AGD House of Delegates (HOD) Policy Manual

HOD 2016

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1
CURRENT POLICIES

1 # Public Affairs Policies

1 Advocacy Policies
2
3 **Accreditation and Recognition of Non-Specialty Areas**
4

2005:5-H-7

"Resolved, that the AGD adopt the following position regarding the accreditation and recognition of non-specialty areas of general dentistry:

AGD Position on
the Accreditation and Recognition of Non-Specialty Areas

The AGD supports excellence in general dentistry and the pursuit of professional development through lifelong learning. Advanced education should meet independent standards so that the education is valid and provides the framework for excellent patient care. General dentistry is not just treating patients – it is being the educated gatekeeper of oral health so that the patient is provided with all the available options for treatment. The knowledge of when to treat and when to refer, and to whom, is the responsibility of the general dentist**.** The general dentist's emphasis is on primary care. They guide patients to efficient, cost effective treatment while maintaining continuity of care.

AGD supports the responsibility of the Commission on Dental Accreditation (CDA) to develop accreditation standards for all formal education programs in dentistry, whether they are in an ADA-recognized specialty, in general dentistry or in a non-specialty area of general dentistry**.** This is not changing the scope of practice for general dentists and dental specialists, nor is it adding new specialties. If non-specialty areas that provide formal advanced education can seek accreditation then the public will benefit.

The general dentist is the coordinator of care and as such should be able to inform the patient of all available treatment options. The general dentist should have access to education in all areas of dentistry, including advanced education programs and continuing dental education.

The specialist is a partner in dental treatment that is dependent upon patient referral from a general dentist. If general dentists have had additional education and training they are able to provide better patient care, treatment planning and know better when to refer to a specialist or another general dentist. This will strengthen the profession.

It is not as important an issue that the public understand the scope of practice between practitioners as it is that they understand how oral health affects their overall health. Clear messages about why it is important to see the general dentist twice a year would be powerful messages to the majority of the public who are interested in their health. Whether the public sees a

specialist or a general dentist should be on the recommendation of their general dentist

The ADA is uniquely poised to promote the image of modern dentistry to the public. It is not the role of the ADA to make patients aware of how to select a specialist – that is the role of the referring general dentist. The ADA should focus on getting the public to the dentist and in working within the legislative arena to see that access to care is improved.

As CDA accredits advanced education programs in general dentistry, the ADA should consider mechanisms for recognizing board certification in general dentistry areas, including the American Board of General Dentistry."

1
2 **Advertising of Credentials**
3
4 Advertising of Credentials
5

2008:314R-H-7 "Resolved, that the AGD adopt *Announcement of Credentials to the Public: A Position Paper* as its policy on the announcement of its FAGD and MAGD credentials."

6
7 **Advocacy Fund**
8

2009:315R-H-7 "Resolved, that the AGD create an Advocacy Fund."

9
10 **American Dental Association**
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12 Advertising campaign, no AGD position on
13

98:19-H-7 "Resolved, that the AGD take no formal position on the ADA's institutional advertising campaign and accompanying assessment."

14
15 Requirement by AGD for membership in
16

79:15-H-6
REVISED
HOD 7/99

"Resolved, that it shall continue to be AGD policy to encourage membership in the American Dental Association, the Canadian Dental Association, or the National Dental Association."

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2
Anesthesiology
3
4 Cost of providing benefit
5

2002:29-H-7 “Resolved, that the Academy of General Dentistry believes patients with physical, developmental, emotional, or medically compromising conditions may require sedation/general anesthesia in private office, hospital, or surgical center settings for the safe and effective treatment of dental disease and/or injury, and be it further

6 Resolved, that sedation and/or general anesthesia and related facility costs
7 for the treatment of dental disease and/or injury in these patients should be
8 a covered benefit in all group medical benefit policies and Medicaid.”
9
10 Training availability
11

90:54-H-7 "Resolved, that the Academy of General Dentistry work with the American Dental Association and the American Dental Education Association to recommend that dental schools and hospital-affiliated teaching institutions establish anesthesiology programs so that dentists seeking in-depth education in anesthesiology will have such training available."

12

94:14.2-H-7 "Resolved, that educational opportunities be available so that general dentists will have adequate opportunity for training in dental anesthesiology in order to provide optimum pain and anxiety control for the public."

13
14
Annual Meeting
15
16 ADEA, report to House by Legislative and Governmental Affairs Council
17

94:22.2-H-7 "Resolved, that the Legislative and Governmental Affairs Council annually report to the Academy of General Dentistry's House of Delegates on the activities of dental schools and other organizations as they relate to the political concerns of general dentistry."

18
19
Contracts
20 Contract analysis service
21

2008:110-H-7 “Resolved, that Policy 88:47-H-7 be amended so that it reads:

“Resolved, that the Academy of General Dentistry offer to its members a contract analysis service, and be it further

Resolved, that members be encouraged to seek the advice of their own attorney before deciding to sign a contract, and be it further

Resolved, that the Dental Practice Council develop means to educate

Academy of General Dentistry members about the ramifications of provider contracts."

Dental Auxiliaries

Advanced Dental hygiene Practitioner Position Statement

2008:322-H-7 (RE-AFFIRMED 2010:307-H-7) "Resolved, that the AGD adopt *the Position Statement on the Advanced Dental Hygiene Practitioner (ADHP) Concept*."

Training, education, and utilization of

2010:305-H-7 "Resolved, that HOD policy 74:13-H-11 be amended"

"Resolved, that in the training, education and utilization of dental auxiliaries for the purpose of assisting the dentist in providing high quality dental care through performance of expanded functions, it shall be the recommendation of the Academy of General Dentistry that such auxiliaries be permitted to perform under the direct supervision of the dentist those functions which do not require the professional skill and judgment of the dentist and are in compliance with laws of states which have provisions for expanded functions, and be it further

Resolved, that the dentists, and only the dentist, is responsible for the examination, making the diagnosis and formulating the plan of treatment, performing surgical or cutting procedures on hard or soft tissue, fitting and adjusting corrective and prosthodontic appliances, prescribing therapeutic agents and making impressions for other than study casts, and be it further

Resolved, that final decisions related to dental practice and utilization of dental auxiliaries rest with the state board of dentistry, and be it further

Resolved, that the AGD recognize the necessity of effectively utilizing dental auxiliaries to maximize the efficient use of the dentist's time and skills."

Dental Consultant

Coalition to restore deduction for student loan interest

93:29-H-7 "Resolved, that the Academy of General Dentistry support the efforts of the Student Loan Interest Deduction Restoration Coalition to restore the deduction of interest paid on student loans."

Must be a licensed dentist

75:27-H-10 "Resolved, that the AGD recognizes that a dental consultant must be a duly licensed dentist within said state."

Dental Education

Deduction of interest paid on student loans

2008:301S-H-7 "Resolved, that the Academy of General Dentistry support efforts to restore the full deduction of interest paid on student loans regardless of income."

Dental schools, support state funding for

80:22-H-7 "Resolved, that AGD recognizes the need for adequate funding to enable dental schools to provide a proper dental education, but at the same time, AGD encourages dental schools to seek state and/or private support in lieu of federal capitation funding."

81:37-H-7 "Resolved, that AGD support the concept of using state funds to assist in maintaining and operating the physical facilities of existing dental schools."

Formal academic process leading to a degree or certificate

81:41-H-7 "Resolved, that AGD endorse the concept of a formal academic process of structured, sequential continued or post-doctoral education, earned through universities or academically accredited teaching institutions over an extended amount of time, which lead to a degree or a certificate."

Four-year curriculum, support of

78:27-H-6 "Resolved, that the AGD expresses its concern with the dilution and shortening of dental school programs for purpose such as the receiving of federal capitation grants, and be it further

Resolved, that the AGD supports a minimum of a four-year approved curriculum to achieve a dental degree, and be it further

Resolved, that the AGD send a letter to all of the existing dental schools expressing our support of those dental schools which have relinquished their three-year programs in favor of pursuing quality four-year dental education programs."

Licensure

82:34-H-7 "Resolved, that in states where laws are already in effect which mandate involvement in continuing education as a condition of dental licensure and/or dental license renewal, AGD's constituent AGD in that state's jurisdiction work with the state board of dental examiners and other appropriate dental agencies to protect the interests of AGD members in that state as mechanisms for enforcement and administration of that requirement are developed and implemented.

2014:204A-H-6 “Resolved, that HOD Policy 96:46-H-7 be amended so that it reads:

"Resolved, that the Academy of General Dentistry encourage its constituent academies to work with state or provincial boards of dental examiners, state legislatures, or regulatory bodies in implementing the following provisions for mandatory continuing dental education when legislation or regulations are under consideration in their states or provinces:

1
2 3 4 1. acceptance of program providers approved by the AGD’s Program Approval for Continuing Education (PACE) Program and the ADA Continuing Dental Education Recognition Program
5
6 2. the acceptability of self-instruction programming;
7
8 9 3. acceptance of the AGD member printout as one form of documentation of the requirement;
10
11 12 4. acceptance of courses relative to the access and delivery of dental care."
13
14 **Dental Laboratory Techniques**
15

76:40-H-11 "Resolved, that the Academy of General Dentistry urge the American Dental Association to, in turn, influence the schools of dentistry to provide significant instruction in dental laboratory technology for dental students so that dental school graduates will have the ability to adequately supervise the laboratory technicians, and be it further

16
17 18 19 20 Resolved, that the Academy of General Dentistry urge the American Dental Association to, in turn, influence the schools of dentistry to institute programs of instruction to train dental laboratory technicians at the college and vocational school level”
21
22 **Dental Materials**
23

79:30-H-6 "Resolved, that the AGD recognizes the need to give the American Dental Association's Council on Dental Materials and Devices appropriate input from general dentists, and be it further

24
25 26 27 Resolved, that the AGD recognizes the opportunity given to its president in the Bylaws to appoint an appropriate representative when it is appropriate for him to do so, and be it further
28
29 30 31 32 Resolved, that the AGD's representative to the American National Standards Committee MD156 for Dental Materials and Devices be named as a consultant to the AGD's Dental Practice Council, if he is not already a member, and be it further
33
34 35 Resolved, that all problems concerning dental materials and devices be considered under the purview of the AGD Dental Practice Council."
36

79:31-H-6 "Resolved, that attendance at MD 156 Committee meetings by a representative of the Academy of General Dentistry be included in the Dental Practice Council's budget, on an annual basis."

Purchasing decisions

82:31-H-7 "Resolved, that the Academy of General Dentistry recognizes the problem of providing the general practitioner with meaningful information upon which to base purchasing decisions, and be it further

Resolved, that the following strategies be implemented in order to accomplish this purpose:

1. Maintain an AGD representative on ANSI MD 156.

2. Recommend through the Dental Practice Council chairman members to participate on ANSI Subcommittees.

3. Relay to the ADA AGD's concerns with regard to having the practicing dentist more informed in order to make proper purchasing decisions.

4. Identify which products should be evaluated.

5. Relay ANSI information to the AGD Foundation Product Comparison Advisory Board.

6. Start Product Comparison Program through AGD Foundation.

7. Publish results of product comparison program in our Journal.

8. Obtain feedback from our membership on which products should be evaluated.

9. Appoint subcommittee of Dental Practice Council to facilitate dental material and device deliberations for the Council."

Dental Practice

Amalgam, position statement supporting

2002:24-H-7 "Resolved, that based on current scientific evidence, including the Food and Drug Administration's February 2002 Consumer Update on Dental Amalgam, the Academy of General Dentistry maintains that amalgam is safe and effective as a dental restorative material."

Analyzed health care data

Methodology and source of funding must be disclosed if used for Benefit determination

2016:309-H-7 “Resolved that AGD HOD policies 2000:24-H-7 and 2000:23-H-7 be revised as follows:

2000:24-H-7
Resolved, that if information gathered from analyzed healthcare data is used for either benefit determination or dentist preferential selection, then the methodology and source of funding involved in the analysis must be publicly disclosed and the methodology in the analysis must be subject to appropriate publication and scrutiny used for accepted scientific and statistical protocol.

2000:23-H-7

“Resolved, that the Academy of General Dentistry supports the concept that if health care data is analyzed, it should only be used to advance scientific knowledge or improve the oral health of the patient, recognizing that such analysis can only look at populations and not individual patients, and be it further

Resolved that individual patient care must include the professional judgment of the treating dentist, and be it further

Resolved, that the-methodologies involved in the analysis must be publicly disclosed and reviewed by the affected communities of interest in order to ensure the quality, integrity, and validity of the analysis."

1
2 ANSI MD 156, AGD representative on
3

2016:312-H-7 “Resolved that AGD HOD policy 97:25-H-8 be revised to recognize the current standard committees:

‘Resolved, that the Academy of General Dentistry recognizes the problem of providing the general practitioner with meaningful information upon which to base purchasing decisions, and be it further

Resolved, that the following strategies be implemented in order to accomplish this purpose:

1. Maintain an AGD representative on the ADA Standards Committee on Dental Informatics (SCDI) and the ADA Standards Committee on Dental Products (SCDP).

2. Recommend members to participate on ANSI subcommittees through the Dental Practice Council Chairperson.

3. Relay to the ADA AGD's concerns with regard to having the

practicing dentist more informed in order to make proper purchasing decisions.

4. Obtain feedback from our members on materials with which they've experienced problems.'"

1
2 Appropriate charges made for administrative work
3

75:28-H-10 "Resolved, that the AGD recognize that it is ethical and proper for appropriate charges to be made when a dentist completes a claim form, a narrative report or other paperwork requiring secretarial, clerical, and professional time as long as the fee is identified."

4
5 Benefit coverage for dental surgery performed in office
6

79:35-H-6 "Resolved, that AGD support the inclusion of clauses in hospitalization and surgical benefits contracts that provide for coverage for dental surgery in the office setting if such surgery would normally be covered were the patient hospitalized for the procedure."

7
8 Biophosphonate therapy
9

2007:27R-H-8 "Resolved, that the AGD communicate the potential serious oral sequelae of bisphosphonate therapy, including osteonecrosis, to the medical and dental communities, and to inform patients of such risk and encourage patients to seek dental care prior to initiating bisphosphonate therapy."

10
11 Bisephenol (BPA)
12

2015: 303R-H-6 "Resolved, that there is no conclusive evidence that currently exists relative to health risks of Bisphenol-A (BPA) exposure from dental materials. AGD fully supports the continued research of BPA safety as it relates to dentistry.

13
14
15 Bleaching trays, license should be required for fabrication of
16

2001:27-H-8 "Resolved, that the Academy of General Dentistry believes that supervising or providing materials or methodology for consumers to make intraoral impressions constitutes the practice of dentistry, which requires an appropriate license in the state or province where the individual is being treated, and be it further

17
18 Resolved, that directing a dental laboratory to fabricate intraoral
19 appliances and devices (including bleaching trays) constitutes the practice
20 of dentistry, which requires an appropriate license in the state or province
21 where the individual is being treated, and be it further
22

Resolved, that in order to protect the health of the public, the Academy of General Dentistry believes that the fabrication of intraoral appliances and devices (including bleaching trays) by dental laboratories requires a proper prescription by a dentist licensed in the state or province where the individual is being treated."

Botox and other facial injectables

2010:308R-H-7 "Resolved, that the AGD supports general dentists receiving education on, and the performance of botulinum toxin and cosmetic dermal filler procedures.

2013:303-H-6 "Resolved, that the Academy of General Dentistry encourage its constituents to lobby their state/provincial dental licensing authorities to expand the scope of practice for general dentists to include the administration of facial injectables for therapeutic and cosmetic purposes."

Child's first visit to dentist, position on

98:24-H-7 "Resolved, that the Academy of General Dentistry officially endorse the position that a child's first visit to the dentist should occur within six months of the eruption of the first tooth."

Claims, prompt payment of

93:22-H-7 "Resolved, that the Academy of General Dentistry ascribes to the American Dental Association's policy on the prompt payment of dental claims, which reads:

'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 (15) business days from receipt of the claim by the third-party payer or be penalized for failure to do so.'"

Code of procedures, endorsed by AGD

74:12-H-11 "Resolved, that the AGD endorse the principle of one code of procedures for dentistry, and be it further

Resolved, that whenever the ADA Council on Dental Benefit Programs or one of its sub-committees considers revisions in the ADA code the Academy of General Dentistry be permitted direct input into such revisions by having representation at those meetings, and be it further

Resolved, that the AGD urge the American Dental Association to take steps to assure that the approved code is used throughout the purview of the Academy of General Dentistry."

1 Consultant, ground rules for claims denial
2

93:27-H-7 "Resolved, that when a third-party dental consultant applies an alternative benefit provision to the treatment plan submitted by the provider dentist, or when a third-party dental consultant denies benefits for reasons other than contract exclusions, the dental consultant must sign the report and provide his/her telephone number, and be it further

3
4 Resolved, that the AGD promote this concept to the American Dental
5 Association, the Canadian Dental Association and third-party payment
6 groups."
7
8 Co-payment and overbilling, waiver of
9

2016:311R-H-7 "Resolved that AGD HOD policy 93:23 H 7 be revised as follows:

"Resolved, that constituents be urged to pursue enactment of legislation that:

1) prohibits systematic non-disclosure of waiver of patient co-payment/overbilling by a dentist and

2) prohibits bad faith insurance practices by third party payers, whereby bad faith insurance practices refers to the failure to deal with a beneficiary of a dental benefit plan fairly and in good faith, or an activity which impairs the right of the beneficiary to receive the appropriate benefit of a dental benefits plan or to receive them in a timely manner, and be it further

Resolved, that third party payers be urged to support this legislative objective.'"

10
11 Corporate Guidelines and Mandates
12

2009:319S-H-7 "Resolved, that the AGD is opposed, as unduly burdensome to general dentistry and the patients it serves, to all corporate mandates that require specified quantities of utilization of the corporation's products in patient's dental treatment, without any qualitative assessment of each dentist's proficiency with the products and without substantial clinical evidence of patient harm as a result of utilization in less than the specified quantities, as prerequisites for continued access to the use of the corporation's product.

13
14
15 Date of manufacture of dental equipment and devices
16

81:26-H-7 "Resolved, that AGD encourage that ADA specifications for dental materials and devices include an expiration date where applicable, and when not applicable a date of manufacture or packaging, and be it further

17

1 Resolved, that the type of date utilized be clearly indicated and separate
2 from a lot or serial number."
3
4 Dental health education for the public
5

81:33-H-7 "Resolved, that AGD support the concept of having public funds used to support dental health education for the public."

6

2017:301-H-11 "Resolved, that the AGD educate the public that there are potential risks, including but not limited to financial, health, and contractual insurance, which may offer limited recourse when dental services are sought outside their countries of residence"

7
8 Dental hygienists, authority of State Boards of Dental Examiners
9

2014:306A-H-6 "Resolved, that policy 92:34-H-7 be revised as follows:

"Resolved, that because of the nature of dentistry and the manner in which it is delivered to the public, it is the policy of the Academy of General Dentistry that dental hygiene should remain under the authority of the various state boards of dental examiners and that dental hygiene education should remain under the purview of and be accredited by the Commission on Dental Accreditation."

10
11 Dental Implants
12

2008:317-H-7 "Resolved, that the AGD policy shall be that dental implants are an accepted modality of treatment."

13

2009:301S-H-7 "Resolved, that the AGD support legislation requiring insurance carriers to cover reimbursement for surgical implant placement and restoration."

14

2009:306-H-7 "Resolved, that, when one or more dentists are involved in dental implant therapy, there should be mutual agreement of the restorative objectives by all parties, including the patient, before any invasive therapy is undertaken."

15

2009:307-H-7 "Resolved, that the AGD adopt the Educational Objectives for the Provision of Dental Implant Therapy."

1
2 Dental insurance plan to include all facets of dentistry
3

2016:310RS-H-7 "Resolved that AGD HOD policy 82:32 H 7 be revised for clarity, as follows:

Resolved, that dental benefits plans should include coverage for all oral health care services and that reimbursement payable or paid by a dental plan for covered services be reasonable and not provide nominal reimbursement in order to claim that services are covered services under the applicable dental plan."

4
5 Dental products, materials, and medications, opposed to bans on the use of
6

2010:306RS1-H-7 "Resolved, that the AGD take appropriate action when necessary to ensure that safe and effective dental materials, products, and/or medications remain approved for use in oral healthcare."

7
8 Dental research, public funding for
9

81:35-H-7 "Resolved, that the AGD support the concept of using public funds if available for dental research."

10
11 Dental Sealant
12

2015:302-H-6 "Resolved, that dental sealants be placed only following proper diagnosis by a licensed dentist, with periodic evaluation by a licensed dentist.

13
14 Dentistry's position on a National Health Program
15

80:25-H-7 "Resolved, that AGD's Guidelines for Dentistry's Position on a National Health Program and other relevant AGD and ADA policy be reviewed in relation to any future legislation mandating dental benefits."

16
17 Dentist's right to collect a larger fee from patient
18

77:14-H-6 "Resolved, that the AGD is opposed to any administrative procedure by a third party payment mechanism which interferes with the dentist's right to collect from a patient a fee greater than that allowed by the carrier's benefit structure except when a dentist has agreed to become a participant in a benefits program that utilizes a usual, customary, and reasonable method of reimbursement as payment in full."

19
20 Diagnosis and treatment of substance abuse
21
22 2013:316-H-6 "Resolved, that in their capacity as primary care providers, general dentists
23 be encouraged to attain education in the diagnosis and treatment of

substance abuse disorders insofar as they relate to oral health issues, and be it further,

Resolved, that the AGD encourages state and district licensing authorities, state and district legislatures, and the federal government to make provisions within the scope of dental practice acts so that general dentists may diagnose and treat substance abuse disorders insofar as they relate to oral health issues."

Diagnostic tests, dentists' right to prescribe and perform

97:26-H-8 "Resolved, that the Academy of General Dentistry recognizes that dentists have the right to prescribe and perform any diagnostic tests deemed necessary providing that:

1. The test is required for the oral diagnosis of or treatment planning for the patient, or the management of a percutaneous injury in a clinical setting.

2. The patient has given informed consent.

3. The test is accompanied, where appropriate, by adequate pre- and post-counseling.

4. There is provision for appropriate referral to a physician responsible for the comprehensive medical care of the patient."

Environmental "best management" practices

2003:12-H-7 AMENDED HOD 2013

2013:310-H-6 "Resolved, that HOD Policy 2003: 12-H-7 be amended to read:

Resolved, that the AGD urge dentists to support environmental "best management" practices, and be it further

Resolved, that the AGD constituents be encouraged to work with their counterpart dental societies to promote environmental best management practices."

Expanded Function Dental Assistant (EFDA)

2011:302RS-H-7 "Resolved, that it is the position of the AGD that the utilization of expanded function dental assistants (EFDA), under the direct supervision of the dentist, providing only reversible procedures is an effective, safe and efficient way to increase capacity and access to care while reducing barriers to utilization of care."

1 Evidence-based dentistry
2
3 Definition of

2000:22A-H-7 “Resolved, that the Academy of General Dentistry believes that evidence-based dentistry is an approach to treatment planning and subsequent dental therapy that requires the judicious melding of systematic assessments of scientific evidence relating to the patient’s medical condition and history, the dentist’s clinical experience, training, and judgment, and the patient’s treatment needs and preferences.”

4
5 Use of
6

2000:22B-H-7 “Resolved, that evidence-based dentistry be utilized to promote the delivery of the most effective care for the patient and not for the determination of dental benefits.”

7
8 Fees, adjustment of
9

93:25-H-7 "Resolved, that the Academy of General Dentistry recognizes that dentists may, upon occasion, adjust fees to classes of individuals, such as relatives, clergy, staff, senior citizens, the indigent, and be it further

10
11 Resolved, that any occasional fee adjustments should not be reflected in determination of
12 UCRs by third parties, and be it further
13
14 Resolved, that the Academy of General Dentistry recommends that this be properly recorded
15 in the dentist's records."
16
17 Fees; i.e., usual, reasonable, customary: definition of
18

93:24-H-7 "Resolved, that the Academy of General Dentistry adopt the American Dental Association's definitions of and policies regarding 'usual, customary and reasonable fees,' which read:

19
20 'Usual fee' is the fee which an individual dentist most frequently charges for a specific dental
21 procedure.
22
23 'Reasonable fee' is the fee charged by a dentist for a specific dental procedure which has been
24 modified by the nature and severity of the condition being treated and by any medical or
25 dental complications or unusual circumstances, and therefore may differ from the dentist's
26 "usual" fee or the benefit administrator's "customary" fee.
27

1 'Customary fee' is the fee level determined by the administrator of a dental benefit plan from
2 actual submitted fees for a specific dental procedure to establish the maximum benefit payable
3 under a given plan for the specific procedure."
4

2015:301S1-H-6 “Resolved, that the Academy of General Dentistry supports the use of practice based peer reviewed research as a means to address current gaps in evidence related to clinical dental practice in order to improve oral health.”

5
6 Flexible Spending
7

2016:307-H-7 “Resolved that AGD HOD policy 2008:308-H-7 be revised to include Health Savings Accounts (HSA), as follows:

‘Resolved, that the AGD support the expansion of Flexible Spending Account (FSA) and Health Savings Account (HSA) reimbursable health items to include oral health items.’

8
9 Flossing
10

2017:304-H-11 “Resolved, that the AGD supports flossing as an integral part of oral hygiene care.”

11
12 Fluoridated public water supplies, public funding for
13

81:32-H-7 "Resolved, that the AGD support the use of public funds to assist local and state governments in seeing that their public water supplies are adequately fluoridated."

14
15 Fluoride in water supplies and toothpaste, position statement
16

2002:21-H-7 “Resolved, that based on the Center for Disease Control’s *Recommendations for Using Fluoride*, the AGD adopt the following position statement:

17 When used appropriately, fluoride is safe and effective in preventing and controlling dental
18 caries. Regular use throughout life will help protect teeth against decay. All water supplies,
19 including bottled water, should have appropriate fluoride levels. All fluoridated items,
20 including toothpaste, should be used as recommended by your dentist.”
21
22 Freedom of choice provider
23

94:30-H-7 "Resolved, that the Academy of General Dentistry actively support "freedom of choice" legislation permitting patients to freely choose their dentist while continuing to utilize their full dental benefits, and be it further

Resolved, that the Academy of General Dentistry actively support "any willing provider" legislation to allow dentists to enroll at any time and to freely participate in dental third-party programs."

Health care reform

2009:316-H-7 “Resolved, that the Academy of General Dentistry participate in any legislative discussions regarding health care reform.”

Health care reform criteria

93:28-H-7 "Resolved, that it is the policy of the Academy of General Dentistry that if dentistry is to be included in any government health care program reform, it must:

1) Be adequately funded to provide broad access;
2) Permit freedom of choice of dentists;
3) Be based on fee-for-service; and
4) Assure high quality dental care.

and be it further

Resolved, in any case where dentistry is included in health care reform, the AGD support the following six recommendations set forth by the American Dental Association:

1. Maintain the advantages of the current dental care and dental benefits system, which would not require inclusion of dental benefits for population groups currently receiving regular dental care, and which would not require public sector participation and subsequent cost transfer. The Association strongly opposes any change in the tax deductibility of current dental benefit coverage.

2. Continue existing policy support for a separate, restructured program of publicly funded dental benefits for indigent persons. Priority consideration should be given to programs for children. The Association urges that these programs be administered in the private sector wherever possible.

3. For population groups currently not receiving regular dental care the Association supports the opportunity for a) small employers purchase dental plans in the private sector, b) development of cooperative dental benefit purchasing alliances administered in the private sector.

4. The Association recommends that preventive services and educational programs for children be included in any health system reform proposal. Preventive services may include

1 but are not necessarily limited to, fluoridation of community water supplies, oral prophylaxis
2 and application of topical fluorides and sealants; dietary fluoride supplements; restoration of
3 carious teeth; maintenance of space resulting from the early loss of primary teeth and patient
4 education.
5
6 5. The Association recommends that in the event that a more comprehensive program is
7 enacted, preventive, diagnostic, emergency services and basic restorative and periodontal care
8 be included for children and the elderly.
9
10 6. The Association believes that if the Medicare program is expanded to include
11 coverage for additional dental health care services, we would endorse the inclusion of a
12 defined dental benefit plan for the elderly population. These services would be expressly
13 focused on those elderly who are in long-term residential care or home-bound. Delivery of
14 these services should not be compromised by discrimination by category of provider
15 (physician or dentist)."
16
17 HPV
18
19 Educating dental profession
20

2017:308-H-11 "Resolved, that the Academy of General Dentistry (AGD) supports educating the dental profession and the public as to the value of dental screenings and HPV vaccination to help prevent Oral Cancer."

21
22 Leased Dental Benefit Networks
23

2017:303-H-11 "Resolved, that the AGD supports federal and state legislative efforts to require that PPO third party payer participation contracts include the requirement that providers shall be provided notice of 1) participation on leased networks, and 2) the identity of payers to which the networks are leased, and that the reimbursement mechanisms used by the lessor shall continue to apply with regard to participation with the lessee."

24
25 Licensing
26
27 Criteria for eligibility
28

2002:28-H-7 "Resolved, that the Academy of General Dentistry believes that to be eligible to apply for an initial license to practice dentistry in the United States or Canada, the candidate must have:

29 Graduated from a dental college with training that is equivalent or higher than that provided
30 by a dental college approved by the American Dental Association's Commission on Dental
31 Accreditation or the Canadian Commission on Dental Accreditation,
32 Passed Part I and Part II of the National Board Exam (or-the National Dental Examining
33 Board Exam in Canada), and

1 Passed a state or provincial licensing examination, or its equivalent, as determined by the state
2 or provincial board of dentistry, and any additional requirements."
3
4 Uniform standards for
5

2014:306B-H-6 "Resolved, that policy 2002:27-H-7 be revised as follows:

"Resolved, that the AGD actively support a uniform standard for licensing dentists in all U.S. states and Canadian Provinces, and be it further

Resolved, that access to oral health care for underserved populations should be addressed by maintaining uniformly enforced licensing standards that would prevent an unequal and unacceptable two-tier level of care."

6
7 Voluntary/Temporary Licensing
8

2009:311-H-7 "Resolved, that the AGD approve the policy Supporting Issuance of Volunteer/Temporary Licenses for Dentists Licensed in Different States"

"Resolved, that the AGD supports the issuance of a temporary license to do volunteer dentistry by dental licensing boards to dentists who are licensed in another state or province when such dentists are seeking such license in order to provide volunteer or charity care."

9
10 Medically compromised dental patients
11
12 Disclosure of relevant information
13

88:54-H-7 "Resolved, that all legislation and regulations to protect confidentiality of information on medically compromised or handicapped patients provide for disclosure of relevant information to members of the individual's direct care-giving team."

14
15 Nutrition
16
17 Sugar and its health care consequences
18

2017:305-H-11 "Resolved, that the AGD Policy Statement on the *Consumption of Sugar and its Health Care Consequences* be adopted as AGD HOD Policy."

19
20 Policy Statement on the Cost-Efficiency
21

2017:307R-H-11 "Resolved, that HOD Policy 2016:301-H-7, Policy Statement on the Cost-Efficiency of Primary Oral Health Care Delivery System be amended as follows:

‘Whereas, the primary oral health care delivery system uses prevention to reduce treatment costs;

Whereas, the primary oral health care delivery system allows for incorporation of administrative, ancillary, and incidental costs;’”

Policy statement on treatment of

88:48-H-7 "Resolved, that the AGD adopt the following policy:

AGD POLICY STATEMENT ON TREATMENT
OF MEDICALLY COMPROMISED DENTAL PATIENTS

With the aging of the population and the spread of infectious diseases, dentists will encounter growing numbers of medically compromised patients, including those with infectious diseases. The general dentist, as primary dental care provider, plays the key role in providing and coordinating dental care for such patients.

In this role dentists have responsibilities to all patients, staff and other parties which they are ethically bound to fulfill.

Responsibilities to the Medically Compromised Patient

o To treat the patient with kindness and compassion, regardless of the nature of the patient's condition.

o To be sufficiently educated to evaluate the dental health of a medically compromised patient and to consult with physicians, when necessary, regarding the patient's medical status.

o To provide appropriate treatment within the dentist's realm of competence.

Responsibilities to Dental Staff

o To ensure that staff are trained in emergency care, the management of special health conditions and the management of medically compromised patients.

o To advise staff of the health status of each patient so they may employ appropriate procedures and avoid procedures that may place themselves or the patient at unnecessary risk.

o To ensure that all staff members are properly educated so they understand that infection control measures, including barrier techniques are in place and practiced routinely to protect them against disease. With this understanding they can properly render compassionate care to a medically compromised patient.

Responsibility to Other Parties

1 o Dentists must observe state and/or federal laws and regulations that require providers
2 to protect the confidentiality of the patient.
3
4 <u>Ethical Considerations for Treating HIV Positive Patients</u>
5
6 The AGD believes that dentists are obligated to observe the American Dental Association's
7 Principles of Ethics and Code of Professional Conduct in the treatment of all patients
8 including those who are medically compromised, of which HIV positive patients are a part."
9
10 <u>Medically indigent, support programs for</u>
11

77:18-H-6 "Resolved, that every effort be made to have indigent dental care programs structured so that they take into consideration the current cost basis involved in providing the dental services."

12

81:31-H-7 "Resolved, that AGD support viable programs to provide dental care to the needy elderly and medically indigent."

13

81:34-H-7 "Resolved, that the AGD support the concept of using public funds if available to provide dental care for the medically indigent."

14
15 <u>Medicare, amendment to reimburse dentists for rendering same service as a physician</u>
16

79:28-H-6 "Resolved, that the AGD support the concept of amending Medicare so that a dentist shall be reimbursed for a dental service rendered under this program if a physician would have been reimbursed for rendering the same service."

17
18 <u>Nutrition and oral health</u>
19

2004:14-H-7 "Resolved, that the Academy of General Dentistry encourages dentists to maintain ongoing knowledge of nutritional recommendations such as in the Dietary Guidelines for Americans published by the U.S. Department of Agriculture and the U.S. Department of Health and Human Services and their Canadian counterparts, as they relate to general and oral health and disease, and be it further

20
21 Resolved, that the Academy of General Dentistry encourage dentists to effectively educate
22 and counsel their patients about proper nutrition and oral health, including eating a well
23 balanced diet and limiting the number of highly cariogenic between-meal snacks, and be it
24 further,
25

1 Resolved, that the Academy of General Dentistry encourage constituent academies to work
2 with school officials to ensure that school food services, including vending services and
3 school stores, provide nutritious food selections, and be it further
4
5 Resolved, that the Academy of General Dentistry opposes targeting children in the promotion
6 and advertisement of foods low in nutritional value and highly cariogenic foods and beverages
7 and be it further
8
9 Resolved, that the Academy of General Dentistry encourages continued federal support for
10 programs that provide nutrition services and education for infants, children, pregnant women
11 and the elderly, and be it further,
12
13 Resolved, that the Academy of General Dentistry encourages the appropriate government
14 agencies to prevent the distribution of non-nutritious and highly cariogenic foods and
15 beverages under federal nutrition service programs."
16
17 Off-Label Use
18

2017:302R-H-11 "Resolved, that Off-Label Use of Dental Products statement be adopted as AGD HOD policy."

19
20 Opioids
21

2017:306-H-11 "Resolved, that the White Paper on the Role of Dentistry in Addressing Opioid Crisis be adopted as AGD HOD policy."

22
23 Oral Conscious Sedation, position statement
24

2005:2R-H-7 "Resolved, that the AGD position on Oral Conscious Sedation is:

1. The Academy of General dentistry believes that the general dentist must have access to appropriate training in the area of anxiolysis and oral conscious sedation. The AGD further believes that continuing education opportunities must continue to be developed to make these courses available to the general practitioner.

2. "Anxiolysis" means removing, eliminating or decreasing anxiety. This may be accomplished by the use of medication that is administered in an amount consistent with the manufacturer's current recommended dosage and/or judgment on the part of the clinician with or without nitrous oxide and oxygen. When the intent is anxiolysis only, the definition of enteral and/or combination inhalation-enteral conscious sedation (combined conscious sedation) does not apply.

3. The Academy of General Dentistry supports the rights of the general dentist to use professional judgment in deciding the appropriate dose for each patient situation, respecting safe dosing parameters.

4. The Academy of General Dentistry believes that each constituent should be in close contact with their licensing boards to communicate the AGD's position on this issue."

1
2 Oral Health Literacy
3

2016:306-H-7 "Resolved that oral health literacy is an integral component of every individual's health and wellbeing. And be it further,

Resolved that oral health literacy is a critical issue that should be addressed in accordance with the following principles:

1. Oral health literacy is the foundation of a lifetime of wellness and must be integrated into all educational and wellness programs.
2. Oral health literacy is a shared responsibility across all sectors.
3. Critical to the advancement of oral health literacy is an established dental home.
4. The dental profession will lead the advancement of oral health literacy, in collaboration with other health professionals.
5. Governmental and private resources dedicated to improving oral health should be strategically directed toward programs that further oral health literacy."

4
5 Parameters of care, ADA
6

91:46-H-7 "Resolved, that the Board be directed to take a firm position that protects and accurately represents the interests of practicing general dentists on the development of parameters of care prior to consideration by the ADA House of Delegates after weighing all available evidence on the issue, including input from the Chairman of the AGD Dental Practice Council."

7
8 Parameters of care, criteria for
9

93:26-H-7 "Resolved, that any parameter of care established for the entire dental profession should be:

10
11 1. Condition-based;
12
13 2. Equally applicable to all dental care providers;
14
15 3. Universally accepted with the dental profession; and
16

1 4. Developed by the American Dental Association with appropriate representation by the
2 affected communities of interest, including the AGD as the representative of general
3 practitioners; and be it further
4
5 Resolved, that the AGD's Dental Practice Council shall continue to monitor the status of
6 parameters and attempt to achieve AGD representation in the development of parameters, and
7 be it further
8
9 Resolved, that the AGD reserves the right to develop its own parameters should the need
10 arise."
11

94:32-H-7 "Resolved, that any parameter of care established for the entire dental profession should be:

12
13 1. Condition-based;
14
15 2. Equally applicable to all dental care providers;
16
17 3. Universally accepted within the dental profession; and
18
19 4. Developed by the American Dental Association with appropriate representation by the
20 affected communities of interest, including the AGD as the representative of general
21 practitioners; and be it further
22
23 Resolved, that the AGD's Dental Practice Council shall continue to monitor the status of
24 parameters and attempt to achieve AGD representation in the development of parameters, and
25 be it further
26
27 Resolved, that the AGD reserves the right to develop its own parameters or oppose the
28 development of parameters should the need arise."
29
30 Preferred Provider Organizations
31

2016:315R-H-7 "Resolved that AGD HOD policy 84:26 H 7 be revised as follows:

'Resolved, that the Academy of General Dentistry use appropriate means are available to ensure that the following provisions are included in and made a part of any state and/or federal law mandating and/or regulating preferred provider organizations:

A. Patients' freedom of choice of dentist must be guaranteed.

B. Preferred provider policies or contracts and preferred provider subscription contracts shall provide the same benefits level to the patient whether rendered by non preferred providers or preferred providers.

C. No dentist willing to meet the terms and conditions offered by a third party shall be excluded.

D. All dentists whose services are required shall have the same opportunity to qualify for payment as a preferred providers under any such policies.

E. The terms and conditions of any third party policies or contracts shall not discriminate by specialty or degree against dentists.

F. A preferred provider subscription contract should be defined as a contract which specifies how services are to be covered by the plan when rendered by non participating providers and by preferred providers.

G. Preferred provider policies or contracts should be defined as insurance policies or contracts which specify how services are to be covered by the plan when rendered by preferred and non preferred providers.

H. When preferred provider organizations are promoted to the public, they cannot do so with any implications of superiority, and all promotional materials used by third parties must state if a preferred provider is a reduced fee contract.

I. The third party shall make provision for a periodic adjustment in level of reimbursement based on the Consumer Price Index or some other equitable basis.

And be it further

Resolved, that the Academy of General Dentistry encourage its Constituent Academies to work toward building these safeguards into any state and/or federal law mandating and/or regulating preferred provider organizations.

1
2 Prepayment plans
3
4 Bill payer system
5

78:24-H-6 "Resolved, that the AGD recognize the 'bill payer system' (direct reimbursement) as one of the acceptable forms of dental prepayment."

6
7 Exclude certain contract language
8

77:12-H-6 "Resolved, that in the interest of providing the best possible level of dental

care for the patient, the Academy of General Dentistry is opposed to the inclusion of 'least expensive but adequate treatment', 'alternate mode of treatment', or similar contract language, in prepayment dental plans, and be it further

1
2 Resolved, that such language be eliminated from prepayment contracts wherever possible, and
3 be it further
4
5 Resolved, that this type of language in existing dental contracts be implemented in such a
6 manner so as not to impugn the integrity of the attending dentist or intrude upon the
7 patient-dentist relationship by either informing or implying that an alternate mode of
8 treatment is appropriate, or influence the patient in any way in his choice of the attending
9 dentist's treatment.”
10
11 Include all phases of preventive dental services
12

81:29-H-7 "Resolved, that the AGD recognize the necessity of having all phases of preventive dental services in the dentist's office included in dental prepayment plans, and be it further

13
14 Resolved, that AGD request the appropriate agencies of the American Dental Association to
15 consider the development of a position statement that would serve to accomplish this
16 purpose."
17
18 Structuring of dental prepayment programs
19

77:17-H-6 "Resolved, that third party mechanisms, including government programs, take these differences into consideration in structuring dental prepayment programs, and be it further

20
21 Resolved, that dental prepayment programs for the non-indigent have a provision whereby the
22 patient will pay the differences between the fee authorized under the program and the normal
23 fee charged."
24
25 Public information available to public of dental office safety
26

92:30-H-7 "Resolved, that the Academy of General Dentistry believes that any advertisement of the HIV status of the dentist or any member of the dental team is misleading to the dental consumer

27
28 and be it further
29

1 Resolved, that all members and dental personnel are encouraged to work to educate the public
2 and all patients on the safety of dental procedures and the precautions taken by dental
3 professionals to safeguard patients' health in the dental office."
4
5 Resource-Based Relative Value Scale
6

89:53-H-7 "Resolved, that the Academy of General Dentistry opposes use of the Resource-Based Relative Value Scale as a method of determining payment for services provided by dentists."

7
8 Rights of employers to provide health care benefits
9

80:24-H-7 "Resolved, that AGD agrees in principle with the traditional rights of all employers to provide health care benefits for their employees, and be it further

10
11 Resolved, that AGD continue its dialogue with the ADA to clarify any proposal to provide
12 dental benefits to federal employees."
13
14 School curricula – oral health education
15

2002:23-H-7 "Resolved, that the Academy of General Dentistry advocates incorporation of oral health education into primary and secondary school curricula with measurable outcomes, as a proven and cost effective disease prevention and universal health promotion program."

16
17 Sleep Apnea
18

2016:317-H-7 "Resolved, that the AGD supports qualified dentists providing treatment for obstructive sleep apnea with custom, titratable oral appliances when prescribed by a referring physician. And be it further resolved; that the AGD supports dentists in the oversight of patients in appliance therapy for obstructive sleep apnea in conjunction with a sleep physician to improve or confirm treatment efficacy."

19
20 Soft drink consumption/pouring rights contracts
21

2004:13-H-7 "Resolved, that the Academy of General Dentistry, through its appropriate agencies, continue to review the supporting data concerning the oral health effects of the increasing consumption of beverages containing sugars, carbonation or acidic components. These products are commonly referred to as "soft drinks," including but not limited to juice drinks, sports drinks and soda pop, and be it further

22 Resolved, that the Academy of General Dentistry encourages its constituents to work with
23 education officials, pediatric and family practice physicians, dietetic professionals, parent
24 groups, and other interested parties, to increase the awareness of the importance of

maintaining healthy vending choices in schools, and to encourage the promotion of fluoridated water and beverages of high nutritional value, and be it further

Resolved, that the Academy of General Dentistry opposes contractual arrangements, including pouring rights contracts, that influence the consumption patterns that promote increased access to 'soft drinks' for children."

Surgeon General's Report on Oral Health

Implementation plan

2001:26-H-8 "Resolved, that it is the role of the Academy of General Dentistry to implement the Surgeon General's Report on Oral Health by:

1. Expanding the demand for and availability of dental continuing education opportunities that:

a. Address the management of the oral health needs of at-risk toddlers, children, special needs, and geriatric patients.

b. Expand the knowledge of practicing dentists in the areas of oral medicine and the relationships between oral health and general health.

2. Working with other health care organizations to expand and elevate the knowledge of health care professionals, policy-makers, and the public (with an emphasis towards underserved communities) about:

a. The relationships between oral health and general health.

b. Oral disease prevention measures including home care, nutrition, fluoride, sealants, and tobacco cessation.

c. Promoting oral health in school curricula.

3. Advocate the development and implementation of appropriate proactive measures that will improve access to dental care (such as student loan forgiveness, tax credits and/or incentives to induce recent dental school graduates to practice in underserved areas)."

Third party mechanisms

Third party plans

2016:304RS-H-7 "Resolved, that the AGD supports third party plans, including medical benefit reimbursements for treatment provided by dentists in the area of sleep related breathing disorders within the dentist's scope of practice."

1 ADA's role in problems with
2

81:27-H-7 "Resolved, that the AGD recognize the American Dental Association's appropriate role in communicating with third party payment mechanisms for the purpose of upholding prepayment standards which have been agreed upon by the profession, and be it further

3
4 Resolved, that all complaints involving third party payment mechanisms taking more than 30
5 days to reimburse patients or dentists for dental services rendered be referred to the ADA so
6 that appropriate dialogue may be instituted with the third party on behalf of the public and the
7 dental profession."
8
9 Claim contested by dental consultant of
10

75:30-H-10 "Resolved, that should a patient's claim be contested by the third party's dental consultant, patient, or the patient's dentist, it shall be submitted to the local level of organized dentistry's peer review system and the third party, the patient, and the dentist should agree that the action of the peer review system is binding."

11
12 Consultant of, should make no representation to patient regarding dentist's service or fee
13

75:29-H-10 "Resolved, that when a patient's claim is considered for modification, and/or review, the third party dental consultant should contact the patient's dentist to discuss the matter fully rather than making any representation to the patient with respect to the dentist's services or fees."

14
15 Diagnostic imaging
16

94:15-H-7 "Resolved, that the Academy of General Dentistry supports third-party reimbursement for all forms of diagnostic imaging determined to be medically necessary by the treating dentist and supported by appropriate clinical criteria."

17
18 Differentials in levels of reimbursement in
19

77:13-H-6 "Resolved, that the Academy of General Dentistry is opposed to differentials in levels of reimbursement in third party programs based on whether or not a practicing dentist is a 'participating' or 'non-participating' dentist in such a program, and be it further

20

1 Resolved, that this resolution be communicated to the ADA, Delta Dental Plans, and all of the
2 participating Delta Dental Plans in every state in the United States."
3

86:34-H-7 "Resolved, that the AGD is unequivocally opposed to any type of separate fee schedules for reimbursement to general practitioners and specialists for the same or similar services."

4
5
6 Fee Determination
7

2009:317RS-H-7 "Resolved, that third party payers should not determine fees for procedures not covered and/or not reimbursed in their policies. And be it further,

Resolved, that the appropriate AGD agencies be directed to help AGD constituents develop legislation that will prevent third party payers from setting fees for non-covered and/or non-reimbursed procedures."

8
9 Fee schedules based on utilization reviews considered arbitrary
10

2000:25-H-7 "Resolved, that the Academy of General Dentistry believes that any fee schedule by third party dental benefit administrators or other entities that separates dentists into different payment levels as determined by statistically based 'utilization reviews' is arbitrary, discriminatory, and not consistent with appropriate patient care."

11
12 Guidelines for handling members' problems with
13

75:33-H-10 "Resolved, that the AGD adopt the following guidelines for handling communications from members on their problems with third party programs:

14
15 a. All complaints must be placed in writing and be sufficiently documented.
16
17 b. The executive director, in consultation with the Dental Practice Council chairman,
18 shall be charged with the responsibility of corresponding directly with those carriers that are
19 acting in opposition to policy previously established by the AGD.
20
21 c. The AGD should seek the help of the American Dental Association on those
22 complaints involving a violation in ADA policy."
23
24 Not to interfere with dentist's diagnosis and treatment
25

75:32-H-10 "Resolved, that the AGD recognize a third party payment mechanism's responsibility to determine its liability and extent of dental benefits but is unalterably opposed to any administrative procedure that interferes with the attending dentist's diagnosis and treatment plan."

1

86:33-H-7 "Resolved, that alternative payment systems for all dental care delivery should not infringe upon the right and responsibility of the licensed practicing dentist to diagnose and treat patients according to the proper standard of care."

2
3 Overpayment recovery practices
4

2003:13-H-7 "Resolved, that the Academy of General Dentistry seek and support efforts opposing third party overpayment recovery practices, except as contractually obligated, when the overpayment was the result of a mistake made by the insurer and accepted by the dentist in good faith without prior or reasonable knowledge of the error, and be it further

5
6 Resolved, that the Academy of General Dentistry seek and support efforts to prevent third
7 party payers from withholding fully assigned benefits to a dentist when an incorrect payment
8 has been made to the dentist on behalf of the subscriber with the same third party payer."
9
10 Participation should not be contingent upon participation in government regulated programs
11

97:30-H-8 "Resolved, that retention of a license to practice dentistry and participation in third party plans should not be contingent upon participation in government regulated programs."

12
13 Reduction/denial of dental benefits must be signed by licensed dentist
14

2000:26-H-7 "Resolved, that the Academy of General Dentistry believes that any third party reduction or denial of dental benefits on the basis of 'not medically necessary or appropriate' must be made on an individual basis and signed by a dentist licensed in the state or province in which the procedures are being performed, and be it further

15
16 Resolved, that the Academy of General Dentistry believes that any third party reduction of
17 dental benefits on the basis of 'least expensive alternative treatment' be made on an individual
18 basis and signed by a dentist licensed in the state or province in which the procedures are
19 being performed, and be it further
20

1 Resolved, that the Academy of General Dentistry believes that any review of clinical records
2 for the purpose of reducing or denying dental benefits must be made on an individual basis
3 and signed by a dentist licensed in the state or province in which the procedures are being
4 performed."
5
6 <u>Regulated by law or state governmental agency</u>
7

85:23-H-7 "Resolved, that all third-party payment mechanisms be regulated by law or through the appropriate state governmental agency to ensure fiscal responsibility and protection of the interests of the public."

8
9 <u>Tissue biopsy</u>
10

2006:25-H-8 "Resolved, that it is the position of the AGD that the decision whether or not to biopsy oral tissues lies within the purview of the treating dentist."

11
12 <u>TMD policy statement</u>
13

86:29-H-7 "Resolved, that the Academy of General Dentistry support legislation and rules and regulations that would require third-party mechanisms selling dental benefits programs based on UCR in a state, to use data that is not more than six months old on the date of filing, and so state this date in published material to users and prospective users of these programs; and be it further

14
15 Resolved, that the AGD communicate the problems being addressed by this resolution to the
16 ADA's Council on Dental Benefit Programs to seek a viable solution; and be it further
17
18 Resolved, that the AGD's Dental Practice Council solutions being offered by the ADA to see
19 if further action by the AGD is needed."
20

89:55-H-7 "Resolved, that the Academy of General Dentistry's TMD Policy is:

21
22 1. The existence of TM orders is undeniable and these disorders can be treated by the
23 general dentist.
24
25 2. There are a variety of viable diagnostic and treatment modalities for TM disorders, as
26 there are in the treatment of physiological disorders, back problems, and many other medical
27 maladies.
28
29 3. Like any disorder or disease, the indication for TMD treatment is a doctor/patient
30 decision. The criteria for this decision is both subjective and objective.
31
32 4. It is not possible to list all the effective (and thus reimbursable) TMD procedures. It is
33 the application of clinical judgment which determines the appropriate treatment modality.

1
2 and be it further
3
4 Resolved, that the Academy of General Dentistry support the concept that comprehensive
5 policies or certificates of health, medical, hospitalization, or accident and sickness insurance
6 should provide reimbursement for the diagnosis and therapeutic treatment of
7 temporomandibular dysfunction/myofascial pain dysfunction and associated diseases and
8 dysfunctions and that benefit coverage be the same as that for treatment of any other joint in
9 the body and be applicable if the treatment is administered or prescribed by a physician or a
10 dentist."
11
12 <u>TMJ</u>
13
14 <u>Medical care contracts should not discriminate against dentists</u>
15

88:52-H-7 "Resolved, that in cases where dentists provide their expertise in treatment of temporo-mandibular joint dysfunction and cranio-mandibular disorders, medical care contracts should not discriminate in benefit payments based on the professional degree of the provider."

16
17 <u>Tooth numbering system</u>
18

81:28-H-7 "Resolved, that the Academy of General Dentistry endorses the universal (1 to 32/a to t) tooth numbering system adopted by the ADA and encourage its immediate implementation through the American Dental Association and the American Dental Education Association and other segments of the dental profession."

19
20 <u>Untoward responses to products, materials, and medications</u>
21

98:23-H-7 "Resolved, that the Academy of General Dentistry encourage its members to be aware of possible untoward responses to products, materials, and/or medications used in the dental office, and that the use of these products, materials and/or medications will be up to the discretion of the treating provider."

22
23 <u>Vaccinations</u>
24
25 2013:306-H-6 "Resolved, that the AGD supports the administration of influenza vaccinations
26 and other vaccinations by general dentists who have attained the training and education to do
27 so."
28
29 <u>Workforce, adequacy of present dental workforce</u>
30

2014:306C-H-6 “Resolved, that policy 2002:26-H-7 be revised as follows:

“Resolved, that the Academy of General Dentistry adopt the following statement relative to the adequacy of the dentist workforce:

The dentist workforce in the United States is sufficient to meet the needs of the public demand for dental services. Geographic imbalances exist in localized areas due to a variety of factors. Where these imbalances result in shortages, the affected regions must be examined and addressed individually for appropriate solutions. The development of a responsive, competent, diverse, and “elastic” workforce should address potential increases in demand for dental services.”

1
2 Workforce Policy Statement
3

2014:304- “Resolved, that the *Optimal Delivery of Oral Health Services through Primary Care: A Comprehensive Workforce Policy Statement* be adopted as AGD HOD Policy.”

4
5 **Dental Practices**
6
7 Open elections and nominations for officers
8

78:23-H-6 "Resolved, that all dental service corporations be requested to have open elections and nominations for officers and members of the Board involving all of its participating dentists so as to give the participating dentists representation in matters relating to improvement of patient services and maintaining high professional standards, and be it further

9
10 Resolved, that this resolution be conveyed to the ADA House of
11 Delegates for implementation."
12
13 To be owned and operated by licensed dentists
14

86:32-H-7 AMENDED HOD 2009

15

2009:300-H-7 “Resolved, that policy 86:32-H-7 be amended so that it reads:”

86:32-H-7 “Resolved, that the AGD recognize that the public is best served when dental practices (those traditional fee for service private practices or any alternative compensation system of practice) are owned and operated by dentists licensed in the state or province of such ownership or operation, and be it further

Resolved, that the AGD supports the inclusion of language in state dental practice acts that would prohibit a party or parties not licensed to practice dentistry from becoming involved in the ownership or control of dental practices with an exception

allowing for the non-dentist survivor or designee of a deceased dentist to retain ownership of the dental practice in order to facilitate an orderly transfer of patient records to a new dentist owner or licensed dental practice with ownership to remain in effect until an orderly transfer can occur or a two year period from the death of the original dentist owner."

Dental Students

Financial assistance to, that restricts choice of geographical location of practice

76:50-H-11 "Resolved, that the AGD oppose any form of federal assistance to dental schools or dental students that restricts the freedom of graduates of dental schools to voluntarily choose the type or the geographical location of their practices, as long as they are able to meet the appropriate state licensing requirements."

Loan program for

81:23-H-7 "Resolved, that AGD recognize the need for the dental profession to offer input into a fair and equitable loan program for dental students, supported by both private and public funds."

81:36-H-7 "Resolved, that AGD recognize the need to have the federal government involved in providing loans to dental students with the provision that all such funds be paid back with appropriate interest."

Recruiting highly qualified students

87:56-H-7 "Resolved that the AGD urge its constituent Academies to continue their involvement with dental schools and alumni associations in recruiting highly qualified students for dental schools."

Denturism

85:24-H-7 "Resolved, that in the interest of the health of the public, the Academy of General Dentistry supports the need of the dentists to be appropriately involved in all dental and oral prosthetic care rendered directly to patients, and as such, opposes the denturism movement."

Direct Reimbursement

Definition of

90:56-H-7 "Resolved, that 'direct reimbursement' be defined as follows:

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

Promotion of

85:28-H-7 "Resolved, that the Academy of General Dentistry continue its support of the American Dental Association's efforts and activities to promote direct reimbursement throughout the country."

97:27-H-8 "Resolved, that the Academy of General Dentistry is in support of and offers encouragement to the ADA in its efforts to promote direct reimbursement."

Dues

Assessment

81:48-H-7 "Resolved, that the Board include an enumeration of any portion of the membership to be suggested for exemption from a future assessment along with its complete rationale for any assessment to be considered in the future by this House of Delegates."

Enteral Conscious Sedation

2015:312S-H-6 "Resolved, that, recognizing the importance of managing anxiety and pain in dental patients, the AGD believes general dentists should:

1. have access to training in anxiety-reduction techniques that may or may not involve medications
2. have access to training in all levels of sedation,
3. have access to sedation certification as required by statute, and
4. be able to practice any level of sedation for which they have been trained."

Federal Services

2012:304-H-6 "Resolved, that the Barriers and Solutions to Accessing Care be adopted as AGD HOD policy."

2012:305-H-6 "Resolved, that the AGD believes that charitable foundations such as Pew Charitable Trusts (Pew) and the W.K. Kellogg Foundation (Kellogg) should focus their resources to fund the solutions that are identified by the AGD, including the solutions contained within the AGD White Paper on Increasing Access to and Utilization of Oral Health Care Services (White

Paper), to improve the status of oral health in underserved and vulnerable populations, and be it further,

Resolved, that the appropriate entity or entities of the AGD determine the feasibility, advisability and when appropriate, the mechanism and timing, to engage charitable foundations such as Pew and Kellogg with the purpose of seeking funding for the solutions that are identified by the AGD including specific solutions that are contained within the AGD White Paper with regard to improving the status of oral health in underserved and vulnerable populations, and be it further,

Resolved, that the appropriate entities report back progress to the 2013 HOD."

2014:302R-H-6 "Resolved that the AGD leadership use the following concepts when in discussions about the midlevel provider model with governmental and regulatory agencies, the profession and the public:

The AGD does not believe that an alternative oral health provider model like the a midlevel provider model is a viable workforce alternative because it is not an economically sustainable solution to treatment delivery and it also creates a two-tier delivery system in which a provider with much less training and education than a dentist treats populations of patients that have far more critical medical and health issues. The AGD has grave concerns that the clinical and didactic education and training of a midlevel provider falls extremely short of the education and training that is required to treat those patients that the proponents of this alternative provider model claim the midlevel provider will treat.

Further, the AGD has published its "White Paper on Increasing Access to and Utilization of Oral Health Care Services" (2008) as well as "Barriers and Solutions to Accessing Care" (2012), which propose various proven solutions to oral health disparities. The AGD believes there are two key components of improving oral health care in America: including fluoridated water, adequate funding and oral health literacy. The AGD hopes all who have concerns with oral health disparities would agree that these two viable options are key to solving the oral health disparities in America."

Benefits for military personnel and their dependents

81:38-H-7 "Resolved, that the AGD support the concept of enhancing the benefits offered to individuals serving in the military by providing dental services for their dependents, and be it further

Resolved, that these dental services shall be provided by the private sector where possible, and be it further

Resolved, that the AGD work to have provisions under which these services are to be provided conform to AGD policy."

Salary reimbursement for military dentists

81:25-H-7 "Resolved, that AGD recognize that factors such as the following items should be taken into consideration in the salary reimbursement for federal service dentists:

- the amount of education acquired by the dentist
- the proficiency of the dentist
- the level of experience of the dentist and the individual's ability to handle the more complex dental procedures in a competent manner
- status, rank, or duties within the group
- tenure
- the cost of living in one geographical area as opposed to another."

91:50-H-7 "Resolved, that the salaries for physicians and dentists in the Federal Services should be determined by the following factors:

1. The scope of responsibility which may be determined by rank, title, etc.

2. The degree of education which may include specialty training, general practice residencies, advanced educational programs in general dentistry, passage of a certifying board, etc.

3. A relationship with the remuneration generally earned by that profession within the practicing civilian sector.

4. Length of service."

Special pay for uniformed services

93:31-H-7 "Resolved, that the Academy of General Dentistry support the upgrading of special pay for dentists in the federal uniformed services, and that this position be properly communicated to the American Dental Association."

Fees

Adjusted for complying with governmental regulations

92:35-H-7 "Resolved, that the Academy of General Dentistry recommends that dentists may incorporate into their normal overhead the cost of complying with OSHA, CDC and other government regulations, and be it further

Resolved, that dentists may charge a separate fee or adjust current fees to cover these costs."

General Dentist

Continued competency

94:24-H-7 "Resolved, that assuring the public of the dental profession's continued competency is best addressed by appropriate continuing dental education, effective peer review, and the proper enforcement of the dental practice acts by the state and provincial boards of dental examiners, and be it further

1 Resolved, that the AGD of General Dentistry continue to express this
2 position by letter to members of the American Association of Dental
3 Examiners Continued Competency Committee and the American
4 Association of Dental Examiners Executive Council before the final
5 presentation of the Continued Competency report, and be it further
6
7 Resolved, that the Academy of General Dentistry express this position by
8 letter to the American Dental Association, the American Dental
9 Education Association and all other individuals and organizations that
10 would be affected by or have influence on this issue."
11
12 Creed of
13

84:17-H-7 "Resolved, that the Academy of General Dentistry establish a creed for the purpose of more closely identifying the organization with a philosophy and code of conduct, and be it further

14
15 Resolved, that the following five statements be adopted as the AGD
16 creed:
17
18 1. To educate myself to perform with greater ability.
19
20 2. To provide and promote the best treatment for my patients.
21
22 3. To treat my patients with continued dignity and empathy.
23
24 4. To share my knowledge with my patients and my profession.
25
26 5. To maintain my integrity and professionalism.
27
28 And be it further
29
30 Resolved that if feasible, the AGD creed be included on the back of the
31 AGD membership cards and used in such other ways determined to be
32 appropriate."
33
34 Definition of
35

2009:310-H-7 "Resolved, that the AGD amend policy 2008:319S-H-7.

"Resolved, that Policy 2007:303-H-7 be amended so that it reads:

2007:303-H-7 "Resolved, that AGD defines a general dentist as 'An individual who has successfully completed formal dental training leading to a DDS, DMD, or comparable degree which qualifies that individual to be a dentist and to accept the professional responsibility for the diagnosis,

treatment, management, and overall coordination of services that meets patients' oral health needs, and who has not announced a limitation of practice to any of the specialty areas recognized by the American Dental Association,' and be it further

Resolved, that the AGD defines 'primary dental care provider' as 'the general or pediatric dentist who accepts the professional responsibility for the treatment of the patient and/or the management and coordination of services to meet the patient's oral health needs, consistent with the ADA Principles of Ethics and Code of Professional Conduct."

1

82:21-H-7 "Resolved, that the AGD recognizes that it is in the best interest of the public for the general dentist to be the primary entry point into the dental care delivery system."

2
3 Resolved, that the AGD advocate this position in programs involving
4 federal and state governments as well as insurance companies so that
5 optimal dental health care will be more readily available to larger
6 segments of the public at less cost."
7

8 **General Practice Residency Program**

9

79:32-H-6 "Resolved, that the AGD support general practice residency programs, and be it further

10
11 Resolved, that the AGD recommend that a significant portion of the
12 content of all general practice residency programs be devoted to but not
13 limited to experience in a hospital environment, and be it further
14
15 Resolved, that the AGD recognizes the concept of and the need for the
16 general dentistry residency."
17

18 Commission on accreditation urged to require that directors of GPR's be general dentists

19

80:33-H-7 "Resolved, that the ADA Commission on Dental Accreditation be urged to require that, in the future, the directors of general practice residency programs and advanced educational programs in general dentistry be well-qualified general dentists."

20

21 **Geriatric Care**

22

76:54-H-11 "Resolved, that the AGD recognizes the importance of dental care for the geriatric patient, and recommends that constituent academies through state dental societies institute whatever means necessary to inform the geriatric patient of the importance of regular dental care, and to aid in the providing of that care to economically disadvantaged geriatric patients."

23

24 **Health Planning**

25

Organized dentistry to provide input for

81:39-H-7

"Resolved, that the AGD recognize the need for appropriate health planning, and be it further

Resolved, that the AGD support the concept of organized dentistry having input into health planning, and be it further

Resolved, that the AGD support the concept of using local funds for health planning, and, when necessary, state and federal funds."

HIV

HIV-infected patients, policy on

88:50-H-7

"Resolved, that the AGD regards HIV-infected patients as medically compromised individuals with an infectious disease who deserve the most considerate and scientifically sound dental care available and be it further

Resolved, that the AGD opposes dental care discrimination against any individual, including those with infectious diseases."

Statement on disclosure and infection control

91:51-H-7
REVISED
HOD 7/99

"Resolved, that the Academy of General Dentistry strongly supports the validity and use of universal precautions and appropriate sterilization procedures as techniques that greatly reduce the risk of transmission of the Hepatitis (HBV) and Human Immunodeficiency (HIV) viruses between health care workers and patients, and be it further

Resolved, that the AGD supports voluntary testing of health care providers for HBV and HIV in the appropriate settings, but opposes mandatory testing because it is impractical and ultimately ineffective as a preventive measure, and be it further

Resolved, that dentists and other health care personnel who believe they are infected with HIV or HBV should obtain medical advice and, if found to be infected, should act upon that advice and submit to regular medical supervision, and be it further

Resolved, that the AGD work to educate the public on the safety of dental procedures and the techniques used by dental professionals to safeguard patients' health."

Implants

96:53-H-7

"Resolved, that as an adjunct to the AGD's existing policy with regard to the consideration of implant dentistry as a specialty, that the following principles be adopted:

1. The AGD actively supports the policy that all qualified dentists be permitted to perform all aspects of implant dentistry including placement and restoration.

2. The AGD believes that it is in the public's best interest that oral implantology not be limited to one discipline of dentistry.

3. The AGD opposes the implication that specialists performing oral implants are also specialists in implantology

4. The AGD opposes any marketing efforts that imply any provider of implants is a qualified oral implantology specialist

Pre-doctoral education

92:32-H-7 "Resolved, that the AGD support pre-doctoral education in the diagnosis, placement and restoration of oral implants in the curricula of all dental schools, and be it further

Resolved, that this resolution be transmitted to the ADA House of Delegates and to the American Dental Education Association."

Infectious Waste

State and government regulation

90:55-H-7 "Resolved, that the AGD recognize that state law and government regulation is determining the definition and handling of infectious waste, and be it further

Resolved, that when evaluating the merit of such regulations, the AGD primarily will be concerned about the safety of the public, and also will insist that the

regulations be based on scientific validity with appropriate consideration given to cost effectiveness."

Insurance, Malpractice

84:24-H-7 "Resolved, that the Academy of General Dentistry continue to support the American Dental Association's three-classification system for malpractice insurance until such time as evidence has been presented to indicate that there is merit in going to another system."

Legislation

Access to dental care

Incentives for dentists to practice in underserved areas

1
2001:29-H-8 “Resolved, that the Academy of General Dentistry believes that in order to encourage dentists to practice in underserved areas, the following must occur:
2
3 a. The period over which student loans are forgiven must be extended to
4 10 years, without a tax liability for the amount forgiven in any year.
5
6 b. Tax credits must be provided for establishing a dental practice in said
7 areas.
8
9 c. Scholarships must be offered to dental students in exchange for serving
10 in said areas.
11
12 d. Federal loan guarantees must be provided for the purchase of dental
13 equipment and materials.
14
15 e. Appropriations for funding an increase in the number of dentists
16 serving in the National Health Service Corps must be enacted.
17
18 f. Active recruitment of applicants for dental schools from underserved areas.”
19
20 Legislative agenda for providing
21
2001:28-H-8
REVISED
HOD 7/2002 “Resolved, that the Academy of General Dentistry believes that any effort to get the necessary personnel to improve access to and utilization of dental care for indigent populations will be multifactoral and complex, and includes but is not limited to the following items (understanding that these items are not prioritized and will vary from state to state):
22
23 a. Take steps to facilitate effective compliance with government-funded
24 dental care programs to achieve optimum oral health outcomes for indigent populations.
25
26 i. raise fees to at least the 75th percentile of fees which dentists currently charge
27 ii. eliminate extraneous paperwork
28 iii. simplify Medicaid rules
29 iv. mandate prompt reimbursement
30 v. educate Medicaid officials regarding the unique nature of dentistry
31 vi. provide block grants to states from the federal government for innovative programs
32 vii. require mandatory annual dental examinations for children entering school (analogous
33 to immunizations) to determine their oral health status
34 viii. encourage education of patients in proper oral hygiene and in the importance of
35 keeping scheduled appointments
36 ix. utilize case management to ensure that the patients are brought to the dental office
37 x. increase general dentists’ understanding of the benefits of treating the indigent
38

1 b. Establish Alternative Oral Health Care Delivery Service Units
2
3 i. provide oral health care, education, and preventive programs in schools
4 ii. arrange for transportation to and from the centers
5 iii. solicit volunteer participation from the private sector to staff the centers
6
7 c. Encourage private organizations such as Donated Dental Services, fraternal
8 organizations, and religious groups to establish and provide service
9
10 d. Provide Mobile and Portable Dental Units to service the underserved and indigent of
11 all age groups
12
13 e. Identify educational resources for dentists on how to provide care to
14 pediatric and special needs patients and increase AGD dentist participation
15
16 f. Provide information to dentists and their staffs on cultural diversity issues which will
17 help them reduce or eliminate barriers to clear communication and enhance understanding of
18 treatment and treatment options
19
20 g. Pursue development of a comprehensive oral health education component for public
21 schools' health curriculum in addition to providing editorial and consultative services to
22 publishers of primary and secondary school textbooks
23
24 h. Increase supply of dental assistants and dental hygienists
25
26 i. Strengthen alliances with ADEA and other professional organizations
27
28 j. Expand the role that retired dentists can play in providing service to the
29 indigent."
30
31 White Paper on Increasing Access to and Utilization of Oral Health Care Services
32

2008:323-H-7 "Resolved, that the AGD adopt the *White Paper on Increasing Access to and Utilization of Oral Health Care Services*."

33
34 AGD opposes limiting political or PAC contributions
35

87:53-H-7 "Resolved, that the Academy of General Dentistry opposes federal legislation reducing limits on political action committee contributions to candidates for elected office."

36
37 Cash method of accounting, not accrual
38

98:26-H-7 "Resolved, that the Academy of General Dentistry support the use of the cash method of accounting, and not the accrual method, where preferred, by dentists engaged in the private practice of dentistry, and be it further

39

1 Resolved, that the Academy of General Dentistry communicate this
2 position, when necessary, to legislative and regulatory entities."
3
4 Community Health Centers
5
2003:15A-H-7 "Resolved, that the AGD recognizes that Community Health Centers can be a component in the effort to increase access to oral health care if the Community Health Center Board partners with local dental societies in order to contract with locally practicing dentists and more adequately identifies and reaches underserved and indigent (defined as 150% of the Federal Poverty Level) populations, and be it further
6
7 Resolved, that appropriate legislative activity be pursued to ensure that
8 Community Health Centers are properly funded and function in the manner
9 for which they were intended."
10
11 Deduction for member dues
12
87:55-H-7 "Resolved, that the AGD support legislation and seek coalitions with other professional organizations that will allow salaried professionals to fully deduct dues to professional organizations without having to exceed the 2% of adjusted gross income now required for deduction of miscellaneous tax deductions."
13
14 Dental Lab Disclosure
15
2008:320RS1-H-7 "Resolved, that the Academy of General Dentistry support legislation that requires dental labs to provide written disclosure to dentists the place of fabrication and the specific composition of all materials used in the fabrication of dental restorations and appliances."
16
17 Federal Trade Commission
18
88:51-H-7 "Resolved, that the Academy of General Dentistry has a high priority in urging every member of Congress to join in the adoption of legislation that would restrict the Federal Trade Commission from intervening in state-regulated professions."
19
20 FTC's efforts to pre-empt state laws re corporate ownership
21
2008:309-H-7 "Resolved, that policy 86:31-H-7 be amended so that it reads:

"Resolved, that in the interest of safeguarding patient care and freedom of choice, the AGD opposes any efforts by the Federal Trade Commission and any other agencies to preempt state laws that prohibit non-dentist owned corporate dental practices, and be it further

Resolved, that the AGD supports any efforts to challenge the Federal Trade

Commission's and any other agency's statutory authority to preempt state laws regarding non-professional, non-provider ownership of health care practices."

1
2 General Practitioner's role as gatekeeper for oral health
3

2008:316-H-7 "Resolved, that the AGD as an organization of general dentists make every effort to inform policy makers of the potential effect increased specialization of dentists will have on the fragmentation of dentistry, especially on rural communities' access to oral health care."

4
5 Government subsidized health care programs
6

78:21-H-6 "Resolved, that AGD oppose all programs that allow government subsidized health care delivery systems to compete unfairly with the private practice delivery system, and be it further

7
8 Resolved, that the Legislative and Governmental Affairs Council direct
9 their efforts in concert with the appropriate councils of the ADA and their
10 constituent legislative councils to gather and disseminate all information
11 which deals with this issue to the appropriate leadership at the national and
12 state levels, and be it further
13
14 Resolved, that the leadership in the profession at national and state levels
15 make every effort to upgrade the information deficit of federal and state
16 legislatures so that they may be fully informed."
17
18 Guidelines for dealing with state legislation
19

2014:303R-H-6 "Resolved, that HOD Policy 89:54-H-7 be amended to read:

"Resolved, that the Academy of General Dentistry use the following guidelines in dealing with members requesting AGD action on legislation being proposed in their state or when lobbying on an issue is deemed appropriate by the AGD:

20
21 1. Members have the right to know existing policies.
22
23 2. The AGD shall make a reasonable effort to work with the
24 constituent prior to undertaking any legislative activity.
25
26 3. The AGD may intervene in the legislative affairs of a state or
27 province with the oversight of the Executive Committee and the
28 LGA Council.
29
30 4. Members requesting support from the AGD for a legislative
31 position may be asked to work through their constituent.
32

5. Constituent secretaries/executive directors and Trustees will be provided with copies of AGD correspondence with their members regarding concerns about legislative issues being considered."

Indigent population, AGD as a voice for the

2008:310RS-H-7 “Resolved, that policy 2003:15B-H-7 be amended so that it reads:

“Resolved, that the AGD continue to be an advocate for the oral health of the general population, including but not limited to the underserved.

Language interpretation at provider’s expense

2001:31-H-8 “Resolved, that the Academy of General Dentistry is opposed to any federal, state or local government mandate that would require a dentist or other health care provider to supply, at the provider’s expense, language interpretation for patients who do not speak English or who have limited proficiency with the English language.”

Legislative or regulatory mandates with inadequate scientific basis

2000:30-H-7 “Resolved, that the Academy of General Dentistry oppose any legislative or regulatory mandate affecting the practice of dentistry which is based on principles that do not have adequate scientific basis as determined by the AGD.”

Link between oral health and overall health

2016:314R-H-7 Resolved, that the Academy of General Dentistry supports legislation that seeks to increase professional and public awareness of accurate and up-to-date current information on the link between oral health and overall health

Managed care, AGD’s legislative priorities regarding

2016:313-H-7 ““Resolved that AGD HOD policy 97:29-H-8 be revised as follows, for clarification:

‘Resolved, that the AGD’s legislative priorities with regard to dental managed care encompass the following:

Patients will have the choice to select a plan with a point-of-service option, with reasonable cost-sharing requirements in premiums and per-service costs provided that those costs are not excessive.

Patients in a plan will be allowed to select their dentist, and change that

selection as the patient feels is necessary.

The plan shall provide access to an adequate mix and number of dentists, including both general dentists and specialists, to ensure access to those services covered by the plan including patients in rural and dentally under-served areas.

The plan shall allow patients with special needs to be referred to appropriate providers including specialists.

The plan shall provide an appropriate appeals and grievance procedure that allows for timely responses to patient and/or provider complaints.

The plan shall provide a dentist, licensed to practice in that state or province where the services are provided, to be responsible for dental treatment policies, protocols, and quality assurance activities.

The plan shall define and disclose limitations on coverage of experimental treatments and provide timely written justification for denial of such treatment to patients.

The plan shall not discriminate in participation, reimbursement, or indemnification against any dentist solely on the basis of his/her license specialty.

The plan shall not prohibit or limit a dentist or other health professional from engaging in communications regarding the patient's health status, health care, treatment options, or utilization review requirements.

The plan shall not provide any financial incentives to dentists, other health professionals, or reviewers to deny or limit care.

The plan shall provide dentists with reasonable notice of termination and allow the dentist to appeal such a decision and take corrective action if necessary.

The plan shall assume any liability resulting from the plan's denying or restricting treatment or referral to specialists.'"

1
2 Mandating preferred provider organizations
3

84:25-H-7 "Resolved, that the Academy of General Dentistry oppose any federal

legislation for the purpose of mandating preferred provider organizations, or pre-empting state laws that regulate preferred provider organizations."

1
2 Medicaid
3

2015:311R-H-6 "Resolved, that a credible Medicaid audit (Recovery Audit Contractor (RAC), and Medicaid Integrity Contract (MIC), etc.) must include an independent, jurisdiction centric licensed peer dentist in the review of the clinical records pertaining to dental treatment."

4
5
6 Military dentists, special pay and incentives for
7

2001:30-H-8 "Resolved, that the Academy of General Dentistry request immediate action to stem the exodus of current military dental officers and assure a continuing supply of quality accessions, and be it further

8
9 Resolved, that the AGD favor increasing additional special pay,
10 establishing incentive pay for dentists, and increasing Health Professions
11 Scholarship Program (HPSP) scholarship funding."
12
13 National Practitioner Data Bank
14

90:57-H-7 "Resolved, that the Academy of General Dentistry work with the ADA to urge Congress and the Department of Health and Human Services to amend the National Practitioner Data Bank so that it will include only information on suspension of license, revocation of license or loss of hospital privileges for disciplinary reasons."

15
16 NIDCR
17

2003:18-H-7 "Resolved, that the Academy of General Dentistry supports the continued existence and current structure and mission of the National Institute of Dental and Craniofacial Research, and be it further

18
19 Resolved, that the AGD will take appropriate steps to lobby in support of
20 NIDCR."
21
22 Nitrous oxide inhalation sedation
23

94:18-H-7 "Resolved, that the Academy of General Dentistry supports the use of scavenging equipment for nitrous oxide, and be it further

24
25 Resolved, that any additional regulation of nitrous oxide be based on valid
26 scientific documentation."
27
28 Prohibit fee capping of non-covered procedures
29

2013:315-H-6 “Resolved, that the AGD encourage and support federal legislation to prohibit fee capping of non-covered procedures by federally sponsored dental insurance plans.”

Prohibiting latex use without documented scientific evidence

98:22-H-7 “Resolved, that the Academy of General Dentistry be directed to oppose any legislation or regulation that is not based on documented scientific evidence of significant general risk to dental patients or workers which would prohibit the use of latex or latex-containing products in the dental office.”

Protect dental insurance as a fringe benefit

81:24-H-7 AMENDED 2008:306-H-7

2008:306-H-7 “Resolved, that policy 81:24-H-7 be amended so that it reads:

"Resolved, that the AGD work to ensure that legislation would not adversely affect an employer's decision to provide dental insurance.”

83:24-H-7 AMENDED 2008:307R-H-7

2008:307R-H-7 “Resolved, that policy 83:24-H-7 be amended so that it reads:

“Resolved, that the AGD resist efforts being made by third party dental benefits programs to prohibit payment based on the specific technique used by the dentist to render treatment for the patient.”

Public disclosure of information in National Practitioner Data Bank

2000:27-H-7 “Resolved, that the AGD oppose public disclosure of National Practitioner Data Bank information because it has the potential to provide misleading information about physician and dentist competency.”

Public Health Service Surgeon General

96:55-H-7 "Resolved, that the Academy of General Dentistry recommends and supports continued and ongoing Congressional funding of the Office of the Surgeon General of the United States Public Health Service in order to fulfill the mission of administration and oversight of the Commissioned Corps of the USPHS,

and be it further

1 Resolved, that the AGD supports the appointment of the Surgeon General
2 from the ranks of the Commissioned Corps of the USPHS in keeping with
3 existing legislation that provides for this result."
4
5 Sales tax on professional services - AGD opposition
6

87:63-H-7 "Resolved, that the AGD recommend that its constituents work with ADA and Canadian dental societies in opposing sales taxes on professional fees and services."

7
8 State over federal regulation of the dental profession
9

82:30-H-7 "Resolved, that the AGD supports the principle that in any regulation of the dental profession the dental health interests of the public are better served by the state rather than federal regulation."

10
11 Student Loan Interest Deduction
12

87:54-H-7 "Resolved, that the AGD support legislation seeking reinstatement of the full tax deductibility of interest payments of student loans."

13
14 Tax credit in states with reimbursement rates below 75th percentile
15

2004:15-H-7 "Resolved, that the Academy of General Dentistry seeks a tax credit not to exceed $5000 for dentists participating in the Medicaid program in states where reimbursement rates are less than the 75th percentile, and be it further

16
17 Resolved, that the credit be calculated on the difference between the state
18 Medicaid reimbursement rate and the most recent ADA Annual Fee Survey
19 75th percentile schedule for the region."
20
21 Tobacco Cessation Treatment
22

2008:313-H-7 “Resolved, that treatment for tobacco cessation including appropriate medication is within the scope of dental practice, and be it further

Resolved, that constituents be encouraged to lobby state and provincial legislatures/dental boards where restrictions exist.”

23
24 Third party reimbursement levels
25

2016:305R-H-7 “Resolved, that the AGD supports legislation for Third Party reimbursement levels that reflect changes in the cost of care and/or cost of living.”

26
27 Tobacco settlement earmarked for health care
28

2000:29-H-7 “Resolved, that the AGD support having monies from the settlement with the tobacco industry be earmarked for health care and be it further

1
2 Resolved, that this position be communicated to constituent AGD
3 presidents who should work with state dental associations to see this is
4 implemented in their respective states.”
5
6 Water quality during routine dental treatments should be appropriate
7

2000:28-H-7 “Resolved, that the AGD supports the use of appropriate water quality during routine dental treatments.”

8
9
10 **Licensure**
11
12 By credentials
13

92:33-H-7 "Resolved, that the Academy of General Dentistry encourage the American Dental Association and the Canadian Dental Association to advocate a position that will encourage the various states or provinces to allow graduates of dental schools accredited by the Joint Commission on Accreditation of Dental Schools to be licensed by credentials in other states or provinces by meeting these criteria as a minimum:

14
15 1. Having successfully passed the National Boards and
16
17 2. Having passed a State or Provincial Board of Dental Examiners
18 exam and/or a regional licensure exam
19
20 3. Having satisfactorily completed a jurisprudence and/or law exam
21 if required by that state or province and
22
23 4. Having satisfactorily complied with the state or provincial law
24 and Principles of Ethics of the state or province in which the
25 individual is currently practicing."
26

94:19-H-7 "Resolved that the Academy of General Dentistry actively support licensure by credentials by providing assistance to any region or constituent requesting support in promoting the issue at the state level."

27
28 **Malpractice Insurance and Litigation**
29
30 Defending their capabilities to render dental procedures
31

81:12-H-7 "Resolved, that members faced with problems of defending their capabilities to render certain dental procedures be advised to seek help from local general practitioners to serve as expert witnesses on their behalf, and be it further

32

Resolved, that the AGD assist individual members in need of credentials by providing them with letters which may indicate any of the following points:

A. The fact that the individual has been a member in good standing of the AGD since a specific date.

B. The number of hours of continuing education on record in the AGD's central office for the member.

C. Verification that the individual has achieved Fellowship or Mastership status in the AGD.

D. Any of the individual's activities as a member, including the committees he has served on and the offices he has held in the AGD."

Mandated Health Benefits

AGD policy on

87:51-H-7 "Resolved, that the Academy of General Dentistry opposes federal and state laws mandating health and related benefits because such laws may increase health care costs, reduce employers' incentives to hire full-time staff members, increase a trend toward underemployment of auxiliaries, and reduce incentives for employers to provide health care benefits since such laws place solo and small group practitioners at an economic disadvantage, and be it further

Resolved, that Congress and the states should explore alternatives to government-mandated benefits, including favorable tax incentives that encourage employer expansion of health care and related benefits."

National Practitioner Data Bank

94:17-H-7 "Resolved, that the Academy of General Dentistry recommends limiting access to the National Practitioner Data Bank to those persons and entities originally authorized to report to and query the data bank by the Health Care Quality Improvement Act of 1986."

OSHA

AGD efforts to control regulations relating to infectious waste control

89:57-H-7 "Resolved, that the AGD work with the ADA in negotiating with OSHA and other governmental agencies to make regulations involving infection control, hazard communication and infectious waste less onerous and more economical for the general public and the dental profession."

AGD influence in adopting guidelines

89:52-H-7 "Resolved, that the Academy of General Dentistry work to influence the formation of OSHA guidelines that would protect the privacy and quality of patient care during the time of office inspection, and be it further

Resolved, that the Academy of General Dentistry request the ADA to include the following points in its negotiations with OSHA:

1. Inspectors should allow normal office operation to continue during inspection.

2. Inspectors should not interfere with patient care.

3. Inspectors should not attempt to speak with a dentist who is engaged in direct patient care or consultation with a patient.

4. Inspectors should not invade or in any way compromise a patient's privacy or confidentiality.

5. Inspectors should not make comments to a dentist, staff or other inspectors within patients' hearing."

AGD supports the ADA's position on OSHA's anticipated rule on Workplace Safety & Health Programs

97:28-H-8 "Resolved, that the AGD support the ADA's position on OSHA's anticipated proposed rule on Workplace Safety & Health Programs as outlined in the letter written by Dr. William S. TenPas and attached to this report as Addendum A.

The AGD specifically supports an exemption in any final OSHA regulation on Workplace Safety & Health Programs for both small employers and low risk employers."

Worker safety regulation, opposition

93:30-H-7 "Resolved, that the Academy of General Dentistry work in conjunction with the American Dental Association to oppose any OSHA worker safety regulations that are not substantiated by scientific documentation."

Patient Records

Confidentiality of

78:22-H-6 "Resolved, that the Academy of General Dentistry support the principle of maintaining the confidentiality of patients' dental records, and be it further

Resolved, that the Academy of General Dentistry considers the compulsory in-office audit of dental offices to be an invasion into the confidentiality of patients' dental records."

Pediatric Dentistry

Defined

95:7-H-7 "Resolved, that the Academy of General Dentistry supports the adoption of the following revised definition of the specialty of pediatric dentistry:

'Pediatric dentistry is an age-defined specialty that provides primary, comprehensive, preventive and therapeutic oral health care for infants and children through adolescence, and may also include the treatment of those with special health care needs.'"

Peer Review Committees

For general dentists

77:11-H-6 "Resolved, that the peer review mechanisms of organized dentistry be the sole factor in determining whether a dentist is qualified to perform a particular dental service, and be it further

Resolved, that the AGD vigorously oppose the formation of lists of dental services which might indicate that a general dentist is not qualified to perform certain procedures."

Quality control review by

76:30-H-11 "Resolved, that the AGD endorses quality control review in the United States only by peer review committees established by ADA constituents and rejects the concept that quality review is the prerogative of prepayment programs."

Post Graduate Training

Availability for all recent graduates

92:36-H-7 "Resolved that the Academy of General Dentistry support, with the American Dental Education Association, the development of one-year postgraduate training programs accessible to all dental school graduates, and be it further

Resolved, that the program(s) incorporate the following concepts:

a) that the program should be in the category of post-graduate education with an appropriate stipend, and should not be a fifth year of dental school with potential for increased student indebtedness.

b) that the program should prepare a dentist for private practice, incorporating both clinical skill enhancement and practice management training.

c) that the Commission on Dental Accreditation should develop and implement appropriate standards and criteria for such one-year postgraduate training program, including the definition of credentials required of program directors.

d) that program(s) be developed with sufficient flexibility for operation in the offices of selected practitioners, indigent care centers or public health sites.

e) that participants in post graduate training at public health sites be eligible for debt repayment programs, and be it further

Resolved that the AGD's position be communicated in writing to both the ADA's Commission on Dental Accreditation and to the American Dental Education Association."

Public Information

Monitoring dental health messages to the public

98:20-H-7 "Resolved, that AGD monitor dental health messages communicated to the public in an effort to see that the interest of the general dentist is properly reflected."

Radiographs/Diagnostic Imaging

Dental assistants must be properly trained to use

80:23-H-7 "Resolved, that AGD recognizes that dental assistants should be properly trained to safely utilize radiological equipment, and be it further

Resolved, that AGD recognizes the need to have dental radiological equipment appropriately monitored in order to ensure the safety of the public, and be it further

Resolved, that AGD encourages the ADA to establish a comprehensive radiological safety program."

Diagnostic Imaging

2013:304-H-6 "Resolved, that the Academy of General Dentistry supports general dentists' utilizing all forms of diagnostic imaging determined to be clinically necessary."

1
2 2013:307R-H-6 "Resolved, that the Academy of General Dentistry supports general dentists' utilizing cone beam imaging of the head and neck after receiving education on the capture and interpretation of such images cone beam imaging."

Submission to insurance carriers

2006:22R-H-7 "The AGD endorses the most current radiographic recommendations developed by the Food and Drug Administration once reviewed by the appropriate AGD agency which will serve as a guide to the general dentist's professional judgment of how to best use diagnostic imaging tools for each patient, and be it further

Salaried Dentists

90:58-H-7 "Resolved, that the AGD strongly support governmental dentists being remunerated at a level competitive with dental incomes in the civilian sector, and be it further

Resolved, that the AGD support legislative proposals that promote an increase in remuneration for dentists serving in the government to a level that is competitive with dentists in the civilian sector."

Sedation

Adequate facilities for teaching

87:57-H-7 "Resolved, that the Academy of General Dentistry use the following definition to define adequate facilities for the teaching of conscious sedation at the undergraduate and continuing dental education levels:

'An area equipped with suction, monitoring equipment, emergency drugs, and equipment to deliver oxygen under positive pressure in relatively quiet and private surroundings.'"

Teaching of, at the undergraduate and CE levels

86:36-H-7 AMENDED HOD 2008

2008:204-H-7 "Resolved, that the following resolution be amended to read:

"Resolved that policy 86:36-H-7 be amended so that it reads:

"Resolved, that the Academy of General Dentistry supports the teaching of conscious sedation at the undergraduate and continuing education levels in dental schools and other adequate teaching facilities as defined by the AGD's Education Council."

Smoking

AGD position on use of Tobacco

90:41-H-7 "Resolved, that the Academy of General Dentistry believes that the use of tobacco has a significantly adverse impact on the public's oral and general health and encourages its members and all general practice dentists and members of the dental health team to promote tobacco abstinence through patient education; and be it further

Resolved, that the AGD encourages all dental offices to serve as model tobacco-free environments and to work actively within the community to promote tobacco abstinence and to educate school-age children on the hazards of tobacco use."

Specialty License Laws

73:20-H-10 "Resolved, that the Academy of General Dentistry continue to oppose the creation of specialty licensure laws within various states and that state Academies should remain vigilant against further expansion of these programs."

74:11-H-11 "Resolved, that the Academy of General Dentistry express its strong opposition to development of specialty license laws as part of state dental practice acts and that the AGD continue to support the position of the American Dental Association."

Specialty Listings

74:5-H-11 "Resolved, that the Academy of General Dentistry urge its members to oppose specialty listings whenever proposed because of the adverse effect such a policy has on selection by the public of a general dentist as the primary vehicle of entry into the dental care delivery system."

State Board of Dentistry

94:16-H-7 "Resolved, that in the interest of the dental health of the public, the Academy of General Dentistry support maintaining the dental licensing authority at the State Board level, and be it further

Resolved, that the Academy of General Dentistry support a single State Board(s) of Dentistry in each state, as the sole regulating authority(ies) for entry level licensure of dentists and hygienists, and be it further

Resolved, that the AGD support state board examinations for entry level licensure, and be it further

Resolved that the following resolution be sent to the ADA's 1985 House of Delegates:

'Resolved, that the American Dental Association, in the interest of the dental health of the public, supports a single State Board of Dentistry in each state, as the sole regulating authority for the delivery of dental care'

and be it further

Resolved, that the following resolution be sent to the ADA's 1994 House of Delegates:

'Resolved that the American Dental Association, in the interest of the dental health of the public, support maintaining the dental licensing authority at the State level and be it further

Resolved, that the American Dental Association support a single State Board of Dentistry in each state, as the sole regulating authority for entry level licensure of dentists and hygienists', and be it further

Resolved that the ADA support state board examination for entry level licensure."

Sterilization

Procedures

92:25-H-7 "Resolved, that the Academy of General Dentistry believes the public good is best served by sterilization procedures for the dental office that provide patients with maximum protection against any possibility of cross contamination and that demonstrate the dentist's commitment to patient health and safety, and be it further

Resolved, that the AGD reaffirms its policy of sterilization by currently accepted methods, including heat sterilization of dental instruments between every patient, and be it further

Resolved, that the Academy of General Dentistry work with the American Dental Association, the Canadian Dental Association, the National Dental Association, and the Centers for Disease Control to encourage all dentists to follow this policy and to raise public awareness of the safety of the dental office and the measures that ensure health and safety of the public and of all involved in dental care delivery."

Surveys

Of dental schools, annually

94:23-H-7 "Resolved, that the annual survey of dental schools to investigate the progress toward an academic postgraduate degree or other recognition for the general practitioner be discontinued as it is no longer effective in evaluating the activities of dental schools with regard to the training of general dentists."

1 **Table of Alloowances**

1 Public Relations Policies
2
3 **Public Information Officers On Constituent Board Of Trustees**
4

87:50-H-7 "Resolved, that the Academy of General Dentistry recommends that all AGD constituents place their Public Information Officers (PIO) on the constituent Boards of Directors to recognize the dedication and accomplishments; and be it further

5
6 Resolved, that AGD constituents be encouraged to require their PIOs to
7 serve a term of no fewer than two years in order to properly organize
8 ongoing programs for promoting dental health to the public; and be it
9 further
10
11 Resolved, that the above statements be added to the text of the next
12 updated AGD Constituent Officers manual and communicated as a
13 separate item of interest to all current constituent presidents,
14 presidents-elect and PIOs and to newly-elected and newly-appointed
15 PIOs."
16
17 **Spokesperson Training Program**

2014:106-H-6 “Resolved that HOD Policy 98:18-H-7 be amended as follows:

“Resolved, that the AGD Spokesperson Training Policy be revised as follows to refine and maintain the confidentiality of the selection process and to provide earlier notification to candidates:

Spokesperson training will be conducted every other year for 10 individuals considered to be leaders of the AGD.

Participants in each workshop will be chosen by the following process:
1) the Council shall choose ten individuals, including any of the top three officers of the organization who have not yet received training, and at least five alternates listed in preferential order at the meeting approximately one year in advance of the workshop, 2) the names shall not be published in the resolution but shall be published in the report so that the Board will not be inhibited in the approval process, 3) the Board shall approve the individuals to attend the workshop at least nine months in advance of the workshop, and 4) the individuals shall be notified within 30 days of the Board decision, in a letter sent by the Executive Director.

In determining workshop participants, the Communications Council will place priority on a cross-section of the membership who are representative of the AGD,

Spokesperson training will be conducted in conjunction with a scheduled AGD meeting, the meeting to be decided by the President in consultation with the Communications Council Chair and Executive Director, to make maximum use of existing resources.”

18
19

1

2 Governance and 3 Operations Policies

1 AGD Foundation Policies
2
3

Foundation

4
5 Focus on access to dental care and oral health literacy
6

2002:34-H-7 "Resolved, that the AGD Foundation be asked to direct its fundraising toward projects dealing with increasing utilization and access to dental care for the underserved and indigent of all ages and their oral health literacy development, and be it further

7 Resolved, that the AGD's agencies be directed to build appropriate projects
8 that will address the above concerns."

9

1
2 Governance and Strategic Initiatives Policies
3
4 **Academy of General Dentistry**
5
6 Clinician
7
8 Code of Conduct
9

2014:116F-H-6 "Resolved, that 90:35-H-7 be amended following approval of the separation of governance and the scientific session."

"Resolved, that it is the policy of the Academy of General Dentistry that all practice-related clinicians at any program provided by the AGD, who have a personal interest or financial investment in a company or product abide by the following:

10
11 1. While it is permissible to mention a product or company in a
12 scientific session and distribute a handout that includes a
13 company name, address, and phone number, clinicians shall avoid
14 anything that could be construed as pushing or actively attempting
15 to sell a particular product or company.
16
17 2. A clinician is prohibited from displaying his/her products
18 anywhere except in the exhibit hall but the clinician may make
19 reference to such an exhibit.
20
21 3. No salesperson representing a company or product may take an
22 active role in the presentation of a course at the scientific session
23 without written approval of the Annual Meetings Council. Such
24 requests must be submitted to the AGD national office five
25 months prior to the date of the meeting."
26 Goals and objectives
27

2017:103-H-11 "Resolved, that HOD Policy 2015:102B-H-6, AGD 2016-2018 Strategic Plan, Goal 1, Strategy 1, be amended as follows: '

2016-2018 Strategic Plan

Goal 1 - Education: Become the most valued resource of quality dental continuing education for general dentists at all stages of their career.

Strategy 1: Create a Scientific Session that will annually attract at least 5% of AGD members by the end of 2018.

Strategy 2: Facilitate education programs that promote members' success and advancement through all stages of their dental career using traditional as well as innovative, cutting edge methods.

Strategy 3: Partner with AGD constituents in the development and delivery of continuing education programs.

Strategy 4: Protect PACE and increase the number of PACE providers.

Goal 2 - Advocacy: Strengthen and protect the general dentistry profession and the oral health of the public.

Strategy 1: Represent the unique interests of general dentists in all advocacy arenas.

Strategy 2: Advocate on behalf of the general dentistry profession as relates to policy making, insurance, licensing, education, and all levels of government.

Strategy 3: Advocate on behalf of the public to ensure safe, best quality dentistry practices and appropriate access to care.

Strategy 4: Develop strong working relationships where appropriate with the AGD constituents, the ADA, and dental specialty organizations in addressing issues of common interest.

Strategy 5: Pursue instruments and resources to empower the AGD's advocacy agenda.

Goal 3 - Membership: Increase the number of full-dues-equivalent members to 27,000 and retain the existing marketshare of United States members by the end of 2018

Strategy 1: Utilize market and member research to determine which current and new member benefits will best serve AGD in attracting and retaining members.

Strategy 2: Provide and promote products and services that meet the current and future needs of members and prospective members in all stages of practice and career paths.

Strategy 3: Retain at least 50% of 2015 new graduate members through 2018.

Strategy 4: Actively recruit dental student members and retain them when they become practicing dentists.

Strategy 5: Attract non-member general dentists by promoting the value of a lifelong learning mindset.

Goal 4 – Communications: Promote the AGD as an organization dedicated to advancing general dentistry through quality continuing education and advocacy.

Strategy 1: Position the AGD as the leading source of information on oral health issues for general dentistry.

Strategy 2: Create and promote a consistent AGD brand that is applied to all marketing vehicles and collateral materials.

Strategy 3: Increase public awareness of the value AGD general dentists bring as gatekeepers to oral health.

Strategy 4: Focus communication efforts on engaging members to advocate on behalf of general dentistry.

Strategy 5: Enhance AGD publications and digital-based communication vehicles to effectively communicate to all AGD stakeholders.

Goal 5 – Organizational Excellence: Ensure that the AGD is financially viable, functions efficiently in a cost-effective manner, and has a mutually supportive relationship with its constituents.

Strategy 1: Ensure the fiscal soundness of AGD.

Strategy 2: Improve the effectiveness and efficiency of AGD headquarters operations.

Strategy 3: Streamline the AGD governance structure and operations.

Strategy 4: Promote an organizational culture that best supports attainment of strategic goals and a healthy operating environment

Strategy 5: Ensure the success of constituents in meeting the needs of grassroots members."

1
2
3 Mission and Vision
4

2015:102A-H-6 "Resolved, that AGD adopt the Vision Statement, and Mission Statement."

AGD Vision
Oral health and better lives through the Academy of General Dentistry

AGD Mission
Advancing general dentistry and oral health through quality continuing education and advocacy."

Official language

95:2-H-7 “Resolved, that the Academy of General Dentistry declare that English is the official language of the Academy of General Dentistry.”

Use of logo and phrase "member of AGD"

89:40-H-7 "Resolved, that all rights to the use of the AGD logo are under the purview of the Academy of General Dentistry, its constituents and components and members of the AGD may not make personal use of the AGD logo without first obtaining the approval of either the component or, if one does not exist in the area, the constituent AGD, and be it further

Resolved, that AGD members be permitted to use the logo and/or the phrase 'member of the Academy of General Dentistry' in communications with the public and be it further

Resolved, that the use of the AGD logo and/or phrase "Member of the Academy of General Dentistry is permitted only when it is not in conflict with (1) The principles of Ethics of the American Dental Association and its constituents and components, or, in Canada, the Canadian Dental Association and the appropriate provincial dental society, and (2) the dental licensing authority in whose jurisdiction the dentist practices."

Annual Meeting

Caucus visits

2015:307S-H-6 “Resolved, that the HOD Policy 2001:4-H-8 be amended to read,

2001:4-H-8 “Resolved, that scheduling of caucus visits for the top three officers and candidates be developed, if a request has been made by the Region, by the Executive Director two weeks in advance of the annual meeting, and be it further

Resolved, that automatic scheduling of officer and executive director visitations be eliminated from regional caucuses unless specifically requested by a region either prior to or during the caucuses.

And be it further,

Resolved, that individuals wishing to address caucuses with specific issues may do so by obtaining the permission of the Regional Director in the interim after the caucus visits have been scheduled.”

And be it further,

Resolved, that the HOD Policy 2002:5-H-7 be amended to read,

2002:5-H-7 "Resolved, that the following ground rules be adopted for candidate caucus visits for candidates for AGD office:

a) If requested by the Region, visitations by candidates to caucuses shall last no more than 15 minutes.

b) Any individual who is a member of the region and is eligible to be in the caucus may pose a question through the Chair to a candidate."

1
2 Delegates
3
4 Committee reports sent to, 10-14 days prior to
5

71:8-H-2 "Resolved, that all committee reports be in the hands of the delegates 10 days to two weeks prior to the annual meeting, including the audited treasurer's report."

6
7 Composition
8

2017:106-H-11 "Resolved, that AGD HOD policy 2013:314RB-H-6 be amended, so that it reads:

Resolved, that the Dental School Program Task Force coordinate the AGD Student Member Delegate Program, and be it further,

Resolved, that the two (2) AGD Student Member Delegates and the two (2) AGD student member Alternate Delegates be recommended through the solicitation of AGD dental school chapters to the Executive Committee of AGD for approval and assignment of Caucus attendance to begin by the 2018 HOD, and be it further,

Resolved, that the House of Delegates continues to be calculated on the basis of 200 members from the constituents and the addition of the two students shall not affect the proportionality of constituent representation to the HOD."

9
10 Delegate/alternate list on web site
11

2014:116I-H-6 "Resolved, that 2000:8-H-7 be amended following approval of the separation of governance and the scientific session."

"Resolved, that the names, addresses, fax numbers, e-mail addresses, and telephone numbers for all delegates and alternate delegates shall be posted

each year 60 days previous to the House of Delegates in the Members Only section of the AGD web site so that members may communicate effectively with their representatives."

1
2 Per diem and travel reimbursement
3

75:24-H-10 "Resolved, that the Executive Director be directed to make full payment for travel and per diem allowance to each state delegate to the annual House of Delegates Meeting when the delegate's position has been maintained by the delegate and/or alternate delegate for the full meeting."

4

2010:112-H-7 "Resolved that Policy 96:56-H-7 be amended so it reads:

"Resolved, that the AGD pay eligible delegates to its House of Delegates:

1. Per diem equal to the number of days the House of Delegates meets in session, at a rate equal to the per diem designated for members of the Board at the same annual meeting.

2. Ground transportation to and from his/her local airport at an amount equal to that designated for members of the Board.

3. Ground transportation to and from the meeting city airport to the headquarters hotel at an amount equal to that designated for members of the Board.

4. Actual air, bus or rail transportation expenses from residence to location of meeting, but in no event to exceed round trip coach airfare (receipt must be attached).

5. If an individual travels by automobile, an allowance based on the prevailing IRS rate may be given providing the total cost does not exceed the fare designated by the AGD's official air carrier to travel to and from the meeting.

and be it further,

Resolved, that any additional subsidy to an AGD delegate is based upon the policies of the constituent which the delegate represents, and be it further

Resolved, that this policy shall become effective at the close of the 1996 Annual Meeting.

5
6 Dental Practice Council sub-committee on the Code
7

2007:311-H-6 "Resolved, that the AGD House of Delegates (HOD) urge the AGD Dental Practice Council to maintain a standing entity on the Code on Dental Procedures and Nomenclature (Code) to dedicate its time and efforts exclusively to ensuring that the voice and needs of general dentists get

adequate representation in the Code revision process before the ADA's Council on Dental Benefit Programs (CDBP) and the Code Revision Committee (CRC)."

1
2 Distribution of commercial literature
3

2014:116H-H-6 "Resolved, that 98:1-H-7 be amended following approval of the separation of governance and the scientific session."

"Resolved, that the distribution of literature concerning dental meetings be limited to that portion of the exhibit hall designed for that purpose at the AGD's scientific session, and be it further

4
5 Resolved, that commercial interests not be allowed to have literature
6 distributed in the AGD House of Delegates at the Annual Meeting, and
7 be it further
8
9 Resolved, that the Credentials and Elections Committee be given the
10 responsibility for determining what other materials may be distributed to
11 the House including the scrutiny of candidate materials to see that they
12 comply with the AGD Election Guidelines, and be it further
13
14 Resolved, that the AGD's Executive Director and Speaker of the House
15 determine whether literature concerning business being considered by the
16 House is appropriate for distribution or display on the screen."
17
18 Elections
19

2016:302-H-7 "Resolved, that the Election Guidelines be amended so that they read:

AGD ELECTION GUIDELINES
(Amended House of Delegates in June 20162015)

I. It is in the best interest of the Academy of General Dentistry (AGD) for its leaders to be exemplary individuals. No candidate or his/her supporters may refer disparagingly to another candidate. All candidates should be promoted on the basis of positive attributes rather than on any negative characteristics of the opposing candidate. The AGD Credentials and Elections Committee (C&E) shall be the overseeing authority for all campaign activities, questions and complaints. All AGD elections should be conducted on a high ethical level. It is, therefore, imperative that all candidates agree to the following rules before beginning their campaigns for election.

II. Commitment to Guidelines
Candidates or their representative for any contested office shall meet via teleconference or other means as soon as possible after the deadline for filing for office has passed to discuss the spirit of the campaign to allow for a fair and transparent campaign. An agreement to abide by the AGD Election Guidelines will be signed by all campaigns in all elections. Thereafter or there upon, all parties for a contested office may agree to any variances, but they must do so in writing and those variances are only for that office for that year. No variance shall economically impact the candidates for the other offices. Staff shall send the changes that all candidates have agreed upon to each candidate for his or her signature. Once every candidate has approved and signed the changes, a copy will be sent to the chair of the Committee to be used in settling any discussions or disagreements that might arise during the campaign. All participants in the election process shall agree to the guidelines no matter what the status of their campaign. The aforementioned agreement, shall include, but not be limited to:

a. Nominating speeches
b. Candidates Forum
c. Reception(s)
d. Financing
e. Advertising

Copies of this agreement shall be signed by each candidate and distributed to each candidate along with the chairperson of the Committee. The C&E Committee shall be charged with enforcing the agreement.

III. Participation in the Campaign
a. Because of their possible wide reaching influence, members of the Executive Committee (EC), Division Coordinators (DCs), Past AGD Presidents, the Parliamentarian and the C&E are prohibited to participate in any way in someone else's campaign, including but not limited to the following:
i. Making nominating speeches
ii. Pictures or quotations in printed material from the candidate
iii. Visiting caucuses with the candidate
iv. Calling Delegates on behalf of the candidate
v. Openly expressing opinions about the candidate or the process
vi. Open and outward support of a candidate throughout the election process. The exception to this is that if these individuals are serving as Delegates or Alternates, then they may ask questions of a candidate during a candidate's visit to his/her regional caucus.

IV. Past AGD Presidents shall not participate in campaigns. Members of the Credentials and Elections Committee and the Parliamentarian to the HOD shall not participate in

campaigns and are further prohibited from running for any AGD office. All other members not mentioned above may participate in the campaigns. Campaign committee members who are also Delegates and Alternates may submit questions to the C&E for the Candidates Forum and can participate in questions and answers of candidates while participating in their own caucus as a Delegate or Alternate.

V. Nominating Speeches:
a. A nominating speech shall be allotted for each candidate, which shall last no longer than two minutes. There will be no seconding speeches for any of the candidates. A "speech" is defined inclusive of a power point or other type of technologically enhanced presentation. All visual aid presentations must be approved by the C&E at least 45 days before presentation to the House of Delegates.
b. The nominating speech must be given by an AGD member. A candidate may choose to have members of the same region or outside of the candidate's region to help run the campaign, endorse the candidate in an approved brochure, or travel with the candidate to the caucuses.
c. Candidates Speech: Each candidate will be asked to present a speech to the House of Delegates (HOD) lasting no longer than five minutes. A "speech" is defined inclusive of a power point or other type of technologically enhanced presentation. All visual aid presentations must be approved by the C&E at least 45 days before presentation to the House of Delegates.

VI. Candidates Forum:
a. There will be a Candidates Forum for contested offices. The Annual Meetings Council in consultation with both the Speaker of the House and the chair of the C&E Committee shall be charged with determining the appropriate time and location for this forum in consultation with the C&E Committee.
b. The Chairperson of C&E shall serve as moderator for the Candidates Forum.
c. Only Delegates and Alternate Delegates may submit questions for candidates to answer during the Candidates' Forum. However, any member may request a Delegate or Alternate to ask a question. Delegates and Alternates will be asked to submit questions 30 days in advance of the HOD. Questions may be submitted in writing to the AGD office before the HOD. All questions submitted will be sorted by staff. Those submitting questions should specify to which office their questions apply (e.g., Vice President, Secretary, Treasurer, Speaker of the House, or Editor). Delegates and Alternates may submit questions at the House of Delegates annual meeting at the First Session of the HOD in receptacles provided by C&E.
d. The Chairperson and Vice-Chairperson of C&E along with staff shall screen all questions to ensure appropriateness and proper grammar. They may combine similar questions.
e. A coin will be tossed to determine the initial order of the candidates for questioning. The order will rotate thereafter.
f. The moderator will then select questions and pose the same questions identifying the Delegate or Alternate posing the question to each candidate running for an identical office. All candidates for a particular contested office will be present when questions are presented, and will share alternatively the opportunity to answer first. Each candidate will be given an identical amount of time to answer all questions. No candidate may take more than two (2) minutes to answer a specific question.

VII. Candidates Reception:
a. The only entertaining permitted by the candidates will be in the Candidate's Reception Room designated by the AGD so that the candidates may have informal dialogue with those who have decision-making roles within the organization. The Candidate's Reception Room shall be open only for formal entertaining during the time designated by the AGD.
b. All candidates will select the menu and equally fund the cost of the Candidate's Reception if they choose to participate in the reception.

c. All signs must be approved by C&E in consultation with AGD Meeting Services Department as to size, number, appropriateness, and location.
d. The same provisions apply to both contested and uncontested candidates.

VIII. Candidate Activity: Acceptable activity in the furtherance of a campaign shall include:
a. The distribution of biographical, issue-oriented, and contact information on the candidate to the AGD, regional, and constituent leaders and the appearance of the candidate at regional caucuses held in conjunction with the AGD Annual Meeting. All such materials must to be approved by the C&E Committee prior to distribution. (See X)
b. Commentary and/or biographical information will be posted on an "Election/Candidates" page on the AGD website. Each Candidate will be given relatively the same amount of space. The C&E must approve all commentary and/or biographical information concerning the candidate before it is posted. Staff will upload the information.
c. Commentary and/or biographical information will be printed in one edition of *AGD Impact* so that side by side comparisons can be made, so long as materials are submitted to meet publication deadlines.
d. A candidate shall only initiate contact with a Delegate or Alternate by mail, e-mail or fax unless the Delegate or Alternate initiates contact. A candidate may not solicit a Delegate or Alternate's phone number. If the method of contact is via e-mail, then such e-mails shall be sent a first time, and then a second and final time with an interval of thirty (30) days between the two e-mails, contingent upon the declaration of candidacies. AGD staff shall send out the e-mails, of all candidates for an office, on the same day, again subject to the declaration of candidacy. The timing of the e-mails shall be determined per the provisions of Section II herein. Mail and fax pieces may be sent out by the candidates or their representatives, but no more than two mail pieces and two faxes may be sent to any individual Delegate or Alternate.
e. A candidate will formally declare his or her candidacy for the coming year's election to constituent officers, Regional Directors, members of the Board and council and committee chairs not earlier than the latter of the commencement of the AGD Board meeting III or January 1st of the year in which the election is held. Notwithstanding this section, all AGD officers are primarily subject to the provisions of the AGD Bylaws, Chapter IX, Section 1(B)4, which states " *An AGD officer must declare for a new office at least (30) days before the Board Meeting III , and resign his or her current office effective at the close of the annual meeting. Once an AGD officer declares for a new office, said resignation is irrevocable*." Such notice may contain biographical and issue oriented information on his or her candidacy. A candidate shall not announce or circulate petitions for signatures at the preceding annual meeting. Nothing in these guidelines, including the filing deadline for other candidates, shall prohibit a candidate who makes a valid declaration of candidacy from campaigning, subject to all provisions of these guidelines.

f. The term "declare" in Chapter IX, Section 1(B)4 means making a written or electronic communication to the AGD Board and officers, Regional Directors, council and committee chairs and constituent officers.

g. The requirement for a candidate to "present" a "petition" in Chapter IX, Section 1(B)2 means that the candidate shall, via electronic or other mechanical means, transmit a petition to the AGD Secretary, with a copy to the AGD Executive Director.

IX. All information (including electronic) to be circulated to the Delegates and Alternate delegates must be approved by C&E prior to distribution to the Delegates and Alternates. This does not include the verbal portion of the candidate's speech.

X. Staff Responsibilities:
a. Staff shall transmit all items which C&E must review to C&E within one (1) work day of staff receiving it from a candidate. Staff shall acknowledge receipt of the candidate's

materials as articulated in Section XI(i) below by electronic means and confirming the numerical sequence. (e.g., "Received Submission 1, item 1) Staff may also be used to aid in forwarding e-mails to Delegates. Staff are not to be used to develop brochures, make phone calls to delegates, or order supplies.
b. Staff will regularly update information on the website about each candidate and will be responsible for sending out regular e-mails through the *AGD In Action* to encourage members to go to each candidate's campaign information housed on the AGD website.

XI. Campaign Materials:
a. All candidates and their supporters are prohibited from using AGD stationery including business cards, and envelopes, issued by the HQ office in supporting a particular candidate for office. Constituent and component AGD stationery may be used only if specifically authorized by the governing body of the particular constituent or component. Individual candidates are prohibited from utilizing component, constituent or AGD stationery in their campaign letters signed by themselves. The use of the AGD logo is permitted in any and all campaign materials.

b. Campaign "Giveaways" of any kind are not allowed. There shall be no packaged food or other gifts distributed by the candidates to anyone as part of the candidates' campaigns.
c. There will be no items mailed by the candidates other than printed materials approved by C&E.
d. Approved badges or pins, may be used to further a candidate's campaign.
e. All campaign materials need to be submitted for approval.
f. Badges, pins, or other campaign items must be sent physically for approval. In the event that a sample cannot be sent, then a picture showing the full detail of the campaign item must be submitted to the C&E for approval. Once approved these will be divulged, by staff, to the other candidates of a contested office.
g. There shall be no delineated restrictions on when or where approved campaign materials and associated paraphernalia is distributed with the exception of the HOD floor, where staff will place all materials prior to the commencement of the First Session of the HOD and unless otherwise noted in these guidelines or other HOD or Board policy. Each candidate shall certify in writing that they are providing a minimum of 270 collated approved materials to be distributed accounting for all seated in the HOD. Candidates are limited to 3 collated items.
h. Candidates must submit a proof copy of all campaign materials, including those that are electronic only to the C&E Committee at least 45 days before the HOD for an initial review. All materials shall be numerically described. (e.g., Submission 1, item 1, etc.) Materials not submitted by the 45-day deadline may not be used. C&E must inform the candidates whether their materials have been approved or require revision within 15 days of their receipt by C&E, but no later than 30 days before the annual meeting. If a candidate's materials do not pass inspection, that candidate will have until 14 days before the annual meeting to revise the materials and resubmit them to the C&E Committee for approval. If materials requiring revision have not been resubmitted by the 14-day deadline, they may not be used. If a candidate is unable to revise some or all of his or her materials to the satisfaction of C&E by the 14-day deadline, he or she may not use the materials that C&E has not approved.
i. In reviewing candidates' materials, the C&E shall enforce the following:

i. Campaign materials may not use the likeness of an incumbent officer (unless the candidate is an incumbent officer.

ii. Campaign materials may not include endorsements from existing officers, DCs, Past AGD Presidents, the Parliamentarian or any member of C&E.

iii. Existing officers, DCs, the Parliamentarian, Past AGD Presidents or any member of the C&E may not endorse a candidate or participate in a candidate's campaign, nor may pictures of such individuals be displayed in a candidate's campaign literature.

XII. Financing

a. Candidates are only permitted to accept funding from the following sources:
  i. The treasury of their own region;
  ii. The constituent and component AGD treasuries within their own region;
  iii. Private individual donations;
  iv. Their own private funds.

b. No corporate donations of any kind may be utilized. This provision does not exclude donations from a dentist's own personally incorporated practice.

XIII. Oversight

a. The C&E shall be charged with the implementation and monitoring of these guidelines.
b. Upon receipt of a written complaint or upon initiation of its own review of campaign related material, the Chairperson of the C&E Committee, in conjunction with the Committee as a whole, shall determine if a violation of the guidelines has occurred.
c. Upon determination that a violation has occurred by a majority vote (for purposes of this provision, the majority will be three votes of the five committee members) the Chairperson shall forward a written letter to the candidate, notifying the candidate of the violation. Upon a second offense, the AGD President shall announce from the podium immediately after the candidate makes his or her speech during the First Session of the HOD that said candidate has twice violated the guidelines. Upon third or subsequent offenses, a written statement notifying Delegates of the number of campaign violations shall be handed to each Delegate as he or she receives their ballot.
d. If it is determined by the Appeals Task Force that a C&E member has violated these guidelines in a significant manner, they will be replaced immediately by the President. Notification will be sent to the Delegates of the replacement.
e. Any candidate so adjudicated shall have automatic right of appeal to the Appeals Task Force through expedited appeal via electronic meeting or other timely means.
f. All complaints and responses must be in writing and copies retained in a C&E file by the Executive Director.
g. The C&E will certify in writing to the Executive Director at the conclusion of the election and after review of any issues or appeals that a fair election was held.

XIV Appeal Task Force

a. This task force, appointed by the President, shall be made up of three (3) DCs.
b. All candidates shall approve of the task force prior to the beginning of the election. If additional task force members are required due to candidates' lack of approval of the aforementioned DC's, the President shall appoint a former AGD Trustee who is not nor ever has been an AGD officer.
c. The three (3) DCs should, if possible, each be from a Region which has no candidates participating in elections for the year in question.
d. The task force will dissolve after certification of a fair election by the C&E after the conclusion of the annual meeting.
e. The chair shall be specified by the appointing individual.
f. Both the C&E, and/or the Appeal Task Force may seek counsel from the AGD attorney if they desire.

XV. Appeals:

a. A candidate has the right to appeal a decision of C&E through expedited appeal via electronic meeting.
b. The Appeal Task Force will make the final decisions on all appeals. They may do this with the guidance of the AGD's legal counsel if they choose."

1 <u>Officers must remain neutral</u>

2000:2-H-7 "Resolved that the AGD officers, in the best interest of the organization, remain neutral in elections for AGD office."

2

1 Minutes, manuals, and reports
2

96:36-H-7 "Resolved, that council and committee minutes be treated as confidential documents, circulated only to those who attended the meeting, and that council and committee reports be considered public documents, and be it further

3
4 Resolved, that council and committee minutes may be made available
5 under the following circumstances:
6
7 1. To the President, President-Elect and Vice President and
8 all members of the council who did not receive an
9 approved copy of the minutes providing at least two weeks
10 have elapsed since the meeting,
11
12 2. To members of the Board who request special sections
13 from the minutes,
14
15 3. To other agencies of the organization who have a need to
16 see the specific section of the minutes in order to facilitate
17 their deliberations,
18
19 4. In response to a subpoena,
20
21 5. In response to a request from anyone who is entitled by
22 law to have access to the minutes,
23
24 6. Upon the agreement of the council chairperson, the
25 President and the Executive Director that access to the
26 minutes should be permitted,
27
28 and be it further
29
30 Resolved, that Board minutes are considered confidential documents,
31 distributed first to only those who attended the meeting, with the
32 corrected minutes to appear in the next Board agenda book which is
33 distributed to all Trustees, Regional Directors and appropriate council
34 and committee chairpersons, and be it further
35
36 Resolved, that once Board minutes have been approved, they will be
37 available to any member and to any other party that is legally entitled to
38 have access to the minutes, and be it further
39
40 Resolved, that workbooks for council and committee meetings are
41 restricted to the President, President-Elect and Vice President and the
42 members of the working council or committee, and be it further
43
44 Resolved, that members of the Board may request specific sections of
45 workbooks which they identify from agendas which they receive, and be
46 it further
47
48 Resolved, that the distribution of workbooks for the Board meetings are
49 restricted to the members of the Board, regional directors, constituent

presidents who have been invited and have indicated they will attend a specific meeting, and those council or committee chairpersons attending the meeting, and be it further

Resolved, that copies of HOD minutes are considered public documents once the minutes have been approved by the next House of Delegates and that such minutes can be made available to any member who requests a copy providing that they are willing to pay for the photocopying and shipping charges, and be it further

Resolved, that HOD minutes are available for public scrutiny or to anyone legally entitled to see them upon payment of any photocopying or shipping costs, including an additional charge to non-members, approximating 150 percent of the cost, and be it further

Resolved, that House of Delegates manuals are to be distributed to all delegates, alternate delegates, members of the Board, regional directors, council and committee chairpersons, past presidents, the salaried executive of those constituents which have one, and former trustees or officers who have requested to receive them, and be it further

Resolved, that additional copies of the House of Delegates manual may be purchased by individual members at a price based on the cost of producing and shipping them, and be it further

Resolved, that this policy supersede all other policies with regard to the distribution of minutes and workbooks within the AGD."

2002:7-H-7 "Resolved, that the minutes for AGD meetings include only the actions of the body and the relevant considerations to the actions and omit attributing comments to specific individuals in the room with the exception of the makers of the motions."

Resolutions, selecting for action

96:37-H-7 "Resolved, that the Speaker of the House and the Executive Director determine those resolutions from the Board which would require action by the House of Delegates, and be it further

Resolved, that in the absence of a consensus, the resolution in question will be submitted to the House of Delegates."

Resolutions with Board votes

96:54-H-7 "Resolved, that the Secretary's report to the House of Delegates, effective with the 1997 Annual Meeting, include the resolutions acted upon by the Board, with the exception of those involving strategies in the long range plan and those that are deemed of a confidential nature by the Board, be published with notation of each Trustee's corresponding vote."

1 House of Delegates
2
3 Access to floor by constituent executives
4

95:5-H-7 "Resolved, that the rules of procedure be changed to allow constituent executives officially listed on the Constituent Officers List access to the floor during the House of Delegates meeting by allowing them to sit with their delegations, and be it further

5
6 Resolved, that no constituent be allowed to seat more than one officially listed executive on
7 the floor of the House of Delegates
8
9 Consent calendar
10

98:2-H-7 "Resolved, that the AGD House of Delegates operate with a consent calendar with each Reference Committee deciding which resolutions are to be placed on a consent calendar based on meeting all of the following criteria:

11
12 1. Recommended by a unanimous vote of the Board not counting those
13 absent or abstaining.
14
15 2. Receive no opposition or attempts to amend in the Reference
16 Committee hearing.
17
18 3. Have had no suggestions for changes in wording by the Reference
19 Committee.
20
21 and be it further
22
23 Resolved, that any delegate have the right to remove a resolution from
24 the consent calendar."
25
26 Press releases
27

2014:116G-H-6 "Resolved, that 94:35-H-7 be amended following approval of the separation of governance and the scientific session."

"Resolved, that the House of Delegates direct the staff to include a framework press release for alternates, delegates and officers in the House of Delegates Manual."

28
29 Seating of Council and Committee Chairpersons
30

91:35-H-7 "Resolved, that AGD council and committee chairpersons or a member of that council as appointed by the President be asked to sit in the front row of the House of delegates with the appropriate staff when resolutions from their agencies of the AGD are being considered and be it further

1
2 Separation of Governance and Scientific Session

2014:104-H-6 “Resolved, that the annual meeting of the AGD House of Delegates (HOD) and all related Governance proceedings be completely separated from the AGD Scientific Session and Convocation beginning in 2017 or sooner if contractual agreements and finances will feasibly allow, and be it further,

Resolved, that the AGD House of Delegates and all related Governance proceedings be moved to September or the fourth quarter of the calendar year, and be it further,

Resolved, that the Speaker of the House be given authority to make any necessary related editorial changes to other sections of the Bylaws that are applicable to this Governance change.”

3 **Board**
4
5 Conflict of interest statement
6

94:5-H-7 "Resolved, that if at any time the Board, a council or committee is involved in a decision in which a Board, council or committee member or Regional Director has a financial interest, that interest must be disclosed and recorded in the minutes, and be it further

7
8 Resolved, that the member or members with a financial interest be
9 required to leave the room and neither participate nor vote in the group's
10 decision, and be it further
11
12 Resolved, that clinicians for various courses in which an honorarium will
13 be paid may not be selected from the council or committee responsible
14 for organizing the event, and be it further
15
16 Resolved, that nothing in this policy shall preclude a member of the
17 Board from participating in establishing the policy for reimbursement of
18 AGD members for personal expenses incurred while on AGD business or
19 other financial decisions delegated in the bylaws to the Board for entire
20 groups of individuals rather than a specific person, and be it further
21
22 Resolved, that votes taken affecting a specific individual within a council,
23 committee, or Board shall be done with the individual out of the room so
24 uninhibited discussion may take place, and be it further
25
26 Resolved, that if a member fails to make such a disclosure the Board may
27 take appropriate action, and be it further
28
29 Resolved, that the AGD's attorney be asked to propose a conflict of
30 interest statement to the Board that would be signed by all AGD council,
31 committee and Board members regarding possible proprietary, financial
32 or personal interests that might conflict with that of the organization."
33

95:1-H-7 Resolved, that the conflict of interest statement be adopted with the addition of the following paragraph under the subheading 'Signature Required Prior to Serving AGD':

1
2 As a condition for selection a candidate for the office of Vice-
3 President, Secretary, Treasurer, Editor or Speaker of the House
4 must sign the following Disclosure Statement and file it with the
5 AGD Secretary prior to announcement of the candidacy to the
6 membership or the Delegates.
7
8 Designate constituent leaders to receive copies of correspondence
9

81:15-H-7 "Resolved, that the House of Delegates recognize that it is the prerogative of the Board to make certain determinations such as designating particular constituent leaders to receive copies of correspondence emanating from the national office."

10
11 Documentation of Expenses
12
13 Paid $1,000 for expenses
14

2010:110bS1 Resolved, that the HOD policy 2008:105R-H-7 be amended as follows:

Each of the 19 trustees be allotted $2,000 and adjusted annually thereafter up to CPI as determined by the budgetary process effective July 21, 2008 (start of 2008/2009 governance year), of AGD funds for the following activities relating to his or her duties as an AGD trustee:

And be it further,

Resolved, that Region 15-16 will give an annual report to the Board as to the effectiveness of the merger. The Board will provide the 2013 HOD with a three year progress report on the merger. And be it further,

Resolved, that the Speaker of the House be authorized to editorially amend the Bylaws relative to any non-substantive references to the number of regions, trustees, etc., not previously identified herein."

15
16 Executive Committee Authority
17

84:18-H-7 "Resolved, that the Executive Committee be given the necessary authority to appropriate funds and authorize an emergency mailing to all AGD members, but use extreme discretion in doing so."

18
19 Location of meetings
20

2015:309-H-6 "Resolved, that HOD Policy 2014:107-H-6 be amended to read:

"Resolved, that the AGD take advantage of super saver and other discounted airfares whenever possible in scheduling meetings and be it further

1
2 Resolved, that officers, members of the Board, Council and Committee
3 be encouraged to take advantage of super saver airfares by:
4
5 1. Offering an extra per diem to an individual staying over on a
6 Saturday night when the savings in airfare more than compensates
7 for it.
8
9 2. Holding Board Meetings within the continental United States in
10 locations where Board members can be encouraged to stay over
11 on a Saturday night to obtain a super saver airfare, and be it
12 further
13
14 "Resolved, that all Council and Committee Meetings be held in Chicago
15 except for:
16
17 1. Meetings of the Annual Meetings Council which may be held at
18 sites selected for Annual Meetings to be held within three years.
19
20 2. Such other meetings as the President may deem necessary which
21 have to be moved to a location outside of Chicago because of
22 justifiable logistical reasons, where the total cost of the airfare
23 will be less or not appreciably more than it would have been held
24 in Chicago.
25
26 3. Any meeting held in conjunction with the AGD's Annual
27 Meeting.
28
29 4. Any meeting held in conjunction with the American Dental
30 Association's Annual Meeting."
31
32 May meetings of the, to be in Chicago
33

97:39-H-8 "Resolved, that the Board be asked to consider holding future May Board meetings in the Chicago area effective in the year 1999-2000."

34
35 Observer designated in absence of Trustee
36

2009:103R-H-7 "Resolved that the Board policy be amended that non-voting observers will be recognized based on parliamentary procedure."

37
38 Stationery
39

1 Title may not be used to promote commercial products or services
2 unrelated to AGD
3

2000:15-H-7 "Resolved, that any individual elected or appointed to positions within the Academy of General Dentistry or its constituent and component academies should not use the title of said position in the promotion of commercial products or services unrelated to the organization, and be it further

4
5 Resolved, that all incoming Officers, Trustees, Regional Directors, and
6 Council and Committee members and Chairs be advised of this policy
7 when they assume office."
8
9 Stipend
10
11 President, President-Elect, and Vice President
12

2008:104R-H-7 "Resolved, that policy 2004:5A-H-7 be amended to read:

"That effective July 21, 2008 (start of 2008/2009 governance year), the annual stipends of the President, President-Elect, Vice President, Treasurer, Secretary, Speaker and Editor respectively be increased to $55,000, $40,000, $27,500, $10,000, $10,000, $5,000 and $21,000, and adjusted annually thereafter up to CPI as determined by the budgetary process."

13
14 **Constituent AGD**
15
16 Delegate reimbursement by
17

78:30-H-6 "Resolved, that this House of Delegates recognize that it is desirable to place a portion of the responsibility for delegate reimbursement at the constituent level."

18
19 Trademark Licensure
20

2014:309-H-6 "Resolved, that any Council, Committee, Region, Constituent or Component shall not be charged a fee for using an AGD Brand, Designation or Registered Name of the AGD. This will include programs sponsored and funded by constituents and components including Mastertrack and Fellowtrack. This will not apply to PACE approval for CE."

21
22 **Councils and Committees**
23
24 Agenda review

1
83:8-H-7 "Resolved, that at the beginning of each administration, the various council and committee chairpersons be given an opportunity to identify other council and committee agendas they would like to receive in order to enhance their effectiveness in running their own councils."

2
3 Appointments
4

2008:103-H-7 "Resolved, that policy 2002:33-H-7 be amended so that it reads:

"Resolved, that the Membership and Dental Education Councils include at least one member out of dental school less than five years at the time of their appointments."

5
6 Appointments, guidelines for President-Elect in making
7

2017:101-H-11 "Resolved, that AGD HOD policy 2002:8-H-7 be revised as follows:

"Resolved, that the following system be used to guide the incoming President in making council and committee appointments:

1. The incoming President will send a letter in April to all Constituent Presidents, Regional Directors, and Trustees asking for council and committee appointment recommendations. The letter will be accompanied by a suggested geographical distribution based on the number of members in each region to help make the appointments as geographically balanced as possible. This geographical distribution list will be based on the present council and committee structure, not including the Local Advisory Committees, the Professional Relations Committee, and all Board Committees. Members of the Examination Council shall not be counted a second time if also serving on Exam Committee A, Exam Committee B, or Exam Committee C. The deadline for responding to this communication will be June 30 of each year.

2. The incoming President will make the appointments in consultation with the Vice President, giving consideration to merit and experience.

3. The incoming President will see that contact is made with each newly appointed member to see that there is a willingness to serve.

4. The Trustees will be given the reconstituted geographical distribution list with the Board Meeting IV book (in the 2016-2017 governance year this will be Board Meeting V).

5. Individual Trustees will give input at the time the Board approves the appointments, and the appointments will not be publicly announced until such time as the Board has taken action on the list of appointments.

6. When the Board has approved the appointments, the councils and committees will be advised of them.

1
2 Assignments to Councils and Committees
3

2008:111-H-7 AS AMENDED "Resolved, that the AGD Bylaws be amended at Chapter XIII, Line 2025, which states:

C. No member of a council may serve more than two (2) consecutive three (3) year terms on a particular council, nor may any member serve on more than one (1) council at a given time. In the event that a member is fulfilling an unexpired term, the unexpired term shall be considered the first full three (3) year term unless the unexpired term is one year or less, in which case the member could serve up to a maximum of seven (7) consecutive years.

and be it further,

Resolved, that the Constitution, Bylaws and Judicial Affairs Council be charged with reviewing the current council and committee structure and report back to the Board and the 2009 House of Delegates for clarification of the Bylaws on appointments to councils, committees, and task forces."

4
5 Council and Committee Charges
6

2007:101RC-H-7 "Resolved that the Board Policy Manual contains the council and committee duties and charges and that it be shared with the HOD and the duties and charges of the council and committees be included in the annual reports."

7
8 Solicitation of individuals to serve
9

76:29-H-11 "Resolved, that a letter be sent to each constituent AGD president at least four months prior to the annual meeting soliciting his opinion on those individuals who might work most effectively on national councils and committees, and be it further

10
11 Resolved, that the constituent presidents be asked to suggest a particular
12 council or committee to which such individuals could be assigned and the
13 rationale for the recommendation, and be it further
14
15 Resolved, that the Academy of General Dentistry's president evaluate
16 these responses in determining the AGD's council and committee
17 structure for the coming year."
18
19 **Component Academies**

1
2 Constituent approvals
3

90:40-H-7 "Resolved, that the Academy of General Dentistry recommend that its constituent academies incorporate provisions into their Bylaws so that component academies can be approved promptly by a Board of Director's rather than having to wait for a General Assembly or House of Delegates to meet which will often occur only once a year."

4
5 **Crisis Communications**
6
7 Timely response by Presidents
8

2012:104-H-6 "Resolved, that the President, President-Elect, and Vice President of the AGD shall collectively be authorized to issue a timely response to any urgent matter placed before them with the understanding that any response shall not be in violation of existing AGD Policy."

9
10 **Dental Education**
11
12 Council on
13
14 Chairperson and Co-Chairperson can make interim decisions
15

75:55-H-10 "Resolved, that the chairperson and co-chairperson of the Dental Education Council be empowered to make interim administrative decisions provided that the substance of these decisions be transmitted to the full council for discussion at its next meeting."

16
17 Redefine FAGD/MAGD parameters to permit continuous accumulation
18 of MAGD participation credits
19

2004:21-H-7 "Resolved, that the Dental Education Council be charged with redefining the parameters for the Fellowship and Mastership award programs with participation credits accumulating in a continuous manner toward Mastership, allowing for the availability of desired courses that are convenient and applicable to patient care and professional preference, and be it further

Resolved, that the Dental Education Council report back to the 2005 House of Delegates with appropriate changes."

20
21 **Dental Interactive Simulation Corporation (DISC)**
22

95:12-H-7 Resolved, that the Academy of General Dentistry continue to have a representative on the Dental Interactive Simulation Corporation's Board;

and be it further

Resolved, that any additional financial support to this endeavor be subject to House of Delegates approval.

Gender

Gender neutral language, use of

92:41-H-7 "Resolved, that all existing AGD rules, regulations and policies be editorially corrected to be non-gender specific, and be it further

Resolved, that all constituents be urged to use gender-neutral language in all official communication."

Long Range Plan

98:27-H-7
REVISED
HOD 7/99

"Resolved, that a new Goal 'J' be added to the goals of the organization for use by the Board and the AGD's councils, committees, and staff in long range planning so that the 10 goals will now read:

Goal A: To provide general dentists with the resources and incentives needed to regularly update and expand the dental knowledge and skills they possess

Goal B: To assist general dentists in evaluating their dental knowledge and skills

Goal C: To effectively represent the interests of general dentists in the formulation of the policies, programs, and procedures adopted by organized dentistry

Goal D: To effectively represent the interests of general dentists in the formulation of public policy

Goal E: To effectively represent the interests of general dentists in the formulation of third-party payment policies and procedures

Goal F: To build and maintain a viable membership base

Goal G: To build a strong viable organization

Goal H: To enhance the image of the Academy of General Dentistry and the general dentists it serves

Goal I: To increase the public's demand for dental care through an understanding of its benefits

Goal J: To effectively involve general dentists in health promotion and wellness"

President

1
2 Honorarium, entertainment budget, and spouse per diem for President and President-Elect
3

89:41-H-7
REVISED
HOD 7/2004
REVISED
HOD 2012

"Resolved, that changes in the President's and President-Elect's honoraria be established by the House of Delegates based on recommendations from the Budget and Finance Committee and Board, and be it further

4 Resolved, that the Budget and Finance Committee continue to see that the
5 President, President-Elect and Vice President are given an approved
6 entertainment budget, and be it further
7
8 Resolved, that the President be given the option of receiving actual
9 expenses including reimbursement for the person he or she identifies to
10 manage social functions at the Annual Meeting and the Board meetings
11 and be it further
12
13 Resolved, that the person identified by the President-Elect to manage
14 social functions be compensated for transportation, not to exceed coach
15 airfare, plus the current daily per diem for AGD volunteers and ground
16 allowance for attending the Board meetings, and be it further
17

Resolved, that the person identified by the Vice President to manage social functions be compensated for transportation, not to exceed coach airfare, plus the current daily per diem for AGD volunteers and ground allowance for attending only the Annual Meeting."

18
19 **Regional**
20
21 Caucus visitations come through the Regional Director
22

90:53-H-7

"Resolved, that the AGD National Office inform council and committee chairpersons, candidates, and constituent presidents, particularly those new to office, that the appropriate way to visit a caucus is to contact the Regional Director."

23
24 Region 7 to be known as the Lionel French Region 7 Caucus
25

82:28-H-7

"Resolved, that the Region 7 caucus held during the Annual Meeting's House of Delegates Session be given the permanent name of the Lionel French Region 7 caucus, and be it further

26
27 Resolved, that this name be so published in appropriate Annual Meeting
28 materials."
29
30 **Regional Directors**
31
32 Seating on floor of House of Delegates
33

87:41-H-7

"Resolved, that Regional Directors be seated with their delegates on the floor of the House of Delegates regardless of their delegate status."

34

1 **Rules of Procedure**
2
3 Conducting Reference Committee hearings and business of the AGD House of Delegates
4

84:12-H-7 "Resolved, that the new Rules of Procedure for Conducting the Reference Committee Hearings and Business of the Academy of General Dentistry's House of Delegates be adopted." (*See Guidelines*)

5

2007:306R-H-6 "Resolved, that the Rules of Procedure for Conducting the Reference Committee Hearings and the Business of the Academy of General Dentistry House of Delegates be amended as follows:

1. The House of Delegates will consider business introduced only in one of the following ways:

a. A resolution submitted on a petition signed by 25 or more active members at least one week prior to the Annual Meeting and directed to the executive director;

…

9. The procedure with regard to handling of nominations at the Opening Session of the House of Delegates for both Academy offices and for positions on the American Board of General Dentistry shall be:

a. The Academy's Secretary shall announce any petitions received at least 60 days prior to the Opening Session of the House of Delegates on behalf of candidates running for Academy of General Dentistry office at the Annual Meeting. No petition will be honored that is received more than one year in advance of the Annual Meeting in which the election takes place.

b. The Immediate Past President shall advise the House of Delegates of the selections made by the full Board for any vacancies on the American Board of General Dentistry. The Secretary shall announce any petitions received at least 60 days in advance of the Opening Session of the House of Delegates on behalf of any candidates running for the American Board of General Dentistry.

c. Credentials of all candidates nominated to Academy of General Dentistry office or to the American Board of General Dentistry shall be published to the members of the House of Delegates at least three weeks prior to the start of the Annual Meeting.

d. A nominating speech of no longer than two (2) minutes will be made on behalf of each candidate. There shall be no seconding speeches. Instead, each candidate for AGD office shall be allowed to address the House of Delegates for no longer than five (5) minutes.

e. Candidates who are unopposed will be declared elected by the presiding officer at the Opening Session. Contested elections shall be conducted at the conclusion of the regional caucuses. To be declared elected, a candidate must have received a majority of the votes cast. In the absence of a majority, a second ballot shall be held between the two (2) candidates receiving the highest number of votes on the first ballot. A petitioned candidate for the American Board of General Dentistry will be running against all three of the candidates proposed by the Academy's Board. Each member of the House of Delegates will be given as many votes as there are positions to be filled on the American Board of General Dentistry, but delegates may not vote for any one candidate more than once. Run-off elections among those candidates who have not yet received a majority of the votes cast shall be between the two candidates who got the highest number of votes on the first ballot. If there is a tie involving more than two of the top candidates, then the House will continue to vote until the tie is broken.

10. The Credentials and Elections Chairperson shall work with staff to post the results of the election in the meeting registration or other appropriate area. The results will specify only one winner and not the vote totals. Each candidate is permitted to name an observer on his or her behalf to view the official counting of ballots undertaken by the Committee on Credentials and Elections. Anyone observing the counting of the ballots must hold these results in confidence until such time as the results have been posted.

1

2010:301a-H-7 "Resolved, that the "Rules of Procedure for Conducting The Reference Committee Hearings and Business of the Academy of General Dentistry's House of Delegates" be amended as follows:

Rules of Procedure for Conducting The Reference Committee Hearings and Business of the Academy of General Dentistry's House of Delegates

1. The House of Delegates (HOD) will consider business introduced only in one of the following ways:

An appropriate resolution emanating from a meeting of the Board of Trustees (Board);

Resolutions emanating from any report of an officer, council or committee;

A resolution submitted in writing and introduced on the floor of a session of the HOD with the unanimous consent of the HOD. Such a resolution requires approval by two-thirds of the delegates present and voting. Reference Committee recommendations are not, however, deemed new business.

2. In keeping with the Constitution and Bylaws of the AGD, no amendment may be made to either the Constitution or the Bylaws unless it has been published to the members at least thirty (30) days in advance of the annual session of the HOD on the AGD Web site and links to the proposed changes will be headlined thereon. If such is the case, the Constitution may be amended by an affirmative vote of at least two-thirds of the certified delegate members present and voting at the annual session of the HOD, and the Bylaws may be amended by an affirmative vote of two-thirds (2/3) of the delegates present and voting.

3. The Speaker of the House, in consultation with the Executive Director, shall make a recommendation to the Board at the regular meeting held before the annual session of the HOD of how the annual reports and resolutions are to be divided among three Reference Committees. All delegates will be strongly encouraged to review all resolutions.

4. The President shall designate five delegates and two non-voting consultants who need not be delegates to serve on each Reference Committee. Members serving on current councils and committees of the organization may not serve on the Reference Committee if that Reference Committee is going to review a report from a council or committee on which the member is currently serving. The two non-voting consultants may, of course, have served on councils or committees whose reports are being reviewed by that Reference Committee.

5. Reference Committee hearings are open to all members of the AGD. At the appropriate time each member may express his/her opinion on a given subject being heard by that Reference Committee.

a. The Chairperson of the Reference Committee shall preside at the Reference Committee hearing. He/she shall be seated with his/her four committee members, a maximum of two consultants, and designated staff from the AGD's headquarters office at a table in the front of the hearing room.

b. The Chairperson of the Reference Committee may limit the length of time each member is allowed to speak, but may not prevent any member from speaking at least once on a given subject. Once debate has been limited by the Chairperson, it shall apply to all future speakers in that particular Reference Committee on that topic.

c. No resolutions may be introduced in the Reference Committee hearing.

d. The purpose of the Reference Committee hearing is only to receive information and opinions. No votes may be taken in the hearing on any resolution.

e. All Reference Committees must remain in session for a minimum of 90 minutes or until all attendees have left the room so that delegates may present their views before all of the Reference Committees.

6. Immediately after the hearing, the five members of the Reference Committee and the Committee's consultants shall deliberate in executive session and make a recommendation to the AGD on each item of business assigned to it. No item of business may be omitted. The Reference Committee may recommend that a resolution be adopted, rejected, amended, referred to committee, or postponed definitely. An amendment may take the form of a substitute resolution. However, the substitute resolution must be completely germane to the original resolution. After the executive session, the report of the Reference Committee shall be prepared by the Chairperson with the assistance of staff from the AGD's headquarters office.

7. At the appropriate time, the presiding officer shall request that each Reference Committee Chairperson deliver his/her report to the HOD. The Chairperson shall move for appropriate action on each recommendation or substitute resolution from the Reference Committee and identify a member of the Reference Committee as the seconder of the motion. At this time, an amendment to the resolution may be offered from the floor. The amendment must receive a second before it can be discussed. A vote on the main motion or resolution will occur after the membership has reached a decision on each amendment which has been duly proposed. No motions to postpone indefinitely will be permitted.

a. Only those sections of the Constitution and Bylaws which have been published to the membership at least thirty (30) days prior to the annual session of the HOD are subject to amendment. It will be the presiding officer's duty to determine whether a proposed amendment to such a resolution is completely germane to the question. If the proposed amendment is not germane to the particular section of the Constitution and Bylaws under scrutiny, it will be his/her duty to rule the amendment out of order and request that it be appropriately introduced at next year's annual session of the HOD.

b. The President shall appoint a parliamentarian to assist and advise

the Speaker of the House in running an orderly meeting in keeping with these Rules of Procedure. All questions not covered by the AGD's Constitution and Bylaws or these Rules of Procedure shall be governed by Sturgis Standard Code of Parliamentary Procedure. A copy of this code shall be maintained by the parliamentarian for reference.

8. Only duly certified delegates or alternate delegates who have been elevated to delegate status may vote or move resolutions on the floor of the HOD. However, any of the following individuals may address the HOD after they are recognized by the presiding officer:

a. All delegates;

b. All AGD officers who are members of the Executive Committee;

c. All Council or Committee chairpersons;

d. All AGD Past Presidents;

e. The Executive Staff of the AGD;

f. All members of the Board who have not otherwise been elected delegates (such Board members may be seated with their Constituent AGD delegations on the floor of the HOD).

h. All Regional Directors who have not otherwise been elected delegates (such Regional Directors may be seated with their constituent academy delegation on the floor of the HOD

The President of the AGD Foundation may have access to the floor, but may address the HOD only if an issue concerns the Foundation.

j. Any AGD member may have access to the floor of the HOD in order to give a nominating speech for a candidate in a contested election.

9. The procedure with regard to handling of nominations at the First Session of the HOD for AGD offices shall be:

a. The AGD's Secretary shall announce any petitions received at least 60 days prior to the First Session of the HOD on behalf of candidates running for AGD office at the annual session of the HOD. No petition will be honored that is received more than one year in advance of the annual session of the HOD in which the election takes place.

10. Council and Committee Chairpersons shall sit in the front row of the HOD with the appropriate staff when resolutions from their agencies of the

AGD are being considered. If a Council or Committee Chairperson is not in attendance at the annual session of the HOD, the President may designate another member of the Council or Committee as a substitute. The Speaker of the House shall recognize such individuals in proper sequence when it is obvious that they need to provide input to the HOD on any proposed change affecting their areas of jurisdiction.

11. Constituent Executives, officially listed in the Constituent Officers List, may sit with their delegations on the floor of the HOD, but no constituent may seat more than one officially-listed executive.

1

2010:301bR-H-7 “Resolved, that the “Rules of Procedure for Conducting The Reference Committee Hearings and Business of the Academy of General Dentistry’s House of Delegates” be amended as follows:

1.

a. A resolution submitted on a petition signed by 25 or more active members at least two weeks prior to the annual session of the HOD and directed to the Executive Director;

d. A resolution introduced by any Constituent AGD or any certified delegate providing that the resolution has been received by the AGD's Executive Director at least two weeks prior to the First Session of the HOD at the annual session of the HOD;

2

3 **Tobacco**

4

5 Tobacco use, prohibition of

6

90:42-H-7 "Resolved, that the Academy of General Dentistry prohibit smoking and all other uses of tobacco at all national council, committee, board and other meetings, including the business and scientific sessions of the AGD Annual Meeting.”

7

Publishing/Production Design Policies

Editor

Editor Emeritus

96:34-H-7 "Resolved, that in recognition of over 20 years of outstanding service as Editor of the Academy of General Dentistry, that Dr. William W. Howard be named the AGD's Editor Emeritus with all of the privileges of a past president and that his new status will be listed on the masthead of *General Dentistry* and *AGD Impact*."

Publications

General Dentistry

Bi-monthly publication

84:20-H-7 "Resolved, that *General Dentistry* should be maintained on a bimonthly publication schedule."

Statement of purpose for

82:26-H-7 "Resolved, that Section 3 of 'General Statement of Goals and Objectives' of the Editorial Policy of the Academy of General Dentistry, as adopted by the 1979 House of Delegates, be replaced, in total, by the following statement:

> '*AGD Impact* is a news publication designed to enhance AGD members' understanding of the political and professional issues that confront them and to disseminate information on the activities and accomplishments of the Academy of General Dentistry. Materials published in *AGD Impact* are usually prepared by the National Office Communications staff. However, responsibility for determining the acceptability of articles produced by the staff or by members of the AGD as well as responsibility for determining the scope of content of *AGD Impact* rests solely with the Editor.'"

2005:24R-H-7 “Resolved, that the mission of *AGD Impact* be augmented to include active promotion of the advocacy efforts, interests, activities and accomplishments of the AGD with emphasis on the use of photographs involving these activities.”

1
2 Sales and Sponsorship Policies
3
4 **E-mail Addresses and Fax Numbers**
5 **<u>No member e-mail or fax information will be provided to corporate sponsors</u>**
6

2016:103R-H-7 "Resolved, that AGD HOD policy 2004:2-H-7 be revised as follows:

"Resolved that the Academy of General Dentistry will not provide member e-mail addresses or fax numbers as part of any external agreement with a Corporate Sponsor, AGD Members Savings & Offers Provider or other list rental; and be it further,

Resolved, that the following guidelines, constructed with input from the AGD Executive Director, Corporate Sponsorships, Group Benefits Council, Membership Council and Communications Council be adopted as further security for member contact information:

1. Each member will be encouraged to permit e-mail news and alerts from the organization on a regularly scheduled basis, and offered the opportunity to decline this offer at any time.
2. All AGD e-mail messages to members will be clearly and appropriately labeled in the subject line of the e-mail and include "opt-out" instructions as well as the physical address and contact information for the AGD.
3. The AGD Web site at www.agd.org will provide the opportunity for members to amend their communication preferences with the AGD at any time."

7
8
9 **<u>Proposed projects of, sponsors to provide estimates</u>**
10

76:36-H-11 "Resolved, that the sponsor of any new proposed project or activity be prepared to provide reasonably accurate estimates of the costs to be incurred and an analysis of the source of income or monies used to fund said project."

11
12 **Web Site**
13
14 <u>In Members Only section</u>
15

98:13-H-7 "Resolved, that AGD accept commercial banner link advertising in the Members Only section of the AGD Home Page using the following criteria as well as AGD's advertising policy:

16
17 <u>Criteria for Establishing Commercial Hyperlinks from the</u>
18 <u>AGD Home Page</u>
19

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22

1. Careful consideration should be given as to whether the link conflicts with the AGD mission, vision, or policies, or with the standards of conduct generally adhered to by members of the dental profession.

2. The hyperlink should offer content enhancement.

3. The AGD's approval for a hyperlink request should include a request from the AGD for a reciprocal link to the AGD site.

4. The AGD's approval for a hyperlink to a site that is not primarily dentistry-related should include a requirement that the link be a direct connection to the specific dentistry-related page on the site.

5. The AGD's web site disclaimer should cover hyperlinks.

6. AGD web site staff should be able to monitor and implement the AGD's policies on hyperlinks under authority of the Internet Council and its chair in much the same way that the AGD's approval of publication display advertisements is delegated to AGD publishing staff under the authority of the AGD editor."

Finance and Information Technology Policies

Budget

2017 Budget

2016:150-H-7 “Resolved, that the 2017 budget with Net Income from Operations of $0 pre-spending and $0 post-spending and a capital budget of $89,500 be approved.

2018 Budget

2017:150S4-H-11 “Resolved, that the 2018 budget with Net Income from Operations of $0 pre-spending and $0 post-spending and a capital budget of $89,500 be approved.

And be it further, resolved, that the budget be amended to include a $3 increase in student dues and be it further resolved that the contingency fund be reduced by $34,420.

Budget and Finance Committee

Investigate indexing system for honorarium increases

2004:5B-H-7 “Resolved, that the Budget & Finance Committee investigate an indexing system for future honorarium increases for the President, President-Elect, Vice President, and Editor.”

Financial

Budget to be modified by Board

72:14-GA-2 "Resolved, that the Board be authorized to modify the budget by a maximum of twenty-five percent as may be indicated during the course of the year."

1
2 Human Resources Policies
3
4
5

1
2 Information Technology Policies
3
4

1
2 Office Services Policies
3

1

Member Programs

Academy of General Dentistry

Restructure of regions in 1993

92:29-H-7 "Resolved, that the House of Delegates be given a report on the desirability of restructuring all of the regions of the organization anytime a request for a realignment of the constituents constituting the various regions is considered by the organization."

2015:305-H-6 "Resolved, that the Virgin Islands AGD Constituent be merged into the Puerto Rico AGD Constituent.

Component Academies

Developing component Academies

87:47-H-7 "Resolved, that constituent AGD Presidents and Regional Directors be asked to consider the following steps in developing component Academies:

A. Identify areas that could be developed as components.

B. Identify a leader within each area to get a group together.

C. Have leaders set up a meeting with a group of interested GPs.

D. Take a team of three constituent representatives to discuss how components could fill the needs of dentists in area.

E. Make it easy to form a component by providing sample constitution and bylaws.

F. Get group to elect officers.

G. Get signature on component petitions at meeting.

H. Show component how to raise seed money: suggest that organizing group contribute $5 or $10 each.

I. Follow up component development by telephone from constituent AGD.

J. Use CDE as a component development tool."

Dues collected by National

2009:100-H-7 "Resolved that the AGD amend policy 84:39-H-7.

Dues collected by AGD headquarters

84:39-H-7 "Resolved, that the component AGDs be given the option of having their dues collected by the national organization, and be it further

Resolved, that only those components submitting a completed and signed Component Dues Update Form by the July deadline shall be eligible to have their dues collected by the national organization for the coming year, and be it further

Resolved, that components who collect any component dues after March 31 forward the dues payment to the AGD headquarters office for processing."

1
2 **Constituent AGD**
3
4 Constitution & bylaws for components
5

97:18-H-8 "Resolved, that constituent academies be advised of the need to have component constitution and bylaws in place, and be it further

6
7 Resolved, that those constituents which have missing component
8 constitution and bylaws be followed up at least every six (6) months until
9 such time as all constitution and bylaws have been received, and be it
10 further
11
12 Resolved, that effective with the 2000 dues year, the AGD will no longer
13 collect dues for those components which have been in operation at least
14 three (3) years and do not have a current constitution and bylaws on file
15 in the AGD's Chicago office."
16
17 Delegate selection
18

91:34-H-7 "Resolved, that the AGD Constituent Academies consider electing their delegates to the AGD HOD with consideration given to appropriate turnover in the delegation so that opportunities are provided for other members to represent the constituent in the AGD House of Delegates."

19
20 Dissolution steps
21

90:33-H-7 "Resolved, that the following steps be taken when it becomes apparent that virtually no activity is taking place within an AGD constituent AGD:

22
23 1. That both the Trustee and the Regional Director be advised to
24 make the necessary contacts within such constituents to generate
25 some meaningful activity including meetings and suitable
26 elections.

2. That once the Regional Director and Trustee have certified that they can generate no meaningful activity that a letter be sent to every member of the constituent AGD indicating that the constituent will be disbanded with all members holding direct membership in the Academy of General Dentistry without being a part of the constituent AGD unless a group can be formed to hold a meeting and elect new constituent officers.

3. That if no response is forthcoming within six months of the date of the letter, the constituent will be classified as unorganized and no longer be entitled to representation in the AGD House of Delegates nor collection of dues by the Academy of General Dentistry".

4. Members of unorganized constituents do not pay constituent dues.

5. Unorganized constituents are not eligible for delegate representation in the House of Delegates.

<u>Financial structure for programs</u>

78:29-H-6 "Resolved, that constituent Academies work towards establishing a financial structure that will offer their members more meaningful programs."

<u>Officers' list to be circulated by National Office</u>

74:10-H-11
REVISED
HOD 7/2000

"Resolved, that the Chicago office of the Academy of General Dentistry assume the responsibility for circulating to each constituent president, executive director/executive secretary and editor a list showing the officers of every AGD constituent, national officers, regional officers, council chairs and members, and be it further

Resolved, that this list be distributed semi-annually, in October and in April, and be it further

Resolved, that the various constituents and components be encouraged to exchange information and publications with one another as a method of making their own organizations more effective."

<u>Recommendation to create dental care committees</u>

89:51-H-7 "Resolved, that the AGD encourage constituents to become more actively involved in dental care issues, by advising constituents to develop dental care committees for the purpose of addressing dental care issues at the state and local levels, and to provide the viewpoint of the general dentist on dental care issues into the state and local dental societies."

1 Reduce CDE fees for dentists out of school 3 years or less
2

89:46-H-7 "Resolved, that the AGD urge its constituents and components to offer continuing education courses at reduced rates to those out of dental school less than 3 years."

3
4 Turnover of leadership
5

90:32-H-7 "Resolved, that the Academy of General Dentistry recommends that every Constituent and Component include a provision in their bylaws for an election of officers that is scheduled on a regular basis and which promotes appropriate turnover, so that more AGD members have an opportunity to participate in leadership positions within organized dentistry."

6
7 **Membership**
8
9 International Membership
10

2014:103-H-6 "Resolved, that all communications to and from international members will be in English only. It shall not be incumbent upon AGD, nor its staff, at any time to translate any materials into or from English. This shall include, but not be limited to PACE materials, CE recording, CE materials, Fellowship Exam, Publications (which will be provided online only), Membership materials, or any web, e-mail or other communication."

11

2014:114-H-6 "Resolved, that the dues for the proposed International Membership category be set at the same amount as the full dues paying US members category for 2015. And be it further,

Resolved, that the International Membership Committee in conjunction with the Membership Council analyze the actual costs for the 2014 International Membership members, make any adjustments, and transmit recommendations for the dues rate for the 2016 International members to the Spring 2015 Board meeting and the 2015 House of Delegates."

12
13 Making membership more meaningful
14

2014:202-H-6 "Resolved, that HOD Policy 78:28-H-6 be amended so that it reads:

"Resolved, that the AGD recommend that its constituents take the necessary steps to make membership more meaningful to their members by:

1. Planning scientific programs and becoming a program provider, and encouraging other groups to provide continuing education within their respective areas;

2. Representing the general dentist within the structure of organized dentistry within the area, and being alert to any action that may affect the interest of the general dentist or of the public being

served by the dental profession."

Regional Directors

Allowance and disbursement guidelines

93:19-H-7 "Resolved, that the Regional Directors of the Academy of General Dentistry receive a maximum allotment based on the following formula:

and be it further

Resolved, that the Regional Directors be required to submit an expense voucher to the AGD Executive Director before any funds are dispersed in accordance with AGD policy directly to the Regional Director rather than through the Treasurer of the region, and be it further

Resolved, that an allotment of $24,200 become effective at the beginning of the 1993-94 fiscal year, and be it further

Resolved, that the annual maximum allowance for Trustees be increased from $1,200 to $1,500, and be it further

Resolved, that the Board be authorized to determine to what extent the Trustees and Regional Directors shall be subsidized to attend special conferences provided by the AGD, such as the bi-annual Leadership Conference, and be it further

Resolved, that these allowances are to be used for enhancing communication within the Trustees' or Regional Director's region or for communications with the Chicago office."

2008:106R-H-7 "Resolved, that policy 99:7-H-7 be amended by addition, so that it reads:

That the Regional Directors of the Academy of General Dentistry receive a maximum allotment based on the following:

Region 1 - $1,700
Region 2 - $1,200
Region 3 - $1,200
Region 4 - $1,200
Region 5 - $1,500
Region 6 - $1,500
Region 7 - $1,300
Region 8 - $1,200
Region 9 - $1,300
Region 10 - $1,600
Region 11 - $1,600
Region 12 - $1,600
Region 13 - $1,200
Region 14 - $1,800
Region 15 - $1,400
Region 16 - $1,300
Region 17 - $1,600
Region 18 - $1,200
Region 19 - $1,500
Region 20 - $1,300

and adjusted annually thereafter up to CPI as determined by the budgetary process effective July 21, 2008 (start of 2008/2009 governance year)."

Can attend all Board meetings at region's expense

1

76:57-H-11 "Resolved, that the Regional Directors be welcome at their or their regions' expense to attend all Board meetings without the right to vote."

2

1
2 Education
3
4 **Advanced Education in General Dentistry**
5

2005:14-H-7 "Resolved, that the AGD's policy statement on Advanced Education in General Dentistry (AEGD and General Practice Residency (GPR) be:

A significant increase in scientific knowledge and technology and the rapid pace of change makes it challenging for dental schools to offer full and well-rounded curricula. Additionally, research has found that the majority of students who consider postgraduate general dentistry programs perceive a lack of experience at the pre-doctoral level relating to clinical dentistry and managing medically compromised patients. PGY-1 programs in general dentistry offer the graduating dental student the following advantages:

1. Common program goals that include expanding clinical competence and gaining proficiency in general dentistry and ADA recognized dental specialties, enhancing skills in the management of medically compromised, geriatric and pediatric patients, increasing knowledge of dental administrative and business management processes, enabling the critical analysis of the dental literature and building skills for effective communication with patients and other medical/dental colleagues.

2. An intensive and supervised practice setting with a favorable teaching staff to resident ratio for the transitional experience between education and practice.

3. Variations in residency training emphasis that provides graduating dental students the opportunity to select programs that offer and focus on those clinical experiences that they wish to become more proficient.

4. Graduates that earn a recognized credential for future dental practice opportunities, including hospital staff privileges, and residency experiences that can serve as a 'spring-board' to consider more focused specialty training.

5. Enhancement of the attitude of residents toward life-long learning and encouragement for the ongoing pursuit of self-motivated professional growth, including teaching.

6. An influential impact on general practice patterns and locations, and

improved access to dental care for underserved populations.

~~7. Appropriate funding and staffing for programs must be identified and committed. "~~

1
2 **American Board of General Dentistry**
3
4 ABGD designation listed in AGD Membership Directory
5

97:20-H-8 "Resolved, that those AGD members who are certified by the American Board of General Dentistry be designated as such in the AGD Membership Directory, and be it further

6
7 Resolved, that all associate members have their specialty designations
8 listed."
9
10 Advertising the ABGD designation to the public
11

2001:36B-H-8 "Resolved, that AGD support the ABGD designation for public use in a means consistent with AGD's FAGD and MAGD designations through the use of the terms 'certified by the American Board of General Dentistry' or 'Board Certified by the American Board of General Dentistry.'"

12
13 Recognition of ABGD recipients
14

2003:7-H-7 "Resolved, that the AGD endorse the recognition of those general dentists newly certified in the American Board of General Dentistry who are AGD members by listing their names in the Convocation program, in other appropriate AGD media, and with recognition at the Convocation."

15
16 Recognized by AGD as the certifying body for graduates of post-doctoral programs in general
17 dentistry
18

2001:36A-H-8 "Resolved, that the Academy of General Dentistry (AGD) recognize the American Board of General Dentistry (ABGD) as the certifying body for graduates of post-doctoral programs in general dentistry accredited by the Commissions on Dental Accreditation (CODA)."

19
20 **Advertising FAGD/MAGD Credentials**
21
22 Fellow or Master of the Academy of General Dentistry
23 General Dentist
24

2000:9-H-7 "Resolved, that the following language be accepted by the Academy of General Dentistry as the appropriate use of the Fellowship and Mastership designations to the public by way of advertising, listings, or office signage:

25

1 ________ ________, DDS, BDS, or DMD, FAGD or MAGD
2 Fellow or Master of the Academy of General Dentistry
3
4 and be it further
5
6 Resolved, that our members be advised through AGD printed
7 communications that our Principles of Ethics allow general
8 dentists to announce Fellowship or Mastership in the area of
9 general dentistry in their announcement of services to patients
10 so long as they avoid any communication that expresses
11 specialization and clearly write out the definition of the
12 initials, in order to not lead the reasonable person to believe
13 that the designation represents an academic degree."
14
15 **Annual Meeting**
16
17 Number of, to be granted annually
18

73:11-H-10 "Resolved, that only one Thaddeus V. Weclew Award may be granted annually, but in those instances where two nominees possess outstanding qualities and are of some special caliber, two Thaddeus V. Weclew Awards may be awarded."

19
20 **Board**
21
22 Authority to
23
24 Approve procedures for processing FAGD and MAGD applications
25

99:44-H-7 "Resolved, that the AGD Board approve procedures and procedural changes related to the mechanics of processing the applications for the Fellowship and Mastership Awards."

26
27 Establish application and FAGD/MAGD exam fees
28

81:21-H-7 "Resolved, that the House of Delegates recognize the authority granted to the Board in the Bylaws to establish not only the application fee for the Fellowship and Mastership, but also the fees to take any examinations connected with these awards."

29
30 Official visits and educational programs
31

94:6-H-7 "Resolved, that if an officer or Trustee of the Academy of General Dentistry is selected to present any educational program in conjunction with an official visitation, they shall be free to engage in such activity, and be it further

32
33 Resolved, that the host organization shall publicize that the officer/trustee
34 is speaking as a clinician with expertise in his/her subject during the

1 scientific program and whose opinion does not necessarily reflect the
2 opinions and/or policy of the AGD, and be it further
3
4 Resolved, that all non-travel expenses related to the scientific
5 presentation shall be borne by the clinician/host arrangement, and be it
6 further
7
8 Resolved, that the expenses related to AGD representation shall be paid
9 in such a manner that no more than one-half of the total transportation
10 expense, per standard AGD travel reimbursement policy, shall be borne
11 by the AGD, and be it further
12
13 Resolved, that appropriate documentation be submitted using the
14 standard AGD form, and be it further
15
16 Resolved, that such activity be fully disclosed to the Executive
17 Committee in writing."
18
19 **Constituent AGD**
20
21 Awards for components
22

91:40-H-7 "Resolved, that the Academy of General Dentistry encourage constituents to develop and administer CE awards for components within their jurisdiction to encourage and recognize the provision of quality continuing dental education at the component level where appropriate."

23
24 **Continued Competency**
25

96:50-H-7 "Resolved, that the AGD's existing policy on continuing competency, which stipulates that assuring the public of the dental profession's continued competency is best addressed by appropriate continuing dental education, effective peer review, and the proper enforcement of the dental practice acts by the state and provincial boards of dental examiners, should be applicable to all dentists."

26
27 **Continuing Dental Education**
28
29 Accreditation of post doctoral programs
30

96:51-H-7 "Resolved, that the Academy of General Dentistry advocate consistent and equitable accreditation of all dental school predoctoral training programs in the United States and Canada by urging the Commission on Dental Accreditation to require that all predoctoral dental education programs, including advanced standing predoctoral programs, lead to a DDS or DMD, and be it further

31
32 Resolved, that the Academy of General Dentistry advocate to the
33 Commission on Dental Accreditation that all predoctoral and advanced
34 standing programs leading to a DDS or DMD degree should meet the

1 same accreditation standard and undergo the same accreditation review
2 process as the core dental program."
3
4 Course Listing Service, cancellation of
5

89:50-H-7 "Resolved, that the Academy of General Dentistry Course Listing Service be discontinued immediately."

6
7 Credit, start date defined
8

2016:105R-H-7 "Resolved, that AGD HOD policy 2008:203R-H-7 be revised as follows:

"Resolved., that the following resolution be amended to read:

90:38-H-7 Resolved, that the CE credit start date for the Fellowship Award be defined as the earliest date at which credit is accepted under AGD policies, i.e.:……….

Resolved, that resolution 2003:31-H-7 be substituted to read:

The AGD recognizes members who wish to resume their membership in the AGD. In order to accommodate these members, two mechanisms are available as follows:

Previous members can rejoin the AGD by paying all applicable current dues. Members that rejoin will not be eligible to submit any CE acquired while not a member but they can claim credit to CE earned during their previous memberships. Members rejoining will receive a new join date.

Previous members can be reinstated into the AGD for up to five (5) years by paying all applicable back dues, current dues, plus an appropriate administrative fee. Reinstatement also allows these members to submit eligible CE acquired during their membership lapse and have it applied to their previous membership CE credits. In order to be reinstated, members must attest to meeting the current membership maintenance requirements of CE credit for each year lapsed. Reinstate members will be able to claim their cumulative membership time."

9

96:44-H-7 "Resolved, that members joining the AGD be permitted to take credit for continuing education courses in accordance with the following schedule:

10
11 1. If a dentist joins before June 30 and pays full-year dues, then
12 courses may be claimed from January 1 of that year.
13
14 2. If a dentist joins between July 1 and September 30 and pays half-
15 year dues, then courses may be claimed from July 1 of that year.
16

3. If a dentist joins between October 1 and December 31, then continuing education credit may be claimed from October 1."

Credit given

2012:201-H-6 "Resolved, that the Fellowship Award Guidelines and the Mastership Award Guidelines, section Other CE Activities for Credit, 1.F be amended by addition of Draft Self-Instruction quizzes for a peer-reviewed scientific journal …..20 hours per quiz."

Defined

2004:16-H-7 "Resolved, that Continuing Dental Education is defined as:

Educational activities designed to review existing concepts and techniques, to convey information beyond basic dental education and to update knowledge on advances in dental and medical sciences. The objective is to improve the knowledge, skills and ability of the individual to deliver the highest quality of service to the public and profession. Basic sciences, behavioral and social sciences, as well as, technical knowledge, influence the professional person and for this reason, educational experiences in all of these areas are an equally valid part of continuing dental education.

Continuing education programs are not sequenced to provide academic credit toward a specialty certificate or academic degree. CE courses are conducted in a wide variety of forms using many methods and techniques and are sponsored by a diverse group of institutions, schools and organizations.

Continuing education should favorably enrich past educational experiences. These programs should make it possible for dentists and allied team members to attune dental practices to modern knowledge as it continuously becomes available. All continuing education should strengthen the habits of critical inquiry and balanced judgment that denote the truly professional and scientific person."

Transcripts

2003:10-H-7 "Resolved, that in the interest of excellent member service, the AGD inform members that they may obtain a transcript of their continuing education records through the AGD Web site or by contacting the Member Services Center, and be it further

Resolved, that the mailing of the annual continuing education transcripts be discontinued in 2004 as being too costly and redundant, and be it further

Resolved, that in 2003, an up-to-date transcript and a letter be sent to all eligible members indicating that in the future transcripts will not be automatically mailed but be available on the AGD's Web site or by contacting the Member Services Center, and be it further

Resolved, that a note to remind members to obtain a transcript of their continuing education records through the AGD's Web site or by contacting the Member Services Center be included with the mailing of the annual dues statements."

Continuing Dental Education Courses

Credit for

New members joining at meeting, courses taken at that meeting

96:42-H-7 "Resolved, that whenever a dental meeting starts in June and ends in July, the prospect who joins at that meeting be allowed to pay half-year dues, and be it further

Resolved, that any courses attended during that meeting by the member who is joining be recorded in their continuing education record, and be it further

Resolved, that whenever a dental meeting starts in September and ends in October, the prospect that joins at that meeting be allowed to join for the next dues year, and be it further

Resolved, that any courses attended during that meeting by the member who is joining be recorded in their continuing education record."

Orofacial Pain

2012:203R-H-6 "Resolved, that the Mastership Award Guidelines be amended by addition as follows:

Subject Category Requirements

Subject Category	Subject Code	Participation Minimum	Required Minimum
Basic Science	010	12	12
Endodontics	070	30	46
Electives	130	30	46
Myofacial Pain/ Occlusion	180	30	46
Orofacial Pain	190	~~12~~ 0	12
Operative Dentistry	250	30	46
Oral/Max Surgery	310	30	46

Anes/Pain Mgmt/
Sedation/
Pharm…………340……………...12…………………12
Orthodontics….370………………12…………………12
Pediatrics……..430………………12…………………12
Periodontics…..490………………30…………………46
Practice Mgmt..550………………..0………………….24
Fixed Prosth….610………………30…………………46
Removable
Prosth………...670………………30…………………46
Implants………690………………30…………………46
Oral Med/Oral
Dx……………730………………12…………………12
Special Pt
Care…………750………………12…………………12
Esthetics ……..780………………30………………....46
TOTAL
HOURS………………………372……………………568
TOTAL REQUIRED…………400…..………………..…600"

Organizational activities

76:39-H-11 "Resolved, that the Academy of General Dentistry reaffirm its position that no continuing education credit be granted for a member's organizational activities and duties relating directly to organized dentistry, unless credit for these activities is specifically approved by the House of Delegates."

Taken after graduation

79:24-H-6 "Resolved, that those individuals who join the Academy of General Dentistry within the first full calendar year following graduation from dental school shall receive applicable AGD credit for continuing dental education courses taken after graduation."

Credit not given for

Courses taken prior to receiving dental degree

2010:204R-H-7 AMENDED HOD 2013

2013:201R-H-6 "Resolved, that AGD student members may earn up to a maximum of 50 hours of CE as lecture and/or self-instruction credit, of which 15 hours can be self-instruction credit, only within the parameters of the Fellowship and Mastership guidelines."

Serving on state boards of dental examiners

79:23-H-6 "Resolved, that service on state boards of dental examiners receive no form

of AGD continuing education credit."

Indigent, on care of

79:33-H-6 "Resolved, that AGD promote programs that combine care of the indigent with participating education courses."

Membership maintenance requirement

79:13-H-6 "Resolved, that the continuing education and membership maintenance requirement shall be implemented for all active members, associate members, Fellows and Masters, except those who are classified as retired or emeritus members and those who are under a waiver of dues."

No pre-requisites or restrictions on enrollment in non-sequential

76:41-H-11 "Resolved, that no prerequisites or restrictions be placed on enrollment in non-sequential continuing education courses, and be it further

Resolved, that if prerequisites are placed on enrollment in sequential continuing education courses, course directors be encouraged to allow enrollment at advanced standing by credentials, and be it further

Resolved, that continuing education program providers provide potential enrollees with detailed information about the material to be covered in a course, and the skills and knowledge necessary to benefit from enrolling in the course."

Precourse checklist for selecting

85:20-H-7 "Resolved, that a pre-course checklist be developed to assist members in selecting from among available continuing education courses, and that this be distributed to members with semi-annual CE printouts, with course record form orders, and to new members."

Dental Auxiliaries

Invited to attend scientific meetings by members

78:32-H-6 "Resolved, that AGD members be encouraged to invite and be accompanied by their dental assistants, dental hygienists, and dental laboratory technicians to selected scientific meetings so that the group can have the benefit of joint continuing education experiences in the interest of working together better as a team to improve the dental health of the public."

Dental Education

Dental school deans to list FAGD of faculty

72:2-H-10 "Resolved, that the AGD encourage all of the dental school deans to include FAGD in their Bulletins listing their faculty and their degrees, and to look with favor towards improving the status of those teachers who have earned their Fellowships."

Formal academic process leading to a degree or certificate

81:41-H-7 "Resolved, that AGD endorse the concept of a formal academic process of structured, sequential continued or post-doctoral education, earned through universities or academically accredited teaching institutions over an extended amount of time, which lead to a degree or a certificate."

Four-year curriculum, support of

78:27-H-6 "Resolved, that the AGD expresses its concern with the dilution and shortening of dental school programs for purpose such as the receiving of federal capitation grants, and be it further

Resolved, that the AGD supports a minimum of a four-year approved curriculum to achieve a dental degree, and be it further

Resolved, that the AGD send a letter to all of the existing dental schools expressing our support of those dental schools which have relinquished their three-year programs in favor of pursuing quality four-year dental education programs."

2005:13H-H-7 Resolved, that the Academy of General Dentistry recommends that dentists receive training on the recognition and evaluation for signs and symptoms consistent with abuse and/or neglect.

Fellowship

Appeal

Of application deadline

96:49-H-7 "Resolved, that the following guidelines be established for considering appeals of the FAGD/MAGD application deadline:

GUIDELINES FOR APPEALS OF
THE FAGD/MAGD APPLICATION DEADLINE

An application for the Fellowship or Mastership award that is received in the Chicago office after the application deadline may be granted on appeal by the Chair of the Dental Education Council under any of the following circumstances:

1. Medically confirmed disability that prevented applicant form applying before the deadline.

2. Medically confirmed, sudden, severe illness that prevented applicant from applying before the deadline.

3. Unusual personal or business circumstances resulting from natural disaster or accident that prevented applicant from applying before the deadline.

The Dental Education Council is not responsible for problems associated with lost or seriously delayed mail, and will not grant an appeal on that basis."

Application

Application amended

2009:200R-H-7 "Resolved that AIRS09#12 - Allocation of CE credit for submission of teaching/publications is approved."

2006:2B-H-7 "Resolved, that section 1 under "Other Activities for CE Credit" of the Fellowship and Mastership Guidelines be amended as follows:

(1) Teaching/Publications
A combined maximum of 150 hours of lecture credit may be applied to the Fellowship/Mastership Award for the following activities:

A) Full- or part-time faculty positions at ADA/CDA–accredited institutions. Full-time faculty may receive 100 hours for the completion of the first academic year after joining the AGD and 25 hours each subsequent year; part-time faculty may receive 50 hours for the completion of the first academic year after joining the AGD and 12.5 hours each subsequent year.

B) Continuing education presentations put on by FAGD/MAGD-program providers. Original presentations receive three hours of credit for each hour of teaching. Repeat presentations receive hour-for-hour credit. Credit will be awarded upon receipt of verification from the program provider.

C) Authorship of a published scientific article in a dental or scientific journal.

D) Authorship of a published dental textbook or chapter in a

published textbook.

E) Authorship of a case report, technique paper, or clinical research report in a dental or scientific journal published in or after July 2000.

F) Successfully reviewing and reporting on manuscripts submitted to General Dentistry and other refereed dental journals.

Credit will be awarded as follows:

- Published scientific article in a refereed journal: 40 hours
- Published scientific article in a non-refereed journal: 30 hours
- Published dental textbook or chapter in a published textbook: 65 hours
- Case report, technique paper or clinical research report in a refereed journal: 10 hours
- Published case report, technique paper, or clinical research report in a non-refereed journal: 5 hours
- Review and report on General Dentistry manuscripts: 3 hours each with a maximum of 9 hours per year
- Draft Self-Assessment quizzes for a peer-reviewed scientific journal: 20 hours per quiz

1

2009:201S-H-7 “Resolved, that the AIRS09#6 - Fellowship/Mastership Award Guideline Change to Allow Case Presentations as CE is approved.

Activities Accepted for Fellowship Credit

6. Case Presentation Required for Certification/Accreditation by ~~Outside~~ Allied Dental Organizations. Upon request up to 75 hours of participation credit may be applied to the award for case presentations presented for the purpose of certification/accreditation by PACE/CERP approved dental organizations. Requests by Allied Dental Organizations for participation credits will be reviewed by the Dental Education and/or PACE Councils for final approval. And be it further

Resolved that the following change be made to the current Mastership Award Guidelines:

Activities Accepted for Mastership Credit

5. Case Presentation Required for Certification/Accreditation by ~~Outside~~ Allied Dental Organizations upon request

Up to 75 hours of participation credit may be applied to the award for case presentations presented for the purpose of certification/accreditation by

PACE/CERP-approved dental organizations. Requests by Allied Dental Organizations for participation credits will be reviewed by the Dental Education and/or PACE Councils for final approval."

1
2 Award guidelines
3

99:45-H-7 RESTORED 2015:204-H-6

4

99:45-H-7 RESCINDED 2014:206-H-6

5

99:45-H-7 "Resolved, that the document 'Fellowship Award Guidelines' (*See Guidelines*) which conforms in its entirety to current policy, be accepted as policy, and be it further

6
7 Resolved, that all subsequent policy changes to the requirements of the
8 Fellowship Award, as stated herein, be accomplished through a revision
9 of these Fellowship Award Guidelines."
10
11
12
13 Award granted in absentia
14

77:15-H-6 "Resolved, that a Fellow or Master who was granted his award 'in absentia' be allowed to participate in a future convocation."

15
16 Both FAGD and MAGD not permitted at same Convocation
17

97:33-H-8 "Resolved, that no member of the Academy of General Dentistry be permitted to receive both the Fellowship and the Mastership award at the same Convocation, effective with the Convocation of 2002."

18
19 Category of membership, Fellowship as a
20

2002:20-H-7 "Resolved, that the AGD recognize that its Fellowship and Mastership designations are categories of membership in the organization that may be announced appropriately to the public but only while an individual maintains membership in the organization, and be it further

21 Resolved, that constituent academies recognize that they may report to
22 appropriate licensing bodies instances of non-members announcing
23 FAGD and MAGD designations to the public because it is false
24 advertising."

25
26 Credit for
27
28 Courses, without time limitation
29

89:45-H-7 "Resolved, that approved FAGD/MAGD credit earned during the periods(s) of AGD membership be applicable to the Fellowship Award without time

limitation, beginning with the Fellowship Class of 1991."

1
2 Life support courses

87:59-H-7
REVISED
HOD 7/99

"Resolved, that life support courses provided by the American Heart Association, the Canadian Heart Association, the American Red Cross, the Canadian Red Cross and their affiliates be accepted for Fellowship/Mastership credit."

3
4 Documentation for course credit over 10 years
5

90:44-H-7

"Resolved, that the AGD accept any of the following original or photocopied documentation for courses older than 10 years as applicable to the Fellowship Award:

6
7 1. Old acceptable course record forms, imprinted or handwritten.
8
9 2. Program provider verification with all appropriate information.
10
11 3. AGD printout.
12
13 4. State or provincial board verification with all appropriate course
14 information.
15
16 5. Substantiation in the AGD file."
17
18 Guidelines for

2014:117-H-6

"Resolved, that the Fellowship Award Guidelines and Mastership Award Guidelines be amended."

Fellowship Award Guidelines

Fellowship Requirements

…

4. Attendance at a Convocation Ceremony, held during the AGD Scientific Session, to receive the award. Successful candidates are allowed three years following approval to complete this requirement.

Mastership Award Guidelines

Mastership Requirements

1. Attendance at a Convocation ceremony, held during the AGD Scientific Session to receive the award. Successful candidates are allowed three years following approval to complete this requirement.

19
20 Advanced specialty education program certificate and credits

2014:207-H-6 "Resolved, that Section 2 of the Activities Accepted for Fellowship Credit, of the Fellowship Award Guidelines and Section 2 of the Activities Accepted for Mastership Credit, of the Mastership Award Guidelines be amended as follows so as to allow credit for the completion of CODA- or CDAC- accredited advanced specialty education programs:

2. Postgraduate Education
a. Effective July 1, 2009.…

b. Effective with programs ending in June 2014, individuals completing a CODA- or CDAC-accredited advanced specialty education program of one year or more in length, a maximum of 150 hours of participation credit may be earned. A copy of the certificate is required to receive credit. And be it further,

Resolved, that Section 5 of the Credit Limitations be amended as follows:
Credit Start Dates: Continuing education credit earned after the credit start date may be applied toward Fellowship award. Credit start dates are assigned upon joining the AGD, as follows:
…

5. Date of residency completion, if membership began within 48 months after completion of a CODA- or CDAC-accredited advanced dental education program."

1
2 Changes in

78:19-H-6 "Resolved, that changes made in the Fellowship or Mastership guidelines which make those guidelines more restrictive, be made effective for all members of the AGD five (5) years after the date of passage of such changes by the AGD House of Delegates."

3
4 Reaffirm
5
6 GPR Policy in FAGD/MAGD Guidelines changes
7

2008:202S-H-7 "Resolved, that the following changes be made to the Fellowship Guidelines:

Activities Accepted for Fellowship Credit
2. Postgraduate Education
Individuals completing a one-year CODA-accredited advanced dental education program (AEGD/GDR/GPR) can earn 150 hours of participation credit. Individuals completing a two-year CODA-accredited advanced dental education program (AEGD/GDR/GPR) can earn 300 hours of participation credit. Credit can be received for non-concurrent completion of both program types for a maximum of 450 hours of participation credit. Credits are apportioned among the subject categories according to a

predetermined ratio of subject hours based upon a survey of one- and two-year AEGD/GDR/GPR programs. A copy of the certificate is required to receive credit. This policy will be implemented beginning ~~January~~ July 1, 2009. Credit is permitted for the completion of programs as follows:

Current member of AGD	100% of credits are awarded
Join AGD within one (1) year of completion of the program	100%“
Join AGD within two (2) years	75%“
Join AGD within three (3) years	50%“
Join AGD within four (4) years	25%“
Join AGD after four years	0%“

Credit Limitations

Credit Start Dates: Continuing education credit earned after the credit start date may be applied toward Fellowship award.

Credit start dates are assigned upon joining the AGD, as follows:

And be it further

Resolved, that the following changes be made to the Mastership Guidelines:

Mastership Requirements

Activities Accepted for Mastership Credit

Course Attendance Credit

Residencies

Individuals completing a one-year CODA-accredited advanced dental education program (AEGD/GDR/GPR) can earn 150 hours of participation credit. Individuals completing a two-year, CODA-accredited advanced dental education program (AEGD/GDR/GPR) can earn 300 hours of participation credit. Credit can be received for non-concurrent completion of both program types for a maximum of 450 hours of participation credit. Credits are apportioned among the subject categories according to a predetermined ratio of subject hours based upon a survey of one- and two-year AEGD/GDR/GPR programs. A copy of the certificate is required to receive credit. This policy will be implemented beginning ~~January~~ July 1, 2009. Credit is permitted for the completion of programs as follows:

Current member of AGD	100% of credits awarded
Join AGD within one (1) year of completion of the program	100% “
Join AGD within two (2) years	75% “
Join AGD within three (3) years	50% “
Join AGD within four (4) years	25% “
Join AGD after four years	0% “

1

1 Publication credits
2

2014:205R-H-6 "Resolved, that the guidelines for awarding continuing education credit for publications be amended as follows:

F) Authorship of a case report, technique paper or clinical research report in a dental or scientific journal published in or after July, 2000.

Credit will be award as follows:

Published scientific article in a refereed journal: ....40 hours
Published scientific article in a non-refereed journal:.......................... 20 hours
Published dental textbook ....40 hours per chapter up to a maximum of 150 hours
Chapter in a published dental textbook...................40 hours per chapter
Published case report, or technique paper or clinical research report in a refereed journal ....10 hours
Published case report, or technique paper or clinical research report in a non-refereed journal ....5 hours"

3
4
5
6 Requirements for application submission
7

2010:201RS1-H-7 "Resolved, that the Fellowship Award Guidelines be amended as follows:

Fellowship Requirements

1. Successful completion of the Fellowship Examination. Any active general dentist member joining the AGD after February 2010 be subject to a 90-day waiting period prior to applying for or sitting for the Fellowship Exam in order to verify their membership status. The Fellowship application and examination must be completed and the application postmarked by the December 31 deadline."

8
9 Self-instruction, 150 credit hours of Fellowship/Mastership credit allowed
10

97:38-H-8 "Resolved, that the AGD allow 150 credit hours of Fellowship/Mastership credit for self-instruction (audio, video, journal, etc.)."

11
12 **Group Benefits**
13

1 Mastership Award
2

99:46-H-7 "Resolved, that the document 'Mastership Award Guidelines' (*See Guidelines*) which conforms in its entirety to current policy, be accepted as policy, and be it further

3
4 Resolved, that all subsequent policy changes to the requirements of the
5 Mastership Award, as stated herein, be accomplished through a revision
6 of these Mastership Award Guidelines."
7
8 **Lifelong Learning and Service Recognition Program**
9

2003:3-H-7 "Resolved, that the AGD offer the Lifelong Learning and Service Recognition (LLSR) program to recognize the accomplishments of AGD Masters for their continuing education and volunteer service to dentistry, and be it further

Resolved, that the document *Lifelong Learning and Service Recognition (LLSR) Guidelines* be adopted."

10

2015:203S-H-6 “Resolved, that the Lifelong Learning and Service Recognition Guidelines Requirement 5 be amended to read,

Lifelong Learning & Service Recognition Guidelines

Why Achieve Recognition?
Lifelong Learning & Service Recognition (LLSR) is a program of formal recognition for Academy of General Dentistry (AGD) Masters in the areas of continuing education, dental-related community service and service to organized dentistry. It is not a credential and in no way may be represented to the public as such. LLSR was created to recognize the achievements of those AGD Masters who clearly recognize the professional obligation to remain current in their profession and to create an example so that each member of the dental profession never loses sight of this obligation. Achieving the LLSR from the AGD tells colleagues and patients of your continued commitment to lifelong learning and quality patient care. A Master may receive LLSR multiple times, in a sequential manner, as long as all requirements are met. Once a Master is first recognized by this achievement, subsequent recognitions may include only those credits and points earned since the date of the previous LLSR recognition.

A Charge to all Masters
Masters of the AGD embody the AGD’s principles and ideals. They accept an obligation to continually prove themselves worthy of that designation throughout their professional lives. There are certain obligations that go along with the honor of becoming a Master in the AGD. Masters are expected to:
1) Continue their commitment to lifelong learning
2) Be a mentor to associates and new dentists
3) Improve the quality of continuing education
4) Be a voice of the general dentist.

LLSR Requirements
1) All applicants must be AGD Masters, with AGD membership in good standing at the time of application and when recognition is received.
2) 500 credit hours are required in course attendance, teaching or publications earned since the date Mastership was received or since a previous LLSR was received. A breakdown of these credits can be found below in the Course Attendance section.
3) Completion of 100 hours of AGD-approved dental-related community/volunteer service and/or service to organized dentistry is required. Hours must have been performed since the date Mastership was received or since a previous LLSR was received. The acceptability of points is subject to review by the Dental Education Council. Examples of acceptable dental-related volunteer service can be found below in the Community and Volunteer Service section.

4) An application must be submitted with the designated application processing fee, which is determined annually by the Dental Education Council. This fee covers direct costs, plus $100 for overhead costs. Applications must be postmarked by December 31.
5) Acceptance or denial will be communicated to applicants following review of the application by the Dental Education Council. All decisions of the council are final. Recognition of LLSR recipients will be at the constituent and/or regional level and through AGD publications. Recipients will be invited to be present and attend the Convocation Ceremony where they will be celebrated by inclusion of their names in the Convocation program. Recipients will be seated in a designated area and will walk across the stage to be honored, and have each of their names read, prior to the FAGD and MAGD awardees."

Course Attendance
1) Completion of 500 hours of FAGD/MAGD-approved continuing education credit. Hours must have been earned since the date Mastership was received or since a previous LLSR was received:
a) At least 150 continuing education hours must be earned in participation course attendance;
b) A maximum of 100 credits for teaching is allowed;
c) A maximum of 100 credits for publications is allowed.

2) Credits for course attendance, teaching or publications must be in at least eight (8) of the following disciplines, although there are no minimums or maximum by discipline. Note: No credits will be accepted for advanced academic education programs, such as residencies or advanced degree programs.

Subject Category	Subject Code
Basic Science	010
Endodontics	070
Electives	130
Myofacial Pain/ Occlusion Orofacial Pain*	200
Operateive Dentistry	250
Oral/Max Surgery	310
Anes/Pain Mgmt/Pharm*	340
Orthodontics	370
Pediatrics	430
Periodontics	490
Practice Mgmt	550
Fixed Prosth	610
Removable Prosth	670
Implants	690
Oral Med/Oral Dx	730

Special Pt Care	750
Esthetics	780

**These changes go into effect January 1, 2017. Any member that has not achieved or applied for Fellowship, Mastership, or LLSR by December 31, 2016, will be expected to meet the updated continuing education requirements at that time.*

Teaching and Publication Credit
1) Full or part-time faculty positions in ADA/CDA-accredited institutions are eligible for up to ten (10) credit hours each year. Verification of teaching appointments is required from each institution and should be included with the application.
2) Teaching continuing dental education courses for organizations that are approved by PACE or an AGD constituent are eligible for credit. Verification is required that indicates the dental discipline and the number of hours. Credit will be given hour-for-hour for each presentation.
3) The publication of a scientific article, case report, technique paper or clinical research report in a scientific journal or textbook is worth ten (10) credit hours. A copy of the articles, with dates of publication, should be submitted with the application.

Community and Volunteer Service
1) One community service point is equal to one hour of volunteer community service. The Dental Education Council will determine which additional categories of service not described in these guidelines may be eligible. Volunteer work for a for-profit organization, such as a dental manufacturer, is not eligible.
2) To document community service, a representative of the organization for which the community/volunteer work was done must complete and sign the provided Volunteer Service Verification Form, which specifies the type(s) and term(s) of volunteer service(s) provided. If additional verification is needed, please attach necessary documentation to this form.
3) No financial remuneration or "in-kind" remuneration may be received for service/volunteer work. Reimbursement of expenses such as airfare, transportation, meals, etc., is allowed.

Categories of community and volunteer service may include, but are not limited to:
a. Providing pro bono dental services through a not-for-profit organization;
b. Mentoring a student, emerging dentist or struggling colleague, through a recognized dental organization;
c. Service in a volunteer dental clinic;
d. Service overseas on a dental mission;
e. Volunteer service in a community program, such as a health fair;
f. Providing presentation on dental-related topics to schools, civic, church or

other community groups or other health professionals;
g. Providing oral cancer screenings at a local church, synagogue, school, health fair, nursing home, retirement community, etc.;
h. Providing dental screenings to athletes through the Special Olympics Special Smiles;
i. Volunteer work at a local or national dental meeting, such as working at the organization's booth;
j. Serving as an unpaid team dentist for a school, college, professional sports team or youth athletic association;
k. Instituting a mouth guard program for a school, college, professional sports team or youth athletic association;
l. Providing dental education programs at elementary or secondary schools;
m. Volunteering as a Boy/Girl Scout merit badge leader for dental health.

Service to Organized Dentistry:
Holding a local, state/provincial or national appointment or an elected office in a dental organization is considered service to organized dentistry. Points are awarded for each month of service, up to 12 points per year per national or local organization.
1) A maximum of 12 points may be earned annually for serving in a national position in a dental organization. Service time of less than one year will be prorated by month. Holding multiple positions at the national level in the same organization is acceptable only up to the 12-point limit each year.
2) A maximum of 12 points may be earned annually for serving in state/provincial, constituent or component positions in a dental organization. Service time of less than one year will be prorated by month. Holding multiple positions in the same local organization is acceptable only up to the 12-point limit each year.
3) To document service to organized dentistry, a representative of the organization for which the service was done must complete and sign the provided Volunteer Service Verification Form, which specifies the type(s) and term(s) of volunteer service(s) provided. If additional verification is needed, please attach necessary documentation to this form.

Application Procedures and Deadline
All LLSR requirements must be completed by the December 31 application deadline. Applications must be postmarked no later than December 31 to be considered for the class immediately following the application deadline, and must include the designated application fee. This fee is determined annually by the Dental Education Council and includes a non-refundable processing fee. The AGD is not responsible for lost or delayed mail. Only the Dental Education Council may determine the acceptability of LLSR applications. Applicants are notified by letter of the Council's decision, and all decisions of the Council are final. Recognition will be provided at the Convocation Ceremony at the AGD Annual Meeting & Exhibits through the inclusion of

names of the new recipients in the Convocation program and in AGD publications.
Direct inquiries regarding the LLSR to:

Academy of General Dentistry
Department of Dental Education
560 W. Lake Street, Sixth Floor
Chicago, Illinois 60661-6600
Phone 888.AGD.DENT (243.3368)
Fax 312.335.3428"

1
2 Guidelines for
3
4 Section 4
5
2006:5B-H-7 "Resolved, that section 3 under Mastership Requirements of the Mastership Guidelines be amended as follows:

1100 total hours of FAGD/MAGD-approved continuing dental education credit, 400 of which must be in participation courses. Participation hours can be earned at any time during membership with an implementation date of January 1, 2007.

6
2015:203S-H-7
7
8 **Program Approval for Continuing Education (PACE)**
9
10 Approval, retroactive

97:35-H-8 "Resolved, that requests for retroactive program provider approval will be accepted only from program providers initially reviewed and approved by the Program Approval for Continuing Education (PACE) Committee at a previous meeting, under the following guidelines:

11
12 1. If the request for retroactive approval exceeds 12 months, the
13 request must be accompanied by an explanation of the reason for
14 the lapse, a fee of $150, and an application for retroactive
15 approval. The application will include a listing of the courses
16 given during the requested dates of retroactive approval and
17 information on any changes made in administration during the
18 period in question. If granted, the period of retroactive approval
19 will not exceed one half of the most recent period granted by the
20 Committee.
21
22 2. If the request for retroactive approval equals 12 months or less,
23 the Committee has the authority to determine the length of the
24 period of retroactive approval it grants, if any, and be it further
25
26 CERP Review Committee, inclusion on list of Program Providers
27

2014:202-H-6 "Resolved, that HOD Policy 98:30-H-7 be amended so that it reads:

"Resolved, that program providers who successfully complete the Continuing Education Recognition Program (CERP) application and approval process be identified as offering courses that are FAGD/MAGD accepted with approval dates as determined by the CERP Committee, unless the Program Approval for Continuing Education (PACE) Committee has credible evidence of non-compliance with AGD's Program Approval for Continuing Education (PACE) Program's standards and criteria."

1
2 Criteria for approval
3

92:37-H-7 "Resolved, that national, non-profit continuing dental education providers meeting the following criteria may apply to the Academy of General Dentistry's Program Approval for Continuing Education (PACE) Committee for waiver of the program provider approval application fee:

4
5–9 Criteria #1: The program provider must be registered in their state or province as a non-profit organization, and must be able to document that status with incorporation documents, or they must be an AGD organization covered under the group tax exemption.
10
11–14 Criteria #2: The program provider must generate no more than $50,000 in gross income annually, as documented by the most recent annual financial statement or Treasurer's report.
15
16–19 Criteria #3: The program provider must not have a reserve fund balance of greater than $3,000, as documented by the most recent annual financial statement or Treasurer's report.
20
21–29 Criteria #4: The program provider must complete both the application for Program Provider Approval and the application for exemption of the program provider fee at least six weeks prior to the meeting of the Program Approval for Continuing Education (PACE) Committee. If the application for fee exemption is rejected, the program provider must submit a check for the program provider fee before the PACE application can be reviewed."
30
31 Guidelines
32

2014:204b-h-6 Resolved that HOD Policy 2007:202-H-6 be amended so that it reads:

"Resolved, that changes to the published PACE Guidelines be adopted upon approval by the PACE Council and the Board"

33
34 Jurisdiction
35

88:46-H-7 "Resolved, that the House of Delegates agree that administration of the Program Provider Approval Program means that the Program Approval for Continuing Education (PACE) Committee shall have jurisdiction over:

A. Application forms and procedures;

B. Notification procedures;

C. How program provider approval statements are worded."

One-year provisional approvals

2003:11-H-7 "Resolved, that the PACE Council may grant 1-year provisional approvals subject to monitoring and/or additional documentation from providers."

Study clubs, approval

90:52-H-7 "Resolved, that study club provider approval be based on AGD Standards and Criteria for program provider approval as determined by the AGD House of Delegates, and be it further

Resolved, that the appropriate national, intrastate, or intraprovincial application process be used by study clubs in the same manner as the approval process of other national or intrastate program providers, and be it further

Resolved, that the Chicago office will send out reminder notices to all intrastate program providers to renew their intrastate approval three months prior to their approval expiration with a carbon copy to the constituent approval representative."

Meeting Services

Annual Meeting

Course Managers, credit given

2014:116D-H-6 "Resolved, that 90:36-H-7 be amended following approval of the separation of governance and the scientific session."

"Resolved, that participation credit be given to those individuals acting as Course Managers for participation courses at the scientific session who pay 50% of the participation course fee and complete the requirements for the participation course, and be it further

Resolved, that lecture credit be given to those individuals serving as Course Managers who are in full attendance at a scientific or participation course at the scientific session effective with the 1990 annual meeting."

Local Advisory Committee

Councils and Committees, eligibility for appointment/reappointment

96:39-H-7 "Resolved, that the Regional Directors and members of the Local Advisory Committee be eligible for appointment or reappointment to a council or committee of the AGD."

Resolved, that the Speaker of the House should recognize such individuals in proper sequence when it is obvious that they need to provide input to the HOD on any proposed change affecting their areas of jurisdiction."

Expenses

97:6-H-8 "Resolved, that the $5,000 Local Advisory Committee fund be increased to $6,000 beginning with the 1997/1998 budget."

Use of $6,000 appropriation

2014:116B-H-6 "Resolved, that 99:11-H-7 be amended following approval of the separation of governance and the scientific session."

"Resolved, that $6,000 be appropriated for the use of each Local Advisory Committee, and be it further

Resolved, that up to $2,000 may be withdrawn by the Chairperson only during each of the first two years in which the meeting is planned, with the remaining expenses reimbursable in the third year with the total three-year expense not to exceed $6,000:

1. To help offset the cost of holding Local Advisory Committee meetings.

2. To pay for recruitment efforts of volunteers' telephone costs connected with the scientific session.

3. To provide travel expenses for certain members of the Local Advisory Committee to come to the preceding scientific session.

4. To help promote the scientific session on a local level.

5. To identify at a cost of no more than $500 the local volunteers for the scientific session."

Past Presidents

Registration fees and special identification badges for

79:17-H-6 "Resolved, that AGD past presidents be presented with a permanent identification badge, and that their registration fees for attending the annual meetings be waived."

For Trustees to attend

Plaque for, at the closing session

80:15-H-7 "Resolved, that the president be presented with an appropriate plaque at the close of the annual meeting, and be it further

Resolved, that the other six (6) officers make a determination of appropriate gifts to be presented to the president and spouse at the President's banquet, and be it further

Resolved, that the total amount to be spent in recognizing the President and spouse shall not exceed $1,000."

Registration fees for Annual Meeting

Clinicians

2014:116A-H-6 "Resolved, that 86:39-H-7 be amended following approval of the separation of governance and the scientific session."

"Resolved, that the registration fee be waived for all clinicians participating in the Scientific Session, including those giving mini-clinics, table clinics, participation courses, and scientific sessions."

Participation courses

2014:116E-H-6 "Resolved, that 84:15-H-7 be amended following approval of the separation

of governance and the scientific session."

"Resolved, that effective with the 1985 annual meeting all individuals registering for participation courses in conjunction with a scientific session must pay the registration fee appropriate to that scientific session."

1

1 Membership Services
2
3 **Annual Meeting**
4
5 Membership recruitment and retention award
6

94:10-H-7 "Resolved, that a merit based membership award system be adopted that will be awarded to constituents according to their size and the outcome of specific programs, and be it further

Resolved, that this award system replace the current membership award system effective with the membership year ending April 30, 1995."

7
8 **Dues**
9
10 Back dues, consideration of requests for
11

96:45-H-7
REVISED
HOD 7/99
AMENDED
HOD 2010

"Resolved, that the following guidelines be adopted for consideration of requests for back dues:

12 For new Members:
13
14 If an individual is delayed from joining the AGD as a result of
15 mishandling of the application by either the headquarters or a constituent
16 office, that individual will automatically have their enroll date backdated
17 to the date of the initial attempt to join. The decision to require payment
18 of back dues will be at the discretion of the director of membership if
19 more than one year has elapsed. Under NO circumstances will an
20 individual who has never held membership previously be allowed to pay
21 back dues for the sole purpose of receiving retroactive credit for courses
22 taken prior to membership unless this is the result of mishandling of their
23 application."
24

2010:101-H-7 "Resolved, that HOD policy 96:45-H-7 is amended by striking the 'For Prior Members' clause."

25
26 Consideration for dentists in full-time medical training
27

83:18-H-7 "Resolved, that dentists in full-time medical training be given the same dues consideration as member dentists taking full-time dental postgraduate education."

28
29 Credit card payment
30

96:38-H-7 "Resolved, that the AGD permit new members and existing members to pay dues by credit card."

1
2 Hardship cases, negotiated by Executive Director
3

85:31-H-7
REVISED
HOD 7/99

"Resolved, that the Membership Services Director be granted the authority to negotiate individual dues payment plans with members in hardship cases as long as all dues are paid within the subject calendar year, and that the nature of these negotiations be reported to the Membership Council at each of its meetings."

4
5 Payment plan, failure to adhere to
6

88:59-H-7
REVISED
HOD 7/99

"Resolved, that the following guidelines be established for administering situations when a member fails to adhere to the negotiated payment plan:

7 1. That when negotiating payment plans, the Membership Services
8 Director or the Manager of Member Records communicate the
9 stipulation that once a payment plan has been agreed to the member
10 is not entitled to have any portion of their payment(s) refunded if
11 the full amount is not paid; and
12
13 2. That the member be kept on the active member roster only as long
14 as he abides by the payment plan; and
15
16 3. That the member be sent a payment reminder once he is in arrears
17 by more than 30 days, and if the payment is not received within 60
18 days of the original due date, that member be removed from the
19 active member roster with an effective withdrawal date equal to the
20 due date for the last payment which was missed; and
21
22 4. That a letter is sent from the Executive Director advising of this
23 action; and
24
25 5. That any partial payments previously remitted be maintained in a
26 holding account until the end of the calendar year, to allow the
27 proper allocation of dues when an individual pays the full balance
28 by the close of the year; and be it further
29
30 Resolved, that should the member decide to pay prior to the end of the
31 year, he may do so only upon receipt of all delinquent installment
32 payments, at which time he may be returned to the active member roster."
33
34 Payment structure, categories, half year
35

84:19-H-7
REVISED
HOD 7/99

"Resolved, that the half-year dues payment structure currently in effect which states that members joining between July 1 and September 30 pay only one-half the National dues amount, pertain only to the following categories of membership:

36
37 1. Second year out of dental school or residency program;
38
39 2. Third year out of dental school or residency program;

3. Fourth year out of dental school or residency program; and

4. All other new members who are otherwise subject to payment of full national dues

and be it further

Resolved, that those joining before the end of their first full year out of dental school or residency program, pay the full reduced national dues amount established no matter what time of the calendar year they join AGD."

<u>Reduced for dentists educated outside US and Canada</u>

81:13-H-7 "Resolved, that dentists educated outside the United States and Canada who establish practice in one of these two countries be granted the privilege of having reduced dues as recent graduates based on their graduation date from a United States or Canadian accredited dental school or their date of licensure, whichever is earlier, rather than their date of graduation from the foreign dental school where they originally acquired their dental education."

<u>Uniform system for collecting</u>

76:28-H-11 "Resolved, that a uniform system for collecting dues be maintained by the AGD's national office and that under this system, only the national and constituent dues be collected by the national organization, and be it further

Resolved, that the constituent's bylaws determine the manner in which the component Academies collect their dues."

<u>Waivers of, for financial reasons</u>

85:33-H-7 AMENDED HOD 2010

2010:107-H-7 "Resolved, that HOD policy 85:33-H-7 be amended as follows:

"Resolved, that the Membership Council use the following guidelines for the purpose of considering granting waivers of dues for hardship for one year periods of time.

These guidelines apply toward a member who has suffered a catastrophic property and/or financial loss due to a federally declared natural disaster; local natural disaster, fire, accident, or other catastrophe."

Waivers of, for reasons other than total disability

83:29-H-7 AMENDED HOD 2010

2010:109RaS2-H-7 "Resolved, that HOD policy 83:29-H-7 be amended as follows:

"Resolved, that the Membership Council be granted the authority to determine whether an individual should be granted a waiver of dues, and be it further

Resolved, that the Membership Council develop guidelines for approving requests for waiver of dues, and be it further

Resolved, that these guidelines be adopted by the Board before any such dues waivers are granted, and be it further

Resolved, that all future waivers of dues shall fall within these guidelines, and be it further

Resolved, that the Membership Council does have the authority to grant waivers of dues subject to guidelines adopted by the Board."

2006:19R-H-7 AMENDED HOD 2010

2010:108b-H-7 "Resolved, that Policy 2006:19R-H-7 be amended as follows:

"Resolved, that the Membership Council modify the dues waiver application to allow members with permanent disability to not have to re-apply annually.

Federal Services

Federal Dental Services

Advice about members separating from

2000:38-H-7 "Resolved, that all individuals separating/separated from the Federal Dental Services be advised of how to transfer membership to the constituent AGD in which they practice or reside, and be it further

Resolved, that constituent membership chairs be advised as members from the Federal Dental Services relocate into their respective areas, and be it further

Resolved, that the Membership Council consider mechanisms for facilitating the orderly transfer of separating/separated dentists from the Federal Dental Services to the respective constituent academies."

Dentists working exclusively at federal installations eligible for

membership in

97:23-H-8 "Resolved, that those dentists who are employed to work exclusively at federal installations/reservations and are not practicing dentistry elsewhere within the state where the federal installation/reservation is located be considered eligible for membership in the respective federal service constituent in which they are working."

Members

Foreign graduates not licensed to practice, may be classified as student

81:14-H-7 "Resolved, that foreign graduates not yet licensed to practice dentistry in the United States or Canada, but taking undergraduate or graduate education in the United States or Canada, may be classified as student members only."

Retired

Must have retired prior to March 31 to qualify

2001:25-H-8 "Resolved, that to be considered for retired membership, an individual must have retired prior to March 31 of the year in which dues are payable."

Membership

Change of address information/change in constituent status

2001:22-H-8 "Resolved, that the AGD obtain information from those members changing addresses from one state or province to another and the reason for the address change, so as to ascertain the nature of the change that would alter a member's constituent status, and be it further

Resolved, that this information should be distributed to the appropriate constituent officers on a semi-annual basis."

Council on

Investigate new approaches to recognize Honorary Fellows

2004:8-H-7 "Resolved, that the Membership Council implement ways to address the benefits received by existing Honorary Fellows and determine ways to recognize future awardees, and report to the January Board."

Directory

Produced bi-annually

2008:107RS-H-7 “Resolved, that a hard copy version of the Membership Directory not be printed by the AGD, as budgeted in 2008, and be it further

Resolved, that no funds will be appropriated to the production of a hard-copy version of the Membership Directory in the future.”

1
2 Processing fee eliminated
3

2002:18-H-7 “Resolved, that the $15 processing fee for new members be eliminated effective October 1, 2002.”

4
5 Reinstatement of
6
7
8 One-time basis without evidence of CDE
9

2008:203R-H-7 “Resolved. that the following resolution be amended to read:

90:38-H-7 Resolved, that the CE credit start date for the Fellowship Award be defined as the earliest date at which credit is accepted under AGD policies, i.e.:

the dates at which credit is accepted for new members, as defined by the House policy, or
the date on which credit begins to accrue for recent dental school graduates,
The date of residency completion for those joining within 12 months of that completion.

And be it further

Resolved, that the following resolution be amended to read:

90:39-H-7 Resolved, that credit for the Fellowship Award begin with the CE credit start date rather than the date of membership.

And be it further

Resolved, that resolution 2003:31-H-7 be substituted to read:

The AGD recognizes members who wish to resume their membership in the AGD. In order to accommodate these members, two mechanisms are available as follows:

Previous members can rejoin the AGD by paying all applicable current dues. Members that rejoin will not be eligible to submit any CE acquired while not a member but they can claim credit to CE earned during their

previous memberships. Members rejoining will receive a new join date.

Previous members can be reinstated into the AGD for up to 3 years by paying all applicable back dues, current dues, plus a $50 administrative fee. Reinstatement also allows these members to submit eligible CE acquired during their membership lapse and have it applied to their previous membership CE credits. In order to be reinstated, members must attest to meeting the current membership maintenance requirements of CE credit for each year lapsed. Reinstate members will be able to claim their cumulative membership time.

1

1 Organizational Marketing
2

1

GUIDELINES

1
2
Public Affairs Guidelines
3

ACADEMY OF GENERAL DENTISTRY

Announcement of Credentials to The Public: A Position Paper

EXECUTIVE SUMMARY

The purpose of the “Credential and Dental Marketing: A Position Paper” (Position Paper) is to set forth to dental regulating bodies of each state (i.e., state dental boards), the reasons that the Academy of General Dentistry (AGD) believes that general dentists should be permitted to advertise credentials earned by meeting rigorous requirements imposed by professional organizations whose educational programs may not be subject to a formal accreditation process.

Professional organizations, as discussed herein and in the Position Paper, are limited to those that award credentials for dentists who have met rigorous requirements in continuing education through targeted PACE or CERP approved coursework, comprehensive examinations, and longevity in dental practice as verified by sustained organizational membership.

Professional credentials awarded by these professional organizations recognize the achievement of **proficiency** in areas of dentistry outside the nine specialties identified by the American Dental Association (ADA).

Proficiency is “the level of knowledge, skills, and values attained when a particular activity is accomplished in more complex situations, with repeated quality, and with a more efficient utilization of time,”[2] and signifies a higher standard than competency.

Patient care and protection is the ultimate goal of the AGD, and public awareness of dentists’ proficiencies through advertising of credentials earned by meeting rigorous requirements imposed by professional organizations shall assist patients in selecting the appropriate dentists for their specific needs, while restrictions to advertising of these credentials may falsely depreciate their value to the public and may obstruct the patients’ ability to make independent, unbiased and fully informed health care decisions.

1 [1] The sole purpose of this Position Paper is to set forth before state dental
2 regulating bodies (i.e., state dental boards), the AGD position provided herein on
3 credential and dental marketing.
4
5 [2] Commission on Dental Accreditation (CODA), Accreditation Standards for
6 Advanced Education Programs in General Dentistry, 1998. *Cited section*
7 *excerpted from definition provided for "Proficient."*
8

Coordination of Benefits Guidelines

1. When a patient has coverage under two or more dental plans, the coverage from those plans should be coordinated so that the patient receives the maximum allowable benefit from each plan. The aggregate benefit should be more than that offered by any of the plans individually, but not such that the patient receives more than the total charges for the dental services received.

2. In determining order of payment for benefits, the following rules should apply:

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

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

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

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

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

    a. When the reduced-fee plan is primary and treatment is provided by a participating dentist, the reduced fee is that dentist's full fee. The secondary plan should pay the lesser of: its allowed benefit or the difference between the primary plan's benefit and the reduced fee.

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

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

4. In coordinating benefits between an indemnity and a capitation dental plan, the following rules should apply:

    a. When the capitation plan is primary, the capitation payments to the treating dentist remain the capitation plan's usual benefits. The

indemnity plan should pay benefits for the patient's surcharges or copayments up to the indemnity plan's allowable benefit.

b. When the indemnity plan is primary, and treatment is received from a capitation-participating doctor, the indemnity plan should pay its allowable benefits. The capitation payments to the dentist are the secondary coverage since they constitute benefits up to the capitation plan's allowable amount.

c. When the indemnity plan is primary, and treatment is received from a non-capitation-participating dentist, the indemnity plan should pay its allowable benefits. The capitation plan will pay benefits, in keeping with the capitation plan's allowed amount for treatment by non-participating dentists.

d. No dental plan should contractually direct a dentist to charge a secondary carrier for more than the amount which would be charged to the patient absent secondary coverage.

5. Third-party payers, representing self-funded as well as insured plans, should be urged to adopt the above guidelines as an industry-wide standard for coordination of benefits.

6. 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 rules to determine coordination of benefits.

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 rules to determine coordination of benefits.'"

Adopted HOD 7/93

Policy Statement on the Cost-Efficiency of Primary Oral Health Care Delivery System

Academy of General Dentistry (AGD)

Introduction

Healthcare expenditures in the United States have risen to nearly $3 trillion, accounting for over 17% of the nation's Gross Domestic Product.[1] Hospital care (32.1%) and physician and clinical services (20.1%) account for over 50% of these expenses.[2] Hospital care includes care delivered through emergency departments (ED) which saw 330,000 preventable visits related to dental decay in 2006, costing $110 million dollars.[3]

Over the course of 2009 through 2013, total health expenditures, as well as physician and clinical services expenditures, increased by 16.5%.[4] These increases were eclipsed by hospital care costs which increased by 20.6%.[5] In this same time period, expenditures for dental services delivered outside the hospital setting increased by only 8.3%.[6] In fact, when adjusted for inflation (8.7% from 2009 through 2013), expenditures for dental services decreased.[7] Moreover, expenditures for dental services that once represented over 7% of total healthcare expenditures, now stand at less than 4% of the national total.[8]

This policy statement begins to explore this cost efficiency of dentistry in comparison to medicine and hospital/ED care.

Executive Summary

The cost efficiency of the practice of dentistry in comparison to medicine, hospital care, and ED dentistry is attributable to a number of key factors that may be unique to the primary oral health care delivery model.

In medicine, the diversification of the workforce away from primary care and toward a proliferation of nurse practitioners and specialists has burdened the consumer with increased cost of care and has adversely affected patient health.[9] While only 20% of physicians are

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1 National health expenditures, average annual percent change, and percent distribution, by type of expenditure: United States, selected years 1960–2013. Table 103 (page 1 of 2). Centers for Medicare & Medicaid Services.
2 *Ibid.*
3 A Costly Dental Destination: Hospital Care Means States Pay Dearly, The Pew Center on the States (February 2012)
4 National health expenditures. *Op. Cit.*
5 *Ibid.*
6 *Ibid.*
7 Historic Inflation Rates: 1914-2015. Retrieved from http://www.usinflationcalculator.com/inflation/historical-inflation-rates/. July 16, 2015.
8 National health expenditures. *Op. Cit.*
9 In the United States, an increase of just one primary care physician is associated with 1.44 fewer deaths per 10,000 persons; adults with a primary care physician rather than a specialist had 33% lower costs of care after adjusting for demographic and health characteristics (Starfield, 2006). Patients with a regular primary care

generalists, 80% of dentists are primary care practitioners - general and pediatric dentists. Additionally, while the practice of nurse practitioners in clinics without the presence of a physician produce multiple visits and cost incidents for the patient, primary care dentistry presently utilizes a dental team model in which dental assistants, hygienists and expanded function auxiliaries operate under the direct or indirect supervision of a dentist, producing a single bundled cost incident.

Moreover, unlike in much of medicine, primary care dental practitioners have established an expectation of recall visits even for the asymptomatic patient, enabling a prevention mindset that diverts more expensive treatment and builds trust by establishing the general or pediatric practice as the patient's dental home.

Additionally, dentists generally charge solely for dental procedures. Anesthesia and laboratory charges are often required to be bundled with the primary procedure by the *Code on Dental Procedures and Nomenclature*. General dentistry does not bill for incidental services, including for the sterilization and upkeep of dental instruments, or for numerous laboratory costs. On the other hand, a physician may charge for the physician's time, the physician assistant's time, the nurse practitioner's time, incidental charges, laboratory costs, and diagnostic interpretation costs. In a hospital setting, these charges may be compounded with ambulance costs, inpatient room charges, operating room charges, pharmacy costs, nursing care, and meals.

These hospital charges are also apparent in visits to EDs that are related to dental caries. Medicaid data shows that the average cost of an enrollee's "inpatient hospital treatment for dental problems is almost 10 times more expensive than preventative care delivered in a dentist's office."[10] Further, "a routine teeth cleaning that could prevent future dental problems can cost up to $100, as compared to $1,000 for ER treatment for untreated cavities and infections."[11]
However, whether the visit is related to prevention in contrast to treatment is not the sole determiner of the increased costs of ER visits. ER visits are far more expensive even when *same or similar* treatment services are compared. "Visits to the ER for dental pain are costly and can range from $400 to $1,500 compared to a $90 to $200 visit to a dentist."[12] Further,

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physician have lower overall health care costs than those without one (Weiss & Blustein, 1996; De Maeseneer, De Prins, Gosset, & Heyerick, 2003). Higher ratios of primary care physicians to population are associated with reduced hospitalization rates (Parchman & Culler, 1994). Patients with a regular primary care provider have 19% lower mortality (Franks & Fiscella, 1998), are 7% more likely to stop smoking, and are 12% less likely to be obese (Arora, et al., 2009). Advisory Committee on Training in Primary Care Medicine and Dentistry. *The Redesign of Primary Care with Implications for Training.* Eighth Annual Report to the U.S. Department of Health and Human Services and to the U.S. Congress. January, 2010.

10 A Costly Dental Destination. *Op. Cit.*

11 Azmat Khan, *More Americans Visiting ER for Dental Care*, PBS (February 28, 2012) (http://www.pbs.org/wgbh/pages/frontline/health-science-technology/more-americans-visiting-er-for-dental-care/)

12 American Dental Association, The Issue: Reduce health care costs and improve patient care by treating dental disease in the dental practice instead of the ER (August 2013) (http://www.ada.org/~/media/ADA/Public%20Programs/Files/ER_Utilization_Issues_Flyer.ashx)

unlike the dental office, the ER visit will often not address the underlying condition or provide the definitive care.[13]

Primary care dentistry's focus on prevention by establishment of the dental home, use of the dental team concept to produce single incidents of cost for the patient, minimized specialization to mitigate care fragmentation, and bundling of incidental and ancillary charges, begins to create an understanding of the comparative cost efficiency of the primary oral health care delivery system.

Policy Statement

Whereas, the primary oral health care delivery system encompasses the delivery of oral health care services via the general or pediatric dentist (primary oral health care practitioners);

Whereas, the primary oral health care delivery system uses prevention to reduce treatment costs;

Whereas, the primary oral health care delivery system allows for incorporation of administrative, ancillary, and incidental costs;

Whereas, primary oral health care practitioners are educated and authorized by state laws to provide all dental services, allowing minimal fragmentation through specialty care;

Whereas, the primary oral health care delivery system utilizes a dental team that functions within the direct or indirect supervision of the general or pediatric dentist to enable single unified cost incidents;

Now therefor, the Academy of General Dentistry resolves as follows:

"Resolved that the primary oral health care delivery system, provided under the direct or indirect supervision of a general or pediatric dentist, is a cost-efficient model of care in comparison to medicine, hospital care, and emergency department care."

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13 Bonnie Miller Rubin, *More patients with routine dental problems turn to hospital emergency rooms*, Chicago Tribune (March 30, 2012). Retrieved from http://articles.chicagotribune.com/2012-03-30/news/ct-met-emergency-room-dentistry-20120330_1_dental-hygienists-pew-children-s-dental-campaign-dental-care.

Dental Care Policy Guidelines

The Academy of General Dentistry notes an increased interest by the general public on all levels in dental care programs both private and government sponsored. In keeping with the general outlook and purposes of the Academy, it is necessary to promulgate certain policy guidelines which will assist the profession and allied agencies involved in the maintenance and improvement of high quality dental care.

The objectives and purposes are:

1. To promote the science and art of dentistry and the betterment of the public health, encourage oral research, and to preserve the rights and freedom of the dentist and the patient.

2. To preserve the right of the general practitioner to engage in dental procedures for which he/she is qualified by training and experience.

3. To provide and guide continuing education programs and study group activity for general practitioners and to encourage and assist practicing dentists to participate in such program toward continuing education competence.

4. To provide effective representation for the general practitioner in all matters of interest to the profession and the public it serves.

5. To maintain an active organization of general practitioners of dentistry.

6. To motivate and assist young men and women in preparing, qualifying and establishing themselves in the general practice of dentistry.

7. To promote uniform methods of reporting treatment contemplated and rendered.

8. To affirm that the prime responsibility of total dental health care rests with the general practitioner.

In fulfilling these goals, the Academy supports the following principles as its policy on dental care programs:

1. Any government dental health program which has as its principal requirements that:

    a. All drinking waters be fluoridated as needed.

    b. Concepts and programs of preventive dentistry be taught and implemented for children in schools, and a program for adult preventive care be instituted both in the dental office and community service clinics.

    c. A massive effort be undertaken to discover the cause and cure of dental disease.

2. The right of the general practitioner to practice all phases of dentistry must be preserved in every state.

3. The doctor-patient relationship must be maintained without interference by a fiscal intermediary.

4. The Academy supports a prepayment evaluation mechanism that establishes a working liaison with insurance carriers and other fiscal agents for the review of prepayment programs. The Academy supports only those prepaid dental programs which meet the standards of the American Dental Association, or its equivalent. The Academy is opposed to any program which denies the right of the dentist to preform any services for which he/she is licensed and qualified to perform or one which limits the patient in his/her freedom of choice of a dentist.

5. Wherever and whenever the Academy finds discrimination in third party programs involving the general practitioner and/or patients, it will make every effort to correct the problem. Failing to do so, the Academy will then seek relief through the American Dental Association or its equivalent or through appropriate legal channels.

6. Legislative contracts should be established and maintained from the individual member up through the state and national levels to assist general practitioners and the community in programs involving health legislation.

7. Every constituent of the Academy shall have an active dental care committee which will report on an annual basis to the AGD National Dental Care Committee for proper coordination and development of programs on a nationwide basis.

8. The Academy supports a pluralistic system of dental prepayment including private insurance carriers, service corporations, private payment by patients and limited government payment.

9. The AGD endorses and supports co-insurance in addition to those programs offering total or paid in full coverage.

10. An acceptable fee for any dental care service is that amount which is mutually agreeable to both the patient and the dentist, based on all factors involved in the treatment. Any fee established by a third party (for example, that called usual and customary) is to be regarded as an indemnification toward the fee agreed by the dentist and the patient.

11. The plan must not involve the dentist as a contractual party nor shall the plan publish a list of participating dentists.

12. The Academy supports the view that the public has the right to have access to comprehensive dental care. However, the Academy opposes any government health program which would use public funds to provide dental care for persons who are financially able to pay for dental services. Current medicaid programs should be expanded to include more comprehensive dental care.

13. The Academy should be represented in all agencies of the American Dental Association or its equivalent which deal with dental care programs. The Academy wishes to cooperate in every possible effort not only on behalf of the general practitioner, but also on behalf of the total profession and the public.

14. The American Dental Association should be encouraged to review dental insurers' plans to make certain the coverage provided is presented accurately to the patient.

1 Adopted GA 2/72
2 Revised HOD 11/74
3 Amended HOD 7/77
4

Educational Objectives for the Provision of Dental Implant Therapy by Dentists

INTRODUCTION

In February 2009, the Academy of General Dentistry (AGD) created an Implantology Task Force (ITF) comprised of nine general practitioners with substantial dental implant experience.

The purpose of the ITF was to review the current state of dental implant training in the United States and formulate guidelines. These guidelines would delineate the objectives that are recommended in coursework for educating dentists about safe and appropriate dental implant therapy.

Various dental implant reference materials were reviewed, and pertinent information gleaned from these sources aided in the construction of this document.

Additionally, the observations and experiences of the members of the ITF, many of whom are educators in implant dentistry, were used to develop these training objectives.

It is not the purpose of these Educational Objectives to define a curriculum for dental implant therapy. Rather, these objectives are to be used as guidelines for educational providers to develop curricula that will adequately prepare dentists for providing safe and appropriate dental implant therapy.

There are a variety of educational outlets available to provide dentists with the necessary training in dental implant therapy. These outlets include, but are not limited to, university-based sources, hospital-based sources, dental organizations, manufacturer-sponsored courses, private individuals, and commercial training centers.

All providers of dental implant continuing education (CE) should be AGD PACE- or American Dental Association (ADA) CERP-approved.

Dental implant therapy can be accomplished successfully by all licensed dentists who have received adequate training. No manufacturer, university, hospital, or provider of CE should limit any licensed dentist from having access to the specific knowledge base or materials needed to provide quality care through the provision of dental implant therapy.

As a "prosthetic discipline with a surgical component," the placement of dental implants is part of the practice of general dentists and specialists alike who have attained the appropriate education.[1]

Dentists performing the surgical placement of dental implants should have an understanding of the final prosthetic goal of each case and the various elements of the restorative process.

Dental implants provide support for restorations that substitute for missing dentition. Dental implant therapy restores the patient's function, form, and esthetics, as well as comfort and

longevity, and has become the tooth replacement methodology of choice for many patients. Additionally, dental implant therapy facilitates the health and preservation of the remaining oral structures.

In anticipation of untoward circumstances that may occur during the treatment process or after the restorative phase has been completed, dentists should have attained the education necessary to be familiar with interventions needed to manage those circumstances.

GLOSSARY

Autogenous graft
Hard or soft tissue harvested from one or more sites and transplanted to another site or other sites in the same individual.[2]

CERP
"Recognizing the need to offer its members and the dental community a way to select continuing education (CE) with confidence, to assist regulatory agencies and other organizations responsible for approving credit, and to promote the continuous improvement of CE, the American Dental Association Continuing Education Recognition Program (ADA CERP) was established in 1993. Through an application and review process, the ADA CERP evaluates and recognizes institutions and organizations that provide continuing education (CE)."[3]

Dental implant
A dental implant is an alloplastic material or device that is surgically placed into or onto orofacial tissues and used for anchorage, functional, therapeutic, and/or esthetic purposes.[2]

Dental implant prosthesis
Syn: Dental implant restoration. "Any prosthesis (fixed, removable, or maxillofacial) that utilizes dental implants in part or whole for retention, support, and stability."[2]

Dental implant therapy
Syn: Implant dentistry, oral implantology. The field of dentistry dealing with the diagnosis, surgical placement, prosthetic reconstruction, and maintenance of dental implants.[2]

Exogenous graft
Hard or soft tissue derived from outside the patient's body.[2]

Familiarity
"A simplified knowledge for the purposes of orientation and recognition of general principles."[4]

PACE
"The Academy of General Dentistry (AGD) Program Approval for Continuing Education (PACE) was created to assist members of the AGD and the dental profession in identifying and participating in quality continuing dental education (CDE). The program provider

approval mechanism is an evaluation of the educational processes used in designing, planning, and implementing continuing education."[5]

DENTAL IMPLANT VARIATIONS

Dentists involved in the practice of implant dentistry should have a familiarity with the various dental implants and dental implant restorations that are presently available, even though the dentists may be placing and/or restoring only one brand or modality.

This familiarity may aid in the recognition of a dental implant device either clinically or radiographically and allow for maintenance protocols. Additionally, familiarity with the various dental implants and dental implant restorations will aid the dentist in exercising his or her professional judgment to treat the patient or make an appropriate referral.

DENTAL IMPLANT CASE TYPES[6]

Current literature indicates that surgery may be divided into two case types: straightforward and complex.

The type of case is not an absolute measure. After completion of adequate coursework in dental implant therapy, the dentist should be able to assess the case type and make treatment or referral decisions accordingly.

Dental implant therapy, regardless of case type, may be performed safely by an appropriately trained dentist, and these case types are not determinative of need for referral.[7]

The following attributes of straightforward and complex cases are indicative but not singularly determinative of the respective case types, and are presented below by interpretation of and/or citation of current literature:[6]

Straightforward case:
Perception of Case: The end prosthetic result and treatment protocols are readily understood.
Tooth Position: Adequate identifiable anatomical landmarks exist to determine optimal tooth position.
Dental Implant Surgery: The dental implant surgery procedure has minimal anatomical risks and can be carried out without the need for significant hard or soft tissue grafting.
Occlusion: The teeth can be replaced without significant alteration to the patient's existing anatomic structures.

Complex case:
Perception of Case: The end prosthetic result and treatment protocols cannot be readily determined without extensive diagnostic and planning techniques and may include multiple stages to achieve the desired outcome.
Tooth Position: Minimal identifiable anatomical landmarks require more extensive diagnostic procedures to determine the optimal tooth position for esthetics and function.
Dental Implant Surgery: The dental implant surgery is a more challenging procedure with notable anatomical risks and may require significant hard or soft tissue grafting.
Occlusion: A deterioration of the patient's anatomic structures requires significant treatment planning to adequately restore the occlusion.

EDUCATIONAL OBJECTIVES

Educational objectives for the straightforward placement of dental implants:

A dentist who intends to engage in the straightforward placement of dental implants should have attained education that includes the educational objectives listed below. The dentist should be familiar with the procedures involved in the assessment, planning, placement, restoration, and maintenance of dental implants.[6]

1. Anatomy of the maxilla and mandible.
2. Pathological processes that occur in the maxilla and mandible.
3. Healing processes that occur following surgery and how to manage postoperative untoward circumstances.
4. Diagnostic imaging of the mandible and maxilla, and how to interpret the findings from these examinations.
5. Clinical assessment of a patient's suitability for dental implants and the medical conditions that could preclude a patient from dental implant therapy or complicate surgery.
6. Infection control and aseptic techniques as applied to dental implant surgery.
7. Techniques involved in harvesting autogenous bone from oral sites for augmentation during dental implant placement.
8. The use of exogenous bone, bone substitutes, and/or soft tissue for augmentation in the placement of dental implants.
9. The use of appropriate pharmaceutical agents in relation to implant dentistry.
10. The dental implant options available and their indications and contraindications.
11. Patient informed consent and how to obtain it prior to dental implant placement.
12. Clinical and laboratory protocols for dental implant therapy, including:
    a. An understanding of the clinical techniques for conventional dental implant restorative procedures.
    b. An understanding of the pre-surgical laboratory procedures and techniques used to provide dental implant therapy.
    c. An understanding of the laboratory techniques used to construct implant-supported prostheses.
    d. An understanding of the clinical restorative procedures involved in straightforward dental implant-supported restorations.

e. A recognition of technical and cosmetic limitations of implant dentistry.

13. Long-term maintenance of dental implants and dental implant restorations.
14. Proper documentation of all clinical activity.[6]
15. Assessment of the occlusion and its relevance in relation to the proposed treatment and longevity of the prosthesis.[8]
16. Interventions and approaches to manage potential complications.

Additional guidelines for complex dental implant therapy:[6]

Experience in the straightforward placement and/or restoration is a prerequisite for complex dental implant therapy.

A dentist should have attained an adequate level of surgical experience and the ability to provide follow-up care to patients who require the placement of dental implants with hard and soft tissue augmentation.

Before complex placement is attempted, a dentist also should have attained the knowledge of the prosthetics necessary for the substantial occlusal alterations that are often needed in restoring and maintaining complex cases.

As dentists advance through the developmental stages of skill acquisition, it would be advantageous for them to seek the assistance and guidance of more experienced dentists to serve as mentors.

DISCLAIMERS

Dental implant therapy may be performed safely by an appropriately trained dentist. These Educational Objectives are not intended to limit the training or practice of dentists in dental implant therapy, nor are they intended to make any representations regarding the qualifications or abilities of any individual dentist or dental specialty.

The AGD expressly disclaims any and all liability arising out of or in any way related to the use, transmission, reliance, or interpretation of these Educational Objectives or any part thereof.

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The AAID's *Guidelines for MaxiCourses®* (2008) also served as a resource for this document.

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Adopted HOD 7/09

POLICY STATEMENT ON TREATMENT OF MEDICALLY COMPROMISED DENTAL PATIENTS

With the aging of the population and the spread of infectious diseases, dentists will encounter growing numbers of medically compromised patients, including those with infectious diseases. The general dentist, as primary dental care provider, plays the key role in providing and coordinating dental care for such patients. In this role dentists have responsibilities to all patients, staff and other parties which they are ethically bound to fulfill.

Responsibilities to the Medically Compromised Patient

- To treat the patient with kindness and compassion, regardless of the nature of the patient's condition.

- To be sufficiently educated to evaluate the dental health of a medically compromised patient and to consult with physicians, when necessary, regarding the patient's medical status.

- To provide appropriate treatment within the dentist's realm of competence.

Responsibilities to Dental Staff

- To ensure that staff are trained in emergency care, the management of special health conditions and the management of medically compromised patients.

- To advise staff of the health status of each patient so they may employ appropriate procedures and avoid procedures that may place themselves or the patient at unnecessary risk.

- To ensure that all staff members are properly educated so they understand that infection control measures, including barrier techniques are in place and practiced routinely to protect them against disease. With this understanding they can properly render compassionate care to a medically compromised patient.

Responsibility to Other Parties

- Dentists must observe state and/or federal laws and regulations that require providers to protect the confidentiality of the patient.

Ethical Considerations for Treating HIV Positive Patients

The Academy believes that dentists are obligated to observe the American Dental Association's Principles of Ethics and Code of Professional Conduct in the treatment of all patients including those who are medically compromised, of which HIV positive patients are a part."

Adopted HOD 7/92

Handling Legislation Regarding General Anesthesia and Sedation Guidelines

REGARDING BOTH GENERAL ANESTHESIA AND IV SEDATION

1. All dentists, regardless of specialty status, should be deemed qualified to render particular modalities of pain control based upon the same qualifications. membership in a specific organization must not be used as a basis for permitting any individual to perform a given modality of pain control.

2. Part One of the ADA's Guidelines should be implemented as a basis for preparing dental school undergraduates to render appropriate pain and anxiety control measures.

3. The dentist must report to the State Board of Dental Examiners any mortality or any incident occurring in the office which results in temporary or permanent, physical or mental injury requiring hospitalization of said patient that is the direct result of dental general anesthesia or sedation.

4. The dentist is responsible for ensuring that the dental office is properly equipped and maintained to safeguard the patient's overall health. The dentist should be prepared to undergo an inspection and evaluation of the facility, equipment, personnel, and procedures used in the office. At least one of the individuals conducting the inspection should be a general dentist qualified to administer general anesthesia and IV sedation, wherever possible.

REGARDING GENERAL ANESTHESIA

1. All dentists not covered by a grandfather clause who wish to administer general anesthesia must complete education equivalent to the number of general anesthesia training hours required in the current oral surgery residency programs. These hours may be acquired on either a full time or part time basis. Dentists qualified under this section shall be encouraged to take refresher courses.

2. Laws enacted must contain a permanent grandfather clause. Demonstration by a general practitioner that he/she has been administering general anesthesia successfully on a regular basis for the last five years shall qualify that dentist as meeting the necessary educational requirements for grandfathering.

3. The dentist is responsible for seeing that an adequately trained individual is with him or her to continuously monitor the patient under general anesthesia.

4. A dentist who has not been trained in administering general anesthesia may obtain a special permit to have general anesthesia administered in his/her office providing he/she has an anesthesiologist, or a certified registered nurse anesthetist or the equivalent on the premises until such time as the patient regains consciousness.

5. A dentist who wishes to administer general anesthesia in his/her office should possess a current certificate in Advanced Cardiopulmonary Life Support issued by the American Heart Association, the American Red Cross, or an equivalent agency-sponsored cardiopulmonary resuscitation course with recertification every two years.

REGARDING SEDATION

1	1.	Sedation can be learned on a CDE basis with reference to the course content described
2		in Part III of the ADA's Guidelines. The time and type of training should be subject to
3		the approval of the Dental Board. This allows for a variety of programs in the same
4		state so that dentists may select the program most appropriate to their backgrounds.
5
6	2.	There is enough evidence to indicate that the clinical and didactic material for sedation
7		can be learned in the undergraduate and graduate levels, and through CDE on a
8		continuous or incremental basis. It is helpful if the course can be conducted in a
9		hospital or dental school environment. Consideration should be given to providing the
10		course on an incremental basis so that it will be available to more of the practicing
11		profession.
12
13	3.	Laws enacted must contain a permanent grandfather clause. Demonstration by a dentist
14		that he/she has been administering sedation successfully on a regular basis for the last
15		three years shall qualify that dentist as meeting the necessary educational requirements
16		for grandfathering. Grandfathered dentists should be encouraged to take periodic
17		refresher courses.
18
19
20	Revised HOD 5/87
21	Revised HOD 7/94
22

Handling Legislation Regarding General Anesthesia and Sedation

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4. The dentist is responsible for ensuring that the dental office is properly equipped and maintained to safeguard the patient's overall health. The dentist should be prepared to undergo an inspection and evaluation of the facility, equipment, personnel and procedures used in the office. At least one of the individuals conducting the inspection should be a general dentist qualified to administer general anesthesia and IV sedation, wherever possible.

Regarding general anesthesia

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<u>Regarding sedation</u>

1. Sedation can be learned on a CDE basis with reference to the course content described in Part III of the ADA's Guidelines. The time and type of training should be subject to the approval of the Dental Board. This allows for a variety of programs in the same state so that dentists may select the program most appropriate to their backgrounds.

2. There is enough evidence to indicate that the clinical and didactic material for sedation can be learned in the undergraduate and graduate levels, and through CDE on a continuous or incremental basis. It is helpful if the course can be conducted in a hospital or dental school environment. Consideration should be given to providing the course on an incremental basis so that it will be available to more of the practicing profession.

3. Laws enacted must contain a permanent grandfather clause. Demonstration by a dentist that he/she has been administering sedation successfully on a regular basis for the last three years shall qualify that dentist as meeting the necessary educational requirement for grandfathering. Grandfathered dentists should be encouraged to take periodic refresher courses.

National Health Care Reform Position Paper

EXECUTIVE SUMMARY

Reform to our nation's health-care system will require a significant restructuring of the current delivery system. However, the Academy believes these changes should be incremental and should build upon the strengths of our current system.

The Academy of General Dentistry believes that any health-care reform plan must require insurers to offer a minimum benefits package, which would be developed and updated yearly by an independent, federally established commission. Community rating would replace experience rating, pre-existing condition exclusions would be prohibited and purchasing corporations or networks would be established to allow the pooling of good and bad risks. In addition, a national risk pool would be established for eligible individuals.

Employers would be encouraged to offer a basic benefits package to all employees. In addition, strong incentives would be developed to promote the purchase of a comprehensive benefits package, which includes dental services. Employers would be required to continue to offer, but not pay for, coverage to employees who have been fired, laid off or have quit.

Medicaid could be expanded and made more efficient through a system of vouchers and subsidies and aggressive anti-fraud measures. Uniform eligibility standards and a uniform basic benefits package and catastrophic care, could be established and could be provided through managed care systems that operate on a group model or on a clinic type (staff model) of delivery system.

Employees would be required to share in premium costs. Incentives would be developed to encourage providers to practice in currently underserved areas and extensive professional liability reforms would be implemented. Administrative costs and waste in the health delivery system would be reduced, and living wills would be recognized.

STATEMENT OF GUIDING PRINCIPLES

The Academy of General Dentistry believes that the following principles must be the ultimate goal of any health-care reform plan. It acknowledges that these goals may not be immediately achievable. However, it affirms that these goals must be the guiding principles behind any reform plan.

The Academy believes that any health-care reform plan must:

1. Provide access to basic health care for all legal residents of the United States, regardless of income.

2. Control escalating health-care costs.

3. Provide high-quality health care.

4. Build upon the strengths of the current system.

5. Be based on an equitable tax policy.

6. Preserve our pluralistic financing, reimbursement and delivery systems to allow patients the freedom to choose their health-care providers and the manner in which their health-care benefits are delivered.

7. Be adequately funded.

8. Include a preventive component.

Rx FOR CHANGE

The Academy of General Dentistry supports incremental reforms to our nation's health-care system that will build upon its current strengths while increasing access and decreasing costs. While gaining control of costs is crucial, the Academy notes that the high quality of health care currently available in the United States should not be compromised in any way.

The U.S. Department of Commerce estimates in its **U.S. Industrial Outlook 1993** that, during 1992, of the $838.5 billion spent on national health expenditures, $40.4 billion was spent on dentists' services, compared to $157.1 billion on physicians' services.

The Commerce Department also found that outlays for physicians' services, home health care, hospital care and nursing home care rose at significantly higher rates between 1987 and 1992 than for dentistry. In fact, the increase in outlays for dentistry has been lower than nearly every other area of health care. Dentistry is one of the few areas where expenditures are still increasing at single digit rates. For example, the Commerce Department reports that from 1991 to 1992, spending for dentistry rose 9.0 percent, while spending for physicians' services rose 10.6 percent during the same time period.

The Academy's position on health-care reform addresses the issue in two parts: (1) broadening access to care and (2) controlling costs.

I. Broadening access to care.

Despite the fact that the United States spends more per capita -- and a greater proportion of its gross domestic product -- than any other industrialized nation in the world on health care, millions of individuals are falling through the cracks in our health-care system.

Two reports -- one released in December 1992 and the other in January 1993 -- although arriving at different figures, both confirm that the number of individuals without health insurance coverage is steadily increasing, ranging from 35.4 million to 36.6 million in 1991. Surprisingly, nearly three-fourths of all uninsured Americans are workers or their dependents, according to a September 1992 General Accounting Office report.

The Academy believes that access to care could be improved by:

1. **Requiring private insurers to offer a federally established minimum package of health-care benefits.**

   An independent commission may be formed to develop and update yearly a minimum benefit package that all private insurers would be required to offer. The independent commission should include representatives from all participants of the health-care system: dentists, physicians, hospitals, government, business, labor, consumers and insurers. This package should be weighted toward preventive benefits since these services are most cost effective.

2. **Creating incentives for employers to provide comprehensive benefits packages to their employees.**

   More favorable circumstances should be created for employers to provide comprehensive health benefits, including dental services, voluntarily. Incentives should include providing employers with the choice of a tax credit or deduction to encourage them to purchase the basic benefits package. The tax credit/deduction should be the same for both large and small businesses.

   The importance of a health-care tax credit/deduction is dramatically highlighted by a January 1993 report released by Communicating for Agriculture (CA), a national rural non-profit advocacy organization. CA found that the loss of the 25 percent deduction for the cost of health insurance benefits for the self-employed is likely to lead to an additional 400,000 uninsured individuals.

   However, given the current political and financial climate, the Academy recognizes that a full 100 percent deduction or tax credit may not be feasible. Therefore, the Academy stresses that whatever limit is finally established be equitable. Large and small businesses, incorporated firms and self-employed individuals should all be given an equal deduction.

   The Academy also believes that funds raised by limiting the deductibility of health-insurance benefits should be used to expand access to health care, not to build highways or for any other reason.

3. **Encouraging employers to offer a basic benefits package to all employees.**

   Employers should offer a basic benefits package to all employees. To encourage this, no employer should be allowed to deduct any part of his/her health-insurance premiums unless he/she offers the basic package to **all** employees. This will discourage large employers from offering health benefits only to upper management, and it will discourage small employers from only purchasing health insurance for themselves.

4. Giving temporarily unemployed persons continued coverage at group rates, and making premium payments tax deductible up to the maximum allowable limit.

This would provide a much-needed safety net for United States workers. Employers should be required to offer, but not pay for, a basic package for this group at regular group rates. This coverage should be offered regardless of the reason for the individual's unemployment. For example, an employer must not be allowed to deny continued coverage simply because a person was fired, laid off or has quit. The payments made for health insurance by the individual should be tax deductible up to the maximum allowable limit.

5. Reforming the insurance market to assure affordable basic benefits for small groups.

Reforms to the insurance industry are fundamental to any solution to the health-insurance problem. Establishing community rating in place of experience rating would reduce the cost of health insurance and make fees more stable from year to year for small businesses and uninsurables by spreading risks. Consequently, if an employee in a small business finds it necessary to utilize health benefits in a given year, he/she won't necessarily increase the rates for his/her company. This, in turn, will encourage more small businesses to provide health-insurance benefits to their employees.

Other necessary reforms include prohibiting pre-existing condition exclusions and developing purchasing corporations or networks to allow the pooling of good and bad risks within small employer pools.

In addition, self-employed persons, unemployed but self-sufficient persons, and adult students should be combined into a national risk pool with coverage provided by private insurers at rates no greater than 125 percent of the group rate for comparable coverage.

6. Reforming Medicaid.

Medicaid should be expanded and made more efficient to reduce costs and to improve access to health-care. There should be uniform eligibility standards across the nation, and a standard benefits package should be developed. The standard benefits package should include a long-term and catastrophic care insurance benefit and preventive services. These benefits should be provided to Medicaid recipients through cost-effective managed care systems that operate on a group model, staff model or clinic type of delivery system.

Medicaid should be expanded to include all categorically impoverished persons, and should cover workers who are not covered under their employer's insurance plans. Low-income individuals should receive assistance in purchasing the basic package of Medicaid benefits through a series of vouchers and subsidies on a sliding scale based on income. The poorest individuals should receive a non-transferable voucher for the purchase of the coverage, and other low-income individuals should receive a subsidy to assist them in purchasing the basic benefit package. This expansion should be paid for by both the federal and state governments.

Medicaid fees should be made comparable to Medicare, and providers must be adequately compensated. Properly compensating health-care providers will prevent cost-shifting and ensure a high standard of care. The importance of adequate funding is highlighted by an April 1992 report released by the Healthcare Financial Management Association (HFMA). HFMA found that reimbursement shortfalls from Medicare and Medicaid are comprising an increasingly larger share of hospital cost-shifting. In 1989, the estimated level of under-compensated care from public payers -- $11.2 billion -- was "reasonably close" to the cost of unsponsored care provided to patients in the form of bad debt and charity care -- $8.9 billion. By 1992, however, the study estimated that undercompensated care from public payers would reach $22.7 billion compared to about $11.9 billion for unsponsored care.

* Aggressive measures should be taken to eliminate fraud and corruption. For example, a data base of all final adverse actions and certain fraud investigations against health-care practitioners should be established. However, such a system must ensure patient confidentiality. The importance of anti-fraud measures is highlighted by testimony presented to Congress in February 1993 by William Mahon, executive director of the National Health Care Anti-Fraud Association, who said that health-care fraud and abuse could cost the nation as much as $94 billion in 1993.

The reformed Medicaid should be transferred to the private sector with at least one hospital-medical-surgical-dental benefit plan or carrier in each state.

7. Instituting a federally supported system of financial incentives for providers in underserved areas.

Financial incentives, such as loan forgiveness, would make less desirable geographic and socio-economic areas more attractive to health-care providers, and would thereby increase the availability of quality health care to all residents.

* **The Board recommended that the third sentence in this paragraph be amended to read "... must ensure patient confidentiality <u>and provider</u> <u>due process</u>." The Board also recommended that the entire paragraph be moved to the last page of the paper, numbered as item 6, and given the title "Eliminating Fraud and Corruption."**

II. Controlling escalating health-care costs.

Controlling escalating costs is crucial to reducing the burgeoning deficit. In addition, reducing health-care costs is one factor that will help United States firms successfully compete in the global marketplace.

According to a September 1992 General Accounting Office report, a survey of medium and large firms found that employer and employee health-benefit costs grew at an average annual rate of 16 percent over the past four years. And, small firms have been experiencing even larger increases.

The Academy believes costs could be controlled by:

1. Implementing tort/professional liability reforms.

Any professional liability reforms must enhance the injured individual's ability to obtain fair compensation and at the same time protect doctors from predatory and unjustified law suits. Tort reforms should include establishing mandatory periodic payments of substantial awards for damages, imposing a ceiling on non-economic damages, implementing mandatory offsets of awards for collateral sources of recovery, limiting attorney's contingency fees, imposing a statute of limitations on health-care-related injuries, devising alternative methods of resolving disputes and requiring medical facilities to use risk management practices.

The National Medical Liability Reform Coalition found in a February 1993 report that the nation's health-care system could save as much as $76 billion over the next five years by reducing or eliminating the practice of "defensive medicine" through implementing reforms such as these.

2. Limiting administrative costs.

Simplifying administrative procedures and making insurance forms uniform would reduce costs significantly. In addition, implementing an electronic claims processing system would streamline the process, thereby reducing costs. A November 1990 report by Families USA Foundation and Citizen Action estimated that $52.8 billion could be saved by simplifying the insurance administrative system of private health insurance.

3. Reducing oversupply of hospital beds and duplicative expensive technology.

Unused hospital beds provide no benefit and contribute to the drain on our limited resources. Reducing the oversupply of beds would help to reduce costs as would reducing duplicative technology. A June 1991 General Accounting Office report found that the medical "arms race" is a significant contributor to rising health-care expenditures. One example the report gave was of a county in Pennsylvania. In this county, a hospital and a group of radiologists each acquired MRI machines. But another MRI machine also serving local residents was already available in the next county. As a result, a small area had three sophisticated diagnostic machines, each costing $1.5 million. With those machines, physicians apparently performed more MRI scans per resident than were done in all of Philadelphia and many other hospitals in the state.

4. Requiring employees to share in premium costs, but make employees' contributions deductible up to the maximum allowable limit.

Requiring employees to share in premium costs is an easy way to promote wiser consumer choices. Additionally, copayments would help to encourage greater personal responsibility on the part of the patient, and to decrease frivolous use of the health-care system without unduly burdening those who truly need to use it.

5. Recognizing living wills in law.

By respecting the wishes of our terminally ill patients and legally recognizing living wills, we could reduce health-care expenditures for the terminally ill.

Adopted HOD 7/93

1
2 **AGD Policy Statement on the Consumption of Sugar and its Health Care Consequences**
3
4 In 2016, the American Heart Association published a scientific statement on the "*Added*
5 *Sugars and Cardiovascular Disease Risk in Children*."[14] Evidence supports the correlation
6 that the consumption of added sugars leads to a myriad of human health problems.
7
8 The term "sugar" refers to any number of carbohydrates with the general chemical formula of
9 $C_n (H_2O)_n$. Sugars are categorized into monosaccharaides (simple sugars) and disaccharides
10 (a sugar formed by two monosaccharides or simple sugars). Scientific research indicates a
11 preference for a sweet taste is evident in infants and childhood.[15] Furthermore, sugar functions
12 as a pain reliever in children[16] and elicits an endogenous opioid release.[17] Carbohydrates
13 provide a ready source of energy for children and assist in their growth. From an evolutionary
14 standpoint, there is a rationale for humans, particularly children's affinity for sweet tasting
15 substances. Notwithstanding, many communities world-wide find that the consumption of
16 sugar has evolved into the over-consumption of sugar.
17
18 Knowledge and data acquired about the health consequences from sugar consumption
19 continue to accumulate. The over ingestion of sugar has adverse effects on local and systemic
20 anatomical structures in the human body.
21
22 The Academy of General Dentistry (AGD) has a vested interest in the health and well-being
23 of children and adults. Sugar consumption is the most important contributing factor of
24 caries,[18,19, 20] which is the most prevalent of worldwide diseases.[21, 22, 23]
25
26 **Physiological Issues Resulting from Sugar Consumption**
27
28 *Caries*
29 Sugars in beverages and foods including breads and other carbohydrates act with bacteria in
30 the mouth to form acid reactions. Over time, a lowered pH in the mouth creates an

14 Vos, MB, et. al. Added Sugars and Cardiovascular Disease Risk in Children: A Scientific Statement from the American Heart Association. Circulation. 2017 May 9; 135(19):e1017-e1034.
15 Ventura AK, Mennella JA. Curr Opin Clin Nutr Metab Care. 2011 Jul; 14(4):379-84.
16 Pepino, MY, Mennella, JA. Sucrose-Induced Analgesia is related to Sweet Preferences in Children but not Adults. Pain. 2005 December 15; 119(1-3): 210–218.
17 Erlanson-Albertsson C. Lakartidningen. 2005 May 23-29; 102(21):1620-2, 1625, 1627.
18 Gupta, P, Gupta, N, Pawar, AP, Birajdar, SS, Natt, AS, Singh, HP. Role of Sugar and Sugar Substitutes in Dental Caries: A Review. ISRN Dentistry Volume 2013, Article ID 519421.
19 World Health Organization. Sugars intake for adults and children. Geneva: WHO; 2015.
20 Moynihan PJ, Kelly SA. Effect on caries of restricting sugars intake: systematic review to inform WHO guidelines. J Dent Res 2014;93:8–18.
21 National Institute of Dental and Craniofacial Research. https://www.nidcr.nih.gov/DataStatistics/FindDataByTopic/DentalCaries/ Accessed July 14, 2017.
22 World Health Organization. Dental Diseases and Oral Health. http://www.who.int/oral_health/publications/en/orh_fact_sheet.pdf Accessed July 14, 2017.

23 Kassebaum, NJ, Bernape, E, Dahiya, M, Bhandari, B, Murray, CJ, Marcenes, W. Global Burden of Untreated Caries: A Systematic Review and Meta-regression. J Dent Res. 2015 May;94(5):650-8

environment where bacteria infiltrate the enamel of the tooth and can cause decay. If left untreated, tooth decay, also known as cavities or caries, can lead to grave consequences including death.

Obesity

The inability to feel full contributes to excess eating and calories. High levels of fructose and other sugars in blood obscure leptin levels in the brain so that satiation is not achieved and consumption continues beyond normal. The most common causes of obesity are overeating and physical inactivity.

Consumption of too many sugary foods and beverages contribute to excess calories and may lead to an increase in weight. Furthermore, studies have confirmed a relationship between childhood and adult obesity[24] and dental caries.[25] Obesity is associated with heart disease, stroke, high blood pressure, diabetes, osteoarthritis, gout, select cancers, and sleep apnea.[26]

Diabetes

A diet high in sugar can increase the likelihood of a diabetes diagnosis. Type 2 diabetes is linked to high levels of sugar in the blood; however, consuming sugar is only one risk factor in acquiring diabetes. Adding one serving of a sweetened beverage to a diet per day increases the risk of diabetes by 15 percent.[27]

Increased Cholesterol

A high sugar diet is linked to unhealthy cholesterol and triglyceride levels. In one study, the cohort that ate the most sugar were more than three times likely to have low high density lipoprotein levels.[28]

Heart Disease

A diet high in sugar may increase the risk of dying from heart disease[29] absent an indication of being overweight. High insulin levels cause abnormal cell growth around artery walls resulting in blood vessel restriction, high blood pressure, heart attack, or stroke.

Beverages and Food

Beverages

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24 Alswat, et. al. The Association between Body Mass Index and Dental Caries: Cross-Sectional Study. J Clin Med Res. 2016 Feb; 8(2):147-152.

25 Hayden C, Bowler JO, Chambers S, Freeman R, Humphris G, Richards D, Cecil JE. Obesity and dental caries in children: A systematic review and meta-analysis. *Community Dent Oral Epidemiol.* 2013; 41(4):289-308.

26 U.S. Centers for Disease Control and Prevention. Adult Obesity & Consequences. https://www.cdc.gov/obesity/adult/causes.html Accessed July 12, 2017.

27 Malik, VS, Popin, BM, Bra, GA, Despres, JP, Willett. WC, Hu, FB. Sugar-Sweetened Beverages and Risk of Metabolic Syndrome and Type 2 Diabetes. Diabetes Care 2010 Oct. 27, vol. 33, no. 11.

28 Welsh, JA, Sharma A, Abramson, JL, Vaccarino, V, Vos, MB. Caloric Sweetener Consumption and Dyslipidemia among US Adults. *Journal of the American Medical Association*, April 21, 2010; vol 303: pp 1490-1497.

29 Yang, Q, Zang, Z, Gregg, EW, Flanders, WD, Merritt, R, Hu, FB. Added Sugar Intake and Cardiovascular Diseases Mortality among US Adults. JAMA Intern Med. 2014;174(4):516-524.

Sugar sweetened beverages (SSB), or drinks with added sugars, are associated with weight gain, obesity, heart disease, type 2 diabetes, and tooth decay.[30] High fructose corn syrup (HFCS) is one type of sugar in SSBs and consists of both glucose and fructose. It allows for rapid absorption of the blood steam, which leads to increased metabolic disturbances. Moreover, HFCS triggers an immune reaction leading to inflammation. HFCS consumption is associated with adult chronic bronchitis,[31] childhood asthma,[32] and other diseases. Public health officials recommend limiting the intake of SSBs, particularly for children. Limitations should be extended to the consumption of 100% fruit juice, as well.

Foods

While much public health focus is relegated to SSB consumption, the intake of sugary foods is equally problematic. Starchy foods in bread, beans, fruit, potatoes, and many others, act with bacteria in the mouth to form acids that can eat away at teeth enamel and lead to caries.[33, 34] Consumption of sugary foods should not be substituted for adherence to sugar-free beverage ingestion. A diet of nutrient rich foods is recommended with minimal intake of added sugars.

Alternate sweeteners

Consumers seeking to replace sugar in food and beverages may pursue sugar substitutes. Alternative sweetener options include sugar alcohols and high-intensity sweeteners. Sugar alcohols, not considered high intensity sweeteners, include sorbitol, xylitol, mannitol, and others, do not promote tooth decay or cause a precipitous increase in blood glucose. Primarily, this class of sweeteners are added to chewing gum, sugar-free candies, and other foods. Sugar alcohols are between 25%-100% as sweet as sugar.[35, 36]

High-intensity sweeteners are many times sweeter than sucrose (table sugar) therefore a smaller amount is needed to achieve the same level of sweetness as sugar. Stevia, monk fruit, saccharine, aspartame, and sucralose are some of the high-intensity sweeteners permitted for use in food and beverages by the U.S. Food and Drug Administration.

Water

An uncontaminated ready source of water must be available to all residents of cities and municipalities. Lead and copper contaminants must be kept out of the water supply and are particularly harmful to fetuses, infants, and young children due to their inherent physiology

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30 Bernabe E, Vehkalahti MM, Sheiham A, Aromaa. A. Suominen AL. Sugar-sweetened beverages and dental caries in adults: A 4-year prospective study. J Dent. 2014. 2014;42(8):952-958.

31 DeChristopher LR, Uribarri J, Tucker KL. Intake of High Fructose Corn Syrup Sweetened Soft Drinks is Associated with Prevalent Chronic Bronchitis in U.S. Adults, Ages 20-55 y. Nutr J. Oct 16, 2015; 14:107.

32 DeChristopher LR, Uribarri J, Tucker KL. Intakes of Apple Juice, Fruit Drinks and Soda are Associated with Prevalent Asthma in US Children aged 2-9 years. Public Health Nutr. 2016 Jan;19 (1):123-130.

33 Doichinova L, Bakardjiev P, Peneva M. Assessment of Food Habits in Children aged 6-12 years and Risk of Caries. Botechnol Biotechnol Equip. Jan 2; 29(1):200-204.

34 Bradshaw, DJ, Lynch RJ. Diet and the Microbial Aetiology of Dental Caries: New Paradigms. Int Dent J. 2013 Dec; 63 suppl 2:64-72.

35 Sugar Alcohols Fact Sheet. Foodinsight.org. http://www.foodinsight.org/articles/sugar-alcohols-fact-sheet Accessed July 14, 2017.

36 Ibrahim, OO. Sugar Alcohols: Chemical Structures, Manufacturing, Properties and Applications. EC Nutrition 4.2 (2016): 817-824.

and size. When used appropriately, fluoride is safe and effective in preventing and controlling dental caries. Regular use throughout life may help protect teeth against decay.

Taxes

Public health advocates are nearly unanimous in support of the adoption of taxes on SSB.[37,38,39, 40] Taxes are proposed to effect changes in policies at local, state, and national levels. Further, taxes are advocated to decrease consumption of sugar sweetened beverages and to fund public health education efforts aimed at a change to healthy nutritional behaviors and choices.

Free market advocates contend that citizens in the U.S. are taxed sufficiently already. SSB taxes may disproportionally affect the poor and tax exemptions apply differently in each locale. For instance, the proposed Cook County, Illinois tax exempts individuals using federal food assistance programs such as the supplemental nutrition assistance program (SNAP).

Lawmakers and citizens should consider what is being attempted by imposing taxes on SSB. Potential reasons cited to adopt a SSB tax are to raise revenue, to change beverage consumption from unhealthy beverages to healthy beverages, decrease incidence of disease, to fund pre-kindergarten, or other rationales. Public policy should be well thought out and aim to address solutions that benefit citizens. Moreover, policy makers should discuss the effects of federal subsidies that have artificially inflated the price of sugars over the last 80 years.

Role of media in promoting poor nutrition

Marketing to children is one factor in the childhood obesity epidemic.[41] Several national and international organizations have advocated for restrictions on marketing to children due to concerns about food and beverages and resulting adverse health consequences.[42] Prior television exposure predicts unhealthy food preferences and diet, as well as parenting

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37 Brownell, KD, Farley, T, Willett, WC, Popkin, BM, Chaloupka, FJ, Thompson, JW, Ludwig, DS. The Public Health and Economic Benefits of Taxing Sugar-Sweetened Beverages. N Engl J Med 2009; 361:1599-1605, Oct. 15.

38 Brownell, KD, Frieden, TR. Ounces of Prevention-The Public Policy Case for Taxes on Sugared Beverages. N Engl J Med 2009; 360:1805-1808, April 30.

39 Jacobson M and Brownell K. Small Taxes on Soft Drinks and Snack Foods to Promote Health. American Journal of Public Health, 90(6): 854–857, June 2000.

40 National Academies of Medicine. A Workshop on Strategies to Limit Sugar-Sweetened Beverage Consumption in Young Children: Evaluation of Federal, State, and Local Policies and Programs. June 21-22, 2017. http://nationalacademies.org/hmd/activities/nutrition/stategiestolimitssbconsumptioninyoungchildren/2017-jun-21.aspx (Accessed July 13, 2017).

41 Food Marketing to Children and Youth (2006). Institute of Medicine. Washington: The National Academies Press, p. 8.

42 WHO Forum. (2006, May 5). Marketing of Food and Non-alcoholic beverages to children, Report of a WHO forum and technical meeting. Oslo, Norway.

factors.[43] Parents may want to set limits on childhood exposure to media in order to establish healthy eating habits for children.

School/Educational Issues

Food and beverage choices available to children should be of high nutritional value. Contractual arrangements, such as beverage pouring rights, that influence increased access to soft drinks for children should be kept out of schools. Parental and caretaker education is needed on what and how to feed children to optimize health and development.

Science evolves over time as more data is known. Health professionals are discovering that food and beverage nutritional content is necessary in order to make informed choices. Federal regulations have assisted in efforts of transparency on ingredient labels.

Education

As society considers the importance of the role of proper nutrition in human health, it is appropriate to consider educational improvement for health care professionals. Dentists and physicians receive limited education on nutrition during their training, and yet, proper nutrition is an essential component to prevent many diseases. Cultural differences also affect food choices therefore, cultural competency is needed to ensure that health professionals dispense the most appropriate advice to parents and children.

Screening for Obesity

Screening for obesity is unlike screening for other systemic diseases and can be accomplished easily by calculating a body mass index (BMI). While a BMI measurement has limitations, it provides an assessment of a standardized height/weight metric. If the patient's BMI measurement is in the overweight or obese categories, dentists may choose to seek a referral to an appropriate health professional to assist in providing relevant nutritional information and advice.

43 Harris, JL, Bargh, JA. The Relationship between Television Viewing and Unhealthy Eating: Implications for Children and Media Interventions. Health Commun. 2009 Oct; 24(7): 660–673.

Academy of General Dentistry Policy Statements and Recommendations

1. *Prevalence of and Connection between Sugar Consumption and Caries:* The Academy of General Dentistry (AGD) has a vested interest in the health and well-being of children and adults. Sugar consumption is the most important contributing factor of caries, which is the most prevalent of worldwide diseases.

2. *Levels of Sugar Consumption:* AGD supports recommendations of sugar consumption for children not to exceed 6 teaspoons per day. However, consumption of less than 3 teaspoons of sugar per day is more optimal. Consumption of sugary foods should not be substituted for adherence to sugar-free beverage ingestion.

3. *Diabetes Identification and Management:* General dentists, as primary health care professionals, have an important role in the identification and management of diabetes. General dentists should be provided the ability, training, and resources to screen for diabetes, and to collaborate with the patient's primary care physicians, as deemed appropriate, to identify and manage diabetes.

4. *Screening for Obesity:* General dentists, as primary health care professionals, have an important role in the prevention of childhood obesity. General dentists should be provided the ability, training, and resources to screen children for obesity using a BMI score and to refer children to pediatric primary care physicians or qualified nutritionists, where deemed appropriate by the dentist. While not a perfect measurement, BMI scores can be helpful in establishing a general assessment of a child's propensity toward obesity.

5. *Taxation and Subsidies:* Lawmakers and citizens should consider all the objectives of taxation when considering imposing taxes on SSB. Potential reasons to adopt an SSB tax may include, but not necessarily be limited to, to raise revenue, change beverage consumption from unhealthy beverages to healthy beverages, decrease incidence of disease, or fund pre-kindergarten. Public policy should be well thought out and aim to address solutions that benefit the health of the U.S. population. Moreover, policy makers should discuss the effects of federal subsidies that have artificially inflated the price of sugars since the 1930s.

6. *Nutrition Education and Training:* Public health professionals should design a campaign for parents and caretakers to target what and how to feed children to optimize health and development. Given that proper nutrition is an essential component to prevent many diseases, resources should be directed to providing dentists and physicians with additional education and/or training on nutrition.

Off-Label Use of Dental Products

Terminology

The term “off-label use” refers to any use of approved drugs, licensed biologics, and approved or cleared medical devices in any manner that is inconsistent with the U.S. Food and Drug Administration’s (FDA) approved labeling of the medical product. “Clinician-directed application” or “physician-directed application” are also terms that are indicative of off-label use.
Labeling means any written material that may accompany a medical product such as prescribing information, a package insert, and professional product instructions.

Off-label use means the use of a medical product for an unapproved indication, patient population, dosage, route of administration, or use outside of the product labeling.

Background- Regulatory Authority

The FDA evaluates medical products for safety and effectiveness. Additionally, the agency regulates the marketing approval, clearance, and licensing of pharmaceutical, over-the-counter, medical device, and biological products in the United States.

The FDA’s regulatory authority extends to the labeling and promotion of medical products. Promotion of the manufacturer’s product entails all written, oral, video, or other activities that contribute to the sales growth of the product. Manufacturers determine the appropriate product claims prior to submission of their application to the FDA, based on scientific data.

The FDA does not regulate the practice of dentistry or medicine. Often referred to as the “Practice of Medicine Exception,” dentists and physicians may prescribe or administer legally marketed products for an off-label indication.

Generally Accepted Practices/ Standard of Care

The practice of dentistry is regulated by state laws and regulations. Dentists should comply with all relevant federal, state, and local laws and regulations.

While the FDA recognizes the Practice of Medicine Exception, tensions remain in efforts to protect the public’s health and safety. Health care practitioners may prescribe any legally marketed product to a patient within a legitimate health care practitioner-patient relationship.[44] Dental professionals may use medical/dental products in the manner they deem appropriate for their patients. Dentists should be aware of product safety concerns and use a sound scientific basis, along with professional judgment, for off-label indications. Adverse patient reactions can be voluntarily reported to the FDA’s MedWatch[45] program.

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44 Buckman Co. v. Plaintiffs' Legal Committee, 531 U.S. 341, 121 Supreme Court. (2001).
45 U.S. Food and Drug Administration; https://www.fda.gov/Safety/MedWatch/default.htm

Standard of care is a medical-legal term that changes over time due to experience and the accumulation of data with a medical product. In some instances, the off-label use of a product is considered standard of care.

Legal Developments

Decisions in several recent court cases have changed the landscape for findings in off-label issues. Truthful off-label promotional speech[46], the FDA's pursuit of misbranding provisions (for statements that were truthful and not misleading)[47], and speech that is solely truthful and not misleading[48] cannot be the basis for a misbranding charge for a manufacturer. Additionally, a problematic decision from the Ninth Circuit[49] appears to confuse the use of adulterated devices caused by unsanitary practices with the use of legally marketed off-label products. Cases may be appealed to the Supreme Court or the FDA may elect to alter their policies.

First Amendment Issues

The FDA recognizes that recent First Amendment jurisprudence creates tension with agency policies intending to protect the public's health. In 2016, the agency convened a Part 15[50] meeting to solicit input from stakeholders. For some patients, approved or cleared products are not available or have failed. The off-label use of medical products by health care professionals provides a necessary treatment for some patients without options.

U.S. health agencies seek to promote robust research and development for medical therapies. Conducting rigorous research studies for some products is difficult, particularly for those therapies intending to treat rare disease indications. The FDA supports medical decision-making for patients in the absence of better options while maintaining a structure meant to incentivize the development of medical products, and encourage the use of labeled indications.

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46 http://www.hpm.com/pdf/blog/Caronia%202d%20Circuit%20Slip%20Opinion.pdf

47 http://cases.justia.com/federal/district-courts/new-york/nysdce/1:2015cv03588/441887/73/0.pdf?ts=1439043366

48 http://www.kslaw.com/imageserver/KSPublic/library/publication/2016articles/4-29-16_Washington_Legal_Foundation.pdf

49 U.S. Court of Appeals for the Ninth Circuit: USA v. Michael Stanley Kaplan, MD. https://cdn.ca9.uscourts.gov/datastore/opinions/2016/09/09/15-10241.pdf

50 U.S. Code of Federal Regulations, Title 21, Chapter 1, Subchapter A, Part 15: https://www.ecfr.gov/cgi-bin/text-idx?SID=449e8b175b9888f5ec4848f1b7da903e&mc=true&tpl=/ecfrbrowse/Title21/21cfr15_main_02.tpl

1 The FDA produced a memorandum[51] in January 2017 summarizing recent court challenges on
2 speech restrictions regarding evidence of intended use, commercial free speech, content and
3 speaker-based restrictions. The document is intended to solicit public feedback on free speech
4 issues while maintaining government interests in protecting the public's health.
5
6 **Restricted Use of Medical Products**
7
8 In 2007, a law[52] was passed granting the FDA new authority to require Risk, Evaluation, and
9 Mitigation Strategies (REMS) to ensure that the benefits outweigh the risks for a particular
10 drug or biological product. A REMS designation may require additional safety procedures
11 prior to prescribing, shipping, or dispensing the drug or biologic. Post-approval studies may
12 also be ordered if serious risk is associated with the use of the product.
13
14 Elements of a REMS may include a medication guide or patient package insert, a
15 communication plan, elements to assure safe use (ETASU), and an implementation system.
16 The ETASU may require any of the following: prescribers with specific training, experience,
17 or special certifications, pharmacies, practitioners, or health care settings that dispense the
18 drug may need to be specially certified, a drug or biologic may be dispensed only in certain
19 health care settings, a drug or biologic may be dispensed with evidence of laboratory test
20 results, and patients may require monitoring or enrollment in a registry. As such, a drug or
21 biologic with a REMS may be limited to the labeled indications of the product, constraining
22 the practice of medicine or dentistry.
23
24 Humanitarian use devices are also restricted for use and are authorized in limited populations,
25 for example, with patients with rare diseases. These types of devices require prior institutional
26 review board (IRB) authorization and must be used according to the FDA approved
27 indication.
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30

51 U.S. Food and Drug Administration. January 2017. Memorandum: Public Health Interests and First Amendment Considerations Related to Manufacturer Communications Regarding Unapproved Uses of Approved or Cleared Medical Products. https://www.regulations.gov/document?D=FDA-2016-N-1149-0040

52 U.S. Food and Drug Administration Amendments Act of 2007; Public Law 110-85. https://www.fda.gov/RegulatoryInformation/LawsEnforcedbyFDA/SignificantAmendmentstotheFDCAct/FoodandDrugAdministrationAmendmentsActof2007/FullTextofFDAAALaw/default.htm

FDA Guidance

In 2017, the FDA released two guidance documents[53, 54]meant to clarify the agency's current thinking on communications about medical and dental product labeling. The guidance documents are non-binding and do not carry the force of law. Alternative approaches may be used if the requirements satisfy applicable statutes and regulations.

Enforcement Trends

Health care practitioners are not immune from prosecution if they engage in off-label sales and marketing activities on behalf or in conjunction with manufacturers of medical products. It should be noted that off-label promotion is strictly scrutinized by federal authorities. Traditionally, rather than risk potential criminal or civil enforcement actions as a result of an unfavorable verdict at trial, manufacturers have settled high profile suits alleging off-label promotion. Manufacturers of medical products are reticent to risk exclusion of participation in federal health programs administrated by the Department of Health and Human Services (DHHS). With recent legal verdicts favorable to manufacturers, they may be unwilling to settle future disputes with federal authorities as readily.

Dental Product Example

Silver diamine fluoride is one example of a dental product that is used off-label. While silver diamine fluoride is FDA-cleared as a Class II medical device to reduce sensitivity in teeth, it is often used to delay tooth decay.

Policy Statement

The Academy of General Dentistry believes that dentists may prescribe or administer legally marketed medical and dental products for an off-label use within the Practice of Medicine Exception. Health care practitioners may prescribe legally marketed medical and dental products in an off-label manner if they believe that such an application is in the best interest of their patient. The practice of dentistry is regulated by state laws and regulations. Dentists should comply with all relevant federal, state, and local laws and regulations. Dentists should be aware of product safety concerns and use a sound scientific basis, along with professional judgment, for off-label indications. Adverse patient reactions can be voluntarily reported to the FDA's MedWatch program.

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53 U.S. Food and Drug Administration. "Drug and Device Manufacturer Communications with Payors, Formulary Committees, and Similar Entities- Questions and Answers," Guidance for Industry and Review Staff, January 2017.
https://www.fda.gov/downloads/drugs/guidancecomplianceregulatoryinformation/guidances/ucm537347.pdf
Accessed March 31, 2017.

54 U.S. Food and Drug Administration. "Medical Product Communications That Are Consistent With the FDA-Required Labeling- Questions and Answers," Guidance for Industry, January 2017.
https://www.fda.gov/downloads/drugs/guidancecomplianceregulatoryinformation/guidances/ucm537130.pdf
Accessed March 31, 2017.

Academy of General Dentistry (AGD) White Paper:
The Role of Dentistry in Addressing Opioid Abuse

<u>Introduction</u>

Opioid and non-opioid analgesics are utilized in dentistry for the management of post-operative pain. Non-opioids, including acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDs), are effective in the management of mild to moderate pain, including the initial management of pain.[55]

The Institute of Medicine (IOM) has noted opioids “can be safe and effective for acute postoperative pain, procedural pain, and patients nearing the end of life who desire more pain relief,” when “used as prescribed.” However, the IOM has also “acknowledge[d] a serious crisis in the diversion and abuse of opioids and a lack of evidence for the long-term usefulness of opioids in treating chronic pain.”[56]

Sales of opioids have quadrupled between 1999 and 2010, and dosage calculated in morphine milligram equivalents (MME) per person has increased over seven-fold from 96 MME per person in 1997 to 710 MME in 2010.[57] Fatalities solely from opioid abuse exceed the combined fatalities from suicide, motor vehicle crashes, and cocaine and heroin use.[58]

Opioid abuse has risen to epidemic levels in the United States. This issue is being addressed by federal and state governments, private industry, health practitioners, and other stakeholders. In recent years, some publications have purported the dental profession to be a significant contributor~~s~~ to the opioid crisis. The purpose of this white paper is to examine the veracity of these claims by a review of the contemporary literature on the role of dentistry on the opioid abuse epidemic. The development of organizational policy based upon this review is also presented.

<u>Background of Prescription Opioid Issues of Abuse and Misuse</u>

The United States has experienced an epidemic of abuse and misuse of opioid medications. Over the past two decades, knowledge of factors leading to addiction were not widely identified or disseminated. Nonetheless, it is incumbent on the health care community to ensure appropriate use of opioid medications.

One of the Food and Drug Administration’s (FDA) charges is to assess the safety and effectiveness of pharmaceuticals. In an effort to facilitate transparency, the agency compiled a

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55 Becker, D.E., and Phero, J.C. Drug Therapy in Dental Practice: Non-opioid and Opioid Analgesics. *Anesth Prog* 52:140-149. 2005.
56 Manchikanti L, Helm S, 2nd, Fellows B, et al. Opioid epidemic in the United States. *Pain Physician*, 2012:15 (3 supl): ES9-ES38.
57 Manchikanti et al., at ES22.
58 *Id.*

timeline[59] of their activities relating to the misuse and abuse of opioid medications. From 1911 to the 1990's, opioid medications were predominantly used for the management of acute pain and chronic cancer pain.

OxyContin® was approved by the FDA on December 12, 1995. Abuse of the formulation was occurring by 2001 as the formulation could be broken, chewed, or crushed for rapid release delivery. Reports of overdose and death from prescription drug products, particularly opioids, increased dramatically. In January 2003, the FDA sent the manufacturer of OxyContin, Purdue Pharma L.P., an extensive warning letter about minimizing serious safety risks and promoting the drug for uses beyond proven safety and effectiveness claims.

In 2007, the FDA Amendments Act granted the FDA authority to require certain post-market measures be implemented to further drug safety, i.e., the Risk Evaluation and Mitigation Strategies (REMS). Other federal agencies, including the Drug Enforcement Agency (DEA) and the Substance Abuse and Mental Health Services Administration (SAMHSA), launched various programs to educate the public and assist in efforts to forestall opioid abuse.

In addition to labeling changes and post-marketing surveillance requirements, abuse deterrent formulations were slowly introduced. After more than a decade of problems with opioid formulations, the FDA in 2016 developed a comprehensive action plan to reassess the agency's approach to opioid medications.

Pharmacies

While the use and abuse of opioid medications is a national issue, there are notable sections of the country with more severe and complex problems. For example, in the state of West Virginia, during a six-year period drug wholesalers shipped 780 million opioids to pharmacies within the state. That number equates to more than 400 pills for every person living in the West Virginia. One pharmacy in Mingo County received 9 million hydrocodone pills in 2 years. In retrospect, the West Virginia Board of Pharmacy failed to enforce appropriate regulations to audit pharmacies dispensing high volumes of opioids.

Pain clinics– the so-called "pill mills"– located in Michigan, Florida, and other states, serve no legitimate medical purpose. These clinics charge customers cash payments in return for narcotics. In many ensuing court cases, most prescriptions in this environment were found to be medically unnecessary.

State Lobbying

A 2016 investigation by the Center for Public Integrity and the Associated Press[60] revealed that state lobbyists funded by a coalition of pharmaceutical companies and allied groups were instrumental in deterring state legislatures from enacting limitations on prescriptions of

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59 U.S. Food and Drug Administration. Timeline of Selected FDA Activities & Significant Events Addressing Opioid Misuse & Abuse, https://www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/UCM332288.pdf, accessed March 29, 2017.

60 "Politics of pain: Drugmakers fought state opioid limits amid crisis," last modified December 15, 2016, https://www.publicintegrity.org/2016/09/18/20200/politics-pain-drugmakers-fought-state-opioid-limits-amid-crisis, accessed March 29, 2017.

opioids. Drug manufacturers adopted a state strategy to include hundreds of lobbyists working behind closed doors to weaken measures for more stringent opioid prescription requirements.

The use and abuse of opioid medications in the U.S. is due to multiple factors. Congressional investigations[61] have been initiated to determine how marketing practices affected sales, prescribing patterns, continuing medical education (CME) accreditation agencies, and state medical board policies.

Review Methods

Databases including PubMed and Medline, as well as resources provided by the United States Centers for Disease Control and Prevention (CDC), and a broader Google search, were employed to retrieve contemporary manuscripts addressing the opioid epidemic. Given the recent boom in opioid distribution, only manuscripts dated within the last twelve years and that specifically addressed dentistry were included as primary resources. However, additional manuscripts were retained as general references for clinical background information on opioid and non-opioid analgesics, and dosage conversion metrics between varying opioids. Given that the intent of this paper was to survey current literature in an effort to assess the role of dentistry to the extent necessary to derive an organizational policy, rather than to produce a clinical study, a formal systematic review process was not followed.

Findings

Number of Prescriptions:
Recent studies attribute 8%[62] to 12% of all opioid prescriptions are written by dentists. [63] Dentists are the leading prescribers when the metric is the percentage of number of prescriptions to persons aged 10 to 19 years, accounting for over 30% of the number of these prescriptions.[64]

Prolonged/multiple prescriptions:

The literature suggests opioid addiction and abuse may be more likely affiliated with prolonged or repeated prescriptions than with one-time prescriptions. “Patients consuming opioids regularly for more than a week may develop some degree of dependence.”[65]

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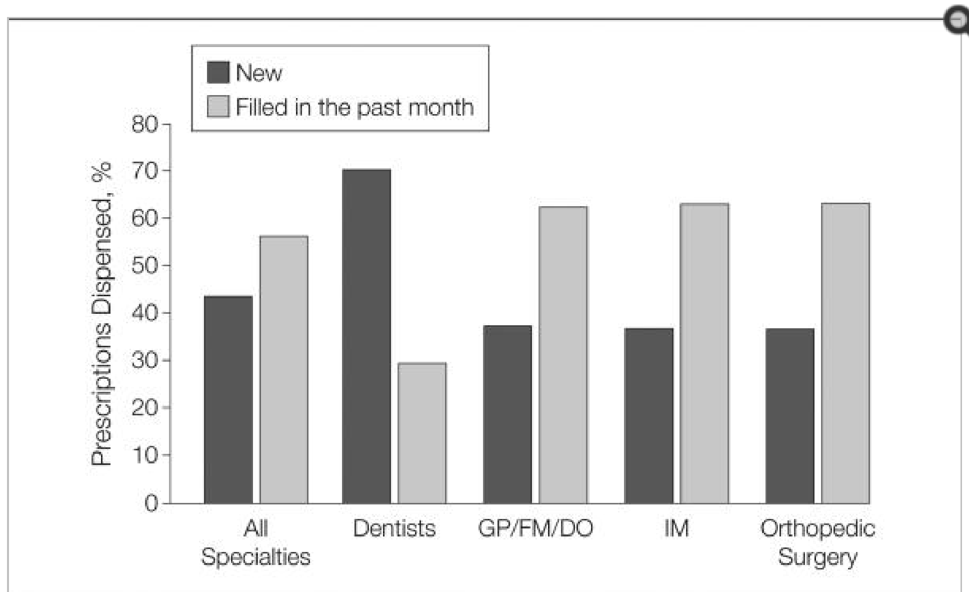
61 U.S. Senate, March 28, 2017. https://www.hsgac.senate.gov/media/minority-media/breaking-opioid-manufacturers-are-subject-of-new-mccaskill-led-wide-ranging-investigation, accessed April 4, 2017.
62 Volkow ND, McLellan TA. Characteristics of Opioid Prescriptions in 2009. JAMA. 2011 April 6; 305(13): 1299–1301. *doi:10.1001/jama.2011.401*. (“Overall, the main prescribers were primary care physicians (general practitioner/family medicine/osteopathic physicians) with 28.8% (22.9 million) of total prescriptions, followed by internists (14.6%, 11.6 million), dentists (8.0%, 6.4 million), and orthopedic surgeons (7.7%, 6.1 million).”)
63 Denisco et. al. Prevention of prescription opioid abuse: The role of the dentist. *JADA 2011;142(7):800-810.* (citing Rigoni GC. Drug Utilization for Immediate- and Modified Release Opioids in the US. Silver Spring, Md.: Division of Surveillance, Research & Communication Support, Office of Drug Safety, Food and Drug Administration; 2003).
64 Volkow et al. (“For patients aged 10 to 19 years, dentists were the main prescribers (30.8%, 0.7 million), followed by primary care (13.1%, 0.3 million) and emergency medicine physicians (12.3%, 0.3 million).”)
65 Becker et al.

According to Volkow et. al. (JAMA, 2011), “On average, across all physician specialties included in this analysis, 56.4% (44.8 million) of opioid prescriptions were dispensed to patients who had already filled another opioid prescription within the past month (**FIGURE 2**).” However, as illustrated by FIGURE 2 below, this number is in stark contrast to prescription patterns of dentists, with repeated prescriptions accounting for less than 30% for prescriptions provided by dentists. [66]

Figure 2



New vs Continuing or Switch/Add-on Opioid Prescriptions Dispensed by US Retail Pharmacies as a Function of Specialty, 2009

Shown are unprojected data. Prior prescriptions (dispensed within the past month) could be from the same or a different prescriber or specialty. GP/FM/DO indicates general practitioner/family medicine/osteopathic physicians; IM, internal medicine.

Thus, contrary to prescription patterns of general practitioners and specialists in medicine, dentists are far less likely to provide refills or multiple prescriptions to the same patient.

Dosage and duration:

Higher dosages may be more likely to result in addiction and abuse than lower dosages, although both carry risk.[67] Most general dentists that prescribe opioids provide only single-fill prescriptions of 10-20 doses to be taken over the course of 2 to 5 days.[68]

Considering a prescription of 4-6 doses per day (every 6 hours or every 4 hours) of hydrocodone/acetaminophen at 5 mg / 300 mg as an example, the maximum daily dosage of hydrocodone would be 20 to 30 mg of hydrocodone. Given the approximate 1-to-1 correlation

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66 Volkow et al.
67 CDC, “Calculating Total Daily Dose of Opioid for Safer Dosage”
68 Denisco et. al., at p. 803

between dosage of hydrocodone and MME, this would correlate to at most 20 to 30 MME/day, over the course of up to 5 days, with no refills. In contrast, a study of the Veterans Health Administration (VHA) patients found that patients that died of opioid abuse were prescribed an average of 98 MME/day, with a duration of 90 days of continuous prescription with an allowance for up to a 30 day gap for obtaining a refill.[69]

The Centers for Disease Control and Prevention (CDC) states 20-50 MME/day as relatively low dosages. While the CDC has identified higher dosages of opioids as primarily associated with higher risk of overdose and death, it also cautions such relatively low dosages should not be ignored.[70]

Where prescriptions are obtained:

“Most abusers report they obtained prescriptions on their own or medications from friends and relatives that had been prescribed opioids.”[71]

> Among persons aged 12 or older in 2009-2010 who used pain relievers non-medically in the past 12 months, 55% obtained pain relievers from a friend or relative for free[72] Among the remaining 45%, 11.4% bought them from a friend or relative (which was significantly higher than the 8.9% from 2007-2008), and 4.8% essentially stole them from a friend or relative. However, only one in 6 or 17.3% indicated that they received the drugs through a prescription from one doctor, while only 4.4% received pain relievers from a drug dealer or other stranger, and 0.4% bought them on the Internet, with no significant changes from 2007 to 2008.[73]

However, “among those who reported getting the pain reliever from a friend or family member for free, 80 percent reported that the friend or family member had obtained the drugs from one prescriber.”[74] Based upon the results of a 2010 survey of dentists in West Virginia, “When asked about doses of IR [immediate release] opioids that dentists suspect patients have left after a third-molar extraction, 41 percent of dentists expected patients to have leftover drugs. It is unknown, however, whether dentists informed patients about how to secure medication so that it was not diverted or how to dispose of unused medication.”[75]

<u>AGD Policy Statement</u>

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69 Bohnert AS, Logan JE, Ganoczy D, Dowell D. A detailed exploration into the association of prescribed opioid dosage and overdose deaths among patients with chronic pain [published online January 22, 2016]. *Med Care*. doi:10.1097/MLR.0000000000000505.

70 *Id.*

71 Volkow et al., at p. 1.

72 Substance Abuse and Mental Health Services Administration. *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings*. http://www.samhsa.gov/data/NSDUH/2k10NSDUH/2k10Results.pdf, page 25.

73 Manchikanti et al., at ES22

74 Denisco et al., at p. 802

75 Denisco et al., at p. 803

In light of the above findings, the Academy of General Dentistry (AGD) adopts the following as the policy of the AGD on the role of dentistry in opioid abuse:

…The dosage and duration of each prescription, and the number of multiple or refill prescriptions to the same patient, must be considered in any assessment of the effect of dentistry upon the epidemic of opioid addiction in the United States;

…Assessments of the causation of opioid addiction based solely upon the number of prescriptions written results in an overestimation of the dental profession's effect on opioid addiction;

…It is nonetheless incumbent upon the profession of dentistry and all dental associations to support and further the education of dentists, dental staff members, and the public to recognize the indicators of propensity and likelihood of opioid addiction, and to understand, consider, and utilize alternative pain management strategies.

Conclusion

Opioid abuse is an ongoing epidemic in the United States. The number of opioid prescriptions written by dentists rank among the highest of health care professionals. However, dentists rank among the lowest in prescribing multiple or refill opioid prescriptions to the same patient, and also in the dosage of each opioid prescription. Studies suggest that these latter factors are of far greater significance in assessing the likelihood of opioid dependence or death from opioid abuse.

On the other hand, despite lower dosages and shorter durations of prescription, surveyed dentists believed that their patients have "leftover" opioids. Studies suggest that a majority of opioid abusers obtain their drugs from friends or family with these "leftover" prescriptions. Therefore, although assessments based solely upon the number of prescriptions exaggerate the effect of dentistry on opioid abuse, it is nonetheless incumbent upon dentistry and dental associations to support and further the education of dentists, dental teams, and the public on opioid addiction, and to understand, consider, and utilize alternative pain management strategies, including non-opioid analgesics, when appropriate and effective.

Resources

U.S. Surgeon General's Call to End the Opioid Crisis
FDA Fact Sheet- FDA Opioids Action Plan
CDC Guideline for Prescribing Opioids for Chronic Pain- U.S., 2016
Prescription Drug Monitoring Programs
Royal College of Dental Surgeons of Ontario: The Role of Opioids in the Management of Acute and Chronic Pain in Dental Practice
Pennsylvania Guidelines on the Use of Opioids in Dental Practice
New Jersey Law Limits Opioid Prescriptions
National Alliance for Model State Drug Laws
Pain Management: Alternative Therapy

OPTIMAL DELIVERY OF ORAL HEALTH SERVICES THROUGH PRIMARY CARE:

A Comprehensive Workforce Policy Statement

Academy of General Dentistry (AGD)

Introduction

In 2008, the Academy of General Dentistry (AGD) published the “White Paper on Increasing Access to and Utilization of Oral Health Care Services,” calling for the implementation of twenty-five proven methods of improving access to and utilization of oral health care services, from Medicaid improvements and loan forgiveness programs, to oral health literacy and strengthening the dental workforce. In 2012, the AGD’s “Barriers and Solutions to Accessing Care” identified solutions to key areas that presented challenges to the delivery of care, including oral health literacy, converting literacy to action, moving from a treatment mentality to a prevention mentality, social and cultural misperceptions, the economics of sustainable care delivery, distribution of provider populations, and addressing patients with special needs.

Despite the various needs that must be addressed to improve oral health in the United States, state legislation has focused on the issue of workforce, thanks to a few vocal groups that have devoted significant resources solely to the promotion of alternative workforce models that utilize lesser-trained non-dentists to provide surgical care to the most vulnerable populations, in a manner that is neither cost-effective nor shown to have produced positive population health outcomes. As the American Dental Association (ADA) stated in “Breaking Down Barriers to Oral Health for All Americans: The Role of Workforce” (2011), we are “disappointed in… the degree to which the fixation on workforce, a deceptively ‘simple’ issue to grasp, has distracted policymakers and those who influence them from the much greater number and complexity of other barriers to care.”

Therefore, the AGD’s “Optimal Delivery of Oral Health Services through Primary Care: Comprehensive Workforce Policy Statement” (Statement), presented here, does not purport to identify the numerous barriers to care, nor does it purport to offer all their solutions. However, the purpose of this Statement is to present a cohesive perspective on the synergy and symbiosis of the dental workforce required for the optimal delivery of oral health care in the United States.

Executive Summary Statement

In medicine, the diversification of the workforce away from primary care and toward a proliferation of nurse practitioners and specialists has burdened the taxpayer with increased cost of care and has adversely affected patient health.[76] Conversely, 80% of the delivery of

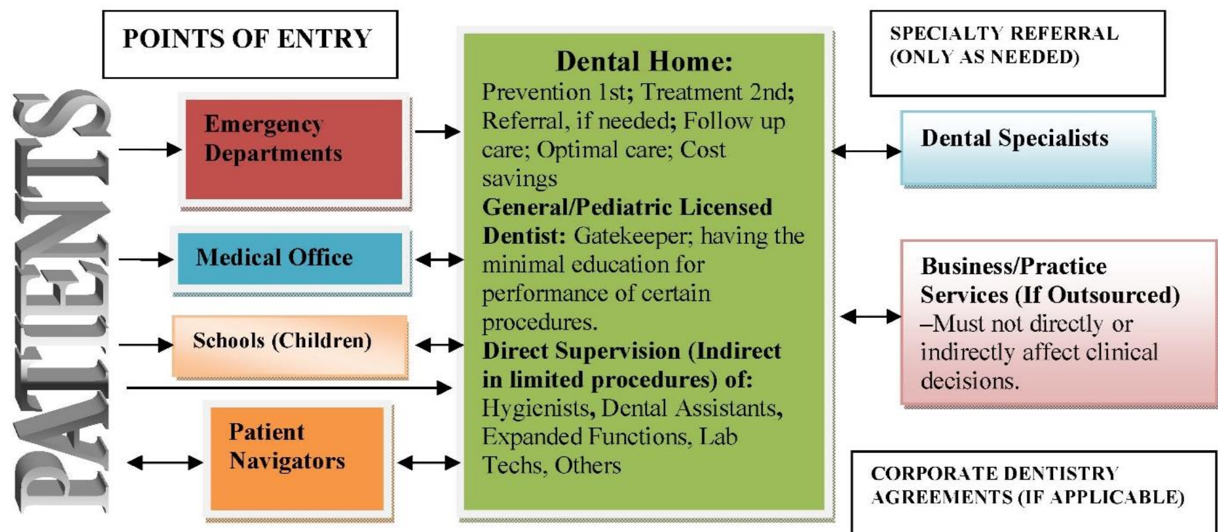
76 In the United States, an increase of just one primary care physician is associated with 1.44 fewer deaths per 10,000 persons; adults with a primary care physician rather than a specialist had 33% lower costs of care after adjusting for demographic and health characteristics (Starfield, 2006). Patients with a regular primary care physician have lower overall health care costs than those without one (Weiss & Blustein, 1996; De Maeseneer,

1 oral health care is provided through primary care – via general and pediatric dentists –
2 enabling a focus on prevention that mitigates more serious and costly health conditions.
3
4 The AGD, along with the ADA, the American Academy of Pediatric Dentistry (AAPD), and
5 other professional organizations, have long touted this philosophy of prevention through the
6 concept of the dental home. "The dental home is the ongoing relationship between the dentist
7 and the patient, inclusive of all aspects of oral health care delivered in a comprehensive,
8 continuously accessible, coordinated, and family-centered way. Establishment of a dental
9 home begins no later than 12 months of age and includes referral to dental specialists when
10 appropriate" (AAPD, Policy on the Dental Home, 2012).
11
12 Unfortunately, many children, especially those who are poor or live in rural communities,
13 have not seen a dentist by the age of 12 months. Moreover, visits to a dentist decline
14 significantly in adult populations.[77] The inclusion of pediatric dentistry but exclusion of adult
15 dentistry in the Essential Health Benefits (EHB) prescribed by the Patient Protection and
16 Affordable Care Act (PPACA) may drive benefits allocations that further distort this statistic.
17 Failure to see a dentist for preventable diseases has produced a heavy cost burden on
18 emergency rooms across our nation. Additionally, economic woes such as unemployment may
19 provoke migration of patient populations that may further affect the longevity and continuity
20 of the relationship between a given dentist and patient. Moreover, the morphology of the
21 dental practice is a complex and unpredictable study, as economic and other considerations
22 drive the eruption of group practices and corporate practices. The AGD's "Investigative
23 Report on the Corporate Practice of Dentistry" (AGD Practice Models Task Force, 2013),
24 presented many of these complexities and unknowns.
25
26 Therefore, while the dental home is at the heart of optimal oral health care delivery, a broader
27 and more cohesive workforce concept must be defined to address the needs of the many who
28 may meander their way into the oral health care system, if at all, through emergency rooms,
29 medical practitioners, public schools, or knowledgeable friends, family members, or others in
30 their communities. This concept is the "dental team concept." The dental team concept is a
31 comprehensive and optimal primary care model of oral health care delivery, under the
32 supervision of a licensed dentist, and with the dental home at its core.
33
34 **<u>Reference Diagram:</u>**
35
36 The following diagram provides a visual representation of the dental team concept to include
37 a snapshot of contemporary considerations in the delivery of oral health care and the role of

De Prins, Gosset, & Heyerick, 2003). Higher ratios of primary care physicians to population are associated with reduced hospitalization rates (Parchman & Culler, 1994). Patients with a regular primary care provider have 19% lower mortality (Franks & Fiscella, 1998), are 7% more likely to stop smoking, and are 12% less likely to be obese (Arora, et al., 2009). Advisory Committee on Training in Primary Care Medicine and Dentistry. *The Redesign of Primary Care with Implications for Training*. Eighth Annual Report to the U.S. Department of Health and Human Services and to the U.S. Congress. January, 2010.

77 According to 2011 statistics provided by the U.S. Centers for Disease Control and Prevention, while 81.4% percent of children ages 2-17 had at least one dental visit in the previous year, that percentage dropped to 61.6% for adults ages 18-64. Retrieved from http://www.cdc.gov/nchs/fastats/dental.htm (January, 2014).

1 the dental home therein. However, the points of entry or other representations in the diagram
2 are not intended to be limiting in the scope of the concept or in the position of the AGD.



3
4
5 **Definitions:**
6
7 General Supervision: The level of supervision in which dentist is not present in the dental
8 office, but has authorized the procedures and they are being carried out in accordance with
9 his/her diagnosis and treatment plan.
10
11 Indirect Supervision: The level of supervision in which the dentist is in the dental office,
12 authorizes the procedure and remains in the dental office while the procedures are being
13 performed by the auxiliary.
14
15 Direct Supervision: The level of supervision in which the dentist is in the dental office,
16 personally diagnoses the condition to be treated, personally authorizes the procedure and,
17 before dismissal of the patient, evaluates the performance of the dental auxiliary.
18
19 Personal Supervision: The level of supervision in which the dentist is personally operating on
20 a patient and authorizes the auxiliary to aid his/her treatment by concurrently performing a
21 supportive procedure
22
23 Dental Auxiliaries – Persons including dental assistants, dental hygienists, dental laboratory
24 technicians, expanded function dental assistants or hygienists, and dental therapists or other
25 'midlevel providers' in states where they are sanctioned by law, and all other individuals who
26 are not licensed dentists, but otherwise provide oral health care.
27
28 Dental Home - "The ongoing relationship between the dentist and the patient, inclusive of all
29 aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated,
30 and family-centered way. Establishment of a dental home begins no later than 12 months of

age and includes referral to dental specialists when appropriate" (AAPD, Policy on the Dental Home, 2012)

Dental Team Concept - A comprehensive and optimal model of oral health care delivery, with a focus on primary care dentistry under the supervision of a licensed dentist, and with the dental home at its core.

Policy Statement

The AGD believes that the dental team concept provides the optimal model of oral health care delivery, and further, that the dental team concept must be consistent with the following workforce principles:

1. The dental home, where dental services are provided only by or under the direct or indirect supervision of a licensed dentist, is the core principle of the dental team concept regardless of the economic or rural status of the patient, or the size, structure, or business agreements of the dental practice.
2. Dental procedures that are surgical and irreversible must only be administered by a licensed dentist (personal supervision) and not relegated to an auxiliary. A procedure is surgical and irreversible if an attempt of performance of the procedure carries with it any risk of an irreversible adverse consequence. Therefore, excavation of decay would fall within a surgical and irreversible procedure.
3. Increased number and use of auxiliaries within the dental home, including expanded function auxiliaries, whereby the auxiliaries act only within the direct or indirect supervision of the licensed dentist when providing dental services, increases the capacity of the dental home.
4. Dental disease is preventable, and prevention creates a lesser cost burden to the patient and the public than treatment. Accordingly, resources should be dedicated to establishing patient navigators within communities, whereby the duties of patient navigators are increasing oral health literacy, converting literacy to action, and providing patient transportation, and not the provision of dental care without the education and license of a dentist.
5. Emergency department dentistry adds a significant economic cost to the patient and the public, and must be mitigated by use of the dental home. Accordingly, the dental team concept requires collaboration between hospitals, medical practitioners, and the dental home, to ensure a transition of the patient from a treatment cycle to a prevention focus. The dental team concept requires referral to and follow-up care by the dental home after dental-related visits to medical practitioners or hospitals, and continued communication between the dental home and patients' medical practitioners.
6. Any agreements between a dental practice and outside entities for the management of business or practice services must not, directly or indirectly, transfer clinical decisions to one who is not a dentist licensed in the state. Indirect transfer is a transfer that could result from provisions that place necessary clinical decision-making for optimal patient care in conflict with business protocols for continued employment or income of the practicing dentist or auxiliaries.
7. The dental team concept consolidates the oral health care needs of the patient through the dental home, and therefore, provides continuity to the patient's care. Where access and utilization have been identified as challenges, this consolidation creates a lesser burden on the patient to know

where to go for care. On the other hand, increased specialization and implementation of unsupervised or generally supervised practitioners operating outside of the dental home, fragments care and places the burden on the patient to seek multiple points of entry into the oral health care system. In the dental team concept, the general or pediatric dentist serves as a gatekeeper of referral needs and the central nervous system of the patient's oral health care network.

Conclusion

In considering the current debate concerning the dental workforce, the AGD remains vigilant in its recognition that patient needs for better oral health, for quality care, and for treatment by those who are sufficiently educated to provide proper care, cannot be compromised. Further, as an organization of dedicated and educated professionals with a responsibility to the public, the AGD strongly feels that it would be negligent to refer this responsibility to the political tides of each state legislature. The AGD believes its core principles and values are in the best interest of its patients and the profession and is pleased to have had this opportunity to address the evolving face of dentistry, and find a cohesion within that evolution to enable dentistry to expand its reach as the beacon for low-cost patient-first preventive healthcare in the United States.

The Academy of General Dentistry

Position Statement on the Advanced Dental Hygiene Practitioner (ADHP) Concept

AGD Dental Practice Council, February 2008
Approved, AGD HOD, July 2008

Introduction

In 2001, *Oral Health in America: A Report of the Surgeon General* unveiled a maldistribution in access to dental care across socioeconomic geographies. The Academy of General Dentistry (AGD) is dedicated not only to correcting the maldistribution in access to dental care, but furthermore, to providing non-discriminatory access to *quality* dental care.

In 2003, the AGD was the first dental professional organization to enter into a Memorandum of Understanding (MOU) with the U.S. Department of Health and Human Services (HHS) in an effort aimed at eliminating oral health disparities, increasing the public's understanding of oral health issues, and expanding access to and utilization of dental care services. Other federal health agencies signing the MOU included the Centers for Disease Control and Prevention (CDC), the Office of Public Health and Science, the Health Resources and Services Administration (HRSA), the Indian Health Service (IHS), and the National Institutes of Health's (NIH) National Institute for Dental and Craniofacial Research (NIDCR).

In its endeavor to eliminate oral health disparities, the AGD has engaged in federal lobbying and state advocacy efforts to support Medicaid and SCHIP programs, and funding thereof. Additionally, the AGD has supported the funding of Title VII dental residency programs. Further, the AGD has promoted patient education, and worked to eliminate impediments to competitive payment by third party payers, include Medicaid contractors, to dentists serving socio-economically disadvantaged populations. Moreover, the AGD encourages its approximately 35,000 members and all general dentists to volunteer their services to needy persons through programs such as Donated Dental Services and Give Kids a Smile. Further, AGD volunteers participate through the Special Olympics provider directory to provide services to persons with intellectual disabilities.

The thread that ties all of the AGD's endeavors on access to care, and constructs the very fabric of the AGD's belief, is that underserved and needy populations deserve the *same* quality of dental care as *all* Americans. Simply stated, reserving a lower quality of care for those facing depressed or oppressed socioeconomic conditions creates a separate and *unequal* standard to which the underserved are undeserved.

Advanced Dental Hygiene Practitioner (ADHP)

What is an ADHP?

The ADHP, a concept developed by the American Dental Hygienists' Association (ADHA), is one of numerous concepts for midlevel dental workforce models which have been introduced as solutions to the challenge of offsetting the maldistribution in access to care. According to the ADHA's Draft Competencies for the Advanced Dental Hygiene Practitioner ("Draft Competencies"), released in June 2007:

> The ADHP is proposed as a cost-effective response to the oral health crisis. The ADHP will work in partnership with dentists to advance the oral health of patients. This new practitioner will provide diagnostic, preventative, therapeutic and restorative services to the underserved public in a variety of settings and will refer those in need to dentists and other healthcare providers. P.6.

How does the ADHP differ from other allied dental models?

While the ADHP may work in partnership with dentists, the ADHP concept is designed for independent practice. Unlike alternative allied dental models, such as Alaska's Dental Health Aide Therapists (DHAT) and the American Dental Association's (ADA) proposed community dental health coordinator (CDHC), an ADHP may work without direct, indirect, or general supervision by a dentist, and without any standing orders or dentist review. That is, the ADHP may fall completely outside the scope of the dental team concept.

However, what appear to be simple fillings or simple extractions may become complicated. For example, a simple filling may open into the nerve of a tooth, presenting an opportunity for the development of an abscess, which, if improperly treated, may become life-threatening. Without the immediate availability and resources of a dental team, the ADHP may be unable to avail himself or herself of the expertise and services of a dentist within the appropriate timeframe to provide the patient with the necessary care.

According to AGD policy, “the AGD supports the dental team concept as the best approach to providing the public with quality comprehensive dental care.” Dentistry, unlike medicine, has its focus on preventative care. The dental team concept provides the patient with a dental home for continuity of comprehensive care with a focus on prevention and treatment to mitigate the need for critical care.

On the other hand, ADHP’s will likely find it less economically feasible to maintain an independent practice without a dentist in the more underserved areas. These underserved areas may include remote rural areas or areas with high indigent populations who are most in need of dental care but least able to pay for it. The dental team concept, with the dentist in direct or indirect supervision of the practice, provides the hygienist with the economic protection and freedom to expand his or her practice to serve the needs of low-income populations through expanded services such as the provision of hygiene education and case management services (especially in the public health setting). Further, the team concept provides the accessibility to the knowledge and resources needed to address complications and compromised systemic health conditions that often plague the indigent and presently underserved.

Additionally, the ADHA’s Draft ADHP Competencies note that independent ADHPs would establish collaborative relationships with dentists and their dental teams, including traditional hygienists, and further, would refer their patient to the dentists as they deem appropriate. However, given the finding that there may be a maldistribution of dentists in underserved areas, access to opportunities for aforementioned collaboration and referral may meet the same challenge as the patients’ access to quality care itself. That is, without dentist supervision through a dental team concept, the independent midlevel provider may only serve the patient as an intermediary of time and money lost, not of care gained.

How does an ADHP differ from a dentist?
Without any dentist supervision or oversight, the ADHP purports to offer comprehensive oral health care in an independent setting except where the ADHP deems that referral to a dentist is needed. As noted above, the comprehensive oral health care purports to include diagnostic, surgical, and irreversible restorative services. In fact, the ADHA’s Draft Competencies cite an excerpt of the American Dental Educators Association (ADEA) report, *Unleashing the Potential*, which reads, “the dental hygienist can substitute for the dentist where there is none.” P. 7.

Given that the unsupervised practice of an ADHP would mirror that of a dentist in the services provided, inclusive of diagnoses and irreversible procedures that are presently reserved for dentists, one must examine whether the education and training of the ADHP meets the minimal competencies required of the dentist in the performance of the same procedures.

The ADHA proposes an ADHP master's degree curriculum to provide the hygienist with the competency required to provide diagnostic, therapeutic, preventative, and restorative services. However, notwithstanding that there is currently no Commission on Dental Accreditation (CODA) approved ADHP master's degree program, dental school curricula designed to graduate DDS recipients are structured only to meet the *minimum* standards for competency in dentistry as set by ADEA for CODA accreditation. Competency achieved through graduate dental education toward a DDS or DMD degree sets the floor, and not the ceiling, for the practice of clinical dentistry. If these are the minimum standards, anything less could not render a practitioner competent to perform dentistry.

Therefore, an ADHP master's degree curriculum, regardless of CODA accreditation, cannot meet the minimum standards of competence to provide dentistry, especially diagnostic and irreversible dentistry, unless the ADHP master's degree curriculum were to adopt the prerequisites of dental school entry and meet or exceed the competencies achieved through dental school. That is, the ADHP master's degree candidate would essentially have to earn a dentist's degree to qualify as a practitioner of the aforementioned dental procedures.

Since the educational framework proposed by the ADHA is intended to fall short of comprehensive dental school curricula, the quality of care provided by an ADHP would fall short of the minimal competency required of a dentist. One could argue that the benefit of competent care in dentistry is already a commodity only available to those who can afford it, and that those who cannot afford it presently get nothing. However, it is the AGD's position that those who cannot afford dental care nonetheless deserve the same quality and competence of care as all.

Further, provision of a lesser quality of care to poorer populations conveys the illusion of care to the patient who might believe that the intermediate patchwork of a midlevel provider is sufficient while in fact clinical care by a dentist is required. Notwithstanding the inherent injustice in providing lesser quality (and

potentially unsafe) care to more needy patients, one must also consider that disadvantaged populations have often neglected their dental health for years, thereby causing complications not as readily prevalent in the more advantaged communities. Further, lower quality patchwork dentistry, without the benefit of dentist supervision or a dental team home, may conceal underlying medical concerns and undermine dentistry and healthcare's growing effort to address dentistry as a doorway for prevention of numerous systemic ailments.

How does the ADHP differ from advanced nurse practitioners?
The ADHA draws upon the advanced nurse practitioner model as setting precedent for the ADHP model. However, the ADHP and advanced nurse practitioner differ fundamentally in the models in which they practice, or intend to practice.

The dental concept and medical concept are vastly different. In the medical concept, the patient's first contact is just the "point of entry." Rich with diagnostic codes, the medical model focuses on a first diagnosis at the patient's "point of entry," and often a second or third diagnosis based upon the direction of referral. Therefore, in the medical model, the first diagnosis, regardless of by whom, merely opens the gateway to further evaluation, and need not disturb subsequent diagnosis or continuity of care

On the other hand, dentistry has served its patients quite well through a "dental team concept," rather than a "point of entry" concept. The dental team concept serves the function of dentistry and patients' access to care with its focus not merely on diagnosis of dental diseases, but rather, on prevention and continuity of care through treatment. That is, in dentistry, the "point of entry" is the point of prevention and treatment, and not just a segue, thereby saving time and cost.

Further, treatment by a dental team varies within acceptable standards of care based upon the assessments, competencies and preferred methodologies of the core dentist. Therefore, fragmentation of diagnosis or preliminary treatment shall not only fragment the dental team concept and dentistry's holistic view of treatment, but also access to consistent quality care. That is, care shall be rendered discontinuous.

Therefore, while one can appreciate the medical model's efforts at a solution to access to care with the adaptation of the nurse practitioner, a similar model would likely have the opposite effect in dentistry; that is, it would *disrupt* continuity of care and access to quality of care for patient populations.

Access to Quality Care, In Summary

Defining the challenge in providing access to quality care is the first step to addressing the challenge. Access to quality care has two components: access and quality. Quality is necessary to ensure patient safety.

Accessibility without quality echoes the “something is better than nothing” approach to care. However, this approach serves only injustice, and not the public need. A court of law does not provide an indigent defendant with a paralegal if he or she cannot afford an attorney. Likewise, accessibility in dentistry is meaningless without equivalent quality care.

Creation of the ADHP concept offers a divergence from the goal of access to quality care. The additional education required under the ADHP model provides students who might otherwise pursue a DDS or DMD with an avenue to spend time and money to earn a title that signifies the ability to provide a quality of care that falls short of the minimum competence required to practice dentistry, especially as related to diagnosis and irreversible procedures. Further, without the minimal education of a dentist, the ADHP may compromise the safety of the patient, and raise questions of assignment of liability.

Additionally, an ADA study[1] revealed that, when provided the opportunity to practice independently to serve the needy, the overhead of maintaining a practice drives independent midlevel practitioners away from underserved areas. Presuming that the pilot study serves as a microcosm, the ADHP concept would fail to provide any indigent care, even that which falls short of the minimal standards of quality and safety. On the other hand, if the ADA study does not serve as a just microcosm, the practice of dentistry by one who has not attained the minimal qualifications of a dentist would nonetheless fall short of said minimal standards.

Given that dentistry, unlike medicine, has a focus on prevention and treatment, and is therefore best served by a point-of-service approach, the AGD supports the dental team concept as the best methodology to providing quality comprehensive care to all patients. The AGD also recognizes socio-economic divisions in the maldistribution in access to care. However, the AGD understands that underserved populations are at the greatest risk for oral and systemic disease, at the greatest need for high-quality comprehensive dental care

and continuity of care, and therefore, least served by intermediate patchwork that may mask the recognition of a need for comprehensive care.

As stated above, the AGD is a leading proponent of making the dental team concept, with dentist supervision, accessible as a cornerstone of quality comprehensive care for underserved populations. The AGD has worked vigorously with state and federal agencies, dental schools, and other avenues to promote public funding, volunteerism, and loan forgiveness for dental students working in underserved areas, among numerous other efforts. However, the ADHP concept offers a diversion of focus, direction, and resources from these efforts, and an opportunity for separate and unequal care, if any, for populations that deserve the same quality as all Americans.

1 Brown, L.J., House, D.R., & Nash, K.D. *The Economic Aspects of Private Unsupervised Hygiene Practice and Its Impact on Access to Care*. Dental Health Policy Analysis Series. American Dental Association, 2005

Referring Dental Patients to Specialists and Other Settings for Care General Guidelines

INTRODUCTION

Appropriate referrals are part of complete, quality health care management. Dentists' predoctoral training in oral diagnosis and treatment planning teaches them that referrals are an essential part of managing their patients healthcare needs. Dentists are expected to recognize the extent of their patient's treatment needs and when referrals are necessary. These Guidelines address the mechanics of dental referrals. They assume the dentist has the requisite skill and knowledge in diagnosis and treatment planning to determine when a referral is needed.[78]

The following citations are found in the American Dental Association's Principles of Ethics and Code of Professional Conduct:

> 2.B. CONSULTATION AND REFERRAL
>
> Dentists shall be obliged to seek consultation, if possible, whenever the welfare of patients will be safeguarded or advanced by utilizing those who have special skills, knowledge, and experience. When patients visit or are referred to specialists or consulting dentists for consultation:
>
> 1. The specialists or consulting dentists upon completion of their care shall return the patient, unless the patient expressly reveals a different preference, to the referring dentist, or if none, to the dentist of record for future care.
>
> 2. The specialists shall be obligated when there is no referring dentist and upon a completion of their treatment to inform patients when there is a need for further dental care.
>
> 2.B.1. SECOND OPINIONS
>
> A dentist who has a patient referred by a third party* for a "second opinion" regarding a diagnosis or treatment plan recommended by the patient's treating dentist should render the requested second opinion in accordance with this Code of Ethics. In the interest of the patient being afforded quality care, the dentists rendering the second opinion should not have a vested interest in the ensuing recommendation.
>
> * A third party is any party to a dental prepayment contract that may collect premiums, assume financial risks, pay claims, and/or provide administrative services.

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[1] The American Dental Association officially recognizes nine specialty areas of dental practice: oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, and dental public health. The procedures for referral to specialists, consulting dentists and other settings of care are generally the same. Therefore, for the sake of simplicity, the term "specialists" in these general guidelines can be read to include non-specialists and other settings to which the treating dentist makes a referral. The referral process is an integral part of dental practice. These guidelines place special emphasis on communications and facilitating and improving the referral process.

4.B. EMERGENCY SERVICE

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

SITUATIONS OR CONDITIONS NECESSITATING A REFERRAL

Patients may need to be referred for several reasons. Any one or any combination of the following situations or conditions may provide the dentist with appropriate rationale for referring a patient:

- level of training and experience of the dentist
- dentist's areas of interest
- extensiveness of the problem
- complexity of the treatment
- medical complications
- geographic proximity of specialists
- patient load
- availability of special equipment and instruments
- staff capabilities and training
- patient desires
- behavioral concerns
- developmentally disabled or handicapped patients
- desire to share responsibility for patient care

ELEMENTS OF DENTAL PATIENT REFERRALS

Interprofessional Communication Needs: General Dentists who initiate patient referrals should convey appropriate information to the specialists and determine on a case-by-case basis what information should be transferred from the following list:

- name, address of the patient
- appointment date and time
- reason for the referral
- general background information about the patient which may affect the referral
- medical and dental information, which may include
    - medical consultations and specific problems
    - previous contributory dental history
    - models
    - radiographs
- projected treatment needs beyond the referral
- urgency of the situation, if an emergency
- information already given or told to patient

Additional information may be found below in the section titled, "Facilitating and Improving the Referral Process."

Communications from the General Dentist to the Patient: Many times the referral process is foreign to dental patients who have become accustomed to receiving their routine care at one specific office. It is essential that all parties involved understand what is necessary to complete the referral successfully. The following points should be considered:

- an assessment of the patient's ability to understand and follow instructions
- explanation of the problem to parent or guardian, if the patient is a minor
- indication of which area of dentistry or specialty is chosen and why
- a specific appointment made while the patient is in the general dentist's office
- if known and requested by the patient, information about the specialist's fee for the initial consultation or examination
- instructions that will assist the patient's introduction to the specialist; i.e., directions to the specialist's office

Communication from the Specialist to the Patient: The specialist should provide the following information to the patient:

- details of the referral services, fees and payment options
- proposed additional and alternative treatment
- details regarding the coordination of future treatment
- follow-up appointment(s) if needed, and a return to the general dentist for completion of other treatments and/or maintenance

Communication Between the Specialist and the General Dentist: Communication between professionals is essential. Patients should receive clear, consistent information about their dental problems and treatment from all dental professionals. Mixed messages can confuse and frustrate patients and can undermine their confidence in the care provided.

It is the role of the general dentist or pediatric dentist to manage the overall dental health care of the patient. Any care rendered by a dentist limiting his or her practice to anu other recognized dental specialty should be coordinated with general or pediatric dentist, with a clear understanding of the role of each in providing care to the patient.

The following steps can facilitate the communication process:

- initial report indicating the preliminary diagnosis by the specialist and anticipated treatment
- progress report, if treatment is extended over a considerable period of time
- final report which includes such things as adverse experiences and maintenance instructions plus recommendations for additional treatment
- any copies or duplicates of appropriate pre-operative or post-operative radiographs taken by the specialist.
- return of any original radiographs or forms provided by the referring dentist

FACILITATING AND IMPROVING THE REFERRAL PROCESS

Personal knowledge of the specialist provider will allow patient need to be met most appropriately. Dentists may wish to begin by looking for specialists with skills, knowledge, experience, and caring attitudes which complement their own. Inquiries about the specialists' training and experience, including their participation in continuing education and study clubs, may assist the dentist in determining where to refer particular cases. A visit to the specialist's office to observe treatment may be helpful.

The primary referring dentist and the specialist should also discuss cooperative working arrangements which would benefit patients being referred. Both practitioners should discuss the referral treatment period and the return of the patient to the primary dentist. This arrangement could be enhanced by an exchange of business cards, referral forms, and patient instructional materials. Availability of the specialist for emergency treatment as well as mid-treatment referrals should be discussed. Radiographs should be promptly forwarded to the specialist and returned to the primary dentist.

Encouraging patient's questions about the referral and responding in lay terminology can ease some of the fears associated with unfamiliar treatments or providers. If language barriers exist, every effort should be made to ensure that the patient fully understands the reasons for the referral.

LEGAL AND ETHICAL ISSUES

Dentists should conduct themselves professionally and with dignity throughout the referral process. In addition to the therapeutic issues which form the basis for the referral, there are also legal and ethical considerations.

Legal Considerations: Dentists should recognize that separate and possibly conflicting legal interests may be involved during a referral. Particular attention should be directed toward patients or providers whose interests and requirements are detailed in contract form. When dentists or patients participate in such arrangements related to dental services, these arrangements should be reviewed carefully with respect to restrictions that may be placed on the dentist's ability to refer patients to other settings or providers for care.

Note: In some situations, a dentist could be held legally responsible for treatment performed by referral dentists. Therefore, dentists should independently assess the qualifications of participating referral dentists as it related to specific patient needs. The dentist is reminded that contract obligations do not alter the standard of care owed to all patients.

Ethical Considerations: Dentists should discuss their referral information with the patient in an appropriate manner. The ADA Principles of Ethics and Code of Professional Conduct Section 4.C. contains the following:

4.C. JUSTIFIABLE CRITICISM

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

4.C.1. MEANING OF “JUSTIFIABLE”

> Patients are dependent on the expertise of dentists to know their oral health status. Therefore, when informing a patient of the status of his or her oral health, the dentist should exercise care that the comments made are truthful, informed, and justifiable. This may involve consultation with the previous treating dentist(s), in accordance with applicable law, to determine under what circumstances and conditions the treatment was performed. A difference of opinion as to preferred treatment should not be

communicated to the patient in a manner which would unjustly imply mistreatment. There will necessarily be cases where it will be difficult to determine whether the comments made are justifiable. Therefore, this section is phrased to address the discretion of dentists and advises against unknowing or unjustifiable disparaging statements against another dentist. However, it should be noted that, where comments are made which are not supportable and therefore unjustified, such comments can be the basis for the institution of a disciplinary proceeding against the dentist making such statements.

Adopted by the AGD House of Delegates, 7/90

Editorially Revised by the AGD Dental Practice Council, 10/06

Universal Access to Health Care Position Paper

The Academy of General Dentistry recognizes that resolving the issue of access to health care is becoming increasingly urgent. This national problem affects Academy members on a variety of levels: As health care providers, small business owners, self-employed persons, and as members of a national organization taking a part in a national debate. This position paper has been drafted from the perspective of the dentist as an employer and small business owner seeking to influence public policy. It recognizes that for fiscal reasons, dentistry is not likely to be included in a universal health program or other broad-based efforts to provide care to the uninsured. It should be noted that this document represents the Academy's current position, which may change as the approaches to and consequences of health care reform become more apparent.

1. Do Not Mandate Employer Coverage

AGD opposes employer mandates because such laws may increase health care costs, reduce employers' incentives to hire full-time staff members, increase a trend toward underemployment of auxiliaries, and reduce incentives for employers to provide health care benefits since such laws place solo and small group practitioners at an economic disadvantage.

Broad-based employer-provided health insurance coverage could be dramatically expanded through a full tax deduction for the costs of health insurance premiums for all businesses and through other tax reforms, coupled with insurance reforms, professional liability reforms, Medicaid and Medicare reforms, and innovative cost containment practices. Creating more favorable conditions for businesses to attain health insurance would relieve much of the pressure on the federal government so that it could focus on insuring the indigent and unemployed.

2. Voluntary Uniform Benefits Package

The Academy supports establishing a recommended federal standard for a minimum benefits package. Incentives should be created to encourage compliance with this standard in order to eliminate the inconsistencies between benefits packages offered under various state laws.

3. Implement Insurance Reform Provisions

Reforms to the insurance industry are fundamental to any solution to the health insurance problem. The reforms must be extensive, restructuring the way health insurance is administered nationwide.

A first step is to establish community rating in place of experience rating. This would reduce the cost of health insurance and make fees more stable from year to year for small businesses and uninsurables by spreading risks. Consequently, if an employee in a small business finds it necessary to utilize health benefits in a given year, he/she won't necessarily increase the rates for his/her entire company. However, community rating must be coupled with patient copayments. This would encourage greater personal responsibility on the part of the patient and decrease frivolous use of the health care system.

Other necessary reforms include banning new pre-existing condition exclusions for individuals who have been continuously insured. Insurance underwriting practices that

prevent the pooling of good and bad risks within small employer pools must be restricted. A voluntary state certification of insurers based on their costs, efficiency, and quality of service should be implemented to help encourage insurers to compete on service rather than risk.

4. Provide Tax Incentives for Small Businesses

In order to make the health insurance market more accessible, particularly to small businesses, unincorporated firms, and the self-employed, a full tax deduction must be offered to all businesses and to individuals who must pay 100 percent of their health care premiums. In addition, state and federal impediments to multiple employer trust arrangements should be removed.

5. Implement Medicare/Medicaid Reforms

Reforming Medicaid is an essential component for reform of the health insurance system. Health care for the indigent should be provided by federal and state governments through an expansion of Medicaid. In addition, workers who are unable to obtain insurance from their employers would receive coverage under Medicaid regardless of income, with premiums set on a sliding scale based on the worker's income. Eligibility for Medicaid must be uniform throughout the United States. Further, Medicare should add a benefit to assist individuals in paying for long-term care insurance.

The cost of Medicaid reforms must be self-financing in order to minimize tax increases. Corruption in the Medicaid system must be eliminated and fraud controlled. In order to increase participation by health care providers in the Medicaid system, reimbursement rates need to be increased. This would also serve to improve the quality of the service Medicaid recipients receive.

There must be no option for employees not to be insured. Should an employee refused coverage under his/her employer's plan and not be covered elsewhere, then he/she must be covered through either a payroll deduction or a line-item deduction on his/her tax form.

6. Financing Mechanism

Reforms to the insurance marketplace, coupled with professional liability reforms and cost containment initiatives (co-insurance, deductibles, etc.), should make health insurance more affordable. The federal government would be responsible for providing care for the indigent, and individuals would have increased responsibility through cost-sharing (co-payments) in every insurance plan.

7. Institute Professional Liability Reforms

Any professional liability reforms must enhance the injured individual's ability to obtain fair compensation and at the same time protect doctors from predatory and unjustified law suits. Tort reforms including limits on contingency fees and punitive damages must be implemented, and alternate dispute resolution systems must be established. Medical facilities should be required to use risk management practices.

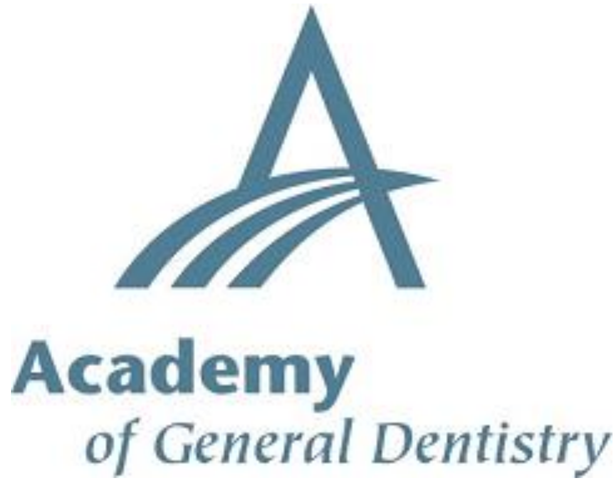
8. Cost Containment

To help keep the costs of health care insurance down to a minimum, consumers would have access to ratings of hospital efficiency and quality and wellness education. This would encourage hospitals to compete based on quality, cost and efficiency. Individuals would be encouraged to make cost-effective management and treatment decisions with the help of deductibles, co-payments and tax incentives. Incentives should be provided to eliminate costly and inefficient paperwork.

9. Long-Term/Catastrophic Care Provisions

Tax incentives would help encourage the purchase of long-term/catastrophic care insurance. Increased consumer protections, Medicare assistance for purchasing long-term/catastrophic care, and a sliding subsidy for low-income beneficiaries should be implemented. Medicaid coverage should be included for those below the national poverty level. In addition, protection against impoverishment must be part of any long-term/catastrophic care plan.

Adopted HOD 7/91



WHITE PAPER
ON INCREASING ACCESS TO AND UTILIZATION OF ORAL HEALTH CARE SERVICES

"to serve and protect the oral health of the public"

Academy of General Dentistry (AGD)
White Paper on Increasing Access to and Utilization of Oral Health Care Services

EXECUTIVE SUMMARY

While patients who have availed themselves of dental services in the United States have enjoyed the highest quality dental care in the world, many patients are underserved presently, thereby raising the need to address both access to care and utilization of care. Access to care refers to the availability of quality care, and utilization of care refers to the behavior and understanding necessary by patients to seek care that is accessible.

Illnesses related to oral health result in 6.1 million days of bed disability, 12.7 million days of restricted activity, and 20.5 million days of lost workdays each year.[1] However, unlike medical treatments, the vast majority of oral health treatments are preventable through the prevention model of oral health literacy, sound hygiene and preventive care available through the dental team concept.

However, present efforts to institute independent mid-level providers—lesser educated providers who are not dentists—to provide unsupervised care to underserved patients are not only economically unfeasible but also work against the prevention model. Because underserved patients often exhibit a greater degree of complication and other systemic health conditions, the use of lesser-educated providers risks jeopardizing the patients' health and safety. This approach will provide lesser quality care to the poor.

Instead, solving the access to and utilization of care issues, thereby bridging the gap between the 'haves' and the 'have-nots,' requires collaboration among professional organizations, local, state, and federal governments, community organizations and other private entities. This collaboration must strive toward a multi-faceted approach that focuses on oral health literacy, incentives to promote dentistry and dental teams in underserved areas (including through increased Medicaid and Title VII funding), provision of volunteer services through programs, such as Donated Dental Services (DDS), and bridging the divide between patients' access and utilization through the use of community services like transportation to indigent populations.

Specifically, the AGD's proposed solutions to the access to and the utilization of oral health care issues include, but are not limited to:

1. Extend the period over which student loans are forgiven to 10 years without tax liabilities for the amount forgiven in any year;
2. Provide tax credits for establishing and operating a dental practice in an underserved area;2

[1]U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2000. NIH publication 00-4713. Available from: URL: http://www.surgeongeneral.gov/library/oralhealth/

2**"The Maine Dental Association's own bill, called 'An Act to Increase Access to Dental Care,' has become law**. Starting next year, dentists will be eligible to receive up to $15,000 in income tax credit annually-for up to five years as long as they practice in underserved areas. The law currently limits participation in the program to five dentists, but the legislature will review its effectiveness in two years, and may then amend it to increase the number of allowed participants." American Dental Association (ADA) *Update*, June 10, 2008 (Retrievable from www.ada.org).

3. Provide federal loan guarantees and/or grants for the purchase of dental equipment and materials;
4. Offer scholarships to dental students in exchange for committing to serve in an underserved area;
5. Increase funding of and statutory support for expanded loan repayment programs (LRPs);
6. Increase appropriations for funding an increase in the number of dentists serving in the National Health Service Corps and other federal programs, such as IHS, programs serving other disadvantaged populations and U.S. Department of Health and Human Services (HHS)-wide loan repayment authorities;
7. Actively recruit applicants for dental schools from underserved areas;
8. Assure funding for Title VII general practice residency (GPR) and pediatric dentistry residencies;
9. Take steps to facilitate effective compliance with government-funded dental care programs to achieve optimum oral health outcomes for indigent populations:
    a. Raise Medicaid fees to at least the 75th percentile of dentists' actual fees
    b. Eliminate extraneous paperwork
    c. Facilitate e-filing
    d. Simplify Medicaid rules
    e. Mandate prompt reimbursement
    f. Educate Medicaid officials regarding the unique nature of dentistry
    g. Provide block federal grants to states for innovative programs
    h. Require mandatory annual dental examinations for children entering school (analogous to immunizations) to determine their oral health status
    i. Encourage culturally competent education of patients in proper oral hygiene and in the importance of keeping scheduled appointments
    j. Utilize case management to ensure that the patients are brought to the dental office
    k. Increase general dentists' understanding of the benefits of treating indigent populations;
10. Establish alternative oral health care delivery service units:
    a. Provide exams for one-year-old children as part of the recommendations for new mothers to facilitate early screening
    b. Provide oral health care, education, and preventive programs in schools
    c. Arrange for transportation to and from care centers
    d. Solicit volunteer participation from the private sector to staff the centers;
11. Encourage private organizations, such as Donated Dental Services (DDS), fraternal organizations and religious groups to establish and provide service;
12. Provide mobile and portable dental units to service the underserved and indigent of all age groups;
13. Identify educational resources for dentists on how to provide care to pediatric and special needs patients and increase AGD dentist participation;
14. Provide information to dentists and their staffs on cultural diversity issues, which will help them reduce or eliminate barriers to clear communication and enhance understanding of treatment and treatment options;

15. Pursue development of a comprehensive oral health education component for public schools' health curriculum in addition to providing editorial and consultative services to primary and secondary school textbook publishers;
16. Increase supply of dental assistants and dental hygienists to engage in prevention efforts within the dental team;
17. Expand the role of auxiliaries within the dental team, including a dentist or under the direct supervision of a dentist;
18. Eliminate barriers and expand the role that retired dentists can play in providing service to indigent populations;
19. Strengthen alliances with American Dental Education Association (ADEA) and other professional organizations like the Association of State and Territorial Health Officials (ASTHO), Association of State and Territorial Dental Directors (ASTDD), National Association of Local Boards of Health (NALBOH), National Association of County & City Health Officials (NACCHO) and so forth;
20. Lobby for and support efforts at building the public health infrastructure by using and leveraging funds that are available for uses other than oral health; and
21. Increase funding for fluoride monitoring and surveillance programs, as well as for the development and promotion of new fluoride infrastructure.

Academy of General Dentistry (AGD)
White Paper on Increasing Access to and Utilization of Oral Health Care Services

I. Introduction

Patients who utilize the services of dentists in the United States enjoy the highest quality dental care in the world. Dentistry is paid for primarily with private sector dollars. In 2004, for example, state, local, and federal government programs paid less than $4.9 billion for dental care compared with $81.5 billion paid through personal health care expenditures, such as out-of-pocket payments, third-party payments, or private health insurance.3

Among the health professions, dentistry is singularly oriented toward ***preventive health.*** The National Institute of Dental and Craniofacial Research (NIDCR) estimates that dentistry's emphasis on preventive oral health measures saved nearly $39 billion during the 1980s. In addition, the Centers for Disease Control and Prevention (CDC) said in an August 2000 letter to Congress that community water fluoridation, which was introduced in public water supplies in the 1940s to help prevent tooth decay, is "one of the greatest public health achievements of the 20th century."

Despite dentistry's successes, significant challenges lie ahead. Two of the biggest challenges in achieving optimal health for all are: 1) ***underutilization of available oral health care;*** and ***2) maldistribution4 in areas of greatest need.***

Access to care and utilization of care must be addressed from the perspective of patient needs, especially the needs of underserved patients who are in greatest need of competent care and exhibit complications and systemic health issues. The Academy of General Dentistry (AGD) is very mindful of the Surgeon General's report (*Oral Health in America: A Report of the Surgeon General)* that stated that oral health care is intimately related to systemic health care. These patients include the indigent, children, rural populations, the developmentally disabled, elderly/nursing home patients, the medically compromised and transient/non-English speaking populations.

Further, the profession must address other challenges, including non-economic barriers, to access and utilization such as patients' behavioral factors, levels of oral health literacy, special needs, financial factors, two-tiered systems of delivery (poor quality care for the poor), maldistribution of dentists and dental team auxiliaries, transportation, location and cultural/linguistic preferences.

The profession is eager to work with private sector groups, community organizations, teaching facilities, US Public Health Service Corps (Corps), Indian Health Service (IHS) and state, local and federal lawmakers to increase oral health literacy to these populations, reduce disparities in oral health status and increase access to and utilization

3 The Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group (2004).
4 The term "maldistribution," as used here and throughout this paper, does not imply or suggest an incorrect or wrongful distribution, but rather, the term is synonymous with **uneven** distribution of dentists and dental teams in relation to the distribution of the presently underserved.

of oral health care services, thereby reducing the incidence of dental disease and associated systemic ailments.

II. Definitions

Access to Oral Health Care Services (Access to Care)—The ability of an individual to obtain dental care, recognizing and addressing the unique barriers encountered by an individual seeking dental care, including the patient's perceived need for care, oral health literacy, dentist and dental team distribution, financial circumstances, special needs, transportation, location, language, cultural preferences and other factors influencing entry into the dental care system.

Independent Mid-Level Provider5—A dental auxiliary, working outside the dental team and without dentist supervision, who accepts the responsibility for patient diagnosis, treatment and coordination of dental services with less education than what is currently required for a practicing dentist.

Oral Health Literacy—The degree to which individuals have the capacity to obtain, process and understand basic oral health information and services needed to make appropriate oral health decisions.6

Underserved—Refers to patients including the poor/indigent, geographically isolated, medically compromised, transient/non-English speaking, developmentally disabled, nursing-home bound (and other institutionalized individuals), the elderly and children, who have historically experienced lowered or no utilization of oral health care services but often exhibit greater need for dental services. These individuals may also have concurrent co-morbidities that complicate treatment, and inadequate oral interventions may lead to unintended adverse medical outcomes.

Utilization of Oral Health Care Services (Utilization of Care)—The percentage of the population receiving oral health care services through attendance to oral health care providers, while taking into consideration factors including, but not limited to, health-related behaviors, oral health literacy, dentist and dental team distribution, financial circumstances, special needs, transportation, location, language, cultural preferences and other factors influencing entry into the dental care system.

III. The State of Oral Health in the United States

Dental disease is important because it impacts both children and adults physically, functionally, emotionally, and socially. It also affects the nation's productivity.

5 Currently there is no suitable definition for a "mid-level provider" within the dental team due to variations and inconsistencies in both the usage of the term "mid-level provider" in dentistry and the delegation of auxiliary duties by different states. **The independent practice of dentistry by non-dentists, outside the scope of the team concept, is a lower level of practice**.

[6]Based on the definition provided by the *Healthy People 2010* report

Oral Health Is Key to General Health

Oral health has not been treated as the important part of overall health that it is. A person cannot be healthy unless he or she also is healthy orally. The mouth can be the window to the rest of the body; it often reflects general health and well-being; alternatively, it can indicate disease and dysfunction. Oral infections can be the source of systemic disease. Individuals with weakened immune systems are especially vulnerable to severe systemic complication, sometimes life-threatening, from oral infections. In addition, research has found associations between chronic oral infections and other health problems, including diabetes, heart disease, and adverse pregnancy outcomes.

The need for dental care cannot be ignored. Unlike many medical conditions, dental problems are not self-limiting. Dental diseases become progressively more severe without treatment, requiring increasingly costly interventions. Initial disease attack, and the treatment required to manage it, often lead to sequela, which require more radical and invasive interventions later in life. On the other hand, ***most dental diseases are prevented easily at little cost through regular examinations in conjunction with appropriate modern preventive modalities.*** In addition, the initial recognition of life-threatening conditions like HIV infection and oral cancer are often made in the dental office.

Parents must understand that oral health is much less arduous and less costly when care is started early and maintained by the regular attendance of a dentist. All children need a dental home and continuous comprehensive care.

IV. Challenges to Access to and Utilization of Care

Increasing utilization of care requires a significant and concentrated effort toward increasing oral health literacy, especially among underserved populations. ***Increased oral health literacy will allow individuals to see value and ask for services and will allow communities to develop a culture of oral health as a priority that they should work to achieve.*** Further, increasing access to care requires a multifaceted solution to promote the practice of quality dentistry in underserved and rural areas and for those with intellectual and developmental disabilities, the elderly, children, the medically compromised and transient/non-English speaking populations. The dental profession is dedicated to working with governmental entities, community organizations, and other private entities to develop solutions to these problems and work toward these endeavors. Workable solutions to access, utilization, and the maldistribution of dentists and dental team auxiliaries are discussed further in Section V below.

The independent mid-level provider

One present challenge to access to and utilization of care arises from within the profession itself and threatens not only to create a two-tiered system of delivery, providing poorer quality care for poor and medically needy populations, but also to divert economic resources from oral health literacy, expansion of quality care, correction of maldistribution, and, most importantly, the commitment to prevention.

Numerous organizations have introduced concepts for advanced training of a hygienist, other auxiliary or another non-dentist, to produce a less clinically and didactically trained provider, commonly referred to as a "mid-level provider." This individual will not have attained the minimum education and competency levels of a dentist but would diagnose, treat and/or manage the oral health of undeserved populations *outside the support of a dental team* and *independent of a dentist's supervision.*

Subtracting from the Prevention Model

Dentistry focuses on preventive care. Therefore, the AGD supports the dental team concept as the best approach to providing the public with quality comprehensive dental care. Further, **the AGD recommends advanced training of auxiliaries to provide greater expertise of preventive care and of treatment within the dental team concept or under the direct supervision of a dentist**. The dental team concept provides the patient with a dental home for continuity of comprehensive care with a focus on prevention and treatment to forestall or mitigate the need for cost-ineffective critical care. It also best ensures that the patient will receive appropriate, competent and safe care.

Further, as stated above, the prevention model has produced not only health benefits to patient populations, but also economic benefits to the health care system. Past advances in the prevention and treatment of oral diseases have been estimated to generate savings of $5 billion per year in dental expenditures alone. Dental expenditures in 2002 exceeded $70 billion, the majority of which were associated with the repair of teeth and their surrounding tissues—and which could have been prevented by regular professional dental care and good home care instructions from the dentist and his/her staff. ***Auxiliaries play the key role in patient education and preventive care within the dental team.***

The concept of independent mid-level providers subtracts from the prevention model as part of a comprehensive oral health umbrella of care to the detriment of access to and utilization of care. ***Removing the oversight of the dentist removes the one professional who has the overall knowledge and training to coordinate all aspects of treatment that patients might need.***

First, concepts that propose the use of the auxiliary workforce to fuel the development of independent mid-level providers result only in the removal of auxiliaries from their preventive role within the dental team. Presently, ***there is a clear maldistribution of hygienists within the dental team, with some regions of the United States experiencing a shortage.*** The diversion of resources to create an independent mid-level provider will serve to further the maldistribution within the dental team and act as a disservice to disease prevention. The utilization of the auxiliary workforce within the team is an approach that can still be enhanced to maximize the benefit for the patients. Training and expanded functions within the dental team can easily increase the number of patients a dentist can treat in a comprehensive manner. Diverting auxiliaries into non-team areas has the opposite effect.

Second, prevention provided away from complete comprehensive care, including that of a dentist, ***puts patients at risk*** of receiving inappropriate and possibly unsafe care. Patients

cannot be expected to make fine distinctions between alternative treatment choices. They assume that the level of care that they receive is adequate and complete. A complete comprehensive care setting will have preventive education for the patients and their family, plus it will have the full compliment of care and diagnosis by a dentist. Without a comprehensive care setting that includes the services of a dentist, duplication of services will become necessary.

Third, resources utilized to train independent practice hygienists or other independent mid-level providers could otherwise be directed toward ***oral health literacy programs and recruitment and incentives for dentists to practice in underserved areas.***

1) Those funds could be used to increase the numbers of dentists being trained, as well as training for expanded duties assistants.
2) The shortage of faculty and teaching facilities is already critical and this infrastructure could not support the added requirement of teaching and time in training independent mid-level providers.
3) The development of a curriculum, which mirrors what is already being done but yields a less qualified product, is a poor fiscal policy and wastes precious dollars and resources.

Conflicts with Economic Realities:
Independent mid-level providers will not be immune to the forces of supply and demand. They will likely find it ***less economically feasible to maintain an independent practice in underserved areas.*** The absence of a full-service, dentist-led practice will only compound their difficulties because they will still have to bear the financial burden of maintaining fully equipped, modern dental facilities and the resultant business risks of their investments. An ADA study[7] revealed that, when provided the opportunity to practice independently to serve the needy, the overhead of maintaining a practice drives independent mid-level providers away from underserved areas. Presuming that the pilot study serves as a microcosm, the mid-level concept would fail to provide any indigent care, even care that falls short of the minimal standards of quality and safety.

Further, underserved areas may include remote rural areas or areas with high indigent populations who are most in need of dental care but are the least able to pay for it. The dental team concept, with the dentist in supervision of the practice, provides the hygienist with the economic protection and freedom to expand his or her practice to serve the needs of low-income populations through expanded services, such as the provision of hygiene education and case management services (especially in the public health setting).

Further, ***the team concept provides the accessibility to the knowledge and resources needed to address complications and compromised systemic health conditions that***

often plague many of the underserved. Without the direct supervision of a dentist, the independent mid-level provider will likely not find a dentist immediately accessible to address complications. Given the finding that there is a maldistribution of dentists in

7 Brown, L.J., House, D.R., & Nash, K.D. *The Economic Aspects of Private Unsupervised Hygiene Practice and Its Impact on Access to Care*. Dental Health Policy Analysis Series. American Dental Association, 2005.

underserved areas, the independent mid-level provider's access to a dentist may meet the same challenge as the patient's direct access to and utilization of the services of a dentist. That is, without dentist supervision through a dental team concept, the independent mid-level provider, if economically able to practice in an underserved area at all, may only serve the patients as an intermediary of time and money lost, not of care gained.

Fails Minimum Educational Standards:
Example independent mid-level provider concepts purport to include diagnostic, surgical, and irreversible restorative services without the direct supervision of a dentist. The American Dental Hygienists' Association's (ADHA) Draft Competencies referred to an excerpt of the American Dental Education Association (ADEA) report, *Unleashing the Potential*, which reads, "In certain settings and situations, they substitute for the dentist where there is none available."8

Given that the unsupervised practice of an independent mid-level provider would mirror that of a dentist in the services provided, inclusive of diagnoses and irreversible procedures that presently are reserved for dentists, one must examine whether independent mid-level provider education and training would meet the minimal competencies required of the dentist in the performance of the same procedures.

The ADHA proposes an Advanced Dental Hygiene Practitioner (ADHP) master's degree curriculum to provide the hygienist with the competency required to provide diagnostic, therapeutic, preventive, and restorative services. However, notwithstanding that currently there is no Commission on Dental Accreditation (CODA) approved ADHP master's degree program, dental school curricula designed to graduate DDS recipients are structured to meet only the *minimum* standards for competency in dentistry as set by the ADEA for CODA accreditation. Competency achieved through graduate dental education toward a DDS or DMD degree sets the floor, and not the ceiling, for the practice of clinical dentistry. ***If these are the minimum standards, anything less could not render a practitioner competent to perform dentistry.***

Therefore, an ADHP master's degree curriculum, regardless of CODA accreditation, could not meet the minimum standards of competence to provide dentistry—especially diagnostic and irreversible dentistry—unless the ADHP master's degree curriculum were to adopt the prerequisites of dental school entry and meet or exceed the competencies achieved through dental school. That is, the ADHP master's degree candidate essentially would have to earn a dentist's degree to qualify as a practitioner of the aforementioned dental procedures.

Lesser Quality Care for Needier Patients:
Since the educational framework proposed by the ADHA—and other organizations touting independent mid-level providers as solutions—is intended to fall short of comprehensive dental school curricula, the quality of care that an independent mid-level provider provides would fall short of the minimal competencies required of a dentist. One

8 Weaver, R.G., Valachovic, R.W., Hanlon, L.L., Mintz, J.S., and Chmar, J.E. *Unleashing the Potential.* American Dental Education Association (ADEA). Retrieved June 27, 2008, from http://www.adea.org/cepr/Documents/Unleashing_the_Potential.pdf.

could argue that the benefit of competent care in dentistry already is a commodity only available to those who can afford it and that those who cannot afford it presently get nothing. However, the AGD strongly believes that those who cannot afford dental care, or perhaps are not aware of the importance of oral health, nonetheless ***deserve the same quality and competence of care*** as all.

***Diagnosis and the performance of irreversible procedures by someone without a dentist's education compromise the safety of the patient*. For the sake of patient safety, the AGD therefore urges that auxiliaries must be prohibited from engaging in the performance of irreversible procedures without direct dentist supervision9 and from diagnosing conditions of oral health regardless of supervision**.

Notwithstanding the inherent injustice in providing lesser quality and potentially unsafe care to more needy patients, one must also consider that disadvantaged populations often have neglected their dental health for years, thereby causing complications that are not as prevalent in better-advantaged communities. ***Without the benefit of dentist supervision or a dental team home, inappropriate care, possibly of unacceptable quality, may conceal or exacerbate underlying medical concerns and undermine dentistry and health care's growing effort to address dentistry as a doorway for the prevention of numerous systemic ailments.***

Dentistry Compared to Medicine:
One might contend that independent mid-level providers in medicine, such as advanced nurse practitioners, have benefited the health care system. However, independent mid-level providers in dentistry and advanced nurse practitioners differ fundamentally in the models by which they practice, or intend to practice.

The dental concept and medical concept are vastly different. With its focus on addressing symptoms of illness rather than prevention of illness, the medical model is driven by a first diagnosis at the patient's "point of entry," and often a second or third diagnosis based upon the direction of referral. Therefore, in the medical model, the first diagnosis, regardless of by whom, merely opens the gateway to further evaluation and need not disturb subsequent diagnosis or the continuity of care.

On the other hand, dentistry has served its patients quite well through the prevention-based "dental team concept" rather than a "point of entry" concept. The dental team concept serves the function of dentistry and patients' access to care with its focus not merely on diagnosis of dental diseases, but rather on prevention and continuity of care through treatment. ***That is, in dentistry, the "point of entry" is the point of prevention and treatment—it is not just a segue to further diagnosis and possible intervention—thereby saving both time and cost*.**

9 If delivery of a local anesthetic is defined as an irreversible procedure, then said delivery may be considered an exception to the prohibition against practice without direct supervision if within the bounds of the laws and regulations of the respective jurisdiction. Additionally, jurisdictions may offer differing viewpoints on the scope of irreversible procedures and the allowance for non-dentists to perform them; however, whether these procedures, such as placement of a core, may be performed without the direct supervision of a dentist would require review and scrutiny on a case-by-case basis to ensure patient safety.

Further, treatment by a dental team varies within acceptable standards of care based upon the assessments, competencies, and preferred methodologies of the core dentist. Therefore, fragmentation of diagnosis or preliminary treatment shall not only hinder the dental team concept and dentistry's comprehensive view of treatment, but also it will hinder access to consistent quality care. That is, ***care shall be rendered discontinuous.***

Finally, it should be noted that dentistry faces significantly lesser insurance coverage for patients than medicine does. Nonetheless, insurance companies are likely to push patients to lower cost care to the detriment of the patient. The AGD resists that effort and encourages competitive quality care to remain within the delivery of oral health care, inclusive of portability of any and all existing insurance coverage.

Therefore, while one can appreciate the medical model's efforts at an albeit inadequate solution to access to care with the adaptation of the nurse practitioner/physician assistant, a similar model likely would produce the opposite of the intended effect in dentistry; that is, it would *disrupt* continuity of care and access to quality of care for patient populations.

The Meaning of Quality Care:
Defining the challenge in providing access to quality care is the first step in *addressing* the challenge. Access to quality care has two components: access and quality. Quality is a necessary component of access to care in order to ensure patient safety.

Accessibility without quality echoes the "something is better than nothing" approach to care. However, this approach serves only injustice, and not the public need. A court of law does not provide an indigent defendant with a paralegal if he or she cannot afford an attorney. In dentistry, this approach is naïve and can lead to tragedy. Inappropriate care, which may lead to unnecessary and dangerous complications, is not better than nothing—in fact, it can be enormously worse. Consequently, ***accessibility in dentistry is meaningless without the assurance of quality care.***

Therefore, ***the inadequately supervised independent mid-level provider holds the false goal of access to and utilization of care by compromising quality and safety while diverting valuable resources away from oral health literacy and expansion of quality care into underserved areas.***

V. Increasing Access and Utilization—A Comprehensive Patient-centered Solution

The profession of dentistry recognizes that the state of oral health cannot be materially advanced without addressing both access to and utilization of care. There are many different factors contributing to disparities in, lack of access to, and low utilization of oral health care services. Given the complexity of the issue, any solution will require a multi-faceted approach that strengthens the parts of the dental delivery system that are working and creates new opportunities to improve the oral health of the nation.

Oral Health Literacy

Oral health literacy must be a cornerstone of improving utilization of care by underserved populations. Professional organizations such as the AGD actively promote publicly available culturally relevant literature and other means to increase oral health literacy among underserved populations. However, true advances in oral health literacy must be driven by collaboration between professional organizations, community organizations, other private entities and governmental entities.10

The AGD believes health policymakers at the local, state and federal levels should continue their efforts to collaborate with the private sector to develop strategies for increasing access to and use of dental services and for decreasing oral health disparities and low oral health literacy. The groundbreaking release, *Oral Health in America: A Report of the Surgeon General,* in May 2000 recommended such public-private partnerships. Further, in the report, then-Surgeon General David Satcher, MD, PhD, referred to a "silent epidemic" of oral diseases among certain population groups in the United States. Following are just a few examples of activities that the AGD has undertaken in an effort to address the Surgeon General's Call to Action and to achieve HHS' *Healthy People 2010* oral health objectives:

1) The AGD created policy resolutions that if implemented would encourage adoption of policies that oppose soda pouring rights in schools because of the deleterious effect on oral health resulting from easy access and increased consumption of soda and increase education on the importance of good nutrition and how good nutrition relates to good oral health.

2) The AGD's Public Relations Council regularly promotes topics and press releases on issues of interest to help mass media increase the consumer's awareness of oral health issues. For example:
   a) The council developed a *Dentalnotes* story, "Dental Sealants—Is Your Child a Candidate?" which included information obtained from the CDC and referenced the *Healthy People 2010* objectives related to sealants;
   b) Built relationships with HHS, Office of Public Health and Science/Office of the Surgeon General allowing for the council's input on a national public service announcement, which reached the top 10 media markets with a message about the link between dental health and overall health;
   c) The council hosted an oral cancer screening event on July 17, 2003. More than 50 consumers were screened, 10 patients were encouraged to visit a dentist, and media coverage included *The Tennessean, Nashville City Paper, WTVF-TV, WLAC-AM*; and
   d) The council hosts SmileLine events at AGD's annual meetings in order to answer patient inquiries about oral health. In 2003, more than 648 calls were answered,

10 As a related component of oral health literacy, the AGD believes in the acceptance and execution of personal responsibility by patients. Being literate about one's oral health, especially in the context of receiving government provided benefits means, for instance, ensuring that one and one's children show up for scheduled appointments. The AGD also believes that a pecuniary interest in treatment facilitates personal responsibility. Commentators ranging from Adam Smith to Milton Friedman have clearly demonstrated that when a financial incentive exists, one is more likely to ensure optimal outcomes. In the context of both private insurance and government benefits, therefore, such a financial incentive would take the form of co-payment for treatment. This construct is even more important for lower socio-economic classes, which might not regularly be exposed to the profit motive.

d) 50 questions were posted to SmileLine Online during the week of event, and 100 volunteers fielded a minimum of approximately eight calls per line per hour.

3) The AGD has worked with the American Optometric Association (AOA) and the American Diabetes Association to inform patients about "above-the-neck" warning signs for diabetes, such as bad breath, bleeding gums, and blurred vision.

4) The AGD's Legislative and Governmental Affairs (LGA) Council focuses its attention on promotion and implementation of the AGD's Memorandum of Understanding (MOU) with HHS. The purpose of the MOU is to provide a framework for cooperation between HHS and the AGD for promoting the *Healthy People 2010* oral health objectives with a focus on access to care, training of workforce, and the education of the public, the profession of general dentistry, and policymakers. This MOU, unique in organized dentistry, is directed to access to care through education of the public and policymakers about the links between oral health and overall health.

Incentives for Dentists to Practice in Underserved Areas

The AGD recognizes that ***the maldistribution of dentists is a significant challenge to access to care.*** To successfully produce equitable distribution in areas now deemed underserved, **incentives must be established to encourage dentists, especially those with GPR or AED training, who have attained the education and expertise to competently and comprehensively address the oral health needs of potentially compromised populations and to practice in underserved areas in conjunction with their dental teams.**

The AGD proposes **the following steps—which are not to be construed as all-inclusive—as incentives to practice in underserved areas and to increase access to care:**

1. Extend the period during which student loans are forgiven to 10 years, without tax liabilities for the amount forgiven in any year;
2. Provide tax credits for establishing and operating a dental practice in an underserved area;11
3. Offer scholarships to dental students in exchange for committing to serve in an underserved area;
4. Increase funding of and statutory support for expanded loan repayment programs (LRPs);
5. Provide federal loan guarantees and/or grants for the purchase of dental equipment and materials;
6. Increase appropriations for funding an increase in the number of dentists serving in the National Health Service Corps and other federal programs, such

11 **"The Maine Dental Association's own bill, called 'An Act to Increase Access to Dental Care,' has become law.** Starting next year, dentists will be eligible to receive up to $15,000 in income tax credit annually-for up to five years as long as they practice in underserved areas. The law currently limits participation in the program to five dentists, but the legislature will review its effectiveness in two years, and may then amend it to increase the number of allowed participants." American Dental Association (ADA) *Update*, June 10, 2008. (Retrievable from www.ada.org.)

as Indian Health Service (IHS) and programs serving other disadvantaged populations, and HHS-wide loan repayment authorities;

7. Actively recruit applicants for dental schools from underserved areas; and
8. Assure funding for Title VII GPR and Pediatric Dentistry Residencies.

Specifically, the GPR and pediatric dentistry residency programs funded by the appropriations bill for the HHS, and education as part of the Health Professions Program under Title VII of the Public Health Service Act, are proven cost-effective, primary care residency programs. They are a small investment with clear benefits.

During the 20-year history of the Title VII support for general dentistry training, 59 new dental residency programs and 560 new positions were created. Approximately 305 of the dentistry graduates from these programs established practices and spent 50 percent or more of their time in health professional shortage areas or settings providing care to underserved communities.

The benefits of GPR programs include:

More primary care providers: GPR programs provide dental graduates with broad skills and clinical experience, allowing them to rely less on specialists. Residents are trained to provide dental care to patients requiring specialized or complex care, such as individuals with intellectual and developmental disabilities, the elderly, high-risk medical patients and patients with HIV/AIDS. Eighty-seven percent of the graduates of GPR programs remain primary care providers after graduation.

Better distribution of care: ***General practice residency programs improve distribution into underserved areas.*** A 2001 Health Resources and Services Administration (HRSA) funded study found that postdoctoral general dentistry training programs, which typically either are dental school- or hospital-based, generally serve as safety net providers to underserved populations.

The GPR program is a model for the type of program that the government should support during times of scarce resources because it is cost-effective, it targets and provides care to underserved populations and it trains practitioners to become comprehensive general dentists, thus keeping more future health care costs to a minimum due to its primary care emphasis.

Legislative and Community Initiatives for Increasing Access to and Utilization of Care

It should be noted that the majority of the areas that the federal government considers underserved are determined by the low economics of the region. This also should bring an understanding that the care in the areas where these patients in the underserved areas live is funded substantially by government-funded programs (i.e., Medicaid).

Historically, ***when states have raised the Medicaid reimbursement rates, the number of provider dentists have increased, which, in turn, has led to a direct increase in patients in underserved areas receiving care.12***

Specifically, the **following are some of the steps that the AGD recommends to increase both access to care and utilization of care**:

1) Take steps to facilitate effective compliance with government-funded dental care programs to achieve optimum oral health outcomes for indigent populations:
   a) Raise Medicaid fees to at least the 75th percentile of dentists' actual fees;
   b) Eliminate extraneous paperwork;
   c) Facilitate e-filing;
   d) Simplify Medicaid rules;
   e) Mandate prompt reimbursement;
   f) Educate Medicaid officials regarding the unique nature of dentistry;
   g) Provide block federal grants to states for innovative programs;
   h) Require mandatory annual dental examinations for children entering school (analogous to immunizations) to determine their oral health status;
   i) Encourage culturally competent education of patients in proper oral hygiene and the importance of keeping scheduled appointments;
   j) Utilize case management to ensure that the patients are brought to the dental office; and
   k) Increase general dentists' understanding of the benefits of treating the indigent.
2) Establish alternative oral health care delivery service units:
   a) Provide exams for one-year-old children as part of the recommendations for new mothers to facilitate early screening;
   b) Provide oral health care, education, and preventive programs in schools;
   c) Arrange for transportation to and from care centers; and
   d) Solicit volunteer participation from the private sector to staff the centers.
3) Encourage private organizations, such as Donated Dental Services (DDS), fraternal organizations, and religious groups to establish and provide service;
4) Provide mobile and portable dental units to service the underserved and indigent of all age groups;
5) Identify educational resources for dentists on how to provide care to pediatric and special needs patients and increase AGD dentist participation;
   Provide information to dentists and their staffs on cultural diversity issues that will help them reduce or eliminate barriers to clear communication and enhance understanding of treatment and treatment options;
6) Pursue development of a comprehensive oral health education component for public schools' health curriculum in addition to providing editorial and consultative services to primary and secondary school textbook publishers;

12 "Over the past decade, Medicaid and Head Start programs have sought to enhance the enrollees' access to early, ongoing, appropriate, comprehensive dental services. However, progress…[has been] hindered by long-standing barriers that discourage dentists' participation in Medicaid. Included among the most widely identified barriers are inadequate program financing and reimbursement." *National Oral Health Policy Center, Technical Issue Brief,* October, 2007. When Medicaid has been expanded and reimbursement rates raised, utilization and care have increased. For example, "in 2000, Michigan's Medicaid dental program initiated Healthy Kids Dental, or HKD, a demonstration program offering dental coverage to Medicaid-enrolled children in selected counties. The program was administered through a private dental carrier at private reimbursement levels… Under HKD, dental care utilization increased 31.4 percent overall and 39 percent among children continuously enrolled for 12 months, compared with the previous year under Medicaid. Dentists' participation increased substantially, and the distance traveled by patients for appointments was cut in half." Michigan Medicaid's Healthy Kids Dental Program: An Assessment of the First 12 Months (2003). *Journal of the American Dental Association (JADA),* Vol. 134, 1509-15 (November, 2003). Michigan is one of many other states where similar results have been noted.

7) Increase supply of dental assistants and dental hygienists to engage in prevention efforts within the dental team;
8) Expand the role of auxiliaries within the dental team including a dentist or under the direct supervision of a dentist;
9) Eliminate barriers and expand the role that retired dentists can play in providing service to indigent populations;
10) Strengthen alliances with ADEA and other professional organizations, such as the Association of State and Territorial Health Officials (ASTHO), Association of State and Territorial Dental Directors (ASTDD), National Association of Local Boards of Health (NALBOH), National Association of County & City Health Officials (NACCHO) and so forth;
11) Lobby for and support efforts at building the public health infrastructure by using and leveraging funds that are available for uses other than oral health; and
12) Increase funding for fluoride monitoring and surveillance programs as well as for the development and promotion of new fluoride infrastructure.

An important distinction must be made between supporting the advancement of auxiliaries within the dental team or under dentist supervision and opposing the independent practice of independent mid-level providers. Education has been the hallmark of the AGD since its inception. ***The education of auxiliaries within the dental team concept will advance the interests of patient health.*** On the other hand, as explained above, the practice of independent mid-level providers impedes the access to and utilization of oral health care services.

Rather, **the AGD strongly supports those individuals who reside in federally designated underserved areas, especially if they possess cultural competency, and who are interested in performing irreversible oral health procedures, to matriculate in dental school**. The AGD stands ready to lobby both Congress and state legislatures to ensure that there are appropriate funding mechanisms for such educational endeavors. The AGD further warrants that, based on its long history of supporting continuing education and its support of mentoring programs, it will make every effort for established dentists to take all necessary steps to ensure the professional development of these new dentists.

VI. Conclusion

The AGD believes the role of the general dentist, in conjunction with the dental team, is of paramount importance in improving both access to and utilization of oral health care services. The AGD is willing and capable of working with other communities of interest to address and solve disparities in access to and utilization of care across the nation. We should work together to make sure that all Americans receive the very best comprehensive dental care that will give them optimal dental health and overall health.

During this process, we must maintain our focus on the patient and maintain awareness that dentistry works best as a preventive system. As noted in *Oral Health in America: A Report of the Surgeon General*, “Oral diseases are progressive and cumulative and

become more complex over time.” Fortunately, “Most common oral diseases can be prevented.”

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Academy of General Dentistry (AGD)
Barriers and Solutions to Accessing Care

INTRODUCTION

In 2000, the U.S. Surgeon General identified the state of oral health in the United States as an epidemic, noting that illnesses related to oral health resulted in 6.1 million days of bed disability, 12.7 million days of restricted activity, and 20.5 million days of lost workdays each year.[79]

Since then, numerous organizations, public and private, have dedicated countless hours and dollars to propose solutions to improve "access to care." However, twelve years after the Surgeon General's report, we have accomplished little to improve the oral health of the public.

The reasons for this are many, from federal and state budgetary constraints, to wasteful expenditures on unproven programs, to misidentification of the problem as a shortage or unwillingness of providers to provide care, to a continued failure to convince the public to embrace and act upon the importance of oral health to produce positive behavioral outcomes.

The focus of this paper is to identify the underlying barriers that have held us back from bettering the state of oral health for the last twelve years, with proven solutions that are within our immediate reach to improve oral health in the United States.

Future publications of the AGD shall further explore each barrier to identify what has worked in pockets and states across the nation, and how we may apply those lessons to overcome barriers in other areas.

BARRIERS AND SOLUTIONS

"Access" is a shorthand term used for a broad set of concerns that center on the degree to which individuals and groups are able to obtain needed services from the health care system. Often, because of difficulties in defining and measuring the term, legislatures equate access with insurance coverage and with having enough doctors and hospitals *within* the areas in which populations live.

However, having insurance or having health care providers located within the immediate vicinity does not guarantee that people who need services will get them. Conversely, when other barriers are addressed, both insured and uninsured residents of federally-sanctioned shortage areas do find and receive care. Therefore, while access has been used by some to refer to coverage and proximity, the extent to which a population "gains access" to health care

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79 U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2000. NIH publication 00-4713. Available from: URL: http://www.surgeongeneral.gov/library/oralhealth/

1 depends upon financial, organizational, and social or cultural barriers that may limit
2 utilization.
3
4 Specifically, addressing the following key barriers will move our nation toward gaining and
5 utilizing available care:
6
7 1. Oral Health Literacy
8 2. Psychological Factors
9 a. Turning literacy into healthy behaviors (Patient activation)
10 b. Treatment mentality vs. prevention mentality
11 c. Social and cultural misperceptions
12 3. Financial Factors
13 a. Economics of sustainable care delivery
14 b. Provider distribution
15 4. Patients with Special Needs
16
17 <u>ORAL HEALTH LITERACY</u>
18
19 Section 5002 of the Affordable Care Act of 2010 defines health literacy as "the degree to
20 which individuals have the capacity to obtain, process, communicate, and understand basic
21 health information and services needed to make appropriate health decisions."80
22
23 "Health literacy in dentistry is 'the degree to which individuals have the capacity to obtain,
24 process and understand basic health information and services needed to make appropriate oral
25 health decisions.'"81
26
27 "In the U.S., limited literacy skills are a stronger predictor of an individual's health status than
28 age, income, employment status, education level, and racial or ethnic group. Limited health
29 literacy is estimated to cost the U.S. between $100 and $200 billion each year."82
30
31 Increased oral health literacy provides a first step toward enabling patients to see value and
32 ask for services, and will allow communities to develop a culture of oral health as a priority
33 that they should work to achieve.
34
35 Oral health literacy efforts have paid dividends in numerous states across the nation. The
36 AGD calls for collaborative actions with all stakeholders to ensure the following actions:
37

80 Tetine Sentell. Implications For Reform: Survey Of California Adults Suggests Low Health Literacy Predicts Likelihood Of Being Uninsured. *Health Affairs*, 31, no.5 (2012):1039
81 ADA Strategic Action Plan 2010-2015, p. 1. Also, "The American Dental Association (ADA) affirmed that limited health literacy is 'a potential barrier to effective prevention, diagnosis and treatment of oral disease,' and 'clear, accurate and effective communication is an essential skill for effective dental practice.'"
82 ADA Strategic Action Plan 2010-15, p.1

1 • Pursue development of a comprehensive oral health education component for public
2 schools' health curriculum in addition to providing editorial and consultative services
3 to primary and secondary school textbook publishers;
4 • Provide exams for one-year-old children as part of the recommendations for new
5 mothers to facilitate early screening;
6 • Equip teachers at various levels with creative educational tools, including educational
7 videos, puzzles, word searches and experiments that show children the value of their
8 teeth and how to care for them;
9 • Train daycare providers and school nurses on the importance of oral health, including
10 on proper nutrition;
11 • Provide dental information to pediatricians regarding use of bottled water, fluoride,
12 fluoride varnishes, and appropriate diets;
13 • Provide multi-factorial interventions and educational programs to parents of young
14 children, including through public media and information provided at hospitals and
15 other healthcare points of care.83
16
17 PSYCHOLOGICAL FACTORS
18
19 *Turning literacy into healthy behaviors (Patient activation)*
20
21 When one truly understands the importance of oral health, he or she acts upon it, and action in
22 turn becomes engrained as value. This - patient activation - is the unspoken solution to
23 improving oral health and yet, it is free and readily available.84
24
25 Unfortunately, studies have shown that education alone does not translate to value that leads
26 to patient activation and positive patient outcomes.85 Education must be coupled with health
27 promotion to ultimately result in patients' realizing and acting upon their need for preventive
28 care, both through self-care at home and through regular visits to their dentist – a dental home.

83 U.K. Report. The oral health of young children should be promoted through multiple interventions and multisessional health promotion programmes for parents.

- Oral health promotion programmes to reduce the risk of early childhood caries should be available for parents during pregnancy and continued postnatally.
- Oral health promotion programmes for young children should be initiated before the age of three years

Oral health promotion programmes should address environmental, public and social policy changes in order to support behaviour change.

84 "…that is, how confident, skillful, and knowledgeable they are about taking an active role in improving their health and health care…" Peter J. Cunningham, Judith Hibbard and Claire B. Gibbons. Raising Low 'Patient Activation' Rates Among Hispanic Immigrants May Equal Expanded Coverage In Reducing Access Disparities. *Health Affairs*, 30, no.10 (2011):1888

85 "A review of public health education interventions found that studies aiming to increase knowledge were successful, but the effect of information acquisition on behaviour was uncertain. It concluded that health education interventions alone are insufficient to change behaviour but can be effective when combined with environmental or legislative changes" (U.K. Study). Also, ")) **In the latest Research!America poll, 97 percent responded that oral health was somewhat or very important to overall health, yet oral health is a top unmet need for many**." Susan A. Fisher-Owens, Judith C. Barker, Sally Adams, Lisa H. Chung, Stuart A. Gansky, Susan Hyde and Jane A. Weintraub. Giving Policy Some Teeth: Routes To Reducing Disparities In Oral Health. *Health Affairs*, 27, no.2 (2008):407

"Health promotion supports individuals in translating their health knowledge into positive behaviours and lifestyles. Health promotion activities should be directed at a wide variety of areas likely to impact on health, eg social, economic and structural environments as well as the policies of public and local institutions. The rationale is to increase the community's day-to-day capacity and ability to follow a healthy lifestyle."86

"[Health promotion] interventions have included the tailoring of information to meet the needs of specific groups, active involvement by participants, direct contact from services and active learning techniques in addition to dental health education."87 This often requires a multi-factorial approach.

Treatment mentality vs. prevention mentality

"A study of decay-related ER visits in 2006 found that treating about 330,000 cases cost nearly $110 million.3 States are saddled with some of these expenses through Medicaid and other public programs."88

"A study in Washington State revealed that a trip to the ER was the first 'dental visit' for one in four children overall, and for roughly half the children younger than 3 and a half years.89

The success of our efforts for oral health improvement should be measured by the outcome goal of no disease. The US, New Zealand and others have a fixation on treatment as the route to health. In contrast is Denmark, a nation whose dental health outcomes are much more positive than those of New Zealand and even the United States. Its success is due to its focus on prevention, starting at a very young age, rather than on fillings, extractions or root canals. By focusing on the preventable nature of dental disease, Denmark has greatly reduced the need for treatment interventions, whereas in New Zealand and elsewhere, the use of increased treatment mainly by therapists has not caused a decrease in the Caries experience.90

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86 U.K. Study…

87 U.K. Study

88 Pew's ER Report, 2012, p. 3.

89 Pew's ER Report, 2012

90 AAPD Policy 2011 Council on Clinical Affairs. New Zealand, known for utilizing dental therapists since the 1920's and frequently referenced as a workforce model for consideration in the US, recently completed its first nationwide oral health status survey in over 20 years. Dental care is available at no cost for children up to 18, with most public primary schools having a dental clinic and many regions operating mobile clinics.22 Overall, 1 in 2 children in New Zealand aged 2–17 years was caries-free. The caries rate for 5 year olds and 8 year olds in 2009 was 44.4% and 47.9% respectively.23These caries rates, which are higher than the US, United Kingdom, and Australia, help refute a presumption that utilization of non-dentist providers will overcome the disparities.

Gillies A. NZ children's dental health still among worst. The New Zealand Herald. March 6, 2011. Available at: "http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10710408". Accessed March 14, 2011.

New Zealand Ministry of Health. Age 5 and year 8 oral health. In: Our Oral Health: Key findings of the 2009 New Zealand Oral Health Survey. New Zealand, 2010. Available at: "http://www.moh.govt.nz/moh.nsf/Files/oralhealth-statistics/$file/age5-year8-oral-health-data-from-school-dental-services-2009-v2.xls". Accessed March 14, 2011.

The issue of emergency room visits is a symptom of our treatment mentality when it comes to healthcare, and the solution is to prevent the need to resorting to oral health care in an emergency room in the first place.

We must work together to restore oral health care from the hospital emergency room back into the home and into the dental home.

Patients need to be connected to a dental home and have a sustainable relationship with a fully-trained dentist.

Solutions targeted to move dentistry away from expensive emergency room care and back to the dental home include:

- Develop and fund patient navigators to work within communities to ensure that patients keep preventive appointments and to minimize emergency room visit and return rates.

Social and cultural misperceptions

"Oral health knowledge and practices differ by ethnicity and culture. Groups vary in beliefs about the usefulness of treating the primary teeth; caries etiologies; the meaning of oral pain, dental discolorations, or loss; home remedies; dental hygiene and preventive efficacy; and trusted dental information sources.

Our Native American populations reflect the stark contrasts in social and cultural realities. Native American children, ages 2-5, are more than three times more likely to have untreated decay than children of the same age group in the general population - 68% vs 19%, respectively.[91]

Some solutions to overcome social and cultural misperceptions include:

- Provide information to dentists and their staffs on cultural diversity issues, which will help them reduce or eliminate barriers to clear communication and enhance understanding of treatment and treatment options;
- Work with community leaders to breakdown the cultural barriers
- Provide oral health information in multiple languages through multiple community channels.[92]

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91 *Retrieved from* http://www.sddental.org/ohc_native_american_oralhealth.htm
92 "It is also worth noting the importance of having outreach and materials for both Medicaid and the insurance exchanges in multiple languages, given that 60.4 percent of the uninsured with low health literacy had limited English proficiency, as did 26.6 percent of the uninsured with adequate health literacy." Tetine Sentell. Implications For Reform: Survey Of California Adults Suggests Low Health Literacy Predicts Likelihood Of Being Uninsured. *Health Affairs*, 31, no.5 (2012):1039-1044

- Work with Indian Health Services (HIS) and community organizations such as COPE.93

FINANCIAL FACTORS

Economics of sustainable care delivery

"When we talk about raising the [Medicaid] reimbursement, we really are looking at being able to reimburse small businesses and dentists to make the care that they provide, sustainable."94

State efforts to make care for all persons economically feasible have been proven to be effective.95

Solutions to make care for vulnerable populations economically feasible include:

- Extend the period over which student loans are forgiven to 10 years without tax liabilities for the amount forgiven in any year;
- Provide tax credits for establishing and operating a dental practice that serves vulnerable populations[96];
- Offer scholarships to dental students in exchange for committing to serve vulnerable populations;
- Provide senior dental students education through the provision of care in outreach community dental facilities supervised by faculty and interacting with other health care providers97;

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93 "The Community Outreach and Patient Empowerment (COPE) Program is a formal collaboration between the Navajo Nation Community Health Representative Program, the Gallup, Shiprock, Fort Defiance and Chinle Service Units of the Indian Health Service, and BWH's Division of Global Health Equity." *Health Workers Help Navajo Patients COPE. Retrieved from http://www.knowledgeofmedicine.com/brigham-womens-hospital-boston/health-workers-help-navajo-patients-cope/*

94 Dr. Oh's testimony with Maine Watch, March 2012 (Retreived from http://www.mpbn.net/Television/LocalTelevisionPrograms/MaineWatch/tabid/477/ctl/ViewItem/mid/3470/ItemId/20955/Default.aspx). Dr. Oh stated, "On average the overhead for providing dental care is quite high; it's about 65% that's on a normal fee but [Medicaid] reimburses dentists at approximately 25% [or similar % in your state] of the usual and customary fees. So if it costs 65% percent to just cover your overhead, that fraction of a reimbursement you get is often a loss. There are many offices that would take [Medicaid] if the reimbursement is brought up to a sustainable level and that would be more fair to the patients and to the providers."

95 "[In Connecticut, in 2007,] there were only 150 dentists who took their Medicaid program to provide dental benefits. The Connecticut legislature realized this and said we have to find a way to make this care sustainable. So, in 2008, they passed legislation to increase the reimbursement for their Medicaid dental procedures. Within a couple of years they went from 150 providers who were accepting Medicaid children to over 1,000. This wasn't dentists who were worried about making money; this wasn't about making the largest possible profit. This was just making sure that the care was reimbursed so that the dentist's office would stay open and they could keep taking the patients." (Dr. Oh, Maine Watch, March, 2012)

96 **"The Maine Dental Association's own bill, called 'An Act to Increase Access to Dental Care,' has become law**. Starting 2009, dentists became eligible to receive up to $15,000 in income tax credit annually-for up to five years as long as they practice in underserved areas.American Dental Association (ADA) *Update*, June 10, 2008 (Retrievable from www.ada.org).

- Increase funding of and statutory support for expanded loan repayment programs (LRPs);
- Provide federal loan guarantees and/or grants for the establishment and equipping of dental clinics for underserved or financially challenged patients;
- Increase appropriations funding to increase the number of dentists serving in the National Health Service Corps and other federal programs, such as Indian Health Services, programs serving other disadvantaged populations and U.S. Department of Health and Human Services (HHS)-wide loan repayment authorities;
- Develop dental clinics within hospitals to treat patient who are too complicated or systemically compromised to treat in community clinics; the hospital dental clinics should have the capacity to accept after-hours emergencies that would otherwise go to higher-cost emergency rooms;
- Fund dentists to provide oral health care within hospital dental clinics;
- Take steps to facilitate effective compliance with government-funded dental care programs to achieve optimum oral health outcomes for indigent populations:
    - Raise Medicaid fees to at least the 75th percentile of dentists' actual fees
    - Eliminate extraneous paperwork
    - Facilitate e-filing
    - Simplify Medicaid rules
    - Mandate prompt reimbursement
    - Educate Medicaid officials regarding the unique nature of dentistry
    - Provide block federal grants to states for innovative programs
    - Require mandatory annual dental examinations for children entering school (analogous to immunizations) to determine their oral health status
    - Encourage culturally competent education of patients in proper oral hygiene and in the importance of keeping scheduled appointments
    - Utilize case management to ensure that the patients are brought to the dental office
    - Increase general dentists' understanding of the benefits of treating indigent populations;
- Encourage funding from organizations that serve the public, such as the W.K. Kellogg Foundation, Pew Charitable Trusts, DentaQuest and the Robert Wood Johnson Foundation, to support the above solutions.

Provider distribution

The AGD recognizes that the distribution of dentists is a consideration to access to care in certain geographic locations. However, the AGD disagrees with Americans being labeled as "underserved" strictly by the ratio of number of dentists to number of persons in their localities, with disregard as to practice capacity, volunteer programs, and other factors.

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97 "The new Commission on Dental Accreditation Standard 1-9, which requires that 'the dental school must show evidence of interaction with other components of the higher education, health care education and/or health care delivery systems,' will help guide more of our schools in this direction." American Dental Education Association (ADEA). *Charting Progress.* May 2012.

Further, as evidenced by the vast number of patients who routinely travel to receive care at volunteer clinic events such as those held by the Missions of Mercy (MOM), it is clear that other financial barriers present a far greater challenge than provider location.

Nonetheless, where distribution of dentists can be addressed with a limited expenditure of resource, it should be addressed. To successfully produce equitable distribution of care in areas now deemed underserved, incentives must be established to encourage dentists, especially those with GPR or AED training, who have attained the education and expertise to competently and comprehensively address the oral health needs of potentially compromised populations and to practice in underserved areas in conjunction with their dental teams. Many of these incentives have been presented as solutions above. However, numerous economically conservative solutions are also readily available to connect the patient to the dentist. Solutions that bridge the location gap include:

- Actively recruit applicants for dental schools from underserved areas;
- Establish alternative oral health care delivery service units:
    - Arrange for transportation to and from care centers
    - Solicit volunteer participation from the private sector to staff the centers;
- Encourage private organizations, such as Donated Dental Services (DDS), fraternal organizations and religious groups to establish and provide service;
- Provide mobile and portable dental units to service the underserved and indigent of all age groups;

PATIENTS WITH SPECIAL NEEDS

Patients with special needs include patients with disabilities, elderly patients, and patients with medical conditions or co-morbidities that require additional care. Vulnerable populations often include a high proportion of patients with special needs, reminding us of the importance of ensuring that these patients receive high-quality care by educated and licensed dentists. Solutions to ensure the provision of high-quality care to these deserving patients include:

- Assure funding for Title VII general practice residency (GPR), advanced education in general dentistry (AEGD), and pediatric dentistry residencies ;
- Identify educational resources for dentists on how to provide care to pediatric and special needs patients;

CONCLUSION

The AGD believes that the role of the general dentist, in conjunction with the dental team, is of paramount importance to improving both access to and utilization of oral health care services. Equally important is the need for every member of the public to understand the importance of his or her own oral health and to transfer that understanding into action.

The AGD is willing and capable of working with other communities of interest to address and solve disparities in access to and utilization of care across the nation. We should work

1 together to make sure that all Americans receive the very best comprehensive dental care that
2 will give them optimal dental health and overall health.
3
4 During this process, we must maintain our focus on the patient and maintain awareness that
5 dentistry works best as a preventive system. As noted in *Oral Health in America: A Report of*
6 *the Surgeon General*, "Oral diseases are progressive and cumulative and become more
7 complex over time." Fortunately, "Most common oral diseases can be prevented."
8

1 Public Relations Guidelines
2
3
4

Governance and Operations Guidelines

1 AGD Foundation Guidelines
2
3
4

Conflict of Interest Policy and Disclosure Statement

It is the policy of the Academy of General Dentistry that individuals who serve in elective or appointive positions on the Academy's Board, councils, or committees must avoid conflicts of interest and self-dealing in matters relating to Academy business. While individuals in elective or appointive positions, or businesses with which they are affiliated, may engage in business transactions with the Academy, such transactions should generally be avoided and must be undertaken only after full disclosure and in independent decision by the appropriate board, council or committee.

Any commercial enterprise wishing to do business with the Academy must disclose the names of members of the Academy who are investors, officers, directors, employees or agents before being considered by the Academy. When any member of an Academy board, council or committee may be financially benefitted as a result of a decision to be made by such group, that interest must be disclosed and recorded in the minutes, and the member must leave the meeting room and neither participate nor vote in the group's decision.

Signature Required Prior to Serving Academy

As a condition for selection a candidate for the office of Vice-President, Secretary, Treasurer, Editor or Speaker of the House must sign the following Disclosure Statement and file it with the AGD Secretary prior to announcement of the candidacy to the membership or the Delegates.

In accordance with these policies, each Academy member elected or appointed to the Board or to a council or committee must sign the following Disclosure Statement prior to serving.

I, ____________________, declare that I have no proprietary, financial or other personal or professional interest of any nature or kind in any product, service and/or company that will, or might, be considered a conflict of interest during my term as an elected or appointed official of the Academy except the following:

____

____

____.

Should I subsequent to signing this Disclosure Statement acquire such an interest, I will promptly sign and file an amended statement.

Further, having read this Conflict of Interest Policy and Disclosure Statement, I understand and agree that as a condition of the Academy, I will abide by these policies, and I have completed this Disclosure Statement to the best of my knowledge and belief.

(Signature)

Adopted HOD 7/95

Determining the Makeup of the House of Delegates

(SYSTEM ADOPTED BY THE BOARD OF DIRECTORS ON SEPTEMBER 5-6, 1974
For Apportioning Representation in the AGD House of Delegates)

1. The paid, active, and emeritus members in each constituent academy are to be counted as of the October 1st immediately preceding the Annual Meeting.

2. A sum total is obtained of all the paid, active, and emeritus members for the entire Academy.

3. From this total is deducted the active and emeritus members who are practicing in unorganized areas. These individuals are not included in the apportionment of delegates.

4. Divide 200 into the total number of paid, active, and emeritus members for the organized constituent academies. Carry this figure to 3 decimal places.

5. Divide the figure obtained in step 4 into the number of paid, active, and emeritus members in each of the constituent academies. Carry this figure out to 3 decimal places.

6. Authorize at least one delegate for each of the organized constituent academies, and a second, third, fourth, etc. delegate to those constituent academies that have a full multiple of the factor obtained in step 4.

7. Total the number of delegates obtained in step 6 and subtract it from 200.

8. Round the highest decimal equivalent to the next higher number of delegates until the full complement of 200 delegates has been reached. (This means that 13.9 would be rounded to 14 delegates, but that 3.65 might not be rounded to 4 delegates if other constituent academies had a higher decimal equivalent to be rounded to the next higher number before the sum total of 200 delegates was reached.)

Adopted HOD 9/74
Modified HOD 5/76

1 **AGD ELECTION GUIDELINES**
2 *(Amended House of Delegates in July 2016)*
3
4 I. It is in the best interest of the Academy of General Dentistry (AGD) for its leaders to be
5 exemplary individuals. No candidate or his/her supporters may refer disparagingly to
6 another candidate. All candidates should be promoted on the basis of positive attributes
7 rather than on any negative characteristics of the opposing candidate. The AGD
8 Credentials and Elections Committee (C&E) shall be the overseeing authority for all
9 campaign activities, questions and complaints. All AGD elections should be conducted on
10 a high ethical level. It is, therefore, imperative that all candidates agree to the following
11 rules before beginning their campaigns for election.
12
13 II. Commitment to Guidelines
14 Candidates or their representative for any contested office shall meet via teleconference or
15 other means as soon as possible after the deadline for filing for office has passed to discuss
16 the spirit of the campaign to allow for a fair and transparent campaign. An agreement to
17 abide by the AGD Election Guidelines will be signed by all campaigns in all elections.
18 Thereafter or there upon, all parties for a contested office may agree to any variances, but
19 they must do so in writing and those variances are only for that office for that year. No
20 variance shall economically impact the candidates for the other offices. Staff shall send the
21 changes that all candidates have agreed upon to each candidate for his or her signature.
22 Once every candidate has approved and signed the changes, a copy will be sent to the chair
23 of the Committee to be used in settling any discussions or disagreements that might arise
24 during the campaign. All participants in the election process shall agree to the guidelines
25 no matter what the status of their campaign. The aforementioned agreement, shall include,
26 but not be limited to:
27
28 a. Nominating speeches
29 b. Candidates Forum
30 c. Reception(s)
31 d. Financing
32 e. Advertising
33
34 Copies of this agreement shall be signed by each candidate and distributed to each
35 candidate along with the chairperson of the Committee. The C&E Committee shall be
36 charged with enforcing the agreement.
37
38 III. Participation in the Campaign
39 a. Because of their possible wide reaching influence, members of the Executive Committee
40 (EC), Division Coordinators (DCs), Past AGD Presidents, the Parliamentarian and the
41 C&E are prohibited to participate in any way in someone else’s campaign, including but
42 not limited to the following:
43 i. Making nominating speeches
44 ii. Pictures or quotations in printed material from the candidate
45 iii. Visiting caucuses with the candidate
46 iv. Calling Delegates on behalf of the candidate

v. Openly expressing opinions about the candidate or the process

vi. Open and outward support of a candidate throughout the election process. The exception to this is that if these individuals are serving as Delegates or Alternates, then they may ask questions of a candidate during a candidate's visit to his/her regional caucus.

IV. Past AGD Presidents shall not participate in campaigns. Members of the Credentials and Elections Committee and the Parliamentarian to the HOD shall not participate in campaigns and are further prohibited from running for any AGD office. All other members not mentioned above may participate in the campaigns. Campaign committee members who are also Delegates and Alternates may submit questions to the C&E for the Candidates Forum and can participate in questions and answers of candidates while participating in their own caucus as a Delegate or Alternate.

V. Nominating Speeches:

a. A nominating speech shall be allotted for each candidate, which shall last no longer than two minutes. There will be no seconding speeches for any of the candidates. A "speech" is defined inclusive of a power point or other type of technologically enhanced presentation. All visual aid presentations must be approved by the C&E at least 45 days before presentation to the House of Delegates.

b. The nominating speech must be given by an AGD member. A candidate may choose to have members of the same region or outside of the candidate's region to help run the campaign, endorse the candidate in an approved brochure, or travel with the candidate to the caucuses.

c. Candidates Speech: Each candidate will be asked to present a speech to the House of Delegates (HOD) lasting no longer than five minutes. A "speech" is defined inclusive of a power point or other type of technologically enhanced presentation. All visual aid presentations must be approved by the C&E at least 45 days before presentation to the House of Delegates.

VI. Candidates Forum:

a. There will be a Candidates Forum for contested offices. The Annual Meetings Council in consultation with both the Speaker of the House and the chair of the C&E Committee shall be charged with determining the appropriate time and location for this forum in consultation with the C&E Committee.

b. The Chairperson of C&E shall serve as moderator for the Candidates Forum.

c. Only Delegates and Alternate Delegates may submit questions for candidates to answer during the Candidates' Forum. However, any member may request a Delegate or Alternate to ask a question. Delegates and Alternates will be asked to submit questions 30 days in advance of the HOD. Questions may be submitted in writing to the AGD office before the HOD. All questions submitted will be sorted by staff. Those submitting questions should specify to which office their questions apply (e.g., Vice President, Secretary, Treasurer, Speaker of the House, or Editor). Delegates and Alternates may submit questions at the House of Delegates annual meeting at the First Session of the HOD in receptacles provided by C&E.

d. The Chairperson and Vice-Chairperson of C&E along with staff shall screen all questions to ensure appropriateness and proper grammar. They may combine similar questions.

e. A coin will be tossed to determine the initial order of the candidates for questioning. The order will rotate thereafter.

f. The moderator will then select questions and pose the same questions identifying the Delegate or Alternate posing the question to each candidate running for an identical office. All candidates for a particular contested office will be present when questions are presented, and will share alternatively the opportunity to answer first. Each candidate will be given an identical amount of time to answer all questions. No candidate may take more than two (2) minutes to answer a specific question.

VII. Candidates Reception:

a. The only entertaining permitted by the candidates will be in the Candidate's Reception Room designated by the AGD so that the candidates may have informal dialogue with those who have decision-making roles within the organization. The Candidate's Reception Room shall be open only for formal entertaining during the time designated by the AGD.

b. All candidates will select the menu and equally fund the cost of the Candidate's Reception if they choose to participate in the reception.

c. All signs must be approved by C&E in consultation with AGD Meeting Services Department as to size, number, appropriateness, and location.

d. The same provisions apply to both contested and uncontested candidates.

VIII. Candidate Activity: Acceptable activity in the furtherance of a campaign shall include:

a. The distribution of biographical, issue-oriented, and contact information on the candidate to the AGD, regional, and constituent leaders and the appearance of the candidate at regional caucuses held in conjunction with the AGD Annual Meeting. All such materials must to be approved by the C&E Committee prior to distribution. (See X)

b. Commentary and/or biographical information will be posted on an "Election/Candidates" page on the AGD website. Each Candidate will be given relatively the same amount of space. The C&E must approve all commentary and/or biographical information concerning the candidate before it is posted. Staff will upload the information.

c. Commentary and/or biographical information will be printed in one edition of *AGD Impact* so that side by side comparisons can be made, so long as materials are submitted to meet publication deadlines.

d. A candidate shall only initiate contact with a Delegate or Alternate by mail, e-mail or fax unless the Delegate or Alternate initiates contact. A candidate may not solicit a Delegate or Alternate's phone number. If the method of contact is via e-mail, then such e-mails shall be sent a first time, and then a second and final time with an interval of thirty (30) days between the two e-mails, contingent upon the declaration of candidacies. AGD staff shall send out the e-mails, of all candidates for an office, on the same day, again subject to the declaration of candidacy. The timing of the e-mails shall be determined per the provisions of Section II herein. Mail and fax pieces may be sent out

by the candidates or their representatives, but no more than two mail pieces and two faxes may be sent to any individual Delegate or Alternate.

e. A candidate will formally declare his or her candidacy for the coming year's election to constituent officers, Regional Directors, members of the Board and council and committee chairs not earlier than the latter of the commencement of the AGD Board meeting III or January 1st of the year in which the election is held. Notwithstanding this section, all AGD officers are primarily subject to the provisions of the AGD Bylaws, Chapter IX, Section 1(B)4, which states " *An AGD officer must declare for a new office at least (30) days before the Board Meeting III , and resign his or her current office effective at the close of the annual meeting. Once an AGD officer declares for a new office, said resignation is irrevocable*." Such notice may contain biographical and issue oriented information on his or her candidacy. A candidate shall not announce or circulate petitions for signatures at the preceding annual meeting. Nothing in these guidelines, including the filing deadline for other candidates, shall prohibit a candidate who makes a valid declaration of candidacy from campaigning, subject to all provisions of these guidelines.

f. The term "declare" in Chapter IX, Section 1(B)4 means making a written or electronic communication to the AGD Board and officers, Regional Directors, council and committee chairs and constituent officers.

g. The requirement for a candidate to "present" a "petition" in Chapter IX, Section 1(B)2 means that the candidate shall, via electronic or other mechanical means, transmit a petition to the AGD Secretary, with a copy to the AGD Executive Director.

IX. All information (including electronic) to be circulated to the Delegates and Alternate delegates must be approved by C&E prior to distribution to the Delegates and Alternates. This does not include the verbal portion of the candidate's speech.

X. Staff Responsibilities:

a. Staff shall transmit all items which C&E must review to C&E within one (1) work day of staff receiving it from a candidate. Staff shall acknowledge receipt of the candidate's materials as articulated in Section XI(i) below by electronic means and confirming the numerical sequence. (e.g., "Received Submission 1, item 1) Staff may also be used to aid in forwarding e-mails to Delegates. Staff are not to be used to develop brochures, make phone calls to delegates, or order supplies.

b. Staff will regularly update information on the website about each candidate and will be responsible for sending out regular e-mails through the *AGD In Action* to encourage members to go to each candidate's campaign information housed on the AGD website.

XI. Campaign Materials:

a. All candidates and their supporters are prohibited from using AGD stationery including business cards, and envelopes, issued by the HQ office in supporting a particular candidate for office. Constituent and component AGD stationery may be used only if specifically authorized by the governing body of the particular constituent or component. Individual candidates are prohibited from utilizing component, constituent or AGD stationery in their campaign letters signed by themselves. The use of the AGD logo is permitted in any and all campaign materials.

1 b. Campaign "Giveaways" of any kind are not allowed. There shall be no packaged food
2 or other gifts distributed by the candidates to anyone as part of the candidates'
3 campaigns.
4 c. There will be no items mailed by the candidates other than printed materials approved
5 by C&E.
6 d. Approved badges or pins, may be used to further a candidate's campaign.
7 e. All campaign materials need to be submitted for approval.
8 f. Badges, pins, or other campaign items must be sent physically for approval. In the event
9 that a sample cannot be sent, then a picture showing the full detail of the campaign item
10 must be submitted to the C&E for approval. Once approved these will be divulged, by
11 staff, to the other candidates of a contested office.
12 g. There shall be no delineated restrictions on when or where approved campaign
13 materials and associated paraphernalia is distributed with the exception of the HOD
14 floor, where staff will place all materials prior to the commencement of the First Session
15 of the HOD and unless otherwise noted in these guidelines or other HOD or Board
16 policy. Each candidate shall certify in writing that they are providing a minimum of 270
17 collated approved materials to be distributed accounting for all seated in the HOD.
18 Candidates are limited to 3 collated items.
19 h. Candidates must submit a proof copy of all campaign materials, including those that are
20 electronic only to the C&E Committee at least 45 days before the HOD for an initial
21 review. All materials shall be numerically described. (e.g., Submission 1, item 1, etc.)
22 Materials not submitted by the 45-day deadline may not be used. C&E must inform the
23 candidates whether their materials have been approved or require revision within 15
24 days of their receipt by C&E, but no later than 30 days before the annual meeting. If a
25 candidate's materials do not pass inspection, that candidate will have until 14 days
26 before the annual meeting to revise the materials and resubmit them to the C&E
27 Committee for approval. If materials requiring revision have not been resubmitted by
28 the 14-day deadline, they may not be used. If a candidate is unable to revise some or all
29 of his or her materials to the satisfaction of C&E by the 14-day deadline, he or she may
30 not use the materials that C&E has not approved.
31 i. In reviewing candidates' materials, the C&E shall enforce the following:
32 i. Campaign materials may not use the likeness of an incumbent officer (unless the
33 candidate is an incumbent officer.
34 ii. Campaign materials may not include endorsements from existing officers, DCs, Past
35 AGD Presidents, the Parliamentarian or any member of C&E.
36 iii. Existing officers, DCs, the Parliamentarian, Past AGD Presidents or any member of
37 the C&E may not endorse a candidate or participate in a candidate's campaign, nor
38 may pictures of such individuals be displayed in a candidate's campaign literature.
39
40 XII. Financing
41 a. Candidates are only permitted to accept funding from the following sources:
42 i. The treasury of their own region;
43 ii. The constituent and component AGD treasuries within their own region;
44 iii. Private individual donations;
45 iv. Their own private funds.

b. No corporate donations of any kind may be utilized. This provision does not exclude donations from a dentist's own personally incorporated practice.

XIII. Oversight

a. The C&E shall be charged with the implementation and monitoring of these guidelines.

b. Upon receipt of a written complaint or upon initiation of its own review of campaign related material, the Chairperson of the C&E Committee, in conjunction with the Committee as a whole, shall determine if a violation of the guidelines has occurred.

c. Upon determination that a violation has occurred by a majority vote (for purposes of this provision, the majority will be three votes of the five committee members) the Chairperson shall forward a written letter to the candidate, notifying the candidate of the violation. Upon a second offense, the AGD President shall announce from the podium immediately after the candidate makes his or her speech during the First Session of the HOD that said candidate has twice violated the guidelines. Upon third or subsequent offenses, a written statement notifying Delegates of the number of campaign violations shall be handed to each Delegate as he or she receives their ballot.

d. If it is determined by the Appeals Task Force that a C&E member has violated these guidelines in a significant manner, they will be replaced immediately by the President. Notification will be sent to the Delegates of the replacement.

e. Any candidate so adjudicated shall have automatic right of appeal to the Appeals Task Force through expedited appeal via electronic meeting or other timely means.

f. All complaints and responses must be in writing and copies retained in a C&E file by the Executive Director.

g. The C&E will certify in writing to the Executive Director at the conclusion of the election and after review of any issues or appeals that a fair election was held.

XIV Appeal Task Force

a. This task force, appointed by the President, shall be made up of three (3) DCs.

b. All candidates shall approve of the task force prior to the beginning of the election. If additional task force members are required due to candidates' lack of approval of the aforementioned DC's, the President shall appoint a former AGD Trustee who is not nor ever has been an AGD officer.

c. The three (3) DCs should, if possible, each be from a Region which has no candidates participating in elections for the year in question.

d. The task force will dissolve after certification of a fair election by the C&E after the conclusion of the annual meeting.

e. The chair shall be specified by the appointing individual.

f. Both the C&E, and/or the Appeal Task Force may seek counsel from the AGD attorney if they desire.

XV. Appeals:

a. A candidate has the right to appeal a decision of C&E through expedited appeal via electronic meeting.

b. The Appeal Task Force will make the final decisions on all appeals. They may do this with the guidance of the AGD's legal counsel if they choose."

1 **Rules of Procedure for Conducting The Reference Committee Hearings and Business of**
2 **the Academy of General Dentistry's House of Delegates**
3
4 1. The House of Delegates (HOD) will consider business introduced only in one of the
5 following ways:
6
7 a. A resolution submitted on a petition signed by 25 or more active members at
8 least two weeks prior to the annual session of the HOD and directed to the
9 Executive Director;
10
11 b. An appropriate resolution emanating from a meeting of the Board of Trustees
12 (Board);
13
14 c. Resolutions emanating from any report of an officer, council or committee;
15
16 d. A resolution introduced by any Constituent AGD or any certified delegate
17 providing that the resolution has been received by the AGD's Executive
18 Director at least two weeks prior to the First Session of the HOD at the annual
19 session of the HOD;
20
21 e. A resolution submitted in writing and introduced on the floor of a session of
22 the HOD with the unanimous consent of the HOD. Such a resolution requires
23 approval by two-thirds of the delegates present and voting. Reference
24 Committee recommendations are not, however, deemed new business.
25
26 2. In keeping with the Constitution and Bylaws of the AGD, no amendment may be made
27 to either the Constitution or the Bylaws unless it has been published to the members at
28 least thirty (30) days in advance of the annual session of the HOD on the AGD Web
29 site and links to the proposed changes will be headlined thereon. If such is the case,
30 the Constitution may be amended by an affirmative vote of at least two-thirds of the
31 certified delegate members present and voting at the annual session of the HOD, and
32 the Bylaws may be amended by an affirmative vote of two-thirds (2/3) of the delegates
33 present and voting.
34
35 3. The Speaker of the House, in consultation with the Executive Director, shall make a
36 recommendation to the Board at the regular meeting held before the annual session of
37 the HOD of how the annual reports and resolutions are to be divided among three
38 Reference Committees. All delegates will be strongly encouraged to review all
39 resolutions.
40
41 4. The President shall designate five delegates and two non-voting consultants who need
42 not be delegates to serve on each Reference Committee. Members serving on current
43 councils and committees of the organization may not serve on the Reference
44 Committee if that Reference Committee is going to review a report from a council or
45 committee on which the member is currently serving. The two non-voting consultants

may, of course, have served on councils or committees whose reports are being reviewed by that Reference Committee.

5. Reference Committee hearings are open to all members of the AGD. At the appropriate time each member may express his/her opinion on a given subject being heard by that Reference Committee.

   a. The Chairperson of the Reference Committee shall preside at the Reference Committee hearing. He/she shall be seated with his/her four committee members, a maximum of two consultants, and designated staff from the AGD's headquarters office at a table in the front of the hearing room.

   b. The Chairperson of the Reference Committee may limit the length of time each member is allowed to speak, but may not prevent any member from speaking at least once on a given subject. Once debate has been limited by the Chairperson, it shall apply to all future speakers in that particular Reference Committee on that topic.

   c. No resolutions may be introduced in the Reference Committee hearing.

   d. The purpose of the Reference Committee hearing is only to receive information and opinions. No votes may be taken in the hearing on any resolution.

   e. All Reference Committees must remain in session for a minimum of 90 minutes or until all attendees have left the room so that delegates may present their views before all of the Reference Committees.

6. Immediately after the hearing, the five members of the Reference Committee and the Committee's consultants shall deliberate in executive session and make a recommendation to the AGD on each item of business assigned to it. No item of business may be omitted. The Reference Committee may recommend that a resolution be adopted, rejected, amended, referred to committee, or postponed definitely. An amendment may take the form of a substitute resolution. However, the substitute resolution must be completely germane to the original resolution. After the executive session, the report of the Reference Committee shall be prepared by the Chairperson with the assistance of staff from the AGD's headquarters office.

7. At the appropriate time, the presiding officer shall request that each Reference Committee Chairperson deliver his/her report to the HOD. The Chairperson shall move for appropriate action on each recommendation or substitute resolution from the Reference Committee and identify a member of the Reference Committee as the seconder of the motion. At this time, an amendment to the resolution may be offered from the floor. The amendment must receive a second before it can be discussed. A vote on the main motion or resolution will occur after the membership has reached a decision on each amendment which has been duly proposed. No motions to postpone indefinitely will be permitted.

a. Only those sections of the Constitution and Bylaws which have been published to the membership at least thirty (30) days prior to the annual session of the HOD are subject to amendment. It will be the presiding officer's duty to determine whether a proposed amendment to such a resolution is completely germane to the question. If the proposed amendment is not germane to the particular section of the Constitution and Bylaws under scrutiny, it will be his/her duty to rule the amendment out of order and request that it be appropriately introduced at next year's annual session of the HOD.

b. The President shall appoint a parliamentarian to assist and advise the Speaker of the House in running an orderly meeting in keeping with these Rules of Procedure. All questions not covered by the AGD's Constitution and Bylaws or these Rules of Procedure shall be governed by the American Institute of Parliamentarians Standard Code of Parliamentary Procedure. A copy of this code shall be maintained by the parliamentarian for reference.

8. Only duly certified delegates or alternate delegates who have been elevated to delegate status may vote or move resolutions on the floor of the HOD. However, any of the following individuals may address the HOD after they are recognized by the presiding officer:

a. All delegates;

b. All AGD officers who are members of the Executive Committee;

c. All Council or Committee chairpersons;

d. All AGD Past Presidents;

e. The Executive Staff of the AGD;

f. All members of the Board who have not otherwise been elected delegates (such Board members may be seated with their Constituent AGD delegations on the floor of the HOD).

h. All Regional Directors who have not otherwise been elected delegates (such Regional Directors may be seated with their constituent academy delegation on the floor of the HOD

i. The President of the AGD Foundation may have access to the floor, but may address the HOD only if an issue concerns the Foundation.

j. Any AGD member may have access to the floor of the HOD in order to give a nominating speech for a candidate in a contested election.

9. The procedure with regard to handling of nominations at the First Session of the HOD for AGD offices shall be:

   a. The AGD's Secretary shall announce any petitions received at least 60 days prior to the First Session of the HOD on behalf of candidates running for AGD office at the annual session of the HOD. No petition will be honored that is received more than one year in advance of the annual session of the HOD in which the election takes place.

10. Council and Committee Chairpersons shall sit in the front row of the HOD with the appropriate staff when resolutions from their agencies of the AGD are being considered. If a Council or Committee Chairperson is not in attendance at the annual session of the HOD, the President may designate another member of the Council or Committee as a substitute. The Speaker of the House shall recognize such individuals in proper sequence when it is obvious that they need to provide input to the HOD on any proposed change affecting their areas of jurisdiction.

11. Constituent Executives, officially listed in the Constituent Officers List, may sit with their delegations on the floor of the HOD, but no constituent may seat more than one officially-listed executive.

Adopted HOD 7/89
Revised HOD 7/91
Amended HOD 7/94
Amended HOD 7/95
Revised HOD 7/99
Revised HOD 8/2001
Revised HOD 7/2002
Revised HOD 6/2007
Revised HOD 7/2010

Publication Credit Guidelines

A scientific article accepted for publication credit must have a hypothesis and be original research, which should follow standard clinical protocols, including a full description of controls and conditions, and drafting of conclusions; and a bibliography in which citations should not be more than five years old, the only exception being a historical review of a product or technique. This definition is exclusive of case reports, technique papers and clinical research reports.

A case report will be accepted as long as it demonstrates a comprehensive treatment plan and indicates why one course of action was chosen in lieu of others. Eligible case reports also must document and illustrate results and emphasize general practice applications.

Technique papers and clinical research reports will be accepted provided there is a clear, concise, thorough description of a clinical or laboratory procedure and it includes appropriate references to recognize contributions of others or to clarify information. Additionally, papers that feature information about specialized or improved techniques or treatments that can be readily applied to general practice should be supported by documented experience, but need not relate specifically to individual cases.

Adopted HOD 7/2000

1 Sales and Sponsorships Guidelines
2
3

Finance and Information Technology Guidelines

1 Finance Guidelines
2
3
4

1 Human Resources Guidelines
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3
4

1 Information Technology
2
3
4

1 Office Services Guidelines
2
3
4

1 # Member Programs
2 # Guidelines

Constituent Services Guidelines

Expectations for AGD Constituent Activity

The mission of the Academy of General Dentistry is to serve the needs and to represent the interests of general dentists and to foster their continued proficiency through quality continuing dental education in order to better serve the public. While the national organization can do much to work toward achieving its mission, many of the goals outlined above are most effectively accomplished on the state and provincial level. The Academy must therefore work in partnership with its constituents in planning effective membership programs and activities.

The following is an outline of constituent activities that should occur in each constituent. It is understood that constituents differ in size, sophistication of activities and available workforce. However, all of these activities should be the goal of each constituent as they respond to their members identified needs and desires.

I Constituent Governance and Administration

A. ***Constitution and Bylaws*** - The National Academy requires that a current copy of the Constitution and Bylaws be on file with the Regional Directors. This document should be updated at least every five years. Constituents are encouraged to have an active council/committee responsible for this activity.

B. ***Board of Directors*** - This can consist of as many members as desired and identified in the Bylaws. Usually the officers and a representative from each component and delegates make up this Board.

1. Duties and Responsibilities - The duties and responsibilities of each of the Board positions should be clearly identified and communicated to the responsible persons.
2. Meetings & Minutes – Constituents with a membership of 1,000 or more members have at least four meetings; constituents with a membership of 500-999 members have at least four meetings; constituents with a membership of 200-499 members have at least three meetings; constituents with a membership of 50-199 members have at least 2 meetings; and constituents with a membership of less than 50 members have at least 2 meetings.
3. Budget and Financial Status - Each constituent should prepare an annual budget based on projected income and programs, projects and administration that involve expenditures. The constituent should include a plan to create reserves (at least 6 months operational costs) for future activities and unexpected expenditures. It is frequently advisable that a Budget and Finance Committee be part of the administrative structure of the constituent.
4. Long Range Plan - It is desirable that a long range plan be developed in lieu of changing directions at each Board meeting. The long range plan helps to solidify energies behind projects that have been agreed upon. It keeps the Board focused on its primary concerns.

C. ***Councils and Committees*** - Each constituent should determine the number of councils and committees needed for its administrative activity, and these should be identified in the Bylaws of the constituent. At a minimum each constituent should have an

executive committee/board to manage affairs between the annual meetings of the membership in general assembly. In addition it is recommended that each constituent establish a council/committee to serve the needs of continuing dental education, membership and communication. There can be a need for additional committees such as legislation, annual meeting, and dental care activities.

D. ***Annual Meetings and Elections*** - Each constituent should schedule at least one annual meeting to provide the membership an opportunity to participate in governance through that general assembly. Many constituents find it profitable to plan a continuing dental education program in conjunction with the annual meeting. The annual elections are most appropriately held during the general assembly meeting.

II Continuing Dental Education

A. ***Program Provider Approval for Intrastate Organizations*** - Each constituent Academy should have a continuing dental education review process which is capable of evaluating program providers or courses in the area. The constituent should be actively involved in approving continuing dental education opportunities given in the area. This should be an ongoing activity so that members will have more Fellowship/Mastership eligible courses available to them.

B. ***Constituent Sponsored CDE*** – One of the basic purposes of the Academy is to foster the proficiency of general dentists through continuing dental education. Constituents with a membership of 200 or more should offer at least two CDE courses, constituents with a membership of 50-199 should offer at least one CDE course, and constituents with a membership of fewer than 50 should offer at least one CDE course which may be co-sponsored or held in conjunction with a state dental society meeting.

At least one of the programs should be a participation program. Constituents should also endeavor to ensure MAGD opportunities for members in their state, either through development of a local program or an agreement with a neighboring constituent.

C. ***Promotion of Fellowship/Mastership Awards*** - This function should be carried out in several areas. First, the constituent should appropriately recognize masters and fellows in its newsletter, at the annual meeting, and by providing impetus for local news media to recognize the new masters/fellows in their area. Second, the development of a Master Track program provides the members within the constituent an opportunity to more efficiently complete their requirements for Mastership. Third, the constituent can contact a dental school or develop on their own a review course for the pre-fellows preparing to take the Fellowship examination.

III Membership

This is the life's blood of any constituent's health. The membership chairperson is certainly a very important functional position in a constituent.

A. ***Active Recruitment*** - In the area of active recruitment, the constituent should have at least two yearly programs for encouraging new generalists, associates, and students to

join the organization. These programs should be coordinated with those of the national organization through a constituent membership chairperson. Individuals involved in the constituent Academy's membership recruitment activity should be aware of what is likely to motivate an individual to join the organization.

B. ***Membership Retention*** - The constituent should routinely reinforce the value of membership to its existing members through a planned retention program. This can be accomplished using a variety of methods, including constituent publications, involving members in constituent activities, and one-on-one contact. In communicating the value of membership, emphasis should be placed on what the organization is doing both nationally and locally on the member's behalf.

C. ***Active Young Dentist/Recent Graduate Program*** - Every constituent should use part of its energies in the membership area to focus on young dentists and recent graduates. Often these individuals just require someone to help them understand the place of organized general dentistry in their professional lives.

D. ***Survey of Members Needs*** - Remember, you will not know unless you ask.

IV Communication

A. Membership

1. ***Newsletter*** - Each constituent should designate a constituent editor who will provide the state or region with a voice, a newsletter or president's letter, that informs, calls members to action, and invites opinion. This is a critical service because a newsletter gives members a sense of involvement and breaks down the distance in different communities. Constituents with a membership of 500 or more should offer at least four forms of communication, constituents with a membership of 200-499 should offer at least two forms of communication, and constituents with a membership of 200 and lower should offer at least one form of communication each year.

2. ***Visible Representation at Other Dental Meetings in the Constituent*** - It is important for each constituent to show the flag when appropriate. The national Academy has a booth with handout materials that can be used for other than AGD meetings within the constituent. This is an ideal opportunity for recruitment and to speak to the entire dental community (specialists, assistants, hygienists, and of course non-member general dentists). The constituent should also have a breakfast or luncheon during the Annual State Dental meeting and use attendance at this meeting as a opportunity to recruit new members.

B. ***Communication with the Public*** - Each constituent should designate a constituent public information officer (PIO) who will serve as the vital communications link between the constituent and the general public in the community. The PIO is responsible for developing a local corps of dentists to implement community programs, such as health fairs, poster and smile contests, fun runs, speakers' bureaus and school visits, that will raise community awareness of dentistry and proper dental health. The PIO should communicate with local newspapers and radio and television

stations on a quarterly basis by sending copies of DentalNotes, the AGD media health tips newsletter, and follow-up each issue to ensure local media placements.

Note: Constituents are encouraged to identify the PIO as Board members and to require the PIO to serve a term of no less than two years in order to properly organize ongoing programs.

V Legislation/Dental Care

A. ***Coordination with the State Political Action Committee*** - The constituent should have a Legislative Chairperson. This person should remain alert to proposed state and federal legislative and regulatory changes affecting the practice of general dentistry. In addition, this person should keep members informed, and be prepared to initiate lobbying activities for legislation which is favorable for the practice of dentistry. The ideal situation would be to have the constituent's legislative goals accomplished by working from within the state dental society.

B. ***Political Action Alerts*** - These can come from the Washington office of the Academy or from the AGD Legislative and Governmental Affairs Council. The individual constituent should have a plan in place to react to these alerts so that the membership is adequately represented in the Legislature process.

C. ***Initiating Legislative Actions*** - Each constituent, after assessing members' needs, may find it advisable to initiate political activity through the appropriate channels. These activities could constitute meaningful activity on the part of the Legislative Council of the constituent.

D. ***Dental Care Activities*** – The constituents that have 500 or more members should have a Dental Care Chairperson and Dental Care Council. This council should be responsible for addressing such issues at the local level as shortage of auxiliaries, illegal advertising, dental practice issues, access to care issues, malpractice suits, and third party payment problems. The Dental Care Council should also provide the AGD's viewpoint on dental care issues to the local dental society.

Adopted HOD 7/91
Revised HOD 7/95
Revised BOT 5/99
Revised HOD 7/2002

Appeals of the FAGD/MAGD Application Deadline Guidelines

An application for the Fellowship or Mastership award that is received in the Chicago office after the application deadline may be granted on appeal by the Chair of the Dental Education Council under any of the following circumstances:

1. Medically confirmed disability that prevented applicant form applying before the deadline.

2. Medically confirmed, sudden, severe illness that prevented applicant from applying before the deadline.

3. Unusual personal or business circumstances resulting from natural disaster or accident that prevented applicant from applying before the deadline.

The Dental Education Council is not responsible for problems associated with lost or seriously delayed mail, and will not grant an appeal on that basis."

Adopted HOD 7/96

AMENDED HOD 2016

Academy
of General Dentistry

Fellowship Award Guidelines

Fellowship Requirements

1. Current AGD membership for three (3) continuous years (36 months) by December 31 of the year in which the application is received, to begin no earlier than the month of dental school graduation; dental license has not been suspended or revoked within the last five years, and is not currently under probation, suspension, or revocation.

2. Completion of 500 hours of FAGD/MAGD-approved continuing education credit, with at least 350 hours earned in course attendance. Mastership credit begins to accrue on the date that the 500-hours requirement has been met, as determined by the Dental Education Council.

3. Successful completion of the Fellowship Examination. Any active general dentist member joining the AGD after February 2010 be subject to a 90-day waiting period prior to applying for or sitting for the Fellowship Exam in order to verify their membership status. The Fellowship application and examination must be completed and the application postmarked by the December 31 deadline.

4. Attendance at a Convocation Ceremony, held during the AGD scientific session, to receive the award. Successful candidates are allowed three years following approval to complete this requirement.

Activities Accepted for Fellowship Credit

Course Attendance Credit

A minimum of 350 hours of continuing education course credit is required for the award. Course content must be directly related to the practice of dentistry with the exception that 10 hours are permitted for self-improvement courses. Course credit can be earned for:

1. Scientific Programs
   A) Attendance at courses put on by FAGD/MAGD-program providers. Approved program providers include those accepted by the Committee on Program Approval for Continuing Education (PACE), intrastate program providers approved by AGD Constituent Academies, or those approved by the ADA's Continuing Education Recognition Program (CERP).
   B) Individual intrastate courses may also be approved by the AGD Constituents.

2. Postgraduate Education
   A) Effective July 1, 2009. Beginning with individuals completing a one-year CODA- or CDAC-accredited advanced dental education program (AEGD/GDR/GPR) in 2009, 150 hours of participation credit may be earned. Individuals completing a two-year CODA- or CDAC-accredited advanced dental education program (AEGD/GDR/GPR) in 2009, 300 hours of participation credit may be earned. Credit can be received for non-concurrent completion of both program types for a maximum of 450 hours of participation credit. Effective August 1, 2016, additional CE credit may not be earned for completion of courses that are required as a mandatory component of a CODA- or CDAC-accredited residency. Any additional CE earned during a residency must include documentation from the CODA- or CDAC-accredited residency director confirming that the additional CE was elective and not a mandatory requirement of the CODA- or CDAC-accredited residency. The DE Council may review documentation and has the authority to confirm whether the CE hours will be allowed for FAGD/MAGD credit. Credits are apportioned among the subject categories according to a *predetermined ratio* of subject hours based upon a survey of one- and two-year AEGD/GDR/GPR programs. A copy of the certificate is required to receive credit.

   B). Effective with programs ending in June 2014, individuals completing a CODA- or CDAC-accredited advanced specialty education program of one year or more in length, a maximum of 150 hours of participation credit may be earned. A copy of the certificate is required to receive credit.

   Credit is permitted for the completion of programs as follows:

Current member of AGD	100% of credits are awarded	
Join AGD within one (1) year of completion of the program	100%	“
Join AGD within two (2) years	75%	“

1 Join AGD within three (3) years 50% “
2 Join AGD within four (4) years 25% “
3 Join AGD after four years 0% “
4
5 3. Federal Dental Service Specialty Rotation Programs
6 Participation in Federal Dental Service Specialty Rotation Programs earns 1 credit hour for each
7 working day in the program. A maximum of 150 hours may be applied to the award.
8
9 4. Self-Instructional Programs
10 Up to 150 hours of credit may be applied to the award for completion of FAGD/MAGD-approved
11 audio, audio/visual, written and other self-instructional programs, provided the program provider
12 verifies satisfactory completion. In addition to the 150 hours self-instructional credit, 15 hours of credit
13 may be awarded one time only to members completing the post-test from the FAGD Exam Study
14 Guide.
15
16 5. Self-Improvement
17 Up to 10 hours of credit may be applied to the award from FAGD/MAGD-approved self-improvement
18 course taken on or after July 1, 1985.
19
20 6. Case Presentation Required for Certification/Accreditation by Allied Dental Organizations upon
21 request.
22 Up to 75 hours of participation credit may be applied to the award for case presentations presented for
23 the purpose of certification/accreditation by PACE/CERP approved dental organizations. Requests by
24 Allied Dental Organizations for participations credits will be reviewed by the Dental Education and/or
25 PACE Councils for final approval.
26
27 *Other CE Activities for Credit*
28 1. Teaching/Publications
29 A combined maximum of 150 hours of teaching or publication credit may be applied toward the
30 Fellowship award for the following activities:
31 A) Full- or part-time faculty positions at CODA- CDAC–accredited institutions. Full-time
32 faculty may receive 100 teaching hours for the completion of the first academic year after
33 joining the AGD and 25 teaching hours each subsequent year; part-time faculty may receive
34 50 teaching hours for the completion of the first academic year after joining the AGD and
35 12.5 teaching hours each subsequent year.
36 *B)* Continuing education presentations put on by FAGD/MAGD-program providers. Original
37 presentations receive three hours of teaching credit for each hour of teaching. Repeat
38 presentations receive hour-for-hour teaching credit. *Credit will be awarded upon receipt of*
39 *verification from the program provider.*
40 C) Authorship of a published scientific article in a dental or scientific journal.
41 D) Authorship of a published dental textbook or chapter in a published textbook
42 E) Authorship of a case report, technique paper or clinical research report in a dental or
43 scientific journal published in or after July, 2000.
44 F) Successfully reviewing and reporting on manuscripts submitted to General Dentistry and
45 other refereed dental journals.
46 G) Draft self-assessment quizzes for peer-reviewed scientific journals, or self-instruction
47 programs from AGD PACE- or ADA CERP-approved organizations.
48 H) Draft self-assessment quizzes from FAGD/MAGD program provider-hosted webinars or
49 electronically-mediated self-instruction programs.
50 Publication credit will be awarded as follows:
51 Published scientific article in a refereed journal......................................40 hours
52 Published scientific article in a non-refereed journal...............................20 hours
53 Published dental textbook.. 40 hours per
54 chapter up to a maximum of 150 hours
55 Chapter in a published textbook **...40 hours per**
56 **chapter**
57 Published case report, technique paper or clinical research report
58 in a refereed journal ....10 hours
59 Published case report, technique paper or clinical research report

1 in a non-refereed journal ....5 hours
2 Review and report on General Dentistry manuscripts:…3 hours each with a
3 maximum of 9 hours per year
4 Review and report on non-AGD refereed dental journal manuscripts:…2 hours each
5 with a maximum of 6 hours per year
6 Draft self-assessment or self-instruction quizzes for a peer-reviewed scientific
7 journal…..20 hours per quiz
8 Draft self-assessment quizzes for FAGD/MAGD program provider-hosted webinars
9 or electronically-mediated self-instruction programs…Three times the length of the
10 program

11 *Credit Limitations*

12 Credit Start Dates: Continuing education credit earned after the credit start date may be applied toward Fellowship award.
13 Credit start dates are assigned upon joining the AGD, as follows:
14 1. January 1, if membership began between January 1 and June 30;
15 2. July 1, if membership began between July 1 and September 30;
16 3. October 1, if membership began between October 1 and December 31;
17 4. Date of dental school graduation, if membership began within the first calendar year after graduation;
18 5. Date of residency completion, if membership began within 48 months after completion of an CODA- or
19 CDAC-accredited advanced dental education program.
20 Subject Category: A maximum of 150 credit hours may be earned in each of the 18 dental subject categories.
21

22 *Application Procedures and Deadline*

23 Applications must be postmarked no later than December 31 to be considered for the class immediately following the
24 application deadline. **The AGD is not responsible for lost or delayed mail.** Please note that Mastership credits begin to
25 accrue on the date that the 500-hours requirement has been met, as determined by the Dental Education Council. The
26 appropriate fee, which includes a non-refundable processing fee, must accompany the Fellowship award application. **All**
27 **FAGD requirements must be completed as of December 31 application deadline. Only the Dental Education Council**
28 **may determine the acceptability of FAGD award applications.** Applications are reviewed by the Council in March of
29 each year and applicants are notified by letter of the Council's decision within three weeks. Final approval is subject to
30 approval by the Board of Trustees
31
32 Direct inquiries regarding the Fellowship Program to:
33 Academy of General Dentistry, Department of Dental Education
34 560 W. Lake Street, Sixth Floor
35 Chicago Illinois 60661
36 Phone 888.AGD.DENT (243.3368)
37 Fax 312.335.3443
38

Lifelong Learning & Service Recognition Guidelines

Why Achieve Recognition?
Lifelong Learning & Service Recognition (LLSR) is a program of formal recognition for Academy of General Dentistry (AGD) Masters in the areas of continuing education, dental-related community service and service to organized dentistry. It is not a credential and in no way may be represented to the public as such. LLSR was created to recognize the achievements of those AGD Masters who clearly recognize the professional obligation to remain current in their profession and to create an example so that each member of the dental profession never loses sight of this obligation. Achieving the LLSR from the AGD tells colleagues and patients of your continued commitment to lifelong learning and quality patient care. A Master may receive LLSR multiple times, in a sequential manner, as long as all requirements are met. Once a Master is first recognized by this achievement, subsequent recognitions may include only those credits and points earned since the date of the previous LLSR recognition.

A Charge to all Masters
Masters of the AGD embody the AGD's principles and ideals. They accept an obligation to continually prove themselves worthy of that designation throughout their professional lives. There are certain obligations that go along with the honor of becoming a Master in the AGD. Masters are expected to:
1) Continue their commitment to lifelong learning
2) Be a mentor to associates and new dentists
3) Improve the quality of continuing education
4) Be a voice of the general dentist.

LLSR Requirements
1) All applicants must be AGD Masters, with AGD membership in good standing at the time of application and when recognition is received.
2) 500 credit hours are required in course attendance, teaching or publications earned since the date Mastership was received or since a previous LLSR was received. A breakdown of these credits can be found below in the Course Attendance section.
3) Completion of 100 hours of AGD-approved dental-related community/volunteer service and/or service to organized dentistry is required. Hours must have been performed since the date Mastership was received or since a previous LLSR was received. The acceptability of points is subject to review by the Dental Education Council. Examples of acceptable dental-related volunteer service can be found below in the Community and Volunteer Service section.
4) An application must be submitted with the designated application processing fee, which is determined annually by the Dental Education Council. This fee covers direct costs, plus $100 for overhead costs. Applications must be postmarked by December 31.
5) Acceptance or denial will be communicated to applicants following review of the application by the Dental Education Council. All decisions of the council are final. Recognition of LLSR recipients will be at the constituent and/or regional level and through AGD publications. Recipients will be invited to be present and attend the Convocation Ceremony where they will be celebrated by inclusion of their names in the Convocation

program. Recipients will be seated in a designated area and will walk across the stage to be honored, and have each of their names read, prior to the FAGD and MAGD awardees."

Course Attendance

1) Completion of 500 hours of FAGD/MAGD-approved continuing education credit. Hours must have been earned since the date Mastership was received or since a previous LLSR was received:

a) At least 150 continuing education hours must be earned in participation course attendance;
b) A maximum of 100 credits for teaching is allowed;
c) A maximum of 100 credits for publications is allowed.

2) Credits for course attendance, teaching or publications must be in at least eight (8) of the following disciplines, although there are no minimums or maximum by discipline. Note: No credits will be accepted for advanced academic education programs, such as residencies or advanced degree programs.

Subject Category	Subject Code
Basic Science	010
Endodontics	070
Electives	130
Myofacial Pain/ Occlusion Orofacial Pain*	200
Operateive Dentistry	250
Oral/Max Surgery	310
Anes/Pain Mgmt/Pharm*	340
Orthodontics	370
Pediatrics	430
Periodontics	490
Practice Mgmt	550
Fixed Prosth	610
Removable Prosth	670
Implants	690
Oral Med/Oral Dx	730
Special Pt Care	750
Esthetics	780

**These changes go into effect January 1, 2017. Any member that has not achieved or applied for Fellowship, Mastership, or LLSR by December 31, 2016, will be expected to meet the updated continuing education requirements at that time.*

Teaching and Publication Credit

1) Full or part-time faculty positions in ADA/CDA-accredited institutions are eligible for up to ten (10) credit hours each year. Verification of teaching appointments is required from each institution and should be included with the application.

2) Teaching continuing dental education courses for organizations that are approved by PACE or an AGD constituent are eligible for credit. Verification is required that indicates the dental discipline and the number of hours. Credit will be given hour-for-hour for each presentation.
3) The publication of a scientific article, case report, technique paper or clinical research report in a scientific journal or textbook is worth ten (10) credit hours. A copy of the articles, with dates of publication, should be submitted with the application.

Community and Volunteer Service
1) One community service point is equal to one hour of volunteer community service. The Dental Education Council will determine which additional categories of service not described in these guidelines may be eligible. Volunteer work for a for-profit organization, such as a dental manufacturer, is not eligible.
2) To document community service, a representative of the organization for which the community/volunteer work was done must complete and sign the provided Volunteer Service Verification Form, which specifies the type(s) and term(s) of volunteer service(s) provided. If additional verification is needed, please attach necessary documentation to this form.
3) No financial remuneration or "in-kind" remuneration may be received for service/volunteer work. Reimbursement of expenses such as airfare, transportation, meals, etc., is allowed.

Categories of community and volunteer service may include, but are not limited to:
a. Providing pro bono dental services through a not-for-profit organization;
b. Mentoring a student, emerging dentist or struggling colleague, through a recognized dental organization;
c. Service in a volunteer dental clinic;
d. Service overseas on a dental mission;
e. Volunteer service in a community program, such as a health fair;
f. Providing presentation on dental-related topics to schools, civic, church or other community groups or other health professionals;
g. Providing oral cancer screenings at a local church, synagogue, school, health fair, nursing home, retirement community, etc.;
h. Providing dental screenings to athletes through the Special Olympics Special Smiles;
i. Volunteer work at a local or national dental meeting, such as working at the organization's booth;
j. Serving as an unpaid team dentist for a school, college, professional sports team or youth athletic association;
k. Instituting a mouth guard program for a school, college, professional sports team or youth athletic association;
l. Providing dental education programs at elementary or secondary schools;
m. Volunteering as a Boy/Girl Scout merit badge leader for dental health.

Service to Organized Dentistry:
Holding a local, state/provincial or national appointment or an elected office in a dental organization is considered service to organized dentistry. Points are awarded for each month of service, up to 12 points per year per national or local organization.
1) A maximum of 12 points may be earned annually for serving in a national position in a dental organization. Service time of less than one year will be prorated by month. Holding

multiple positions at the national level in the same organization is acceptable only up to the 12-point limit each year.

2) A maximum of 12 points may be earned annually for serving in state/provincial, constituent or component positions in a dental organization. Service time of less than one year will be prorated by month. Holding multiple positions in the same local organization is acceptable only up to the 12-point limit each year.

3) To document service to organized dentistry, a representative of the organization for which the service was done must complete and sign the provided Volunteer Service Verification Form, which specifies the type(s) and term(s) of volunteer service(s) provided. If additional verification is needed, please attach necessary documentation to this form.

Application Procedures and Deadline

All LLSR requirements must be completed by the December 31 application deadline. Applications must be postmarked no later than December 31 to be considered for the class immediately following the application deadline, and must include the designated application fee. This fee is determined annually by the Dental Education Council and includes a non-refundable processing fee. The AGD is not responsible for lost or delayed mail. Only the Dental Education Council may determine the acceptability of LLSR applications. Applicants are notified by letter of the Council's decision, and all decisions of the Council are final. Recognition will be provided at the Convocation Ceremony at the AGD Annual Meeting & Exhibits through the inclusion of names of the new recipients in the Convocation program and in AGD publications.

Direct inquiries regarding the LLSR to:

Academy of General Dentistry
Department of Dental Education
560 W. Lake Street, Sixth Floor
Chicago, Illinois 60661-6600
Phone 888.AGD.DENT (243.3368)
Fax 312.335.3428

Adopted HOD 7/2003
Amended HOD 6/2015

Academy
of General Dentistry

Mastership Award Guidelines

Mastership Requirements

1. Current membership in good standing in the Academy of General Dentistry at the time of application; dental license has not been suspended or revoked within the last five years, and is not currently under probation, suspension, or revocation.
2. Fellowship in the Academy of General Dentistry. Mastership and Fellowship may not be conferred in the same year.
3. 1100 hours of FAGD/MAGD-approved continuing dental education credit, 400 of which must be in participation courses. Participation hours can be earned at any time during membership with an implementation date of January 1, 2007.
   A) 600 credit hours must be earned in specific disciplines, as outlined under "Subject Category requirements."
   B) A participation course is defined as one in which all course participants actively manipulate dental material or devices, treat patients or otherwise practice skills or techniques under the supervision of a qualified instructor.
   C) The participation activities must represent a minimum of 30% of total course time and must directly address the educational objectives of the course and be an extension and amplification of the lecture portion of the course.
4. Attendance at a Convocation ceremony, held during the AGD scientific session to receive the award. Successful candidates are allowed three years following approval to complete this requirement.

Activities Accepted for Mastership Credit

Course Attendance Credit

1. Continuing Education Courses
   A) Attendance at courses put on by FAGD/MAGD-program providers. Approved program providers include those accepted by the Committee on Program Approval for Continuing Education (PACE), intrastate program providers approved by AGD Constituent Academies, or those approved by the ADA's Continuing Education Recognition Program (CERP).
   B) Individual intrastate courses may also be approved by the AGD Constituents.

2. Residencies
   A) Effective July 1, 2009. Beginning with individuals completing a one-year CODA-accredited advanced dental education program (AEGD/GDR/GPR) in 2009, 150 hours of participation credit may be earned. Individuals completing a two-year CODA-accredited advanced dental education program (AEGD/GDR/GPR) in 2009, 300 hours of participation credit may be earned. Credit can be received for non-concurrent completion of both program types for a maximum of 450 hours of participation credit. Credits are apportioned among the subject categories according to a *predetermined ratio* of subject hours based upon a survey of one- and two-year AEGD/GDR/GPR programs. A copy of the certificate is required to receive credit. Credit is permitted for the completion of programs as follows:
   B). Effective with programs ending in June 2014, individuals completing a CODA- or CDAC-accredited advanced specialty education program of one year or more in length, a maximum of 150 hours of participation credit may be earned. A copy of the certificate is required to receive credit.

Current member of AGD	100%	of credits are awarded
Join AGD within one (1) year of completion of the program	100%	"
Join AGD within two (2) years	75%	"
Join AGD within three (3) years	50%	"
Join AGD within four (4) years	25%	"
Join AGD after four years	0%	"

3. Federal Dental Service Specialty Rotation Programs
Participation in a Federal Dental Service Specialty Rotation Program earns one hour of participation credit for each working day of the program. A maximum of 200 MAGD hours may be applied to the award for this activity.

5. Self-Instructional Courses
Credit may be earned for completion of audio, audio/visual, written and other self-instructional programs, provided the FAGD/MAGD-approved sponsor verifies satisfactory completion. A maximum of 150 hours of credit may be applied to the award for self-instruction courses. In addition to the 150 hours, 15 hours of self-instructional credit maybe awarded one time only to members completing the post-test from the FAGD Exam Study Guide.

6. Case Presentation Required for Certification/Accreditation by Allied Dental Organizations upon request.
Up to 75 hours of participation credit may be applied to the award for case presentations presented for the purpose of certification/accreditation by PACE/CERP approved dental organizations. Requests by Allied Dental Organizations for participations credits will be reviewed by the Dental Education and/or PACE Councils for final approval.

Other CE Activities for Credit

2. Teaching/Publications
A combined maximum of 150 hours of lecture credit may be applied toward the Mastership award for the following activities:
   A) Full- or part-time faculty positions at ADA/CDA–accredited institutions. Full-time faculty may receive 100 hours for the completion of the first academic year after joining the AGD and 25 hours each subsequent year; part-time faculty may receive 50 hours for the completion of the first academic year after joining the AGD and 12.5 hours each subsequent year.
   B) Continuing education presentations put on by FAGD/MAGD-program providers. Original presentations receive three hours of credit for each hour of teaching. Repeat presentations receive hour-for-hour credit. *Credit will be awarded upon receipt of verification from the program provider.*
   C) Authorship of a published scientific article in a dental or scientific journal.
   D) Authorship of a published dental textbook or chapter in a published textbook
   E) Authorship of a case report, technique paper or clinical research report in a dental or scientific journal published in or after July, 2000.
   F) Successfully reviewing and reporting on manuscripts submitted to General Dentistry and other refereed dental journals.

Credit will be awarded as follows:
Published scientific article in a refereed journal......................................40 hours
Published scientific article in a non-refereed journal...............................20 hours
Published dental textbook.. 40 hours per chapter up to a maximum of 150 hours
Chapter in a published textbook ....40 hours per chapter
Published case report, technique paper or clinical research report
in a refereed journal ....10 hours
Published case report, technique paper or clinical research report
in a non-refereed journal ....5 hours
Draft Self-Assessment or self-instruction quizzes for a peer-reviewed scientific journal…..20 hours per quiz

Subject Category Requirements
A minimum number of credits must be earned in each of the 18 dental subject categories listed below. Of the ‘required minimum’ hours needed in each category, a specific portion must fulfill the ‘participation minimum’

requirements. The difference between the ‘total hours’ and ‘total required’ may be taken from any of the 18 disciplines.

Subject Category	**Subject Code**	**Participation Minimum**	**Required Minimum**
Basic Science	010	12	12
Endodontics	070	30	46
Electives	130	30	46
Myofacial Pain/Occlusion	180	30	46
Orofacial Pain**	190	0	12
Operative Dentistry	250	30	46
Oral/Max Surgery	310	30	46
Anes/Pain Mgmt/Sedation/Pharm**	340	12	12
Orthodontics	370	12	12
Pediatrics	430	12	12
Periodontics	490	30	46
Practice Mgmt	550	0	24
Fixed Prosth	610	30	46
Removable Prosth	670	30	46
Implants	690	30	46
Oral Med/Oral Dx	730	12	12
Special Pt Care	750	12	12
Esthetics	780	30	46
Total hours		**372**	**568**
Total Required		**400**	**600**

These changes go into effect January 1, 2017. Any member that has not achieved or applied for Fellowship, Mastership, or LLSR by December 31, 2016, will be expected to meet the updated continuing education requirements.

Application Procedure and Deadline

Applications must be postmarked no later than December 31 to be considered for the class immediately following the application deadline. **The AGD is not responsible for lost or delayed mail**. The appropriate fee, which includes a non-refundable processing fee, must accompany the Mastership award application. **All MAGD requirements must be completed as of to the December 31 application deadline date. Only the Dental Education Council may determine the acceptability of MAGD award applications.** Applications received by December 31 are reviewed by the Council at its spring meeting. Applicants are notified by letter within three weeks of the Council’s decision.

Direct inquiries regarding the Mastership Program to:
Academy of General Dentistry
Department of Dental Education
211 East Chicago Avenue, Suite 900
Chicago Illinois 60611-1999
Phone 888.AGD.DENT (243.3368)
Fax 312.335.3428

1 Meeting Services Guidelines
2
2014:105R-H-6 "Resolved, that the Meeting Services Guidelines Scientific Session Fees Annual Meetings Council be amended to read

Scientific Session Fees Annual Meetings Council

AGD member dentist registrants who purchase tickets for scientific sessions and then find that they are elevated to delegate or alternate delegate status may obtain a full refund of their scientific session ticket(s)

REFUNDS FOR TICKETS PURCHASED

Cancellation requests received less than 30 days prior to the first official day of the annual meeting, with the exception of AGD member dentist registrants who have been elevated to delegate or alternate delegate status, will not be eligible for a credit or refund.
3
4
5
6

1 Membership Services Guidelines
2
3 Guidelines for Consideration of Requests for Back Dues
4 ***(*This document has been superseded by Policy 96:45-H-7 as amended***
5 ***by the 1999 House of Delegates)***
6
7 For New Members:
8 If an individual is delayed from joining the Academy as a result of mishandling of the
9 application by either the headquarters or a constituent office, that individual will
10 automatically have their enrollment date backdated to the date of the initial attempt to
11 join. The decision to require payment of back dues will be at the discretion of the
12 Director of Membership if more than one year has elapsed. Under NO circumstances
13 will an individual who has never held membership previously be allowed to pay back
14 dues for the sole purpose of receiving retroactive credit for courses taken prior to
15 membership, unless this is a result of mishandling of their application.
16
17 For Prior Members:
18 An individual whose membership has lapsed may be provided the opportunity to pay
19 back dues for the years lapsed, on an individual basis upon consideration of the
20 Membership Council.'"
21
22
23 Revised HOD 1999
24
25

1 Organizational Marketing Guidelines