

CDA Public Affairs

Policy Archive

(general policies and position statements)

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Community and Public Health

Abuse Awareness, Detection and Reporting

Dental Care Providers are Mandated Reporters (18S1-1999)

Resolved, that since all licensed dental care providers in California are mandated reporters, the California Dental Association urge its members to become familiar with and report all physical signs of child abuse, child neglect, elder abuse, elder neglect and domestic violence that are observable in the normal course of the dental visit and report the suspected cases to the proper authorities, and be it further

Resolved, that the CDA continue to develop membership resource material related to abuse detection and reporting, and be it further

Resolved, that all existing and new materials and training courses include reporting criteria, reporting mechanisms and the ramifications of this reporting requirement, and be it further

Resolved, that the Council on Community Health monitor state and federal legislative and regulatory activity on abuse and neglect and make information on this subject available.

Access to Care

Integrated Medical-Dental Care and Access to Oral Medicine (3-2021)

Resolved, that the California Dental Association pursue advocacy, education and policies that improve medical-dental integration and collaboration and reduce barriers between dentistry and medicine, and be it further

Resolved, that the California Dental Association support policies, advocacy and education to support members interfacing with medical plans, medical billing or the interaction between medical and dental plans.

Progress Report on Access to Care [2RC-2011-H] (38-2015)

Resolved, that the [access to care activity report](#) of Resolution 2RC-2011-H: Phased Strategies for Reducing the Barriers to Oral Health in California be filed.

Dental Care Capacity Task Force Final Report (27-2015)

Resolved, that the [report of the dental care capacity task force](#) be filed.

Student Participation at CDA Cares Events (18-2013)

Whereas, California dental students have brought added value to and been a significant part of the success of CDA Cares events, bringing their knowledge of dentistry and a passion for giving back to their communities, and Whereas, the most important person at CDA Cares is the patient, and the goal of each clinic is to treat as many patients as possible during the two-day clinic, and

Whereas, dentist volunteers consistently fill the available dental operatories and shifts, and

Whereas, the Dental Board of California has stated that dental students may only practice in a board-approved extramural facility and it does not define CDA Cares as such, therefore be it

Resolved, that CDA policy reflect that California dental students bring unique value, knowledge and skills to CDA Cares clinics and should be utilized to provide assistance with the essential volunteer areas of dental assisting, patient counseling and guidance, radiography, sterilization, the distribution of instruments and supplies, and be it further

Resolved, that CDA recognize California dental students' knowledge, skills, compassion, and generosity of spirit to CDA Cares clinics.

Barriers to California Dental Students Providing Care at CDA Cares Events (18-2012)

Resolved, that the appropriate CDA entity investigate the barriers to California dental students with clinical privileges in their last two years providing direct patient care at CDA Cares events, develop strategies to mitigate those barriers, and work with the dental schools and appropriate state entities to address them, and be it further

Resolved, that the result of this evaluation be reported back to the 2013 House of Delegates.

Improved Understanding of the Capacity of the Dental Care System in California (16RC-2012)

Whereas, the data on private-practice and community clinic systems is seven years old; and

Whereas, a different set of data sets and assumptions than those made in the capacity analysis by Dr. Brown, et. al. could have greatly changed the projected availability of excess capacity in the dental care system in California; and

Whereas, the total capacity of the dental care system in California is a rapidly changing value, adjusting to the economic, and regulatory environment in the State; and

Whereas, changes in means to licensure both in the State of California and other states, has lowered the barriers to interstate migration;
Therefore, be it:

Resolved, that the president appoint a task force to do the following:

- 1) to review and re-examine the capacity data and the premises used in the capacity study; and
- 2) to obtain current data for the State of California to better understand how the capacity responds to forces inside and outside of the profession; and
- 3) to further evaluate how this clarification of capacity changes could be used to improve access to care for all Californians, and be it further;

Resolved, the task force be comprised of one member each from the Policy Development Council and Government Affairs Council, two at large members, and one member from either the Workforce Research and Forecasting Task Force or Access Workgroup, and be it further;

Resolved, that the task force provide a report to the Board of Trustees and 2013 House of Delegates.

Delivery of Irreversible/Surgical Dental Treatment (24S1-2011)

Resolved, that quality of care and patient safety shall be foremost in all CDA efforts related to the reduction of oral health disparities in California, and be it further

Resolved, that CDA continue its commitment to using an evidence-based process in making recommendations to reduce oral health disparities, and be it further

Resolved, that as compelling data on the quality, safety and cost effectiveness of irreversible / surgical procedures (including but not limited to extractions, pulpotomies, cavity preparation) performed by non-dentists does not now exist, until such data on which to base a recommendation are available that indicate that this model will reduce barriers to care, CDA opposes any scope of practice changes allowing non-dentist providers to perform such procedures, and be it further

Resolved, that the California Dental Association use its resources to promote this position to all public, private and

governmental stakeholders and decision makers to the fullest extent.

Phased Strategies for Reducing the Barriers to Oral Health in California (2RC-2011)

Resolved, that the Access Proposal: [Phased Strategies for Reducing the Barriers to Dental Care in California](#) serve as a framework for the association in addressing access to care issues, and be it further

Resolved, that CDA pursue the strategy recommendations in Phase 1 of the *Access Proposal*, including sponsoring any necessary legislation, and be it further

Resolved, that the Phase 1 activities be overseen by the appropriate CDA entities, including the Government Affairs Council and the Policy Development Council, with implementation reports provided to, and any necessary funding recommendations approved by, the Board of Trustees, and be it further

Resolved, that the strategy recommendations in Phases 2 and 3 of the *Access Proposal* be further developed by the appropriate CDA entities, drawing on the experience of implementing Phase 1 and any changes to the access to care needs within the state, and be it further

Resolved, that a comprehensive report on progress of all implementation activities be provided annually to the House of Delegates through Phase 3, and be it further

Resolved, that as Phase 3 is being developed, CDA seek to increase the number of General Practice Residency/Advanced Education in General Dentistry opportunities and encourage students to participate in them through increased funding, increased incentives, and increased information sharing with dental students regarding issues of access/barriers to care instead of a mandated one year post-graduate residency.

Access to Care [36S1-2008-H] Report (31-2010)

Resolved, that this report on the status of Resolution 36S1-2008-H directed activities be filed, and be it further

Resolved, that a final comprehensive report be provided to the 2011 House of Delegates.

Access to Care Analysis (36S1-2008)

Resolved, that the California Dental Association supports improving access to oral health care for all Californians, and be it further

Resolved, that the President direct the appropriate CDA entity to analyze the lack of access to oral health care and consider solutions including but not limited to increasing dentist participation in public supported programs,

expansion of loan repayment programs for community service in underserved populations and improving levels of reimbursement in publicly supported programs, and be it further

Resolved, that this CDA entity consult with a cross-section of those providing care or are knowledgeable about providing care to underserved populations, and be it further

Resolved, that a report on this issue be presented to the 2009 Board of Trustees and House of Delegates.

Overcoming Cultural and Linguistic Barriers in Oral Health Care (41-2008)

Resolved, that the report on Overcoming Cultural and Linguistic Barriers in Oral Health Care policy be filed.

Overcoming Cultural and Linguistic Barriers in Oral Health Care (17RC-2007)

Resolved, that CDA supports the goal of achieving cultural and linguistic competency within the dental profession in order to improve access to oral health care and overall health care outcomes for California's diverse population, and be it further

Resolved, that CDA encourages dental professionals to use communication aids and programs to reduce cultural and linguistic barriers in the provision of oral health care, and be it further,

Resolved, that the appropriate CDA entities are encouraged to review and evaluate their respective programs to ensure members are provided with assistance in providing oral health care and education to the state's diverse population, and be it further

Resolved, that a progress report and outcome summary be presented to the 2008 House of Delegates.

Expansion of Dental Services in Safety Net Clinics (46-2006)

Resolved, that CDA supports the role safety net clinics have in providing care to underserved populations, and be it further

Resolved, that CDA supports expansion of dental services in safety net clinics by initially facilitating communication between clinics and dental components, being an information resource, and providing technical assistance to

members or community organizations seeking to expand their local safety net clinics to include services.

Retired Dentists Who Wish to Provide Care in Underserved Communities (33-2003)

Resolved, that the appropriate agencies of CDA, TDIC (through CDAHCI) and the CDA Foundation be urged to work in cooperation with the Dental Board of California and the legislature to reduce barriers for retired dentists who wish to provide care to patients in underserved communities.

Position Paper on Access to Care (28-2002)

Resolved, that the position paper on Access to Care be approved.

Access to Care

INTRODUCTION

During the last several years, significant attention has been devoted to discussions regarding the health care delivery system in the United States and, specifically, how individuals access the services they require. Until recently, these discussions have largely focused on the medical care delivery system, while the dental care delivery system has remained an afterthought. However, increased awareness of and sensitivity to the needs of the dentally underserved has elevated the importance of access to dental care.

On a national level, the American Dental Association (ADA), the Centers for Medicare and Medicaid Services (CMS), and the Health Resources Services Administration (HRSA) have conducted national summits for the purpose of addressing the issue of access to care, as well as identifying and recommending action steps. The U.S. Surgeon General, in both the *Healthy People 2010 Objectives* and the first ever *Report on Oral Health in America*, clearly identified access to care as an issue in need of immediate resolve to reduce the disparities among all populations. For example, among the Surgeon General's recommendations is "the establishment of a National Oral Health Plan – a community wide partnership to reduce oral health disparities, change oral health perceptions among the public and policy makers, develop a scientific and evidence based approach, an improved infrastructure that would integrate oral health into general health, and the removal of barriers between individuals and the oral health services they require."¹

In California, access to dental care is a growing concern for much of the state's population – in particular, children

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 Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. (Page 11)

and their families living below federal poverty guidelines, individuals with special needs, and the elderly on limited incomes. Some barriers to accessing dental services include a migrant population, a lack of adequate transportation services to and from dental offices, rural populations, limited financial resources, and a lack of knowledge about the importance of oral health.

CDA POLICY

The California Dental Association (CDA) has supported a variety of activities designed to improve access to care, as well as the overall oral health status of Californians. These efforts have included state legislative and regulatory initiatives to expand school-based dental sealant/oral health education programs for children, creation of student loan forgiveness programs, licensure by credential, increases in funding to broaden the benefits of government-funded programs, as well as increases in reimbursement levels for services provided under these public programs. At the state and local levels, the California Dental Association has led the way in increasing the number of California communities with fluoridated water supplies, which has increased the percentage of Californians benefiting from fluoridation. CDA's local dental societies remain active throughout the state, providing services and support ranging from community clinics, foundation support, school-based educational programs and mobile dental services. In addition to participating in a variety of the programs and efforts previously mentioned, individual dentists provide significant pro bono work within their own practices.

The California Dental Association affirms that access to oral health care is a matter of importance for all Californians in order to maintain overall health and well-being. As a fundamental guiding principle, the California Dental Association adopts the Surgeon General's finding that "oral health is integral to general health and is essential to the overall health and wellbeing of all individuals."¹²

Recognizing the complex nature of access to care, the increased level of public attention, and the need to do more in addressing these pressing issues, the California Dental Association has developed a comprehensive set of recommendations for consideration. In so doing, the association and its members acknowledge that access to dental care is a multi-faceted issue that will require multi-agency and multi-organizational cooperation in order to adequately address the challenges associated with improving access. Thus, addressing access to care will require public, private, professional, business and government participation in order to move closer to

solutions that will and should go well beyond the resources of the California Dental Association.

GUIDELINES AND RECOMMENDATIONS

Availability of Dental Care Providers

The California Dental Association will promote and support an increase in the availability of providers who participate in and deliver oral health care to California's underserved and special needs populations. Additionally, CDA will promote and support the expansion of the public health infrastructure and public/private partnerships to ensure a "safety net provider network" to provide treatment for underserved, special needs and at-risk populations. Efforts to expand public health infrastructure will be primarily focused in geographic areas or in special needs populations that the current dental delivery system, which relies heavily on private practice dental offices, is having difficulty reaching.

The California Dental Association will advance programs designed to encourage the location of dental care professionals in isolated and/or underserved geographic regions throughout the state, as well as supporting licensure statutes dealing with licensure by credential and scope of practice flexibility.

The California Dental Association will support and promote dental, dental hygiene and dental assisting educational programs designed to increase the number of providers who practice in underserved areas and/or treat special needs populations. The development of new or the expansion of existing traditional and non-traditional allied training programs designed to meet the need for increased allied dental personnel will be encouraged and supported by CDA.

All efforts related to scope of practice and licensure will be undertaken with an understanding and acknowledgment of the importance of appropriate education and training.

Financial Barriers

The California Dental Association will support programs aimed at reducing financial barriers to oral health care with recognition of the inherent costs associated with the provision of dental care while, at the same time, maintaining the financial viability of the dental practice.

CDA encourages regular periodic reviews and surveys of the extent and comprehensiveness of dental benefits packages based on fiscally responsible and financially viable models for dental care.

² 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 Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. (Page 1)

Effective and Efficient Dental Care

The California Dental Association supports effective and efficient dental care delivery systems and supports research in dental care programs designed to reduce disparities in oral health among various population groups within the state. To that end, CDA supports oral health services research at the federal, state and local levels in the organization, delivery, financing, utilization, patient and provider behavior, desired outcomes, effectiveness, and cost issues associated with the provision of effective and efficient dental care. In striving to achieve greater efficiency and efficacious treatment methods, quality should not be compromised.

CDA supports the funding and expansion of community water fluoridation efforts and other preventive measures as effective and efficient methods for achieving optimal oral health. Additionally, the California Dental Association supports school-based and school-linked prevention and treatment programs, whenever possible preserving a dental relationship with a provider in the community as a school-linked program is preferred. However, CDA recognizes that this may not always be possible and therefore, school-based programs may be necessary. CDA also supports statewide education initiatives designed to promote the essential role of oral health as an integral part of general health. CDA also supports a state dental director position within the California Department of Public Health, along with local dental director positions across the state to advance efforts that "promote every Californian having access to regular dental care (a dental home)."³

Partnerships

The California Dental Association will seek cooperative alliances with other health professions, federal, state and local governments, non-profit organizations, consumer groups and private entities in order to promote access to oral health care. In addition, CDA will assist its component dental societies, as well as ethnic dental societies in their efforts to assess and improve access to dental care for their respective communities.

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³ California Dental Association, Statement on Prevention of Early Childhood Caries, HOD Resolution 11, Attachment A, 2001

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Access to Care Definitions and Policies (8RC-2001)

Resolved, that the definitions of "oral health" and "access to oral health care" be approved as amended, and be it further

Resolved, that the policy statements geared towards improving access to care be adopted.

Access to Care Definitions and Policies

DEFINITIONS

Definition of "Oral Health"

CDA defines "oral health" as freedom from diseases and disorders that affect the oral, dental and craniofacial tissues.⁵

Definition of "Access to Oral Health Care"

CDA defines "access to oral health care" as the ability of the public or an individual to obtain oral health care.

POLICY RECOMMENDATIONS

Overarching Policy

CDA adopts as a fundamental principle the Surgeon General's finding that oral health is integral to general health and is essential to the overall health and well-being of all Americans.⁵

Availability of Dental Care Providers

It is CDA policy to promote and support an increase in the availability of providers who participate in and deliver oral health care to California's underserved and special needs populations.

Financial Barriers

It is CDA policy to support programs that reduce financial barriers to oral health care with recognition of the inherent costs of providing quality dental care.

Effective and Efficient Dental Care

It is CDA policy to support effective and efficient dental care geographically convenient and physically accessible dental care delivery systems.

Partnerships

It is CDA policy to seek cooperative alliances with other health professions; federal, state and local governments; non-profit organizations; consumer groups and private entities to promote access to oral health care.

Definition of Oral Health and Access to Oral Health Care (56-1997)

Reference: Superseded by 8RC-2001

Restriction on Access to Care or Lowering of Standards of Care (29-1997)

Resolved, that the Restriction on Access to Care or Lowering of Standards of Care (56-1976-H) be amended to read as follows:

Resolved, that the Council on Legislation monitor and consider seeking legislation which will have an effect of declaring any health program, public or private, to be in violation of state regulations if such program resulted in a reduction of access to health care or a lowering of standards of health care, and be it further

Resolved, that the results of such efforts be reported semi-annually to the Board of Trustees and annually to the House of Delegates.

Access to Health Care/Mandated Health Care (48-1990)

Reference: Superseded by 22-1993

Access to Dental Care (30S1-1989)

Reference: Superseded by 48-1990

Policy on Free Clinics (16-1977)

Resolved, that the Policy on Free Clinics be modified and adopted.

Policy on Free Clinics

A free clinic for purposes of this policy shall be defined as a facility for the provision of dental treatment to patients unable to obtain such care for themselves—who are not covered under any federal, state or other governmental program—at no fee. The dentists providing the care shall volunteer their services.

1. CDA does not encourage the formation of a free clinic when facilities and funds are otherwise available to provide oral health care for the patients involved.
2. Screening mechanisms shall be followed which will determine that the patients are actually eligible recipients of the services.
3. The clinic shall be bound by the same ethical standards that all member dentists of the California Dental Association must follow.
4. Provisions must be made for adequate and proper post-operative and follow-up care.
5. The free clinic should work in close harmony with the appropriate state and component societies, thereby encouraging the advice and participation of the dentists in the area it serves.

Restriction on Access to Care or Lowering of Standards of Care (56-1976)

Reference: Amended by 29-1997

Provision of Dental Care to Needy (11-1973)

Resolved, that California Dental Association continue to exert its influence to increase dental service to the truly needy, discourage administrative waste, and increase participation by the dental profession by establishing a more realistic fee structure.

Bioterrorism and Disaster Preparedness

Bioterrorism and Disaster Preparedness Policy Update (2-2009)

Resolved, that Bioterrorism and Disaster Preparedness Policy (15-1984) be revised as attached.

Resolved, that the House of Delegates approve the policy statement and recommendations regarding the Role of Dentists in a Disaster/Emergency Situation.

Role of Dentists in Disaster/Emergency Situations

California faces potential disasters such as earthquakes, floods, fires, and other catastrophic occurrences. Such events could result in mass casualties reaching the tens of thousands, and could surpass the medical capability of the State to respond effectively.

Every available resource for help must be employed in order to save lives and mitigate suffering. Dentists, with their knowledge of anatomy, physiology, pharmacology, and sterile surgical techniques would be invaluable in providing emergency care to disaster victims.

In addition to having the training and ability to provide services such as triage, vaccinations, and suturing, dental offices located throughout most communities have many of the same resources as hospitals. These include sterilization equipment, air and gas lines, suction equipment, and radiology capabilities. Activated dental offices could serve as “mini-hospitals” when local hospital facilities become overwhelmed or when a concentration of patients requires isolation.

On January 1, 2009, Assembly Bill 2210 (Price), sponsored by CDA, was enacted. During a declared emergency, the law allows the California Dental Board to suspend compliance with any provision of the Dental Practice Act that would adversely affect a licensee’s ability to provide emergency medical care and protects a dental professional from liability while providing uncompensated emergency medical care consistent with his/her education and emergency training.

Therefore, it is proposed that dental professionals seek additional disaster/emergency response training, and during a declared state of emergency, dental professionals provide not only the forensic expertise for which dentistry is known, but also assist as members of the emergency response team to provide emergency medical care.

Mass Disaster and Bioterrorism Dental Response Team (27S1-2002)

Resolved, that the California Dental Association endorses the concept of a statewide mass disaster and bioterrorism dental response team, and be it further

Resolved, that the appropriate CDA entity work with dentists active in forensics as they create a mass disaster response team with two components – a mass disaster dental identification team and a bioterrorism response team, and be it further

Resolved, that CDA support would be administrative in nature only and that only costs for training of volunteers and operation of the team would be borne by the volunteers who chose to participate.

Bioterrorism and Disaster Preparedness Policy (15-1984)

Reference: Superseded by 2-2009

Children, Seniors and Special Needs Populations

Children

Perinatal Oral Health Consensus Statement and Guidelines (4-2010)

Resolved, that oral health during pregnancy and early childhood evidence-based guidelines for health professionals be adopted.

Reference: [Perinatal Oral Health Guidelines](#)

Oral Health Assessment for California School Children Report (23-2004)

Resolved, that the Oral Health Assessment for California School Children report be filed, and be it further

Resolved, that the report be forwarded to the Council on Legislation (Government Affairs Council) for consideration of legislative action.

Note: Legislation (AB 1433) was signed by the governor in 2006 and went into effect on January 1, 2007.

Every Child Receives a Dental Exam Prior to Entering School (29-2003)

Resolved, that the California Dental Association supports the concept of every child receiving a dental exam prior to entering school, and be it further

Resolved, that a Task Force be created to develop a position paper and implementation strategy in support of these principles, and be it further

Resolved, that a status report be provided to the fall 2004 CDA Board of Trustees.

Position Paper on Prevention of Early Childhood Caries (11RC-2001)

Resolved, that the CDA position paper, Prevention of Early Childhood Caries, be approved as amended.

Prevention of Early Childhood Caries

INTRODUCTION

The California Dental Association accepts the American Dental Association's definition of early childhood caries (ECC) as defined in Resolution 57 - adopted by the 2000 ADA House of Delegates as:

"...the presence of one or more decayed (non-cavitated or cavitated lesions), missing (due to caries) or filled tooth surfaces in any primary tooth in a preschool-age child between birth and 71 months of age..."²

Furthermore, ECC is an infectious, easily transmittable and preventable disease. These facts invite early intervention and make possible a direct impact on the health of the public. Through innovative dental care and coordinated legislation, public policy, professional enhancement and public health instruction programs, the long-range consequences of ECC and their costs to the public can be averted or substantially reduced. The Surgeon General's Report on Oral Health encourages the dental profession to take a leadership role in the collaboration with other health care providers and community agencies to reduce the burden of oral disease in America.

PREVENTIVE INTERVENTION

Early assessment allows the timely delivery of educational information and preventive therapies to "at risk" populations in order to avoid the need for later surgical intervention. The primary caries causing bacteria, mutans streptococci, are transmitted from primary care giver to infant. It is imperative that high-risk individuals be identified at an early age, preferably prenatally, and that appropriate strategies be adopted. These strategies

² American Dental Association, Statement on Early Childhood Caries, HOD Resolution 57, 2000.

include anticipatory guidance and behavior modification (oral hygiene and feeding practices), prescription of antimicrobial mouth rinses for high-risk care givers, application of fluoride varnishes to non-cavitated white lesions, and restorative treatment of active disease in the form of untreated cavitated lesions. CDA recognizes that an effective strategy for addressing ECC has two parts: first to lower the numbers of cariogenic bacteria in the caregiver's mouth in order to delay inoculation of the child as long as possible and second, to arrest by early treatment the non-cavitated, decalcified lesions existing in the child's dentition.

RISK INDICATORS

Epidemiologically, ECC occurs in all racial and socioeconomic groups; however, it tends to be more prevalent in low-income children where it occurs in epidemic proportions. Known factors that serve as risk indicators for dental caries in children are:

1. Medically compromised children,
2. Children of high caries-risk caregivers (mother),
3. Children with demonstrable plaque, demineralization, and/or staining on teeth,
4. Children who sleep with a bottle, or at the breast,
5. Late order siblings of a mild to moderate caries-risk parent,
6. Children of low socioeconomic families.

RISK ASSESSMENT

In order to identify high-risk individuals at an early age, every child should have a risk assessment for ECC between the third trimester of term and 6 months of age by a qualified healthcare professional. These assessments could be incorporated into "well baby" visits and prenatal counseling. Continuous assessment could be incorporated with childhood immunization visits. The physician (pediatrician) or a physician auxiliary (NP, PA, nurse) should be trained and capable of providing: 1) risk assessment, 2) anticipatory guidance/prevention and 3) for every moderate and high-risk child, referral to a "dental home" in order to receive comprehensive interventive dental care.

In 1992, the American Academy of Pediatrics developed the concept of the Medical Home which states, "A medical home is not a building, house, or hospital, but rather an approach to providing health care services in a high-quality and cost-effective manner. Children and their families who have a medical home receive the care that they need from a pediatrician or physician whom they trust. Pediatricians and parents act as partners in a medical home to identify and access all the medical and non-medical services needed to help children and their families achieve their maximum potential where care is accessible,

family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent."³ A Dental Home, based on the Medical Home model, would provide:

1. An accurate risk assessment for dental diseases,
2. An individualized preventive dental health program based upon the risk assessment,
3. Anticipatory guidance about growth and development issues (i.e., teething, digit or pacifier habits and feeding practices),
4. A plan for emergency dental trauma,
5. Information about proper oral care,
6. Information regarding proper nutrition and dietary practices,
7. Assessment of fluoride uptake and consideration of supplementation as necessary,
8. Serve as a humane, positive psychological/emotional environment within which to establish positive attitudes about dental health without developing the classic dental phobias that are common with many adults,
9. Assessment and treatment of patient needs for restorative, surgical and orthodontic/orthopedic dental care,
10. Serve as a referral hub for timely intervention and treatment of dental pathologies that cannot be treated within the "Dental Home."

CONCLUSION

The California Dental Association recognizes that early childhood caries is an infectious and preventable disease, which has long-range consequences in that it predisposes the individual to a lifetime of dental, medical and social problems affecting health and quality of life, at enormous cost to society. Prevention of ECC requires a strategy of risk assessment, anticipatory guidance, preventive therapies and therapeutic intervention. It is incumbent on dental professionals to take a leadership role in the collaboration with other health care providers and community agencies to reduce the burden of oral disease in America.

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- 2) American Academy of Pediatric Dentistry. Infant Oral Health Care, Reference Manual, 1999- 2000:77.
- 3) American Academy of Pediatric Dentistry. Periodicity of Examination, Preventive Dental Services, and Oral Treatment for Children, Reference Manual, 1999-2000:79.

Position Paper on Early Childhood Caries (ECC) (32RC-2000)

Resolved, that the appropriate agency of CDA develop a position paper on early childhood caries (ECC) encouraging the use of anticipatory guidance to assist in eliminating the threat to the public's health and welfare, and be it further

Resolved, that a program be developed by the appropriate agency of CDA to publicize the infectious, transmittable and preventable nature of ECC to the public, other health care professions and public policymakers, and be it further

Resolved, that the appropriate agency of CDA conduct briefing sessions with legislators and health department officials apprising them of the epidemic nature and consequences of ECC, encouraging them to develop or enhance existing programs to control and eradicate this disease, and be it further

Resolved, that funding beyond those provided by the Council on Community Health for this project be sought from professional associations and other civic and philanthropic groups.

Health Care Policy on Infant Health Care (50-1998)

Resolved, that the California Dental Association endorse the following oral health care policy on infant health care:

The infant oral health care visit should be seen as the foundation on which a lifetime of preventive education and dental care can be built, in order to help assure optimal oral health into childhood. Oral examination, anticipatory guidance including preventive education, and appropriate therapeutic intervention for the infant can enhance the opportunity for a lifetime of freedom from preventable oral disease.

RECOMMENDATIONS

1. Infant oral health care education begins ideally with prenatal oral health counseling for parents. A postnatal initial oral evaluation visit should occur within six months of the eruption of the first primary tooth and no later than 12 months of age.
2. At the infant oral evaluation visit, when feasible, the dentist should:

- a. Record a thorough medical and dental history, covering the prenatal, perinatal and postnatal periods;
- b. Complete a thorough oral examination;
- c. Assess the patient's risk of developing oral and dental disease, and determine an appropriate interval for periodic reevaluation based on that assessment;
- d. Discuss and provide anticipatory guidance regarding dental and oral development, fluoride status, non-nutritive oral habits, injury prevention, oral hygiene, and effects of diet on the dentition.

Solicitation of Patients at Schools (15-1994)

Resolved, that it is the policy of this association that programs promoting dental health, such as dental screening, mouth guard programs and application of sealants, provide a valuable service to the public and should be encouraged, and be it further

Resolved, that use of such programs to solicit children at any private or public school for the purpose of generating referrals or for the financial benefit of dentists participating in such programs is deemed not to elevate the esteem of the dental profession.

Baby Bottle Tooth Decay (32RC-1993)

Reference: Rescinded by 5-2009

California Child Health and Disability Prevention Program (13-1992)

Resolved, that the California Dental Association encourage the California Child Health and Disability Prevention Program to:

1. Change the age at which a child is eligible to begin dental treatment from three years of age to between six to twelve months of age.
2. Allow eligible children to access emergency dental services at any age.
3. Adopt the Periodicity of Examination, Preventive Dental Services and Oral Treatment for Children, developed by the American Academy of Pediatric Dentistry, and supported by the ADA through its publications, and be it further

Resolved, that the California Dental Association encourage its members to follow the periodicity schedule developed by the American Academy of Pediatric Dentistry.

Reference: See SB 111 Dental Health Education Program (81-1990)

SB 111 Dental Health Education Program (81-1990)

Resolved, that the California Dental Association vigorously pursue a \$2.00 (two dollars) per child increase in funding through the Legislature and Office of the Governor for the state-sponsored SB 111 dental health education program and also work to expand the number of children that can be serviced by these cost-efficient projects.

Seniors

Geriatric Oral Health Access (21S1-2013)

Resolved, that the proper CDA entity provide resources and support to help component societies in establishing a Geriatric Oral Health Access Program, to reach out to administrators, continuing education directors and nursing directors in long term care facilities, and small assisting living facilities to train their caregivers in implementation of personalized daily oral health care plans, and be it further

Resolved, that the proper CDA entity consider pursuing strategies to make personalized daily oral health care plans mandatory in all long-term care and assisted care facilities.

Senior Oral Health (26-2008)

Resolved, that CDA support the dissemination and marketing of educational materials developed by the University of Pacific, Center for Special Care to improve the oral health of seniors, and be it further

Resolved, that CDA support the development of legislation to increase the annual requirement for oral health training for caregiver staff of long-term care facilities, and be it further

Resolved, that CDA support the translation, posting and dissemination of oral health fact sheets and/or other materials directed at seniors and caregivers, and be it further

Resolved, that a report be provided to the Policy Development Council in 2010, and be it further

Resolved, that up to \$60,000 from the issues fund be approved for the implementation of these strategies.

Senior Dent Program (26-1990)

Resource: Rescinded by 41-2007

SNF Model Guidelines (5-1987)

Resource: Rescinded by 5-2009

SNF Study (4-1987)

Resolved, that the report entitled California Skilled Nursing Facilities Residents: A Survey of Dental Needs be approved, and be it further

Resolved, that the report be presented to the Legislature and disseminated to the public as appropriate.

Special Needs

Addressing Barriers to Oral Health Care for Special Health Care Needs Patients (7RC-2022)

Resolved, that a Special Health Care Needs Policy be developed, and be it further,

Resolved, that the appropriate CDA entity evaluate the current public policy landscape for the most significant options to address the policy, including legislative, regulatory action and state or federal funding to improve access to oral health for the special health care needs population, and be it further,

Resolved, that the proposed policy be provided to the 2023 House of Delegates and a report regarding this activity as well as implementation of the \$50 million Specialty Dental Clinic grant program and \$10 million Community Based Dental Student Rotation Grant.

Disability Access Improvements – Unruh Act and California Disabled Persons Act (42-2010)

Resolved, that the appropriate CDA entity consider options, including legislation, that will improve access to the disabled and protect small businesses from unwarranted litigation by requiring a ninety day notice to cure period before a lawsuit alleging disability access violations may be filed, and be it further

Resolved, that CDA work in alliance with other impacted parties to achieve a unified voice in these efforts.

Expansion of Donated Dental Services Program (27-2008)

Resolved, that the Donated Dental Services program be expanded to operate on a full-time basis with greater saturation within southern California, and be it further

Resolved that the programs operation will move from CDA to the CDA Foundation as of January 1, 2009, and be it further

Resolved, that up to \$225,000 from the strategic fund be dedicated in 2008 and 2009 for this expansion, with a report on this program to be made at the August 2009 board meeting.

Community Fluoridation

CDA Fluoridation Policy (3S1-2014)

Resolved, that the CDA Community Fluoridation Policy (3-2009-H) be revised as attached.

Community Fluoridation

Resolved, that the members of the California Dental Association continue to provide leadership in support of communities seeking or maintaining water fluoridation and other fluoride programs, and be it further

Resolved, that CDA will provide leadership and guidance to determine the appropriate strategy to accomplish its fluoridation goals.

Water Fluoridation

WHEREAS: Dental decay is one of the most universal diseases, and

WHEREAS: CDA's leadership of community water fluoridation in California has supported successful expansion of community water fluoridation such that the majority of Californians now have access to fluoridated water, and

WHEREAS: Prevention of dental disease is one of the major objectives of the California Dental Association, therefore be it

RESOLVED, that the members of the California Dental Association continue to provide the leadership to support ongoing efforts to expand community water fluoridation and maintain fluoridation of existing water systems in California.

Fluoridation Media Training (46S1-1995)

Resolved, that the House of Delegates applaud CDA's efforts on the promotion of community water fluoridation, and be it further

Resolved, that CDA develop an issue specific training course designed to develop well versed individuals in the issues related to the promotion of community water fluoridation, which could include the training of non dentists, and be it further

Resolved, that the selection and approval of the individuals be coordinated through the Council on Community Health.

Policy Statement on Fluoridation (27-1973)

Reference: 27-1973 was superseded by 41-1990;
41-1990 was superseded by 3-2009

Health Equity

Diversity, Equity, Inclusion and Belonging (DEIB) Policy (2-2022)

Resolved, that the Diversity, Equity, Inclusion and Belonging Policy be adopted.

Diversity, Equity, Inclusion and Belonging Policy

Health disparities exist across California that disproportionately affect historically underserved communities due to systemic, social and economic inequities.

CDA reaffirms its commitment to combating barriers that permeate the health care system and other parts of society that lead to poor health outcomes for patients. CDA shall implement additional measures that address societal impediments beyond the dentist-patient relationship.

Military

On-Base Dental Facilities for Military Dependents (53RC-1998)

Resolved, that the California Dental Association oppose the establishment of on-base dental facilities for military dependents until the military base in question satisfactorily establishes:

- remote status (that is, location remote from adequate civilian facilities) and
- lack of an adequate supply of dentists within 30 miles of the base.

Communications Between Military and Community Dentists (42RC-1998)

Resolved, that the California Dental Association supports the American Dental Association 1998 House of Delegates action as follows:

Resolved, that active duty military dentists and component dental society members be urged to establish and maintain regular channels of communication, including participation by the active duty military in local dental societies, and be it further

Resolved, that active duty military dentists be urged to keep local civilian dental officials informed of military activities, current or pending of relevance to area dentists where such information is not restricted, and be it further

Resolved, that the American Dental Association continue to monitor and assure that military contracts which will affect dental practices in the area of a military base are established with proper adherence to existing government policies and guidelines. The American Dental Association will also notify the local dentists, through the auspices at the local branch or organized dentistry, as well as the constituent societies and facilitate the establishment of a process for input.

Rescission of Designation of Remote Status for Military Installations Policy (24-1997)

Resolved, that the policy, Designation of Remote Status for Military Installations (76-1976-H) be rescinded.

Designation of Remote Status for Military Installations (76-1976)

Reference: Rescinded by 24-1997

Oral Health Protection and Disease Prevention

Dentist Administration of Vaccines to Patients (2-2021)

Resolved, that the California Dental Association supports the authorization of dentists to administer vaccinations to combat health disparities, prevent the transmission of communicable diseases and improve community vaccine uptake in California, and be it further

Resolved, that the California Dental Association supports the authorization of dentists to immunize patients against appropriate diseases, including HPV-related oropharyngeal cancer, to improve patient health.

Recognition of Gum Disease Awareness Month (9RC-2016)

Resolved, that the California Dental Association recognizes the risks of periodontal disease and its correlation with other serious medical conditions, and be it further

Resolved, that the California Dental Association recognizes the importance of educating citizens and promoting periodontal disease prevention and treatment, and be it further

Resolved, that the California Dental Association urge the American Dental Association to recognize March as Gum Disease Awareness Month.

Dentists Providing Influenza Vaccines (39-2015)

Resolved, that CDA approve policy acknowledging that dentists have the ability to administer influenza vaccines, and be it further

Resolved, that as dentists move to become active partners in the integrated health care delivery system their ability to influence the public's oral and systemic health can be expanded, and be it further

Resolved, that allowing dentists to administer influenza vaccinations to their patients in coordination with medical plans and their patient's physicians will expand public access to the flu vaccine and improve public health.

Sealants (1-2009)

Resolved, that CDA supports the use of dental sealants for all Californians at risk of developing caries, and be it further

Resolved, that CDA promote the attached ADA's 2008 sealant guidelines and evidence-based recommendations for the use of pit and fissure sealants, and be it further

Resolved, that CDA support improved dental benefit coverage for sealants on primary and permanent teeth of children and adults, and be it further

Resolved, that the strategies identified by the sealant workgroup be considered when developing sealant promotion activities of the association, and be it further

Resolved, that CDA educate members about the benefits of sealants through all means possible including, but not limited to, the CDA journal, CDA update, CDA web site and CDA Presents the Art and Science of Dentistry.

Reference: ADA 2008 sealant guidelines
[ADA 2016 sealant guidelines](#) (updated version)

Soda Consumption Fee to Fund Oral Health Prevention and Treatment Programs (28-2008)

Resolved, that CDA pursue the enactment of a manufacturer's fee on the syrup used to produce soda, sport, and energy drinks, and be it further

Resolved, that up to \$150,000 from the Issues Fund be approved to fund the costs of these efforts.

Oral Piercing (25RC-2008)

Resolved that CDA oppose intraoral and perioral piercings due to the risks associated with the placement and wearing of oral piercings, and be it further

Resolved, that CDA encourage dental professionals to educate patients about the risks of oral piercings as well as the hygiene and management of existing oral piercings to help reduce damaging effects, and be it further

Resolved, that CDA should ensure that patient education materials consistent with this policy be made available to dentists and patients on the CDA web site.

Adoption of CAMBRA Consensus Statement Principles (18RC-2007)

Resolved, that the following main principles for "Caries Management by Risk Assessment" be adopted:

- Modification of the Oral Flora to favor health;
- Patient education and informed participation;
- Remineralization of non-cavitated lesions of enamel and dentin/cementum;
- Minimal operative intervention of cavitated lesions and defective restorations.

Prevention of Dental Disease (25-2006)

Resolved, that the updated "Prevention of Dental Disease" policy be approved.

Prevention of Dental Disease

Since dental disease affects almost everyone at some time in their lives, is largely preventable and affects health and wellbeing for life, the single most important effort of the California Dental Association is prevention of dental disease. Successful prevention involves:

Oral Hygiene: The patient must clean his or her mouth thoroughly, at least twice each day, by:

- A. Brushing properly with a soft manual toothbrush, or electric toothbrush, and
- B. Using dental floss, or other interdental cleaner, to break up the naturally forming bacterial plaque which, left alone, leads to tooth decay, periodontal disease and eventual tooth loss.

Nutrition: Proper nutrition is critically important to dental health as well as general health. A balanced diet, consisting of lean protein, largely unrefined carbohydrates, low in saturated fats, and high in vitamin and mineral rich vegetables and fruit is essential to good oral and overall health. Additionally, food and drink with high sugar content, high acid content and low nutritional value contribute to dental caries and enamel erosion, as well as obesity type 2 diabetes and other diseases, and should be avoided.

Tobacco: Tobacco use has been estimated to account for over 90 percent of cancers of the oral cavity and pharynx

and thus represents the greatest single preventable risk factor for oral cancer. Both smoking and spit (smokeless) tobacco (moist snuff and chewing tobacco) are associated with a number of other oral conditions, including oral mucosal lesions, that may progress to oral cancer. Tobacco use contributes to periodontal disease, heart disease and other cancers of the body. For these reasons, use of all tobacco products should be avoided.

Decay Prevention: Along with proper nutrition and oral hygiene, decay is best prevented by maintaining a balance between the factors that promote decay and those that protect from decay.

The factors that promote decay are recognized as:

- A. Acid-producing bacteria
- B. Inadequate saliva flow
- C. Frequent eating or drinking of fermentable carbohydrates

Decay protection factors include:

- A. Saliva flow and its components
- B. Fluoride for remineralization
- C. Antibacterial agents, such as chlorhexidine, xylitol and potentially others
- D. Regular professional care

Fluoride is known to effectively promote remineralization of tooth surfaces and significantly reduce decay. Fluoride can be delivered systemically, through public water supplies, bottled water, or oral supplements, as well as applied topically, through toothpaste, brush-on gels and varnishes, and mouth-rinses.

CDA supports adjusting the natural fluoride levels of the state's water supplies to the optimally recommended concentration for each community as the most safe, effective and efficient way to provide fluoride's decay protective qualities to Californians.

Additional protection from decay can be obtained by:

- A. The use of pit and fissure sealants. The National Dental Caries Prevalence Survey (1980) revealed that 84 percent of decay in children 5 to 17 involved pit and fissures. Sealants are very effective in reducing the incidence of pit and fissure decay by placing a plastic coating on the chewing surfaces of teeth.
- B. Use of antibacterial agents, such as chlorhexidine, to reduce the level of acid-producing bacteria.
- C. Use of xylitol products. Xylitol is a sugar alcohol that has been shown to inhibit the growth of decay causing bacterial. This is especially useful in delaying the onset of caries in very young children. Studies show that *Streptococcus mutans* is passed from parents to their newborn children, thus beginning the growth of these decay-producing bacterial in the child. Regular use of xylitol by mothers has been demonstrated to

significantly reduce this bacterial transmission, resulting in fewer cavities for the child.

- D. Preventing “early childhood caries,” also known as “baby bottle tooth decay.” Never allow the child to fall asleep with a bottle, or drink from a “sippy cup,” for extended periods of time, containing any liquid except water. Additionally, reducing the level of decay producing bacteria in the caregiver’s mouth reduces the incidence of early decay for the child.

Prevention of Periodontal Disease: Three out of four adults are affected by gum disease. More than one-half of all adults over the age of 18 have at least the early stages of this disease, and by age 65 more than 60% of adults experience significant signs of disease. This condition can be prevented by seeking professional care, understanding its causes and practicing good oral hygiene.

CDA believes that all available means should be employed to inform the public about the value of preventative dentistry. Every dentist should continue to make preventative dental health education a regular part of his/her practice. CDA is keenly aware that the general population is growing older. More individuals are living longer, and the maintenance of their oral health needs will be of progressively greater significance in the practice of dentistry. The dentists of CDA are committed to the continuing efforts in promoting dental awareness and education to our elderly population.

CDA also believes that any publicly-funded dental care program should provide coverage to needy children so that they will reach adulthood in a state of good oral health and with proper oral health habits well established.

CDA maintains that oral health education should be an integral part of general health education in public and private school curricular from kindergarten through high school.

RESOURCES

- 1) American Dental Association. “Dental Topics.” Accessed at <http://www.ada.org/prof/resources/topics/index.asp>
- 2) “Diagnosis and Management of Dental Caries Throughout Life.” National Institutes of Health Consensus Development Conference Statement, March 2001. Accessed at <http://consensus.nih.gov/2001/2001DentalCaries115html.htm>
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- 4) US Department of Health and Human Services. Centers for Disease Control and Prevention “Oral Health Resources.” Accessed at <http://www.cdc.gov/OralHealth/index.htm>
- 5) U.S. Department of Health and Human Services. “Oral Health in America: A Report of the Surgeon General.”

National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. Accessed at <http://www2.nidcr.nih.gov/sgr/sgrweb/home.htm>

- 6) National Institute of Dental and Craniofacial Research. “Diseases and Conditions.” Accessed at <http://www.nidcr.nih.gov/HealthInformation/DiseasesAndConditions/default.htm>

Behavior Modification Strategies to Improve Oral and General Health (17RC-2006)

Resolved, that the “Behavior Modification Strategies to Improve Oral and General Health” policy be adopted.

Behavior Modification Strategies to Improve Oral and General Health

There exists a wide range of strategies to modify behavior for the purpose of improving the public’s health. Immunization programs, seat belts, helmet laws, and no-smoking areas are examples of these strategies. Designed to protect people from dangerous or risky behaviors for their “own good,” they were established to ensure the public-as-a whole remains healthy – thereby saving the public-as-a-whole the cost of caring for unhealthy individuals.

Awareness that poor nutritional practices contribute to dental caries, obesity, diabetes, osteoporosis, as well as other diseases in children and adults, and concern over the resulting individual and societal health implications, have produced a wide range of proposals to modify these behaviors. Through previous policy, the California Dental Association has affirmed the importance of oral health to general health, concurring with the findings of the 2000 report of the U.S. Surgeon General that “oral health is integral to general health and is essential to the overall health and wellbeing of all individuals.” In recognition of this essential link, CDA supports the following behavior modification strategies to improve public health:

- 1) First consideration should be given to:
 - A. Disclosure of nutritional information, including the impact on health resulting from excessive consumption,
 - B. Restrictions on the marketing and availability of products of low nutritional value and high sugar/calorie content, especially to children while their care is entrusted to public and private entities.
- 2) Secondary consideration should be given to:
 - A. Marketplace interventions, such as product-specific taxation
 - B. Publicly-funded educational campaigns.

- 3) In general, less restrictive remedies should be considered before more restrictive remedies are supported.
- 4) Whenever public funds will be generated by a legislative remedy, CDA should pursue directing any appropriate portion of these funds toward oral health.

Healthy Vending Choices in Schools (24RC-2001)

Resolved, that the California Dental Association encourages component dental societies to work with education officials, pediatric and family practice physicians, dietetic professionals, parent groups and all other interested parties, to increase awareness of the importance of maintaining healthy vending choices in schools.

Prevention of Dental Disease (64-1989)

Reference: Updated by 25-2006

Oral Health 2000/Healthy People 2000 (56-1977)

Resolved, that the California Dental Association recognize and embrace the goals and objectives of Oral Health America as set forth in the directives of Oral Health 2000/Healthy People 2000, and be it further

Resolved, that CDA, its component societies, and its members at large rise to this challenge set forth and become active participants in community or in-office activities in response to this challenge, and be it further

Resolved, that CDA, its component societies, and its members at large cooperate in gathering pertinent data needed to verify the Oral Health 2000 goals.

Over-the-Counter Mouthwashes Containing Ethanol (48RC-1994)

Resolved, that the California Dental Association's Council on Community Health be directed to reassess the issue of over-the-counter (OTC) mouthwashes containing ethanol, execute the directives of Resolution 29RC-1993, and report to the December 1994 Board of Trustees, and be it further

Resolved, that the Thirteenth District caucus submit a resolution to the 1994 ADA House of Delegates requesting that ADA actively review the matter of OTC ethanol-containing mouthwashes, both with or without the ADA Seal of Acceptance, to assure that these products have appropriate safety caps and warning labels.

Oral/Facial Protectors Use in Sporting Events (31RC-1992)

Resolved, that the California Dental Association endorses the use of oral/facial protectors by school aged participants in sports activities with a significant risk of injury at all levels of competition, including practice sessions, physical education and intramural programs, and be it further

Resolved, that the association's members be urged to play an active role in encouraging and assisting state and local youth sports organizations to become more active in the use of protective equipment, not only to prevent sports injuries but to reduce health care costs, and be it further

Resolved, that the Council on Dental Health be directed to develop formal policies, recommendations, and programs aimed at encouraging widespread use of oral/facial protectors by athletes and athletic programs with strategies for implementation, and be it further

Resolved, that the Council on Dental Health report to the December Board of Trustees those proposals.

Tobacco

Tobacco and Nicotine Product Policy (8-2019)

Resolved, that the Tobacco, Nicotine and Recreational Inhalants policy be adopted, and be it further

Resolved, that the policies Taxation of Tobacco Products (33-1993), Tobacco Products (43-1991), and CDA Members as Tobacco Use Counselors (54S1-1989) be rescinded.

Tobacco, Nicotine and Recreational Inhalants

CDA recognizes that dentists play a pivotal role in supporting the improvement of public health through the delivery of quality oral health care and patient education. As health professionals, dentists have a professional responsibility to educate and advise patients regarding the health risks associated with, and support cessation of, the use of cigarettes, smokeless tobacco, electronic cigarettes, vaping and other alternative delivery systems for tobacco, non-tobacco nicotine and other unprescribed inhalants (collectively referred to herein as "nicotine and recreational inhalants").

CDA has been a leader in the curtailment of tobacco and nicotine product sales and availability over the course of several decades. CDA supports state and local policies that reduce use of and access to nicotine and recreational inhalant products utilizing various means, including via taxation and restriction of consumer access.

CDA will continue to educate members on the most current research on health risks associated with nicotine and recreational inhalants, and inhalant systems, including electronic cigarettes, vaping and other alternative delivery systems, and provide access to patient-centric educational resources on use-prevention and cessation so that members may be equipped to educate their patients and the public.

Taxation of Tobacco Products (33-1993)

Reference: Rescinded by 8-2019

Tobacco Products (43-1991)

Reference: Rescinded by 8-2019

CDA Members as Tobacco Use Counselors
(54S1-1989)

Reference: Rescinded by 8-2019

Dental Care, Benefits and Delivery Systems

Anesthesia and Conscious Sedation

Sedation and Anesthesia in the Dental Office (31-2006)

Resolved, that the updated "Sedation and Anesthesia in the Dental Office" position paper be approved.

Sedation and Anesthesia in the Dental Office

The effective control of anxiety and pain has been an integral part of dental practice since the early development of the profession. There exists a population of patients, because of their need for extensive treatment, acute situational anxiety, uncooperative age appropriate behavior, immature cognitive functioning, disabilities, or medical conditions, who can now be comfortably and successfully treated. In the past, many of these patients would have needed to undergo difficult dental procedures without the benefit of anesthesia, or forgo treatment altogether.

CDA recognizes that conscious sedation, deep sedation and general anesthesia are safe and appropriate means of managing patient behavior and producing a positive psychological response to dental treatment. CDA supports an appropriately trained dentist's right to administer conscious sedation, deep sedation and general anesthesia, and has demonstrated a commitment to both patient safety and access to oral health care through involvement in the development of anesthesiology standards, statutes and reimbursement policies in California. CDA supports regulatory standards to ensure that only appropriately trained dentists and those dentists who meet the regulatory requirements by virtue of their clinical experience use conscious sedation, deep sedation and general anesthesia.

To ensure appropriate training and maximum safety, CDA recommends dentists follow California law and the American Dental Association's *Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists* and *Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry*. These documents establish high standards for the training and use of conscious sedation, deep sedation and general anesthesia in dentistry and undergo annual review by ADA.

Anesthesiology and Hospital Benefits for Dental Treatment (55RC-1997)

Resolved, that the California Dental Association support the inclusion of anesthesiology and hospital or surgi-center benefits for the dental treatment of children and persons with disabilities, in all medical insurance, HMO and managed medical care plans on a pre-authorization basis, and be it further

Resolved, that the appropriate councils pursue legislation in support of the inclusion of anesthesiology and hospital or surgi-center benefits for the dental treatment of children and persons with disabilities.

Approval of Standards for Administration of Parenteral Conscious Sedation (28-1997)

Resolved, that the policy, Approval of Standards for Administration of Parenteral Conscious Sedation (14RC-1988-H) be rescinded.

Sedation in the Dental Office (16RC-1988)

Reference: Position paper approved by 16RC-1988; updated and approved by 31-2006.

Approval of Standards for Administration of Parenteral Conscious Sedation (14RC-1988)

Reference: Rescinded by 28-1997. See "Parenteral Conscious Sedation Permit" (16-1984)

Parenteral Conscious Sedation Permit (16-1984)

Resolved, that CDA recommend to the Board of Dental Examiners and State Legislature the development of a "Parenteral Conscious Sedation Permit", with accompanying appropriate qualification standards, and be it further

Resolved, that this permit be separate from the general anesthesia permit already enacted, and be it further

Resolved, that criteria, standards and qualification be formed which protect the public and allow qualified dentists to meet or to exceed reasonable requirements to perform parenteral conscious sedation.

Dental Benefit Programs

Dental Benefits (8-2022)

Resolved, that within the limits of law, the appropriate CDA entity gather data related to dental benefit plans in California, such as annual benefit maximums, percentage of premiums collected spent on treatment, as well as aggregated, aged and anonymized data on submitted dental fees and dental plan reimbursement rates to the extent available, and be it further

Resolved, that CDA use such data to continue to explore legislative, regulatory and/or legal actions focused on reimbursement rates, including specialist rates that reflect the overall cost of practicing dentistry in California, as well as dental plan payment and processing policies and annual dental benefit maximums to improve and benefit patient care, and be it further

Resolved, that the CDA Board of Directors, in the event that a new task force be convened, include specialists as well as general dentists in the CDA panel addressing these issues, and be it further

Resolved that the CDA Board of Directors be urged to allocate appropriate funds for such actions, and be it further

Resolved, that updates regarding this activity be provided to membership periodically, with the first update provided no later than 180 days following the 2022 House of Delegates, and a summary report be provided to the 2023 House of Delegates.

Medicare Task Force Report (7-2019)

Resolved, that the [Medicare Task Force report](#) be filed.

Dental Benefits and Economics Task Force Report (6-2019)

Resolved, that the [Dental Benefits and Economics Task Force report](#) be filed.

Medicare Task Force (19-2018)

Resolved, that CDA form a task force to explore the issues relevant to the inclusion of dental benefits into the Medicare program, including implications in California on the aging population and the delivery of care, and be it further

Resolved, that the board of trustees be urged to approve the scope of work and necessary funding for the task force's activity, and be it further

Resolved, that the task force report be presented to the CDA 2019 House of Delegates.

Dental Benefit Directive (18-2018)

Resolved, that for the purpose of evaluating potential legal or legislative actions, the appropriate CDA entity be urged to obtain data regarding members' concerns about dental carriers' actions against members, including but not limited to, inappropriate claim delays and denials, and be it further

Resolved, that the Dental Benefits and Economics Task Force be urged to use the collected data to make recommendations about how CDA can advocate and address benefits related issues on behalf of members.

Dental Benefits and Economics Task Force (13S1-2017)

Resolved, that a task force be created to address dental insurance and practice economic issues and make recommendations on how CDA can address and assist members in responding to changes in dental insurance coverage and practice economics, and be it further

Resolved, that the task force place specific priority on researching dental payment denials and delays, and urge the board of trustees to intervene and take appropriate action if necessary, and be it further

Resolved, that the task force provide a preliminary report to the 2018 House of Delegates, with a final report to the 2019 House of Delegates.

Restriction of Fee Caps (30-2010)

Resolved, that the Report on Restriction of Fee Caps be filed.

Restrict Fee Caps (36RC-2009)

Resolved, that the appropriate CDA entity consider options, including potential legislation, that will result in removal or restriction of insurer's caps for non-covered services, and be it further

Resolved, that a report be presented to the 2010 House of Delegates.

Business Model Formula to Compare Dental Plan Benefits (32-2006)

Resolved, that Resolution 27RC-1995-H, the Business Model Formula to Compare Dental Plan Benefits, be rescinded.

Standards for Dental Benefit Plans (29RC-2006)

Resolved, that the Standards for Dental Benefit Plans be approved as revised.

Standards for Dental Benefit Plans

1. Organized dentistry at all levels should be regularly consulted by third-party payers with respect to the development of dental benefit plans that best serve the interests of covered patients.
2. Joint health efforts should be made by organized dentistry and third-party payers to promote oral health with emphasis on preventive treatment.
3. All legally qualified dentists should be eligible for dental plan networks.
4. Plans that restrict patients' choice of dentists should not be the only plans offered to subscribers. In all instances where this type of plan is offered, patients should have the option, at least annually, to choose a plan that affords unrestricted choice of dentist.
5. The provisions and promotion of the program should be in accordance with the "Principles of Ethics" of the American Dental Association and the Code of Ethics of the California Dental Association.

The design of dental benefit plans differs from that of medical plans:

Dental disease does not heal without therapeutic intervention, so early treatment is the most efficient and least costly.

The need for dental care is universal and ongoing, rather than episodic.

The need for dental care is highly predictable and does not have the characteristics of an insurable risk. The dental needs of individuals in an insured group vary considerably.

Patient cooperation and post-treatment maintenance is critical to the success of dental treatment and the prevention of subsequent disease.

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

The association believes that cost-savings is best achieved through adjusting patient cost-sharing, rather than through the erosion of a plan's scope of benefits.

6. In order that the patient and dentist may be aware of the benefits provided by a dental benefit plan, the extent of any benefits available under the plan should be clearly defined, limitations or exclusions described, and the application of deductibles, copayments, and coinsurance factor explained to the patients by the third-party payers and employers. This should be communicated in advance of treatment.
7. The patient should also be reminded that he or she is fundamentally responsible to the dentist for total payment of services received. In those instances where the plan makes partial payment directly to the dentist, the remaining portion for which the patient is responsible should be prominently noted in the "Explanation of Benefits" (EOB) provided to the patient.
8. Each dentist should have the right to determine whether to accept payment directly from a third-party payer.
9. Third-party payers should make use of dental society peer review mechanisms as the preferred method for the resolution of differences regarding the provision of professional services.
10. Procedures for claims processing should be efficient and reimbursement should be prompt.
11. Dentists should comply with reasonable requests from third-party payers for information regarding services provided to patients covered under the plan.
12. Third-party payers' administrative procedures should be designed to enhance the dentist-patient relationship and avoid any interference with it.
13. When patient eligibility is certified through the predetermination process, the third-party payer shall be committed to reimburse on the basis of that initial certification with the provisions of that plan, unless and until written notification is provided in a timely manner to the dentist and the patient by the payer that change in eligibility status has occurred.

When such a change in eligibility occurs, a period of not less than thirty days should be allowed for continuation and, when possible, completion of the treatment.
14. The treatment plan of the attending dentist, as agreed upon by his patient, shall remain the exclusive prerogative of the dentist and should not be

unilaterally interfered with by third-party administrators or payers, or their consultants.

The California Dental Association opposes any abuse of the "Least Expensive, Professionally Acceptable Treatment" concept and will inform the public of the barrier such abuse represents to the attainment of quality dental care. When an insoluble dispute occurs between an attending dentist and a third party regarding a treatment plan, peer review should be accepted by all parties involved as the mechanism for solution. Peer review should be entered into prior to the third-party's determination of reimbursable benefits in such cases.

15. A dental benefit plan should include the following procedures:

- a. Diagnostic: Provides the necessary procedures to assist the dentist in evaluating the conditions existing and the dental care required.
- b. Preventive: Procedures that prevent initiation and/or progression of dental disease in adults and children, including infant oral health care and the establishment of the dental home.
- c. Emergency Care: Provides the necessary procedures for treatment of pain, infection and/or injury. It should also cover the necessary emergency procedures for treatment to the teeth and supporting structures.
- d. Restorative: Provides the necessary procedures to restore the teeth.
- e. Oral and Maxillofacial Surgery: Provides the necessary procedures for extractions and other oral surgery, including preoperative and postoperative care.
- f. Endodontics: Provides the necessary procedures for pulpal and root canal therapy.
- g. Periodontics: Provides the necessary procedures for the treatment of the soft and hard tissues supporting the teeth.
- h. Prosthodontics: Provides the necessary procedures, associated with the construction, placement, or repair of fixed prostheses, removable partial dentures, complete dentures and maxillofacial prostheses.
- i. Orthodontics: Provides the necessary treatment for the supervision, guidance and correction of developing and mature dentofacial structures.

16. The financial reserves of the plan should be adequate to assure continuity of the program.

Underfunded Dental Delivery Systems (27-1997)

Resolved, that the Underfunded Dental Delivery Systems policy (32S1-1995-H) be rescinded.

Medical Savings Accounts (40S1-1995)

Resolved, that the CDA's Council on Legislation study the concept of medical savings accounts, and be it further

Resolved, that the council report its findings to the December 1995 meeting of the Board of Trustees.

Underfunded Dental Delivery Systems (32S1-1995)

Reference: Rescinded by 27-1997

Business Model Formula to Compare Dental Benefit Plans (27RC-1995)

Reference: Rescinded by 32-2006

Benefits for Restorations Necessitated by Wear (93-1990)

Resolved, that the California Dental Association supports the inclusion of dental benefits for restorations necessary to restore tooth structure which has been destroyed by wear (attrition, erosion, or abrasion), and be it further

Resolved, that this position be communicated to all third party payers which exclude this service, as well as the California Department of Corporations for its consideration in regulating benefits provided by health care service plans.

Guidelines for Dealing with Dental Benefit Plans (40-1990)

Resolved, that the California Dental Association take a firm lead in establishing guidelines for dealing with dental benefit plans to encourage the improvement of the health of the public, to promote the art and science of dentistry and to represent the interest of the members of the profession and the public which it serves, and be it further

Resolved, that Resolution 35-1973 be rescinded.

Standards for Dental Benefit Plans (39S1-1990)

Reference: Updated by 29RC-2006

ADA Statement on Dental Consultants (38-1990)

Resolved, that the appended ADA Statement on Dental Consultants be approved, and be it further

Resolved, that Resolution 39-1975 be rescinded.

ADA Statement on Dental Consultants

During the past decade, third-party payers and plan purchasers have increasingly turned to the use of dental consultants in order to streamline the claims review process.

The Council on Dental Care programs initially applauded the use of dental consultants by third-party payers as a means of receiving professional advice on certain aspects of dental benefits plans. While the council still believes that there is value to third-party payers' use of dental consultants, it also believes that some clear distinctions must be made between dental consultants and dental claims reviewers.

Dental claims reviewers are, to all intents and purposes, clerical staff and work under supervision. They do not necessarily have, or need, clinical dental or dental practice background, and are trained specifically by the third-party payer to review dental claims that are uncomplicated and require straightforward processing.

Dental consultants are licensed dentists who, even if not currently practicing, have many years of experience in practice and can and should:

Offer a professional opinion regarding complicated dental treatment;

Request consultations from specialists for certain specialty-related cases, when necessary;

Provide advice to third-party payers regarding the merit and value of dental benefits plan designs;

Educate plan purchasers regarding the impact alternative, less costly treatment may have on the life of a tooth, overall oral health, etc.

Alert third-party payers when dentists' treatment patterns are changed by cost containment strategies to the detriment of the patients;

Provide guidance to third-party payers regarding the importance of the dentist/patient relationship;

Inform third-party payers, plan sponsors and subscribers about the availability and value of the profession's peer review system;

Initiate dialogue with organized dentistry regarding questionable treatment modalities;

Inform the dental profession of those treatment procedures on which questions of judgment between the dentist and

dental consultant are most likely to result in areas of disagreement;

Discuss treatment decisions with dentists on a professional level;

Explain clearly to practicing dentists the provisions of particular contracts and the benefit limitations of those contracts; and

Demonstrate knowledge of contract interpretation, and laws and regulations governing dental practice in those jurisdictions affected by their consulting activities, as well as accepted standards of administrative procedure within the dental benefits industry.

Dentists have a fundamental obligation to serve the best interests of the public and their profession. This obligation can never be abrogated for any reason. In order to maintain independent thought and judgment regarding dental matters, the council believes that dental consultants should be practicing dentists for a minimum of 50% of their time, thus ensuring familiarity with current clinical procedures and practice through such mechanisms as continuing education, or have been in practice for a minimum of ten years immediately preceding employment as a dental consultant, and remain involved in the continuing dental education process in order to stay current with clinical procedures and changing technology. It is strongly recommended that dental consultants be members of the American Dental Association.

Dental Benefit Plans (16RC-1988)

Resolved, that CDA position papers on Continuing Education, Licensure by Credentials and Reciprocity, Peer Review System, Professional Advertising, Professional Liability, Quality Assurance and Sedation in the Dental Office be approved as submitted, and be it further

Resolved, that the CDA position papers on Auxiliary Supervision and Patient of Record, Performance of Restorative Functions by Dental Auxiliaries and Prevention of Dental Disease be remanded to the councils of origin for further evaluation, and be it further

Resolved, that the CDA position papers on PSRO's, Dentist Unions, Department Store Dentists be deleted, and be it further

Resolved, that the CDA position papers on Dental Benefits Plans and Denturism be approved as amended.

Dental Benefit Plans

Dental benefit plans, commonly called dental insurance, have benefited millions of Americans by helping them defray the costs of obtaining care on a regular basis. CDA

favors expansion of well-designed dental benefit programs that provide better dental health for more people.

CDA also recognizes the benefits to the public of having diversity among the "third party" organizations that underwrite and/or administer programs. They include dental service corporations, trust funds, insurance companies, foundations, and state and federal government. CDA is aware that a dental benefit program may also be provided without a third party organization through a direct reimbursement model. The association believes that any well-designed dental benefit program should include the following:

- Adequate funding to provide the benefits offered;
- Efficient administration to assure prompt and necessary treatment for covered patients, and timely compensation for providers, at the lowest practicable administrative cost;
- Freedom of choice of the patient to select any dentist that services the program and freedom of any dentist who wishes to service the program to have that opportunity;
- Periodic right of the beneficiaries of a program to opt out of any plan that limits them to treatment by a "closed panel" operation (one where they have a portion of the cost covered only if they accept treatment from a limited number of dentists selected by the plan administrators). This can be done in a "dual choice" format, where patients have the choice of a limited number of dentists in one plan, and open choice in another.

Dental Plan Information Service

The California Dental Association, as a public service, can assist employers, unions or other groups interested in obtaining dental care coverage. CDA does not approve or disapprove of any specific prepaid plan or type of plan. However, the CDA Dental Plan Information Service can provide prospective policyholders information on the types of plans available, define various prepayment and direct reimbursement concepts, and answer questions about dental procedures.

Usual, Customary and Reasonable (UCR) Fees and Table of Allowances

The UCR system is one in which the dentist is paid on the basis of the fees which he regularly charges. The Table of Allowances method pays benefits on the basis of a percentage of a schedule of benefits (regardless of the individual dentist's fees) which is set by the plan administrator and purchaser. The terms usual, customary and reasonable are defined in many contracts approximately as follows:

- Usual: The usual fee is the fee which an individual dentist most frequently charges for a specific dental procedure.

- Reasonable: The reasonable fee is the fee charged by a dentist for a specific dental procedure which has been modified by the nature and severity of the condition being treated and by any medical or dental complications or unusual circumstances, and therefore may differ from the dentist's "unusual" fee or the benefit administrator's "customary" fee.
- Customary: The customary fee is the fee level determined by the administrator of a dental benefit plan from actual submitted fees for a specific dental procedure to establish the maximum benefit payable under a given plan for that specific procedure. *Such schedules should be updated annually and based upon a statistically valid number of dentists' fee schedules.*

The Table of Allowances refers to a fixed amount that a program will pay for a given service without regard to the actual fee charged. Unless the table is current and realistic in terms of actual dental service fees, the patient's co-payment will be higher than that normally required in a UCR program.

Dual Choice – And Fee-For-Service

In capitation programs, a fixed amount is paid to contracting dentists per covered person, per month, regardless of the amount of care actually needed or actually performed. In the fee-for-service method, benefits are paid for services actually performed.

Capitation plans in California usually restrict choice of dentists, and are thus called closed panels. (The terms "closed panel" and "capitation" often are used synonymously, although they are not synonyms.) CDA prefers that any capitation/closed panel be offered in conjunction with an alternative plan allowing for unlimited choice of a dentist on a fee-for-service basis (dual choice).

CDA is opposed to clearly under-funded plans that experience has shown have very little, if any, chance to provide the benefits expected by the purchaser's group. The normally high utilization during the first two years of all new programs can overwhelm and bankrupt a plan that is underfinanced and/or understaffed.

Administrative Use of X-Rays

X-rays are an important and necessary adjunct to a proper clinical examination, but are not the sole factor in diagnosis and treatment planning. They should be taken only as needed for diagnostic purposes and used, along with other data, for treatment purposes. X-rays should not be interpreted and used alone, especially by non-dentists, to determine aspects of treatment planning.

CDA is opposed to taking unnecessary dental x-rays on a routine or mandatory basis solely for insurance cost control purposes or to verify that treatment was performed. Better auditing procedures are available that do not expose patients to unnecessary radiation.

CDA believes that voluntary submission of duplicates of pretreatment and/or post-treatment x-rays, taken solely for diagnostic purposes, should be at the discretion of the treating dentist.

"Least Expensive Professionally Adequate Treatment"

Many carriers have attempted to market programs based on what they call "least expensive professionally adequate treatment." This means the plan will pay for the least costly approach to a dental situation, as long as it is "adequate," in a professional sense. CDA is concerned with such provisions because an overzealous entity would be able to dictate benefits based purely on cost consideration, rather than on the dental health needs of the patient as determined by the dentist. Patients could be denied professionally indicated treatment and suffer direct interference in their relationship with their dentist. In cases where there is a dispute over treatment planning and benefit determination, peer review is available to dentists, insurance companies and patients.

The Denti-Cal Program

CDA strongly supports programs that provide dental care for the economically disadvantaged, including Denti-Cal, which is the publicly funded dental portion of the federal Medicaid program for California's 2.7 million welfare recipients.

Since 1974, this program has been administered by the California Dental Service (now known as Delta Dental Plan) in order to reduce administrative costs and make more services available to more eligible people. The Delta-administered program has demonstrated that the private and public sectors can work together to create better, more effective use of public funds.

Since 1972, the dental services component of the Consumer Price Index has increased by 151% (186% for physician services component) while Denti-Cal's reimbursement rates have increased by 35.47% over the same period. The Denti-Cal program paid an average of 41% of dentists billed charges for 89 million dental claims in 1984. That figure has decreased even further since 1984.

Although CDA members are providing care at fee levels drastically below those normally charged for private patients, CDA supports the Denti-Cal program and encourages its members to participate primarily because of the profession's moral obligation in this regard, while

maintaining strong legislative efforts to increase reimbursement rates to a reasonable level.

Inclusion of Certain Benefits within Dental Care Plans (36RC-1985)

Resolved, that CDA recommend to ADA that its Council on Dental Care Programs advise third party payers that certain treatments, such as, but not limited to, pit and fissure sealants, fluoride rinses, bonded composite restorations, periodontal therapy, and other preventive and operative programs are currently within the accepted standard of dental care, and be it further

Resolved, that the California Dental Association, in concert with ADA, use all appropriate means to ensure that third party dental plans include as benefits all dental treatment which meets current standards of dental care.

CDS Policies and Procedures (15-1985)

Resolved, that the position paper regarding CDA policies and procedures developed by the Council on Dental Care, as revised, be approved, and be it further

Resolved, that the position paper be prominently noticed and published in the CDA Journal.

CDS Policies and Procedures

For several years, the insurance industry and other entities have methodically attempted to identify and standardize health treatment for reimbursement purposes. To this end, CDA has worked with the insurance industry and others in developing health benefits and scope of coverage in order that the public may receive reimbursement for health care. This relationship has been, in the main, successful. It will continue to benefit the public as long as the provider is free to exercise necessary professional judgment.

To assure a desirable level of care for the public, CDA has incorporated in its Code of Ethics and its peer review system a dedication to improve the dental health of the public. The association strongly resists any encroachment by third parties, or any other entity, that may preclude the exercise of professional judgment which could lead to lowering those standards of care long recognized by the dental community.

The purpose of this paper is to clearly state the problem between CDA and CDS regarding procedures and policies utilized by CDS in its role as a health care service corporation. It is hoped that the issues raised here will lead to a positive resolution of long-standing problems.

Background

CDS is a specialized health care service plan, licensed by the California Department of Corporations and governed

by the Knox-Keene Health Care Service Plan Act. Under that governance and through contracts with purchaser groups, CDS must provide to eligible subscriber groups, for a set premium paid by respective groups, comprehensive dental care as determined by standards of generally accepted dental practice. CDS in turn contracts with individual dentists to provide dental care services and these dentists become participating members of the corporation. In the CDS Participating Rules, signed by each participating dentist, it states that ". . . a participating dentist shall schedule and provide all dental treatment for eligible patients in accordance with applicable standards of the dental profession in his community."

Under Knox-Keene legislation, CDS must provide comprehensive, standard of care dental care under its plans. Services may be limited or excluded, but only by contractual agreement with the purchaser. If necessary, and upon agreement between the dentist and patient, services which are contractually limited or excluded may be performed. The patient is responsible for the entire fee in such instances.

The crux of the problem relates to the point that all services provided which do not fall within contractual limitations or exclusions are compared against standards of generally accepted dental practice as defined by CDS. Such services not within the standards are considered deviations and are the dentist's sole responsibility. Neither CDS nor the patients are financially liable.

CDS clarifies deviations (and other procedures) through processing policies. Processing policies are internal CDS procedures which actually are business controls and often serve to restrict the dentist's professional judgment. These deviations are defined by CDS as policies which reflect standard group contract limitations, plus provisions of the CDS Participating Dentist Rules and clarifications of what is accepted dental practice in specific instances.

In order to limit or exclude any dental service, CDS must indicate clearly in the subscriber contract what those limitations or exclusions are, in addition to delineating what portion of the fee is the responsibility of the covered individual (patient). According to the Knox-Keene Act, any charge in excess of the agreed upon copayment level which is made to the patient constitutes an illegal surcharge.

In summary, CDS' contractual limitations and exclusions—for which the patient may be charged—are not to be confused with CDS' internal processing policies, which may and do entail other limitations not set forth in the purchaser contract. Limitations not delineated in the purchaser contract, but rather handled under processing policies, conforming to standards of the dental community may not conform to CDS' definition of standards of generally accepted dental practice. CDS will not reimburse a dentist for procedures falling outside the processing

policy limitations, nor may the dentist charge the patient for those procedures.

Examples related to foregoing:

CDS contractual limitation: Oral prophylaxis is a benefit only twice in any 12-month period. The fee for additional prophylaxis is the patient's responsibility.

CDS contractual exclusion: Prescription drugs, premedication and analgesia are excluded. The fee is the patient's responsibility.

CDS processing policy: Crown build-ups performed on the same date as the crown preparation are included in the fee for a total procedure. A separate fee may not be charged to the patient by the participating dentist.

Procedure Code 452

Problems with procedure code 452 (root planing) are long standing. This procedure code has become the focus of the current controversy between the association, CDS and the dental community and serves, for purposes of this paper, to illustrate the entire issue of policies and procedures' difficulties.

CDA, through the Council on Dental Care, and the California Society of Periodontists (CSP), was involved in discussions with CDS during the development of the new CDS periodontal reporting guidelines. CDS was very concerned about what it considered to be an over utilization of certain periodontal procedures, specifically root planing and subgingival curettage, which at that time were combined under procedure code 452. CDA advocated complete separation of the two procedures and, responding to CDS' expressed need to control its expenditures, suggested during one of the discussions that a limitation be placed on the root planing procedure in order for CDS to limit its liability. CDA further stated that four quadrants of root planing in 24 months would probably serve the majority of patients, under the concept of a contract limitation.

CDA naturally assumed that with contract limitation in place for this procedure, over utilization could be effectively controlled and that any limitation imposed on the root planing procedure would be handled in the same manner as other existing limitations such as prophylaxis, a contractual limitation, under which the patient is financially responsible for necessary procedures in excess of the limitation. CDS proceeded with the suggested 452 separation and adopted the 4-in-24 limitation for root planing (now procedure 452). However, rather than a contractual limitation, CDS added the root planing limitations to its processing policies in establishing four quadrants of root planing in 24 months as the standard of care.

In all of the discussions regarding the guidelines, CDA emphasized that the two year limitation must not be considered the standard of care; that it was rather a contract limitation standard and that the responsibility for payment of treatment deemed necessary beyond the limitation would be the patient's responsibility. It was never accepted by anyone present on behalf of the association, or the CSP, that necessary services in excess of the four in 24 limitation would be performed free of charge by the dentist provider.

Subsequent to implementation, many dentists learned of the policy through receipt of notice of payment forms indicating that neither CDS nor the patient were responsible for additional root planning procedures. CDS has responded to objections from the dental community by stating that its processing policies are guidelines, not an inflexible standard, and that additional root planning procedures may be billed either as procedure 452 (if justified to CDS as appropriate) or as follow-up procedures under code 450 (using this code, procedures in excess of contract limitation may be charged to the patient). However, when a claim is submitted for procedure 452, judged by the treating dentist to be a procedure 452, not a follow-up, if the four quadrants in 24 months maximum has been exceeded, normal claims processing procedures are followed, the claim is denied and the patient receives an adjustment notice indicating that the dentist may not charge a fee for the procedure. Even when the claim action is appealed by the dentist and subsequently approved (rarely), CDS has created a credibility problem between the doctor and the patient. CDS has stated that their position is nonnegotiable.

Problem

Because of the concentration on concerns related to procedure 452, it has appeared that the problem is 452. Procedure 452 per se is not the issue. Procedure 452 is merely the current, best example of what could become a most serious problem for the dental community. The issue is that of a third party establishing the standard of care.

When CDS, the first dental service benefit corporation in the country, was established, it sought and received input from the California Dental Association and many procedures and policies were the result of deliberations with the profession. As CDS evolved, and as other third party carriers began to finance dental care through insurance coverage, CDS' original, generally accepted standards of care policies, developed by dentist participants, were shifted to a composite group representing management (dentists and non-dentists), lay persons and dentists. The shift from the profession setting the standards to CDS setting the standards was critical. In hindsight, it seems clear that CDA should have been more forceful in stating that standards of care had actually become scope of coverage tied to standards of care and that the not so subtle difference was critical.

The danger now, it would seem, is that with the recent shift of CDS' board to lay member majority, CDS' standards of care may translate increasingly to scope of coverage. The shift to more limitations handled under processing policies denials is not difficult to imagine.

It must be stressed that CDA understands scope of coverage philosophy, procedures and necessity. It must also be stressed that CDA understands the critical difference between scope of coverage and standard of care. Procedure 452 limitations can be understood and accepted under scope of coverage, but not under standard of care when that standard is in fact business processing policy limitation.

Continuation and expansion of their processing policy concept could well open the door for CDS, or any payment plan, to adopt other limitations as processing policies. One can speculate on the effective marketing tool this could provide in the dental benefits marketplace. If, for example, CDS would delete the current contractual limitations and make them processing policies, an enhanced benefits package could be sold for the same premium, positively affecting CDS' marketing position at the possible expense of many California dentists.

Faced with such problems, it is likely that many dentists will become increasingly reluctant to provide necessary dental care when they know they will not be reimbursed. This could, in turn, lead to more malpractice litigation.

It appears that all possible dialogue with CDS has been exhausted without any resolution of the problem. However, CDA's position remains unchanged. CDA will continue to vigorously resist any encroachment on the professional judgment of the dentist by third parties. The association will also make every effort to preserve the integrity of the dentist-patient relationship.

The foregoing leads to the following question. When the dentist signs a participating agreement requiring him or her to provide treatment in accordance with applicable standards of the dental profession in the community and subsequently the third party institutes procedures which preclude attainment of those standards, has there been a breach of contract? It is necessary that this question be answered.

Predetermination of Benefits (42-1975)

Resolved, that CDA approve the concept of predetermination of benefits, but that it oppose the concept of reducing or eliminating benefits solely because this step was not followed, and be it further

Resolved, that this concept be included in the CDA requirements for prepaid dental care plans.

Guidelines for Dental Consultants (39-1975)

Reference: Rescinded by 38-1990

Guidelines for Dealing with Dental Care Programs (35-1973)

Reference: Rescinded by 40-1990

Direct Reimbursement

Internet-Based Direct Reimbursement Software (30RC-2002)

Resolved, that the CDA executive director delegate to the appropriate entities/divisions the task of reviewing an internet-based direct reimbursement software program as to its technological soundness and any anti-trust implications, and be it further

Resolved, that these findings be reported and any recommendations forwarded to the 2003 CDA house.

Direct Reimbursement Promotion (27-2001)

Resolved, that CDA continue to promote direct reimbursement (DR) to its members and the business community as a membership benefit until the 2002 house of delegates, and be it further

Resolved, that a DR business plan be developed and presented to the March 2002 board of trustees and if the promotion of DR is transferred to a CDA for-profit subsidiary, DR will continue to be promoted regardless of profitability, and be it further

Resolved, that the business plan include the investigation of an outside TPA using existing CDA brokers to handle the leads from CDA members and the ADA.

Direct Reimbursement (19RC-1998)

Resolved, that it is CDA policy to ensure its continued commitment to direct reimbursement (DR) as a membership benefit, with the awareness of the DR program's inability to generate revenue, and be it further

Resolved, that with the oversight provided by the DR committee, CDA will continue to promote DR in its traditional form and market DR via CDA's broker network, and be it further

Resolved, that DR marketing efforts be expanded at this time into small and mid-sized employer market segments, and other association/affinity groups, that a trained broker network be supported and expanded within these

marketing efforts, and other external marketing methods be explored, and be it further

Resolved, that funding be maintained to oversee other DR activities such as member education, member lead follow-up, component resource and promotion of DR to companies not willing to work with a third-party administrator (TPA) or broker, and be it further

Resolved, that CDAHCI through its information technology department, work to evaluate and/or develop the concept currently identified as "electronic DR," and be it further

Resolved that the House of Delegates recommends that the DR committee and staff, and any necessary consultants, research and report back to the 1999 House of Delegates the feasibility of transitioning the broker for-profit subsidiary as a self-sustaining business by the year 2002, and be it further

Resolved, that the CDA DR committee continue to work with DR staff and serve as a liaison between the CDAHCI for-profit subsidiary through the CDA board of trustees, CDA members and staff.

Direct Reimbursement Claims Administration (45-1995)

Resolved, that CDA appoint Schultz Rowson/Direct Reimbursement Benefit Plans as its endorsed direct reimbursement claims administrator, contingent on finalization of an acceptable contract between Schultz Rowson and CDA/TDC, and be it further

Resolved, that a portion of existing DR advertising/promotion monies be used, as deemed expedient, for commissions to benefits brokers who sell the DR concept to employers, and be it further

Resolved, that regular updates be provided to the House of Delegates and Board of Trustees regarding the effectiveness and cost efficiency of broker involvement in CDA's DR promotion program.

Establishment of Direct Reimbursement Standing Committee (17S1-1992)

Reference: Superseded by 6-2003, dissolving the committee and assigning oversight of direct reimbursement issues to the Council on Dental Care.

Direct Reimbursement Promotional Program (57RC-1990)

Reference: Superseded by 17S1-1992

Direct Reimbursement (30RC-1985)

Reference: Superseded by 57RC-1990

Discount and Pre-Paid Plans

Supplementary Recommendations for Prepaid Dental Care Plans (14-1977)

Reference: Rescinded by 39S1-1990

Acceptance of Prepaid Plans (12-1977)

Reference: Rescinded by 39S1-1990

Evidence-Based Dentistry

Evidence-Based Dentistry (23S1-2000)

Resolved, that the Council on Dental Care and the Council on Dental Research and Developments, in concert with the Division of Communications and Marketing, develop an action plan to disseminate information regarding evidence-based dentistry and its potential for abuse, including the full budgetary impact for presentation to the fall 2002 Board of Trustees.

Government Programs

Medi-Cal Dental Providers (6RC-2022)

Resolved, that the appropriate CDA entity engage with the state to push for regular review of the sustainability of dental provider rates in the Medi-Cal Dental Program and explore funding opportunities to increase rates and promote access to care throughout the State of California, and be it further

Resolved, that the appropriate CDA entity gather data and feedback from dentists, including enrolled and non-enrolled providers, to help inform the state about program adjustments that can be made to reduce administrative burdens and barriers to care, and be it further

Resolved, that the appropriate CDA entity work with dental societies and the state to educate dentists about the Medi-Cal Dental Program, including changes to benefit design, provider enrollment, billing and rates, and be it further

Resolved, that the CDA Board of Directors be urged to allocate appropriate funds for such actions, and be it further

Resolved, that a report be provided to the 2023 House of Delegates regarding this activity.

Geographic Managed Care (45RC-2010)

Resolved, that based on consistent research findings over a 15-year period, CDA actively pursue the directive of Resolution 17RC-1996, to oppose expansion of geographic managed dental care (GMC), and seek elimination of geographic managed dental care in Sacramento, and, be it further

Resolved, that as an initial step toward the elimination of mandatory patient participation in GMC Sacramento, efforts be undertaken to allow voluntary patient participation in GMC Sacramento, and be it further

Resolved, that the appropriate CDA entity determine whether clear performance measures of the GMC plans exist and if so, work to ensure enforcement of such performance measures up to and including significant payment withhold for performance failure, and be it further

Resolved, that should no such performance measures exist, CDA work with the State Department of Health Care Services, the Sacramento District Dental Society and any other appropriate agencies to develop such measures and appropriate penalties for failure to comply.

Examination Benefit Under Denti-Cal (31-1997)

Resolved, that Examination Benefit Under Denti-Cal (28-1983-H) be amended as follows:

"Resolved, that CDA works with the State Department of Health Services to provide for compensation of dentists for the performance of examinations on Denti-Cal patients each time an examination is rendered. This compensation shall be provided whether or not images are utilized in the examination."

Geographic Managed Dental Care (17RC-1996)

Resolved, that the California Dental Association opposes any expansion of the state geographic managed dental care pilot program and supports elimination of the Sacramento pilot program, due to the lack of evidence to support the stated goals of cost-savings, increased access and improved quality of care as reported by the state of California.

State Mandated Dental Care Programs (37RC-1995)

Resolved, that it is the position of the California Dental Association that state mandated dental care programs should assure eligible recipients' equal access to care through the freedom to choose their own dentists, and be it further

Resolved, that all eligible recipients who seek dental care on a fee-for-service basis are assured access to care without discriminating against any licensed provider.

Pit and Fissure Sealants for Children Served by Medi-Cal (85-1990)

Resolved, that the California Dental Association vigorously pursue all legislative and/or regulatory avenues for achieving its stated policy of making pit and fissure sealants available as a preventive measure to all children served by the Medi-Cal program.

Reference: See California Child Health and Disability Prevention Program (13-1992)

Denti-Cal Compliance with Accepted Standards of Care (37-1990)

Resolved, that the California Dental Association take appropriate action to bring the Denti-Cal program into compliance with accepted standards of care and inform the state and the fiscal intermediary that the present method of benefit administration is inconsistent with accepted ethical, academic, and community standards of care, and be it further

Resolved, that Resolution 25-1983-H be rescinded.

Reform of Denti-Cal Program (51-1989)

Resolved, that the California Dental Association join with other interested groups in California to seek reform of the Denti-Cal program.

Examination Benefit under Denti-Cal (28-1983)

Reference: Amended by 31-1997

Denti-Cal Utilization Control - Compliance with Standard of Care (25-1983)

Reference: Rescinded by 37-1990

Health Care Reform

Expanding Access to Oral Health Care Coverage (16RC-2006)

Resolved, that the "Expanding Access to Oral Health Care Coverage" policy statement be adopted.

Expanding Access to Oral Health Care Coverage

Oral health is integral to general health and is essential to the overall health and wellbeing of all individuals.

Consequently, access to oral health care is a matter of importance for all Californians.

The California Dental Association supports the expansion of access to oral health care, including extending systems of oral health care coverage to groups that have traditionally been uninsured and who have been without access to existing public health programs and commercial dental insurance. CDA supports inclusion of oral health care benefits in any basic or essential health care benefit plan, provided such programs incorporate the following general principles:

- 1) Expansion of oral health care benefits should not be equated with a government-run, single-payer system of coverage for everyone; expanded access for the uninsured should be achieved through a variety of means, and should not prohibit or discourage comprehensive private insurance or payment for care through other resources.
- 2) Providing comprehensive oral health care coverage to all Californians is a desirable goal, however economic realities in the private sector, and fiscal realities in the public sector, may make establishment of systems to provide comprehensive dental care coverage unfeasible. Given these limitations, systems to expand access to oral health care benefits to the uninsured should also meet the following parameters:
 - A) The integrity of the dentist-patient relationship in determining appropriate treatment approaches must remain paramount.
 - B) The scope of benefits shall adhere to the following priority of treatment objectives:
 1. Relief of pain and treatment of infection.
 2. Prevention of oral diseases.
 3. Elimination of oral diseases that exhibit a worsening prognosis.
 4. Return of oral function.
 - C) The scope of benefits of any dental care program must drive the funding of the program.
 - D) Fair payment to providers must cover the actual cost of treatment and reasonable overhead.
- 3) Funding for and administration of oral health care should be separate from the administration and funding of the medical side of any system of expanded access to care in order to protect the long-term integrity of the oral health care program.

Participation in Debate on Health Care Reform (32-1997)

Resolved, that *Participation in Debate on Health Care Reform* (18RC-1994-H) be amended as follows:

Resolved, that the California Dental Association participate in national and state efforts to:

1. Ensure that organized dentistry be included in discussions of public health reform policy.
2. Ensure the continued tax deductibility of dental benefits.

Rescission of Dental Health Care Task Force Policy (26-1997)

Resolved, that the Dental Health Care Task Force (38S4-1993-H) policy, shown in Attachment A, be rescinded.

Participation in Debate on Health Care Reform (18RC-1994)

Reference: Amended by 32-1997

Equal Reimbursement for Same Service (7-1994)

Whereas, it is critical that those dentists who may wish to participate in a health care reform program, or who provide services that may be included in a health care reform benefits package (such as trauma or reconstructive surgery), not be excluded or discriminated against based on their medical or dental degree, and

Whereas, the American Medical Association has adopted a policy that non- M.D.s be reimbursed less than M.D.s for performing the same services, and

Whereas, it is CDA policy to oppose discrimination by health benefit plans based on the medical or dental degree of the provider, be it

Resolved, that the California Dental Association will strongly advocate that health care reform legislation specifically contain protection against discrimination based on the medical or dental degree of the provider.

Dental Health Care Task Force (38S4-1993)

Reference: Rescinded by 26-1997

Hospital Issues

The Dental Patient Hospital History and Physical Examination Privilege (29-1990)

Resolved, that the position paper entitled *The Dental Patient Hospital History and Physical Examination Privilege* be approved.

The Dental Patient Hospital History and Physical Examination Privilege

The Board of Commissioners of the Joint Commission of Accreditation of Healthcare Organizations has adopted a revised version of the Medical Staff Chapter of the Accreditation Manual for Hospitals. The document identifies physicians and other qualified individuals as potential hospital staff members, and deletes specific identification of dentists from the composition of the medical staff. In effect, however, the role of the dentist in the hospital remains unchanged.

Dr. Charles McCallum, the ADA's commissioner for the Joint Commission on Accreditation of Healthcare Organizations Board of Commissioners (JCAHO), stated, "The new standards are more flexible, and far less prescriptive, so, rather than having things prescribed at a national level, more decisions will be made at a local level. This is why dentists should become more active and make sure that they have input at the local level. This is not inconsistent with the whole flavor of decentralization and deregulation that is going on today."

Another significant change affecting dentistry also appears in the JCAHO manual. Following many years of persuasive effort by the American Dental Association, JCAHO finally agreed to review the issue of permitting qualified dentists to perform hospital admitting history and physical examinations. Following a lengthy and in-depth study, the JCAHO concluded that some oral and maxillofacial surgeons are so qualified.

As a consequence, the current edition of the JCAHO Accreditation Manual states, "A qualified oral surgeon who admits patients without medical problems may complete an admission history and physical examination if they have such privileges, and may assess the medical risks of the procedure to the patient, if qualified to do so." This new standard specifically states that qualified oral surgeons may perform the admitting history and physical examination, and assess the medical risks, only for their own healthy patients, if granted that privilege by the hospital at which they are a staff member.

This JCAHO policy is not a mandate and applies only to oral and maxillofacial surgeons who have successfully completed a graduate program in oral and maxillofacial

surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education. This means those individuals completing an ADA-approved residency in oral and maxillofacial surgery are qualified under the JCAHO guidelines.

The reason oral and maxillofacial surgeons are now allowed this privilege is that their hospital-based, four-year formal residency programs document that sufficient training and experience is provided in patient evaluation and physical diagnosis, and there is adequate clinical experience to qualify them to assess the risk of surgery and anesthesia. A core medical/surgical year includes a minimum rotation of four months on general surgery, two months on internal medicine and four months on the anesthesia service.

Dentistry, in general, has made deep inroads with this new JCAHO standard. It is anticipated that, with time, experience and specific training program modifications, the application of this privilege expansion may be extended to additional qualifying disciplines within dentistry.

How does the qualified dentist gain this privilege at his own local hospital? Frequently, with difficulty. Dentists must now ask that medicine share something that organized medicine believes it holds exclusively and need not share.

Since the Joint Commission's action, there is an increase in the number of hospitals in the state of California which have rules and regulations which limit oral and maxillofacial surgeons' ability to perform admitting history and physical examinations. Why? Because the California Medical Association (CMA) has advised its members to ignore the JCAHO position on dental history and physicals. They emphasize that Title 22 provisions supersede the Joint Commission on Accreditation of Healthcare Organizations. CMA has also published model medical staff bylaws that do not recognize the hospital history and physical examination privilege for qualified oral and maxillofacial surgeons.

It will take time for California law to catch up with the new standards of the Joint Commission on Accreditation of Healthcare Organizations. It also will require considerable effort to make that happen. The true impediment to qualified dentists performing their own complete admitting history, physical evaluation and risk assessment for the patients they hospitalize is local community hospital bylaws, rules and regulations.

To arrange a change in the way things are done in the hospital, either the hospital organized staff bylaws must be changed, hospital by hospital, or a new state law must force change, in umbrella fashion, upon all hospitals across the state to accept complete admitting hospital history and physical examinations by qualified dentists. To

accomplish this, either separate legislation is required regarding hospital dental patient care, or a change in Title 22 is needed. This solution would obviate the need for struggling with each individual local hospital in order that the qualified dentist be given the patient examination privilege.

The Council on Hospital, Geriatric and Prosthetic Dentistry has proposed that CDA seek new state legislation which would provide that dentists deemed qualified by the credentials committees of all California hospitals be granted the opportunity to provide an admitting history and physical examination. CDA support of such legislation has resulted.

Texas is one state known to the CDA Council on Hospital, Geriatric and Prosthetic Dentistry that has implemented legislation mandating hospital history and physical evaluation by dentists. With minimal rewording, that Texas language could also work well in California.

Since the California Dental Practice Act already allows the dentist to perform patient physical evaluation, it seems best to alter the state Health and Safety Code by legislative action. The following specific language, if put into law, could solve the problem:

"A licensed general acute care hospital as defined in subdivision (a) of Section 1250 shall permit a qualified dentist to take complete case histories and perform complete physical evaluations, which may be used for the purpose of admitting patients to hospitals for the practice of dentistry, to the extent such activities are necessary in the exercise of due care in conjunction with the practice of dentistry as defined in Section 1625 of the Business and Professions Code, provided further that no dentist shall automatically be entitled to membership on the medical staff or to exercise any clinical privileges at a hospital merely because that dentist has a license to practice dentistry or because that dentist is authorized to take histories and perform physical evaluations as stated herein."

Meanwhile, concomitant with an attempt to change state law, it is advisable that dental members of each local hospital staff who feel qualified to perform their own complete patient admitting, history and physical evaluation band together and actively work to initiate appropriate changes in the bylaws of their local hospital. Such changes should be directed toward the individual dentist's qualification.

In dealing with the hospital staff, it should be made clear that qualified dentists are interested in performing history and physical examinations for their own patients only, for dental care only, and then only upon ASA Class I patients.

It must be emphasized that patients who present with medical problems would require a consultation by the

appropriate medical specialist, who would then assume responsibility for that physical infirmity during the patient's hospitalization.

Dentists performing the complete admitting patient history and physical examination will blend into routine hospital protocol if certain concepts are incorporated into the hospital regulations. The admission and preanesthetic history and physical examination should be categorized as a hospital privilege.

Just as for any other staff doctor, and for any other staff privilege, the qualified dentist may be required to demonstrate competence to perform history and physical evaluation through the appropriate hospital credentialing body. Each dentist credentialed by the hospital staff credentials committee would be assigned a preceptor, just as is done for any other hospital privilege.

At the end of a specific preceptorship period, the preceptor's objective evaluation of that dentist's physical evaluation of each patient would determine whether or not the routine admitting history and physical examination privilege is extended permanently. This system certainly would verify qualification by demonstration.

A medical history and physical examination taken by a physician does not relieve the dentist of his responsibility to that patient for total care. The physician does not necessarily understand the extent of the proposed dental procedure, so he really cannot accurately assess total risk to the patient. Only the dentist is really aware of the magnitude of the patient's proposed hospital care. Only that dentist can accurately determine the total physical risk to the patient for a specific dental and anesthetic procedure.

Despite the fact that a hospital currently requires that a physician perform the admitting history and physical examination, it is strongly urged that, for each individual admission, the qualified dentist perform and report a complete, well-prepared, carefully documented medical history and physical evaluation for every patient, and not simply limit patient appraisal to the head and neck. This way, with time, documentation will develop to permit comparison between what the dentist has recorded in the way of a history and physical examination and that which the physician has presented for the same patient. The dentist's history and physical report and risk assessment must be at least equal to that prepared by the physician.

Later, presentation of this documentation to the Hospital Bylaws Committee, Credentials Committee, Qualifications Committee, Executive Committee and, ultimately, perhaps even to the entire medical staff can demonstrate, unequivocally, the ability of qualified dentists to perform the history and physical examination and risk evaluation at the same level of expertise as their medical colleagues.

Hospital History and Examination Privileges (5-1985)

Reference: Superseded by 29-1990

Managed Care

Policy Concerning Managed Care (22-1993)

Resolved, that CDA supports the concept of dental care coverage since dental care is an essential component of total health care, and be it further

Resolved, that if any mandate for employer provided health insurance, including dentistry, is considered, CDA be proactively involved in negotiation and discussion; in the event coverage is put in place, such coverage should be separately funded and administered, and be it further

Resolved, that CDA's position be consistent with the American Dental Association's policies on dental care programs, and be it further

Resolved, that Resolution 48-1990-H is hereby rescinded.

Patient-Provider-Plan Communications

Toll-Free Telephone Service (30S1-2006)

Resolved, that Resolution 77RC-1990-H, Toll-Free Telephone Service by Third Party Carriers, be rescinded, and be it further

Resolved, that third party carriers be urged to continue to offer adequately staffed and maintained toll-free telephone service.

Preservation of Dentist-Patient Relationship (22-2001)

Resolved, that the ADA Board of Trustees be urged to take appropriate additional legal action in consultation with the division of legal affairs to preserve the sanctity of the dentist-patient relationship, and be it further

Resolved, that CDA applauds and appreciates the current work ADA is doing on behalf of the member dentist in advocating against third-party dental reimbursement interferences, and be it further

Resolved, that the CDA House of Delegates strongly recommends that its delegates to the 2002 ADA House of Delegates urge the ADA to raise advocacy against third-party dental reimbursement interferences to the highest priority in its strategic plan, and be it further

Resolved, that CDA urges ADA to increase its budgetary allowance so it may aggressively study and pursue methods to improve the patient reimbursement system from dental insurance companies.

Standardization of Third Party Post-Claim Forms (42-1995)

Resolved, that the California Dental Association bring to the 1995 American Dental Association House of Delegates a resolution for the appropriate agency to standardize third party post-claim communication forms.

Disclosure of Administration Costs by Third Party Payors (38RC-1994)

Resolved, that the Council on Legislation, or other appropriate CDA agency, be directed to actively pursue legislation, administrative actions, or regulatory actions requiring all third party dental payors to disclose to purchasers, consumers and appropriate state agencies the percentage of premium dollars actually spent on patient care (exclusive of quality control).

Insurance Company Review and Communications Concerning Appropriateness of Treatment (63S1-1992)

Resolved, that as a matter of policy, the California Dental Association is opposed to the practice of insurance companies communicating with patients regarding supposed inappropriateness of proposed treatment modalities, and be it further

Resolved, that as a matter of California Dental Association policy, insurance companies be informed that the welfare of the patient requires that conflicts regarding appropriateness of treatment not only be communicated to the dentist exclusively, but that the dentist should be able to hold this discussion specifically with the consultant who has challenged the treatment plan, if he/she so chooses, and be it further

Resolved, that as a matter of policy, the California Dental Association adopt the position that all insurance company reviews of treatment proposals, or actual treatment by specialty dentists, be conducted exclusively by consultants who share the same specialty, and be it further

Resolved, that the Council on Dental Care will further develop specific policies for relationships with third parties.

Claims Processing by Third Party Carriers (80S1-1990)

Resolved, that all third party carriers be urged to process all claims within 30 days.

Toll-Free Telephone Service by Third Party Carriers (77RC-1990)

Reference: Rescinded by 30S1-2006

Third Party Carrier Acceptance of ADA "Attending Dentist Statement" (76S1-1990)

Resolved, that third party carriers be urged to accept the ADA standard "Attending Dentist Statement" as an appropriate means of submitting claims for payment and predetermination of benefits.

Guidelines for Informed Consent (10-1988)

Resolved, that the Guidelines for Informed Consent, developed by the Judicial Council and the Council on Dental Care, be approved.

Guidelines for Informed Consent

Informed consent has been defined as a "... judge's groping efforts to delineate physicians' duties to inform patients of the benefits and risks of diagnostic and treatment alternatives, including the consequences of no treatment..." As such, the primary objective of providing this information should be to facilitate the patient's ability to make informed treatment choices and have more control over the direction of care, rather than to avoid legal action.

The guidelines contained herein are meant to assist you, the dental practitioner, in providing your patients with information necessary for the patient to make an informed decision on suggested modes of treatment. These guidelines are not all inclusive but have been developed to provide you with an understanding of the types of issues which should be addressed and, in some situations, suggested methods for presenting that information.

1. Do not consider any form you use as a substitute for taking necessary time with a patient to discuss treatment options.
2. Make clear and thorough notes of your meeting with the patient in the patient's chart.
3. Explain adequately and thoroughly any planned treatment or alternative methods, and the merits of each.
4. Disclose any risks, hazards and benefits of each proposed treatment plan.
5. Consider each patient's state of mind when providing treatment plan risks, hazards, benefits or alternatives.
6. If in doubt, suggest that the patient repeat what you've said to ensure the patient's understanding and/or provide a written description of the procedure to be performed, to be signed by the patient after he/she has reviewed and understands it.
7. Explain the proposed methods of treatment in clear layperson's language. Avoid confusing medical/dental terminology.

8. Clearly explain the conditions that could persist if treatment is neglected.
9. Explain to the patient that, as the chosen treatment progresses, other undisclosed conditions may be discovered that would require treatment at the same time.
10. Inform the patient that although projected results of the chosen treatment plan can be outlined in advance, no guarantee or assurance of results can be provided.
11. Disclosure to a patient need not be made for relatively minor risks inherent in common procedures when it is common knowledge that such risks inherent in the procedure are of very low incidence.
12. If a patient specifically requests that he/she not be informed, and this is a free, uninfluenced decision by the patient, the dentist should state this clearly in the patient's record. It is also suggested that the patient be asked to sign this statement.

Third Party Interference with Dentist/Patient Relationship (31S1-1985)

Resolved, that it is the policy of CDA that appropriate dental care is a matter to be determined solely between the dentist and the patient. Any interference by a third party payer with the determination of standard of care or any interference with the dentist-patient relationship through processing policies, payment or reimbursement mechanisms, or misleading information to insureds, is improper because it interferes with the provision of quality dental care and is contrary to the public welfare, and be it further

Resolved, that CDA take appropriate action such as public awareness campaigns, legislation or legal action to enforce this policy.

Provider Rights

Policy Opposing Discrimination Based Upon Medical/Dental Degree (7-1994)

Whereas, it is critical that those dentists who may wish to participate in a health care reform program, or who provide services that may be included in a health care reform benefits package (such as trauma or reconstructive surgery), not be excluded or discriminated against based on their medical or dental degree, and

Whereas, the American Medical Association has adopted a policy that non M.D.'s be reimbursed less than M.D.'s for performing the same services, and

Whereas, it is CDA policy to oppose discrimination by health benefit plans based on the medical or dental degree of the provider, be it

Resolved, that the California Dental Association will strongly advocate that health care reform legislation specifically contain protection against discrimination based on the medical or dental degree of the provider.

Opposition to Third Party Limitations on the Practice of Dentistry (62S1-1991)

Resolved, that the California Dental Association opposes any action or position of any health care provider organization that artificially imposes limits on the practice of dentistry, or any such action or position that prevents a licensed dentist from performing any and all of the professional activities for which he or she is licensed, and for which he or she can show evidence of training and current competency, and be it further

Resolved, that the House of Delegates mandates that the officers and staff of this association shall act expeditiously to counter any attempts to restrict the legal practice of dentistry by individuals or organizations outside of dentistry, its own associations, schools, and licensing authorities.

Entitlement to Equal Payment as Physician for Same Procedure (52-1975)

Resolved, that the California Dental Association adopt the concept that a legally qualified practitioner of dentistry shall be entitled to payment at least equal to that rendered physicians for performing the same procedure, when such procedure is allowed under a program offered by an insurance carrier, a service corporation, a trust fund, or under a governmental program.

Standard of Care/Quality Assurance

Unfair or Undiagnosed Treatment Recommendations by a Non Dentist – Whistleblower Protection (2-2022)

Resolved, that the appropriate CDA entity evaluate the current protections for whistleblowers and consider whether legislative or regulatory action is necessary to enhance those protections, and be it further

Resolved, that the appropriate CDA entity consider educational offerings for members related to whistleblower protections and dental ethics, and be it further

Resolved, that a report be provided to the 2023 House of Delegates regarding this activity.

Quality Assurance Position Paper (43-1997)

Resolved, that the *Quality Assurance Position Paper* (16RC-1988-A6) as shown in Attachment A be approved as amended.

Quality Assurance

Concern for the quality of services constitutes the very heart of the dentist's responsibility to the public.

The California Dental Association was the first dental organization in the United States to develop criteria to evaluate the quality of dental services rendered by its members. The association in 1975 developed a manual, *Quality Evaluation for Dental Care*, which outlines objective, valid, reliable and practical criteria to evaluate individual dental procedures. These criteria are used in conjunction with the association's peer review system, which was developed in 1976 to arbitrate disputes between dentists and patients. With objective guidelines available, a uniformly high level of quality measurement is available to consumers in California.

The association has also developed standards for the designs of prepaid dental care programs to enhance the quality of care. These standards outline service priorities so that meaningful guidelines are available to consumers and purchasers of dental insurance plans.

The association supports legislation and provision in the Dental Practice Act to maintain licensing boards and licensing examinations and also supports the development of national accreditation programs for training dentists, dental hygienists, dental assistants and dental laboratory technicians to assure that the quality of education remains high.

The association believes the dentist is uniquely qualified to render quality care to the public and maintains the dentist is ultimately responsible for the care rendered to the public. CDA is opposed to legislation allowing auxiliary personnel to provide services directly to the public until it can be demonstrated that the quality of care rendered is sufficient to ensure that quality care will be delivered.

Regulation of All Dental Care Plans (14-1996)

Resolved, that the California Dental Association urge the governor and state legislators to assure consistent quality standards of dental care in California, and be it further

Resolved, that CDA urge these quality standards for dental care be applied statewide by all appropriate state agencies, and be it further

Resolved, that the CDA Council on Legislation promote legislation to regulate all dental care plans under one state entity using uniform regulations.

Parameters of Care (18-1993)

Resolved, that the California Dental Association support the concept and development of parameters of care.

Maintenance of Emergency Drugs in the Dental Office (59S1-1991)

Resolved, that the California Dental Association is in support of the concept of maintaining emergency drugs in the dental office, and be it further

Resolved, that the nature of these drugs should be determined by the individual practicing dentist according to the needs of his or her practice and special training, and be it further

Resolved, that the California Dental Association opposes any efforts on the part of non-licensing third parties to impose their own emergency drug requirements upon dental licensees.

Quality Assurance (16RC-1988)

Reference: Amended by 43-1997

Policy on Promotion of High Standards for Health Care (53-1976)

Resolved, that the California Dental Association hereby adopt a formal policy that high standards of health care are not subject to compromise without injury to the public good; and that all deliberations and negotiations by the association and its representatives will be dedicated to the promotion of these principles.

Dental Emergency Care (66-1975)

Reference: Rescinded by 5-2009

Use of Images

Substitute the Word *Images* for *Radiographs* (32-1998)

Resolved, that the word "images" be substituted for the word "radiographs" in the following policy statements:

Interpretation of Images by Third Party Carriers (25-1979)

Resolved, that any and all interpretation of images by third party carriers be conducted by a qualified consultant of the carrier, and be it further

Resolved, that at no time should interpretation of these images requiring professional judgment be conducted

by anyone other than a licensed dentist, and be it further

Resolved, that any evidence which demonstrates violations of this policy should be forwarded to the Council on Dental Care for investigation and appropriate action.

Importance of Images as Benefit in Dental Care Plan (29S2-1989)

Resolved, that the California Dental Association communicate to third party payers and to dental benefit purchasers the importance of radiographic examination images in patient diagnosis and comprehensive treatment and that all images be included as a benefit whenever clinically indicated, and be it further

Resolved, that this resolution be presented to the ADA House of Delegates for their approval.

Third Party Denti-Cal Review of Images (27-1983)

Resolved, that CDA investigate qualifications of Denti-Cal and all other third party carrier personnel who are making clinical determinations on the basis of submitted images and other clinical data, and seek compliance with the California State Dental Practice Act, and be it further

Resolved, that CDA seek legislation requiring the identification of all dental consultants and further require the identification and signature of the dental consultant on all dental insurance claim forms that are altered or denied on the basis of images or other clinical findings.

Guidelines on the Use of Images in Dental Benefit Programs (31-1998)

Resolved, that the ADA policy entitled, *Guidelines on the Use of Images in Dental Benefit Programs*, be adopted as CDA policy, and be it further

Resolved, that the dental profession adhere to state law and the CDA *Code of Ethics* and ADA *Principles of Ethics and Code of Professional Conduct* whether submitting or reviewing dental images for the purpose of third-party reimbursement.

ADA Guidelines for Use of Images in Dental Benefit Programs (1995:617)

The American Dental Association's recommendations on selection criteria for images states that diagnostic imaging should be used only after clinical evaluation, review of the patient's history, and consideration of the dental and general health needs of the patient. The type, frequency

and extent of diagnostic images necessary for each individual patient will be provided in accordance with the dentist's professional judgment.

The Association believes that the following guidelines should be applied in the use of images in dental care plans:

1. Images should be generated only for clinical reasons as determined by the patient's dentist. Clinical images may be used as part of a system for determining those benefits to which the patient is entitled under the terms of a contract. However, third-party payers should not request that images be generated for administrative purposes and dentists should not comply with such requests.
2. When a dentist determines that it is appropriate to comply with a third-party payer's request for images, a duplicate set should be submitted and the originals retained by the dentist.
3. There are many instances in which a determination of care cannot be made solely on the basis of images and it is improper for third-party payers to deny care or make determinations about treatment that could not ordinarily be made without proper evaluation of the patient.
4. Third-party payers shall not use images to infringe upon the professional judgment of the treating dentist or to interfere in any way with the dentist-patient relationship. All questions of interpretation of images must be reviewed by a dentist consultant.
5. Patients should be exposed to radiation only when clinically necessary, as determined by the treating dentist. Postoperative images should be required only as part of dental treatment.
6. It is important that images be correctly identified and be of diagnostic quality.
7. Third-party payers should protect the confidentiality of all records, including images, which are submitted to them by dental offices. All images submitted to third-party payers should be returned to the treating dentist within fifteen (15) working days.
8. Images held by parties other than the treating dentist should not be transmitted to any agency or entity without written consent of the dentist or patient.
9. Where a claim or predetermination request indicates that images are provided, the third-party payer should immediately notify the submitting dentist's office if the images are missing.

10. A patient's predetermination request or claim should not be prejudiced by the third-party payer's loss or misplacement of images.
11. Images are an integral part of the dentist's clinical records and, as such, should be considered the property of the dentist where consistent with state law. Because it is necessary for a dentist to maintain accurate and complete records, third-party payers should accept copies of images in lieu of originals.
12. Any additional costs incurred by the dentist in copying images and clinical records for claims determination should be reimbursed by the third-party payer or the patient.

Denti-Cal Utilization Controls on Images (30-1997)

Resolved, that *Denti-Cal Utilization Controls on Radiographs* (26-1983-H) be amended as follows:

Denti-Cal Utilization Control on Images

Resolved, that the CDA determine if Denti-Cal utilization controls, as applied to images, comply with the guidelines set by the U.S. Department of Health and Human Services, the Food and Drug Administration, and the American Dental Association, and be it further

Resolved, that if the proper standard of care is not being adhered to, CDA should take steps to obtain compliance including the initiation of legislation if appropriate.

Use and Submission of Dental Images for Reimbursement (64RC-1997)

Reference: Superseded by 31-1998

Importance of Radiographs as Benefit in Dental Care Plan (29S2-1989)

Reference: Amended by 32-1998

Third Party Denti-Cal Review of Radiographs (27-1983)

Reference: Amended by 32-1998

Denti-Cal Utilization Controls on Radiographs (26-1983)

Reference: Amended by 30-1997

Interpretation of Radiographs by Third Party Carriers (25-1979)

Reference: Amended by 32-1998

Guidelines for the Submission of Dental X-Rays to Third Party Carriers (19-1977)

Reference: Superseded by 31-1998

Education, Licensure, Practice and Professional Relations

Allied Dental Health Personnel – Scope of Practice

Registered Dental Hygienists in Alternative Practice (38-2004)

Resolved, that CDA continue to support policies that confirm the dentist as the primary oral health care provider, and be it further

Resolved, that the appropriate CDA entity take action to ensure that patients are protected by supporting policies that encourage relationship development between dentist and RDHAPs for the purpose of providing high quality care to the patients being served by RDHAPs, and be it further

Resolved, that the appropriate CDA entity educate CDA members about RDHAP, including their training and responsibilities, liability, and/or any other practice models planned for advocacy, adoption and/or implementation.

Surgical Instrument Usage by Allied Dental Health Personnel (22-2002)

Resolved, that the Surgical Instrument Usage by Allied Dental Health Personnel position paper be adopted.

Surgical Instrument Usage by Allied Dental Health Personnel

The California Dental Association recognizes the current use of surgical instruments (curettes, lasers, scalpels) for soft tissue surgery by dentists, and members should be aware of the California Dental Association laser position paper. It strongly supports standardized education and training programs for those using these instruments as an adjunct to their practices. CDA supports training for all members of the dental team. Such training should include didactic, laboratory and clinical exercises specific to the procedure to insure clinical competency of the dentist and patient safety.

The standard of care and instrument usage for soft tissue curettage in dentistry is evolving and increased interest in the use of alternatives to standard instrumentation is reflected in the use of lasers by dentists as well as Registered Dental Hygienists (RDH). The Dental Board of California does not specifically restrict laser usage by RDHs. Current California law allows RDHs to use lasers in accordance with the customary standards of practice of the

dental community. Only those lasers, which have received approval by the FDA for the particular procedure, is allowed AND hygienists can only perform the procedure if it is currently allowed by law and regulation. No auxiliary may provide any service, including the use of a laser, if doing so would be beyond the scope of their education, experience and training (see Section 1684, Dental Practice Act).

Questions have been raised regarding the efficacy of soft tissue curettage. Soft tissue curettage in and of itself or combined with scaling and root planing, some case studies notwithstanding¹, has not been shown to reduce periodontal inflammation or improve healing over that achieved by scaling and root planing alone².

CDA supports the premise that the dentist is responsible for the patient safety in his/her care. Education on the use of lasers is readily available to dentists and registered dental hygienists. Therefore, it is the position of the California Dental Association, that any dentist selecting laser instrumentation as an adjunct to their practice, should insure that he/she and/or the dental hygienist is operating surgical instruments in a safe manner, and in accordance with the scope of the practice of his or her license, OSHA and ANSI laser safety and staff training requirements.

Intra-Oral Use of Surgical Instrument by Auxiliaries (25RC-2001)

Reference: Superseded by 22-2002

Policy on Allied Dental Health Personnel (13RC-2001)

Resolved, that the revised Policy on Allied Dental Health Personnel be adopted as amended.

Policy on Allied Dental Health Personnel

Background: At the direction of the 1998 CDA House of Delegates, the Council on Education and Professional Relations (CEPR) reviewed association policies within its purview for timeliness and appropriateness, and forwarded recommendations to the Board of Trustees regarding amendments, rescission, and sunset dates for those policies. The board approved the council's recommendation to rescind Resolution 37-1988, Allied Dental Health Personnel, and further directed the council to develop a policy on Allied Dental Health Personnel that reflects current trends and CDA's role in allied dental health personnel issues.

¹ Gregg, RH, McCarthy D, Laser Periodontal Therapy: case reports, *Dent Today* 2001;20:10

² Dederich DN, Drury, GI, Laser Curettage: where do we stand, *J Cal Dent Assoc* 2002;30:5

Dental Hygiene: Current statistics, as well as reports from CDA's components and practicing dentists, indicate that there is a statewide shortage of dental hygienists. The Board of Dental Examiners report that there are 13,644 dental hygienists with active licenses, and 28,945 dentists with active licenses in California, which translates to a 2.15 ratio of dentists to hygienists. Additionally, statistics show that there are a larger percentage of dental hygienists that practice on a part-time basis as compared to their dentist employers, and dentists traditionally remain in their profession longer than dental hygienists. In fact, only 45% of dental hygienists remain in the career 15 years or longer.

It is anticipated, however, that the dental hygiene shortage problem will be reduced slightly in the next few years due to several issues. First, there are three new dental hygiene programs (Santa Rosa Community College, Southwestern College and Shasta College) that have recently enrolled their first classes of dental hygiene students. Another program is under development in Stockton. The addition of these four programs will increase the number of ADA accredited hygiene programs in California from sixteen (16) to twenty (20) with an enrollment capacity in excess of 500.

Second, the Committee on Dental Auxiliaries (COMDA) has recognized a 16 percent increase in the number of dental hygiene examination candidates since 1996, which has been affected, in part, by dental hygiene candidates who are returning to California to take the dental hygiene examination after having completed dental hygiene education programs in other states. To meet the increased number of out-of-state dental hygiene examination candidates and the number of anticipated new dental hygiene graduates, COMDA has agreed to add a third two-day dental hygiene examination to its annual schedule beginning in the year 2000.

Additionally, it is anticipated that the recent creation of the RDHAP category will provide an avenue for career growth that will encourage retention among dental hygienists. CDA should consider legislative solutions such as licensure by credential for dental hygienists and allowing foreign-trained dentists and senior dental students to be eligible for the dental hygiene licensing examination.

These positive measures, however, do not assure a solution to the statewide dental hygiene shortage. The increase in the number of dental school graduates, the influx of graduates of non-accredited dental schools, and issues such as licensure by credential will impact the demand for dental hygienists. CDA should continue to monitor the effects of these developments and continue to encourage expansion of dental hygiene educational opportunities.

Dental Assisting: Dentists recognize a shortage of qualified dental assistants in all geographic areas of California. Information from recent surveys completed by both dental

assisting and registered dental assisting education program leaders indicate that programs are having a difficult time filling their classes. Additionally, dentists report that many of the candidates for dental assisting positions have difficulty in conforming to the traditional aspects of employment in the health care field. These generational differences and the transitional mindset of the young workforce results in a high turnover rate.

This phenomenon is not specific to dentistry. Labor statistics show that non-college graduates under the age of 25 remain at a job 3.3 years. Contributing to this statistic is the low unemployment rate that encourages today's employees to look at more attractive career options, and provides the opportunity for dental assistants to move easily from one dentist employer to another.

CDA should continue to support existing programs that help assess the problems in retention among dental assistants and should continue to take action to help inform dentists of ways to retain their staff. For example, in 1995 the Council on Education and Professional Relations mailed surveys to over 2,800 RDA's and almost 1,200 RDH's to assess the reasons that individuals are attracted to dental auxiliary careers, and reasons why these individuals either remain in or leave the career. Results of this survey were printed in an article entitled, "RDA and RDH" Retention Surveys in the July 1996 issue of the *CDA Journal*. The issues most frequently cited by RDA's for leaving the career were lack of employment benefits and lack of respect by employers.

CDA should continue to include these issues in the discussion of auxiliary scope of practice as part of its California Dental Law Course. Additionally, CEPR's activities in developing several formats for allied dental health symposia that address the issue of staff retention and respect, and assisting CDA's components in presenting these symposia, should be continued.

CEPR's Auxiliary Recruitment and Retention Program is an integral part of the solution to the manpower shortage and should be continued. Recent projects directed at the field of dental assisting include the development of a brochure discussing career paths in dentistry, distribution of copies of the brochure to all public high schools and community colleges in California, and promoting participation in Dental Assisting Recognition Week which is annually sponsored by the California Dental Assistants Association. Current projects include the development of an in-office achievement program that provides an outline whereby dentists can evaluate and appropriately compensate dental assisting staff members, posting education information for dental assistants on the internet, and developing a dental career promotion display for dental office reception areas. The council also continues to promote its *On-the-Job Training Manual* through articles and the Internet and by providing an *On-the-Job Training Manual* for dentists to view and order at CDA's Scientific Sessions.

1201 Financial and Insurance Services should be encouraged to amend its RDA Scholarship program to include students of DA education programs.

In the regulatory arena, CDA should urge the DBOC and COMDA to adopt a less restrictive structure of delegating duties to dental assistants so that maximum career growth and utilization of qualified personnel may be achieved.

Dental Laboratory Technology: There is an impending crisis with regard to dental laboratory manpower. There are several issues affecting the current and future availability of dental laboratory technicians. One issue is a lack of economic incentive for individuals to enter the dental laboratory technology field. Most individuals entering the field earn only minimum wage. As skills and experience expand, wages increase, but still remain low. Only those who specialize in dental ceramics or become dental laboratory owners find that the field adequately meets their financial needs. As a result, fewer individuals are choosing dental laboratory technology as an entry-level career.

A second economic factor that is influencing the decrease in the number of dental laboratory technicians is the increase in the number of dentists who use foreign and out-of-state dental laboratories that offer discount mail-order laboratory services.

An additional concern regarding dental technology manpower is the number of current dental laboratory technicians who are approaching retirement age.

To help counter these factors and encourage retention of dental laboratory technicians, CDA should continue to contribute funds to scholarship programs sponsored by the dental laboratory industry to assist dental laboratory technicians who are applying for national certification. CDA should also support dental laboratory technology certification programs and encourage local components to invite dental laboratory technicians to their meetings to discuss mutual concerns with dentist-members.

REFERENCES

- 1) California Board of Dental Examiners Committee on Dental Auxiliaries
- 2) CDA's Council on Education and Professional Relations, RDH and RDA Retention Surveys, *CDA Journal*, 24(7): 29-40, 1996.
- 3) Employment trend information extracted from various articles printed in the Sacramento Bee, June 1999- August 1999.

Dental Assistants (14-2000)

Resolved, that CDA supports the career ladder for dental assisting and recommends that regulations in the dental assisting area encompass:

Continued and expanded performance of intraoral duties by dental assistants;

Protection of on-the-job training for dental assistants;

A system of education for advanced dental assisting duties leading to licensure, including the concept of specialized dental assistants, and a broad interpretation of the dental practice act related to delegation of duties in order to meet evolving technological and professional needs.

Placement of Actisite Fibers (12-1995)

Resolved, that the California Dental Association support the Board of Dental Examiners advisory statement on the placement of Actisite fibers by dental auxiliaries.

"Registered Dental Assistants and Hygienists in Extended Functions (EFs) are allowed to perform cord retraction of gingivae for impression procedures. Registered Dental Assistants are allowed to apply periodontal dressings. The procedure described does not fit either of these categories; therefore, auxiliaries would not be allowed to perform the procedure since any intra-oral procedure performed by an auxiliary must be affirmatively allowed in regulation."

Unsupervised Practice of Dental Hygiene (11-1992)

Resolved, that the California Dental Association is opposed to the unsupervised practice of registered dental hygienists, and be it further

Resolved, that the California Dental Association reestablish and maintain on an as-needed basis, a Committee on a Single Standard of Care for the purpose of developing and implementing association directives related to this issue.

Coronal Polish by Registered Dental Assistants (19-1989)

Resolved, that the California Dental Association support coronal polish by a registered dental assistant as part of a prophylaxis, and be it further

Resolved, that the California Dental Association support regulatory changes to broaden existing regulations to allow registered dental assistants to perform coronal polish as part of a prophylaxis, as well as under existing settings.

Role and Duties of Registered Dental Hygienists (18-1989)

Resolved, that the position statement on the Roles and Duties of Registered Dental Hygienists be approved.

Roles and Duties of Registered Dental Hygienists

ROLE: Registered dental hygienists are support members of the dental team to assist the dentist in providing dental care to the dentist's patients.

SUPERVISION: Registered dental hygienists should perform their duties under the direct, personal or indirect supervision of the supervising dentists. However, in those states which provide for both general and direct supervision of registered dental hygienists, the duties shall not be delegated to the registered dental hygienist by the supervising dentist until the patient has been initially examined and diagnosed by the dentist.

After the initial examination and diagnosis by the supervising dentist, additional examinations of each patient shall be completed by the dentist as determined by the customary practice and standards of the dental profession. Registered dental hygienists may not perform any additional dental treatment other than that which is contained in the written treatment plan until the supervising dentist has reexamined the patient and provided new or additional instructions.

DUTIES: Hygienists' duties are to support the dentist in the delivery of dental care. The duties should never be performed independently of the dentist's professional judgment or a separate treatment procedure outside of the dentist's supervision. Hygienists' duties are dental treatment. Therefore, the diagnosis for dental treatment and subsequent delegation of duties to registered dental hygienists must be made by a dentist.

Delegation of Auxiliary Duties (17-1989)

Resolved, that the California Dental Association endorse and support the Board of Dental Examiners' proposed regulatory language concerning the appropriate "Delegation of Auxiliary Duties," and be it further

Resolved, that the Board of Dental Examiners' proposed regulatory language concerning the appropriate "Delegation of Auxiliary Duties" be adopted as the formal position of the California Dental Association.

Delegation of Auxiliary Duties

1. Add Section 1065 to the California *Dental Practice Act* 1065. Responsibility of the dentist regarding treatment of patients.

- (a) The dentist has a continuing responsibility for determining the course and sequence of treatment for each patient.
- (b) Except as provided below, it is unprofessional conduct for a dentist to require or permit an auxiliary to perform any procedure on a patient not previously seen by that dentist unless the dentist has reviewed the patient's medical and dental history, performed a preliminary extra-oral medical and intra-oral examination and determined the course or sequence of treatment for the patient. A dental auxiliary may, however, perform the following duties (if permitted by law for that classification of auxiliary) prior to any examination of the patient by the dentist:

2. Expose emergency radiographs upon direction of the dentist.
3. Perform extra-oral duties or functions specified by the dentist.
4. Perform mouth-mirror inspections for oral cavity, to include charting of obvious lesions, malocclusions, existing restorations and missing teeth.

Allied Dental Health Personnel – Education and Licensure

Foreign-Trained Dentists Sitting for Hygiene Exam (45-2004)

Resolved, that the appropriate CDA entity study the feasibility of including foreign-trained dentists as being eligible to sit for the hygiene boards as one possible mechanism to address the hygiene shortage, and be it further

Resolved, that a report be provided to the 2005 House of Delegates.

Equitable Hygiene Exam Fees (39-2004)

Resolved, that the appropriate CDA entity be instructed to pursue an appropriate remedy to establish that the fee for taking the dental hygiene board exam is similar or comparable for all examinees.

ADHP Licensure (37S1-2004)

Resolved, that all new proposals for licensure being considered for dental school graduates be similarly promoted for all licensed allied dental health professionals to create parity in licensure.

Resolved, that a report be provided to the 2005 House of Delegates.

Dental Hygiene Admissions Criteria (27-2000)

Resolved, that the California Dental Association, through the Council on Education and Professional Relations, more fully examine and study the current statewide community college dental hygiene admissions criteria and policies, and be it further

Resolved, that if the study shows a need for guidance from CDA on dental hygiene admission criteria and policies, the Council on Education and Professional Relations explore possible means to influence the California community college system to modify the current admissions policies and procedures with the intent of returning to a more comprehensive system of dental hygiene candidate evaluation and selection, and be it further

Resolved, that a report and/or proposed action be forwarded to the 2001 CDA House of Delegates for its consideration.

Accredited Dental Hygiene Education Programs (22RC-1998)

Resolved, that CDA support only those registered dental hygiene education programs that are accredited by the Commission on Dental Accreditation.

Dental Hygiene Academia Acceptance Criteria (41RC-1995)

Reference: Superseded by 27-2000

Dental Hygiene Program (35S1-1994)

Resolved, that the Thirteenth District Caucus urge the 1994 American Dental Association House of Delegates to petition the Commission on Dental Education to remove the words "not for profit" from accreditation standard #1 of the Accreditation Standards for Dental Hygiene Programs.

RDA "Practical" Examination (65S1-1991)

Resolved, that the Council on Education and Membership Services request the Board of Dental Examiners to evaluate the registered dental assistant examination process with particular emphasis relative to the practical portion in order to more effectively achieve an examination that is consistent and standardized.

Dental Hygiene Licensure Requirements (38-1977)

Resolved, that graduation from an accredited dental hygiene program or completion of dental hygiene requirements in an accredited dental school education program be the essential pre-requisite for dental hygiene examination and licensure, and be it further

Resolved, that the California Dental Association take appropriate action to encourage the ADA to adopt this policy.

Experimentation and Training of Auxiliaries (57-1974)

Resolved, that the California Dental Association adopt a policy that experimentation in training and utilization of dental auxiliaries be carried out only under the auspices of or under the direction of an accredited dental school.

Allied Dental Health Personnel – Shortage

Address Hygiene Staff Shortage in the Dental Workforce (5RC-2022)

Resolved, that the appropriate CDA entity prioritize accordingly addressing the hygiene shortage by working closely with the California Dental Hygienists' Association, and other entities as appropriate, to determine different avenues to increase the number of hygienists in the workforce. Examples include, but are not limited to, increasing the number of hygiene schools, increasing the number of graduating students per class, as well as fast track dental hygiene licensing for foreign trained dentists and be it further

Resolved, that a report be provided to the 2023 House of Delegates regarding this activity.

Dental Office Staffing Task Force Report (9-2018)

Resolved, that the [Dental Office Staffing Task Force Report](#) be filed.

Dental Office Staffing (11-2017)

Resolved, that the appropriate CDA entity study and develop actionable statewide solutions in response to the dental office staffing shortage, and be it further

Resolved, that findings with recommendations be made to the 2018 House of Delegates.

Report on Expanded Duty of Dental Assistants and California Dental Hygiene Programs (43-2008)

Resolved, that the attached report regarding the number of graduating hygienists from California dental hygiene programs and the regulatory status of the expanded duty functions for registered dental assistants be filed in accordance with resolution 51-2007-H.

Reference: [Status of Expanded Duty Dental Assistants and California Dental Hygiene Programs](#)

Report on California Hygienist Graduates and Regulatory Status of Expanded RDA Duties (51-2007)

Resolved, that a report be brought to the 2008 House of Delegates regarding the number of graduating hygienists from California dental hygiene programs and the regulatory status of the expanded duty functions for registered dental assistants.

Report on Expanded Duty of Dental Assistants and California Dental Hygiene Programs (19S1-2007)

Resolved, that the response to resolution 47S1-2006-H "Status of the Expanded Duty of Dental Assistants and Hygiene Programs" be filed.

Status of Resolution 38RC-2005-H: Dental Assisting and Prophylaxis (47S1-2006)

Resolved, that the response to resolution 38RC-2005-H, Dental Assisting and Prophylaxis be filed, and be it further

Resolved, that the Policy Development Council provide a report to the 2007 House of Delegates on the following issues:

- the regulatory status of the expanded duty functions for registered dental assistants;
- the number of new dental hygiene programs in the State of California; and
- the number of expected graduates from all dental hygiene programs in California for the years 2008, 2009 and 2010.

Hygiene Program Accreditation/Program Development Team (41-2006)

Resolved, that Resolution 31RCA-2004, "CDA Accreditation Program Development Team," be rescinded, and be it further

Resolved, the unused funds be reallocated to the CDA Strategic Fund.

Dental Hygiene Shortage (38RC-2005)

Resolved, that the Policy Development Council study increasing the scope of practice of registered dental assistants to include the prophylaxis of type I and II periodontal cases under the direct supervision of a licensed dentist following specified years of experience and additional training, and be it further

Resolved, that the Policy Development Council provide its findings to the Board of Trustees for review in time for the 2006 House of Delegates.

CDA Dental Hygiene Program (31RCA-2004)

Reference: Rescinded by 41-2006

CDA Dental Hygiene Program (31RCB-2004)

Resolved, that CDA approve the concept of a CDA-sponsored dental hygiene school, and be it further
Resolved, that the development of a detailed dental hygiene school business plan – to include a funding plan, site selection, faculty recruitment, admission policies, geographical equity – be referred to the appropriate CDA entity, and be it further

Resolved, that a status report on the progress of the CDA dental hygiene school be made to the 2005 House of Delegates.

Hygiene Feasibility Study (28-2003)

Resolved, that the House of Delegates file the report completed October 2003 on the feasibility of the California Dental Association initiating a dental hygiene educational program, and be it further

Resolved, that the report be acknowledged as completing the first phase of required analysis by addressing the concept of feasibility, and be it further

Resolved, that in order to complete the analysis the appropriate CDA entity undertake a practical study of the various operational models outlined in the feasibility study, and be it further

Resolved, that an educational business plan be developed for the recommended model(s), and be it further

Resolved, that a report be made to the 2004 House of Delegates.

Dental Auxiliary Shortage Action Plan (39-2001)

Resolved, that in keeping with the adoption of Resolution #33RC-2000-H, the Board of Trustees be directed by the House of Delegates to address the action steps noted in that resolution, and be it further

Resolved, that an action plan be presented not later than the summer session of the 2002 Board of Trustees, and be it further

Resolved, that the Board of Trustees forward a separate report to the House of Delegates on the issue of dental auxiliary shortage.

Feasibility of the Formation of a CDA Proprietary Dental Hygiene Education Program (36-2001)

Resolved, that the appropriate CDA entity undertake a study to assess the feasibility of the formation of a CDA proprietary dental hygiene education program, and be it further

Resolved, that the House of Delegates recommend that the Board of Trustees allocate up to \$20,000 from the CDA reserves to fund this study, and be it further

Resolved, that a report be made to the fall 2002 Board of Trustees.

Dental Auxiliary Shortage (33RC-2000)

Resolved, that CDA, its leadership and appropriate councils and committees acknowledge the dental auxiliary shortage as a crisis, assign it high priority and make use of appropriate resources, innovation, focus and response towards this need, and be it further

Resolved, that in accordance with CDA's new strategic plan, the appropriate CDA entity develop an action plan to address the issue, and be it further

Resolved, that the action plan be provided to the May 2001 Board of Trustees.

Dental Auxiliary Manpower (37-1988)

Resolved, that the House of Delegates of the California Dental Association approve the revised report as amended by the House and recommendations of the Council on Education and Membership Services on the issue of dental auxiliary manpower, and be it further

Resolved, that the House of Delegates of the California Dental Association approve the expenditure of \$2,000 to conduct a mailing to dental auxiliaries as specified in the report.

Auxiliary Manpower: The Role of the California Dental Association

The availability of qualified dental auxiliaries, particularly dental assistants, is escalating to crisis status for many California dentists.

Limited earning capacity and equally limited prospects for career advancement without additional educational training, coupled with the high cost and length of RDA programs, have resulted in prospective assistants entering other employment areas.

For young individuals who may be interested in dental assisting as a career, the limited earning capacity and career growth do not appear to merit the time invested

(time normally spent without income due to classroom requirements).

Dental assisting programs statewide are experiencing decreased enrollment and some have closed. With the decline in enrollment comes a comparative decline in the quality of individuals presenting themselves to dental assisting programs.

The shortage of dental hygienists may not be attributed to the same problems plaguing the dental assistant. Income for hygienists is very competitive with other career choices requiring equal education. While potential for career advancement is not significant without additional education and training, dental hygiene as a career provides flexibility in scheduling and high pay.

Dental hygiene programs throughout the state are full and have waiting lists of qualified individuals. Currently, in the State of California there are 16 ADA accredited dental hygiene programs. Historically, dental hygiene programs have tied their enrollment to that of dental schools. If dental school enrollment decreased seats available in dental hygiene programs also decreased. While seeming a logical response to avoid an oversupply of hygienists, this practice does not take into account that dentists remain in their chosen profession longer than dental hygienists. In order to increase the availability of dental hygienists, the number of programs and class sizes of programs must be increased.

The CDA Board of Trustees addressed this issue previously by passing a resolution to encourage the expansion of existing dental hygiene programs and the development of new programs in dental schools and community colleges. The Council on Education and Membership Services of the California Dental Association has reviewed the problems relating to availability of dental auxiliaries and has developed several recommendations to improve the current situation.

In determining the direction of the association, several major factors were considered: recruitment, career ladder, educational programs and existing requirements, component dental society involvement, and adequacy of licensure examinations.

Recommendations for CDA action follow:

1. SELECT Program Promotion of Auxiliary Careers: The ADA SELECT program has incorporated dental auxiliaries into its promotional materials and programs aimed at selecting quality applicants to dental schools/auxiliary programs.

It is the Council on Education and Membership Services' recommendation that CDA's SELECT committee follow suit, with emphasis primarily on dental assisting. As previously mentioned, dental

hygiene is not at a loss for applicants—merely slots to accommodate them. Dental assisting on the other hand is in need of applicants. By promoting the auxiliary career choices through the SELECT program in high schools and community colleges an increased awareness of these career choices will occur.

2. Mailing to RDAs/RDHs: The state Board of Dental Examiners has licensed nearly 43,000 dental auxiliaries (30,000 RDAs and 13,000 RDHs) since licensure for auxiliaries was implemented. It is estimated that there are 14,000 non-active (expired) licentiates and an unknown number of non-practicing yet still licensed auxiliary personnel. Additionally, within the active, licensed personnel there are several individuals who for whatever reason, have allowed their licenses to become delinquent (an individual has five years to renew their license before it actually expires, requiring relicensure).

This group of licentiates holding recently expired or delinquent licenses represents a significant pool of trained and qualified dental auxiliaries.

The intent of a CDA mailing to this group would be to communicate to them several items.

- A. Inform them of the current status of their license (particularly important for delinquent licenses) If they do not renew, the individual may be required to sit for examination again) and how to renew and/or reactivate.
 - B. Inform them of the shortage of qualified dental personnel.
 - C. Encourage them to return to the profession emphasizing that the shortage of personnel places them in an excellent negotiating position.
 - D. Provide them with a listing of CDA component dental societies to contact for additional information and/or placement.
3. The mailing would consist of a letter, listing of component dental societies and a yet-to-be determined article, brochure or copy of advertisement. Component Involvement: Development of grass roots involvement and cooperation within each component dental society with the respective dental assisting/dental hygiene programs in their locale (if applicable) and recruiting at high schools and community colleges.

The Santa Clara County Dental Society, for example, has advisory committees for both the vocational education and the San Jose City College dental assisting programs in their area. These advisory committees assist in setting the program, setting the curriculum, provide lectures and provide interest and

concern in the training of the individuals who take part in these programs.

Development of an in-house placement program for each component to assist dentists/auxiliaries in need of employees/employment. The Santa Clara County Dental Society has developed a placement program which assists both job seekers and job providers. Auxiliary personnel seeking a job contact the dental society, fill out an employment application stating their personal requirements. The staff of the dental society screens the applicants and then proceeds to match the needs of the seeker with those of a provider.

Santa Clara County Dental Society reports this service is one of, if not, the most used service provided by the society. Additionally, a service such as this would certainly enhance the dentist/auxiliary relationship and reinforce the dental team concept.

4. Dental Assisting Program: Encourage dental assisting programs to reduce the overall length of programs while at the same time emphasizing/increasing the clinical training and hands on experience of the participants.
5. On-The-Job-Training: Seek regulatory change to reduce the on-the-job training requirement from its current length of 18 months to a period of not less than 6 months to a year.
6. Evaluation of RDA Practical Examination: Request through a legislator that the Audit General of the State of California evaluate the overall efficacy of the RDA practical examination and recommend appropriate modifications.

The RDA practical examination requires that each applicant be prepared to perform four of the six procedures listed below. (Procedures to be performed are determined by examination committee prior to exam).

- Application of rubber dam
- Application of matrix band for amalgam prep
- Application of base/liner into a prepared tooth
- Application of periodontal dressing
- Application of temporary sedative dressing into prepared tooth

In 1987, 2,762 individuals took the RDA practical examination. The pass rate was 60%.

An investigation by the Auditor General would determine whether the RDA practical examination does in fact, adequately test an individual on the duties a registered dental assistant performs in a dental office.

Increased Dental Hygiene Class Size (13-1988)

Resolved, that CDA support the concept of increasing the class size for existing hygiene programs, and be it further

Resolved, that dental schools and community colleges without existing hygiene programs be encouraged to establish dental hygiene programs.

Continued Competency/Continuing Education

Continuing Education (28RC-2006)

Resolved, that the Policy on Continuing Education be approved.

Policy on Continuing Education

California Dental Association members have demonstrated their support of continuing education since the association's first annual meeting in 1870, when educational lectures on new developments and clinical techniques were presented. Today, the association continues that support through Scientific Sessions programs, online courses, and a speakers bureau. The association is committed to creating programs that promote life-long learning for a knowledge-based profession, and to increasing and enhancing educational opportunities. The association's Code of Ethics states that dentists have the obligation to advance their knowledge and keep their skills current by continuing education throughout their active professional careers. CDA firmly believes that the public health and safety is served by requiring dentists to continue their education after receiving their license to practice dentistry.

CDA strongly supports mandatory continuing education of a minimum 50 hours for dentists. The 50 units of continuing education is a reasonable amount of units for dentists to obtain during the two-year license renewal cycle. Moreover, the minimum 50-unit requirement offers sufficient education to enhance the dentist's skills and knowledge of new procedures and techniques. The mandatory requirement of 50 units of continuing education also encourages the dentist to learn and adopt new techniques and procedures to replace obsolete or less effective ones. Mandatory continuing education ensures that the dentist, who usually operates in an independent setting without supervision or review, obtains objective information and knowledge of recent developments in dentistry. Continuing education is but one dimension of continued competency.

The Dental Board of California began requiring in 1998 that all licensees take a required number of continuing education units on infection control and California Dental

Practice Act (formerly law), respectively. The impetus for the mandated courses originates with the Dental Board's citations and enforcement actions which identified licensees' deficiencies in these areas. CDA supports the Dental Board's ability to mandate courses in areas where licensees are deficient and believes that mandatory courses should be limited to those areas where the Dental Board has evidence of licensees' deficiencies.

CDA supports allied dental health personnel improving their knowledge and skills through continuing education. Except for registered dental hygienists in alternative practice (RDHAPs), state law requires licensed allied dental health personnel to complete 25 continuing education units every two-year license renewal cycle. RDHAPs are required to complete 35 units. Today's dental practices require personnel who keep current in many aspects of dentistry—from materials to patient communications to dento-legal areas. CDA's educational programs reach out to provide excellent training opportunities for the entire dental team.

Position Paper on Continued Competency (36RC-1998)

Resolved, that the revised CDA position paper on continued competency be adopted as amended as Attachment B, and be it further

Resolved, that this document be included in the next revision of the CDA Policy Manual.

Concept of Continued Competency

Continued competency as it relates to the practice of dentistry in California can best be defined as "ensuring that an individual licensed to practice under the Dental Practice Act retains and exhibits the requisite knowledge, ability and skills necessary to practice at or above the present standard of care."

It is indisputable that maintenance of clinical and didactic skills for dental professionals is desirable. The protection of the public and the self-governing responsibility of the profession dictates that the philosophical goal of the dental community should be to ensure that its licentiates are competent. However, it must be stated that no amount of clinical or didactic training will improve the ethical and/or moral conduct of individuals in their respective practice.

A method of determining and ensuring continued competency as defined above does not currently exist within the state of California. A system of mandatory continuing education does exist for all licentiates in California; of course, this is but one dimension of ensuring continued competency. CDA has consistently supported this system and firmly believes that the public health and safety is best served by requiring licentiates to continue their education after receiving their license to practice.

There are currently trends in both medicine and dentistry that increase the likelihood that post-licensure competency assessment could face the membership soon. Both the California and American Medical Associations have concluded that their members will be required to undergo this form of assessment and have become pro-active in adopting continued competency assessment programs.

In view of these trends, it is clear that the dental profession must address the issue of continued competency from a proactive position. California Dental Association has done this through the creation of the Quality Improvement Through Lifelong Learning (QUIL3) program.

In addition, given present trends related to post-licensure competency assessment, the association will best serve its members by closely monitoring regulatory and legislative bodies and managed care organizations which may seek to impose mandatory continued competency programs. California Dental Association should make every effort possible to have a pro-active and participatory role in the process of researching, defining, and developing such programs.

Until statistically valid data is available which clearly demonstrates the need for a mandatory continued competency program, the California Dental Association does not support this concept. Further study needs to be conducted to determine the current level of clinical competency among dental practitioners, including specialists and dental auxiliary personnel, in private practice settings. The Board of Dental Examiners and the dental schools should be involved in such a study.

Quality Improvement Through Lifelong Learning (Quil3) (14-1997)

Resolved, that the voluntary continued competency assessment project be replaced by a new program, the "Quality Improvement Through Lifelong Learning" Program (Quil3), and be it further

Resolved, that Quil3 be adopted as presented and made available to CDA members upon request, and be it further

Resolved, that responsibility to study, implement, and refine the Quil3 program be assigned to the Council on Education and Professional Relations upon adjournment of the 1997 House, and be it further

Resolved, that any further changes to the Quil3 program be approved by the House of Delegates prior to implementation.

Position Paper on Continued Competency (22-1991)

Reference: Superseded by 36RC-1998

Continuing Education (16RC-1988)

Reference: Superseded by 28RC-2006

Dental Education

Accreditation of International Dental Schools (9-2005)

Resolved, that CDA adopt policy that urges the Commission on Dental Accreditation to provide accreditation to international dental schools.

Dental Education Including After Hours On-Call Experience (59-1992)

Resolved, that CDA urge the five dental schools in the state of California to support and encourage programs which will provide each dental student with direct after hours on-call experience.

Reference: See Dental Hygiene Education (35S1-1994)

Graduates of Non-Accredited Dental Schools (45-1990)

Resolved, that California Dental Association policy regarding graduates of non-accredited dental schools' licensure is that such graduates should have training and competency to meet the standards of graduates of dental schools accredited by the Commission on Dental Accreditation, and be it further

Resolved, that in order to protect the dental health of the people of California, CDA seek legislation to repeal section 1636 of the Dental Practice Act and to require that graduates of non-accredited dental schools complete a course of study as proposed in the ADA policy on graduates of non-accredited dental schools, and be it further

Resolved, that CDA encourage all California dental schools to establish an international dental program to provide dental education leading to the D.D.S. or D.M.D. degree, and be it further

Resolved, that with the adoption of this policy, Resolutions 13S3-1984-H, 41-1987-H, and 25RC-1985-H will be rescinded as CDA policy.

Reference: See Protocol for Dental School Remedial Education Program (20RC-1984)

Educational Requirements for Graduates of Non-Accredited Dental Schools (41-1987)

Reference: Rescinded by 45-1990

Non-Accredited Dental Schools (25RC-1985)

Reference: Rescinded by 45-1990

Educational Course for Graduates of Non-Accredited Dental Schools (13S3-1984)

Reference: Rescinded by 45-1990

Use of DDS or DMD Degree (22-1978)

Reference: Rescinded by 22-1996

Dental Laboratories

Dental Laboratory [Resolution 28-2010-H] Report and Recommendation (6S1-2011)

Resolved, that the [report of the Dental Laboratory Task Force](#) be filed, and be it further

Resolved, that the appropriate CDA entity consider sponsoring legislation to require all commercial dental laboratories providing lab services to California dentists to provide written disclosure to the dentist of the materials used in, and the place of origin of, all dental prostheses fabricated by the laboratory and provided to the dentist for placement in a patient's mouth, and be it further

Resolved, that the appropriate CDA entity consider sponsoring legislation requiring all commercial dental laboratories providing services to California dental offices to register with the Dental Board of California, and be it further

Resolved, that CDA actively seek opportunities to improve collaboration with the California Dental Laboratory Industry and to communicate about dental lab issues through such venues as *CDA Presents*, *CDA Journal*, *CDA Update*, Component Dental Society meetings and continuing education offerings, and to encourage enhanced collaboration between California dental schools and dental laboratory technician education programs.

Issues Affecting Dental Laboratories and Dental Laboratory Technicians [Resolution 31-2009-H] Report (28-2010)

Resolved, that CDA consider sponsoring legislation in 2011 requiring all dental laboratories doing business in California to provide dentists with documentation of the materials used and place of origin of all dental prosthesis fabricated by the laboratory and provided to the dentist for placement in a patient's mouth, and be it further

Resolved, that the CDA President appoint a task force, made up of representatives from CDA, the dental

laboratory industry, the California dental schools, and other appropriate experts to evaluate ways to assist and enhance the stature and viability of the dental laboratory industry in California, and be further

Resolved, that the task force provide a report with recommendations to the 2011 CDA House of Delegates.

Issues Affecting Dental Laboratories and Dental Laboratory Technicians (31-2009)

Resolved that the attached progress report on Resolution 37RC-2008-H be filed, and be it further

Resolved, that a follow-up report be presented to the 2010 House of Delegates.

Registration of Dental Laboratories and Dental Laboratory Technicians (26-1991)

Resolved, that in the absence of compelling evidence of public safety concerns, and in the knowledge that the dentist is ultimately responsible for patient care, including the quality of dental prostheses, CDA opposes licensure and/or registration of dental laboratories and/or dental laboratory personnel, and legislation to accomplish that purpose, and be it further

Resolved, that Resolution 22S2-1990 is hereby rescinded.

Registration of Dental Laboratories and Dental Laboratory Technicians (22S2-1990)

Reference: Rescinded by 26-1991

Recognition of CDT's (22S1-1989)

Resolved, that the American Dental Association currently recognizes CDT's upon completion of 25 years of meritorious service to the dental profession. The California Dental Association endorses this recognition and recommends its continuance.

Elimination of State Tax on Dental Prostheses (50-1976)

Resolved, that the California Dental Association make every effort to eliminate the state tax now applicable to the fabrication of dental prostheses.

Concept of Statutory Control of Dental Laboratories and/or Dental Laboratory Technicians (60-1974)

Reference: Superseded by 26-1991

Registration of Dental Laboratory Technicians (9-1973)

Reference: Rescinded by 22S2-1990

Dental Specialties

Academic Standards (34-2000)

Resolved, that the California Dental Association has determined that an absence of mandatory minimum academic standards as a prerequisite to announcing dental specialty status or credentials poses a significant danger to the patients of California, and be it further

Resolved, that the California Dental Association has determined that successful completion of a formal, full-time advanced education program (graduate or post-graduate level) of at least twelve months' duration is one of the standards that must be met in order to announce credentials in areas of dentistry not recognized by the ADA as specialty areas, and be it further

Resolved, that the California Dental Association has determined that the successful completion of educational programs accredited by the Commission on Dental Accreditation, two or more years in length, as specified by the American Dental Association Council on Dental Education, or achieving diplomat status from an American Dental Association recognized certifying board, are among the general standards that must be met to announce specialization and limitation of practice in an area of dentistry approved by the ADA as a specialty area, and be it further

Resolved, that the California Dental Association urges the Dental Board of California to proceed immediately to adopt regulations to establish the foregoing academic standards as prerequisites to announcing dental specialty status or credentials in order to protect the public from potential harm, and be it further

Resolved, that if necessary, the Council on Legislation consider introducing legislation to set forth in state law academic standards as prerequisites to announcing dental specialty status or credentials in order to protect the public from potential harm.

Definition of Dentistry (43S1-1999)

Resolved, that the California Dental Association recognizes the need for a definition of dentistry, and be it further

Resolved, that the California Dental Association recognizes that this definition will provide latitude for future advances in education, training and technology, and be it further

Resolved, that the California Dental Association adopt the definition of dentistry, as adopted by the American Dental Association House of Delegates in 1997, which is as follows:

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

And be it further

Resolved, that the California Dental Association adopt the definition of public health dentistry as defined by the American Dental Association:

Dental Public Health is the science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is that form of dental practice which serves the community as a patient rather than the individual. It is concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs as well as the prevention and control of dental diseases on a community basis. (Adopted May 1976)

And be it further

Resolved, that the California Dental Association adopt the definition of endodontics as defined by the American Dental Association:

Endodontics: That branch of dentistry which is concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues. Its study and practice encompass the basic clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions. (Adopted December 1983)

And be it further

Resolved, that the California Dental Association adopt the definition of oral and maxillofacial pathology as defined by the American Dental Association:

Oral and maxillofacial pathology is the specialty of dentistry and discipline of pathology that deals with the nature, identification and management of diseases affecting the oral and maxillofacial regions. It is a

science that investigates the causes, processes, and effects of these diseases. The practice of oral pathology includes research and diagnosis of diseases using clinical, radiographic, microscopic, biochemical or other examinations. (Adopted May 1991)

And be it further

Resolved, that the California Dental Association adopt the definition of oral and maxillofacial surgery, as defined by the American Dental Association:

Oral and maxillofacial surgery is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region." (Adopted October 1990)

And be it further

Resolved, that the California Dental Association adopt the definition of orthodontics and dentofacial orthopedics as defined by the American Dental Association:

Orthodontics and Dentofacial Orthopedics: That area of dentistry concerned with the supervision, guidance and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and the adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex. Major responsibilities of orthodontic practice include the diagnosis, prevention, interception and treatment of all forms of malocclusion of the teeth and associated alterations in their surrounding structures; the design, application, and control of functional and corrective appliances; and the guidance of the dentition and its supporting structures to attain and maintain optimum occlusal relations in physiologic and esthetic harmony among facial and cranial structures. (Adopted December 1980)

And be it further

Resolved, that the California Dental Association adopt the definition of pediatric dentistry as defined by the American Dental Association:

Pediatric Dentistry is an age-defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence including those with special health care needs. (Adopted 1995)

And be it further

Resolved, that the California Dental Association adopt the definition of periodontics as defined by the American Dental Association:

Periodontics: That specialty of dentistry which encompasses the prevention, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and esthetics of these structures and tissues. (Adopted December 1992)

And be it further

Resolved, that the California Dental Association adopt the definition of prosthodontics as defined by the American Dental Association:

Prosthodontics: That branch of dentistry pertaining to the restoration and maintenance of oral function, comfort, appearance and health of the patient by the restoration of the natural teeth and/or the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes. (Adopted May 1976)

And be it further

Resolved, that when the definition of dentistry and/or a definition of a recognized ADA specialty is modified or added by the ADA House of Delegates, that this new definition will be automatically adopted as the new CDA definition.

Recognition of Dental Specialties (19-1994)

Resolved, that the following policy concerning recognition of dental specialties be approved:

It is the policy of the California Dental Association that it shall recognize only those dental specialties formally recognized by the American Dental Association.

Implant Dentistry (8RC-1993)

Resolved, that the California Dental Association does not support the recognition of implant dentistry as a dental specialty.

Special Permit in Oral and Maxillofacial Surgery (13RC-1991)

Resolved, that CDA approve the concept of a special permit in oral and maxillofacial surgery for dentists licensed in California as physicians, to be issued by the state Board of Dental Examiners, and be it further

Resolved, that CDA continue to support legislation to create such a special permit, and be it further

Resolved, that if this legislation is passed, CDA Bylaws amendments will be presented to the 1992 CDA House of Delegates as follows:

Chapter II, Section 20, a, 2c: Is a current holder of a special permit in oral and maxillofacial surgery issued by the state Board of Dental Examiners.

Denturism/Alternative Dental

Rescission of CDA Policy on Holistic Dentistry (35-1999)

Resolved, that the policy on holistic dentistry (1-1983-H) be rescinded.

Alternative Modes of Dental Care (34S1-1998)

Reference: Superseded by 35-1999

Denturism (16RC-1988)

Resolved, that CDA position papers on Continuing Education, Licensure by Credentials and Reciprocity, Peer Review System, Professional Advertising, Professional Liability, Quality Assurance and Sedation in the Dental Office be approved as submitted, and be it further

Resolved, that the CDA position papers on Auxiliary Supervision and Patient of Record, Performance of Restorative Functions by Dental Auxiliaries and Prevention of Dental Disease be remanded to the councils of origin for further evaluation, and be it further

Resolved, that the CDA position papers on PSRO's, Dentist Unions, Department Store Dentists be deleted, and be it further

Resolved, that the CDA position papers on Dental Benefits Plans and Denturism be approved as amended.

Denturism

The delivery of denture care frequently presents some of the most complex health problems encountered in dental practice. In California, only a licensed dentist who has extensive theoretical and practical education and training in all aspects of dental care is qualified to provide this important health service.

The denture is not an innocuous health aid. When an ill-fitting denture is worn for a time, serious problems can arise including abrasions, contusions, inflammation, overgrowth of soft tissues, rapid destruction of bone needed for denture support, and disturbances of jaw function. All of these problems can produce general health hazards, eating problems and difficulty in speaking.

Constant irritation, if continued over a long period, also can contribute to the development of benign and malignant tumors.

The overriding importance of the biological aspect of denture care has long been realized by the dental profession and has resulted in the delegation of the mechanical, extraoral phase of denture fabrication to the qualified dental laboratory technician. This has freed the dentist's time for various other phases of denture care that need his or her skills and knowledge: visual, tactile and radiographic diagnostic examination; diagnosis and treatment of existing conditions; impressions and study models; centric relations of the jaws; articulation; try-in fitting and adjustments; and follow-up examinations and adjustments.

CDA is opposed to allowing a person who has only mechanical skills in the laboratory construction of a denture only to provide the various other phases of complete denture care. To do so would be to ignore the anatomic, physiologic and psychologic variables in which the dentist has had extensive training in his or her professional education.

The Association recognizes the importance of providing affordable and easily accessible dental care, including denture treatment, to needy senior citizens. However, CDA believes these individuals are entitled to receive the same high standard of quality dental care which more affluent persons receive from fully trained and licensed dentists. For this reason, CDA has developed a program called Senior-Dent, to provide comprehensive, low-cost dental care to persons over age 60, through over 7,000 participating dentists statewide. Referrals to local dentists are obtained by contacting the CDA office directly, via a toll-free number. In addition, many local (county) dental societies have established dental care foundations, which provide lower cost care and assist needy senior citizens in paying for their dental care.

Policy on Holistic Dentistry (1-1983)

Reference: Rescinded by 35-1999

Elective Facial Cosmetic Surgery

Use of Botulinum Toxin and Dermal Fillers by Dentists (8-2018)

Resolved, that CDA seek a regulatory clarification from the Dental Board of California that the administration of botulinum toxin and dermal fillers in the peri-oral region as part of a comprehensive dental treatment plan is included within the current Dental Practice Act.

Note: The dental board responded to CDA's request for clarification in a letter dated April 8, 2019:

[Dental board's response to Botox clarification](#) (letter)

Licensure and the Dental Board of California

National Clinical Licensure Exam (10S1-2005)

Resolved, to rescind Resolution 28-2001-H, and be it further

Resolved, that CDA support the elimination of human subjects/patients in the clinical licensure examination process with the exception of alternative methods of licensure examinations that are carried out within the dental schools' curricula, and be it further

Resolved, that CDA support the concept of a national clinical licensure exam, and be it further

Resolved, that CDA approve the components of the "ADA Report of the Task Force on the Role of Patient-Based Examinations (2002)," as well as the "Characteristics of an Ideal National Clinical Licensure Exam" as objectives for an ideal national clinical licensure exam.

ADA Report of the Task Force on The Role of Patient-Based Examinations (2002)

An ideal clinical licensure examination process should:

- Be an activity involving an independent party within the educational process.
- Allow for assessment of the full continuum of a candidate's competence.
- Instill public confidence.
- Evaluate candidate competence within the context of a treatment plan that meets the patient's needs.
- Provide valid data for outcomes assessments as required by the accreditation process.
- Be provided at a reasonable cost to the applicant.

Characteristics of an Ideal National Clinical Licensure Exam:

- Psychometrically valid and relevant to current dental practice.
- Policies and procedures treat candidates fairly and professionally and ensure timely and complete communication of exam logistics and results.
- Eliminates circumstances that allow commercial procurement of exam patients.
- If patients are used, processes exist to ensure their safety and protection.
- Regular calibration and consistent implementation.

- Allows for remediation at candidate's school.

Western Regional Exam Board (47-2004)

Resolved, that the California Dental Association is in support of the California dental school deans' work in recognizing the Western Regional Exam Board as an examination alternative in California, and be it further

Resolved, that the ongoing work of the Task Force on Licensure is critical and fully supported.

Dental Scope of Practice (41-2004)

Resolved, that, for the sake of the health and safety of patients, the dentists' scope of practice be actively and fervently defended against incursion from any group or agency, and that this position become foundational CDA policy.

Licensure by Credential (30RC-2004)

Resolved, that the Council on Legislation (Government Affairs Council) be urged to pursue legislation to allow dentists, who are licensed in other states but have less than five years clinical experience, to become licensed in California without clinical examination if the applicant is committed to full-time practice for a minimum of two years in a community health clinic or in an underserved area or as full-time faculty at an accredited dental education program for a minimum of two years.

Licensure-by-Graduation Pilot Testing (29RC-2004)

Resolved, that CDA seek to work cooperatively with the Dental Board of California and the California dental schools to implement a valid licensure-by-graduation process, and be it further

Resolved, that the appropriate CDA entity pursue pilot testing of licensure-by-graduation models with an annual progress report to the House of Delegates and, if necessary, seek appropriate funding from the 2005 Board of Trustees.

PGY-1 Licensure (28S1-2004)

Resolved, that the Council on Legislation (Government Affairs Council) be urged to pursue legislation recognizing successful completion of a Commission on Dental Accreditation (CODA) accredited post-doctoral general dentistry program of at least one year duration or completion of a CODA -accredited program in an ADA recognized specialty program as fulfilling the clinical examination requirement for purposes of licensure in California.

Task Force on Licensure (26RC-2003)

Resolved, that the House of Delegates file the report of the Task Force on the Evaluation of Existing and Alternatives to California's Clinical Licensure Examination, and be it further

Resolved, that Resolution 1-1978-H be rescinded, and be it further

Resolved, that a Task Force on Licensure be created and charged to:

- Conduct further research on the licensure by graduation models for California graduates to determine which would be the most appropriate.
- Consider the advantages, disadvantages, and impacts to all licensure candidate pools as well as to the profession of dentistry, of any changes or alternatives to the current licensure processes.
- Review data on the impact of licensure by credential in California and determine if changes to that program should be recommended.
- Review model legislation on changing the California licensure process.

And be it further

Resolved, that the task force present a progress report at the 2004 House of Delegates, and be it further

Resolved, that the November 2003 Board of Trustees be directed to address 2004 funding needs for the task force and its project.

Dental Materials Fact Sheet (39-2003)

Resolved, that the appropriate entity(s) at CDA be instructed to take definitive strong action to advocate that the proposed "consumer-friendly" dental materials fact sheet, to be issued by the Dental Board of California, not be released containing any language that is not reflective and consistent with consensus science regarding dental restorative materials and that it contains no misleading language or content.

Investigations and Discipline (32-2003)

Resolved, that the Council on Legislation be strongly urged to sponsor legislation to amend the Dental Practice Act to include an appropriate statute of limitations on investigations and discipline by the Dental Board of California relative to allegations of unprofessional conduct against licensees.

Unnecessary Hearings (31-2003)

Resolved, that the appropriate CDA entity be directed to explore with other regulated professions, the Department of Consumer Affairs, the attorney general's office and other interested parties, the feasibility of adopting regulations or administrative procedures to prevent unnecessary rehearings by boards or agencies where a licensee accused of unprofessional conduct has prevailed in a hearing before an administrative law judge, and be it further

Resolved, that the entity report its findings and recommendations to the board of trustees, and be it further

Resolved, that if the board of trustees determines that an administrative approach is not feasible, the board encourage the Council on Legislation to pursue legislation to remedy the problem.

Eligibility for Dental Hygiene Licensure Examination (40S1-2002)

Resolved, that the appropriate CDA entities explore the feasibility of legislation that would provide for a dental student who has successfully completed the educational equivalency of a commission on dental accreditation (CDA) approved dental hygiene curriculum as certified by the dean of their respective dental schools to be eligible to take the dental hygiene licensure examination.

Evaluate the Existing and Alternatives to California's Clinical Licensure Examination Process (26RC-2002)

Resolved, that the CDA Council on Education and Professional Relations identify and evaluate the existing and alternatives to California's clinical licensure examination process, and be it further

Resolved, that the Council provide a report on its findings to the 2003 CDA House of Delegates.

Elimination of the Use of Live Patients in the Clinical Licensure Exam (28-2001)

Reference: Rescinded by 10S1-2005

Licensure by Credential (45RC-1999)

Reference: Superseded by 30RC-2004

Position Paper on Licensure by Credential (35RC-1998)

Reference: Superseded by 30RC-2004

Reciprocity as a Means of Licensure (23-1998)

Resolved, that CDA oppose reciprocity as a means of licensure in California, and be it further

Resolved, that this CDA position be embodied in the next revision of the CDA Policy Manual.

Non-Adoption of Administrative Judgments (58-1997)

Reference: Superseded by 31-2003

Right to Practice (23-1997)

Resolved, that the California Dental Association supports the right of dentists to practice to the extent of their education, training and credentialing.

Fair and Equitable Generation of Revenues by the Board of Dental Examiners (91-1990)

Resolved, that CDA Council on Dental Care and Council on Education and Membership Services request that the Board of Dental Examiners use the information available from the Department of Consumer Affairs certificate of registration, and be it further

Resolved, that the Board of Dental Examiners address a fair and equitable method of generating revenues that is the same for all dentists, whether practicing as professional corporations, partnerships, or sole proprietors.

Dental Students Practicing as Dental Hygienists (71-1989)

Resolved, that the California Dental Association support the CDA student members' efforts to secure the opportunity for dental students and graduates of California dental schools who have met appropriate standards of competency to practice dental hygiene while in school and for up to six months following graduation, and be it further

Licensure by Credentials and Reciprocity (16RC-1988)

Reference: Superseded by 23-1998, 35RC-1998 and 45RC-1999

Licensure for Graduates of Non-Accredited Dental Schools (13S3-1984)

Reference: Rescinded by 45-1990

Opioids

Opioid Policy (6-2018)

Resolved, that the CDA Opioid Policy be adopted.

CDA Opioid Policy

CDA recognizes that dentists play a pivotal role in providing quality care, ensuring patient safety, and supporting the improvement of public health. The misuse and abuse of opioids has resulted in epidemic levels of addiction and death in California and nationally. As prescribers of opioids for dental pain management, dentists have a professional responsibility to reduce the misuse and abuse of opioids, and through education and advocacy, CDA has been a leader in responding to this public health crisis.

CDA will continue to demonstrate proactive leadership in addressing the opioid crisis through education and promotion of evidence-based acute pain management practices, and collaborative partnerships with specialty dental organizations, dental schools, patients and parents of patients to both reduce reliance on opioids for dental pain management and to minimize minors' first exposure to opioids.

CDA will promote the use of prescription drug monitoring programs, substance use disorder education, and enhanced collaboration between dentists and their medical colleagues to assist in identifying a patient's full medication profile and potential substance use disorders prior to prescribing an opioid.

Sleep Disordered Breathing

Sleep Disordered Breathing Final Report (28-2015)

Resolved, that the report of sleep disordered breathing be filed, and be it further

Resolved, that CDA reaffirms existing policy related to sleep disordered breathing (25RC-2011), and be it further

Resolved, that CDA recognizes the unique role dentists can continue to play in the screening, referral for diagnosis and treatment of sleep disordered breathing, and be it further

Resolved, that CDA continues to seek opportunities to educate its members and the public about the importance of proper diagnosis and treatment of sleep disordered breathing.

Sleep Disordered Breathing (25RC-2011)

Resolved, that it is appropriate for dentists to screen patients for signs and symptoms of sleep disordered breathing and to work with physicians to diagnose and treat sleep disordered breathing, and be it further

Resolved, that CDA supports increased awareness and the education of dental and medical professionals on appropriate involvement in the screening, diagnosis and treatment of sleep disordered breathing, and be it further

Resolved, that CDA supports efforts at the federal and state levels to ensure dentists are recognized members of the health care team managing sleep disordered breathing, and to ensure that patients' health care benefits are maintained regardless of whether a dentist or physician provides patient care.

Social Couponing

Social Couponing (4RCB-2012)

Resolved, that the appropriate CDA entity encourage the Dental Board of California to provide clarification of whether social couponing is in compliance with California Law.

Social Media

Social Media (21-2012)

Resolved, that the appropriate agencies in conjunction with the student delegation pursue enabling legislation.

Resolved, that the appropriate CDA entity evaluate social media and internet referral services in an effort to ensure the fair business practices by such entities.
(Resolution 21A-2012-H)

Resolved, that CDA continue to provide guidance and educate members on the ethical and effective use of social media and internet referral services.
(Resolution 21B-2012-H)

Use of Lasers

Policy Statement on Dental Lasers (15RC-2002)

Resolved, that Resolution 14RC-1994 be rescinded, and be it further

Resolved, that CDA recognizes that a laser is an invasive surgical instrument, and as such, has the potential to cause patient harm, and be it further

Resolved, that CDA adopt the following policy statement on dental lasers:

- Lasers have multiple medical and dental uses;
- Lasers should be used only by health care providers who are certified and appropriately trained to do so; and
- Lasers should only be used for scientifically valid and FDA-approved purposes.

Position Paper on Dental Lasers (14RC-1994)

Reference: Rescinded by 15RC-2002

Environmental Health and Safety

Infection Control

Policy Regarding Treatment of HIV Seropositive Patients (33-1997)

Resolved, that the policy regarding Treatment of HIV Seropositive Patients (23RC-1988) be amended as follows:

Resolved, that it is the policy of California Dental Association that a dentist must not refuse to treat a patient whose condition is within the dentist's realm of competence solely because the patient is HIV seropositive.

Policy Regarding Treatment of HIV Seropositive Patients (23RC-1988)

Reference: Amended by 33-1997

Continuing Education in Infection Control (29RC-1986)

Resolved, that CDA, through the appropriate council or agency, urge members and their auxiliaries to enroll in and successfully complete a continuing education course in the prevention of cross-contamination and infectious disease control in the dental office and laboratory.

Occupational Safety and Health

Directory of OSHA Resources (23-2006)

Resolved, that Resolution 33-1999-H, Directory of OSHA Resources, be rescinded, and be it further,

Resolved, that the appropriate CDA entity consider the addition of a directory of consultants to the CDA website.

Statement on Use of Dental Needle Systems and Needle Devices (26-2006)

Resolved, that Resolution 21-1999-H, "Statement on the Use of Dental Needle Systems and Needle Devices," be rescinded.

Statement on Use of Dental Needle Systems and Needle Devices (21-1999)

Reference: Rescinded by 26-2006

Inspections and Penalties (31-1999)

Resolved, that the policy on Inspections and Penalties (45RC-1992-H) be rescinded.

Policy on Dentist In-Office Training Program (32-1999)

Resolved, that the Policy on Dentist In-Office Training Program (67RC-1991-H) be rescinded.

Directory of OSHA Resources (33-1999)

Reference: Rescinded by 23-2006

Policy on Material Safety Data Sheets (34-1999)

Resolved, that the policy on Material Safety Data Sheets inclusion with products (42RC-1991-H) be rescinded.

Directory of OSHA Resources (11RC-1994)

Reference: Amended by 33-1999

Unwarranted/Excessive CAL-OSHA Regulations and Penalties (60S1-1992)

Resolved, that CDA will monitor Cal-OSHA regulations and penalties relating to dental offices, and be it further

Resolved, that CDA will provide legal help to members on a test case basis whose penalties from Cal-OSHA have been deemed by CDA to be unwarranted or excessive, and be it further

Resolved, that CDA request assistance (monetary and/or legal) from ADA in these endeavors.

Inspections and Penalties (45RC-1992)

Reference: Rescinded by 31-1999

Material Safety Data Sheets Inclusion with Products (42RC-1991)

Reference: Rescinded by 34-1999

Dentist In-Office OSHA Training Program (67RC-1991)

Reference: Rescinded by 32-1999

Guidelines for Compliance with OSHA Hazardous Waste Communication, Release and Response and Infection Control Plans (23-1990)

Resolved, that the Guidelines for Compliance with OSHA Hazardous Communication, Release and Response and Infection Control Plans as developed by the Council on

Dental Research and Developments be adopted, and be it further

Resolved, that the guidelines be sold to member dentists renewing their membership prior to January 1, 1990 at a cost of \$15.00, and be it further

Resolved, that after January 1, 1990, the guidelines be sold to member dentists at the actual reproduction and shipping costs of \$25.00 each, and be it further

Resolved, that the guidelines be available to non-CDA member dentists upon request for the cost of \$225.00.

Attachment: Available upon request

Note: This publication was renamed "CDA Regulatory Compliance Manual" and purchase costs increased by the Board of Trustees Resolution #86-1997-B:

Resolved, that the name of the SB 198 and OSHA Compliance Manual be changed to CDA Regulatory Compliance Manual, and be it further

Resolved, that after January 1, 1998, the fee for the manual will be \$45 for CDA members, and \$250 for nonmembers, plus tax and shipping.

The manual can be downloaded from CDA Online at no cost to members.

Regulatory Agencies

Local Regulatory Agencies (48RC-1998)

Resolved, that the California Dental Association will work with local components to ensure that regulations and fees implemented by local regulatory agencies are reasonable and appropriate, and be it further

Resolved, that challenge will be considered and undertaken if necessary.

Scientifically Based Dental Regulations (46-1994)

Resolved, that CDA strongly oppose any governmental agency regulation affecting clinical dental practice that is not supported by consensus science, and be it further

Resolved, that CDA be directed to request that regulatory agencies produce the scientific epidemiological evidence to support their regulatory activities.

Waste Management

Guiding Principles on Amalgam and Wastewater (4-2009)

Resolved, that CDA's best management practices be amended to include the installation of ISO 11143 Compliant Amalgam Separators, and be it further

Resolved, that CDA's *Guiding Principles on Amalgam and Wastewater* be amended to reflect this amendment as attached.

Guiding Principles on Amalgam and Wastewater

The California Dental Association (CDA) recognizes that dental amalgam is a safe and cost-effective restorative material, and that the right to select appropriate dental materials belongs to the patient and treating dentist. Several national and international health agencies also share the opinion that dental amalgam is safe and effective.

Dentists care about the environment and are willing to take reasonable steps to minimize the impact of dental office waste to the environment. CDA recognizes that initiatives have been taken at the local, state, national, and international levels to reduce the release of all forms of mercury to the environment.

CDA strongly encourages members to recycle any bulk mercury or mercury-containing waste in the dental office. (Note: State regulation requires that if this waste is not recycled, then it must be managed as hazardous waste.)

CDA strongly encourages component dental societies to work with local agencies to educate and promote waste reduction and management programs, such as bulk mercury collection and recycling programs.

Dentists shall adhere to [best management practices](#) (BMPs) for all dental office waste as outlined in "An Ounce of Prevention: Dental Office Waste Management Guide," part of the CDA Regulatory Compliance Manual and posted on CDA Online. Following BMPs for amalgam waste can significantly reduce the amount of amalgam that could be improperly disposed.

Dental Office Hazardous Waste and Recycling (27-2006)

Resolved, that Resolution 22-1999-H, "Dental Office Hazardous Waste," be rescinded, and be it further

Resolved, that a new policy, "Dental Office Hazardous Waste and Recycling," be approved.

Dental Office Hazardous Waste and Recycling

The California Dental Association advocates the position that dental offices should recycle as many waste streams as possible. Dental offices have benefited from the outreach and education efforts of various regulatory agencies and CDA staff and now routinely recycle amalgam, lead foil, and silver-bearing photo wastes.

Given the efforts of the dental profession and the small amounts of waste generated, it is clear that education and outreach efforts have done more to foster compliance than traditional "command-and-control" regulations. Continued emphasis on education versus citation is the most beneficial and cost-effective mechanism to ensure that hazardous waste streams are diverted from waste water and landfills.

BACKGROUND

California dental offices must comply with the state's hazardous waste regulations because they generate wastes such as sterilizing solutions, scrap amalgam, photographic solutions, and lead foil. Although the quantity of waste each office generates is very small, state law requires each office obtain an EPA identification number, follow complex rules regarding storage and disposal, complete hazardous materials contingency plans, and, in some cities and counties, pay hazardous materials storage and waste generator fees. Dental offices are also subject to inspections from local regulatory agencies.

Under federal hazardous waste laws, most dental offices are classified as "conditionally exempt small quantity generators" (CESQG) and are exempt from regulation because they generate less than 100 kgs of hazardous waste in a month. Federal law only requires CESQGs to properly dispose of the waste.

PROPOSED ACTION

As health care providers, dentists are sensitive to environmental issues. Regulatory programs by which the environment can be protected without a significant burden to dentists and their patients are possible.

The recent expansion of many Household Hazardous Waste collection events to include CESQG's has been a boon to dentistry. By allowing dentists to benefit from the local agencies "economy of scale" dentists now have the option to pay reduced disposal fees at HHW events if they are willing to transport waste materials to the event location. CDA supports the continued expansion of these programs to all counties.

CDA also supports revision to laws and regulations governing dental office hazardous wastes to make the fees and paperwork more proportional to the type and quantity of waste generated. Recognition of efforts made by

dentistry to turn more waste streams into recycling channels should be given greater consideration in the regulatory scheme.

CDA supports efforts to ensure more consistency among the Certified Unified Program Agencies (CUPAs) which enforce hazardous materials and hazardous waste requirements at the local level. CUPAs should have the following provisions:

1. A special fee schedule which would charge no more than \$50.00 in fees (hazardous materials and hazardous waste fees combined) for dental offices that recycle and neutralize all possible waste streams. This would encourage dental offices to appropriately route waste streams and recognize the very small quantities of waste which would find their way to landfills from these practices.
2. A reduced inspection schedule for dental offices who "self-certify" that they recycle and reduce wastes as above. It is proposed that the inspections would be once every two years. The inspections would also be a combined inspection (including hazardous waste and waste water components) to foster a more holistic, consistent and less confusing view of hazardous materials and waste management.
3. Other dental office wastes, which will be specified, would be excluded from hazardous waste regulation.
4. Dental offices would continue to comply with waste amalgam program elements, including: trap and filter use, collection and containment of wastes, storage procedures, recordkeeping and use of the certified waste removal service.

Reference: [Table 1: Comparison of Federal and State Regulation of Dental Office Waste](#)

Amalgam Wastewater Guiding Principles (23-2002)

Reference: Superseded by 4-2009

Dental Office Hazardous Waste and Recycling (27-2006-H) – cont'd

Table 1: Comparison of Federal and State Regulation of Dental Office Waste

TYPE OF WASTE/ AMOUNT GENERATED	FEDERAL LAW Resource Conservation and Recovery Act (RCRA)	STATE LAW
Photographic fixer (contains soluble silver) 5 gal/month	Small quantities must be properly disposed. In the case of this waste, it must be recycled.	SB 2111 made state law similar to federal law. Fixer can be recycled through a qualified vendor or taken to CESQG events locally.
Vapo-Steril (flammable waste) <1 cup/month	No requirements as this is not a RCRA waste.	Generators are required to obtain a Cal-EPA identification number; complete annual EPA ID and manifest fee forms; complete hazardous waste contingency forms; maintain manifests and record of generation; follow regulations for proper containment, labeling, signage, storage, and disposal; and pay CUPA fees, which range in the state from \$75 to \$400. Alternatively, this material may be eligible for disposal via CESQG events locally.
Glutaraldehyde (toxic waste) < 5 gallons/month	No requirements as this is not a RCRA waste.	Generators have the option of disposing of this material as a hazardous waste (see above) or they may follow Cal/EPA guidelines to neutralize this waste stream and dispose of it via their sanitary sewer (local agency permitting).
Dental Amalgam (toxic waste) < 1 pound/month	Waste qualifies as a scrap metal and can be excluded from federal regulations if handled appropriately.	Dental amalgam can be accumulated as scrap metal. Amalgam debris caught in the dental unit traps and vacuum filters along with carving scrap are designated as universal wastes which are less stringently regulated than other hazardous wastes. Generators are required to dispose of amalgam using a qualified recycler or may dispose of the material through CESQG events, if available.
Other Universal Wastes	Wastes such as fluorescent tubes, batteries and mercury thermostats are classified as "Universal Wastes" which are regulated on a more relaxed set of requirements.	This requirement was recently extended to small businesses like dental practices. As of February 2006, dental offices must ensure that these waste streams are disposed of through approved "universal waste handlers" and not disposed of in the regular trash. Generators may also choose to bring these materials to CESQG events, if available.

Attachments

Resolution 27

Dental Care Capacity Task Force Research Update

Action Required

Board of Trustees

Background

In 2012, the House of Delegates (house) adopted Resolution 16RC-2012-H establishing the Dental Care Capacity Task Force (task force) to: 1) to review and re-examine the capacity data and the premises used in the capacity study; and 2) to obtain current data for the State of California to better understand how the capacity responds to forces inside and outside of the profession; and 3) to further evaluate how this clarification of capacity changes could be used to improve access to care for all Californians.

In 2013, the Board of Trustees (board) ratified the following presidential appointments to the task force:

Steven Friedrichsen, DDS	Chair
Nita Dixit, DDS	At-large
Debra Finney, DDS	Workforce Research TF/Access Workgroup (1)
Robert Hanlon, Jr, DMD	Government Affairs Council (1)
Irene Hilton, DDS	Trustee
W. Craig Noblett, DDS	Trustee
Brian Shue, DDS	At-large
Walter Weber, DDS	Policy Development Council (1)

Task Force Processes and Activity:

The task force initially considered the information and analyses needed to address the three components of Resolution 16RC-2012-H. In conducting the work of the task force, the chair served as direct liaison with CDA staff, the task force used multiple conference calls for involvement of the full task force in real time discussions and used electronic communication for review and editing.

As the task force established the desired array of information and analyses that would address the resolution, it was apparent that existing data from available sources were limited, restricting the possibilities for analyses. It was recognized that initiating new research specifically to gather data for the work of the task force would be necessary and the new surveys/studies should use a reliable methodology and report results in terms that were easily communicated. The task force developed a request for proposal to meet the criteria of the resolution and reviewed submissions from multiple vendors. The task force worked with CDA staff to match the scope of the project with the available resources.

In January 2014, the task force accepted a proposal from the ADA Health Policy Institute (ADA HPI) for the following studies:

- *Dentist workforce projections in California*
- *Getting More Dentists to Participate in Medi-Cal: Insights from an Innovative State-wide Survey*
- *Dental Care Service Delivery within Federally Qualified Health Centers in California*

Dr. Marco Vujicic and the staff of the ADA HPI discussed the proposed research and methodology in depth with the task force and presented the research findings in a webinar format to form the final task force report.

ADA HPI Report Findings:

The ADA HPI's research and findings titled: "[An Analysis for the California Dental Association - March 2015](#)" (HPI Analysis) provides detailed information related to the methods used for data collection and analysis, and explains the complexity of analyses needed to fully assess the numerous factors that influence access to dental care. The essential findings from the ADA HPI report to the task force that address the resolution language;

52 "...evaluate how this clarification of capacity changes could be used to improve access to care for all
53 Californians..." include the following:

54
55 *Future Supply of Dentists in California:* The number of dentists per capita in California will continue to
56 increase in the near term; peaking in 2018 at 77.2 dentists /100,000 Californians. Following that peak,
57 the ratio of dentists to population will gradually decrease through 2033 to 74.7/100,000 {HPI: Executive
58 Summary Pages 3-4; Table 9 Page 19 and Figure 4, Page 20}. Overall, using predicted dentist to
59 population ratios, the projected supply of dentists is relatively stable through 2033 with 3.6 percent decline
60 in overall chair time following a peak in 2018. {HPI: Page 24}

61
62 *Dentist Participation in Medi-Cal Dental Program:* The ADA HPI research team surveyed California dentists
63 and used a new methodology to assess their potential participation in the Medi-Cal dental program under
64 different scenarios. The finding that low reimbursement rates was the primary reason for non-participation
65 (though not the only reason) validates previous studies. {HPI: Executive Summary Page 4; Page 28}.

66
67 Further, a notable finding of the HPI Analysis is the demarcation of the levels of Medi-Cal dental program
68 reform necessary – which were shown to be substantial - to positively impact dentist participation. As an
69 example, the HPI Analysis indicated that the number of dentists willing to become Medi-Cal dental providers
70 would more than double if the reimbursement was set at 55 percent of the typical insurance charges, the
71 missed appointment rate was decreased and there was timely payment and modest assistance with
72 administrative requirements. {HPI: Page 4; Page 34; Figure 4, Page 46; and Figure 5, Page 47} Further
73 research would be required to quantitatively estimate the impact of additional dentist participation on Medi-
74 Cal utilization rates, as well as the cost-benefit of the Medi-Cal program reforms needed to elicit that
75 participation {HPI: Page 38}.

76
77 *Dental Care Services in FQHC's:* The ADA HPI survey of the Federally Qualified Health Centers (FQHC)
78 found that the majority of the FQHC's individual clinic sites (63.2 percent) do not provide dental care
79 services onsite or under contractual arrangement. {HPI: Figure 1, Page 66} The sites that do offer dental
80 services have a higher level of reported busyness (54.9 percent were either "too busy to treat all people
81 requesting appointments" or "provided care to all who requested, but were overworked.") but also
82 demonstrated some reserve dental care capacity. {HPI: Figure 2, Page 67} The HPI Analysis suggests that
83 "...significant opportunities may exist to expand the dental safety net by increasing the number of...sites that
84 provide dental care services... However, further analysis is needed to estimate how many additional patients
85 would gain access to care..." {HPI: Page 69}

86 87 **Task Force Summary:**

88 Although not specifically designed to quantify unused capacity, the research provided some evidence of reserve
89 dental care capacity. The data in support of unutilized dental care capacity is based on the reported levels of
90 busyness by dentists surveyed; the high percentage of dentists who are prepared to accept new patients with
91 insurance or who self-pay; the reported 63.2 percent of FQHC clinic sites that do not provide dental services;
92 and the reported levels of busyness within the FQHC's. However, whatever reserve capacity may exist has not
93 been quantified, and it has not effectively been converted to access for populations in need; primarily
94 influenced by Medi-Cal dental program shortcomings and lack of public health infrastructure, including
95 significant numbers of FQHC clinic sites without dental services.

96
97 ADA HPI's analyses reflect the challenges and limitations of analyzing California's complex system of dental
98 care delivery that involves thousands of providers, who work in private and public systems that are functionally
99 separate, to provide care to millions of culturally, economically, and ethnically diverse people, in
100 geographically dissimilar regions. With that recognition, the task force is pleased with results of ADA HPI's
101 completed analyses and believes they provide valuable insight into dental care delivery in California.

Recommendations:

These analyses update CDA research on the capacity of the dental care system in California, conducted in 2008-2011 as part of a comprehensive project to develop strategies to reduce barriers to dental care in California. The original body of research produced over 20 recommendations, to be implemented in three phases, over seven plus years (*CDA's Access Plan*). The task force recognizes the value of having access to current, relevant data on California's dental delivery system and recommends that CDA continue to work in collaboration with other entities to evaluate California's dental care needs and realize the objectives of its plan goals. The task force further recommends that CDA consider conducting additional research should the need and benefit for those efforts be deemed valuable to its strategic plan and its mission.

At their July 24-25 meeting, the board unanimously approved that this final Dental Care Capacity Task Force report be filed in accordance with Resolution 16RC-2012-H.

Attachments

None

Financial Impact

None

Recommendation

The Board of Trustees recommends approval of the following resolution by the House of Delegates:

27. Resolved, that the Report of the Dental Care Capacity Task Force be filed.

Resolution 7: Medicare Task Force Report

Medicare Task Force

In 2018, the house of delegates (house) approved the creation of a task force to study adding dental benefits to Medicare, as follows:

Resolution 19-2018-H: Resolved that CDA form a task force to explore the issues relevant to the inclusion of dental benefits into the Medicare program, including implications in California on the aging population and the delivery of care, and be it further

Resolved, that the board of trustees be urged to approve the scope of work and necessary funding for the task force's activity, and be it further

Resolved, that the task force report be presented to the CDA 2019 House of Delegates

The board of trustees (board) established the Medicare task force (task force) shortly thereafter, further defining the scope of work. The board directed the task force to prepare a report on the potential implications of including dental benefits within the Medicare program, taking into account the changing dental benefits marketplace both in California and nationally. Furthermore, the task force was charged with providing a summary of relevant CDA and ADA policies, current national advocacy efforts, proposed benefit designs and potential economic factors for patients and dentists, including policy or other recommendations.

President Dr. Del Brunner appointed eight members to the task force:

Dr. Gary Herman, chair	Dr. Irving Lebovics
Dr. Wade Banner	Dr. Afshin Mazdeyansnan
Dr. Elisa Chavez	Dr. Richard Nagy
Dr. Gary Dougan	Dr. Julia Townsend

The task force conducted its work over several meetings (detailed below), utilizing an online platform for document sharing and review between meetings.

- May 3, Sacramento
- May 31, WebEx
- June 14, WebEx
- July 18, Sacramento
- August 7, WebEx
- September 13, WebEx

Process

The task force began by gathering information from several sources and experts, including:

- Lu Zawistowich, president, CapView Strategies, an expert in the field of federal health care programs, who provided a basic Medicare program overview, the legislative and regulatory framework, program integrity protections, information on beneficiaries and providers and potential opportunities.
- ADA Health Policy Institute's Marko Vujicic and Cassie Yarborough, who presented findings from consumer and dentist opinion research commissioned by ADA and discussed some projections on the economic impact to dental practices if a dental benefit were added to Medicare Part B. HPI also provided some research Medscape completed in 2014, seeking to capture physicians' experience and satisfaction with Medicare as well as career satisfaction in medicine.
- Dr. Elisa Chavez, who presented The Santa Fe Group's Medicare dental benefit analyses to the group. Dr. Chavez repeated a presentation that was given at the National Oral Health Conference in April in Memphis, Tenn., detailing the activity of The Santa Fe Group and Oral Health America – a collaborative effort that included numerous experts. A 2017 Medicare dental benefit proposal developed by Drs. Judith Jones and Michael Monopoli and published in the *Compendium of*

Continuing Education in Dentistry, October 2017, Volume 38, Issue 10; and a 2018 white paper, "An Oral Health Benefit in Medicare Part B: It's Time to Include Oral Health in Health Care," published by Oral Health America, were also provided to the task force for review. important

Task force members were also provided with background on the national and California health care environments, Medicaid and Medicare programs, data on aging Californians and other relevant materials as they were identified; and they engaged in a detailed analysis of potential benefit approaches and multiple considerations.

Summary of Findings

Task force analysis and discussion produced the following key findings:

Adding a dental benefit to Medicare has the potential to:

- Increase access to dental benefits.
- Increase access to dental services.
- Support better care integration.
- Decrease medical care costs.
- Increase the opportunity for improved health outcomes for aging Americans.

Individual dentists may support adding a dental benefit to Medicare because it:

- Opens up new avenues for care.
- Opens up a market for new patients.
- Is a steady, reliable reimbursement source for care.
- Increases opportunities for dentists to engage in other elements of the health care system/pursue other careers within the health care system.
- Supports dentists to do what's best for the patient and is consistent with a dentist's commitment to professional ethics and their personal, professional mission.

Patients will benefit if a dental benefit is added to Medicare because it:

- Increases access to dental services by providing financial support for (some portion) of patients' dental care needs – care that is primarily an out-of-pocket expenditure now for older Americans.
- Ensures (at minimum) the patient receives a diagnosis and knows the care they need.
- Connects patients to a dental home.

Potential risks for organized dentistry and dentists for remaining on the sidelines:

- Not engaging – taking no action – *is an action* that leaves dentistry, dentists and patients vulnerable to results that are influenced by others who do not know dentistry.
- Failing to engage may negatively impact the professions' reputation, creating the perception that dentistry does not care about the needs of aging Americans.
- Dentistry may miss the opportunity to raise its profile and influence within health care.
- Failing to engage in work to improve access to care for at-risk populations is counter to dentistry's mission.

Potential risks for dentists and organized dentistry if a benefit is established in Medicare:

- For current cash-paying patients over the age of 65, Medicare reimbursements will likely be lower.
- Mature dental practices that have an established patient base and are not seeking new patients may not benefit and may lose patients if they do not participate.
- There may be increased administrative burdens that are unfamiliar to dentists; working with government programs may be perceived as a stressor, especially for the solo practitioner.
- Dentists will incur costs associated with EHR/IT changes and support that may be required
- Dental reimbursement rates in Medicare may influence the benchmarks for commercial rates.
- Rates may become stagnant or be lowered over time.

- Engaging in Medicare benefits advocacy could alienate members who disagree with organizational involvement, decisions or the outcome

Two common misconceptions task force members felt were essential to clarify are:

- The differences between Medicare and Medicaid (Medi-Cal in California) are not well understood, which frequently results in people judging them as similar: poorly run and underfunded. In fact, these two programs are **entirely different**, including the source of their funding, administration and payment structures.
- If Medicare gains a dental benefit, it does not mean that dentists will be required to participate. As with other plans and programs, participating is an active decision made by the dentist.

Thorough discussion of these issues and concerns led the **task force to recommend that organized dentistry be engaged in the Medicare dental benefit advocacy space because:**

- Increasing access to dental services is consistent with our professional mission, as an organization and as individuals.
- Organized dentistry is the expert voice on oral health; we understand and should represent the concerns of patients and clinically practicing dentists.
- Without organized dentistry “at the table,” others will design a program that dentists and patients must live with.
- Dentistry’s reputation with the public and standing within health care will be enhanced with our engagement. Further, dentistry risks damaging its reputation if dentists are viewed as unconcerned about the needs of aging Americans.

Furthermore, the task force recommended that CDA conduct additional research. Task force members were very aware of what is not yet known and potential risks if a benefit is poorly designed and/or poorly reimbursed. In consideration of this, the task force identified the following areas for additional research:

- Qualitative research into California member preferences, testing various scenarios and the needs of distinct practice types.
- Economic modeling of aggregate effect on dental practices.
- Pilot testing a new Medicare benefit, taking a modified approach (regional, partial Part B benefit, etc.): This approach would allow an incremental process for designing a Medicare dental benefit, learning what works well, what adjustments are beneficial for patients and/or providers and expanding best practices over time.

Conclusion

The task force undertook the charge of the house with diligence and a commitment to understand the Medicare program and advocacy to provide dental benefits to America’s seniors and share this information and their evaluation with the house. The task force considered the many forces shaping the national debate, including ongoing advocacy by multiple senior-interest groups; research on consumer desire for dental coverage and concern that the loss of benefits will affect their health as they age; support expressed by segments of the dentist community, especially dentists entering the field and whose practices look different than the generation before them, where expanded patient populations and innovative practice models may mean opportunity and bills introduced by multiple members of Congress.

The task force also recognized that not all dentists will want to participate in Medicare; many will have established practices and be unable to expand to treat additional populations or adjust to the requirements of a new payer system. Furthermore, task force members discussed potential implications of adding a dental benefit to Medicare on other payers and the health care delivery and reimbursement systems as a whole and were optimistic about additional funding becoming available for dental care, but also mindful that much is unknown and the entire healthcare delivery system is in a state of transition. It is in this context that the task force evaluated the pros and cons of potential benefit approaches and the opportunities and risks for organized dentistry, dentists and patients to engage.

This work produced a consensus among task force members that organized dentistry must be actively engaged in the Medicare dental benefits advocacy space. While many reasons were identified, of particular significance to members was that the actions of the profession must be consistent with its mission and role as the expert voice on oral health and be responsive to the needs of this growing and vulnerable portion of America. Members also felt that organized dentistry must participate to ensure that the needs of both patients and practicing dentists are accurately represented and appropriately addressed in program design. If the profession does not proactively exercise its influence and expertise in the process, decisions may be made by others with a limited understanding of the practice of dentistry and what is at stake if a meaningful and sustainable benefit is not produced.

The task force also recognized that there are details that are not yet known and made recommendations for further study in areas where additional information may be beneficial. This work is ongoing.

In October, the board received a presentation of the task force report, with the understanding that the house be asked to file the report in accordance with resolution 19-2018-H.

Financial Impact: None

Attachments

A. Medicare Dental Benefit Research Report

Recommendation: The house of delegates is asked to approve the following resolution:

Resolved, that the Medicare Task Force Report be filed.

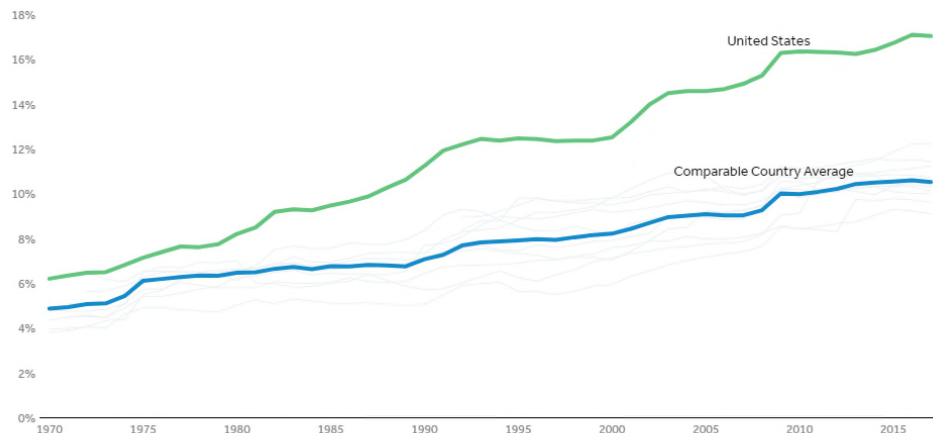
Medicare Dental Benefit Research Report

Introduction

The U.S. health care system, which spends on health services consistently and disproportionately more than other industrialized countries, has seen extensive growth in costs over the last 40 years.

Since 1980, the gap has widened between U.S. health spending and that of other countries

Health consumption expenditures as percent of GDP, 1970 - 2017



Notes: U.S. values obtained from National Health Expenditure data. Health consumption does not include investments in structures, equipment, or research.

Source: KFF analysis of OECD and National Health Expenditure (NHE) data • [Get the data](#) • PNG

Peterson-Kaiser
Health System Tracker

Large numbers of individuals without health care coverage, ineffective prevention and management of chronic diseases, escalating prescription drug prices and the overuse of emergency rooms for care are just some of the pressures on the health care system that have led to rising costs.

The national response to these pressures and an intensified need to reverse these trends led to the implementation of the Affordable Care Act (ACA) in 2014. The ACA introduced delivery reforms in various programs aimed at improving efficiency, increasing the quality of care and reducing cost. These included, but were not limited to, accountable care organizations (ACOs), bundled payments, value-based reimbursement and medical homes. As the health care system evolves under these changes, Medicare, the biggest single force within the system, is playing an increasingly significant role in testing new approaches.

Furthermore, the forces influencing change within the Medicare program are also shaping the commercial health care marketplace, with plans, both medical and dental, watching closely and adopting similar delivery reforms and cost-control strategies. These reforms are driving change in the dental benefits marketplace, affecting the dental profession in the form of shifting, and often-reduced reimbursement, as well as increased interest in metrics and scrutiny on the evidence base for treatment.

Contributing to this environment of changing practice is a call for better integration of medical and dental care, recognizing dentistry's role in the treatment and care of patients with compromised health conditions such as HIV/AIDS, head and neck cancers, osteoporosis, Alzheimer's disease, diabetes, cardiovascular disease, stroke, chronic obstructive pulmonary disease, pregnancy and others.

Also relevant to this discussion is growing advocacy to add dental benefits for seniors covered under Medicare and work that has begun on proposed dental benefit designs. Additionally, active attention to the need to provide dental coverage for aging Americans is being driven by congressional leaders, who are hearing from constituents displeased to learn that they will not have dental coverage in Medicare, and payers, who are looking at unconventional ways to lower costs and seeing potential savings from better chronic disease management.

ADA is aware of this activity but has yet to establish a position to direct engagement in these efforts. Further, health policy in California has been on a multiyear trajectory to expand coverage to all Californians. There is significant advocacy on issues like reestablishing the individual mandate for health care (to be enacted in 2020), expanding access to care and services covered through the state's Medi-Cal system and establishing a single-payer system. This is the landscape of the current health care coverage environment in which the 2018 house of delegates (house), through Resolution 19-2018-H, directed the appointment of a task force to explore the issues relevant to the inclusion of dental benefits in the Medicare program with a report to the 2019 house.

Background

Government Health Programs: The Medicare and Medicaid programs were established by the U.S. Congress in 1965. According to the Center for Medicare and Medicaid Services (CMS), combined, these two programs provide health coverage to over 133 million individuals (60 million in Medicare, 73 million in Medicaid/CHIP) throughout the United States with over 6.1 million enrollees in California. Approximately 1 in 3 Americans is covered under one of these programs; however, significant gaps in dental coverage remain for adults enrolled in both the Medicaid and Medicare programs.

CMS, an agency of the U.S. Department of Health and Human Services, oversees both the Medicare and Medicaid programs, and though they are sometimes compared to each other, the programs actually vary significantly in terms of benefits, payment mechanisms, funding and administration. Notably, Medicaid programs are developed, partly funded and fully administered by each state under broad federal guidelines. Rules vary significantly from state to state, and the condition of a state's budget has a significant impact on benefits and reimbursements, resulting in variability in coverage as well as volatility year to year as to if or what dental procedures will be covered for adults.

Adult dental benefits are currently covered in California for those who qualify for Medicaid (known as Medi-Cal in California), and of the estimated 5 million people over age 65 in California, 1.4 million qualify for benefits. Almost 20% of older Californians have too much income to qualify for Medi-Cal but not enough to pay for basic needs, including oral health care. Conversely, very sparse dental benefits are provided through Medicare and only under very limited circumstances with a narrow list of specific procedures. Below is a comparison of the Medicaid and Medicare programs.

Medicaid: Medicaid [and the Children's Health Insurance Plan (CHIP)] are safety net public assistance health insurance programs for low-income and disadvantaged Americans. Funded jointly by federal and state budgets and administered by states, these programs provide coverage to nearly 60 million Americans, including the required groups of children, pregnant women, parents, seniors and individuals with disabilities. In order to participate in Medicaid, federal law requires states to cover certain population groups and gives them the flexibility to cover other population groups as they prefer.

According to a Kaiser Family Foundation analysis, Medicaid accounts for 11% of the federal budget and total Medicaid spending exceeded \$557 billion in 2017. Unlike Medicare, which employees pay into over their working lifetimes, Medicaid is funded jointly by the federal government and the states. The federal government pays states for a specified percentage of program expenditures, called the federal Medical Assistance Percentage. States pay their portion out of the state's general fund.

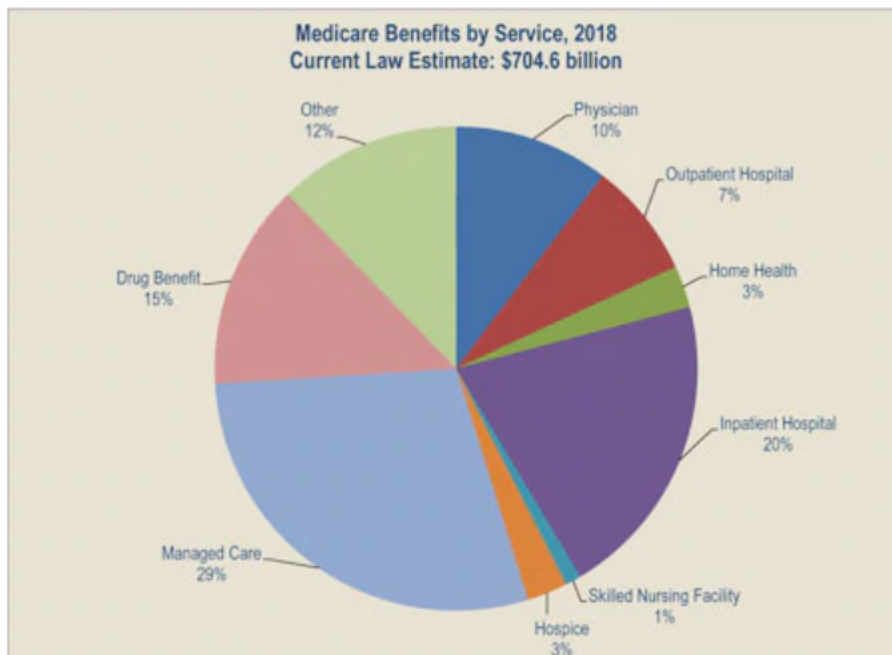
As noted above, states establish and administer their own Medicaid programs and determine the type, amount, duration, scope of services and reimbursement rates within broad federal guidelines. States are required to cover certain "mandatory benefits" and can choose to provide other "optional benefits," including prescription drugs and adult dental benefits. Additionally, states have the option to establish share-of-cost requirements for Medicaid enrollees. States also have choices regarding, and are responsible for, reimbursements and delivery system design under Medicaid.

Federal Medicaid rules require states to provide coverage for dental services for all child enrollees, ages 0-20, as part of a comprehensive set of benefits referred to as the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirement. Dental services for children under EPSDT must minimally include relief of pain and infections, restoration of teeth and maintenance of dental health.

Adult dental coverage, per federal law, is an optional Medicaid benefit. States have flexibility to determine whether dental benefits are offered to adult Medicaid enrollees, as there are no federal minimum requirements for adult dental coverage. Except for during the years of the Great Recession, 2009-2014, California has provided dental benefits for adults in its Medicaid program, covering care, though sometimes limited, in most treatment categories, including diagnostic, preventive, restorative, endodontic, periodontic, fixed and removable prosthodontics, oral surgery and adjunctive services.

To qualify for Medicaid adult dental benefits in California, a person must be age 21 or older with a family income at or below 138% of the Federal Poverty Level (FPL) (\$16,395 for an individual; \$35,534 for a family of four). Children, defined as age 20 and under, qualify for Medicaid if their family's income is at or below 266% of FPL (\$68,495 for a family of four).

Medicare: Medicare, a national health insurance program initially created to support the health of America's aging population, is wholly run by the federal government and administered by CMS. Over the years, the program has expanded to cover some disabled population groups; its services have also expanded, notably to cover limited long-term care and prescription drugs (optional). States do not pay for nor have implementation oversight for Medicare. It is financed through a combination of three sources of funding: general revenues (43%), payroll taxes (36%) and beneficiary premiums (15%); taxes and interest make up the remaining 4%. Medicare spending accounted for 15% of the federal budget in 2018 and 20% of total national health spending in 2017. Net federal outlays for Medicare in 2018 were reportedly \$593 billion according to the U.S. Department of Health and Human Services; percentages for services are represented in the graph below:



CMS Medicare Budget Overview: <https://www.hhs.gov/about/budget/fy2018/budget-in-brief/cms/medicare/index.html>

In 2018, over 60 million Americans benefited from some form of Medicare coverage under Part A (hospital insurance), Part B (medical insurance), Part C (Medicare Advantage Plans) and Part D (prescription drug coverage). Parts A and B are referred to as the "original" or "traditional" Medicare programs, while Part C offers Medicare beneficiaries the option of enrolling in a managed care plan that combines the coverage of

Parts A and B and sometimes D. Part D prescription drug coverage is available for purchase in addition to Parts A and B.

Medicare Advantage enrollees account for 35% of the Medicare population, with close to two-thirds of those enrollees selecting an HMO product. Medicare Advantage plan premiums are generally less expensive than traditional Medicare, and Medicare Advantage plans may offer additional benefits normally not included with traditional Medicare, such as eyeglasses. Dental benefits are offered by some Medicare Advantage plans at an additional premium or, in some instances, included as a loss leader to attract more enrollees. For many of the plans, annual benefit limits and deductibles apply, similar to those of commercial dental plans. Further, Medicare Advantage plans are not required to provide comprehensive nor uniform dental benefits and vary considerably by plan and geographic region. Notably, plans are generally only available in large population centers, leaving rural residents without a plan option. Many of the larger commercial dental plans offer specific Medicare Advantage plans, including Humana, Delta Dental, Aetna, Cigna, Anthem Blue Cross and Blue Shield.

Approximately 65% of Medicare enrollees select traditional Medicare for coverage due to the greater number of physicians who participate with traditional Medicare than with Medicare Advantage plans. Traditional Medicare does not cover dental care, dental procedures or dental prostheses. There are rare instances that permit coverage of dental services that are necessary for the provision of certain Medicare-covered medical services. Medicare may also cover certain medical procedures that dentists are licensed to perform (for example, a biopsy for oral cancer). In addition, some dental items and services, such as dental sleep apnea devices, may be covered in certain geographic areas through local coverage determinations, provided specific requirements are met.

Medicare Part A does provide coverage for dental services in very limited circumstances. These exceptions to the dental service exclusion occur "...in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services."

Examples of exceptions to the dental service exclusion include:

- Extraction of teeth to prepare for radiation therapy.
- An oral or dental examination performed on an inpatient basis as part of comprehensive workup prior to renal transplant surgery.

In those instances when Medicare pays for the initial treatment, the program does not pay for any follow-up dental care after the underlying health condition has been addressed. However, Medicare will pay for some dental-related hospitalizations, for example, if the patient develops an infection after having a tooth pulled or the patient requires observation during a dental procedure due to a health-threatening condition.

Medicare provider reimbursement: An important element in a discussion of government health care programs is understanding the differences between the Medicare and Medicaid programs. State Medicaid programs, which rely heavily on state budgets, are commonly reported to provide low reimbursement rates and suffer from poor administration. Medicare is administered entirely by rules established by the federal government and funded in significant part by the individuals who receive services in the form of payroll taxes, premiums and co-pays. Review of a 2014 Medscape survey on physicians' opinions of Medicare that was provided to the task force by ADA reveals that out of 10 common medical plans, Medicare ranked near the bottom of the list for reimbursement rates and fast, accurate responses to questions, but also ranked among the top three on many other plan functions, including fewest denials, ease of precertification and preapproval and speed of claims payments, and was rated fourth overall for the "ease of doing business." It should be noted that this relative provider satisfaction with Medicare contrasts significantly with the dissatisfaction providers typically express with reimbursement and ease of office operations with Medicaid programs.

To understand more about physician reimbursements in Medicare, below is some basic history on the process:

Medicare Part B, which pays for physician inpatient and outpatient services, covers basic diagnostic and preventive services without a patient co-pay. Additional care the patient may need is paid 80% by Medicare and 20% by the patient. At the program's inception, to address the concerns of health care providers and ensure cooperation and successful implementation, physician reimbursement rates were established using a formula known as the customary, prevailing and reasonable system. However, by the 1980s, the weaknesses in this system became increasingly evident and reforms were instituted. The excerpt below, from an article published in 2007 in *The Journal of Bone and Joint Surgery Inc.*, sheds some light on these changes:

Under the customary, prevailing, and reasonable system, physicians had incentives to raise charges, leading to a rapid increase in program payments. Furthermore, there arose wide geographic fee variations, disconnects between reimbursements and resources utilized, and different payments for the same service depending on the physician's specialty.

The Omnibus Budget Reconciliation Act of 1989 established a Medicare fee schedule for physicians that decoupled Medicare's payment rates from the physicians' charges for services. Rather than continuing to pursue a charge-based payment system, a resource-based relative value system was developed. The Health Care Financing Administration awarded William Hsiao, PhD (Harvard School of Public Health), the contract for evaluating the so-called relative values of physician work. The objective of the resource based relative value system was to assign each Current Procedural Terminology (CPT) code a relative value unit (RVU). An RVU is a nonmonetary relative unit of measure that indicates the relative resources required to perform a medical service. This system permits objective comparison of the work involved in performing each procedure relative to all other procedures.

This change in the rate-setting process led AMA to establish the Specialty Society Relative Value Scale Update Committee (RUC), which develops physician work RVUs annually for new and revised CPT codes using a detailed survey methodology among physicians. While this is not a process led by or under government control, according to the article's authors, "Since 1993, CMS has accepted, on the average, >90% of the annual RVU recommendations made by the RUC. Since 2001, CMS has accepted $\geq 95\%$ of the RUC's recommendations for new and revised codes."

Subsequent congressional actions led to the requirement that changes to RVUs be budget neutral, so a decision to give a procedure or type of physician visit a higher rating means another will be lowered. Much of this work has been centered on trying to equalize the value of physicians' knowledge and time spent with patients, regardless of whether that is diagnostic skill or technical surgical skill.

While this is a very cursory look at how the system for valuing care and assigning reimbursement to physicians has changed since the program's inception, there are a couple of potentially relevant points for dentistry:

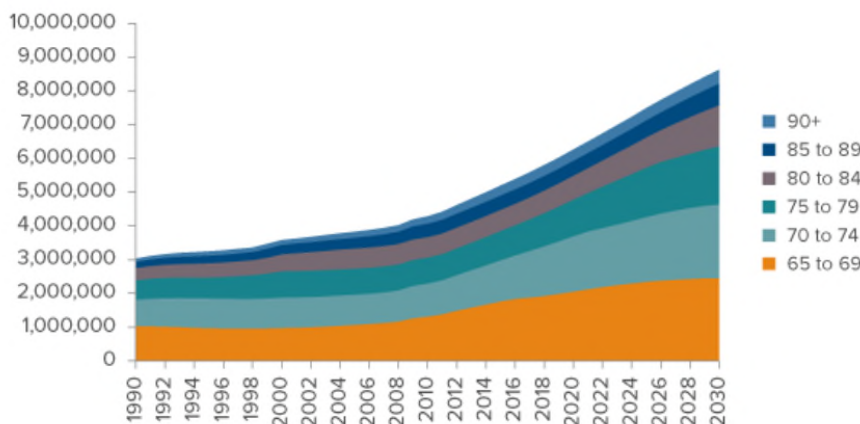
- Changes to the process for setting reimbursements to physicians has been an effort to level payments in a way that values all physicians' competencies – be they for superior diagnostic skills or surgically technical skills.
- Rather than leave this process entirely to the federal government, organized medicine (AMA) stepped up to provide a process (RUC) that engages all physician specialties and seeks to value time and resources when setting rates.
- Should Congress place dental benefits into Medicare Part B, as many are currently advocating, dentistry can reference the history of how benefits are established and how rates are set in medicine to guide its engagement.

Aside from direct-to-physician payments from CMS through Medicare Part B, health plans are also a source of reimbursement to physicians, as Medicare enrollees can purchase coverage for care through Medicare Advantage plans (Part C) and prescription drug plans (Part D). When a beneficiary receives a service covered by a plan they have purchased, the premiums, benefits and reimbursements are administered by the plan – a system that is familiar to dentists. Should dental care become covered by Medicare, depending on where these benefits are placed, dentists may find themselves in new “reimbursement territory” with payments directly from CMS or more familiar “reimbursement territory” with dental plans, or potentially both, as a hybrid benefit may be possible (See Table 3).

The growing senior population: The number of people age 65 and older in the United States is steadily increasing due to the baby boomer population (born 1946-1964). As of 2018, there were over 46 million adults over the age of 65. By 2033, the U.S. Census Bureau estimates that, for the first time, the population age 65 and older will outnumber people younger than 18 in the U.S. The 65 and older population will more than double 2018 estimates to 98 million by 2060. People in this age group will comprise of nearly 1 in 4 American residents at that time.

In California, according to a 2015 report of the Public Policy Institute of California, the over-65 population is expected to be 87% higher in 2030 than in 2012, an increase of more than 4 million people. This population will also grow more racially and ethnically diverse and be comprised of more seniors who are single and/or childless than ever before, signaling a necessity to reconsider how the support services and health care needs of this population can be effectively met.

Figure 1. California’s senior population will nearly double by 2030



SOURCE: State of California, Department of Finance, State and County Population Projections by Race/Ethnicity, Sex, and Age 2010-2060, Sacramento, California, December 2014.

NOTE: See [Technical Appendix A](#) for detailed tables and [Technical Appendix B](#) for data and methods used to generate the projections.

Coverage implications: Despite the large number of individuals covered by Medicaid and Medicare, including some who have coverage through Medicaid because of their income level, others who have coverage through Medicare because of their age or disability, and even some who have both (known as “duals” or “Medi/Medi” beneficiaries), the National Association of Dental Plans (NADP) reports approximately 74 million Americans are without dental coverage and 70% of adults over the age of 65 have no dental insurance. Individuals without dental benefits are more likely to have extractions and dentures and less likely to have restorative care or receive treatment for periodontal disease. Furthermore, those without dental benefits report higher incidences of other illness and are 67% more likely to have heart disease, 50% more likely to have osteoporosis and 29% more likely to have diabetes.

According to a Families USA survey released in December 2017, the top reason why adults do not visit the dentist is due to cost. For Medicare-insured adults, cost is identified as the No. 1 reason for not seeing a dentist, followed by having dentures or not having teeth and not needing dental care. Studies also report that the cost barriers for dental care are considerably higher than for other types of health care services.

National activity: Health care costs in the U.S., which consume a significant proportion of the gross domestic product (17.9% in 2017) and continue to rise, are generating intense interest to identify effective strategies to reverse this trend. Concurrently, evidence on the association between disease states of the mouth and body is also growing, and multiple studies have produced data suggesting that the provision of dental services could reduce complications and costs associated with several chronic and costly conditions, which has notable implications for savings in the Medicare program. For example:

- A 2016 analysis by Avalere Health, conducted for Pacific Dental Services, estimated the impact of providing periodontal services for Medicare beneficiaries with diabetes, coronary artery disease and stroke. The proposal placed a benefit for periodontal treatment in Medicare Part B – at a cost of \$825 for the initial treatment and \$250 for maintenance (in 2016 dollars) – limited to patients with one of the three chronic diseases. Avalere estimated that the benefit would produce \$63.5 billion in savings over 10 years – \$7.2 billion in additional costs for the periodontal services coupled with \$70.7 billion in savings, primarily from fewer hospitalizations and emergency room visits.
- A 2014 study by researchers from the University of Pennsylvania, which reviewed data from records of a health plan with a corresponding dental plan, concluded that patients with Type 2 diabetes who received periodontal treatment had reduced annual total medical costs of \$2,840.

Added to evidence for health care savings is concern from consumers, as more and more seniors are losing employer-sponsored insurance after retiring and gaining Medicare but realizing they are losing dental benefits. This concern is being amplified by advocacy organizations, such as Families USA, AARP, the National Committee to Preserve Social Security and Medicare, Justice in Aging and Oral Health America (which recently ceased operation). These groups, appropriate to their missions, are focusing on the needs of and benefits to consumers for adding dental benefits to Medicare.

Relevant to this discussion is research conducted by ADA's Health Policy Institute, which explored consumer and dentist opinions on adding a Medicare dental benefit and discussed some projections on the economic impact to dental practices if a dental benefit were added to Medicare Part B. The "Big Picture Conclusions" from that research were:

- There is strong support among older Americans for a dental benefit within Medicare. It is atop the "wish list" of additional health care services to be covered.
- There is strong support among dentists for a comprehensive dental benefit in Medicare, though there is also a notable pattern with support highest in the youngest age range (79.3% for dentists under the age of 40), declining by age to 66.5% among dentists over the age of 65. Also of interest was data showing that the lowest support (41%) came from ADA members who are male, solo practicing, do not have open chair time and are over the age of 55.
- A large majority of dentists responded positively to the question "If a dental benefit was included in Medicare and payment rates were 80% of typical private dental insurance rates, how likely are you to accommodate Medicare patients in your practice?"
- Dentists report they would be more likely to participate in Medicare if the ADA influenced the design of the benefit.
- Under a Part B scenario, HPI estimated that there would be between 4 million and 14 million new dental patients among Medicare beneficiaries, generating between 26 and 89 new patients and \$32,000 to \$97,000 of additional income per general dentist (nationwide).

Promoting current research on the interrelationship between diseases of the mouth and body, CDA is participating in a coalition of more than 100 health and advocacy organizations, including AARP, the American Diabetes Association, the American College of Physicians, the Association of State and Territorial

Dental Directors, the American Medical Association, the California Medical Association, Pacific Dental Services, Center for Medicare Advocacy, and Families USA, seeking to clarify existing statute regarding Medicare's responsibility to cover medically necessary health care services.

Also, on the national front, The Santa Fe Group, a think tank of dental educators, researchers and other stakeholders concerned about oral health, is serving as a convener of ideas on this subject. These activities resulted in the development of two proposals:

- The first, developed in 2017 by Drs. Judith Jones and Michael Monopoli (known as the "Compendium"), proposes diagnostic, preventive and basic care be placed into Medicare Part B with no co-pay to "remove barriers to the care needed to eliminate pain, infection, and inflammation." An optional "Level 2" plan with a \$1,500 annual maximum would also be available to cover additional options for care.
- The group's second proposal, published in a 2018 Oral Health America white paper entitled "An Oral Health Benefit in Medicare Part B: It's Time to Include Oral Health in Health Care," places dental services in Medicare Part B using the existing medically necessary and reasonable standard that applies to all Part B services. Preventive services such as cleanings, X-rays, screenings and examinations would be covered in a similar fashion to services already provided through Medicare "wellness visits." The plan does not create tiers of covered care, as did the 2017 plan, and though covered services would need to be defined and some services may not be included, the authors envision the full oral health benefit would be in Part B.

Congress is also becoming active on this issue, with Maryland Sen. Ben Cardin, Pennsylvania Sen. Bob Casey, Texas Congressman Lloyd Doggett and California Congresswomen Lucille Roybal-Allard and Nanette Barragan introducing bills that remove the existing restriction on dental services and add either a dental benefit alone, or dental, vision and hearing benefits to Medicare Part B.

Task Force Discussion

As directed by the house, the task force undertook a thorough analysis of this issue, considering the potential implications of the inclusion of a dental benefit into the Medicare program, taking into account the changing dental benefits marketplace both in California and nationally; current national advocacy efforts on this issue; proposed benefit designs; and potential economic factors for patients and dentists. The task force also considered existing professional policy and mission, what we know about our organizational capacity and members' needs, wants and preferences with regard to engaging in activities to expand dental benefits to aging Californians through the Medicare program.

Central to the task force discussion was the basic question: Should organized dentistry take an active role in the advocacy to add dental benefits to Medicare? That discussion involved an exploration of the pros and cons and perceived benefits, opportunities and risks of adding dental benefits to the Medicare program not only for organized dentistry, but for dentists and patients as well.

With regard to organized dentistry's engagement, task force members expressed that doing so would give the profession the opportunity to be the "expert voice" and represent the needs of patients and clinicians as program details are developed; support dentistry/dentists to be equal partners with medicine/physicians; increase the opportunity for dentistry to influence people's health and the health care system; and demonstrate a commitment to the profession's mission to increase access to dental care for vulnerable, at-risk and underserved populations and to improve patient health and well-being.

The task force also noted there are risks if organized dentistry fails to represent the needs of clinically practicing dentists, suggesting that the vacuum left by dentistry's absence allows others to shape the outcomes, leaving dentists vulnerable to a new system designed by "other" advocates and with potentially unfavorable elements that may be forced upon participating dentists. The task force further expressed concern that if dentistry avoids engaging in this discussion and process, it may negatively impact the profession's reputation, creating the public perception that dentistry does not care about the needs of aging Americans. The profession may miss the

opportunity to raise its profile and influence within health care, contributing to perceptions that dentistry is a second-tier profession/dentists are not physicians' equals. Lastly, task force members expressed concern that failing to work to improve access to care for at-risk populations is counter to CDA's mission.

While this discussion produced a consensus among task force members that organized dentistry should be actively engaged in the Medicare dental benefit advocacy space, a concern was also noted that if dentistry *does* step up, there is a risk of disengaging members who disagree with organizational involvement, decisions or the outcome.

The task force extended their analysis on the pros and cons for practicing dentists, identifying the following potential opportunities and risks of including a dental benefit in Medicare:

Opportunities for dentists:

- Allows new models of care to develop.
- Opens up a market of new patients; provides a source of patients for dentists seeking to grow their practice.
- Infuses billions of dollars into dental care; provides a steady, reliable reimbursement source.
- Increases opportunities for dentists to engage in other elements of the health care system/pursue other careers within the health care system.
- Supports dentists to do what's best for the patient and is consistent with a dentist's commitment to professional ethics and their personal, professional mission.

Risks or potential losses for dentists:

- For current cash-paying patients over the age of 65, reimbursements will likely be lower.
- Mature dental practices that have an established patient base and are not seeking new patients may not benefit and may lose patients if they do not participate.
- Dental reimbursement rates in Medicare may change the benchmarks for commercial rates.
- Rates may become stagnant or be lowered over time.
- There may be increased administrative burdens that are unfamiliar to dentists; working with government programs may be perceived as a stressor, especially for the solo practitioner.
- Dentists will incur costs associated with EHR/IT changes and support that may be required; may be less of a risk for larger practices that already have systems in place that may be compatible.

Benefit approaches: In order to look at these issues more closely for both dentists and patients, the task force undertook an evaluation of various proposed approaches for offering benefits, as summarized below:

Table 3

"Where" in Medicare	Part B	New & Separate Benefit: "Part E"	Hybrid of Part B & Part E
Who is covered	All Medicare enrollees.	Enrollees who purchase offered plan.	<u>Prevention & basic care:</u> all enrollees; potential for other "medically necessary" services to be covered by Part B for certain enrollees (e.g. periodontal services for people with diabetes). <u>Treatment/"non-Part B" services:</u> Enrollees who purchase a "Part E" dental plan receive that coverage.
Benefits	Prevention and basic care are covered at	Parameters of benefit package would likely be	<u>Prevention and basic care</u> covered at 100%; potential

	100%; additional services are paid 80% by Medicare and 20% by enrollee; no annual cap/maximum. Details of dental benefits included/excluded in Part B is a government decision and would occur during the program development process.	established during the creation of Part E. Dental plans would also likely have a role in benefit design and reimbursements, which are also likely to be related to premiums paid.	for other "medically necessary" services to be covered by Part B at 80%-20% Medicare-enrollee split. <u>Treatment:</u> Same as Part E for enrollees who purchase a dental plan; NA for enrollees without a plan and paying out-of-pocket.
Claims administration	CMS	Dental plan	<u>Part B covered services:</u> CMS <u>Non-Part B services/other treatment services:</u> Dental plan, if purchased by enrollee.
Funding source	Federal government (no state contribution) through general revenue, payroll taxes and monthly premiums (deducted from enrollee SS checks), as well as enrollee co-pays (20%) for some portions of care.	Enrollee via plan premiums and any required deductibles/co-payments.	<u>Part B covered services:</u> Same as Part B. <u>Non-Part B services/other treatment:</u> Same as Part E for enrollees who purchase a dental plan; NA for enrollees without a plan and paying out-of-pocket.
Reimbursements	Details on how this would work for dentistry are unknown, but physician reimbursements use a relative value unit (RVU) process developed by an AMA committee (RUC) and approved by CMS.	Unknown; likely would be established during the creation of Part E and would be related to benefits and premiums.	<u>Part B covered services:</u> Same as Part B. <u>Non-Part B services/other treatment:</u> Would mirror Part E for enrollees with a plan; out-of-pocket for enrollees without a plan.

These three primary approaches to offer dental benefits to Medicare enrollees:

1. Place all covered dental benefits into Medicare Part B (blue column).
2. Create a new part of Medicare ("Part E") where a standard dental benefit design is developed and made available to all Medicare enrollees for optional purchase, following the same approach that was used to cover prescription drugs through Medicare Part D (yellow column).
3. Combine these two approaches whereby a portion of care is placed into Part B (i.e. basic diagnostic and preventive services or even a greater set of services considered "medically necessary" to reduce/manage co-morbid conditions, such as diabetes, CVD or stroke) and a Part E plan is offered for purchase to support coverage for other dental services (green column).

To support a deeper understanding of these options, the task force evaluated potential pros and cons to dentists and patients for each. Understanding that much is still unknown, task force members agreed that all the options under discussion have the potential to increase:

- Access to dental benefits.
- Access to dental services.
- Better care integration.
- Decrease medical care costs.
- Opportunity for improved health outcomes.

However, the task force also noted that these approaches have different strengths relative to each other. The task force advised that regardless of the coverage approach taken, if dental coverage is added as a Medicare benefit, organized dentistry must be engaged in shaping benefits and reimbursements and ensuring that the

needs of clinically practicing dentists are well-represented, as well as being engaged in supporting members with regard to understanding billing/coding and other required administrative changes.

The task force also expressed concern that there are two commonly held misconceptions regarding Medicare and it is important to ensure that members have correct information and understand that:

- Medicare and Medicaid (Medi-Cal), though both government benefit programs, are entirely different programs. Their funding, administration and payment structures are very different (see extensive discussion above).
- If Medicare gains a dental benefit, it does not mean that dentists will be required to participate. As with other plans and programs, participating is an active decision made by the dentist.

Table 4 summarizes key points captured in this discussion, without prioritization or value-weighting.

"Where" in Medicare	Part B	New & Separate Benefit: "Part E"	Hybrid of Part B & Part E
Pros for dentists/ dentistry	<ul style="list-style-type: none"> • All Medicare enrollees (millions of people) will have this coverage. • Consistent source of patients and revenue. • No cap/annual maximum. • Utilizes existing 80%-20% payment system whereby the federal government pays most of the cost and the patient pays the rest. • Removes dental plan from middle-man role. • Brings additional funding directly into the dental space; adds resources to the "pie." • Option most likely to immediately raise the visibility of the importance of oral health to general health across the professions and among the public; would place oral health care on the same playing field as the rest of medicine. • Absence of dental services now provides opportunity for organized dentistry to be involved in shaping a new benefit. 	<ul style="list-style-type: none"> • May give dentistry/dental experts the most opportunity to influence the benefit design/create something most ideal. • Working with dental plans is familiar to dentists/requires the least amount of change. • Plan purchase is optional – patients who access care now may continue with their current behavior/decide they do not need to purchase the offered plan. 	<ul style="list-style-type: none"> • Part B is about covering "basic/necessary care," so putting diagnostic and preventive (possibly other) dental services into Part B is consistent with that; adding the option for dental plan purchase (Part E) to assist with treatment costs completes coverage options for consumers. • All enrollees have at least some basic dental coverage; drives patients into offices. • Creates a dental home. • Placing a portion of the dental benefit into Part B (e.g. diagnostic and preventive care) leaves more of the purchased dental benefit available to cover treatment costs (benefit goes farther/is more meaningful). • The benefit of the dental-medical nexus is retained; patients will see dentists more often than their physicians, increasing the opportunity for dentists to contribute to increased overall health (i.e. chronic disease screenings). • May be easiest buy-in/ facilitate dentists to ease into participating in a new system.

Cons for dentists/ dentistry	<ul style="list-style-type: none"> • Reimbursement rate-setting system (RVU) is already in place for physicians and may be used to set dental reimbursement rates. • Recognizing the “differences” in dentistry may be difficult. • Range of services covered may be limited, so not necessarily a meaningful benefit. • New administrative requirements and potential costs related to coding/billing, EHR, IT support. • Dentists must meet all participation requirements regardless of whether they have many or just a few patients with Medicare dental benefits. 	<ul style="list-style-type: none"> • Uptake/number of lives covered is likely to be smaller. • Dental plans remain involved in the middle-man role; a portion of the funding goes to plans, rather than care; unfavorable plan policies may remain. • Current cash-paying patients may decide to purchase the offered plan, which may change reimbursement levels. 	<ul style="list-style-type: none"> • Plan policies and limitations still in place for portion of care covered by Part E purchased plan. • Still requires updating systems/EHR/coding and billing changes. • If reimbursements in either Part B or Part E are not sustainable, this will not work as intended.
Pros for patients	<ul style="list-style-type: none"> • Universal access to coverage; everyone gets it regardless of income. • Establishes or maintains a dental home. • No cap/annual maximum. • Utilizes existing 80%-20% payment system. • Simplest /easiest/most familiar to navigate. 	<ul style="list-style-type: none"> • Optional purchase. • Premium reflects benefit and may support offering a more meaningful benefit package. 	<ul style="list-style-type: none"> • Ensures patient receives a diagnosis/knows the care they need; establishes or maintains a dental home. • Preserves more of the dental benefit for care; more value.
Cons for patients	<ul style="list-style-type: none"> • Raises premiums for all enrollees who pay premiums now* (though less for covered individuals than other coverage options) • Range of services may be limited, so may be a limited benefit. <p>*low-income seniors do not pay Medicare premiums</p>	<ul style="list-style-type: none"> • Coverage dependent on ability to pay. • Premiums likely higher. • Plan policies may be difficult/limiting. 	<ul style="list-style-type: none"> • Plan policies and limitations still affect patients who purchase Part E portion of the plan. • Trickiest to navigate; requires the most education; potentially too confusing.

618
619 Though the task force identified several potential benefits for dentistry, dentists and patients should aging
620 Californians gain dental benefit coverage through Medicare, it was also very aware of what is not yet known
621 and potential risks if the benefit is poorly designed and/or poorly reimbursed. In consideration of this, the task
622 force identified the following areas for additional research:

- Qualitative research of California member preferences, testing various scenarios and the needs of distinct practice types.
- Economic modeling of aggregate effect on dental practices.
- Pilot testing a new Medicare benefit, taking a modified approach (regional, partial Part B benefit, etc.): This approach would allow an incremental process for designing a Medicare dental benefit, learning what works well, what adjustments are beneficial for patients and/or providers and expanding best practices over time.

Conclusion

The task force undertook the charge of the house with diligence and a commitment to understand the Medicare program and current advocacy efforts aimed to provide dental benefits to America's seniors and share this information and their evaluation with the house. The task force considered the many forces shaping the national debate, including ongoing advocacy by multiple senior interest groups; research on consumer desire for dental coverage and concern that the loss of benefits will affect their health and well-being as they age; and support expressed by segments of the dental community, especially dentists entering the field whose practices look different than the generation before them, where expanded patient populations and innovative practice models mean opportunity; and bills introduced by multiple members of Congress.

The task force also recognized that not all dentists will want to participate in Medicare. Many will have established practices or be unable to expand to treat additional populations or adjust to the administration and technological requirements of a new payer system. Furthermore, task force members discussed potential implications of adding a dental benefit to Medicare on other payers and the health care delivery and reimbursement systems as a whole and were optimistic about additional funding becoming available for dental care, but also mindful that much is unknown and the entire health care delivery system is in a state of transition. It is in this context that the task force evaluated the pros and cons of potential benefit approaches and the opportunities and risks for organized dentistry, dentists and patients to engage.

This work produced a consensus among task force members that organized dentistry must be actively engaged in the Medicare dental benefits advocacy space. While many reasons were identified, of particular significance to members was that the actions of the profession must be consistent with its mission and role as the expert voice on oral health and be responsive to the needs of this growing and vulnerable portion of America. Members also felt that organized dentistry must participate to ensure that the needs of both patients and practicing dentists are accurately represented and appropriately addressed in program design. If the profession does not proactively exercise its influence and expertise in the process, decisions may be made by others with a limited understanding of the practice of dentistry and what is at stake if a meaningful and sustainable benefit is not produced.

The task force acknowledged that there is much in the way of details that is not yet known and made recommendations for further study in areas where additional information may be beneficial. That work is ongoing.

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Resolution 6: Dental Benefits and Economics Task Force Report

Dental Benefits and Economics Task Force (with an update from the board of trustees)

In 2017, the house of delegates (house) recommended the creation of a task force as follows:

Resolution 13S1-2017-H: Resolved, that a task force be created to address dental insurance and practice economic issues and make recommendations on how CDA can address and assist members in responding to changes in dental insurance coverage and practice economics, and be it further

Resolved, that the task force place specific priority on researching dental payment denials and delays and urge the board of trustees to intervene and take appropriate action if necessary, and be it further

Resolved, that the task force provide a preliminary report to the 2018 House of Delegates, with a final report to the 2019 House of Delegates.

Additionally, the 2018 house adopted the following resolution:

Resolution 18-2018-H: Resolved, that for the purpose of evaluating potential legal or legislative actions, the appropriate CDA entity be urged to obtain data regarding members' concerns about dental carriers' actions against members, including but not limited to inappropriate claim delays and denials, and be it further

Resolved, that the Dental Benefits and Economics Task Force be urged to use the collected data to make recommendations about how CDA can advocate and address benefits-related issues on behalf of members.

The dental benefits and economics task force (task force) was subsequently established by the board of trustees (board) and charged with identifying opportunities for CDA to further assist members in response to the changing dental benefits marketplace through the evaluation of the changing economic factors in California. A preliminary report was provided to the 2018 house (Attachment A), along with a supporting [educational session](#). The final report encompasses the task force's findings identified since the 2018 house including board approved recommendations, and current data collection results (Attachment B).

Task Force Composition

President, Dr. Del Brunner appointed the following individuals for 2019:

Virendra Patel, DDS, chair	Sunjay Lad, DDS
Richard Barnes, DDS	Irving Lebovics, DDS
Martin Courtney, DDS	Michael Perry, DDS
May Hayder, DDS	J. Werhan, CPA/PFS
M. Saleh Kholaki, DDS	

The task force held several meetings (in person and via teleconference) and utilized an online communication platform between meetings. The task force evaluated current CDA policy on dental benefit and economic issues; gathered and evaluated relevant dental benefits information; assessed the contributing economic factors affecting dentists and their practices; and conducted a gap analysis of existing policy, educational materials/resources and programs offering recommendations as to how CDA may assist our members.

2019 Task Force Findings

The 2018 task force findings are delineated in the preliminary report (Attachment A). In 2019, the task force considered additional factors that influence dental practice economics. Highlights of those findings include:

Dental education costs/student debt

- In 2018, the American Dental Education Association (ADEA) stated the average total educational debt for dental school graduates was \$285,000, with over 40% of graduates having more than \$300,000 of educational debt.

- The burden of dental school debt, which ranges from \$300,000 to \$600,000 for California dental school graduates, is impacting younger dentists' ability to purchase an existing dental practice or open a de novo practice.

Dental practice and dental benefit trends

- In California, approximately 7% of dentists currently work in DSOs, compared to 8.3% nationally.
- ADEA data from 2015 through 2018 reflect the increasing percentage of recent dental school graduates who have opted to work in corporate-owned dental practices (11% in 2015, 16% in 2018) versus seeking employment as an associate dentist in an existing private practice or in non-DSO group practices.
- The growth of DSOs has been driven by several factors, mostly due to scale economy advantage and efficiencies that allow for multiple clinical locations to share the administrative costs, including accounting, human resource management, supply purchasing and marketing.
- Contracting practices of dental benefit companies have changed, reflecting the purchasing patterns of employers toward lower-cost plans (e.g. Delta Dental PPO products). Dentists associating in or purchasing practices are unable to negotiate the same contracts as their predecessors, affecting the earning capacity of the associates or purchasing dentists.

Dental practice overhead

- According to industry benchmarks, the total overhead costs in dental practices range from 46% to 74% of collections, however, these ranges vary from practice to practice based on specialty.
- Variable costs, including dental supplies, drugs and lab fees, will account for 13% to 18% of collections, payroll is 20% to 26%, facility costs range from 6% to 8%, business expenses will account for 5% to 7% and marketing expenses widely range from 2% to 15% of collections.

Legislative landscape

- The current legislative environment in California favors health care legislation that addresses consumer protections, active shifts toward in-network providers, price and contract transparency and cost containment efforts.
- CDA has a strong history of third-party payer issue advocacy, including legislation addressing non-covered services, transparency and notification periods, and the litigation against Delta Dental, which is the most significant dental benefit legal victory in history. Two examples of current legislative efforts sponsored by CDA that address member benefit issues in this environment are:
 - AB 954 (Wood 2019) builds on transparency efforts by requiring that additional information be provided to dentists in their participating provider agreements regarding network leasing. This legislation was passed by the legislature and is awaiting Gov. Newsom's signature.
 - SB 1008 (Skinner 2018) builds upon the required disclosure of how much premium revenue is spent on patient care versus administrative costs (known as the dental medical loss ratio) by requiring all dental plans to use a uniform matrix to disclose their benefits directly to consumers, similar to the one used by medical plans. This will provide plan beneficiaries with a uniform summary of plan details, including covered services, reimbursement levels, estimated enrollee cost share, limitations and exceptions. CDA remains an engaged stakeholder in the development of the SB 1008 matrix as the implementation takes place in January 2021.

CDA dental benefit policies

- CDA has several dozen policies regarding dental care, benefits and delivery systems, dating back more than 30 years. As many of these policies are outdated, they require further evaluation for amendments or deletion.

TDSC supply purchasing

- Growing out of the previous dental benefits task force work, TDSC was launched to provide an e-commerce site that offers members direct access to negotiated savings on dental supplies and small equipment.
- Members of organized dentistry are realizing significant supply cost savings by purchasing through TDSC.

- TDSC has now partnered with state dental associations and is providing supply savings to dentists in 47 states and expects to be expanded to the remaining three states by 2020. This expansion creates a sustainable model for the business and maximizes savings delivered to members.

Members' dental benefit concerns

- Since the April 2019 initiation of a new process for tracking members' dental benefit concerns, more than 1000 cases have been opened and analyzed.
- Ninety percent of these requests for assistance result from a lack of office training on claims submission/dental benefit issues (see Attachment B for details).
 - Billing Service Endorsed Program: CDA is in the process of establishing an endorsed program for dental office billing, as data reviewed by the task force reveal that due to the ever-increasing complexity associated with dental benefit plan participation, members may be interested in and benefit from access to professional assistance with claims submission, appeals and collections.

Key Takeaways

The following are comprehensive takeaways that were identified based on the key findings:

- The health care environment and the U.S. economy have irrevocably changed, yet the dental benefit plans offered and accompanying reimbursement models have not evolved.
- As a side effect of marketplace changes, the pricing of dental services has diminished while overhead costs continue to rise, placing additional economic pressures on dentists as they run their dental practices.
- Dentists need to understand and analyze their contracting relationships with dental plans and how negotiated fees affect their practice economics and impact the sale of their practice.
- Dentists continue to face bureaucratic and systemic challenges with dental benefit companies. This creates additional barriers to providing care for enrollees.
- Areas of misalignment may exist between a plan's administration of enrollee benefits and the professional standards of care.
- Wide variation in dental plan payment and processing policies creates challenges for dentists and their office teams to understanding and achieving efficient claims submission and timely reimbursement.
- The shift of enrollment from commercial dental benefit plans to other payers such as Medicaid and Medicare Advantage may impact benefit design and reimbursement levels.
- Medicare Advantage enrollment is expected to grow to 40% of all 29 million Medicare enrollees by 2025. Currently, 57% of Medicare Advantage plans include a mandatory dental benefit and another 11% include an optional benefit.
- The interest to integrate oral health and physical medicine, particularly in the Medicaid and Medicare programs, has the potential to bring both challenges and opportunities to the profession.
- Dental student debt has an impact on younger dentists' practice model and location choices.
- CDA provides a significant number of tools, education and resources to support dentists addressing dental benefits matters through Practice Support, however these are underutilized.
- Opportunities exist for CDA to further promote member awareness of the dental benefit resources, tools and processes available to them and their office teams through CDA communications and Practice Support.

Conclusion

The task force spent the last 18 months examining the health care and dental benefits marketplace, considering the multitude of factors that shape its function and influence dentists' experience, including data collected from the 2018 house directive to dive deeper into members' experiences and concerns by developing a systematic way to gather and analyze this information (Attachment B).

Notable in this work was the task force's recognition of the complexity of the benefits marketplace – with a myriad of different companies having different contracts, protocols and requirements – and the effect this has on dental practices. Other influences, such as stagnant reimbursement rates and annual caps, increased out-of-pocket expenses for patients, rising costs of goods and services, high student debt and invisible network leasing, are just some of the complicating factors for dentists who are running their own practices and navigating this alone. These factors also shape practice model decisions and likely influence trends that show growing dentist participation in group practices and DSOs.

The task force's diligent evaluation and discussion produced areas of opportunity and a targeted set of recommendations that build upon the work that CDA is already doing in the dental benefits space. That work includes, but is not limited to, multiple years of successful legislation to increase plan value and transparency, litigation affecting fair contracting, establishing the largest and most successful online dental supply purchasing company (TDSC) to benefit member dentists and developing an online, easy-to-access dental benefit complaint reporting process for continuous member data collection and evaluation.

The recommendations were also shaped by regulatory constraints in the benefit marketplace, including the California Legislature's commitment to protecting consumers in the health care delivery marketplace, federal ERISA plans that cover a large percentage of Californians but over which states have no jurisdiction, and federal antitrust laws, which prohibit dentists from acting together to influence contracting, reimbursements or practice modalities.

With this as background, the task force identified opportunities in three main categories: educational opportunities for dental students and members; advocacy with the California Legislature and dental benefit plans; and enriched member services in the form of developing endorsed relationships with vendors that can support our members in their practices, which resulted in the recommendations identified below. Additional suggestions offered in Attachment C were considered, and some may be revisited based on member need assessments and evaluation.

In October, the board received a presentation of the task force work, including recommendations for action and the final task force report. Following the discussion, the board unanimously approved the following resolution by card vote, with the understanding that the house be asked to file the report in accordance with resolution 13S1-2017-H:

Resolved, that the California Dental Association pursue the following advocacy, educational and member support strategies to address dental benefit and economic challenges in California:

- Provide members access to vetted professional services for billing, claims and payment denial resolution.
- Continued advocacy for increased accountability and transparency from dental plans on behalf of patients and dentists, including uniformity of dental plan disclosures utilizing online portals.
- Advocate for the provision of dental practice economics and standards (including financial planning) within dental school education.
- Continued reporting and education regarding dental benefit issues and economic trends for members, utilizing multiple channels including *CDA Presents*, *cda.org*, publications, social media, etc., and be it further

Resolved, that the Dental Benefits and Economics Task Force report be filed.

Financial Impact: All proposed programs will have associated costs. Cost estimates will be developed by appropriate entities within CDA and evaluated by the board for prioritization and implementation.

Attachments

- A. Dental Benefits and Economics Task Force Preliminary Report, 2018 House of Delegates
- B. Dental Benefits Submission Form Results
- C. Additional Task Force Suggestions

Recommendation: The house of delegates is asked to approve the following resolution:

Resolved, that the Dental Benefits and Economics Task Force report be filed.

Dental Benefits and Economics Task Force Preliminary Report 2018 House of Delegates

Information Only

Dr. Viren Patel, chair

Background

Working with the payment policies of patients' dental benefit plans remains a source of frustration for many dentists. CDA has responded to these concerns in a number of ways, including sponsoring legislation, developing resources and membership education programs through CDA Practice Support as well as the provision of direct assistance to members with payment disputes.

Additionally, in 2011 the CDA House of Delegates established a dental benefits taskforce to:

"Research the dental benefits industry, including but not limited to, the impact of dental plan policies and procedures and contracting requirements on dental practices and to identify strategies to enhance the position of providers and patients in the dental benefit marketplace..."

The work of the 2011 dental benefits task force led to the identification of additional CDA member resources, including the creation of The Dentists Supply Company (TDSC). TDSC was created to assist CDA members who are seeking ways to reduce overhead costs and remain competitive in the changing health care environment. In addition to TDSC, CDA created supplemental dental benefit resources through CDA Practice Support, pursued legislation (AB 1962) to require the disclosure of dental premium percentages that are used for administrative costs and profits versus directed back into patient care (dental medical loss ratio) and initiated litigation in response to Delta Dental of California's announcement to unilaterally change its reimbursements calculations. This litigation resulted in a \$65 million settlement agreement, which will be dispersed to dentists affected by Delta Dental's application of the inflationary adjustment percentage to requested fee increases during the period of Jan. 1, 2011, through Sept. 14, 2017. CDA also secured additional disclosures and protection for dentists as part of the settlement.

While CDA's efforts have resulted in significant progress for CDA members and their patients, continuing concerns about the dental benefits industry and the impact it has on dental practices and patient care remains problematic. As a result, a resolution submitted to the 2017 CDA House of Delegates was approved creating the Dental Benefits & Economics (DBETF) task force:

Resolution 13S1-2017-H: Dental Insurance Relations Task Force

Resolved, that a task force be created to address dental insurance and practice economic issues and make recommendations on how CDA can address and assist members in responding to changes in dental insurance coverage and practice economics, and be it further

Resolved, that the task force place specific priority on researching dental payment denials and delays and urge the board of trustees to intervene and take appropriate action if necessary, and be it further

Resolved, that the task force provide a preliminary report to the 2018 House of Delegates, with a final report to the 2019 House of Delegates.

In March, CDA President Natasha Lee appointed the following individuals to the Dental Benefits and Economics task force:

Virendra Patel, DDS, chair

Richard Barnes, DDS

Martin Courtney, DDS

May Hayder, DDS

M. Saleh Kholaki, DDS

Sunjay Lad, DDS

Irving Lebovics, DDS

Michael Perry, DDS

Paul Reggiardo, DDS

Ariane Terlet, DDS

Benjamin Tsaur, DDS

J. Werhan, CPA/PFS

The timeline for the task force's work includes delivery of this preliminary report, an information-gathering phase that will continue into 2019, with anticipated findings and recommendations reported to the 2019 House of Delegates.

Task Force Objectives and Scope of Work

The task force's goal is to identify opportunities for CDA to further assist members in response to the changing dental benefits marketplace through the evaluation of the changing economic factors in California. This task force is evaluating current CDA policy on dental benefit and economic issues; gathering and evaluating relevant dental benefits information; assessing the contributing economic factors affecting dentists and their practices; and conducting a gap analysis of existing policy, educational materials/resources and programs. Upon completion of this work, the task force will provide recommendations on how the organization may take actions that support the successful resolution of member dental benefit concerns.

Activities to Date

At its initial meeting, the task force developed a list of topics for inquiry, showing particular interest in understanding the economic shifts that have occurred since the previous task force met, dental benefit changes over the last decade and the trends moving forward.

The task force prioritized its efforts in 2018 by focusing on the research of dental payment denials and delays as identified in the resolution from the house. The information gained from CDA Practice Support's presentation, described below, informs the key takeaways for the task force on this particular issue.

The task force met four times (May through August) and has three additional meetings scheduled for 2018, (October 3, November 2 and December 12). To date, the task force has participated in discussions with the following invited guests:

- Anders Bjork, vice president, CDA Market Research and Insights
- Irving Lebovics, DDS
- Sunjay Lad, DDS
- Peter Hilsenrath, PhD — Joseph M. Long Chair of Healthcare Management and Professor of Economics, University of the Pacific
- Jeffrey Michael, PhD — Director of the Center for Business and Policy Research and Professor of Public Policy, University of the Pacific
- Steve Samich, assistant vice president, AON
- Jason Tyson, senior vice president, Bank of America
- Jerry Berggren, director of research and information, the National Association of Dental Plans
- Melanie Duval, director, CDA Practice Support, and
- Cindy Hartwell, dental benefits analyst, CDA Practice Support
- Brianna Pittman-Spencer, CDA legislative director
- Mary Watanabe, deputy director, Health Policy and Stakeholder Relations of the Department of Managed Health Care

The following briefly summarizes the highlights of the 2018 presentation:

Economic Trends

- The cost of health care is adversely affecting productivity and growth of the U.S. economy.
- Dental accounted for 5 percent of personal health care spending in California compared to 4.4 percent nationally in 2014.
- The Affordable Care Act brought the proportion of the national population with health insurance to more than 90 percent (93 percent in California).
- Growth of commercial dental insurance has not been as widespread as health insurance due to higher cost sharing, with enrollees absorbing deductibles, copayments, premiums and the costs for noncovered services.
- Unemployment in California is at or near record lows now, slightly exceeding 4 percent, and the anticipated trend is that it will continue to decrease into 2020, dipping below 4 percent.

- Small businesses are increasingly concerned about finding and retaining skilled labor, along with affordable housing and transportation costs in order to meet consumer demand for services.
- California inflation has risen faster than U.S. inflation for the past three years, with housing as the primary cause.
- Given the current political climate, there is increased pressure and consideration toward a possible universal/single payer system for California.

Dental Benefit Trends

Enrollment

- National enrollment trends show that 77 percent of Americans have dental benefits with little more than half obtaining their benefits through their employer or directly purchasing individual plans (51 percent). More than a quarter of those with dental benefits receive them through a public program, such as Medicaid (26 percent). Approximately 23 percent of Americans do not have any form of dental benefit coverage.
- Dental preferred provider option products (DPPOs) accounted for more than 80 percent of the commercial dental benefits sold nationally in 2016, up from 62 percent in 2006. Fully insured dental benefit plans account for just over half of administrative service only (ASOs) plans.
- In California, 87 percent of residents have some form of dental benefit coverage, with more than half (53 percent) being enrolled in a commercial plan and just over a quarter (27 percent) enrolled in Medicaid. Nearly 16 million Californians are enrolled in a DPPO, 3 million are enrolled in dental health maintenance organizations (DHMOs) and less than a million are enrolled in traditional indemnity products.
- Approximately half of DPPO enrollees are in a self-funded plan (governed by federal laws) versus fully insured (governed by state law).
- National enrollment trends indicate there are a few key segments to watch, including discount dental plans, Medicaid and Medicare Advantage. The shift of enrollment from commercial dental benefit plans to other payers may impact benefit design and reimbursement levels.

Funding

- Over the course of the last eight years, the source of dental premium payments have shifted considerably from the employer to employees paying an increasing portion of the premium cost.
- Despite the shift in premium costs, employer attitudes about the importance of dental benefits hasn't shifted significantly over the past four years, with more than 80 percent of employers seeing dental as essential or a differentiator.
- Dental premiums have remained relatively flat in the past six years while medical premiums have increased an average of 3.5 percent over the same period.
- As medical premiums increase, employers (and employees) are frequently meeting increased medical premiums by making cuts to ancillary benefits, including dental.
- Dental plans report that 51 percent of enrollees have an annual dental benefit maximum that is \$1,500 per year or higher, an increase of 4 percent since 2012.
- Based on consumer surveys, it is estimated that only 14 percent of enrollees reach their annual maximum, while dental plans have anecdotally stated that less than 10 percent of enrollees reach or exceed their annual maximum. The low percentage of enrollees reaching their annual maximum creates a disincentive for purchasers to raise the annual benefit maximum.
- Consumers demonstrate a high level of satisfaction and willingness to refer a friend to their dental plan.
- The most important plan attribute for consumers is their dentist's participation in their plan's network.

Regulatory Perspective

- The Department of Managed Health Care (DMHC) regulates 123 health plans, including 15 dental plans and two dental/vision plans under the authority of the Knox-Keene Act. All dental HMO products and some dental PPO/EPO products fall under the authority of the DMHC. The other dental PPO plans fall under the authority of the Department of Insurance.
- As an agency, the DMHC mission states that it protects the health care of 26 million Californians by ensuring proper licensure, compliance and financial stability of the plans.

- In 2017, the DMHC Help Center assisted 164,151 health care consumers and handled 11,964 complaints. Of the nearly 12,000 complaints received, just over 200 were complaints regarding dental plans. The majority of dental complaints filed were related to benefits and coverage disputes, claims payment and enrollment.
- The DMHC receives approximately 4,833 provider complaints annually. As of July 2018, the Help Center has received only 25 provider complaints against dental plans. The majority of those complaints were related to reimbursement denials after eligibility was verified.
- The DMHC also monitors the dental medical loss ratios (MLRs) reported by the dental plans in compliance with AB 1962 (Skinner). Among other data, the MLR reports disclose the percentages of dental premiums collected that are directed to patient care.
- DMHC does not regulate medical or dental products offered by employers that are self-funded plans. Self-funded plans fall under the federal Employee Retirement Income Security Act of 1974, known as ERISA. Because these self-funded programs fall under the jurisdiction of federal law, they are generally exempt from state law requirements.

Legislative Landscape

- The current legislative environment in California favors health care legislation that drives consumers/enrollees to in-network providers to address cost containment and affordability of coverage and care priorities.
- Due to its commitment to affordability and cost containment, California's legislature has opposed federal efforts to repeal and replace the Affordable Care Act.
- Legislative proposals that support consumer protections in the form of increased transparency have proven successful (e.g., AB 72 — surprise/balance billing).

Dental Benefit Purchaser Trends

- The most common dental plan design remains passive, meaning the benefits payable (reimbursement levels, annual max and deductibles) are the same regardless of whether the enrollee seeks treatment in- or out-of-network, and traditionally structured with 100/80/50 percent coverage.
- Plans are starting to see a shift toward active plans. These plans differentiate reimbursement rates, annual maximums and deductibles based on providers' contracting status to incentivize enrollees to see in-network providers.
- Benefit designs have shifted over the past few years to protect patients from unnecessary radiation (frequency limits on radiographs) as well as to encourage prevention (fluoride, sealants, etc.)
- Most employers are continuing to select standalone dental plans. Bundling with a medical plan may prove financially advantageous, but there is limited experience with these plans to date.
- The trend of dental plan utilization of leased or wrapped network providers is continuing to grow. This is resulting in an increased selection of PPO network providers allowing for increased savings to plans, employers and enrollees. This practice has raised concerns from providers who unknowingly become participants in leased networks due to lack of understanding.
- As benefit dollars become stretched for purchasers, there is a prevalent shift toward dental benefits being a voluntary (ancillary) versus mandatory (necessary) benefit.
- Dental pricing trends reflect that PPO plan premiums increased by 4 percent to 6 percent in 2016 and are expected to remain the same for the next two years.

Dental Practice Transition Trends

- The amount of dental school debt, ranging from \$300k to \$600k for California dental school graduates, is impacting younger dentists' ability to purchase an existing dental practice or start one from scratch.
- Dental practice purchasing has slowed down due to the increasing number of new dentists who elect to work for large groups or dental service organizations (DSOs), especially in their first few years in practice.
- In California, approximately 7 percent of dentists currently work in DSOs, compared to 8.3 percent nationally.

Current CDA Endeavors to Address Dental Benefit Issues

CDA Practice Support Dental Benefit Resources

The CDA Practice Support team presented to the task force on the most common topics/concerns raised by CDA members and the resources available to address their concerns, including but not limited to plan denials and payment delays.

CDA Practice Support has been providing CDA members with direct advisor support, educational presentations and online and printed resources for eight years on the topics of dental benefits, regulatory compliance, practice management and human resources. Practice support analysts receive more than 6,000 CDA member calls per year, with nearly a third of those calls related to dental benefit issues. Dental benefit issues are the most time- and resource-intensive topic areas for the analysts and sometimes require multiple follow-up calls to resolve a single issue.

The following dental benefit topics are listed in priority order below based on member call and email volume to Practice Support over the past year:

- Delta Dental (688)
- Contracts (485)
- Billing (434)
- Fees/Discounts/Refunds (398)
- Appeals (including claim denials and disputes) (157)
- Claim Denials (149)
- Audits (127)

Practice support analysts assist member dentists and their staff on a case-by-case basis by educating them about the issue, guiding them through the necessary processes to address the concern and depending on the issue, will either advocate on the member's behalf to the plans or regulator, refer the member's issue to another CDA department (Public Affairs or Legal) or, if it's a national issue, the ADA.

More recent dental benefit call trends indicate that the following topics are on the rise: dental plan in-office audits, contracting, network leasing, noncovered services capping and refund demands.

Practice support watches for trends and works closely with the Public Affairs team to identify potential advocacy and legislative opportunities. Additionally, Practice Support and Public Affairs meet with some of the larger dental plans on a regular basis to address concerns on behalf of members.

Practice Support currently distributes information and educational resources utilizing multiple channels, including cda.org, *CDA Presents* and the *CDA Update*, in addition to presentations at component dental societies. On average, dental benefit online articles receive five times more page views than those for other topics. There have been 64 dental benefit programs offered at *CDA Presents* since the fall of 2014, representing 4 percent of the total sessions offered. Dental benefit programs have an average of 175 attendees, and the number of sessions offered for dental benefit topics has remained constant over the course of the past five years.

Legislative Efforts

- Over the course of the past decade or so, CDA has successfully sponsored legislative proposals that address dental benefit challenges experienced by our members and the patients they serve, including coordination of benefits (AB 895), refund demands (SB 1387), noncovered services (AB 2275), dental plan disclosures to providers (AB 2252) and dental plan premium transparency (AB 1962).
- CDA sponsored Senate Bill 1008 this year to require dental plans to provide clear, transparent information to patients. The legislative and regulatory arenas continue to present opportunities to hold dental benefit plans accountable.

Preliminary Task Force Takeaways

- Health care remains at the forefront within state and national economic and legislative environments.
- There is continued focus and pressure in these environments on health care cost containment, including everything from driving enrollees toward in-network providers to evaluation of alternative coverage and care models.
- California's health care economy remains robust and enrollment in dental plans is significantly higher at 87 percent in comparison to 77 percent nationally.
- Reimbursement rates continue to be suppressed by dental plans due to continued downward pressure on premiums and the shift of the dental benefit premium costs from employers to enrollees.
- CDA Practice Support data indicates that the predominant dental benefit concerns for CDA members are issues with Delta Dental of California (including the current CDA litigation, contracting, fee filings and audits), contracting, billing and challenges with fees, discounts and refund requests from dental plans.
- Member dental benefit concerns are being well addressed and supported through CDA Practice Support; very few, if any, are being left unaddressed or unresolved.
- There are significant dental benefit resources available to CDA members offered by CDA Practice Support via multiple channels, including one-on-one assistance provided to dentists and their staff
- There are processes in place at the dental plan and regulator (DMHC) levels for providers that are not being utilized to address a variety of dental benefit challenges where more member education could be beneficial.
- Opportunities exist for CDA leadership who are being approached by members about what CDA can do to promote member awareness of the dental benefit resources, tools and processes available to them and their office teams.

Conclusion

The presentations and research conducted to date have contributed to an understanding of the current health care environment and the current dental benefit challenges CDA members face in their dental practices. The task force appreciated learning how CDA is currently assisting members with their dental benefit concerns and is pleased to report this information to the house. The task force recommends that a detailed presentation on members' dental benefit concerns and the CDA Practice Support resources that address those concerns be presented at the CDA House of Delegates. The purpose of the presentation is to help support delegate leaders who are concerned about this issue to better understand and to help promote member awareness of the dental benefit resources, tools and processes available to them and their office teams.

Moving forward in 2019, the task force would like to further explore the dental insurance and practice economics issues, changes and trends and how CDA may be able to proactively address those for members. Areas of inquiry and discussion may include dental school graduate debt, the impact of changing dental practice models, regulatory gaps or opportunities that may be addressed through advocacy efforts and ways to address and educate members about broader economic and dental benefit issues. A final report of its findings and recommendations will be provided to the 2019 house.

Financial Impact: None

Attachments: None

Dental Benefits Submission Form Results

In response to Resolution 18-2018-H, the process for intake of member dental benefit questions and concerns was streamlined, categorized and reported utilizing a member-initiated online dental benefits submission form. The task force was consulted throughout the process and informed of the process results.

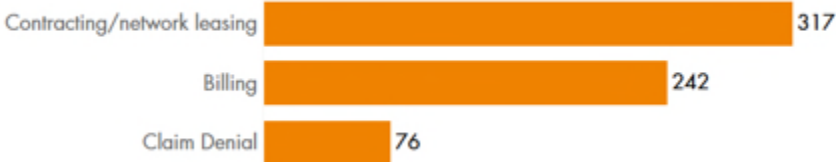
This automated case management process allows for improved data analysis and collection along with enhanced security features to ensure HIPAA compliance. The streamlined workflow provides additional opportunity to identify the source of a member's concerns and potential areas where CDA can further assist our members, including advocacy.

Practice Support worked to develop the new form and process in Q1 2019, conducting a soft launch on April 1 for testing prior to the formal launch on May 1.

The form was marketed utilizing the following channels:

- CDA marketing and advertising channels (email, e-newsletter, website, social media, *Journal* and *Update* ad space)
- Component promotional materials and component newsletter
- Member Services in-bound calls (cross-promote)
- *CDA Presents*

Since implementation of the form, CDA has tracked and received nearly 1,100 submissions. Additional data collected regarding dental benefit issues and available resources may be found in the annual dental benefit resources report provided to the house. Below are relevant statistics of the inquiries received since April:

Cases opened	1,088						
Members assisted	774						
Cases closed	703						
Top three commonly reported member issues (since April 2019)	 <table><tr><td>Contracting/network leasing</td><td>317</td></tr><tr><td>Billing</td><td>242</td></tr><tr><td>Claim Denial</td><td>76</td></tr></table>	Contracting/network leasing	317	Billing	242	Claim Denial	76
Contracting/network leasing	317						
Billing	242						
Claim Denial	76						
Dental plans associated with issues	<ul style="list-style-type: none">• No plan indicated (288)• Delta Dental of California (222)• Other – smaller plans not identified (94)• MetLife (26)• Cigna (24)						
Resolution (root cause of the problem)	<p>Lack of office training/education on dental benefit issues is resulting in 90% of the reasons for member outreach to CDA for assistance. Additional analysis of the data revealed challenges with the top five topic areas:</p> <ul style="list-style-type: none">• 413 - contracting and network leasing issues• 292 - billing questions• 63 - claim denials• 52 - coordination of benefits• 43 - quality assurance audits						

Additional Task Force Suggestions

Member education: The task force recognizes that there is a gap in the knowledge and business skills for many dentists and their team members when dealing with dental plan contracting, billing and claim denials. While CDA Practice Support offers a variety of resources and individual member assistance, this member benefit remains an underutilized resource. There are a myriad of other resources offered through non-CDA affiliated online discussion groups, practice management consultants, practice management courses, and dashboard providers that offer key practice indicator information to assist dentists with analyzing one's practice numbers and the impact of dental plan contracting. In addition to the educational recommendations noted above, the task force is suggesting the following actions be considered based on resource priorities:

- Offer front office dental benefits training and include "how to use cda.org and Practice Support resources" as part of the curriculum.
- Provide educational programs at the local components and/or utilize outside consultants to market and educate members on dental benefit issues and CDA Practice Support resources.
- Increase member awareness of Practice Support resources and benefits through the identification and targeted engagement of non-utilizing members.
- Increase the availability of member resources/tools to assist recent graduates with student debt.
- Develop practice simulation tools to assist dental school students with practice economic and dental benefit issues.
- Develop patient education tools on how to utilize their dental benefits.

Advocacy: The task force acknowledges the strength of CDA's advocacy program and recommends the following actions for consideration:

- Continue to develop and enhance our relationship with the National Association of Dental Plans and the larger dental plans to ensure improved communication and understanding.
- Advocate for the deductibility of student loan interest.
- Explore opportunities with relevant stakeholders to address the cost of dental school education.
- Remain proactive on behalf of the profession in identifying future dental benefit approaches and potential payment models.

Endorsed programs and resources: Claims handling and billing were identified by the task force as ongoing challenges for members. Based on this finding, CDA is vetting potential billing programs to offer as an endorsed program. Also, the task force suggests that CDA vet practice management vendors that are able to assist members with making the necessary changes in their practices to adapt to the economic and dental benefit challenges they face.

Resolution 9**Dental Office Staffing Task Force Report****Action Required**

Dental Office Staffing Task Force (with Board of Trustees addition)

Background

Dental office staff identified the need for CDA's engagement in helping members to successfully hire and retain dental office staff, and directed the organization to study the issue and identify solutions (Resolution 11-2017-H):

Resolved, that the appropriate CDA entity study and develop actionable statewide solutions in response to the dental office staffing shortage, and be it further

Resolved, that findings with recommendations be made to the 2018 House of Delegates.

This resolution, brought by the San Francisco, Marin County, Orange County, Harbor, and Southern Alameda County dental societies was the culmination for many of these components of years of recognizing a growing problem among members related to hiring and retaining dental office staff. As described in the resolution, though some components had discussed their concerns with CDA, it became clearer over time that these concerns were becoming more widespread as the economy continued to recover, employment rates fell and housing costs rose.

Several components reported evaluating both local vs. statewide options to increase the dental workforce, noting the challenges they face in California's current robust and tech-driven economy. Potential activities included developing a comprehensive dental practice resource kit with intermediate and long-term remedies for dental office staffing, and a marketing campaign to promote dental office staffing as a career path. Components report that over the course of these discussions there was agreement that a multipronged approach would be necessary, and because this is a statewide issue, CDA is in the best position to take the lead for developing appropriate strategies to address identified shortages.

The 2017 House of Delegates (house) approved resolution 11-2017-H to establish the Dental Office Staffing Task Force (task force), and in the first quarter of 2018 CDA President, Natasha Lee, appointed the following dental professionals to the task force:

• Dr. Robert Gandola	Chair
• Dr. Carolyn Brown	Member
• Dr. Douglas Cassat	Member
• Dr. Oariona Lowe	Member
• Dr. Carliza Marcos	Member
• Dr. Isaac Navarro	Member
• Dr. John Pruett	Member
• Dr. William Sands	Member
• Dr. Julia Townsend	Member
• Linda Abrahams, executive director, MCDS	Member
• Shari Becker, RDA	Member

The task force has conducted its work using Basecamp, an online communications platform and the following WebEx and in-person meetings:

- May 2 (WebEx)
- June 6 (CDA headquarters)
- July 18 (WebEx)
- August 3 (CDA headquarters)
- September 4 (WebEx)

The task force began by surveilling the environment. This work included a survey of dental assisting schools to learn about educational programs offerings, including but not limited to program duration, costs, financial aid and applicant trends. The task force also surveilled components to learn about component activities related to members' staffing needs, and in particular, to understand what has been helpful and what has not worked well. Some members also reached out to survey a limited number of dentists and dental assistants.

The task force's analysis was informed by the following presentations:

1. Economic influences on the entry and mid-level job market in California
 - **Peter Hilsenrath, PhD** – Joseph M. Long Chair of Healthcare Management and Professor of Economics, University of the Pacific
 - **Jeffrey Michael, PhD** – Director of the Center for Business and Policy Research and Professor of Public Policy, University of the Pacific
2. Orange Chair Diaries (CDA produced career development toolkit) – Mary Sobieralski, RDH
3. California Medical Association's (CMA) member staffing assistance program - Mitzi Young, Physician Advocate, California Medical Association

Findings

Below is a summary of the general findings from research, presentations and discussion:

Economic influences

- The job market is strong, with unemployment in California at or near record lows. This may be driving a perception that finding a job/getting hired is easy, reducing job switching costs and contributing to increasing employee mobility (i.e. negatively impacting retention).
- Fastest job growth is occurring in inland areas of the state: Stockton, Fresno and Inland Empire are the top three. This might indicate an exodus from the coastal city areas into the valleys where housing is relatively less expensive and growth is not constrained to the same extent as densely-populated urban centers.
- Researchers and members report that dental assisting pay and benefits are not enough, or are perceived as not enough to be sustainable for employees, especially in the bay area and where housing costs are high.
- Technology companies are perceived by millennials in particular as offering a better/higher paying career than dental assisting, diverting candidates who might otherwise have chosen dental assisting.
- There is still a significant lag in the post-recession re-entry into the job market for a portion of the age group who might choose dental assisting; the reasons for this lag are not all known or well understood.
- There also appears to be a trend in the types of employment environments that attract young workers that make the dental office less attractive (i.e. flexible hours, working from remote locations, etc.), which may negatively affect the size of the job applicant pool.
- Member discussion:
 - Indications are that many who would be successful dental assistants and great dental team members choose other careers perceived to have better pay, benefits and future over the long run.
 - Because of other careers that compete for the hearts and minds of potential assisting candidates, pay and benefits must be competitive and the job must be perceived as having/adding value; out-of-the-box thinking may be helpful in meeting staff needs.
 - Dentists learn clinical skills in school, but not management skills; many may not understand that they play a pivotal role in building a stable, loyal and skilled dental team.

Dental assisting education

- Response from the survey of schools was variable, with 20 providing complete/near complete information and others failing to respond at all.
 - Program duration ranged from 9 months to 2 years.

- Program costs ranged significantly, from \$1,000 to \$16,000, with many in the \$2,000-\$5,000 range; financial aid is often available.
- Most programs reported a drop in enrollment over the last few years.
 - Programs that increased outreach have seen improved enrollments.
 - Programs generally report an increase in students who are not prepared to be successful in the educational process or in the dental assisting field, citing tardiness and absenteeism as one of the most common concerns. Further, most programs report losing students over the course of the program.
- Programs report that students who successfully complete a program are hired at almost 100% by graduation or shortly thereafter. Programs also report that dental hygiene schools recruit high performing students directly into hygiene programs.
- Programs report salaries ranging from \$14/hr. to \$26/hr.; vary greatly by geography; average reported salary \$18/hr.
- Member discussion:
 - Skill level of graduating assistants varies widely.
 - Requiring schools to adhere to CODA accreditation standards may help standardize assisting education across all programs/locations.
 - Schools do not usually teach computer skills, but this is a growing need for office/assisting staff.

Career promotion/building a pipeline

- The Orange Chair Diaries materials were viewed as valuable/well-received when developed by CDA in the early-mid 2000s.
 - CDA invested significantly in toolkit/video production and active promotion.
 - Commitment to the program diminished after several years as organizational priorities shifted. Despite this, people who knew about the materials have continued to use them.
- Member discussion:
 - Knowledge about dental assisting careers is low; need to promote the profession as early as middle and high school.
 - Understanding that there is a robust dental assisting career ladder is also low.
 - Counselors and others who could promote dental assisting as a career appear not to do so often enough/appear to promote other careers to students who might be good candidates for assisting.
 - User-friendly career-promoting materials should be developed and promoted, and the commitment to this should be sustained over time.
 - ROP and internship-type programs are beneficial to successful recruitment into the field.
 - The military can be a successful place to recruit/many of the skills built during service (punctuality, attention to detail) are transferable to dental assisting; need to make sure military transition counselors have the information they need to promote dental assisting.

Professional staffing services

- Inquiry to CMA as to how they address member staffing concerns revealed:
 - Meeting staffing needs is a frequent member concern.
 - Problem too large for CMA staff to address using internal resources; developed an endorsed program approach.
 - CMA staff person connects member with endorsed program and supports member through the decision to use the service.
 - Initial response is almost always “sticker shock;” final response is almost always satisfaction, with most recognizing that they already expand many resources – human and financial – doing this themselves.
 - Endorsed Program services that are provided on the front side:
 - Coaching services to the hiring manager regarding salaries, benefits, and interviewing.
 - Screen initial candidates and present 2-3 best candidates.
 - Schedule interviews.

- Complete all on-boarding requirements.
- Services provided on the back side:
 - Coach/counsel client and/or candidate on issues that arise to support success.
 - Anticipate 6-month process for deciding permanent hire.
 - Manage candidate release process if that becomes necessary.

Component activities

- Component activities range significantly throughout the state.
- Components frequently support services that facilitate connecting offices looking for staff with potential candidates looking for jobs (job boards, links to online sites like Indeed, Craigslist, Facebook, Swiss Monkey, etc.).
- Most components who have dental assisting schools in their jurisdictions are involved with those schools, including member dentists sitting on the schools' advisory boards.
 - Some components have become more deeply involved, subsidizing school budgets or offering student scholarships.
- Promoting dental assisting through career days, job fairs, etc. is intermittent and tends to occur more by individual dentists than as a component-sponsored activity.
- Some components are actively promoting internship programs to introduce high school students to dentistry.
 - San Mateo County Dental Society recently launched an innovative new dental internship program in partnership with the county office of education that exposes 11th & 12th grade students to the dental office through a 4-week placement in the front office. Currently, 10 students are participating.
 - San Francisco Dental Society has also begun an office internship program for high school students.

Task force member surveys

- Inquiries with dental assistants revealed:
 - Many entered the field because the bar was not too high for them to do so (i.e. length of education, job opportunity offered).
 - Job satisfaction comments include enjoying working with people and the variation in duties/tasks.
 - Concerns with pay and benefits.
- Inquiries with dentists revealed:
 - Many provide significant on-the-job-training, whether that is to further train an assisting school graduate or train a DA to become an RDA using an OJT approach.
 - The majority of dentists queried generally viewed OJT positively and indicated they would be willing to provide OJT again.
 - Pay, benefits, and FT vs PT employment varies significantly.
 - Hiring appears to occur through multiple means, including job postings/online services (e.g. Craigslist), personal contacts, and schools.

Task force members considered these findings and engaged in an in-depth discussion of these matters to develop a comprehensive list of actions that individually and collectively may improve members' experience hiring and retaining office staff generally, and dental assistants in particular. These actions relate to:

- Increasing data collection on the dental assisting profession and shortage for advocacy purposes.
- Removing barriers for out-of-state assistants to gain California licensure.
- Promoting dental careers to build a workforce pipeline.
- Improving the quality of dental assisting staff through stronger educational programs.
- Providing education to member dentists on the requisites for building a stable, loyal and skilled staff, including the essentials of offering competitive salary and benefits, and soft skills for team management.

The task force also recognized the importance of local, on-the-ground work in this area and developed a list of potential activities for local dental components to consider.

The task force recognized that there are many elements that influence successful finding, hiring and retaining office staff, including the pivotal role of competitive salaries, benefits, employment policies, and the importance of engaging at the local level in educational programs and career building activities. The task force developed a comprehensive set of activities at every level – the individual dentist, the component and CDA to improve office staffing, and provides this to the organization for evaluation of the resources required for implementation (Attachment A).

In fulfillment of the 2017 house directive for the task force to develop “. . . actionable statewide solutions in response to the dental office staffing shortage . . .” the task force prioritized the following state-level actions CDA can initiate. The task force further encourages the more comprehensive list of recommendations (Attachment A), be evaluated for the resources necessary to accomplish and recommends that it serve as a list for potential further action.

In October, the board approved the following resolution, by vote of 41 to 3:

Resolved, that the House of Delegates file the Dental Office Staffing Task Force report, and be it further

Resolved, that the Board of Trustees pursue the following advocacy, educational and local support strategies for addressing dental office staffing shortages in California:

- Advocate with the California Office of Statewide Health Planning and Development to conduct a forecast analysis of dental assisting, and promote the results to address any identified shortage.
- Advocate for the Dental Board of California to remove barriers to dental assistants from other states who would qualify as a registered dental assistant to be quickly approved for licensure in California.
- Develop materials to educate external stakeholder on careers in dentistry for the purpose of promoting dental careers and building a dental assisting pipeline.
- Adapt/optimize CDA resources, including using multiple CDA platforms, to educate and assist members to understand the pivotal role they play in, and build skills for, successful hiring, developing, and retaining skilled staff.
- Initiate a project whereby local components can share the specifics of successful local activities.

Attachments

A. Comprehensive List of Recommendations

Financial Impact

All programs will have associated costs. Cost estimates will be developed by appropriate entities within CDA, and evaluated by the board for prioritization and implementation.

Recommendation

The house is asked to file this report in accordance with resolution 11-2017-H, via the following resolution:

Resolved, that the Dental Office Staffing Task Force report be filed.

Comprehensive List of Recommendations

Workforce development: The task force recognizes that in order to advocate effectively for increased support for dental assisting as a career in California, it is essential to know more about the assisting workforce/shortage. Potential actions for CDA in the area of workforce development include:

- Advocate with the California Office of Statewide Health Planning and Development to conduct a forecast analysis of dental assisting and disseminate the results with the legislature/ appropriate state agencies.
- Engage ADA on similar advocacy at the national level (i.e. HRSA).
- Study California's dental assisting career pathway to better understand how it functions and how it can be maximized for both dentist and assistant benefit.

Dental assisting career pipeline: Develop materials promoting dental careers for use by members, school counselors, military transition counselors and others to introduce dental careers to middle and high school students, service members transitioning out of military service, and others who may be exploring career options. Materials should highlight that there is a robust dental assisting career ladder. This recommendation:

- Acknowledges the benefit of CDA's previous program – known as Orange Chair Diaries – and does not require specific adherence to that program, but rather acknowledges the value of promoting the profession for the purposes of building a pipeline. It is also worth noting that as dental staff shortages extend beyond California, it may be useful to explore partnerships with other state associations/ADA;
- Should include information about Community Health Workers (CHW)/ Community Dental Health Coordinators (CDHC).
- Will be most effective with an organizational commitment to ongoing promotion and support.

Licensure portability: Advocate for the Dental Board of California to remove barriers to dental assistants from other states who would qualify as a registered dental assistant to be quickly approved for licensure in California.

- There was particular interest in doing this for dental assistants who have DANB certification as a Certified Dental Assistant (CDA) and/or assistants associated with military service members' relocation into California.
- Dentist licensure by credential might be a model adapted for assistants.

CDA Practice Support: Adapt/optimize PS resources to assist members to be proactive in the hiring, developing, and retaining skilled staff. Several potential resources were discussed, including:

- Potential Endorsed Programs:
 - Support services for employee hiring, onboarding, and dismissal services.
 - Applicant verification/background check services.
- HR toolkit that specifically addresses practices that lead to successful staffing, such as:
 - Benefit of and instructions for setting and communicating transparent employment policies (i.e. pay increases, continuing education benefits).
 - Recruitment and retention calculator/tool
 - The crucial role of competitive wages and benefits in hiring and retaining.
- Soft skills training: These recommendations are founded on the understanding that dentists are not trained in how to be employers. It acknowledges that dentists may not know the elements necessary for - nor fully understand that they must be proactive in - creating a stable, loyal, and high-functioning dental team to be successful - including the importance of offering salaries and benefits sufficient to meet employee housing and career aspiration needs, as well as creating an environment of mutual respect and appreciation.

The task force recommends CDA utilize multiple CDA educational platforms (CDA Presents, CDA Journal, speakers' bureau, etc.) to offer education and training that increases understanding of and skills related to:

- The dentist's role in the employer-employee relationship, including skills for choosing and keeping the right staff – including the use of the 3 "C"s of hiring – character, chemistry, and competency; identifying shared values; and creating and nurturing an environment of mutual respect.
- The importance of non-salary support: how atypical types of support can make the difference for an employee (i.e. paying for childcare; paying for parking). This recommendation includes the suggestion to engage the dental assisting community (CDAA) to develop content.
- Crucial Conversations skills.

Dental Assisting Education: Explore actions that increase the pool of available and well-qualified dental assistants, including:

- Work through the regulatory process with the dental board to identify and take corrective action with underperforming schools.
- Standardize dental assisting education – perhaps through advocating that dental assistants graduate from a CODA approved school for CA licensure.
- Increase resources/opportunity for dentists, either individually or through a group process to train (undertrained or untrained) assistants directly.
 - IHS and the military have dental assisting training curricula which CDA may be able to access (Dr. Brown has submitted that request).
- Advocate for support of ROP programs and other dental assisting education at the state level as appropriate.

Local components: The task force acknowledges that local components are already engaged in activities that support members to attract, hire, and retain staff, and recognizes that need for, and the capacity to take local action varies from component to component. With that as context, the task force made these recommendations for CDA to support components:

- CDA to develop a system by which components can share successful activities.
- Components that collect localized salary information share their methodology with other components.
 - CDA can support this recommendation by assuring components have an appropriate methodology for collecting this type of data and the legal parameters for doing so.

The task force offers these additional recommendations for components to consider, as appropriate:

- Convene local communities of interest to address concerns/ advocate for dental assisting education. This may include component members, dental assisting educators, dental assisting leaders, high school educators/local officials, etc. Areas of interest/development may be:
 - High school ROP programs
 - Educational grant programs
 - Office internship programs
 - "Out-of-the-box" problem-solving at the local level, which may include such things as working collectively to address housing and transportation needs

Status of Expanded Duty Dental Assistants and California Dental Hygiene Programs

Policy Development Council Response to Resolution 51-2007-H

BACKGROUND

In 2006, the House of Delegates (HOD) received *Dental Assisting and Prophylaxis*, a report which provided information on dental assistants who perform limited prophylaxis. The report noted the pros and cons for establishing this type of dental personnel, and provided an assessment of need. The report acknowledged that expanding the dental assisting scope of practice to include prophylaxis is consistent with current association policy. The Association has not proposed legislation to this effect because implementation of legislation passed in 2004 to expand current dental assisting duties has been delayed and is now in the process of being repealed and replaced with new legislation.

In 2007, the HOD received the *Status of Expanded Duty Dental Assistants and California Dental Hygiene Programs*, a report detailing the regulatory status of the expanded duty functions for registered dental assistants, the number of new dental hygiene programs in California, and the number of expected graduates from all dental hygiene programs in California. In an effort to remain informed, the House approved Resolution 51:

Resolved, that a report be brought to the 2008 House of Delegates regarding the number of graduating hygienists from California dental hygiene programs and the regulatory status of the expanded duty functions for registered dental assistants.

This report is in response to Resolution 51 and updates the *Status of Expanded Duty Dental Assistants and California Dental Hygiene Program*.

REGULATORY STATUS OF THE EXPANDED DUTY FUNCTIONS FOR REGISTERED DENTAL ASSISTANTS

In 2002, the Dental Board sunset review committee recommended a comprehensive evaluation of the dental assisting structure. In 2004, SB 1546 (Figueroa) was enacted which called for the creation of three new specialty categories: registered restorative assistant, registered surgery assistant, and registered orthodontic assistant. SB 1541 (Ducheny) was enacted in 2006, to place the work experience pathway for dental assistants into law.

In January 2008, following six years of legislative and regulatory work, the Dental Board of California acknowledged that even with the significant efforts of many parties and the additional time provided by two legislative extensions, an overly burdensome structure had inadvertently been created for general dentists and for those wishing to enter or expand within the dental assisting profession.

Directly following the January Dental Board meeting, CDA engaged representatives from the dental assisting community, orthodontics, oral surgery, periodontics, and general dentistry to participate in a process to create an efficient, feasible and effective dental assisting structure. AB 2637 is the result of that process. If enacted, AB 2637 would:

- 1) Repeal SB 1546 scheduled to take effect January 1, 2010;
- 2) Maintain the existing career ladder from Dental Assistant (DA) to Registered Dental Assistant (RDA) to Registered Dental Assistant in Extended Functions (RDAEF);
- 3) Develop more substantive duties for DAs, RDAs and RDAEFs, including the educational and training requirements for those duties;
- 4) Establish two permits – Orthodontic Assistant Permit (OAP) and Dental Sedation Assistant Permit (DSAP) – which can be obtained by a DA, RDA or RDAEF by completing additional education and training, and passing a state administered examination.

DENTAL HYGIENE PROGRAMS IN CALIFORNIA

Information from the American Dental Association Survey Center shows California currently has 21 dental hygiene programs.

CABRILLO COLLEGE	LOMA LINDA UNIVERSITY	SOUTHWESTERN COLLEGE
CERRITOS COLLEGE	OXNARD COLLEGE	TAFT COLLEGE
CHABOT COLLEGE	PASADENA CITY COLLEGE	UNIV OF SOUTHERN CALIFORNIA
CYPRESS COLLEGE	RIVERSIDE COMMUNITY COLLEGE	UNIVERSITY OF THE PACIFIC
DIABLO VALLEY COLLEGE	SACRAMENTO CITY COLLEGE	WEST LOS ANGELES COLLEGE
FOOTHILL COLLEGE	SANTA ROSA JUNIOR COLLEGE	WESTERN CAREER COLLEGE
FRESNO CITY COLLEGE	SHASTA COLLEGE	SAN JOAQUIN VALLEY COLLEGE

A dental hygiene program at the College of San Mateo is expected to open in fall 2010. Capacity of the school will be 50 students, 25 students in each class. Members of the San Mateo County, Mid-Peninsula, and San Francisco dental societies made financial commitments to the program and supported the local community college bond measure approved by voters in 2006. The College of San Mateo will house the program in a new campus building that will also house dental assisting and nursing programs.

Additionally, Southwestern College plans an expansion to include an accelerated program for internationally educated dentists. The goal was to open the program in spring 2009, but they are still in the process of developing curriculum and do not expect to meet that goal.

NUMBER OF GRADUATES AND EXPECTED GRADUATES FROM ALL DENTAL HYGIENE PROGRAMS IN CALIFORNIA FOR THE YEARS 2004 - 2011

Accredited dental education programs are required to complete annual surveys. Survey information was requested from the American Dental Association Survey Center, which provided statistics from the 2004-05 school year to the 2006-07 school year (see table below).

Capacity, Enrollment, and Graduate Statistics for California Dental Hygiene Programs

Year	Capacity	1 st Year Enrollment	Graduates	Graduation Rate
2004 - 05	571	551	497	88%
2005 - 06	619	583	496	81%
2006 - 07	651	569	505	89%
2007 - 08*	651	615	577	94%
2008 - 09*	651	618	583	95%
2009 - 10*	651	620	590	95%
2010 - 11*	701	665	633	95%

* Estimated; assumes San Mateo will open as planned in fall 2010

Graduation rates for all dental hygiene programs for each year were estimated because the ADA does not request this information from individual programs. It should be noted that a decrease in graduation rates from California's dental hygiene programs has occurred since 1995, when an open enrollment policy established a lottery system to determine admissions. Since that time, however, program directors have worked with their community college boards, per state regulation, to raise GPA requirements and tighten admission criteria. As new schools gain experience and more well-prepared applicants are admitted, it is anticipated that between 2004 and 2011, graduation rates will increase by approximately 25 percent and then become steady.

Further, discrepancies in capacity and 1st year enrollment are also evident; total differences, 2004 to 2007, range from a low of 20 in 2004-05 to a high of 60 in 2006-07. The reasons that capacity and actual enrollment do not match are varied. A difference of less than five between capacity and 1st year enrollment is not unusual, as a few

students tend to drop out before starting a program. Programs with differences greater than five are noted in the table below; explanations for the differences follow.

**California Dental Hygiene Programs with Large Differences
Between Capacity and 1st Year Enrollment 2004-2007**

YEAR	DIFFERENCE	SCHOOL
2004-05	14	Shasta College
2005-06	7 30	Fresno City College Silicon Valley College
2006-07	60	Western Career College

Council staff discussed with ADA Survey Center staff possible reasons for the large differences. The discrepancy for Shasta College most likely results from a change in its program capacity for each year 2000 to 2006, starting with 14, to 23, 26, 30, 28 and 16 respectively. According to Fresno City College staff, the enrollment difference was most likely due to students dropping before the program started.

The Silicon Valley College program was absorbed by Western Career College, San Jose in 2005, which explains the difference of 30 students. Western Career College staggers its enrollment between its two campuses, Sacramento and San Jose. The total program capacity between both campuses is 60 enrolled students. The first class of hygiene students started in Sacramento in September 2005; San Jose started its first class in January 2006. The difference between capacity and 1st year enrollment in 2005-06, 60 students, is explained by the fact that the San Jose program had not yet enrolled its 30 students at the time it completed the 2005-06 ADA survey. The other 30 students can be explained by the fact that Western allows graduates to return to the school to practice as students because California law regarding dental hygienists states that only hygiene students and registered dental hygienists can practice dental hygiene. While these “students” have already graduated, they are included in the total capacity of the school, reported by the ADA Survey Center as 90 students.

Future ADA Survey Center reports will most likely continue to reflect a difference of approximately 30 students for Western Career College.

CONCLUSION

The Policy Development Council respectfully submits this report to the House of Delegates and reaffirms its conclusion in the original report, Dental Assisting and Prophylaxis. As noted above, the provisions of SB 1546 (2004, Figueroa) are in the process of perhaps being repealed by AB 2637 (2008, Eng), which would create a new career pathway for dental assisting. Should that change in dental assisting regulation become enacted and implemented, the Government Affairs Council could then consider the political feasibility of pursuing legislation related to the further expansion of dental assisting.

CDA Division of Public Policy I S S U E S U M M A R Y

Dental Laboratories

Introduction

The 2008 CDA House of Delegates (house) adopted Resolution 37RC-2008-H, which directed the Policy Development Council (council) to “study the issues affecting dental laboratory technicians including workforce characteristics, training, current and future workforce capacity, and outsourcing and quality of materials,” and to “report to the 2009 house on their findings and recommendations.” At its January 2009 meeting, the council formed a workgroup to study the issue and develop recommendations for the full council. This issue summary attempts to frame the fundamental issues for workgroup and council consideration.

The sponsor of Resolution 37RC-2008-H, the San Diego County Dental Society, identified a series of specific issues it felt were worthy of consideration. These included:

- The increasing use of dental laboratories outside of the U.S. and whether that is a cause or symptom of the shortage of U.S. lab technicians.
- Potential FDA requirement to identify the origin and content of any prosthesis and/or that any offshore laboratories be registered.
- Public education about opportunities in laboratory technology through media, advertising and special promotions by manufacturers and dental societies.
- Dissemination of information about careers in dental laboratory technology to high schools and community colleges.
- Joint Continuing Education to foster interaction and advancement of skills between dentists and lab technicians.
- Mandatory technician certification, implying the necessity of a formal technical education.

The increasing concern in the dental community about the dental lab workforce appears to stem from two distinct but interrelated issues: 1) A perceived steady diminution in the quality of laboratory work, perhaps resulting from a shortage of certified lab technicians; and 2) A growing sense of alarm about the difficulty dentists have in verifying the materials used in the lab work they order, a problem best epitomized by the discovery in early 2008 of lead in restorations obtained from China. These over-arching issues are complex and multi-faceted, and some of the possible remedies would require resources that are difficult to come by, especially in the current economy.

Background and Discussion

According to the National Board for Certification in Dental Laboratory Technology, the first known independent dental laboratory in the United States was opened in 1887. Prior to that time, dentists performed any necessary laboratory work themselves, but by 1910, commercial dental laboratories managed by dental technicians had become more predominant. Much like the dental profession itself, as the laboratory profession matured there became an increasing interest in organizing as such, and the National Association of Dental Laboratories (NADL) was formed in 1950. In 1954 the NADL began to develop the first national certification program for dental technicians, and the National Board for Certification (NBC) was formed in 1954, with the first Certified Dental Technician (CDT) certificates awarded in 1959. In 1974, the National Board for Certification added a Certified Dental Laboratory (CDL) program requiring ongoing continuing education and self-certification by laboratories themselves, which in order to be certified must have each specialty unit overseen by a CDT.

Over the years, the NBC certification process has remained the “gold standard” for validating the qualifications of dental lab technicians, coupled with Committee on Dental Accreditation (CODA) evaluation of laboratory technician education programs. In order to become a CDT, an applicant must document one of several combinations of CODA accredited education and/or professional experience (i.e. five years of on-the-job training experience with no formal education, or completion of a two-year CODA accredited program and two years of practical experience), and pass a written and a practical examination. There are then various continuing education and other requirements for annual certificate renewal.

For many years, dentists developed strong ongoing relationships and worked effectively with dental laboratories, typically small laboratories in their communities. Gradually, though, over the course of the past decade, new

trends have emerged both nationally and in California that have generated increasing concerns about the long-term viability of the dental lab industry.

In February 2005, the ADA hosted a two-day Dental Technology Summit, a gathering of numerous representatives of various parties interested in the status of the dental laboratory industry, including general dentists, specialists, laboratories, educators, dental manufacturers, etc. Gordon J. Christensen, DDS, MSD, PhD submitted a summary of the conference's results, entitled "Dental Laboratory Technology in Crisis," which was published in two parts in the May and June 2005 issues of the *Journal of the American Dental Association* (JADA). The conferees identified four fundamental issues critical to the future of the industry:

- Dental laboratory educational programs and recruitment – The conferees found that there are insufficient incentives for individuals to obtain training from CODA accredited educational programs and to become certified. There are only 20 accredited programs remaining in the entire country (two in California, down from eleven back in the 1980s), and the modest income gain that typically results from certification does not provide much incentive for people to go through that process versus on-the-job training.
- Dental laboratory technician certification issues – For many of the above reasons, the perceived value of certification is low. No state requires certification to work in a lab, and only a small handful of states require that at least one supervising individual be certified.
- Offshore dental laboratories – Many dentists are unaware of the increasing amount of dental lab work being done overseas. Because there is so little state regulation of dental laboratories, there is little if any way for a dentist to know if the laboratories he or she works with are outsourcing all or parts of their work overseas, unless the laboratories disclose that information voluntarily. Without voluntary disclosure, dentists have no way to verify the materials being used or the quality thereof. Even if the dentist is aware that work is being done overseas, there is relatively little opportunity for communication and coordination with an overseas lab regarding the work that is to be done.
- Dentist/laboratory technologist interaction: A general consensus of the conference attendees was that the current educational and professional structure rarely fosters ongoing interaction between dental technology and clinical dentistry. While some accredited dental technology programs do work directly with dental and/or dental assisting schools, lab employees who receive on-the-job training often have little or no contact with the dentists or patients they are serving, which does not contribute to a sense of dental lab work as a rewarding, long-term career choice.

In February 2008, the issue of dental laboratory quality standards was brought to the forefront again with a media report from Ohio about lead having been found in prostheses manufactured in China and shipped to the U.S. Although there have been no additional incidents reported, the Ohio case added to existing concerns on the part of dentists and patients about how they can assure the quality of materials used by overseas laboratories. Although importers of dental prostheses are required to be registered with the federal Food and Drug Administration (FDA), and are potentially subject to inspection, the sheer volume of goods being imported into this country makes it difficult to assure absolute compliance with U.S. standards. Thus, the lack of direct regulation of laboratories in most states (including California) or of explicit disclosure requirements for laboratories using overseas manufacturers makes it very difficult for dentists to be sure of what they are purchasing.

CDA Policy

CDA policy in the area of dental laboratories is somewhat restrictive, and would probably need to be modified if the association were interested in increased state regulation of dental laboratories. Resolution 26-1991-H, which has never been modified or rescinded over the past 18 years, resolved that "in the absence of compelling evidence of public safety concerns, and in the knowledge that the dentist is ultimately responsible for patient care including the quality of dental prostheses, CDA opposes licensure and/or registration of dental laboratories and/or dental laboratory personnel, and legislation to accomplish that purpose..."

In 2001, the house approved a revised Policy on Allied Dental Health Personnel (Resolution 13RC-2001-H), which include a section on dental laboratories. Although the policy statement acknowledged growing concern about an "impending crisis" caused by lack of incentives for qualified individuals to enter the field and the increased outsourcing of lab work, the statement's recommended actions were limited to contributing funds to "scholarship programs sponsored by the dental lab industry to assist dental laboratory technicians who are applying for national certification," along with supporting dental lab certification programs in general and "encourag(ing) local components to invite dental laboratory technicians to their meetings to discuss mutual concerns with dentist-members."

ADA Policy

The primary ADA policy document related to dental laboratories is its Statement on Prosthetic Care and Dental Laboratories, which was first adopted in 1990 and has been amended six times since, most recently in 2007. The statement is somewhat noncommittal about the ADA's position on state regulation of dental laboratories, emphasizing the primary responsibility of the dentist for all aspects of patient care and opposing "the creation of additional regulatory boards to oversee dental care and therefore, oppos(ing) any form of governmental regulation or licensure of dental laboratories not promulgated under the auspices of the state board of dentistry." The statement acknowledges that some states have chosen to require some form of certification or registration of dental laboratories and/or technicians, but does not take a position on that issue in and of itself, beyond the implication that any such regulation should be under the state dental board's jurisdiction.

The most recent addition to the statement was made by the 2007 ADA House of Delegates (ADA house). Resolution 6H-2007 added a section urging constituent dental societies "to pursue legislation or voluntary agreements to require that a domestic dental laboratory which subcontracts the manufacture of dental prostheses notify the dentist in advance when such prostheses, components or materials indicated in the dentist's prescription are to be manufactured or provided, either partially or entirely, by a foreign dental laboratory or any domestic ancillary dental laboratory."

In addition to this policy, the 2008 ADA house approved Resolution 62H-2008, which called on the ADA to convene a Future of Dental Laboratory Technology Conference, gathering together specified interested stakeholders to consider issues relating to the dental laboratory technician workforce, the changing marketplace for dental prosthetic solutions, and safety and regulatory concerns related to dental laboratories, including off-shore dental laboratory outsourcing. That conference was held on August 9, 2009, at ADA headquarters in Chicago.

California Law

The only current reference to dental laboratory work in California's Dental Practice Act is the exclusion from the definition of dentistry of "the construction, making, verification of shade taking, alteration or repairing of bridges, crowns, dentures, or other prosthetic appliances, or orthodontic appliances, when the casts or impressions for this work have been made or taken by a licensed dentist, but a written authorization signed by a licensed dentist shall accompany the order for the work or it shall be performed in the office of a licensed dentist under his or her supervision." There are otherwise no licensure, registration, or certification requirements for dental laboratories or technicians, nor are there any requirements for disclosure of outsourcing to other domestic or overseas laboratories.

Other State Laws

Currently, only five states (Florida, Kentucky, Oklahoma, South Carolina, and Texas) have some form of mandatory registration of dental laboratories and/or dental lab technicians. Of these, only Kentucky and South Carolina require all dental technicians to be registered with their respective boards of dentistry. The other states only require the laboratories themselves to be registered, although some do require that at least one lab employee be a certified dental technician. South Carolina is the only state that offers its own written exam for dental technicians, although it also allows registration applicants to pass the NBC exam instead. South Carolina also requires registered dental technicians to have completed a board-approved two-year educational program, three years of work experience under the direct supervision of a licensed dentist or registered dental technician, or national certification as a Certified Dental Technician through the NBC. South Carolina also takes things a step further than any other state by requiring that any out-of-state lab performing work for a South Carolina licensed dentist have at least one authorizing employee who is registered with the state board. Texas, on the other hand, requires dental laboratories to register both themselves and their dental technician employees with the state Board of Dental Examiners, and requires each lab to provide proof that at least one employed technician is certified by a nationally recognized board (i.e. the NBC).

In recent years, an increasing number of states have enacted laws requiring disclosure by dental laboratories of the country of origin in which the work was performed, as well as the materials used. Florida and South Carolina enacted new laws in 2008. Florida's law also requires that laboratories provide any certificates of authenticity available from manufacturers, and requires that the owner or at least one employee of every registered lab document 18 hours of continuing education as a condition of biennial renewal. South Carolina's law is similar, but does not include the certificate of authenticity requirement, and instead requires laboratories to include the percentage of each ingredient contained in the device. The Ohio State Dental Board has developed guidelines for a standardized prescription form for dentists to provide to their laboratories, which includes a tear-off "Dental Restoration Point of Origination Form" which the lab is required to provide to the requesting dentist when the case

is received but before actual fabrication. Other state laws only require the materials disclosure to be included with the completed work.

Issues For Consideration

Because dental laboratories and dental laboratory technicians are essentially unregulated in California, there are many possible directions for CDA to consider addressing the concerns raised by Resolution 37RC-2008-H. As these issues are discussed, it is important to examine the potential ramifications of each action prior to making a decision to move forward.

Perhaps the most fundamental overarching concern expressed by dentists is that it is becoming increasingly difficult to assess exactly what quality of product they are receiving for the price being charged. Particularly in these difficult economic times, dentists have to carefully weigh the sometimes conflicting pressures of quality versus price. Unfortunately, the most commonly identified potential policy solutions to the problem could create their own conflicting pressures.

The most basic potential “solution” to the dental lab quality issue would be to find ways to encourage more people to become certified dental technicians. This solution, however, collides with the fundamental problem of program availability. While lab technicians do not have to complete a two-year accredited training program in order to become certified, these programs are generally considered to significantly improve the quality of the technician’s output, and certainly make the certification process easier to complete. However, the number of accredited programs in California has dwindled from 11 to two over the last 25 years, and efforts in various parts of the state to start new programs have run into great difficulty, largely due to financial and physical resource limitations at already overwhelmed community colleges. While enacting a law requiring technicians to be registered, or requiring laboratories to employ a specified number of CDTs, might make sense in theory, it is not at all certain that an increased supply of training programs (or spaces within existing programs) could be established to meet the law’s demands. No matter what training requirements were established, the price pressures coming from individual patients as well as insurance companies would make it difficult for laboratories to increase compensation to make it worthwhile for people to complete the certification process.

The issue of overseas outsourcing presents its own set of policy dilemmas. The ADA encourages states to enact laws requiring laboratories to disclose to dentists when they are sending work out of state or overseas, but it is difficult to see how effective such a law would be in California without at the same time requiring all laboratories to be registered with the Dental Board. Without the ability to identify the laboratories, it is doubtful that the state could adequately enforce a disclosure law. Of course, moving into the area of lab registration presumes the need for some basic standards for qualification, which in most states that have done so means requiring that at least some of the lab’s personnel themselves be certified or registered. Requiring technician certification then brings us full circle to the very issues raised in the preceding paragraph. In addition, South Carolina is the only state so far that has developed its own lab technician registration examination; other states rely on the existing, private NBC certification process. California generally does not have a history of allowing private entities to certify the qualifications of state licensees. At a time of severely limited state resources, policymakers may not be terribly interested in creating a new licensure category with a new state examination.

Conclusion

The issues raised above are not intended to throw “cold water” on all the proposed solutions to the concerns dentists have about the dental laboratory industry. Rather, they are meant to assist CDA in sorting through the relative costs and benefits of the different possible remedies. With the ADA preparing for another major conference on this subject later this year, and with dentists continuing to raise concerns, this clearly is an issue that needs to be addressed in a multi-faceted way.

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