Call to Order and Introductions: President Bruce Barrette called to order the 10th meeting of the ADEX House of Representatives at 8:15 a.m. on Sunday, November 9, 2014 in the Signature Ballroom, Doubletree Hotel, Rosemont, IL.

Roll Call: President Barrette introduced the members of the House of Representatives: Dentist/Administrator Representatives: Dr. Lisa Fox, CO; Dr. Mark Baird, HI; Dr. Robert Gherardi, NM; Dr. Timothy Pinther, NV; Dr. Jonna Hongo, OR; Dr. Scott Houfek, WY; Dr. Keith Clemence, WI; Dr. Mary Starziak, IL; Dr. Stephen Pritchard, IN; Dr. Rhonda Hennessy, MI; Dr. Jacinto Beard, OH; Dr. George Martin, AR; Dr. Katherine King, KY; Dr. Charles Holt, Jr., TN; Dr. Z. Vance Morgan, SC; Dr. Evelyn M Rolon, VA; Dr. C. Richard Gerber, WV; Dr. Maurice Miles, MD; Dr. Lisa Deem, PA; Dr. David Perkins, CT; Dr. Jezzelle Sonnier, DC; Dr. Arthur McKibbin, Jr, NH; Dr. Joseph Battaglia, NJ; Dr. Russell Chin, RI; Dr. Charles Zois, me; Dr. Milton Glicksman, MA; Dr. David Averill, VT; Dr. William Chesser, AL; Dr. Dean Manning, LA; Dr. Jeffery Hartsog, MS; Dr. Kenneth Sadler, NC; Dr. Augusto Cesar Garcia-Aguirre, PR; Dr. Leonard Britten, FL; Dental Hygiene Representatives: Mary Davidson, RDH, OR, District 2; Ms. Nan Kosydar Dreves, RDH, WI, District 4; Ms. Lynda Sabat, RDH, OH District 5; Ms. Sherie Williams Barbare, SC, RDH, KY District 6; Cheryl Bruce, RDH, MD, District 7; Sibyl Gant, RDH, DC, District 8; Ms. Karen Dunn RDH, MA, District 10; Ms. Carla Stack, RDH, NC, District 11; Ms. Irene Stavros, RDH, FL, District 12; Consumer Representatives: Ms. Lisa Wark, NV, District 2; Ms. Clance LaTurner, IN, District 5; Mr. Allan Horwitz, PA, District 7; Ms Lynn Joslyn, NH, District 9; Ms. Diane Denk, ME District 10; Dr. James Hemby, NC, District 11; There were 49 out of 55 State Board, District Hygiene and Consumer Representatives present.

President Barrette introduced ADEX officers, Dr. Stan Kanna, HI, Vice-President; Dr. William Pappas, NV, Secretary, Dr. Robert Jolly, AR, Treasurer, and Dr. Guy Shampaine, MD, Immediate Past President.

President Barrette also introduced representatives from Associate Member organizations: Dr. Ronald Lemmo, Trustee representing the American Dental Association (ADA); Ms. Kristopher Mendoza, representing the American Dental Students Association (ASDA); Dr. Peter Robinson, American Dental Education Association (ADEA); Dr. William Judson, representing the National Dental Board of Canada (NDEB); Dr. Gerard Dillion, representing the National Board of Medical Examiners (NBME) and Mr. David Johnson representing the Federation of State Medical Boards, (FSMB).

ADEX Board of Directors Members in attendance: District 4; Dr. Michelle Bedell, SC, Dr. Dennis Manning, IL, District 5; District 6; Dr. John Reitz, PA, District 7; Dr. Robert Ray, DC, District 8; Dr. Richard Dickinson, VT, District 10; Dr. Wade Winker, FL, District 12; Ms. Mary Johnston, RDH, MI, Hygiene Member; Ms. Mary Ann Burch, RDH, KY, Dental Hygiene Member

Additional Guests: Dr. Rene McCoy-Collins, District of Columbia Board; Dr. Al Rizkalla, VA, ADEX Dental Exam Committee; Ms. Molly Nadler, Past Executive Director of ADEX; Pat Connoly-Atkins, MA-NERB; Dr. Scott Phillips, MS, ADEX Dental Exam Committee;
Ms Laverne Whitmore, RDH, IN, ADEX RDH Exam Committee; Ms. Kathleen Gazzola, RDH, ADEX RDH Exam Committee; Dr. LeeAnn Podruch, VT, ADEX Exam Committee; Mr. Michael Zeder, MD, NERB; Mr. Hal Haering, AZ, Chair, ADEX QA Committee; Dr. John Erhard, ADEX Dental Exam Committee; Dr. J. Gordon Kinard, NV, ADEX QA Committee; Dr. Roddy Scarbrough, MS, ADEX Dental Exam Committee; Ms. Kathleen White, Executive Director-SRTA, VA, Dr. Marc Muncy, AR, President-Elect-SRTA; Dr. H.R. Marshall, WV, President-SRTA; Dr. Ellis Hall, NERB, MD; Alex Vandiver, MD, Executive Director –NERB; Dr. Chip McVea, President-CITA; Ms. Leah Diane Howell, Executive Director Mississippi Dental Board, and Mr. James Tarrant, IL, Executive Director –AADB.

Also in attendance: David L. Hankey, Esq, ADEX General Counsel and Patrick D. Braatz, ADEX volunteer Administrator

Presentations from Associate Members

FSMB - Mr. David Johnson brought greetings from the Federation of State Medical Boards and said that next year he would be willing to provide more information regarding Federation work on an interstate licensing proposal that they are working on.

ADA – Dr. Ronald Lemmo, ADA Treasurer and Trustee.

Good Morning:

Before I deliver my remarks on behalf of the ADA, I would like to take the opportunity to congratulate ADEX as you approach the 10 year anniversary of serving the licensing bodies, the profession and the public we have the privilege of serving.

I would also like to thank the Executive Committee for your Hospitality during my visit, and recognize Dr Bruce Barrette for his Leadership and his successful year as President of ADEX. I look forward to working with Dr Stan Kanna and wish him well as he takes over at the helm of ADEX.

I would also like to recognize Patrick Braatz for his Volunteerism as the Executive Director of ADEX; thank you for your commitment; it has not gone unnoticed.

Lastly I would like to recognize Dr Guy Shampaine for his dedication over the years in helping to develop a licensing process that can lead the profession to an initial licensing exam that is accepted by all jurisdictions.

I have had the pleasure of serving with many of these individuals as well as many of you in the House of Representatives during my tenure on the Council of Dental Education and Licensure and throughout my years of involvement at the ADA, and I look forward to the opportunity to work with ADEX as the ADA representative to this House.

The ADA greatly benefits from its close working relationship with the ADEX. I am pleased to represent the ADA at your meeting. This official liaison between the ADA and ADEX dates back to 2005; we have had many good years together.

As most of you know, the Council on Dental Education and Licensure is the ADA’s go-to agency for policy and advocacy regarding trends in testing, licensure and dental education.
Today I want to update you on ADA activities regarding the process in which you are directly involved: a test for initial dental licensure. This fall CDEL undertook a special survey project regarding the Curriculum Integrated Format examination process.

ADA policy has supported the Curriculum Integrated Format-type clinical examinations since 2007.

The Council’s goal is to assess the effectiveness of the Curriculum Integrated Format Assessment in the clinical licensure process. Specifically, to examine the extent to which all aspects of the Curriculum Integrated Format, as defined in ADA policy (Trans.2007:389), are utilized by dental schools, regional testing agencies and dental students.

The Council hears anecdotal reports about the successes and challenges of this examination format. I’m sure you hear the same. The Council believes valid data on opinions and experiences are needed. Collecting this information from stakeholders can greatly inform future licensure and testing policy discussions for the Council and the ADA.

Deans of dental schools, representatives of regional testing agencies and recent dental school graduates will be surveyed.

On this same theme, to be frank, the ADA hears from new dentists their belief that the use of patients in high-stakes examinations is passé among other professions. We have heard anecdotal report of ethical breeches, liability challenges for dental schools that “sanction” care that is not comprehensive, and a hue and cry for dentistry to move toward simulation and other forms of objective non-patient testing.

As you know, ADA policy “supports the elimination of patients in the clinical licensure examination process with the exception of the curriculum integrated format as defined by the ADA.”

Then, at the same time, experienced examiners believe that a clinical examination using patients, whether traditional or Curriculum Integrated Format is the only valid method available right now.

I applaud ADEX for the announcement of creating a pilot project to explore enhancements to the CIF format that addresses some of the concerns voiced by the ADA and ASDA.

On the subject of licensure mobility, new dentists yearn for increased state licensure mobility without retaking a regional examination, given the frequency with which their families move. A scan of state regulations shows that about 20 states currently accept results of all five regional examinations. New dentists tell us they would like to see that expanded. ADA policy reinforces the new dentists’ opinions: “Requiring a candidate who is seeking licensure in several jurisdictions to demonstrate his or her theoretical knowledge and clinical skill on separate examinations for each jurisdiction seems unnecessary duplication.”

Where will these divergent opinions and approaches lead us? The ADA and CDEL are collecting some useful data to begin to assess part of the picture. I will keep you updated as long as I serve as the ADA liaison.

I wish you a successful meeting and look forward to our continuing discussions.
ADEA - Dr. Robinson, brought greetings from the American Dental Educators Association.

ASDA – Ms. Kristopher Mendoza, President of the American Student Dental Association brought greetings on behalf of the ASDA

NBME- Dr. Gerard Dillon, brought greetings from the National Board of Medical Examiners on their 100th Anniversary.

NDEB – Dr. William Judson, brought greetings from Canada and updated the members on items that the NDEB are working on.

Adoption of Agenda: Dr. Charles Holt, Jr, TN moved Dr. Maurice Miles, MD seconded a motion to adopt the agenda with the proviso that the President could reorder items if necessary. The motion passed by general consent.

Adoption of Proceedings of the 9th ADEX House of Representatives, November 10, 2013

Dr. Charles Holt, JR., TN, moved and Mr. Alan Horowitz, PA, NH seconded a motion to adopt the Proceeding of the 9th ADEX House of Representatives, November 10, 2013. The motion passed by General Consent.

President’s Report

Dr. Bruce Barrette, President of ADEX gave the following report:

Today marks the tenth Annual Meeting of ADEX and this past year has been both productive and busy. It’s been a year in which we have continued to grow but at the same time we’ve worked to consolidate our past gains and plan for the future of our organization.

Due to our increase in size, the effectiveness of the ADEX dental exam committee was becoming a concern. So it was decided to divide the committee into 5 subcommittees in the areas of endodontics, prosthetics, periodontics, restorative and scoring and appointed chairs for the subcommittees. By doing this it would allow the subcommittees more time to efficiently work on specific issues pertaining to their particular area. Our dental exam chair compiled lists of agenda items that he received from individual examiners and the testing agencies. These items were prioritized and distributed to the chairs of the subcommittees. During August, September and October, the subcommittees held teleconferences during which they discussed and voted on their issues. Their recommendations were brought to the full committee, which met Friday for approval. Later you’ll be presented the recommendations of the full committee. Dr. Scott Houfek, dental exam chair, Mr. Patrick Braatz, volunteer executive director and I participated on all the calls and I know I speak for the three of us in our appreciation for the thoroughness and thoughtfulness that all the subcommittees exhibited.

In a major change for the ADEX dental exam, this past year saw us combine two scoring criteria (Satisfactory and Minimally Acceptable) into a new rating level called Acceptable. This now gives us a three rating level scoring system defined as Acceptable, Marginally Sub-standard, and Critical Deficiency. In addition, the dental exam committee has continued with their ongoing work of refining the exam and has devoted a great deal of time and effort this year to reviewing our criteria.
It is with great joy and happiness that we announce that the new computerized ADEX dental hygiene exam to be administered by NERB and SRTA is nearing completion and we anticipate it will be operational later in this coming exam cycle. All of us are aware of the diligence and hard work that took place. Publically, I want to take this opportunity to thank all the members of the ADEX dental hygiene committee for their efforts. It's been a long journey but the exam is now close to being ready and I feel sure that when it's implemented it will be well received.

Our efforts have not only continued but also intensified in developing a state of the art calibration system. As you know last year we hired Dr. Howard Strassler to head up our efforts. During the past year, he has been busy attending exams and acquiring images for our image bank. At the same time, we have been working closely with our friends at Bright link in developing a unique software system that will enable us to project a different calibration exam for our graders at every site. In addition, our three testing agencies have kindly offered to us the use of their libraries of images, which will greatly enhance our final product. In August, the perio/restorative calibration exercise was initially field tested at the New York exam and a final field test will occur in December with full implementation scheduled for the perio/restorative exams in Jan., Feb., and March.

We continue to grow and flourish. The ADEX dental examination fully complies with the ADA guideline for the utilization of the Curriculum Integrated Format method for live patient examinations. We are especially excited about a project that we expect to undertake during the next six months in which we would pilot an examination with one dental school. Educators from the school would be ADEX calibrated in the selection of lesions and would make those selections as part of a current treatment plan. Any follow-up would be undertaken immediately by the faculty. ADEX examiners would have final say over the selection and all other aspects of the examination would follow ADEX protocols and would be conducted by ADEX examiners.

As partial results of the pilot project we are forming an ad hoc committee titled Patient Ethics Advisory Committee consisting of educators, professional association representatives and examiners whose charge will be to review and evaluate our procedures to ensure that they are ethically compliant and further provide transparency to our process.

The ADEX dental examination is the most accepted initial exam for initial licensure in the United States. During the past four years, we have doubled in size and now have 43 states and 3 jurisdictions that recognize the ADEX exam for initial licensure. The remaining states that do not recognize ADEX are: Alaska, California, South Dakota, Oklahoma, Delaware, Georgia and New York.

Since the last Annual Meeting, the Louisiana state board has voted to join ADEX and during the past month, the Virgin Islands and New York in dental hygiene have also joined and I'm being told another state has sent us membership papers. ADEX now has 35 member states and jurisdictions. We continue to reach out to those states that don't recognize ADEX for licensure, states that do accept the exam for licensure but aren't members of ADEX and all entities that can help us achieve our goal of a single uniform national exam. Because state board members are constantly changing, we also recognize a need to keep our member state boards updated and educated on examining issues and those efforts are ongoing and will continue to increase in the future.

Recently, we have had inquiries about membership from some international countries. Those countries have been visited, extensive conversions have occurred with them and
within ADEX. As a consequence, the bylaw committee, later in the meeting, will be submitting a proposal for membership to the House.

As we stated during last year’s Annual meeting, we have made it a high priority to evaluate our organization and create a business plan for the future. We hired Ms. Sarina Butler from the Butler Group to facilitate the process and in June the Executive Committee and the Board of Directors meet with her in Chicago. During the course of that meeting and a series of follow up teleconferences, a five-year business plan was developed. Later in the meeting Sarina will outline the highlights of the plan. I am confident that with the implementation of this plan, some parts of which have already begun being initiated, ADEX will prosper during the next 5 years.

Please join with me in saluting the people who have helped with the preparations for this meeting and assisted the sub-committees on Friday with note taking: Ivan Tellez, Wendy Fischer, Karen Lorge, Kathleen White and Diane Howell who also assisted with the AV.

This is the fourth and final time that I have addressed the House as your president. I want to take this opportunity to acknowledge the members of the House and all the people who have served on our committees especially the people who have chaired our standing committees; specifically, Hal Haering on the Quality Assurance Committee, Bob Ray on the By-Laws Committee, Clance LaTurner and Mary Johnson on the Communications Committee, Bob Jolly and Bo Smith on the Finance Committee and Bill Pappas on the Calibration Committee for their commitment in time and expertise to ADEX.

Much of the success that we’ve achieved has come from the support of the Board of Directors and I wish to recognize all the members, both past and present, who have been a part of the Board. At the same time, we would not have made the progress that we have, without the backing and the cooperation of the testing agencies. At Nerb, Dave Perkins, Ellis Hall, Michael Zeder, Alex Vandiver and all the staff. At SRTA, Bob Jolly, Dick Martin, Mark Muncy, Kathleen White and all their staff. And at CITA, Chip McVea, Cindy Jones and their staff.

Since the mid 90’s I’ve worked with Nan Dreves first on the Wisconsin Dental Board, later at CRDTS and more recent as the chair of the ADEX dental hygiene exam committee. With grace, tact, and a healthy measure of humor she has guided the dental hygiene committee during the past two years in order to come to a consensus for the new dental hygiene exam. At the same time I would like to acknowledge the contributions, which Nancy St. Pierre made as Dental Hygiene chair.

Our dental exam chair, Scott Houfek was a one of the originators of ADEX and was the first President of ADEX. At a particularly challenging time in ADEX’s history he was faced with a difficult decision whether to remain with and be a part of ADEX. To the benefit of ADEX he chose to stay and support ADEX with his experience and expertise. Today marks the end of his term, as ADEX Dental Exam Chair and we wish him the best.

Patrick Braatz has been my friend for the past 20 years. His devotion and passion for this organization by now should be evident to everyone in this room. He has during the past 5 years amazed all of us with his organizational skills, efficiency and good humor. Those skills and his commitment to ADEX will continue to enhance and enable ADEX to prosper in the future.
Ten years ago four people had an idea for a universal national exam in dentistry and dental hygiene. I've already mentioned one of them, Scott Houfek. Another one is also here and his contributions to not only ADEX but also the entire examining community are indisputable and momentous. In referring to him one of our examiners put it best in saying “When you look up in the sky there are many bright stars but there is always one that shines the brightest.” He was the second president of ADEX and I am proud to announce beginning February 1, 2015 the new CEO of ADEX, my friend. Guy Shampaine.

During the past three years through monthly calls and face-to-face meetings, I have been a witness to their wisdom and respect for all opinions that my fellow Executive Committee members have demonstrated. Without any hesitation, I am confident that through the leadership of Stan Kanna along with Bill Pappas and Bob Jolly that they will, during the next few years lead this organization to new heights and fulfill our dream of a single uniform national exam.

I want to thank you all of you for the support you’ve given me over the past four years. It has been an honor and a privilege to work with all of you as we have developed an exam that is recognized across the country for its excellence and an exam that truly protects the public. From the bottom of my heart, thank you.

Presentation by Dr. Stanwood Kanna, Vice-President of ADEX to Dr. Bruce Barrette outgoing President of ADEX

There are a few of us who have been with ADEX almost since the beginning. I met my good friend Dr. Bruce Barrett when the CRDTS dental testing agency administered the very first ADEX examination in the country in Honolulu, HI on December 5, 2005. His passion and dedication as an examiner for CRDTS and his skill and leadership within the organization lead CRDTS to be one of the top Dental Testing Agencies in the Country. Bruce took his leadership skills and knowledge in dental testing and dedicated his energy to developing and forwarding the initiative of a Uniform National Dental and Dental Hygiene licensure examination, ADEX.

His commitment to advancing ADEX and bringing it to fruition was met with many challenges, some manageable, some very difficult but he did not stray from his ideals. When CRDTS pulled out of the ADEX process in 2009 Bruce sacrificed his Presidency of CRDTS to continue the now increasingly challenging process of ADEX. The NERB and Nevada were the only ones left administering the ADEX examination. This was the lowest point in the ADEX process.

Dr. Scott Houfek was the ADEX president and had been its awesome leader since its formation, Dr. Guy Shampaigne was Vice-President and Dr. Bruce Barrette was its secretary /treasurer. Our very own Patrick Braatz was our administrator. This leadership kept the ADEX process alive because they believed that ADEX was and is the best examination in the country and that the goal of a Uniform national dental and dental hygiene licensure examination was worth fighting for. Dr. Shampaigne then took over leadership of the NERB and Dr. Bruce Barrette took over leadership of ADEX at a time when we needed the best of the best leadership in both organizations.

Bruce had to make strong decisions and he sacrificed both professionally and personally as he lead ADEX forward. In 2010 we had 23 States as members of ADEX. Through Bruce’s leadership of ADEX and the dedication of many unheralded heroes ADEX has come from the bottom of the hole to become the premier Dental and dental hygiene licensure examination in the country and our dream of becoming a Uniform national licensure examination is just on the horizon. ADEX currently has 36 member States and
jurisdictions. We now have the NERB, SRTA and CITA administering the ADEX examination and the exam is being accepted in 43 US States and 3 jurisdictions. We are even going international.

Is this all Bruce’s doing? No, but someone had to lead ADEX and make the decisions that kept the process moving forward. Someone had to answer the challenges from outside and internally. Someone had to give more than he received. His tenure now ends as President of ADEX and it is time for new leadership to take over and continue the process. It is time for us to recognize our President, our friend, our colleague, our mentor for his dedication and leadership of ADEX and its goals.

It is my pleasure to recognize our friend Dr. Bruce Barrette, President of ADEX

Presentation from Dr. Chad Buckendahl, Psychometrician:

Dr. Chad Buckendahl presented a brief history of test development and validation that began at least with Chinese civil service examinations and expanded rapidly in the U.S. after WWI and the development of Army Alpha.

An overview of a validation framework that includes operational, policy, and innovation sources of evidence that is driven by the intended use of scores and decisions for a testing program.

Operational characteristics will often start with evidence of content and response processes that for licensure programs are based on a practice or occupational analysis. This is a primary source of evidence in establishing the job-relatedness of the examinations to the expectations of the profession. Additional considerations around reliability (i.e., estimates of measurement error in scores, examiner judgments, decisions) and fairness (e.g., due process, bias) were also discussed.

Additional components of the validation framework (policy and innovation) were discussed also with examples of how each could be evaluated in the context of the clinical judgments and skills based exams offered by ADEX.

Encouragement to move beyond intuitive test theory to become better consumers of information about development and revision of tests.

Presentation from:

Sarina A. Butler, a principal of The Butler Group, presented highlights of the Strategic Business Plan the Board of Directors developed in June and subsequently adopted in September.

The plan is designed to achieve the ADEX mission to develop and maintain the dental profession’s national initial licensing examinations, and to assure that these examinations provide fair and uniform testing that is consistent, proven, valued and universally accepted so that a candidate’s clinical competency may be determined and so that the public interest may be safeguarded.

The plan identifies goals, strategies and actions within a five-year timetable. It also specifies committees and individuals within ADEX who have principal responsibility for each action identified. Some of the initiatives defined by the plan already are underway. Two major actions – the appointment of a full-time chief operations officer and a member as chief executive officer – were approved during the November, 2014 meetings of the
Board and the House of Representatives. Others will be launched over the coming years.

Presentation from:

Howard Strassler, DMD, ADEX Consultant on Calibration:

The identification of images for categories and criteria for the restorative examination is progressing smoothly. Enough images have been identified and loaded on the BrightLink server for the administration of a pilot exam at NYU on August 12, 2014. The pilot examination was integrated with the restorative examination presentation. The mechanics for administering the examination was presented. As part of the pilot examination a survey was filled in by the examiners taking the pilot to provide feedback. Results of the survey were presented, as well as, some modifications to the calibration examination will be implemented based upon the survey results. A second pilot examination will be administered at NYU December 5, 2014 at NYU, as well as, a presentation on the new format for the restorative calibration will be presented at the NERB meeting in January, 2015. Dr. Pappas presented an overview of the restorative calibration and the pilot at the SRTA meeting over the summer.

Dr. Scott Houfek, Chair - ADEX Dental Examination Committee - Dental Examination Overview

Report from the ADEX Dental Subcommittee on Prosthodontics

- That testing agencies supplied stent to be used to verify critical deficiencies on all three pros preparations.
- That Agency supplied stent to be used to verify critical deficiencies for endentulous proximal surfaces only on axial reduction.
- That any criteria that includes over or under reduction be separated into two separate criteria and graded separately.
- That in the “Margin Definition” if there is a concavity cupped or J shaped with unsupported enamel it will be a deficiency.
- That the protocol for marking teeth should only be done in the mouth on the labial/buccal surface after the exam starts following CDC (wrapped writing instrument) guidelines for infection control.
- The manikin exam to be deemed acceptable, the typodont must be mounted into a simulated patient head which includes minimally the facial features below the supraorbital region, the extra oral tissues and a working hinge function. Any deviation must be pre-approved by the ADEX Prosthodontic Committee.
- That the chair appoints a small committee to review current pfm and all ceramic crown preparation criteria and designs. During the interim period all prosthodontic preparations must follow current ADEX criteria. (wing preparations)
- That throughout the manual all references to gold be changed to metal.
- That Walls, Taper and marginal width in the all ceramic crown prep that lingual clearance be included as a definition of axial reduction.
• That the Exam criteria: Full Metal Crown Prep Marginal Width Feather margin or no margin is a critical deficiency. Margin with .5 to 1 m is acceptable. 1-2 is Sub-standard or a detectable margin less than .5mm. Feel a margin or is less than .5mm is a sub-standard, over 2 is critical deficiency.

• To remove all references to “optimal” and change all material measurement standards to mathematical symbols. Criteria will be adjusted to have no unmeasurable area. The motion passed by general consent.

• That any criteria that includes over or under reduction be separated into two separate criteria and graded separately. The motion passed by general consent.

Report from the ADEX Dental Subcommittee on Periodontics

• To charge the Periodontics Ad Hoc Committee to develop a more relevant and simplified periodontal clinical examination. Motion passed by general consent.

• To include a more relevant and simplified periodontal component to the ADEX clinical examination.

• To allow a candidate a second periodontal treatment selection if the first treatment selection is rejected. This second treatment selection can be in the same patient or in a new one. If the second treatment selection is rejected that is then considered a failure.

• To charge the periodontal Ad Hoc committee to investigate the feasibility of including a periodontal assessment on the candidate’s restorative patients.

Report from the ADEX Dental Subcommittee on Endodontics

• That a Protocol be developed for the Marking of teeth that must be done after both the typodont has been mounted and the beginning of the examination with the utilization of the CDC guidelines.

• That a rubber dam be in place prior to the initiation of the access opening.

• That the adoption of the proposed criteria for anterior and posterior endodontics.

PROPOSED: Anterior Access Opening Acceptable Criteria

1. The placement of the access opening is on the lingual surface directly over the pulp chamber and allows for:
   • Pulp horns to be fully removed
   • Complete debridement of the pulp chamber
   • Provides straight line access to the root canal system.

2. The size of the access opening:
   • Allows for complete removal of the pulp horns
   • The incisal aspect of the access opening is not less than 3 mm from the incisal edge which provides for a fully supported incisal edge
   • The cervical aspect of the access opening is not less than 4 mm from the lingual CEJ which provides for a fully supported cingulum
   • The widest portion of the preparation mesio-distally is not greater than one half of the lingual surface which provides for fully supported marginal ridges (approximately 2 mm)
3. From the lingual surface to the cervical portion, the internal form tapers to the canal opening with slight irregularities, if any.

**PROPOSED: Anterior Access Opening Marginally Substandard Criteria**

1. The placement of the access opening is not directly over the pulp chamber but does allow:
   - Complete debridement of the pulp chamber
   - Access to the root canal system.

2. The size of the access opening:
   - The incisal aspect of the access opening is not less than 2 mm from the incisal edge which provides for a supported incisal edge
   - The cervical aspect of the access opening is not less than 3 mm from the lingual CEJ which provides for a supported cingulum
   - The widest portion of the preparation mesio-distally is greater than one half of the lingual surface but provides for supported marginal ridges (greater than 1 mm)

**PROPOSED: Anterior Access Opening Critically Deficient**

1. The placement of the access opening is NOT over the pulp chamber and/or does NOT allow:
   - Complete debridement of the pulp chamber or
   - Access to debride the root canal system

2. The size of the access opening:
   - Does NOT allows removal of the pulp horns
   - The incisal aspect of the access opening is less than 2 mm from the incisal edge which compromises the incisal edge
   - The cervical aspect of the access opening is less than 3 mm from the lingual CEJ which compromises the cingulum
   - The preparation compromises the mesial and/or distal marginal ridge(s) (1 mm or less)

3. The internal form exhibits excessive gouges which compromises the integrity of the tooth.

4. Reduction of the crown has been performed.

**PROPOSED: Anterior Canal Instrumentation Acceptable**

1. The canal is shaped to a continuous taper to allow adequate debridement and obturation.
2. The cervical portion of the canal is of appropriate location and size to allow access to the apical root canal system.
3. The mid root portion of the canal blends smoothly with the cervical portion, without ledges or shoulders.
4. The apical portion of the canal is prepared to the anatomical apex of the tooth or up to 1 mm short of the anatomical apex.

**PROPOSED: Anterior Canal Instrumentation Marginally Substandard**

1. In the cervical portion, the canal is over or under prepared but still allows adequate debridement and shaping without affecting the integrity of the tooth structure.
2. The mid root portion of the canal does not blend with the cervical region of the canal and/or canal irregularities are present that will inhibit but not prevent canal obturation.
3. The apical portion of the canal is under-prepared more than 1 mm and up to 3 mm short of the anatomical apex.
4. The mid root or apical portion of the canal is transported, but the apical portion of the preparation is still congruent with the anatomical apex.

PROPOSED: Anterior Instrumentation Critically Deficient

1. The cervical portion of the canal is grossly over prepared affecting the integrity of the tooth structure.
2. The mid root portion of the canal has significant instrumentation irregularities that will compromise obturation.
3. The apical portion of the canal is over-prepared beyond the anatomical apex or is under prepared more than 3 mm short of the anatomic apex.
4. The apical portion of the canal preparation is transported to the extent that the apical portion of the canal is not instrumented.
5. Any portion of the tooth is fractured.
6. Any portion of the tooth is perforated.

PROPOSED: Anterior Canal Obturation Acceptable

1. The root canal is obturated at the anatomical apex or up to 1 mm short of the root apex.
2. The apical third of the obturation in the root canal is dense and without voids.
3. The gutta percha in the root canal is up to 1 mm apical to the CEJ when measured from the facial.
4. Gutta percha and/or sealer is/are evident in the pulp chamber extending up to 1 mm coronal to the CEJ when measured from the facial.
5. A file is separated in the root canal but does not affect the obturation of the root canal.

PROPOSED: Anterior Canal Obturation Marginally Substandard

1. The root canal is obturated with gutta percha more than 1 mm but no more than 3 mm short of the apical foramen.
2. There are minor voids present throughout the obturation of the root canal.
3. The gutta percha in the root canal is more than 1 mm but less than 3 mm apical to the CEJ when measured from the facial.
4. Gutta percha and/or sealer is/are evident in the pulp chamber extending more than 1 mm but no more than 2 mm coronal to the CEJ when measured from the facial.
5. A file is separated in the root canal but allows obturation of the root canal which is otherwise evaluated as marginally substandard.

PROPOSED: Anterior Canal Obturation Critically Deficient

1. The root canal is obturated with gutta percha more than 3 mm short of the anatomical apex or beyond the anatomical apex.
2. There are significant voids throughout the obturation of root canal, there is no gutta percha present in the root canal or a material other than gutta percha was used to obturate the root canal.
3. The gutta percha in the root canal is more than 3 mm apical to the CEJ when measured from the facial.
4. Gutta percha and/or sealer is/are evident in the pulp chamber extending more than 2 mm coronal to the CEJ when measured from the facial.
5. A file is separated in the root canal and either prevents obturation or allows obturation at a critically deficient level.
6. There is restorative material present in the pulp chamber.

**POSTERIOR ACCESS OPENING**
**PROPOSED ACCEPTABLE**

1. The placement of the access opening is over the pulp chamber allowing debridement of the pulp chamber and straight line access to the three root canals located in the tooth.
2. The access opening is in the mesial triangular pit and central fossa of the tooth and:
   - The mesial extent of the access preparation is not less than 3 mm from the mesial marginal ridge of the tooth.
   - The buccal extent of the access preparation is not less than 2 mm from the line bisecting the mesiobuccal and distobuccal cusp tips.
   - The distal extent of the access preparation is not less than 2 mm from the oblique ridge.
   - The palatal extent of the access preparation is not less than 2 mm from the palatal cusp tip.
3. The depth of the access preparation removes the entire roof of the pulp chamber and all three canals can be accessed.
4. The internal form of the access preparation leaves at least 2 mm of supported lateral tooth structure at any point of the preparation and tapers to the canal orifices with no or slight gouges.

**POSTERIOR ACCESS OPENING**
**PROPOSED MARGINALLY SUBSTANDARD**

1. The placement of the access opening is not directly over the pulp chamber and hinders but allows complete debridement of the pulp chamber and hinders but allows access to the 3 root canals.
2. The access opening is in the mesial triangular pit and central fossa of the tooth and:
   - The mesial extent of the access preparation is not less than 2 mm from the mesial marginal ridge.
   - The buccal extent of the access preparation is not less than 1 mm from the line bisecting the mesiobuccal and distobuccal cusp tips.
   - The distal extent of the access preparation is not less than 1 mm from the oblique ridge.
   - The palatal extent of the access preparation is not less than 1 mm from the palatal cusp tip.
3. The internal form of the access preparation leaves at least 1 mm of lateral supported tooth structure at any point of the preparation and tapers to the canal orifices with moderate gouges.

**POSTERIOR ACCESS OPENING**
**PROPOSED CRITICALLY DEFICIENT**

1. The placement of the access opening is not over the pulp chamber and does not allow complete debridement of the pulp chamber or access to the 3 root canals.
2. The access opening is either grossly under-or-over-extended in one or more of the following categories:
• The mesial extent of the access preparation is less than 2 mm distal to the mesial marginal ridge.
• The buccal extent of the access preparation is less than 1 mm to the line bisecting the mesiobuccal and distobuccal cusp tips.
• The distal extent of the access preparation is less than 1 mm from the oblique ridge.
• The palatal extent of the access preparation is less than 1 mm from the palatal cusp tip.

3. The depth of the access preparation does not remove the roof of the pulp chamber to the extent that all pulp tissue can be removed and all 3 canals can be accessed.

4. The depth of the access preparation does not remove more than 2 mm from the floor of the pulp chamber and/or the pulpal floor at the center of the floor is more than 10 mm deep when measured from the buccal cavosurface margin of the access preparation.

5. The internal form of the access preparation leaves less than 1 mm of lateral supported tooth structure at any point of the preparation and/or tapers to the canal orifices with gross ledges that will inhibit access to the root canal orifices.

6. There is a perforation in any aspect of the access preparation.

7. Reduction of the crown has been performed.

That the adoption of the proposed criteria for anterior and posterior endodontics. The motion passed by general consent.

**Report from the ADEX Dental Subcommittee on Restorative Dentistry**

• That the Asst. Chief be allowed to perform CFE upgradeable procedures only if they have been calibrated.

• That the Committee that the M & D language be eliminated on the progress sheet for the posterior Composite. The motion passed with general consent.

• That prior to presenting a preparation to the express chair for modification; candidates acknowledge on the modification form that their preparation meets the acceptable criteria. If the preparation fails to meet the acceptable criteria a 10 point penalty will be assessed. The motion passed by general consent.

• That regarding the references to the 11/12 explorer is removed from the restorative section of the manual. The motion passed with general consent.

• That all examiners be prompted to confirm Liner/Base issue vs. only the first examiner. The motion passed with general consent.

• To remove the word Base and to simplify the entire liner protocol.

• That the following editorial changes for 2015 manual in the Scoring Criteria C. II Amalgam Prep Treatment Management Marginally substandard should be “hemorrhagic” instead of hemorrhage. Scoring Criteria Posterior Occlusal Composite Prep Internal Form Critical Deficiency 1. DEJ should be the end of sentence no #3, #2 should be what is written for #3.

• That the following editorial change for the 2015 manual in Scoring Criteria; Posterior Proximal Occlusal Composite Preparation Internal from Marginally
substandard #3. Remove the word “sharp”. The motion approved by general consent.

- That the following editorial changes for 2015 Manual in Scoring Criteria: Internal Form Critical Deficiency for all preparations the following be added to #3, or assigned carious lesions has not been accessed. The motion approved by general consent.

- That the following editorial changes for 2015 Manual in Scoring Criteria: Anterior Class II Composite Preparation External Outline Form Treatment Goals Critical deficiency the following be removed from #2 the word mesiodistally. The motion approved by general consent.

- That the following editorial changes for 2015 Manual in Scoring Criteria: Class II Amalgam Preparation External Outline form under Marginally Substandard remove in #4 “The isthmus is less than 1mm” and move it to Critical Deficiency. The motion approved by general consent.

- To develop a format to allow for the use of an indirect pulp cap procedure for the 2016 restorative examination and that a small committee of the Restorative Subcommittee will develop the format. The motion approved by general consent.

- That a small committee to look at the Indirect Pulp Cap be created, Dr. Peter Yaman will Chair with Dr. Hongo, Dr. Rosenblum and Dr. Wester serving on the Committee.

**Report from the ADEX Dental Subcommittee on Scoring**

- That a Chief or Captain not be allowed to call for three new graders when one examiner has changed their vote.

- Regarding the number of subs to cause a failure and that scoring criteria should be reduced to two categories that of either PASS or FAIL, and that both need to be defined for the 2016 Examination cycle.

- That the qualifying pocket depth requirement be eliminated. Pt qualification will be based on having 12 surfaces of qualifying sub gingival calculus only.

- That if the first perio pt is not approved a second calculus distribution may be submitted with a penalty of 21 points. If a second distribution is not submitted the failure remains.

- That a pilot study be conducted to further implement (true) CIF policies/procedures to include ADEX calibrated faculty for the approval of lesions as presented by the candidate. All other aspects of the exam and candidate performance remain the same according to current ADEX guidelines. The motion passed by general consent.

- That data analysis for each exam component including an analysis of time expended. (all time(s) to be accounted for). Include all P/F results relative to time expended. This is a Psychometrician project.

Cheryl Bruce, RDH, MD moved and Dr. Mark Baird, HI seconded a motion to accept the Dental Examination Committee Report. Motion approved by general consent.
ADEX Manual focusing on content, criteria and scoring reviewed and approved.

Front cover design reviewed and draft submitted to manual committee for redesign.

New calibration slides reviewed and proposed for use by each agency. Different agencies need to supplement the ADEX calibration slides with their own.

Calibration devices for calculus detection and 11/12 explorers provided for potential use in calibration in each agency.

Change in selection of calculus to provide an improved fairness in the “playing field” recommended and approved. The Case selection consists of one full quadrant plus two posterior teeth from one other quadrant. If needed to fulfill the calculus requirements, the Case may also include two more posterior teeth from the same quadrant where the required two additional posterior teeth are located. The candidates must list 12 surfaces where they believe qualifying calculus is located. Examiners will add two more surfaces from within the selection where qualifying calculus is located. All the surfaces in the selection must be debrided and will be evaluated. As always only 12 surfaces will be evaluated for qualifying calculus removal.

Point values for different portions of the examination did not change.

Use of electronics for the NERB examinations will not occur until spring 2015. A demonstration from Brightlink was well received.

Welcome to new members and appreciation to committee members going off the committee expressed.

Special recognition to Irene Stavros, Manual Committee Chair expressed with utmost gratitude.

Ms. Cheryl Bruce, RDH, MD moved and Ms. Lynda Sabat, RDH, OH seconded a motion to accept the Dental Hygiene Examination Committee Report. Motion approved by general consent.

Treasurer Report and ADEX Budget

Dr. Robert Jolly, ADEX Treasurer reported that the current ADEX Fund Balance is $141,849.62

Dr. August Cesar Garcia-Aguirre, PR moved and Dr. Arthur McKibbin, Jr., NH seconded a motion to accept the Treasurer’s Report. Motion passed by general consent.

Business Session

Proposed Bylaws Amendments: Dr. Robert Ray, Chair of the By-Laws Committee reported on the recommended changes to the ADEX by-Laws as suggested by the ADEX Corporate Counsel.
Dr. Scott Houfek moved, seconded by Dr. Jonna Hongo, OR to approve the report of the ADEX Bylaws Committee. The motion approved by General Consent.

Nomination of ADEX Officers for 2014 – 2015: Dr Barrette passed the gavel to Dr. Shampaine, Immediate Past President to accept the nominations for the Officers of ADEX.

Dr. Mark Baird moved and Dr. Keith Clemence seconded a motion to nominate Dr. Stanwood Kanna, HI as President of ADEX for 2014- 2015 term. There were no other nominations.

Dr. Charles Zois, ME moved and Dr Katherine King seconded a motion to nominate Dr. William Pappas, NV as Vice-President of ADEX for 2014 - 2015 term. There were no other nominations.

Dr. Z. Vance Morgan, SC moved and Dr. Scott Houfek, WY seconded a motion to nominate Dr. Robert Jolly, AR as Secretary of ADEX for 2014 - 2015 term. There were no other nominations.

Dr. Jezzelle Sonnier, DC moved and Dr. Jonna Hongo, OR seconded a motion to nominate Dr. Jeffery Hartsog, MS as Treasurer of ADEX for 2014 - 2015 term.

Dr. Charles Zois, ME moved and Dr. Arthur McKibbin, NH seconded a motion to nominate Dr. Richard Dickinson, VT as Treasurer of ADEX for 2014 - 2015 term.

Nomination of Dental Hygiene Board of Directors Member

Ms. Cherly Bruce, RDH, MD moved and Dr. Charles Zois, ME, seconded a motion to nominate Ms. Mary Ann Burch of Kentucky as a Dental Hygiene Member to the ADEX Board of Directors to serve out the 2 year term due to the vacancy created by the resignation of Mr. James “Tuko” McKernan of Nevada.

For the Officer Positions and the Dental Hygiene Member for the Board of Directors that have no opposition the House of Representative approved them by acclamation.

Election of ADEX Treasurer

For the Position of Treasurer the Members of the House of Representatives were instructed to complete a ballot and to hold that ballot as it would be collected by Dr. Guy Shampaine and Mr. Patrick Braatz.

Following the collection of all of the ballots, Mr. David Hankey, Esq, ADEX General Counsel and Mr. Patrick Braatz, ADEX volunteer Administrator were instructed to count the ballots and report back to the House of Representatives the vote.

Approval of Proposed Bylaws Amendments

Dr. Scott Houfek, WY moved, seconded by Dr. Jonna Hongo, OR to approve the recommended ADEX Bylaws changes as modified. The motion approved by General Consent.

Caucuses: The House broke into District Caucuses.
### District Elections

The following are the caucus election results and include new appointees as well as re-elected representatives:

#### District 2:
- Patricia Parker, DDS, OR, District Director Term 2015 HOR
- Mary Davidson, RDH, OR, HOR RDH Rep. Term 2015 HOR
- TBD, OR, RDH Exam Committee Member, Term 2016 HOR
- Lisa Wark NV, Consumer Rep. Term 2015 HOR
- Dr. Rick Thiriot, NV, District Educator DEC Term 2016 HOR

#### District 3:
- TBD District Director, Term 2017
- TBD HOR RDH Rep., Term 2017
- TBD HOR Consumer Rep., Term 2017
- TBD Educator, DEC, Term 2017

#### District 4:
- Dr. Keith Clemence, WI, District Director Term Expires 2015 HOR
- Nan Kosydar Dreves, RDH, MBA, HOR RDH Rep. Term Expires 2015 HOR
- Beth Clemence, RDHEC Member, Term 2015 HOR
- Judy Ficks, RDH, HOR Consumer Member, Term Expires 2015 HOR
- Dr. Leo Huck, District Educator DEC, Term 2016 HOR

#### District 5:
- Dr. Dennis Manning IL, District Director Term 2016 HOR
- Lynda Sabat, RDH, OH, HOR RDH Rep., Term 2015 HOR
- Laverne Whitmore, RDH, PA RDHEC Member, Term 2016 HOR
- Ms. Clance LaTurner, IN, HOR Consumer Rep. Term 2015 HOR
- Dr. Peter Yaman, MI, Educator DEC, Term 2017 HOR

#### District 6:
- Dr. Michelle Bedell, SC, District Director, Term 2017 HOR
- Sherie Williams Barbare, RDH, SC, HOR RDH Rep., Term 2015 HOR
- Mary Ann Burch, RDH, KY, RDHEC Member, Term 2016 HOR
- Bettye Richert, TN, HOR Consumer Rep., Term 2015 HOR
- Dr. Rick Archer, VA, Educator DEC Member, Term 2016 HOR

#### District 7:
- Dr. John Reitz, PA, District Director, Term 2015 HOR
- Mariellen Brickley-Raab, RDH HOR Rep., Term 2015 HOR
- Cheryl Bruce, RDH, MD, RDHEC Member, Term 2017 HOR
- To Be Determined, HOR Consumer Rep., Term 2015 HOR
- TBD Educator DEC, Term 2017 HOR

#### District 8:
- Dr. David Perkins, CT District Director, Term 2016 HOR
- Sibyl Gant, RDH, DC, RDH HOR Rep., Term 2015 HOR
- Lynn Martell, CT, RDHEC Member, Term 2016 HOR
- TBD HOR Consumer Rep.
- Dr. R.L. MacNeil, DDS CT, Educator DEC, Term 2017 HOR

#### District 9:
- Dr. Arthur Andy McKibbin, NH, District Director, Term 2016 HOR
- Shirley Birenz, RDH, NJ, RDH HOR Rep., Term 2015 HOR
- Susan Perlini, RDH, RI, RDHEC Member, Term 2015 HOR
- Ms. Lynn Joslyn, NH HOR Consumer Rep., Term 2015 HOR
- Dr. Marc Rosenblum, NJ, Educator DEC, Term 2017 HOR

#### District 10:
- Dr. Richard Dickinson, VT, Term 2017 HOR
Karen Dunn, RDH, MA, HOR RDH Rep., Term 2014 HOR
Carol Williams, RDH, ME, RDHEC Member, Term 2017 HOR
Diane Denk, ME, HOR Consumer Rep., Term 2015 HOR
Dr. Steven DuLong, MA, Educator, DEC, Term 2016 HOR

District 11:  Dr. Jeffery Hartsog, MS, District Director, Term 2015 HOR
Carla Stack, RDH, NC, HOR RDH Rep., Term 2015 HOR
Janet Brice McMurphy, RDH, MS, RDHEC Member, Term 2015 HOR
Jim Hemby, NC, HOR Consumer Rep., Term 2015 HOR
Dr. Scott Phillips, MS Educator DEC, Term 2015 HOR

District 12:  Dr. Wade Winker, FL, District Director, Term 2017 HOR
Irene Stavros, RDH, FL, HOR RDH Rep., Term 2015 HOR
Catherine Cabanzon, RDH, FL, RDHEC Member, Term 2017 HOR
Vicki Campbell, FL, HOR Consumer Rep., Term 2015 HOR
Dr. Robert Perdomo, FL, Educator DEC, Term 2016 HOR

District 13:  TBD District Director, Term 2017
TBD HOR RDH Rep., Term 2017
TBD HOR Consumer Rep., Term 2017
TBD Educator, DEC, Term 2017

Election of ADEX Treasurer

Mr. Patrick Braatz, ADEX volunteer Administrator reported that there were 46 ballots cast out of 49 eligible votes and the Dr. Jeffery Hartsog, MS received the highest number of voted and would be the ADEX Treasurer for 2014 - 2015.

Approval of 2015 Dental Examination:

Dr. Charles Holt, Jr., TN moved and Ms. Clance LaTurner, IN seconded a motion to approve the dental examination as recommended by the Board of Directors. The motion passed by general consent.

Approval of 2015 Dental Hygiene Examination:

Ms. Cheryl Bruce, RDH, MD moved and Ms. Irene Stavros, FL seconded a motion to approve the dental hygiene examination as recommended by the Board of Directors. Motion passed by general consent.

Dr. Augusto Cesar Garcia-Aguirre, PR, Moved and Dr. Dennis Manning, IL a motion to have the Board of Directors and the ADEX Bylaws Committee look at the configuration of the ADEX Districts since many thing have changed since those ADEX District were first created. The motion passed by general consent.

Future Meeting Dates

The 11th ADEX House of Representatives Meeting will be held November 15, 2015 at the Doubletree Hotel O’Hare/Rosemont, IL

Dr. Jonna Hongo OR moved, and Ms. Nan Kosydar Dreves, WI seconded a motion to set the tentative date of November 15, 2015 as the 11th Annual Meeting of the ADEX House of Representatives and that the Board of Directors is empowered to select other dates if that date is not workable. Motion passed by general consent.
Adjournment: Dr. Arthur McKibbin, NH moved and Dr. Augusto Cesar Garcia-Aguirre, PR, seconded a motion for adjournment. The motion passed by general consent. The meeting was adjourned at 11:55 a.m. CDT

Proc. 10th H of R 11.09.14(1)