Michigan Dental Association

MEETING OF THE BOARD OF TRUSTEES
December 5-6, 2013
Okemos, Michigan

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The Future of Dentistry
2013 Strategic Plan Annual Review
Member Media Relations
Michigan Dental Association

MINUTES OF THE BOARD OF TRUSTEES
December 5-6, 2013
Okemos, Michigan

OFFICERS:
Dr. Norman Palm, president
Dr. Martin Makowski, president-elect
Dr. Mark Johnston, vice-president
Dr. Debra Peters, speaker (for a portion)
Dr. Virginia Merchant, editor
Dr. Charles Burling, secretary
Dr. Stephen Harris, treasurer
Mrs. Grace DeShaw-Wilner, CAE, interim CEO/executive
director

TRUSTEES:
Dr. Mark Barsamian
Dr. James Cantwil (for a portion)
Dr. Brian Cilla
Dr. Curles Colbert
Dr. Howard Hamerink
Dr. Vincent Mack
Dr. Scott Meldrum
Dr. William Metz
Dr. William Patchak
Dr. Paul Revard
Dr. Danielle Ruskin
Dr. Colette Smiley
Dr. Robert Tremblay
Dr. Michele Tulak-Gorecki

LEGAL COUNSEL:
Mr. Dan Schulte

ADA NINTH DISTRICT TRUSTEE:
Dr. Gary Jeffers

ABSENT:
Dr. Robert Richards

MDA STAFF: (for a portion)
Sherry Bryan, Membership Coordinator
Tammy Cauthen, Human Resource Assistant
Bernie Droste, CMP, Manager of Continuing Education
David Foe, MA, Director of Print and E-Publications
Patti Fox, Receptionist
Tom Kochheiser, CAE, Director of Public Affairs
Jennifer Lennemann, Assistant to the Executive Director
Josh Lord, MBA, Director of Membership and Strategic Initiatives
Jeff Mertens, Communications and Technology Coordinator
Jo Ann Murphy, senior professional review assistant
Michelle Nichols-Cruz, Board and House Administrator
Stefani Olds, Member Image Enhancement Specialist
Bill Sullivan, JD, Director of Government and Insurance Affairs
April Stopczynski, Public Affairs and Government/Insurance AffairsAssistant
Andrea Sundermann, CAE, Director of Continuing Education
Christine Wilson, Professional Review Assistant
MDAIFG STAFF: (for a portion)

Tina Croley, Commercial Lines Manager
Jeni Drummond, Personal Lines Manager
Cindy Hoogasian, Marketing Manager
Misty Ward, Commercial Lines Account Coordinator
Jeff Spindler, director, property/casualty programs
Craig Start, MBA, President Thursday CE voucher
Tina Voss, Program Manager, Blue Cross Blue Shield
Elise Witte, Executive Assistant
Darren Zwick, Director, MDA Services

GUESTS: (for a portion)

Samuel Bander, DDS, West Michigan President-Elect
Tamara Bauer, DDS, Central District President
Sherill Behnke, DDS, Dental PAC Director
Eugene Bonofiglo, DDS, MDA Past President
Michael Booth, DDS, MDA Insurance & Financial Group Director
Karen Burgess, MBA, CAE
Susan Carron, DDS, MS, MDA Foundation Director
John Carter, DDS, Dental PAC Director
Gerri Cherney, MDA Honorary Past President
Todd Christy, DDS, MDA Insurance & Financial Group Director
Grace Curcuru, DDS, MDA Foundation Director
Joanne Dawley, DDS, MDA Past President/Chair, Governance Work Group
Larry DeGroat, DDS, MDA Insurance & Financial Group Chair
Mr. Curt DeRoo, Kerr, Russell and Weber
Nathalie Dube, DDS, MDA Governance Work Group
Nicholas Fontana, DDS, MDA Insurance & Financial Group Director
Rhonda Hennessy, DDS, Chair, Committee on Governmental and Insurance Affairs
Raymond Gist, DDS, MDA Past President
George Goodis, DDS, MS, MDA Past President
Thomas Goodsell, DDS, MDA Foundation Director
Michael Jennings, DDS, MDA Foundation President Thursday CE voucher
John Kamar, DDS, Oakland District Executive Director
Michael Malhofer, Chair, Committee on Peer Review/Ethics
Lawrence Marcotte, DDS, MDA Past President
Kathy Mielke, RDH, MDA Foundation Director
Dale Nester, DDS, MDA Insurance & Financial Group Vice-Chair
Charles Palumbo, DDS, Dental PAC Director
Kevin Rebhan, DDS, MDA Governance Work Group
Edwin Secord, DDS, MS, MDA Past President
Don Smith, DDS, MS, MDA Foundation Director
Scott Smith, DDS, MDA Foundation Director
Connie Verhagen, DDS, MS, MDA Past President
William Wright, DDS, MS, MDA Past President
GUEST PRESENTERS:
Susan Radwan, Med, CAE, SMP, Leading Edge Mentoring
Marko Vujicik, PhD, ADA Managing Vice President, Health Policy Resources

THURSDAY, DECEMBER 5, 2013:

BECOMING A STRATEGIC GOVERNING BODY:
Ms. Sue Radwan, Med, CAE, SMP, Leading Edge Mentoring, provided the Board and guests
with a presentation on becoming a strategic governing body. Click here to view the PowerPoint
presentation.

The primary job of leaders is planning for change. The roles are not about maintaining the
organization but how to plan for change.

Each Board member was asked to consider what value-added space they bring to the table as
well as what value-added space the Board as a whole brings to the table. The Board must be
looking to the future and helping MDA prepare for what is to come.

There are three types of Governance:

1. Fiduciary Mode:
   - Boards are concerned primarily with the stewardship of tangible assets
     - Board assures faithfulness to mission, accountable for performance, and
       compliant with laws and regulations.

2. Strategic Mode:
   - Boards create a strategic partnership with management
     - Board delegates to management and assures operational performance through
       defining broad expectations and deploying resources appropriately

3. Generative Mode:
   - Boards provide a critical source of leadership for the organization.
     - Board seeks cues and clues from the environment, chooses and applies
       frames for sense-making, thinks retrospectively.
       - This is where broad goal-setting and direction-setting originate.

Ms. Radwan explained that the Board must periodically be in the “helicopter view” in order to
look at the environment for cues and clues (i.e., what are the relationships MDA should or
should not be in from this perspective)?

The Board’s job is to spend more time in the helicopter view to work on the future of the
organization and less time on what is currently happening.
It is the Board’s role to be ahead of where the staff is in the implementation of the strategic plan. Consider what needs to be integrated into the plan; don’t look at the details; stay in the “helicopter view” to always look to the future by looking for the cues and clues.

When the Board makes a change, there are always unintended consequences. Many times those consequences are negative if they are not made in the “helicopter view”. The Board should do what it can to mitigate those unintended consequences.

Form follows function. Define the function that needs to be created and then determine the form.

Governance in the 21st Century is seeing to it that the organization
- achieves what it should and
- avoids unacceptable situations

Governance takes place from the “helicopter view”. The Board provides direction and should have a matrix to measure how/when the work gets done.

What constitutes openness and feedback?

<table>
<thead>
<tr>
<th>Transparency</th>
<th>Evaluation</th>
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<tr>
<td>o Conflict of Interest Policy</td>
<td>o Debriefing from your process and integrating lessons learned</td>
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<td>o Openness with members for both the good and bad news</td>
<td>o Creating metrics to know if you are being effective</td>
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<tr>
<td>o Inclusion</td>
<td>o Self-assessment</td>
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What do the Generations Value?

Explore how some organizations succeed through the shifts in generations and why others do not. This is a good strategic question for the Board. What is the value of each of the generations?

To truly understand membership and the generations you need to know how to do business differently to make value for those different generations. Look at the structure/committees in place – do they appeal to the younger generation/other generations? How do we bridge the gap when there are differences and make sure everyone is involved in the change? People support what they help to create. Determine whose voice has not been heard and bring them into the mix. There will be more buy-in by being more inclusive.

Generational clashes are real and are happening now. This generation of technology is changing the way we communicate. There is a major change in thinking that is going to cause the association to shift. It cannot be staff that helps members understand the value of change; it must be the Board. The Board should listen to member’s concerns, inform them of the possibilities and seek their thoughts on what will make them comfortable.
Transparency

Conflicts of interest present a conflict with the legal fiduciary duty of loyalty.

- Anytime a topic is being discussed and the board member, a relative or close business associate has a monetary gain at play in the decision, the board member has a clear conflict of interest.
  - Appropriate behavior is for the board member to declare the conflict then absent him/herself from the room so that the Board may be able to discuss the matter without undue influence.
  - The Board has a choice about the involvement of the member who has the conflict:
    - Participate fully since the conflict is not significant
    - Stay in the room and participate in the dialogue, but not the vote
    - Leave the proceedings and allow the board to discuss and vote without undue influence.
  - The obligation of confidentiality continues indefinitely, not just while the individual is serving on the Board.

Openness

The 21st century playing field

- No longer can associations contain the bad news revelations.
- Best to be the first out with the news so the board/MDA can shape the dialogue.

The process that the board engages in is more important than the decision that is made. It is important to make sure that the process is right.

Evaluation

- Feedback is the “breakfast of champions”! Make sure that:
  - Actual results are measured against expected results
  - We are reflecting on lessons learned after any process
  - Self-assessment of any volunteer process occurs

FRIDAY, DECEMBER 6, 2013:

ANNOUNCEMENTS:

New Business:

President Palm asked if there was any new business to be submitted for this Board meeting. The Board was informed that if new business is not submitted to the Central Office 14 days prior to a Board meeting a 2/3 vote of the voting members of the Board present is required to consider the resolution. No new business was presented.

Conflict of Interest:

President Palm informed the Board that this agenda item is a time for trustees to mention or ask questions/comments regarding conflict of interest. The conflict of interest policy states that the
trustee should report potential conflicts to the president with the Board making the final decision as to whether a conflict exists. No conflicts of interest were noted.

Board members were provided with the new Conflict of Interest Policy, adopted at its September 2013 meeting. President Palm requested that each Board member sign the new conflict of interest policy.

**Announcements, Interim CEO/Executive Director:**

Mrs. Grace DeShaw-Wilner, interim executive director, informed the Board of the following significant staff anniversaries with the MDA:

**5 Years:**
- Joanne Floyd, membership coordinator
- Josh Lord, MBA, director of membership and strategic initiatives

**15 Years:**
- Kesha Dixon, government/insurance affairs assistant
- Patti Fox, receptionist
- April Stopczynski, public affairs and government/insurance affairs assistant

**President:**

President Palm introduced the new MDA Executive Director, Ms. Karen Burgess, MBA, CAE. She attended the Macomb Presidential Visit recently and will officially begin employment on January 6, 2014.

**THE FUTURE OF DENTISTRY:**

Mr. Marko Vujicic, PhD, ADA Managing Vice President, Health Policy Resources, provided the Board and guests with a presentation on the future of dentistry. [Click here](#) for a copy of the PowerPoint presentation.

Mr. Vujicic discussed fundamental structural changes (not related to fluctuation) that have and are occurring such as spending on dental care.

**Dentist Busyness:**

Wait time for a general practitioner dental appointment has been steadily declining; it has been a smooth trend over the last 10 years.

**Dentist Earnings and the Economy:**

Dentist earnings have been stagnating since the early 2000’s. From the economic perspective it is scary. Mr. Vujicic tried to find dentists that were not experiencing changes in the bottom line. The good news is the decline has stopped and is now flat.

The US economy has technically had three years of economic recovery. Not many are experiencing the recovery, including dentists. Why did spending fall in the early 2000’s?
1. The main reason is a reduction in utilization of dental care by working age adults since the early 2000’s. This is unrelated to the economic downturn. The decline is happening across all income groups. Those with dental benefits, Medicaid, no insurance all declined. More adults going into Medicaid and out of private insurance.

2. Kid’s utilization increased. The gain among children is more focused on poor and near poor kids. The increase in low income kids is persistent across states; there are only three that did not receive an increase. Michigan lands in the middle – above the national average. Children’s use of dental care has been increasing due to the push for access to care and increased reimbursement.

The breakdown of dental benefits for children is:

1. None
2. Private
3. Public

Children are being taken out of commercial insurance and into Medicaid as many states have improved their Medicaid programs.

Access to Care:
Emergency room use for dental has doubled in the past decade with young adults driving the increase in emergency use. They also have the biggest decline in insurance coverage and the sharpest decrease in dental care use.

A Look Forward:

Dental Spending – A New Normal:
Dr. Vujicik conducted an experiment by aging the population forward and making some assumptions. If nothing is done, the new normal will be pretty flat dental spending. There will be more seniors demanding dental care but the younger adults not having insurance is a concern.

Number of Dentists:
With the increasing number of dental students and dentists not retiring combined with flat dental spending, there is great concern for the busyness of dentists.

Affordable Care Act:
- 55% decline in the number of children without dental benefits
- 5% decline in the number of adults without dental benefits.
- Will not affect dentistry busyness.
- Phase I – getting more people covered.
- Phase II and III – managing costs
ADA/MDA Must Support Dentists & Influence Behavior:

Help Dentists Improve Efficiency
- Identify, understand and educate dentists about the various practice models that are emerging
  
- Seek out and share “best practices” among the industry to improve efficiency of dental offices

Better Understand Behavior
- Dig deeper into why adults – especially young adults – are less likely to go to the dentist
  --Cost? Lack of insurance?
  --Changing values?
- Explore ways to influence behavior
  --Oral Literacy Campaign
  --Direct Reimbursement 2.0; it’s time to revisit DR

A commercial plan for kids typically covers 100% of preventive dental. There is even room to raise utilization with commercially insured.

Medicaid beats the commercial market in utilization in four states. Michigan has a large gap between Medicaid and the commercially insured population. There is room to improve in Michigan.

Tomorrow’s health care environment is going to bust out silos. It will require all health care providers to communicate and work together with regard to their shared individual patients. There will opportunities for dentists to interact with the rest of the health care world.

If pediatricians were lined up with dentists and encouraged their children patients to visit that dentist, this could increase dentist busyness.

There are incredible opportunities but not ones that dentists typically are comfortable with as solo practitioners. Dentists need to explore and research pros and cons of collaborating with other health care providers, and explore new payment systems as the next step.

Emergency Room Dental Visits Consist of:
- 40% uninsured
- 30% Medicaid
- 30% commercially insured

Young people coming out of school will have more debt than in the past – this is not unique to dentistry.

The ADA will be doing research on whether student indebtedness causes the new graduate to go into non-ownership practice. Practice expenses are not going to change because of technology and what patients want. Times will be tougher for all new grads. Dentistry is still an attractive option as a career but not as much as it was 30 years ago.
Dr. Vujicik suggested that direct reimbursement be looked at again as a viable mechanism for
dental reimbursement.

Dr. Vujicik’s final message is that ADA/MDA need to be obsessed with new graduate career
success.

**BOARD CAPACITY BUILDING DISCUSSION:**
The Board conducted an exercise designed to develop group discussion abilities. The topic was
chosen by President Palm and is intended to spark controversy.

The topic for this meeting: *MDA Should Align Its Branding More with ADA and Should Brand
Its Logo with the ADA’s Logo?*

The discussion began with Dr. Charles Burling providing the pro point of view and then Dr.
James Cantwil providing the con point of view.

**Dr. Charles Burling – Pro**
As you consider great leaders and great organizations, two traits have always impressed me,
consistency in leadership and adaptability in decision making. These are not mutually
exclusive.

As you enter the MDA headquarters, two things stand out beyond the beautiful and well
maintained building. Patti Fox greets you with a warm and sincere smile and a welcoming
attitude as if you just entered your best friend’s home. She typifies the deep values of the MDA
staff and is a great first impression for our organization. Over her right shoulder is a display of
unique trophies that states that the MDA is the best of the best in numerous areas of dentistry as
recognized by our peers at the ADA. You recognize that we are branded by your second step
into our building with the ADA. We’ve continued to brand with the ADA by sending leaders
like Dr. Ray Gist, who went on to lead the ADA during very difficult times as its
president. Many currently and historically have served in leadership roles at the national
level. We have sent the truly best of our best to make the ADA stronger and better throughout
our years of affiliation with the ADA. These efforts have consistently made our efforts of co-
branding stronger.

Although we have been consistent in branding the MDA as a vital and important part of the
ADA, we now must be adaptive in our decision making process. We have worked diligently to
develop the MDA brand and now any efforts to co-brand with the ADA must be reviewed
closely to not diminish the status of the current MDA brand. We must be adaptive enough to
review every aspect of the brand and not blindly follow. Our decision making must lead in a
direction that is positive for the MDA membership.

For co-branding to succeed it must present a win-win-win situation. A win for the ADA by
having our very best at their table, a win for the MDA with access to resources the ADA offers
beyond our scope of availability, but also a win for our components, our membership, our for
profit subsidiaries, our political advocates, and our foundation who must grow positively from
this branding. Branding that must help members succeed. Consistency negates hypocrisy which
causes defeat and division. Adaptability negates defeat and leads to consistency. Decisions on
comboining must operate within this circle of victory to create a win-win-win environment.

James Cantwil – Con

Are values, strategies and operational philosophies congruent between the two organizations?
The recent ADA vs. MDA House of Delegates votes say not.

Once you join and co-brand it is all for one and one for all. Keeping members happy is a contact
sport and it requires fast response to local issues.

There can be two great happy families living separately but put them in the same house for a
month and see what happens.

The ADA does a great job with national issues. When you have one or both trying to dictate
what is to be done it creates conflict.

It’s a matter of tying together…

- Who’s effort generates most of the revenue?
- Is revenue used to off-set membership dues or will there be other winners not chosen by
  the majority?
- The ADA Foundation vs. the MDA Foundation

Co-branding the ADA with all of the state dental associations would be like taking five pieces
from 50 different puzzles and expecting them to fit together.

Reaction and Comment:

- Branding – Member vs. Public:
  MDA stands to lose if IFG services are co-branded with the ADA. Smaller states or
  states with lower dues probably have more to gain with co-branding.
- Perhaps there is a way MDA can co-brand to a certain level.
- If ADA approaches MDA with specifics on co-branding, MDA would look at the
  proposal but would what the cost would be to MDA?
- MDA should focus on the young dentist and be obsessed with them and what is best for
  them in terms of co-branding. The young dentist needs to see the MDA/ADA as one.
- Each state has its own issues/concerns. Some things can be generalized but most things
  are not. If we combine too much, we lose value for members such as political advocacy.
- The majority of dental associations do not have a *Journal* like the MDA; they have
  newsletters.
- MDA has some of the highest dues across the country but has many products/services.
  Smaller states rely more on the ADA.
- The ADA has great resources. If the branding is not cookie cutter co-branding could be a
  possibility
How would it affect MDA nationally?

If branding is defined as sharing the same vision/mission/logo than that is currently done.

Synergy between all three tripartites. Marko Vujicik left us with the point that MDA should be concerned with the younger dentist. There were very few young dentists at the ADA meeting. Go the other direction. What is the connection with the components--where the young dentists are--and the MDA/ADA?

MDA could consider sub brands to focus on the younger dentist.

MDA could work together with the ADA on public education campaigns.

When it comes to member-to-member programs they need to stay separate.

Rather than co-branding, the Board should discuss how to make all three parts stronger by determining what each organization does best--better define the roles of each.

The Board would like to talk more in the future about branding and alignment. The Board was informed that there is a difference between branding and alignment. The ADA Board will be considering a proposal to develop a tripartite alignment. How could this work, what is done best at each level and how can an approach be developed that will work best for each organization?

This will be a one year to 18 month project.

President Palm will discuss with Ms. Burgess and Mrs. DeShaw-Wilner how the MDA should proceed (i.e., wait for ADA to complete its project, or discuss and provide ADA with information?).

DISCUSSION OF PRIORITY TOPIC:

Consideration of How the Shift in Member Demographics Will Affect Member Expectations:

This topic was discussed by the Board at its June 2013 meeting. At that meeting it requested additional information on demographics. It was provided with a written executive summary.

The Board reviewed a partial list of MDA services. The Board was asked to come prepared with feedback on the following:

1) How many of these services does the MDA “need” due to revenues and how many are needed as they provide a service/value?

2) What do we need to change? Are there services we should add or eliminate?

3) Where do we need to be with our services?

4) Are there areas of information we should be looking at?

5) Should staff be tracking member usage for every service (some programs are tracked, several are not)

Board Comments:

1. Surprised the MDA is not tracking services. When talking about generational groups how do we know what the generations need?

2. Need to track information that is sent out and whether it was valued.
3. The younger generation won’t put up with services/etc. that takes too long to sign up for. Our processes need to be simplified if we expect members to register for services online.

4. MDA has a diverse population of members to provide services to. Some of the services are geared toward specific segments of membership – determine whether it is still valued/needed.

5. Review each service to determine if or where it fits in the MDA strategic goals.

6. Would have to review the service and what need it fills for membership.

7. What are the top 10 utilized services and lowest 10? Who uses them? What could MDA do to improve the lowest 10?

8. It is difficult to know where MDA is to go in the future if it doesn’t know where it is at now. MDA must take a helicopter view of what members want/need.

9. MDA needs to go out into the practices/component societies to diagnose what the problems are and provide them with the appropriate service. MDA needs to be proactive in letting the members know what is available to them.

The Board requested that staff:

1. Develop metrics on the top 10 most utilized and least 10 utilized services

2. Look into marketing services/products better to the members

3. Look into generational issues

4. Add Foundation services to the list of products/services

5. Determine what information can be shared between the MDA and its organizations; data sharing

6. Determine how to track usage. Consider tracking the lower used services first to get a feel for how to track.

Mr. Josh Lord, director of membership and strategic initiatives, informed the Board that there is a level of IT required, as well as staff compliance, to track all of these services and the MDA is just not at that level right now.

The management team consistently works with their staff to review services on a daily basis. Those that are not working for the member are no longer done.

LEADERSHIP DEVELOPMENT INSTITUTE:

Background information is contained in a report dated November 26, 2013.

A fee for the individual to participate was discussed however the Work Group believes it should be at no-cost to the participants. The Board is being encouraged to request that the tri-partite (components and ADA) supplement funding for pilot program.

MDA has applied for funding of the propose pilot through the ADA’s MPG program. An answer from the ADA is expected in January. In addition, MDAIFG has been requested to fund this pilot project as well.

The following were adopted:
Resolved, that up to $80,000 be allocated from the Strategic Project Reserve Fund to cover the projected expenses of the Leadership Institute pilot program.

Resolved, that a Leadership Institute Applicant Evaluation Work Group be formed and that the following be considered for appointment to the Work Group: MDA’s immediate past president, MDA Board members, members of the Leadership Institute Work Group, members of subsidiary boards, MDA’s CEO and MDA’s director of membership and strategic initiatives.

Resolved, that the following criteria be used to facilitate the evaluation of institute candidates:

- Member in good standing
- One written paragraph that addresses the question, “Why are you interested in participating in the MDA’s Leadership Institute?”
- Two endorsements of the applicant (via a signature on the application)
- Compelling CV/resume No restrictions based on age or past participation
- Dental students are excluded for the pilot program

REVIEW OF FUND BALANCES:
Treasurer Harris reviewed with the Board the balances of the 2013 Contingency Fund and the Non Reserve Fund.

CONSENT CALENDAR:
Nine recommendations were contained on the Consent Calendar.

The following was adopted:

Resolved, that the following be adopted:

COMMITTEE ON GOVERNMENTAL AND INSURANCE AFFAIRS (CGIA)

Senate Bills 648-649 – Student Loan Repayment
Recommendation Number: 492

COMMITTEE ON GOVERNMENTAL AND INSURANCE AFFAIRS (CGIA)

Senate Bill 635 – Private Exam Rooms in Nursing Homes
Recommendation Number: 491
COMMITTEE ON GOVERNMENTAL AND INSURANCE AFFAIRS (CGIA)

Senate Bills 575-578 – Health Licensing Boards Disciplinary Subcommittee
Recommendation Number: 489

COMMITTEE ON GOVERNMENTAL AND INSURANCE AFFAIRS (CGIA)

Senate Bills 568-570 – Independent Practice for Physicians Assistants and Advanced Nurse Practitioners
Recommendation Number: 488

COMMITTEE ON GOVERNMENTAL AND INSURANCE AFFAIRS (CGIA)

House Bill 5048 – Drunk/High Health Professionals
Recommendation Number: 493

COMMITTEE ON GOVERNMENTAL AND INSURANCE AFFAIRS (CGIA)

Topic: Registered Dental Assistant Licensing for Veterans
Recommendation Numbers: 494-495

The recommendations are listed below in their entirety:

5-1213 Resolved, that the Michigan Dental Association supports Senate Bills
648-649, regarding student loan repayment. 
Adopted Board Policy Manual

6-1213 Resolved, that the Michigan Dental Association is neutral on Senate Bill 635
regarding private exam rooms in nursing homes. 
Adopted

7-1213 Resolved, that the Michigan Dental Association supports Senate Bills
575, 576, 577 and 578 regarding Health Licensing Boards Disciplinary Subcommittee. 
Adopted Board Policy Manual

8-1213 Resolved, that the Michigan Dental Association is neutral on Senate Bills
568-570 regarding independent practice for physician’s assistants and advanced nurse practitioners. 
Adopted

9-1213 Resolved, that the Michigan Dental Association supports House Bill
5048, regarding health professionals engaging in the practice of the health profession while under the influence of drugs or alcohol. 
Adopted Board Policy Manual

10-1213 Resolved, that Resolution 10-913 regarding registered dental assistant licensing for veterans be rescinded and removed from the Board Policy Manual. 

Resolved, that the Michigan Dental Association supports the proposed bill concept dated 11/22/13 which would waive the licensing application fee for veterans applying for Registered Dental Assistant licensure.

Adopted

Resolved, that the Michigan Dental Association Board of Trustees hereby ratifies and approves the recommended appointments of the following individuals as governors of the Dental PAC Board of Governors:

Region II:
Brian Rathke, DDS
(3-year term from January 1, 2013 to December 31, 2015)

Region V:
Sherill Behnke, DDS
(3-year term from January 1, 2013 to December 31, 2015)

Region VI:
James Cantwil, DDS
(3-year term from January 1, 2013 to December 31, 2015)

Region VIII:
John Buchheister, DDS
(3-year term from January 1, 2013 to December 31, 2015)

Resolved, that the officers of the Dental PAC Board of Governors for the 2013 year be:

Chair: Kerry Kaysserian, DDS
Vice-Chair: Bill Wright, DDS, MS
Secretary/Treasurer: John Buchheister, DDS

STRATEGIC PLANNING:
The Board was provided with a written 2013 Strategic Plan Annual Review.

REPORT FROM 9TH DISTRICT TRUSTEE:
Dr. Gary Jeffers, 9th District Trustee, provided the Board with a report on ADA activities:

- Dr. Jeffers attended a one hour organizational meeting in November and was provided with his assignments:
  1. Audit Committee
  2. ADA Foundation Board of Directors
  3. Council on Dental Education and Licensure’s DAT Committee
- Michael Gallery is working with the ADA on its strategic plan.
- Trustee class: Drs. Jeffrey Cole, Delaware, Andy Kwasny, Pennsylvania, Alvin Stevens, Alabama
- Dr. John Shenkin was elected ADA 2nd vice president

MORTGAGE BURNING:
Treasurer Harris informed the Board that following the meeting there will be an official “burning of the MDA mortgage” outside the building.
MDA INSURANCE AND FINANCIAL GROUP (MDAIFG):

Background information is contained in a report to the Board dated December 6, 2013.

MDAIFG is now at the point where the MDA needs to approve the concept of moving forward with the MEWA (Michigan Employer Welfare Agreement). Legal counsel stated that MDAIFG needs to go to the State of Michigan for approval no later than late February 2014. Mr. Start is quite confident that the MDA will be very competitive now that IFG has had an opportunity to review the products that are available.

MDAIFG previously conducted an e-survey of the MDA membership explaining the new MEWA process. It received 70% positive feedback on the MEWA, 15% that were not interested and 15% that were on the fence.

MDAIFG would like to have the third party administrator be Blue Cross but it is not on board yet. There is a 50/50 chance of this occurring.

MDAIFG staff heard presentations from three third party administrators who can service a MEWA and two were forwarded to the MDAIFG Board. The MDAIFG Board heard presentations from both, and will meet on January 10, 2014 to make a selection.

Claims processing is a sophisticated technical process that MDAIFG does not want to become involved in.

There are two risks involved with a self-funded health insurance plan:

1. Have to build the product without customers. There is a cost involved in setting this up.

2. Self-funded financial risk. MDAIFG will be responsible if claims are more than premiums. The reserve is 10-15M which would allow MDA to suffer a couple of bad years without raising rates. If the plan continues to run in the negative, MDAIFG can: raise rates, use the Rate Stabilization Reserve or assess the subscribers.

Dentists have less health risks and the occupation itself is not risky. Those two things work in the favor of the plan.

While the MDA Board will elect the members of the first MEWA Board in order to set up the MEWA, in the future the participants of the MEWA will elect the Board members.

The following were adopted:

14-1213 Resolved, that the Michigan Dental Association Health Benefit Plan Trust in form and substance as attached hereto as Exhibit "A" is hereby approved; and

Resolved, that those individuals who have agreed to be participants in the Health Benefit Plans to be offered by the Michigan Dental

Minutes of the Board of Trustees
December 5-6, 2013
Page 16
Resolved, that any officer of MDA is hereby authorized to act with the plan beneficiaries' trustees and MDA-IFG trustees in taking all steps deemed reasonable or necessary to obtain a certificate of authority from the state of Michigan to operate the Michigan Dental Association Health Benefit Plan Trust as a MEWA pursuant to Michigan law and ERISA and to offer health benefits coverage pursuant to said Trust to members of the MDA and their employees.

15-1213 Resolved, that MDA is hereby authorized in conjunction with the trustees of the MDA-Group Insurance Trust (GIT), following execution of the Michigan Dental Association Health Benefit Plan Manual, to transfer assets of the MDA–GIT to the Michigan Dental Association Health Benefit Plan Trust.

ACTION ITEMS:

GOVERNANCE WORK GROUP:

MDA Bylaws and Policy Changes:

Background information is contained in a report to the Board dated September 10, 2013.

The Board reviewed the proposed Bylaws changes submitted by the Governance Work Group, Michael Gallery, OPIS and Dan Schulte, legal counsel. The Work Group is not asking the Board to approve the Bylaws at this time. It is seeking input on the proposed changes only.

In addition, the Board reviewed recommendations to approve a revised trustee cycle, Nominating Committee Guidelines and Candidate Guidelines.

Board Feedback:

Nominating Committee Guidelines:

1. A question was raised as to why the date of June 15 was chosen as the date for regions to submit the name of their Nominating Committee member as some regions may be able to choose a representative in time due to their meeting schedules. This date was not chosen arbitrarily as the committee is to be appointed by the June MDA Board meeting. The workgroup suggested regions start thinking now about who they want to serve on the Nominating Committee so that they have a name by June 15. Board members should work with their regions now in getting this information out to the region they represent.

2. How will the committee meet, how often and how will it be funded? It is a committee of the House and will be funded through the House budget. It is hoped that some of the meeting can be held electronically with one to two in-person meetings.

3. The guidelines don’t state that the region member chosen has to be a member of that region. The Board understands that this could happen and regions should be allowed to
have someone serve from another region so long as the appointment is made through the region. MDA should not tie the hands of the regions.

4. The Nominating Committee will look for individuals who are scanners and planners. It will review the skill sets needed to make the board complete, and recruit with these skills sets in mind. It will also make an effort to insure there is diversity.

Vacancy:

1. Those that elect the trustees have the authority to remove the trustee for any reason. The Board can only remove a trustee for cause.

2. A question was raised as to why a ¾ vote was recommended by the workgroup in order to remove a trustee for any cause. The board verified with legal counsel that there is no legal reason for a ¾ vote. The board determined that the final decision on the vote will be a decision of the House of Delegates and therefore chose not to change the workgroup’s recommendation.

3. If a trustee is running for an officer position and wins the election, the House will fill the trustee position at that House meeting. The Nominating Committee will know if a current trustee is running for an officer position and be prepared.

4. President-Elect succession is not included in the Bylaws draft revision. It was requested that this be included and legal counsel will add it.

5. Voting for trustees: The Board requested that this section be worked on more by legal counsel and the speaker of the house so that the process is spelled out very clearly.

6. The Board is aware that Dr. Steve Harris is running for vice president at the 2014 HOD and if he wins there will be a vacancy for the trustee position he held. The Board’s position is that this would create a vacancy rather than an expired term and thus would not be filled as the workgroup’s recommendation is that 2014 vacancies not be filled.

Reduction of Trustees:

1. At the request of a trustee, the Board discussed the additional work load of a trustee if the board were reduced in size. The Board believes this point was addressed in the Q&A to the House of Delegates as follows:

   “While there are 9 Board members, there are also 6 officers, so 15 Board members in total. Duties can be reassigned to staff or to other members thus bringing more members into leadership opportunities. The way assignments are made would need to be reviewed. For example, the Michigan Board of Dentistry—A Board member attends the meetings and brings information to the MDA Board. Executive staff or another member could perform this function; it doesn’t have to be a Board member.”

   In addition, the point was made that there are board members going off the board that may want to remain or be appointed as liaisons to outside groups. We just need to creatively think this through as it’s not insurmountable.

2. A trustee commented that downsizing could cause disenfranchisement by the trustees leaving the board and there will be fewer Board members to provide a historical perspective and knowledge.
It is thought that individuals can stay involved in other ways. They can serve on committees formed by the Board to explore certain issues and report back to the Board. They can be retained as liaisons to outside groups.

Bylaws Review (Legal counsel will incorporate the Board’s suggested changes into the draft it will review at its February Board meeting):

1. The Board agreed that the Executive Director should serve as the Secretary of the House of Delegates. Currently the Board Secretary also serves as the HOD Secretary.
2. Chapter III, House of Delegates, Section 13. Standing Rules, remove point D, Referendum as this is no longer necessary with the Board serving as the governing body.
3. Chapter III, House of Delegates, Section 14. Committees, A. Committee on Credentials, Rules and Order, a. Personnel. The Board believes that the speaker should appoint members of the committee rather than the president as it is a House committee.
4. Chapter III, House of Delegates, Section 14. Committees, B. Reference Committees, a. Personnel. The Board believes that the speaker should appoint members of the committee rather than the president as it is a House committee.
5. Chapter III, House of Delegates, Section 15. Election Procedures, A. Time and Method of Voting. Change the duty from the Secretary/Treasurer to the Executive Director.
6. Chapter IV, Board of Trustees, Section 4, Term of Office. The Board discussed term limits at great length. While it believes that term limits should be in place, it also believes that it is the prerogative of the House to make that decision. It requested that the House be provided with suggested language for term limits. It believes that a trustee should serve no more than two three-year terms and the portion of any unexpired term for which they are elected. Legal counsel will assure that the proposed Bylaws are clear.
7. Chapter V, Elective Officers. The Board requested that legal counsel address a succession plan for the president-elect position should it become vacant.
8. Chapter V, Elective Officers, Section 7. Duties, C. Secretary/Treasurer. Remove “House of Delegates” from point a. as the Executive Director will serve as the Secretary for the House of Delegates.
9. Chapter VIII, Executive Committee, Section 1. Composition. Make sure that it is clear that the Speaker of the House is a non-voting, ex-officio member.

The following was proposed for adoption:

Recommendation 485:
Resolved, that the following recommendation be forwarded to the 2014 MDA House of Delegates with a recommendation for adoption:

Resolved, that to establish a revised trustee cycle, the following process will be followed:

- The following trustee position expires at the end of the May 2014 House meeting and will not be filled: XII (Kalamazoo Valley/Lakeland Valley)
- Remaining trustees would serve in 2014
- Remaining trustees, if interested, would apply along with other interested members, to the Nominating Committee for the nine positions to take effect beginning in 2015
- Trustees elected by the House to serve for 2015 would then draw for a term
- No switching of draws as it creates other issues.
The draw would include three positions for a three-year term, three positions for a two-year term and three positions for a one-year term.

Those drawing a three-year term would be eligible for reappointment for one additional three-year term.

Those drawing a two-year term would be eligible for reappointment for two additional three-year terms.

Those drawing a one-year term would be eligible for reappointment for two additional three-year terms.

Any previous term on the board is not taken into consideration and they begin on the Board fresh.

The following was adopted as amended:

16-1213 Resolved, that the following recommendation be forwarded to the 2014 MDA House of Delegates with a recommendation for adoption: Adopted As Amended to 2014 MDA HOD

Resolved, that to establish a revised trustee cycle, the following process will be followed:

- The following trustee position expire at the end of the May 2014 House meeting and will not be filled: XII (Kalamazoo Valley/Lakeland Valley)

- If a vacancy is created due to a trustee being elected as an officer, the vacated trustee position will not be filled.

- Remaining trustees would serve in 2014
- Remaining trustees, if interested, would apply along with other interested members, to the Nominating Committee for the nine positions to take effect beginning in 2015
- Trustees elected by the House to serve for 2015 would then draw for a term
- No switching of draws as it creates other issues.

- The draw would include three positions for a three-year term, three positions for a two-year term and three positions for a one-year term.
- Those drawing a three-year year term would be eligible for reappointment for one additional three-year term.
- Those drawing a two-year year term would be eligible for reappointment for two additional three-year terms.
- Those drawing a one-year year term would be eligible for reappointment for two additional three-year terms.
- Any previous term on the board is not taken into consideration and they begin on the Board fresh.
The following were adopted:

17-1213  **Resolved**, that the following recommendation be forwarded to the 2014 MDA House of Delegates with a recommendation for adoption:

Adopted to 2014 MDA HOD

Resolved, that the Michigan Dental Association Nominating Committee Guidelines, dated December 6, 2013 be adopted.

18-1213  **Resolved**, that the following recommendation be forwarded to the 2014 MDA House of Delegates with a recommendation for adoption:

Adopted to 2014 MDA HOD

Resolved, that the MDA Candidate Guidelines, dated December 6, 2013.

19-1213  **Resolved**, that the MDA Board of Trustees recommends to the House of Delegates that the Bylaws contain language on term limits for Board members.

Adopted

President Palm reminded the Board of its duty of loyalty. The policies adopted are interim and the Board must speak as one voice.

SPECIAL COMMITTEE ON ANNUAL SESSION

2016 Annual Session in Detroit (Cobo):

Background information is contained in a report to the Board dated November 18, 2013.

The Board was informed that Cobo is under new management; the same company that manages the De Vos Place in Grand Rapids. MDA will see a new Cobo if it chooses to hold the Annual Session there in 2016.

The cost difference between Novi and downtown Detroit was discussed by the committee and it believes the additional cost will be worth it.

The Board was informed that the downtown area has its own police force that is connected to Cobo. Safety concerns should not be an issue.

The following was adopted:

20-1213  **Resolved**, that the Michigan Dental Association hold its 2016 Annual Session in downtown Detroit, and be it further

Adopted
Resolved, that the Special Committee on Annual Session review and evaluate the results from the 2016 Annual Session and report back to the board prior to recommending a location for the 2019 Annual Session.

OLD BUSINESS

Board Core Values of Governing:
Background information is contained in a report to the Board dated November 6, 2013.

The following was adopted:

21-1213 Resolved, that the core values of the MDA Board of Trustees are: 

1. Ethical standards
2. Embrace proactivity vs. reactivity (think future not past or present)
3. A culture dedicated to openness and a commitment to transparency
4. Recognize the concept that “members are owners”
5. Remember that trustees are fiduciary to the MDA (not individual components)
6. Recognize diversity in viewpoints
7. Verify that results align with policies and the strategic plan

MEMBER MEDIA RELATIONS:
Ms. Stefani Olds, member image enhancement specialist, provided the Board with a report on the MDA’s media relations to include goals and objectives, social media (YouTube, Twitter, Facebook, Flicker, Pinterest, Instagram, LinkedIn, Google+), media kits, and member involvement. [Click here](#) for a detail report.

INFORMATIONAL:
The Board reviewed the following informational items. No action was required.

- September 2013 Board Minutes
- Committee Minutes (those posted online since the September Board meeting)
- MDA Calendar of Referrals
- MDA Legislative Update
- Joint Meeting of the MDA and Subsidiary Chief Officers
- Public Health Code Advisory Committee
- Mandated Dental Screening for Kindergarten
- ADA 2nd Vice President
- ADA Webinar: Discussion of the ADA Strategic Plan January 2015 – January 2020
OFFICER, TRUSTEE, LIAISON AND STAFF ANNOUNCEMENTS:

Fund Balances:
Treasurer Harris informed the Board that the Emergency Reserve Fund and the Strategic Project Reserve Fund are fully funded at 55% and 15% respectively with 7% in the General Fund.

Mission of Mercy:
The 2014 MOM Committee has met twice and is working on floor plans at Ferris State University. Dr. Kevin Sloan has completed a course on one day dentures and will provide this service at the MOM event.

The MDA recently received the following financial commitments for the 2014 MOM:

• Delta Dental Foundation -- $40,000
• MDA Foundation -- $5,000
• Mecosta County - $4,000
• Delta In Kind Services -- $1,800
• Local Walmart – $500

The committee is hopeful that it will be able to provide the Board with a proposal for the 2016 MOM next summer. Dr. Grace Curcuru was thanked for all of her fundraising efforts.

MDA In-Kind Services:
A Board member questions why the 2014 MOM projected financials do not include costs for MDA in-kind services. The reason is that Foundation’s do not like to see costs incurred from staff time of the parent group. It is the donation of the parent group and is not included on the financial spreadsheet.

A report from the Charity Programs Work Group will be provided to the Board in February and will answer many of the questions regarding MDA in-kind services.

University of Michigan Special Needs Clinic:
The University of Michigan is creating a Special Needs Clinic and the MDA may receive a request to provide a donation.

MICHIGAN DENTAL ASSOCIATION FOUNDATION:
Dr. Michael Jennings, president, Michigan Dental Association Foundation, provided the Board with a report on Foundation activities.

• The Foundation continues to work on its strategic plan. It has restructured several committees to incorporate its core initiatives more effectively.
• Awarded nine scholarships this year for a grand total of 124 scholarships and $147,000 since 2000.
• Awarded four access to care grants this year
Partnered with Old Newsboys Good Fellows to provide 36,000 holiday toothbrush kits to underprivileged children in the Detroit area. Partners this year were the University of Detroit Mercy, Delta Dental Foundation, Quantum Labs and Procter and Gamble.

The Foundation assisted with Give Kids a Smile Day activities at both dental schools.

Partnered with Delta Dental Foundation on the “From Drool to School” initiative targeting Head Start/Great Start collaborative programs across Michigan.

The Foundation Board approved a 2:1 matching program for philanthropy. It will function similarly to the 3:1 public relations program but will have a match for local components to help in starting or continuing worthy philanthropic causes in their areas. These matching funds could be used for MOM programs.

The Foundation recently hired Ms. Nancy Maier, its first employee and the new chief development officer.

Fundraising in 2014:

- Consider personally reaching out to components not only for donations but for those willing to serve on the Foundation Board or committees.
- Consider becoming a member of the Foundations Inner Circle which demonstrates a level of commitment.
- Planned Giving
  - Car Raffle at Annual Session (a 2-year lease on a 2014 Mustang or $14,000 travel voucher or $14,000 cash. Sales are limited to 425 tickets and they have sold out every year.)
  - Golf outing to be held Friday, May 16 in Clarkston.
  - Make a $25 tax deductible donation to the Foundation and receive one of a variety of holiday ornaments.

Dr. Jennings acknowledged the MDA’s strategic foresight to involve the Foundation along with the other subsidiaries in the various long range organizational opportunities this past year. As Sue Radwan said last evening “People support what they create”. There is nothing more true.

Cap Wiz:
When Board members receive a Cap Wiz alert, Ms. Lynn Aronoff, grassroots coordinator, asked that they forward the action alert to others.

Critique of Meeting:
President Palm asked Board members to critique this meeting. Comments were:

- First few hours of the meeting were very enjoyable; discussion was outstanding. Good to hear viewpoints of others.
- Consider beginning board meetings at 8:30am instead of 9:00am when the board members stay overnight the night before.
Executive Session

The outcomes of the executive session are now considered policy and are public knowledge. The discussion that took place in the meeting that led to the actions, however, are confidential and are not to be shared.

2014 MDA AWARDS:

John G. Nolen Meritorious Award:
The following was adopted:

22-1213  Resolved, that the 2014 John G. Nolen Meritorious Award be presented to Richard Jankowski, DDS, Central District Dental Society.  Adopted

Emmett C. Bolden Dentist Citizen of the Year Award:
The following was adopted:

23-1213  Resolved, that the 2014 Emmett C. Bolden Dentist Citizen of the Year Award be presented to Wilhelm Piskorowski, DDS, Macomb District Dental Society.  Adopted

Matt Uday New Dentist Leadership Award:
The following was adopted:

24-1213  Resolved, that a 2014 Matt Uday New Dentist Leadership Award be presented to Dr. Kathryn Swan, West Michigan District Dental Society.  Adopted

Public Service Award:
The following was adopted:

25-1213  Resolved, that a 2014 Public Service Award be presented to: Cathryn Caldwell, RDH, Darcie Moran, Sue Thoms, Steve Harris, DDS, Ronald Morris, DDS.  Adopted

Public Relations Award:
The following was adopted:

26-1213  Resolved, that a 2014 Public Relations Award be presented to the Saginaw Valley District Dental Society.  Adopted
Executive Session

The outcomes of the executive session are now considered policy and are public knowledge. The discussion that took place in the meeting that led to the actions, however, are confidential and are not to be shared.

Special Award for MOM Committee:

The following was adopted:

27-1213 Resolved, that the 2013 Mission of Mercy Committee be awarded with a special MDA recognition. Adopted

New Delta Dental Employee Program:

The Board discussed a new provision in Delta’s dental benefit for its employees of Delta Dental Plan Michigan, Ohio and Indiana. Essentially it involves an optional genetic testing for periodontal disease.

The Board decided on the following action plan:

• Coordinate with the other two state dental associations impacted (Ohio and Indiana)
• An article for the MDA Journal is in process.
• President Palm will send an email to all MDA members
• MDA leadership will consider having Dr. Ted Hart, ADA’s consulting geneticist, provide a course at MDA Annual Session or at the MDA building to educate MDA members so they have the knowledge to be able to discuss the topic with their patients
• A position statement on this issue could be discussed at the January EC meeting.

Norman Palm, DDS, MS
President

Charles Burling, DDS
Secretary
Becoming a Strategic Governing Body: Governance & Leadership for the 21st Century

PRESENTED BY SUE RADWAN, CAE, SMP
LEADING EDGE MENTORING
GRAND LEDGE, MICHIGAN

The PRIMARY JOB of Leaders

Planning & Change
Types of Governance

I. Fiduciary Mode
II. Strategic Mode
III. Generative Mode

Type I: Fiduciary Mode

- Boards are concerned primarily with the stewardship of tangible assets
  - Board assures faithfulness to mission, accountable for performance, and compliant with laws and regulations.
Type 2: Strategic Mode

- Boards create a strategic partnership with management
  - Board delegates to management and assures operational performance through defining broad expectations and deploying resources appropriately.

Type 3: Generative Mode

- Boards provide a critical source of leadership for the organization.
  - Board seeks cues and clues from the environment, chooses and applies frames for sense-making, thinks retrospectively.
  - This is where broad goal-setting and direction-setting originate.
What is Governance in the 21st Century?

Seeing to it that the organization
  ▪ achieves what it should and
  ▪ avoids unacceptable situations

Governance takes place from the “helicopter view”.

Let’s Get into the Helicopter

Work ON the Enterprise First

1. Work ON the Enterprise
2. Work IN the Enterprise
3. Check ON the Enterprise

SCAN & PLAN  IMPLEMENT  EVALUATE
### Analytic Thinking (Analysis of Today) vs. Systems Thinking (Synthesis for the Future)

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<th>Systems Thinking</th>
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<td>1</td>
<td>We/they</td>
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<td>2</td>
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<td>Interdependent</td>
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<td>3</td>
<td>Activities/tasks/means</td>
<td>Outcomes/Ends</td>
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<td>Problem solving</td>
<td>Solution-seeking</td>
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<td>5</td>
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<td>Shared vision</td>
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<td>Units/departments</td>
<td>Total organization</td>
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<td>Cross-functional teamwork</td>
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<td>Closed environment</td>
<td>Openness and feedback</td>
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<td>9</td>
<td>Department goals and budgets</td>
<td>Core strategies that dept goals and budgets support</td>
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<td>Strategic planning project</td>
<td>Strategic management system</td>
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<td>11</td>
<td>Hierarchy and controls</td>
<td>Serve the beneficiary</td>
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<td>12</td>
<td>Not my job</td>
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### What constitutes openness and feedback?

**Transparency**
- Conflicts of Interest Policy
- Openness with members for both the good **and** bad news
- Inclusion

**Evaluation**
- Debriefing from your process and integrating lessons learned
- Creating metrics to know if you are being effective
- Self-assessment
Transparency

Conflicts of Interest presents a conflict with your legal fiduciary duty of loyalty

- Anytime a topic is being discussed and you, a relative or close business association, have a monetary gain at play in the decision, you have a clear conflict of interest.
  - Appropriate behavior is to declare the conflict then absent yourself from the room so that the Board may be able to discuss the matter without undue influence.
  - The Board has choice about the involvement of the member who has the conflict:
    ◦ Participate fully since the conflict is not significant
    ◦ Stay in the room and participate in the dialogue, but not the vote
    ◦ Leave the proceedings and allow the board to discuss and vote without undue influence.
- Your obligation of confidentiality continues indefinitely, not just while you are serving on the Board.

Openness

- The 21st century playing field
  - No longer can associations contain the bad news revelations.
  - Best to be the first out with the news so you can shape the dialogue.
Inclusion

- People support what they help to create
  - Co-creation is the name of the game in the 21st century
- Whose input do we need to make an informed decision?
  - Your decision-making processes are actually MORE important than the decisions you make.

Evaluation

- Feedback is the “breakfast of champions”!
  - Actual results measured to expected results?
  - Reflecting on lessons learned after any process?
  - Self-assessment of any volunteer process
Board Member Engagement

- Commitment to be involved
  - Focus on the *added value* that you can bring
- Commitment to reflect on what is best for the membership
  - Delivering member value should be the total focus
- Commitment to contribute time, talent and treasure
- Commitment to follow through on what you promise to do

Creating a Culture of Trust

- Achieving results
- Acting with integrity
- Demonstrating concern

*Robert Bruce Shaw*
*Trust in the Balance*
A Culture of Trust
Three Pre-requisites

1. Clarity and consensus about what will constitute success.
2. Open access to common information.
3. Confidence in the competence of your partners.
4. You must be trustworthy.

Are You Trustworthy?

In order to create trust, you must be *trustworthy.*

- Authentically value and respect the membership
- Respect for the competency of the leadership team and staff
- Needs and interests of the organization trump personal career goals and ego needs
- Be aware of the organization’s condition and its environment to help members understand what the organization is doing and why
- Be knowledgeable about association law, best practice, options and consequences
Annual Agenda Planning
Creating Your Annual Plan of Work

1. **Brainstorm topics** for exploration and accomplishment that will bring added value to the organization.

2. **Select** the priority topic.

3. **Discuss what we need to learn** about this issue before we can speak to it in informed policy.
   - What do we need to learn from our membership?

4. **Plan the annual “curriculum”** with installments of information.

5. After each installment presented, **ask and discuss how the information impacts the organization** and its policy.
   - Collect the nuggets of important perspectives to incorporate into policy at a given point in time.
A Profession in Transition

A Look Back, A Look Forward

Marko Vujicic, PhD
Managing Vice President
Health Policy Resources Center

A Dynamic Environment
A Dynamic Environment

http://www.ada.org/escan

A Profession in Transition:
Key Forces Reshaping the Dental Landscape

About Me

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Total Dental Spending

Figure 2: National Dental Expenditure per Capita (in constant 2011 dollars)


Note: Expenditure adjusted for inflation using the GDP implicit price deflator.
### Dentist Busyness

**Mean Wait Time for GP Dentist Appointment**

- **Source:** ADA Health Policy Resources Center annual Survey of Dental Practice.
- **Note:** Indicates the mean wait time in days for an appointment with a general practice dentist.

### Dentist Earnings

**GP Dentist Earnings and the Economy**

- **Source:** ADA Health Policy Resources Center; Bureau of Economic Analysis; Bureau of Labor Statistics.
- **Note:** Net income data are based on the ADA Health Policy Resources Center annual Survey of Dental Practice and are weighted to adjust for representativeness. Shaded areas denote recession years according to NBER. GDP is deflated using the GDP deflator. Net income is deflated using the all items CPI. All values are in constant 2012 dollars.
**Dentist Earnings**

**Dental Care Use**

**Figure 1:** Percentage of the Population with a Dental Visit in the Year, 2000-2011

Source: Medical Expenditure Panel Survey, AHRQ. Notes: Changes are statistically significant at the 5% level for children ages 2-18 (2000-2011), at the 1% level for adults ages 19-64 (2003-2011), and at the 1% level for adults ages 65 and over (2000-2011).
Dental Care Use

Figure 3: Percentage of Children Ages 2-18 with a Dental Visit in the Year for Select Income Groups, 2000-2011

Source: Medical Expenditure Panel Survey, AHRQ. Notes: Changes are significant at the 1% level for FPL ≤100% and at the 5% level for FPL 100-200% (2000-2011).

Note: Data for AK, AZ, CA, CT, HI, IL, MA, MN, NE, NJ, NV, NY, OR, VT, and WI are through 2007. Data for all other states are through 2013. Data for NE, NM, WY, KT, NV, and CA may not adequately capture dental visits within FQHCs. In the calculation of the total number of children on Medicaid with a dental visit, utilization rate for children with private dental benefits is for the U.S. and is based on most recent data available. CAAGR is compound annual growth rate; FPL is federal poverty level. Source: CMS (Medicaid HAE) for state-level Medicaid data; MOSF for utilization data for children with private dental benefits.
Dental Care Use

Figure 4: Percentage of Adults Ages 19-64 with a Dental Visit in the Year for Select Income Groups, 2000-2011

Source: Medical Expenditure Panel Survey, AHRQ. Notes: Changes are significant at the 10% level for FPL <100% (2000-2011), at the 5% level for FPL 100-200% (2003-2011), and at the 1% level for FPL 400%+ (2003-2011).

Dental Care Use

Percent of Low-income Adults With a Dental Visit

Source: Behavioral Risk Factors Surveillance Survey. Note: Utilization rates from this survey are known to be inflated. However, the trend over time is statistically robust.
Dental Benefits

Figure 1: Source of Dental Benefits, Children Ages 2 to 18

![Figure 1: Source of Dental Benefits, Children Ages 2 to 18](image)

Source: Medical Expenditure Panel Survey, AHRQ. Notes: All changes are significant at the 1% level (2003-2011).

Dental Benefits

Figure 2: Source of Dental Benefits, Adults Ages 19 to 84

![Figure 2: Source of Dental Benefits, Adults Ages 19 to 84](image)

Source: Medical Expenditure Panel Survey, AHRQ. Notes: Changes for private and public benefits are significant at the 1% level (2001-2011). Changes for the uninsured are significant at the 5% level (2001-2011).
Access to Care

**Figure 3:** Dental Emergency Department Visits as a Percent of Total Dental Visits by Age in the United States, 2000 to 2010

Sources: National Hospital Ambulatory Medical Care Survey, NCHS, Medical Expenditure Panel Survey, AHRQ.

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Access to Care

**Figure 2:** Percentage of the Population Indicating Cost as a Barrier to Receiving Needed Dental Care by Age

Source: National Health Interview Survey, AHRQ. Notes: Changes from 2000 to 2010 for age groups 21 to 34, 35 to 49, 50 to 64, and 65+ are statistically significant at the 1 percent level. Changes from 2010 to 2012 for age groups 2 to 20, 21 to 34, 35 to 49, and 50 to 64 are statistically significant at the 1 percent level. Changes from 2010 to 2012 for age group 65+ is significant at the 10% level.
A Look Forward…

Dental Spending – a ‘New Normal’

**Historical Annual Per Capita Dental Spending Growth Rates**

- 1996-2002: 3.9%
- 2002-2007: 1.8%
- 2007-2010: -0.3%

**Projected Future Annual Per Capita Dental Spending Growth Rates (HPRC Analysis)**

- 2010-2020: 1.3%
- 2020-2030: 0.6%
- 2030-2040: 0.1%

**Source:** Centers for Medicare and Medicaid Services; U.S. Bureau of Economic Analysis; U.S. Census Bureau.

**Source:** 1996-2010 Medicaid Expenditure Panel Survey (MEPS), AHRQ. 2012 U.S. Census National Population Projections.
Number of Dentists

![Graph showing the number of dentists per 100,000 population from 2000 to 2011 for Michigan and the total US. The graph shows an increase in the number of dentists over time. Source: Health Policy Resources Center, American Dental Association; Census Bureau. Note: Includes all dentists who are professionally active.]

Impact of ACA

![Graph showing the impact of ACA on the number of children and adults gaining benefits through the ACA, by source of dental benefits (millions). The graph indicates a total gain of 17.7 millions with 5.3 millions being gained through Medicaid. Source: Milliman, Inc., analysis commissioned by the ADA; Analysis by the ADA Health Policy Resources Center.]

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**Impact of ACA**

- **55%**
  - Decline in the # of children without dental benefits

- **5%**
  - Decline in the # of adults without dental benefits

**Emphasis on Value**

“Providers should be required to measure…improvements in quality of life, functioning and longevity.

After a patient has a knee replaced, can she walk normally? When a child has asthma can he play school sports? Unfortunately, the measurements we use today leaves us unable to make many of these vital judgments about the quality of doctors, hospitals or health care organizations.

Congress should direct CMS to identify and adopt useful standardized measures that address consumer and purchaser concerns.”

*David Lansky, CEO, Pacific Business Group on Health, speaking on behalf of Boeing, Target, Disney, Wal-Mart, Intel, GE, Wells Fargo and the California Public Employees Retirement System.*
Opportunity

Support Dentists & Influence Behavior

Help Dentists Improve Efficiency
- Identify, understand, and educate dentists about the various practice models that are emerging
- Seek out and share “best practices” among the industry to improve efficiency of dental offices
- ADA’s Center for Professional Success

Better Understand Behavior
- Dig deeper into why adults – especially young adults – are less likely to go to the dentist
  - Cost? Lack of insurance?
  - Changing values?
- Explore ways to influence behavior
  - Oral Literacy Campaign
  - DR 2.0
Support Dentists & Influence Behavior

Figure 2: Percent of Children with a Dental Visit in the Past Year, Commercially and Medicaid Insured

- Commercial (2009 and 2010 Average)
- Medicaid (2010)

Source: Commercial data from 2009-2010 Tenen Health MarketScan® Research Databases. Medicaid data from 2010 Centers for Medicare & Medicaid Services (CMS) 415 report. Note: States are ordered from left to right according to the relative gap between the commercial and Medicaid populations. Population is based on children ages 0-29 continuously enrolled in a dental plan for 90 days.

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Support Dentists & Influence Behavior

Medicaid Dental Fees as % of Commercial Dental Fees, 2012

Source: American Dental Association Health Policy Resources Center. Medicaid fee data captured from state Medicaid websites. Market data from Fair Health database. Fee index composed of a representative basket of commonly used CPT procedure codes: 021231, 023191, 032210, 011133, 019340. Rates weighted by total billings based on 2010-2012 Fair Health data.

ADA American Dental Association® © 2011 American Dental Association, All Rights Reserved
Can oral health professionals save healthcare dollars through chairside chronic disease screenings?

Table 2. Main results and sensitivity analysis. Estimated savings at different referral completion rates

<table>
<thead>
<tr>
<th>Exam administrator</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Assistant and GP dentist</td>
<td>$65.3 million ($20.82)</td>
<td>$46.5 million ($14.84)</td>
<td>$5.1 million ($1.61)</td>
</tr>
<tr>
<td>Referral Completion Rate</td>
<td>83%</td>
<td>77%</td>
<td>63%</td>
</tr>
</tbody>
</table>

Notes: Savings are calculated after labor costs are accounted for. Savings per person screened in parenthesis. Labor costs estimated from 2012 ADA Survey of Dental Practice. GP-General Practice. All estimates in 2011 dollars. Jontell and Glick (2009) and Forrest et al. (2007) estimated an 83% referral completion rate. Undiagnosed Prevalence Rates: 7.35% has only undiagnosed hypercholesterolemia, 19.31% has only undiagnosed hypertension, 3.70% has only undiagnosed diabetes, 4.26% have undiagnosed hypertension and hypercholesterolemia, 0.51% have undiagnosed diabetes and hypercholesterolemia, 2.13% have undiagnosed diabetes and hypertension and 0.01% have all three conditions that are undiagnosed.
Opportunities Await

Additional Resources from the ADA

To access the groundbreaking report A Profession in Transition visit:

http://www.ada.org/escan

To access reports and data from the ADA Health Policy Resources Center visit:

http://www.ada.org/1442.aspx

To access a new CE course on the implications of the ACA on the dental care system look under ‘Free Courses’ at:

http://www.adaceline.org/

To contact the Health Policy Resources Center please email: hprc@ada.org

Thank You!
2013 Strategic Plan Annual Review

Helping Member Dentists Succeed
The MDA’s Mission

*Helping Member Dentists Succeed*

The MDA’s Vision

*Michigan’s Oral Health Authority Dedicated to the Public and the Profession*

The MDA’s Values

We are guided by integrity and ethics
We are committed to the improvement of the public’s oral health
We believe oral health is integral to overall health
We believe in an inclusive environment that embraces diversity
We believe the profession of dentistry and the oral health team must be led by dentists to ensure the safety of the public
We believe life-long learning is critical to excellence in patient care
Introduction

The MDA adopted its most recent strategic plan in 2008. The plan was designed to be evergreen, to evolve organically through a combination of Board dialogue, staff visioning, and assessing members’ needs as the MDA’s environment undergoes constant change.

The plan’s goals are intended to represent the opportunities and challenges that are most critical to members’ success and that of the association. Moreover, the tactics linked to each goal are developed to create the level and type of outcomes desired to allow the association to check the goal off its list, and to replace the objective with a new measure that links to the strategic positioning of the organization.

Since 2008, the following has been achieved:

- The completion of one goal:
  - Ensure the association’s financial stability by developing a 70 percent reserve threshold
- The completion of 41 tactics:
  - 41 percent have been related to supporting members’ practice management needs
  - 31 percent have been related to ensuring the association’s financial stability
  - 17 percent have been related to addressing access to care
  - 8 percent have been related to legislative and insurance affairs
  - 3 percent have been related to leadership development and volunteer engagement

The current plan includes the following goals and corresponding tactics:

- Help members succeed at the business-side of their practice
  - 17 tactics
- Increase members’ involvement in legislative affairs
  - 6 tactics
- Increase the dental benefits IQ of members and their staff
  - 1 tactic
- Public policy on access to care will be consistent with MDA policy
  - 2 tactics
- Assure sustainable leadership development and engaged volunteerism throughout the MDA and its components
  - 2 tactics
The current strategic plan is intended to include no more than six goals. In 2013 the MDA completed one of its original four strategic planning goals, assuring the association’s financial stability by achieving a 70 percent reserve level. The Board approved replacing the financial stability goal with the leadership/volunteerism goal at its June 2013 meeting. Four of the MDA’s original strategic planning goals continue to be in-progress.
The MDA’s staff meets regularly to develop new tactics to address the goals of the strategic plan. To date, 41 tactics have been completed; 17, or 41 percent, have been completed in 2013. Please note that the strategic plan in its entirety does not represent all of the day-to-day activities performed by volunteer leaders and staff that is done to help members succeed. However, it does provide a high-level overview of the types of initiatives that are carried out to address goals within the plan.
**Goal 1: Help Members Succeed at the Business-Side of Their Practice**

Currently, 17 tactics are being worked on to address this goal. One has been given the highest priority, as indicated by the Level 5 designation. Four have been given a Level 4 designation; nine are of a mid-level priority; and three have been named as a lower-level priority.

<table>
<thead>
<tr>
<th>Priority Level</th>
<th># of Tactics</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Pass legislation RE changes to current dental CT requirements</td>
</tr>
<tr>
<td>5</td>
<td>Develop New Radiography Program</td>
</tr>
<tr>
<td>4</td>
<td>Expand HR assistance to members</td>
</tr>
<tr>
<td>3</td>
<td>Repackage and market Dental Benefits Communication Toolkit</td>
</tr>
<tr>
<td>3</td>
<td>Include tangible benefits on auto reply when applicant’s membership is paid in full</td>
</tr>
<tr>
<td>2</td>
<td>Send sample mailer to members highlighting HR manual</td>
</tr>
<tr>
<td>2</td>
<td>Send sample mailer to members highlighting Regulatory manual</td>
</tr>
<tr>
<td>1</td>
<td>Offer peer-to-peer CE sessions</td>
</tr>
<tr>
<td>1</td>
<td>Offer HR training session using HR manual as guide</td>
</tr>
<tr>
<td>1</td>
<td>Offer HR training session using Regulatory manual as guide</td>
</tr>
<tr>
<td>0</td>
<td>Explore CE tracking system for members</td>
</tr>
<tr>
<td>0</td>
<td>Create patient communication letters</td>
</tr>
<tr>
<td>0</td>
<td>In Office Training</td>
</tr>
<tr>
<td>0</td>
<td>Brainstorming with staff RE CE Enhancements</td>
</tr>
<tr>
<td>0</td>
<td>Ensure components follow through when applicant indicates interest in volunteering</td>
</tr>
<tr>
<td>0</td>
<td>Brainstorming on how to best promote ADA Survey Center</td>
</tr>
<tr>
<td>0</td>
<td>Brainstorming on how to create database of advocates for specific MDA services</td>
</tr>
</tbody>
</table>
Goal 2: Increase Members’ Involvement in Legislative Affairs

At this time, a total of six tactics are supporting the fulfillment of this goal. Three have been given the highest level priority, Level 5, and two have been named as Level 4 priorities. One tactic has been designated as a lower-level priority. In 2013, the Board voted to separate the legislative affairs strategic planning goal from the insurance affairs goal, as it decided it is important to distinguish between these two critical areas.
Goal 3: Increase Dental Benefits IQ of Members and Their Staff

One tactic is currently in process that is related to this goal. It has been designated as a Level 4 priority. Because the Board recently separated this goal from the corresponding legislative affairs goal, efforts are under way to add more initiatives on this front.
Goal 4: Public Policy on Access to Care will be Consistent with MDA Policy

At this time, two tactics, both with a Level 5 designation, are being worked on to address this goal. In 2013, the Board re-worded this goal to better reflect the desired outcome it wants achieved.
Within the newest strategic planning goal are two tactics with a Level 4 designation. It is expected this goal and corresponding tactics will be pivotal in the near future given the important role this goal will play in relation to the potential realignment of the MDA’s governance structure.
Historical Review of Completed Tactics

Highlighted below are all of the tactics that have been completed to address goals within the strategic plan.

<table>
<thead>
<tr>
<th>Task</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’m Sorry Legislation</td>
<td>Practice Management</td>
</tr>
<tr>
<td>Out of State Prescription Legislation</td>
<td>Practice Management</td>
</tr>
<tr>
<td>MAPS History Legislation</td>
<td>Practice Management</td>
</tr>
<tr>
<td>Volunteer Immunity Legislation</td>
<td>Access</td>
</tr>
<tr>
<td>55% Non-Dues Revenue</td>
<td>Financial Stability</td>
</tr>
<tr>
<td>Back Up on Fee Survey</td>
<td>Practice Management</td>
</tr>
<tr>
<td>Liaison List</td>
<td>Access</td>
</tr>
<tr>
<td>Board of Trustees Finance Survey</td>
<td>Financial Stability</td>
</tr>
<tr>
<td>25% Waiver</td>
<td>Financial Stability</td>
</tr>
<tr>
<td>Patient Information Form</td>
<td>Practice Management</td>
</tr>
<tr>
<td>Goodwill of a Practice Article</td>
<td>Practice Management</td>
</tr>
<tr>
<td>Nonrenewal Count Below 164 by 5/18/12</td>
<td>Financial Stability</td>
</tr>
<tr>
<td>Spokesperson Training</td>
<td>Access</td>
</tr>
<tr>
<td>Practice Management List</td>
<td>Practice Management</td>
</tr>
<tr>
<td>Dental Insurance Myths Column</td>
<td>Legislative/Insurance</td>
</tr>
<tr>
<td>Document on School-Based Care</td>
<td>Access</td>
</tr>
<tr>
<td>Recruit Five Nonmembers from Henry Ford Event</td>
<td>Financial Stability</td>
</tr>
<tr>
<td>Promote Member Involvement in Legislative Affairs</td>
<td>Legislative/Insurance</td>
</tr>
<tr>
<td>Quarterly Articles on Practice Management from Endorsed Companies</td>
<td>Practice Management</td>
</tr>
<tr>
<td>Journal Access-to-Care Series</td>
<td>Access</td>
</tr>
<tr>
<td>License Renewal Assistance</td>
<td>Practice Management</td>
</tr>
<tr>
<td>Series of Third Party Payer Articles</td>
<td>Legislative/Insurance</td>
</tr>
<tr>
<td>Create Disposing of Dental Records Packet</td>
<td>Practice Management</td>
</tr>
<tr>
<td>How to Stay Out of Trouble Checklist</td>
<td>Practice Management</td>
</tr>
<tr>
<td>Outreach Calls to Current Members</td>
<td>Financial Stability</td>
</tr>
<tr>
<td>Packet on Reputation Management</td>
<td>Practice Management</td>
</tr>
<tr>
<td>Journal Article - Stay Out of Trouble</td>
<td>Practice Management</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Three New Annual Session Initiatives</td>
<td>Practice Management</td>
</tr>
<tr>
<td>Transition to VDBA Relationship</td>
<td>Financial Stability</td>
</tr>
<tr>
<td>Present Expenses at Executive Staff Meetings</td>
<td>Financial Stability</td>
</tr>
<tr>
<td>Establish Non-Reserve Spending Criteria</td>
<td>Financial Stability</td>
</tr>
<tr>
<td>Repayment of Detroit District Dental Society Loan</td>
<td>Financial Stability</td>
</tr>
<tr>
<td>Present to Finance Committee on Expenses</td>
<td>Financial Stability</td>
</tr>
<tr>
<td>Educate Public/Media/Lawmakers through Social Media</td>
<td>Access</td>
</tr>
<tr>
<td>Launch Twitter</td>
<td>Access</td>
</tr>
<tr>
<td>Present Surplus Budget for 2014</td>
<td>Financial Stability</td>
</tr>
<tr>
<td>Forward recommendation on leadership institute to EC</td>
<td>Leadership/Volunteerism</td>
</tr>
<tr>
<td>Complete four component roadshow visits</td>
<td>Financial Stability</td>
</tr>
<tr>
<td>Checklist for a member who is joining a practice as an associate</td>
<td>Practice Management</td>
</tr>
<tr>
<td>Checklist for a member who is an associate and who is leaving a practice</td>
<td>Practice Management</td>
</tr>
<tr>
<td>Checklist for a member who is an associate and who is leaving a practice</td>
<td>Practice Management</td>
</tr>
</tbody>
</table>
Overview:
My efforts to further position the Michigan Dental Association and its members as Michigan’s oral health authority include: media relations and social media. Both platforms connect the MDA directly to the public, and help facilitate and promote a positive image of members at both the local level and statewide level.

Goals:
Each effort and their major objectives have their own individual goals. However, the overall goals are as listed below.

- Build Awareness – Enhance the visibility of the MDA and its members
- Influence Public Perception – The MDA and its members are viewed as trustworthy healthcare professionals and active community members
- Motivate Action – Distinguish MDA member dentists in order to prompt the public to choose an MDA member when seeking a dentist
- Legislative Advocacy – Highlight various legislative efforts to gain support and raise awareness

Media Relations:
The media is the number one source in shaping public perception— Positive media coverage can be worth tens of thousands of dollars in advertising. Good media relations must be earned, which is why it is critical to develop a comprehensive media relations plan.

Goals:
- Establish media relations throughout the state
- Increase positive media coverage of the MDA and its members
- The media contact the MDA for any dental related issue

Strategy - Media Kits:
In order to establish media relations, during National Dental Hygiene month (October), more than 300 media kits were distributed throughout the state. The kits were sent to a select group of newspaper, television and radio media contacts, who have either covered the MDA/members in the past or cover relevant beats, such as health and community news reporters.

The kits were intended to re-introduce the MDA and raise awareness of all that the MDA and its members do. The theme of the kits aimed to brand members as active community members. The idea behind the media kits was to give select media contact an inside glimpse of the MDA in order to potentially spark ideas for future coverage.

Each kit contained a printed piece that included a letter from me, MDA fact sheet, and a general overview of the MDA, a 2min2x toothbrush timer imprinted with the MDA’s logo (with the hopes that it will sit on the reporter’s desk), and a flash drive also imprinted with the MDA’s logo. The flash drive was
intended to be their “ultimate oral health resource,” with a variety of engaging material relevant to the following categories and sub-categories:

Michigan’s Oral Health Authority
• Oral Health = Overall Health
• Experts in Dentistry
• Political Advocacy

Dedicated to the Public
• Access-to-Care Programs
• Mission of Mercy
• National Children’s Dental Health Month
• Members Making a Difference

And the Profession
• Component Societies
• Dental Schools
• Public Safety/Well-being

Strategy - Member Involvement:
A new member program was launched to enable members to submit their newsworthy endeavors. In turn, the MDA promotes the stories to the local media and facilitates media coverage. Members were encouraged to participate in the program via two informational postcard mailings, an extensive journal article and an infographic. There are continuous efforts in place to promote the program to members.

Insights:
It has been almost a month since the launch of the Members Making a Difference initiative. Below are highlights of the project’s status and relevant work efforts:

• I have received approximately fifteen submissions from members, such as Halloween candy buy backs, free dental care days, etc.
• A PR calendar has been created for the next year in order to organize all media outreach endeavors, and reports the status of each one; the calendar is shared between Tom, April and I.
• Take a Bite Out of Cancer media kits were distributed shortly after the initial media kits, which acted as a follow up to the original kits and intended to further establish relations. The kits contained the actual oral swab kit, encouraging their participation in the initiative, and a news release that detailed the campaign and recapped the press conference.
• There have been a total of five media inquiries in response to the Take a Bite kits, and it is anticipated that there will be more. *See Take a Bite Media Coverage log
• In order to maintain media relations I will ensure there is a regular flow of media outreach, along with the below tactics:
  o Provide interesting, timely information when it is needed;
  o be sure to not overwhelm them with a flood of stories;
  o update media lists periodically to ensure the story is going to the appropriate contact.
• All media coverage on the MDA and its members will continue to be logged. Since the project’s launch their has already been a significant increase in positive coverage. *See Clips
• The MDA’s crisis communication plan will be updated, with two different protocols for Members Making a Difference and larger-scale media-related issues.

Social Media:
New media allows organizations a variety of opportunities, such as monitoring and engaging, the ability to reach out to opinion leaders, respond, create grass roots efforts, share information, and develop relationships in real time. Social media has become a vital tool for all public relations efforts.

Goals: *To be determined, stay tuned*
The MDA has two primary target audiences to consider in all social media endeavors: Members and the Public. Within those targets include the media, legislators and other organizations. Thus, it is important for each platform to have its own individual strategy with respective goals.

Currently, all MDA social platform are under review—reports are underway that assess, analyze and compare each platform. Based on the report’s conclusions, objectives for improvement will be developed and discussed, and a defined strategy for each platform will be established. Upon establishing a strategic approach for each platform, the 2014 Social Media Strategy report will then be distributed.

Below are strategic prompts for each platform: *Organized by level of importance*

**Strategy - Facebook:**
Facebook has made numerous changes in 2013 that can significantly benefit the MDA. Organizations now have the ability to mobilize communities, organize events, increase fundraising, reduce costs with free online tool and raise awareness through viral networks.

The MDA’s Page is member-focused, but “public-friendly” in that content posted will not negatively impact the MDA to the public. To carter to the primary audiences a separate page will be constructed that is public-focused. However, the member Page will still be “public-friendly.”

**Strategy - YouTube:**
YouTube’s visual nature allows organizations to create an emotional appeal. Considering YouTube is the second most powerful social network for consumer engagement, we need to consider how the platform reflects the MDA and its members. YouTube has introduced the Nonprofit Program, a call-to-action feature to drive sign-ups, donations, website traffic, and any other response in which users take action.

The MDA’s YouTube channel was established as a member-oriented platform. However, the Mission of Mercy and Take a Bite Out of Cancer videos are being promoted to both members and the public. Similar to Facebook, a separate channel will be constructed for the public.

**Strategy - Twitter:**
Twitter is a direct line to the community. The benefits for nonprofits include relationship building and marketing, exchange of information, and remaining up-to-date on local and statewide oral health news.

The MDA’s Twitter account is public-focused, and its primary use will be to target and engage the media and legislators when necessary.
Strategy - Flickr:
Unlike other social networks, Flickr’s sole purpose is to showcase the work of the organization and to increase visibility. The platform allows organizations to tell a story via images. One can download the images directly to your computer, which makes it an easy tool for the media to pick and choose images to include in coverage.

The MDA’s Flickr will have photos from Mission of Mercy and the Take a Bite Out of Cancer press conference, and will be updated on a continuous basis. This platform will be used for media purposes—the link will be provided in all media outreach efforts for their convenience.

Strategy - Pinterest:
Pinterest is essentially a virtual scrapbook that allows you to “pin” websites and images that you like and want to refer back to later, and is another image platform that can show your purpose and mission. Everything you pin is clickable—you can link to your website, news articles, etc. The goal of Pinterest is to connect people based on shared tastes and interests.

Pinterest will be the next social endeavor for the MDA, and is a perfect platform to reach the public. The core user group is upper-income women from the American Midwest between the ages of 18 and 34, which is also the MDA’s target demographic for the statewide public education campaign. The MDA’s relevant categories are also popular categories of interest, such categories include: health, family/parenting, children and volunteering.

Strategy - Instagram:
Instagram is a social network that operates through a smart phone application that lets you take a picture and, with filters and contrast, turn it into a work of art. Unlike Flickr, Instagram photos cannot be downloaded, and similarly to Pinterest, the hashtag ability allows you to connect with people who share interested in health, dental health, nonprofits, etc.

The MDA can utilize Instagram as a promotional tool, as well as share the enhanced photos on all other social networks. Instagram is extremely popular for young adults and will be used to connect with dental students.

Strategy - LinkedIn:
LinkedIn is no longer just a place to post your resume and look for a job. A company page on LinkedIn legitimizes your organization’s purpose and mission with professionals and corporations. A LinkedIn profile can be very valuable for nonprofits—users can add causes they support on their profiles.

It has been decided that this platform will be put on hold. However, Josh will continue to manage the page at on a minimal basis.

Strategy - Google+:
Google uses “social signals” to help decide what content rises or fall on its search pages, and since it owns Google+ what is done on that network plays a role in what people see when they search keywords. In addition to influencing the MDA’s SEO, unlike any other social platform, Google+ can help us cater to both the public and members—circles allow you to target key messengers, rather than bombard non-interested parties, and is a great way to engage within circles.

It has been decided that this platform will be put on hold until further notice.
Insights:
Below are highlights of each platform’s current status.

• Facebook
  o The MDA’s Page has a total of 2,012 likes, and continues to gain about five like per week.
  o Compared to the previous month, the number of people who have liked, commented, shared, responded or answered has increased by 10.3%.
  o The number of people the Page reaches has also increased by 51.7%.
  o MDA members and dental health organizations make up the majority of viewers and engagers. Dental-related individuals, including dental hygienists, dental chains, dental manufacturers/suppliers, promotional services for dentists, and family members of dentists make up a small portion.
  o Types of posts include: MDA Announcements/Alerts, Photos, Humor/Human Interest, Members in the Media, Member Opportunities, Videos, Dental Student Updates, and Holidays/National Observances
  o When searching for the keywords: ‘Michigan dental,’ ‘Michigan dental health,’ and ‘Michigan dentist,’ the MDA’s Page was listed number one; Delta Dental Michigan was listed as number 20.

• Twitter
  o The MDA’s Twitter account has a total of 1,119 followers, and continues to gain approximately 15 followers per week.
  o Follower demographics include: Members of the Media, Dental Associations, Dental Health and General Health Organizations, Michigan Legislators, Dental Profession/Members, General Members of the Public, Michigan Businesses/Organizations, Dental Manufacturers/Suppliers and Promotional Services.
  o We have had two celebrity Tweets from the popular rock band One Direction
  o Types of Tweets include: Oral Health Tips, MDA Members in the Media, National and Local Oral Health News, Humor/Human Interest Tweets, and ReTweets.

• YouTube
  o There are a total 71 subscribers to the MDA’s channel, with the majority being members and other dental health professionals.
  o Four videos are uploaded annually, with the most recent being the Take a Bite Out of Cancer promo video, and the Mission of Mercy recap video.
  o With the addition of the two videos mentioned above, which were uploaded in the past 30 days, there has been a significant increase in the channel’s performance—660 views and an estimated 1,392 minutes watched.

• LinkedIn
  o A total of 393 individuals follow the MDA’s LinkedIn profile, which are made up of members, dental health related individuals, dental students and MDA employees.
<table>
<thead>
<tr>
<th>Outlet</th>
<th>Outlet Type</th>
<th>Circulation</th>
<th>Date</th>
<th>Coverage</th>
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<td>WILX</td>
<td>Television</td>
<td>N/A</td>
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<td>Press conference</td>
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<td>wilx.com</td>
<td>Online version</td>
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<td>Press conference; 40 sec. video</td>
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<td>Lansing State Journal</td>
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<td>fox47news.com</td>
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<td>Campaign overview with oral swab kit image</td>
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<td>Campaign overview with oral swab kit image</td>
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Michigan dentists offer chance to join bone marrow registry during office visits in November

November 19, 2013

GRAND RAPIDS, MI – A campaign by Michigan dentists to sign up bone marrow donors saved five lives last year. Now the dentists hope to improve on that success.

The effort, led by Grand Rapids dentist Dr. Steve Conlon, gives patients a chance to become part of the international bone marrow registry when they visit a participating dentist’s office in November. The patients just submit a self-administered oral swab.

In 2012, 2,500 swabs were submitted, and five matches were made with people in need of a bone marrow transplant.

“Bone marrow matches are hard to make, so the fact that we were able to save five lives as a result of last year’s campaign means we’re fired up to exceed that this year,” said Conlon, whose father-in-law died of leukemia.

The Michigan Dental Association and the Leukemia & Lymphoma Society of Michigan are sponsoring the drive. The swab kits are provided at no charge by the Leukemia and Lymphoma Society, in partnership with DKMS labs.

According to the dental association, 5,100 cancer patients in Michigan and more than 1 million nationwide are waiting for a bone marrow transplant.

Sue Thoms covers health care for MLive/The Grand Rapids Press. Email her at sthoms1@mlive.com or follow her on Twitter, Facebook or Google+. 

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Kent County's dental checkup reveals oral health crisis, report finds

November 8, 2013

GRAND RAPIDS, MI – Kent County underwent a dental checkup recently, and the results were not good.

The county is experiencing an oral health crisis, according to the Kent County Oral Health Exam, a report released Thursday, Nov. 7, by a coalition of health care and community leaders. Thousands of adults and children go without basic oral health care, such as oral hygiene, routine cleaning, sealants and early treatment of cavities and gum disease.

"We often see the toll of untreated oral health issues in our hospitals," said Dr. Edward Cox, co-chairman of the Kent County Oral Health Coalition. "Lack of access to less expensive preventive care results in costly visits to emergency departments."

Here are a few of the findings from the report:

• The county ranks last in the state for dental visits for 1-year-olds on Medicaid, with only .2 percent of the children seeing a dentist before their second birthday.

• 26 percent of adults have not seen a dentist in the past year; that includes 48 percent of those without dental insurance

• 26 percent of those surveyed said they have untreated oral health issues.

• The supply of dentists serving low-income patients meets only 29 percent of the need in the county and 55 percent of the need in the city of Grand Rapids.

• There were an estimated 7,667 visits to the emergency department for preventable dental conditions in 2011.

"The great, great majority of dental disease is preventable," said Dr. Colette Smiley, a dentist and co-chairwoman of the coalition. "When you consider that, our efforts and our resources are going to focus on prevention, on the education of community members and on improving oral health literacy."

The coalition, formed in 2011 and housed by First Steps, includes dentists and representatives of the health department, hospitals and social service agencies.
“We came together to address access to care for children. Very quickly, we realized you cannot improve a child’s oral health without improving the adults’ oral health, as well,” Smiley said. “It quickly transitioned to an organization focused on oral health of the greater community.”

To assess the state of oral health locally, the group conducted three surveys and researched state and national data.

Now, the group is focused on addressing two areas of concern: access to dental care and education. It has been involved in efforts to provide dental care to older adults at Grand Rapids Community College and to create a dental clinic in Kentwood. A partnership between the county and nonprofit Michigan Community Dental Clinics plans to open the clinic in the former library building at 4700 Kalamazoo Ave. SE.

“We want to let this community know this is attainable. Yes, you can have good oral health,” Smiley said. “Dental disease is preventable, and here are the tools that you need for yourself and your family to have good oral health for a lifetime.”

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Will work for dental: A new health care model?

'Pay-it-forward' program in Battle Creek helps low-income patients work for their dental treatment.

November 16, 2013

BATTLE CREEK, Mich. — Kelly Price knows too well the pain of infected teeth and how they become so sensitive it hurts to eat or drink. He has suffered with that in the past and still has several teeth that need to be extracted, but the 51-year-old unemployed machinist can't afford to see a dentist.

That's why on a morning last month he was helping out at the Food Bank of South Central Michigan filling bags for weekend meals for needy children with Special K cereal, cans of spaghetti and meatballs, green beans and a juice drink.

The hours Price volunteers inside the sprawling warehouse in "cereal city" will help him get to see a dentist for free. "I would rather pay with cash, but if this is the only way I can do it (that's) fine because I am helping someone else and it all works out," he said.

Price is one of the more than 4,000 adults who since 2007 have received care under the Calhoun County Dentists' Partnership — a privately financed program that requires patients to perform some volunteer work to qualify for the free dental services. The "pay it forward" model enables low-income, uninsured patients to earn their care by helping local non-profits, including the local homeless shelter, Red Cross and Salvation Army.

The effort, being replicated in a dozen other communities such as Springfield, Mo., and South Bend, Ind., fills a crucial need because the federal health law, which expands insurance coverage to millions of people, does nothing to improve adults' access to dental care. The law expands dental coverage only to children.

Kip Etheridge, a dentist who sees patients from the program in his office a few hours a month, said the volunteer work makes them more vested in their care and reduces the number of people who don't show up for the program's dental appointments.

"It's not free care, they work for it, and that aspect is what has encouraged dentists to participate," Etheridge said.
The program has attracted attention from dentists across Michigan and federal health officials.

"The Calhoun County program epitomizes the best kind of private sector, community-based solution to access-to-care problems," said Norm Palm, president of the Michigan Dental Association. "This program is organized in a way that everyone can win."

A GAP IN CARE

The use of dental services has declined significantly since 2007. About 36% of U.S. residents saw a dentist in 2011, according to the America Dental Association. Nationally, more than 73% of low-income adults younger than 65 lack dental coverage, according to a study by the Kaiser Family Foundation. (Kaiser Health News is an editorially independent program of the foundation).

But even that underestimates the problem, because Medicare, the federal program for the elderly and disabled, typically does not cover dental services. Even adults who qualify for Medicaid, the state-federal health insurance program for the poor, have no dental benefits in eight states and in 17 other states only have dental coverage for emergencies such as relief of pain and infection, according to a study commissioned this year by the American Dental Association.

Lacking coverage, many patients don't seek help until the dental pain gets severe, and then they often head to hospital emergency rooms.

The number of dental visits to hospital ERs doubled from 1.1 million in 2000 to 2.1 million 2010, according to a recent study by the American Dental Association.

In 2006, at least three patients a day were showing up at Bronson Battle Creek Hospital complaining of dental pain, but the facility could offer them only pain pills or antibiotics and urge them to see a dentist. That's when the hospital, local dentists and community health and business leaders conceived the volunteer model.

The partnership has cut by 70% the number of patients with dental pain showing up at the hospital ER, according to a study published in the journal Health Affairs in September.

Patients must volunteer four hours for every $100 worth of care. While some do the minimum, others accrue hundreds of hours so they can use them to obtain dental services for years. To be eligible, people must have incomes below 200% of the federal poverty level, or about $24,000 for an individual in 2013, and lack dental coverage.

Before they see a dentist, patients must also attend a two-hour oral health class and be seen by a hygienist, who reviews their health history and does a dental screening and cleaning. That shortens the time the dentists need to spend with the patients and determines which dentist will treat the patient. Dentists decide which services they prefer to offer.
More than 40 dentists participate — or nearly half of those in the county. Most of the dentists provide their services for free. The program offers a $1,000 annual bonus to the dentists, but very few have accepted that, program officials say.

Using money donated by the United Way and local foundations, the program spends $140,000 a year for the two part-time hygienists, a two-person staff to manage the program and dental supplies.

Michigan is one of about 30 states that allow hygienists to work under indirect supervision of a dentist, meaning the dentist does not have to be in the same location as the hygienist. Program officials say that's been a key component because it makes it easier to schedule patients, keep costs down and reduce the time dentists need to spend with each patient.

'AN AWESOME PROGRAM'

Ian Gallagher, 31, who has been unemployed since 2009, signed up for the program last month when his tooth started throbbing. He hasn't seen a dentist since losing dental coverage in 2003. Before his screening exam, he volunteered at Battle Creek Pride, a gay and lesbian advocacy group. "This is an awesome program," he said while meeting with the hygienist. He is scheduled to have the tooth extracted in November.

Samantha Pearl, executive director of Community HealthCare Connections that runs the partnership, said she estimates the partnership this year will generate about 16,000 hours of volunteer work — or the equivalent of nine full-time workers. "Every person has something that they are uniquely qualified to give and this works when we are all contributing," she said.

In the past year, the program has expanded so four hours of volunteer service can buy six months of chiropractic treatment. A local orthodontist has offered to help people under age 23. A local lab also has donated its expertise to make dentures.

Pearl said the challenge is keeping up with demand. The dental program is working to lower wait times to see dentists from a few months to a few weeks. With more employers in Michigan dropping health and dental coverage, more people will need help, she said.

Charles Palumbo, a Battle Creek dentist who helped launch the program and has extracted hundreds of teeth from people who have come through it, said volunteering is important for the patients. "We want them to have a sense of dignity as opposed to an entitlement to what is happening," he said. "We want them to feel like they are paying for services."

Kaiser Health News is an editorially independent program of the Henry J. Kaiser Family Foundation, a non-profit, non-partisan health policy research and communication organization not affiliated with Kaiser Permanente.

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