective.*

- The perception of those interviewed about DR did not vary with the medium that first introduced them to DR. The print ads were seen as intriguing and the disk was viewed as very innovative. The timing of the campaign was seen as difficult. The distinction between DR and traditional fee-

for-service plans was not seen clearly. Many who used the disk wanted more in-depth information and an immediate cost comparison with their current plan. Generally, they were intrigued by the DR concept.

Discussion: The creativity of the materials used was clearly recognized. The timeliness of future campaigns must be addressed, as well as the process for obtaining cost projections. The information on the disks should be expanded. There appears to be a new receptiveness for DR in the dental benefits marketplace.

Conclusions: The ADA DR advertising campaign was successful, both in increasing awareness of DR in the business community and in generating inquiries. Objective study of the results of the campaign has yielded insights into the direction future advertising efforts should take and modifications that should be made to increase the effectiveness of the program.

Since the greatest yield seems to follow direct mail efforts, we should expect that inquiries will continue to come to the Association, since the direct mail campaign was begun in August and was the last to be completed.

The success of the ad campaign is due to careful identification of the appropriate target audience, determining the most efficient vehicles to reach that audience, and development of a creative message and innovative means to deliver that message.

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

Report 23

Dissolution of American Dental Insurance Company, Ltd.

Background: During the approximate ten-year period ending in 1986, there was a steady and significant increase in the incidence and severity of dental malpractice allegations as well as a corresponding rise in the cost of professional liability insurance. This was part of a broader trend in malpractice litigation affecting most if not all health care providers. The problem was exacerbated by an inflationary economy which helped fuel the rise in the costs of defending claims and, more critically, jury awards for damages and pre-trial settlements. This in turn made dental malpractice litigation more attractive to the plaintiff's bar, which was largely compensated under the contingency fee system, thus contributing to the increase in claim frequency. At the time, these loss trends were not entirely understood and there was a widespread concern that the increasing number of claims was of such severity that insurers might ultimately abandon the dental marketplace. To protect the profession against the possibility that insurance protection could become commercially unavailable at justifiable cost, the Council on Insurance recommended that the Association develop a captive insurance company as a contingency measure. It was proposed that the company meet all the regulatory and legal requirements for operation as a commercial insurer, but not be capitalized until necessary. The Board of Trustees accepted the Council's recommendation at its August 1985 meeting and adopted Resolution B-87-1985 (*Trans.1985*:533) calling for the development of a "shelf" insurance company. This action was reaffirmed by the House of Delegates through the adoption of Resolution 109H-1985 (*Trans.1985*:579).

The American Dental Insurance Company, Ltd. was incorporated in Bermuda on July 8, 1986. Bermuda was selected as the Company's domicile because its laws and regulations facilitated the rapid and economical establishment of insurance companies. The application for incorporation provided that the Company would be entirely owned by the Association and would underwrite dental professional liability insurance policies exclusively. Although the Company was not capitalized, an annual fee has been paid to the Bermuda government to maintain its incorporated status. The amount of this fee is $3,360 in 1996. Since the establishment of the captive, the Association has expended a total of $35,770 in Bermuda government fees. Additional expenses include the fees charged by the Association's Bermuda legal counsel, the firm of Conyers, Dill & Pearman.

Recommendation: At its July 1996 meeting, the Board considered and accepted a recommendation submitted by the Council on Insurance that the Bermuda shelf-captive be dissolved. The Board shared the Council's judgment that the likelihood that the company will need to be activated is extremely remote. Since the company's establishment, conditions in the dental professional liability insurance marketplace have steadily improved and there is now an unprecedented number of insurers marketing policies to dentists. In some cases, premiums are lower than in 1986; and the Council believes that no segment of the profession has experienced a significant increase in coverage costs since 1986. Similarly, the terms of coverage offered today are also often more liberal than was the case ten years ago. The Council can identify no trends which might imperil these favorable conditions and thus cannot envision any realistic scenario under which the Association would find it in the membership's interests to activate the shelf-captive.

There will be no cost to dissolving the current shelf-captive. If it should later become necessary to establish a new company, the Association can do so within a relatively brief period of time. The Association's Bermuda legal counsel estimates the costs of reestablishing a shelf-captive would be approximately $11,000 at current fee levels.

For these reasons, the Board agreed there is no compelling reason to continue expending Association resources to maintain the shelf-captive. It adopted Resolution B-99-1996 which calls for the American Dental Insurance Company, Ltd. to be dissolved and Resolution B-87-1985 (*Trans.1985*:533) to be rescinded. It further directed that a resolution be transmitted to the House of Delegates calling for the rescission of Resolution 109H-1985 (*Trans.1985*:579).

Resolution

93. Resolved, that Resolution 109H-1985 (*Trans.1985*:579), Self-Insured and Self-Administered Professional Liability Insurance Program, be rescinded.

Report 24

Information Technology Project

Background: In February 1994, the Board of Trustees authorized the development of an information technology strategic plan to improve the Association's operating effectiveness (*Supplement* 1994:461). Implementation of the plan began in 1995 and is scheduled to continue for three years at an estimated cost of $5.6 million. The project is funded from the Restricted Investment Account of the Reserve Division. The Board of Trustees reviews a quarterly status report on the project, which indicates actual expenditures compared with budgeted projections.

This program is a major undertaking which requires the introduction of new technology as well as the ongoing support of existing systems and service to the membership. The goal is to provide a systems platform that is both financially supportable and sufficiently flexible to adapt to the evolving needs of the organization and its members. A plan was developed and implemented which will facilitate that goal. Software that is used by constituent and component dental societies for membership is being supported and included in the program.

A review of ADA requirements was conducted through interviews with each division in January and February of 1995. The information gathered through those meetings indicated that communication was the single highest priority. Work flow management and office automation were identified as having the highest impact on Association efficiency. Importantly, a high level of enthusiasm for the project was evident. Achievement of the program goal was focused on implementing a client-server computing environment with an emphasis on communication, work flow, training, support and a solid platform to host the various applications and other capabilities outlined in the 1994 study by Arthur Andersen. Monthly meetings of the staff Advisory Committee (AC2000) continue to confirm those findings and provide an avenue for the various divisions to raise issues and share ideas concerning the program. The balance of this report provides a summary of accomplishments for this program over the last 12 months (September 1995 to September 1996) as well as an overview of future activities.

Stabilizing the Current Environment: Steps taken in 1995 to stabilize the existing technology environment paid dividends in 1996. Those steps included stabilizing the current Micromembership system; reorganizing computer operations; implementing operational procedures in the current network environment; replacing several key servers; and improving the help desk function (*Supplement* 1995:429). With the cooperation of Association staff, these steps enable the maintenance of adequate service levels in the existing systems while focusing resources and management attention on the new environment.

Review by Computer Sciences Corporation: Computer Sciences Corporation (CSC) was engaged to conduct a review of program plans, assist in identifying critical success factors and perform quarterly program audits which measure actual performance against planned activity. CSC reviewed the program as a whole and provided positive feedback on the approach, identified several critical factors, and recommended strategies to ensure that those critical factors are achieved. Additionally, CSC specifically reviewed two key projects concerning the infrastructure and the Tripartite Association Management module. CSC's recommendations at the overall program level and the specific project level have been or are in the process of being implemented. Future CSC quarterly program audits will help ensure that program goals are being achieved and critical factors are being addressed.

Introduction of New Technology: As previously reported, the technology infrastructure, which includes network cabling, file server computers, network communication hardware, desktop computers and office automation software, is critical to meet program goals. The technology infrastructure provides the computing platform on which all the applications and other features outlined in the original Andersen study will run. Further, it must be highly maintainable and scalable to meet the needs of the Association today and in the future. CSC gave the infrastructure design high marks for providing an industry-standard, maintainable and forward-looking computing environment. Specifically, the infrastructure design includes the following features:

- The network hardware and software is designed to meet existing and future needs of the Association. Capacity is expandable as needs are identified in a specific location or area. A high-speed switched ethernet built around 3Com equipment and a Microsoft NT operating system provide a reliable network supported by quality vendors.
- Fiber optic cable provides a high-speed communications link between the floors while "Type 5" copper cable (an accepted standard for high-speed voice and data communication) supplies a reliable connection within each floor.
- The network servers are high-end computers from Compaq Corporation. These servers contain large amounts of memory and hard drives which can be quickly replaced in the event of a problem.
- Reliability and recovery are ensured by the use of high-capacity tape drives for system backups, uninterruptible power supplies (UPS) and Compaq's Insight Manager software that identifies potential hardware problems before they occur.
- Desktop computers, also from Compaq Corporation, are high-quality Pentium machines to facilitate staff productivity in the new environment.
- Microsoft Backoffice, which includes NT/Server, systems management, e-mail, mainframe connectivity and SQL server database software forms the backbone of the new environment. These integrated pieces of software are designed to work together to provide a cost-effective, robust set of tools to effectively manage and utilize various features of the network.
- The software used on each desktop computer is the Microsoft Office Pack, which includes the Windows 95

operating system, Word for word processing, Excel for spreadsheets, Power Point for presentations, Exchange for e-mail and Schedule Plus for scheduling. These components provide an easy-to-use, integrated and fully functional platform to facilitate the day-to-day work of the Association.
- Microsoft Access, a database and application development tool, is available for applications and database projects.

The technology infrastructure implementation plan specifies a floor-by-floor upgrade at the Association's Headquarters in Chicago. Every staff member has attended or will attend three days of training on the new systems and software. The training, provided by Catapult, a Chicago-based training company, presents an introduction to the new environment to enhance productivity. The implementation, scheduled to be completed in early October, has gone very smoothly with desired goals being achieved.

Also included in the technology infrastructure project is the Paffenbarger Research Center (PRC) in Gaithersburg, Maryland and the Association's Washington, D.C. office. The PRC enhancement, which included network, server and software upgrades as well as training, was completed early this summer and has provided a real benefit to that location. The Washington, D.C. upgrade will consist of new server and communication hardware, software upgrades and training. The existing network is already consistent with the technology infrastructure specifications and did not require major modification. The Washington, D.C. office system is scheduled to be completed in October.

Technology Vision: The future software infrastructure of the Association is envisioned to contain the following major components and will serve as the Association's core system.

- Entity Database: The Entity Database 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 managed by the ADA Information Technology staff. The foundation of the Entity Database will be data from the association management software which contains membership and related information.
- Customer Service Center: The Customer Service Center will provide centralized support for handling member inquiries. This feature depends on the Entity Database (see above) and the information clearinghouse (see below) to achieve its full potential of handling member inquiries accurately and quickly.
- Integrated Application Software: Integrated Application Software will help ensure that information in the Entity Database is accurate. This means that data from "feeder" systems (membership, financial, subscriptions, etc.) must integrate with each other and the Entity Database.
- Finance Systems: Initial work has begun on the project to replace the Association's mainframe-based finance applications. The new applications are expected to include general ledger, accounts payable, accounts receivable, fixed assets, project accounting and budgeting. The goals in selecting a new suite of financial programs are to improve performance and ease of use, to expand functionality and to improve system-to-system communication.
- Meetings and Events: The existing system has a number of excellent features and has served the Association well. However, this system needs improvements in ease of use and the ability to exploit new technology developments including the Internet.
- Information Clearinghouse: The Information Clearinghouse concept will provide a way of accessing information available at the ADA. Survey results, library information, research activities and statistical information will be easily accessible. It is anticipated that the Internet and the ADA Web page will play a major role in providing a method for members to utilize the information clearinghouse.
- Communications Infrastructure 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. The Internet provides an ideal environment to become the communications infrastructure as demonstrated by the award-winning ADA ONLINE web page project.

Program Spending Summary:

Budget	$5,600,000
Expenditures to date (as of July 31, 1996)	$2,062,151
Committed	$ 939,131
Remaining	$2,598,718

This summary shows the initial budget of $5,600,000 allocated from the Restricted Investment Account of the Reserve Division; actual expenditures of $2,062,151 as of July 31, 1996; and a committed amount of $939,131 which represents funds encumbered but not yet expended. The remaining funds of $2,598,718 will be required to complete the program.

Tripartite Association Management System: The vision statement for this important project states that:

> The vision for this project is to develop an easy-to-use integrated association management software product. This software will serve as the platform for meeting the changing needs of organized dentistry, and will enhance tripartite dentistry's position as the premier information resource, reinforcing the value of membership.

The constituent and component dental societies are important to the success of this program and to that end several steps were completed in the last 12 months. A focus group met at the 1995 annual session in Las Vegas to discuss direction and review alternatives. The focus group called for a tripartite survey of current software use and required features for a new system. The survey was conducted in November 1995 and was followed by a conference call with the focus group. The results of the survey and consultation with the focus group highlighted the importance of a tripartite system and resulted in the creation of a Software Needs Identification Team, composed of representatives from constituents, components and the ADA. Following a successful Software

Needs Identification Team meeting in early June, the Board directed that a project be funded to meet the needs identified. The project is scheduled to continue through 1998 at an estimated cost of $691,000 and is funded from the Restricted Investment Account of the Reserve Division. The Board of Trustees reviews a quarterly status report on the project, which indicates actual expenditures compared with budgeted projections. Specific modules or functions identified by the Software Needs Identification Team include:

- Membership database records management, process and data;
- Interface to a third-party report generator that will allow exported data into office software and telecommunications;
- Dues/membership;
- Referrals;
- Meetings; and
- Legislative contact management.

It has been determined that the first three modules (membership database records management, interface to a third-party report generator, and dues/membership) would also be useful to the ADA Membership and Dental Society Services division. The adoption of these modules for use at the ADA is contemplated to improve membership responsiveness and service.

It should be noted that the Board is committed to the use of new information technology to better serve ADA members, meet tripartite needs for easy-to-use new software with expanded functionality, and enhance seamless telecommunications of dues data for optimal membership marketing.

Tripartite Association Management System Spending Summary:

Budget	$691,000
Expenditures to date (as of July 31, 1996)	$ 5,413
Committed	$ 61,600
Remaining	$623,987

This summary shows the initial budget of $691,000 allocated from the Restricted Investment Account of the Reserve Division; actual expenditures of $5,413 as of July 31, 1996; and a committed amount of $61,600 which represents funds encumbered but not yet expended. The remaining funds of $623,987 will be required to complete the project.

Program Summary: The program will impact the Association's activities far into the future. The Board believes that appropriate care is being taken to assure that the new technology base will be sustainable, affordable and well-suited to respond to changing member requirements.

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

Report 25

Association Activities Related to Competency Issues

Background: In recent years, there has been considerable interest in the issue of competency assessment. Several organizations are involved in activities related to competency assessment, and the issue has broad implications for the dental profession as a whole. Competencies for new graduates and continued competency will impact areas such as dental school curricula, accreditation standards, initial licensure, licensure by credentials and practice standards, to name a few. It will be important that all communities of interest maintain an open dialogue regarding competencies, and that the American Dental Association, as the umbrella organization for the profession, be actively involved in these activities.

American Association of Dental Examiners Activities: The American Association of Dental Examiners (AADE) established a committee to address the issue of continued competency evaluation. A document titled Criteria and Mechanisms for Continued Competency has been approved by the AADE House of Delegates. A representative from the ADA Board of Trustees has served on this committee as a liaison from the Board. The committee is currently investigating mechanisms for evaluating competencies, and is in the process of formulating a five-year plan to address this issue.

American Association of Dental Schools Activities: The American Association of Dental Schools (AADS), with the support of the American Dental Association and other organizations, has initiated a project to identify the competencies that should be demonstrated by predoctoral students. The AADS has developed a draft document titled Competencies for the New Dentist and this document has been reviewed on behalf of the Association by a working group appointed by ADA President William S. Ten Pas. The working group's main concern was that the issue of competencies for the new dentist has implications for the profession beyond its intended use in assisting dental schools in curriculum development.

Continued Competency Issues: At the direction of the ADA Board, the Council on Dental Practice has developed a report on the issues related to voluntary continued competency. This report, which was reviewed by the Board at its September 1996 meeting, recommends that the Association conduct a feasibility study of the issues, processes and financial commitment necessary to develop a voluntary competency assessment program for dentists.

Discussion: In light of the above, and in consideration of other competency related activities, such as those initiated by the California Dental Association, the Board believes it is important for the Association to remain closely involved in discussions about competency. Since some of these competency activities are being directed by the educational community and some by the examining community, the Board also believes it is important for these groups to communicate effectively with each other, and to ensure that the point of view of the practicing community is fully represented. In this regard, the Association can and should serve as a facilitator to bring together interested communities for purposes of discussion and the development of a consensus within the profession.

Since the issue of competency is vitally important for the entire profession, the Board believes the Association's activities in this area should be coordinated to ensure that all appropriate points of view are considered. At its July 1996 meeting, the Board authorized the appointment of a broad interagency Association task force to establish an ongoing dialogue with the appropriate communities of interest. It is anticipated that the proposed interagency competency task force will review existing reports on competency and interface with other organizations and agencies both within and outside the Association considering the broad issues of initial and continued competency.

The task force will develop a comprehensive report for the Board of Trustees, which will in turn make recommendations to the 1997 ADA House of Delegates to determine what, if any, action should be undertaken.

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

Notes

Appendix

Notes

Index to Resolutions

1995 Resolutions

Resolutions 149 through 157 will be indexed in *Transactions*, 1996.

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