



Policies

Adopted by the House of Delegates

1997 - 2024

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 – 2024. 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 Table of Contents

ADA

- Election of ADA Trustee3
- Funding for ADA Candidates3

Dental Schools

- Involvement of Dental School Deans in Organized Dentistry3
- ISDS Position Statement on Proposed Mid-Level Dental Provider Models.....3
- ISDS adopts the ADA’s Comprehensive Policy on Dental Licensure4

Dentistry for School Children

- School Based Oral Health Prevention Programs4
- Dental Clinics in School Health Centers.....4
- School Dental Exams for Children Entering 2nd, 6th and 9th4

General Dentistry

- Opposition to Denturism4
- Supervision of Medically Compromised Patients4
- Limiting Oral Piercings by Non-Dentists4
- Definition of Dental Emergency4
- Definition of Dental Underserved Areas5
- Supply of Practicing Dentists in Illinois5
- Recruitment of Minorities into Dentistry5
- Definition of Basic Oral Health5
- Education is a Critical Aspect of Good Oral Health5
- Definition of Access to Care in Emergency Dental Situations5
- Definition of Access to Care for Non-Emergency Dental Treatment.....5
- Policy on Tobacco Use5
- Use of E-cigarettes.....5

General Housekeeping

- Assumption of CDS Dues Billing6

Insurance & Medicaid

- Statewide Universal Healthcare That Includes Dental Coverage6
- Incentives to Attract Dentists to Practice in Medicaid & Underserved Areas6
- Further Expansion of Medicaid Program.....6
- Expansion of Public Dental Clinics7
- Policies on Dental Benefit Programs7
- Illinois Dental Medicaid Carve Out.....7

Registered Dental Hygienists

- Dental Hygiene Education7
- Supply of Practicing Dental Hygienists in Illinois.....7

Guidelines Governing the Conduct of Campaigns for ISDS Offices 7

- Candidate Agreement.....10

Diversity, Equity & Inclusion.....10

Legislation.....11

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. Money will be withdrawn from the Society's reserves. (Res.#12-2022)

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)

ISDS Position Statement on Proposed Mid-level Dental Provider Models

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.
- Should a delivery care model utilizing Mid-Level Providers, under full control of the dentist, and adhering to our policy statement, demonstrate a positive impact on access to care such model would be worthy of examination, discussion, and consideration. (Res. #14-2010, Res.#6-2023)

ISDS adopts the ADA's Comprehensive Policy on Dental Licensure (2018:341).
(Res. #15-2022)

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 should be examined and diagnosed by a licensed dentist prior to obtaining treatment, unless provided otherwise in the Illinois Dental Practice Act. (Res. #8-2002, Res. #16-2022)

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.

Dentists should use their professional judgement in determining a patient's need for emergency care. (Res. #14-2006, Res. #17RC-AM-2022)

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

Although the current 12 dental hygiene programs in Illinois were at one point sufficient to meet the needs of residents statewide, the COVID-19 pandemic created a shortage with many leaving the profession or retiring sooner than anticipated. Dental hygiene programs in Illinois should look for opportunities to increase class size where possible to address this shortage. To also address this shortage, measures should be explored of how dental auxiliary staff, under proper supervision and training, can be utilized to render care. (Res. #15-2006, Res. # 18-2022)

Guidelines Governing the Conduct of Campaigns For ISDS Offices

Campaign Guidelines for ISDS Offices (Res. # 13-2006, Res. # 14-2012, Res. #19-2022, Res. #8-2023)

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 their campaign.

B. The Election Review Committee shall be responsible for determining if any violation(s) of these guidelines occurred and providing notice of such violation(s), in accordance with Section 9.

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 only campaign within their own ISDS component or Chicago Dental Society (CDS) branch. Associate members of CDS shall not campaign within any branches prior to formal announcement.

Campaign activities outside a candidate's own ISDS component or CDS branch shall not begin 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 they submit a written, signed statement of candidacy to the Secretary of the ISDS House. The signed statement shall be comprised of this House policy on Guidelines Governing the Conduct of Campaigns for ISDS Office and 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 first verifying eligibility and then sending a notice to the ISDS membership and posting on the ISDS website www.isds.org.

3. Presentations

A. During the year of their candidacy, candidates are expected to address the ISDS membership during the ISDS Capital Conference and the ISDS Annual Session. The Election Review Committee will determine the process to randomly select the speaking order of the candidates. The speaking order from the ISDS Capital Conference will be reversed for the ISDS Annual Session. Each candidate is allowed up to five minutes for their speech at each event.

B. A "Formal Presentation" is considered a speaking or presentation opportunity of any type (i.e. direct or indirect, formal or informal) by a candidate pertaining to the position the candidate is seeking. Candidate is allowed one Formal Presentation per campaign cycle per district, component, or branch. Candidate is responsible for coordinating with a district, component, or branch to schedule a formal presentation, and districts, components, and branches are requested to provide an appropriate opportunity for the candidates to meet with their members. It is recommended that such forums be structured to allow:

- 1) All candidates to make presentations;
- 2) Districts, components, and branches freedom to assess candidates; and
- 3) Each candidate to respond to questions.

C. Notwithstanding any of these Guidelines, nothing in these Guidelines shall prevent a candidate from traveling on a personal basis or attending a meeting, conference or other event as an official ISDS representative. Campaigning while personally traveling or attending events as an ISDS representative is strictly prohibited.

D. All candidates are strongly encouraged to follow these same guidelines for Formal Presentations towards any dentally-related fraternal groups or study clubs, formal or informal, that are not districts, components, or branches.

4. Campaigning

Each candidate shall be limited to \$3,000 in expenses to campaign for office. For expenses related to costs to communicate with members in any manner, including but not limited to printing, postage, telephone, hospitality, electronic media and promotional novelties, but does not include

personal expenses related to travel, hotel and meals. The manner and frequency in which the candidates contact delegates and alternate delegates is at the discretion of the candidates.

5. Profile

Candidates' campaign statements and profiles will be formally printed in the August edition of the Illinois Dental News. Prior to that time, candidates' statements and profiles will also be posted on the ISDS website, www.isds.org. The Election Review Committee will annually determine the question(s) asked of candidates to be published in the August edition of the Illinois Dental News, as well as any limits on the length of response or otherwise.

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, on the opening day of the House of Delegates in the election year, and at ISDS Capital Conference during the election cycle. Brochures can be brought to the Formal Presentation at a specific district, component, or branch meeting, 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.

A candidate's brochure shall be sized so that if printed the literature is no larger than an 8 ½ x 11 inch piece of paper, which can contain content on both sides.

7. Agreement to Campaign Guidelines

A candidate's signature at the bottom of the guidelines shall constitute acknowledgement that they have received these guidelines and agree to abide by the provisions contained herein.

8. Questions

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

9. Violations

A. With candidates ultimately seeking to serve ISDS in a fiduciary capacity, all candidates should strive to run an ethical campaign that steers clear of committing any violations against the Guidelines Governing the Conduct of Campaigns for ISDS Offices. If a potential violation is believed to have occurred, the candidates should make a good faith effort amongst themselves to resolve the violation in a way satisfactory to all candidates for the elected position. If a potential violation cannot be satisfactorily resolved, such potential violation should be reported to the chair of the Election Review Committee and Secretary of the House of Delegates for review.

B. Because a policy is nearly impossible to be explicitly all encompassing, a candidate should first look to reach a consensus and agreement with the other candidates for the elected position when a guideline is not specifically outlined or unclear. If no consensus and agreement can be reached by the candidates, one candidate should be designated to contact the chair of the Election Review Committee and Secretary of the House of Delegates. The Election Review Committee will rule on the interpretation of the situation, which will then serve as a Guideline Governing the Conduct of Campaigns for ISDS Offices and to be followed by the candidates.

C. In the event a violation of the Guidelines Governing the Conduct of Campaigns for ISDS Offices is determined by the Election Review Committee and was officially reported more than fourteen (14) days prior to the House of Delegates convening, the Election Review Committee, if it cannot resolve the violation between the candidates, shall post a report of the violation in the House of Delegates section on the ISDS website, www.isds.org. In addition, an email reporting any such violations will be sent by the Election Review Committee to each certified delegates and alternate delegates with a working email address on file with ISDS on or about fourteen (14) days prior to the convening of the House of Delegates.

D. In the event a violation of the Guidelines Governing the Conduct of Campaigns for ISDS Offices is determined by the Election Review Committee and was officially reported in the period from fourteen (14) days prior to the convening of the House of Delegates through the elections, then the Election Review Committee, if it cannot resolve the violation between the candidates, shall report those violations to the House of Delegates. The report will be given orally by the Election Review Committee chair (or a designee of the Election Commission if the chair is absent from the House of Delegates session) at the first meeting of the House.

E. Should an allegation of a violation of the Guidelines Governing the Conduct of Campaigns for ISDS Offices be made against an individual or entity not affiliated with a campaign, the Election Review Committee shall review the allegation and determine if a violation has occurred. If so, the candidate affected by the infraction will be notified, and shall be responsible for contacting the individual or entity involved and using their best efforts to curtail the violation.

F. In addition to the foregoing notifications of violations, all violations of the Campaign Rules that occur shall be reported orally at the House of Delegates meeting by the Election Review Committee.

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 Name (Printed) _____

Candidate's Signature _____ Date _____

Office Candidate is Seeking _____

Diversity, Equity & Inclusion

Policy Statement

ISDS welcomes diversity and stands against all forms of racism, discrimination, and bias in our dental society and in the population we serve. We advocate on behalf of our patients and profession. ISDS provides the tools for our members to excel and succeed. Our members work to ensure Illinoisans receive optimal oral care.

Success can be achieved only with all its members' participation, inclusion, and engagement, from all backgrounds and talents. Our goal is possible only if we welcome and celebrate diversity and ensure equity amongst members.

Definitions

Diversity:

ISDS defines diversity through many dimensions, including, but not limited to race, ethnicity, national origin, gender identity, age, physical abilities, sexual orientation, religious and ideological beliefs, parental status, socioeconomic status, level of education, professional practice modality and personal lifestyle preferences.

Equity:

Equity is grounded in the principle of fairness. ISDS will respect and value the differences of our members by identifying and removing barriers, including structural barriers, to ensure that historically marginalized groups have the same opportunity to succeed at ISDS. Providing training and mentorship of younger generation dentists, of diverse background, is crucial to the success of future leaders and engaged membership.

Inclusion:

The Illinois State Dental Society strives to model diversity and inclusion in everything we do. We believe that these foster an innovative and dynamic culture and lead to sustainable results. They allow us to further advance the dental profession, improve the oral health of the public, and promote equity and access to oral health. As a result, we serve and support the different identities, beliefs and perspectives of a diverse membership, leadership, workforce and staff, as well as a wide range of communities and organizations.

(Res. # 10RC-2022)

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)



Current Policies

Adopted
1954–2024

Preface

This book contains major policies adopted by the American Dental Association House of Delegates from 1954 through 2024 that are still in effect in 2025, 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.

Elizabeth A. Shapiro, D.D.S., J.D., C.A.E.
Interim Executive Director

Table of Contents

17 Abuse and Neglect

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

18 Access

Dental Care for Veterans (*Trans.*2024:XXX)

Availability of Dentists for American Indians and Alaska Natives (*Trans.*2023:XXX)

Public Funding for Oral Health Care Provided at Academic Dental Institutions (*Trans.*2023:XXX)

Availability of Dentists for Underserved Populations (*Trans.*2016:318; 2024:XXX)

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

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

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

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

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

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

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

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

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

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

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; 2020:287)

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

23 Accreditation of Educational Programs

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

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

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

24 ADA Strategic Plan

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

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

25 Advertising

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

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

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

Guidelines for Dentist Advertising (*Trans.*1979:647; 2022:368)

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

26 Allied Dental Education and Personnel

Increasing Allied Personnel in the Workforce (*Trans.*2024:XXX)

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

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

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

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

Comprehensive Policy Statement on Allied Dental Personnel (*Trans.*1996:699; 1997:691; 1998:713; 2001:467; 2002:400; 2006:307; 2010:505; 2021:330)

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

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

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

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

Criteria for Recognition of a Certification Board for Dental Assistants (*Trans.*1989:520; 2014:460; 2019:278; 2024:XXX)
 Delegation of Radiographic Film Exposure (*Trans.*1982:534)

33 Amalgam

National Pretreatment Standard for Dental Office Wastewater (*Trans.*2019:305)
 Dental Facility Amalgam Wastewater Policy (*Trans.*2003:387; 2024:XXX)
 Precapsulated Amalgam Alloy (*Trans.*1994:676; 2022:364)
 Use of Amalgam as Restorative Material (*Trans.*1986:536; 2022:353)

34 Anesthesia and Sedation

Guidelines for the Use of Sedation and General Anesthesia by Dentists (*Trans.*2007:282; 2012:468; 2016:277)
 Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (*Trans.*2007:282; 2012:469; 2016:277)
 ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists (*Trans.*2007:384)

54 Antitrust

Antitrust Reform (*Trans.*2016:314; 2021:323)

55 Children

Support for the American Academy of Pediatric Dentistry Guideline on Perinatal and Infant Oral Health Care (*Trans.*2021:328)
 Support for the American Academy of Pediatric Dentistry Policy on Early Childhood Caries (*Trans.*2021:325)
 Drinking Water in Schools (*Trans.*2016:323)
 Child Identification Programs (*Trans.*2014:506)
 Prevention and Control of Early Childhood Caries (*Trans.*2014:507)
 Principles for Developing Children's Oral Health Programs (*Trans.*2012:444; 2014:506)
 School-Based Oral Health Programs (*Trans.*2010:557)
 Oral Health Assessment for School Children (*Trans.*2005:323; 2013:360)
 Non-Dental Providers Completing Educational Program on Oral Health (*Trans.*2004:301; 2014:505; 2021:329)
 Non-Dental Providers Notification of Preventive Dental Treatment (*Trans.*2004:303; 2014:505; 2021:329)
 Parent and Caregiver Oral Health: Patient Education (*Trans.*2001:428; 2014:504; 2021:329)
 Dental Care for Children With Cleft Lip, Cleft Palate and other Craniofacial Anomalies (*Trans.*1963:287; 2016:315)

59 Communications

Hyperlink Embedding in Policy Statements (*Trans.*2008:440)
 Standards for Dental Society Publications (*Trans.*1997:303, 660; 2010:602; 2023:XXX)
 ADA Positions, Policies and Definitions in ADA Publications (*Trans.*1996:732)
 Preferred Professional Terminology (*Trans.*1977:914; 1997:661)

62 Constituent and Component Societies

Sustaining the Pipeline of Volunteer Leadership (*Trans.*2021:277)
 Funding of Visits by ADA Officers (*Trans.*2017:254)
 Implementation of a Uniform Dues Transaction (*Trans.*2017:254)
 Recognition of the Alliance of the American Dental Association (*Trans.*2015:270)
 Optional Donation on Constituent Society Dues Statement for Well-Being Programs (*Trans.*2012:445)
 Constituent Nominations of New Dentist Delegates (*Trans.*2011:546)
 Supporting Constituents With Third-Party Payer Issues (*Trans.*2004:307)
 Financial Hardship Dues Waivers (*Trans.*2002:381; 2018:300)
 Streamlining Membership Category Transfers (*Trans.*2001:426; 2018:300)
 Affiliation With the Alliance of the American Dental Association (*Trans.*1997:701)
 Legislative Delegations (*Trans.*1995:648; 2021:324)
 Participation in Public Agency Sponsored Programs Involving Dental Health Benefits (*Trans.*1995:648)
 Registration Fees for Members (*Trans.*1989:537)
 Protection of Retirement Assets (*Trans.*1987:521; 2021:321)
 Involvement of Students in Society Activities (*Trans.*1979:649)
 Mechanism for Complaints and Referrals (*Trans.*1972:669; 2023:XXX)

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

64 Consumers

Clarification of Dental Professional Credentials (*Trans.*2003:354; 2023:XXX)

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

65 Continuing Education

Professionalism and Ethics Continuing Education (*Trans.*2024:XXX)

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

Acceptance of Formal Continuing Education Courses Offered by ACCME or IPCE Accredited Providers
(*Trans.*2010:576; 2022:353)

Policy Statement on Continuing Dental Education (*Trans.*2006:331; 2011:465; 2017:274; 2022:352; 2024:XXX)

Policy Statement on Lifelong Learning (*Trans.*2000:467; 2022:351)

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

67 Councils

Inclusion of Confidentiality Statement on Meeting Agenda (*Trans.*2022:375)

Transparency (*Trans.*2009:404; 2017:254; 2022:340)

Utilization of Multi-Council Task Forces (*Trans.*2001:447; 2022:341)

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

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

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

68 Definitions

Definition of ADA Diversity (*Trans.*2019:245)

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

Use of "Usual Fee" and "Maximum Plan Benefit" in Dental Benefit Programs (*Trans.*2010:546; 2011:452;
2024:XXX)

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

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

Continuing Competency (*Trans.*1999:939; 2021:298)

Dentistry (*Trans.*1997:687; 2015:254; 2020:326)

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

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

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

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

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

Balance Billing (*Trans.*1994:653)

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

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

Medically Necessary Care (*Trans.*1990:537; 2024:XXX)

Direct Reimbursement (*Trans.*1989:548; 2024:XXX)

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

Treatment Plan (*Trans.*1978:499)

Oral Diagnosis (*Trans.*1978:499)

Cosmetic Dentistry (*Trans.*1976:850)

72 Dental Benefit Programs

Annual Maximums in Dental Benefit Programs and Out of Pocket Costs (*Trans.*2024:XXX)

Summary of Benefits for Dental Plan Comparisons for Plan Purchasers (*Trans.*2024:XXX)

Dental Benefits within Affordable Care Act and a Public Option (*Trans.*2021:284; 2023:XXX)

Discrimination of Benefit Payment Based on Professional Degree of Provider (*Trans.*2021:320)

Guaranteeing Patient's Freedom of Choice of Dentist (*Trans.*2021:339)

Policy for the Elimination of Wait Periods for Children in Dental Benefit Plans (*Trans.*2021:284)

Statement on Programs Limiting Dental Benefit to Network Providers (*Trans.*2019:257)

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

Provider Rating by Third Parties (*Trans.*2014:455; 2022:347)

Principles for the Application of Risk Assessment in Dental Benefit Plans (*Trans.*2009:424; 2013:321)
 Real-Time Claims Adjudication (*Trans.*2007:419)
 Principles for Pay-for-Performance or Other Third-Party Financial Incentive Programs (*Trans.*2006:328; 2013:310)
 Review of Evidence-Based Reports Denying Reimbursement (*Trans.*2002:423)
 Government-Sponsored Dental Programs (*Trans.*1998:705)
 Guidelines on Coordination of Benefits for Group Dental Plans (*Trans.*1996:685; 2009:423)
 Opposition to Dental Benefit Plans or Programs Conflicting With ADA Policies (*Trans.*1995:620)
 Dental Coverage for Retiring Employees (*Trans.*1993:689)
 Opposition to Fraudulent and Abusive Practices Under Public and Private Dental Benefits Programs
 (*Trans.*1990:537)
 Evaluation of Dental Care Programs (*Trans.*1989:548)
 Statement on Dental Benefit Plans (*Trans.*1988:481; 2013:316)
 Standards for Dental Benefit Plans (*Trans.*1988:478; 1989:547; 1993:696; 2000:458; 2001:428; 2008:453;
 2010:546)
 Education of Prospective Purchasers of Dental Benefit Programs (*Trans.*1986:515)
 Programs in Conflict With ADA Policies (*Trans.*1979:638)
 Government Reports on Payments to Dentists (*Trans.*1976:858; 2013:305)

80 Dental Benefit Programs—Organization and Operations

Third Party Payer Contracting Practices (*Trans.*2022:348)
 Third-Party Payment Choices (*Trans.*2017:265)
 Comprehensive ADA Policy Statement on Inappropriate or Intrusive Provisions and Practices by Third Party Payers
 (*Trans.*2016:290; 2017:266)
 Statement on Dental Consultants (*Trans.*2010:555)
 Use of DEA Numbers for Identification (*Trans.*2000:454; 2013:306)
 Payment for Temporary Procedures (*Trans.*1999:922)
 Limitations in Benefits by Dental Insurance Companies (*Trans.*1997:680; 2011:453)
 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)
 Explanation of Benefits (EOB) Statement and Identification of Claims Reviewers (*Trans.*1995:610; 2015:243;
 2022:346)
 Eligibility and Payment Dates for Endodontic Treatment (*Trans.*1994:674)
 Authorization of Benefits (*Trans.*1994:665; 2013:306; 2017:264)
 Benefits for Incomplete Dental Treatment (*Trans.*1994:655)
 Extending Dental Plan Coverage to Dependents of Beneficiaries (*Trans.*1993:694)
 Plan Coverage for Treatment of Teeth Needing Restoration Due to Attrition, Wear and Abrasion (*Trans.*1993:693)
 Appropriate Use of Dental Benefits by Patients and Third-Party Payers (*Trans.*1993:688)
 Statement on Preventive Coverage in Dental Benefits Plans (*Trans.*1992:602; 1994:656; 2013:306; 2018:312;
 2023:XXX)
 Preauthorization of Benefits (*Trans.*1992:597)
 Qualifications of Participating Dentists (*Trans.*1991:639)
 Age of “Child” (*Trans.*1991:635; 2013:307)
 Dental Benefit Plan Terminology (*Trans.*1991:634; 2012:440)
 Inclusion of Radiographic Examinations in Dental Benefits Programs (*Trans.*1991:634)
 Pre-Existing Condition Exclusion (*Trans.*1991:634)
 ADA’s Dental Claim Form (*Trans.*1991:633; 2001:428; 2013:307)
 Audits of Private Dental Offices by Third-Party Payers (*Trans.*1990:540; 2005:325)
 Bulk Benefit Payment Statements (*Trans.*1990:536; 2013:308; 2015:243)
 Coverage for Treatment of Temporomandibular Joint Dysfunction (*Trans.*1989:549)
 Payment for Prosthodontic Treatment (*Trans.*1989:547)
 Benefits for Services by Qualified Practitioners (*Trans.*1989:546)
 Equitable Dental Benefits for Relatives of Dentists (*Trans.*1987:502)
 Identification of Claims Reviewer (*Trans.*1985:584)
 Frequency of Benefits (*Trans.*1983:548)
 Third-Party Acceptance of Descriptive Information on Dental Claim Form (*Trans.*1978:507; 2013:308)
 Charge for Administrative Costs (*Trans.*1974:656; 1989:553; 2013:308)
 Radiographs in Diagnosis (*Trans.*1974:653)
 Limitation of Payments to Specialty Groups (*Trans.*1965:63, 353)

89 Dental Care and Dental Health

Comprehensive Statement on Oral Health Services During Pregnancy (*Trans.2024:XXX*)
 Role of Dental Health in the Management of Systemic Conditions and Outcomes of Medical and Surgical Procedures (*Trans.2024:XXX*)
 A Culture of Safety in Dentistry—Voluntary Reporting (*Trans.2021:331*)
 Oral Health Equity (*Trans.2021:329*)
 The Practice of Dentistry and Cannabis (*Trans.2021:300*)
 ADA Statement on the Use of Silver Diamine Fluoride (SDF) to Arrest Carious Lesions (*Trans.2020:304*)
 Dentistry is Essential Healthcare (*Trans.2020:305*)
 Diagnostic Testing by Dentists (*Trans.2020:321*)
 Direct to Consumer Dental Laboratory Services (*Trans.2018:304*)
 Do-It-Yourself Teeth Straightening (*Trans.2017:266*)
 Policy Statement on the Role of Dentistry in the Treatment of Sleep Related Breathing Disorders (*Trans.2017:269; 2019:270; 2021:290*)
 Medical (Dental) Loss Ratio (*Trans.2015:244; 2019:262; 2024:XXX*)
 ADA Policy on Professional Tooth Whitening (*Trans.2008:477; 2024:XXX*)
 Update on Dental Tourism (*Trans.2008:454*)
 Patient Safety and Quality of Care (*Trans.2005:321*)
 Responsibility for the Oral Health of Patients (*Trans.2004:334*)
 Quality Health Care (*Trans.1995:609; 2013:311*)
 Certification or Approval of Dental Care Facilities (*Trans.1993:689*)
 Dental Care in Institutional and Homebound Settings (*Trans.1986:518; 2013:341*)
 Health Planning Guidelines (*Trans.1983:545; 2014:503; 2021:326*)

94 Dental Education

Federal Student Loan Forgiveness (*Trans.2022:368*)
 Patients with Special Needs (*Trans.2021:298*)
 Federal Student Loan Programs (*Trans.2019:297*)
 Federal Student Loan Repayment Incentives (*Trans.2019:297; 2024:XXX*)
 General, Pediatric and Public Health Dental Residency Programs (*Trans.2019:298*)
 Consultation and Evaluation of International Dental Schools (*Trans.2005:298*)
 Participation in International Higher Education Collaborative Networks (*Trans.2003:368*)
 Assistance to Dental Schools Upon Closure (*Trans.1992:610*)
 Support for the Continued Existence of Private and Public Dental Schools in the United States (*Trans.1989:522; 2016:299*)
 Dental Degrees (*Trans.1972:698; 2016:299*)
 Support of Dental Education Programs (*Trans.1972:697; 2016:299*)

96 Dental Insigne

Official Emblem for Dentistry (*Trans.1965:228, 364*)

97 Dentist Health and Well-Being

Dental Schools to Provide Education to Dental Students on Drug and Alcohol Use and Misuse (*Trans.2014:453*)
 Statement on Dentist Health and Wellness (*Trans.2005:321; 2017:264*)
 Statement on Substance Abuse Among Dentists (*Trans.2005:328*)
 Statement on Substance Use Among Dental Students (*Trans.2005:329*)
 Guiding Principles for Dentist Well-Being Activities at the State Level (*Trans.2005:330; 2012:442; 2023:XXX*)

99 Diagnostic and Procedure Codes

Monitoring and Resolution of Code Misuse (*Trans.2007:419*)
 Development of ADA SNODENT Clinical Terminology (*Trans.1995:619; 2013:309*)
 Reporting of Dental Procedures to Third Parties (*Trans.1991:637; 2009:418; 2013:303; 2016:284*)
 Authority for the Code on Dental Procedures and Nomenclature (*Trans.1989:552; 2008:453*)

100 Electronic Technology

Statement on Electronic Health Record and Data Exchange in Dentistry (*Trans.2024:XXX*)
 Incorporating Prescription Drug Monitoring Program (PDMP) Into Practice (*Trans.2023:XXX*)

Promoting Use of DICOM in Dentistry (*Trans.2023:XXX*)
 Policy Statement on the Use of Augmented Intelligence in Dentistry (*Trans.2021:282*)
 Submission of Attachments for Electronic Claims (*Trans.1997:677*)
 Recognition of Tooth Designation Systems for Electronic Data Interchange (*Trans.1994:675; 2013:324*)

103 Employee Retirement Income Security Act (ERISA)

Anesthesia Coverage Under Health Plans (*Trans.2021:334*)
 Provisions for ERISA Plans (*Trans.2021:338*)

104 Evidence-Based Dentistry

Dissemination of Information Contrary to Science (*Trans.2006:346; 2022:368*)
 Complementary and Alternative Medicine in Dentistry (*Trans.2001:461; 2017:277; 2022:356*)
 Policy Statement on Evidence-Based Dentistry (*Trans.2001:462; 2012:469; 2017:275; 2022:354*)

105 Federal Dental Services

Rank and Status of Dentists in the Uniformed Services and the Veterans Health Administration (*Trans.2021:318*)
 Support for Deployed Dentists (*Trans.2020:334*)
 Dues Exemption for Active Duty Members (*Trans.2004:297, 335; 2015:296*)
 Wartime Waivers for Reservists (*Trans.2003:354*)

106 Federal Health Agencies

Office of the U.S. Surgeon General (*Trans.1995:648*)

107 Fees

Maximum Fees for Non-Covered Services (*Trans.2010:616; 2020:317*)
 Statement on Reporting Fees on Dental Claims (*Trans.2009:419*)
 Fee Reimbursement Differentials (*Trans.1993:697*)
 Policy on Fees for Dental Services (*Trans.1990:540; 2013:319*)
 Fee Profiles (*Trans.1987:502; 2013:309*)

108 Finance

ADA Reserves (*Trans.2008:443; 2012:409*)
 Long-Term Financial Strategy of Dues Stabilization (*Trans.2008:421; 2012:410; 2019:244*)

109 Fluoride and Fluoridation

Community-Based Topical Fluoride Programs (*Trans.2014:507*)
 Bottled Water, Home Water Treatment Systems and Fluoride Exposure (*Trans.2002:390; 2013:342; 2021:327*)
 Groundwater With Natural Levels of Fluoride Higher Than 2.0 Parts Per Million (*Trans.1999:921*)
 Operational Policies and Recommendations Regarding Community Water Fluoridation (*Trans.1997:673; 2015:273*)
 Policy on Fluoridation of Water Supplies (*Trans.1950:224; 2015:274*)

111 Forensic Dentistry

Dental Radiographs for Victim Identification (*Trans.2003:364; 2012:442*)
 Dental Identification Teams (*Trans.1994:654; 2012:441*)
 Dental Identification Efforts (*Trans.1985:588*)
 Uniform Procedure for Permanent Marking of Dental Prostheses (*Trans.1979:637; 2012:448*)

112 General Practice

Status of General Practice (*Trans.1973:725*)

113 Global Affairs

Need of Dental Public Health Education and Oral Health Services in Underserved Countries (*Trans.1999:906*)

114 Health Care Data

Position Statement on the Appropriate Use of Data From Quality Measurement (*Trans.*1998:701; 2013:311)

115 Health Insurance Portability and Accountability Act (HIPAA)

Need for HIPAA Standards Reform (*Trans.*2003:384; 2016:317; 2021:323)

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)

116 Health Programs: National and State

Engaging Community-Based Health Centers (*Trans.*2023:XXX)

Use of Health Care Effectiveness Data and Information Set (HEDIS) for Utilization Measures (*Trans.*2013:344)

Bone Marrow Matching Programs (*Trans.*2012:458)

State No Fault and Workers' Compensation Programs (*Trans.*2008:460)

Dentists on Staffs of Local Health Departments (*Trans.*1967:325; 2016:315)

117 Health System Reform

Health Care Reform (*Trans.*2009:485)

Universal Healthcare Reform (*Trans.*2008:433)

Legislative Separation of Medicine and Dentistry (*Trans.*1996:715)

Employer Mandates (*Trans.*1994:645)

Tax Preferred Accounts (*Trans.*1994:637; 2012:495)

Inclusion of Members of Congress in Health Care Legislation (*Trans.*1993:718; 2019:298)

Freedom of Choice in Selection of Health Care Provider Under Universal Health Care System Reform (*Trans.*1993:717; 2012:495)

Employer Subsidy (*Trans.*1993:665)

120 Hospitals

Guidelines for Hospital Dental Privileges (*Trans.*2015:274)

Hospital Medical Staff Membership (*Trans.*1999:923)

Economic Credentialing (*Trans.*1993:692)

Physical Examinations by Dentists (*Trans.*1977:924; 1991:618)

121 House of Delegates

Program Assessment Criteria (*Trans.*2017:254)

Term Limits for ADA Delegates (*Trans.*2012:412)

Term Limits for Alternate Delegates (*Trans.*2012:412)

Regular Comprehensive Policy Review (*Trans.*2010:603; 2012:370)

Conflict of Interest Policy (Disclosure Policy) (*Trans.*2010:624; 2011:537; 2013:341; 2019:296)

Posting of Financial Information (*Trans.*2009:493; 2012:407)

Annual Session Dress Code (*Trans.*1999:981)

Availability of ADA House Materials to Members (*Trans.*1991:606)

Availability of House of Delegates Transcripts (*Trans.*1990:570)

Criteria for Restructure of Trustee Districts (*Trans.*1986:498)

Election of Delegates (*Trans.*1979:646)

123 Illegal Dentistry

Opposition to Unlicensed Dental or Dental Hygiene Practice (*Trans.*2023:XXX)

Dental Society Activities Against Illegal Dentistry (*Trans.*1977:934; 2001:435)

Opposition to "Denturist Movement" (*Trans.*2001:436)

"Denturist" and "Denturism" (*Trans.*1976:868; 2001:436)

124 Infection Control and Infectious Diseases

Infection Control in the Practice of Dentistry (*Trans.*2012:470; 2019:266; 2024:XXX)

125 Insurance Programs

Sponsorship or Endorsement of National Professional Liability Insurance Program (*Trans.*1995:603)
Hospitalization Insurance for Dental Treatment (*Trans.*1972:674; 2013:309)

126 Intellectual Property

ADA Intellectual Property Licensing Protocol (*Trans.*2008:495)

127 Laboratories and Technicians

Registration of Dental Laboratories (*Trans.*2013:323)
Statement to Encourage U.S. Dental Schools to Interact With U.S. Dental Laboratories (*Trans.*2010:547; 2023:XXX)
Certifying Board in Dental Laboratory Technology (*Trans.*2002:400; 2014:460)
Criteria for Recognition of a Certification Board for Dental Laboratory Technicians (*Trans.*1998:92, 713; 2014:462; 2019:280)
Support of the Dental Laboratory Technician Certification Program and Continuing Education Activities (*Trans.*1997:682; 2010:547)
Statement on Prosthetic Care and Dental Laboratories (*Trans.*1990:543; 1995:623; 1999:933; 2000:454; 2003:365; 2005:327; 2007:430; 2018:305)
Recognition Program for Meritorious Service by Certified Dental Technologists (*Trans.*1987:496; 1999:922)

132 Legislation

Limited English Proficiency (*Trans.*2005:338; 2021:320)
Trade Agreements (*Trans.*1993:711)
Campaign Finance Reform (*Trans.*1987:520)
Government Intrusion Into Private Practice (*Trans.*1976:857)

133 Legislation—Dental Care and Dental Benefits

Financing Oral Health Care for Adults Age 65 and Older (*Trans.*2020:285)
Oral Health Care for the Elderly (*Trans.*2020:279)
Support for the Children's Health Insurance Program (*Trans.*2020:339)
Dental Benefits in a Child Support Order (*Trans.*2018:362; 2024:XXX)
Freedom of Choice in Publicly Funded Aid Programs (*Trans.*2006:344; 2021:320)
Mandated Assignment or Authorization of Dental Benefits (*Trans.*2006:316)
Alteration of Dental Treatment Plans by Third-Party Claims Analysis (*Trans.*1999:929; 2013:320; 2019:252)
Dental Claims Processing (*Trans.*1999:930)
Third-Party Payers Overpayment Recovery Practices (*Trans.*1999:930; 2013:312; 2021:284)
Patient and Provider Advisory Panel (*Trans.*1997:704)
Community Rating, Risk Pools and Portability for Health Benefit Coverage Plans (*Trans.*1995:648)
Legislation Regulating All Dental Benefits Programs (*Trans.*1993:694)
Timely Payment of Dental Claims (*Trans.*1991:639)
Continuation of Doctor/Patient Relationship (*Trans.*1991:627)
Reimbursement Under Third-Party Programs (*Trans.*1983:584; 1992:604)
Itemization of Dental Charges (*Trans.*1979:634)

136 Legislation—State

Regulating Non-Dentist Owners of Dental Practices (*Trans.*2011:491; 2019:255)
Fabrication of Oral Appliances Used With Tooth Whitening Products (*Trans.*2002:397)
States' Rights Affecting the Practice of Dentistry (*Trans.*1996:715)
Use of Expert Witnesses in Liability Cases (*Trans.*1986:531; 2021:319)
Suggested Dental Practice Acts (*Trans.*1978:529; 2021:321)
Legislative Assistance by the Association (*Trans.*1977:948; 1986:530; 2019:310)
Recommendations and Guidelines for Assistance to Constituent Societies in Litigation of Dental Practice Acts (*Trans.*1958:278, 405)

138 Licensure

Comprehensive Policy on Dental Licensure (*Trans.*2018:341)
 State Board Support for CODA as Responsible to Accredit Dental Education Programs (*Trans.*2003:367; 2012:463)
 Policy on Licensure of Dental Assistants (*Trans.*2000:474)
 Promotion of Freedom of Movement for Dental Hygienists (*Trans.*1990:550; 2018:321)

140 Managed Care and Utilization Review

Full Disclosure of Financial Incentives and Other Health Plan Information (*Trans.*1996:692)
 Administrative Practices Encouraging Dentist Selection Based on Cost (*Trans.*1995:610; 2020:305)
 Prohibition of “Hold Harmless” Clauses (*Trans.*1995:651)
 Requirements for Managed Care Programs (*Trans.*1995:627; 2000:466)
 Statement on Managed Care and Utilization Management (*Trans.*1995:624; 2023:XXX)
 Practitioner Protections in Managed Care Plans (*Trans.*1994:643)
 Guidelines on Professional Standards for Utilization Review Organizations (*Trans.*1992:601; 2001:433)
 Use of Statistics in Utilization Review (*Trans.*1989:542)
 Statement on Capitation Dental Benefit Programs (*Trans.*1985:582; 1993:689; 2013:303)

145 Medicaid and Medicare

Comprehensive Statement on Dental Medicaid Programs (*Trans.*2023:XXX)
 Payment for Services for Individuals with Medical Conditions in Publicly Funded Programs (*Trans.*2023:XXX)
 Medicaid Dental Loss Ratios: Accountability and Oversight (*Trans.*2022:369)
 Guidelines for Medicaid Dental Reviews (*Trans.*2020:335)
 Advocate for Adequate Funding Under Medicaid Block Grants (*Trans.*2011:498; 2014:499)
 Support of Current Medicaid Law and Regulations Regarding Dental Services (*Trans.*2010:603; 2014:500)
 Funding for Non-Dental Providers Preventive Care (*Trans.*2004:300)

148 Membership

Policy on Diversity and Inclusion (*Trans.*2021:277)
 ADA Member Conduct Policy (*Trans.*2011:530; 2020:335; 2024:XXX)
 Parallel Membership Categories (*Trans.*2008:482; 2018:299)
 Two-Year Recent Graduate Reduced Dues Program (*Trans.*2008:482; 2021:277)
 Long-Term Dues Waivers (*Trans.*2002:384)
 Administrative Process for Transferring Members (*Trans.*2001:422)
 Tripartite Membership Application Procedures (*Trans.*1998:685; 2014:524; 2018:299)
 Compliance With Civil Rights Laws (*Trans.*1997:666)
 Association Support for Members Participating in Various Reimbursement Systems (*Trans.*1996:674)
 Promoting the Value of Tripartite Dentistry (*Trans.*1995:606; 2013:365)
 Transfer Nonrenews (*Trans.*1995:605; 2018:299)
 Utilization of Tripartite Resources (*Trans.*1995:604; 2018:300)
 ADA Membership Requirement for Continuing Dental Education Speakers (*Trans.*1992:620)
 Nonmember Utilization of ADA Member Benefits (*Trans.*1990:532; 2023:XXX)
 Collaboration with Other Organizations to Support ADA Recruitment and Retention Activities (*Trans.*1989:540; 1997:659; 2018:301)
 Application Process for Direct ADA Membership (*Trans.*1989:539; 2023:XXX)
 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)
 Dental Organization Membership Contingent on ADA Membership (*Trans.*1985:610; 1996:667)
 Student Membership (*Trans.*1977:957; 1996:673; 2015:291)
 Dentists Retired From Federal Service (*Trans.*1963:285; 1996:671)

151 National Practitioner Data Bank

National Practitioner Data Bank Statute of Limitations (*Trans.*2020:334)
 National Practitioner Data Bank Self-Generated Inquiries (*Trans.*1993:706; 2015:272; 2020:334)

152 Nursing Homes

Statement on Dental Care in Nursing Homes (*Trans.*1991:619)

155 Occupational Safety and Health

Policies and Recommendations on Occupational Safety and Health (*Trans.*2016:322)

156 Oral Health Literacy

Use of Health Literacy Principles for All Patients (*Trans.*2016:322; 2021:327)

Oral Health Education in Schools (*Trans.*2014:506; 2016:319; 2021:330)

Communication and Dental Practice (*Trans.*2008:454; 2013:342; 2021:326)

Limited Oral Health Literacy Skills and Understanding in Adults (*Trans.*2006:317; 2013:342; 2021:330)

Encouraging the Development of Oral Health Literacy Continuing Education Programs (*Trans.*2006:316; 2021:326)

Definition of Oral Health Literacy (*Trans.*2005:322; 2006:316)

157 Oral Piercing

Policy Statement on Intraoral/Perioral Piercing, Tooth Gems/Jewelry and Tongue Splitting (*Trans.*1998:743; 2000:481; 2004:309; 2012:469; 2016:300; 2021:299)

158 Patient Health Information

Patient Rights and Responsibilities (*Trans.*2009:477; 2024:XXX)

Confidentiality and Privacy Regarding Health Information (*Trans.*1999:951; 2000:507; 2021:321)

161 Peer Review Mechanisms

Guidelines on the Structure, Functions and Limitations of the Peer Review Process (*Trans.*1992:37, 603)

Disputes Concerning Dental Treatment Provided Under Dental Benefits Programs (*Trans.*1992:600)

Use of Peer Review Process by Patients and Third-Party Payers (*Trans.*1990:534)

Dentist Participation in Peer Review Organizations (*Trans.*1987:501)

Constituent Society Peer Review Systems (*Trans.*1981:573)

164 Pledge and Prayer

Recognition of Diversity (*Trans.*1995:607; 2019:247)

The Dentist's Pledge (*Trans.*1991:598; 2014:479)

165 Pollution

Use of Environmentally Conscientious Measures in the Production, Packaging and Shipping of Dental Products (*Trans.*2013:314)

166 Practice Administration

Statement Regarding Employment of a Dentist (*Trans.*2013:353; 2018:357; 2019:251)

Ownership of Dental Practices (*Trans.*2000:462)

Ownership of a Dental Practice Following Death or Incapacity of a Dentist (*Trans.*2000:462)

Supporting Dentists in All Practice Modalities (*Trans.*1994:637; 2019:252; 2024:XXX)

168 Prevention and Health Education

Human Papillomavirus (HPV) Education and Collaboration (*Trans.*2023:XXX)

Vaccine Administration by Dentists (*Trans.*2020:306)

Human Papillomavirus (HPV) Vaccination for the Prevention of Infection with HPV Types Associated with Oropharyngeal Cancer (*Trans.*2018:351)

Integration of Oral Health and Disease Prevention Principles in Health Education Curricula (*Trans.*2016:322)

Oral Evaluations for High School Athletes (*Trans.*2016:343)

Policies and Recommendations on Diet and Nutrition (*Trans.*2016:320; 2023:XXX; 2024:XXX)

Support of Science Fairs (*Trans.*2016:322)

Early Detection and Prevention of Oral and Oropharyngeal Cancer (*Trans.*2014:506; 2019:277)

Patient Safety (*Trans.*2001:429; 2014:504)

Inclusion of Basic Oral Health Education in Nondental Health Care Training Programs (*Trans.*1995:609; 2014:503)

Orofacial Protectors (*Trans.*1994:654; 1995:613; 2016:322; 2023:XXX)

Policy Governing Use of American Dental Association Oral Health Information Statement (*Trans.*1969:193, 322; 2012:494)

171 Professional Judgment

Dentist's Freedom to Exercise Individual Clinical Judgment (*Trans.*1997:705)
Infringement on Dentists' Judgment (*Trans.*1991:634)

172 Public Health Emergencies and Declared Disasters

Temporary Expansion of Scope During Public Health Crisis (*Trans.*2020:305)
Dentistry's Role in Emergency Preparedness and Disaster Response (*Trans.*2007:431)
State Mass Disaster Plan (*Trans.*2002:387)
Liability Protection for Responders During Public Health Emergencies (*Trans.*2002:398; 2024:XXX)

173 Research

Advancing Equity in Dental Research Funding (*Trans.*2022:356)
Scientific Assessment of Dental Restorative Materials (*Trans.*2003:387; 2022:354)
Study of Human Remains for Forensic and Other Scientific Purposes (*Trans.*2002:421)
Dental Research by Military Departments (*Trans.*1970:451; 2016:316; 2021:318)
Use of Laboratory Animals in Research and Training (*Trans.*1964:254; 2006:329; 2017:279)

174 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)
Recognition of Operative Dentistry, Cariology and Biomaterials as an Interest Area in General Dentistry (*Trans.*2016:304; 2017:274)
Criteria for Recognition of Interest Areas in General Dentistry (*Trans.*2010:579; 2018:324)
Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists (*Trans.*2001:470; 2004:313; 2009:443; 2013:328; 2018:326; 2022:357)

179 Substance Use Disorders

ADA Policy on Opioid Prescribing (*Trans.*2018:310)
Statement on the Use of Opioids in the Treatment of Dental Pain (*Trans.*2016:286)
Statement on Alcoholism and Other Substance Use Disorders (*Trans.*2005:328; 2018:309)
Statement on Provision of Dental Treatment for Patients With Substance Use Disorders (*Trans.*2005:329)
Statement on Alcohol and Other Substance Use by Pregnant and Postpartum Patients (*Trans.*2005:330)
Guidelines Related to Alcohol, Nicotine, and/or Drug Use by Child or Adolescent Patients (*Trans.*2005:330)
Insurance Coverage for Chemical Dependency Treatment (*Trans.*1986:519; 2012:442)

181 Taxation

Advocacy for Tax Policy Advantageous to the Practice of Dentistry (*Trans.*2022:369)
Retirement Account Distributions for Educational Expenses (*Trans.*2022:341)
Tax Treatment of Employer-Paid Fringe Health Benefits (*Trans.*2019:298)
Tax Treatment of Professional Dues (*Trans.*2019: 298)
Tax Treatment of Student Loan Interest, Scholarships and Stipends (*Trans.*2019: 298)
Tax Deductibility of Dental and Medical Expenses (*Trans.*1982:549; 1989:548)

182 Teledentistry

Comprehensive ADA Policy Statement on Teledentistry (*Trans.*2015:244; 2020:314; 2021:272)

184 Tobacco, Tobacco Products and Smoking

Tobacco Use, Vaping and Nicotine Delivery Products (*Trans.*2020:336; 2024:XXX)

186 Tort Reform

Limits on Non-Economic Damages (*Trans.2020:338*)
Principles for Tort Reform (*Trans.2020:345*)
Professional Liability Insurance Legislation (*Trans.1984:548; 2021:319*)

187 Volunteerism

Participation in Dental Outreach Programs (*Trans.2010:587; 2016:299*)
Volunteerism (*Trans.2003:368*)

188 Workforce

Dental Students and Residents as Dental Hygienists (*Trans.2024:XXX*)
Expedited Residency for Foreign Born, United States-Trained Dental Professionals (*Trans.2024:XXX*)
Internationally Trained Dentists as Dental Hygienists (*Trans.2024:XXX*)
Policy on Native American Workforce (*Trans.2011:491*)
ADA's Position on New Members of the Dental Team (*Trans.2009:419*)
Collaboration With Specialty Organizations on Workforce (*Trans.2009:420*)
Opposition to Pilot Programs Which Allow Nondentists to Diagnose Dental Needs or Perform Irreversible Procedures (*Trans.2010:521*)
Diagnosis or Performance of Irreversible Dental Procedures by Nondentists (*Trans.2004:328; 2010:494*)
Measuring the Demand for Dental Services (*Trans.1995:623*)
Support for Programs That Forecast Public Demand for Dental Services (*Trans.1995:609*)
Dental Needs Survey (*Trans.1985:588*)
Determining Health Professional Shortage Areas (*Trans.1984:538; 1996:681; 2021:320; 2023:XXX*)

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

Dental Care for Veterans (*Trans.2024:XXX*)

Resolved, that the American Dental Association supports legislative efforts to achieve optimal oral health and wellbeing for all veterans, and be it further

Resolved, that for veterans eligible for VA dental care, the ADA supports an increase in funding, specifically dedicated to Veterans Health Administration Office of Dentistry, such that it is sufficient to ensure access to care, and be it further

Resolved, that the ADA encourage the United States Veterans Health Administration to raise awareness about availability of dental benefits following enrollment either through VA dental care or through VA Dental Insurance Program (VADIP) based on established eligibility criteria, and be it further

Resolved, that for programs such as VA Dental Insurance Program (VADIP) where third-party carriers are used to administer the benefit, carriers should be subjected to annual transparent reporting of network adequacy and allowed amounts with reimbursement rates sufficient to ensure access to care. These programs should be efficiently administered with transparent reporting of loss ratios, and be it further

Resolved, that the ADA supports the federal authorization of administrative support resources within the Veterans Administration Medical Centers to assist veterans to identify and utilize dental services offered outside VA dental care, and be it further

Resolved, that the ADA support the work of state and local dental societies with outreach strategies to assist veterans with unmet dental treatment needs by serving as a resource in finding dental homes for veterans, and be it further

Resolved, that the ADA support state and local dental society efforts to connect dentists wishing to serve Veterans with outreach organizations like Veterans Service Organizations to help improve access to care

Availability of Dentists for American Indians and Alaska Natives (*Trans.2023:XXX*)

Resolved, that the American Dental Association supports enhancing federal appropriations dedicated to helping the Indian Health Service Division of Oral Health increase the number of dentists that are available to treat American Indians and Alaska Natives, and be it further

Resolved, that the ADA supports collaborating with the Indian Health Service to close gaps in access to dental care and address the current and future oral health needs of American Indians and Alaska Natives, including the practical and cost-effective use of dentists in private practice, recent graduates of pre- and postgraduate

educational programs (i.e., externships, internships, and other advanced education), and dentists in the Tri Service Military Reserve, and be it further

Resolved, that the ADA supports and encourages American Indian and Alaska Native students to pursue careers in dentistry.

Public Funding for Oral Health Care Provided at Academic Dental Institutions (*Trans.2023:XXX*)

Resolved, that the following policy titled Public Funding for Oral Health Care Provided at Academic Dental Institutions be adopted:

Resolved, that the American Dental Association supports enhancing federal and state funding for academic dental institutions to provide oral health care services to underserved, unserved and uninsured indigent populations.

Availability of Dentists for Underserved Populations (*Trans.2016:318; 2024:XXX*)

Resolved, that state and local dental societies be encouraged to participate in programs that support and promote 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 state and local dental societies be encouraged 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

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.

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.

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; 2020:287)

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. Advocate for an adequately funded and efficiently administered dental benefit plan supporting the oral health of the elderly.
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 Dental Lifeline Network
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.

Guidelines for Dentist Advertising (Trans.1979:647; 2022:368)

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

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

Increasing Allied Personnel in the Workforce **(Trans.2024:XXX)**

Resolved, that the ADA prioritize lobbying efforts focused on allied dental education debt relief for graduates of CODA-accredited dental education programs, and be it further

Resolved, that state dental associations advocate for increased resources from state and local governments for community and technical college dental hygiene and dental assisting education programs to enhance, modernize, and expand training facilities and increase program enrollment capacity; offer competitive salaries to full-time faculty members; and provide scholarships and/or student debt relief, especially for those students who commit to work in underserved areas, and be it further

Resolved, that state dental associations investigate the creation and implementation of awareness and pipeline programs for the dental hygiene and dental assisting professions, depending on the needs of the individual state.

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; 2021:330)**

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.

* 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."

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 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 through the ADA licensed curriculum as a dental trained professional with community health worker 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 licensed dentists. CDHCs also perform limited clinical duties only as allowed by their State Practice Acts 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, faith based settings, 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 dental offices.

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.

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; 2019:278; 2024: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 more than fifteen 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 have passed at least one examination of 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 to those who qualify for certification.

The Board may require a 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.2019:305*)

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 Facility Amalgam Wastewater Policy (*Trans.2003:387; 2024:XXX*)

Resolved, that the Association strongly encourages dental facilities to adhere to dental best management practices for amalgam waste handling and disposal that include but are not limited to operation, maintenance, and record-keeping requirements, chairside traps, amalgam separators compliant with ISO 11143, ANSI/ADA Standard 108 or successors, and using a suitably licensed or permitted commercial waste disposal service to dispose of collected amalgam, in compliance

with the EPA Clean Water Act, and supports other voluntary efforts by dentists to reduce amalgam discharges in dental facility wastewater, and be it further

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

Resolved, that the appropriate agencies of the Association continue to disseminate information to the state and local 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 dental facilities effectively reduce amalgam in dental facility 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 facilities 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.

Precapsulated Amalgam Alloy (*Trans.1994:676; 2022:364*)

Resolved, that the ADA strongly recommends that when using amalgam, dentists use precapsulated amalgam alloy, also referred to as encapsulated amalgam alloy, in their dental practices.

Use of Amalgam as Restorative Material (*Trans.1986:536; 2022:353*)

Resolved, that the ADA recommends that clinicians review the risks and benefits of all restorative options with their patients, and that dental amalgam restorations continue to be used when appropriate for patient care, and be it further

Resolved, that the ADA supports the globally recognized need to reduce environmental mercury as set forth in the Minamata Convention on Mercury (September 2019) as a common good, and recognizes the responsibility of dentists to care for their patients' well-being, in keeping with the ADA *Principles of Ethics and Code of Professional Conduct*, 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*.

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.

¹Excerpted 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.

¹Excerpted 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 Classification²

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

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

		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 Guidelines³

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 Sedation section of the *ADA Guidelines for Teaching*

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.

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 their 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 their 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 recertification 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 their 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 CO₂ 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 operator 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](#) and the ASA Physical Status Classification System can be obtained from the [American Society of Anesthesiologists](#).

- The dentist must monitor ventilation and/or breathing by monitoring end-tidal CO₂ 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,

⁴ Standardized BMI category definitions can be obtained from the [Centers for Disease Control and Prevention](#) and the ASA Physical Status Classification System can be obtained from the [American Society of Anesthesiologists](#).

legal guardian or care giver, including pre-operative fasting instructions based on the ASA Summary of Fasting and Pharmacologic Recommendations.

- 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 CO₂ 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 CO₂ must be continuously monitored and evaluated.
- Non-intubated patient: End-tidal CO₂ 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 CO₂

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.

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)

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.

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.

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)

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

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

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

continual - repeated regularly and frequently in a steady succession.

continuous - prolonged without any interruption at any time.

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

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

Levels of Knowledge

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

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

Levels of Skill

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

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

American Society of Anesthesiologists (ASA) Patient Physical Status Classification²

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		

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.

treatment of the patient would lead to a significant increase in the threat to life or body part)

American Society of Anesthesiologists' Fasting Guidelines³

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

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.

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

C. Sequence of Pain Control Didactic and Clinical

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

included for demonstration of minimal and moderate sedation techniques.

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

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

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.
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.

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.

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 obviating 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; 2021:323)

Resolved, that the American Dental Association 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, and be it further

Resolved, that the ADA supports changes in antitrust laws that would make professional societies and their members exempt from antitrust scrutiny for the narrow area of collective bargaining, so that dental societies can collectively negotiate on behalf of members.

Children

Support for the American Academy of Pediatric Dentistry Guideline on Perinatal and Infant Oral Health Care (*Trans.2021:328*)

Resolved, that the American Dental Association supports the American Academy of Pediatric Dentistry Anticipatory Guideline on Perinatal and Infant Oral Health Care (2021):

Anticipatory guidance in the perinatal and infant period includes assessment of any growth and development issues that the parents should be aware of or need referral to the child's medical provider. AAPD BP Periodicity Schedule Assessment of caries risk that should be considered in counselling the parents regarding the child's fluoride exposure, including consumption optimally fluoridated water, appropriate frequency and quantity of brushing with fluoridated toothpaste, and need for professional topical fluoride applications. (AAPD BP Fluoride) Anticipatory guidance during this infant period also entails oral hygiene instruction, dietary counselling regarding sugar consumption, frequency of periodic oral examinations (AAPD Periodicity Schedule), and information regarding non-nutritive habits that if prolonged may result in flaring of the maxillary incisor teeth, open bite, and a posterior cross bite. (Dogramaci and Rossi-Fedele, 2016). Counselling regarding safety and prevention of orofacial trauma would include discussions of play objects, pacifiers, car seats, electrical cords, and injuries due to falls when learning to walk.

Recommendations

1. Advise expecting and new parents regarding the importance of their own oral health and the possible transmission of cariogenic bacteria from parent/primary caregiver to the infant.
2. Encourage establishment of a dental home that includes medical history, dental examination, risk assessment, and anticipatory guidance for infants by 12 months of age.
3. Provide caries preventive information regarding: high frequency sugar consumption; brushing twice-daily with optimal amount fluoridated toothpaste; safety and efficacy of optimally-fluoridated community water; and for children at risk for dental caries, fluoride varnish and dietary fluoride supplements (if not consuming optimally-fluoridated water).
4. Assess caries risk to facilitate the appropriate preventive strategies as the primary dentition begins to erupt.

5. Provide information to parents regarding common oral conditions in newborns and infants, non-nutritive oral habits (e.g., digit sucking, use of a pacifier), teething (including use of analgesics and avoidance of topical anesthetics), growth and development, and orofacial trauma (including play objects, pacifiers, car seats, electric cords, and falls when learning to walk).
6. When ankyloglossia results in functional limitations or causes symptom, the need to surgical intervention should be assessed on an individual basis.
7. When a patient presents with a prematurely erupted primary tooth (i.e., natal or neonatal tooth), decisions regarding intervention should be individualized, based on the interference with feeding, the risk of detachment and aspiration, and any medical or contributing considerations.

Support for the American Academy of Pediatric Dentistry Policy on Early Childhood Caries (*Trans.2021:325*)

Resolved, that the American Dental Association supports the Policy Statement of the American Academy of Pediatric Dentistry (AAPD) on Early Childhood Caries (2021):

The AAPD recognizes the unique and often virulent nature of ECC. Non-dental healthcare providers who identify ECC in a child should refer the patient to a dentist for treatment and establishment of a dental home (AAPD Dental home) immediate intervention is indicated, and non-surgical interventions should be implemented when possible to postpone or reduce the need for surgical treatment approaches. Because children who experience ECC are at greater risk for subsequent caries development, preventive measures (e.g., dietary counseling, reinforcement of toothbrushing with fluoridated toothpaste), more frequent professional visits with applications of topical fluoride, and restorative care are necessary.

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)

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 persons 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; 2021:329)

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, 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 encourage constituent societies to support this policy.

Non-Dental Providers Notification of Preventive Dental Treatment (Trans.2004:303; 2014:505; 2021:329)

Resolved, that prior to any preventive dental treatment, a dental disease risk assessment should be performed

by a dentist or appropriately trained dental or medical provider 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 utilize care coordination to refer the patient to a dentist for a comprehensive examination and to establish a dental home with a report of the services rendered given to the custodial parent or legal guardian.

Parent and Caregiver Oral Health: Patient Education
(Trans.2001:428; 2014:504; 2021:329)

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 parents, caregivers and their children, and be it further

Resolved, that the ADA work with the prenatal and perinatal professional community to ensure that expectant parents and caregivers are provided relevant oral health care information during the perinatal period.

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; 2023:XXX*)

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 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 their competence so they can provide better health service, and (2) to keep them 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.

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 them 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, they 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 they 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 their 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 their 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. They should understand that it is their 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, they 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.

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.”

Constituent and Component Societies

Sustaining the Pipeline of Volunteer Leadership (Trans.2021:277)

Sustaining the Pipeline of Volunteer Leadership

Resolved, that new dentists be considered as essential leaders in the tripartite, and be it further

Resolved, that constituent dental societies be urged to develop and implement strategies to grow and maintain new dentist participation in leadership, which may include:

- Leadership development
- Dedicated leadership positions for new dentists
- Programs that support the pathway to leadership for new graduates
- Other opportunities to foster leadership growth.

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.

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; 2021:324)

Resolved, that the American Dental Association encourages members to join and actively participate in the American Dental Political Action Committee's Grassroots Program.

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; 2021:321)

Resolved, that retirement savings accounts should be exempt from nondomestic judgments.

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; 2023:XXX)

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.

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; 2023:XXX*)

Resolved, that the ADA establish pages on the ADA web sites (ADA.org and MouthHealthy.org) to assist consumers in making an informed choice of a dental practitioner that includes, but is not limited to:

1. The names of all of the 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 sites.

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

Professionalism and Ethics Continuing Education (*Trans.2024:XXX*)

Resolved, that members of the ADA be encouraged to invest in Professionalism and Ethics continuing education courses to foster improved communication by and among members.

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).

Acceptance of Formal Continuing Education Courses Offered by ACCME or IPCE Accredited Providers (*Trans.2010:576; 2022:353*)

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

Policy Statement on Continuing Dental Education (*Trans.2006:331; 2011:465; 2017:274; 2022:352; 2024:XXX*)

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; practice management; physical and mental wellness; 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 National Commission on Recognition of Dental Specialties and Certifying Boards. Continuing dental education should be a part of a lifelong continuum of learning.

Acceptable Course Titles and Descriptions:

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.

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 their 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 dental boards and/or legislatures may by law specify as acceptable. The Association urges the state dental 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)
- presentation at a poster session or table clinic
- 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)
- membership on a state dental board or committee; participation in a state dental board, complaint investigation, peer review or quality care review evaluation
- successful completion of the Integrated National Board Dental Examination, fellowship/certification examinations in general dentistry or interest areas in general dentistry, a recognized dental specialty certification examination, the National Board Dental Hygiene Examination, or the Dental Assisting National Board (DANB) Examination
- participation in test development or calibration for written and clinical dental, dental hygiene and dental specialty certification examinations
- providing volunteer pro bono dental services at a non-profit entity or event
- participation in dental research as a principal investigator or research assistant
- attendance at a study club meeting that uses audio, video, live presentations or written materials
- dental coursework taken during postdoctoral education or a CODA-accredited residency program

Policy Statement on Lifelong Learning (*Trans.2000:467; 2022:351*)

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 their knowledge and skills in all appropriate areas of the profession.

The Association is committed to serving as a supportive resource to facilitate lifelong learning and continuing competency by assisting members in identifying appropriate sources and mechanisms for meeting this responsibility for the benefit of the public and the profession. The Association encourages the investigation of new methods of supporting continuing competency of its members and urges state dental boards to not utilize methods such as mandated periodic in-office audits and/or comprehensive written examinations and/or clinical, patient-based competency assessments, manikin-based competency assessments, or virtual reality competency assessments as a means of measuring or assessing the continuing competency of dentists or as a requirement for license renewal. Continuing competency for renewal of state permits (such as anesthesia permits) may require ongoing competency assessments and office audits, in addition to specialty board requirements which may require regular competency assessment to maintain board certification.

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

Inclusion of Confidentiality Statement on Meeting Agenda (*Trans.2022:375*)

Resolved, that the following reminder concerning the treatment of ADA confidential information be included on all ADA meeting agendas.

Members of the [Insert Name of Agency] and ADA staff are reminded that any sensitive or confidential information or material that is disclosed or discussed during the meeting must remain confidential and members shall not disclose that sensitive or confidential information to any individual or entity to whom access has not been provided by the ADA in the ordinary course of its operations and dealings. Divulging ADA confidential information without approval is a violation of the ADA Member Conduct Policy (*Trans.2011:530; 2020:335*).

and be it further

Resolved, that the ADA nondisclosure agreement be signed by all members of the ADA Board of Trustees, Councils and Committees each year as a reminder of the existing duty of confidentiality.

Transparency (*Trans.2009:404; 2017:254; 2022:340*)

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 shall direct the ADA Foundation and any subsidiary 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; 2022:341*)

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 the *Bylaws*, Chapter X., Section 20. Special Committee; and the *Governance and Organizational Manual*, Chapter X. Committees, Special Committees and Subcommittees.

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 ADA Diversity (Trans.2019:245)

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.

Use of “Usual Fee” and “Maximum Plan Benefit” in Dental Benefit Programs (Trans.2010:546; 2011:452; 2024:XXX)

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

Usual fee is the full 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 judgement. A contractual relationship does not change a dentist's full (usual) fee.

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 (also known as “maximum plan allowance” or “allowable amount” by certain dental plans) 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, and be it further

Resolved, that standardized methodologies should be used when establishing “allowable amounts” and the

methodology should be shared with individual dentists when they are asked to sign a network agreement and anytime thereafter when “allowable amounts” are adjusted. Such “allowable amounts” should be adjusted annually at least based on CPI for dental services, and be it further

Resolved, that the ADA also believes that third party payers have an obligation to plan beneficiaries to provide information on eligibility and benefits prior to dental visits regardless of whether the plan beneficiary chooses to receive care from a network or an out-of-network dentist, and be it further

Resolved, that the ADA also believes in the right of every dentist who is out-of-network to be able to balance bill the patient up to the dentist's full (usual) fee.

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.

Continuing Competency (Trans.1999:939; 2021:XXX)

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

Continuing competency: The continuance of the appropriateness, necessity and quality of the care provided by dentists in order to maintain and improve the dental oral, and craniofacial health of their patients in accordance with the ethical principles of dentistry.

Dentistry (Trans.1997:687; 2015:254; 2020:326)

Resolved, that the profession of dentistry is essential and defined as the evaluation, diagnosis, prevention and/or

treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, craniomaxillofacial area and/or the adjacent and associated structures and their impact on the human body, provided by dentists, within the scope of their education, training and experience, in accordance with the ethics of the profession and applicable law, and be it further

Resolved, that dentistry is essential and should remain an independent health care profession that safeguards, promotes and provides care for the health of the public which may be in collaboration with other health care professionals.

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 their 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 their 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 their 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.

Medically Necessary Care (Trans.1990:537; 2024:XXX)

Resolved, that the term “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, breathing, swallowing or chewing, and be it further

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.

Direct Reimbursement (Trans.1989:548; 2024:XXX)

Resolved, that “direct reimbursement” be defined as follows:

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

and be it further

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 the public, business community and dentists.

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

Annual Maximums in Dental Benefit Programs and Out of Pocket Costs (*Trans.2024:XXX*)

Resolved, that the ADA does not support annual or lifetime maximums in any dental benefit programs and believes that total out-of-pocket costs are an important barrier to care, and be it further

Resolved, that the ADA recognizes that dental benefit plans often use annual maximums as a cost-control mechanism, and be it further

Resolved, that when benefit plan issuers apply an arbitrary annual maximum, they should be required to evaluate utilization and out-of-pocket costs including deductibles, co-insurance, non-covered services, and expenses above the plan annual limits each year in order to set annual maximums which should increase annually at least based on the CPI for dental services, and be it further

Resolved, that aside from annual maximums, co-insurance is an important contributor to out-of-pocket costs, and plans should not impose significant co-insurance, resulting in cost barriers to care. Diagnostic and preventive services should be covered at 100% and should not be included in the annual maximum, and be it further

Resolved, that dental benefit plan issuers must account for inflation when setting premiums and should not engage in multi-year contracts with employers that do not account for rising costs to provide dental care.

Summary of Benefits for Dental Plan Comparisons for Plan Purchasers (*Trans.2024:XXX*)

Resolved, that dental plans provide a summary of benefits and post this information on the payer's web portal so that plan purchasers can make informed decisions when comparing various plans on the market, and be it further

Resolved, that the summary of benefits information should be easy for plan purchasers to access and understand, and be it further

Resolved, that, at a minimum, all dental plan summaries of benefits information should include a brief description of the following items:

1. Annual Maximums
2. Co-payments
3. Co-Insurance
4. Limitations
5. Deductibles
6. Frequency of Covered Procedures
7. Out of Network Benefits
8. Waiting Periods
9. Predetermination Requirements
10. Exclusions
11. Enrollment Periods

12. Patient Incentives for maintaining Oral Health
13. Network Adequacy
14. Alternate Benefit Provisions
15. Lifetime Maximums

Dental Benefits within Affordable Care Act and a Public Option (*Trans.2021:284; 2023:XXX*)

Resolved, that within the Affordable Care Act:

- Dental benefits, both pediatric as well as adult benefits should be considered "Essential Health Benefits".
- Coverage inside and outside of the Marketplaces must include pediatric and adult dental benefits.
- There should be no dollar-value annual and lifetime maximums in and out of the ACA Marketplaces.
- Dental coverage should be available to consumers through Stand Alone Dental Plans.
- Diagnostic and preventive dental services embedded within Qualified Health Plans should be covered without any additional co-payment, co-insurance or deductibles.
- Dental care is essential across the individual's life span. Individuals seeking to purchase benefits in the Marketplaces must be able to purchase dental benefits without having to first purchase a medical plan.
- Plan designs should remain flexible and offer consumers adequate choices balancing cost and benefit value.
- Dental Plans offered in the Marketplaces must be required to transparently report Medical (Dental) Loss Ratios (MLR/DLR).
- Cost sharing assistance or premium tax credits should be available to consumers purchasing dental plans.
- Dependent children should be allowed to remain on their parents plans until age 26 in any dental plan.

and be it further

Resolved, that any plan, including a public option plan, that provides dental coverage within the Marketplaces established by the Affordable Care Act, should:

- Allow freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit.
- Not force any providers, including those already participating in existing public programs, to join a Marketplace plan network and instead should support fair market competition, including

meaningful negotiation of contracts and annual adjustment of fee schedules.

- Only include minimal and reasonable administrative requirements to promote participation and provide meaningful access.

Discrimination of Benefit Payment Based on Professional Degree of Provider (Trans.2021:320)

Resolved, that that the American Dental Association opposes discrimination of benefit payment based on the type of license and/or professional degree of the dentist and/or physician.

Guaranteeing Patient's Freedom of Choice of Dentist (Trans.2021:339)

Resolved, that the patient's right to choose any licensed dentist must be preserved, and be it further

Resolved, that the American Dental Association opposes any arrangement that eliminates, interferes with, or otherwise limits the patient's freedom of choice, and be it further

Resolved, that any plan with an arrangement that eliminates, interferes with, or otherwise limits the patient's freedom of choice, should include notice to prospective plan purchasers and recipients that it may be necessary to change dentists to utilize that coverage.

Policy for the Elimination of Wait Periods for Children in Dental Benefit Plans (Trans.2021:284)

Resolved, that the American Dental Association supports the elimination of wait periods for treatment, including orthodontic treatment, for children from dental benefit plans.

Statement on Programs Limiting Dental Benefit to Network Providers (Trans.2019:257)

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 their 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

Provider Rating by Third Parties (Trans.2014:455; 2022:347)

Resolved, that the ADA opposes third-party provider ratings systems based on cost or non-validated utilization patterns because they are inherently flawed, unreliable, and potentially misleading to the public, and be it further

Resolved, that the appropriate agencies of the Association inform third party payers of this opposition and urge them not to include such ratings in their communications to the public, and be it further

Resolved, that the appropriate ADA agency prioritize legislative efforts to prevent the use of such flawed and misleading provider rating systems as part of dental insurance reform, and be it further

Resolved, that third parties who publish provider rating systems should clearly convey to the public that provider ratings are not based on care quality but rather practitioner conformity with dental plan design and cost containment for the insurance plans, and be it further

Resolved, that third parties who publish provider rating systems should be transparent regarding the methodology, provide detailed quarterly reports to the provider, provide a mechanism to appeal and improve provider scores as well as a mechanism to opt-out from being publicly rated.

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

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*)

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*)

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.

Patients should also be reminded that they are 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.

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.

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

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

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 Payer Contracting Practices **(Trans.2022:348)**

Resolved, that the ADA urge that any amendments to existing third party payer contracts between a dentist and a third party payer, dental benefits administrator or a dental network leasing company require signature by the dentist, and be it further

Resolved, that such amendments with any and all changes to the contract terms, policy manual and fee schedule be communicated to the dentist via certified mail at least 90 days prior to the date of implementation and to require the dentist's signature to opt in, and be it further

Resolved, that when third party payers choose to establish a new network using the name, image and likeness of dentists participating in the carrier's existing network, then dentists should be provided the opportunity to opt-in to such new networks.

Third-Party Payment Choices (Trans.2017:265)

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 they accept 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; 2022:346*)

Resolved, that all communications from a third-party payer or other benefits administrator that attempt to explain the reason(s) for a benefit reduction or denial to beneficiaries of a dental benefits plan, include the following statement:

Any difference between the fee charged and the benefit paid is due to limitations in your dental benefits contract. Please refer to 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 the ADAs model explanation of benefits statement be the basis for any national standard for EOB statements, and be it further

Resolved, that when the EOB lists procedures used to determine benefits that are different from submitted procedures then payers should not apply frequency limits to the benefitted 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 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.

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 their 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; 2023:XXX*)

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 should include, but not be limited to, the following preventive 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 and oropharyngeal cancer and other dental/medical related conditions;
- preventive resin restorations;
- resin infiltrations;
- fixed and removable appliances to prevent malocclusion;
- 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, dental- and medical related conditions, 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 they are 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 their 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 their legal counsel, in order to be informed of their 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 their 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 their 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.

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

Comprehensive Statement on Oral Health Services During Pregnancy (*Trans.2024:XXX*)

Resolved, that the following Comprehensive Statement on Oral Health Services During Pregnancy be adopted.

Comprehensive Statement on Oral Health Services During Pregnancy

Resolved, that the ADA encourage all pregnant persons and persons of child-bearing age to have a regular dental examination and dental treatment as needed throughout all stages of pregnancy, and be it further

Resolved, that the ADA acknowledges that preventive, diagnostic, restorative and surgical dental treatment rendered to promote health and eliminate disease is safe throughout pregnancy, is supported by the American College of Obstetrics and Gynecology, and is effective at maintaining the oral and overall health of the pregnant person, and be it further

Resolved, that dental coverage of pregnant persons be extended for one-year post-partum to be included in all dental benefit programs to improve the dental health of the pregnant person as well as to promote Age One dental visits for very young children, and be it further

Resolved, that the ADA support federal advocacy efforts to increase funding for women's oral health research, ensure that women are adequately represented as research subjects in dental clinical trials, and help disseminate research information, on women's oral health issues as needed and appropriate.

Role of Dental Health in the Management of Systemic Conditions and Outcomes of Medical and Surgical Procedures (*Trans.2024:XXX*)

Resolved, that the American Dental Association acknowledges that there is scientific evidence that dental health is intrinsically linked and integral to the health outcomes of medical and surgical procedures and systemic conditions, and be it further

Resolved, that the ADA believes that optimizing oral health is an important component of clinical care prior to the performance of medical and surgical procedures that are intrinsically linked and integral to health outcomes, and be it further

Resolved, that the ADA encourages patients and medical teams to collaborate with dentists to obtain a dental examination, consultation and treatment, when appropriate, and be it further

Resolved, that dentists should be recognized as an integral part of any multidisciplinary health care team to support medically necessary care essential to the successful management of a medical or dental condition, and be it further

Resolved, that the ADA encourages research through the National Institute of Dental and Craniofacial Research (NIDCR) and other appropriate agencies who traditionally oversee such research along with collaboration between dentists and other health care providers to help identify systemic conditions which are suspected to have a relationship to a patient's oral health.

A Culture of Safety in Dentistry—Voluntary Reporting (*Trans.2021:331*)

Resolved, that the American Dental Association acknowledges the value of self-reporting dental patient safety issues to a certified Patient Safety Organization that complies with the Patient Safety Rule of the Department of Health and Human Services, as critical to our professional responsibility for education and self-regulation, and be it further

Resolved, the American Dental Association encourages the voluntary reporting of near misses and adverse incidents to the Dental Patient Safety Foundation in an anonymous and non-discoverable manner, and be it further

Resolved, that the American Dental Association utilizes submitted reports to develop and report on improved safety measures for the profession of dentistry.

Oral Health Equity (*Trans.2021:329*)

Resolved, that the American Dental Association (ADA) defines oral health equity as optimal oral health for all people. The ADA is committed to promoting equity in oral health care by continuing research and data collection, advocating to positively impact the social determinants of oral health, reinforcing the integral role of oral health in overall health, supporting cultural competency and diversity in dental treatment, disease prevention education, and supporting efforts to improve equitable access to oral health care.

The Practice of Dentistry and Cannabis (*Trans.2021:300*)

Resolved, that the ADA encourage the development of best practices for the management of patients and their caregivers, dentists, and dental team members who are under the influence of cannabis.

ADA Statement on the Use of Silver Diamine Fluoride (SDF) to Arrest Carious Lesions (*Trans.2020:304*)

ADA Statement on the Use of Silver Diamine Fluoride to Arrest Carious Lesions

38% Silver Diamine Fluoride (SDF) is a topical antimicrobial and remineralizing agent which was cleared by the FDA as a Class II medical device to treat tooth sensitivity. In certain circumstances, SDF may be used as a non-restorative treatment to arrest carious lesions on primary and permanent teeth. The use of SDF to arrest carious lesions requires diagnosis and monitoring by a dentist.

When using SDF for caries management, the following protocols should be followed:

1. Development of a patient-specific treatment plan by the dentist.
2. Patients or their lawful guardians should be informed of all available treatment options, possible side effects, and the need for follow-up monitoring when giving informed consent.
3. The application of SDF may be delegated to qualified allied dental personnel with the appropriate training and supervision in accordance with state laws and in conjunction with the above protocols.

and be it further

Resolved, that the ADA supports SDF as a covered benefit by third-party payers, and be it further

Resolved, if the tooth treated with SDF requires further treatment, that this restorative treatment or extraction of the tooth also remain a covered benefit.

Dentistry is Essential Healthcare (Trans.2020:305)

The American Dental Association supports the following policy:

1. Oral health is an integral component of systemic health.
2. Dentistry is essential healthcare because of its role in evaluating, diagnosing, preventing or treating oral diseases, which can affect systemic health.
3. The term “Essential Dental Care” be defined as any care that prevents or eliminates infection, preserves the structure and function of teeth as well as the orofacial hard and soft tissues, and that this term be used in lieu of the terms “Emergency Dental Care” and “Elective Dental Care” when communicating with legislators, regulators, policy makers and the media in defining care that should continue to be delivered during global pandemics or other disaster situations, if any limitations are proposed.
4. Government agencies such as the Department of Homeland Security and the Federal Emergency Management Agency

have acknowledged dentistry as an essential service needed to maintain the health of Americans. State agencies or officials should recognize the oral health workforce when designating its essential workforce during public health emergencies, in order to assist them in protecting the health of their constituents.

Diagnostic Testing by Dentists (Trans.2020:321)

Resolved, that dentists with the requisite knowledge and skills can order and administer diagnostic medical tests to screen patients for chronic diseases and other medical conditions that could complicate dental care or put the patient and staff at risk, and be it further

Resolved, that point of care testing to screen is within a dentist’s scope of practice, and be it further

Resolved, that point of care testing results be communicated with the patient and the patient be referred to their physician for appropriate diagnoses and treatment, and be it further

Resolved, that dentists comply with federal and state requirements, as appropriate, to administer the tests.

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; 2019:270; 2021:290)

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 modalities exist to treat SRBD. Oral appliances, specifically custom-made, titratable devices can improve SRBD in adult patients. Oral appliance therapy (OAT) can improve or effectively treat OSA in adult patients, especially those who are intolerant of positive airway pressure therapy (PAP therapy). 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 patients are at risk and appropriate candidates for sleep apnea tests (SAT) the dentist may order or administer the appropriate SAT in accordance with applicable laws. If risk for SRBD is determined, patients and pertinent patient information and SAT data should be referred, to the appropriate physicians for 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 obstructive sleep apnea, and for severe obstructive sleep apnea when a CPAP cannot or will not be 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, home sleep apnea tests (HSAT) may be used by the dentist to help define the optimal target position of the mandible. A dentist trained in the use of HSAT'S 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 regarding the patient's treatment progress and any recommended follow-up treatment.
- Follow-up sleep testing should be conducted so the physician is able to evaluate the improvement or confirm treatment efficacy for the OSA.

Medical (Dental) Loss Ratio (Trans.2015:244; 2019:262; 2024: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, specifically:

- (A) The numerator is the sum of (1) the amount paid for clinical dental services provided to

enrollees and (2) the amount paid to providers on activities that improve oral health through clinical services for plan enrollees.

- (B) The denominator is the total amount of premium revenue, excluding only (1) federal and state taxes, (2) licensing and regulatory fees paid, and (3) any other payments required by federal law,

and be it further

Resolved, that states pursuing MLR, refer to the definitions of each of the amounts referenced in the numerator and denominator within the ADA's Glossary of Dental Administrative Terms maintained by the ADA Council on Dental Benefit Programs (CDBP), 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, which contains the same information required in the 2013 federal MLR Annual Report Form (CMS-10418) along with number of enrollees, the plan cost-sharing and deductible amounts, the annual maximum coverage limit and the number of enrollees who meet or exceed the annual coverage limit and to establish a specific loss ratio for dental plans in each state, and be it further

Resolved, that a "specific loss ratio" be calculated by each state as the average dental loss ratio for each market segment (large group and small/individual groups as defined within the state). If the average loss ratio is less than 85% for large group plans and 83% for small/individual groups, then states should aspire to establish a mechanism to have MLR improved to at least this benchmark over time. For those carriers reporting MLR above 85%, such carriers should be required to maintain operations at that level, and be it further

Resolved, that when a carrier fails to meet the MLR, the carrier be required to issue rebates to plan purchasers, and be it further

Resolved, that instituting an MLR should not result in premium rate increases in excess of the percentage increase of the latest dental services Consumer Price Index as reported through the US Bureau of Labor Statistics.

ADA Policy on Professional Tooth Whitening (Trans.2008:477; 2024:XXX)

Resolved, that, because every patient's oral health needs and circumstances are unique, the American

Dental Association encourages patients to consult with a licensed dentist to determine if professionally applied whitening/bleaching is an appropriate course of treatment.

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; 2021:326)

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.
5. The Association support collaboration with state and local oral health coalitions to complete the objectives of effective health planning in areas of common ground between the organizations.

Dental Education

Federal Student Loan Forgiveness (*Trans.2022:368*)

Resolved, that it is the position of the American Dental Association (ADA) that dentists should not be excluded from government relief of public and commercial student loan debt without obligation or condition, and be it further **Resolved**, that the following principles guide the ADA efforts to shape specific student loan forgiveness proposals:

1. Education debt associated with graduate and professional programs should be eligible.
2. Any means testing should account for regional differences in cost of living and purchasing power.
3. The consideration for eligibility and amount of forgiveness should account for the cost, length and rigor of dental education programs.

Patients with Special Needs (*Trans.2021:298*)

The dental profession's continued ability to effectively provide dental care for America's special needs population is dependent on sustaining a strong educational foundation in this area. The ADA encourages efforts to maintain and expand the availability of courses and programs at the predoctoral, advanced and continuing educational levels that support practitioners in providing dental treatment to patients whose medical, physical, psychological, cognitive or social situations make it necessary to consider a wide range of assessment and care options. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. The ADA encourages dental practitioners to regularly participate in continuing education in this area.

Federal Student Loan Programs (*Trans.2019:297*)

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 their 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.2019:297; 2024: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, and be it further

Resolved, that the ADA lead efforts to protect the eligibility status of program participants when unforeseen circumstances, such as the removal of a health professional shortage area designation, undermine the participating dentist's good faith efforts to meet their service obligations.

General, Pediatric and Public Health Dental Residency Programs (*Trans.2019:298*)

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.

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*)

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*)

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*)

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; 2023:XXX)

Resolved, that the ADA supports efforts by 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 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. 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 are encouraged to engage with state regulatory agencies in their mission to protect the public and providing support for dentists by eliminating barriers and reducing stigma associated with seeking mental and behavioral health services.
4. Dental societies should be advocates for dentists to have the same rights of privacy and confidentiality of personal medical information as other persons.
5. 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.

6. 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.
7. The dental society should also ensure that those who serve as dentist peer assistance volunteers are appropriately trained and supervised in these activities.
8. 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
9. Dental societies are strongly encouraged to offer continuing education programs on the prevention, recognition and treatment of professional impairment.
10. 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).

Electronic Technology

Statement on Electronic Health Record and Data Exchange in Dentistry (*Trans.2024:XXX*)

Resolved, that the following policy, Statement on Electronic Health Record and Data Exchange in Dentistry, be adopted.

Statement on Electronic Health Record and Data Exchange in Dentistry

The adoption of Health Information Technology (HIT) in dental offices has increased, marked by the widespread implementation of electronic health records (EHR), practice management systems, and related software. In navigating this evolving landscape, the American Dental Association (ADA) assumes a pivotal role in shaping the HIT environment and advocating the establishment of regulatory frameworks, standards, and industry-wide adoption imperatives that align with the needs of dental practices and patients.

The ADA represents the interests of the dental profession and patients in all aspects of the development and implementation of electronic technologies with research, scientific, educational, administrative, and clinical applications in dentistry through the following activities:

- Collaborating with national organizations responsible for developing standards in electronic data exchange;
- promoting and securing industry commitment to the adoption of standards;
- leveraging legislative and regulatory opportunities to support the use of electronic technologies; and
- leading appropriate efforts to resolve legislative, regulatory, and industry barriers to the adoption and use of electronic technologies.

The ADA supports the following principles to be upheld by the industry providing electronic health records, practice management systems, diagnostic tools, and treatment applications that align with the advancements in digital technologies.

Patient-Centric Care and Privacy:

- Ensure that all EHR systems prioritize patient care and maintain confidentiality and integrity of the data.
- Allow patient access to electronic Protected Health Information (ePHI) in their preferred method.
- Implement strict access controls and audit trails to protect patient information from unauthorized access.

Interoperability and Data Exchange:

- Adoption of ADA standards as an American National Standards Institute (ANSI)-accredited Standards Developing Organization (SDO), as well as collaboration with International Organization for Standardization (ISO) international standards for health data to ensure interoperability and compatibility.
- Adopt standardized data formats and communication protocols to facilitate seamless and secure data exchange between systems and care providers.
- Ensure uninterrupted, usable, perpetual access to the entire electronic health record in a standards-based, interoperable, and structured format.

Data Quality and Integrity:

- Maintain high standards of data accuracy, completeness, and timeliness to support clinical decision-making and treatment planning.
- Implement data validation and correction mechanisms to minimize errors and discrepancies in patient records.

Innovation and Technology Adoption:

- Encourage innovation and the development of EHR systems and digital tools that enhance diagnostic and treatment capabilities in dentistry.
- Ensure new technologies are evaluated for clinical effectiveness and safety before implementation and post-market evaluation after appointment.

Security and Compliance:

- Assurance of appropriate and robust security systems to maintain confidentiality.
- Adhere to national regulations concerning data protection and privacy (i.e., Health Insurance Portability and Accountability Act (HIPAA)).
- Assure data security in transit and at rest (i.e., Transport Layer Security (TLS 1.3), Advanced Encryption Standard (AES 256)).

Training and Education:

- Provision of timely, comprehensive, ongoing team-based training, education, and technical support to avoid disruption in patient and provider health care delivery.
- Promote awareness of best practices, data management, and security among dental professionals.

Ethical Use of Data:

- Promote the ethical use of artificial intelligence and machine learning technologies in dentistry by establishing clear guidelines and standards.
- Ensure the ethical use of EHR data for research and development, with appropriate patient consent and safeguards.

Incorporating Prescription Drug Monitoring Program (PDMP) Into Drug (Trans.2023:XXX)

Resolved, that the American Dental Association encourage dental and prescription software vendors to include PDMP compliance tools in software they sell to dental professionals in all new and updated versions of their software, and be it further

Resolved, that the ADA recommends that dentists request that their software vendors include PDMP compliance tools in the software they provide, and be it further

Resolved, that the ADA agencies that develop standards for dental software include PDMP compliance tools as an essential element of dental practice management and prescription software.

Promoting Use of DICOM in Dentistry (Trans.2023:XXX)

Resolved, that the policy statement, Promoting Use of DICOM in Dentistry, be adopted:

Promoting Use of DICOM in Dentistry

Resolved, the appropriate ADA agencies collaborate with interested dental specialty societies to understand issues related to DICOM and image exchange to facilitate development of the appropriate and necessary specifications, standards and guidance; and be it further,

Resolved, that the appropriate ADA agencies review and facilitate updating the DICOM standards as needed for dentistry, and be it further,

Resolved, that after the necessary standards and educational tools are developed, the appropriate ADA agencies urge legislators and/or regulators to require the use of DICOM standards across applicable products or systems that exchange images in dentistry, and be it further

Resolved, that the ADA urge the dental software industry to adopt DICOM standards to ensure interoperability between systems.

Policy Statement on the Use of Augmented Intelligence in Dentistry (Trans.2021:282)

Augmented intelligence (AI) is the theory and development of computer systems that can perform tasks that would otherwise require human intelligence, such as visual perception, speech recognition, decision-making and translation between languages. The term

may also be applied to any software that performs intelligent behavior and acts intelligently.

The ADA supports using AI as a tool to supplement the dentist's clinical judgment rather than a technology to replace or override it, while taking into account a patient's clinical presentation, including history, examination, and relevant tests.

- The ADA encourages the development of thoughtfully designed, high-quality, clinically validated dental AI.
- The ADA urges dental professionals to become fully informed about AI technology and how it might support the delivery of patient care.
- The ADA encourages training and education for dental students to ensure that all clinicians in the United States can incorporate AI into clinical practice.

Dental AI Developers: The ADA urges entities to incorporate the following principles when developing AI systems for dental care applications:

- Integrate, when possible, the perspective of practicing dentists in the development, design, validation, and implementation of dental care AI;
- Design and evaluate AI systems following the best practices in dentistry;
- Ensure that the development process of such systems is transparent and conforms to leading standards for reproducibility;
- Address bias and avoid introducing or exacerbating health care disparities when testing on vulnerable populations or deploying new AI tools;
- Demonstrate the efficacy and accuracy of AI systems with reliable data obtained from the relevant clinical domains;
- Safeguard the privacy of patients and other individuals and securing their personal and medical information.

Clinical Practitioners: The ADA supports the following principles for the introduction of AI systems into clinical dental practice:

- Produce outcomes that match or exceed the currently accepted standard of care;
- Prioritize patient safety when using an AI system;
- Encourage dental educators to introduce clinical AI systems in practice and to foster digital literacy in the current and future dental workforce;
- An AI system in clinical dental practice should be supervised by a dentist;

- Identify and acknowledge the limitations of an AI system in clinical decision-making, and continue to collaborate or consult with clinical colleagues as appropriate;
- Demonstrate the efficacy of AI systems with reliable data obtained from the relevant clinical domains;
- Interpret data from dental AI to allow for clinical observation and judgment input from dentists, with an ongoing emphasis on risk management, accountability, and bias;
- Obtain the appropriate informed consent, permission, privacy controls, checks for accuracy and relevance of any patient data used in original development or ongoing refinement of AI algorithms;
- Use patient data only for the stated purpose and storing such data securely.

Third-Party Payers: The ADA supports the following principles for the introduction of AI systems into the claims adjudication processes by third-party payers:

- All decisions on treatment are appropriately the result of a joint discussion between the patient and the dentist;
- If AI is used by dental benefit plans as a tool to assist with claims processing or adjudication, that tool should not be used to diagnose or dictate a treatment plan that interferes with the doctor-patient decision process or deny any benefits that the patient is entitled to under their plan;
- Any AI tool used by third party payers should not be used to direct patients to specified preferred providers;
- AI systems should not allow for denial of claims without consultant review.

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.

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 their 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.

Employee Retirement Income Security Act (ERISA)

Anesthesia Coverage Under Health Plans (Trans.2021:334)

Resolved, the ADA supports the position that all health plans, including those governed by the Employee Retirement Income Security Act, should be required to cover general anesthesia and/or hospital or outpatient surgical facility charges incurred by covered persons who receive dental treatment under anesthesia, due to a documented complexity, behavioral, physical, mental or medical reason as determined by the treating dentist(s) and/or physician.

Provisions for ERISA Plans (Trans.2021:338)

Resolved, that the American Dental Association supports the following provisions for ERISA plans:

1. Beneficiaries of employee health benefit plans should have the right to receive health care from the providers of their choice
2. Employee health benefit plans should be prohibited from discriminating against legally qualified health care providers and to assure the solvency of such plans
3. Plan subscribers in Employee Retirement Income Security Act-regulated dental benefit programs should have the same protections that are commonly enjoyed by subscribers of state-regulated programs including the elimination of missing tooth clauses after one year of premium payments and the prohibition of down coding of fixed prosthesis to removable prosthesis
4. Self-insured payers and/or utilization review organizations should be held liable for any negligent utilization review decision that overturns the health care provider's clinical decision
5. Patients who suffer as the result of negligent utilization review decisions should be entitled to meaningful remedies and fair compensation
6. Patients who are denied benefits should have the right to an appropriate appeal mechanism under self-funded group health plans

Evidence-Based Dentistry

Dissemination of Information Contrary to Science (*Trans.*2006:346; 2022:368)

Resolved, that it is the position of the American Dental Association that dentists rely on the preponderance of peer-reviewed, evidence-based science that is relevant and available when advocating positions with government authorities.

Complementary and Alternative Medicine in Dentistry (*Trans.*2001:460; 2017:277; 2022:356)

The ADA, consistent with its commitment to evidence-based dentistry and the improvement of oral health, supports including complementary and alternative medicine therapies as an adjunct to traditional diagnostic and treatment approaches, as long as they are based on sound scientific principles and demonstrated clinical safety and effectiveness.

Policy Statement on Evidence-Based Dentistry (*Trans.*2001:462; 2012:469; 2017:275; 2022:354)

Introduction: 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.

Principles of Evidence-Based Dentistry: The Association supports the concept of evidence-based dentistry developed through systematic examination of the best available scientific data. Evidence-based dentistry provides a framework to help dentists use, appraise and apply research evidence in clinical practice.

A primary goal of evidence-based dentistry is to improve the quality of dental treatment and oral health care through the objective appraisal of the best available evidence and the development of systematic reviews and evidence-based guidelines and recommendations that can assist clinicians in the conscientious and judicious use of current best evidence, taking into consideration

the patient's preferences and values. Another goal of evidence-based dental practice is to improve clinicians' skills in diagnosing oral and dental diseases and providing evidence-based treatment interventions that help achieve optimal outcomes for patients.

The ADA works to support clinicians in making decisions about the provision of patient-centered, evidence-based treatment and care to allow such decisions to be based on current best evidence, individual clinical expertise and the individual patient's preferences and values. The ADA supports use of quality research findings to systematically build the evidence base used to inform delivery of care, treatment interventions and patient-important outcomes. The ADA also supports the following:

- encouraging incorporation of EBD recommendations in the practice of dentistry;
- supporting teaching about methodology of—and the findings from—EBD recommendations in dental schools;
- advancing policy that encourages patient care in alignment with EBD guidance, where appropriate, and suggests consideration be given to using EBD recommendations to contribute to the development of quality improvement measures;
- the development of EBD resources to guide the practice of dentistry;
- enhancing oral health equity and the equitable provision of patient-centered, evidence-based dental treatment; and
- the development of EBD recommendations that advance evidence-based diagnosis and patient-centered oral health care.

The ADA also recognizes that treatment recommendations should be determined for each patient by their dentist, and that patient preferences should be considered in all decisions. Additionally, dentist experience, diagnostic findings and other patient circumstances 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.

Federal Dental Services

Rank and Status of Dentists in the Uniformed Services and the Veterans Health Administration (Trans.2021:318)

Resolved, that flag rank(s) of dental officers should be protected and enhanced in all branches of the uniformed services, and their offices should have the appropriate status and funding to carry out their missions effectively, and be it further

Resolved, that the American Dental Association supports a 2-star equivalent rank or higher for the chief dental officers for the uniformed services and the Veterans Health Administration, and be it further

Resolved, that graduates of a two year comprehensive dental residency or a dental specialty residency recognized by the National Commission on Recognition of Dental Specialties should be awarded special pay while serving in the federal dental services.

Support for Deployed Dentists (Trans.2020:334)

Resolved, that the American Dental Association give its utmost support to its members who may be called to active duty, and be it further

Resolved, that the ADA encourages dentists to volunteer 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, and be it further

Resolved, that it is the ADA'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 deployed military dentists who are serving on active duty should be eligible to have their continuing education requirements waived, and be it further

Resolved, that dentists who reopen their practices following a period of military deployment should be exempt from having their unemployment insurance premiums increased or incurring any other financial penalties due to unemployed staff having drawn unemployment benefits during the period of office closure.

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.

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.

Federal Health Agencies

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; 2020:317)

Resolved, that the Association opposes any third-party contract provisions that establish limits on dentists' charges for services that are not "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 the carrier provides payment for the covered services under the patient's policy in an amount that reflects the costs of the services rendered by using the current year's averaged fee from similar geographic areas and adjusts such amounts every year to reflect inflation.

Statement on Reporting Fees on Dental Claims (Trans.2009:419)

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.

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 their 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 their 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; 2019:244*)

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; 2021:327*)

Resolved, that in order to ensure optimal fluoride intake, the American Dental Association supports actions by its members to educate their patients and communities 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, telephone number and website, and be it further

Resolved, that the American Dental Association urges its members and the public to refer to the International Bottled Water Association's "List of Brands Containing Fluoride," and be it further

Resolved, that the American Dental Association supports the inclusion of information on the effect of various home water treatment system's on water fluoride levels.

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.

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; 2021:323*)

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.

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

Engaging Community-Based Health Centers **(Trans.2023:XXX)**

Resolved, that the American Dental Association supports and encourages collaboration between organized dentistry and community-based health centers at all levels of the tripartite to improve the oral health of vulnerable, uninsured, underinsured and underserved communities, and be it further

Resolved, that the Association encourages member dentists to participate on community health center boards and constituent dental societies to consider health center dentist participation on their boards to foster collaboration to improve oral health, and be it further

Resolved, that Association encourages constituent dental societies to foster relationships with state and regional primary care associations to strengthen the oral health safety net, and be it further

Resolved, that the Association encourages community health center dental programs and dental practices to consider contractual relationships as allowed by federal regulations, to improve access to dental care for vulnerable, uninsured, underinsured and underserved communities.

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

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.

* 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."

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, caregivers 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 (CHIP) 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; 2019:298*)

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.

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.

Regular Comprehensive Policy Review (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; 2019:296)

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

Opposition to Unlicensed Dental or Dental Hygiene Practice (*Trans.2023:XXX*)

Resolved, that it is the position of the American Dental Association that no person should practice, attempt to practice, or offer to practice dentistry or dental hygiene without a proper license, and be it further

Resolved, that the designated state practice act enforcement authority should be expeditious in prosecuting individuals who are practicing dentistry or dental hygiene without a license, and be it further

Resolved, that individuals found to be practicing dentistry or dental hygiene without a proper license should be prosecuted to the fullest extent of the law.

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; 2019:266; 2024:XXX)**

Resolved, that it be ADA policy to support the implementation of standard precautions and infection control recommendations appropriate to the clinical setting, per Centers for Disease Control and Prevention guidance. This includes the 2003 [Guidelines for Infection Control in Dental Health Care Settings](#), 2016 Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care, and any Interim Guidance or published guideline updates from the Centers for Disease Control and Prevention (CDC), and be it further

Resolved, that the ADA urges practicing dentists, allied team members 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, and be it further

Resolved, that the appropriate agencies prioritize more environmentally sustainable infection control standards, balancing the need for asepsis with the impact on our environment.

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; 2023:XXX)

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 these programs be encouraged to collaborate on curricula including current prosthetic design and manufacturing trends and techniques.

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; 2019:280)

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 they are 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 their 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 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; 2021:320*)

Resolved, that the American Dental Association considers accommodating the language needs of English-limited patients to be a shared responsibility, which cannot be fairly visited upon any one segment of a community, and be it further

Resolved, that the ADA opposes 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.

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

Financing Oral Health Care for Adults Age 65 and Older (*Trans.2020:285*)

Resolved, that the American Dental Association recognizes that oral health care for adults age 65 and older depends on acceptable and sustainable financing of that care, and be it further

Resolved, that for the purpose of presenting potential legislation that includes dental benefits for adults age 65 and over in a tax payer-funded public program such as Medicaid, CHIP, privately administered Medicare or other federal or state programs, then the ADA shall support a program that:

- Covers individuals under 300% FPL
- Covers the range of services necessary to achieve and maintain oral health
- Is primarily funded by the federal government and not fully dependent upon state budgets
- Is adequately funded to support an annually reviewed reimbursement rate such that at least 50% of dentists within each geographic area receive their full fee to support access to care
- Includes minimal and reasonable administrative requirements
- Allows freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit

and be it further,

Resolved, that the appropriate agency urge passage of legislation to enable dental offices to offer in-office membership plans to support direct care for all seniors.

Oral Health Care for the Elderly (*Trans.2020:279*)

Resolved, that the American Dental Association supports the development of policy at the federal, state, and local levels that supports the fair, equitable, choice-driven provision of dental care to promote improved health and well-being in elderly patients.

Support for the Children's Health Insurance Program (*Trans.2020:339*)

Support for the Children's Health Insurance Program

Resolved, that that the American Dental Association supports the Children's Health Insurance Program (CHIP), and be it further

Resolved, that funds dedicated to the program should be used to provide medical and dental care to children with family income less than or equal to 200 percent of the federal poverty level before any expansion to children in families above that level, and be it further

Resolved, that decisions to cover children beyond 200 percent of the federal poverty level continue to be made on a state-by-state basis.

Dental Benefits in a Child Support Order (*Trans.2018:362; 2024:XXX*)

Resolved, that it is the position of the American Dental Association that dental care support should be required in child custody orders as a child support obligation, and be it further

Resolved, that the ADA encourage state and federal efforts to require dental care support in child custody orders as a child support obligation.

Freedom of Choice in Publicly Funded Aid Programs (*Trans.2006:344; 2021:320*)

Resolved, that any licensed dentist should be able to 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; 2019:252*)

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; 2021:284)

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 or recouping payment when a payment made in error has been made on behalf of a different patient covered by the same third-party payer or because of an alleged overpayment to a different dentist, and be it further.

Resolved, that dental plans should not retroactively deny, adjust, or seek recoupment or refund of a paid claim for dental care expenses submitted by a provider for any reason, other than fraud or for duplicate payments on claims received from the same plan for the same service from a provider, after the expiration of six months from the date that the initial claim was paid. The plan must provide information about why a refund is due, including the name of the patient, date of service and service provided along with the reason for the overpayment and allow the provider six months before the refund must be paid. The provider should be allowed 30 days to contest the refund request, and be it further

Resolved, that dental plans, representing self-funded and fully-insured plans, be urged to adopt these guidelines as an industry-wide standard for alleged overpayment of benefits to dentists.

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 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.

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 their 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; 2019:255)

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.

Use of Expert Witnesses in Liability Cases (Trans.1986:531; 2021:319)

Resolved, that plaintiffs and their attorneys in professional liability actions should be required 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 expert witnesses in court proceedings should be required 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 court rules should require that juries be instructed on the availability of alternative treatments and the role of patients in their own care, as appropriate.

Suggested Dental Practice Acts (Trans.1978:529; 2021:321)

Resolved, that state dental practice acts should be consistent with American Dental Association policies, as appropriate and feasible.

Legislative Assistance by the Association (Trans.1977:948; 1986:530; 2019:310)

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.

State Board Support for CODA as Responsible to Accredite 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; 2020:305*)

Resolved, that the American Dental Association opposes any administrative practice or financial incentive that is utilized by benefit managers and/or administrators of dental benefit programs 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 explanation of benefits (EOB) statement is not the appropriate document to promote the use of a dentist other than the treating dentist.

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; 2023:XXX*)

The American Dental 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. The dentist should provide care, in consultation with the patient, that is evidence-based or scientifically sound and necessary for the diagnosis and treatment of disease to promote, preserve and restore oral health form and function.
2. **Benefit Plan Design.** Benefit plan design is managed by plan purchasers. Benefit plan design must be evidence-based or scientifically sound and promote, preserve and restore oral health form and function.

Statement on Utilization Management

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 should be based on scientifically sound, clinically relevant and reliable research; plan coverage should be designed and maintained through evaluation and analysis of data; education and information about different types of procedures and their outcomes should be provided; patients should have the opportunity to make treatment decisions based on a clear understanding of available options.
- **Plan Purchasers**—should provide constant feedback regarding the effectiveness of their plans, thus ensuring a meaningful benefit for their employees; should request data regarding the plan's loss ratio; should communicate with the Association regarding advances in procedures and technology for consideration in updating plan coverage.
- **Dental Profession**—should have the opportunity for involvement in the process of plan design to ensure appropriate treatment based on parameters of care developed and maintained by the profession.

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."

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 their 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.
- 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.
 - Protocol for review of emergency care must be clearly defined.
 - Ongoing inpatient stays may be reviewed, but routine daily reviews should not be conducted on all such stays.
 - 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.
 - 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:
- kept confidential in accordance with applicable federal and state laws;
 - used solely for the purposes of utilization review, quality assurance, discharge planning and catastrophic case management; and
 - 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.

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 their 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 their 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

Comprehensive Statement on Dental Medicaid Programs (*Trans.2023:XXX*)

Comprehensive Statement on Dental Medicaid Programs

Medicaid is a taxpayer funded public health insurance program based on federal-state partnership. Medicaid covers low-income people including families and children, pregnant women, the elderly, and people with disabilities. Each state and territory determine eligibility criteria and program structure to support delivery of care to underserved populations.

General Program Considerations: While children covered by Medicaid programs have access to a mandatory Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, the ADA strongly supports a comprehensive adult dental benefit for the Medicaid-eligible population in an adequately funded program and encourages the federal and state governments to institute an adult dental benefit in Medicaid. The ADA believes that the federal Medicaid match for children and adult dental care should be enhanced to 90/10 or better (FMAP).

Medicaid Program Structure: The ADA believes that successful Medicaid programs are those that are supported by a strong state level multi-stakeholder Medicaid Dental Advisory Committee that can provide guidance and analysis of program success, support program integrity and participate in program improvement initiatives. Such a committee should also be supported by a full-time Chief Dental Medicaid Director.

In addition to a Medicaid Dental Advisory Committee, the ADA believes that state-level peer-review committees with dentists licensed in the state in collaboration with local dental public health professionals, can support Medicaid programs in assessing clinical issues related to administering the Medicaid benefit.

The ADA encourages state dental associations to remain a significant voice within their state Medicaid programs and in turn should encourage their Medicaid programs to share program decisions which impact access, quality of care and availability of specialty care. The ADA encourages all state dental associations to actively participate in the establishment or continuation of an existing Medicaid Dental Advisory Committee which includes representation from dental public health and dental education professionals, that is recognized

by the state Medicaid agency as the professional body to provide recommendations on Medicaid dental issues.

The ADA strongly believes that every patient should have a dental home and a managed care plan should never be addressed as the “dental home” for a Medicaid enrolled beneficiary¹.

The ADA also supports the rights and freedom of patients to choose their own dentist, as well as their own Medicaid Managed Care Plan².

Provider Participation: The ADA encourages dentists to participate in the Medicaid program. The ADA encourages dentists to refer patients seeking care, to dentists enrolled in Medicaid in those instances wherein they are unable to accommodate them. The ADA supports a dentist’s autonomy to choose their level of participation in Medicaid programs.

Network adequacy for Medicaid programs is dependent on the adequate number and diversity of providers to address the disease burden and promote prevention. The ADA believes that Medicaid programs should establish policies that incentivizes any dentist willing to provide a dental home for children from birth to age 5. Dentists should be allowed to claim a tax credit for the first \$10,000 of services (based on the most recent Code on Dental Procedures and Nomenclature (CDT) codes) and credited at a rate consistent with the dentists’ full fees for that region or state.

Opportunities for early-career dentists to engage with state Medicaid programs can be enhanced through loan repayment programs for dentists who are willing to treat a disproportionate number of Medicaid beneficiaries. Such loan repayment programs should be commensurable with the level of Medicaid participation. The ADA also supports additional funding such as enhanced reimbursement to dental schools that treat Medicaid beneficiaries.

Annually reviewed reimbursement, aligned with current Fair Health provider charges data, is necessary to assure adequate compensation such that the majority of dentists in a region would be encouraged/motivated to participate in the program.

Transparency & Reporting: The ADA believes that transparency and standardization of reporting data in all Medicaid programs relating to access to care, patient / provider satisfaction rates, and network adequacy is essential for the public, state dental

¹ *Current Policies*, Definition of Dental Home (*Trans.2005:322; 2010:548; 2014:505*)

² *Current Policies*, Government-Sponsored Dental Programs (*Trans.1998:705*)

associations, researchers and other stakeholders to effectively assess the success of the Medicaid program regardless of whether the program is administered directly by the state or through managed care contracts. Data should be publicly available on an annual basis. When the Medicaid benefit is administered through managed care contracts, information regarding medical/dental loss ratio should also be made publicly available.

Administrative Practices: To better ensure patient safety and access to care, the ADA believes that Medicaid programs should:

- Based on provider experience, use a single credentialing system across all managed care plans within Medicaid (state specific) to decrease administrative burdens, such that providers who are willing to participate can join the program in a timely manner thus ensuring an adequate network.
- Establish uniform processes to transfer prior authorizations between managed care plans.
- Support coverage for caries risk assessment, case management, transportation, language services, appointment compliance, desensitization visits for patients with disabilities and coordination of other medical appointments.
- Support coverage for preventive services related to tobacco cessation, nutritional counseling, home care practices, and any other services that improve overall health outcomes.
- Conduct any necessary audits through 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.
- Ensure that each managed care entity establishes a designated Provider Advocate position to conduct educational sessions for participating providers and provide ongoing technical and navigational support.
- Address case management for Special Needs patients through enhanced payment schedules.

The ADA encourages state dental associations, whenever possible, to actively participate in any request for information, request for proposals, or contract development processes using resources developed by the Association to ensure appropriate administration of Medicaid managed care.

Payment for Services for Individuals with Medical Conditions in Publicly Funded Programs (Trans.2023:XXX)

Payment for Services for Individuals with Medical Conditions in Publicly Funded Programs

Resolved, that the American Dental Association support payment for dental services, under Medicare, when the dental procedure is intrinsically linked and integral to the health outcomes of the covered medical procedure, and be it further

Resolved, that if legislators or regulators seek to support payment for dental care for adults over age 65 for dental services associated with otherwise covered medical procedures in any taxpayer funded public program, then the ADA may support a program that:

- provides a dental benefit for individuals when systematic peer reviewed current scientific evidence as assessed by the ADA supports improved health outcomes for that covered medical procedure
- covers the range of services on both in-patient and out-patient basis necessary to achieve the desired improvement in health outcomes
- is adequately funded to support an annually reviewed reimbursement rate such that 80% of dentists within each geographic area receive their full fee (80th percentile) to support access to care
- includes minimal and reasonable administrative requirements including the use of the CDT Code for reporting dental procedures and use of the dental claim form (837D electronic standard or the ADA paper claim form)
- allows freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit

and be it further

Resolved, that the ADA emphasize that dental offices are different from medical offices given the equipment and overhead expenses for procedures routinely performed in every dental office and the current Relative Value Unit (RVU) system in medicine is not applicable to dentistry.

Medicaid Dental Loss Ratios: Accountability and Oversight (Trans.2022:369)

Resolved, that the American Dental Association recommends that U.S. Centers for Medicare & Medicaid Services (CMS) publish a state by state assessment of managed care organizations with the percentage of allocated Medicaid funding that is being spent on dental services, and be it further

Resolved, that the American Dental Association recommends that CMS require each state Medicaid agency to monitor the dental loss ratio among their

contractors.

**Guidelines for Medicaid Dental Reviews
(Trans.2020:335)**

Resolved, that the American Dental Association encourages state dental associations to work with their respective state Medicaid agency to adopt such guidelines for Medicaid Dental Reviews and/or in States that use a managed care model to incorporate such guidelines into their request for proposal (RFP) to third-party payers interested in managing the dental benefit:

Guidelines for Medicaid Dental Reviews

The Auditor/Reviewer shall demonstrate adherence, not only to individual State Board regulations and requirements, but also an understanding, acceptance and adherence to Medicaid State guidelines and specific specialty guidelines as applicable. In addition, the Auditor/Reviewer shall demonstrate experience in treatment planning specific patient demographic groups and/or unique care delivery sites that influence treatment planning being reviewed.

It is recommended that entities, which conduct Medicaid Dental reviews and audits, utilize auditors and reviewers who:

1. Have a current active license to practice dentistry in the State where audited treatment has been rendered and be available to present their findings.
2. Are of the same specialty (or equivalent education) as the dentist being audited.
3. Document and reference the guidelines of an appropriate dental or specialty organization as the basis for their findings, including the definition of *Medical Necessity* being used within the review.
4. Have a history of treating Medicaid recipients in the state in which the audited dentist practices.
5. Have experience treating patients in a similar care delivery setting as the dentist being audited, such as a hospital, surgery center or school-based setting, especially if a significant portion of the audit targets such venues.

In addition, these entities shall be expected to conduct the review and audit in an efficient and expeditious manner, including:

1. Stating a reasonable period of time in which an audit can proceed before dismissal can be sought.
2. Defining the reasonable use of extrapolation in the initial audit request.

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.

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.

Membership

Policy on Diversity and Inclusion (Trans.2021:277)

The ADA is committed to a culture of diversity and inclusion to foster a safe and equitable environment for its membership. In this environment, representation matters and every member is provided intentional opportunities to make meaningful contributions. Diverse viewpoints and needs are heard, valued and respected.

The ADA embraces diversity and inclusion to drive innovation and growth, ensure a relevant and sustainable organization and deliver purposeful value to members, prospective members, and stakeholders. The ADA's commitment to diversity and inclusion will further advance the dental profession, improve the oral health of the public, and achieve optimal health for all.

ADA Member Conduct Policy (Trans.2011:530; 2020:335; 2024:XXX)

1. Members' discussions, activities, or interactions that refer or relate to, reflect on or represent dentist(s) or the profession of dentistry, should be respectful and free of demeaning, derogatory, profane, offensive or defamatory language.
2. Members, at meetings of the American Dental Association and constituent and component society meetings, and at all other times when serving in the capacity of an ADA, constituent or component society representative, will act in good faith, with honesty and integrity, and conduct themselves in a professional and respectful manner.
3. Members are encouraged to foster an inclusive environment that enhances professional relationships.
4. Members should be courteous, professional, and respectful of the practice choices of their colleagues when discussing or communicating about dental practice modalities.
5. Members should abide by and respect the decisions and policies of the Association and the constituent and component dental societies. Any criticism or challenges to existing policies or decisions shall be undertaken in a professional manner.
6. Members have an obligation to be informed about and use Association and constituent and component dental society policies for communication and dispute resolution.
7. 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.
8. Members must respect and protect the intellectual property rights of the Association and the

constituent and component dental societies, including any trademarks, logos, and copyrights.

9. Members must not use Association or constituent or component dental society membership directories, on-line member listings, or attendee records from 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.
10. Members must treat all confidential information furnished by the Association and the constituent and component dental societies as such and must not reproduce materials without written approval.
11. Members must not violate the attorney-client privilege or the confidentiality of executive sessions conducted at any level within the Association.
12. Members must fully disclose conflicts, or potential conflicts, of interest and make every effort to avoid the appearance of conflicts of interest.

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.

Two-Year Recent Graduate Reduced Dues Program (Trans.2008:482; 2021:277)

Resolved, that the ADA urges constituent and component societies to adopt the ADA two-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 their 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.

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; 2023:XXX)

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 ensure that a nonmember cannot utilize ADA member benefits to imply membership and/or promote their practice to the public, and be it further

Resolved, that the member-nonmember price differential for ADA products and services should demonstrate and highlight the value of ADA membership.

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; 2023:XXX*)

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 and component societies to promote tripartite membership to ADA direct member dentists consistent with the ADA *Bylaws*.

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.

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.

National Practitioner Data Bank

National Practitioner Data Bank Statute of Limitations (*Trans.2020:334*)

Resolved, that National Practitioner Data Bank malpractice payment entries involving dentists should be expunged after seven years, provided a further incident has not been reported.

National Practitioner Data Bank Self-Generated Inquiries (*Trans.1993:706; 2015:272; 2020:334*)

Resolved, that entities not otherwise authorized to query the National Practitioner Data Bank should be prohibited 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.

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.

Oral Health Literacy

Use of Health Literacy Principles for All Patients (*Trans.2016:322; 2021:327*)

Resolved, that ADA supports the continuing education of oral health professionals regarding 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; 2021:330*)

Resolved, that the Council on Advocacy for Access and Prevention work with the appropriate ADA agencies and national education organizations to increase the number of school districts requiring oral health education for K-12 students based on the 2016 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, private and charter elementary and secondary schools.

Communication and Dental Practice (*Trans.2008:454; 2013:342; 2021:326*)

Resolved, that the ADA affirms that clear, accurate and effective communication is an essential skill for patient-centered dental practice, and be it further
Resolved, that this communication be delivered in a culturally competent manner.

Limited Oral Health Literacy Skills and Understanding in Adults (*Trans.2006:317; 2013:342; 2021:330*)

Resolved, that the ADA recognizes a lack of health literacy as a significant barrier to effective prevention, diagnosis and treatment of oral disease, and be it further

Resolved, that dental offices encourage staff training in the principles of health literacy to improve patient health outcomes.

Encouraging the Development of Oral Health Literacy Continuing Education Programs (*Trans.2006:316; 2021:326*)

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 in a culturally-competent, plain language, accurate manner with all patients.

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,
Tooth Gems/Jewelry and Tongue Splitting**
(*Trans.*1998:743; 2000:481; 2004:309; 2012:469;
2016:300; 2021:299)

Resolved, that the American Dental Association advises against the practices of cosmetic intraoral/perioral piercing, tooth gems/jewelry and tongue splitting, due to the increased risk of negative health outcomes.

Patient Health Information

Patient Rights and Responsibilities (*Trans.2009:477; 2024:XXX*)

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 patient centered care.

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 5-1 states: “The dental school must have a published policy addressing the meaning of and commitment to patient-centered care and distribute the written policy to each student, faculty, staff and patient.” 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.*
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, revised October 2024

Confidentiality and Privacy Regarding Health Information (Trans.1999:951; 2000:507; 2021:321)

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

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.*

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.

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; 2019:247)

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; 2019:251*)

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.

Supporting Dentists in All Practice Modalities (*Trans.1994:637; 2019:252; 2024:XXX*)

Resolved, that the American Dental Association advocates for the profession of dentistry, striving for a culture of inclusion and belonging for every dentist in each stage of their career and in all practice modalities and settings, and be it further

Resolved, that the ADA supports the ability of dentists to freely choose a practice modality that best suits their professional and personal preferences and that the ADA advocates that all dental settings should provide the ability for independent clinical judgement, preserve the doctor patient relationship, and uphold the ADA's established ethical standards, and be it further

Resolved, that the ADA encourages state and local dental societies to be inclusive of and build strategic engagement with dentists in all practice modalities.

* 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) Education and Collaboration (Trans.2023:XXX)

Resolved, that the ADA encourages education of the dental profession at the state and local levels on the importance of preventing HPV cancers, and be it further
Resolved, that the ADA encourages collaboration with other health care organizations to support patient education on HPV prevention.

Vaccine Administration by Dentists (Trans.2020:306)

Resolved, that it is the position of the American Dental Association that dentists with the requisite knowledge and skills should be allowed to administer critical vaccines to prevent life or health-threatening conditions and protect the life and health of patients and staff at the point of care.

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; 2023:XXX; 2024:XXX)

Resolved, that the American Dental Association acknowledges that oral health depends on proper diet and nutrition, and it is beneficial for consumers to avoid a steady diet of ultra-processed foods—defined as industrial creations reformulated with little if any whole foods, often additives and containing large amounts of added sugar and salt—especially those containing added sugars—and low pH-level acids to help maintain optimal oral health, and be it further

Dentist's Role in Nutrition and Oral Health

Resolved, that the ADA encourages the dental professional community to pursue continuing education credit opportunities that highlight nutritional science and motivational counseling, so that they may empower their patients to adopt a healthy dietary pattern of consuming a balanced diet with little to no ultra-processed foods containing added sugar, and be it further
Resolved, that the ADA encourages the dental professional community to support their communities to:

- Promote widespread access to safe optimally fluoridated drinking water.
- Reduce the consumption of added sugar and sugar-sweetened beverages.
- Promote lifelong healthy behaviors, including appropriate oral hygiene measures, limiting consumption of ultra-processed foods containing added sugar, and seeing the dentist regularly.
- Reflect the link between oral health and overall health and well-being.
- Create environments where healthy foods are an attractive and affordable choice for all students.
- Oppose programs that promote or otherwise incentivize consumption of ultra-processed foods (e.g. pouring rights contracts, etc.)

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 the dental professional community 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 health care professionals, dietitians, social workers, community health workers, and other nutrition stakeholders to raise interprofessional awareness about the relationship between diet, nutrition, and oral health, and be it further

Resolved, that the ADA supports projects to educate the public to maintain a healthy diet and to reduce consumption of added sugar, and be it further

Resolved, that the ADA encourages constituent and component dental societies to work with state and local officials to ensure 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 collaboration with state and local officials to reduce consumption of ultra-processed foods, especially those containing added sugars, and promote nutritious and health diets in schools, and be it further.

Resolved, that the ADA supports the World Health Organization's 2015 Guideline on Sugar Intake for Adults and Children, and be it further

Resolved, that the ADA encourages collaboration between dental societies, local health departments, and community health centers to develop programs and initiatives that bring locally sourced nutritious foods to underserved communities, to food insecure individuals, and to local corner stores, and be it further

Resolved, that the ADA encourages collaboration with community stakeholders and state and local officials to develop alternative access points to healthy foods in underserved communities and FDA-designated food deserts, including the development of small footprint grocery stores, grocery coops, and community gardens,

and be it further

Government Affairs

Resolved, that the ADA should give priority to the following to advance 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, oral health associations with ultra-processed foods

and 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 to increase consumer awareness about the role ultra-processed foods play in maintaining optimal oral health, including 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.
6. Supporting legislative actions, and state or federal programs that aim to address food insecurity, reduce or eliminate food deserts, and improve transportation infrastructure in underserved communities.

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; 2019:277*)

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.

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; 2023:XXX)

Resolved, that the American Dental Association recognizes the preventive value of orofacial protectors including, but not limited to, mouthguards, helmets, and face shields, 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 organizations, sports conferences, sanctioning bodies, school federations and others to mandate the use of orofacial protectors to prevent or reduce injuries from sports, and be it further

Resolved, that the ADA supports dental benefit coverage by third party payors for orofacial protector services.

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.

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.

Public Health Emergencies and Declared Disasters

Temporary Expansion of Scope During Public Health Crisis (*Trans.2020:305*)

Resolved, that the ADA supports the utilization of dentists who choose to participate to increase medical capacity during declared local, state or federal public health emergencies to include:

1. Administering critical vaccines
2. Performing FDA-authorized diagnostic tests to screen patients for infectious diseases
3. Taking patient medical histories and triaging medical patients
4. Performing other ancillary medical procedures and activities, as requested by medical personnel, to expand the nation's surge capacity

and be it further

Resolved, that dentists should be granted immunity from personal liability and restrictions on the above listed services they provide for the duration of the emergency.

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 Responders During Public Health Emergencies (*Trans.2002:398; 2024:XXX*)

Resolved, that the American Dental Association supports the position that dentists should be granted immunity from personal liability for the services they provide when taking part in the medical response to a declared public health emergency, national disaster, or other mass casualty event, and be it further

Resolved, that a federal declaration of temporary liability protection should preempt state liability laws and dental practice acts.

Research

Advancing Equity in Dental Research Funding (*Trans.2022:356*)

Resolved, that the American Dental Association supports sustained, robust funding for basic, translational, and clinical oral and craniofacial health research to improve health outcomes in diverse populations across the lifespan, and be it further **Resolved**, that the ADA supports robust efforts to create a diverse, equitable and inclusive dental research workforce that reflects the diversity of the nation and embodies dentistry's values of diversity, equity and inclusion.

Scientific Assessment of Dental Restorative Materials (*Trans.2003:387; 2022:354*)

Resolved, that although the safety and efficacy of dental restorative materials has been extensively researched, the Association, consistent with its Research Priorities and evidence-based practice, will 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, policy makers, government agencies, and other communities of interest about the scientific methods used to assess the safety and efficacy of dental restorative materials, and be it further **Resolved**, that the Association 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.

Dental Research by Military Departments (*Trans.1970:451; 2016:316; 2021:318*)

Resolved, that military dental research is unique in that it focuses on the oral and craniofacial needs of active duty military personnel, such as:

- Improving dental readiness.
- Minimizing in-theater dental emergencies.
- Treating and ameliorating combat-related disfigurement and loss of facial function.

and be it further

Resolved, that each military branch should continue to support such research.

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.

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; 2022:357*)

Introduction

The Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists contain criteria that specialty applicants and the recognized specialty sponsoring organizations and certifying boards must meet in order to become and/or remain recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards (National Commission).

A specialty is a discipline of dentistry that has a separate, distinct and well-defined focus based on unique advanced knowledge, skills and training that has been formally recognized by the National Commission 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 in disciplines of dentistry in which advanced knowledge, skills and training are essential to maintain and restore oral health.

Not all disciplines in dentistry will satisfy the requirements for specialty recognition and there should be no expectation that all disciplines in dentistry will meet the Requirements for Recognition of Dental Specialties. Disciplines of dentistry that are not currently recognized as a specialty by the National Commission and believe they can meet all of the Requirements for Recognition of Dental Specialties should contact the National Commission for a formal Application for Specialty Recognition. When making decisions related to specialty recognition, the National Commission will only determine compliance with the criteria outlined in the Requirements for Recognition.

If a discipline of dentistry is granted specialty recognition by the National Commission, a national board for certifying diplomates in accordance with the "*Requirements for National Certifying Boards for Dental Specialists*" must be established and recognized by the National Commission as the national certifying board for the specialty.

Requirements for Recognition of Dental Specialties

A sponsoring organization seeking specialty recognition in a discipline of dentistry that is not currently recognized as a dental specialty must be able to provide documented evidence that the discipline satisfies all the Requirements for Recognition of Dental Specialties specified in this section. Specialty sponsoring organizations recognized by the National Commission must be able to show continued compliance

with the Requirements for Recognition of Dental Specialties specified in this section.

- (1) In order for a discipline of dentistry to become and/or remain recognized as a dental specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of the 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 have either completed an advanced education program that is a minimum of two (2) academic years in length accredited by the Commission on Dental Accreditation in the proposed or recognized specialty or have sufficient educational and/or practice experience in the specialty as deemed appropriate through written criteria established by the sponsoring organization and its certifying board; and (c) that demonstrates the ability to establish and maintain a certifying board, if the sponsoring organization is not recognized by the National Commission. The recognized specialty sponsoring organization must continue to have a recognized certifying board that continually meets the Requirements for Recognition of National Certifying Boards for Dental Specialists in order to remain recognized.
- (2) A proposed or recognized specialty must be a distinct and well-defined field that requires unique advanced knowledge, skills and training 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 practice of a proposed or recognized specialty requires advanced knowledge, skills and training that: (a) in their entirety, are separate and distinct from the knowledge, skills and training required to practice in any recognized dental specialty; and (b) cannot be accommodated through minimal modification of any of the recognized dental specialties.
- (4) A proposed or recognized specialty 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 the educational needs of the discipline at the predoctoral, postdoctoral and continuing education levels; (c) actively engages in research that establishes evidence-based validity of therapy used by practitioners in the proposed or recognized specialty; and (d) demonstrates a need for service that is not currently being met by general practitioners or any of the recognized dental specialties.

- (5) A proposed or recognized specialty must have a direct benefit/impact on clinical patient care and meet the needs of its patient population.
- (6) A proposed or recognized specialty must have formal advanced education programs accredited by the Commission on Dental Accreditation that are a minimum of two (2) academic years in length.

Requirements for National Certifying Boards for Dental Specialists

In order to become, and remain, eligible for recognition by the National Commission as a national certifying board for a dental specialty, the specialty must have a recognized sponsoring organization that meets all of the Requirements for Recognition of Dental Specialties. A close working relationship must be maintained between the recognized sponsoring organization and the certifying board. A certifying board seeking recognition must be able to provide documented evidence showing that it satisfies all the Requirements for Recognition of National Certifying Boards for Dental Specialists specified in this section.

Certifying boards recognized by the National Commission must be able to show continued compliance with all of the Requirements for Recognition of National Certifying Boards for Dental Specialists as specified in this section.

Organization of Boards

- (1) An applicant and a recognized certifying board must have no less than five (5) and no more than twelve (12) voting directors/officers designated on a rotation basis in accordance with a method approved by the National Commission. Although the National Commission does not recommend a single method for selecting directors/officers of boards, directors/officers may not serve for more than a total of nine (9) years. All voting directors/officers must be diplomates of that specific certifying board and the certifying board may establish additional criteria/qualifications if they so desire.
- (2) An applicant and a recognized certifying board must have a certification program that is comprehensive in scope and meets the needs of the diplomate practitioners in the recognized specialty and the profession and protects the public. Further, the certifying board must provide evidence of a close working relationship with a recognized specialty sponsoring organization that meets all of the Requirements for Recognition of Dental Specialties.
- (3) An applicant and a recognized certifying board must provide evidence of adequate financial viability to conduct its certification program.

- (4) An applicant and a recognized certifying board may outsource administrative duties to suitable external consultants and/or external agencies to assist in daily operations, and/or examination functions. If the certifying board does outsource administrative and/or examination functions, the certifying board must submit documentation describing the process. External and internal consultants who participate in the development and/or administration of certification examinations must be diplomates in the specialty that is being examined.

Operation of Boards

- (1) An applicant and a recognized certifying board must only certify qualified dentists as diplomates in the specialty area recognized by the National Commission. No more than one (1) certifying board will be recognized by the National Commission for the certification of diplomates in a recognized specialty area of practice.
- (2) An applicant and a recognized certifying board must give at least one (1) examination in each calendar year and must announce examination details at least six (6) months in advance of the examination. In extraordinary circumstances, recognized certifying boards may request a conditional waiver of exception from the National Commission.
- (3) An applicant and a recognized certifying board must maintain a current list of diplomates.
- (4) An applicant and a recognized certifying board must submit to the National Commission data relative to financial viability and operations, written examination procedures, candidate examination guidelines and procedures, certification and recertification examination content, test construction and evaluation, and the reporting of results. Examination procedures and results should follow the Standards for Educational and Psychological Testing, including validity and reliability evidence. A diplomate in good standing may, upon written request, obtain a copy of the annual examination technical and financial reports of the certifying board. The recognized certifying boards will submit the required documentation on a cycle established by the National Commission.
- (5) An applicant and a recognized certifying board must require diplomates to engage in lifelong learning and shall encourage continuous quality improvement.
- (6) An applicant and a recognized certifying board must provide to the National Commission evidence of examination and certification of a significant number of additional dentists in order to warrant approval of and continued recognition by the

National Commission. The recognized certifying boards will submit the required documentation on a cycle established by the National Commission.

- (7) An applicant and a recognized certifying board must bear sole authority and responsibility for conducting the certification programs, the evaluation of the qualifications and competence of those certified as diplomates, and the issuance of certificates.

Certification Requirements

- (1) An applicant and a recognized certifying board must require, for eligibility for certification as a diplomate, the successful completion of an advanced education program that is two (2) or more academic years in length accredited by the Commission on Dental Accreditation

Although full-time, continual attendance in a Commission on Dental Accreditation accredited advanced education program is desirable, the period of advanced education need not be continuous, nor completed within successive calendar years. An advanced educational program equivalent to two (2) or more 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 (4) calendar years, may be considered acceptable in satisfying this requirement. Short continuation, refresher courses (educational experience only obtained through continuing education) and teaching experience in a specialty department in a dental education facility will not be accepted in meeting any portion of this requirement.

A certifying board may establish an exception (alternative pathway) to the qualification requirement of completion of an advanced education program that is two (2) or more academic years in length accredited by the Commission on Dental Accreditation for the unique candidate who can demonstrate comparable educational and/or training requirements to the satisfaction of the certifying board. A certifying board must submit a separate petition to the National Commission for permission to establish and/or revise policy on alternative pathways.

- (2) An applicant and a recognized certifying board must establish minimum requirements for years of practice in the area for which certificates are granted. The years of advanced education in the discipline specific specialty may be accepted toward fulfillment of this requirement.

- (3) An applicant and a recognized certifying board, in cooperation with their recognized specialty

sponsoring organization, must prepare and publicize joint recommendations on the Commission on Dental Accreditation educational standards for the advanced education programs for that specialty.

Substance Use Disorders

ADA Policy on Opioid Prescribing (*Trans.2018:310*)

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*)

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*)

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*)

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*)

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 for the treatment of chemical dependency (including alcoholism)

* Note: Editorially corrected.

Taxation

Advocacy for Tax Policy Advantageous to the Practice of Dentistry (*Trans.2022:369*)

Resolved, that the American Dental Association oppose tax policies that would unduly burden the practice of dentistry, and support tax policies that would benefit dentists.

Retirement Account Distributions for Educational Expenses (*Trans.2022:341*)

Resolved, that the American Dental Association supports allowing early withdrawals from tax-favored retirement savings accounts to be exempt from taxes and/or penalties when the funds are used to pay for an individual's dental education.

Tax Treatment of Employer-Paid Fringe Health Benefits (*Trans.2019:298*)

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.2019:298*)

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: 298*)

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 their dependents should be tax deductible without regard to adjusted gross income.

Teledentistry

Comprehensive ADA Policy Statement on Teledentistry (Trans.2015:244; 2020:314; 2021:272)

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:

- Synchronous (live video): Live, two-way interaction between a person (patient, caregiver, or provider) and an oral health care practitioner using audiovisual telecommunications technology.
- Asynchronous (store and forward): 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: While in-person (face to face) examination has been historically the most direct way to provide care, advances in technology have expanded the options for dentists to communicate with patients and with remotely located licensed dental team members. The ADA believes that examinations performed using teledentistry can be an effective way to extend the reach of dental professionals, increasing access to care by reducing the effect of distance barriers to care. Teledentistry has the capability to expand the reach of a dental home to provide needed dental care to a population within reasonable geographic distances and varied locations where the services are rendered.

In order to achieve this goal, services delivered via teledentistry must be consistent with how they would be delivered in-person. Examinations and subsequent interventions performed using teledentistry must be based on the same level of information that would be available in an in-person (face to face) environment, and it is the legal responsibility of the dentist to ensure that all records collected are sufficient for the dentist to make a diagnosis and treatment plan. The treatment of patients who receive services via teledentistry must be properly documented and should include providing the patient with a summary of services. A dentist who uses teledentistry shall have adequate knowledge of the nature and availability of local dental resources to provide appropriate follow-up care to a patient following a teledentistry encounter. A dentist shall refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in case of emergency.

Insurer reimbursement of services provided must be made at the same rate that it would be made for the services when provided in person, including reimbursement for the teledentistry codes as appropriate.

Patients' Rights: Dental patients whose care is rendered or coordinated using teledentistry modalities have the right to expect:

1. That any dentist delivering, directing or supervising services to a patient of record using teledentistry technologies will be licensed in a state or other territory or jurisdiction of the United States or be providing these services as otherwise authorized by the dental board of that state, territory or jurisdiction.
2. That any dentist delivering, directing or supervising services to a new patient using teledentistry technologies will be licensed in the state or other territory or jurisdiction of the United States where the patient receives the services.
3. Access to the name, practice address, telephone number, emergency contact information, and email address of the virtual practice. Access to the names, licensure information, and board certification qualifications of all oral health care practitioners who provide care via teledentistry in the practice. Prior to the virtual visit, the patient should be informed of the name, licensure information, and qualification of the oral healthcare practitioners conducting the visit and virtual care.

4. That the delivery of services through teledentistry technologies will follow evidence-based practice guidelines, to the degree they are available, consistent with accepted standards of care as a means of ensuring patient safety, quality of care and positive health outcomes.
5. That patients 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.
6. 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.
7. That the provision of services using teledentistry technologies will be properly documented, that the records and documentation collected will be provided to the patient upon request and that the limitations (if any) of teledentistry encounters should be disclosed to a patient prior to the initiation of any teledentistry encounter.
8. That any patient has the right to discuss their treatment with any third party. A patient should not be required to agree to any provision that restricts the patient's freedom to bring any concerns about their dental treatment to the attention of an entity of the patient's choosing.
9. 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.
10. 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 (face to face) services.
11. That the dentist shall determine the delivery of services using teledentistry technologies and all services 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 (face to face) 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, territory or jurisdiction of the United States 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 who deliver services through teledentistry modalities must be licensed or credentialed in accordance with the laws of the state, territory or jurisdiction in which the dentist practices. Allied dental personnel who deliver services through teledentistry modalities must be licensed or credentialed in accordance with the laws of the state, territory or other jurisdiction in which the patient receives service. The delivery of services via teledentistry must comply with the scope of practice laws, regulations or rules applicable to the encounter. Teledentistry cannot be used to expand the scope of practice or change permissible duties of allied dental personnel. 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 (face to face) encounters. Coverage for services delivered via teledentistry modalities will be at the same levels as those provided for services provided through in-person (face to face) 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 as indicated above.

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

Tobacco Use, Vaping and Nicotine Delivery Products (*Trans.2020:336; 2024:XXX*)

Tobacco Use, Vaping, and Nicotine Delivery Products

Dentist's Role in Preventing Tobacco Use

Resolved, that dentists should be fully aware of the oral and maxillofacial health risks that are causally associated with tobacco use, including higher rates of tooth decay, receding gums, periodontal disease, mucosal lesions, bone damage, tooth loss, jaw bone loss and more, and be it further

Resolved, that dentists should routinely screen patients for tobacco and non-tobacco nicotine use and provide clinical preventive services, such as in-office cessation counseling, to prevent first-time tobacco use and encourage current users to quit, and be it further

Resolved, that the dentists and health organizations should provide educational materials to help prevent first-time use and encourage current users to quit, and be it further

Resolved, that these educational materials should be developed or provided by credible and trustworthy sources with no ties to the tobacco industry or its affiliates, and be it further

Cessation Counseling and Nicotine Replacement Therapies

Resolved, that aside from the intended use of approved tobacco cessation products and nicotine replacement therapies, the American Dental Association discourages the use of all nicotine products, and be it further

Resolved, that dentists should be fully informed about nicotine cessation interventions and routinely apply those techniques to help patients stop using tobacco, and be it further

Resolved, that dentists should obtain an adequate health history and when necessary, inform the patient about the Quitline to receive additional resources for tobacco cessation, and be it further

Resolved, that third-party payers should cover professionally administered cessation products and services (e.g., cessation counseling, prescription medications, etc.) as an essential plan benefit, and be it further

Modified Risk Tobacco Products

Resolved, that the American Dental Association does not consider the concept of “modified risk”—which is allowing some tobacco and other nicotine products (e.g., snus, electronic nicotine delivery systems) to be marketed as having a reduced or modified health risk

compared to others (e.g., cigarettes)—to be a viable public health strategy to reduce the death and disease associated with tobacco use, and be it further

Resolved, that modified risk tobacco product (MRTP) applications should include extensive data examining the comparative impact on oral and maxillofacial health, both to the individual and the population as a whole, and the data should be made publicly available, and be it further

Regulation of Tobacco Products, Vaping Devices, and Other Nicotine Delivery Systems

Resolved, that the American Dental Association recognizes nicotine as an addictive chemical and supports its regulation as a controlled substance, and be it further

Resolved, that the ADA supports state and federal authority to investigate and strictly regulate nicotine and nicotine-containing products, including those made or derived from tobacco, and be it further

Resolved, that these nicotine-containing products include, but are not limited to:

- Cigarettes.
- Cigars (both premium and non-premium).
- Pipe tobacco.
- Hookah (also called waterpipe tobacco).
- Roll-your-own tobacco.
- Smokeless tobacco (e.g., chewing tobacco, moist snuff, snus, etc.).
- Dissolvables (e.g., nicotine lozenges, strips, sticks, etc.).
- Nicotine gels (absorbed through the skin).
- Electronic nicotine delivery systems (e.g., e-cigarettes, e-hookah, e-cigars, vape pens, advanced refillable personal vaporizers, e-pipes, etc.).

and be it further

Resolved, that the ADA supports strict regulation of these and other nicotine-containing products by (but without being limited to):

- Prohibiting product sales in all venues, including through vending machines and the internet.
- Levying significant taxes on these products.
- Setting age restrictions to purchase and receive these products.
- Requiring oral health warning statements, graphic images and ingredient disclosures on product packaging.
- Restricting the addition of added flavors (including menthol) and other ingredients and ingredient levels (including nicotine).

- Regulating second hand exposure to environmental smoke and vapor.
- Banning all forms of advertising and marketing (including bans on free sampling, product giveaways, promotional items, event sponsorships, etc.).
- Imposing licensure requirements for product wholesalers and retailers.
- Prohibiting the use of these products on and around public and private property, including government buildings and school campuses.

Tort Reform

Limits on Non-Economic Damages (*Trans.2020:338*)

Resolved, that medical liability reform legislation should not override state limits on non-economic damages.

Principles for Tort Reform (*Trans.2020:345*)

Resolved, that the American Dental Association supports tort reform legislation that includes, but is not limited to:

1. mandatory periodic payments of substantial awards for damages;
2. a ceiling on non-economic damages;
3. mandatory offsets of awards for collateral sources of recovery;
4. limits on attorneys' contingency fees;
5. a statute of limitations on health care-related injuries; and
6. state duties concerning alternative methods of resolving disputes.

Professional Liability Insurance Legislation (*Trans.1984:548; 2021:319*)

Resolved, that the American Dental Association monitor and constituent dental societies be urged to monitor federal and state legislation for challenges to tort reform that would result in liability insurance premiums rising and leading to increased health care costs for patients, and be it further

Resolved, that the ADA should stand ready to aid and assist constituent dental societies experiencing a crisis of rising malpractice insurance premiums due to tort reform challenges.

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.

Workforce

Dental Students and Residents as Dental Hygienists (Trans.2024:XXX)

Resolved, that states should be encouraged to adopt policies allowing active dental students and residents who have completed all of their required hygiene competencies to practice dental hygiene or to practice as other dentist-supervised allied dental team members, subject to state licensure requirements.

Expedited Residency for Foreign Born, United States-Trained Dental Professionals (Trans.2024:XXX)

Resolved, that the American Dental Association supports expedited United States residency status for non-resident, United States-trained dentists, dental hygienists, and dental assistants, who commit to practicing in underserved areas for a period of at least three years.

Internationally Trained Dentists as Dental Hygienists (Trans.2024:XXX)

Resolved, that states should be encouraged to adopt policies allowing dentists who have completed a dental education program, outside the United States, subject to state licensing board requirements, to obtain a license to practice dental hygiene.

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.

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.

Determining Health Professional Shortage Areas (*Trans.1984:538; 1996:681; 2021:320; 2023:XXX*)

Resolved, that the American Dental Association supports and encourages the accurate, timely, and objective determination of federal and state dental health professional shortage area designations, and be it further

Resolved, that the ADA opposes using dentist-to-population ratios as the exclusive measure for designating dental health professional shortage areas or evaluating or recommending programs for dental education or dental care.