Illinois State Dental Society

ISDS

Education • Legislation • Communication

Policies

Adopted by the House of Delegates

1997 - 2019

The Bylaws of the Illinois State Dental Society Chapter XIII, Section IV. I. a. require the Board of Trustees to conduct a review of all ISDS policies adopted by the House of Delegates every five years beginning in 2012. The policies in this document have been adopted by the Illinois State Dental Society from 1997 – 2019. Each policy is listed in a category and arranged in chronological order. The resolution number and year adopted by the House of Delegates are listed after each policy.

ISDS Policies Adopted by the House of Delegates
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ADA

Election of ADA Trustee
Starting in 2005, the policy of this Society for selecting nominees for the position of Trustee of the ADA from the 8th District shall rotate in the following order: Chicago District, Districts outside the Chicago District, all Districts, (then repeat). (Res. #5-2004)

Funding for ADA Candidates
That any member wishing to be a candidate for an ADA elected office and seeking an endorsement and financial support from ISDS, must first be endorsed by his or her component.

That if a candidate is presented to the ISDS, the ISDS President will appoint a sub-committee to assess the qualifications of the ADA candidate(s). The subcommittee will be made up of 5 members of the 8th District delegation of which two (2) will be from the Downstate Districts, two (2) from the Chicago District, and the current ISDS President. The purpose for this subcommittee will be to determine the qualifications of the candidate(s) so that a recommendation to endorse or not endorse can be transferred to the Board of Trustees of ISDS.

That all candidate(s) be referred to the Board of Trustees with a subcommittee recommendation for endorsement or not endorsement.

That if the Board of Trustees grants its endorsement, the Board of Trustees may contribute to a candidate's campaign in an amount up to the following depending on which ADA elected office the candidate is seeking: President-Elect $25,000, 2nd Vice-President $2,000, Speaker of the House $10,000, Treasurer $10,000.

That the Board of Trustees will accumulate funds for contribution toward these future ADA campaigns by adding $10,000 to the 2012 budget and $5,000 to each year's budget thereafter until $35,000 has been accumulated. After disbursement, monies will be replenished in similar increments until the maximum is once again reached. In the event that money is necessary for a certain level of contribution prior to it having been accumulated, money will be withdrawn from society reserves and replenished in similar increments. (Res. #11–2011)

Dental Schools

Involvement of Dental School Deans in Organized Dentistry
The Deans of dental schools in Illinois are requested to maintain membership in the American Dental Association and encourage all faculty and students of the dental schools to also be members. (H: 98)

Illinois Dental School Issues
Illinois has a sufficient supply of practicing dentists to meet the oral healthcare needs of its residents and the current trend indicates that this will continue for the near future. There may be a mal-distribution of general dentists and specialists that affect some rural areas, but the majority of Illinois residents live within a reasonable distance, 30 miles or 30 minutes, of a dentist. (Res. # 15-2006)

ISDS Position Statement on Proposed Mid-level Dental Provider Models

Overview and Background Facts:
The Illinois State Dental Society is committed to providing quality dental care to the people of the State of Illinois based on a professional education system that ensures the highest level of safety of the public we serve.

Over the last two years, several groups have become interested in finding a solution that would allow the underserved, mainly Medicaid enrolled, to obtain easier access to dental services. While this has been a goal of ISDS for decades, real solutions can only be found when all of the facts are understood. Interest in developing another type of dental care provider, occasionally referred to as a "mid-level" provider, is thought to be an easy answer to a complicated issue and falls short of its goal.

There is not a shortage of dentists licensed to practice in Illinois. When comparing the number of dentists to the overall population of Illinois, the ratio is better now that it was in 1978. At the end of 2009, one dentist was licensed for every 1,269 Illinois residents compared to one dentist to 1,301 residents in 1978. In the last thirty-one years (from 1978-2009) Illinois currently has the most licensed dentists it has ever had (10,170) except in 1990 when 10,278 dentists were licensed to practice in Illinois.

Midwestern University located in Downers Grove, Illinois will open a new dental school in the fall of 2011. Midwestern is expected to admit 125 students into each class, and it is expected that 40% of those students will be residents and most likely begin practicing in Illinois upon graduation. This will have an additional benefit to Illinois that will offset any coming retirement of the "baby-boomer" generation of dentists. Similarly, across the country, an additional seven new dental schools are currently under development.

The high standard of formal education that general dentists, dental specialists, dental hygienists and many dental assistants receive in this country is overseen by the Commission on Dental Accreditation (CODA). CODA accredits over 1,350 dental and allied dental programs in the United States.

The mission of the Commission on Dental Accreditation is to serve the public by establishing, maintaining and applying standards that ensure the quality and continuous improvement of dental and dental-related education and reflect the evolving practice of dentistry. The Commission, established in 1975, is nationally recognized by the United States Department of Education (USDE) to accredit dental and dental-related education programs conducted at the post-secondary level. The Commission functions independently and autonomously in matters of developing and approving accreditation standards, making accreditation decisions on educational programs and developing and approving procedures that are used in the accreditation process.

At the end of 2009, over 2.5 million citizens of Illinois were enrolled in the Illinois Medicaid program. This is nearly one of every five of the Illinois population. In 1999, 1.25 million lives were covered by Medicaid. The doubling of the number of residents covered by the program has stressed the dental delivery system.

Since 2008, ISDS has presented a comprehensive approach to address the problems of providing care to the underserved population. The ISDS Bridge to Healthy Smiles campaign showed how raising reimbursement rates, opening public clinics and encouraging recent dental school graduates to establish a practice in a designated underserved area will begin to solve the access problems for this population. Without a comprehensive approach, real long-term success will not be achieved.

Comments:
There may be an economically induced shortage of dentists serving the underserved Medicaid population. As of the end of 2009, about 2,400 dentists are enrolled to provide care to the over 2.5 million Medicaid recipients. The economic shortage is caused by the chronic underpayment to dentists that heavily discourage them from providing treatment to this population. This state funding dilemma will face any type of dental care provider that serves this population on a fee-for-service basis.

A typical dental practice operates with overhead costs of 64% of the fee charged to a patient. On average, Illinois Medicaid reimburses a dentist only 46% of what is typically billed, so it literally costs most private practicing dentists to provide care to the Medicaid population. Illinois' reimbursement level for most restorative procedures ranks 48th in the country.

The most economically efficient way to address the dental care needs of the underserved population is to educate the children and adults in the factors that lead to dental disease and how best to prevent them from occurring before they begin. Dentists and the public health community agree that prevention and education are the keys to solving the long-term dental needs of this population and addressing any health care disparity. Increasing oral health literacy is imperative to addressing the needs of the underserved populations.

The comprehensive dental team of dental auxiliaries led by a dentist offers a full array of dental services with clear roles and lines of supervision. If a dentist is not leading the team, problems can occur as to who is responsible and who has the actual training and comprehensive education to properly diagnose and treat a dental condition.

The level of education and clinical training required to earn a dental degree, and the high academic standards of dental schools, are on par with those of medical schools and are essential to preparing dentists for the safe and effective practice of modern dental care.

Prior to admission to dental school, applicants have significant educational requirements. Traditionally, dental students have earned a bachelor degree and have taken rigorous admission examinations just to begin their 4-year general dental education. The curricula during the first two years of dental and medical school are essentially the same with students completing such biomedical science courses as anatomy, biochemistry, physiology, microbiology, immunology and pathology. For the protection of the public, completing this type of extensive education is required to perform the surgical procedures necessary to treat conditions of the teeth, bone, gums and the entire oral cavity and to assess complex medical conditions of the patient.

Foreign countries that have attempted to utilize mid-level dental providers have not solved their access to dental care problems. The idea that mid-level providers will practice solely in underserved areas has not been proven. In Canada and New Zealand, it is reported that most of the mid-level providers that originally began careers in underserved areas have migrated to urban areas in an attempt to earn a living.

The United States has the highest level of dental care in the world. Most of the countries that are trying to provide dental care utilizing mid-level providers started with a standard of care that would not be acceptable in the United States.

ISDS Position Statement:
For the protection and safety of the public:

- The dentist, as head of the dental team, must be solely responsible for examination, evaluation, diagnosis and development of the patient's treatment plan.
- All dental team members, regardless of designation, must be under the appropriate level of supervision by a dentist.
- Based on the high level of education and clinical skill required, only a dentist must perform surgical procedures on patients. Surgical procedures are defined as the cutting and/or removal of hard or soft tissue(s) from the oral cavity, including tooth structure.
- Any member of the dental team that is required to be licensed to practice must be required to obtain his/her education from an institution accredited by the Commission on Dental Accreditation (CODA).
- The most effective and efficient means of improving the oral health condition of underserved patients are diagnosis and treatment of disease by the dentist as the head of the team and utilizing properly educated auxiliary members of the dental team, prevention of disease by increasing oral health literacy and increased Medicaid reimbursement levels. (Res. #14–2010)

Eliminating Use of Human Subjects in Board Examinations

That the ISDS support the ADA's current policy on Eliminating Use of Human Subjects in Board Examinations (Trans. 2005:335; 2013:351) stating:

> *Resolved, that dental students providing patient care under the direct and/or indirect supervision of qualified faculty is an essential method of learning clinical skills including the ability to manage the anxieties, fears, reflexes and other emotions related to dental treatment, and be it further*
>
> *Resolved, that the Association recognizes that ethical considerations, including those identified in the ADA Council on Ethics, Bylaws and Judicial Affairs statement entitled "Ethical Consideration Process" (Annual Reports and Resolutions 2008:103), may arise from the use of patients in the clinical licensure examination process, even though the clinical examination process is itself ethical, and be it further*
>
> *Resolved, that the ADA supports the elimination of patients in the clinical licensure examination process with the exception of the curriculum integrated format, as defined by the ADA, within dental schools and be it further*
>
> *Resolved, that the Association encourages all states to adopt methodologies for licensure that are consistent with this policy."* (Res #6-2017)

The ADA defines **Curriculum Integrated Format (CIF)** as:

> *An initial clinical licensure process that provides candidates an opportunity to successfully complete an independent "third party" clinical assessment prior to graduation from a dental education program accredited by the ADA Commission on Dental Accreditation.*
>
> *If such a process includes patient care as part of the assessment, it should be performed by candidates on patients of record, whenever possible, within an appropriately sequenced treatment plan. The competencies assessed by the clinical examining agency should be selected components of current dental education program curricula.*
>
> *All portions of this assessment are available at multiple times within each institution during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake any portions of the assessment which they have not successfully completed.* (Res. #16RC-2013)

Dentistry for School Children

School Based Oral Health Prevention Programs

ISDS supports school based oral health prevention programs that meet the following criteria:

- The program is only offered to children enrolled in Medicaid or in subsidized school lunch programs.
- The program must provide each child with an examination, prophylaxis, fluoride treatment and sealants along with a basic level of oral health education with consideration given toward the time frame for such services.
- The program must have a formal referral process to a local health department and /or local private dentists to treat the restorative care needs of the children that were detected during the examinations.
- The programs must have a quality assurance component that conducts periodic sealant retention checks. (Res. # 18-2006)

Dental Clinics in School Health Centers

In some cases, public clinics are expanding their ability to provide dental services by placing dental operatories in public schools. ISDS supports these efforts as long as they are limited to providing dental services to the Medicaid and other underserved children in the school. (Res. # 18-2006)

School Dental Exams for Children Entering K, 2nd, 6th and 9th

The Illinois State Dental Society supports the policy that all children should have a school dental examination performed by a dentist prior to entering kindergarten, second, sixth and ninth grades. (Res. #10 -2012)

General Dentistry

Opposition to Denturism

The ISDS is opposed to any legislation that would permit non-dentists to provide dentures to the public since this jeopardizes the health and welfare of the people of the State of Illinois. (Res. # 13-1997)

Supervision of Medically Compromised Patients

That it is the policy of the Illinois State Dental Society that medically compromised patients in long term care facilities, developmentally disabled facilities and homebound patients need to be examined and diagnosed by a licensed dentist prior to obtaining any treatment. (Res. #8-2001)

Limiting Oral Piercings by Non-Dentists

That the ISDS considers the piercing of the tongue, lips, cheeks or any other area of the oral cavity (intra or peri) to carry a serious risk of infection and/or damage to the mouth and teeth. (Res. #15-2001)

Definition of Dental Emergency. A dental emergency is an oral condition that occurs suddenly and creates an urgent need for professional consultation and or treatment. The clinical condition may include hemorrhage, infection, pain, and trauma. (ISDS Parameters of Care Document – The Dental Emergency 1993) (Res. # 14-2006)

Definition of Dental Underserved Areas

The use of geographic service areas is the most realistic way to determine what is truly an underserved area. Designated underserved areas that use political boundaries such as census tracts, county and state boundaries are not realistic as they do not reflect actual purchasing patterns of the local residents. (Res. # 18-2006)

Supply of Practicing Dentists in Illinois

Illinois has a sufficient supply of practicing dentists to meet the oral healthcare needs of its residents and the current trend indicates that this will continue for the near future. There may be a mal-distribution of general dentists and specialists that affect some rural areas, but the majority of Illinois residents live within a reasonable distance, 30 miles or 30 minutes, of a dentist. (Res. # 15-2006)

Recruitment of Minorities into Dentistry

Illinois dentists and dental schools need to work together to recruit under-represented minorities into dentistry. ISDS should assist in developing programs with the Illinois dental schools that attempt to reach college-bound high school students and to introduce the profession of dentistry to junior high students. (Res. # 15-2006; #5-2017)

Definition of Basic Oral Health

Basic oral health is defined as the freedom from pain and infection, and the ability to function in society. (Res. # 14-2006)

Education is a Critical Aspect of Good Oral Health

Basic oral health education is an important and often overlooked aspect of prevention. Properly trained oral health professionals should be better incorporated into local public infrastructures to provide oral health education to WIC, HeadStart, parenting and other community-based programs.

ISDS should consider an additional level of oral health care professional that focuses on education.

ISDS should encourage all public health departments to employ an oral health professional whose principal responsibility is to serve as an oral health educator. (Res. # 16-2006)

Definition of Access to Care in Emergency Dental Situation

A patient of record should have a reasonable expectation to have their dental emergency addressed within 24-48 hours. Communities should endeavor to work with the local dentists to help address how individuals who do not have a dental home can obtain emergency dental care. (Res. # 14-2006)

Definition of Access to Care for Non-Emergency Dental Treatment

An individual should have a reasonable expectation to obtain an initial visit with a general dentist within 4 weeks. Ideally, the general dentist should be located no more than the greater of 30 miles or 30 minutes from the residence or place of employment of the individual. (Res. # 14-2006)

Policy on Tobacco Use

In order to provide a tobacco free environment for those attending functions of the Society, the ISDS prohibits tobacco use of any kind, at all meetings of the organization. (Res. #11 – 2012)

Use of E-Cigarettes

ISDS adopted the following regarding the use of e-cigarettes:
That ISDS encourage oral health care professionals to learn about the different shapes and types of e-cigarettes and the risks of all forms of e-cigarette use.

That ISDS encourage members of the dental team, when taking health histories, to ask about all forms of tobacco and nicotine use, including cigars, cigarettes, smokeless tobacco, hookahs and various forms of e-cigarettes, including small, discreet flash drive sized devices and not limit the discussion to cigarettes.

That ISDS encourage members of the dental team to proactively educate patients, especially young people and pregnant women, about the risks of all forms of tobacco product use, including e-cigarettes.

That ISDS encourage oral health professionals to encourage patients who do use a substance, as described above, to quit when appropriate.

That ISDS encourage dentists to report injuries resulting from the use of e-cigarettes to the Federal Drug Administration at https://www.safetyreporting.hhs.gov. (Res#12 – 2019)

General Housekeeping

Assumption of CDS Dues Billing

The House approved the transfer of dues collection of the Chicago Dental Society members to the ISDS staff. (Res. #6-2003)

Insurance & Medicaid

Statewide Universal Healthcare That Includes Dental Coverage

Any statewide universal health care plan must be an adequately funded system that uses a variety of mechanisms to allow all residents to obtain a primary level of dental care.

A primary level of dental care is defined as the evaluation (including examination), diagnosis, management and overall coordination and/or delivery of services by a dentist to meet the patient's oral health needs for the prevention and treatment of oral disease and injury and the restoration and maintenance of health. (ADA Primary Dental Care 1994:668) (Res. # 17-2006)

Incentives to Attract Dentists to Practice in Medicaid & Underserved Areas

Higher reimbursement is needed to attract dentists to participate in the Medicaid program especially in certain rural areas. In order to attract dentists to provide care to Medicaid patients, ISDS supports the offering of incentives in certain designated counties where no general dentists currently participate in the program. In certain counties that have little to no specialty care, ISDS supports incentives to selected specialties to encourage them to participate in the program.

The Illinois legislature should appropriate funds to the Illinois Department of Public Health to provide dental scholarships and loan repayment programs to aid in attracting dentists to practice in underserved areas. (Res. # 17-2006)

Further Expansion of Medicaid Program

The Medicaid program appears to have begun to take adequate steps to address the preventive aspects of the children's program with recent reimbursement increases for preventive services and the increasing number of school-based preventive programs. However, but until the rest of the program achieves similar advances, the entire program will continue to suffer.

The existing Medicaid program is already strained and, until additional funding is used to raise reimbursement rates for all of the services needed to obtain a primary level of dental care as defined by the ADA, the current participating dentists will not be able to supply the dental care needs of this population. The minimum level of reimbursement for all covered services should be

at least 64% of the median fee charged by dentists according to the most current regional ADA fee survey. (Res. # 17-2006)

Expansion of Public Dental Clinics

Public clinics are a key factor in providing dental care to the working poor and Medicaid populations. ISDS supports public funding to establish and sustain additional dental clinics and to make it attractive for dentists to practice in their clinics. Public clinics should provide dental services to achieve good oral health and not just limit care to preventive services. (Res. # 18-2006)

Policies on Dental Benefit Programs

That the Society's adopt the ADA Policies on Dental Benefit Programs. (Res. # 12- 2012)

Illinois Dental Medicaid Carve Out

That ISDS support any future efforts proposed in the legislature to carve out or modify the Illinois dental Medicaid program from the current managed care organization (MCO) structure using dental administrators who subcontract with the MCOs to a stand-alone dental program with either one or multiple dental entities competing for providers and patients in order to provide the best options and reimbursement. (Res. #10-2019)

Registered Dental Hygienists

Dental Hygiene Education

The Board of Trustees supports dental hygiene educational methods which meet the standard for accreditation of the Commission on Dental Accreditation. (Res. #1-1999)

Supply of Practicing Dental Hygienists in Illinois

The current 13 dental hygiene programs in Illinois will create a sufficient and ongoing supply of dental hygienists to meet the needs of its residents statewide. Although a sufficient supply currently exists in the state, in some areas served by a dental hygiene program, a local oversupply may occur. (Res. # 15-2006)

Guidelines Governing the Conduct of Campaigns For ISDS Offices

Campaign Guidelines for ISDS Offices (Res. # 13-2006, Res. # 14-2012)

1. Committee

A. An Election Review Committee, consisting of the ISDS President, President-elect, Vice President, Treasurer and Secretary shall oversee and adjudicate all issues in races for ISDS offices. The ISDS President shall be the chair of the Election Review Committee. In the event that a member of the Election Review Committee is a candidate in a contested race, that member shall be excused from any Committee deliberations involving his or her race.

B. The Election Review Committee shall be responsible for enforcing these guidelines.

2. Announcement

A. Candidates shall not formally announce for office until the final day of the ISDS Annual Session House of Delegates meeting immediately preceding their candidacy. Prior to this formal announcement, candidates may freely campaign within their own ISDS component or CDS branch.

Campaign activities outside a candidate's own ISDS component or CDS branch shall begin only after the official announcement, but not before the last day of the ISDS Annual Session House of Delegates in the year prior to the election.

B. A candidate shall have been deemed to have "formally announced" when he or she submits a written, signed statement of candidacy to the Secretary of the ISDS House. The statement shall include the candidate's name and the office that the candidate is seeking. Once a formal announcement is received at ISDS headquarters, the Secretary of the House will certify the member's candidacy by sending a notice to components and the House of Delegates.

3. Presentations

During the year of their candidacy, candidates are expected to address the ISDS membership during the ISDS Capitol Conference (April) and the ISDS Annual Session (September)

Each candidate for a particular office will be invited to a specific district, component, or branch meeting to ensure an equal opportunity to meet with ISDS members. To be fair to each candidate, the district, component, or branch must give each candidate the courtesy of a 30-day written notice that it would like the candidates to attend their meeting for the purpose of a campaign presentation. If a candidate cannot attend that meeting, s/he must be given another opportunity to present.

4. Campaigning

Each candidate shall be limited to $3,000 in expenses to campaign for office. Such expenses are those that relate to costs to communicate with members in any manner, including but not limited to printing, postage, telephone, hospitality, and promotional novelties, but does not include personal expenses related to travel, hotel and meals.

5. Profile

Candidates' campaign statements and profiles will be formally printed in the August, IL Dental News. Prior to that time, candidates' statements and profiles will also be posted on the ISDS website.

6. Distribution of Materials at House of Delegates

A candidate's brochure may be distributed at the ISDS House of Delegates on the final day of House business in the year immediately preceding their election and on the opening day of the House of Delegates in the election year. Brochures can be brought to any or all of the campaign presentations at specific district, component, or branch meetings provided that the candidate is present. No material may be distributed within the ISDS House of Delegates without first obtaining permission from the Secretary of the House.

7. Agreement to Campaign Guidelines

All candidates shall acknowledge that they have received these guidelines and agree to abide by the provisions contained herein within 14 days of formally announcing as a candidate for office. A candidate's signature at the bottom of the guidelines shall constitute this acknowledgement and agreement.

8. Questions

Any questions regarding these Guidelines should be directed to the chair of the Election Review Committee for clarification.

Candidate Agreement

I acknowledge that I have reviewed these Guidelines Governing the Conduct of Campaigns for ISDS Offices and agree to abide by its provisions during the period of my candidacy.

Candidate's Signature _____ Date: _____

Legislation

It shall be ISDS House of Delegates policy that implied in any resolution seeking legislative changes, the Government Affairs Committee is authorized, with the approval of the Board of Trustees or the Executive Committee if the full board is unable to meet, to agree to legislation that may not encompass all details of the original resolution. Any agreed to changes will be reported back to the House at its next regular meeting. (Res. #4 - 2018)

ADA American Dental Association®

America's leading advocate for oral health

Current Policies

Adopted
1954–2019

211 East Chicago Avenue
Chicago, Illinois 60611

Preface

This book contains major policies adopted by the American Dental Association House of Delegates from 1954 through 2019 that are still in effect in 2020, except for policies that appear in the Association's *Constitution and Bylaws, Governance and Organizational Manual* and *Principles of Ethics and Code of Professional Conduct*. Other actions of the House which are generally more directive in nature are not included as major policy. Policies adopted in earlier years were published in *Digest of Official Actions*, *1946–1953* and *Digest of Official Actions, 1922–1946.*

Within each classification, the policy resolutions and statements are arranged in reverse chronological order. The citations show the year and page number, for both the original policy and Amendments, from the annual *Transactions of the American Dental Association.* All Amendments have been integrated with original policy resolutions and statements.

An individual wishing to trace the development of American Dental Association policies will find it convenient to use the *Index of Official Actions*, which shows the page numbers in *Transactions* of all actions of the House of Delegates and Board of Trustees.

Kathleen T. O'Loughlin, D.M.D, M.P.H.
Executive Director

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Abuse and Neglect

Educating Dental Professionals in Recognizing and Reporting Abuse (*Trans.*2014:507)

Resolved, that the ADA supports educating dental professionals to recognize abuse and neglect across all age groups and reporting such incidences to the proper authorities as required by state law.

Access

Availability of Dentists for Underserved Populations (*Trans.*2016:318)

Resolved, that constituent societies be urged to participate in programs that encourage dentists to serve underserved populations and that offer case management resources to enable dentists to provide oral health care for institutionalized and homebound individuals, including those who are physically, emotionally and mentally disabled, and be it further
Resolved, that constituent societies be urged to seek fiscal resources to provide case management in support of dentists providing oral health care for these individuals, and be it further
Resolved, that the ADA, working with other affected organizations, review or conduct studies on the availability and scope of dental programs for the treatment of special needs populations, including physically, emotionally and mentally disabled patients.

Evaluation and Fulfillment of Unmet Dental Needs (*Trans.*2016:316)

Resolved, that constituent dental societies be encouraged to promote oral health using culturally competent strategies for underserved communities and share these efforts with legislators and other public health officials

Designation of Individuals With Intellectual Disabilities as a Medically Underserved Population (*Trans.*2014:508)

Resolved, that the American Dental Association support a simplified process across appropriate governmental agencies to designate individuals with intellectual disabilities as a medically underserved population, and be it further
Resolved, that the ADA seek to collaborate with the American Medical Association and the American Academy of Developmental Medicine and Dentistry to promote this process to appropriate governmental agencies.

Manufacturer Sponsorship of Dental Programs and Promotional Activities (*Trans.*2014:502)

Resolved, that the ADA and the dental industry coordinate programs promoting dental health in the best interests of the American public.

Dental Access Barriers (*Trans.*2010:566)

Resolved, that the ADA, in communications regarding dental access issues, emphasize barriers to care including, but not limited to:

a. financial barriers
b. geographic barriers
c. governmental policy barriers
d. personal barriers
e. cross-cultural barriers
f. language barriers

Incentives for Dental School Graduates to Work in Tribal Areas (*Trans.*2006:338; 2016:316)

Resolved, that in collaboration with the Indian Health Service, the appropriate agencies of the Association investigate, develop and support new or enhanced programs and incentives for post-dental school programs and clinical experiences for recent graduates of CODA-accredited dental schools and CODA accredited programs of recognized dental specialties to work in remote American Indian/Alaska Native communities, and be it further

Resolved, that the ADA will work with the US Public Health Service, the Indian Health Service, and charitable foundations to establish a process whereby individuals may gain access through links on the ADA, ASDA and other Web page lists of USPHS and IHS dental openings as well as access to information concerning relevant loan repayment programs within the USPHS and the IHS.

Dental Program for Remote Alaskan Residents (*Trans.*2004:323)

Resolved, that the American Dental Association encourage the Public Health Service/Indian Health Service and the Tri Service Military Reserve to work together to establish civic action programs to provide needed oral health care in remote and frontier communities of Alaska, and be it further
Resolved, that the Tri Service Military Reserve Forces be formally requested to provide oral health care support in the needed areas of Alaska, and be it further
Resolved, that the ADA encourage the Alaskan Native Tribal Health Consortium to consider the utilization of the Tri Service Military Reserve Forces to provide health care services in their respective communities.

Vision Statement on Access for the Underserved and Promotional Activities (*Trans.*2004:321; 2014:503)

Resolved, that the American Dental Association support efforts to establish programs and services that improve access to oral health care, while maintaining a single standard of oral health care.

The Association thereby:

- Recognizes that oral health is integral to overall health and can affect a person's self-esteem, ability to learn and employability.
- Acknowledges that oral health disparities and the extent and severity of untreated dental disease—especially among underserved children—is unacceptable.
- Commits through advocacy and direct action, to identify and implement market-based solutions that capitalize on the inherent strengths of the American dental care system.

The Alaska Native Oral Health Access Task Force—Strategies to Assure Access to Quality Health Care for Native Alaskans (*Trans.*2004:291; 2010:521)

Resolved, that in response to the Alaska Native Oral Health Care Access Task Force's findings and recommendations and to the unique and separate challenges that Alaska presents, the following strategies to assure access to quality health care for Native Alaskans be approved:

1. The ADA encourage the establishment of a work group that includes tribal leaders and the Alaska Dental Society (ADS) to facilitate improved access to oral health care for the Alaskan village populations.
2. The ADA work with the ADS and tribal leaders to seek federal funding with the goal of placing a dental health aide (i.e., a Primary Dental Health Aide I or II) trained to provide oral health education, preventive services and palliative services (except irreversible procedures, including but not limited to tooth extractions, cavity and stainless steel crown preparation and pulpotomies) in every Alaska Native village that requests an aide.
3. The ADA support the use of Expanded Functions Dental Health Aides I and II where appropriate to improve the efficiency of delivering oral health care services to Alaska Natives within the Community Health Aide Program.
4. The ADA continue to support current federal policy that facilitates the entry of American Indians/Alaska Natives into the health professions, especially in the field of dentistry.
5. The ADA work to ensure that representatives of the ADS are included in oversight activities concerning the dental health aide program and other programs affecting the delivery of oral health care services to Alaska Natives.
6. The ADA offer, and the ADS be encouraged to offer, to work with the tribal leaders to increase the use of telecommunications to ensure the proper delivery of oral health care in the villages.
7. The ADA take actions that help to significantly increase the number of dentists and dental hygienists available to provide services to Alaska Natives in the rural villages through private contracts and volunteerism and to facilitate the placement of donated dental equipment, including encouraging the ADS to establish a volunteer position to coordinate these activities with the tribes.
8. The ADA offer, and the ADS be encouraged to offer, to explore ways of working with the Denali Commission and the tribes to expedite the building of dental clinics in rural Alaska villages.
9. The ADA offer to work with the ADS, Alaska Native Tribal Health Consortium, the Alaska Native Health Board and others to lobby for increased federal funding to help ensure that improvements in community water quality in the rural Alaska villages include fluoridation.
10. The ADA work with the ADS and tribes to help reduce the consumption of soft drinks and other cariogenic products.
11. Consistent with the needs and desires of tribal leaders, the ADA support the increased use and funding of military reservist dentists, including dental specialists, in delivering care to Alaska Natives in remote, rural villages.
12. The ADA through its agencies help to facilitate the placement of volunteer dentists and dental hygienists in tribal and Indian Health Service facilities nationwide.
13. The ADA is opposed to nondentists or non-licensed dentists, (except dentists who are faculty members of CODA-accredited dental schools) making diagnoses, developing treatment plans or performing surgical/irreversible procedures.
14. The ADA will work to help tribes and tribal leaders understand the dangers and patient health risks of nondentists making diagnoses or performing irreversible dental procedures, including but not limited to tooth extractions, pulpotomies and cavity and stainless steel crown preparation.

Legislation to Increase Federal and State Funding of Oral Health Care Services Provided at Academic Dental Institutions (*Trans.*2002:404)

Resolved, that the Association work collaboratively with the American Dental Education Association and other appropriate organizations to develop and advocate for legislation that increases the provision of oral health care services to underserved, unserved and uninsured indigent populations seeking treatment at academic dental institutions through federal and state funding mechanisms that financially assist those dental institutions.

ADA Policy on the Aged, Blind and Disabled (*Trans.*2002:390; 2012:455)

Resolved, that the Association supports appropriate initiatives and legislation to improve and foster the oral health of aged, blind and disabled persons, and be it further
Resolved, that "people with intellectual disabilities" be utilized when referring to persons previously acknowledged as "mentally retarded," and be it further
Resolved, that constituent and component dental societies be encouraged to support state and local initiatives and legislation to improve the oral health of aged, blind and disabled persons, and be it further
Resolved, that dental and allied dental programs be encouraged to educate students about the oral health needs and issues of aged, blind and disabled persons.

Access to Dental Services for the Underserved (*Trans.*2000:500)

Resolved, that the appropriate agencies of the Association support the development of state legislative models to be used by constituent societies to resolve issues related to access to dental care for the underserved, indigent and special needs children and adults, and be it further
Resolved, that the Association monitor, respond and, if necessary, pursue federal legislation to improve access to dental care of this same population using the following guidance:

A. Collection of Data and Development of Definitions

Terms, such as "need and demand for services" and "dental shortage areas" will be defined and data regarding the prevalence of dental disease among underserved children shall be collected and reported.

B. Reimbursement for Dental Health Care Providers

Grants shall be made to participating states that agree to make the application, claims processing, and reimbursement systems more like the marketplace. This would include, for example, higher reimbursement levels and use of the ADA claim form and code.

C. Education

Grants to develop and/or enhance educational programs to educate pediatric and general dentists to serve children will be provided and federal loan repayment options for dentists who serve in faculty positions and/or who conduct research shall be made available.

D. Availability of Providers

Educational loan reductions for dentists in underserved areas and grants for mobile dental facilities that provide comprehensive care.

E. Federally Qualified Health Centers

Require FQHCs to make it a priority to provide care to the indigent and to provide reports regarding their funding.

F. Oral Health Awareness and Social Training

Materials will be developed to increase oral health care awareness and to promote better oral health care.

G. Community Water Fluoridation

Appropriate federal agencies shall increase research and public awareness efforts regarding the benefits of community fluoridation and grants will be provided to communities for water supply fluoridation.

H. Scope of Dental Practice Laws Protected

No provision of this guidance shall be interpreted to expand the scope of dental practice to allow untrained and/or unqualified personnel to perform any dental service.

Informational Support for Members Providing Oral Care in Long-Term Care Facilities (*Trans.*1997:671; 2013:342)

Resolved, that constituent dental societies be encouraged to collect, maintain and distribute to members information about federal and state laws and regulations, including the Incurred Medical Expenses reimbursement mechanism, for provision of dental care in long-term care facilities, assisted living facilities, and private homes.

Comprehensive Lists of State Programs Providing Oral Health Services (*Trans.*1995:609; 2016:318)

Resolved, that each constituent and component dental society be encouraged to participate in state and local oral health coalitions to maintain a comprehensive listing of the numerous and varied programs that provide oral health services to underserved and unserved individuals, and be it further
Resolved, that such a listing include programs sponsored by departments of public health, hospitals, educational institutions, civic and fraternal organizations, religious organizations and private initiatives.

Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care (*Trans.*1979:357, 596)

Resolved, that the House of Delegates approves the scope and direction of Report 5 on the *Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care* and requests implementation of its recommendations through coordinated Association activity.

Summary of Recommendations, Report 5 of the Board of Trustees to the House of Delegates, on Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care (*Trans.*1979:357, 596)

1. Increase Association efforts to promote the concepts of prevention within the profession and the public sector, including government.
2. Draw freely on the special professional abilities of dentists who are expert in practice, in public health, in research and in education.
3. Actively seek allies throughout society on specific activities that will help improve access to care for all.
4. Maintain and coordinate council and other Association activities involved in this program.
5. Maintain quality dental care in all aspects of the delivery system.
6. Seek new ways for the Association to assist state and local dental health units to strengthen themselves.
7. Speak clearly to the public and to government about their respective responsibilities with respect to dental health.
8. Recognition that the traditional form of private practice will remain the major source of dental care coupled with an understanding that other sources of care exist and should receive objective attention.
9. Press for more efficient administration of and more equitable reimbursement under Medicaid and similar programs.
10. Intensify efforts at the federal level to mandate basic dental benefits for all Medicaid recipients.
11. Explore the funding of a pilot program to obtain broader Medicaid dental care benefits at the state level.
12. Explore the use of elementary and secondary schools in providing patient education, referral and oral prophylaxis dental services to children.
13. Emphasize comprehensive dental services in addressing the need of the elderly.
14. Intensify efforts to Amend Medicare to include dental benefits.
15. Seek ways to extend private group dental prepayment benefits to the elderly.
16. Develop minimal criteria that state dental societies must take to be eligible for Association assistance to provide access programs for denture care.
17. Investigate ways to improve increased opportunity for dental care for the elderly through a greater availability and effective utilization of dentists and dental auxiliaries.
18. Establish a national organization concerned with the dental health of the elderly.
19. Develop a program to provide assistance and information to state and local societies to assist dentists in caring for handicapped and disabled patients.
20. Maintain support of the National Foundation of Dentistry for the Handicapped.
21. Identify and publicize other sources of care for the handicapped, institutionalized and homebound.
22. Develop a better information base on the dental health needs of the long-term homebound.
23. Help establish appropriate continuing education for practitioners and cooperate with dental educators regarding any necessary additions to the undergraduate and postgraduate dental school curricula.
24. Implement appropriate methods of providing more accessible dental care to nursing home residents.
25. Explore the potential for resolving problems of limited health manpower and capital resources in nursing homes.
26. Reexamine existing Association policy respecting the National Health Service Corps and program activity.
27. Continued support of the Health Professions Placement Network.
28. Continued support of the Dental Planning Information System to enhance its ability to provide information on care delivery in remote areas.
29. Cooperate more closely with dental health departments in states with a high number of remote area residents, including possible funding of demonstration projects.
30. Expansion of the Association’s present role in stimulating the growth of dental prepayment.
31. Broaden sources of prepayment coverage beyond the workplace.
32. Support extension of group dental prepayment benefits to federal employees and military dependents.
33. Work with private and governmental groups in developing a more detailed base of information on dental prepayment.

Guideline for Dental Societies in Cooperating With Consumers (*Trans.*1971:51, 486; 2016:318)

Resolved, dental societies are urged to collaborate with consumer focused organizations to promote and support oral health, science-based treatment rationale, and the educational foundation of the profession of dentistry.

Accreditation of Educational Programs

State Board and Commission on Dental Accreditation Roles in Candidate Evaluation for Licensure (*Trans.*2003:367)

Resolved, that the Association urge state boards of dentistry to continue to support the role of the Commission on Dental Accreditation as the agency responsible for the evaluation of dental education programs.

Single Accreditation Program (*Trans.*1996:696; 2010:577)

Resolved, that the American Dental Association support a single accreditation program for dental and dentally-related educational programs.

Sponsorship of Dental Accreditation Programs (*Trans.*1972:697; 2003:367; 2016:298)

Resolved, that the American Dental Association supports the concept of nongovernmental, voluntary accreditation, and be it further
Resolved, that the American Dental Association opposes the development of federal or state dental accreditation programs in the United States.

Note: The Association, through the Commission on Dental Accreditation, has standards and requirements for the accreditation of various dental education programs. The Commission has been responsible for developing, revising and approving these accreditation standards since 1975. As such, these standards are not included in this publication, but are available upon request through the Commission office.

ADA Strategic Plan

Changes in ADA Strategic Plan (*Trans.*1997:714; 2012:518)

Resolved, that the ADA Board of Trustees be urged to seek input from communities of interest, including representatives from the House of Delegates, in the development of the ADA Strategic Plan.

Recommendations of Future of Dentistry Report (*Trans.*1983:552; 2013:313)

Resolved, that the Association accept the following five principal recommendations of the Future of Dentistry Report as priority guidelines for the ADA to prepare the profession for the challenges of the future.

- convert public unmet need into demand for dental services;
- prepare the practitioners (existing and future) to be more patient/market oriented;
- broaden practitioners' clinical skills and mix of services offered to the public;
- influence the quality and quantity of the workforce; and
- stimulate research and development.

Advertising

Opposition to Corporate Mandated Requirements for Patient Treatment (*Trans.*2009:420)

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

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

Best Dentists Lists (*Trans.*2005:339)

Resolved, that American Dental Association policy is that any published lists of "best dentists" should incorporate a full disclosure of the selection criteria, including, but not limited to, any direct or indirect financial arrangements.

Disclaimer Policy for ADA Advertisers and Exhibitors (*Trans.*1996:732)

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.

State Regulation of Advertising (*Trans.*1984:549)

Resolved, that constituent dental societies be urged to consider state legislation, consistent with the recognized rights of commercial speech, that will authorize the appropriate agencies of state government to regulate dentist advertising in the public interest to ensure the dissemination of complete and accurate information through appropriate means of communications including time, manner and place.

Guidelines for Dentist Advertising (*Trans.*1979:647)

Resolved, that the American Dental Association offer its assistance to constituent dental societies and encourage them to cooperate with state boards of dental examiners in the development of meaningful guidelines based on rules and regulations related to dentist advertising.

Institutional Advertising (*Trans.*1979:598)

Resolved, that the Association expand the concept of dental health education of the public by including institutional advertising.

Guidelines for State Boards of Dental Examiners on the Definition of Routine Dental Services for Purposes of Dentists' Advertisements (*Trans.*1977:616, 945)

1. Definition of a Routine Dental Service: A dental service may be considered routine for an individual practitioner[1] if it has the following characteristics:

a. It is performed frequently in his or her practice.
b. It is usually provided at a set fee.
c. It is provided with little or no variance in technique.
d. It includes all professionally recognized components within generally accepted standards.

2. General Test for Routine Service: In general, a dental service advertised as available at a set fee may be considered a routine service if the dentist regularly performs and actually provides that service at the specified fee to substantially all patients receiving that service. Whenever the contents of a dentist's advertisement are under scrutiny by the state board of dental examiners, the dentist should have the responsibility to submit proof that his or her advertisements meet this test.

3. Disclosures to Accompany Advertising: The U.S. Supreme Court, in its written opinion in the *Bates* case, suggested several types of restrictions that state regulatory agencies might validly impose or continue to impose upon professional advertising. The Court cited, for example, that "there may be reasonable restrictions upon time, place and manner of advertising." Also emphasized were 'the special problems of advertising on the electronic broadcast media.' In discussing the content of professional advertisements, the Court also stressed the need to require disclosures, disclaimers and warnings even where the advertisement is truthful on its face. State dental boards might give attention to the development of "disclosure" requirements particularly. Disclosures may be in order where complications are likely to arise or where special classes of patients such as children are involved.

[1] The Committee's basic definition of a routine dental service is applicable to specialists' services as well as those of general dentists.

4. Definition of Professionally Recognized Dental Services: Announcing to the public that a particular dental service is available in a practitioner's office at a set fee may be inherently deceptive without a professionally recognized definition of what must be included as one of his or her routine services, for example, that service should include local anesthesia and postoperative care where indicated. Or, if the dentist includes a prophylaxis as one of his or her advertised services, that should mean more than the application of a prophylaxis paste in a rubber cup. Likewise, if the dentist advertises denture care, that service should include a reasonable period of post-treatment care. The considerable difficulty in defining the professionally necessary components of all major dental procedures or services is recognized. But this task must be done to insure that the board's monitoring of dentists' advertising is designed precisely to protect the public; such protection will also guarantee fairness to all dentists.

In fashioning definitions for major dental services, the state boards of dental examiners should rely upon the constituent dental associations as the prime resource for developing those definitions. If the expert resources of a dental school are available, the boards should consider using those resources jointly with the constituent dental association. Again, it is emphasized that a dentist who is not prepared to offer the essential elements of each dental service he or she advertises is deceiving the public. But, without official regulations promulgated by state dental boards to all licensed dentists defining the professionally recognized components of all major dental services, there can be no effective prevention of such deceptive advertisements.

5. Other Recommendations to State Boards of Dental Examiners: These suggested guides for state dental examining boards are intended to be fully responsive to the boards' prime obligation to serve the public interest. In addition to the recommendations specifically treated in earlier portions of this report, it is suggested that the boards give careful scrutiny to the manner in which fees are represented in dentists' advertising. It is especially recommended that fees contained in advertisements of routine dental services be specific and not expressed in ranges. If a service fits the indicia of "routine," that routine service should be readily provided at a precise fee. In the *Bates* case, the U.S. Supreme Court emphasized that any fee that is advertised should extend for a reasonable period of time. That requirement is also endorsed.

Guidelines for an Advertising Code (*Trans.*1971:108, 563; 1997:659)

The Council on Communications of the American Dental Association recommends the following guidelines to dental societies wishing to establish advertising codes or to revise their present ones:

1. The advertising code should provide that advertising uphold the dignity of the profession. Advertising text or illustrations, whether for dental or nondental products or services, should not be blatant, in bad taste or derogatory of other products or services, and should not make exaggerated claims or misleading statements.
2. The advertising code should protect the health and welfare of the public by demanding evidence of the safety and effectiveness of the products advertised.
3. The advertising code should provide that no advertising be accepted which might encourage a dentist to neglect or abrogate his or her professional responsibility.
4. The advertising code should provide that no advertising be accepted which might encourage a dentist to violate the professional code of ethics.
5. The advertising code should provide that no advertising should relate to any professional course of study, clinic, lecture or demonstration unless presented under the auspices of the American Dental Association, a constituent or component dental society, one of the eight recognized specialty groups or other dental society, a hospital approved by the American Dental Association or an accredited college, university or other institution of higher learning.
6. The advertising code should not conflict with federal and state laws, including antitrust statutes and dental practice acts, and should provide that all advertisements comply with these laws.

Statement of Policy on Use of Name of American Dental Association (*Trans.*1962:210, 284; 1999:974)

1. Any product mentioned in advertising or educational materials in which the Association's name is used must meet the requirements of the Association's *Advertising and Exhibit Standards*.
2. All advertising or educational material in which the Association's name is to be used must be submitted in advance for review and approval by the pertinent Association agency.
3. The Association's name should be used solely to vouch for those facts which are directly related to dental health. The name should be separated from the promotional or commercial message insofar as possible. The Association's name may not be used simply to state that a product is advertised in Association publications or at the Association's annual session.
4. Claims made for products and statements made in educational materials must be accurate in fact and in implication, and in accord with current scientific knowledge. Thus, if an Association statement about a product is authorized for use in public advertising, the Association name may be used only in connection with the authorized statement. Additionally, all other parts of the advertisement must delineate the usefulness of the product within the letter and the spirit of the Association statement.
5. Use of the Association's name must be in keeping with good taste and professional dignity.

Allied Dental Education and Personnel

Statement Supporting the Dental Team Concept (*Trans.*2013:313)

Resolved, that constituent dental societies, dental educators and dental examiners are encouraged to work closely and cooperatively with the ADA to support the dental team concept to prevent fragmentation of the dental team, and be it further

Resolved, that these parties are urged to support ADA policies on supervision of dental auxiliaries in all settings including, but not limited to, educational institutions, skilled nursing facilities and public health clinics.

ADA's Position on Dental Mid-Level Provider (*Trans.*2008:439)

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

ADA Support for Constituent Societies in Dealing With Dental Mid-Level Provider Proposals (*Trans.*2008:502)

Resolved, that the ADA public affairs and advocacy efforts should assist constituent societies in dealing with proposals to change the scope of practice for allied dental personnel by focusing on determining need, promoting sufficient education, training, supervision by a dentist and a scope of practice that ensures the protection of the public's oral health. The ADA should offer support to those constituent societies facing potential scope of practice changes to enable the best possible outcome.

Development of Alternate Pathways for Dental Hygiene Training (*Trans.*1998:714; 2014:459)

Resolved, the American Dental Association supports the alternate pathway model of Dental Hygiene Education as used in Alabama.

Comprehensive Policy Statement on Allied Dental Personnel (*Trans.*1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307; 2010:505)

Comprehensive Policy Statement on Allied Dental Personnel

General Principles

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

The dentist is ultimately responsible, ethically and legally, for patient care. In carrying out that responsibility and to increase the capacity of the profession to provide patient care in the most cost-effective manner, the dentist may delegate to allied dental personnel certain patient care functions for which the allied dental personnel has been trained. In an ongoing effort to address the health care needs of the American public, new members of the dental team may be developed. The scope of function and level of supervision should be determined by the profession so as to ensure adequate patient care and safety.

The recognized categories of allied dental personnel are dental hygienists, dental assistants, community dental health coordinators 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 allied dental personnel. A dental technician who performs a supportive function in an environment outside the dental office may be properly termed a supportive or allied member of the dental health team.

Delegation of Functions

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

The American Dental Association has the responsibility to provide guidance to all agencies, organizations and governmental bodies, such as state

dental boards and legislatures, that have an interest in, or responsibility and authority for, decisions on utilization, education, and supervision of allied dental personnel. In this context, the primary responsibility is to assure that decisions on allied dental personnel utilization will not adversely affect the health and well-being of the public or cause an increased risk to the patient. In meeting these responsibilities, dentists must also identify those functions or procedures that require the knowledge and skill of the dentist. Thus, the ADA must continue to promote that these functions be performed by a licensed dentist in order to support the highest quality of oral health care by maintaining that the dentist be the healthcare provider that performs examinations/evaluations; diagnoses; treatment planning; and surgical/ irreversible procedures; prescribes work authorizations; prescribes drugs and other medications; and administers enteral, parenteral or inhalational sedation, or general anesthesia.*

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

Utilization of allied dental personnel must be based on (1) the best interests of the patient; (2) the education, training and credentialing of the allied dental personnel; (3) considerations of cost-effectiveness and efficiency in delivery patterns; and (4) valid, independent research demonstrating the feasibility and practicality of utilizing allied dental personnel in such roles in actual practice settings.

Delegation of Expanded Functions

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

Supervision of Allied Dental Personnel

In all instances, a dentist assumes responsibility for determining, on the basis of diagnosis, the specific treatment patients will receive and which aspects of treatment may be delegated to qualified personnel. As the dentist is best educated and trained to provide the care and has the responsibility for patient care, supervision by the dentist is paramount in assuring the highest quality of care and the safety of the patient. The degree of supervision required to assure that treatment is appropriate and does not jeopardize the systemic or oral health of the patient varies with the nature of the procedure and the medical and dental history of the patient, as determined with evaluation and examination by the dentist. Supervision and coordination of treatment by a dentist are essential to comprehensive oral health care and unsupervised practice by allied dental personnel has the potential to reduce the quality of oral health care and could fail to protect the public. The unauthorized and improperly supervised delivery of care by allied dental personnel is opposed by the American Dental Association. The types of supervision are defined in the glossary of terminology at the end of this policy statement.

The ADA has always promoted policy that protects the health of the public. Personal, direct and indirect supervision are the appropriate levels of supervision for the delegation of duties to allied dental personnel. However in some states licensed dental hygienists are permitted to perform duties, except for intraoral expanded functions, under general supervision or public health supervision, as delegated by the supervising dentist. In order to assure the safety of the patient, the following criteria must be followed whenever functions are performed under general supervision.

1. Any patient to be treated by a dental hygienist must first become a patient of record of a dentist. A patient of record is defined as one who:

    a. has been examined by the dentist;
    b. has had a medical and dental history completed and evaluated by the dentist; and
    c. has had his/her oral condition diagnosed and a treatment plan developed by the dentist.

2. The dentist must provide to the dental hygienist prior written authorization to perform clinical dental hygiene services for that patient of record. Such

* Note: This sentence was editorially corrected in 2011 at the request of the Council on Dental Education and Licensure from "… ; and administers enteral, parenteral, inhalational, or general anesthesia" to "…; and administers enteral, parenteral or inhalational sedation, or general anesthesia."

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 allied dental personnel is in compliance with policies of the American Dental Association.

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

Allied Dental Personnel Education

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

Licensed or legally permitted dentists must be involved in the clinical supervision of allied dental personnel education programs, in accordance with state law. Programs should be administered or directed by a dentist whenever possible.

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

Expanded functions education programs are designed to prepare dental auxiliaries to provide expanded dental services under the direction and appropriate supervision of a dentist. Programs accredited by the Commission on Dental Accreditation (CODA) typically prepare the expanded functions auxiliary to perform legally permitted clinical services. However, other programs, CODA accredited or approved by the respective state's board of dental examiners, which utilize such methods as institutionally-based didactic course work, in-office clinical training, or electronic distance education can be an acceptable means to train expanded functions auxiliaries. Boards of dentistry are urged to review such innovative programs for acceptance.

Neither the dental hygiene education curriculum nor the expanded function education program provides adequate preparation to enable graduates to provide comprehensive oral health care or to practice without the supervision of a dentist.

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

Licensure of Dental Hygienists

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

Constituent Legislative Activities

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

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

Glossary of Terminology Related to Allied Dental Personnel Utilization and Supervision

This Glossary is designed to assist in developing a common language for discussion of allied dental personnel issues by dental professionals and public policy makers. 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.

Allied Dental Personnel: Team members who assist the dentist in the provision of oral health care and who are employed in dental offices or other patient care facilities.

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

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

Community Dental Health Coordinator (CDHC): An individual trained in an ADA pilot program as a community health worker with dental skills. Their aim is to improve oral health education and to assist at-risk communities with disease prevention. Working under the supervision of a dentist, a CDHC helps at-risk patients improve their preventive oral health through education and awareness programs, navigate the health system and receive care from a dentist in an appropriate clinic. CDHCs also perform limited clinical duties, such as screenings, fluoride treatments, placement of sealants and temporary restorations and simple teeth cleanings, until the patient can receive comprehensive services from a dentist or dental hygienist. Upon graduation, they will work primarily in public health and community settings like clinics, schools, churches, senior citizen centers, and Head Start programs in coordination with a variety of dental providers, including clinics, community health centers, the Indian Health Service and private practice dentists.

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

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

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 allied team member.

Dental Hygienist: An individual who has completed an accredited dental hygiene education program and 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 allied team member.

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

Examination/Evaluation, Comprehensive: A dentist performs an evaluation and recording of the patient's dental and medical history and a general health assessment, and a thorough evaluation and recording of the extraoral and intraoral conditions of the hard and soft tissues. This may require interpretation of information acquired through additional diagnostic procedures. It includes an evaluation for oral cancer where indicated, the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.

Examination/Evaluation, Limited: A dentist performs an evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Typically, patients receiving this type of evaluation

present with a specific problem and/or dental emergencies, trauma, acute infections, etc.

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

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

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

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

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

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

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

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

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

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

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

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

New Clinical Responsibilities for Dental Assistants (*Trans.*1996:701)

Resolved, that the American Dental Association urge its constituents to develop new clinical responsibilities to become available to dental assistants, and be it further **Resolved,** that these clinical responsibilities include the recommended duties of coronal scaling and polishing to be performed under the direct supervision of the dentist.

Maintenance of Multi-Pathway Options for Dental Assistants (*Trans.*1996:696)

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.

Statement on Credentialing Dental Assistants (*Trans.*1995:634)

Resolved, that the American Dental Association recognizes and encourages the advancement of education and job qualifications for dental assistants and thus believes that voluntary credentialing is appropriate for dental assistants who perform duties as defined by the state dental practice acts.

Dentist Administered Dental Assisting and Dental Hygiene Education Programs (*Trans.*1992:616; 2010:542)

Resolved, that licensed or legally permitted dentists must be actively involved in the clinical supervision of

dental assisting and dental hygiene educational programs, and be it further
Resolved, that dental assisting and dental hygiene educational programs should be administered or directed by a dentist whenever possible.

Certifying Board in Dental Assisting (*Trans.*1990:551; 2014:460)

Resolved, that the American Dental Association approves the Dental Assisting National Board, Inc. as the national certifying board for dental assisting.

Criteria for Recognition of a Certification Board for Dental Assistants (*Trans.*1989:520; 2014:460; 2019:XXX)

An area of subject matter responsibility of the Council on Dental Education and Licensure as indicated in the *Governance and Operational Manual* of the American Dental Association is certifying boards and credentialing of allied dental personnel. The Council studies and makes recommendations on policy related to the approval or disapproval of national certifying boards for allied dental personnel (each of which is referred to herein after as “the Board”).

A mechanism should be made available for providing evidence that a dental assistant has acquired the knowledge and ability that is expected of an individual employed as a dental assistant through a program of certification. Such a certification program should be based on the educational requirements for dental assistants approved by the Commission on Dental Accreditation.

The dental profession is committed to assuring appropriate education and training of all personnel who participate in the provision of oral health care to the public. The following basic requirements are applied by the Council on Dental Education and Licensure for the evaluation of an agency which seeks recognition of the American Dental Association for a program to certify dental assistants that reflects educational standards approved by the dental profession.

I. Organization

1. The Board shall have no less than five nor more than nine voting members designated on a rotating basis in accordance with a method approved by the Council on Dental Education and Licensure. The following organizations/interests shall be represented on the Board:

a. American Dental Assistants Association
b. American Dental Association
c. American Dental Education Association
d. American Association of Dental Boards
e. Public
f. The at-large population of Board Certificants

All dental assistant members shall be currently certified by the Board.

2. The Board shall submit to the Council on Dental Education and Licensure evidence of adequate financial support to conduct its program of certification.

3. The Board may select suitable consultants or agencies to assist in its operations, such as the preparation and administration of examinations and the evaluation of records and examinations of candidates. Dental assistant consultants should be certified by the Board.

4. The Board shall submit in writing to the Council on Dental Education and Licensure a program sufficiently comprehensive in scope to meet the requirements established by the American Dental Association for the operation of a certifying board for dental assistants. This statement should include evidence that the Board has the support of the American Dental Assistants Association, the organization representative of dental assistants, as well as other groups within the communities of interest represented by the Board.

II. Operation of Board

1. The Board shall grant certification to individuals who have provided evidence of knowledge-based competence in dental assisting.

2. The Board shall submit in writing to the Council on Dental Education and Licensure a plan for renewal of certificate currently held by certified persons.

3. The Board shall submit annually to the Council on Dental Education and Licensure data relative to its financial operations, applicant eligibility criteria, examination procedures and pass/fail results of its certifying examination. The Certification Board must establish and maintain documented policies concerning current, prospective and lapsed certificants including, but not limited to: eligibility, application, assessments, certification renewals and appeals. Additionally, the Certification Board must establish, analyze, publish and review examination content outlines which lay the foundation for the knowledge and skills tested on the assessment instruments and provide evidence of validity and reliability.

4. The Board shall administer the certification examinations at least twice each calendar year with administrations publicized at least six months prior to the examination.

5. The Board shall maintain and make available a current list of all persons certified.

6. The Board shall have authority to conduct the certification program; i.e., the Board shall be responsible for evaluating qualifications and competencies of

persons certified and for maintaining adequate standards for the annual renewal of certificates. However, proposals for important changes in the examination eligibility criteria or the Board procedures and policies must be circulated reasonably well in advance of consideration to affected communities of interest for review and comment. Proposed changes must have the approval of the Council on Dental Education and Licensure.

7. The Board shall maintain close liaison with the organizations represented on the Board. The Board shall report on its program annually to the organizations represented on the Board.

III. Granting Certificates

1. In the evaluation of its candidates for certification, the Board shall use standards of education and clinical experience approved by the Commission on Dental Accreditation. The Board shall require for eligibility for certification the successful completion of a dental assisting education program accredited by the Commission on Dental Accreditation, and satisfactory performance on an examination prescribed by the Board.

2. The Board shall grant certification or recertification annually to those who qualify for certification.

The Board may require an annual certificate renewal fee to enable it to carry on its program.

IV. Waivers

It is a basic view of the Council that all persons seeking certification shall qualify for certification by completing satisfactorily a minimum period of approved training and experience and by passing an examination. However, the Council realizes that there may be need for a provision to recognize candidates who do not meet the established eligibility criteria on educational training. Therefore, the Board may make formal requests to the Council on Dental Education and Licensure regarding specific types of waivers which it believes essential for certification and/or certificate renewal. Such requests shall be substantiated and justified to and supported by the organizations represented on the Board; only waivers approved by the Council on Dental Education and Licensure may be used.

Delegation of Radiographic Film Exposure (*Trans.*1982:534)

Resolved, that the American Dental Association, in the public interest, supports the principle that dentists who choose to delegate the taking of radiographic films should delegate the function to personnel who have had a structured course in such procedures, and be it further **Resolved,** that a structured course in radiography is defined as a planned sequence of instruction of specified content, designed to meet stated educational objectives and to include evaluation of attainment of those objectives.

Amalgam

National Pretreatment Standard for Dental Office Wastewater (*Trans.*2019:XXX)

Resolved, that the following principles guide the American Dental Association's support for pretreatment standard for dental office wastewater:

1. Any regulation should require covered dental offices to comply with best management practices patterned on the ADA's best management practices (BMPs), including the installation of International Organization for Standardization (ISO) compliant amalgam separators or separators equally effective.
2. Any regulation should defer to existing state or local law or regulation requiring separators so that the regulation would not require replacement of existing separators compliant with existing applicable law.
3. Any regulation should exempt dental practices that place or remove no or only de minimis amounts of amalgams.
4. Any regulation should include an effective date or phase-in period of sufficient length to permit affected dentists a reasonable opportunity to comply.
5. Any regulation should provide for a reasonable opportunity for covered dentists to repair or replace defective separators without being deemed in violation of the regulation.
6. Any regulation should minimize the administrative burden on covered dental offices by (e.g.) primarily relying upon self-certification (subject to verification or random inspection) and not requiring dental-office-specific permits.
7. Any regulation should not include a local numerical limit set by the local publicly owned treatment works (POTW).
8. Any regulation should not require wastewater monitoring at the dental office, although monitoring of the separators to assure proper operation may be required.
9. Any regulation should provide that compliance with it shall satisfy the requirements of the Clean Water Act unless a more stringent local requirement is needed.

Dental Office Wastewater Policy (*Trans.*2003:387)

Resolved, that the Association strongly encourages dentists to adhere to best management practices and supports other voluntary efforts by dentists to reduce amalgam discharges in dental office wastewater, and be it further

Resolved, that the Association encourages constituent and component societies to enter into collaborative arrangements with regional, state or local wastewater authorities to address their concerns about amalgam in dental office wastewater, and be it further

Resolved, that the appropriate agencies of the Association continue to disseminate information to the constituent and component societies to help them address concerns of regional, state or local wastewater authorities about amalgam in dental office wastewater, and be it further

Resolved, that the appropriate agencies of the Association continue to investigate products and services that will help dentists effectively reduce amalgam in dental office wastewater and keep the profession advised, and be it further

Resolved, that the Association include in its advocacy messages the importance of basing environmental regulations or guidance affecting dental offices on sound science, and be it further

Resolved, that the Association continue to identify and urge the Environmental Protection Agency to fund studies that accurately and appropriately identify whether amalgam wastewater discharge affects the environment.

ADA Action Plan on Amalgam in Dental Office Wastewater (*Trans.*2002:422; 2007:441)

Resolved, that the ADA defines "dental best management practices" to mean a series of amalgam waste handling and disposal practices that include but are not limited to initiating bulk mercury collection programs, using chair side traps, amalgam separators compliant with ISO 11143 and vacuum collection, inspecting and cleaning traps, and recycling or using a commercial waste disposal service to dispose of the amalgam collected, and be it further

Resolved, that the ADA take, and constituent and component dental societies be urged to take, immediate steps to increase universal awareness and use of best management practices by dentists to reduce amalgam waste, and be it further

Resolved, that the ADA acknowledges the need for flexibility for each constituent and component society to make appropriate policy choices on behalf of their members based on local conditions.

Precapsulated Amalgam Alloy (*Trans.*1994:676)

Resolved, that the ADA recommends that dentists eliminate the use of bulk dental mercury and bulk amalgam alloy and that they use only precapsulated amalgam alloy in their dental practices.

Use of Amalgam as Restorative Material (*Trans.*1986:536)

Resolved, that based on current documented scientific research, the conclusions of conferences and

symposiums on the biocompatibility of metallic restorative material, and upon joint reports of the Council on Dental Materials, Instruments and Equipment and the Council on Dental Therapeutics of the Association, the continued use of dental amalgam as a restorative material does not pose a health hazard to the nonallergic patient, and be it further

Resolved, that to advocate to a patient or the public the removal of clinically serviceable dental amalgam restorations solely to substitute a material that does not contain mercury is unwarranted and violates the *ADA Principles of Ethics and Code of Professional Conduct*, and be it further

Resolved, that in those instances where state dental boards initiate proceedings on this question that the ADA cooperate in such proceedings by making available scientific personnel as expert witnesses

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Anesthesia and Sedation

Guidelines for the Use of Sedation and General Anesthesia by Dentists (*Trans.*2007:282; 2012:468; 2016:277)

I. Introduction

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

Dentists must comply with their state laws, rules and/or regulations when providing sedation and anesthesia and will only be subject to Section III. Educational Requirements as required by those state laws, rules and/or regulations.

Level of sedation is entirely independent of the route of administration. Moderate and deep sedation or general anesthesia may be achieved via any route of administration and thus an appropriately consistent level of training must be established.

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

II. Definitions

Methods of Anxiety and Pain Control

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

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

The following definitions apply to administration of minimal sedation:

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

dosing for minimal sedation via the enteral route – minimal sedation may be achieved by the administration of a drug, either singly or in divided doses, by the enteral route to achieve the desired clinical effect, not to exceed the maximum recommended dose (MRD).

The administration of enteral drugs exceeding the maximum recommended dose during a single appointment is considered to be moderate sedation and the moderate sedation guidelines apply.

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

If more than one enteral drug is administered to achieve the desired sedation effect, with or without the concomitant use of nitrous oxide, the guidelines for moderate sedation must apply.

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. The use of the MRD to guide dosing for minimal sedation is intended to create this margin of safety.

moderate sedation - a drug-induced depression of consciousness during which patients respond *purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.[1]

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

[1]Excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014, of the American Society of Anesthesiologists (ASA)

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

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

deep sedation - a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.[1]

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

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.[1]

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

Routes of Administration

> *enteral* - any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].
>
> *parenteral* - a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].
>
> *transdermal* - a technique of administration in which the drug is administered by patch or iontophoresis through skin.
>
> *transmucosal* - a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.
>
> *inhalation* - a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

Terms

> *analgesia* **–** the diminution or elimination of pain.
>
> *local anesthesia* - the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.
>
> *Note*: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression, especially in combination with sedative agents.
>
> *qualified dentist* - a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations.
>
> *operating dentist* – dentist with primary responsibility for providing operative dental care while a qualified dentist or independently practicing qualified anesthesia healthcare provider administers minimal, moderate or deep sedation or general anesthesia.
>
> *competency* – displaying special skill or knowledge derived from training and experience.
>
> *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.

[1]Excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014, of the American Society of Anesthesiologists (ASA)

continuous - prolonged without any interruption at any time.

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

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

American Society of Anesthesiologists (ASA) Patient Physical Status Classification[2]

Classification	Definition	Examples, including but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, *ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Examples include (but not limited to): recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or *ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	
*The addition of "E" denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)		

American Society of Anesthesiologists Fasting Guidelines[3]

Ingested Material	Minimum Fasting Period
Clear liquids	2 hours
Breast milk	4 hours
Infant formula	6 hours
Nonhuman milk	6 hours
Light meal	6 hours
Fatty meal	8 hours

III. Educational Requirements

A. Minimal Sedation

1. To administer minimal sedation the dentist must demonstrate competency by having successfully completed:

   a. training in minimal sedation consistent with that prescribed in the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*,

   or

   b. comprehensive training in moderate sedation that satisfies the requirements described in the Moderate

[2] ASA Physical Status Classification System is reprinted with permission of the American Society of Anesthesiologists, Updated by ASA House of Delegates, October 15, 2014.

[3] American Society of Anesthesiologists: Practice Guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures. Anesthesiology 114:495. 2011. Reprinted with permission.

Sedation section of the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced,

or

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

and

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

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

B. Moderate Sedation

1. To administer moderate sedation, the dentist must demonstrate competency by having successfully completed:

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

or

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

and

c. 1) A current certification in Basic Life Support for Healthcare Providers and
2) Either current certification in Advanced Cardiac Life Support (ACLS or equivalent) or completion of an appropriate dental sedation/anesthesia emergency management course on the same recertification cycle that is required for ACLS.

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

C. Deep Sedation or General Anesthesia

1. To administer deep sedation or general anesthesia, the dentist must demonstrate competency by having completed:

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

and

b. 1) A current certification in Basic Life Support for Healthcare Providers and
2) either current certification in Advanced Cardiac Life Support (ACLS or equivalent) or completion of an appropriate dental sedation/anesthesia emergency management course on the same re-certification cycle that is required for ACLS.

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

IV. Clinical Guidelines

A. Minimal sedation

1. Patient History and Evaluation

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

2. Pre-Operative Evaluation and Preparation

- The patient, parent, legal guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- An appropriate focused physical evaluation should be performed.
- Baseline vital signs including body weight, height, blood pressure, pulse rate, and

respiration rate must be obtained unless invalidated by the nature of the patient, procedure or equipment. Body temperature should be measured when clinically indicated.
- Preoperative dietary restrictions must be considered based on the sedative technique prescribed.
- Pre-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian or care giver.

3. Personnel and Equipment Requirements

Personnel:

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

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- Documentation of compliance with manufacturers' recommended maintenance of monitors, anesthesia delivery systems, and other anesthesia-related equipment should be maintained. A preprocedural check of equipment for each administration of sedation must be performed.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.

4. Monitoring and Documentation

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

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

Oxygenation:
- Oxygen saturation by pulse oximetry may be clinically useful and should be considered.

Ventilation:
- The dentist and/or appropriately trained individual must observe chest excursions.
- The dentist and/or appropriately trained individual must verify respirations.

Circulation:
- Blood pressure and heart rate should be evaluated pre-operatively, post-operatively and intraoperatively as necessary (unless the patient is unable to tolerate such monitoring).

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

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The qualified dentist or appropriately trained clinical staff must monitor the patient during recovery until the patient is ready for discharge by the dentist.
- The qualified dentist must determine and document that level of consciousness, oxygenation, ventilation and circulation are satisfactory prior to discharge.
- Post-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian or care giver.

6. Emergency Management

- If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient is returned to the intended level of sedation.
- The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of minimal sedation and providing the equipment and protocols for patient rescue.

B. Moderate Sedation

1. Patient History and Evaluation

Patients considered for moderate sedation must undergo an evaluation prior to the administration of any sedative. This should consist of at least a review at an appropriate time of their medical history and medication use and NPO (nothing by mouth) status. In addition, patients with significant medical considerations (e.g., ASA III, IV) should also require consultation with their primary care physician or consulting medical specialist. Assessment of Body Mass Index (BMI)[4] should be considered part of a pre-procedural workup. Patients with elevated BMI may be at increased risk for airway associated morbidity, particularly if in association with other factors such as obstructive sleep apnea.

2. Pre-operative Evaluation and Preparation

- The patient, parent, legal guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- An appropriate focused physical evaluation must be performed.
- Baseline vital signs including body weight, height, blood pressure, pulse rate, respiration rate, and blood oxygen saturation by pulse oximetry must be obtained unless precluded by the nature of the patient, procedure or equipment. Body temperature should be measured when clinically indicated.
- Pre-operative verbal or written instructions must be given to the patient, parent, escort, legal guardian or care giver, including pre-operative fasting instructions based on the ASA Summary of Fasting and Pharmacologic Recommendations.

3. Personnel and Equipment Requirements

Personnel:

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

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- Documentation of compliance with manufacturers' recommended maintenance of monitors, anesthesia delivery systems, and other anesthesia-related equipment should be maintained. A preprocedural check of equipment for each administration of sedation must be performed.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- The equipment necessary for monitoring end-tidal CO_2 and auscultation of breath sounds must be immediately available.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravascular or intraosseous access should be available until the patient meets discharge criteria.

4. Monitoring and Documentation

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

Consciousness:

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

Oxygenation:

- Oxygen saturation must be evaluated by pulse oximetry continuously.

Ventilation:

- The dentist must observe chest excursions continually.

[4] Standardized BMI category definitions can be obtained from the Centers for Disease Control and Prevention or the American Society of Anesthesiologists.

- The dentist must monitor ventilation and/or breathing by monitoring end-tidal CO_2 unless precluded or invalidated by the nature of the patient, procedure or equipment. In addition, ventilation should be monitored by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope.

Circulation:

- The dentist must continually evaluate blood pressure and heart rate unless invalidated by the nature of the patient, procedure or equipment and this is noted in the time-oriented anesthesia record.
- Continuous ECG monitoring of patients with significant cardiovascular disease should be considered.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages and their administration times, including local anesthetics, dosages and monitored physiological parameters.
- Pulse oximetry, heart rate, respiratory rate, blood pressure and level of consciousness must be recorded continually.

5. Recovery and Discharge
   - Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
   - The qualified dentist or appropriately trained clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
   - The qualified dentist must determine and document that level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
   - Post-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian or care giver.
   - If a pharmacological reversal agent is administered before discharge criteria have been met, the patient must be monitored for a longer period than usual before discharge, since re-sedation may occur once the effects of the reversal agent have waned.

6. Emergency Management
   - If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient is returned to the intended level of sedation.
   - The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue.

C. Deep Sedation or General Anesthesia

1. Patient History and Evaluation

   Patients considered for deep sedation or general anesthesia must undergo an evaluation prior to the administration of any sedative. This must consist of at least a review of their medical history and medication use and NPO (nothing by mouth) status. In addition, patients with significant medical considerations (e.g., ASA III, IV) should also require consultation with their primary care physician or consulting medical specialist. Assessment of Body Mass Index (BMI)[4] should be considered part of a pre-procedural workup. Patients with elevated BMI may be at increased risk for airway associated morbidity, particularly if in association with other factors such as obstructive sleep apnea.

2. Pre-operative Evaluation and Preparation
   - The patient, parent, legal guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative or anesthetic agents and informed consent for the proposed sedation/anesthesia must be obtained.
   - Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
   - A focused physical evaluation must be performed as deemed appropriate.
   - Baseline vital signs including body weight, height, blood pressure, pulse rate, respiration rate, and blood oxygen saturation by pulse oximetry must be obtained unless invalidated by the patient, procedure or equipment. In addition, body temperature should be measured when clinically appropriate.
   - Pre-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian or care giver, including pre-operative fasting instructions based on the ASA Summary of Fasting and Pharmacologic Recommendations.

[4] Standardized BMI category definitions can be obtained from the Centers for Disease Control and Prevention or the American Society of Anesthesiologists.

- An intravenous line, which is secured throughout the procedure, must be established except as provided in part IV. C.6. Special Needs Patients.

3. Personnel and Equipment Requirements

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

- A dentist qualified in accordance with part III. C. of these Guidelines to administer the deep sedation or general anesthesia.
- Two additional individuals who have current certification of successfully completing a Basic Life Support (BLS) Course for the Healthcare Provider.
- When the same individual administering the deep sedation or general anesthesia is performing the dental procedure, one of the additional appropriately trained team members must be designated for patient monitoring.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- Documentation of compliance with manufacturers' recommended maintenance of monitors, anesthesia delivery systems, and other anesthesia-related equipment should be maintained. A pre-procedural check of equipment for each administration must be performed.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.
- Equipment and drugs necessary to provide advanced airway management, and advanced cardiac life support must be immediately available.
- The equipment necessary for monitoring end-tidal CO_2 and auscultation of breath sounds must be immediately available.
- Resuscitation medications and an appropriate defibrillator must be immediately available.

4. Monitoring and Documentation

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

Oxygenation:

- Oxygenation saturation must be evaluated continuously by pulse oximetry.

Ventilation:

- Intubated patient: End-tidal CO_2 must be continuously monitored and evaluated.
- Non-intubated patient: End-tidal CO_2 must be continually monitored and evaluated unless precluded or invalidated by the nature of the patient, procedure, or equipment. In addition, ventilation should be monitored and evaluated by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope.
- Respiration rate must be continually monitored and evaluated.

Circulation:

- The dentist must continuously evaluate heart rate and rhythm via ECG throughout the procedure, as well as pulse rate via pulse oximetry.
- The dentist must continually evaluate blood pressure.

Temperature:

- A device capable of measuring body temperature must be readily available during the administration of deep sedation or general anesthesia.
- The equipment to continuously monitor body temperature should be available and must be performed whenever triggering agents associated with malignant hyperthermia are administered.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages and their administration times, including local anesthetics and monitored physiological parameters.
- Pulse oximetry and end-tidal CO_2 measurements (if taken), heart rate, respiratory rate and blood pressure must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The dentist or clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The dentist must determine and document that level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient and parent, escort, guardian or care giver.

6. Special Needs Patients

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

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

7. Emergency Management

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

Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (*Trans.*2007:282; 2012:469; 2016:277)

I. Introduction

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

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

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

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

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

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

The predoctoral curriculum should provide instruction, exposure and/or experience in anxiety and pain control, including minimal and moderate sedation. The predoctoral program must also provide the knowledge and skill to enable students to recognize and manage

any emergencies that might arise as a consequence of treatment. Predoctoral dental students must complete a course in Basic Life Support for the Healthcare Provider. Though Basic Life Support courses are available online, any course taken online should be followed up with a hands-on component and be approved by the American Heart Association or the American Red Cross.

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

Level of sedation is entirely independent of the route of administration. Moderate and deep sedation or general anesthesia may be achieved via any route of administration and thus an appropriately consistent level of training must be established.

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

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

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

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

II. Definitions

Methods of Anxiety and Pain Control

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

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

The following definitions apply to administration of minimal sedation:

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

dosing for minimal sedation via the enteral route – minimal sedation may be achieved by the administration of a drug, either singly or in divided doses, by the enteral route to achieve the desired clinical effect, not to exceed the maximum recommended dose (MRD).

The administration of enteral drugs exceeding the maximum recommended dose during a single appointment is considered to be moderate sedation and the moderate sedation guidelines apply.

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

If more than one enteral drug is administered to achieve the desired sedation effect, with or without the concomitant use of nitrous oxide, the guidelines for moderate sedation must apply.

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. The use of the MRD to guide dosing for minimal sedation is intended to create this margin of safety.

moderate sedation - a drug-induced depression of consciousness during which patients respond

[1] Excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014, of the American Society of Anesthesiologists (ASA)

purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.[1]

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

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

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

deep sedation - a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.[1]

general anesthesia – a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.[1]

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.[1]

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

Routes of Administration

> *enteral* - any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].
>
> *parenteral* - a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].
>
> *transdermal* - a technique of administration in which the drug is administered by patch or iontophoresis through skin.
>
> *transmucosal* – a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.
>
> *inhalation* - a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

Terms

> *analgesia* **–** the diminution or elimination of pain.
>
> *local anesthesia* - the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.
>
> *Note*: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must always be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression especially in combination with sedative agents.
>
> *qualified dentist* – a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations.
>
> *must/shall* - indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

[1] Excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2014, of the American Society of Anesthesiologists (ASA)

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

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

continual - repeated regularly and frequently in a steady succession.

continuous - prolonged without any interruption at any time.

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

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

Levels of Knowledge

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

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

Levels of Skill

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

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

American Society of Anesthesiologists (ASA) Patient Physical Status Classification[2]

Classification	Definition	Examples, including but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, *ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Examples include (but not limited to): recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or *ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	
*The addition of “E” denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)		

[2] ASA Physical Status Classification System is reprinted with permission of the American Society of Anesthesiologists, Updated by ASA House of Delegates, October 15, 2014.

American Society of Anesthesiologists' Fasting Guidelines[3]

Ingested Material	Minimum Fasting Period
Clear liquids	2 hours
Breast milk	4 hours
Infant formula	6 hours
Nonhuman milk	6 hours
Light meal	6 hours
Fatty meal	8 hours

Education Courses

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

1. Competency Courses are designed to meet the needs of dentists who wish to become competent in the safe and effective administration of local anesthesia, minimal and moderate sedation. They consist of lectures, demonstrations and sufficient clinical participation to assure the faculty that the dentist understands the procedures taught and can safely and effectively apply them so that mastery of the subject is achieved. Faculty must assess and document the dentist's competency upon successful completion of such training. To maintain competency, periodic update courses must be completed.

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

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

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

III. Teaching Pain Control

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

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

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

B. Pain Control Curriculum Content:

1. Philosophy of anxiety and pain control and patient management, including the nature and purpose of pain
2. Review of physiologic and psychologic aspects of anxiety and pain
3. Review of airway anatomy and physiology
4. Physiologic monitoring
   a. Observation
      (1) Central nervous system
      (2) Respiratory system
         a. Oxygenation
         b. Ventilation
      (3) Cardiovascular system
   b. Monitoring equipment
5. Pharmacologic aspects of anxiety and pain control
   a. Routes of drug administration
   b. Sedatives and anxiolytics
   c. Local anesthetics
   d. Analgesics and antagonists
   e. Adverse side effects
   f Drug interactions

[3] American Society of Anesthesiologists: Practice Guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures. Anesthesiology 114:495. 2011. Reprinted with permission.

g. Drug abuse

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

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

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

Clinical experience in minimal and moderate sedation techniques should be related to various disciplines of dentistry and not solely limited to surgical cases. Typically, such experience will be provided in managing healthy adult patients.

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

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

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

IV. Teaching Administration of Minimal Sedation

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

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

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

1. Describe the adult anatomy and physiology of the respiratory, cardiovascular and central nervous systems, as they relate to the above techniques.
2. Describe the pharmacological effects of drugs.

3. Describe the methods of obtaining a medical history and conduct an appropriate physical examination.
4. Apply these methods clinically in order to obtain an accurate evaluation.
5. Use this information clinically for ASA classification risk assessment and pre-procedure fasting instructions.
6. Choose the most appropriate technique for the individual patient.
7. Use appropriate physiologic monitoring equipment.
8. Describe the physiologic responses that are consistent with minimal sedation.
9. Understand the sedation/general anesthesia continuum.
10. Demonstrate the ability to diagnose and treat emergencies related to the next deeper level of anesthesia than intended.

Inhalation Sedation (Nitrous Oxide/Oxygen)

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

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

B. Inhalation Sedation Course Content:

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

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

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

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

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

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

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

Enteral and/or Combination Inhalation-Enteral Minimal Sedation

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

1. Describe the basic components of inhalation sedation equipment.
2. Discuss the function of each of these components.
3. List and discuss the advantages and disadvantages of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
4. List and discuss the indications and contraindications for the use of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
5. List the complications associated with enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
6. Discuss the prevention, recognition and management of these complications.
7. Administer enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation) to patients in a clinical setting in a safe and effective manner.
8. Discuss the abuse potential, occupational hazards and other effects of enteral and inhalation agents.
9. Discuss the pharmacology of the enteral and inhalation drugs selected for administration.
10. Discuss the precautions, contraindications and adverse reactions associated with the enteral and inhalation drugs selected.
11. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for management of life-threatening situations.
12. Demonstrate the ability to manage life-threatening emergency situations, including current certification in Basic Life Support for Healthcare Providers.
13. Discuss the pharmacological effects of combined drug therapy, their implications and their management. Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

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

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

C. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Duration: Participants must be able to document current certification in Basic Life Support for Healthcare Providers and have completed a nitrous oxide competency course to be eligible for enrollment in this course. While length of a course is only one of the many factors to be considered in determining

the quality of an educational program, the course should include a minimum of *16 hours*, plus clinically-oriented experiences during which competency in enteral and/or combined inhalation-enteral minimal sedation techniques is demonstrated. Clinically-oriented experiences may include group observations on patients undergoing enteral and/or combination inhalation-enteral minimal sedation. Clinical experience in managing a compromised airway is critical to the prevention of life-threatening emergencies. The faculty should schedule participants to return for additional clinical experience if competency has not been achieved in the time allotted. The educational course may be completed in a predoctoral dental education curriculum or a postdoctoral continuing education competency course.

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

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

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

V. Teaching Administration of Moderate Sedation

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

Completion of a pre-requisite nitrous oxide-oxygen competency course is required for participants combining moderate sedation with nitrous oxide-oxygen.

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

1. List and discuss the advantages and disadvantages of moderate sedation.
2. Discuss the prevention, recognition and management of complications associated with moderate sedation.
3. Administer moderate sedation to patients in a clinical setting in a safe and effective manner.
4. Discuss the abuse potential, occupational hazards and other untoward effects of the agents utilized to achieve moderate sedation.
5. Describe and demonstrate the technique of intravenous access, intramuscular injection and other parenteral techniques.
6. Discuss the pharmacology of the drug(s) selected for administration.
7. Discuss the precautions, indications, contraindications and adverse reactions associated with the drug(s) selected.
8. Administer the selected drug(s) to dental patients in a clinical setting in a safe and effective manner.
9. List the complications associated with techniques of moderate sedation.
10. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for the prevention and management of emergency situations.
11. Discuss principles of advanced cardiac life support or an appropriate dental sedation/anesthesia emergency course equivalent.
12. Demonstrate the ability to manage emergency situations.
13. Demonstrate the ability to diagnose and treat emergencies related to the next deeper level of anesthesia than intended.

B. Moderate Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations.
3. Use of patient history and examination for ASA classification, risk assessment and pre-procedure fasting instructions.
4. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
5. Description of the sedation anesthesia continuum, with special emphasis on the distinction between the conscious and the unconscious state.

6. Review of adult respiratory and circulatory physiology and related anatomy.
7. Pharmacology of local anesthetics and agents used in moderate sedation, including drug interactions and contraindications.
8. Indications and contraindications for use of moderate sedation.
9. Review of dental procedures possible under moderate sedation.
10. Patient monitoring using observation and monitoring equipment, with particular attention to vital signs, ventilation/breathing and reflexes related to consciousness.
11. Maintaining proper records with accurate chart entries recording medical history, physical examination, informed consent, time-oriented anesthesia record, including the names of all drugs administered including local anesthetics, doses, and monitored physiological parameters.
12. Prevention, recognition and management of complications and emergencies.
13. Description, maintenance and use of moderate sedation monitors and equipment.
14. Discussion of abuse potential.
15. Intravenous access: anatomy, equipment and technique.
16. Prevention, recognition and management of complications of venipuncture and other parenteral techniques.
17. Description and rationale for the technique to be employed.
18. Prevention, recognition and management of systemic complications of moderate sedation, with particular attention to airway maintenance and support of the respiratory and cardiovascular systems.

C. Moderate Sedation Course Duration and Documentation: The Course must include:

- A minimum of 60 hours of instruction plus administration of sedation for at least 20 individually managed patients.
- Certification of competence in moderate sedation technique(s).
- Certification of competence in rescuing patients from a deeper level of sedation than intended including managing the airway, intravascular or intraosseous access, and reversal medications.
- Provision by course director or faculty of additional clinical experience if participant competency has not been achieved in time allotted.
- Records of instruction and clinical experiences (i.e., number of patients managed by each participant in each modality/route) that are maintained and available for participant review.

D. Documentation of Instruction: The course director must certify the competency of participants upon satisfactory completion of training in each moderate sedation technique, including instruction, clinical experience, managing the airway, intravascular/intraosseous access, and reversal medications.

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

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

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

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

ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists (*Trans.*2007:384)

Introduction: The administration of sedation and general anesthesia has been an integral part of dental practice since the 1840s. Dentists have a legacy and a continuing interest and expertise in providing anesthetic and sedative care to their patients. It was the introduction of nitrous oxide by Horace Wells, a Hartford, Connecticut dentist, and the demonstration of anesthetic properties of ether by William Morton, Wells' student, that gave the gift of anesthesia to medicine and dentistry. Dentistry has continued to build upon this foundation and has been instrumental in developing safe and effective sedative and anesthetic techniques that have enabled millions of people to access dental care. Without these modalities, many patient populations such as young children, physically and mentally challenged individuals and many

other dental patients could not access the comprehensive care that relieves pain and restores form and function. The use of sedation and anesthesia by appropriately trained dentists in the dental office continues to have a remarkable record of safety. It is very important to understand that anxiety, cooperation and pain can be addressed by both psychological and pharmacological techniques and local anesthetics, which are the foundation of pain control in dentistry. Sedation may diminish fear and anxiety, but do not obliterate the pain response and therefore, expertise and in-depth knowledge of local anesthetic techniques and pharmacology is necessary. General anesthesia, by definition, produces an unconscious state totally obtunding the pain response.

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

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

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

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

Education

Training to competency in minimal and moderate sedation techniques may be acquired at the predoctoral, postgraduate, graduate, or continuing education level. Dentists who wish to utilize minimal or moderate sedation are expected to successfully complete formal training which is structured in accordance with the ADA's *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students.* The knowledge and skills required for the administration of deep sedation and general anesthesia are beyond the scope of predoctoral and continuing education. Only dentists who have completed an advanced education program accredited by the Commission on Dental Accreditation (CODA) that provides training in deep sedation and general anesthesia are considered educationally qualified to use these modalities in practice.[1]

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

Safe Practice

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

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

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

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

State Regulation

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

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

Research

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

Antitrust

Antitrust Reform (*Trans.*2016:314)

Resolved, that the ADA strongly supports eliminating the current insurance industry exemption from anti-trust laws including support for legislation to clarify, Amend or, if necessary, repeal the McCarran-Ferguson Act's antitrust immunity for the business of health insurance, and be it further

Resolved, that the ADA strongly opposes any legislation that would extend an antitrust exemption to the insurance industry for information gathering endeavors such as collecting and distributing information on cost and utilization of health care services, and be it further

Resolved, that the ADA supports changes in federal antitrust laws that will enable dentists to practice effectively within the health care system, and be it further

Resolved, that the ADA supports legislative and regulatory activities to change the antitrust safe harbor guideline for dental networks based on percentage of provider participation in favor of a guideline relying on a health plan's market share, and be it further

Resolved, that the ADA work closely with constituent and component societies to provide them the most current and comprehensive antitrust information and guidance available, on an as-needed basis, and be it further

Resolved, that the ADA utilize appropriate resources to work with other provider groups to Amend antitrust laws to allow dentists and other providers to negotiate collectively with health care purchasers, and be it further

Resolved, that the ADA support effective regulation of insurance companies including**:** the establishment of requirements for disclosure to dentists prior to signing network participation contracts**;** and current and complete information relating to the establishment of payment reimbursement rates and claims experience.

Legislative Support to Allow Collective Bargaining by Professional Societies (*Trans.*2001:440; 2015:271)

Resolved, that the Association support legislation that would allow professional societies and their members to be considered as "one" and exempt from antitrust scrutiny for the narrow area of collective bargaining, so that dental societies could collectively negotiate on behalf of members.

Financial, Political and Administrative Consequences of Collective Bargaining Legislation (*Trans.*2000:506)

Resolved, that in pursuing antitrust relief as mandated by current policies, the Association be mindful of any such concerns raised by consultants with respect to legal and economic aspects of collective bargaining legislation, to assure legislation is in the best interests of the profession.

Children

Drinking Water in Schools (*Trans.*2016:323)

Resolved, recognizing that safe, free drinking water is an essential component of student health and wellness, ADA supports the development of school drinking water policies, programs and procedures:

- designed to make safe, free drinking water readily available in multiple locations throughout the school day and at school-sponsored events and activities;
- that include water promotion strategies detailing the consumption of water as a healthy beverage, and
- that govern the purchase, placement, distribution and maintenance of systems designed to provide access to safe, free drinking water.

Child Identification Programs (*Trans.*2014:506)

Resolved, that the ADA supports child identification programs that include scientifically demonstrated valid dental related components, including the documentation of the child's dental home, and be it further
Resolved, that the ADA supports constituent and component dental societies promoting partnerships with sponsoring organizations of these child identification programs.

Prevention and Control of Early Childhood Caries (*Trans.*2014:507)

Prevention and Control of Early Childhood Caries

1. The American Dental Association recognizes Early Childhood Caries (ECC) as the presence of one or more decayed, noncavitated or cavitated lesions, missing due to caries, or filled tooth surfaces in any primary tooth in a child under the age of six. In children younger than three years of age, any sign of smooth-surface caries is indicative of severe early childhood caries (S-ECC). From ages three through five, one or more cavitated, missing (due to caries) or filled smooth surfaces in primary maxillary anterior teeth or a decayed, missing, or filled score of greater than or equal to four at age 3, greater than or equal to five at age 4, or greater than or equal to six at age 5 surfaces also constitutes S-ECC.

2. The Association recognizes that oral health is an important part of overall health. ECC is a health problem throughout the population that poses a significant health burden in specific at-risk communities.

3. The Association recommends health professionals and the public recognize that a child's teeth are susceptible to decay as soon as they begin to erupt and that ECC is a multifactorial, transmissible disease that is reversible in its early stages and its progression is affected by many different risk and protective factors.

4. The Association recommends parents and guardians, as a child's first tooth erupts, to:

    - Schedule the child's first dental visit. Children should have a Dental Home before age one.
    - Begin brushing twice daily with no more than a smear (rice-sized amount) of fluoride toothpaste for children younger than 3 years old and a pea-sized amount of fluoride toothpaste for children 3 to 6 years old. This recommendation is taken from the ADA Council on Scientific Affairs *Fluoride Toothpaste Use for Young Children,* JADA*,* February 2014.

5. The Association recommends its members educate parents, including expectant parents, and caregivers about establishing a Dental Home before age one, provide them with oral health education based on the child's developmental needs and explain methods for reducing the risk for ECC, including specific details of how to reduce risk factors and promote protective factors.

6. The Association recommends state and local dental societies act as a resource for the medical community and public health programs (e.g., Women, Infants and Children [WIC] and Head Start). Dentistry can be instrumental in educating other health professionals and the public about risk factors for ECC and the importance of the establishment of a Dental Home before age one.

7. The Association recognizes that the unique characteristics of ECC should be considered in selecting treatment protocols that are based on a child's individual risk.

8. The Association, recognizing that the science surrounding ECC continues to evolve, encourages research activities to study risk factors, preventive practices, disease management strategies and new technologies to address the challenges posed by this multifactorial disease.

Principles for Developing Children's Oral Health Programs (*Trans.*2012:444; 2014:506)

Resolved, that the following Principles for Developing Children's Oral Health Programs be adopted as the Association's framework for guiding policy development at the federal, state and local level for improving children's oral health:

Principles for Developing Children's Oral Health Programs

1. Increase public awareness of the relationship and importance of children's oral health to overall health.
2. All dental services necessary to prevent oral disease and restore oral structures to health and function should be available to all children.
3. All children, from birth up to the age of 21 years, should be included in any program developed to improve the oral health of children. Existing resources should be made available on a priority basis to the most vulnerable, and expanded on a planned and systematic basis to include everyone as rapidly as resources permit. Adequate funding should be prioritized so those children with the greatest need and those who will most benefit from care are first in line.
4. All individuals who have an interest in the oral health of children including parents, healthcare providers, pregnant women and caregivers need to understand the importance of oral health, oral hygiene fundamentals, diet and nutritional guidelines, the need for regular dental care and how to navigate the health care delivery system to get dental care for children.
5. Individuals should be encouraged to be responsible for their own health. Parents and caregivers should be motivated to accept responsibility for the oral health of their children as well as being active in the doctor-patient relationship.
6. Parents and caregivers should establish a dental home with a dentist before age one to determine appropriate preventive and restorative treatment.
7. Continuing education should be made available for all primary healthcare providers and training should be provided for community program staff such as daycare workers and Head Start staff.
8. Encourage cooperation between representative members of the dental profession and the private and public agencies at the local, state and national levels in the planning, operation, evaluation and financing of children's oral health programs.
9. Provide adequate funding for research to develop, implement, improve and evaluate programs and procedures which focus on improving the oral health of children.
10. Provide adequate reimbursement for professional services.
11. Eligibility to programs increasing access to essential oral health care should reflect regional differences in the cost of living and purchasing power.
12. The scope of the children's oral health program should be determined at the community level and be based on the general standards which have been established through the state and national programs.
13. Population and clinical preventive measures, which are evidenced based, should be an integral component when developing children's oral health programs. For example, fully funding community water fluoridation initiatives and school based oral health programs.
14. The services, existing resources and facilities of all private and public healthcare providers should be utilized in programs that are developed to improve the oral health of children.

School-Based Oral Health Programs (*Trans.*2010:557)

Resolved, that the American Dental Association recognizes that school-based oral health programs can play an important role in preventing and controlling dental caries in children and adolescents and can assist in the referral of those patients to establish a dental home, and be it further

Resolved, that the ADA create a page on its Web site dedicated to providing information on school-based oral health programs including links to external resources designed to assist professional providers, school boards and the public establish and maintain such programs in a safe and ethical manner, and be it further

Resolved, that the ADA approach national school agencies, including but not limited to the National School Boards Association, to discuss possible collaborations to promote materials pertaining to school-based oral health programs.

Oral Health Assessment for School Children (*Trans.*2005:323; 2013:360)

Resolved, that the ADA supports oral health assessments for school children, intended to gather data, detect clinically apparent pathologic conditions and allow for triage and referral to a dentist for a comprehensive dental examination, and be it further

Resolved, that the ADA supports state dental associations' efforts to sponsor legislation to provide oral health assessments for school children, and be it further

Resolved, that ADA recommends that school children receive a comprehensive examination conducted by a licensed dentist, and be it further

Resolved, that the ADA supports efforts to educate policymakers and the public that oral health is an integral part of overall health, and as such, oral health assessments should be given the same priority as other health assessments for children, and urges state and local dental societies to take similar actions.

Non-Dental Providers Completing Educational Program on Oral Health (*Trans.*2004:301; 2014:505)

Resolved, that only dentists, physicians, and their properly supervised and trained designees, be allowed to provide preventive dental services to patients of all ages, and be it further
Resolved, that anyone that provides preventive dental services should have completed an appropriate educational program on oral health, common oral pathology, dental disease risk assessment, dental caries and dental preventive techniques appropriate for the age groups under their care, and be it further
Resolved, that the ADA urge constituent societies to support this policy.

Non-Dental Providers Notification of Preventive Dental Treatment (*Trans.*2004:303; 2014:505)

Resolved, that prior to any preventive dental treatment, a dental disease risk assessment should be performed by a dentist or appropriately trained physician, and be it further
Resolved, that risk assessments, screenings or oral evaluations of patients by non-dentists are not to be considered comprehensive dental exams, and be it further
Resolved, that it is essential that non-dentists who provide preventive dental services refer the patient to a dentist for a comprehensive examination and to establish a dental home.

Dental Care for Children With Cleft Lip, Cleft Palate and other Craniofacial Anomalies (*Trans.*1963:287; 2016:315)

Resolved, that with the cooperation and assistance of the Academy of Dentistry for the Handicapped, American Association of Orthodontists, American Cleft Palate-Craniofacial Association, and American Academy of Pediatric Dentistry, constituent and component dental societies are urged to aid in the development of appropriate programs to assure comprehensive dental care, including orthodontic treatment, for children with a cleft lip, cleft palate or other craniofacial anomalies that limit a child's ability to maintain proper oral health and normal function, and be it further
Resolved, that such programs be developed at the local level in accordance with the American Dental Association's policies on community dental health programs.

Communications

Hyperlink Embedding in Policy Statements (*Trans.*2008:440)

Resolved, that where appropriate, electronic versions of policy statements should be embedded with hyperlinks to supporting documents, references and media, and be it further
Resolved, that such accompanying supporting material should be reviewed with the same care as the actual policy statement before publication by the appropriate ADA agencies.

Standards for Dental Society Publications (*Trans.*1997:303,660; 2010:602)

Standards for Dental Society Publications has been edited to incorporate developments since the document was revised by the Council on Journalism in 1969 and approved by the House of Delegates. These Standards are for dental society published publications; other publications, such as those published by a for-profit subsidiary, may require different or additional considerations.

Objective: The dental society publication is both an educational tool and a channel of communication between the dental society and members. An increasing number of dental society publications are posted on the Internet and the content is potentially accessible by the general public. This fact should be taken into consideration during the editing process.

While emphasis in content may vary, the objectives of the publication should be (1) to broaden the dentist's professional knowledge and improve his/her competence so he/she can provide better health service, and (2) to keep him/her informed on professional affairs. To accomplish these objectives, a society's publication should:

1. inform the dentist on issues of concern to the profession;
2. communicate the dental society's policies and actions on professional issues;
3. report the news and latest developments in the profession;
4. communicate government rules and regulations;
5. assist the dental society with membership recruitment and retention efforts;
6. inform and market to members available benefits and services;
7. provide a forum to address the needs and concerns of members, including the latest issues;
8. recognize the achievement and efforts of individuals who have worked hard for the advancement of the profession;
9. elicit the support and participation of the membership; and
10. maintain a balanced content with an attractive and interesting format.

The objectives of other dental publications, such as school, alumni, dental student, fraternity and commercial, should closely parallel those of dental society publications, namely education and communication, and the same standards should apply to all dental publications.

Types of Publications: Each dental society should first determine the type or types of publications that will best serve the needs of its members—newsletter, tabloid, bulletin, journal or a combination of newsletter and journal. The type(s) of publications selected by the dental society will depend on the purpose to be served, but the type(s) selected should be well designed, attractive and readable—the best the society can afford. When possible, a graphic arts designer should be employed to design a pleasing and practical format.

Frequency of Publication: To communicate adequately with members, journals and newsletters should be sent on a regular basis. The dental society should issue some form of publication, preferably monthly but no less than four times a year.

Content: The dental society's publication is one of the few *tangible* items it has to offer members. It should be regarded as one of the chief architects of a dental society's image. A dental society's effectiveness is often perceived by how well the publication serves the needs and expectations of the members. The publication, in order to be relevant, must continually reflect the trends affecting the profession.

The format of the publication will, to some extent, determine its content. However, the following items are recommended: scientific articles; editorials; reports on current issues; national and local dental news; dental society actions and reports; information on dental programs, benefits and services; information on government rules and regulations; profiles of members with outstanding achievement; and a section where members can express their opinions.

Dental Society Responsibilities: The major responsibilities of the dental society, as owner of the publication, are selecting the editor, managing editor and/or business manager, either by election or appointment; determining the type, scope and frequency of the publication; establishing written editorial and advertising policies for the guidance of the editor; and determining how the publication will be financed. The governing body of the society may appoint a committee to act in an advisory capacity to

the editor, yet permitting him/her necessary editorial freedom.

Editing a dental publication is not one person's job, just as a dental publication does not belong to one person. The editor must be sensitive to the needs and concerns of dental society officials and the membership at large. Although the editor has the freedom to determine the content of a dental society's publication, he/she should adhere to the standards of publication outlined in this document. Dental society officials have the obligation to restrict that freedom if the editor fails to abide by these standards. The editor may receive a stipend and should have adequate editorial and secretarial assistance. In addition, the editor's expenses should be paid to journalism conferences, where he/she can learn to produce a better journal, and to other meetings which should be reported to the members. The editor's budget should also include funds to cover legal fees, including for consultation, as appropriate.

The dental society should subsidize the cost of its publication as it does other services to its members. The publication should not be required to be self-supporting. Additional revenue may be obtained from subscription fees and from the sale of appropriate advertising.

Selection of the Editor: The editor should be selected for his/her ability and appointed or elected for a term of from three to five years, with the option to reappoint for additional terms. The dental society that changes editors every year or two is doing itself a disservice, as training and experience make the editor more valuable to his/her society. Similarly, the dental society that retains an editor for too long will stagnate, preventing the expression of new ideas and depriving other individuals from the opportunity to hold the office of editor.

Duties of the Editor: The editor should attend meetings of the administrative body of the dental society. He/she should understand that it is his/her chief job to *communicate* rather than make policy. By having direct access to discussions and to all information pertaining to issues being considered by the society, he/she will be better prepared to report on those issues to the members. The editor should be mindful of legal and other publishing considerations that could affect the society.

Editorial Staff: The size of the editorial staff will depend on the size and frequency of the publication. The staff of the larger publication may include a managing editor, business manager, advertising manager, art director, assistant editors, associate editors, manuscript editors, district editors or correspondents and a secretary. The minimum staff should include district correspondents and a part-time secretary to prepare copy for the printer. The staff should be well trained. This can be done by the editor, by distributing a manual of instruction and by staff journalism conferences.

A manual for district editors or correspondents should contain the following information: the type of material to be submitted for publication (news—personal or dental society, editorials, reports or features), guidelines on preferred style, instructions on how to prepare the copy, length of copy and a schedule for submission of material. The manual may also contain aids to better writing.

Publication Policies: The following policies are recommended for maintaining the standards of professional journalism:

1. *Ownership.* The dental society should control both the editorial and advertising content of its publications.
2. *Content and Format.* The content and format of the publication should be in keeping with professional ideals and be representative of the strength and vision of its sponsor. The editor should frequently monitor the readership to determine whether the content of the communication is relevant to the interests of the readership and is effectively presented. This may be accomplished through periodic readership surveys and analysis of remarks, letters and editorials. The editor should encourage dentists who submit articles to dental society publications to be ADA members.
3. *Scientific Articles.* Scientific articles should be supported by adequate scientific evidence. It is advisable for editors to have scientific articles peer reviewed by experts in the appropriate fields of research or clinical practice to ensure that articles are scientifically, structurally and ethically sound. Statistical analysis in scientific papers should be reviewed by experts to avoid publishing intentional or unintentional distortions that would support a paper's theories. Articles that have been peer reviewed should be labeled as such. Scientific information must also be clearly distinguishable from advertisements.
4. *News.* News sources should be examined for reliability, potential bias and conflict of interest. These sources should be identified whenever possible. The publishing of hearsay or information given by sources that wish to remain anonymous or offer favors in exchange for publication should be avoided. Care should be taken that advocacy is not inadvertently published as news. Facts for news or any other articles should never be deliberately distorted.
5. *Editorials.* Opinion should be clearly identified to avoid confusion with fact. Editorials and commentaries should be clearly labeled as such.
6. *Advertising.* If the publication carries advertising, the sponsoring dental society should control it. Ideally, advertising should be placed in the publication so that it does not interfere with the continuity of the scientific or editorial material. The

publication should have a written advertising code to assist the editor, managing editor or business manager in evaluating the advertising. Where practical, this code should include guidelines for the acceptance of:

a. *Ads for Products and Services*. Ads should be included only for those products that have been found safe, effective and scientifically sound; and for those services that have been found to be reputable and of value.
b. *Classified Advertisements*.

The code should also include guidelines for *nonacceptance* of advertisements. No advertising claims should be permitted which are false, misleading or deceptive.

7. *Photographs and Illustrations.* Photographs should not be altered through darkroom techniques or digitized manipulation. Altered photographs are as misleading as falsified statistics. Photographs and illustrations should not be used—either overtly or by implication—to negatively portray individuals or the dental society.
8. *Protection.* The publication should be copyrighted to protect the rights of the publisher and authors and to prevent unethical and unauthorized use of the material. The editor must operate within the limits of copyright laws. In addition, the editor should take appropriate steps, including the placement of appropriate disclaimers to protect the society and those involved in the publication from other legal risk, including antitrust, libel and anything that would affect the society's tax status. Mistakes should be rectified in print as soon as possible.
9. *Reprint Policy.* Occasionally, the editor receives a request from another publication for an article or for permission to reprint articles from publications. Evaluation of such a request should be based primarily on the standards, not solely the ownership, of the publication making the request. A written policy should be established to serve as a guide in acting on requests for permission to reprint articles and to guard against the inappropriate use of reprinted material.

Standards for Evaluation: The following standards can be used for evaluating all dental publications, both professional and commercial:

1. *Worthwhile Content.* The content of the publication, both editorial and advertising, should be in accord with the objectives of the American Dental Association—to encourage the improvement of the oral health of the public, to promote the art and science of dentistry and to represent the interests of the members of the dental profession and the public it serves.
2. *Appropriate Advertising Standards.* The publication should have advertising standards which prohibit the acceptance of advertising for products whose safety and effectiveness have not been demonstrated. The claims for the products, particularly those affecting oral health, should be supported by scientific evidence.
3. *Sound, Appropriately Intended Articles.* Scientific articles appearing in the publication should be supported by adequate scientific evidence; nonscientific articles should be in keeping with the purposes of the profession. Quoted authors must be given due credit. The publishing of papers by authors with conflicts of interest or hidden agendas should be identified and avoided. The publication of papers with questionable coauthorship should also be avoided.
4. *Protection of Members.* The publication staff and the officers of the dental society must take care that individuals, all levels of organized dentistry and the public are not harmed through unfair and damaging statements or through appearing to endorse potentially injurious goods and services. Stereotypical views of persons based on racial, ethnic, religious, political, cultural or occupational identification, gender or sexual preference are to be avoided. The publication should be judicious about naming colleagues who may be accused of violations of the dental practice act, insurance fraud, criminal activity or malpractice until due process has run its course.
5. *Honesty.* The publication may report controversy, but it should never create it. Distortion of facts, unbalanced management of issues, and managed information may self-serve the short-term goals of the governance of the parent organization, but such practices eventually undermine the integrity of the dental society and its publications.
6. *Lawful Conduct.* The publication should avoid inclusion of materials that may lead to legal prosecution, including with respect to laws on copyright and trademark, libel and antitrust.

ADA Positions, Policies and Definitions in ADA Publications (*Trans.*1996:732)

Resolved, that all ADA publications, excluding periodicals, clearly identify references to positions, policies or definitions that differ from official ADA positions, policies or definitions, in a manner that assures clear, consistent communication to members.

Preferred Professional Terminology (*Trans.*1977:914; 1997:661)

Resolved, that in matters pertaining to dental care, the American Dental Association encourages the use of the title "dentist" rather than "provider" whenever possible, and be it further

Resolved, that the use of the term “profession” be encouraged when referring to dentistry rather than the word “industry,” and be it further

Resolved, that the use of the term “workforce” be encouraged when referring to dentistry rather than the word “manpower,” and be it further

Resolved, that the use of the term “oral health” be encouraged when referring to dentistry rather than “dental health

Complementary and Alternative Medicine in Dentistry

Policy Statement on Complementary and Alternative Medicine in Dentistry (*Trans.*2001:460; 2017:277)

Policy Statement on Complementary and Alternative Medicine in Dentistry

In September 2002, the National Center for Complementary and Alternative Medicine partnered with the National Institutes of Health (NIH) and the Agency for Healthcare Research and Quality to commission the Institute of Medicine (IOM) to convene a study committee to investigate scientific, policy and practice questions arising from the use of complementary and alternative medicine (CAM) therapies by the American public.[1]
The IOM committee's final report[1] describes the current use of CAM in the United States, the populations using them, a summary of current practices and policies, and the development of conceptual framework linked to research and decision-making. One of the key messages from the cited report states:

> "The committee recommends that the same principles and standards of evidence of treatment effectiveness apply to all treatments, whether currently labeled as conventional medicine or CAM. Implementing this recommendation requires that investigators use and develop as necessary common methods, measures, and standards for the generation and interpretation of evidence necessary for making decisions about the use of CAM and conventional therapies."[1]

Historically, dentistry has evolved as a strong and respected profession based on sound science, a moral commitment of service to the public, and an ethical obligation to protect the health of the patient. The ADA strongly supports this tradition of dentistry as a profession rooted in constantly evolving scientific information and an ethical duty to act for the benefit of others.

The dental community has always been open to emerging diagnostic and treatment approaches that over the years have improved the oral health of the public, the health of the dental team and the practice of dentistry. The ADA, consistent with its commitment to evidence-based dentistry and the improvement of oral health, supports those diagnostic and treatment approaches that allow both patient and dentist to make informed choices among safe and effective options. The provision of dental care should be based on sound scientific principles and demonstrated clinical safety and effectiveness.

The ADA is open to the idea of integrating new therapies in clinical practice, along with those that have been already tested and shown to be safe and effective in improving patient outcomes. However, the ADA also acknowledges that interventions which are considered CAM are usually understudied interventions that require further scientific testing and investigation to draw reliable conclusions about their safety, effectiveness and potential benefits beyond placebo.

Health care interventions, whether or not considered CAM, should be subject to testing using similar research standards and scientific rigor to provide a strong, evidence-based foundation for their safety and appropriate use. Within this context, the notion of CAM as a specific subset of interventions that belong to a specific discipline can be considered questionable.

[1] Institute of Medicine (US) Committee on the Use of Complementary and Alternative Medicine by the American Public. Complementary and Alternative Medicine in the United States. Washington (DC): National Academies Press; 2005:2. Available at: https://www.ncbi.nlm.nih.gov/books/NBK83799/. Accessed June 12, 2017.

Constituent and Component Societies

Funding of Visits by ADA Officers (*Trans.*2017:254)

Resolved, that any host dental organization inviting ADA officers to an event be asked when feasible to fund the costs of such attendance.

Implementation of a Uniform Dues Transaction (*Trans.*2017: 254)

Resolved, that to simplify the member experience, all constituent societies are urged to use a uniform dues transaction which allows acceptance of dues payments in installments, permits payment of dues with a credit or debit card, and permits auto-renewal of dues, with an opt-out option.

Recognition of the Alliance of the American Dental Association (*Trans.*2015:270)

Resolved, that the ADA 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, and be it further
Resolved, that all spouses of ADA members are urged to become members of the Alliance of the American Dental Association, and be it further
Resolved, that the Alliance of the American Dental Association is urged not to adopt any provision in its constitution and bylaws that is in conflict with the ADA *Constitution and Bylaws*.

Optional Donation on Constituent Society Dues Statement for Well-Being Programs (*Trans.*2012:445)

Resolved, that the American Dental Association urges each constituent dental society to implement an optional donation line item for well-being programs on its annual dues statement.

Constituent Nominations of New Dentist Delegates (*Trans.*2011:546)

Resolved, that the American Dental Association encourage each state dental association to bring at least one new dentist as a delegate or alternate delegate to the annual American Dental Association's House of Delegates, and be it further
Resolved, that each association be urged to report to each House of Delegates their respective new dentist delegates or alternates.

Dissemination of Information Contrary to Science (*Trans.*2006:346)

Resolved, the ADA urges constituent and component societies to rely on peer-reviewed science, as relevant, when advocating positions with state and local governmental authorities.

Supporting Constituents With Third-Party Payer Issues (*Trans.*2004:307)

Resolved, that the ADA actively solicit information regarding third-party payer problems from members and all tripartite data sources, and be it further
Resolved, that the appropriate ADA agencies identify these third-party trends and critical issues and proactively use this analysis to facilitate efforts by constituent societies to address and resolve these issues with state and regional regulatory authorities.

Financial Hardship Dues Waivers (*Trans.*2002:381; 2018:300)

Resolved, that as a membership retention tool, the ADA strongly encourages its state and local dental societies to grant full or partial waivers to members who experience a significant limitation in income, whether it is due to family leave, other life disruption or practice circumstances, and be it further
Resolved, that state and local dental societies be urged to use the online dues waiver application, and be it further
Resolved, that state and local dental societies be urged to offer the same level of waivers that are available from the ADA so that members are afforded the same opportunities for assistance, regardless of state or local dental society.

Streamlining Membership Category Transfers (*Trans.*2001:426; 2018:300)

Resolved, that in order to ensure the smooth transition of dental students to active tripartite membership upon graduation from dental school, the state and local dental societies be urged to implement the following steps to streamline membership processing.

- Revise state and local dental society bylaws language, if necessary, to eliminate approval by a volunteer agency or by vote of the membership, or other procedural barriers to active membership for dental students graduating from a dental school who are eligible for tripartite membership in that state.

- Identify, annually, fourth-year students who plan to enter practice in the state following graduation.
- Accept into active membership any person holding a D.D.S., D.M.D. or equivalent degree, including assignment to a component.
- Expedite completion of a transfer to active membership at all three levels of the tripartite through the established processes.
- Invoice new active members at the appropriate first-year-out rate through the reduced dues program in accord with regular dues renewal process.

Affiliation With the Alliance of the American Dental Association (*Trans.*1997:701)

Resolved, that the American Dental Association continue to actively seek Alliance of the American Dental Association (AADA) involvement at all levels within the Grassroots program, and be it further
Resolved, that the American Dental Association urge those constituent and component societies that do not have an affiliation with AADA to attempt to establish and recognize such an organization.

Legislative Delegations (*Trans.*1995:648)

Resolved, that the Association continue to encourage individual ADA members to join the ADA Grassroots Program, and be it further
Resolved, that ADA members representing constituent and component societies who travel to Washington, D.C. be encouraged to visit with their senators and representatives to discuss legislative issues of importance to the profession and to coordinate this activity with the ADA Washington Office.

Participation in Public Agency Sponsored Programs Involving Dental Health Benefits (*Trans.*1995:648)

Resolved, that the American Dental Association urges constituent and component societies to participate actively in planning and preparation of all programs involving dental health benefits which may be sponsored by public agencies at any level.

Registration Fees for Members (*Trans.*1989:537)

Resolved, that as a membership benefit, the American Dental Association urges its constituent and component societies and other dental meetings to charge a lesser registration fee to other constituent and component ADA members than to nonmembers.

Protection of Retirement Assets (*Trans.*1987:521)

Resolved, that the ADA strongly support efforts by the constituent society at the state legislature level to enact laws which exempt IRS qualified Keogh, Corporate Pension or Profit Sharing Plans, and Individual Retirement Accounts from attachment to satisfy any nondomestic judgment.

Involvement of Students in Society Activities (*Trans.*1979:649)

Resolved, that the American Dental Association strongly encourage constituent and component dental societies to formally involve dental students in the activities and official meetings of those societies.

Mechanism for Complaints and Referrals (*Trans.*1972:669)

Resolved, that in the interest of the public and the profession, dental societies at the appropriate level should establish a mechanism to give attention to complaints, including fee complaints, and the existence of the mechanism should be made known to the public, and be it further
Resolved, that in the interest of the public, dental societies at the appropriate level should establish a mechanism to respond to patient requests for referral to dentists, and be it further
Resolved, that local dental societies should continue to operate and publicize emergency dental referral services that provide ready accessibility of professional services in emergencies or take prompt action to establish an emergency referral service.

State Dental Programs (*Trans.*1954:278; 2013:341)

Resolved, that constituent dental societies be urged to support state oral health programs in their respective state by (1) assuming the necessary leadership to secure the appropriation of state funds earmarked for dental health purposes, (2) fostering the appointment of a capable state dental director, and (3) aiding in the establishment of a sound administrative position for the state oral health program.

Consumers

Clarification of Dental Professional Credentials (*Trans.*2003:354)

Resolved, that the ADA establish an area on the ADA web site to assist consumers in making an informed choice of a dental practitioner that includes, but is not limited to:

1. The names of the nine ADA recognized specialties;
2. The names, phone numbers and web sites of the ADA recognized specialty organizations;
3. Information from the ADA *Principles of Ethics and Code of Professional Conduct* about advertising by general dentists and specialists, guidelines for announcing limitation of practice and the use of other credentials;
4. Other appropriate information that would help consumers make an informed choice.

and be it further
Resolved, that constituent and component societies be encouraged to provide this information on their web site and in yellow page ads.

Consumer Directories (*Trans.*1976:930; 2012:511)

Resolved, that constituent and component dental societies be encouraged to produce, develop, maintain and update ethical “consumer directories” of dentists in their areas which will provide appropriate information to the public, and be it further
Resolved, that constituent and component societies be urged to actively communicate with responsible state or local consumer organizations the availability of such directories on component, constituent and ADA websites.

Continuing Education

Policy on State Dental Board Recognition of the Commission for Continuing Education Provider Recognition (*Trans.*2017:275)

Resolved, that the American Dental Association urges all state dental boards to recognize the Commission for Continuing Dental Education Provider Recognition as a national agency responsible for the approval of continuing dental education providers, and to accept for licensure renewal purposes dentists' participation in continuing education courses offered by providers approved by the Commission for Continuing Education Provider Recognition through the Continuing Education Recognition Program (CERP).

Titles and Descriptions of Continuing Education Courses (*Trans.*2014:463)

Resolved, that continuing education course titles and descriptions should be structured such that the titles and descriptions do not explicitly or implicitly infer that attendees can perform procedures beyond their legal scope of practice.

Acceptance of Formal Continuing Medical Education Courses Offered by ACCME Accredited Providers (*Trans.*2010:576)

Resolved, that the American Dental Association urges state boards of dentistry to accept for licensure renewal purposes dentists' participation in formal continuing medical education courses offered by continuing education providers accredited by the Accreditation Council for Continuing Medical Education (ACCME).

Policy Statement on Continuing Dental Education (*Trans.*2006:331; 2011:465; 2017:274)

Definition of Continuing Dental Education:
Continuing dental education consists of educational activities designed to review existing concepts and techniques, to convey information beyond the basic dental education and to update knowledge on advances in scientific, clinical, and non-clinical related subject matter, including evidence-based dentistry and ethics. The objective is to improve the knowledge, skills and ability of the individual to provide the highest quality of service to the public and the profession. All continuing dental education should strengthen the habits of critical inquiry, balanced judgment and ethics that denote the truly professional and scientific person and should make it possible for new knowledge to be incorporated into the practice of dentistry as it becomes available.

Continuing education programs are typically designed for part-time enrollment and are of variable duration. In contrast to accredited advanced dental education programs, continuing dental education programs do not lead to eligibility for ethical announcements or certification in a specialty recognized by the American Dental Association. Continuing dental education should be a part of a lifelong continuum of learning.

Acceptable Subject Matter: In order for specific course subject material to be acceptable for credit, the stated course objectives, overall curriculum design or topical outlines should be clearly stated. The information presented should enable the dental professional to enhance the oral health and well-being of the public, either directly or through improved effectiveness of operations in dental practice, or through expansion of present knowledge through research. The dental professional should be able to apply the knowledge gained within his or her professional capacity.

Acceptable Activities: Continuing education activities are conducted in a wide variety of forms using many methods and techniques which are sponsored by a diverse group of institutions and organizations, including formally structured educational content offered by accredited or approved providers, and other types of activities that state boards and/or legislatures may by law specify as acceptable. The Association urges the state boards to allow maximum flexibility for an individual to choose content and learning activities based on individual preferences, needs, interests and resources. Additionally, clinical credit should be awarded for all activities related to the delivery of dental procedures including those with ethical components and self study activities.

Acceptable forms might include but are not limited to:

- participation in a formal continuing education course (a didactic and/or participatory activity to review or update knowledge of new or existing concepts and techniques)
- delivery of a formally structured continuing education course
- general attendance at a multi-day convention type meeting (a meeting held at the national, state or regional level which involves a variety of concurrent educational experiences)
- authorship of publications (e.g., a book, a chapter of a book or an article or paper published in a professional journal)
- completion of self study activities such as online courses and research, webinars, journal articles and downloadable books (individualized course of study which is structured and organized, but is available on

an unscheduled and unsupervised basis; a method of providing feedback to the learner on performance or comprehension must be incorporated into the self-study activity)
- enrollment in a preceptor program (an independent course of study with a formally structured, preplanned and prescheduled curriculum where the participant observes and provides patient treatment using criteria and guidelines provided by the instructors; this type of study does not lead to an academic degree)
- academic service (e.g., instruction, administration or research related to undergraduate, postgraduate or graduate dental or allied dental training programs)
- presenting posters or table clinic
- participation on a state dental board, a board complaint investigation, peer review or quality care review procedures
- successful completion of Part II of the National Board Dental Examination, a recognized dental specialty examination or the National Board Dental Hygiene Examination if taken after initial licensure
- test development for written and clinical dental, dental hygiene and dental specialty examinations
- volunteering pro bono dental services or community oral health activities through a public health facility
- participation in dental research as a principal investigator or research assistant

Policy Statement on Lifelong Learning (*Trans.*2000:467)

The Association advocates lifelong learning to enhance and update the knowledge base of dentists, to stimulate ongoing professional growth and development and to improve professional skills. Dentists have a responsibility to pursue lifelong learning throughout their professional careers. The Association recognizes that its members represent a broad community of interest and possess highly diverse learning styles that can be accommodated by a variety of educational methods. Members are encouraged to identify individual needs and develop and implement a plan to meet these needs. This plan may include, but not be limited to, staying current with professional literature, seeking current information applicable to one's practice, and participating in formal continuing dental education activities. The increasing pace of change in technology and skills necessary to practice dentistry necessitates the continuous deliberate acquisition of knowledge and skills to provide the highest quality of oral health care. A professional should address a broad spectrum of topics to update his or her knowledge and skills in all appropriate areas of the profession.

The Association is committed to serving as a supportive resource to facilitate the lifelong learning process and to assist members in identifying appropriate sources and mechanisms for meeting this responsibility for the benefit of the public and the profession.

Lifelong Continuing Education (*Trans.*1999:941)

Resolved, that the American Dental Association supports lifelong continuing education of its members and encourages various methods of demonstrating continuing competency through the oversight of dental practitioners by state boards of dentistry and peer review, and be it further

Resolved, that the Association discourages methods such as mandated periodic in-office audits and/or comprehensive written examinations as a means of measuring or assessing the continuing competency of dentists or as a requirement for license renewal, and be it further

Resolved, that the Association encourages the investigation of new methods of supporting continuing competency of its members, and be it further

Resolved, that the American Dental Association promote and defend this policy in any and all discussions concerning the issue of competency.

Promotion of Continuing Education (*Trans.*1968:257)

Resolved, that constituent dental societies, in consultation with state boards of dentistry, are urged to develop mechanisms to foster the continued education of dentists licensed in their jurisdiction.

Councils

Transparency (*Trans.*2009:404; 2017:254)

Resolved, that action items and approved minutes of all open meetings of ADA councils, committees and of the Board of Trustees be promptly posted in the Members Only section on ADA.org, and be it further
Resolved, that the ADA, as the sole shareholder of ADABEI, shall direct ADABEI and any other subsidiaries to post on ADA Connect or its equivalent for the House of Delegates, all approved minutes of Board meetings, and be it further
Resolved, that security in the Members Only section on ADA.org be enhanced as may be necessary so as to ensure that members will have exclusive access to the information contained in this Web site area.

Utilization of Multi-Council Task Forces (*Trans.*2001:447)

Resolved, that the American Dental Association utilize multi-council task forces when rapid responses are required to address emerging issues, and include the necessary expertise from members of relevant councils on these task forces as provided in Chapter XI, Section 10 of the *Bylaws*.

Review of Reports and Studies by the ADA Board of Trustees (*Trans.*1995:652)

Resolved, that all council and committee reports and studies requested by the House of Delegates or the ADA Board of Trustees be reviewed and acted upon by the ADA Board of Trustees before any dissemination to "communities of interest."

Joint Meeting Approval (*Trans.*1985:610)

Resolved, that Association agencies obtain prior approval from the Board of Trustees for conduct of joint or co-sponsored conferences, programs or meetings on topics or issues not in accord with Association policy or current program activity.

Council Membership Restriction (*Trans.*1973:645)

Resolved, that members of the Council on Dental Benefit Programs, during their terms on the Council, should not be an officer, trustee, board member or dental consultant for any insurance company, medical or dental service corporation.

Definitions

Definition of Diversity (*Trans.*2019:XXX)

Resolved, that the ADA defines diversity through many dimensions, including, but not limited to race, ethnicity, national origin, gender identity, age, physical abilities/qualities, sexual orientation, religious and ideological beliefs, professional practice choices and personal lifestyle preferences.

Definition of Oral Health (*Trans.*2014:465)

Resolved, that the following definition of oral health be adopted.

> Oral health is a functional, structural, aesthetic, physiologic and psycho-social state of well-being and is essential to an individual's general health and quality of life.

Definitions of "Usual Fee" and "Maximum Plan Benefit" (*Trans.*2010:546; 2011:452)

Resolved, that the following definitions of "usual fee" and "maximum plan benefit" be adopted:

> *Usual fee* is the fee which an individual dentist most frequently charges for a specific dental procedure independent of any contractual agreement.
>
> It is always appropriate to modify this fee based on the nature and severity of the condition being treated and by any medical or dental complications or unusual circumstances.
>
> *Maximum plan benefit* is the reimbursement level determined by the administrator of a dental benefit plan for a specific dental procedure. This may vary widely by geographic region or by benefit plans within a region.

and be it further
Resolved, that the use of the terms "customary" or "UCR" to justify denial of a claim or communicate with patients or dental benefit plan purchasers is inappropriate due to the arbitrary and prejudicial manner in which it can be designated, and be it further
Resolved, that the ADA should communicate these definitions to insurance regulators, consumer advocacy groups, and dental benefits administrators to encourage the proper use of these terms.

Dental Tourism (*Trans.*2008:454)

Resolved, that the following definition of dental tourism be adopted:

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

Definition of Dental Home (*Trans.*2005:322; 2010:548; 2014:505)

Resolved, that the definition of "dental home" (*Trans.*2005:322; 2010:548) be Amended to read as follows:

> *Dental Home*. The ongoing relationship between the dentist who is the Primary Dental Care Provider and the patient, which includes comprehensive oral health care, beginning before age one, and continuing throughout the patient's lifetime, with appropriate referral as necessary.

Dental Enrollment Credentialing (*Trans.*2002:395)

Resolved, that the term "dental enrollment credentialing" is a formal process that defines the standards and requirements for participation in third-party programs. The process verifies professional qualifications in order to allow licensed dentists to provide services to members of these programs.

Adding the ADA Definition of Dentistry to Existing Dental Regulatory Provisions (*Trans.*2001:440)

Resolved, that the American Dental Association encourages and supports efforts to include the ADA Definition of Dentistry into existing dental statutory and regulatory provisions, and be it further
Resolved, that the states should be encouraged and supported to include in their statutory and regulatory processes, ADA definitions of existing dental specialties in order to delineate the scope of dental education and training, and be it further
Resolved, that the constituent dental societies should seek legislative and regulatory changes to incorporate the following definitions as recognized and promulgated by the ADA:

> Definition of Dentistry (*Trans.*1997:687)—"Dentistry is defined as the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders, and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body; provided by a dentist, within the scope of his/her education, training and experience in accordance with the ethics of the profession and applicable law"; and the current definition of the recognized specialties:

Dental Public Health, Endodontics, Oral and Maxillofacial Pathology, Oral and Maxillofacial Radiology, Oral and Maxillofacial Surgery, Orthodontics and Dentofacial Orthopedics, Pediatric Dentistry, Periodontics and Prosthodontics; as approved by the Council on Dental Education and Licensure.

Continuing Competency (*Trans.*1999:939)

Resolved, that the following definition of continuing competency be adopted.

Continuing competency: The continuance of the appropriate knowledge and skills by the dentist in order to maintain and improve the oral health care of his or her patients in accordance with the ethical principles of dentistry.

Dentistry (*Trans.*1997:687; 2015:254)

Resolved, that dentistry is defined as the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body; provided by a dentist, within the scope of his/her education, training and experience, in accordance with the ethics of the profession and applicable law.

Professional Dental Care (*Trans.*1996:689)

Resolved, that the following definition of professional dental care be adopted.

Professional dental care is the diagnosis, treatment planning and implementation of services directed at the prevention and treatment of diseases, conditions and dysfunctions relating to the oral cavity and its associated structures and their impact upon the human body.

The implementation of professional dental care, which includes diagnostic, preventive, therapeutic, restorative, oral and maxillofacial surgical, endodontic, orthodontic, periodontic, prosthodontic and aesthetic (cosmetic) services shall be provided to dental patients by a legally qualified dentist or physician operating within the scope of his or her training.

Primary Dental Care (*Trans.*1994:668; 2010:562; 2012:441; 2014:506)

Resolved, that the definition of Primary Dental Care (*Trans.*1994.668; 2010:562; 2012:441) be Amended to read as follows:

Primary Dental Care. The dental care provided by a licensed dentist to patients beginning before age one and throughout their lifetime. Primary dental care is directed to evaluation, diagnosis, patient education, prevention, treatment planning and treatment of oral disease and injury, the maintenance of oral health, and the coordination of referral to specialists for care when indicated. Primary dental care includes services provided by allied personnel under the dentist's supervision.

Primary Dental Care Provider (*Trans.*1994:668; 2010:548)

Resolved, that the definition of Primary Dental Care Provider (*Trans.*1994:668) be Amended to read as follows:

Primary Dental Care Provider. A licensed dentist who accepts the professional responsibility for delivering primary dental care.

Freedom of Choice (*Trans.*1994:667)

Resolved, that the following definition of Freedom of Choice be accepted as policy of the American Dental Association:

Freedom of Choice. The concept that a patient has the right to choose any licensed dentist to deliver his or her oral health care without any type of coercion.

Fee-for-Service (*Trans.*1994:666)

Resolved, that the following be the definition of Fee-for-Service:

Fee-for-Service. A method of reimbursement by which the dentist establishes and expects to receive his or her full fee for the specific service(s) performed.

Balance Billing (*Trans.*1994:653)

Resolved, that the following be the definition of Balance Billing:

Balance Billing. Billing a patient for the difference between the dentist's actual charge and the amount reimbursed under the patient's dental benefit plan.

Tooth Designation Systems (*Trans.*1994:652; 2002:394; 2013:301)

Resolved, that the American Dental Association accepts the Universal/National Tooth Designation System and the ISO/ANSI/ADA Specification No. 3950 for Designation System for Teeth and Areas of the Oral

Cavity as the human tooth and oral cavity enumeration schemas, and be it further
Resolved, that the Universal/National Tooth Designation System is defined as follows:

Permanent Dentition

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

Supernumerary teeth are identified by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar (e.g., supernumerary #51 is adjacent to the upper right molar #1; supernumerary #82 is adjacent to the lower right third molar #32).

Primary Dentition

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

Supernumerary teeth are identified by the placement of the letter "S" following the letter identifying the adjacent primary tooth (e.g., supernumerary "AS" is adjacent to "A"; supernumerary "TS" is adjacent to "T").

and be it further
Resolved, that ISO/ANSI/ADA Specification No. 3950 for Designation System for Teeth and Areas of the Oral Cavity is defined as in standards documents prepared and published by the ADA Standards Committee on Dental Informatics.

Active and Inactive Dental Patients of Record (*Trans.*1991:621; 2012:441)

Resolved, that only for the purposes of evaluating or appraising the assets of a dental practice do the following definitions of the terms "active" and "inactive" dental patients of record apply:

Active Dental Patient of Record: An active dental patient of record is any individual in either of the following two categories: Category I—patients of record who have had dental service(s) provided by the dentist in the past twelve (12) months; Category II—patients of record who have had dental service(s) provided by the dentist in the past twenty-four (24) months, but not within the past twelve (12) months. Patients who have requested their records be transferred to another dentist or who have indicated they will be discontinuing their treatment, as substantiated in the patient's record, should be excluded from the "active" patient category. Each of these categories of active patients of record can be further divided into: (1) new or regular patients who have had a complete examination done by the dentist and, (2) emergency patients who have only had a limited examination done by the dentist.

Inactive Dental Patient of Record: An inactive dental patient of record is any individual who has become a patient of record and has not received any dental service(s) by the dentist in the past twenty-four (24) months.

Individual Practice Association (*Trans.*1990:540)

Resolved, that the following definition of Individual Practice Association be adopted:

A legal entity organized and governed by individual participating dentists for the primary purpose of collectively entering into contracts to provide dental services to enrolled populations.

Medically Necessary Care (*Trans.*1990:537)

Resolved, that the following definition of "medically necessary care" be adopted:

Medically necessary care means the reasonable and appropriate diagnosis, treatment, and follow-up care (including supplies, appliances and devices) as determined and prescribed by qualified, appropriate health care providers in treating any condition, illness, disease, injury or birth developmental malformations. Care is medically necessary for the purpose of: controlling or eliminating infection, pain and disease; and restoring facial configuration or function necessary for speech, swallowing or chewing.

and be it further
Resolved, that the appropriate agencies of the Association distribute this definition of "medically necessary care" to third-party payers, plan purchasers, professional health organizations and state and federal regulatory agencies.

Direct Reimbursement (*Trans.*1989:548)

Resolved, that "direct reimbursement" be defined as follows:

Direct reimbursement is a self-funded program in which the individual is reimbursed based on a percentage of dollars spent for dental care provided, and which allows beneficiaries to seek treatment from the dentist of their choice.

Fee-for-Service Private Practice (*Trans.*1979:620)

Resolved, that the following definition of the traditional fee-for-service private practice of dentistry be approved:

> The traditional fee-for-service private practice of dentistry, historically the basic and most prevalent method for delivery of oral health care, is a mode in which the dentist, as a solo practitioner or in a group, is ultimately responsible for all professional and business aspects of the practice. In this mode the fee to the patient is dictated by the service rendered, the patient maintains the freedom of choice of the dentist and the dentist has the freedom of choice of patients.

Treatment Plan (*Trans.*1978:499)

Resolved, that the following definition of "treatment plan" be adopted:

> The treatment plan is the sequential guide for the patient's care as determined by the dentist's diagnosis and is used by the dentist for the restoration to and/or maintenance of optimal oral health.

Oral Diagnosis (*Trans.*1978:499)

Resolved, that the following definition of "oral diagnosis" be adopted:

> 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.

Cosmetic Dentistry (*Trans.*1976:850)

Resolved, that cosmetic dentistry be defined as encompassing those services provided by dentists solely for the purpose of improving the appearance when form and function are satisfactory and no pathologic conditions exist.

Dental Benefit Programs

Statement on Programs Limiting Dental Benefit to Network Providers (*Trans.*2019:XXX)

The ADA supports approaches to designing dental benefit programs that allow patients the freedom to choose a dentist and receive benefit payment.

A Closed Panel Dental Benefit Plan exists when patients eligible to receive benefits can receive them only if services are provided by dentists who have signed an agreement with the benefit plan to provide treatment to eligible patients. As a result of the dentist reimbursement methods characteristic of a closed panel plan, only a small percentage of practicing dentists in a given geographical area are typically contracted by the plan to provide dental services.

An Exclusive Provider Organization (EPO) is a type of Preferred Provider Organization (PPO) under which patients must use providers from the specified network of dentists to receive a benefit; there is no payment for care received from a non-network provider except in an emergency situation.

A Dental Health Maintenance Organization (DHMO) is a dental benefit plan that is a legal entity that accepts the responsibility to provide or otherwise ensure the delivery of an agreed upon set of comprehensive oral health care services for a voluntarily enrolled group of persons in a geographic area, with dental care provided by only those dentists having contracts with the DHMO to provide these services.

The ADA opposes these approaches as the *only* dental benefit plans available to patients. To protect the patient's freedom to receive benefits for dental services provided by any legally-qualified dentist of his or her choice, the ADA suggests the following guidelines for dental benefit plan sponsors who choose to offer these types of dental benefit programs:

1. Benefit programs that offer dental benefits through these types of plans should also offer a Freedom of Choice Plan with equal benefits which permits free choice of dentist under a fee-for-service arrangement. Under this system, individual consumers should have periodic options to change plans.

2. There should be equal premium dollars per subscriber available for all dental plans being offered and the amount of the premium dollars available for dental care should increase annually.

3. All dentists willing to abide by the terms of the programs provider contract should be eligible to participate in the program.

4. Dental subscribers in these plans should be made fully aware of, and have access to, the profession's peer review mechanism.

5. Payments for services rendered should be based on the services rendered.

6. All dentists should be eligible to receive equal reimbursement from the dental plan/benefit program regardless of the dentist's participation status.

7. When requested by the patient, these plans should pay for a second opinion from a dentist of the patient's choosing.

8. A complete description of benefits provided under each plan should be given to all eligible individuals prior to each enrollment period. Benefit limitations and exclusions of each plan should be clearly described, and a complete and current list of dentists who participate in these plans should be provided and updated semi-annually.

9. The Freedom of Choice Plan should be designated the primary enrollment plan, i.e., eligible individuals who fail to enroll in any plan should be enrolled in the freedom of choice plan.

Genetic Testing for Risk Assessment (*Trans.*2017:266)

Resolved, that for the health and well-being of the public, the American Dental Association believes that any payer organization using a genetic test to determine eligibility for benefit coverage for specific oral healthcare services and any manufacturer of a test(s) used in such an effort must publish specific information on:

- Confirmation from an independent third party agency of test validity and reliability for the intended purpose
- Analysis on how this specific plan design will impact health outcomes and plan costs
- Disclosure of financial relationships between the manufacturer and payer
- Disclosure of bias and conflict of interest between the test manufacturer, investigators providing evidence and literature used to promote the test and plan design and with the payer organization

Dentist Rating by Third Parties (*Trans.*2014:455)

Resolved, that the ADA believes third-party dentist ratings systems based on cost or non-validated utilization patterns are inherently flawed, unreliable, and potentially misleading to the public, and be it further
Resolved, that the appropriate agencies of the Association will advise third parties, particularly those that publish ratings or rankings of dentists or dental practices based on selective and limited criteria, about ADA policies relating to ratings systems and encourage them not to include such ratings in their communications to the public, and be it further
Resolved, that the ADA pursue appropriate legal, administrative and other actions to oppose and prevent third parties from developing and using such inherently flawed, unreliable, and potentially misleading dentist ratings and ranking systems, and be it further
Resolved, that the ADA draft model legislation to oppose such objectionable dentist rating and ranking systems in federally-regulated dental benefits plans and support states in advocacy efforts to oppose such systems in state-regulated plans.

Principles for the Application of Risk Assessment in Dental Benefit Plans (*Trans.*2009:424; 2013:321)

Principles for the Application of Risk Assessment in Dental Benefit Plans

Individual Risk Assessment:

1. The assessment of the risk for the development of oral diseases, the progress of existing disease or the adverse outcomes of treatment of oral disease for an individual patient is a professional matter that is the sole responsibility of the attending dentist.
2. Individual risk assessment is an important consideration in developing a complete diagnosis and treatment recommendations for each patient, the complexity of which is influenced by the oral health status, goals and desires of the individual patient. The assessment should be scientifically based, clinically relevant and continually refined through outcomes studies.
3. There should be no interference by outside parties in the patient-doctor relationship by injecting factors unrelated to the patient's needs in any aspect of the diagnosis of the patient's oral health status or the attending dentist's treatment recommendations.
4. Risk assessments are tools which can be utilized periodically on a schedule determined by the attending dentist and should be based upon the needs and medical status of the individual patient, since risk can change over time due to application of preventive measures, changes in science, the effects of therapy and changes in patient behaviors.
5. Self-administered patient questionnaires provided by third-party payers used for risk assessment purposes should contain the admonition that they are not to be considered as a substitute for a clinical evaluation performed by a dentist.

Population Risk Assessment:

1. Risk assessment for populations is a science separate from individual patient risk assessment, one that requires different skills and techniques than those used in the assessment of individual patients.
2. If dental plans develop models to categorize their members based on risk, this should be accomplished through a scientifically validated method.
3. At no time should these risk assessment models be applied to design benefit packages for the purpose of limiting benefits.
4. Eligibility for preventive services within a dental benefit plan should not be limited based on population level risk assessment.

Real-Time Claims Adjudication (*Trans.*2007:419)

Resolved, the appropriate ADA agencies monitor any new real-time claims adjudication initiatives to determine the impact on dentists, and be it further
Resolved, that the appropriate ADA agencies communicate to dental plans, employers and patients the concerns about current payment issues, while encouraging the dental benefits industry to move towards real-time claims adjudication, and be it further
Resolved, that the appropriate ADA agencies educate dentists about the complexities of claims adjudication and third-party payment processes to enable them to more efficiently manage their practices, and be it further
Resolved, that the appropriate ADA agencies work with the national organizations responsible for developing electronic standards for electronic data interchange (EDI) to encourage the development of real-time claims adjudication standards.

Principles for Pay-for-Performance or Other Third-Party Financial Incentive Programs (*Trans.*2006:328; 2013:310)

Principles for Pay-for-Performance or Other Third-Party Financial Incentive Programs

1. The primary objective of Pay-for-Performance (P4P) or other third-party financial incentive programs must be improvement in the quality of oral health care, so performance measures in those programs should be valid measures of healthcare quality.

2. The provisions of P4P or other third-party financial incentive programs should not interfere with the patient-doctor relationship by injecting factors unrelated to the patient's needs into treatment decisions. Treatment plans can vary based on a clinician's sound judgment, available evidence and the patient's needs and preferences. Benchmarks to judge performance should allow for such variations in treatment plans.
3. The incentives in P4P or other third-party financial incentive programs should reward both progressive quality improvement as well as attainment of desired quality metrics.
4. P4P or other third-party financial incentive programs should not limit access to care for patients requiring extraordinary levels or types of care, nor provide a disincentive for practitioners to treat complex or difficult cases because of concern about performance ratings. There should be a system of risk adjustments for difficult or complex cases.
5. The measures upon which incentive payments are based:
   - should be valid, reliable and feasible and based on valid science
   - should be standardized and have broad acceptance within the dental community
6. Before comparing measure scores between two entities the results should be risk-adjusted to account for patient differences and must factor in patient compliance.
7. Reporting of quality to the public should be fair and provide an opportunity for dentists to comment on ratings. Payers should discuss quality problems they identify with dentists before any public reporting of ratings.
8. Participation by dentists should be voluntary, with no financial penalties for not participating.
9. Savings in costs should not accrue to plans but should be returned to patients in reduced co-payments or expansion of benefits.
10. Development and subsequent reassessment of P4P or other third-party financial incentive programs should be done, with input from participating dentists.

and be it further
Resolved, that the American Dental Association use these principles in discussions with organizations designing P4P or other third-party financial incentive programs and also monitor and continue to evaluate Pay-for-Performance or other third-party financial incentive programs being implemented in dental benefit plans, and be it further
Resolved, that the ADA advocacy efforts with respect for P4P or other third-party financial incentive programs be guided by these principles.

Review of Evidence-Based Reports Denying Reimbursement (*Trans.*2002:423)

Resolved, that all complaints reported to the ADA between third-party payers and ADA members regarding interpretation of evidence-based reports be referred to the Council on Dental Benefit Programs with input from the appropriate Association agencies for review.

Government-Sponsored Dental Programs (*Trans.*1998:705)

Resolved, that the ADA strongly encourage all government-sponsored dental programs to support the concept of patient/enrollee freedom of choice in selection of dental benefit plans, and be it further
Resolved, that all government-sponsored programs allow for patient/enrollee selection of dental benefits plans independently from their selection of other health/medical benefit plans, and be it further
Resolved, that all government-sponsored dental benefit programs include a fee-for-service dental benefit option, where the patient/enrollee may use the services of any licensed dentist of their choice.

Guidelines on Coordination of Benefits for Group Dental Plans (*Trans.*1996:685; 2009:423)

Guidelines on Coordination of Benefits for Group Dental Plans

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

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

and be it further
Resolved, that third-party payers, representing self-funded as well as insured plans, should be urged to adopt these guidelines as an industry-wide standard for coordination of benefits, and be it further
Resolved, that constituent societies are encouraged to seek enactment of legislation that would require all policies and contracts that provide benefits for dental care to use these guidelines to determine coordination of benefits, and be it further
Resolved, that all third parties providing or administering dental benefits should adopt a unified standardized formula for determining primary or secondary coverage and that the formula should be readily applied by dental providers based on information easily obtained from the patient, and be it further

Resolved, that the ADA seek federal legislation requiring that third parties comply with a standardized formula for determining primary and secondary coverage, and be it further
Resolved, that the ADA, through its appropriate agencies, urge the National Association of Insurance Commissioners (NAIC) to Amend their model legislation to conform with ADA policy.

Opposition to Dental Benefit Plans or Programs Conflicting With ADA Policies (*Trans.*1995:620)

Resolved, that the American Dental Association is opposed to any dental benefit plan or program and any financing mechanism for the delivery of dental care which conflicts with the policies or mission of the ADA.

Dental Coverage for Retiring Employees (*Trans.*1993:689)

Resolved, that the American Dental Association recognizes the importance of extending dental benefits to retirees, and be it further
Resolved, that plan purchasers should continue dental coverage for retiring employees if it was offered in the past, or as an option for retirees to purchase at their own expense if it is not part of an employee retirement package, and be it further
Resolved, that the ADA work with third-party payers, the Department of Defense, the American Association of Retired Persons and other appropriate organizations to encourage the development of dental plans for purchase by the retired population, individually or through groups.

Opposition to Fraudulent and Abusive Practices Under Public and Private Dental Benefits Programs (*Trans.*1990:537)

Resolved, that the American Dental Association opposes all forms of fraudulent activity by any party to a dental benefits plan, and be it further
Resolved, that the Council on Dental Benefit Programs, in conjunction with other appropriate Association agencies, work cooperatively with insurance industry organizations, government agencies and other appropriate national organizations to develop effective strategies for detection and discipline of fraudulent and abusive practices under publicly and privately funded dental benefits programs, and be it further
Resolved, that in this effort, attention be given to such practices engaged in by dental benefits administrators, patients and dentists.

Evaluation of Dental Care Programs (*Trans.*1989:548)

Resolved, that the American Dental Association recognizes the propriety of providing group dental care as a benefit of employment, and urges that the methods of financing and administering such programs be in keeping with the policies and principles of the Association, and be it further
Resolved, that the Association and its constituent and component societies maintain active communication with all groups interested in the development and operation of group programs for dental care, providing them with the Association's guidelines for dental benefit coverage.

Statement on Dental Benefit Plans (*Trans.*1988:481; 2013:316)

From their inception, dental benefit plans have had the support of the American Dental Association on the premise that they can increase the availability of dental care and consequently foster better oral health in the United States. Research confirms that utilization of dental services increases proportionately with the availability of dental benefits.

In the interest of assuring that the best level of dental care possible is available under dental benefit plans, the following guidelines are offered for reference in the establishment and growth of dental benefit plans.

Mechanisms for Third-Party Payment. The Association believes that the dental benefit programs administered by commercial insurance companies, dental service corporations, other service corporations and similar organizations offering dental plans are an effective means of assisting patients in obtaining dental care. Conventional dental benefit plans are usually structured in ways that encourage prevention. Health maintenance organizations have followed dentistry's example and represent a similar approach in their preventive orientation. Direct reimbursement dental plans reimburse patients based on dollars spent, rather than on category of treatment received, and provide maximum flexibility to their specific dental needs.

The Association also believes that if dental plans restricting patients' freedom of choice are offered to subscribers, a plan that offers free choice of dentist should be offered as an option. This approach should include periodic options to change plans and equal premium dollars per subscriber for each option.

Standards for Dental Benefit Plans. The Association urges all purchasers and third parties involved with dental benefit plans to review the "Standards for Dental Benefit Plans." These "Standards" have been developed to reflect the profession's views on all types of dental benefit plans and will be a useful benchmark in reviewing the many options that are available.

Dental Society Review Mechanisms. The Association urges patients, plan purchasers and third-party payers to make use of the peer review committees that have been established by the constituent dental societies. The

Association believes that it is important to use review mechanisms as established by organized dentistry, in order to obtain objective and impartial professional review. Third-party review is recognized as an important first step in the screening process for clarification and resolution of disputes which arise out of pretreatment or post-treatment review. However, it is not equivalent to, nor is it a substitute for, the constituent or component peer review process.

Statement on Areas Needing Improvement. The American Dental Association believes that dental benefit plans should include, but not be limited to, the following preventive services:

1. Topical fluoride applications for children and all at risk populations
2. Prophylaxis as indicated by a healthcare provider
3. Application of pit and fissure sealants as warranted
4. Space maintainers
5. Oral health risk assessments
6. Screening and education for oral cancer and other dental/medical related conditions
7. Oral hygiene instruction
8. Dietary consultation

Research has shown that substantial numbers of covered individuals do not utilize their dental benefit plans. The Association supports a dental benefit plan design which encourages utilization of diagnostic and preventive services, such as a plan that covers these services at 100%, without a deductible.

The Association and its constituent and component societies should maintain active communication with all groups and individuals interested in the development and operation of dental benefit plans. Because of this activity, a great deal of knowledge about all aspects of dental benefits has been acquired. The dental profession is eager to share this knowledge with all interested parties.

Standards for Dental Benefit Plans (*Trans.*1988:478; 1989:547; 1993:696; 2000:458; 2001:428; 2008:453; 2010:546)

1. Organized dentistry at all levels should be regularly consulted by third-party payers with respect to the development of dental benefit plans that best serve the interests of covered patients.
2. Joint efforts should be made by organized dentistry and third-party payers to promote oral health with emphasis on preventive treatment.
3. Plan purchasers should be informed that oral conditions change over time and, therefore, “maximum lifetime benefit” reimbursement restrictions should not be included in dental plans. Dental plans should be designed to meet the oral health needs of patients.
4. Patients should have freedom of choice of dentist and all legally qualified dentists should be eligible to render care for which benefits are provided.
5. Plans that restrict patients’ choice of dentists should not be the only plans offered to subscribers. In all instances where this type of plan is offered, patients should have the annual option to choose a plan that affords unrestricted choice of dentist, with comparable benefits and equal premium dollars.
6. The provisions and promotion of the program should be in accordance with the *Principles of Ethics* of the American Dental Association and the codes of ethics of the constituent and component societies involved.
7. The design of dental benefits plans differs from that of medical plans:

   - Dental disease does not heal without therapeutic intervention, so early treatment is the most efficient and least costly.
   - The need for dental care is universal and ongoing, rather than episodic.
   - The need for dental care is highly predictable and does not have the characteristics of an insurable risk.
   - The dental needs of individuals in an insured group vary considerably.
   - Patient cooperation and post-treatment maintenance is critical to the success of dental treatment and the prevention of subsequent disease.

   Therefore, the American Dental Association recommends that for preventive, diagnostic and emergency services, dental benefit plans should not contain deductibles or patient copayments, because they discourage patients from entering the system. Patient participation in the cost of complex care should be sufficient to motivate patients to adequately maintain their oral health.

   Rather than excluding categories of services, the Association believes that cost containment is best achieved by varying the patient participation in the costs of treatment and imposing annual limitations on benefits.
8. In order that the patient and dentist may be aware of the benefits provided by a dental benefit plan, the extent of any benefits available under the plan should be clearly defined, limitations or exclusions described, and the application of deductibles, copayments and coinsurance factors explained to the patients by the third-party payers and employers. This should be communicated in advance of treatment.

   The patient should also be reminded that he or she is fundamentally responsible to the dentist for the total payment of services received. In those instances where the plan makes partial payment directly to the dentist, the remaining portion for which the patient is responsible should be prominently

noted in the Explanation of Benefits Statement (EOB) provided to the patient.
9. Each dentist should have the right to determine whether to accept payment directly from a third-party payer.
10. Third-party payers should make use of dental society peer review mechanisms as the preferred method for the resolution of differences regarding the provision of professional services. Effective peer review of fee disputes, quality, and appropriateness of treatment should be made available by the dental profession.
11. Procedures for claims processing should be efficient and reimbursement should be prompt. The third-party payer should use or accept the American Dental Association's "ADA Dental Claim Form" and the *Code on Dental Procedures and Nomenclature* that the Council on Dental Benefit Programs has approved after appropriate consultation with representatives of nationally recognized dental benefit organizations and the ADA-recognized dental specialty organizations.
12. Dentists should comply with reasonable requests from third-party payers for information regarding services provided to patients covered under a plan.
13. Third-party payers' administrative procedures should be designed to enhance the dentist-patient relationship and avoid any interference with it.
14. When patient eligibility is certified through the predetermination process, the third-party payer shall be committed to reimburse on the basis of that initial certification within the provisions of that plan, unless and until written notification is provided in a timely manner to the dentist and the patient by the payer that change in eligibility status has occurred.
15. When such a change in eligibility occurs, a period of not less than 30 days should be allowed for continuation and, when possible, completion of treatment.
16. The treatment plan of the attending dentist, as agreed upon by the patient, shall remain the exclusive prerogative of the dentist and should not be unilaterally interfered with by third-party administrators or payers, or their consultants.
17. The American Dental Association opposes any abuse of the "Least Expensive, Professionally Acceptable Treatment" concept and will inform the public of the barrier such abuse represents to the attainment of quality dental care. When an insoluble dispute occurs between an attending dentist and third party regarding a treatment plan, peer review should be accepted by all parties involved as the mechanism for solution. Peer review should be entered into prior to the third-party payer's determination of reimbursable benefits in such cases.
18. A dental benefit plan should include the following procedures:

    A. *Diagnostic.* Provides the necessary procedures to assist the dentist in evaluating the conditions existing and the dental care required.
    B. *Preventive*. Provides the necessary procedures or techniques to assist in the prevention of dental abnormalities or disease.
    C. *Emergency Care*. Provides the necessary procedures for treatment of pain and/or injury. It should also cover the necessary emergency procedures for treatment to the teeth and supporting structures.
    D. *Restorative*. Provides the necessary procedures to restore the teeth.
    E. *Oral and Maxillofacial Surgery*. Provides the necessary procedures for extractions and other oral surgery including preoperative and postoperative care.
    F. *Endodontics*. Provides the necessary procedures for pulpal and root canal therapy.
    G. *Periodontics*. Provides the necessary procedures for treatment of the tissue supporting the teeth.
    H. *Prosthodontics*. Provides the necessary procedures associated with the construction, replacement, or repair of fixed prostheses, removable partial dentures, complete dentures and maxillofacial prostheses.
    I. *Orthodontics*. Provides the necessary treatment for the supervision, guidance and correction of developing and mature dentofacial structures.

19. The financial reserves of the plan should be adequate to assure continuity of the program.
20. Reimbursement schedules and claim documentation requirements should be based on procedures performed by the dentist and not on the specialty status of the dentist performing them.
21. The methodology used by plan administrators to set reimbursement schedules should rely on current, geographic and other relevant data and be readily available to patients, plan purchasers and dentists.
22. Profiling to establish a different rate of reimbursement for the provider should not be used as a means of cost control by the plan administrators.
23. The data, calculations and methodology used for practice profiling of individual dentists should be made available to those dentists upon request.
24. Information on the possibility of post-payment utilization review, and any consequences of same, must be provided to both participating and non-participating dentists.

Support for Individual Practice Associations (IPAs) (*Trans.*1988:475; 1994:655; 2000:458; 2013:305)

Resolved, that the American Dental Association provide information to members and plan purchasers about dental individual practice associations (IPAs) that includes legal and regulatory limitations on the uses of IPAs.

Education of Prospective Purchasers of Dental Benefit Programs (*Trans.*1986:515)

Resolved, that the Association engage in an aggressive program to educate prospective purchasers to the advantages of dental benefit programs that are compatible with private practice, fee-for-service dentistry and freedom of choice, and be it further
Resolved, that in this effort, promotion of the direct reimbursement model is preferable, but other models may be acceptable.

Direct Reimbursement Concept (*Trans.*1982:518)

Resolved, that the ADA recognizes that the direct reimbursement concept can be an efficient, economical and cost-effective method of reimbursing the patient for dental expenses, and be it further
Resolved, that the Council on Dental Benefit Programs continue to present the direct reimbursement concept to both the public and the business community.

Programs in Conflict With ADA Policies (*Trans.*1979:638)

Resolved, that the Association does not advocate programs that are in conflict with ADA policies.

Direct Reimbursement Mechanism (*Trans.*1978:510)

Resolved, that the Direct Reimbursement mechanism, a method of assistance in which beneficiaries are reimbursed by the employer or benefits administrator for any dental expenses, or a specified percentage thereof, upon presentation of a paid receipt or other evidence that such expenses were incurred, is a recognized dental benefits approach available to purchasers of dental assistance plans.

Government Reports on Payments to Dentists (*Trans.*1976:858; 2013:305)

Resolved, that government agencies issuing reports on reimbursements paid to dentists for services rendered under public programs be strongly urged to release such information in a clear context accompanied by such facts as:

- the number of dentists represented in the payment
- the number of patients cared for, and the fact that these payments are gross receipts from which the dentist(s) must pay all overhead costs

Dental Benefit Programs—Organization and Operations

Third-Party Payment Choices (*Trans.*2017:265)

Third-Party Payment Choices

The American Dental Association urges third-party payers to support a dentist's right to receive a traditional paper check in lieu of alternative payment methods as payment for services rendered to a beneficiary of a dental benefits program. The ADA opposes third-party payer payment methodologies that require a dentist to accept virtual credit card payments, electronic funds transfer (EFT) payments or any other payment options as the only payment option without an opportunity to choose a paper check.

Virtual credit cards may apply processing fees and these fees can be much higher than the fees agreed upon by the dentist when signing the original credit card agreement.

While EFT improves efficiency for the payers and may, in the long-term, be beneficial for dental practices, there are some dental offices that may incur problems due to their current patient management systems not being fully equipped to handle end-to-end electronic claims processing in particular bulk claim payments. Under current circumstances dentists are simply left with having to deal with bank charges levied to adopt EFT or paying to get upgraded to new software simply to handle EFT and electronic remittance advice (ERA) transactions seamlessly. This results in little to no improvement in practice efficiency.

In addition, the ADA believes dental claims should be reimbursed within fifteen (15) business days from receipt of the claim by the third-party payer.

Comprehensive ADA Policy Statement on Inappropriate or Intrusive Provisions and Practices by Third Party Payers (*Trans.*2016:290; 2017:266)

The American Dental Association opposes interference in the treatment decisions made between doctor and patient. Plans which contain inappropriate and intrusive provisions substitute business decisions for treatment decisions made through a patient-doctor dialogue. Such provisions and practices deny patients their purchased benefits and robs them of their rights as informed consumers of healthcare.

Plans which contain provisions, such as those listed below, should disclose them to the plan purchasers and to patients. Dentists should be made aware of these practices when offered a contract.

The ADA is of the opinion that a list of practices by third-party payers that are inappropriate or intrusive and interfere with the doctor-patient relationship includes but is not limited to the following:

Bad Faith Practices: Not treating a beneficiary of a dental benefit plan fairly and in good faith; or a practice which impairs the right of a beneficiary to either receive the appropriate benefit of a dental benefits plan, or to receive the benefit in a timely manner.

Some examples of potential bad faith practices include, but are not limited to:

1. failure to properly investigate the information in a submitted claim
2. unreasonably and purposely delaying or withholding payment of a claim
3. withholding funds from bulk benefit payments for services rendered to unrelated patients as a means of settling disputes over prior claims experienced with the dentist either from an alleged past overpayment by the plan or retroactive ineligibility of benefits for a patient

Inappropriate Fee Discounting Practices: Requiring a dentist, who does not have a participating provider agreement, to accept discounted fees or be bound by the terms and conditions set forth in the participating provider contracts signed by other dentists.

Some examples of inappropriate fee discounting practices include, but are not limited to:

1. issuing reimbursement checks which, upon signing, result in the dentist accepting the amount as payment in full
2. using claim forms which, upon signing, require the dentist to accept the terms of the plan's contract
3. issuing documentation that states the submittal of a claim by a dentist means that he or she accepts all terms and conditions set forth in the participating provider contract
4. sending communications to patients of nonparticipating dentists which state the patient is not responsible for any amount above the maximum plan benefit

Lowering Patient Benefits and Claims Payment Abuse: Intentionally lowering the benefit to the beneficiary and/or lowering the allowable amount to the dentist negating the code for the actual services performed by the dentist. These practices, coupled with contractual clauses that require the dentist to accept the plan payment as payment in full, compound the problem.

Some examples of claims payment abuse include, but are not limited to:

1. **Downcoding:** using a procedure code different from the one submitted in order to determine a benefit in an amount less than that which would be allowed for the submitted code
2. **Bundling of Procedures:** the systematic combining of procedures resulting in a reduced benefit for the patient/beneficiary
3. **Limiting Benefits for Non-Covered Services:** mandating a discounted fee for procedures for which the plan pays no benefit
4. **Least Expensive Alternative Treatment Clauses:** contractual language that allows a plan to only pay for the least expensive treatment if there is more than one way to treat a condition
5. **Most Favored Nation Clauses:** contractual language that requires a dentist to give the beneficiaries of a dental plan the same lower fee that the dentist may have charged another patient

Disallowed Clauses: Contractual language that prohibits a dentist from charging a patient for a covered procedure not paid for by the benefit plan.

Some examples of disallowed procedures include, but are not limited to:

1. direct and indirect pulp caps when provided in conjunction with the final restoration or sedative filling for the same tooth
2. frequency limitations such as sealants, which are repaired or replaced by the same dentist within two years of initial placement
3. surgical procedures to multiple sites when performed on the same day of service

Using Non-Dentist Personnel for Adjudication of Benefit: A practice where a non-dentist determines the medical necessity for benefit adjudication. Any determination of medical necessity for the purposes of benefit adjudication should only be made by a dentist licensed in the state in which the procedures are being performed.

Restricting Dialogue between Dentists and Patients or Public Agencies: Contractual language that restricts dentists from fulfilling their legal and ethical duties to appropriately discuss with patients, other health care providers, 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 dentist.

Automatic Assignment of Participating Dentist Agreements: Contractual language which allows PPO leasing companies and third-party payers to obligate the dentist to participate in any other third party payer or managed care network without full disclosure of fees, processing policies and written consent from the dentist. This is typically accomplished by selling or providing the discount rate information to any other third-party payers and/or other managed care networks.

Non-Disclosure of fee schedules and processing policies prior to contracting: Requiring a dentist to evaluate a contract with a carrier without full disclosure of the fee-schedules and processing policies as it applies to all plans administered by the carrier.

Statement on Dental Consultants (*Trans.*2010:555)

Resolved, that the following Statement on Dental Consultants be adopted.

Statement on Dental Consultants

Third-party payers and plan purchasers have used dental consultants in order to streamline the claims review process for many years.

The American Dental Association initially saw a positive potential in the use of dental consultants by third-party payers as a means of receiving professional advice on certain aspects of dental benefits plans. While the ADA still believes that there is value to third-party payers' use of dental consultants, it also believes that some clear distinctions must be made between dental consultants and dental claims reviewers.

Dental claims reviewers work under supervision. They do not necessarily have, or need, clinical dental or dental practice background, and are trained specifically by the third-party payer to review dental claims that are uncomplicated and require straightforward processing.

Dental consultants are licensed dentists who, even if not currently practicing, have many years of experience in practice and can and should:

- Offer a professional opinion regarding complicated dental treatment
- Provide their name, degree, license number and direct phone number to the treating dental office
- Request consultations from specialists for certain specialty-related cases, when necessary
- Provide advice to third-party payers regarding the merit and value of dental benefits plan designs
- Educate plan purchasers regarding the impact

alternative, less costly treatment may have on the life of a tooth, overall oral health, etc.
- Alert third-party payers when dentists' treatment patterns are changed by cost containment strategies to the detriment of the patients
- Provide guidance to third-party payers regarding the importance of the dentist/patient relationship
- Inform third-party payers, plan sponsors and subscribers about the availability and value of the profession's peer review system
- Initiate dialogue with organized dentistry regarding questionable treatment modalities
- Inform the dental profession of those treatment procedures on which questions of judgment between the dentist and the dental consultant are most likely to result in areas of disagreement
- Discuss treatment decisions with dentists on a professional level
- Explain clearly to practicing dentists the provisions of particular contracts and the benefit limitations of those contracts
- Demonstrate knowledge of contract interpretation, and laws and regulations governing dental practice in those jurisdictions affected by their consulting activities, as well as accepted standards of administrative procedure within the dental benefits industry
- Dentists reviewing claims submissions must be licensed in the United States, preferably within the jurisdiction of the dentist treating the patient in accordance with applicable state law

Dentists have a fundamental obligation to serve the best interests of the public and their profession. This obligation can never be abrogated for any reason. In order to maintain independent thought and judgment regarding dental matters, dental consultants should be competent with regard to current clinical procedures and practice through such mechanisms as continuing education, or have been in practice for a minimum of ten years immediately preceding employment as a dental consultant, and remain involved in the continuing dental education process in order to stay current with clinical procedures and changing technology.

It is strongly recommended that dental consultants be members of the American Dental Association.

and be it further
Resolved, that the American Dental Association distribute copies of this Statement to all third-party payers, and be it further
Resolved, that third-party payers, including dental consultants to payers, should not exceed their legitimate role in the processing of dental benefit claims, and specifically, third-party payers and dental consultants should not:

- Change code numbers as submitted without written permission of the attending dentist
- Redefine code numbers, nomenclatures or descriptors except as provided for in their CDT license agreements
- Disapprove complex cases without seeking the advice of appropriately trained consultants

and be it further
Resolved, that the ADA urge third-party payers and administrators to identify dental consultants by name in any correspondence to attending dentists.

Use of DEA Numbers for Identification (*Trans.*2000:454; 2013:306)

Resolved, that the ADA agrees with the Drug Enforcement Administration (DEA) that the DEA number is to be used solely for purposes of prescribing controlled substances.

Payment for Temporary Procedures (*Trans.*1999:922)

Resolved, that provisional or interim restorations and prostheses are valid treatment modalities that should be reimbursable, and be it further
Resolved, that the American Dental Association urge third-party payers to accept this policy.

Limitations in Benefits by Dental Insurance Companies (*Trans.*1997:680; 2011:453)

Resolved, that, since the term "usual, customary and reasonable" is often misunderstood by patients and tends to raise distrust of the dentist in the patient's mind by suggesting the dentist's fees are excessive, the American Dental Association urges all third-party payers employing this terminology to substitute the term "maximum plan benefit" in all patient communications and explanations of benefits, and be it further
Resolved, that appropriate agencies of the American Dental Association and constituent dental societies urge purchasers of dental benefit plans to eliminate pre-existing condition clauses from their contracts, and be it further
Resolved, that appropriate agencies of the American Dental Association urge purchasers of dental benefit plans to increase yearly maximum benefits to be consistent with cost-of-living increases, and be it further
Resolved, that appropriate agencies of the American Dental Association notify all providers of dental benefits of these new policies, and be it further
Resolved, that the American Dental Association seek legislation and/or regulations to accomplish these goals, and be it further
Resolved, that constituent dental societies be urged to seek legislation or regulation in their individual states to accomplish these same requirements.

Guidelines on Capture and Use of Diagnostic Images by Dentists, and by Third-Party Payers or Administrators of Dental Benefit Programs (*Trans.*1995:617; 2007:419; 2016:284)

Resolved, that the following guidelines pertain to dentists:

1. Dentists should refer to the joint ADA/FDA publication titled DENTAL RADIOGRAPHIC EXAMINATIONS: RECOMMENDATIONS FOR PATIENT SELECTION AND LIMITING RADIATION EXPOSURE, or its successors, for assistance in determining clinical necessity for such diagnostic imaging.
2. If a third party requests an image which was not generated as part of the dentist's clinical treatment, dentists should consider the clinical necessity of the image in connection with the request.
3. When a dentist determines that it is appropriate to comply with a third-party payer's request for images, submit a duplicate set and retain the originals.
4. Postoperative images should be required only as part of dental treatment.
5. Images must be correctly identified and be of diagnostic quality.
6. Images are an integral part of the dentist's clinical records and are considered the dentist's property, consistent with state law.
7. The confidentiality of images and all other patient record content must be maintained in accordance with applicable HIPAA and state privacy and security regulations.
8. Additional costs incurred by the dentist in copying images and clinical records for claims determination that are not reimbursed by the third-party payer may be billed to the patient.

and be it further

Resolved, that the following guidelines pertain to third-party payers and dental benefit plan administrators:

1. Payers and administrators should refer to the joint ADA/FDA publication titled DENTAL RADIOGRAPHIC EXAMINATIONS: RECOMMENDATIONS FOR PATIENT SELECTION AND LIMITING RADIATION EXPOSURE, or its successors, for assistance in determining their necessity for such diagnostic imaging. Third-party payers should not request that images be generated solely for administrative purposes.
2. All images, including duplicates, except those submitted in digital or other electronic form, and whether or not it has been requested, should be returned to the dentist.
3. It is improper for third-party payers to deny authorization for payment or make determinations about treatment based solely on images.
4. Third-party payers should not use images to infringe upon the professional judgment of the treating dentist or to interfere in any way with the dentist-patient relationship. All questions of interpretation of images must be reviewed by a dentist consultant.
5. Clinical images should only be requested when they will be reviewed by a dentist to make a determination regarding the patient's entitlement to benefits. Dentists reviewing images for this purpose should be licensed in the U.S., preferably within the jurisdiction of the dentist providing the images in accordance with applicable state law.
6. Patients should be exposed to radiation only when clinically necessary, as determined by the treating dentist. Postoperative images should be required only as part of dental treatment.
7. Third-party payers must protect all images submitted by dental offices in accordance with applicable HIPAA and state privacy and security regulations.
8. All images submitted to third-party payers should be returned to the treating dentist within fifteen (15) working days. Images received in an electronic form should be permanently deleted within 30 days of the completion of claims adjudication.
9. Where a claim or predetermination request indicates that images are provided, the third-party payer should immediately notify the submitting dentist's office if the images are missing.
10. A patient's predetermination request or claim should not be prejudiced by the third-party payer's loss or misplacement of images.
11. As it is necessary for a dentist to maintain accurate and complete records, third-party payers should accept copies of images in lieu of originals.
12. Any additional costs incurred by the dentist in copying images and clinical records for claims determination should be reimbursed by the third-party payer.

Explanation of Benefits (EOB) Statement and Identification of Claims Reviewers (*Trans.*1995:610; 2015:243)

Resolved, that in all communications from a third-party payer or other benefits administrator which attempt to explain the reason(s) for a benefit reduction or denial to beneficiaries of a dental benefits plan, the following statement be included:

> Any difference between the fee charged and the benefit paid is due to limitations in your dental benefits contract. Please refer to (*insert pertinent provisions of summary plan description*) of your summary plan description for an explanation of the specific policy provisions which limit or exclude coverage for the claim submitted.

and be it further

Resolved, that in reporting the benefit determination to the beneficiary, the following information be reported on the explanation of benefits statement:

1. the treatment reported on the claim by CDT codes as submitted by the dentist; and
2. a statement indicating how the submitted procedures were adjudicated.

and be it further
Resolved, that if EOB statements list CDT codes on which benefits were determined that are different from what was submitted by the treating dentist then payers should not use the code applied for adjudication to limit the frequency of that procedure, and be it further
Resolved, that in all correspondence between a third-party carrier and the patient regarding the patient's dental claims, the carrier should provide the name, area code and telephone number of the individual who is acting on behalf of the carrier, and be it further
Resolved, that the Council on Dental Benefit Programs work with third-party payers, plan purchasers, benefits consultants, and government agencies to implement this policy.

Eligibility and Payment Dates for Endodontic Treatment (*Trans.*1994:674)

Resolved, that the American Dental Association, through its Council on Dental Benefit Programs, encourages all third-party payers to recognize the date that endodontic therapy is begun as the eligibility date for coverage for endodontic therapy, and be it further
Resolved, that the Association, through its Council on Dental Benefit Programs, encourages all third-party payers to recognize the completion date as the date of service, that is, the payment date, for endodontic therapy.

Authorization of Benefits (*Trans.*1994:665; 2013:306; 2017:264)

Resolved, that the American Dental Association supports the right of each dentist to accept or reject assignment of benefits from any dental benefits plan, and be it further
Resolved, that the Association supports the right of every patient to assign his or her benefits to the treating dentist and to have the assignment honored by the third-party payer, and be it further
Resolved, that when a third-party payer submits payment directly to the patient, contrary to the patient's authorized preference, the dentist has the right to request payment directly from the patient. If the patient declines, then it is the third-party payer's responsibility to submit the correct payment to the dentist within fifteen (15) days of being notified of the incorrect payment, and to submit the payment to the dentist whether or not the third-party payer has received reimbursement from the patient, and be it further
Resolved, that in those states where dentists are not notified of the rescission of a prior assignment of benefits, the Association encourage state dental societies to seek legislative relief.

Benefits for Incomplete Dental Treatment (*Trans.*1994:655)

Resolved, that the Association work with plan purchasers and third-party payers to see that dental plans should provide appropriate benefits for incomplete dental treatment as a result of a patient discontinuing treatment for any reason.

Extending Dental Plan Coverage to Dependents of Beneficiaries (*Trans.*1993:694)

Resolved, that dental plan purchasers be encouraged to extend coverage to the dependents of beneficiaries, and be it further
Resolved, that the term "dependent" include spouse, children, and other members of the household who are financially dependent on the beneficiary as defined by the Internal Revenue Service (IRS).

Plan Coverage for Treatment of Teeth Needing Restoration Due to Attrition, Wear and Abrasion (*Trans.*1993:693)

Resolved, that dental benefit plans should provide coverage for restoration of teeth that have structural loss due to attrition, abrasion and/or erosion.

Appropriate Use of Dental Benefits by Patients and Third-Party Payers (*Trans.*1993:688)

Resolved, that the American Dental Association supports the appropriate use of dental benefits by patients and third-party payers, and be it further
Resolved, that in order for patients to receive the benefits to which they are entitled, the ADA opposes the practice by third-party payers of reclassifying treatment in such a way as to reduce or limit the patient's rightful dental benefit coverage.

Statement on Preventive Coverage in Dental Benefits Plans (*Trans.*1992:602; 1994:656; 2013:306; 2018:312)

Resolved, that preventive dentistry refers to the procedures in dental practice and health programs which aid in the prevention of oral diseases, and be it further
Resolved, that the American Dental Association recognizes the importance of implementing preventive oral health practices as an effective means of promoting optimal oral health to all individuals, and be it further
Resolved, that the ADA urges that all dental benefit plans include the following procedures as covered services for all patients unless otherwise indicated:

- prophylaxis;
- topical fluoride applications;
- application of pit and fissure sealants and reapplication as necessary;
- interim caries arresting medicament application (e.g. silver diamine fluoride);
- space maintainers at appropriate developmental stages;
- oral health risk assessments;
- screening and education for oral cancer and other dental/medical related conditions;
- preventive resin restorations;
- resin infiltrations;
- fixed and removable appliances to prevent malocclusion;
- athletic mouth guards;
- prescription or use of supplemental dietary or topical fluoride for home use; and
- in-office patient education, (i.e. oral hygiene instruction, dietary counseling and tobacco cessation counseling with regard to the promotion of good oral and overall health).

and be it further
Resolved, that the Council on Dental Benefit Programs continue to recommend to third-party payers, service plans, prospective purchasers and policyholders that contract limitations on frequency of providing benefits allow for coverage of preventive services at least "twice in a calendar (or contract) year" and more frequently if risk factors are identified that warrant increased frequency.

Preauthorization of Benefits (*Trans.*1992:597)

Resolved, that the American Dental Association is opposed to any dental benefit clause that would deny or reduce payment to the beneficiary, to which he or she is normally entitled, solely on the basis of lack of preauthorization.

Qualifications of Participating Dentists (*Trans.*1991:639)

Resolved, that the American Dental Association supports the position that all dentists licensed in their state shall be eligible to participate in all public and private third-party programs.

Age of "Child" (*Trans.*1991:635; 2013:307)

Resolved, that when dental plans differentiate coverage of specific procedures based on the child or adult status of the patient, this determination be based on the clinical development of the patient's dentition, and be it further
Resolved, that for the sole purpose of eligibility for coverage, chronological age of at least 21 be used to determine enrollment status.

Dental Benefit Plan Terminology (*Trans.*1991:634; 2012:440)

Resolved, that all parties involved with dental benefits be encouraged to use dental benefit plan terminology consistent with definitions included in the current edition of the Glossary of Dental Clinical and Administrative Terms on ADA.org, and be it further
Resolved, that the American Dental Association support continued development and use of consistent and accurate terms relating to dental benefits.

Inclusion of Radiographic Examinations in Dental Benefits Programs (*Trans.*1991:634)

Resolved, that in working with plan purchasers, health benefits consultants and third-party payers, the American Dental Association stress the importance of including, as part of a comprehensive dental benefits program, radiographic examinations in patient diagnosis and treatment when indicated, as determined by the treating dentist.

Pre-Existing Condition Exclusion (*Trans.*1991:634)

Resolved, that the American Dental Association, along with its constituent and component societies, urge inclusion of coverage in all dental benefits plans for pre-existing conditions which would otherwise be covered, including replacement of missing teeth, and to provide coverage for the continuation of treatment plans already in progress when the patient first becomes enrolled in the plan.

ADA's Dental Claim Form (*Trans.*1991:633; 2001:428; 2013:307)

Resolved, that the Council on Dental Benefit Programs, with the approval of the Board of Trustees, have the authority to evaluate and effect all changes to the American Dental Association's Dental Claim Form in consultation with the ADA recognized specialty organizations as well as the dental benefits and electronic data interchange industries, and be it further
Resolved, that the constituent dental societies be encouraged to work with third-party payers to take whatever steps are necessary to influence dentists and third parties in their respective states to use and accept the most current Dental Claim Form.

Audits of Private Dental Offices by Third-Party Payers (*Trans.*1990:540; 2005:325)

Resolved, that where the dentist is under no direct contractual obligation with a third-party payer, the decision to comply with requests for in-office audits should be made independently by the individual dentist

after consulting with his or her attorney for a determination of the legal implications of such decision, and be it further
Resolved, that in those instances where the dentist has expressly agreed in a contract to comply with office audit procedures, and in the event of an audit, the dentist is encouraged to obtain a written description and scope of the audit procedures and should seek the advice of his or her legal counsel, in order to be informed of his or her rights and potential liabilities regarding such audit, and be it further
Resolved, that dentists should consider their potential legal liability under applicable state and federal privacy laws in consultation with their attorneys when negotiating contracts that oblige them to allow third-party payer audits of the practices

Bulk Benefit Payment Statements (*Trans.*1990:536; 2013:308; 2015:243)

Resolved, that the ADA goes on record as being opposed to bulk payments by a third-party payer. In the interest of facilitating prompt settlement of patients' accounts, bulk benefit payments may be made by a third-party but should include a statement containing, at a minimum, the following information for each claim payment represented in the bulk payment:

1. Subscriber (employee) name;
2. Patient name;
3. Dates of service;
4. Specific service reported on the submitted claim, by *CDT Code* number and nomenclature;
5. Total fee charged;
6. Statement indicating how the submitted procedures were adjudicated;
7. Total covered expense;
8. Total benefits paid;
9. In instances where benefits are reduced or denied, an explanation of the reason(s) why the total covered expense differs from the total fee charged, consistent with Association policy on Explanation of Benefits Statements; and
10. If the bulk payment amount on the EOB reflects the final amount paid to the dentist, taking into account any secondary plan payment, then the individual claim amounts should also be adjusted appropriately to avoid discrepancy between the individual claim amounts listed on the EOB and the bulk payment amount.

and be it further
Resolved, that third party payers should not withhold funds from current bulk benefit payments as a means of settling disputes over prior claims experience with the dentist or another dental office and that state dental societies be encouraged to seek legislation to resolve this problem, and be it further
Resolved, that bulk payments should be issued to dentists at intervals of not longer than every ten business days, and be it further
Resolved, that the Council on Dental Benefit Programs work with the insurance industry and third party payers to incorporate this policy into their administrative procedures.

Coverage for Treatment of Temporomandibular Joint Dysfunction (*Trans.*1989:549)

Resolved, that the American Dental Association encourage all third-party payers to offer benefit coverage for diagnosis and treatment of bone and joint disorders without discrimination, and be it further
Resolved, that the ADA strongly recommends that all third-party payers coordinate the coverage between medical and dental plans to eliminate any disparity in benefits coverage and reimbursement for such disorders, and be it further
Resolved, that the ADA strongly encourages constituent dental societies to seek legislation and/or a ruling from the state insurance commissioner that health benefit plans offer coverage for diagnosis and treatment for bone or joint disorders without discrimination.

Payment for Prosthodontic Treatment (*Trans.*1989:547)

Resolved, that the Council on Dental Benefit Programs encourages all third-party payers to recognize the preparation date as the date of service, that is, payment date, for fixed prosthodontic treatment, and be it further
Resolved, that the Council on Dental Benefit Programs encourages all third-party payers to recognize the final impression date as the date of service, that is, payment date, for removable prosthodontic treatment.

Benefits for Services by Qualified Practitioners (*Trans.*1989:546)

Resolved, that beneficiaries of a health benefits plan are entitled to benefits for covered treatment if that treatment is provided by a legally qualified dentist or physician operating within the scope of his or her training and licensure, and be it further
Resolved, that benefits that would otherwise be payable should not be denied solely on the basis of the professional degree and licensure of the dentist or physician providing treatment, if that treatment is provided by a legally qualified dentist or physician operating within the scope of his or her training and licensure, and be it further
Resolved, that in those states that do not have such a law, constituent dental societies be urged to seek legislation that would prohibit discrimination in benefit payments based on the professional degree and

licensure of the dentist or physician providing treatment, and be it further
Resolved, that all constituent dental societies be encouraged to monitor the way in which these laws are enforced in their states, and to bring to the attention of the state legislatures and the public any efforts that are clearly too inadequate to succeed.

Medically Necessary Care (*Trans.*1988:474; 1996:686; 2014:451)

Resolved, that the American Dental Association advocate on behalf of patients to ensure the language specifying treatment coverage in health insurance plans is clarified so that medically necessary care, essential to the successful treatment of a medical or dental condition being treated by a multidisciplinary health care team, is available to the patient, and be it further
Resolved, that third-party payers and their consultants should only make benefit determinations based on medical necessity if they have the complete information required for a definitive diagnosis.

Equitable Dental Benefits for Relatives of Dentists (*Trans.*1987:502)

Resolved, that group benefit plan contracts should not contain exclusions for reimbursement for treatment based on the familial relationship of the treating dentist and the beneficiary, and be it further
Resolved, that such existing exclusions be deleted from all dental benefit plan contracts as they are renewed, and be it further
Resolved, that carriers, service corporations, other third-party payers and state insurance regulatory agencies be informed of this policy.

Identification of Claims Reviewer (*Trans.*1985:584)

Resolved, that in all correspondence between a third-party carrier and a dentist regarding a patient or a claim, the carrier should provide the name of a specific individual with whom to make contact in reference to that claim, and be it further
Resolved, that the patient's full name, the claim number and a toll-free telephone number should also be provided.

Frequency of Benefits (*Trans.*1983:548)

Resolved, that the Council on Dental Benefit Programs continue to recommend to insurance firms, service plans, prospective purchasers and policyholders that, where considered necessary and appropriate, contract limitations on frequency of providing benefits for certain services be stated as "twice in a calendar (or contract) year" rather than "once in every six months."

Third-Party Acceptance of Descriptive Information on Dental Claim Form (*Trans.*1978:507; 2013:308)

Resolved, that the descriptive narrative included on a claim submission when the *CDT Code* nomenclature includes "…by report" in its nomenclature, be given professionally appropriate consideration during adjudication by third-party payers, and be it further
Resolved, that any descriptive narrative voluntarily submitted by the dentist to assist in benefit determination should be considered during claim adjudication by the third-party payer.

Charge for Administrative Costs (*Trans.*1974:656; 1989:553; 2013:308)

Resolved, that when costs are incurred by dental providers for non-clinical services, separate fees may be charged for such services.

Radiographs in Diagnosis (*Trans.*1974:653)

Resolved, that the House of Delegates reconfirms that a diagnosis and treatment plan cannot be made from radiographs alone. Benefits shall not be determined solely on the basis of radiographic evidence.

Limitation of Payments to Specialty Groups (*Trans.*1965:63, 353)

The American Dental Association opposes the limitation of payments under prepaid dental care programs to those "qualified" in a particular specialty of dentistry for the following reasons:

1. The patient's right to freedom of choice in the selection of a dentist should not be abridged.
2. The licensed dentist is permitted to perform all operations and provide all services prescribed in the state dental practice act.
3. The patient should have access, when desired, to any practitioner in any field of dental practice.
4. Dentists have the professional competence to make patient referrals when necessary.

Dental Care and Dental Health

Direct to Consumer Dental Laboratory Services (*Trans.*2018:304)

Resolved, that the ADA strongly discourages the practice of direct to the consumer dental laboratory services because of the potential for irreversible harm to patients.

Do-It-Yourself Teeth Straightening (*Trans.*2017:266)

Resolved, that for the health and well-being of the public, the American Dental Association believes that supervision by a licensed dentist is necessary for all phases of orthodontic treatment including:

- oral examination
- periodontal examination
- radiographic examination
- study models or scans of the mouth
- treatment planning and prescriptions
- periodic progress assessments and
- final assessment with stabilizing measures

and be it further

Resolved, that the ADA strongly discourages the practice of do-it-yourself orthodontics because of the potential for harm to patients.

Policy Statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders (*Trans.*2017:269; 2019:XXX)

Sleep related breathing disorders (SRBD) are disorders characterized by disruptions in normal breathing patterns. SRBDs are potentially serious medical conditions caused by anatomical airway collapse and altered respiratory control mechanisms. Common SRBDs include snoring, upper airway resistance syndrome (UARS) and obstructive sleep apnea (OSA). OSA has been associated with metabolic, cardiovascular, respiratory, dental and other diseases. In children, undiagnosed and/or untreated OSA can be associated with cardiovascular problems, impaired growth as well as learning and behavioral problems.

Dentists can and do play an essential role in the multidisciplinary care of patients with certain sleep related breathing disorders and are well positioned to identify patients at greater risk of SRBD. SRBD can be caused by a number of multifactorial medical issues and are therefore best treated through a collaborative model. Working in conjunction with our colleagues in medicine, dentists have various methods of mitigating these disorders. In children, the dentist's recognition of suboptimal early craniofacial growth and development or other risk factors may lead to medical referral or orthodontic/orthopedic intervention to treat and/or prevent SRBD. Various surgical modalities exist to treat SRBD. Oral appliances, specifically custom-made, titratable devices can improve SRBD in adult patients compared to no therapy or placebo devices. Oral appliance therapy (OAT) can improve OSA in adult patients, especially those who are intolerant of continuous positive airway pressure (CPAP). Dentists are the only health care provider with the knowledge and expertise to provide OAT.

The dentist's role in the treatment of SRBD includes the following:

- Dentists are encouraged to screen patients for SRBD as part of a comprehensive medical and dental history to recognize symptoms such as daytime sleepiness, choking, snoring or witnessed apneas and an evaluation for risk factors such as obesity, retrognathia, or hypertension. If risk for SRBD is determined, these patients should be referred, as needed, to the appropriate physicians for proper diagnosis.
- In children, screening through history and clinical examination may identify signs and symptoms of deficient growth and development, or other risk factors that may lead to airway issues. If risk for SRBD is determined, intervention through medical/dental referral or evidenced based treatment may be appropriate to help treat the SRBD and/or develop an optimal physiologic airway and breathing pattern.
- Oral appliance therapy is an appropriate treatment for mild and moderate sleep apnea, and for severe sleep apnea when a CPAP is not tolerated by the patient.
- When a physician diagnoses obstructive sleep apnea in a patient and the treatment with oral appliance therapy is recommended through written or electronic referral, a dentist should evaluate the patient for the appropriateness of fabricating a suitable oral appliance. If deemed appropriate, a dentist should fabricate an oral appliance, monitor its effectiveness and titrate the appliance as necessary**.**
- Dentists should obtain appropriate patient consent for treatment that reviews the proposed treatment plan, all available options and any potential side effects of using OAT and expected appliance longevity.
- Dentists treating SRBD with OAT should be capable of recognizing and managing the potential side effects through treatment or proper referral.

- Dentists who provide OAT to patients should monitor and adjust the Oral Appliance (OA) for treatment efficacy as needed, or at least annually. As titration of OAs has been shown to affect the final treatment outcome and overall OA success, the use of unattended cardiorespiratory (Type 3) or (Type 4) portable monitors may be used by the dentist to help define the optimal target position of the mandible. A dentist trained in the use of these portable monitoring devices may assess the objective interim results for the purposes of OA titration.
- Surgical procedures may be considered as a secondary treatment for OSA when CPAP or OAT is inadequate or not tolerated. In selected cases, such as patients with concomitant dentofacial deformities, surgical intervention may be considered as a primary treatment.
- Dentists treating SRBD should continually update their knowledge and training of dental sleep medicine with related continuing education.
- Dentists should maintain regular communications with the patient's referring physician and other healthcare providers to the patient's treatment progress and any recommended follow-up treatment.
- Follow-up sleep testing by a physician should be conducted to evaluate the improvement or confirm treatment efficacy for the OSA, especially if the patient develops recurring OSA relevant symptoms or comorbidities.

Medical (Dental) Loss Ratio (*Trans.*2015:244; 2019:XXX)

Resolved, that the ADA supports the concept of a "Medical Loss Ratio" for dental plans defined as the proportion of premium revenues that is spent on clinical services, and be it further
Resolved, that dental plans, both for profit and nonprofit should be required to make information available to the general public and to publicize in their marketing materials to plan purchasers and in written communications to their beneficiaries the percentage of premiums that fund treatment and the percentage of premiums that go to administrative costs, promotion, marketing and profit, or in the case of nonprofit entities, reserves, and be it further
Resolved, that the ADA support legislative efforts to require dental benefit plans to file a comprehensive MLR report annually and to establish a specific loss ratio for dental plans in each state and ERISA benefit plans.

ADA Policy on Tooth Whitening Administered by Non-Dentists (*Trans.*2008:477)

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

Update on Dental Tourism (*Trans.*2008:454)

Resolved, that the following definition of dental tourism be adopted:

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

and be it further
Resolved, that the appropriate agencies of the ADA continue to promote the importance of a dental home while working for increased affordable access to dental care and freedom of choice so that every American who needs dental care can receive it, and be it further
Resolved, that the appropriate agencies of the ADA establish a repository of information relevant to dental tourism, that the information be collected in a manner that protects patient confidentiality and that the information is used in a lawful manner, and be it further
Resolved, that the appropriate agencies of the ADA increase efforts to provide patients, insurance companies and plan purchasers with credible information and resources about quality dental care, including follow-up, delivered by professionals with accredited education, and be it further
Resolved, that in keeping with the ADA position on freedom of choice, patients seeking dental care outside of the U.S. should do so voluntarily, and that prior to travel, be urged to arrange for local follow-up care to ensure continuity of care upon return to the U.S., and be it further
Resolved, that patients who have insurance coverage for dental care performed outside the U.S. should confirm with their insurer and/or employer that follow-up treatment is covered upon return to the U.S., and be it further
Resolved, that patients choosing to travel outside the

U.S. for dental care should seek information about the potential risks of combining certain procedures with long flights and vacation activities, and be it further
Resolved, that the transfer of patient records to-and-from facilities outside the U.S. should be consistent with current U.S. privacy and security guidelines.

Patient Safety and Quality of Care (*Trans.*2005:321)

Resolved, that it is the ADA's position that health care should be:

- *safe*—avoiding injuries to patients from the care that is intended to help them
- *effective*—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively)
- *patient-centered*—providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions
- *timely*—reducing waits and sometimes harmful delays for both those who receive and those who give care
- *efficient*—avoiding waste, including waste of equipment, supplies, ideas and energy
- *equitable*—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status

Responsibility for the Oral Health of Patients (*Trans.*2004:334)

Resolved, that a dentist must have the primary responsibility for the oral health care of each patient, regardless of the provision of some preventive or education services by non-dentists.

Quality Health Care (*Trans.*1995:609; 2013:311)

Oral health care is an integral component of health care. The Association promotes the public's oral health through commitment of member dentists to provide quality dental care.

Quality of care is the degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Institute of Medicine).

Quality oral health care is characterized by the effective integration of multiple components of care consisting of prevention, acceptable treatment modalities, access, availability, utilization, patient management, patient autonomy, practice management, dental ethics and professionalism.

Quality oral health care is only possible when treatment decisions and planning are determined by the dentist and the patient, based on the patient's oral health needs and health status.

Any entity which seeks to participate in the managed dental benefit marketplace should be required by federal and state legislation to design and fund managed care dental plans that emphasize the value and importance of prevention, utilization, access, availability, cost effectiveness, acceptable treatment modalities, specialist referrals, the profession's peer review system and an efficient administrative process.

Certification or Approval of Dental Care Facilities (*Trans.*1993:689)

Resolved, that the American Dental Association oppose the concept of "certification" or "approval" of dental care facilities above and beyond legal requisites of state dental licensure as a prerequisite for providing dental care or for reimbursement for providing dental care.

Dental Care in Institutional and Homebound Settings (*Trans.*1986:518; 2013:341)

Resolved, that appropriate agencies of the American Dental Association work with national organizations involved with care for the aged, blind and disabled in homebound or longer term care facilities in formulating policies that will assure delivery of comprehensive dental care, and be it further
Resolved, that constituent and component dental societies be urged to work with health care facility administrators, dental and medical directors and other responsible parties to assure that any underserved populations are receiving comprehensive dental care under the supervision of a licensed dentist.

Health Planning Guidelines (*Trans.*1983:545; 2014:503)

Resolved, that the following health planning guidelines be adopted:

1. The Association supports a voluntary system of cooperative health planning at the state and local level.
2. Health planning should be directed at locally determined efforts to improve access to health care and avoid duplication of effort to maximize limited resources.
3. Dentists should have equal input along with other health care providers.
4. Public and private sector financing for health planning should have adequate appropriations designated to accomplish the stated objectives.

Dental Education

Federal Student Loan Programs (*Trans.*2019:XXX)

Resolved, that the American Dental Association supports the federal graduate and professional degree student loan programs authorized under the Higher Education Act of 1965, with an emphasis on:

1. Protecting access to federal Direct Unsubsidized Stafford Loans (Direct Loans) and Grad PLUS loans for graduate and professional degree students.
2. Reinstating eligibility for graduate and professional degree students to take advantage of federal Direct Subsidized Stafford Loans.
3. Removing annual and cumulative borrowing limits on federal student loans.
4. Lowering the interest rates and fees on federal student loans.
5. Capping total amount of interest that can accrue on federal student loans.
6. Halting the accrual of federal student loan interest while a dentist is completing a medical/dental internship or residency.
7. Extending the period of federal student loan deferment until after a new dentist has completed his or her medical/dental internship or residency.
8. Permitting federal graduate student loans to be refinanced more than once.
9. Simplifying and adding more transparency to the federal graduate student loan application process.
10. Encouraging institutions of higher education and lenders to offer training to help students make informed decisions about how to finance their graduate education.
11. Encouraging collaborative approaches to handling borrowers who fail (or are at risk of failing) to fully repay their federal student loan(s) in the required time period.

and be it further
Resolved, that the ADA's position on allowing private lenders to have a role in the federal student loan program shall depend on whether the loan terms and conditions and borrower protections are guaranteed to be as favorable or better than the existing system of federal student loans, and be it further
Resolved, that the ADA supports strengthening federal regulations for the protection of all student loan borrowers.

Federal Student Loan Repayment Incentives (*Trans.*2019:XXX)

Resolved, that the American Dental Association supports using state and federal funds to provide payments toward a dental professional's outstanding federal student loans in exchange for practicing in underserved areas, entering and remaining in public service and academic teaching and research positions, and filling other gaps in areas of national need, and be it further
Resolved, that the ADA supports removing barriers that prohibit those with private graduate student loans from taking advantage of state and federal student loan repayment programs.

General, Pediatric and Public Health Dental Residency Programs (*Trans.*2019:XXX)

Resolved, that the American Dental Association supports using state and federal funds to support general, pediatric, and public health dental residency programs, including those authorized under Title VII of the Public Health Service Act, for dentists to obtain extended clinical training and experience in facilities that provide a disproportionate level of care to the underserved.

Consultation and Evaluation of International Dental Schools (*Trans.*2005:298)

Resolved, that the ADA and its Board of Trustees support the Commission on Dental Accreditation's initiative to offer consultation and accreditation services to international dental schools.

Participation in International Higher Education Collaborative Networks (*Trans.*2003:368)

Resolved, that the Association continue and the Commission on Dental Accreditation be urged to continue to participate in international higher education collaborative networks, to ensure that the Association and the Commission are positioned to collaborate, assist, participate, and provide consultation on international standards for dental education and clinical practice.

Communication Strategies for Increasing Awareness of Issues in Dental Education (*Trans.*2002:404)

Resolved, that the Association work collaboratively with the American Dental Education Association and the dental specialty organizations to develop communication strategy(s) for increasing awareness at the grassroots level of the problems facing dental education and the potential impact of this situation on dental practitioners and report these strategies to their respective organizations for possible action.

Assistance to Dental Schools Upon Closure (*Trans.*1992:610)

Resolved, that in the event an accredited dental school announces the intention to cease operations, the ADA work closely with the American Dental Education Association to assist the affected dental students in locating positions in other accredited dental schools.

Support for the Continued Existence of Private and Public Dental Schools in the United States (*Trans.*1989:522; 2016:299)

Resolved, that the American Dental Association strongly supports the continued existence of the private and public dental schools in the United States and the need for dental education to remain an integral part of the university community and an inviolate part of the higher education system

Dental Degrees (*Trans.*1972:698; 2016:299)

Resolved, that the American Dental Association supports the principle that degree determination is the prerogative of the individual educational institution.

Support of Dental Education Programs (*Trans.*1972:697; 2016:299)

Resolved, that the American Dental Association encourages members of the profession to support vigorously, through direct financial contributions and political activity, dental education programs which have been accredited by the Commission on Dental Accreditation.

Dental Insigne

Official Emblem for Dentistry (*Trans.*1965:228, 364)

Resolved, that the design or insigne for dentistry as described and portrayed in the report of the Bureau of Library and Indexing Service be reapproved as the official emblem for dentistry in the United States of America.

Dentist Health and Well-Being

Dental Schools to Provide Education to Dental Students on Drug and Alcohol Use and Misuse (*Trans.*2014:453)

Resolved, that U.S. dental schools are urged to incorporate the American Dental Association Dentist Health and Wellness Program's complimentary resources on emotional health and drug and alcohol abuse into the dental education curriculum to help minimize risks to dental students' health, professional status and patient safety, and be it further
Resolved, that state and/or constituent dental societies be urged to support this effort through their current or future well-being programs.

Statement on Dentist Health and Wellness (*Trans.*2005:321; 2017:264)

Statement on Dentist Health and Wellness

To preserve the quality of their performance and advance the welfare of patients, dentists are encouraged to maintain their health and wellness, construed broadly as preventing or treating acute or chronic diseases, including mental illness, addictive disorders, disabilities and occupational stress. When health or wellness is compromised, so may be the safety and effectiveness of the dental care provided. When failing physical or mental health reaches the point of interfering with a dentist's ability to engage safely in professional activities, the dentist is said to be impaired.

In addition to maintaining healthy lifestyle habits, every dentist is encouraged to have a personal physician whose objectivity is not compromised. Impaired dentists whose health or wellness is compromised are urged to take measures to mitigate the problem, seek appropriate help as necessary and engage in an honest self-assessment of their ability to continue practicing.

Dentists are strongly encouraged to have adequate disability and overhead protection insurance coverage which they review on a regular basis.

The ADA and/or its constituent and component societies, as appropriate, are encouraged to assist their members in being able to provide safe and effective care by:

- promoting health and wellness among dentists
- supporting peers in identifying dentists in need of help
- intervening promptly when the health or wellness of a colleague appears to have become compromised, including the offer of encouragement, coverage or referral to a dentist well-being program
- encouraging the development of mutual aid agreements among dentists, for practice coverage in the event of serious illness
- establishing or cooperating with dentist (or multidisciplinary) well-being programs that provide a supportive environment to maintain and restore health and wellness
- establishing mechanisms to assure that impaired dentists promptly cease practice
- reporting impaired dentists who continue to practice, despite reasonable offers of assistance, to appropriate bodies as required by law and/or ethical obligations
- supporting recovered colleagues when they resume patient care

Statement on Substance Abuse Among Dentists (*Trans.*2005:328)

Statement on Substance Abuse among Dentists

1. Dentists who use alcohol are urged to do so responsibly. Dentists are also urged to use prescription medications only as prescribed by an appropriate, licensed healthcare professional and to avoid the use of illegal substances.
2. Colleagues, dental team members, and the dentists' family members, are urged to seek assistance and intervention when they believe a dentist is impaired.
3. Early intervention is strongly encouraged.
4. Dentists with addictive illness are urged to seek adequate treatment and participate in long-term monitoring protocols to maximize their likelihood of sustained recovery.
5. Impaired dentists who continue to practice, despite reasonable offers of assistance, may be reported to appropriate bodies as required by law and/or ethical obligations.
6. Dentists in full remission from addictive illness should not be discriminated against in the areas of professional licensure, clinical privileges, or inclusion in dental benefit network and provider panels solely due to the diagnosis and recovery from that illness.
7. The ADA encourages additional research in the area of dentist impairment and the factors of successful recovery.

Statement on Substance Use Among Dental Students (*Trans.*2005:329)

Statement on Substance Use Among Dental Students

1. The ADA supports educational programs for dental students that address professional impairment associated with substance abuse.
2. Dental students who use alcohol should strive to do so responsibly. Dental students are also urged to use prescription medications only when prescribed by an appropriate, licensed healthcare professional and to avoid the use of illegal substances.
3. Dental school administration and faculty are encouraged to promptly intervene once aware of inappropriate substance use by a student.
4. Dental schools are strongly encouraged to support a student's referral to an addiction treatment program, if appropriate, and indicated by a thorough evaluation, prior to making disciplinary decisions.
5. Dental schools are encouraged to support only the responsible use of alcohol on their premises or at their functions or by faculty when with students in social settings.

Guiding Principles for Dentist Well-Being Activities at the State Level (*Trans.*2005:330; 2012:442)

Resolved, that the ADA supports efforts by constituent and component dental societies in the development, maintenance, and collaboration with effective programs to identify and assist those dentists and dental students affected by conditions which potentially impair their ability to practice dentistry, and be it further **Resolved,** that constituent and/or component dental societies be urged to adopt the following Guiding Principles for Dentist Well-Being Activities at the State Level.

Guiding Principles for Dentist Well-Being Activities at the State Level

1. Constituent dental societies, on behalf of their well-being programs, are encouraged to negotiate contracts or agreements with state dental boards, licensing agencies and other regulatory agencies to encourage dentists with substance use disorders to get into treatment before they have an alcohol- or drug-related incident.
2. State-level programs to prevent and intervene in dentist and dental team member impairment should be strengthened, supported and well publicized as the most humane and effective method of protecting the interests of the public and of dental professionals.
3. Dental societies should be advocates for dentists to have the same rights of privacy and confidentiality of personal medical information as other persons.
4. Those dental societies that administer dentist well-being programs are urged to maintain a strong working relationship with their state boards of dentistry and with the appropriate ADA agencies.
5. The dental society should ensure that those who serve as dentist peer assistance volunteers are provided immunity from civil liability, except for willful or wanton acts.
6. The dental society should also ensure that those who serve as dentist peer assistance volunteers are appropriately trained and supervised in these activities.
7. Dental societies in states where services are provided to dentists by multidisciplinary or physician health programs are urged to develop strong relationships with those programs, in order to:

    a. educate service providers about the particular needs of dentists and the dynamics of dental practice
    b. assist providers in outreach to dentists in need of assistance
    c. support dentists and families if treatment is necessary
    d. assist program providers in developing monitoring contracts appropriate to individual dentist's practice situations
    e. assist program providers in advocating for program participants with the dental board or licensing agency

8. Constituent and component dental societies are strongly encouraged to offer continuing education programs on the prevention, recognition and treatment of professional impairment.
9. Dental societies are encouraged to support well-being volunteer liaison activities to their dental schools.

Diagnostic and Procedure Codes

Monitoring and Resolution of Code Misuse (*Trans.*2007:419)

Resolved, that the ADA educate members on the appropriate use of the *Code on Dental Procedures and Nomenclature* and encourage them to report misuse by third-party payers, and be it further
Resolved, that the ADA actively pursue violations of the third-party licensing agreement for use of the *Code on Dental Procedures and Nomenclature*.

Development of ADA SNODENT Clinical Terminology (*Trans.*1995:619; 2013:309)

Resolved, that the Council on Dental Benefit Programs, acting within its *Bylaws* authority, shall continue to develop and, in conjunction with the National Library of Medicine and International Health Terminology Standards Development Organization, to maintain the SNODENT clinical terminology system, and be it further
Resolved, that the American Dental Association encourage universal adoption of the ADA's SNODENT clinical terminology system by: public and private healthcare organizations; national and international standards development organizations; national quality measurement initiatives; dental schools; dental information technology vendors, including but not limited to developers of Electronic Health Records (EHR) systems, digital imaging systems, and peripheral devices that capture clinical data; health information databases and networks; electronic data interchange organizations; plan purchasers; third-party payers and third-party organizations.

Reporting of Dental Procedures to Third Parties (*Trans.*1991:637; 2009:418; 2013:303; 2016:284)

Resolved, that the ADA's *Code on Dental Procedures and Nomenclature* (CDT Code), as the named national standard code set for transmitting information about dental procedures between dentists and third-party payers, must be used on HIPAA standard electronic transactions that include claims and payments, as well as on the ADA Dental Claim Form, and be it further
Resolved, that when a CDT Code entry includes "…by report" in its nomenclature, or when an unusual procedure, or one that is accompanied by unusual circumstances, is documented with an "unspecified…procedure, by report" CDT Code that procedure code and its accompanying narrative description should be accepted by the third-party payer to assist in benefit determination.

Authority for the Code on Dental Procedures and Nomenclature (*Trans.*1989:552; 2008:453)

Resolved, that the ADA's *Code on Dental Procedures and Nomenclature* is a working document of the Association designed to facilitate reporting of dental treatment on dental benefit claim forms, and be it further
Resolved, that the Council on Dental Benefit Programs, with the approval of the Board of Trustees, have the authority to effect changes to the *Code* in consultation with national dental organizations and the dental benefits industry in accordance with a process that reflects applicable legal and regulatory requirements (e.g., the Health Insurance Portability and Accountability Act of 1996).

Disaster Plan

Dentistry's Role in Emergency Preparedness and Disaster Response (*Trans.*2007:431)

Resolved, that because dentists have the clinical skills and medical knowledge that are invaluable assets in a mass casualty event, dentists be given the opportunity with additional targeted training to become more effective responders to natural disasters and other catastrophic events, and be it further
Resolved, that the American Dental Association provide leadership in national, state and community disaster planning and response efforts by increasing participation in coalitions and programs that put "disaster preparedness into practice," and be it further
Resolved, that the ADA promote multidisciplinary disaster education and training programs such as core, basic and advanced disaster life support courses, or other courses that train dentists and dental staff in the handling of declared emergencies, and be it further
Resolved, that the ADA advocate for national emergency preparedness solutions through research, public policy, and legislation.

State Mass Disaster Plan (*Trans.*2002:387)

Resolved, that the American Dental Association develop a response plan template that constituent and component dental societies can use to develop a response plan that can be integrated into the local mass disaster plan, and be it further
Resolved, that the ADA encourage the constituent and component dental societies to develop a plan for dentistry to respond to mass disasters that can be integrated into their local mass disaster plan using the ADA template as a model, and be it further
Resolved, that the ADA encourage constituent and component dental societies to establish a working relationship with the local public health and emergency management agencies.

Liability Protection for Bioterrorism Responders (*Trans.*2002:398)

Resolved, that the American Dental Association seek or support, and the constituent dental societies be urged to seek or support, federal and state legislation to grant dentists immunity from personal liability and restrictions on the services they provide when responding to a mass disaster following a declaration by an appropriate authority that an emergency situation exists that warrants such an action, for the duration of that emergency, and be it further
Resolved, the federal declaration should preempt state liability laws and dental practice acts.

Electronic Technology

Dental Practice Management Software (*Trans.*2001:428)

Resolved, that the Association seek federal legislation requiring practice management vendor contracts to include perpetual access to electronic dental records in a structured inter-operable format (e.g., csv, txt, mutually agreed upon format).

Submission of Attachments for Electronic Claims (*Trans.*1997:677)

Resolved, that the American Dental Association supports the position that for the submission of electronic claims, attachments (i.e., radiographs, models, etc.) should be sent only when the carrier requests that specific attachments be forwarded to process the claim.

Seamless Electronic Patient Record (*Trans.*1996:694)

Resolved, that the American Dental Association believes that, for optimal patient benefit, with assurance of confidentiality safeguards, appropriate health information should be available at the time and place of care to practitioners authorized by the patient through the development of a computer-based patient health record, and be it further
Resolved, that the architecture of a computer-based patient health record should be 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.

Costs for the Submission of Electronic Dental Claims (*Trans.*1995:623)

Resolved, that because of the current dynamics of the electronic claims payment marketplace, the ADA should work to protect the interest of the dentist by seeking to minimize or eliminate the costs to the dentist for the submission of electronic dental claims.

Recognition of Tooth Designation Systems for Electronic Data Interchange (*Trans.*1994:675; 2013:324)

Resolved, that the American Dental Association recognizes that the two major systems used in the United States for tooth designation are the Universal/National Tooth Designation System and the ISO/ANSI/ADA Specification No. 3950 for Designation System for Teeth and Areas of the Oral Cavity, and be it further
Resolved, that electronic oral health records should be designed to provide dentists the flexibility to select which tooth designation system best suits his or her office, and be it further
Resolved, that the ADA urge the developers of the software intended for electronic transmission of clinical information ensure the software is capable of translating tooth designation information into either system, and be it further
Resolved, that the American Dental Association, through its activities as secretariat and sponsor of the Accreditation Standards Committee (ASC) MD 156, support integration of the ISO/ANSI/ADA Specification No. 3950 for Designation System for Teeth and Areas of the Oral Cavity, in addition to the Universal/National Tooth Designation System, into clinical computer systems to allow information on tooth designation and other areas of the oral cavity to be transmitted electronically, and be it further
Resolved, that the American Dental Association encourage all accredited dental schools to familiarize dental students with both the Universal/National Tooth Designation System and the ISO/ANSI/ADA Specification No. 3950 for Designation System for Teeth and Areas of the Oral Cavity.

Electronic Technology Activities (*Trans.*1993:695; 2013:313)

Resolved, that the field of electronic technology is a high priority for the American Dental Association, and be it further
Resolved, that appropriate agencies of the Association provide full services in the areas of information science and dental electronic technology, and report developments and trends in these fields on a regular basis to the Board of Trustees, and be it further
Resolved, that the Association is opposed to mandatory participation in electronic data interchange for dental claims processing.

Electronic Technology in Dentistry (*Trans.*1992:608)

Resolved, that the American Dental Association represent the interests of the dental profession in all aspects of the development, growth and implementation of electronic technologies with administrative and clinical applications in dentistry, computer-based patient records, practice management systems, diagnostic and treatment applications of new technology, and the appropriate security systems to maintain confidentiality.

ADA Involvement in Electronic Data Interchange Activities (*Trans.*1992:598)

Resolved, that the American Dental Association be actively involved at the policy-making levels of national organizations responsible for developing standards in electronic data interchange (EDI) that will affect the clinical, administrative, scientific and educational components of dentistry.

Development of Electronic Dental Patient Records (*Trans.*1992:598)

Resolved, that the American Dental Association facilitate the development of electronic dental patient records through involvement with appropriate organizations and efforts to resolve legal, legislative and regulatory barriers to the evolution of this application of electronic technology.

Employee Retirement Income Security Act (ERISA)

Advocating for ERISA Reform (*Trans.*2009:474; 2014:500)

Resolved, that the appropriate agencies of the ADA identify those features of ERISA that exempt some plans from state regulation to protect consumers, and be it further
Resolved, that the ADA aggressively seek legislation to change the Act to create these consumer safeguards under federal law or allow regulation of these plans by the states.

Amendments to ERISA to Achieve Greater Protections for Patients and Providers (*Trans.*1995:649)

Resolved, that the Association support legislative activities to directly Amend the ERISA statute in an effort to achieve greater protections for patients and providers, and be it further
Resolved, that one of these protections assure that patients who are denied benefits have the right to an appropriate appeal mechanism.

Amendment of Employee Retirement Income Security Act (*Trans.*1994:644)

Resolved, that the appropriate agencies of the American Dental Association seek federal legislation to Amend the Employee Retirement Income Security Act (ERISA) to hold self-insured payers and/or utilization review organizations liable for any negligent utilization review decision which overturns the health care provider's clinical decision, and ensure meaningful remedies and fair compensation to patients who suffer as a result of such negligent utilization review decisions, and be it further
Resolved, that the appropriate agencies of the American Dental Association work to ensure that any health system reform proposals address the problems of remedy and compensation created by ERISA for patients in self-funded plans.

Employee Retirement Income Security Act (ERISA) Enforcement Activities (*Trans.*1992:622)

Resolved, that the American Dental Association continue its efforts in concert with appropriate public and private entities to achieve vigorous enforcement of the provisions of the Employee Retirement Income Security Act in order to provide plan subscribers in ERISA-regulated dental benefit programs with the same protections as are commonly enjoyed by subscribers of state-regulated programs.

Amendment of Employee Retirement Income Security Act (*Trans.*1982:550; 1989:561)

Resolved, that the ADA initiate and actively support legislation Amending the Employee Retirement Income Security Act (ERISA) to assure that beneficiaries of employee health benefit plans have the right to receive health care from the providers of their choice, to prevent plans from discriminating against legally qualified health care providers and to assure the solvency of such plans.

Evidence-Based Dentistry

Policy Statement on Evidence-Based Dentistry (*Trans.*2001:462; 2012:469; 2017:275)

Introduction: In the early 1990s, a process for decision-making emerged in medicine and other health fields that relies on systematic approaches to summarize the large volume of literature to assist patients and health care providers with translating evidence into clinical practice. David Sackett and colleagues defined evidence-based medicine as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research."[1]

Simply stated, evidence-based medicine is "the integration of the best research evidence with clinical expertise and patient values."[2] With rapidly evolving science and technology, dentistry has also faced the complex demands of integrating and effectively implementing changes in treatment modalities that can arise from new scientific evidence.

To address these challenges, the dental profession has endorsed an evidence-based approach to clinical practice and oral health care, which is commonly known as evidence-based dentistry (EBD). The American Dental Association (ADA) continues to pursue a leadership role in the field of EBD to help clinicians interpret and apply the best available evidence in everyday practice.

Definition of Evidence-Based Dentistry: The ADA defines the term *evidence-based dentistry* as an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences[3,4]

In adopting this definition for EBD, the ADA also recognizes that treatment recommendations should be determined for each patient by his or her dentist, and that patient preferences should be considered in all decisions. Dentist experience and other circumstances, such as patients' characteristics, additionally should be considered in treatment planning and determining treatment needs. EBD does not provide a "cookbook" that dentists must follow, nor does it establish a standard of care. The EBD process must not be used to interfere in the dentist/patient relationship, nor is it to be used as a cost-containment tool by third-party payers.

ADA Center for Evidence-Based Dentistry: The Association supports the concept of evidence-based dentistry developed through systematic examination of the best available scientific data. In 2007, the Association established the ADA Center for Evidence-Based Dentistry to provide leadership in implementing initiatives related to EBD.

To realize its vision of disseminating the best available evidence and helping practitioners implement EBD, the ADA Center for Evidence-Based Dentistry works in collaboration with the Council on Scientific Affairs to convene expert panels that review the collective research evidence and develop evidence-based clinical practice guidelines on key clinical issues. The Association will continue developing evidence-based clinical practice guidelines and working with collaborative groups to conduct systematic reviews, critically appraise the reviews and policies developed by other organizations, and develop mechanisms for translating and disseminating information to the membership.

EBD Resources: Detailed information on EBD, evidence-based clinical practice guidelines, systematic reviews, EBD terminology, courses/workshops, critical summaries of systematic reviews and other resources are available on the website of the ADA Center for Evidence-Based Dentistry (http://ebd.ada.org/). Concise, user-friendly EBD resources from the ADA Center for EBD and other organizations are useful resources that can assist practitioners with integrating the best available evidence with clinical expertise and the needs and preferences of the individual dental patient.

[1] Sackett DL, Rosenberg WM, Gray JA, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't. BMJ 1996 Jan 13;312(7023):71-2.
[2] Sackett DL, Straus SE, Richardson WS, et al. (eds.). *Evidence-Based Medicine: How to Practice and Teach EBM* (2nd ed.). Edinburgh: Churchill Livingstone, 2000.
[3] American Dental Association. *Transactions* 2001; 462.
[4] Frantsve-Hawley J, Meyer DM. The evidence-based dentistry champions: a grassroots approach to the implementation of EBD. J Evid Based Dent Pract 2008; 8:64-69.

Federal Dental Services

Rank Equivalency for Chief Dental Officers of the Federal Dental Services (*Trans.*2012:496)

Resolved, that the American Dental Association supports a 2-Star equivalent rank or higher for the Chief Dental Officers for the US Army, US Navy, US Air Force, US Public Health Services and the Veterans Administration.

Support for Dentists Temporarily Called to Active Service (*Trans.*2012:496)

Resolved, that the American Dental Association give its utmost support to our members who may be called to active duty, and be it further
Resolved, that constituent and component dental societies be urged to develop a network of volunteer dentists to help maintain the practices of dentists who are temporarily activated into military service by practicing in the deployed dentist's office and treating their patients.

Dues Exemption for Active Duty Members (*Trans.*2004:297, 335; 2015:296)

Resolved, that constituent and component dental associations be encouraged to waive constituent and component dental association dues of members who are temporarily called to active duty with a federal service for the period of active duty plus six months.

Exemption From Unemployment Insurance Liability for Active Duty Dentists (*Trans.*2004:321)

Resolved, that constituent societies be urged to review their states' unemployment insurance statutes so that dentists who are called to active military duty and close their dental offices are not impacted adversely by the law upon returning to their active practices.

Deployed Dentists and Mandatory Continuing Education Requirements (*Trans.*2004:314)

Resolved, that it is the Association's position that military deployment is a learning experience that provides opportunities to treat complex cases, sometimes under difficult circumstances, and be it further
Resolved, that constituent dental societies be urged to support state legislation or state board regulations that would allow deployed military dentists who are serving on active duty to have their continuing education requirements waived.

Wartime Waivers for Reservists (*Trans.*2003:354)

Resolved, that tripartite members in good standing who serve in the uniformed services reserves or National Guard, when called to active duty for a period of time over and above their ongoing service, are encouraged to apply for a partial or full dues waiver of membership dues as provided by the ADA *Bylaws,* and be it further
Resolved, that ADA component and constituent societies be encouraged to publicize the availability of the waiver process to the membership and to expedite processing of the waiver applications without financial disclosure statements when requests for these waivers are received.

Restoration of the Rank of Brigadier General to the Army Reserve Position of Deputy Assistant Surgeon General for Dental Services (*Trans.*1992:622)

Resolved, that the American Dental Association support the reinstatement of the Brigadier General rank for the position of Deputy Assistant Surgeon General for Dental Services, Army Reserves.

Compensation of Dental Specialists in the Federal Dental Services (*Trans.*1990:557; 2012:496)

Resolved, that the American Dental Association recommends that graduates of all ADA-recognized dental specialties and other Commission on Dental Accreditation-accredited two year residency programs be eligible for special remuneration in the federal dental services.

Dentistry in the Armed Forces (*Trans.*1972:718; 2012:496)

Resolved, that in order to ensure the provision of high quality health care to those in active military service the American Dental Association affirms the dental officer's proper role in command functions relating to the provision of oral health care and supports dental corps control over the financial and other resources needed to carry out their health care missions.

Federal Health Agencies

Dental Focus in Federal Health Agencies (*Trans.*2012:497)

Resolved, that the American Dental Association seek to establish within the Department of Health and Human Services a policy level office for dental activities with appropriate status and funding administered by dentists and in close liaison with organized dentistry, and be it further

Resolved, that the ADA seek to protect and enhance the status and funding of federal dental agencies, the integrity of federal dental programs and the roles and duties of federal dental officers, and be it further

Resolved, that the ADA seek to ensure that the views of organized dentistry are appropriately reflected in the work of federal advisory committees.

Office of the U.S. Surgeon General (*Trans.*1995:648)

Resolved, that the ADA supports the existence of the Office of the U.S. Surgeon General.

Fees

Maximum Fees for Non-Covered Services (*Trans.*2010:616)

Resolved, that the Association oppose any third party contract provisions that establish fee limits for non-covered services, and be it further
Resolved, that "covered service" is defined as any service for which reimbursement is actually provided on a given claim, and be it further
Resolved, that "non-covered service" is defined as any service for which the third party provides no reimbursement, and be further
Resolved, that the Association pursue passage of federal legislation to prohibit federally regulated plans from applying such provisions, and be it further
Resolved, that the Association encourage constituent dental societies to work for the passage of state legislation to prohibit insurance plans from applying such provisions.

Statement on Reporting Fees on Dental Claims (*Trans.*2009:419)

Statement on Reporting Fees on Dental Claims

1. A full fee is the fee for a service that is set by the dentist, which reflects the costs of providing the procedure and the value of the dentist's professional judgment.
2. A contractual relationship does not change the dentist's full fee.
3. It is always appropriate to report the full fee for each service reported to a third-party payer.

Fee Reimbursement Differentials (*Trans.*1993:697)

Resolved, that the Association recognizes that fee reimbursement differentials may exist due to the need to provide services in locations other than the dental office (e.g., hospitals, nursing homes, extended care facilities, etc.), time needed to perform a procedure, and other factors that would justify a different fee reimbursement, and be it further
Resolved, that contractual relationships with various payers should not have fee reimbursement differentials for the same procedure under the same conditions of such magnitude as to result in economic coercion, and be it further
Resolved, that there are distinct differences between the delivery of dental and medical treatment and because of these differences, the design of the dental plan must differ from that of the medical plan, and be it further
Resolved, that the application of global budgeting to limit care shall not include dentistry, but if such financing techniques are applied, then dentistry should be treated as a separate entity.

Statement on Determination of Maximum Plan Benefit (Formerly "Customary Fees") by Third Parties (*Trans.*1991:633; 2010:545; 2011:453)

Resolved, that appropriate agencies of the ADA take action to encourage the adoption of these guidelines at both the state and federal level.

Statement on Determination of Maximum Plan Benefit (Formerly "Customary Fees") by Third Parties

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.

Therefore, policy-makers should develop guidelines for regulations which:

- Establish standard terminology for identifying benefits in policies, Explanation of Benefits and other descriptive materials
- Establish a standard screen setting method (such as percentile) and/or require a policy statement, which describes the overall percentage of services (percentile) the policy should allow in full
- Require disclosure regarding the average percentage of claim dollars submitted anticipated to be allowed
- Require disclosure describing the frequency of updates and/or the basis for screen development
- Require disclosure describing how region and specialty were considered in setting the Maximum Plan Benefit Screens
- Require carriers to use sufficient data when determining Maximum Plan Benefit Screens (whether from claims experience or other sources)
- Require carriers to demonstrate how they have set their screens and how they have determined if sufficient data were employed

Policy on Fees for Dental Services (*Trans.*1990:540; 2013:319)

Resolved, that the fiscal and health interests of patients are best served by the existence of an economic climate within which a dentist and his or her patient are able to freely arrive at a mutual agreement with respect to fees for service, and be it further

Resolved, that the American Dental Association considers third-party intervention in fee determination to be potentially anticompetitive in nature and to be a disservice to the public, which is interested in securing the best possible dental care for themselves and their families, and be it further

Resolved, that the Association is opposed to any law, regulation or third-party intervention that disrupts the relationship between the dentist and patient, including, but not limited to, encouraging patients to select dentists principally on the basis of cost, and be it further

Resolved, that if a disagreement with regard to fees arises between a dentist, a patient and/or third-party and the component or constituent dental society accepts fee dispute cases for review, the complaint should be transmitted to the appropriate constituent and component dental society, which should then be available to assist in resolving the disagreement within the limitations of applicable law.

Fee Profiles (*Trans.*1987:502; 2013:309)

Resolved, that when a dentist is employed and then leaves for new employment or to open his or her own practice, all insurance companies and/or dental service corporations shall allow said dentist to establish a new fee profile, and be it further

Resolved, that dentists beginning practice should be made aware of this policy on the development of individual fee profiles and also made aware of the ADA's contract analysis service which is authorized to analyze various types of dental provider contracts at no charge to members who request a review through their constituent dental society, and be it further

Resolved, that the Council on Dental Benefit Programs work with the insurance industry, dental service corporations and other appropriate agencies to assist dentists beginning practice.

Finance

ADA Reserves (*Trans.*2008:443; 2012:409)

Resolved, that the Board be urged to target the ADA's liquid reserves at a level of 50% of the Association's annual budgeted operating expenses. Liquid reserves are defined as the total net uncommitted balance of the Reserve Division Account, and be it further
Resolved, that upon a finding by the Board that a predicted drop in liquid reserves below 40% is unlikely to be corrected absent action by the Association, the Board be urged to reduce expenses even if such reduction results in delay in implementation of previously adopted House initiatives.

Long-Term Financial Strategy of Dues Stabilization (*Trans.*2008:421; 2012:410; 2019:XXX)

Resolved, that the Board develop annual budgets and manage the Association's finances and reserves in accordance with the goal of long-term financial stability for the Association. Inflation affects the ADA's costs to deliver existing programs. To minimize volatility in membership dues and keep pace with normal inflation, consider each year a minimum dues adjustment equal to multiplying (a) the dues of an active member for the prior year by (b) the prior five years average U.S. Consumer Price Index percent change, rounded up to the nearest dollar amount ("Dues Adjustment"). The Dues Adjustment should be considered in addition to any other annual dues increase that year.

Fluoride and Fluoridation

Community-Based Topical Fluoride Programs (*Trans.*2014:507)

Resolved, the American Dental Association recognizes that community-based topical fluoride programs are safe and efficacious in reducing dental caries.

Bottled Water, Home Water Treatment Systems and Fluoride Exposure (*Trans.*2002:390; 2013:342)

Resolved, that in order to ensure optimal fluoride intake, the American Dental Association supports actions by its members to educate their patients regarding the level of fluoride in bottled water and the possible removal of fluoride by some home water treatment systems, and be it further
Resolved, that the American Dental Association urges its members to inquire about their patients' primary and secondary water source as part of the health history, and be it further
Resolved, that the American Dental Association supports the labeling of bottled water with the fluoride concentration of the product and company contact information including address and telephone number, and be it further
Resolved, that the American Dental Association supports the inclusion of information on the system's effect on water fluoride levels with each home water treatment system.

Groundwater With Natural Levels of Fluoride Higher Than 2.0 Parts Per Million (*Trans.*1999:921)

Resolved, that the American Dental Association urge state dental societies to continue efforts to educate professionals and consumers about the role of fluoride in community oral health, and be it further
Resolved, that the Association urge state dental societies to encourage state and local dental public health and drinking water authorities to identify the state's groundwater sectors with natural fluoride levels that exceed 2.0 parts per million, and be it further
Resolved, that the Association encourage state and local dental societies to communicate with local health and drinking water authorities regarding standards for fluoride levels, and be it further
Resolved, that the Association urge dentists to become familiar with the water fluoride concentrations in their area of practice that exceed 2.0 parts per million and provide appropriate counseling to parents and caregivers of young children to reduce the risk of dental fluorosis in permanent teeth, and be it further
Resolved, that the Association encourage dentists to educate pediatric health care workers about groundwater sectors and water systems with fluoride levels that exceed 2.0 parts per million so that parents and caregivers of young children receive appropriate counseling to reduce the risk of dental fluorosis in permanent teeth.

Operational Policies and Recommendations Regarding Community Water Fluoridation (*Trans.*1997:673; 2015:273)

1. The Association endorses community water fluoridation as a safe, beneficial and cost-effective and socially equitable public health measure for preventing dental caries in children and adults.
2. The Association supports the fluoridation of community water systems as recommended by the U.S. Public Health Service.
3. The Association urges individual dentists and dental societies to exercise leadership in all phases of activity which lead to the initiation and continuation of community water fluoridation, including making scientific knowledge and resources available to the community and collaborating with state and local agencies.
4. The Association encourages governmental, philanthropic and other entities to make funding available to communities seeking to initiate and/or maintain community water fluoridation.
5. The Association supports the following actions to maintain the quality of national community water fluoridation and its infrastructure:

    - performance of periodic assessments of community water fluoridation infrastructure needs by appropriate state agencies;
    - allocation of needed resources to or by appropriate state agencies to upgrade and maintain the fluoridation infrastructure; and
    - observance of the standards established by the appropriate state agencies related to engineering and administrative recommendations for water fluoridation in accordance with guidance issued by the Centers for Disease Control and Prevention.

Policy on Fluoridation of Water Supplies (*Trans.*1950:224; 2015:274)

Resolved, that in the interest of public health, the American Dental Association recommends the fluoridation of community water systems in accordance with the standards established by the appropriate authority, and be it further
Resolved, that the American Dental Association supports ongoing research on the safety and effectiveness of community water fluoridation.

Forensic Dentistry

Dental Radiographs for Victim Identification (*Trans.*2003:364; 2012:442)

Resolved, that the ADA promote to practicing dentists the importance of providing, as permitted by law, radiographs, images and records on patients of record that are requested by a legally authorized entity for victim identification and which will be returned to the dentist when no longer needed, and be it further
Resolved, that copies of these records should be retained by dentists as required by law.

Dental Identification Teams (*Trans.*1994:654; 2012:441)

Resolved, that the American Dental Association supports the American Board of Forensic Odontologists' recommendation to develop dental identification teams that can be mobilized at times of need for local or regional mass fatality incidents (MFI), and be it further
Resolved, that state and regional ID teams receive initial and ongoing training by forensic odontologists experienced in MFI response.

Dental Identification Efforts (*Trans.*1985:588)

Resolved, that the ADA encourage dental societies, related dental organizations and the membership to participate in efforts designed to assist in identifying missing and/or deceased individuals through dental records and other appropriate mechanisms.

Uniform Procedure for Permanent Marking of Dental Prostheses (*Trans.*1979:637; 2012:448)

Resolved, that the American Dental Association support the use of uniform methods of marking dental prostheses for identification purposes, and be it further
Resolved, that a system of dental prosthetic identification should meet the following criteria:

1. Patient specific identification, used with patient consent, should be incorporated into the dental prosthesis.
2. The identification should be legible and permanent.
3. The procedure for applying the identification markings should be clinically safe, economically practical and cosmetically acceptable.

General Practice

Status of General Practice (*Trans.*1973:725)

Resolved, that the American Dental Association make a concentrated effort to promote the status of the general practice of dentistry and encourage graduating dental students to seek a career in the general practice of dentistry.

Global Affairs

Need of Dental Public Health Education and Oral Health Services in Underserved Countries (*Trans.*1999:906)

Resolved, that the ADA recognizes the need for the education of providers of dental care in the underserved world and of its responsibility to support the efforts of legitimate organizations to assist in providing this service, and be it further

Resolved, that the ADA remain proactive in creating higher visibility and sensitivity in the needs of the underserved nationally and internationally with regard to oral health care.

Donation of ADA Library Materials (*Trans.*1993:684; 2012:512)

Resolved, that the ADA donate its excess library materials to organizations in need of these materials, and be it further

Resolved, that the ADA encourage its allied dental organizations to also donate their excess materials.

Health Care Data

Position Statement on the Appropriate Use of Data From Quality Measurement (*Trans.*1998:701; 2013:311)

Data from quality measurement can provide very useful information when addressing the many different issues confronting the health care system, from improving the quality and effectiveness of patient care, to improving the efficiency of care, to designing health benefit plans based on the value of care. While data from quality measurement can be used productively, it can also be misused and counterproductive. Measure specifications must be precisely designed to address specific concerns. One set of data cannot appropriately fit all purposes.

Quality measures are used today for three quite distinct purposes: quality improvement, accountability and research. One set of uniform measures does not satisfy the discrete needs of each purpose, e.g.: improve the quality of care; demonstrate accountability in the delivery of health care; and conduct research on the effectiveness of health care, or on the efficiency of different delivery and financing structures.

Practitioners and health care institutions, such as hospitals, frequently use data from measurement for internal quality improvement, where the objective is:

- to understand the process of care and how it varies
- to understand how the process of care relates to the effectiveness of care for patients
- to clarify the clinician's perspective on the process of care and the need to change
- to plan and test changes in the process of care

The data collected for *quality improvement* is used in planning and implementing change. Thus, it should not be used prematurely as a conclusive or absolute statement about the quality of care. Because internal quality improvement requires that practitioners identify potential quality of care concerns, critique the process of care and test change, the practitioner must know that the data will remain confidential and will not be used as a premature judgment of either the practitioner or the process of care. Thus, internal improvement data should not be used for purposes of public accountability.

Accountability is distinct from internal quality improvement. Accountability data is intended to be publicly reported. It is generally focused on the results or outcomes of care, and is often (but not exclusively) used to compare institutions, practitioners and health plans. In using such data for comparison, the sample must be large and the measures must be adjusted for the different populations, environments and markets within which the practitioners, health plans and institutions operate. For example, the measures must be risk-adjusted for severity of illness or demographic factors.

Quality of care research is often focused on examining the outcomes of care or the effectiveness of care. Measures should be specified in a manner that yields very precise results. Identifying and controlling variables that can influence the results is a more precise and extensive part of the data collection process than it is in either internal assessment or accountability.

There are overlaps among the measures used for internal quality improvement, public accountability and research. The results of research can be applied to identifying the best practices for quality improvement. Likewise, the need for accountability can set agendas for outcomes research and internal quality improvement. Internal quality improvement can define reasonable expectations for public accountability and the need for specific outcomes research. However, the feedback that will occur among internal quality improvement, accountability and research, should not be confused with the distinct purposes of each and the need for different measures for each. The limits of the data collected from each sphere of assessment should be recognized. Caution should be used in interpreting measurement data.

Health Insurance Portability and Accountability Act (HIPAA)

Need for HIPAA Standards Reform (*Trans.*2003:384; 2016:317)

Resolved, that the appropriate agencies of the American Dental Association work with the dental specialty organizations and other health care associations to continue to make every effort to limit the adverse effects of the HIPAA regulations for dentists and their patients, and be it further

Resolved, that the appropriate Association agency seek the establishment of reasonable transition periods between proposed new versions of the electronic dental claim standard so as to reduce the substantial financial burden placed on small providers, such as dentists, to implement new electronic claims standards, and be it further

Resolved, that the appropriate Association agency encourage educational efforts by HHS to clarify the HIPAA regulations and counter the misrepresentations and misunderstandings that interfere with the doctor-patient relationship and are impeding the effective delivery of quality health care.

Proposal for the ADA Dental Claim Form to be Maintained in a Form That Coincides With the HIPAA-Required ANSI X12 837—Dental Transaction Set (*Trans.*2001:434)

Resolved, that the appropriate Association agencies endeavor to coordinate modifications to both the ADA Dental Claim Form and the Health Insurance Portability and Accountability Act of 1996 standard 837, electronic dental claim for consistency and location of data content.

Health Programs: National and State

Use of Health Care Effectiveness Data and Information Set (HEDIS) for Utilization Measures (*Trans.*2013:344)

Resolved, that the ADA promote the adoption of the comprehensive measures developed by the Dental Quality Alliance for assessing quality of state Medicaid/CHIP programs, and be it further
Resolved, that the ADA provide technical support to the constituent dental societies to assist them with this issue.

Bone Marrow Matching Programs (*Trans.*2012:458)

Resolved, that the ADA urges members to support participation in bone marrow matching programs by providing appropriate literature in their offices, gathering samples and forwarding them for registration.*

State No Fault and Workers' Compensation Programs (*Trans.*2008:460)

Resolved, that the American Dental Association, together with its constituent and component societies, urge state no fault and workers' compensation programs to include dental coverage for workplace and motor vehicle injuries, and be it further
Resolved, that the ADA supports application of the following principles in legislation governing no-fault and workers' compensation programs:

1. that the objective of such programs should be to restore to health those patients requiring treatment as the result of a workplace or motor vehicle injuries
2. that such programs should allow patients the freedom to choose their own dentist
3. that coverage for treatment include or take into account the need for present and future treatment needed as result of workplace or motor vehicle injuries
4. that treatment of pre-existing medical or dental conditions should be covered when the injury exacerbated the condition, or treatment of the condition is necessary as part of the final therapy to restore the patient's oral and maxillofacial health
5. that such programs should accept and use the ADA *Code on Dental Procedures and Nomenclature* and the ADA Dental Claim Form when processing dental claims for workplace and motor vehicle injuries
6. that the timeframes for reimbursement or payment on claims for dental treatment resulting from workplace and motor vehicle injuries be in accordance with the state prompt payment laws where applicable
7. that the patient should bear no financial loss for treatment costs as a result of receiving treatment resulting from workplace or motor vehicle injuries
8. that the dentist should be compensated for care rendered in accordance with the dentist's treatment plan and existing fee schedule
9. that such programs should make available an appeals process to patients and dentists for benefits determinations made on claims resulting from workplace or motor vehicle injuries

Health Centers (*Trans.*2005:338; 2016:338)

Resolved, that the ADA support collaboration between health centers and community private dental providers, especially those with specialty experience in disease management and those participating in the Medicaid program, and be it further
Resolved, that each constituent dental society is urged to collaborate with the primary care association in their state to address oral health care access and is encouraged to facilitate the formation of dental advisory boards in cooperation with the staff in Health Centers in their area and be it further
Resolved, that constituent and component societies be urged to report on these efforts to the Council on Government Affairs.

Community Health Centers (*Trans.*2002:415; 2016:314)

Resolved, that the ADA shall, and constituent societies are urged to, continue to lobby to support the accurate, timely determination of federal and state dental health professional shortage area designations, and be it further
Resolved, that the ADA shall, and constituent societies are urged to, support efforts to improve the efficiency and effectiveness of Federally Qualified Health Center oral health programs in order to increase capacity to improve the oral health of underserved populations seeking care at these facilities, and be it further,
Resolved, that ADA members are encouraged to participate on health center Boards of Directors and other administrative bodies to ensure the clinics' effectiveness in treating underserved patients in the community, and be it further
Resolved, that the Association encourage improving access to underserved populations through increased

* Note: This sentence was editorially corrected in 2017 at the request of the Council on Scientific Affairs from "…participation in the bone marrow matching program" to "…participation in bone marrow matching programs."

private contracting between health centers and private sector dentists.

National Health Service Corps Policy on Scholarships and Loan Repayments (*Trans.*1988:488; 2016:347)

Resolved, that the ADA work to expand the availability of National Health Service Corps (NHSC) scholarships and loan repayments for dentists and dental students who agree to work in a NHSC-approved site.

Utilization of Dentists by Indian Health Service (*Trans.*1987:519; 2016:317)

Resolved, that the ADA support federal appropriations to increase the number of dentists to meet the needs of Alaska Natives and American Indians and be it further, **Resolved**, that the ADA collaborate with the Indian Health Service to seek ways to meet the number of dentists needed to address current and future oral health needs of these populations, including the use of dentists in private practice.

High Blood Pressure Programs (*Trans.*1974:643; 2013:343)

Resolved, that the American Dental Association supports member participation in the National High Blood Pressure Program.

Dentists on Staffs of Local Health Departments (*Trans.*1967:325; 2016:315)

Resolved, that component dental societies be urged to collaborate with the staff of local health departments to better understand community health program structures, processes and outcomes. Such collaboration may include periodic meetings with health department officials and appointment of dentists to health departments.

Health System Reform

Health Care Reform (*Trans.*2009:485)

Resolved, that in addition to existing association policy (Universal Healthcare Reform *Trans.*2008:433), the ADA shall also advocate that any health care reform proposal:

1. Maintains the private health care system;
2. Should increase opportunities for individuals to obtain health insurance coverage in all U.S. jurisdictions;
3. Assures that insurance coverage is affordable, portable and available without regard to preexisting health conditions;
4. Develops prevention strategies that encourage individuals to accept responsibility for maintaining their health and which may reduce costs to the health care system;
5. Be funded in a sustainable, budget neutral manner that does not include a tax on health care delivery;
6. Exempts small business employers from any mandate to provide health coverage;
7. Include incentives for individuals and employers to provide health insurance coverage;
8. Contain medical liability (tort) and insurance reforms;
9. Encourage the use of electronic health records with rigorous privacy standards; and
10. The American Dental Association supports Health Savings Accounts, Flexible Spending Accounts or any other tax incentive programs that allow alternative methods of funding health care costs.

and be it further
Resolved, that the ADA shall direct its lobbying efforts to assure that legislators fully understand the consequences of any health care reform legislation, and be it further
Resolved, that the ADA direct its lobbying efforts to inform our federal legislators of the ADA's existing health care reform policy and advocate for efforts to implement it, and be it further

Resolved, that the ADA's Health Care Reform policy be promoted to the dental profession and the public through the *ADA News*, ADA Web site and other appropriate avenues of communication.

Universal Healthcare Reform (*Trans.*2008:433)

Resolved, that the following be adopted as the Association's policy on oral health care for utilization during discussions on health care reform:

IMPROVING ORAL HEALTH IN AMERICA

ORAL HEALTH IS ESSENTIAL FOR A HEALTHY AMERICA

DENTAL CARE IS ESSENTIAL TO OVERALL HEALTH. Americans cannot be healthy without it.

HEALTH CARE IS A SHARED RESPONSIBILITY. No law, regulation or mandate will improve the oral health of the public unless policymakers, patients and dentists work together with a shared understanding of the importance of oral health and its relationships to overall health.

PREVENTION PAYS. The key to improving and maintaining oral health is preventing oral disease. Community-based preventive initiatives, such as community water fluoridation and school-based screening and sealant programs are proven and cost-effective measures. These should be integral to oral health programs and policies, and will provide the greatest benefit to those at the highest risk of oral disease.

IMPROVING ORAL HEALTH LITERACY MAKES PATIENTS BETTER STEWARDS OF THEIR OWN HEALTH. Patients, parents, pregnant women, care-givers and others need to understand the importance of good oral health, oral hygiene fundamentals, diet and nutritional guidelines, the need for regular dental care and, in many cases, how to navigate the system to get dental care**.**

PATIENTS NEED A DENTAL HOME. All patients should have an ongoing relationship with a dentist with whom they can collaboratively determine preventive and restorative treatment appropriate to their needs and resources.

ACCESS IS A KEY TO GOOD ORAL HEALTH

IMPROVING ORAL HEALTH IN AMERICA REQUIRES A STRONG PUBLIC HEALTH INFRASTRUCTURE TO OVERCOME OBSTACLES TO CARE. The current dental public health infrastructure is insufficient to address the needs of disadvantaged groups. Efforts to improve access to dental care require investment in the nation's public health infrastructure. The ADA recognizes that community-based disease prevention programs must be expanded and barriers to personal oral health care eliminated, if we are to meet the needs of the population.

REIMBURSEMENT MATTERS. Increased access to care for people covered by government-assisted dental programs depends on fair and adequate provider reimbursement rates. The vast majority of government programs are so seriously under-funded that dentists cannot recover the cost of materials used in providing care.

IMPROVING ACCESS IN UNDERSERVED AREAS REQUIRES EXTRA-MARKET INCENTIVES. Federal, state and local governments must develop financial incentives, such as student loan forgiveness, tax credits or other subsidies, to encourage dentists to locate their offices in areas that cannot otherwise support private dental practice.

PATIENTS WITH THE GREATEST NEED MUST BE FIRST IN LINE FOR CARE. Under-funded government programs fail to provide minimally adequate care to all they purport to cover. Funding should be prioritized so that those with the greatest need and those who will most benefit from care are first in line. For example, people needing emergency care, pregnant women, and children needing diagnostic and preventive care should take precedence over other underserved groups.

COST-EFFECTIVE ALLOCATION OF LIMITED GOVERNMENT FUNDS IS ESSENTIAL. With very limited government resources, children, pregnant women, the vulnerable elderly and individuals with special needs should receive diagnostic, preventive and emergency care. Adult emergency care should also be covered. Limited government resources should allow for additional routine dental care coverage for all underserved populations as well as diagnostic and preventive for adults. With sufficient funding, complex or comprehensive care should also be covered.

THE GOVERNMENT MUST FUND PUBLIC HEALTH BENEFIT PROGRAMS ADEQUATELY. Programs such as Medicaid and the State's Children Health Insurance Program (SCHIP) must ensure that vulnerable children and adults with inadequate resources have access to essential oral health care. Programs such as Medicaid must cover dental benefits for adults. Children in low-income families who are not eligible for Medicaid must have access to essential oral health care through SCHIP. Eligibility should reflect regional differences in the cost of living and purchasing power.

WE MUST BUILD ON CURRENT SUCCESSES

OPEN MARKETS ENSURE COMPETITION AND INNOVATION. The dental private practice delivery system, which operates almost entirely separate from its medical counterpart, serves the vast majority of Americans well. While a fully-functional public health infrastructure is essential, efforts to broaden access to care for people who currently are underserved would be best accomplished by bringing more people into the private practice system.

PRIVATE DENTAL BENEFITS WORK. Benefits should be administered by independent companies, selected in the open market. Experience in other countries has shown that a single-payer system would stifle access, innovation and reduce the quality of patient care.

UNIVERSAL DENTAL COVERAGE MANDATES WILL NOT SOLVE THE ACCESS TO CARE PROBLEM. Many dental diseases and conditions are preventable with patient compliance and are inexpensive in relation to cost of treatment, therefore developing federal and state government programs that address not only funding but also non-economic barriers to care are necessary. The great majority of Americans already have access to dental care, and millions can afford care without having dental benefits. The government can use tax policy to encourage small employers and individuals to purchase dental benefit plans in the private sector or develop cooperative purchasing alliances for the segment of the population with privately-funded care.

FOSTERING THE NEXT GENERATION OF DENTISTS MUST BE A PRIORITY. Having a sufficient number of dentists to provide care to all who require it depends upon a number of critical factors, including sufficient government support of dental higher education, overcoming current faculty shortages, providing affordable student loan programs, advanced public health training and ensuring the financial viability of dental practices.

PATIENTS MUST RECEIVE CARE FROM A PROPERLY EDUCATED AND TRAINED ORAL HEALTH WORKFORCE. The U.S. dental delivery system owes much of its success to the team model, which includes dental hygienists and assistants working under the supervision of a licensed dentist. While many underserved communities might benefit from the addition of specially trained, culturally-prepared dental support personnel, appropriate education, training and

dentist supervision is essential to ensure quality dental care.

Legislative Separation of Medicine and Dentistry (*Trans.*1996:715)

Resolved, that the American Dental Association work to assure that dentistry is addressed separately from medicine in any health care reform legislation.

Employer Mandates (*Trans.*1994:645)

Resolved, that the American Dental Association opposes employer mandates to purchase health care benefits for employees as a component of health system reform.

Tax Preferred Accounts (*Trans.*1994:637; 2012:495)

Resolved, that the American Dental Association supports the use of tax preferred accounts for medical and dental expenses as a component of health system reform.

Inclusion of Members of Congress in Health Care Legislation (*Trans.*1993:718; 2019:XXX)

Resolved, that the American Dental Association supports including all members of Congress and all federal employees in any comprehensive health care legislation passed for the population as a whole.

Freedom of Choice in Selection of Health Care Provider Under Health Care System Reform (*Trans.*1993:717; 2012:495)

Resolved, that individual freedom of choice in selection of health care provider must be made available to all recipients of benefits under any reform of the health care system.

Employer Subsidy (*Trans.*1993:665)

Resolved, that the Association supports the establishment of a cap on the employer's share of the premium payment for medical benefits, and tax credits to help defray the employer's cost of providing health coverage.

Dentists as Providers in All Public and Private Health Care Programs and Discrimination in Payment for Services Performed by Licensed Dentist (*Trans.*1990:559)

Resolved, that the American Dental Association, through its appropriate agencies, seek to ensure that all health legislation and all public and private health care programs that include care of a nature that a dentist is licensed to perform and traditionally renders, include dentists as providers, and be it further
Resolved, that there be no discrimination in the payment schedule or payment provision of covered services or procedures when performed by a licensed dentist.

Hospitals

Guidelines for Hospital Dental Privileges (*Trans.*2015:274)

Resolved, the American Dental Association believes that all dentists who practice in hospitals should be eligible for privileges that should include performance of history and physical examinations, diagnosis, treatment and admission in accordance with their education, training and current competencies, consistent with the protocols and guidelines of the hospital where they have privileges.

Hospital Medical Staff Membership (*Trans.*1999:923)

Resolved, that the American Dental Association supports active hospital medical staff membership for qualified dentists that request such appointment, and be it further
Resolved, that active medical staff membership for these dentists conveys upon them all appropriate rights and privileges of any other active medical staff member, including but not limited to: the right to vote, hold office, apply for clinical privileges and if necessary, the right to a fair hearing and appellate review, and be it further
Resolved, that the process and general criteria for medical staff membership and privileges for dentists should be the same as for any other medical staff member, and be it further
Resolved, that dentists who receive such membership be encouraged to be active in the hospital and in its related committees in order to raise the profile of dentists as contributing medical staff members, and be it further
Resolved, that should cases of national significance concerning denial or revocation of privileges for qualified dentists be brought to the attention of the Association, the Board of Trustees be urged to take appropriate action, including legal action.

Economic Credentialing (*Trans.*1993:692)

Resolved, that the American Dental Association believes that membership on a hospital medical staff and the delineation of privileges in a hospital should be based on quality of care and professional competency data, and be it further
Resolved, that the ADA will work with other organizations to eliminate economic credentialing, which is defined as the use of economic criteria that are not related to quality of care or a dentist's professional competency, when determining qualifications for that individual's clinical staff membership or privileges, and be it further
Resolved, that dentists with hospital clinical staff privileges be encouraged to work with hospital administrators and trustees to determine and develop appropriate uses of utilization and other financial data that may be collected, and be it further
Resolved, that the ADA will offer its assistance, with the concurrence of the constituent dental society, to the dental staff of a hospital to assure that the hospital's bylaws provide an appropriate role for the dental staff in the development of policy dealing with exclusive contracts or the closure of dental departments.

Physical Examinations by Dentists (*Trans.*1977:924; 1991:618)

Resolved, that dentists who by reason of training and who have demonstrated proficiency to the satisfaction of the governing body of a hospital, should be permitted to perform the medical history, physical examination and evaluation of hospitalized dental patients.

House of Delegates

Program Assessment Criteria (*Trans.*2017:254)

Resolved, that all councils receive annual training on their fiduciary responsibilities to the Association, and be it further
Resolved, that each agency of the Association apply the strategic plan and the effectiveness of each program to meet the goals of the program in order to evaluate Association programs under its control or oversight, and be it further
Resolved, that each council, or, where appropriate, the Board, shall review all resolutions having cost implications for the Association associated with that council or the Board, provided the resolution has been submitted prior to the first posting of resolutions to delegates, and shall provide a written report to the House that includes the council's (or Board's) recommendation with respect to the final disposition of the resolution and assessment in light of the strategic plan.

Term Limits for ADA Delegates (*Trans.*2012:412)

Resolved, that all constituencies be urged to implement term limits for ADA delegates.

Term Limits for Alternate Delegates (*Trans.*2012:412)

Resolved, that all constituencies be urged to implement term limits for ADA alternate delegates.

Review of Association Policies (*Trans.*2010:603; 2012:370)

Resolved, that the Board of Trustees develop a timetable and protocol to allow the comprehensive review of all Association policies every five years, and be it further
Resolved, that the councils, committees, taskforce, or other Association agency assigned with the review consider the following in making recommendations:

- Relevance to current situation
- Continued need
- Consistency with other Association policies
- Appropriateness of language and terminology

and be it further
Resolved, that recommended rescissions and revisions will be brought to the House of Delegates in resolution form for debate and approval, and be it further
Resolved, that changes to policy reflected in this resolution shall be effective immediately.

Conflict of Interest Policy (Disclosure Policy) (*Trans.*2010:624; 2011:537; 2013:341; 2019:XXX)

Resolved, that chairs of any meeting of the ADA, including Executive Committee, Board of Trustees, councils, committees and the House of Delegates include the disclosure policy as a written part of the agenda at each meeting:

> In accordance with the ADA Disclosure Policy, at the appropriate time anyone present at this meeting is obligated to disclose any personal, professional or business relationship that they or their immediate family may have with a company, professional organization or individual doing business with the ADA, when such company, professional organization or person is being discussed. This includes, but is not limited to insurance companies, sponsors, exhibitors, vendors and contractors.

and be it further
Resolved, that the disclosure policy be read at the opening of each meeting of the House of Delegates, and be it further
Resolved, that when speaking on the floor of the House of Delegates or in Reference Committees, those individuals/members shall first identify those relationships before speaking on an issue related to such conflict of interest.

Posting of Financial Information (*Trans.*2009:493; 2012:407)

Resolved, that the ADA post in the delegates' section of ADA.org, ADA Connect, or the equivalent, copies of all audit reports and management letters associated with the audit report of the ADA and its subsidiaries within 30 days after Board of Trustees review, and be it further
Resolved, that the ADA post in the delegates' section of ADA.org, ADA Connect, or the equivalent, copies of the quarterly financial reports within 30 days after Board of Trustees review.

Annual Session Dress Code (*Trans.*1999:981)

Resolved, that the House of Delegates adopt business casual attire.

Availability of ADA House Materials to Members (*Trans.*1991:606)

Resolved, that all nonconfidential ADA House of Delegates reports and proposed resolutions, including reference committee reports, be made available to ADA members upon request and that the charge for these materials shall be commensurate with the cost to provide the service, and be it further
Resolved, that the dates, times and locations of ADA House of Delegates' sessions and reference committee meetings be circulated in advance to all members and be publicly posted at the ADA Annual Scientific Sessions.

Availability of House of Delegates Transcripts (*Trans.*1990:570)

Resolved, that the official transcript of the American Dental Association House of Delegates be made available in toto to any active, life or retired member of the Association, and be it further
Resolved, that the cost of this transcript be borne by the individual or constituent requesting said transcript.

Criteria for Restructure of Trustee Districts (*Trans.*1986:498)

Resolved, that the American Dental Association establishes the following criteria for considering any proposals for the restructure of its trustee districts:

The total number of trustee districts shall be seventeen.*

- No single state shall constitute more than one trustee district.
- Any state or group of states attaining membership of 6,000 active, life and retired members and desiring to become a trustee district may petition the House of Delegates for reapportionment of trustee districts.
- When any trustee district falls below membership of 4,500 active, life and retired members, the Board of Trustees shall develop a reapportionment proposal bringing all districts up to the minimum membership requirement.

Election of Delegates (*Trans.*1979:646)

Resolved, that the American Dental Association recommends that all delegates be chosen by an elective process excluding the federal dental services.

* Note: This policy has been editorially changed to reflect the actions of the 2000 House of Delegates which increased the number of trustee districts from sixteen to seventeen.

Illegal Dentistry

Activity to Stop Unlicensed Dental or Dental Hygiene Practice (*Trans.*1999:949)

Resolved, that each constituent dental society be urged to support enactment of legislation which gives each Board of Dental Examiners the means to stop the illegal practice of dentistry or dental hygiene by an unlicensed person.

Dental Society Activities Against Illegal Dentistry (*Trans.*1977:934; 2001:435)

Resolved, that the American Dental Association urge constituent and component dental societies to inform the Council on Dental Practice of society activities which relate to combating illegal dentistry, and be it further
Resolved, that the Council on Dental Practice provide this information to all constituent and component societies on a timely and periodic basis, and be it further
Resolved, that the American Dental Association Board of Trustees be authorized to provide financial aid to any constituent dental society that is faced with the imminent prospect of a substantial effort to legalize or promote denturism or any illegal practice of dentistry in its state through legislative action or use of the initiative process.

Opposition to "Denturist Movement" (*Trans.*2001:436)

Resolved, that the Association vigorously opposes denturism, the denturism movement, and all other similar activities, regardless of how they are designated, in this country.

"Denturist" and "Denturism" (*Trans.*1976:868; 2001:436)

Resolved, that when the words "denturist" or "denturism" and all synonymous terms are used in American Dental Association publications, the terms should be accompanied by a brief but prominent footnote indicating that a "denturist" is a person who is educationally unqualified to practice dentistry in any form on the public, and be it further
Resolved, that constituent and component societies act in concert with the American Dental Association.

Infection Control and Infectious Diseases

Infection Control in the Practice of Dentistry (*Trans.*2012:470; 2019:XXX)

Resolved, that it be ADA policy to support the implementation of standard precautions and infection control recommendations appropriate to the clinical setting, per the 2003 Guidelines for Infection Control in Dental Health Care Settings and the 2016 Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care from the Centers for Disease Control and Prevention (CDC), and be if further
Resolved, that the ADA urges practicing dentists, dental auxiliaries and dental laboratories to keep up to date as scientific information leads to improvements in infection control, and be it further
Resolved, that this policy includes implementation of CDC recommendations for vaccination and the prevention and management of exposures involving non-intact skin, mucous membranes and percutaneous injuries.

Insurance Programs

Sponsorship or Endorsement of National Professional Liability Insurance Program (*Trans.*1995:603)

Resolved, that prior to considering the sponsorship or endorsement of any national professional liability insurance program, the Board of Trustees shall present said program to the House of Delegates for consideration and approval.

Hospitalization Insurance for Dental Treatment (*Trans.*1972:674; 2013:309)

Resolved, that the Association actively urge medical plans to include hospitalization benefits for dental treatment in public and private insurance programs so that the resources of a hospital are available to those dental patients whose condition, in the professional judgment of the dentist, makes hospitalization necessary.

Intellectual Property

ADA Intellectual Property Licensing Protocol (*Trans.*2008:495)

Resolved, that the ADA Board of Trustees, in connection with any proposed non-de minimis grant by the ADA of rights in or to ADA intellectual property, require the ADA council(s) having substantive knowledge of the intellectual property to be involved from the beginning in discussions concerning the proposed grant, to review the terms of such proposed grant and to make recommendation(s) to the Board of Trustees on the proposed grant, and be it further

Resolved, that the ADA Board of Trustees, after having considered the recommendations of the appropriate ADA council(s), when appropriate, make a determination concerning the proposed grant.

Laboratories and Technicians

Registration of Dental Laboratories (*Trans.*2013:323)

Resolved, that in order to enhance dental patient health and safety, the ADA urges all state dental boards to register U.S. dental laboratories.

Statement to Encourage U.S. Dental Schools to Interact With U.S. Dental Laboratories (*Trans.*2010:547)

Resolved, that the ADA encourage all U.S. dental schools to use U.S. dental laboratories for fabrication of undergraduate and graduate dental students' restorative prostheses, in lieu of sending the prescription for these medical devices abroad, and that the ADA believes that the educational process of U.S. dental students would be enhanced by interaction with local dental laboratories, and be it further

Resolved, that the ADA encourage U.S. dental schools to use their own in-house dental laboratories wherever possible in order to facilitate the valuable interaction between dental students and certified dental laboratory technicians as this will afford the dental students with the valuable experience necessary to facilitate the successful fulfillment of a prescription for fabrication of dental prostheses, and be it further

Resolved, that the ADA encourage U.S. dental schools to combine dental education programs with dental laboratory technology programs wherever dental laboratory technology programs are located within commuting distance of the dental school, and that these programs/curricula could include, but are not limited to, dental morphology/occlusion, prosthetic design and fabrication, waxing, casting, surveying of study casts, and incorporation of CAD/CAM technology.

Certifying Board in Dental Laboratory Technology (*Trans.*2002:400; 2014:460)

Resolved, that the American Dental Association approves the National Board for Certification in Dental Laboratory Technology as the national certifying board for dental laboratory technology.

Criteria for Recognition of a Certification Board for Dental Laboratory Technicians (*Trans.*1998:92, 713; 2014:462; 2019:XXX)

An area of subject matter responsibility of the Council on Dental Education and Licensure as indicated in the *Governance and Operational Manual* of the American Dental Association is certifying boards and credentialing of allied dental personnel. The Council studies and makes recommendations on policy related to the approval or disapproval of national certifying boards for allied dental personnel (each of which is referred to hereinafter as "the Board").

A mechanism for the examination and certification of dental laboratory technicians is necessary to provide the dental profession with an indication of those persons who have demonstrated their ability to fulfill the dental laboratory work authorization. Such a certification program should be based on the educational requirements for dental laboratory technicians approved by the Commission on Dental Accreditation.

The following basic requirements are applied by the Council on Dental Education and Licensure for the evaluation of an agency which seeks recognition of the American Dental Association for a program to certify dental laboratory technicians on the basis of educational standards approved by the dental profession.

I. Organization: An agency that seeks approval as a Certification Board for Dental Laboratory Technicians should be representative of or affiliated with a national organization of the dental laboratory industry and have authority to speak officially for that organization. It is required that each dental laboratory technician member of the Certification Board hold a certificate in one of the areas of the dental laboratory technology.

II. Authority and Purpose: The rules and regulations established by the Certification Board of Dental Laboratory Technicians will be considered for approval by the Council on Dental Education and Licensure on the basis of these requirements. Changes that are planned in the rules and regulations of the Certification Board should be reported to the Council before they are put into effect. The Board shall submit data annually to the Council on Dental Education and Licensure relative to its financial operations, applicant admission and examination procedures, and results thereof.

The principal functions of the Certification Board shall be:

a. to determine the levels of education and experience of candidates applying for certification examination within the requirements for education established by the Commission on Dental Accreditation;
b. to prepare and administer comprehensive examinations to determine the qualifications of those persons who apply for certification; and

c. to issue certificates to those persons who qualify for certification and to prepare and maintain a roster of certificants.

III. Qualifications of Candidates: It will be expected that the minimum requirements established by the Certification Board for the issuance of a certificate will include the following:

a. satisfactory legal and ethical standing in the dental laboratory industry;
b. graduation from high school or an equivalent acceptable to the Certification Board;
c. a period of study and training as outlined in the Accreditation Standards for Dental Laboratory Technology Education Programs, plus an additional period of at least two years of working experience as a dental laboratory technician; or, five years of education and/or experience in dental technology; and
d. satisfactory performance on examination(s) prescribed by the Certification Board.

IV. Standards: The Certification Board must establish and maintain documented policies concerning current, prospective and lapsed certificants including, but not limited to: eligibility, application, assessments, certification renewals and appeals. Additionally, the Certification Board must establish, analyze, publish and review examination content outlines which lay the foundation for the knowledge and skills tested on the assessment instruments and provide evidence of validity and reliability.

Support of the Dental Laboratory Technician Certification Program and Continuing Education Activities (*Trans.*1997:682; 2010:547)

Resolved, that the American Dental Association encourage dental laboratory technicians to achieve certification status and pursue the continuing education that is required to provide dentists with technical support that will contribute to high standards of restorative dental care, and be it further

Resolved, that the American Dental Association encourage efforts by those engaged in dental laboratory technology and dental laboratory technology education to ensure that the future workforce in dental laboratory technology is adequately educated and skilled in the art and science of dental laboratory technology by promoting pursuit of certification, and be it further

Resolved, that the American Dental Association encourage constituent and component dental societies to recognize the continuing education needs of certified dental technicians by inviting their attendance at appropriate continuing education seminars and encouraging their attendance as presenters.

Statement on Prosthetic Care and Dental Laboratories (*Trans.*1990:543; 1995:623; 1999:933; 2000:454; 2003:365; 2005:327; 2007:430; 2018:305)

Introduction: Patient care in dentistry often involves the treatment, restoration or reconstruction of oral and peri-oral tissues. The dentist may elect to use various types of prostheses or appliances to treat the patient and may utilize the supportive services of a dental laboratory and its technical staff to custom manufacture the prostheses or appliances according to specifications determined by the dentist.

Since the dentist-provider is ultimately responsible for the patient's care, the Association believes that he or she is the only individual qualified to accept responsibility for prosthetic or appliance care. At the same time, the dental profession recognizes and acknowledges with gratitude and respect the significant contributions of dental laboratory technicians to the health, function and aesthetics of dental patients.

This statement outlines the Association's policy on the optimal working relationship between dentist and dental laboratory, the regulation of dental laboratories and issues regarding the provision of prosthetic or appliance care. A glossary of terms is a part of this statement.

Because of the dentist's primary role in providing prosthetic or appliance dental care, the Association, through its Department of State Government Affairs and the Council on Dental Practice, provides upon request assistance to state dental societies in dealing with issues addressed in this statement.

Diagnosis and Prosthetic Dental Treatment: It is the position of the American Dental Association that diagnosis and treatment of patients utilizing prostheses or appliances must be provided only by licensed dentists and only within the greater context of evaluating, treating and monitoring the patient's overall oral health. The Association believes that the dentist, by virtue of education, experience and licensure, is best qualified to provide prosthetic or appliance treatment to the public with the highest degree of quality. As a result of its belief that dental care is the responsibility of a licensed dentist, the Association opposes prosthetic or appliance dental treatment by any other individuals. Further, the Association will actively work to prevent the enactment of any legislation or regulation allowing such activity or programs, on the grounds that it would be dangerous and detrimental to the public's health.

Working Relationships between Dentists and Dental Laboratories: The current high standard of prosthetic or appliance dental care is directly related to, and remains dependent upon, mutual respect within the dental team for the abilities and contributions of each member. The following guidelines are designed to foster good relations between dental laboratories, dental laboratory technicians and the dental profession.

Applicable laws shall take precedence if they are inconsistent with any of the following guidelines.

The Dentist:

1. The dentist should provide written instructions to the laboratory or dental technician. The written instructions should detail the work which is to be performed, describe the materials which are to be used and be written in a clear and understandable fashion. A duplicate copy of the written instructions should be retained for a period of time as may be required by law.
2. The dentist should provide the laboratory/technician with scanned digital or accurate impressions, casts, occlusal registrations and/or mounted casts. Materials submitted should be identified.
3. The dentist should identify, as appropriate, the crown margins, post palatal seal, denture borders, any areas to be modified and the type of design of the prosthesis or appliance on all cases.
4. The dentist should furnish instruction regarding preferred materials, coloration, and description of prosthetic tooth/teeth to be utilized for fixed or removable prostheses which may include, but not be limited to a written description, photograph, drawing or shade.
5. The dentist should provide verbal or written approval to proceed with a laboratory procedure, or make any appropriate change(s) to the written instructions as the dentist deems necessary, when notified by a laboratory/dental technician that a case may have a questionable area with respect to paragraphs 2-4.
6. The dentist should clean and disinfect all items according to current infection control standards prior to sending them to the laboratory/technician. All prostheses, appliances and other materials that are forwarded to the laboratory/technician should be prepared for transport utilizing an appropriate container and packaged adequately to prevent damage and maintain accuracy.
7. The dentist should return all casts, registration and prostheses/appliances to the laboratory/technician if a prosthesis/appliance does not fit properly, or if shade selection is incorrect.

The Laboratory/Technician:

1. The laboratory/technician should custom manufacture dental prostheses/appliances which follow the guidelines set forth in the written instructions provided by the dentist, and should fit properly on the casts and mounting provided by the dentist. Original written instructions should be retained for a period of time as may be required by law.

   When a laboratory provides custom-printed written instruction forms to a dentist, the laboratory document should include the name of the laboratory and its address, provide ample space for the doctor's written instruction, areas to indicate the desired delivery date, the patient's name, a location for the doctor to provide his/her name and address, as well as to designate a site for the doctor to provide a signature. The form should also allow for other information which the laboratory may deem pertinent or which may be mandated by law.
2. The laboratory/technician should return the case to the dentist to check the mounting if there is any question of its accuracy or of the bite registration furnished by the dentist.
3. The laboratory/technician should match the shade which was described in the original written instructions.
4. The laboratory/technician should notify the dentist within two (2) working days after receipt of the case, if there is a reason for not proceeding with the work. Any changes or additions to the written instructions must be agreed to by the dentist and must be initialed by authorized laboratory personnel. A record of any changes shall be sent to the dentist upon completion of the case.
5. After acceptance of the written instructions, the laboratory/technician should custom manufacture and return the prostheses/appliances in a timely manner in accordance with the customary manner and with consideration of the doctor's request. If written instructions are not accepted, the laboratory/technician should return the work in a timely manner and include a reason for denial.
6. The laboratory should follow current infection control standards with respect to the personal protective equipment and disinfection of prostheses/appliances and materials. All materials should be checked for breakage and immediately reported if found.
7. The laboratory/technician should inform the dentist of the materials present in the case and may suggest methods on how to properly handle and adjust these materials.
8. The laboratory/technician should clean and disinfect all incoming items from the dentist's office; e.g., impressions, occlusal registrations, prostheses, etc., according to current infection control standards.

   All prostheses, appliances and related items which are returned to the dentist should be cleaned and disinfected, according to current infection control standards, placed in an appropriate container, packed properly to prevent damage, and transported.
9. The laboratory/technician should inform the dentist of any subcontracting laboratory/technician employed for preparation of the case. The laboratory/technician should furnish a written order to the dental laboratory which has been engaged to perform some or all of the services on the original written instructions.
10. The laboratory/technician should not bill the patient directly unless permitted by the applicable law. The laboratory should not discuss or divulge any business arrangements between the dentist and the laboratory with the patient.

Instructions to Dental Laboratories: Complete and clearly written instructions foster improved communication and working relationships between

dentists and dental laboratories and can prevent misunderstanding. State dental practice acts may specify the extent and scope of written instructions that are provided to dental laboratories for the custom manufacture of prostheses or appliances. These acts may describe the written instructions from the dentists to the dental laboratory as a “prescription” while other states refer to the instructions as a “work authorization” or “laboratory work order.” Realizing that terminology in state dental practice acts differ, constituent dental societies are urged to investigate appropriate terminology for their dental practice acts regarding the term(s) used to describe the written instructions between a dentist and a dental laboratory and between dental laboratories for subcontract work, since the term selected may have tax implications depending on state tax revenue codes.

Identification of Dental Prostheses: The Association urges members of the dental profession to mark, or request the dental laboratory to mark, all removable dental prostheses for patient identification. Properly marked dental prostheses assist in identifying victims in mass disaster, may be useful in police investigations and help prevent loss of the prostheses in institutional settings.

Shade Selection by Laboratory Personnel: Selection of the appropriate shade is a critical step in the custom manufacture of an aesthetically pleasing prosthesis. The Association believes that when a dentist requests the assistance of the dental laboratory technician in the shade selection process, that assistance on the part of the dental laboratory technician does not constitute the practice of dentistry, providing the activity is undertaken in consultation with the dentist and that it complies with the express written instructions of the dentist. The shade selection site, whether dental office or laboratory (where lawful), should be determined by the professional judgment of the dentist in the best interest of the patient and where communication between dentist, patient and technician is enhanced. When taking the shade in the laboratory, the dental technician should follow the appropriate clinical infection control protocol as outlined in the ADA’s infection control guidelines when dealing with the patient.

Regulation of Laboratories: The relationship between a dentist and a dental laboratory requires professional communication and business interaction. The dental laboratory staff may serve as a useful resource, providing product and technical information that will help the dentist in the overall planning of treatment to meet each patient’s needs. The dental laboratory staff may also consult with the dentist about new materials and their suggested uses. The Association applauds such cooperative efforts so long as the roles of the parties remain clear; the dentist must be responsible for the overall treatment of the patient and the dental laboratory is responsible for constructing high quality prostheses or appliances to meet the specifications determined by the dentist.

Some dentists may choose to own or operate a dental laboratory for the custom manufacture of prostheses or appliances for their patients or those patients of other dentists. The Association opposes any policy that prevents, restricts, or precludes dentists from acquiring ownership in dental laboratories.

In some states the issue of dental laboratory regulation has been addressed through requirements for registration, certification, licensure bills and some hybrids thereof. The Association believes the basic tenet of regulation by any governmental agency is the protection of the public’s health and welfare. In the delivery of dental care, that collective welfare is monitored and protected by state dental boards that have the jurisdictional power, as legislated under the state dental practice act, to issue licenses to dentists. These boards also have the power to suspend or revoke such licenses if such action is deemed warranted.

For decades, the public health and welfare has proven to be adequately protected under the current system of dental licensure. The dentist carries the ultimate responsibility for all aspects of the patient’s dental care, including prosthetic or appliance treatment. In a free market society, dentists select dental laboratories that provide the best quality services and prostheses. The Association opposes the creation of additional regulatory boards to oversee dental care and therefore, opposes any form of governmental regulation or licensure of dental laboratories not promulgated under the auspices of the state board of dentistry. The Association believes that a single state board of dentistry in each state is the most effective and cost-efficient means to protect the public’s dental welfare.

Notification of Prosthetic or Appliance Cases Sent to Foreign or Ancillary Domestic Labs for Custom Manufacture: Constituent dental societies are urged to pursue legislation or voluntary agreements to require that a domestic dental laboratory which subcontracts the manufacture of prostheses or appliances notify the dentist in advance when such prostheses, components or materials indicated in the dentist’s prescription are to be manufactured or provided, either partially or entirely, by a foreign dental laboratory or any domestic ancillary dental laboratory.

Glossary of Terms Relating to Dental Laboratories

Introduction: This glossary is designed to assist in developing a common language for discussion of laboratory issues by dental professionals and public policy makers. Certain terms may also be defined in state dental practice acts, which may vary from state to state.

Must: Indicates an imperative need or duty; an essential or indispensable item, mandatory.

Should: Indicates a suggested way to meet the standard; highly desirable.

May or Could: Indicates a freedom or liberty to follow suggested alternatives.

Dental Appliance: A device that is custom manufactured to provide a functional, protective, esthetic and/or therapeutic effect, usually as a part of oro-facial treatment.

Dental Laboratory: An entity that engages in the custom manufacture or repair of dental prostheses/appliances prostheses as directed by the written prescription or work authorization form from a licensed dentist.

Dental Prosthesis: An artificial appliance custom manufactured to replace one or more teeth or other oral or peri-oral structures in order to restore or alter function and aesthetics.

Laboratory Certification: A form of voluntary self-advancement in which a recognized, nongovernmental agency verifies that a dental laboratory technician or a dental laboratory has met certain predetermined qualifications and is granted recognition.

Laboratory Registration: A form of regulation in which a governmental agency requires a dental laboratory or dental laboratory technician to meet certain predetermined requirements and also requires registration with the agency and payment of a fee to conduct business within that jurisdiction.

Laboratory Licensure: A form of regulation in which a governmental agency, empowered by legislative fiat, grants permission to a dental laboratory technician or dental laboratory to provide services to dentists following verification of certain educational requirements and a testing or on-site review procedure to ensure that a minimal degree of competency is attained. This form of regulation requires payment of a licensing fee to conduct business within a jurisdiction and may mandate continuing education requirements.

Work Authorization/Laboratory Work Order: Written directions or instructions from a licensed dentist to a dental laboratory authorizing the construction of a prosthesis or appliance. The directions or instructions included often vary from state to state but typically include: (1) the name and address of the dental laboratory, (2) the name and identification number, if needed, of the patient, (3) date, (4) a description of the work necessary and a diagram of the design, if appropriate for the prosthesis or appliance, (5) the specific type of the materials to be used in the construction of the prosthesis or appliance, (6) identification of materials used and submitted to the laboratory, and (7) the signature and license number of the requesting dentist. In those states where the term "prescription" is used in place of the term "work authorization" or "laboratory work order," prescription is defined as written instructions from a licensed dentist to a dental laboratory authorizing the construction of a prosthesis or appliance to be completed and returned to the dentist.

Recognition Program for Meritorious Service by Certified Dental Technologists (*Trans.*1987:496; 1999:922)

Resolved, that the American Dental Association endorse and support a program, conducted by the state and local dental societies, recognizing the meritorious service performed by individual Certified Dental Technologists on appropriate anniversaries of service to the dental profession, as determined by the Council on Dental Practice.

Legislation

Limited English Proficiency (*Trans.*2005:338)

Resolved, that the Association work with the appropriate federal agencies, advocacy groups, trade associations, and other stakeholders to ensure that accommodating the language needs of English-limited patients is recognized as a shared responsibility, which cannot be fairly visited upon any one segment of a community, and be it further

Resolved, that the Association support appropriate legislation and initiatives that would enhance the ability of individuals of limited English proficiency to effectively communicate in English with their dentist and the dental office staff, and be it further

Resolved, that the Association oppose federal legislative and regulatory efforts that would unreasonably add to the administrative, financial, or legal liability of providing dental services to limited English proficient patients, such as being required to provide interpreters on demand as a condition of treating patients receiving state and/or federal benefits, and be it further

Resolved, that constituent and component dental societies be encouraged to support state, local, and private sector efforts to address the language needs of English-limited patients, and be it further

Resolved, that dental and allied dental programs be encouraged to educate students about the challenges associated with treating patients of limited English proficiency.

Trade Agreements (*Trans.*1993:711)

Resolved, that the ADA opposes any trade agreement that circumvents accreditation standards and/or state licensure requirements.

Campaign Finance Reform (*Trans.*1987:520)

Resolved, that the American Dental Association opposes public financing of congressional campaigns, and be it further

Resolved, that the American Dental Association opposes legislation which would restrict the ability of political action committees to conduct their activities.

Government Intrusion Into Private Practice (*Trans.*1976:857)

Resolved, that the American Dental Association is opposed to any unnecessary intrusion, either by state or federal government, into the private practice of dentistry.

Legislation—Dental Care and Dental Benefits

Dental Benefits in a Child Support Order (*Trans.*2018:362)

Resolved, that the American Dental Association pursue federal legislative or regulatory efforts to require dental support in child custody orders as a child support obligation, like medical support, and be it further
Resolved, that constituent societies of the American Dental Association be urged to pursue individual state legislative or regulatory efforts to require dental support in child custody orders as a child support obligation.

Legislation to Require Dental Benefit Plans to Provide Dental Consultant Information (*Trans.*2010:546)

Resolved, that the American Dental Association pursue federal legislation or regulation to require federally regulated dental benefit plans to provide in the explanation of benefits the name, degree, license number, and direct phone number of the licensed dentist or of any other individual who makes the final decision involved in accepting or rejecting any dental claim, and be it further
Resolved, that the ADA request that constituent and component dental societies pursue state legislation or regulation to require dental benefit plans to provide in the explanation of benefits the name, degree, license number, and direct phone number of the licensed dentist or of any other individual who makes the final decision involved in accepting or rejecting the dental claim and that dentists reviewing claims submissions must be licensed in the United States, preferably within the jurisdiction of the dentist treating the patient in accordance with applicable state law.

Reauthorization of the State Children's Health Insurance Program (*Trans.*2007:451)

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

Freedom of Choice in Publicly Funded Aid Programs (*Trans.*2006:344)

Resolved, that the ADA pursue regulatory or legislative action to mandate that any licensed dentist may participate in a publicly funded program without joining a third-party network that requires them to also see privately funded commercial patients under a managed care contract.

Mandated Assignment or Authorization of Dental Benefits (*Trans.*2006:316)

Resolved, that constituent societies be urged to seek appropriate regulatory and/or legislative action to mandate that, if a patient assigns or authorizes benefits to a dentist, the insurance carrier shall be required to follow that directive and remunerate the dentist directly.

Alteration of Dental Treatment Plans by Third-Party Claims Analysis (*Trans.*1999:929; 2013:320; 2019:XXX)

Resolved, that in consideration of existing policy on standards for dental benefit plans (*Trans.*1988:478; 1989:547; 1993:696; 2000:458; 2001:428; 2008:453; 2010:546), the challenge of a dental treatment plan by a third-party claims analysis is considered diagnosis and thereby constitutes the practice of dentistry, which can only be performed by a dentist licensed in the state in which the procedures are performed, who has equivalent training with that of the treating dentist, and carries with it full liability, and be it further
Resolved, that the formulation or alteration of a treatment plan without a dental clinical examination of the patient by a dentist legally authorized to practice in the state in which the patient is treated should be prohibited, and be it further
Resolved, that the ADA encourage the adoption of these positions by the American Association of Dental Boards, all state dental associations, and all states' boards of dentistry, and be it further
Resolved, that the ADA urges state dental associations and all states' boards of dentistry to pursue legislation and/or regulations to meet this end.

Dental Claims Processing (*Trans.*1999:930)

Resolved, that the American Dental Association seek or support legislation, and/or a directive through agency rules and/or regulations, that requires the purchaser of a dental benefit program to also provide a means, other than dental offices, through which the recipient of the benefit can process a claim.

Third-Party Payers Overpayment Recovery Practices (*Trans.*1999:930; 2013:312)

Resolved, that the American Dental Association shall and its constituent societies are urged to seek or support legislation to prevent third-party payers from withholding assigned benefits when a payment made in error has been made on behalf of a different patient covered by the same third-party payer.

ERISA Reform (*Trans.*1998:738)

Resolved, that the ADA seek federal legislation and/or regulation that would prohibit ERISA and all health benefit plans from excluding coverage of general anesthesia and/or hospital or outpatient surgical facility charges incurred by covered persons who receive dental treatment under anesthesia, due to a documented physical, mental or medical reason as determined by the treating dentist(s) and/or physician.

Patient and Provider Advisory Panel (*Trans.*1997:704)

Resolved, that the Association seek, and the constituent societies be urged to seek, legislation or regulation at the federal or state level, respectively, that would require any entity that offers coverage of dental benefits through a network of participating dentists to establish an advisory panel made up of covered patients and an advisory panel made up of participating dentists, and be it further
Resolved, that these panels would provide meaningful input to the plan, on an ongoing basis, on its design and policies.

Community Rating, Risk Pools and Portability for Health Benefit Coverage Plans (*Trans.*1995:648)

Resolved, that the Association endorses appropriate legislative initiatives establishing the concept of community rating for health benefit coverage plans, and be it further
Resolved, that the Association endorses appropriate legislative initiatives establishing the concept of risk pools for small employers and individuals to facilitate the purchase of health benefit coverage plans, and be it further
Resolved, that the Association endorses appropriate legislative initiatives intended to facilitate the portability of health benefit coverage plans.

Legislation to Guarantee Patient's Freedom of Choice of Dentist (*Trans.*1995:631)

Resolved, that the American Dental Association actively pursue legislation that will guarantee the patient's right to choose any licensed dentist to deliver his or her oral health care without any type of coercion, and be it further
Resolved, that the American Dental Association take legislative action to oppose any arrangement that eliminates, interferes with, or otherwise limits the patient's freedom of choice.

Legislation Regulating All Dental Benefits Programs (*Trans.*1993:694)

Resolved, that constituent dental societies be encouraged to serve the best interests of the public by developing and/or supporting legislation which regulates all dental benefit programs, including provisions that ensure freedom of choice of a dentist and that require the option of fee-for-service dental care where HMOs or closed panel coverage are offered, and be it further
Resolved, that, absent state regulation, the ADA support federal legislation that would require employers to provide the option of a dental benefit program allowing for the freedom of choice of a dentist and the option of fee-for-service dental care where HMOs or closed panel coverage are offered, and be it further
Resolved, that all benefits be paid without discrimination based on the professional degree and license of the dentist or physician providing treatment.

Timely Payment of Dental Claims (*Trans.*1991:639)

Resolved, that the appropriate agencies of the American Dental Association, and its constituent dental societies, be urged to seek legislation which would require all public and private third-party payers to reimburse dental claims within fifteen (15) business days from receipt of the claim by the third-party payer or be penalized for failure to do so.

Continuation of Doctor/Patient Relationship (*Trans.*1991:627)

Resolved, that the American Dental Association take appropriate legislative action to oppose governmental and third-party intrusion in the doctor/patient relationship.

Legislation Prohibiting Discrimination of Benefit Payment Based on Professional Degree of Provider (*Trans.*1989:562)

Resolved, that appropriate agencies of the American Dental Association prepare model legislation and, upon request, actively assist constituent dental societies in the pursuit of any legislative and administrative initiatives that may be needed to ensure that all states prohibit discrimination of benefit payment based on the type of license and/or professional degree of the dentist and/or physician.

Legislative Clarification for Medically Necessary Care (*Trans.*1988:474; 1996:686)

Resolved, that constituent dental societies be encouraged to pursue legislation or regulation at the state level to have the language in health benefit plans clarified so that medically necessary care, essential to the successful treatment of a medical or dental condition being treated by a multidisciplinary health care team, is a required extension of covered medical procedures, and be it further

Resolved, that the appropriate Association agencies seek federal legislative or regulatory actions to have the language in health benefit programs clarified so that medically necessary care, essential to the successful treatment of a medical or dental condition being treated by a multidisciplinary health care team, is a required extension of covered medical procedures.

Reimbursement Under Third-Party Programs (*Trans.*1983:584; 1992:604)

Resolved, that the appropriate agencies of the ADA encourage constituent societies to apprise their state legislatures of the need for legislation prohibiting insurance companies and other third-party payers from lowering the amount of reimbursement to a patient because the patient has chosen a dentist who is not a participating provider under the patient's dental coverage, and be it further

Resolved, that the appropriate agencies of the Association pursue federal legislation that will protect a patient from lower levels of reimbursement based on his or her choice of dentists who are not participating providers in the patient's dental plans.

Itemization of Dental Charges (*Trans.*1979:634)

Resolved, that the American Dental Association is opposed to legislation which would mandate that patient invoices contain an itemization of charges related to the dental treatment, including separation of commercial dental laboratory fees, because of the ensuing confusion it would certainly create.

Legislation—State

Regulating Non-Dentist Owners of Dental Practices (*Trans.*2011:491; 2019:XXX)

Resolved, that in order to protect the oral health and safety of patients, and to ensure their continuity of care, the ADA, urge and assist constituent societies to advocate for the regulation of entities that provide dental services but are owned or controlled by non-dentists, non-dentist corporations, or dentists not licensed in that state, and be it further
Resolved, that licensing and state authorities be urged to establish regulations which hold entities providing dental services that are owned by non-dentists, non-dentist corporations, or dentists not licensed in that state to the same ethical and legal standards as those that are owned by state licensed dentists, and be it further
Resolved, that any entity providing dental services should be required to register with their state dental licensing board and obtain a business license from the appropriate state agency as required by law.

Fabrication of Oral Appliances Used With Tooth Whitening Products (*Trans.*2002:397)

Resolved, that only licensed dentists or their supervised dental auxiliaries, in compliance with applicable state law, be permitted to make impressions for the fabrication of appliances used with tooth whitening products, and be it further
Resolved, that this information be communicated to all organizations (e.g., state boards of dentistry and the Centers for Disease Control and Prevention) working to protect the public from harm and infectious disease.

States' Rights Affecting the Practice of Dentistry (*Trans.*1996:715)

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.

Legislation Reflecting ADA Policy on Primary Dental Health Care Provider (*Trans.*1990:559)

Resolved, that the American Dental Association urge constituent societies to reinforce the intent of the policy (*Trans.*1981:564) to reflect by legislative initiative that the dentist is the primary dental health care provider to the public, and be it further
Resolved, that the appropriate agencies of the Association develop model legislation that will assist requesting states to enact legislation which will direct third-party payers, when paying benefits for dental services to health care providers, to do so only to a licensed dentist.

Legislation Prohibiting Waiver of Patient Copayment/Overbilling (*Trans.*1990:534)

Resolved, that constituent dental societies be urged to pursue enactment of legislation that: (1) prohibits systematic nondisclosure of waiver of patient copayment/overbilling by a dentist and (2) prohibits bad faith insurance practices by third-party payers, consistent with Association policy, and be it further
Resolved, that third-party payers be urged to support this legislative objective.

Use of Expert Witnesses in Liability Cases (*Trans.*1986:531)

Resolved, that the American Dental Association urge constituent dental societies to actively support legislation and changes in court rules that would require plaintiffs and their attorneys in professional liability actions to include with each complaint the affidavit of a health care professional, who practices in the same field or specialty as the defendant and who has reviewed the patient record and related materials, stating that there is reasonable and meritorious cause for filing the action, and be it further
Resolved, that constituent dental societies be urged to actively support legislation and changes in court rules that would require expert witnesses to possess the clinical knowledge and skill to qualify them on the subject of their testimony and familiarity with the practices and customs of practitioners in good standing in the locality where the defendant practiced when the incident occurred, and be it further
Resolved, that constituent dental societies also be urged to actively support legislation and changes in court rules requiring courts in appropriate cases to instruct juries on the availability of alternative treatments and the role of patients in their own care.

ADA Assistance in Legislative Initiatives (*Trans.*1982:513)

Resolved, that when a state dental association notifies the American Dental Association that it is involved in the signature gathering phase of an initiative petition which would adversely affect dentistry in that state, then the American Dental Association shall assist the state dental association in developing strategy for media releases, and be it further

Resolved, that all media responses during the signature gathering phase be released through the state dental association.

Suggested Dental Practice Acts (*Trans.*1978:529)

Resolved, that the ADA supports only those suggested dental practice acts that are consistent with Association policies, and be it further

Resolved, that the appropriate agency of the Association provide a timely, ongoing analysis to constituent societies of any suggested state dental laws that are developed by any agency outside the Association, with particular references as to how such proposed dental practice acts may be in conflict with Association policies.

Legislative Assistance by the Association (*Trans.*1977:948; 1986:530; 2019:XXX)

Resolved, that the American Dental Association shall not assist any organization, agency, group or individual who is attempting to alter the laws of a state without the consent and approval of the constituent society, and be it further

Resolved, that when the American Dental Association is aware of pending legislation within a state which is in opposition to existing Association policy or is otherwise detrimental to the best interests of the public, the Association shall inform the constituent society of the implications of such legislation, urge the constituent society to take appropriate action and offer assistance in addressing the issue.

Recommendations and Guidelines for Assistance to Constituent Societies in Litigation of Dental Practice Acts (*Trans.*1958:278, 405)

Recommendations

1. Each constituent society should notify the Association of any litigation involving the state dental law as soon as possible after the constituent society becomes aware that such litigation is pending. In this connection the Board of Trustees should be informed that the agencies of the Association will communicate with the constituent societies, the larger component societies and the state dental examining boards on a regular basis for the purpose of obtaining information on litigation related to their state dental laws. The information obtained will be made available routinely by newsletter, special bulletin or other communication. This information service will be directed primarily to the attorneys retained by the constituent and component dental societies and the attorneys retained by the state examining boards.
2. Each constituent society that contemplates initiating litigation related to the enforcement of the dental practice act and supporting that litigation with society resources should notify the Association of its plans and keep the Association informed of the progress of the suit. This will permit the interested Association agencies to evaluate the prospective litigation with a view to (a) furnishing material which might be helpful to the society's attorney, and (b) assisting in obtaining expert witnesses if that need is indicated. (The agencies of the Association provided information to the Utah and Georgia constituent societies when litigation was being planned in those states. The litigation was concluded recently in the appellate courts of Utah and Georgia with decisions favorable to the constitutionality of the dental laws in those states.)
3. Where it appears that the failure to institute the needed litigation under the dental practice act is caused by the inadequacy of state funds available for dental law enforcement, it is suggested that the constituent society consider urging an increase in annual renewal fees necessary to support an effective enforcement program.

Guidelines

1. The society has notified the Association of the litigation at a time that permits the agencies of the Association to be of maximum assistance in offering suggestions on the enforcement program or the litigation.
2. The society has made every reasonable effort to obtain the funds needed to sustain the litigation from its own resources.
3. The need for additional funds is immediate.
4. Failure to obtain additional funds would seriously impair the constituent society efforts to pursue the litigation to a successful conclusion.
5. The disposition of the issue or issues under litigation would have a direct and substantial impact upon the dental profession nationally.
6. The financial aid requested is commensurate with the benefits reasonably expected to result, on a nationwide basis, from a favorable result of the litigation.

Licensure

Comprehensive Policy on Dental Licensure (*Trans.*2018:341)

COMPREHENSIVE POLICY ON DENTAL LICENSURE

General Principles

- One standard of competency for dental licensure must be in place in order to provide quality oral health care to the public.
- Provisions for freedom of movement across state lines for all dental professionals should exist to facilitate the provision of quality oral health care to the public.
- Federal licensure and federal intervention in the state dental licensure system are strongly opposed.
- Efforts of unlicensed and unqualified persons to gain a right to serve the public directly in the field of dental practice are strongly opposed.
- Elimination of patients in the clinical licensure examination process is strongly supported to address ethical concerns, including those identified in the ADA Council on Ethics, Bylaws and Judicial Affairs statement entitled Ethical Considerations When Using Patients in the Examination Process (*Reports* 2008:103). State dental societies and dental boards are urged to work toward acceptance of valid and reliable clinical assessments that do not require single-encounter performance of procedures on patients.
- The state boards of dentistry in each state or licensure jurisdiction are the sole licensure and regulating authorities for all dentists and allied dental personnel.
- State dental boards are encouraged to require verification of completion of continuing dental education as a condition for re-registration of dental licenses.
- Dentists identified as deficient through properly constituted peer review mechanisms should undergo assessment and corrective competency-based education and such provisions should be included in laws, rules and regulations.

Initial Licensure

States are urged to accept the following common core of requirements for initial licensure:

1. Completion of a DDS or DMD degree from a university-based dental education program accredited by the Commission on Dental Accreditation.
2. Successful passage of the National Board Dental Examination, a valid and reliable written cognitive test.
3. A determination of clinical competency for the beginning practitioner, which may include:

    - Acceptance of clinical examination results from any clinical testing agency; or
    - Graduation from CODA-accredited PGY-1 program, that is, a residency program at least one year in length at a CODA-accredited clinically-based postdoctoral general dentistry and/or successful completion of at least one year of a specialty residency program; or
    - Completion of a portfolio-type examination (such as employed by the California Dental Board) or similar assessment, that uses the evaluation mechanisms currently applied by the dental schools to assess student competence; or
    - An Objective Structured Clinical Examination (OSCE), that is, a valid and reliable non-patient based examination consisting of multiple, standardized stations that require candidates to use their clinical knowledge and skills to successfully complete one or more dental problem-solving tasks.

Curriculum Integrated Format Clinical Examination

A Curriculum Integrated Format (CIF) clinical examination addresses ethical concerns associated with single encounter patient-based examinations currently administered by dental clinical testing agencies. A CIF provides candidates opportunities to successfully complete independent “third-party” clinical assessments on patients of record prior to graduation from a dental education program accredited by the Commission on Dental Accreditation. The curriculum integrated format, as defined below, should only be employed as a licensure examination until a non-patient based licensure examination is developed that protects the public and meets psychometric standards. The Association believes that the following CIF provisions must be required by state boards of dentistry and incorporated by testing agencies for protection of the patient:

- A CIF examination must be performed by candidates on patients of record within an appropriately sequenced treatment plan.

- The competencies assessed by the clinical examining agency must be selected components of current dental education program curricula and reflective of current dental practice.
- All portions of the CIF examination must be available at multiple times within each institution during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake prior to graduation any portions of the examination which they have not successfully completed.

Graduates of Non-CODA Accredited Dental Education Programs

For initial licensure in dentistry, international graduates of non-CODA accredited dental education programs should possess the following educational credentials: 1) completion of a university-based dental education program accredited by the Commission on Dental Accreditation (CODA) leading to a DDS or DMD degree or 2) graduation from a postgraduate program in general dentistry accredited by the Commission on Dental Accreditation.

Licensure by Credentials

States should have provisions for licensure of dentists who demonstrate they are currently licensed in good standing and also have not been the subject of final or pending disciplinary action in any state or jurisdiction in which they have been licensed. This should also apply to experienced, internationally-trained dentists, who have been licensed in a U.S. jurisdiction, and who may or may not have graduated from a CODA-accredited dental school.

Appropriate credentials may include:

- DDS or DMD degree from a dental education program accredited by the Commission on Dental Accreditation
- Specialty certificate/master's degree from accredited program
- Specialty Board certification
- GPR/AEGD certificate from accredited program
- Current license in good standing
- Passing grade on an initial clinical licensure exam, unless initial license was granted via completion of PGY1, Portfolio examination, or other state-approved pathway for assessment of clinical competency.
- Documentation of completion of continuing education

For dentists who hold a current dental license in good standing in any jurisdiction, state dental boards should:

- Accept pathways that allow for licensure without completing an additional clinical examination, e.g., by credentials, reciprocity, and/or endorsement.
- Consider participation in licensure compacts
- Implement specialty licensure by credentials and/or specialty licensure to facilitate licensure portability of dental specialists.
- Make provisions available for a limited or volunteer license for dentists who wish to provide services without compensation to critical needs populations within a state in which they are not already licensed.
- Make provisions available for limited teaching permits for faculty members at teaching facilities and dental programs accredited by the Commission on Dental Accreditation.

Licensure by Credentials for Dentists Who Are Not Graduates of CODA-Accredited Dental Education Programs

State dental societies and dental boards are strongly encouraged to grant the same benefits of licensure mobility to U.S. currently-licensed dentists who were licensed by their respective jurisdictions prior to state implementation of the requirement for graduation from a CODA-accredited dental school with a DDS or DMD degree.

Examinations for Allied Dental (Non-Dentist) Personnel (*Trans.*2010:595; 2018:322)

Resolved, that the ADA strongly urges state dental boards to require examination of candidates for dental licensure separately from candidates for allied dental (non-dentist) licensure.

State Board Support for CODA as Responsible to Accredit Dental Education Programs (*Trans.*2003:367; 2012:463)

Resolved, that the Association urge state boards of dentistry to continue to support the role of the Commission on Dental Accreditation as the agency responsible for the accreditation of dental education programs.

Policy on Licensure of Dental Assistants (*Trans.*2000:474)

Resolved, that it is the policy of the American Dental Association that licensure of dental assistants is not warranted.

Promotion of Freedom of Movement for Dental Hygienists (*Trans.*1990:550; 2018:321)

Resolved, that the state boards of dentistry be urged to give consideration to the profession's ongoing need for dental hygienists and develop licensure mobility pathways under which dental hygienists licensed in good standing in one state may be licensed for practice in another state without completing an additional clinical examination.

Managed Care and Utilization Review

Full Disclosure of Financial Incentives and Other Health Plan Information (*Trans.*1996:692)

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 spent for patient treatment.

Administrative Practices Encouraging Dentist Selection Based on Cost (*Trans.*1995:610)

Resolved, that the American Dental Association take appropriate legislative action to oppose any administrative practice or financial incentive that is utilized by benefit managers and/or administrators of dental prepayment plans that force or otherwise encourage patients to select the dentist from whom they will seek care principally on the basis of cost, and be it further

Resolved, that the appropriate agency report to the ADA House of Delegates as to the action taken to fulfill this resolution.

Prohibition of "Hold Harmless" Clauses (*Trans.*1995:651)

Resolved, that the American Dental Association initiate the development of federal and, upon request, state legislation necessary to prohibit the inclusion of "hold harmless" clauses in managed care provider contracts, to the extent that such clauses seek to shift managed care plans' liability to dentists for adverse patient care outcomes due to actions by plans taken pursuant to contractual provisions or restrictions, and be it further

Resolved, that the American Dental Association continue its educational efforts to help dentists make informed, individual decisions about signing managed care plan contracts.

Requirements for Managed Care Programs (*Trans.*1995:627; 2000:466)

Resolved, that the following minimum requirements for managed dental care programs that address both legislative/regulatory and plan design issues, as Amended, be adopted:

Requirements for Managed Care Programs—Legislative/Regulatory

1. Managed care organizations (MCOs) should be financially solvent and in compliance with federal and state laws established for insurance companies and service corporations.
2. Managed care plans should have sufficient funds to pay for treatment obligations beyond the life of the plan.
3. Allocation of premium dollars collected by MCOs should, by law, be clearly delineated and filed with the appropriate regulatory agency for each of the managed care plans sold. In addition, managed care plans (both for-profit and nonprofit) should be required by federal and state law to publicize in marketing materials to plan purchasers and in written communications to patients the percentage of premiums that fund treatment and the percentage of premiums that go to administrative costs, promotion, marketing and profit (or in the case of nonprofit entities, reserves).
4. There should be no discrimination against the dentist based on degree and/or specialty.
5. Due process under the law should be an integral part of every managed care plan for participating dentists.
6. In capitation plans, the portion of per capita payments allocated for treatment should be sufficient to provide services to an actuarially-

supported and monitored percentage of the plan's subscribers. Per capita payments allocated for treatment should be calculated annually based on the previous six months' price index as it relates to dental services.

7. Outcomes data regarding treatment should be based on a uniform system of diagnostic codes, treatment codes and specific elements of patient records.
8. All plans shall collect accurate data from the dental care providers for all plan enrollees and include all treatment rendered to each patient in that plan. These data should be made available to enrollees, plan purchasers, appropriate regulatory agencies and any other entity that is responsible for evaluating the plan.

Requirements for Managed Care Programs—Plan Design

1. Utilization review programs used by MCOs should be used to promote an efficient distribution of the plan's resources. All incentives, financial and otherwise, to practitioners to manipulate the provision of treatment to patients should not, in any manner or form, be part of the utilization review process and should be eliminated from all existing programs.
2. Geographic distribution of participating dentists must match the same geographic areas from which employers draw their employees.
3. Access to care should be promoted by good geographic distribution and representation of dentists (general practitioners and specialists). Terms agreed to between the dentist and plan regarding treatment of the plan's subscribers during non-peak hours of the dental practice should be clearly spelled out to the plan purchaser and the plan's subscribers.
4. Plan design should involve the MCOs, plan purchasers and participating dentists so that the needs of plan subscribers are met. Employee populations change from company to company and plans must accommodate those differences.
5. Patients should have the "freedom of choice" to select their dentist. If their chosen dentist is outside the plan, a reasonable "point of service" cost should be established.
6. Credentialing, internal protocols and quality assurance mechanisms, included in each managed care plan, should be clearly stated to plan purchasers and participating dentists.
7. Liability associated with plan restrictions on treatment and referral to specialists should be assumed by the MCO.
8. The percentage of anticipated utilization of managed care plans by enrollees must be made available to providers solicited to participate in the plans prior to any contract(s) being signed by the providers. An error of 5% or over will require managed care plans to renegotiate the per capita payments or the discounted fees to compensate the provider(s) for loss of income due to the increased or decreased utilization.
9. As pertaining to capitation plans, the patient should have 30 days to select their dentist. If the patient has not selected a dentist, the plan will immediately inform the patient of a selection and the patient will have the option of altering the selection at any time during their plan involvement.

Statement on Managed Care and Utilization Management (*Trans.*1995:624)

The American Dental Association shares the national concern expressed by government, business, industry, and the professions about the rising cost of health care. The Association supports legitimate, valid efforts to stabilize the cost of health care in the United States. However, in addressing the problem, it is all too easy to adopt simplistic solutions that, in the short term, will result in less-than-optimum care for patients, and in the long term, will result in increased costs.

The concept of "managed care" has been universally promoted as a method of containing health care costs. After examination of this concept by the Association, it became evident that while the term is widely used, its meaning could not be more elusive. The Association defines managed care as follows:

> Managed care is any contractual arrangement where payment or reimbursement and/or utilization are controlled by a third party.

This concept represents a cost-containment system that directs the utilization of health care by:

a. restricting the type, level and frequency of treatment;
b. limiting the access to care;
c. controlling the level of reimbursement for services; and
d. controlling referrals to other practitioners.

The Association believes that the public must be served and protected through the appropriate management of:

1. **Dental Care.** Dental care is managed by the treating dentist. Dental care is provided by the treating dentist based on a dental evaluation, the development of an individualized treatment plan and a consultation with the patient.
2. **Benefit Plan Design.** Benefit plan design is managed by plan purchasers. Benefit plan design must be scientifically sound, clinically relevant and reliable. Plan design may also include cost-containment measures, such as annual maximums, copayments, limitations, predeterminations, exclusions, enrollment periods and patient incentives for maintaining oral health.

3. **Program Costs.** Program costs are managed by plan administrators. Oversight of the program may include implementation of the plan agreement through monitoring utilization, preauthorizing treatment, requiring second opinions, reviewing claims and collecting and evaluating claims data.

Definitions of the terms “cost containment” and “managed care” vary greatly and are open to interpretation by various organizations. The Association believes that “managed care,” as currently applied to the practice of medicine, is not relevant to the practice of dentistry. Dentistry is, by and large, a self-contained discipline. In most instances, a general dentist can diagnose and treat a patient’s condition from beginning to end. This fact is reflected in the demographics of the dentist population in the United States: approximately 86% are general practitioners and 14% are in specialty practice, compared with 12% general practitioners and 88% specialists in medicine.

The practice of dentistry is procedural and cognitive. While there are eight recognized dental specialty areas of practice, the licensed general dentist is trained to perform services in all areas of dentistry. When compared with the numerous specialties and subspecialties of medicine, and the increasingly limited area of practice commanded by the “family physician,” the latitude of a dentist’s license to diagnose and treat a patient’s oral health condition becomes clear. In addition, dentistry is almost exclusively an outpatient service, although there are limited situations where treatment is most appropriately performed in a hospital setting. The concept of “case management” has long been a foundation of dental practice in the United States.

Outside the practice of dentistry, there are additional factors that influence the utilization of dentistry, such as benefit plan design which integrates controls through copayments, annual maximums, exclusions and limitations, preauthorizations, etc.

For these reasons, the Association believes that the concept of managed care is financial in nature and, regardless of the type of plan, refers only to cost containment. Utilization management refers to administration of the plan as it relates to plan design. The Association defines utilization management as”...a set of techniques used by or on behalf of purchasers of health care to manage the cost of health care prior to its provision by influencing patient care decision making through case-by-case assessment of the appropriateness of care based on accepted dental practices.”

The techniques embraced by utilization management, as defined, should equally serve patients, plan purchasers and the dental profession by providing the following:

- **Patients**—parameters of care based on scientifically sound, clinically relevant and reliable research; plan coverage designed and maintained through evaluation and analysis of data; education and information about different types of procedures and their outcomes; opportunity to make treatment decisions based on a clear understanding of available options.
- **Plan Purchasers**—constant feedback regarding the effectiveness of their plans, thus ensuring a meaningful benefit for their employees; data regarding loss ratio; communication with the Association regarding advances in procedures and technology for consideration in updating plan coverage.
- **Dental Profession**—opportunity for involvement in the process of plan design to ensure appropriate treatment based on parameters of care developed and maintained by the profession.

An area of concern for the Association and others is the increased reliance on statistically-based utilization review of claims as a complete program for managing costs.

In dentistry, utilization review initiatives are classified as retrospective review of treatment. This usually takes the form of a statistically-based, dentist-specific system which analyzes patterns of claims reporting under dental care plans.

The statistics compiled under this system are procedure-specific and are used by the utilization review administrator to develop various statistical “norms” which are used to establish dental practice patterns by which all dentists are judged.

The Association believes that statistically-based utilization review should not be used to determine acceptable norms or clinical standards of dental practice. The Association has defined statistically-based utilization review as a system “...that examines the distribution of treatment procedures based on claims information and in order to be reasonably reliable, the application of such claims analyses of specific dentists should include data on type of practice, dentist’s experience, socioeconomic characteristics and geographic location.”

Statistically-based utilization review has fostered a new service area, and the growth of utilization review companies competing for this business must be recognized for its potential to help solve the problem of health care costs, or to substantially add to or create new problems. Treatment plans and claims are being reviewed by clerks, statisticians and actuaries, not by licensed practitioners. Patients are being denied coverage for care based on such reviews.

The Association believes that utilization management, prescribed by the patient’s dentist which protects the lifetime long-term care concerns of the public, is a concept that offers opportunities for patients, plan purchasers, dentists and plan administrators to jointly achieve their common goals: to share information and concerns regarding standards of care; to improve patient education; to develop meaningful benefit coverage; to respond to advances in technology; and to stabilize the cost of health care in the United States.

Automatic Review of Denied Claims by Independent Dental and/or Medical Experts (*Trans.*1994:645)

Resolved, that the appropriate agencies of the American Dental Association seek federal legislation and encourage constituent societies to seek state legislation so that if a Health Maintenance Organization (HMO), capitation program, or Preferred Provider Organization (PPO) denies a claim for treatment or tests required for treatment it considers dentally or medically unnecessary, the denial would be subject to automatic review by independent dental and/or medical experts.

Practitioner Protections in Managed Care Plans (*Trans.*1994:643)

Resolved, that the Association initiate and/or participate in the development of federal and, upon request, state legislation necessary to protect the rights of dentists who choose to participate in managed care plans.

Guidelines on Professional Standards for Utilization Review Organizations (*Trans.*1992:601; 2001:433)

Resolved, that the Guidelines on Professional Standards for Utilization Review Organizations (UROs) (Reports:33) be adopted as policy of the American Dental Association, and be it further

Resolved, that organizations who subcontract to provide utilization review services for licensed UROs must be equally licensed and meet the same standard as the contracting UROs, and be it further

Resolved, that the state dental societies seek legislative and/or regulatory actions to have these Guidelines integrated into laws, rules and regulations governing utilization review organizations and their activities, and be it further

Resolved, that for UROs that are not state regulated, the appropriate Association agencies seek federal legislative or regulatory actions to have the Guidelines integrated into laws, rules and regulations governing utilization review organizations and their activities.

Resolved, that these Guidelines apply to all entities that perform utilization review services, including but not limited to independent Utilization Review Organizations (UROs) acting on behalf of a dental plan, and a utilization review operation within and part of a dental plan or third-party payer.

Guidelines on Professional Standards for Utilization Review Organizations

Utilization review is a rapidly growing new industry that has yet to prove its effectiveness in containing costs without harming patient care. Because utilization review has the effect of influencing benefit plan design based on least costly procedures rather than positive treatment outcomes, the Association believes that utilization review organizations should be licensed by the appropriate state agency. The Association also believes that compliance with professional standards for licensing should not be voluntary. The utilization review process is a tool to assess patient treatment. Post-payment utilization review is used by third-party entities to monitor treatment received by patients and to provide feedback to dentists participating in the dental plan; it should not be used for collection or recovery of past reimbursements.

In the interest of assuring that where utilization review programs exist, they should be conducted as efficiently and effectively as possible and there should be minimal disruption to the delivery of health care. The following guidelines are recommended to achieve uniformity in the structure and operation of utilization review programs.

1. Utilization review organizations (UROs) should be financially solvent and in compliance with applicable federal and state laws. While utilization review programs may play an important role in promoting an efficient distribution of health care resources, the decision as to what health care treatment an individual patient actually receives must remain the prerogative of the practitioner and his or her patient or the patient's representative.
2. All incentives, financial and otherwise, for practitioners, hospitals and third-party payers to manipulate the provision of treatment to patients should not, in any manner or form, be a part of the utilization review process and should be eliminated from all existing programs.
3. Utilization review organizations should be legally responsible and liable for any adverse outcomes based on their treatment decisions.
4. Staff should be properly licensed, trained, qualified and supervised. Physicians, dentists and other health professionals conducting reviews of health care services, and other clinical reviewers conducting specialized reviews in their area of specialty, should be currently licensed or certified by an approved state licensing agency.
5. In conducting utilization reviews, only the information necessary to certify a procedure, treatment, admission or length of stay should be collected. Data requirements should be limited to the following elements:

Patient Information
Name
Address
Date of Birth
Sex
SS Number or Patient ID Number
Name of Payer(s) or Plan
Plan ID Number

Enrollee Information
Name
Address
SS Number or Employee ID Number
Relation to Patient
Employer

Health Benefit Plan
Group Number/Plan ID Number
Other Coverages Available (including Workers Comp, Auto, CHAMPUS, Medicare, etc.)

Attending Practitioner Information
Name
Address
Phone Numbers
Degree
Specialty/Certification Status
Tax ID or SS Number

Diagnosis/Treatment Information
Diagnoses
Proposed Procedure(s) or Treatment(s) (with associated CDT, CPT or ICD codes if available)
Proposed Procedure Date(s), Admission Date(s) or Length of Stay

Clinical/Treatment Information
Sufficient for support of appropriateness and level of service proposed
Contact person for detailed clinical information

Facility Information
Type (such as office/clinic, inpatient, outpatient, special unit, SNF, rehab)
Status (licensure/certification status, etc.)
Name
Address
Phone Number
Tax ID or Other ID Number

Concurrent (Continued Stay) Review Information
Additional Days/Services/Procedures Proposed
Reasons for Extensions (including clinical information sufficient for support of appropriateness and level of service proposed)
Diagnoses (same/changed)

For Admissions to Facilities Other Than Acute Medical/Surgical Hospitals
Additional information:
History of Present Illness
Patient Treatment Plan and Goals
Prognosis
Staff Qualifications
24-Hour Availability of Staff

For Special Situations
Additional information necessary for the treatment of the patient's condition such as discharge planning or catastrophic case management

6. Written procedures should be in place to assure that reviews are conducted in a timely manner.

    a. Certification determinations should be made within two working days of receipt of the necessary information on a proposed service or admission requiring a review determination.
    b. Protocol for review of emergency care must be clearly defined.
    c. Ongoing inpatient stays may be reviewed, but routine daily reviews should not be conducted on all such stays.
    d. The same procedural codes, code modifiers and a common practitioner tax ID number to assist practitioners in dealing with multiple health benefit plans in their service areas should be used.
    e. Health care providers, patients and their representatives should be informed of URO policies relating to denial of claims based on lack of or failure to provide necessary information for review.

7. Procedures should be adopted for appeals of determinations not to certify an admission, procedure, service or extension of stay. The right to appeal should be available to the patient or enrollee and to the attending practitioner. If the determination is denied after review by the URO's appropriate practitioner advisor, the patient, enrollee or attending practitioner should have the right to a review by another medical consultant or peer review body.

8. There should be written procedures for assuring that patient information obtained during the process of utilization review will be:

    a. kept confidential in accordance with applicable federal and state laws;
    b. used solely for the purposes of utilization review, quality assurance, discharge planning and catastrophic case management; and
    c. shared with only those agencies who have authority to receive such information.

9. When a utilization review process identifies a dentist for further scrutiny, verifiable notice must be provided to the dentist, and such notice include the basis, duration, expected outcomes and all consequences of the scrutiny.

10. When the utilization review process involves subjecting a patient to clinical evaluation, such evaluation should be undertaken through the constituent peer review process.

Regulation of Utilization Management Organizations (*Trans.*1991:636)

Resolved, that the constituent societies be encouraged to seek state legislation to establish standards for the regulation and oversight of all organizations that provide dental utilization management, managed care review or prior review of dental treatment services, and be it further **Resolved,** that the constituent societies be encouraged to seek state legislation and regulations to require certification of all organizations that provide dental utilization management, managed care review or prior

review of dental treatment services and that persons involved in the utilization management process in decisions affecting patient care are licensed dentists and are appropriately qualified, and be it further
Resolved, that the Association study the feasibility of seeking federal legislation to regulate utilization review and management organizations and report back to the 1992 House of Delegates.

Utilization Management (*Trans.*1990:541)

1. The term "managed care" refers to a cost containment system that directs the utilization of health benefits by:

    a. restricting the type, level and frequency of treatment;
    b. limiting the access to care; and
    c. controlling the level of reimbursement for services.

2. A system of "statistically based utilization review" is one that examines the distribution of treatment procedures based on claims information and in order to be reasonably reliable, the application of such claims analyses of specific dentists should include data on type of practice, dentist's experience, socioeconomic characteristics and geographic location.

3. "Utilization management" is a set of techniques used by or on behalf of purchasers of health care benefits to manage the cost of health care prior to its provision by influencing patient care decision-making through case-by-case assessments of the appropriateness of care based on accepted dental practices.

Use of Statistics in Utilization Review (*Trans.*1989:542)

Resolved, that it is the position of the American Dental Association that statistically based utilization review should in no way be used to determine acceptable norms or clinical standards of dental practice.

Statement on Capitation Dental Benefit Programs (*Trans.*1985:582; 1993:689; 2013:303)

A capitation dental benefit program is one in which a dentist or dentists contract with the program's sponsor or administrator to provide all or most of the dental services covered under the program to subscribers in return for payment on a per capita basis.

It is a practical certainty that not all dentists in a given community will participate in a capitation program. Therefore, the opportunity for capitation program subscribers to freely choose their dentist is restricted.

Inherent design limitations in capitation dental benefit programs make it incumbent upon the American Dental Association to provide the following recommendations to group benefit purchasers considering such programs:

1. Capitation dental benefit programs should be offered only as an additional alternative to a benefit program which does not restrict the subscriber's opportunity to receive treatment from the dentist of his or her choice on a fee-for-service basis.
2. The scope of services covered in the freedom of choice and capitation programs should be equal.
3. Each employee (or group member) should be provided comprehensive, unbiased information about the programs being offered and should be given a reasonable opportunity to select the program which the employee believes best suits his or her needs, as well as periodic opportunities thereafter to choose to continue enrollment in the program of the employee's initial selection or to enroll in a different program.
4. All dentists willing to abide by the terms of the capitation program's provider contract should be eligible to participate in the program.
5. There should be no automatic enrollment in capitation dental benefit programs.
6. A system of monitoring the dental needs and treatment provided under a capitation dental benefit program should be required of the administrator by the group purchaser. In this regard, the dental needs and procedures performed should be reported, not merely on an aggregate, but on an individual patient basis.
7. All services provided by specialists should be separately reported on both an aggregate and individual patient basis.
8. Patients treated under a capitation dental benefit program should be provided in writing a list of their overall dental needs and the dental procedures rendered at each treatment visit.
9. Questions regarding the quality, appropriateness or thoroughness of treatment provided under capitation dental benefit programs should be resolved through the peer review system of the appropriate dental society.

Medicaid and Medicare

State Medicaid Dental Peer Review Committee (*Trans.*2018:361)

Resolved, that the American Dental Association encourages all state dental associations to work with their respective state Medicaid agency to create a dental peer review committee, made up of licensed current Medicaid providers who provide expert consultation on issues brought to them by the state Medicaid agency and/or third party payers.

Peer-to-Peer State Dental Medicaid Audits (*Trans.*2017:234)

Resolved, that the American Dental Association encourages all state dental associations to work with their respective state Medicaid agency to ensure that Medicaid dental audits be conducted by dentists who have similar educational backgrounds and credentials as the dentists being audited, as well as being licensed within the state in which the audit is being conducted.

Chief State Medicaid Dental Officer and Medicaid Dental Advisory Committee (*Trans.*2015:275)

Resolved, that the American Dental Association encourages all state dental associations to work with their state Medicaid agency in hiring a Chief Medicaid Dental Officer, who is a member of organized dentistry, and be it further

Resolved, that the American Dental Association encourages all state dental associations to actively participate in the establishment or continuation of an existing Medicaid dental advisory committee that is recognized by the state Medicaid agency as the professional body to provide recommendations on Medicaid dental issues.

Advocate for Adequate Funding Under Medicaid Block Grants (*Trans.*2011:498; 2014:499)

Resolved, that the ADA advocate for adequate funding and to ensure adequate safeguards are in place to provide comprehensive oral health care to underserved children and adults in any legislation that would convert the federal share of Medicaid to a block grant to the states, and be it further

Resolved, that the ADA opposes any such block grant proposal in the event adequate funding and safeguards cannot be assured to provide comprehensive oral health care to underserved children and adults.

Support of Current Medicaid Law and Regulations Regarding Dental Services (*Trans.*2010:603; 2014:500)

Resolved, that the Association seek to retain federal statutes or regulations regarding the definition of "dental services" under Medicaid so they continue to require dental care services be delivered by a dentist or under the appropriate supervision of a dentist, and be it further

Resolved, that Association constituent societies encourage their members to enroll in Medicaid.

Medicaid and Indigent Care Funding (*Trans.*2006:338; 2014:499)

Resolved, that the ADA make lobbying for adequate funds to provide oral health care to Medicaid and other indigent care populations a high priority and that the constituent and component societies be urged to do the same, and be it further

Resolved, that the ADA and its constituent and component societies carry out an intensive educational program, subject to current budgetary limits, to enlighten the public and government agencies of the value of oral health care and the consequences of untreated oral health disease to the overall health of our citizens and to health care payment systems, and be it further

Resolved, that the appropriate ADA agency study how to improve health outcomes through greater accountability and responsibility of dental patients to the care, educational and preventive opportunities provided to them.

Support for Adult Medicaid Dental Services (*Trans.*2004:327)

Resolved, that the ADA adopt policy supporting the inclusion of adult dental services in the federal Medicaid program, and be it further

Resolved, that the ADA take every opportunity to educate policy makers that, consistent with ADA's position on health system reform (*Trans.*1993:664; *Trans*.1994:656) oral health is an integral part of overall health, and be it further

Resolved, adult coverage under Medicaid should not be left to the discretion of individual states but rather, should be provided consistent with all other basic health care services.

Funding for Non-Dental Providers Preventive Care (*Trans.*2004:300)

Resolved, that funding for the provision of dental preventive services by non-dental providers should not come from dental assistance program budgets.

Federal Tax Credit/Voucher for Medicaid Dentist Providers (*Trans.*2003:383; 2014:499)

Resolved, that the American Dental Association seek to enact a federal tax credit/voucher to apply to the first $10,000 of Medicaid dental services provided by a licensed dentist, and be it further
Resolved, that these credits be based upon the most recent CDT codes and credited at a rate consistent with the most recent ADA Survey of Dental Fees for that region or state.

Increase Federal Medicaid Funding (*Trans.*2002:409)

Resolved, that the American Dental Association work to enact federal legislation to enhance the federal Medicaid match to 90/10 for dental care.

Fee-For-Service Medicaid Programs (*Trans.*1999:957)

Resolved, that the ADA support and encourage states to adopt adequately funded fee-for-service models for Medicaid programs to increase dentist participation and increase access to care for Medicaid participants.

Elimination of Disparities in Coverage for Dental Procedures Provided Under Medicare (*Trans.*1993:705)

Resolved, that the Association seek legislation to provide fair and equitable treatment to all Medicare recipients by eliminating disparities in coverage for dental procedures, and be it further
Resolved, that the Association seek legislation which would provide for payment of dental services under Part B of Medicare in cases where the dental procedure is necessary and directly associated with a medical procedure or diagnosis.

Membership

ADA Member Conduct Policy (*Trans.*2011:530)

ADA Member Conduct Policy

1. Members should communicate respectfully in all interactions with other dentists, dentist members, Association officers, trustees and staff.
2. Members should respect the decisions and policies of the Association and must not engage in disruptive behavior in interactions with other members, Association officers, trustees, or staff.
3. Members have an obligation to be informed about and use Association policies for communication and dispute resolution.
4. Members are expected to comply with all applicable laws and regulations, including but not limited to antitrust laws and regulations and statutory and common law fiduciary obligations.
5. Members must respect and protect the intellectual property rights of the Association, including any trademarks, logos, and copyrights.
6. Members must not use Association membership directories, on-line member listings, or attendee records from Association-sponsored conferences or CE courses for personal or commercial gain, such as selling products or services, prospecting, or creating directories or databases for these purposes.
7. Members must treat all confidential information furnished by the Association as such and must not reproduce materials without the Association's written approval.
8. Members must not violate the attorney-client privilege or the confidentiality of executive sessions conducted at any level within the Association.
9. Members must fully disclose conflicts, or potential conflicts, of interest and make every effort to avoid the appearance of conflicts of interest.

New Dentist Involvement in Volunteer Leadership (*Trans.*2009:487)

Resolved, that new dentists (defined as dentists graduating less than ten years previously) be encouraged to become involved as volunteers in organized dentistry, and be it further

Resolved, that constituent dental societies be urged to include new dentists in the leadership development process, offer new dentists volunteer opportunities, and be inclusive of new dentists in the leadership education offered.

Parallel Membership Categories (*Trans.*2008:482; 2018:299)

Resolved, that state and local dental societies be urged to create parallel membership categories to mirror those available at the ADA level.

Four-Year Recent Graduate Reduced Dues Program (*Trans.*2008:482)

Resolved, that the ADA urges constituent and component societies to adopt the ADA four-year reduced dues structure for recent dental school graduates.

Long-Term Dues Waivers (*Trans.*2002:384)

Resolved, that the ADA strongly encourage members to apply for retired status if they are not receiving income from dental related activities for a period of more than one year, whether due to disability, family leave, or any other cause.

Administrative Process for Transferring Members (*Trans.*2001:422)

Resolved, that in the interest of a member who changes the location of his or her residence and or practice from the jurisdiction of one constituent and or component society to another during the membership year, the dental society in the member's new location be urged to accept the dentist as a member without imposing additional dues for the balance of that membership year.

Tripartite Membership Application Procedures (*Trans.*1998:685; 2014:524; 2018:299)

Resolved, that the ADA urges state and local dental societies to review their own membership application procedures to ensure that they support a consistent application process that minimizes membership barriers and presents a positive member experience, and be it further

Resolved, that the ADA urges the use of its ADA Universal membership application, and be it further

Resolved, that the ADA state and local dental societies be urged to process new members applications within a combined timeframe of 30 days.

Compliance With Civil Rights Laws (*Trans.*1997:666)

Resolved, that all constituent and component societies should be urged to continually comply with the applicable civil rights laws in their membership practices.

Association Support for Members Participating in Various Reimbursement Systems (*Trans.*1996:674)

Resolved, that the American Dental Association respects its members' rights to choice of reimbursement and encourages their active participation in the Association.

Diversity in Association Membership Marketing and Consumer-Related Materials (*Trans.*1995:606)

Resolved, that the American Dental Association is committed to promoting an inclusive environment that values and embraces the diversity of its membership, and be it further
Resolved, that the Association reflect this diversity in its membership marketing and consumer-related materials.

Promoting the Value of Tripartite Dentistry (*Trans.*1995:606; 2013:365)

Resolved, that constituents and components be encouraged to identify new mechanisms to promote the value of tripartite membership, and be it further
Resolved, that these mechanisms include a focus on tripartite membership as a foundation for a successful practice and career, and be it further
Resolved, that constituent and component societies be encouraged to communicate these messages through their respective programs and printed and electronic communication channels.

Transfer Nonrenews (*Trans.*1995:605; 2018:299)

Resolved, that the Association strongly encourage state and local dental societies to address the issue of transfers who do not renew their membership, and be it further
Resolved, that the state and local dental societies be urged to review the list from the ADA Association Management System for known transfers into their jurisdiction for address verification and follow-up, and be it further
Resolved, that state and local volunteers be encouraged to make personal contact with transfers and invite them to join their societies.

Utilization of Tripartite Resources (*Trans.*1995:604; 2018:300)

Resolved, that state and local dental societies be encouraged to utilize tripartite resources in planning and implementing their respective membership communications to demonstrate the full array of member benefits available.

ADA Membership Requirement for Continuing Dental Education Speakers (*Trans.*1992:620)

Resolved, that the American Dental Association require all dentists presenting ADA-sponsored continuing education programs, who are eligible for active, life or retired membership in the Association, to be active, life or retired members, in good standing, at the time the appropriate contract is executed with the provision that membership shall be maintained during the period that a presentation is made, and be it further
Resolved, that foreign dentists presenting ADA-sponsored continuing education programs are not required to be members unless they are eligible for active ADA membership, and be it further
Resolved, that constituent and component dental associations be encouraged to adopt policy requiring dentist continuing education speakers to be members of the American Dental Association, when eligible.

Nonmember Utilization of ADA Member Benefits (*Trans.*1990:532)

Resolved, that the ADA Board of Trustees review the policies pertaining to nonmember utilization of ADA member benefits and take whatever action is necessary to insure that a nonmember cannot utilize ADA member benefits to imply membership and/or promote his or her practice to the public, and be it further
Resolved, that the pricing differential for ADA products and/or services between members and nonmembers be at the maximum the law will allow in order to increase the tangible benefits of being a member of the ADA.

Collaboration with Other Organizations to Support ADA Recruitment and Retention Activities (*Trans.*1989:540; 1997:659; 2018:301)

Resolved, that the American Dental Association urge other dental organizations to collaborate with the membership recruitment and retention activities of the American Dental Association, and be it further
Resolved, that the American Dental Association encourage other dental organizations to collaborate with the exchange of current information on membership and specialty status with the ADA on an annual basis.

Application Process for Direct ADA Membership (*Trans.*1989:539)

Resolved, that the American Dental Association verify eligibility of direct members on an annual basis and urge constituent societies to assist in the verification of employment status of direct members, and be it further
Resolved, that the American Dental Association encourage constituent societies to promote tripartite membership to federally employed dentists when appropriate.

Requirement for Membership Maintenance in ADA for Fellows of the American College of Dentists, the USA Section of the International College of Dentists and the Pierre Fauchard Academy (*Trans.*1989:538; 2012:512)

Resolved, that the American College of Dentists, the USA Section of the International College of Dentists and the Pierre Fauchard Academy be advised upon request on an ongoing basis when a member is dropped from the roster of the ADA, and be it further
Resolved, that the ACD, USA Section of the ICD and the Pierre Fauchard Academy be encouraged, when legally feasible, to require continuing membership in the ADA for those members in good standing.

Dental Organization Membership Contingent on ADA Membership (*Trans.*1985:610; 1996:667)

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 who currently require members or applicants to also hold membership in the American Dental Association be annually asked by the American Dental Association to verify these dentists' current membership in the American Dental Association.

Differential Charges According to Membership Status (*Trans.*1982:506; 2004:294; 2018:300)

Resolved, that those activities of the ADA that require direct or indirect charges for services or materials to the membership shall carry charges which reflect a differential for dentists who are not members of the Association, except that membership applicants who are eligible to receive interim services under the ADA *Governance and Organizational Manual* may, during the interim period in which their applications are being processed, purchase items at a member rate through the ADA Catalog, receive complimentary copies of the *Journal of the American Dental Association* and the *ADA News* and have access to the ADA.org member-only areas, and be it further
Resolved, that all constituent societies of the Association be urged to adopt similar policy.

Student Membership (*Trans.*1977:957; 1996:673; 2015:291)

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, the American Dental Association and the student's respective constituent and component societies, and be it further
Resolved, that all deans and faculties of dental schools be encouraged to promote membership at all levels of organized dentistry, and be it further
Resolved, that deans and faculty members be encouraged to become members of the ADA.

Dentists Retired From Federal Service (*Trans.*1963:285; 1996:671)

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 provided they have maintained continuous direct ADA membership.

Qualifications for Membership (*Trans.*1959:219; 1996:672; 2013:365)

Resolved, that the constituent societies be requested to examine their bylaws and consider making any changes in the qualifications for an appropriate membership category to permit a dentist licensed in another state to become a member with other than resident active membership category.

National Practitioner Data Bank

Statute of Limitations (*Trans.*1997:708)

Resolved, that the American Dental Association urges the appropriate federal agency to take administrative action to cause National Practitioner Data Bank malpractice payment entries involving dentists to be expunged after seven years have passed, provided a further incident has not been reported.

National Practitioner Data Bank Self-Generated Inquiries (*Trans.*1993:706; 2015:272)

Resolved, that the Association seek appropriate federal action to prohibit an entity not otherwise authorized to query the Data Bank from coercing a provider to provide a self-query as a requirement for employment or to participate in a health insurance plan or for professional liability coverage, and be it further

Resolved, that the Association seek appropriate federal action to prohibit providers from being required to assign their rights of self-query to third parties.

Nursing Homes

Statement on Dental Care in Nursing Homes (*Trans.*1991:619)

Introduction: The need for dental care among the chronically ill and the older adults who are residents of nursing homes is well recognized by the dental profession. If the needs of these groups are to receive the attention they deserve, leadership by the health profession is essential. If expanded oral health care in nursing homes is to meet the high standards recommended by the dental profession, dental societies should provide the necessary leadership.

On December 22, 1987, the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), Pub. L. 100-203, was enacted. This legislation included extensive revisions to the Medicare and Medicaid statutory requirements for nursing facilities. The requirements provide the dental profession with an opportunity to integrate oral health into the total health care and rehabilitation program for nursing home patients. Effective dental society response to the requirements could provide a foundation for a dental program to serve the chronically ill and elderly of the community.

The dental profession has long recognized that individuals do not cease to need treatment when they become elderly, chronically ill and/or institutionalized. However, continued need for oral health care has not been fully recognized by caregivers or the individuals themselves.

Promoting and coordinating programs for the provision of oral health care in nursing homes is properly the responsibility of the local dental society or of a group of dentists in the community. Recommendations by the American Dental Association or its constituent societies must be implemented and interpreted by local dental societies and/or local dentists to fit the needs of the community. The following steps are recommended for long-term care or residential facilities in developing an oral health care program.

Role of the Dentist:

Selection. Dental societies should work with nursing homes and their organizations to facilitate arrangements between dentists and nursing homes. Oral health care programs for nursing homes should be organized by an individual dentist or a group of dentists. The local society should survey nursing homes in the area to determine the status of their oral health care programs and their need for dentists.

Recommended Responsibilities. Dentists should make recommendations in the following areas: initial examination provisions of emergency dental services; mechanisms to provide needed dental treatment; policies on oral hygiene; coordination of services with medical, nursing and other staff; continuing in-service dental health education for both patients and staff; and training staff to assist patients in proper oral hygiene.

Recommended Program for Nursing Homes: The following recommendations are made for an effective dental health program in nursing homes and other residential institutions.

Oral Health Policies. The continuing oral health program in a nursing home should be based on the following principles:

1. Patients should have a dental examination upon admission and at least annually thereafter.
2. Periodic evaluations should be made, with particular attention to the detection of possible malignant lesions.
3. Needed dental treatment should be provided according to the physical and psychological ability of the patient to receive care.
4. The dentist should be informed of any physical or mental condition or medication which might affect the patient's ability to receive dental treatment.
5. If at all possible, treatment should be performed by the patient's own dentist.
6. The staff should be instructed to be alert to any changes in the patient's oral health status.
7. The dentist should provide consultation on diet and nutrition.
8. All removable dental prostheses (i.e. complete and/or partial dentures) should be identified with the wearer's name and/or initials following admission to the facility.
9. All staff should be given oral hygiene instruction and should be taught to assist patients in practicing recommended daily oral hygiene procedures.

Treatment Levels. The provision of dental services must be adapted realistically to the medical, psychological and social needs of the patient and in accordance with the advice of the patient's physician. Dental needs should be weighed against the patient's general level of health. It must be recognized that some patients are unwilling or unable to receive indicated dental treatment.

The following priorities are recommended for care of adults: (1) relief of pain and treatment of acute infections; (2) elimination of pathological conditions and extraction of unsavable teeth; (3) removal of irritating conditions which may lead to malignancies; (4) treatment of bone and soft tissue disease; (5) repair of injured or carious teeth; and (6) replacement of lost teeth and restoration of function.

Special attention should be given to the early detection of oral manifestations of systemic diseases and detection of oral lesions.

Facilities for Provision of Treatment. The following four methods may be used in making dental treatment available to nursing home patients: (1) establishment of a dental office in the facility; (2) transporting patients to private dental offices; (3) transporting patients to other facilities where dental services are available; and (4) bringing portable dental equipment to the patients.

The initial dental evaluation of the patient could include a determination of the locale necessary for treatment. It has been demonstrated that the great majority of nursing home or homebound patients can be treated in private dental offices if transportation is made available.

Portable dental equipment should be available in order that dentists may render necessary treatment in the nursing home for non-ambulatory patients.

The availability of dental facilities in hospitals and public health facilities should be explored. Groups of patients could be transported to the clinic or hospital facilities.

Oral Health Education: A continuing program of oral health education should be conducted for all parties in the nursing homes: patients, nurses and other staff and administrators. This should include demonstration of routine oral hygiene, how the nursing home staff can assist patients in practicing oral hygiene and the development or instruction of special techniques for meeting needs of disabled patients.

The consulting dentist might consider holding regular in-service programs or a dental health day during which periodic examinations are performed and dental health educational instruction provided to all. Attention must be given to instruction in use of toothpastes and mouthwash, toothbrushing, flossing, and care and cleansing of dentures.

Dental health educational materials, including films, are available from the American Dental Association and state health departments.

The Nurse's Role. One of the most important considerations that a nurse should have for the patient is that of good oral hygiene. In nursing homes, many patients do not have the strength or emotional stability to maintain good oral hygiene. The nurse should aid and instruct patients in brushing their teeth at proper times. Where this procedure is not possible, the patient's lips, teeth and gingiva should be rubbed lightly with moistened cotton or gauze. All removable prostheses should be properly cleansed. The nurse should be trained to identify oral lesions, swellings and other irregularities and to call the dentist when such lesions are noted.

Instruction to the Patient. In order to encourage full cooperation, the patient should be instructed in the following areas of personal hygiene:

a. the role of toothpastes, powders and mouthwashes in proper oral hygiene;
b. the methods of toothbrushing and the type of brush to use;
c. the proper use of dental floss;
d. the care and cleansing of prosthetic appliances; and
e. the importance of daily oral hygiene maintenance for the patient's well-being.

Financial Considerations. Payment for services should be made on a fee-for-service or other acceptable basis. Many nursing home patients are covered for health services by publicly funded care programs. Medicare, however, provides indemnity for limited oral surgical procedures only. Many state Medicaid programs provide coverage of dental services for the indigent and medically indigent. Some patients might be eligible for payment by local welfare agencies or voluntary agencies.

There is, however, a little-known provision called Post-Eligibility Treatment of Income (PETI), contained in the Medicaid Program, that can provide a mechanism to fund oral health care for eligible nursing home patients. The PETI provision allows institutionalized Medicaid recipients with supplemental sources of income to pay for remedial medical services including dental care out of their supplemental income that otherwise would be surrendered to the facility. Restrictions and administrative details of the PETI provision will vary from state to state. Specifics can be obtained by contacting the local Medicaid office.

Nursing home administrators, dentists and dental societies should work together toward a mutually acceptable arrangement for providing and funding care. Patients unable to pay for needed dental care should not be denied such care for financial reasons.

Role of Dental Auxiliaries. Dental hygienists and specially trained dental assistants can be invaluable in the effective operation of dental programs in nursing homes. In addition to assisting dentists in providing treatment, dental auxiliaries can assist patients with oral hygiene and provide dental health educational information. Dental auxiliaries are particularly important in the efficient use of portable dental equipment.

Cooperation of Nursing Homes. Administrators of nursing homes should be encouraged to consider the purchase of dental equipment. One nursing home might purchase equipment to be used by several facilities or several facilities might purchase equipment jointly.

Nursing homes should provide transportation and escorts for patients to the private dental office or other dental facilities.

Dental Society Support for Dentists. Dental societies should support the efforts of dentists working in nursing homes. Supporting activities could be carried out by constituent societies, component societies or, where component societies are not the same as the

geographical community, by local groups of dentists under the coordination of the constituent or local society.

In addition to identifying the local need for dentists, the society should coordinate their activities and determine the feasibility of broadening dental care programs for nursing homes to include other facilities and homebound patients. The use of portable equipment may be considered.

It is essential that dental care programs for nursing homes be integrated with community programs for the chronically ill and the elderly and that all health and social welfare agencies are fully informed of the program. This is important to create community interest and support that may result in program expansion or increased funding.

On behalf of the consulting dentists, the state and local societies can carry on liaison and communications functions with all community organizations involved in the care and welfare of these patients. This will include medical, nursing, nursing home, social, and other health and welfare agencies as well as voluntary organizations and service clubs.

The dental society may also provide consultation on dental care requirements to new nursing homes, hold dental health educational meetings for nursing home administrators and staff, and provide dental health educational programs for elder care organizations.

Continuing education workshops or conferences should be held at the state or local level for dental professionals working with the chronically ill and homebound. Periodic reports could be submitted to dental journals to create and maintain interest in the program.

In all these functions, the local dental society or dental group should work with the state dental division and local health department and make use of their consultation, facilities and materials.

Role of Dental Schools. Dental schools in the locality should be urged to assume a role in developing dental care programs for nursing homes or the homebound. These programs could provide valuable experience for dental students to make them aware of the dental needs existing outside of the dental office.

Dental schools should provide continuing education courses for practicing dentists in care for the elderly and chronically ill as well as carry out research programs on the specialized techniques or methods of delivery of dental services to this special population group.

Occupational Safety and Health

Policies and Recommendations on Occupational Safety and Health (*Trans.*2016:322)

Resolved, that the ADA recognizes the importance of engineering and work practice controls recommended by the Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control and Prevention in preventing the transmission of bloodborne pathogens from needlestick and other sharps-related injuries in dental settings, and be it further

Resolved, that the ADA encourages dentists to maintain knowledge of and compliance with federal standards and other applicable regulations for eliminating or minimizing occupational exposure to bloodborne pathogens and preventing injury and illness in dental settings, and be it further

Resolved, that it is the position of the American Dental Association that its members, in an effort to promote a safe workplace, use materials in the dental health care setting that have been appropriately labeled by the manufacturer or distributor to comply with the OSHA Hazard Communication Standard, and for which the manufacturer/distributor has supplied a current safety data sheet (SDS), and be it further

Resolved, that the ADA support its members by providing access to current information, forms, and prototypes as needed to help them comply with occupational safety and health requirements affecting dental health care settings, and be it further

Resolved, that the ADA encourages and supports fair systems of compliance with applicable state and federal law(s) for preventing injury and illness in the dental office.

Older Adults

Education of AARP on Benefits of Oral Health Agenda (*Trans.*1989:568)

Resolved, that agencies of the ADA continue efforts to educate the leadership of the American Association of Retired Persons (AARP) on the benefits of an acceptable oral health agenda for older Americans together with appropriate financing mechanisms.

Reduced Fee Programs for the Elderly Poor (*Trans.*1980:591)

Resolved, that constituent dental societies be encouraged to develop access programs providing reduced fee comprehensive dental care to financially distressed elderly persons.

Oral Health Literacy

Use of Health Literacy Principles for All Patients (*Trans.*2016:322)

Resolved, that ADA supports the use of health literacy principles and plain language for *all* patients and providers to make it easier for them to navigate, understand and use appropriate information and services to help patients be stewards of their oral health.

Oral Health Education in Schools (*Trans.*2014:506; 2016:319)

Resolved, that the Council on Access, Prevention and Interprofessional Relations work with the appropriate ADA agencies to increase the number of school districts requiring oral health education for K-12 students based on the 2012 School Health Policies and Practices Study (SHPPS) data, and be it further **Resolved,** that, where applicable, the ADA supports the inclusion of the current National Health Education Standards in the accreditation requirements for all public and private elementary and secondary schools

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Communication and Dental Practice (*Trans.*2008:454; 2013:342)

Resolved, that the ADA affirms that clear, accurate and effective communication is an essential skill for patient-centered dental practice.

Limited Oral Health Literacy Skills and Understanding in Adults (*Trans.*2006:317; 2013:342)

Resolved, that the ADA recognizes that limited oral health literacy is a potential barrier to effective prevention, diagnosis and treatment of oral disease.

Encouraging the Development of Oral Health Literacy Continuing Education Programs (*Trans.*2006:316)

Resolved, that the Council on Dental Education and Licensure and other appropriate ADA agencies encourage the development of undergraduate, graduate and continuing education programs to train dentists and allied dental team members to effectively communicate with patients with limited literacy skills.

Definition of Oral Health Literacy (*Trans.*2005:322; 2006:316)

Resolved, that it is the ADA's position that oral health literacy is the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate oral health decisions.

Oral Piercing

Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting (*Trans.*1998:743; 2000:481; 2004:309; 2012:469; 2016:300)

Resolved, that the American Dental Association advises against the practices of cosmetic intraoral/perioral piercing and tongue splitting, and views these as invasive procedures with negative health sequelae that outweigh any potential benefit.

Patient Health Information

Patient Rights and Responsibilities (*Trans.*2009:477)

Resolved, that constituent and component societies be encouraged to use the ADA Dental Patient Rights and Responsibilities Statement as a guide in developing a, or revising an existing, patient rights and responsibilities statement, and be it further
Resolved, that constituent and component societies encourage their members to make available the patient rights and responsibilities statement to each patient and to post it conspicuously in their offices and clinics.

ADA Statement on Dental Patient Rights and Responsibilities

Background: The ADA Council on Ethics, Bylaws and Judicial Affairs (CEBJA) has developed the following template Dental Patient Rights and Responsibilities Statement (DPRR Statement) as a guide and as an aid to be used by constituent and component societies and practitioners in creating their own dental patients rights and responsibilities statements. In the DPRR Statement that follows, the term "rights" is used not in a legal sense, but merely to convey an indication that a patient should have an expectation of experiencing treatment in accordance with the enumerated "rights." Several other dental and medical related organizations publish patient rights statements; indeed, CEBJA reviewed those statements during the development of the DPRR Statement, as well as Standard 5-3 of the ADA Commission on Dental Accreditation (CODA) Standards for Predoctoral Dental Education Programs, which also refers to a statement of patients' rights.

The DPRR Statement grew out of a collaborative ethics summit conducted in March 2006 by the American College of Dentists (ACD) and the American Dental Association (ADA) on the topic of commercialism in dentistry. Members of CEBJA were invited to attend along with representatives from ADA and ACD leadership, the ADA Council on Dental Education and Licensure, the recognized specialty groups, the National Dental Association, the U.S. Department of Veterans Affairs, the American Dental Education Association, dental school deans and faculty, ethicists, dental editors and leading representatives from the insurance, practice management and dental product manufacturers industry.

The Summit attendees noted that patients have become more assertive in seeking elective procedures and that the dental profession seeks to be mindful of protecting patient autonomy while balancing the importance of overall dental health and lifelong consequences. One of the outcomes of the Summit was the recommendation that CEBJA, the ADA agency dedicated to promoting the highest ethical and professional standards in the provision of dental care to the public, develop a patient rights document that would have the benefit and protection of the patient as its primary objective. It was envisioned that the patient rights document would also serve to remind patients and dentists of the importance of informed consent by involving patients in treatment decisions in a meaningful way. (See also *ADA Principles of Ethics and Code of Professional Conduct,* Section 1, Principle: Patient Autonomy.)

The CODA Standard 5-3 states: "The dental school must have developed and distributed to all appropriate students, faculty, staff and to each patient a written statement of patients' rights. The primacy of care for the patient should be well established in…assuring that the rights of the patient are protected." An online investigation revealed the existence of patient rights statements for dental schools as well as three dental societies–California Dental Association, Minnesota Dental Association and Pennsylvania Dental Association. In addition, the AMA incorporates statements of patient rights and responsibilities within its Code of Medical Ethics. The ADA document is based on common elements from the patient rights statements used by the dental schools and the three dental associations. The experience from these communities suggests the impact of the DPRR Statement as an educational tool to promote thorough patient-dentist discussions of treatment options.

The rights and responsibilities enumerated in the DPRR Statement were developed as a suggested guide for the development of an appropriate patient relationship where consideration is given to a patient's autonomy and the dentist's clinical skills and judgment.

ADA Dental Patient Rights and Responsibilities Statement

Your dentist is the best source of information about your dental health and wants you to feel comfortable about your dental care. Maintaining healthy teeth and gums means more than just brushing and flossing every day and visiting your dentist regularly. As an informed dental patient, it also means knowing what you can expect from your dentist and dental care team and understanding your role and responsibilities in support of their efforts to provide you with quality oral health care.

The rights and responsibilities listed below do not establish legal entitlements or new standards of care, but are simply intended to guide you through the development of a successful and collaborative dentist-patient relationship.

Patient Rights

1. *You have a right to* choose your own dentist and schedule an appointment in a timely manner.
2. *You have a right to* know the education and training of your dentist and the dental care team.
3. *You have a right to* arrange to see the dentist every time you receive dental treatment, subject to any state law exceptions.
4. *You have a right to* adequate time to ask questions and receive answers regarding your dental condition and treatment plan for your care.
5. *You have the right* to know what the dental team feels is the optimal treatment plan as well as the right to ask for alternative treatment options.
6. *You have a right to* an explanation of the purpose, probable (*short and long term*) results, alternatives and risks involved before consenting to a proposed treatment plan.
7. *You have the right* to be informed of continuing health care needs.
8. *You have a right to* know in advance the expected cost of treatment.
9. *You have a right to* accept, defer or decline any part of your treatment recommendations.
10. *You have a right to* reasonable arrangements for dental care and emergency treatment.
11. *You have a right to* receive considerate, respectful and confidential treatment by your dentist and dental team.
12. *You have a right to* expect the dental team members to use appropriate infection and sterilization controls.
13. *You have a right to* inquire about the availability of processes to mediate disputes about your treatment.

Patient Responsibilities

1. *You have the responsibility to* provide, to the best of your ability, accurate, honest and complete information about your medical history and current health status.
2. *You have the responsibility* to report changes in your medical status and provide feedback about your needs and expectations.
3. *You have the responsibility to* participate in your health care decisions and ask questions if you are uncertain about your dental treatment or plan.
4. *You have the responsibility to* inquire about your treatment options, and acknowledge the benefits and limitations of any treatment that you choose.
5. *You have the responsibility for* consequences resulting from declining treatment or from not following the agreed upon treatment plan.
6. *You have the responsibility to* keep your scheduled appointments.
7. *You have the responsibility to* be available for treatment upon reasonable notice.
8. *You have the responsibility to* adhere to regular home oral health care recommendations.
9. *You have the responsibility to* assure that your financial obligations for health care received are fulfilled.

August 2009

Confidentiality and Privacy Regarding Health Information (*Trans.*1999:951; 2000:507)

Resolved, that the following be adopted as the American Dental Association's policy on health information confidentiality and privacy.

Legislation

- The Association supports legislative and regulatory actions that protect the confidentiality and privacy of patient health information.
- In particular, the Association believes minimum safeguards are needed to protect patients against wrongful disclosure and/or use of patient identifiable information, and to protect their providers as a result of wrongful disclosure or use by third parties who are properly given access to that information.

Limits on disclosure and use of patient-identifiable information

- Generally, the disclosure and/or use of patient-identifiable information by health care providers should be limited to that which is necessary for the proper care of the patient, or authorized by the patient and/or other applicable law.
- Use of patient-identifiable health information by an entity that receives that information from a patient's health care provider should be limited to that necessary for the proper care of the patient, except for research purposes as identified herein.
- Subsequent holders of patient information should be prohibited from changing health information or conclusions submitted by the patient's health care provider.

Patients' rights

- Patients should have the right to know who has access to their personally identifiable health information and how that information has been used.
- A patient's general consent to the release of

confidential health information to a third party, such as a health plan, should not be legally sufficient to permit subsequent release by that third party of the information.
- With appropriate limitations designed to protect the integrity of the attending doctor's records and to ensure against unauthorized disclosure or unduly burdensome requests, patients should be afforded the opportunity to see their treatment records and obtain copies.

Unauthorized disclosure of patient-identifiable health information

- Patients should have a fair opportunity to seek legal redress if their personally identifiable health information has been willfully and wrongly released.
- No liability should arise against a provider who, in good faith and for the purpose of providing appropriate health care, unintentionally releases confidential health information in a manner not permitted by law.
- A health care provider who has properly disclosed patient-identifiable health information to a third party should be immune from liability for subsequent disclosure or misuse of that information by that third party.

Use of health information for research

- Generally, all identifying information should be removed when health records are used for research purposes. Identifiable data should be released only after approval of an Institution Review Board, pursuant to applicable review procedures and protocols.
- Legislative exemptions to patient consent requirements for research purposes should be narrowly drawn.

Use of health information by law enforcement

- Except as otherwise provided by applicable laws, law enforcement officials should be required to obtain a binding court order, warrant or subpoena before having access to patient records.

Practice considerations

- Dentists should know their ethical and legal obligations regarding patient confidentiality and privacy.
- Dentists should engage in sound risk management techniques to ensure compliance, including office protocols, record maintenance and training to protect such information.

and be it further
Resolved, that the Association track and advocate privacy laws governing the Internet in their applicability to the privacy of patient records, and be it further
Resolved, that the Association advocate in its legislative and regulatory efforts that all points of potential interception, sale or unauthorized electronic transmission from doctor to third party be included in consideration of electronic privacy laws.

Peer Review Mechanisms

Guidelines on the Structure, Functions and Limitations of the Peer Review Process (*Trans.*1992:37, 603)

The function of a peer review committee is to review matters regarding the appropriateness of care and/or quality of treatment. Peer review committees also may, acting in an advisory capacity, provide for the appropriate review of fees.

Dental societies should establish peer review committees which provide for the review of differences of opinion between a dentist and a patient, or a dentist and a third-party agency. Third-party agencies may include insurance carriers, dental service corporations, dentist consultant, administrators of health and welfare trusts, alternative benefit plans, government agencies, and employers who have implemented self-funded and self-administered dental plans.

Requests submitted by a dentist for review of treatment rendered by another dentist should be channeled to that agency, which the constituent or component society has determined should review allegations of gross or continual faulty treatment by a dentist. This could be the judicial committee or committee on ethics, or some combination thereof. It could also be the state board of dentistry.

In all instances, the peer review committee should carry out its responsibilities within a reasonable period of time that makes its efforts effective.

To guide dental societies in establishing peer review committees, consideration of the following is recommended:

Directives

1. The constituent society is responsible for establishing peer review committees.
2. The committee membership should be composed primarily of general practitioners who have the qualifications and experience to render a considered opinion as to the dental standards of the community.
3. The committee should consider problems submitted by patients, dentists and third-party agencies.
4. The committee will not review any case without access to the treatment records.
5. The committee is not vested with disciplinary authority, but should provide recommendations for remedial action where appropriate.
6. The committee should utilize standard procedures and forms in obtaining data required for adequate evaluation.
7. Constituent dental societies should develop standardized review criteria for use by peer review committees during the clinical examination stage of the peer review process.
8. The committee may not consider cases in litigation.
9. The committee should have a clearly outlined process for dealing with repeat adverse decisions against a practitioner and for handling requests for appeal.
10. Constituent societies should have appropriate liability insurance to protect all members of peer review committees, as well as the societies sponsoring the peer review activity.
11. Constituent societies should have appropriate statutory protection for immunity from liability for all members of peer review committees, the societies sponsoring the peer review activity and for confidentiality of records.

Recommendations

12. Review of problems involving practicing dentists who are not members of the dental society is encouraged.
13. The committee should establish a policy that parties appearing before it do not have the right to be represented by an attorney.
14. Information on the purpose, function and availability of the peer review process should be communicated to dental society members, the public and other interested agencies.

The following guidelines are suggested to assist dental societies in implementing the foregoing principles.

Organization: The peer review committee should be a permanent committee of the dental society with appropriate status and liaison with related committees. It could be a freestanding committee, or subcommittee of the committee, or Council on Dental Benefit Programs or other body charged with the responsibility for managing issues regarding dental benefit plans.

Composition: The committee membership should be composed primarily of general practitioners who have the qualifications and experience to render a considered opinion as to the dental standards of the community. Terms on the committee should be staggered to ensure continuity of experience. The appointment of a lay person to serve on the peer review committee is encouraged.

The committee should have specialists as resources who can be appointed if the dentist being reviewed is a specialist and requests a committee composed of like specialists. If the committee feels the need for additional expertise, other members may be appointed on an ad hoc basis.

Submission Procedures: All requests for peer review will be submitted in writing, accompanied by supporting records and other appropriate consent forms and pertinent information, to the constituent or component

dental society. All parties to a peer review case should be asked to agree in writing to abide by the peer review committee's recommendation.

In cases involving a third-party payer, the payer should first have made an attempt to contact the dental office for clarification on a clerical or claim reporting problem, or to have had its dental consultant contact the dentist on issues involving professional judgment or contract interpretation.

The payer should notify the patient of a delay in payment of a claim, with further explanation that the case has been submitted for review.

Constituent dental societies are urged to cooperate in every appropriate way to resolve peer review cases in which the parties involved reside in different states or in different jurisdictions within the same state.

Mediation: The component peer review committee chairman should appoint a committee member to serve as mediator. All contact made by the mediator should be carefully documented. The mediator submits a written report to the chairman stating only the facts of the case. The mediator will advise whether mediation was successful. The mediator's role is advisory and does not involve a clinical examination of the patient.

Review Panel: The committee chair will appoint a minimum of three members to review the case. Panel members should have the opportunity to evaluate the specifics of the case, individually conduct a clinical examination if necessary, and make final recommendations to the committee chairman reflecting the collective opinion of the panel members. Panel members must not discuss the findings amongst themselves or in any way appear to collaborate in the decision.

Communications and Record Keeping: The chairperson of the committee shall report the decision and recommendations to all parties within 60 to 90 days from initiation of the review. While original documents and records should be returned, copies of all documents and records obtained during the review process, including the decision and any recommendations, must remain confidential and should be immediately forwarded to the constituent society executive offices. An attorney should be consulted to determine individual state provisions for retention of case records.

Appeal Mechanism: Within 30 days of receipt of a component dental society's peer review committee decision, all parties have the right to appeal, in writing, to the constituent dental society peer review committee which generally serves as the appellate body. An appeal can only be considered if it is shown that (a) proper procedure was not followed, (b) information previously unavailable at the time of review has become available or (c) the decision was perceived to have been contrary to any evidence and testimony presented. The decision of the appellate body is final within the peer review context.

Considerations for Peer Review and Dental Plans: The quality of the dental treatment provided under dental plans is the logical concern of the dental profession and questions regarding that quality are within the purview of the peer review process.

Review of the dental treatment provided under a dental plan should include a determination that the services were performed and that the treatment was appropriate and rendered in a satisfactory manner.

In the course of peer review function, specific deficiencies or problems prevalent in a particular plan may become evident. General information regarding the administrative or other aspects of the plan should be communicated, as appropriate, to the constituent society body vested with the responsibility for monitoring dental benefit plans.

Disputes Concerning Dental Treatment Provided Under Dental Benefits Programs (*Trans.*1992:600)

Resolved, that disputes concerning dental treatment provided under dental benefits programs be referred to the treating dentist's constituent dental society peer review process, and be it further

Resolved, that in those states where peer review is not available, the review should be conducted by the peer review committee based in the third-party payer's and/or the dentist consultant's state of record.

Use of Peer Review Process by Patients and Third-Party Payers (*Trans.*1990:534)

Resolved, that patients and third-party payers be encouraged to use the dental profession's peer review process to address issues or disputes concerning dental treatment provided under dental benefits programs, and be it further

Resolved, that the Council on Dental Benefit Programs work with third-party payers, plan purchasers, benefits consultants and government agencies to include the following paragraph in the "claim appeals" section of the Summary Plan Description provided to dental benefits plan subscribers:

> State and local dental societies provide an impartial means of dispute resolution regarding your dental treatment. This process, called Peer Review, may be available to you in addition to the (*insert name of benefit plan or benefit administrator*) appeal process. For more information about Peer Review, contact your local dental society.

Dentist Participation in Peer Review Organizations (*Trans.*1987:501)

Resolved, that the Association encourage the constituent dental societies to take action to assure full and equitable participation of dentists as members of the

Peer Review Organizations in their respective areas and as members of their governing boards as long as dental services are being reviewed.

Constituent Society Peer Review Systems (*Trans.*1981:573)

Resolved, that constituent dental societies be urged to effect all necessary changes in their peer review systems to establish those systems in accordance with the provisions of the Association's *Peer Review Procedure Manual*.

Pledge and Prayer

Recognition of Diversity (*Trans.*1995:607; 2019:XXX)

Resolved, that in recognition of diversity and to be inclusive of our membership, meetings of this Association may begin with a personal moment of reflection or silent prayer.

The Dentist's Pledge (*Trans.*1991:598; 2014:479)

Resolved, that the following "Dentist's Pledge" be approved:

The Dentist's Pledge

I, (dentist's name), as a member of the dental profession, shall keep this pledge and these stipulations.

I understand and accept that my primary responsibility is to my patients, and I shall dedicate myself to render, to the best of my ability, the highest standard of oral health care and to maintain a relationship of respect and confidence. Therefore, let all come to me safe in the knowledge that their total health and well-being are my first considerations.

I shall accept the responsibility that, as a professional, my competence rests on continuing the attainment of knowledge and skill in the arts and sciences of dentistry.

I acknowledge my obligation to support and sustain the honor and integrity of the profession and to conduct myself in all endeavors such that I shall merit the respect of patients, colleagues and my community.

I further commit myself to the betterment of my community for the benefit of all of society.

I shall faithfully observe the American Dental Association's *Principles of Ethics and Code of Professional Conduct*.

All this I pledge with pride in my commitment to the profession and the public it serves.

and be it further
Resolved, that the pledge be transmitted to U.S. dental schools for use as appropriate.

Pollution

Use of Environmentally Conscientious Measures in the Production, Packaging and Shipping of Dental Products (*Trans.*2013:314)

Resolved, that the American Dental Association strongly encourages dental manufacturers to employ environmentally conscientious measures in the production, packaging and shipping of their products including, but not limited to, the use of disposable materials that are biodegradable whenever possible.

Practice Administration

Statement Regarding Employment of a Dentist* (*Trans.*2013:353; 2018:357; 2019:XXX)

These guidelines provide guidance for practice owners or management companies (collectively "employers") in their working relationships with dentists associated with their practices, either as employees or independent contractors, except for postdoctoral education programs where a resident dentist is an employee of the educational program (collectively "employees"). The purpose of these guidelines is to protect the public in the provision of safe, high-quality and cost-effective patient care. Employers and employees should recognize and honor each of the guidelines set forth in this policy statement.

I. As described in the *ADA Principles of Ethics and Code of Professional Conduct,* dentists' paramount responsibility is to their patients. An employee dentist should not be disciplined or retaliated against for exercising independent professional judgment in patient assessment, diagnosis, treatment and comprehensive management, including with respect to but not limited to:

    a. The use of any materials, or the delivery of a prosthetic device, that represents an acceptable standard of care or the refusal to use materials or deliver a prosthetic device that does not represent an acceptable standard of care;
    b. The use of techniques that are reasonably believed to be within the standard of care and are in the patient's best interest or the refusal to use techniques that are not within the standard of care and are not in the patient's best interests (recognizing the patient's right to select among treatment options);
    c. The mandated provision of treatment that the employee dentist feels unqualified to deliver; and
    d. The provision of treatment that is not justified by the employee dentist's personal diagnosis for the specific patient.

II. All employers and employee dentists must conform to applicable federal, state, and local laws, rules and regulations. Employed dentists should not be disciplined or retaliated against for 1) adherence to legal standards and 2) reporting to appropriate legal authorities suspected illegal behavior by employers. Employers should make certain that, for example:

    a. Appropriate business practices, including but not limited to billing practices, are followed;
    b. Facilities and equipment are maintained to accepted standards;
    c. Employment contractual obligations are adhered to.
    d. Employment practices must prohibit discrimination including hiring and compensation practices on the basis of, but not limited to, race, creed, color, gender, national origin, gender identity, sexual orientation, age or disability.

III. Because a dentist is functioning within a professional domain, anyone employing a dentist should, for example:

    a. Guard against lay interference in the exercise of a dentist's independent professional judgment in patient assessment, diagnosis, treatment and comprehensive management;
    b. To the extent permitted by law, promptly provide the dentist access to all relevant patient records in the event of peer review, board complaint or lawsuit, both during and subsequent to the dentist's employment; and
    c. Recognize and honor the dentist's commitment, as an ADA member, to comply with the *ADA Principles of Ethics and Code of Professional Conduct.*

* Dentists are advised that employment contracts may have provisions that conflict with these guidelines and the ADA recommends that dentists seek legal counsel when considering how contracts affect their professional rights and responsibilities.

and be it further
Resolved, that the Association publish and promote this statement to all dentist and non-dentist employers and employees, and be it further
Resolved, that the Association encourage constituent societies to utilize this statement to facilitate legislative and regulatory measures to ensure the fair and ethical treatment of dentist employees and the patients that they treat.

Ownership of Dental Practices (*Trans.*2000:462)*

Resolved, that the Association supports the conviction long held by society that the health interests of patients are best protected when dental practices and other private facilities for the delivery of dental care are owned and controlled by a dentist licensed in the jurisdiction where the practice is located.

Ownership of a Dental Practice Following Death or Incapacity of a Dentist (*Trans.*2000:462)*

Resolved, that, in the case of a deceased or incapacitated dentist, in order to protect the interests and the oral health of the patients in that practice, the dentist's non-dentist surviving spouse, heir(s), or legal representative(s), as appropriate, should be allowed to maintain ownership of the dental practice for two years to allow for continuity of care during the orderly transition to a new owner, and be it further

Resolved, that all constituent dental societies be encouraged to seek state legislation that would allow the non-dentist surviving spouse, heir(s), or legal representative(s), as appropriate, of a deceased or incapacitated licensed dentist to maintain ownership of the dental practice for a reasonable period of time to allow for continuity of care during the orderly transition of the practice to a new owner, and be it further

Resolved, that the legislation allow the dentist's non-dentist surviving spouse, heir(s), or legal representative(s), as appropriate, to employ or contract with entities to conduct the business of the practice, including persons licensed in that state to practice dentistry or dental hygiene as defined in the dental practice act.

Dentists' Choice of Practice Models (*Trans.*1994:637; 2019:XXX)

Resolved, that the ADA supports the ability of dentists to freely choose a practice model best suited to their professional preference and training so they can assist patients in achieving the highest quality dental health without interference of their clinical independence.

* Note: At the request of the Council on Dental Practice, in 2020 the policy "Ownership of Dental Practices (*Trans.*2000:462)" was administratively divided into two policies. Three resolving clauses relating to death or incapacity of a dentist were moved under a new policy titled: "Ownership of a Dental Practice Following Death or Incapacity of a Dentist. (*Trans.*2000:462)." One resolving clause, remains under the title: "Ownership of Dental Practices (*Trans.*2000:462)." The resolving clauses in both policies were adopted in 2000.

Prevention and Health Education

Human Papillomavirus (HPV) Vaccination for the Prevention of Infection with HPV Types Associated with Oropharyngeal Cancer (*Trans.*2018:351)

Resolved, that the American Dental Association (ADA) adopts the position that HPV vaccination, as recommended by the CDC Advisory Committee on Immunization Practices, is a safe and effective intervention to decrease the burden of oral and oropharyngeal HPV infection, and be it further
Resolved, that the ADA urges dentists, as well as local and state dental societies, to support the use and administration of the HPV vaccine as recommended by the CDC Advisory Committee on Immunization Practices, and be it further
Resolved, that the ADA encourages appropriate external agencies to support research to improve understanding of the natural history of oral HPV infection, transmission risks, screening and testing.

Integration of Oral Health and Disease Prevention Principles in Health Education Curricula (*Trans.*2016:322)

Resolved, the American Dental Association supports the integration of principles of oral health and disease prevention in science and health education curricula in elementary and secondary schools, colleges and universities to increase the knowledge of the relationship between oral health and overall health and to promote behaviors that reduce the risk of oral disease or injury.

Oral Evaluations for High School Athletes (*Trans.*2016:343)

Resolved, that the American Dental Association supports the inclusion of an oral evaluation by a dentist and counseling regarding oral-facial protection as part of the pre-participation physical examination required for high school athletes.

Policies and Recommendations on Diet and Nutrition (*Trans.*2016:320)

Resolved, that oral health depends on proper nutrition and healthy eating habits, and necessarily includes avoiding a steady diet of foods containing natural and added sugars, processed starches, and low pH-level acids, and be it further
Resolved, that the ADA acknowledges it is beneficial for consumers to avoid a steady diet of foods containing natural and added sugars, processed starches, and low pH-level acids as a way to help maintain optimal oral health, and be it further
Resolved, that the ADA supports the findings and recommendations in the Council on Access, Prevention and Interprofessional Relations Supplemental Report 3 to the 2012 House of Delegates: Formulating a Strategic Approach for Addressing the Complex Emerging Issues Related to Oral Health and Nutrition in the United States (*Suppl*.2012:4114), and be it further

Dentist's Role in Nutrition and Oral Health

Resolved, that the ADA encourages dentists to routinely counsel their patients about the oral health benefits of maintaining a well-balanced diet and limiting the number of between-meal snacks, and be it further
Resolved, that the ADA encourages dentists to stay abreast of the latest science-based nutrition recommendations and nutrition-related screening, counseling, and referral techniques, and be it further
Resolved, that the ADA encourages dentists to serve on local school wellness planning boards to establish and maintain local school wellness policies that:

- Appropriately balance the nutritional benefits of consuming certain foodstuffs and the risk of tooth decay.
- Promote lifelong mouth healthy behaviors, such brushing twice a day, flossing once a day, limiting consumption of sugary snacks and beverages, and seeing the dentist regularly.
- Reflect the inextricable link between oral health and overall health and well-being.

and it be further

Access and Prevention

Resolved, that the ADA supports its members by providing access to current information and educational materials, and cultivating learning opportunities (e.g., continuing education modules, etc.), for dentists to learn more about the relationship between diet, nutrition, and oral health—including latest science-based nutrition recommendations and nutrition-related screening and counseling techniques, and be it further
Resolved, that the ADA encourages collaborations with dieticians and other nutrition experts to raise interprofessional awareness about the relationship between diet, nutrition, and oral health, and be it further
Resolved, that the ADA supports projects, as appropriate and feasible, to educate the public about the oral health benefits of maintaining a healthy diet, and to encourage consumers to adopt healthier diets and establish better eating habits, and be it further
Resolved, that the ADA supports public information campaigns to reduce the amount of added sugars consumed in American diets, and be it further
Resolved, that the ADA encourages constituent and component dental societies to work with state and local

officials to ensure locally-administered nutrition and food assistance programs have an oral health component (e.g., WIC, SNAP, NSLP, etc.), and be it further
Resolved, that the ADA encourages constituent and component dental societies to work with state and local school officials to prohibit schools from entering into contractual arrangements, including school pouring rights contracts, that incentivize schools to sell and aggressively advertise foods and beverages with high added sugar content on school grounds (e.g., providing free samples, posting signage, branding school equipment, sponsoring events, etc.).
Resolved, that the ADA supports the World Health Organization's 2015 Guideline on Sugar Intake for Adults and Children, and be it further

Government Affairs

Resolved, that the ADA should give priority to the following when advancing public policies on diet, nutrition, and oral health:

1. Ensuring government-supported nutrition education and food assistance programs (e.g., WIC, SNAP, NSLP, etc.) have an oral health component, such as and general guidelines that promote good oral health.
2. Encouraging federal research agencies to develop the body of high-quality scientific literature examining, among other things, the extent to which dental caries rates fluctuate with changes in total added sugar consumption, and over what period(s).
3. Maintaining the separate line-item declaration of added sugars content on Nutrition Facts labels, and listing the declared added sugars content in relatable terms (e.g., teaspoons, grams, etc.).
4. Supporting legislative and regulatory actions, as appropriate and feasible, to increase consumer awareness about the role dietary sugar consumption may play in maintaining optimal oral health, and the potential benefits of limiting added sugar consumption in relation to general and oral health.
5. Requiring third-party payers to cover nutrition counseling in dental offices as an essential plan benefit.

Support of Science Fairs (*Trans.*2016:322)

Resolved, that recognizing their educational value, the ADA supports dental society promotion and participation in science fairs.

Early Detection and Prevention of Oral and Oropharyngeal Cancer (*Trans.*2014:506; 2019:XXX)

Resolved, that the American Dental Association recognizes that early oral and oropharyngeal cancer diagnosis has the potential to have a significant impact on treatment decisions and outcomes, and supports routine visual and tactile examinations for all patients, and be it further
Resolved, that the Association supports state and local Association-sponsored education activities to promote the prevention and early detection of oral and oropharyngeal cancer.

Prevention Research to Aid Low Income Populations (*Trans.*2001:441)

Resolved, that the ADA continue to propose and/or support legislation and federal and state programs which will address the issue of the disproportionately high levels of dental disease in lower socioeconomic populations, direct extensive research to accurately identify the factors that are causing such discrepancies, and develop programs through working with other organizations and government agencies that will be effective with these populations, and be it further
Resolved, that the ADA through its appropriate agencies monitor the progress on all efforts both private and public towards improved oral health of lower socioeconomic group populations.

Patient Safety (*Trans.*2001:429; 2014:504)

Resolved, the Association work in cooperation with constituent and component dental societies and other major health care organizations to encourage the development of collaborative projects regarding patient safety, and be it further
Resolved, that appropriate Association agencies disseminate information on patient safety to the membership.

Inclusion of Basic Oral Health Education in Nondental Health Care Training Programs (*Trans.*1995:609; 2014:503)

Resolved, that the Association encourage the inclusion of basic oral health education, such as the Smiles for Life curriculum, in the curricula of nondental health care professional training programs.

Orofacial Protectors (*Trans.*1994:654; 1995:613; 2016:322)

Resolved, that the American Dental Association recognizes the preventive value of orofacial protectors and endorses the use of orofacial protectors by all participants in recreational and sports activities with a significant risk of injury at all levels of competition including practice sessions, physical education and intramural programs, and be it further

Resolved, that the ADA supports collaboration with international and national sports conferences, sanctioning bodies, school federations and others to mandate the use of orofacial protectors.

Federally Funded Dental Health Education and Prevention (*Trans.*1971:528)

Resolved, that the American Dental Association is wholeheartedly in favor of a federally funded national dental health care program based on dental health education and prevention, and be it further
Resolved, that the American Dental Association take immediate action to design a comprehensive educational program to be used in conjunction with federally funded programs for prevention.

Policy Governing Use of American Dental Association Oral Health Information Statement (*Trans.*1969:193, 322; 2012:494)

Pamphlets, educational posters, textbooks, videos, web content and other oral health information materials, designed for use in schools or for the general public, will be reviewed by the Council on Communications, and other appropriate councils of the American Dental Association. If the consultants approve the materials as being scientifically accurate, written permission will be given to permit use of the American Dental Association's oral health information statement:

> The information on oral health contained in this (pamphlet, video, etc.) is considered by the American Dental Association to be in accord with current scientific knowledge (date).

1. Request for permission to use the Association's statement must be made on the form provided by the Council on Communications.
2. The material must be designed and distributed to serve the best interest of the public and the profession.
3. The review of all materials, regardless of the medium, should be initiated at the manuscript stage. As one example, completed videos will not be reviewed unless the producer is willing to reshoot any sections found to be inaccurate by the Council.
4. The finished material must also be reviewed by the Council just as it is to be used, along with any supplementary materials which are also to be distributed. The Association's statement shall be used in a size and style which, in the opinion of Association agencies, is appropriate to the material.
5. If the material carrying the Association's name is printed, one copy should be sent electronically to the Council for its files.
6. All information pertaining to oral health must be found to be consistent with available scientific evidence.
7. If the material contains statements which fall within the purview of other authoritative agencies or organizations, the Council may require that these statements be consistent with the standards of these agencies or organizations.
8. The material must be primarily education in nature. It should not contain promotional text for a product or service. If products are mentioned in the material, directly or indirectly, they must meet the advertising and exhibit standards of the American Dental Association. In such a case, the finished material may be required to carry an additional statement as follows:

   > This does not constitute an endorsement by the American Dental Association of any products or services mentioned.

9. At any time when (a) content changes are made, or (b) new use is made of the material, reapplication must be made to the Council for use of the Association's statement.
10. From time to time, the Council may query the producer or distributor to make certain these regulations are being observed.

Preventive Dental Procedures (*Trans.*1967:325; 2013:342)

Resolved, that constituent dental societies support the use of preventive procedures in all dental offices, and be it further
Resolved, that constituent and component societies support continuing education programs in the effective use of preventive procedures.

Professional Judgment

Dentist's Freedom to Exercise Individual Clinical Judgment (*Trans.*1997:705)

Resolved, that the American Dental Association advocate legislation or regulation at the federal level to ensure that dentists are free to exercise individual clinical judgment and render appropriate treatment to their patients without undue influence by any third-party business entity, and be it further

Resolved, that the constituent societies be urged to advocate similar legislation or regulation at the state level.

Infringement on Dentists' Judgment (*Trans.*1991:634)

Resolved, that the American Dental Association encourage constituent and component dental societies to actively support Association policy which identifies the treatment plan for a patient as the exclusive prerogative of the attending dentist as agreed to by the informed patient, and be it further

Resolved, that the appropriate agencies of the Association support and assist dental societies in resisting, by whatever lawful means possible, infringement upon dentists' ability to freely exercise their professional judgment.

Research

Policy Statement on Comparative Effectiveness Research and Patient-Centered Outcomes Research (*Trans.*2011:457; 2016:302)

The American Dental Association (ADA) has a long history of identifying and supporting scientific advances in dentistry. Through rigorous scientific inquiry and knowledge sharing, the ADA supports advancements in dental research that improve the health of all Americans.

As an organization with a strong commitment to evidence-based dentistry and improving patient outcomes, the ADA supports comparative effectiveness research and patient-centered outcomes research (CER and PCOR) as methodologies that can lead to improved clinical outcomes, more cost-effective and personalized treatments, and increased patient satisfaction. Concurrently, such research should be designed to address important variables that may impact outcomes, such as patient subgroups to help address biological variability and individual patient needs.

Through the 2010 Patient Protection and Affordable Care Act, Congress has established an independent, non-profit organization to conduct comparative effectiveness research and patient-centered outcomes research. This organization, the Patient-Centered Outcomes Research Institute (PCORI), seeks public input and feedback prior to adoption of priorities, agendas, methodological standards, peer review processes and dissemination strategies.

Therefore, the ADA urges PCORI or other CER/PCOR entities to incorporate the following principles when evaluating diagnostic or treatment modalities pertaining to the provision of oral health care.

1. CER/PCOR Must Be Well Designed.

Objective, independent researchers should conduct thorough, rigorous and scientifically valid research with specific outcome measures. The researchers' and sponsors' actual potential and perceived conflicts of interest must be disclosed.

Protocols must be developed to ensure sound, reliable and reproducible research. Additionally, all efforts must be made to reduce bias in research protocols, literature reviews and clinical summaries.

Patient safety, confidentiality of personal health information and data security must be assured. Institutional review boards (IRBs) must be used to consider whether any risk to patients is balanced by potential research gains. Informed consent must be obtained from patients participating in CER and PCOR studies.

CER and PCOR must adequately consider specific populations by race, gender, ethnicity, age, economic status, geography or any other relevant variable to assure the applicability of the study.

Long-term and short-term studies should be performed and adequately funded. Periodic reevaluation must be done to determine the efficacy of oral health related to CER/PCOR.

2. CER PCOR Process Must Be Open and Transparent.

Setting research priorities, developing research techniques and selecting investigators must be accomplished following an equitable, transparent process that emphasizes engagement with patients and openness to ideas from individuals across the health care community.

3. CER/PCOR Should Not Limit Innovative Treatments or Diagnostics.

CER/PCOR should not act to limit the continued development of innovative therapeutic or diagnostic modalities.

4. The Doctor/Patient Relationship Must Be Maintained.

The unique dentist/patient relationship and patient autonomy are overriding principles that must be included when assessing CER/PCOR information. Results from CER/PCOR studies should not be used to mandate or predetermine a course of treatment for an individual patient, nor should it be used to determine a standard of care.

5. CER/PCOR Should Be Widely Disseminated.

Balanced, clear, accurate, effective and timely communication of results, written with the audience in mind, should be made. PCORI or other CER/ PCOR research entities should work with the ADA to disseminate results that are relevant to oral health care providers.

6. CER/PCOR Should Not Be Payment Driven.

PCORI or other CER/PCOR entities should not make recommendations on payment or coverage decisions. The primary focus of research designed and/or supported by PCORI or other CER and PCOR entities should be to improve patient outcomes, quality of care and/or quality of life.

7. CER/PCOR Should Address Dental Treatment Outcomes.

The dental profession needs PCOR and CER for improved evaluation of health outcomes in clinical practice. This includes independent evaluation of the effectiveness of specific treatments in dental practice,

and improved measurement and assessment of patient-centered outcomes over time.

Scientific Assessment of Dental Restorative Materials (*Trans.*2003:387)

Resolved, that although the safety and efficacy of dental restorative materials has been extensively researched, the Association, consistent with its Research Agenda, will continue to actively promote such research to ensure that the profession and the public have the most current, scientifically valid information on which to make choices about dental treatment requiring restorative materials, and be it further

Resolved, that the Association use its existing communications vehicles to educate opinion leaders and policy makers about the scientific methods used to assess the safety and efficacy of dental restorative materials, and be it further

Resolved, that the Association continue to promptly inform the public and the profession of any new scientific information that contributes significantly to the current understanding of dental restorative materials.

Study of Human Remains for Forensic and Other Scientific Purposes (*Trans.*2002:421)

The American Dental Association supports the preservation and study of human remains for forensic, scientific or other research purposes, provided that ethical, legal, cultural and religious considerations are addressed and the dignity and privacy of the individual are respected.

Research Funds (*Trans.*1984:519; 1999:974; 2016:302)

Resolved, that the ADA urges appropriate external agencies and organizations to provide funding for basic and clinical research that advances the scientific basis of dentistry and the oral and craniofacial health sciences.

Dental Research by Military Departments (*Trans.*1970:451; 2016:316)

Resolved, that the ADA considers oral and craniofacial research to be an integral component of the military dental corps' mission and believes that each military branch should continue to support such research at the basic and applied science levels.

Use of Laboratory Animals in Research and Training (*Trans.*1964:254; 2006:329; 2017:279)

Policy Statement on Use of Laboratory Animals in Research and Training

Resolved, that the American Dental Association favors all reasonable efforts that would ensure the humane treatment of laboratory animals in research and training, in accordance with applicable laws, guidelines and regulations, but opposes the enactment of legislation, guidelines and regulations that would impede the progress of research, and be it further

Resolved, that the American Dental Association encourages researchers and dental material manufacturers to replace animal models with non-animal methodologies whenever the non-animal alternatives would accomplish the same purpose.

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Specialties, Specialization and Interest Areas in General Dentistry

Policy on State Dental Board Recognition of the National Commission on Recognition of Dental Specialties and Certifying Boards (*Trans.*2018:323)

Resolved, that the American Dental Association urges all state dental boards to recognize the National Commission on Recognition of Dental Specialties and Certifying Boards as the agency responsible for the recognition of dental specialties and dental specialty certifying boards.

Recognition of Operative Dentistry, Cariology and Biomaterials as an Interest Area in General Dentistry (*Trans.*2016:304; 2017:274)

Resolved, that operative dentistry, cariology and biomaterials is an interest area in general dentistry recognized by the American Dental Association and sponsored by the Academy of Operative Dentistry.

Criteria for Recognition of Interest Areas in General Dentistry (*Trans.*2010:579; 2018:324)

Criteria for Recognition of Interest Areas in General Dentistry

1. The existence of a well-defined body of established evidence-based scientific and clinical dental knowledge underlying the general dentistry area - knowledge that is in large part distinct from, or more detailed than, that of other areas of general dentistry education and practice and any of the dental specialties recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards.

   Elements to be addressed:

   - Definition and scope of the general dentistry area
   - Educational goals and objectives of the general dentistry area
   - Competency and proficiency statements for the general dentistry education area
   - Description of how scientific dental knowledge in the area is substantive and distinct from other general dentistry areas

2. The body of knowledge is sufficient to educate individuals in a distinct advanced education area of general dentistry, not merely one or more techniques.

   Elements to be addressed:

   - Identification of distinct components of biomedical, behavioral and clinical science in the advanced education area
   - Description of why this area of knowledge is a distinct education area of general dentistry, rather than a series of just one or more techniques
   - Documentation demonstrating that the body of knowledge is unique and distinct from that in other education areas accredited by the Commission on Dental Accreditation
   - Documentation of the complexity of the body of knowledge of the general dentistry area by identifying specific advanced techniques and procedures, representative samples of curricula from existing programs, textbooks and journals

3. The existence of established advanced educational programs with structured curricula, qualified faculty and enrolled individuals for which accreditation by the Commission on Dental Accreditation can be a viable method of quality assurance.

   Elements to be addressed:

   - Description of the historical development and evolution of educational programs in the area of advanced training in general dentistry
   - A listing of the current operational programs in the advanced general dentistry training area, identifying for each, the:
     a. Sponsoring institution;
     b. Name and qualifications of the program director;
     c. Number of full-time and part-time faculty (define part-time for each program);
     d. Curriculum (course outlines, student competencies, class schedules);
     e. Outcomes assessment method;
     f. Minimum length of the program;
     g. Certificate and/or degree awarded upon completion;
     h. Number of enrolled individuals per year for at least the past five years*; and
     i. Number of graduates per year for at least the past five years.*

   **If the established education programs have been in existence less than five years, provide information since their founding.*

- Documentation on how many programs in the education area would seek voluntary accreditation review, if available

4. The education programs are the equivalent of at least one 12-month full-time academic year in length. The programs must be academic programs sponsored by an institution accredited by an agency recognized by the United States Department of Education or accredited by the Joint Commission on Accreditation of Healthcare Organizations or its equivalent rather than a series of continuing education experiences.

   Elements to be addressed:

   - Evidence of the minimum length of the program for full-time students
   - Evidence that a certificate and/or degree is awarded upon completion of the program
   - Programs' recruitment materials (e.g., bulletin, catalogue)
   - Other evidence that the programs are bona fide higher education experiences, rather than a series of continuing education courses (e.g., academic calendars, schedule of classes, and syllabi that address scope, depth and complexity of the higher education experience, formal approval or acknowledgment by the parent institution that the courses or curricula in the education area meet the institution's academic requirements for advanced education)

5. The competence of the graduates of the advanced education programs is important to the health care of the general public.

   Elements to be addressed:

   - Description of the need for appropriately trained individuals in the general dentistry area to ensure quality health care for the public
   - Description of current and emerging trends in the general dentistry education area
   - Documentation that dental health care professionals currently provide health care services in the identified area
   - Evidence that the area of knowledge is important and significant to patient care and dentistry
   - Documentation that the general dentistry programs comply with the ADA *Principles of Ethics and Code of Professional Conduct,* as well as state and federal regulations

Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists (*Trans.*2001:470; 2004:313; 2009:443; 2013:328; 2018:326)

Introduction

A specialty is an area of dentistry that has been formally recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards as meeting the "Requirements for Recognition of Dental Specialties" specified in this document. Dental specialties are recognized to protect the public, nurture the art and science of dentistry, and improve the quality of care. It is the Association's belief that the needs of the public are best served if the profession is oriented primarily to general practice. Specialties are recognized in those areas where advanced knowledge and skills are essential to maintain or restore oral health.[1]

Not all areas in dentistry will satisfy the requirements for specialty recognition. However, the public and profession benefit substantially when non-specialty groups develop and advance areas of interest through education, practice and research. The contributions of such groups are acknowledged by the profession and their endeavors are encouraged.

The sponsoring organization must submit to the National Commission on Recognition of Dental Specialties and Certifying Boards a formal application which demonstrates compliance with all the requirements for specialty recognition.

Following recognition of a specialty by the National Commission on Recognition of Dental Specialties and Certifying Boards a national board for certifying diplomates in accordance with the "Requirements for National Certifying Boards for Dental Specialists" may be established as specified in this document.

Requirements for Recognition of Dental Specialties

A sponsoring organization seeking specialty recognition for an area must document that the discipline satisfies all the requirements specified in this section.

(1) In order for an area to become and/or remain recognized as a dental specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of that proposed or recognized dental specialty; (b) in which the privileges to hold office and to vote on any issue related to the specialty are reserved for dentists who either have completed an advanced education program accredited by the Commission on Dental Accreditation in that proposed or recognized specialty or have sufficient experience in that specialty as deemed appropriate by the sponsoring organization and its certifying board; and (c) that

[1] Association policies regarding ethical announcement of specialization and limitation of practice are contained in the *ADA Principles of Ethics and Code of Professional Conduct*.

demonstrates the ability to establish a certifying board.
(2) A proposed specialty must be a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates as defined by the Commission on Dental Accreditation's Accreditation Standards for Dental Education Programs.
(3) The scope of the proposed specialty requires advanced knowledge and skills that: (a) in their entirety, are separate and distinct from the knowledge and skills required to practice in any recognized dental specialty; and (b) cannot be accommodated through minimal modification of a recognized dental specialty.
(4) The specialty applicant must document scientifically, by valid and reliable statistical evidence/studies, that it: (a) actively contributes to new knowledge in the field; (b) actively contributes to professional education; (c) actively contributes to research needs of the profession; and (d) provides oral health services in the field of study for the public; each of which the specialty applicant must demonstrate would not be satisfactorily met except for the contributions of the specialty applicant.
(5) A proposed specialty must directly benefit some aspect of clinical patient care.
(6) Formal advanced education programs of at least two years accredited by the Commission on Dental Accreditation must exist to provide the special knowledge and skills required for practice of the proposed specialty.

Requirements for National Certifying Boards for Dental Specialists

In order to become, and remain, eligible for recognition by the National Commission on Recognition of Dental Specialties and Certifying Boards as a national certifying board for a dental specialty, the specialty shall have a sponsoring organization that meets all of the elements of Requirement (1) of the Requirements for Recognition of Dental Specialties. A close working relationship shall be maintained between the sponsoring organization and the certifying board. Additionally, the following requirements must be fulfilled.

Organization of Boards

(1) Each Board shall have no less than five or more than 12 voting directors designated on a rotation basis in accordance with a method approved by the National Commission on Recognition of Dental Specialties and Certifying Boards. Although the Commission does not prescribe a single method for selecting directors of boards, members may not serve for more than a total of nine years. Membership on the board shall be in accordance with a prescribed method endorsed by the sponsoring organization. All board directors shall be diplomates of that board and only the sponsoring organizations of boards may establish additional qualifications if they so desire.
(2) Each board shall submit in writing to the National Commission on Recognition of Dental Specialties and Certifying Boards a program sufficiently comprehensive in scope to meet the requirements established by the American Dental Association for the operation of a certifying board. This statement should include evidence of sponsorship of the board by a national organization that meets all the elements of Requirement (1) of the Requirements for Recognition of Dental Specialties.
(3) Each board shall submit to the National Commission on Recognition of Dental Specialties and Certifying Boards evidence of adequate financial support to conduct its program of certification.
(4) Each board may select suitable consultants or agencies to assist in its operations, such as the preparation and administration of examinations and the evaluation of records and examinations of candidates. Consultants who participate in clinical examinations should be diplomates.

Operation of Boards

(1) Each board shall certify qualified dentists as diplomates only in the special area of dental practice approved by the National Commission on Recognition of Dental Specialties and Certifying Boards for such certification. No more than one board shall be recognized for the certification of diplomates in a single area of practice.
(2) Each board, except by waiver of the National Commission on Recognition of Dental Specialties and Certifying Boards, shall give at least one examination in each calendar year and shall announce such examination at least six months in advance.
(3) Each board shall maintain a current list of its diplomates.
(4) Each board shall submit annually to the National Commission on Recognition of Dental Specialties and Certifying Boards data relative to its financial operations, applicant admission procedures, and examination content and results. Examination procedures and results should follow the Standards for Educational Psychological Testing, including validity and reliability evidence. A diplomate may, upon request, obtain a copy of the annual technical and financial reports of the board.
(5) Each board shall encourage its diplomates to engage in lifelong learning and continuous quality improvement.
(6) Each board shall provide periodically to the National Commission on Recognition of Dental Specialties and Certifying Boards evidence of its examination and certification of a significant number of additional dentists in order to warrant its continuing approval by the National Commission

on Recognition of Dental Specialties and Certifying Boards.

(7) Each board shall bear full responsibility for the conduct of its program, the evaluation of the qualifications and competence of those it certifies as diplomates, and the issuance of certificates.

(8) Each board shall require an annual registration fee from each of its diplomates intended to assist in supporting financially the continued program of the board.

Certification Requirements

(1) Each board shall require, for eligibility for certification as a diplomate, the successful completion of an advanced education program accredited by the Commission on Dental Accreditation of two or more academic years in length, as specified by the Commission.

Although desirable, the period of advanced study need not be continuous, nor completed within successive calendar years. An advanced educational program equivalent to two academic years in length, successfully completed on a part-time basis over an extended period of time as a graduated sequence of educational experience not exceeding four calendar years, may be considered acceptable in satisfying this requirement. Short continuation and refresher courses and teaching experience in specialty departments in dental schools will not be accepted in meeting any portion of this requirement.

Each board may establish an exception to the qualification requirement of completion of an advanced specialty education program accredited by the Commission on Dental Accreditation for the unique candidate who has not met this requirement *per se*, but can demonstrate to the satisfaction of the certifying board, equivalent advanced specialty education. A certifying board must petition the National Commission on Recognition of Dental Specialties and Certifying Boards for permission to establish such a policy.

(2) Each board shall establish its minimum requirements for years of practice in the area for which it grants certificates. The years of advanced education in this area may be accepted toward fulfillment of this requirement.

(3) Each board, in cooperation with its sponsoring organization, shall prepare and publicize its recommendations on the educational program and experience requirements which candidates will be expected to meet.

Specialty Areas of Dental Practice (*Trans.*1995:633; 2018:330)

Resolved, that the specialty areas of dental practice meet the ADA's "Requirements for Recognition of Dental Specialties" to assure the public of the competence of the dentist who holds himself/herself out to the public as a specialist who performs services which require formal advanced education, training and skills beyond those commonly possessed by the general practitioner.

Dentistry as an Independent Profession (*Trans.*1995:640)

Resolved, that dentistry should continue to be a profession of its own and should not become a medical specialty.

Requirements for Board Certification (*Trans.*1975:690; 2018:325)

Resolved, that candidates for board certification who completed the prescribed length of education for board certification in a program of an institution then listed by the Council on Dental Education and Licensure prior to 1967 and who have announced ethically limitation of practice in one of the recognized dental specialties are considered educationally eligible.

Substance Use Disorders

ADA Policy on Opioid Prescribing (*Trans.*2018:310)

ADA Policy on Opioid Prescribing

Continuing Education

Resolved, that the ADA supports mandatory continuing education (CE) in prescribing opioids and other controlled substances, with an emphasis on preventing drug overdoses, chemical dependency, and diversion. Any such mandatory CE requirements should:

1. Provide for continuing education credit that will be acceptable for both DEA registration and state dental board requirements,
2. Provide for coursework tailored to the specific needs of dentists and dental practice,
3. Include a phase-in period to allow affected dentists a reasonable period of time to reach compliance,

and be it further

Dosage and Duration

Resolved, that the ADA supports statutory limits on opioid dosage and duration of no more than seven days for the treatment of acute pain, consistent with Centers for Disease Control and Prevention (CDC) evidence-based guidelines.

and be it further
Resolved, that the ADA supports improving the quality, integrity, and interoperability of state prescription drug monitoring programs.

Statement on the Use of Opioids in the Treatment of Dental Pain (*Trans.*2016:286)

1. When considering prescribing opioids, dentists should conduct a medical and dental history to determine current medications, potential drug interactions and history of substance abuse.
2. Dentists should follow and continually review Centers for Disease Control and State Licensing Boards recommendations for safe opioid prescribing.
3. Dentists should register with and utilize prescription drug monitoring program (PDMP) to promote the appropriate use of controlled substances for legitimate medical purposes, while deterring the misuse, abuse and diversion of these substances.
4. Dentists should have a discussion with patients regarding their responsibilities for preventing misuse, abuse, storage and disposal of prescription opioids.
5. Dentists should consider treatment options that utilize best practices to prevent exacerbation of or relapse of opioid misuse.
6. Dentists should consider nonsteroidal anti-inflammatory analgesics as the first-line therapy for acute pain management.
7. Dentists should recognize multimodal pain strategies for management for acute postoperative pain as a means for sparing the need for opioid analgesics.
8. Dentists should consider coordination with other treating doctors, including pain specialists when prescribing opioids for management of chronic orofacial pain.
9. Dentists who are practicing in good faith and who use professional judgment regarding the prescription of opioids for the treatment of pain should not be held responsible for the willful and deceptive behavior of patients who successfully obtain opioids for non-dental purposes.
10. Dental students, residents and practicing dentists are encouraged to seek continuing education in addictive disease and pain management as related to opioid prescribing.

Statement on Alcoholism and Other Substance Use Disorders (*Trans.*2005:328; 2018:309)

Resolved, that the ADA Statement on Alcoholism and Other Substance Use Disorders (*Trans.*2005:328) be Amended as follows:

Statement on Alcoholism and Other Substance Use Disorders

1. The ADA recognizes that alcoholism and other substance use disorders are primary, chronic, and often progressive diseases that ultimately affect every aspect of health, including oral health.
2. The ADA recognizes the need for research on the oral health implications of chronic alcohol, tobacco and/or other drug use.
3. The ADA recognizes the need for research on substance use disorders and successful treatment protocols among dentists, dental and dental hygiene students, and dental team members.

and be it further
Resolved, the ADA encourages the states to create and maintain well-being programs that address substance use disorders as well as other mental and physical challenges that dentists might experience throughout their career.

and be it further

Resolved, the ADA encourages the states to maintain a list of volunteer dentists experienced with health and well-being challenges to provide support and make it available to dentists faced with like challenges.

Statement on Provision of Dental Treatment for Patients With Substance Use Disorders (*Trans.*2005:329)

Statement on Provision of Dental Treatment for Patients With Substance Use Disorders

1. Dentists are urged to be aware of each patient's substance use history, and to take this into consideration when planning treatment and prescribing medications.
2. Dentists are encouraged to be knowledgeable about substance use disorders—both active and in remission—in order to safely prescribe controlled substances and other medications to patients with these disorders.
3. Dentists should draw upon their professional judgment in advising patients who are heavy drinkers to cut back, or the users of illegal drugs to stop.
4. Dentists may want to be familiar with their community's treatment resources for patients with substance use disorders and be able to make referrals when indicated.
5. Dentists are encouraged to seek consultation with the patient's physician, when the patient has a history of alcoholism or other substance use disorder.
6. Dentists are urged to be current in their knowledge of pharmacology, including content related to drugs of abuse; recognition of contraindications to the delivery of epinephrine-containing local anesthetics; safe prescribing practices for patients with substance use disorders—both active and in remission—and management of patient emergencies that may result from unforeseen drug interactions.
7. Dentists are obliged to protect patient confidentiality of substances abuse treatment information, in accordance with applicable state and federal law.

Statement on Alcohol and Other Substance Use by Pregnant and Postpartum Patients (*Trans.*2005:330)

Statement on Alcohol and Other Substance Use by Pregnant and Postpartum Patients

1. Dentists are encouraged to inquire about pregnant or postpartum patients' history of alcohol and other drug use, including nicotine.
2. As healthcare professionals, dentists are encouraged to advise these patients to avoid the use of these substances and to urge them to disclose any such use to their primary care providers.
3. Dentists who become aware of postpartum patients' resumption of tobacco or illegal drug use, or excessive alcohol intake, are encouraged to recommend that the patient stop these behaviors. The dentist is encouraged to be prepared to inform the woman of treatment resources, if indicated.

Guidelines Related to Alcohol, Nicotine, and/or Drug Use by Child or Adolescent Patients (*Trans.*2005:330)

Guidelines Related to Alcohol, Nicotine, and/or Drug Use by Child or Adolescent Patients

1. Dentists are urged to be knowledgeable about the oral manifestations of nicotine and drug use in adolescents.
2. Dentists are encouraged to know their state laws related to confidentiality of health services for adolescents and to understand the circumstances that would allow, prevent or obligate the dentist to communicate information regarding substance use to a parent.
3. Dentists are encouraged to take the opportunity to reinforce good health habits by complimenting young patients who refrain from using tobacco, drinking alcohol or using illegal drugs.
4. A dentist who becomes aware of a young patient's tobacco use is encouraged to take the opportunity to ask about it, provide tobacco cessation counseling and to offer information on treatment resources.
5. Dentists may want to consider having age-appropriate anti-tobacco literature available in their offices for their young patients.
6. Dentists who become aware of a young patient's alcohol or illegal drug use (either directly or through a report to a team member), are encouraged to express concern about this behavior and encourage the patient to discontinue the drug or alcohol use.
7. A dentist who becomes aware that a parent is supplying illegal substances to a young patient, may be subject to mandatory reporting under child abuse regulations.

Insurance Coverage for Chemical Dependency Treatment (*Trans.*1986:519; 2012:442)

Resolved, that the ADA believes that any ADA or constituent [*]sponsored or endorsed medical and disability insurance coverage should include coverage

[*] Note: Editorially corrected.

for the treatment of chemical dependency (including alcoholism)

Taxation

Tax Treatment of Employer-Paid Fringe Health Benefits (*Trans.*2019:XXX)

Resolved, that the American Dental Association is opposed to all forms of taxes on health care services, including employer-paid fringe health benefits.

Tax Treatment of Professional Dues (*Trans.*2019:XXX)

Resolved, that the American Dental Association supports policies that would allow employed professionals to deduct certain professional expenses, such as the full amount of dues paid to professional organizations, from their income taxes.

Tax Treatment of Student Loan Interest, Scholarships and Stipends (*Trans.*2019:XXX)

Resolved, that the American Dental Association supports the tax deductibility of interest on health profession student loans, and be it further
Resolved, that the ADA supports a tax exemption for scholarship assistance and stipends awarded to health professions students under federal programs.

Tax Deductibility of Dental and Medical Expenses (*Trans.*1982:549; 1989:548)

Resolved, that all costs incurred by an individual for the dental and medical expenses of the individual and his or her dependents should be tax deductible without regard to adjusted gross income.

Teledentistry

Comprehensive ADA Policy Statement on Teledentistry (*Trans.*2015:244)

Teledentistry refers to the use of telehealth systems and methodologies in dentistry. Telehealth refers to a broad variety of technologies and tactics to deliver virtual medical, health, and education services. Telehealth is not a specific service, but a collection of means to enhance care and education delivery.

Teledentistry can include patient care and education delivery using, but not limited to, the following modalities:

- Live video (synchronous): Live, two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology.
- Store-and-forward (asynchronous): Transmission of recorded health information (for example, radiographs, photographs, video, digital impressions and photomicrographs of patients) through a secure electronic communications system to a practitioner, who uses the information to evaluate a patient's condition or render a service outside of a real-time or live interaction.
- Remote patient monitoring (RPM): Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider (sometimes via a data processing service) in a different location for use in care and related support of care.
- Mobile health (mHealth): Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and personal digital assistants (PDA).

General Considerations: The treatment of patients who receive services via teledentistry must be properly documented and should include providing the patient with a summary of services. Dentists who deliver services using teledentistry must establish protocols for appropriate referrals when necessary.

Patients' Rights: Dental patients whose care is rendered or coordinated using teledentistry modalities have the right to expect:

1. That any dentist delivering services using teledentistry technologies will be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's dental board.
2. Access to the licensure and board certification qualifications of the oral health care practitioner who is providing the care in advance of the visit.
3. That the delivery of services through teledentistry technologies will follow evidence-based practice guidelines, to the degree they are available, as a means of ensuring patient safety, quality of care and positive health outcomes.
4. That they will be informed about the identity of the providers collecting or evaluating their information or providing treatment, and of any costs they will be responsible for in advance of the delivery of services.
5. That relevant patient information will be collected prior to performing services using teledentistry technologies and methods including medical, dental, and social history, and other relevant demographic and personal information.
6. That the provision of services using teledentistry technologies will be properly documented and the records and documentation collected will be provided to the patient upon their request.
7. That services provided using teledentistry technologies and methods include care coordination as a part of a dental home and that the patient's records be made available to any entity that is serving as the patient's dental home.
8. That the patient will be actively involved in treatment decisions, will be able to choose how they receive a covered service, including considerations for urgency, convenience and satisfaction and without such penalties as higher deductibles, co-payments or coinsurance relative to that of in-person services.
9. That the delivery of services using teledentistry technologies are performed in accordance with applicable laws and regulations addressing the privacy and security of patients' private health information.

Quality of Care: The dentist is responsible for, and retains the authority for ensuring, the safety and quality of services provided to patients using teledentistry technologies and methods. Services delivered via teledentistry should be consistent with in-person services, and the delivery of services utilizing these modalities must abide by laws addressing privacy and security of a patient's dental/medical information.

Supervision of Allied Dental Personnel: The extent of the supervision of allied dental personnel should conform to the applicable dental practice act in the

state where the patient receives services and where the dentist is licensed. The dentist should be knowledgeable regarding the competence and qualifications of the allied personnel utilized, and should have the capability of immediately contacting both the allied dental personnel providing service and the patient receiving services. All services delivered by allied dental personnel should be consistent with the ADA Comprehensive Statement on Allied Dental Personnel.

Licensure: Dentists and allied dental personnel who deliver services through teledentistry modalities must be licensed or credentialed in accordance with the laws of the state in which the patient receives service. The delivery of services via teledentistry must comply with the state's scope of practice laws, regulations or rules. The American Dental Association opposes a single national federalized system of dental licensure for the purposes of teledentistry.

Reimbursement: Dental benefit plans and all other third-party payers, in both public (e.g. Medicaid) and private programs, shall provide coverage for services using teledentistry technologies and methods (synchronous or asynchronous) delivered to a covered person to the same extent that the services would be covered if they were provided through in-person encounters. Coverage for services delivered via teledentistry modalities will be at the same levels as those provided for services provided through in-person encounters and not be limited or restricted based on the technology used or the location of either the patient or the provider as long as the health care provider is licensed in the state where the patient receives service.

Technical Considerations: Dentists are encouraged to consider conformance with applicable data exchange standards to facilitate delivery of services via teledentistry modalities. These include, but are not limited to, Digital Imaging and Communications in Medicine (DICOM) standards when selecting and using imaging systems, X12/HL7 for the exchange of information and ICD-9/10-CM/SNOMED/SNODENT for documentation consistency.

Tobacco, Tobacco Products and Smoking

Policies and Recommendations on Tobacco Use (*Trans.*2016:323)

Dentist's Role in Preventing Tobacco Use

The ADA supports professional education related to the importance of primary prevention of tobacco use.

The ADA urges its members to become fully informed about tobacco cessation intervention techniques to effectively educate their patients to overcome their addiction to tobacco.

The ADA supports training and education for dental professionals to ensure that all clinicians in the United States have the knowledge, skills and support systems necessary to inform the public about the health hazards of tobacco products and to provide effective tobacco cessation strategies.

The ADA urges dentists and health organizations to provide educational materials on tobacco use prevention or cessation to patients and consumers developed by credible and trustworthy sources with no ties to the tobacco industry or its affiliates.

Access and Prevention

The ADA continue to educate and inform its membership and the public about the many health hazards attributed to the use of traditional and non-traditional tobacco products, including e-cigarettes, e-cigarette cartridges, snus, dissolvable tobacco, tobacco gels, and other products made or derived from tobacco.

The ADA encourages its members and dental societies to collaborate with students, parents, school officials, and members of the community to establish tobacco-free schools.

The ADA does not consider marketing some tobacco products as safer or less harmful to an individual's health than others to be a viable public health strategy to reduce the death and disease associated with tobacco use.

Government Affairs

The ADA should give priority to the following when advancing public policies to prevent tobacco use:

1. Protecting and enhancing state and federal regulatory authority to ban or otherwise prevent the use of traditional and non-traditional tobacco products;
2. Banning the sale of traditional and non-traditional tobacco products in all venues, including through vending machines and the internet;
3. Levying significant excise taxes on traditional and non-traditional tobacco products;
4. Setting age restrictions for purchasers of traditional and non-traditional tobacco products;
5. Requiring oral health warning statements and graphic images on traditional and non-traditional tobacco products;
6. Barring companies from marketing some traditional and non-traditional tobacco products as being less harmful to the oral health than others;
7. Regulating exposure to environmental tobacco smoke (ETS);
8. Banning all forms of traditional and non-traditional tobacco product advertising and marketing (including bans on free sampling);
9. Imposing licensure requirements for traditional and non-traditional tobacco product retailers;
10. Prohibiting the use of traditional and non-traditional tobacco products on public and private property, including government buildings and school campuses;
11. Requiring third-party payers to cover professionally administered tobacco cessation services (e.g., cessation counseling, prescription medications, etc.) as an essential plan benefit.

The ADA should encourage federal research agencies to develop the body of credible, peer-reviewed scientific literature examining, among other things:

1. The immediate and long-term effects of traditional and non-traditional tobacco product use on oral health;
2. The viability of new cessation products and strategies;
3. The validity of claims that some traditional and non-traditional tobacco products are less harmful to the oral cavity than others.

Governance

The ADA supports the adoption of tobacco free policies and accordingly, prohibits use of any tobacco products at all ADA sponsored meetings and conferences.

The ADA shall not accept advertisements from tobacco companies or groups aligned with the tobacco industry concerning tobacco use, prevention, or cessation in any of its official publications or media, including the Journal of the American Dental Association, ADA News, and ADA.org.

Tort Reform

ADA Support for Medical Injury Compensation Reform (*Trans.*2005:342)

Resolved, that the ADA proactively lobby for liability reform legislation and such legislation should not override state limits on non-economic damages, and be it further
Resolved, that the ADA actively communicate its position on medical liability reform in all appropriate policy/decision-making venues, and be it further
Resolved, that the ADA continue to pursue coalition opportunities with other impacted health care professionals.

Federal Tort Reform Legislation (*Trans.*1993:708)

Resolved, that the Association support changes in federal tort reform legislation designed to rectify the problems in the current system which, in the judgment of the Association, unnecessarily contribute to the cost of health care, and be it further

Resolved, that the Association support tort reform legislation that includes but is not limited to mandatory periodic payments of substantial awards for damages; a ceiling on non-economic damages; mandatory offsets of awards for collateral sources of recovery; limits on attorneys' contingency fees; a statute of limitations on health care-related injuries; and state duties concerning alternative methods of resolving disputes.

Professional Liability Insurance Legislation (*Trans.*1984:548)

Resolved, that the American Dental Association and constituent dental societies support federal and state legislation, as appropriate, to deal fairly and equitably with the problems of rapidly increasing professional liability insurance costs which contribute significantly to higher costs of health care services for patients, and be it further
Resolved, that legislative or other approaches to the professional liability problem be studied and developed in cooperation with other health organizations and interested parties.

Volunteerism

Participation in Dental Outreach Programs (*Trans.*2010:587; 2016:299)

Resolved, students in U.S. dental schools and pre-dental programs who participate in a dental outreach program (e.g., international service trips, domestic service trips, volunteerism in underserved areas, etc.) are strongly encouraged:

- To adhere to the ASDA Student Code of Ethics and the ADA *Principles of Ethics and Code of Professional Conduct;*
- To be directly supervised by dentists licensed to practice or teach in the United States;
- To perform only procedures for which the volunteer has received proper education and training.

Volunteerism (*Trans.*2003:368)

Resolved, that the Association support a campaign to encourage volunteerism on dental school faculties, in organized dentistry and in access to care, and be it further

Resolved, that the campaign also encourage philanthropy to dentistry at the local, state and national levels.

Women's Oral Health

Dental Examinations for Pregnant Women and Women of Child-Bearing Age (*Trans.*2014:508)

Resolved, that the ADA urge all pregnant women and women of child-bearing age to have a regular dental examination.

Dental Treatment During Pregnancy (*Trans.*2014:508)

Resolved, that the ADA acknowledges that preventive, diagnostic and restorative dental treatment to promote health and eliminate disease is safe throughout pregnancy and is effective in improving and maintaining the oral health of the mother and her child.

Women's Oral Health Research (*Trans.*2001:460)

Resolved, that the ADA support increased funding for, and enhanced grant opportunities in, women's oral health research; support federal agency efforts to ensure that women are adequately represented as research subjects in dental clinical trials; and help disseminate research information, hold educational briefings and provide educational materials on women's oral health issues, as needed and appropriate.

Women's Oral Health: Patient Education (*Trans.*2001:428; 2014:504)

Resolved, that the ADA work with federal and state agencies, constituent and component dental societies and other appropriate organizations to incorporate oral health education information into health care educational outreach efforts directed at mothers and their children, and be it further

Resolved, that the ADA work with the obstetric community to ensure that pregnant women are provided relevant oral health care information during the perinatal period.

Workforce

Policy on Native American Workforce (*Trans.*2011:491)

Resolved, that the American Dental Association supports efforts by Native American communities to build capacity and improve the availability of community-based oral health services, and be it further
Resolved, that the ADA nationally advocate for a larger and more diverse Native American dental workforce by promoting awareness of Native American oral health issues, enlisting useful partnerships and being a resource to tribes and organizations that recruit, support and promote dental education for Native Americans, and be it further
Resolved, that Native American communities and populations be urged to build upon existing educational programs that are consistent with ADA policy with local constituent and component dental societies to improve access to dental education resources for Native Americans in their areas and to improve cultural understanding and awareness of need.

ADA's Position on New Members of the Dental Team (*Trans.*2009:419)

Resolved, that the determination of workforce needs are under the jurisdiction of the state and are determined at the state level, and any proposed new member of the dental team should be established at the state level with the advice and counsel of the relevant ADA constituent dental society, and be it further
Resolved, that this does not include any ongoing pilot initiatives that the ADA presently is involved in, and be it further
Resolved, that when state governments consider regulatory or legislative authorization of a new dental team member, the ADA may assist and serve as a resource at the request of a constituent dental society as they respond to workforce needs and advocate for the best workforce solution, and be it further
Resolved, that the ADA recommends that any new member of the dental team be supervised by a dentist and be based upon a determination of need, sufficient education and training through a CODA accredited program, and a scope of practice that ensures the protection of the public's oral health.

Collaboration With Specialty Organizations on Workforce (*Trans.*2009:420)

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

Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform Irreversible Procedures (*Trans.*2010:521)

Resolved, that the ADA may support pilot programs that do not jeopardize the patient's oral health, as based on a valid assessment demonstrating that the program is necessary to fulfill an unmet need and the program does not allow a nondentist to diagnose, treatment plan or perform irreversible surgical procedures, and be it further
Resolved, that the ADA critically review and seek opportunity for input into any pilot program or study that has potential for significant impact on the dental profession, and be it further
Resolved, that the policy of the ADA shall be to actively participate in discussions/dialogue with government, oral health care organizations or other agencies involved in dental workforce issues or oral health care issues, and be it further
Resolved, that the policy of the ADA shall be to seek funding for Association studies on dental workforce models or oral health care delivery issues or their evaluations, and be it further
Resolved, that if a pilot program involves a new member of the dental team, the new team member must be supervised by a dentist, and be it further
Resolved, that the development of any new member of the dental team be based upon determination of need, CODA-accredited dental school or advanced dental education program, and a scope of practice that ensures the protection of the public's oral health.

Diagnosis or Performance of Irreversible Dental Procedures by Nondentists (*Trans.*2004:328; 2010:494)

Resolved, that the American Dental Association by all appropriate means strive to maintain the highest quality of oral health care by maintaining that the dentist be the healthcare provider that performs examinations/ evaluations, diagnoses, and treatment planning, and be it further
Resolved, that the dentist be the health care provider that performs surgical/irreversible procedures, and be it further
Resolved, that surgical procedures be defined as the cutting or removal of hard or soft tissue.

Maldistribution of the Dental Workforce (*Trans.*2001:442; 2014:500)

Resolved, that appropriate agencies of the ADA develop a framework to help those states with a maldistribution of the dental workforce, and be it further
Resolved, that the framework may include, but is not limited to:

- Model legislation to help attract dentists to underserved areas of states. The legislation may include, but is not limited to:

    a. Tax incentives for dentists practicing in underserved areas.
    b. Payback of all or a portion of dental school tuition if the new dentist practices in an underserved area.
    c. Scholarships for dental students and post-doctoral residents and students who practice in underserved areas after graduation.
    d. Loan forgiveness for dental students and post-doctoral residents and students who practice in underserved areas after graduation.

- Establishing a list of opportunities that are available from rural communities who are willing to provide financial support to dentists moving to their area.

Measuring the Demand for Dental Services (*Trans.*1995:623)

Resolved, that any measures of the capacity of the dental system to provide additional care take into account the individual variations in practice styles, specialties, preferences, locations and patient demand for dental services.

Support for Programs That Forecast Public Demand for Dental Services (*Trans.*1995:609)

Resolved, that the American Dental Association supports efforts to monitor, maintain and strengthen programs that attempt to forecast public demand for dental services and which track trends in dental services utilization, and be it further
Resolved, that this manpower information be forwarded to the appropriate Association agencies which can assess its potential impact on any state or national legislative reform proposals.

Dental Needs Survey (*Trans.*1985:588)

Resolved, that the ADA Board of Trustees encourage and the ADA staff provide assistance to constituent and dental societies who wish to conduct local or regional dental needs surveys, and be it further
Resolved, that all costs for staff assistance not included in the Association budget be borne by the constituent or component dental society conducting the study.

Use of Dentist-to-Population Ratios (*Trans.*1984:538; 1996:681)

Resolved, that the American Dental Association urges all governmental, professional and public agencies, and schools of dentistry to refrain from using dentist-to-population ratios exclusively in evaluating or recommending programs for dental education or dental care.